South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

23 February 2017

10:00-13:00

Ashford 111 Centre,
Moat Way, Willesborough,
Ashford, Kent, TN24 0TL

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
181/16	10.00	Chairman's introduction	-	-	GC
182/16	10.01	Apologies for absence	-	-	GC
183/16	10.02	Declarations of interest	-	-	GC
184/16	10.03	Minutes of the previous meeting: January 2016	**Y**	Decision	GC
185/16	10.05	Matters arising (Action log)	**Y**	Decision	GC
Organisational culture					
186/16	10.10	Patient story	-	Set the tone	
187/16	10.15	Chief Executive's report	**Y**	Information	GD
Trust strategy					
188/16	10.30	Unified Recovery Plan Update) Quality) Recovery) Finance	**Y**	Assurance	JA EW JA DH
189/16	10.50	CQC Action Plan Update & Exception Report	**Y**	Assurance	EW
190/16	11.20	Handover Delays Update	**Y**	Information	JA
Allocating resources to achieve plans					
191/16	11.30	Financial Recovery Plan	**N**	Assurance	DH
192/16	11.45	2017/18 Contract Update	**Y**	Information	JA
Ten minute Break					
Monitoring performance					
193/16	12.00	Integrated performance report	**Y**	Assurance	DH

Holding to account					
194/16	12.15	Medicines Management	**Y**	Information	EW
195/16	12.30	Any other business	**-**		GC
196/16	-	Review of meeting effectiveness	**-**		ALL
Close of meeting					

Date of next Board meeting: 28 March 2017 – Tangmere MRC

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 26 January 2017,

Tangmere MRC
Minutes of the meeting, which was held in public.

Present:

Sir Peter Dixon	(PD)	Chairman
Graham Colbert	(GC)	Independent Non-Executive Director & Deputy Chair
Alan Rymer	(AR)	Independent Non-Executive Director
Richard Webber	(RW)	Acting Executive Paramedic Director
David Hammond	(DH)	Executive Director of Finance & Corporate Services
Emma Wadey	(EW)	Acting Executive Director of Quality and Patient Safety
Joe Garcia	(JG)	Interim Executive Director of Operations
Jon Amos	(JA)	Acting Executive Director of Strategy & Business Development
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

159/16 Chairman's introductions

PD welcomed to the meeting board members, those in attendance, and the staff, governors and members of the public observing. He reminded all present of our aim to hold all future board meetings at Trust venues, because it is the right thing to do and because it will save on the expense of external venues.

PD introduced Daren Mochrie, the Trust's new Chief Executive who starts on 1 April 2017, who was observing the meeting.

PD thanked TW for whom this will be his last board meeting. TW has been with the Trust for over six years and has in that time provided great assistance to the Board, most recently as Audit Committee Chair.

PD then confirmed that Katrina Herrin, Independent Non-Executive Director had stepped down for personal reasons. The recruitment process to replace Katrina is being considered by the Council of Governors.

PD also thanked Rory McCrea for his efforts, following his resignation, also for personal reasons. The Trust had appointed Dr. Carson to cover while more permanent arrangements could be made, but sadly he very recently became too unwell to continue and so steps are being taken to ensure cover is in place, as quickly as possible.

Finally, PD referred to the quality of some of the papers before the Board of Directors being not as good as they should be, but acknowledged this was in part a consequence of the significant pressure the Trust is currently facing.

160/16 Apologies for absence

The following apologies were noted;

Geraint Davies	(GD)	Acting Chief Executive
Terry Parkin	(TP)	Independent Non-Executive Director
Lucy Bloem	(LB)	Independent Non-Executive Director

161/16 Declarations of conflicts of interest

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

162/16 Minutes of the meeting held in public on 24 November 2016

Subject to an incorrect initial on page 7 (DG instead of DH) The minutes were approved as a true and accurate record.

163/16 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.

PD asked why the item on STP is in Part 2. There was a discussion about some these conversations in the past needing to be taken in private until issues had been agreed, but now they are in the public domain future items would be taken in public.

164/16 Patient story 10.17

This story related to positive feedback from a Hospice about its experience of SECamb. The crew used as the example had provided excellent care and, in particular, showed compassion. They took flowers to family subsequently to express condolences as the patient has died soon after their admission to hospital. The Hospice felt that such compassions accorded well with its own values.

PD felt that at a time when things are difficult it is helpful to be reminded of the really good service we provide, and not solely focus on when things go wrong. On behalf of the Board PD congratulated the crew involved.

EW added that this is just one of many stories of positive feedback, which actually far outweighs in numbers the complaints we receive. This story also highlights the Trust's vital role in the end of life care pathway.

165/16 Chief Executive's report.

In GD's absence DH highlighted the following;

- Following a robust procurement process, the Trust secured Cleric Computer Services to as our new CAD provider.
- The operations restructure is moving at pace.
- The winter period was a challenging time for the Trust and the whole NHS. There were particular issues relating to out of hours' services, plus huge hospital handover delays. In December alone 7700 hours were lost and this is a national problem. JG confirmed that these lost hours were based on excess of 45 minute delays and because the policy indicates 15 minutes this is an even bigger issue. There was a system-wide meeting recently but while this raised the awareness, which is good, it is action we need.

- Commissioning negotiations went well, and the discussions helped to acknowledge the funding gap. Work is underway between now and March to identify the size of the gap and how it will be closed to ensure the Trust is funded to appropriate level to ensure it is able to provide safe and effective services.
- The money continues to be a focus, and we are still forecasting £7.1m deficit, which is clearly not ideal but does represent the cost of recovery. A number of actions have been taken to ensure good financial control with many of the ideas coming from staff to help us improve efficiency. This has helped us make good progress to reduce the underlying deficit.
- NAO report was published on 26.01.17. We welcome this report, which highlights the challenges ambulance trusts face.

TW referred back to the contract negotiations and reinforced the need for the Trust to recognise what it needs to do to improve efficiencies. In other words, the gap isn't just a gap in funding, but also about the way we operate. DH agreed, and explained the negotiations recognised the net gap, after the work the Trust needs to do which forms part of the cost improvement planning.

JA added that we talked at the Board before about a £40m gap. The gap we are now referring to £26m accounts for the £14m that we acknowledge is within our control.

GC noted that while we have agreed to work with CCGs on the PID, this needs to happen, because until then we don't have a sensible settlement. DH agreed and confirmed that in the next two months we will be clear with the Board on where we get to and if we don't get a reasonable outcome then we will need to decide as Board how we take this forward. DH reminded the Board that if we don't reach agreement then the contract precedent results in the contract not coming in to force from 1 April 2017.

166/16 HQ Update

PD had expected the HQ move would happen first, before EOC, and asked why it is the other way round. DH explained this is by design due to the risks being with the creation of the EOC and so allowing more time for additional testing.

GC asked about the extent to which staff know when they are moving. SG confirmed this will be clear by the end of February as per the consultation plan.

167/16 BAF

PL introduced the paper and explained the thinking behind the arrangement of these strategic risks, which he acknowledged deliberately does not align to the annual objectives as per the norm in much of the NHS.

TW firstly noted that it was good to have a BAF after some considerable time, and liked the fact that it doesn't align in the traditional way as it provides a sharper focus.

There was a discussion about how it might be improved further and, where possible, to avoid overlap between risks. On the area relating to Fundamental Standards there was a view that this might be too broad and perhaps it could be sub-divided. There was also a challenge from the NEDs about the scoring being a little favourable, but the Board agreed that the relevant assurance committees can test this going forward.

TH explored the different aspects of the BAF and there was some agreement that although one executive director is listed as the lead, the risk touches on other responsibilities. PD felt that while this isn't the finished article it gives a direction of travel and through the Board's committees it can be taken forward.

In the context of the discussion about linking the BAF to the risk register, EW described the work currently ongoing with Datix and felt that we should be in a much better place with this from April. EW acknowledged the frustration of the Board but reinforced the need to get it right, given the long-standing weakness with the risk register.

Action:
BAF to be reviewed again at the next Audit Committee

168/16 Risk Management Strategy & Policy

PD asked why risk management sits with the Chief Nurse, reminding the Board that we agreed in summer this would overburden the portfolio. PD suggested that while clinical risk might well properly sit with the Chair Nurse, corporate risks, including finance, should sit with another executive, possibly the Finance Director or as in some other Trusts, a Deputy Chief Executive.

DH confirmed that this isn't for decision today, as there is still a bit of work to do. On the point raised by PD, DH explained that we are currently still in consultation and once this is concluded we will take the opportunity to review portfolios.

TW asked that we ensure consistent terminology, but subject to this he felt this was the right way forward.

AR asked whether this complies with latest NHS guidance and EW confirmed that it does.

PD reinforced the need to ensure that the Audit Committee, the purpose of which is also to assure itself relating to risk, has overall responsibility for ensuring risks are properly managed.

Action:
Risk Strategy & Policy to be received by the Audit Committee in March and then to Board for decision.

169/16 Financial Recovery Plan

DH confirmed that we are reporting the same deficit forecast as at Q1. This remains a challenge, but is deliverable, as set out in the paper.

In terms of the immediate actions, DH explained this doesn't really do anything new, other than try to ensure better control and grip. The aim of the weekly finance newsletter is to reinforce the need to use resources efficiently and there have been lots of good ideas generated, which is positive.

DH confirmed that the plans for 2017/18 are underway and EW assured the Board that quality impact assessments are being undertaken; the Deputy Chief Nurse sits on the Financial Sustainability Steering Group. PL added that the Quality & Patient Safety Committee in March is testing the effectiveness of the QIA process in relation to CIPs.

AR asked about investments and DH explained that we have a 2017-19 capital plan approved by the board. There may be some movement with this, to take account of changing priorities, but this is the framework. Changes will be made in accordance with the SFIs.

TH asked about the continuity of services rating for NHSI (4). DH explained the triggers which for us is the gap from the original plan and use of agency staff.

170/16 HART

PD felt that this isn't a good piece of work as the benefits and risks don't align.

DH confirmed that HART was funded nationally 6 years ago, and since then we have written off over the life of the asset(s) with a plan to replace them when needed. The cost is £1.6m as set out in the business case. Due to time constraints to lay off the orders, we now need to make the decision. This is a must do to ensure national interoperability. We have agreed to move to the end of process so the spend will be in 2017/18.

DH confirmed that the business case is misguided in terms of financial appraisal, as we will make this decision at the time. So all we are asking today is for the Board to approve the overall expenditure.

GC asked about what flexibility we have and whether we have checked we have the right number and mix of vehicles. DH confirmed that we have; this has been tested and confirmed. We are on the national specification and the must haves are as directed nationally. The suppliers and prices are nationally approved.

TH asked whether the £1.6m was in original capital plan. DH confirmed that it was

Resolution:
The Board approved the £1.6M capital expenditure for HART

Comfort break

171/16 CQC Improvement Plan

EW introduced the paper confirming that this is the monthly update against the 16 'must do' actions. She highlighted two key issues; there are more areas of red and an increased number of actions. EW explained this is considered to be positive as it demonstrates the greater level of scrutiny, by us identifying areas in addition to those specifically identified by CQC. Our new governance structure provides for the Steering Groups to test the actions and how they relate to outcomes. There has been much progress with 100+ actions completed, but there are some areas where the action plan isn't robust enough to remedy the underlying issues. The areas at risk are set out in the exception reports. PD agreed the need to be a bit cautious about progress.

AR noted his comfort by the executive scrutiny, and asked how the CQC's assessment aligns with the executive, in terms of progress. EW explained that the CQC don't give very much feedback about progress; they will test this when they return to re-inspect services. Our internal scrutiny is therefore key.

AR asked about the exception report on staff capacity, which focusses on the structural gap, rather than what we are doing on recruitment. JG explained that this is about whether we will establish staff numbers to deliver the statutory target; the answer is we won't. So it has to remain red, despite the work we are doing on funded establishment and the work we have done to reduce vacancies.

DH commented that there is a danger that we interpret CQC findings too literally. This is just one element of the URP and we are looking currently through the PMO to ensure it is truly unified.

PD comforted that we are now looking at things CQC did not find.

EW added that we are reviewing the evidence of completed actions/programmes and where appropriate moving these in to business as usual. We need to do this in way where the system of internal control continues the monitoring to ensure consistent improvement and early identification of issues and risks.

TW asked about the evidence and business as usual, and how we ensure local management works effectively. EW referred to the quality reviews (mock inspections), building on the existing OU score card, and the self- assessment against the fundamental standards.

JG added that with the operations restructure it is imperative we get it right as it is predicated on people leading people. We have provided protected time (50%) to ensure effective management and leadership.

172/16 Integrated Performance Report

Workforce:
SG explained we are working to ensure better data / metrics to ensure the right balance for the Board. This will include more targets so the Board is better sighted on progress. The issues to highlight include; the vacancy rate being within the 10% target; workforce plans being developed; and sickness remaining constant. The sickness metrics is a concern (as we wouldn't expect it to be static indicating potential issues with the data) and so we have asked Internal Audit to take a look. We are expecting statutory and mandatory training to be on target by the end of the year.

Performance:
JG explained that we had higher than anticipated activity. Red 2, in particular, was significantly above prediction. 8080 hours were lost through hospital handover delays. But for this, we would have met the revised trajectories. Call answering improved significantly. Much focus has been given to help reduce call cycle times. The tail is improving by 8 minutes. In summary, we are getting back to normal after a difficult period.

GC asked whether we will miss the revised trajectory for January. JG confirmed we would do for Red 2 and Red 19; but Red 1 we should meet. In terms of February JG expects us to back on trajectory.

TH asked about the tail noting that we don't really give this much focus. JG agreed that the focus is more on the front end than the tail end and explained that when looking at the 99th percentile, for Green 2 we at an average of six hours during the worst period over Christmas. This has now improved to two hours, but the concern is in getting the balance between hitting targets and ensuring a safe service.

EW confirmed that the Quality and Patient Safety Committee will be scrutinising the tail as will the executive risk and assurance group.

Clinical Effectiveness:
RW confirmed that for stroke within 60 minutes we are second nationally. Heart attack conveyance is also good. STEMI however is in the lower quartile for the Stroke Care Bundle, although the difference in terms of numbers is relatively small.

TW suggested that we could make a positive difference on survival to discharge by deciding which hospitals to take patients to. We know the outcomes of some units are better than others. He urged some work to look at this to ensure a protocol which supports conveyance to the right units. RW agreed that this would be a good idea, but it needs system agreement. JA explained that our clinical strategy is looking at patient segmentation and with STPS asking for input for a cardiac arrest strategy, the STP will have a role in this, to help where patients are taken.

Quality & Safety:
EW also noted the work on reviewing the data. On Duty of Candor this isn't about us not following guidance but how we record compliance. Incident reporting is increasing which is positive. SI investigation timeliness is still poor. Complaint response timeliness is also poor, despite being markedly improved than this time last year. EW confirmed that everyone who complains receives a call from the patient experience team to agree how they want their concerns taken forward.

The Board asked about safeguarding training and EW confirmed that performance against the agreed trajectories will be included next month.

Action:
Compliance with trajectory for safeguarding training to be included in the IPR from February

173/16 Risk Register
Item deferred.

174/16 QPS Escalation report
Paper taken as read. No questions as the main concern relates to the next item on medicines management.

175/16 Medicines Management
PD explained that we are finding new issues, which in some ways shows our system of internal control is working. But we need assurance as a board that we have the resource and the processes to ensure we fix this problem urgently.

DH confirmed that the paper sets out the key issues. In terms of action we have taken, we have been working with our Improvement Director and engaged the Chief Pharmacist at NHSi to review and diagnose the medicines management function. Clearly, there is much still to do. Some immediate actions have been taken as set out in paper. The executive is considering progress next week, in the context of AC falling ill.

EW reinforced the immediate actions taken to protect patients and staff.

AR acknowledged that leadership is all important, but some things like locks etc. don't require much clinical leadership. TW agreed, and noted that this is another area where local management is varied regarding compliance. PD agreed and this goes to the change in culture needed and the approach to doing the right things.

EW noted that while there are many concerns, there is also some really good practice, e.g. where we have omnicells. Until this is widespread we need to ensure practice is consistently good.

TW asked about the Aspirin issue and its suspension. RW explained aspirin is still given routinely. This is about IV Aspirin used by only a small number of CCPs. We are the only ambulance trust using it and we are seeking external advice about how to take this forward.

176/16 Audit Committee
Having already covered BAF and risk management earlier on the agenda, TW confirmed that we have general issues with systems of internal control as evidenced by more amber/red internal audit reports than before. When we come to the head of internal audit opinion we may drop down the scale, so we need to focus on ensuring staff know their responsibilities.

There was a discussion about the higher level of assurance provided before by internal audits being misplaced, given the issues we now know existed and, therefore, the limited assurance now being a more accurate indication of where we actually are.

DH agreed, but noted that the work of internal audit is over the course of 12 months and so reflects where we have been rather than necessarily where we are. So in the next 12 months we should see assurance improve if indeed our systems of internal control are improving.

AR commented that he has a sense from discussions today that we have more grip on a range of issues than before. This should mean we are less reliant on internal audit to find things and therefore fewer surprises.

177/16 Workforce & Wellbeing Committee Escalation report

AR confirmed that the committee received assurances on meal breaks and shift overruns. Weaknesses in the report are being considered by the executive. AR added that our operating plan to NSHI was not based on a detailed workforce plan so is more speculative. DH agreed; it is based on where we are now. We need to look at recruitment / skill mix in the round as JA added that once we have agreed strategy we need an annual business planning cycle to take account of all the various elements.

178/16 Finance & Investment Committee Escalation report

GC set out the issues considered by this Committee as outlined in the paper

179/16 Any other business

None

180/16 Review of meeting effectiveness

PD asked if members felt the meeting was effective. The Board was broadly content; a sense that it feels more business-like than in the past, which is positive.

In closing, PD thanked TW again for his contributions during his time at the Trust and asked for any final reflections. TW reflected that the last 18-24 months have been very difficult times, and on the leadership challenges which he felt we should all take responsibility for. Final thought is that we are all here for patients, regardless of our backgrounds and roles.

On behalf of CoG, Brian Rockwell, Lead Governor, who was observing the meeting, thanked TW for his work over the years and his candor with governors.

Questions from observers

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1. **Is the Board is confident that the Trust's formal Grievance procedure is working in an optimal way?**
   PD asked SG to look at these concerns, and stated that the Board is not yet confident the Trust's formal processes work well, not just grievance, as evidenced by discussions today. TH will scrutinize this at the Workforce and Wellbeing Committee

2. "**Does the Board plan to ensure that all of SECamb's 66 Ambulance Community Response Posts will be visible to the public, i.e. have some form of signage, and - if so - when will the Billingshurst ACRP feature in the programme**."
   DH confirmed that there are no plans but where appropriate we will ensure appropriate signage. Locations of each site are on the website.

There being no further business, the meeting closed at 13.01pm

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
27.10.2016	127/16	to report back to the January Board on plans to resolve call taker audits.	Joe Garcia	January	Board	C	**Verbal Update to be provided 26.01.2017: J**G explained that the number of audits is currently not sufficinet and so steps are being taken to increase capacity to ensure more audits as part of the 111 team.
27.10.2016	132/16	The output from the M&M Group to be monitored via the quality and patient safety committee	Peter Lee	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	C	**Update 26.01.17**: EW explained that details of all SIs will form part of the quality report to QPS which will include a summary of the incidents and benchmarking date. A thematic analysis will then come to Board, at least annually.
27.10.2016	134/16	Paper on 111 to come to the Board after consideration by the Executive	David Hammond	Q4	Board	IP	**Update 26.01.17**: DH explained this will be picked up as part of the strategy review and conversations with commissioners, before coming to the Board in March
24.11.2016	144/16	Update on the progress with Handover delays to the Board in February	Geraint Davies	23.02.17	Board	C	On agenda
24.11.2016	146/16	The Board to receive an overview of the progress against the URP	Geraint Davies	23.02.17	Board	C	On agenda
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	C	**Update to be provided 26.01.17** JG explained that at the last board meeting we confirmed around 50% identification of Red 1 calls. As of end of Jnuary we are consistently achieving 60% and since 24.01.17 75%. GC asked how 75% compares nationally. JG confirmed SCAS are at 85% but they have added additional questions. TW asked whether the new CAD will allow for us to ask additional questions too; JG confirmed it would. PD summarised that good progress is being made but we need to keep it up.
26.01.2017	167/16	BAF to be considered by the Audit Committee in March	PL	01.03.2017	Board	C	**On agenda**
26.01.2017	168/16	Risk Strategy & Policy to be received by the Audit Committee in March and then to Board for decision	PL	28.03.2017	Board	IP	**On agenda for Audit Committee**
26.01.2017	172/16	Compliance with trajectory for safeguarding training to be included in the IPR from February	EW	23.02.2017	Board	C	**Included in IPR**

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	187

Name of meeting	Trust Board
Date	23.02.2017
Name of paper	Chief Executive's Report
Executive sponsor	Acting Chief Executive
Author name and role	Geraint Davies, Acting Chief Executive
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.

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

February 2017

1. Introduction

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 Changes at Director/Senior Management level

2.1.1 Further to previous Board updates, Dr Andy Carson was unfortunately unable to remain with the Trust as Interim Medical Director, due to unexpected health issues. In liaison with our regulator NHS Improvement and the CQC, we are currently in the process of finalising the appointment of an Interim Medical Director to start shortly.

2.1.2 The Trust has recently appointed a new Independent Non-Executive Director. Dr Angela Smith, from Brighton, will initially serve a three-year term running until February 2020, and replaces Trevor Willington whose final term of office ended at the end of January. Dr Smith started with the Trust on 1 February 2017 and is the Chair of the Audit Committee.

2.1.3. The recruitment and selection process for a substantive Chairman for the Trust is continuing, with interviews taking place on 21 February 2017.

2.2 Care Quality Commission (CQC) inspection

2.2.1 The Trust has now received confirmation that the CQC will be re-inspecting the Trust between 15 & 18 May 2017. Requests for information in preparation for this inspection are already coming into the organisation.

2.2.2 The Trust is continuing to deliver the CQC action plan as part of the Trust's broader Recovery Plan, focussing on the 'must dos' and 'should dos' identified by the CQC during their inspection in May 2016.

2.3 Medicines Management

2.3.1 As part of the Recovery Plan, the Trust is currently conducting a detailed review of its management of medicines, including a review of the type of drugs used by practitioners. The paper on medicines management later in the agenda describes more about this.

2.4 Work with Professor Duncan Lewis

2.4.1 I am pleased that a project to help support the steps we have already taken to tackle bullying and harassment issues within the Trust is now underway. This is led by Professor Duncan Lewis from the University of Plymouth who is a recognised expert in this field.

2.4.2 Professor Lewis has been asked to undertake a diagnostic review process through the use of a survey tool and mixed staff focus groups and then to produce a report helping to focus on the principal issues.

2.4.2 We are grateful to Health Education Kent, Surrey & Sussex for funding this important piece of work.

2.5 National media coverage

2.5.1 Following the leaking of a number of internal confidential reports to the national media, the Trust has been the focus of significant negative national and regional media coverage during February.

2.5.2 The media coverage focussed on a range of historic allegations covering a number of issues, which were investigated and dealt with at the time.

2.5.3 Although we cannot be sure where this leak originated, my message to staff about this expressed disappointment that such sensitive information was provided to the press, despite the steps we have taken to provide for staff to raise concerns internally, including anonymously. I think it is important to emphasise that this message was not in any way intended to restrict staff from speaking up, quite the opposite, my intention was to highlight the most effective ways in which this can be done.

2.6 Engagement with NHS Improvement

2.6.1 As part of the Trust's ongoing recovery, members of the executive team met with the CQC at the end of January and with NHS Improvement and key stakeholders on the 14 February, to discuss progress and risks associated with the recovery plan.

3. Regional Issues

3.1 Contract negotiations

3.1.1 Work continues jointly with commissioners to address the structural gap identified in funding, with an independent review planned to occur in March to fully assess the gap and make recommendations to address it.

3.2 Financial position

3.2.1 The Trust continues to report a forecast outturn at 31 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 Good progress is being made on the implementation of a number of immediate financial measures including significant reductions in the Trust's use of agency staff. I would like to take this opportunity to thank staff for their efforts in ensuring efficient use of resources and for the number of ideas they have put forward to ensure we are as efficient as we can be.

3.3 Sustainable Transformation Plans (STPs)

3.3.1 Meetings have recently been held with the leadership of the Kent and Medway and Surrey Heartlands STPs to ensure alignment between the Trust Strategy Review and the work of the STPs

4. National Issues

4.1 Association of Ambulance Chief Executive (AACE) Awards 2017

4.1.1 On 7 February 2017, I was very proud to be present at the Association of Ambulance Chief Executives' Outstanding Achievement Awards to witness Kimberley Alexander receive her award in the tutor and educator category.

4.1.2 Kimberley, who is based at Leatherhead, was nominated by the Trust for 'her enthusiasm, experience and empathy for the student' which we felt made her an excellent candidate for this prestigious award.

5. Recommendation

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

Geraint Davies, Acting Chief Executive

16 February 2017

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	188/16

Name of meeting	Trust Board
Date	23 February 2017
Name of paper	Unified Recovery Plan Delivery Progress
Responsible Executive	Jon Amos, Acting Director of Strategy and Business Development
Author	Ellie Wilkes, Interim Head of PMO
Synopsis	This paper provides a summary of the progress made in relation to the improvements being made in the Programme Management Office (PMO) and describes the recently implemented governance structure to oversee programme delivery of the URP. A summary of the current state of work being led by each of the three Steering Groups; Organisational Recovery, Financial Sustainability and Quality, which form the Unified Recovery Plan (URP) is provided through three separate dashboards and risk registers.
Recommendations, decisions or actions sought	What is the board / committee being asked to consider and/or decide?) To note the progress made in relation to the PMO improvements) To note the revised governance structure

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**

Unified Recovery Plan Delivery Progress

1. Introduction

1.1. This paper provides the Board with a summary of the progress made in relation to improving the Programme Management Office (PMO) and describes the recently implemented Governance structure to oversee Programme delivery.

1.2. The purpose of the paper is to provide assurance of the governance structures being implemented and future developments with regard to integrated reporting.

2. Changes to the PMO and Governance Structures

2.1. There are a series of improvements being introduced to the PMO to improve its functionality and drive progress. Additional capability and capacity is being provided by EY over a three month period. EY developed a work plan following a two week assessment of the current state of the PMO function and delivery of this is being tracked formally through a monthly gateway meeting.

2.2. The work plan focuses on improving overall governance and reporting, introducing and embedding standardised systems and processes, upskilling the PMO team, and developing an integrated dashboard reporting structure.

2.3. There is a new governance structure in place to run the URP with three recently formed Steering Groups, each chaired by a Director, to oversee delivery of the Programme. The Steering Groups, in turn, report into the Turnaround Executive which will be attended by all of the Directors.

2.4. Appendix A illustrates how this new structure operates. Guidance outlining the key roles and responsibilities within the Programme governance has been circulated for comment, with the aim for it to be introduced in the coming week.

2.5. There will continue to be other systems and processes introduced to the PMO. Alongside these, the focus will be to embed the new governance structure and ensure steering group chairs (and Executive Sponsors) are driving delivery and holding responsible officers to account. The Turnaround Executive is a key meeting where the steering group chairs and wider Executive Management team will share progress, discuss and manage risk, and review escalation points from the Steering Groups.

2.6. Appendix B illustrates the proposed information flow through the organisation and to key external stakeholders. This is based on maintaining one source tracker (database), updated on a weekly basis through project highlight reports, which will then produce dashboards to monitor and track progress and risk. Dashboards will be supported by summary exception reports to highlight key risks and provide

assurances on mitigation. The benefit will be to have 'one version of the truth' flowed from projects up through to the Board. There still needs to be discussion with the chairs of the Quality, Finance and Audit Committees as to requirements and frequency of reporting in relation to the Programme.

3. URP Progress and Risks

3.1. As part of the PMO improvements to date, each Steering Group now has an accurate and up to date Dashboard and active Risk Log. The move to integrated highlight reporting, consistent across the three Groups, is underway but not yet complete. Therefore the update to the Board this month on overall URP progress is provided as three separate reports.

3.2. Going forward, the intention is to provide a Programme Dashboard, Programme Risk Register and Summary Exception Report covering the entire programme. This will first be reviewed through the Risk and Assurance Executive Group and then presented to the Board for review and discussion.

3.3. There will be the opportunity to provide comment on functionality and content allowing further development of the integrated dashboard reporting function.

4. Summary

4.1. This paper has provided the Trust Board with the proposed governance structure and supporting information flows for the URP Programme. Successful implementation will require support from the organisation to fully embed.

4.2. The Board has been provided with a suite of dashboards to provide a status update of the Programme across the three Steering Groups with supporting narrative to expand upon risk areas.

4.3. Moving forward the Board will receive an integrated Programme Dashboard, Risk Register and Summary Exception Report to ensure full sightedness of progress made and the key risks to delivery.

5. Recommendation

5.1. The Board is asked to note the paper and discuss the appendices with specific attention to the governance structure

5.2. The Board is asked to support the further development of an Integrated Programme Reporting Structure

Appendix A

South East Coast Ambulance Service NHS
NHS Foundation Trust

Overall Governance Structure

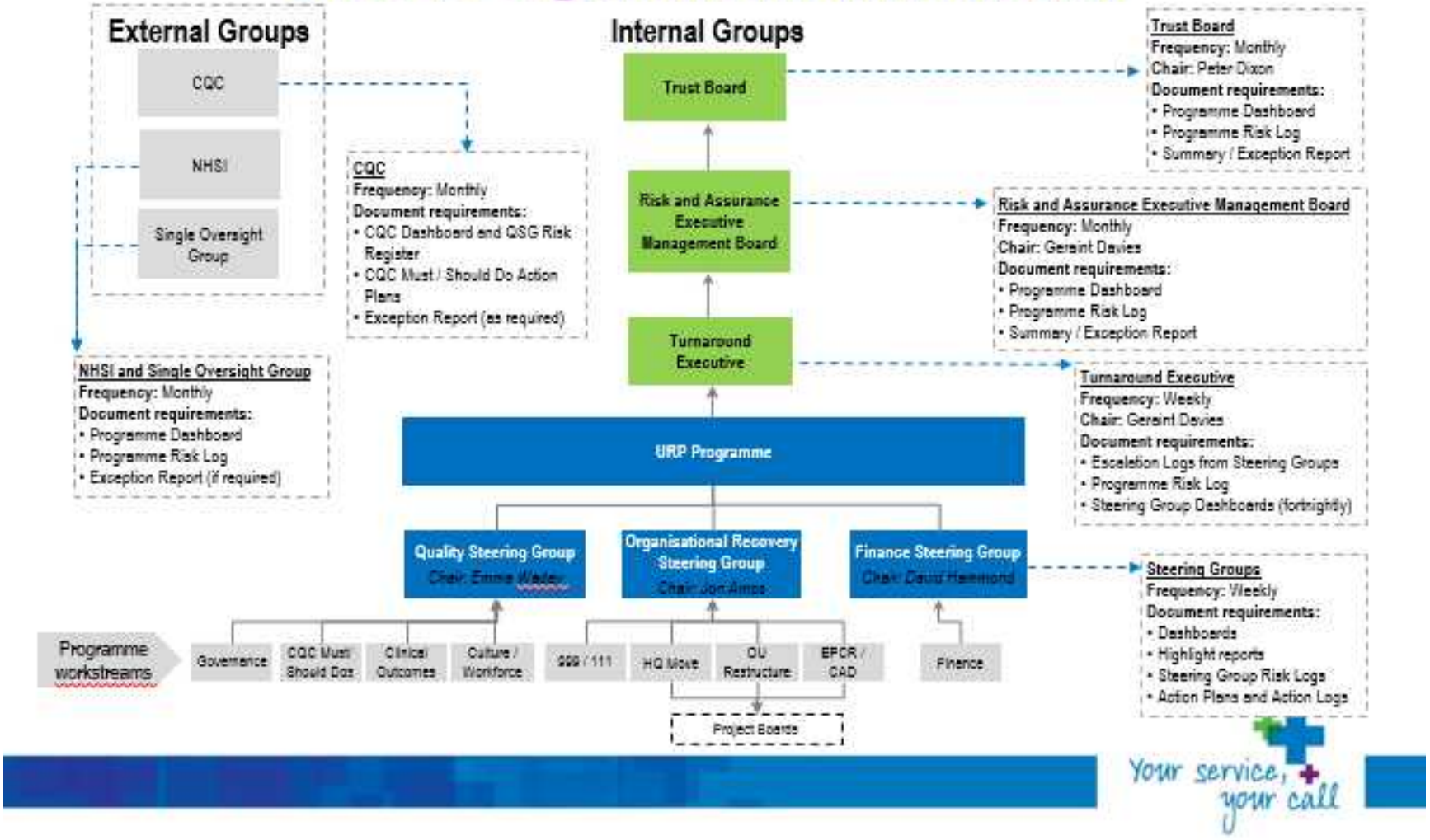
Your service, your call

DRAFT

Appendix B

South East Coast Ambulance Service NHS
NHS Foundation Trust

DRAFT Programme Information Flow



Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	188/16

Name of meeting	Trust Board
Date	23rd February 2017
Name of paper	Unified Recovery Plan – Recovery Work Programme Update
Responsible Executive	Jon Amos, Acting Director of Strategy and Business Development
Author	Jon Amos, Acting Director of Strategy and Business Development
Synopsis	This paper provides a high level summary of progress and risks in relation to the recovery work programme.
Recommendations, decisions or actions sought	▪ To note the progress made in relation to the recovery work programme ▪ To review the risks associated with the recovery work programme

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

Unified Recovery Plan – Recovery Work Programme Update

1. Introduction

1.1. This paper provides the Board with a summary of the progress made in relation to the work overseen by the new recovery steering group. It highlights progress and risks to delivery for individual projects which are red RAG rated.

2. Recovery Steering Group

2.1. The recovery steering group meets weekly and is chaired by the Executive Director of Strategy and Business Development. It reviews escalations from the programme manager, projects and workstreams where there are risks or scope creep and programme actions and risks. It also reviews any projects or workstreams submitted for closure to ensure appropriate transition of any residual actions to business as usual functions and seeks assurance that benefits have been realised.

2.2. To date this has helped clarify scope, benefits and risks for a number of project areas, ensuring SROs, project managers and workstream leads are held to account and also ensuring that project managers have support in escalating concerns. Weekly escalation then occurs to the Turnaround Executive, chaired by the CEO, for any issues which cannot be managed within the programme.

2.3. Details are included below of the current status of projects and workstreams and red risks are included for review by the board

3. Recommendation

3.1. The Board is asked to note the progress and review the risks

Unified Recovery Plan ("URP") Dashboard

Extract from Improvement Tracker

South East Coast Ambulance Service NHS
NHS Foundation Trust

Current period of reporting	*07/02/2017*	*to*	*15/02/2017*
Previous period of reporting	*31/01/2017*	*to*	*07/02/2017*
Last updated	15/02/2017		

Key:
- Red
- Amber
- Green
- Blue (closed)

Dashboard

Current Period
Project Delivery RAG Status

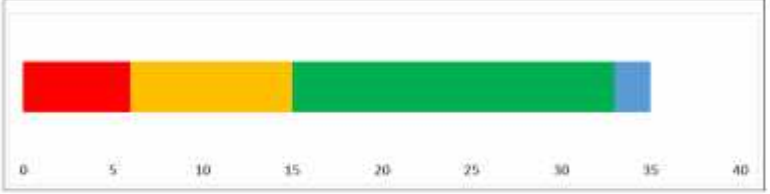
Portfolio delivery RAG status by risk group

Current Period
Project Delivery RAG Status

Portfolio	Red	Amber	Green	Blue	Total
111 Performance Improvement		2			2
999 Performance Improvement	5	2	3	2	12
Clinical Outcomes		1	9		10
Culture & Workforce		1	4	3	8
EPCR			1		1
OU Restructure			1		1
Move to HQ / EOC		1			1
Grand Total	5	7	18	5	35

Previous Period
Project Delivery RAG Status

Portfolio delivery RAG status by risk group



Previous Period
Project Delivery RAG Status

Portfolio	Red	Amber	Green	Blue	Total
111 Performance Improvement		2			2
999 Performance Improvement	6	1	3	2	12
Clinical Outcomes		1	9		10
Culture & Workforce		4	4		8
EPCR			1		1
OU Restructure			1		1
Move to HQ / EOC		1			1
Grand Total	6	9	18	2	35

Commentary

Comments
1. Dashboard shows update for Projects under URP (currently excludes CQC must do, CQC should do and Finance projects)
2. HQ move will turn to RED following Organisational Recoveries steering group meeting on 15 February 2017 - next dashboard will reflect this
3. Project Manager for Clinical Outcomes has been absent over last few weeks - data on the tracker and dashboard will be updated on return
4. Net reduction in Reds due to progress in Private Ambulance Providers ("PAPs") plus hear and treat. However revised demand management plan (DMP) has slipped into Red (see below)

Extract of Projects ranked as "Red" for Delivery

Project	Current RAG	Previous RAG	Rationale	Mitigating action	Owner	RAG post mitigating action
Forecasting and scheduling process reviewed and action plan delivered	Red	Red	At risk because OU restructure is delaying the implementation of a new scheduling structure until June. Therefore a number of actions on the plan cannot be completed until the team knows what the structure looks like (e.g. clarity on roles and responsibilities)	Reviewing what else needs to be done in terms of scheduling process and review the project in line with recent changes and understand whether the project needs to be changed as a result	Sue Skelton	Amber
Improved call answer service	Red	Red	At risk due to a number of activities in plan which cannot be delivered because of financial restrictions and dependency on the new CAD system	Rapid review of project scope and KPIs to assess impact of non delivery. Consideration to a refocused mandate (focus on staff retention as key cause for non delivery) that will deliver the required benefits	Sue Skelton	Amber
Reduced hospital turnaround time	Red	Red	At risk as hospital handover policy has not gained support required from Commissioners and Acute Trusts	Mitigation plan in place which looks at establishing an incident command hub in order to gain greater grip and control. Also completing detailed analysis of data to identify improvement opportunities	Chris Stamp	Amber
Reduced response ratio	Red	Red	At risk because there is a big dependency on CAD to deliver automated response plans - which will not be available until June when new CAD is operating	The team is working towards changing the ratio of Single Vehicle Resource ("SVR") to Double Crew Ambulance ("DCA"). Also put CCPs (Critical Care Paramedics) back into System Status Plan ("SSP")	Sue Skelton	Amber
Revised demand management plan (DMP) implemented	Red	Green	At risk due to delay in final sign off of proposed plan	Escalate to executive team through turnaround executive meeting on 22 February 2017	Sue Skelton	Green

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	189/16

Name of meeting	Board Meeting
Date	23/02/17
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 & 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 summary 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 Improvement Plan – Summary Exception Report

Period: 15th January– 15th February 2017

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.

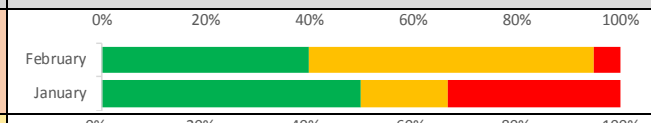
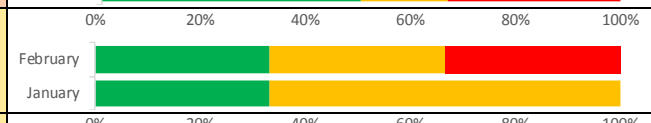
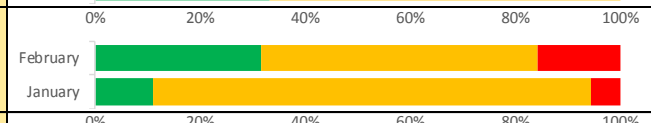
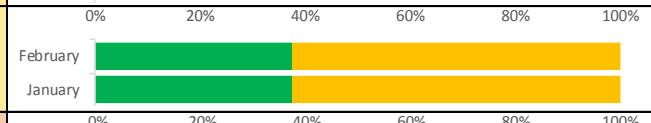
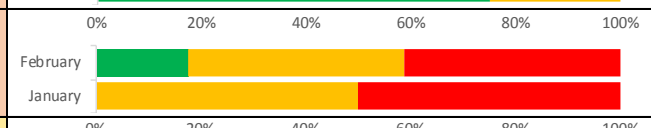
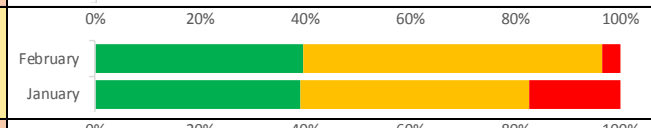
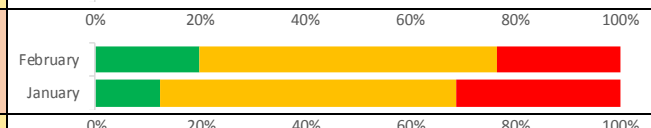
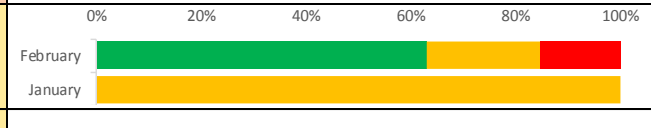
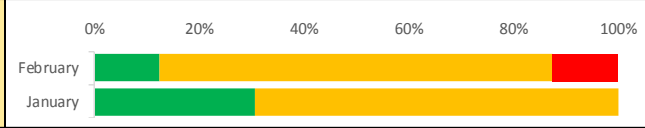
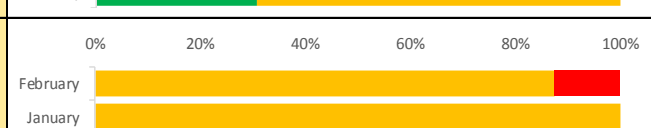
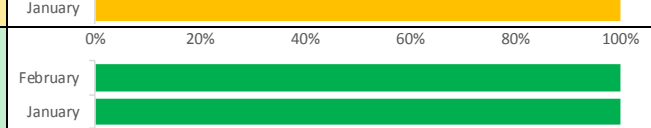
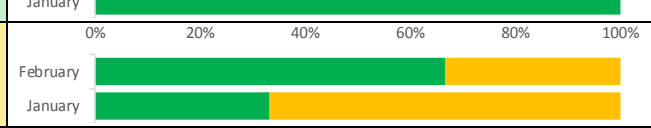
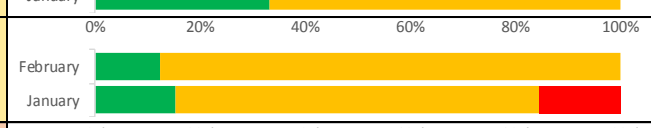
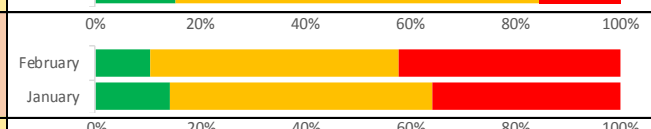
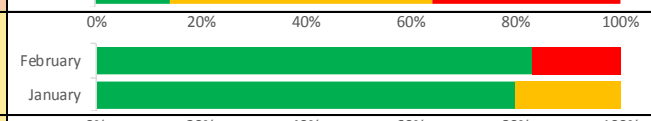
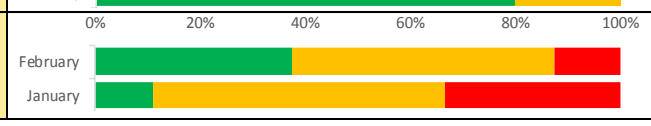
1.2. A Quality Steering Group to provide additional internal scrutiny of the CQC action plan was introduced in late December. This weekly meeting supported by the PMO and chaired by the Interim Chief Nurse oversees the progress of actions and ensures the evidence of completion is sufficient to meet all 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 continued to evolve to be a more comprehensive document providing greater assurance that its completion will demonstrate, safe, effective, responsive, caring and well led services.

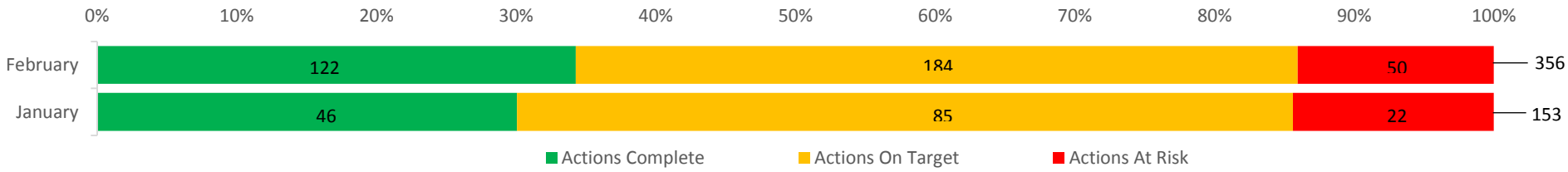
South East Coast Ambulance Service - CQC Must Do Improvement Tracker

CQC Dashboard - 15 February 2016

Domain	CQC Area	CQC Type	Workstream	Confidence of delivery on time and realising benefits	Progress against actions%	Number of At Risk Items	Project lead	Executive lead
Safe	Security	Must do	2. Security Improvement Plan	At Risk		1	Dan Garret	Joe Garcia
	CAD	Must do	3.0 CAD Improvement Plan	On Target		1	Mark Chivers	David Hammond
	Incidents	Must do	7. Incident and SI Reporting Improvement Plan	On Target		3	Sara Songhurst	Emma Wadey
	Infection prevention	Must do	10.0 Infection Prevention and Control Improvement Plan	On Target		0	Aide Hogan	Emma Wadey
	Medicines	Must do	14.0 Medicines Management Improvement Plan	At Risk		9	Fiona Wray	Geraint Davies
	Patient records	Must do	15.0 Patient Records Improvement Plan	At Risk		7	Fiona Wray	Geraint Davies
	Training	Must do	1. Safeguarding Improvement Plan	On Target		2	Sara Songhurst	Emma Wadey
Effective	Operational performance 999	Must do	8.0 Take action to ensure that national performance targets are met	At Risk		7	Sue Skelton (Lynda Pegler)	Joe Garcia
	Operational performance 111	Must do	16. NHS 111 Improvement Plan	On Target		7	John O'Sullivan	Joe Garcia
	Outcomes	Must do	9.0 Outcomes Improvement Plan - Take action to improve outcomes for patients who receive care and treatment	On Target		1	Andy Collen	Richard Webber
Responsive	Scheduling	Must do	13. Safe Resource Dispatch	On Target		1	Chris Stamp	Joe Garcia
	HART	Must do	4.0 HART Improvement Plan	Complete		0	Andy Cashman	Richard Webber
		Must do	12.0 HART Staffing Improvement Plan	On Target		0	Andy Cashman	Richard Webber
Well-led	Governance	Must do	6.0A Corporate Governance	On Target		0	Peter Lee	Geraint Davies
		Must do	6.0B Clinical Audit	At Risk		8	Fiona Wray	Geraint Davies
	PTS	Must do	5.0 PTS Improvement Plan	On Target		1	Sue Skelton	Joe Garcia
	Resourcing	Must do	11.0 Staff and resourcing improvement plan	On Target		2	James Pavey	Joe Garcia

2. CQC Must Do Dashboard

3. CQC Must Do Improvement Plan Progress:



CQC Must Do Progress Summary
• This month saw a significant focus on improving the quality of reporting to the CQC, with approximately 200 more actions added to the Tracker across all Must Do areas. This demonstrates growth in our understanding of both the issues and solutions required • Demonstrable growth (~160%) was seen in the number of completed actions, highlighting the good progress made in delivery • The number of at-risk actions has also grown significantly (~130%) showing that there a still a number of barriers to delivery. The main themes within this include resource constraints, financial constraints, and bottle necks at the sign off stage • Must Do Actions 10. Infection Prevention and 4. HART are well on track with delivery and exploring steps to embed changes as BAU • Key risks lie in failing to deliver on three Must Do actions within the medical directorate with the most serious being 14. Medicines Management, followed by 6B. Clinical Audit and 15. Patient Records • A key driver behind the risks and challenges with medicines management has been a historical lack of leadership and governance over medicines (with a longstanding gap in the role of Chief Pharmacist), leading to the development of a culture of complacency around medication safety throughout the organisation • We currently have significant resourcing challenges within the medical directorate, placing us at significant risk of failing to deliver short term improvements on the three Must Do actions. There is currently heavy reliance on thin resources without the clinical capability to make the executive decisions required. • In addition to these challenges, the size of the medicines management project, is highly resource intensive, which has come at a cost of progressing on the patient records and clinical governance Must Do action plans. The pace of delivery on medicines management is also slower than preferred due to resource challenges
NHSI/ CQC Feedback

• SECAmb had its Single Oversight and Progress Review meetings on the 14th February to share the progress made with the improvement plan. The key highlights from these meetings include:
  ○ Acknowledgement of the significant progress that has been made to address issues with CAD, Safeguarding, Infection Control, Complaints, financial management and 111 responsiveness.
  ○ The need to clarify how the responsibilities of the Medical Director are being covered until this post is recruited to.

- The need for greater pace and additional support in addressing the gaps in control relating to medicines management (there is a separate paper on this – agenda item 194/16)

4. Summary Exception Report:

CQC Domain	CQC Must Do Workstream	Risk description	Risk before mitigation	Mitigating Action	Risk after mitigation	Owner
Safe	Medicines management	• The Trust was not fully aware of the wide range of medicine management issues that existed. Following the CQC inspection additional issues relating to medicine management have been identified through staff raising concerns, internal audits and review of practice. • Changes implemented to practice is not followed through, highlighting significant leadership and cultural issues • Lack of expertise to implement some immediate improvements		• Interim Chief Pharmacist appointed • Full Diagnostic • Review of Scope of practice and PGDs • Unannounced Medicines management Inspection audits underway to visit all locations.		Geraint Davies
Safe	Security	• Limited capacity of current Security Manager – one man team with significant remit. This impacts on the Trust's ability to audit sites		• Submission of approval to recruit an additional resource to support the current Security Manager. However, given current financial constraints this is not likely to be approved		Joe Garcia

CQC Domain	CQC Must Do Workstream	Risk description	Risk before mitigation	Mitigating Action	Risk after mitigation	Owner
		continuously for security		• Considering alternative avenues to share load across security and operations		
Safe	Patient records	• Loss of patient records between completion and scanning by the patient records department • Inconsistency in records completion and quality of clinical entries • Gap in leadership and expertise in current team		• PCR boxes available in locations to provide safe storage • Local quality audits being completing by CTLs		Geraint Davies
Effective	999 operational performance	Failed implementation of a new Hospital Handover Policy. This did not gain support of the local commissioners and Acute Trusts and has therefore not been signed off		1. Actions taken to ensure better grip exists on current management and escalation processes within existing handover policy. Two Incident command hubs to be established to support this. 2. The Conveyance, Handover and Transfer of Care policy re issued and staff prepared to undertake MEWS clinical assessments prior to decision to handover 3. Additional work with commissioners continues to find whole systems solutions to hospital delays.		Joe Garcia
Well led	Clinical audit	• Vacancy in the Head of Clinical Audit, and under performance of the current interim Clinical Audit Lead resulting in limited progress on		• Action plan has been reviewed to highlight areas of focus		Geraint Davies

CQC Domain	CQC Must Do Workstream	Risk description	Risk before mitigation	Mitigating Action	Risk after mitigation	Owner
		Clinical Audit Must Do action plans				

5. Summary

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

5.2. It has been noted that steady improvement and progress continues to be made across the majority of areas. However, increased capability and the effectiveness of more robust internal governance processes has identified that medicines management and clinical audit are at significant risk of non-completion by the end of March 2017.

5.3. Increases in demand, handover delay and limitations in resources has also effected our ability to deliver of national targets within our 999 service. Despite this, a number of changes are underway to increase productivity to improve performance.

6. Recommendations

6.1. The board are 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.

6.2. The board are also asked to note the continued risk areas of Medicines management, clinical audit and our ability to meet national targets for our 999 service.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	190/16

Name of meeting	Trust Board
Date	23rd February 2017
Name of paper	Handover Delays
Responsible Executive	Jon Amos, Acting Director of Strategy and Business Development
Author	Jon Amos, Acting Director of Strategy and Business Development
Synopsis	This paper provides a summary of the current handover delay challenges and actions being taken to address this issue by the Trust and at system level
Recommendations, decisions or actions sought	To note the current data in relation to handover delays and the actions 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

Handover Delays

1. Introduction

1.1. Handover delays have become a national focus in recent months with both NHS Improvement and NHS England seeking action to address this safety concern. At this stage the majority of action expected has been requested of ambulance services in the way of reporting and escalation however system actions are now also under discussion.

1.2. This paper provides the Board with a summary of key metrics in relation to handover delays to highlight the persistent problem. The paper also sets out emerging actions being taken by the Trust and actions planned by the system to assist in addressing these issues.

2. Current Position

2.1. Ambulance handover delays saw the worst ever month in January with 7,950 hours lost. Compared to the previous January there were 1% fewer conveyances to hospital by ambulance (37,810 compared to 38,138 in January 2016) whilst ambulance hours lost due to handover delays increased 73% (from 4,583 to 7,950). A month by month comparison is provided in appendix 1.

2.2. Daily tracking of handover breaches >60mins is now occurring with this data shared at acute Trust level with NHS Improvement on a daily basis. Appendix 2 shows the Trust wide position. This focus on long delays initially is assisting in refocussing the conversation with the system on patient safety and experience.

3. Actions

3.1. An action plan, tracked by the PMO has been developed for handover delays, to ensure tracking of progress of external actions and clear governance for holding to account in driving forward internal actions.

3.2. The Trust is currently introducing a new ‘Delayed Handover Form’ which will help to ensure patient safety when delays in handover do occur. This will facilitate regular clinical observations, assessment of risk and communication with hospital staff based on the patient’s latest clinical condition. This standardised approach will also assist in setting consistent clinical triggers for incident reporting of any delays for clinically unstable patients.

3.3. An incident command hub is being introduced into EOC which will become the focal point for all hospital handover delays. This aims to increase consistency in the way with which hospitals are communicated with in relation to handover delays.

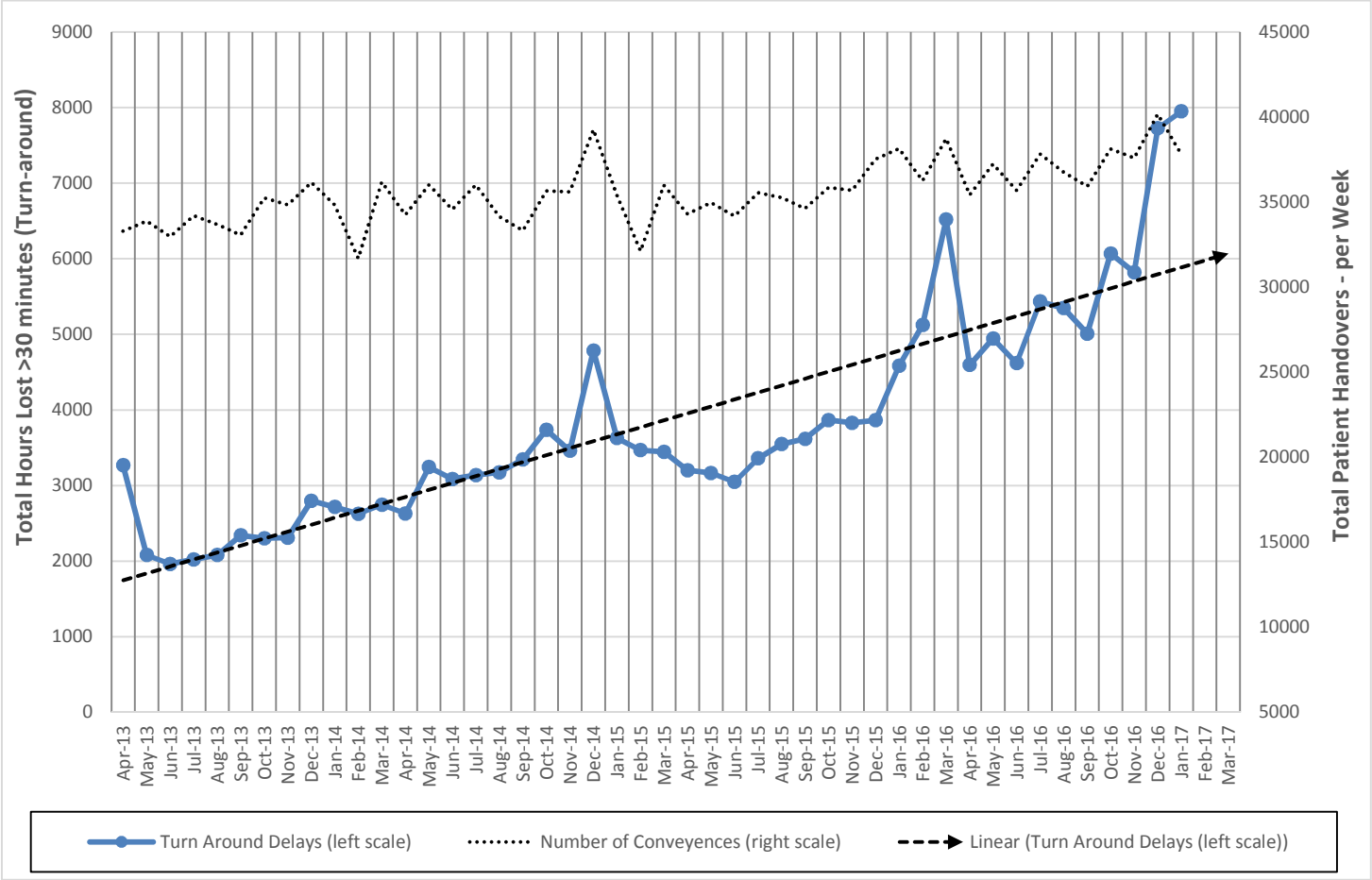
3.4. A review of data processes will occur in the coming weeks, supported by NHS Improvement, to ensure that data capture at the point of handover is understood by all in the system. A hospital by hospital review will then be supported by NHS Improvement.

3.5. A system-wide action plan to introduce measures to address some of the underlying issues is being finalised by NHS Improvement following input from SECAmb and other partner organisations. This will become part of the work plan for each of the A&E Delivery Boards and aims to address a number of issues across the pathway which have been identified as likely to smooth flow and reduce system bottlenecks.

4. Recommendation

4.1. The Board is asked to note the current data, actions being taken by the Trust and planned system actions.

Appendix 1


Total Hours Lost >30 minutes (Turn-around)
Total Patient Handovers - per Week
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
45000
40000
35000
30000
25000
20000
15000
10000
5000
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
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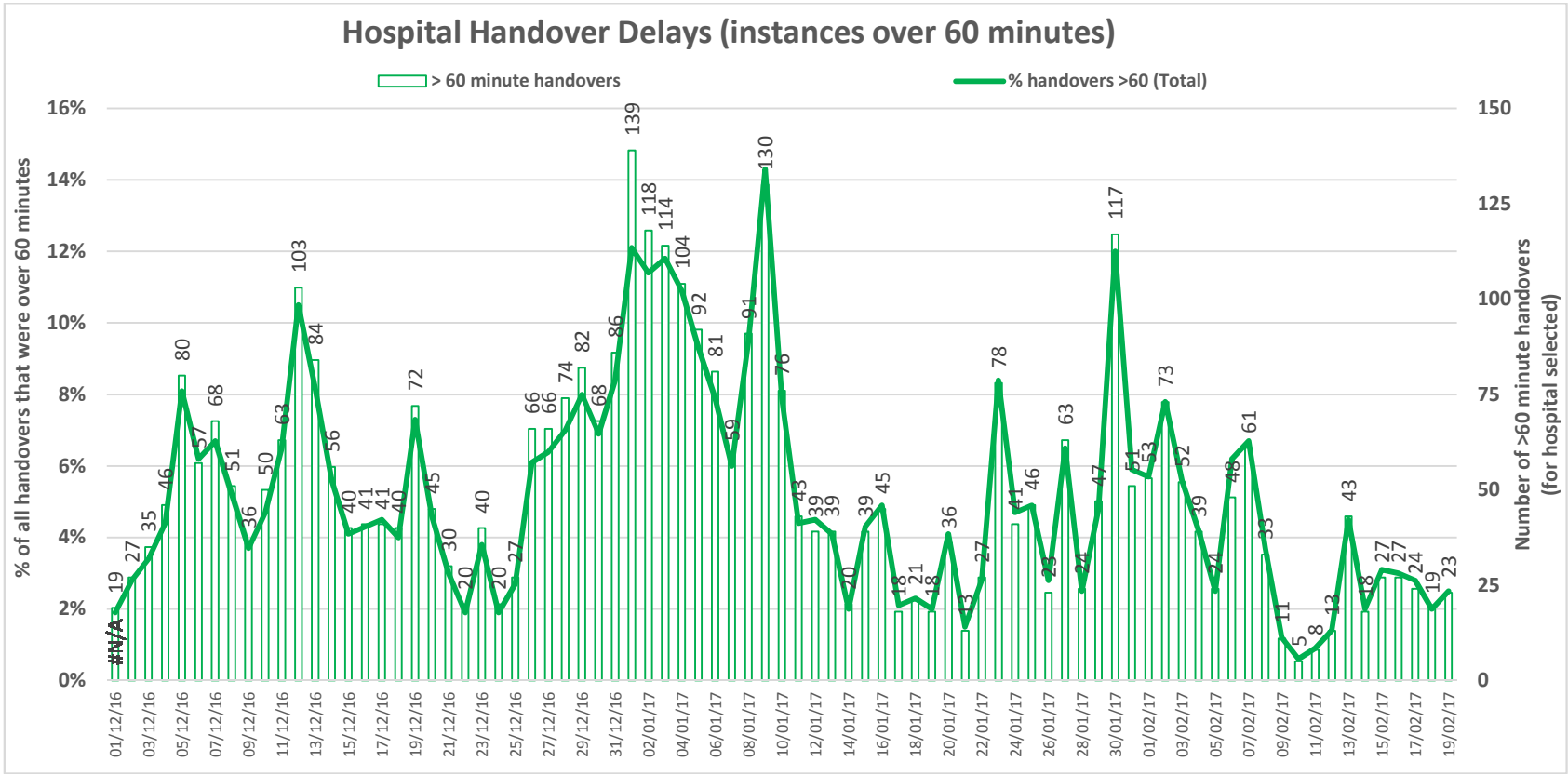
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Turn Around Delays (left scale)
Number of Conveyences (right scale)
Linear (Turn Around Delays (left scale))

Appendix 2


Hospital Handover Delays (instances over 60 minutes)
> 60 minute handovers
% handovers >60 (Total)
% of all handovers that were over 60 minutes
Number of >60 minute handovers (for hospital selected)
16%
14%
12%
10%
8%
6%
4%
2%
0%
150
125
100
75
50
25
0
#N/A 19 27 35 46 80 57 68 51 36 50 63 103 84 56 40 41 41 40 72 45 30 20 40 20 27 66 66 74 82 68 86 139 118 114 104 92 81 59 91 130 76 43 39 39 20 39 45 18 21 18 36 13 27 78 41 46 23 63 24 47 117 54 53 73 52 39 24 48 61 33 11 5 8 13 43 18 27 27 24 19 23
01/12/16
03/12/16
05/12/16
07/12/16
09/12/16
11/12/16
13/12/16
15/12/16
17/12/16
19/12/16
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22/01/17
24/01/17
26/01/17
28/01/17
30/01/17
01/02/17
03/02/17
05/02/17
07/02/17
09/02/17
11/02/17
13/02/17
15/02/17
17/02/17
19/02/17

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	192/16

Name of meeting	Trust Board
Date	23rd February 2017
Name of paper	2017/18 Contract Update
Responsible Executive	Jon Amos, Acting Director of Strategy and Business Development
Author	Jon Amos, Acting Director of Strategy and Business Development
Synopsis	This paper provides a summary of the current progress in addressing the contractual gap and sets out next steps
Recommendations, decisions or actions sought	) To note the current progress) To discuss the implications of the delayed end date) To agree on-going monitoring and review

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

Contract Update - Addressing the Contractual Gap

1. Introduction

1.1. As part of contract mediation it was agreed that whilst contracts would be signed on 23 December 2016 a Contract Precedent would be undertaken before 31 March 2017 to address the remaining structural gap in the contract.

2. Current Position

2.1. This work did not start with the expected pace, with the CCGs agreeing their lead team for taking this work forwards at the end of January 2017. The work is however now proceeding at pace but due to this delay will now not conclude until late April 2017. These delays have been highlighted to both NHS Improvement and NHS England.

3. Next Steps

3.1. An independent review will take place through March and April to 'understand the performance and financial baseline and opportunities for change within SECAmb and the wider system'. The review will be focussed at Trust level and will utilise existing work where available such as recent Lightfoot and NAO reports. The cost of this review will be shared equally between the Trust and the 22 CCGs

3.2. The outputs from this review are expected to be:

3.2.1. Agreeing the financial/performance gap and its drivers

3.2.2. Agreeing the impact of planned SECAmb actions

3.2.3. Agreeing the system response to the remaining gap

3.3. This work is expected to produce both an action plan and to propose performance improvement trajectories aligned to the action plan.

4. Recommendation

4.1. The Board is asked to note the current progress, discuss the implications of a delayed end date for the independent review and to agree on-going monitoring by the board.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	193/16

Name of meeting	Board Meeting
Date	23th February 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).	Yes / **No** If yes and approval or ratification is required, a completed EA Record must be attached.

Executive Summary

SECAmb's 999 did not achieve the commissioner set trajectories for Red 1, Red 2 and Red 19 for January. However, the 999 Improvement Plan with the exception of the Hospital Turnaround performance, remains on track. Hospital delays in January were higher than the circa 7,700 hours in December and over double the maximum level agreed with commissioners. SECAmb has been working with both commissioners, acute hospitals and NHSI to strengthen its hospital handover procedures and reduce delays at hospital. In addition, demand was circa 4% above commissioned levels in January and 5.5% above last year's YTD position.

KMS111 achieved its best monthly operational performance of the winter and clinical performance in general continued to improve. In particular, the Combined Clinical KPI was 81.6%, 17% better than the NHS England national average.

The Surrey PTS contract will be transferred to South Central Ambulance Service at the beginning of the new financial year and work is underway to support commissioners with the transition.

The clinical performance data continues to show variable standards in delivering patient outcomes. Clinical Outcome Ambulance Quality Indicator (cAQIs) performance was better than the national mean for three of the eight cAQIs with Stroke 60 ranking first nationally. The poorest performance was for ROSC Utstein which was showing a 5.9% negative variance from the national average. The other indicators which are below the national average are: ROSC, STEMI Care Bundle and Stroke Care Bundle.

The incident reporting system, DATIX, has been upgraded and incident categories reviewed in conjunction with service users. Incident reporting remains consistent for the year and has continued to improve and increase in comparison from 2015/16.

There are 4 new SIs' reported in January, three relate to non-conveyance and subsequent deterioration of the patient. Two of the new Sis' in January were reported within 72 hours of occurring.

Complaints responses show an in month improvement for "on time return rate" from 72% to 82%, the implementation of a complaint call back initiative have contributed to the timeliness of returns.

Short term sickness absence levels have increased from previous months likely due to seasonal influences. Long term sickness absence levels have reduced slightly from the previous month and significantly from the previous year.

Appraisals and Mandatory Training compliance both show negative variance from the plan. The appraisal rate will remain below target through the year however it is expected that Mandatory training compliance will deliver on target.

There was a single case of whistle blowing in January 2017, SECAmb will investigate fully and aim to come to a mutually satisfactory for outcome both the Trust and the individual who raised the concern as swiftly as possible.

The Trust's financial performance remains on forecast to deliver the £7.1M deficit as reported since M3 of the financial year. The Trust has been instructed by NHSI to include in the M10 position, the cost of paramedic re-banding which comes into effect from 31st December but not to include the income from the Department of Health which offsets this. This instruction has changed the FOT deficit has changed to £7.7m. The Trust has been advised by NHSI that discussions are ongoing between Department of Health and NHS England around funding the costs of the Paramedic re-

banding. The underlying FOT remains at the £7.1m deficit with the remedial actions undertaken since December taking hold.

As in previous months, the Trust continues to be at level 4 using the NHSI Use of Resources Rating (UOR), which potentially triggers financial special measures. The drivers behind the adverse rating have been the variance against APR largely as a result of agency expenditure. The Trust has addressed spend on temporary staffing and the number agency staff has reduced from 170 wte to 110 wte in January with further reductions planned. The FOT on agency spend indicates a lower UOR by 31 March 2017. In addition, controls around discretionary spend have been tightened.

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. Short term sickness absence levels have increased from previous months likely due to seasonal influences. Long term sickness absence levels have reduced slightly from the previous month and significantly from the previous year.

2.1.2. Appraisals and Mandatory Training compliance both show negative variance from the plan. The appraisal rate will remain below target through the year however it is expected that Mandatory training compliance will deliver on target.

2.1.3. There was a single case of whistle blowing in January 2017, SECAmb will investigate fully and aim to come to a mutually satisfactory for outcome both the Trust and the individual who raised the concern as swiftly as possible.

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		**3.2%**	2.7%		**3.2%**	
Wf-1B	Long Term Sickness - Rate		**2.5%**	3.6%		**2.5%**	
Wf-2	Staff Appraisals	75%	**50.0%**	60.6%			
Wf-3	Mandatory Training Compliance (All Courses)	94%	**78.5%**	88.5%			
Wf-4	Total injuries			73		**550**	632
Wf-5	Total physical assaults		**14**	18		**180**	163
Wf-6	Vacancies (Total WTE)		**323.2**				
Wf-7	Annual Rolling Staff Turnover		**16.9%**	14.2%			

Wf-8	Reported Bullying & Harassment Cases		**1**			**14**	
Wf-9	Cases of Whistle Blowing		**1**			**3**	

2.3. Workforce Commentary

2.3.1. Although short term sickness absence levels have increased from previous months, this is often explained by seasonal influences. The long term sickness absence levels have reduced slightly from the previous month and significantly from the previous year. The Trusts commitment to practical advice, support and signposting to various wellbeing services has seen a reduction in conditions relating to stress/anxiety and other psychological illness.

2.3.2. Appraisals and Mandatory Training compliance both show negative variance from the plan. It is expected that the appraisal rate will remain below target through the year. This has been recognised and action taken to address issues of clarity of purpose and objectives as well as low staff engagement. Following a successful pilot, a new online system has been developed with the intention to roll out Trust-wide in April 2017. The feedback received provides a healthy optimism that we will be on target for 90% by the end of the year, in line with the CQC action plan. It is expected that Mandatory training compliance will deliver on target as activity in the final quarter picks up.

2.3.3. Following significant improvements in recording and reporting vacancies across the Trust, we can now be assured that the vacancy rate of 9.28% is reflective of our current position. This enables Managers and Human Resources (HR) Business Partners (BPs) to develop robust workforce plans for 2017/18 which in turn can be relied upon to produce effective and efficient recruitment and retention strategies and plans.

2.3.4. Working against a backdrop of increased pressure on all of its services, as expected, we have seen a levelling out of annual rolling staff turnover (16.9%) this month. However, this remains a challenge for the Trust so we continue to closely monitor staffing levels and stability.

2.3.5. Following the appointment of a Whistleblowing Champion at Board level and various avenues of structured support for staff who may wish to raise serious concerns, cases of whistle blowing are thankfully rare. It is with great sadness that we report a single case in January 2017. We will be providing the necessary assurances to both the Trust and the individual who raised the concern that it will be our priority to investigate fully and come to a mutually satisfactory outcome as swiftly as possible.

2.3.6. Again cases of Bullying and Harassment are thankfully rare but none the less significant in terms of their effect on the individuals concerned and the Trust as a whole. The Trust promotes a zero-tolerance approach to unacceptable behaviours and encourages staff to speak out and hold each other to account wherever behaviours fall short of our values, especially in showing respect, integrity and taking responsibility. In December 2016 we reviewed and updated our Bullying and Harassment Policy to strengthen that resolve and raise awareness to staff of the support available.

2.4. Workforce Charts

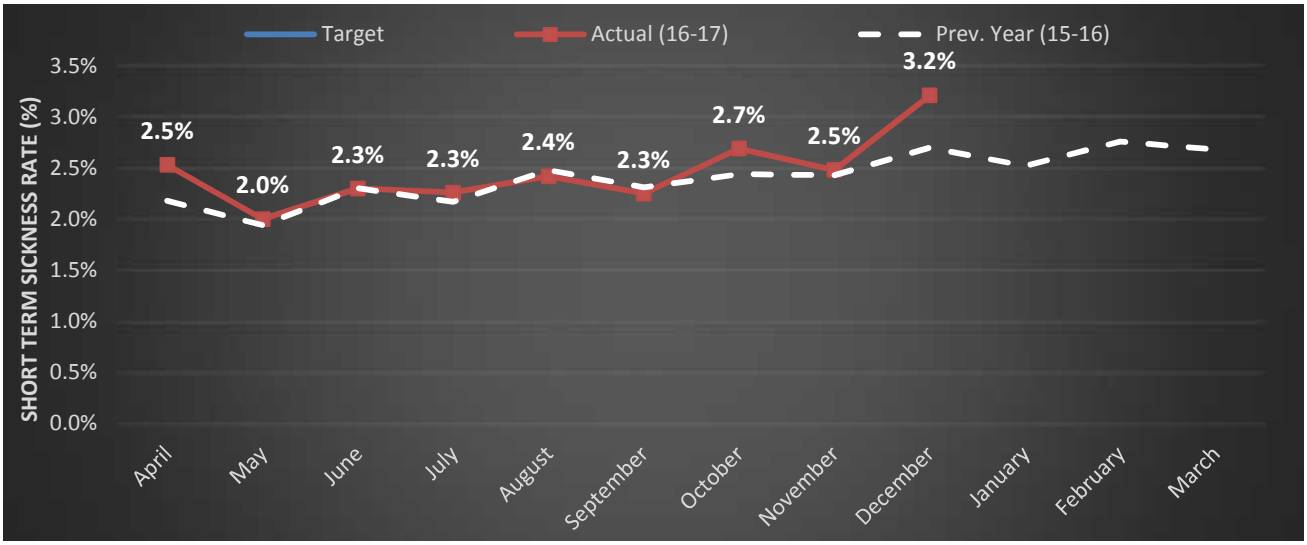

Figure Wf-1A - Short Term Sickness Rate

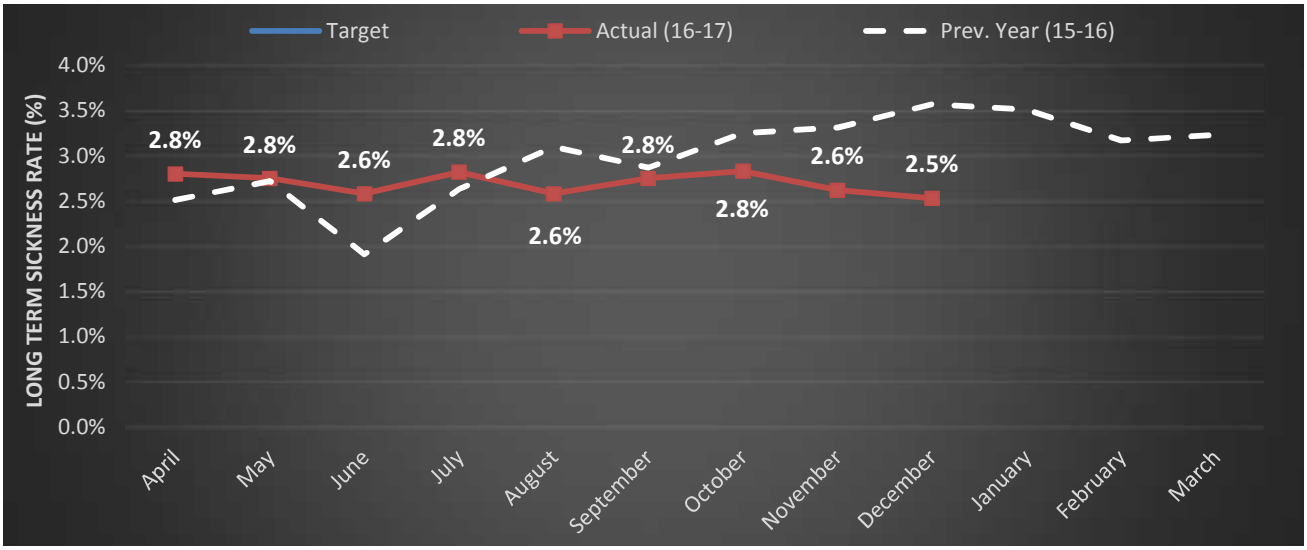

Figure Wf-1B - Long Term Sickness – Rate

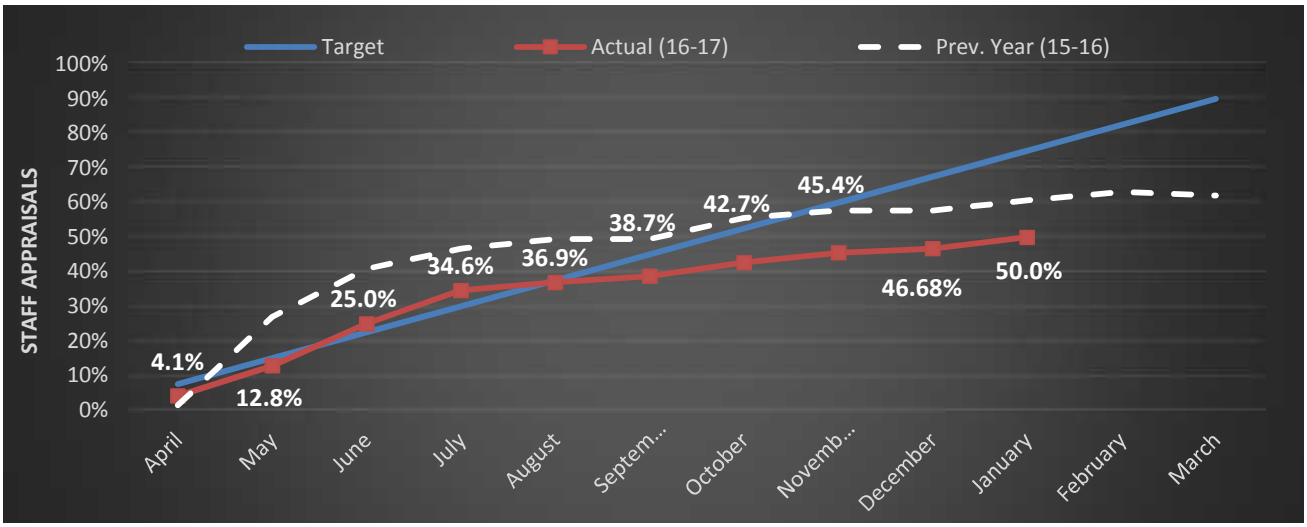

Figure Wf-2 - Staff Appraisals

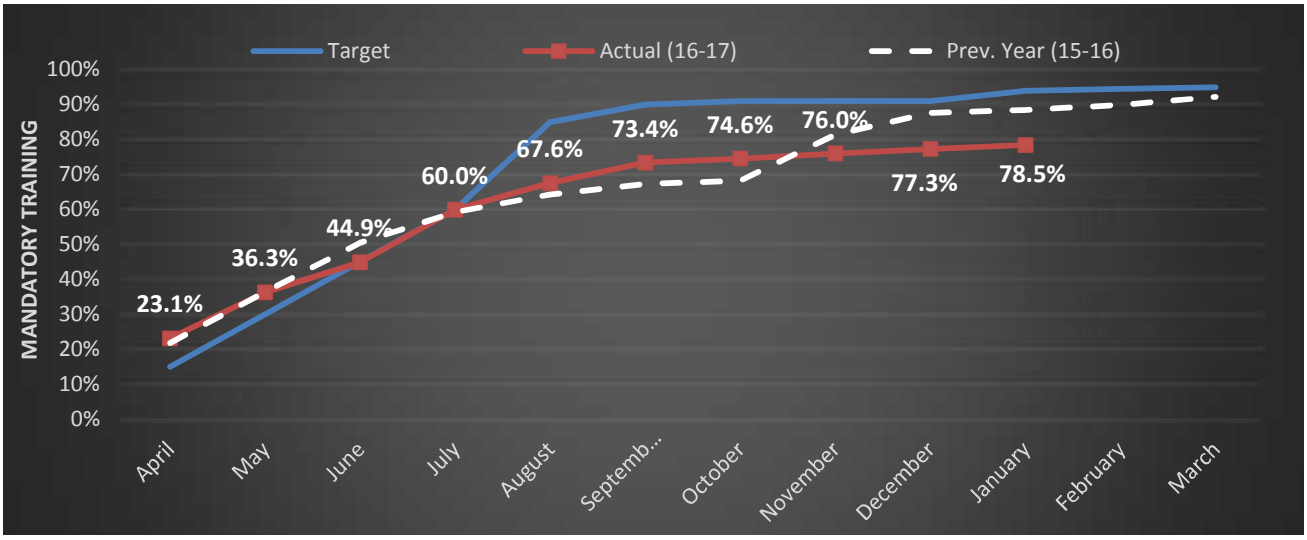

Figure Wf-3 - Mandatory Training Compliance (All Courses)

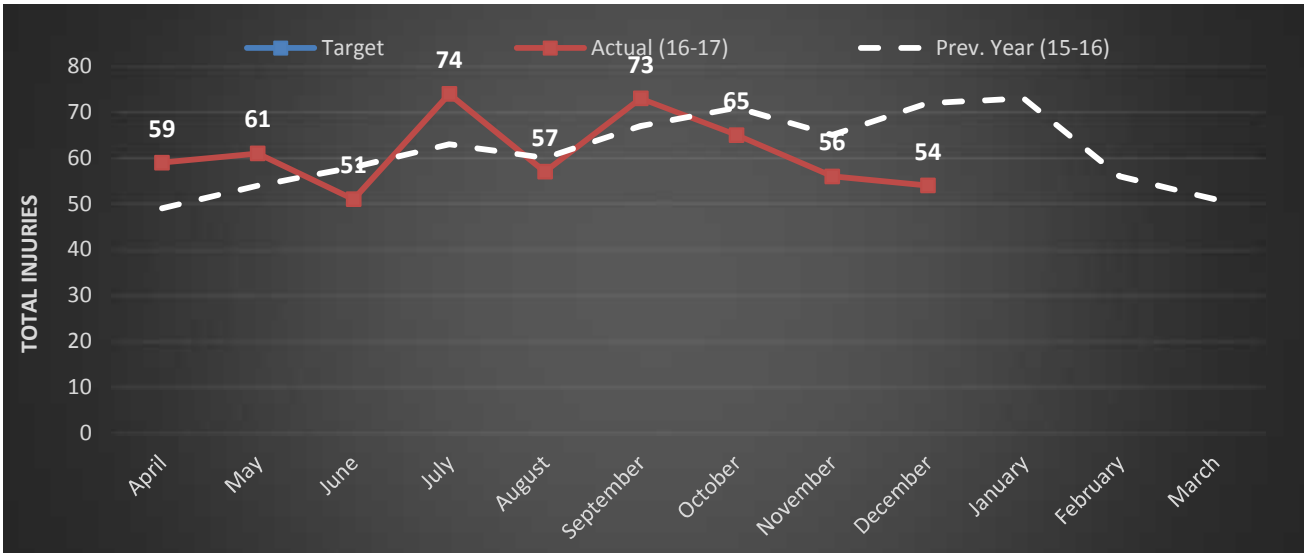

Figure Wf-4 - Total injuries Jan17 figure yet to be handed in.

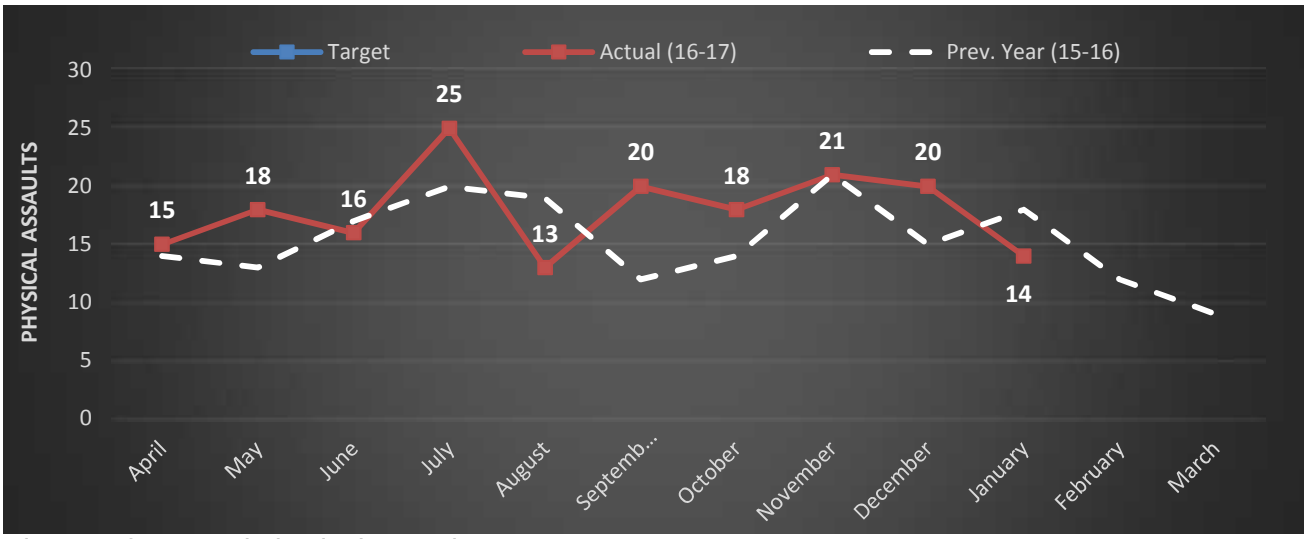

Figure Wf-5 - Total physical assaults.

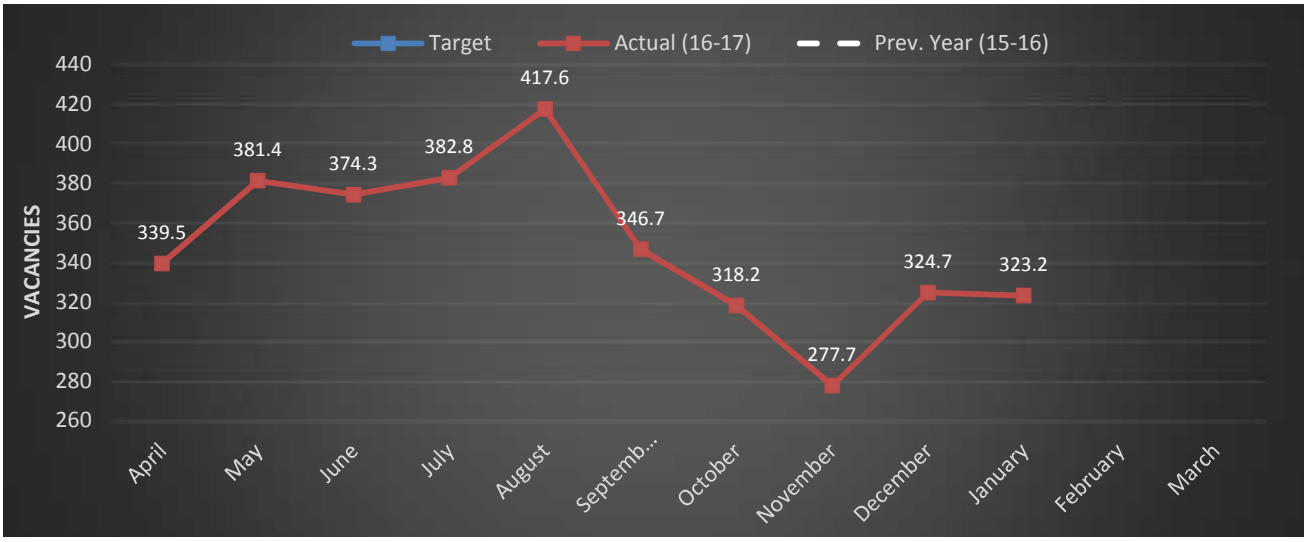

Figure Wf-6 - Vacancies (Total WTE)

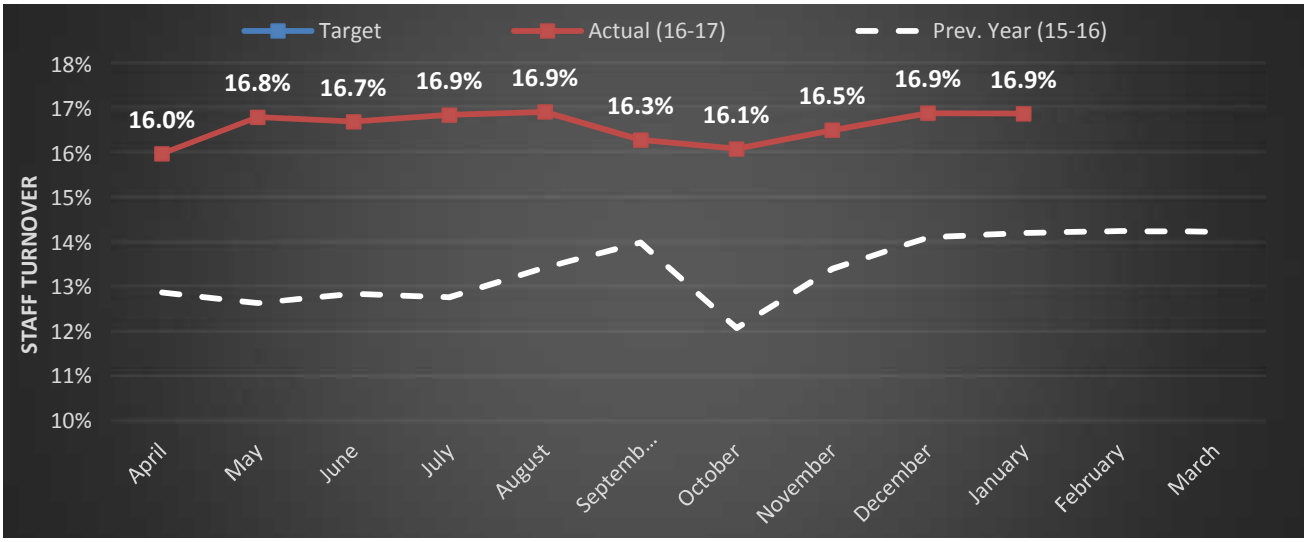

Figure Wf-7 - Annual Rolling Staff Turnover

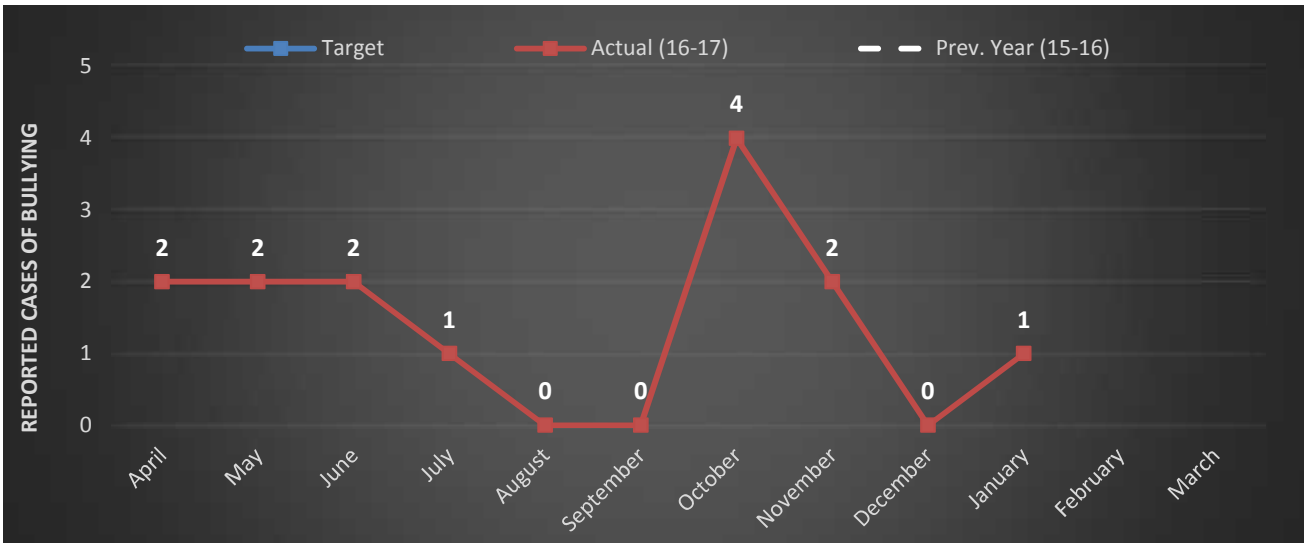

Figure Wf-8 - Reported Bullying & Harassment Cases

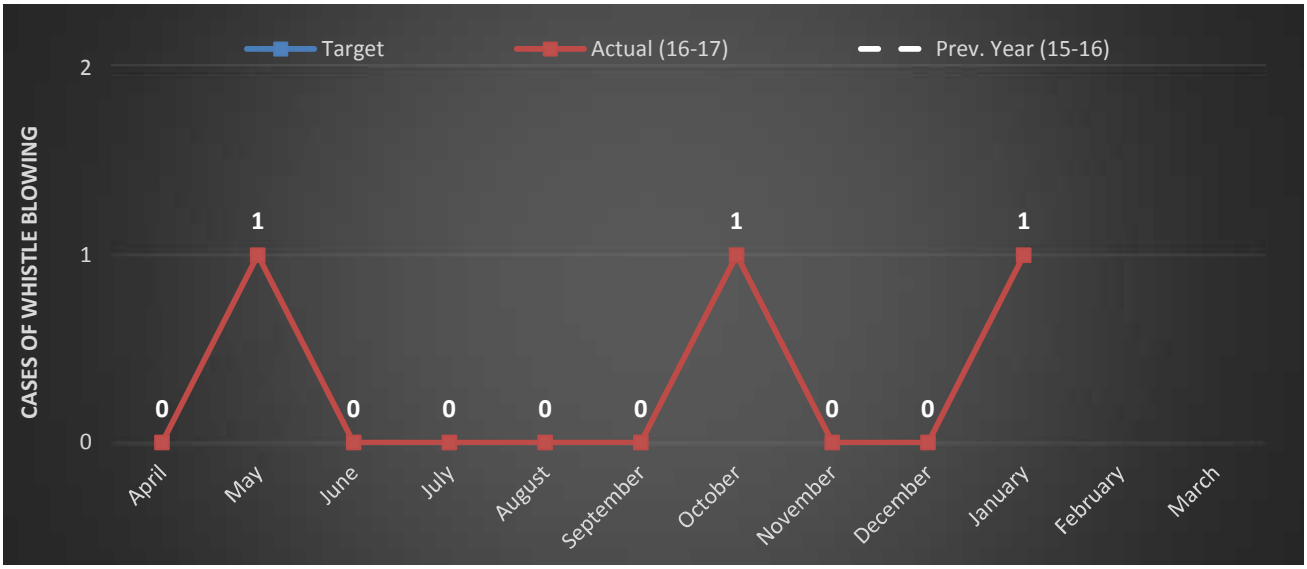

Figure Wf-9 - Cases of Whistle Blowing

3. Operational Performance

3.1. Operational Performance Summary

3.1.1. SECAmb's 999 response time performance was under the national targets and SECAmb did not achieve the new trajectories for Red 1, Red 2 and Red 19 for January.

3.1.2. The 999 Improvement Plan, with the exception of the Hospital Turnaround performance remains on track. Hospital delays in January were worse compared with the circa 7700 hours in December and 7950 in January, over double the maximum level agreed with commissioners. SECAmb has been working with both commissioners and acute hospitals to strengthen its hospital handover procedures and reduce delays at hospital.

3.1.3. Demand was circa 3.9% above the plan agreed with commissioners for the month and 5.4% above last year's YTD position. SECAmb has increased its Hear and Treat performance and its call answer performance in January.

3.1.4. KMS111 achieved its best monthly operational performance of the winter and the clinical performance in general continued to improve, in particular the Combined Clinical KPI was 81.6% which was 17% better than the NHS E national average.

3.1.5. The Surrey PTS contract is transferred to South Coastal Ambulance Service (SCAS) at the beginning of the new financial year. The service has and will continue to deliver performance, above the levels attained in the previous year.

3.2. Operational Performance Commentary

3.2.1. The Red 1 position was much improved on the December position but less than the revised January target. The reduction in Red 2 performance was primarily due to a significant loss of resource hours through Hospital Turnaround delay which was greater than December and compounded by the impacts of increased activity which was 4% above the forecast.

3.2.2. Demand was circa 4.0% above the plan agreed with commissioners for the month and 5.5% above last year's YTD position. Both activity and performance continues to show a slow but steady improvement based on the February performance to date.

3.2.3. SECAmb has successfully implemented Nature of Call and Dispatch on Disposition as planned on the 18th October as part of the national pilot for the Ambulance Response Programme. No serious clinical incidents have been reported since go live, we have improved to circa 60% plus of Red 1's are being identified during the Nature of Call process, compared to the national assumption of 75%, whilst not realising the national assumption this is still in line with other Ambulance Services.

3.2.4. The Trust has implemented plans to increase contribution from community first responders (CFRs). This entails improving technical links with CFRs, new processes in EOC to mobilise the CFRs and an extensive engagement campaign with the CFRs themselves. Benefits are being realised in January are above the planned trajectories for this group of responders.

3.2.5. SECAmb has increased its Hear and Treat performance for January. There is already an encouraging improvement in the Hear and Treat ratios and further

recruitment of clinicians continues, SECAmb has 31 WTE in post and are aiming for a total 45 WTE.

3.2.6. Call answer performance improved from last month's performance despite the January activity and SECAmb achieved 88.1% in 5 seconds compared to a revised trajectory plan of 90%.

3.2.7. 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 January were worse compared with the circa 7700 hours in December over double the maximum level agreed with commissioners. January saw 7950 lost hours which was the single biggest impact on our performance trajectory. Hospital Turnaround delay is the single most factor which impacts SECAmb performance and we have least control. A recent instruction from NHSI to increase the prompts to Acute Hospital Directors On-Call for every patient delay over 1 hour is being developed into a robust Operational Plan to ensure consistency across the region.

3.2.8. January 2017 was the first full month of KMSS 111 operating without call activity from the East Kent CCG's. Despite the reduction in operating area, activity remained high due to the intense pressure experienced by the wider health system in the first ten days of 2017. At a national level, January 2017's 111 call volumes matched those of January 2016, which was itself a month of concentrated winter pressures.

3.2.9. The service achieved its best monthly operational performance of the winter, with an "Answered in 60" SLA KPI of 83.7%, and a Call Abandonment rate of 2.9%. Operationally KMSS 111 achieved 15 Green and 5 Amber days for SLA in January.

3.2.10. There was a system wide surge in demand and pressure at the beginning of the month, with many Emergency Departments, GP Out of Hour's services (OOH) and the 999 services in escalation at the end of the New Year holiday period. A solitary day (2nd January) contributed to 58% of the service's abandoned call volume for the entire month. Call volumes for January totalled 96,799; this comprised 90,829 "standard" calls and 5,970 calls answered via the Interactive Voice Recognition (IVR) line.

3.2.11. KMSS 111 continued its collaboration with the wider health system, and focused on the protection of Emergency Departments and the Ambulance Service through the use of bespoke "comfort scripts" to manage patient expectations and providing additional clinical resource to validate referrals. The commissioner-led decision not to sanction the closure of GP OOH's services enabled KMSS 111 in its efforts to ensure appropriate avoidance of Emergency Departments and Ambulance referrals, facilitating the movement of patients through the urgent and emergency care system. KMSS 111's ED referral rate (6.52%) and its Ambulance referral rate (10.96%) remain better than the national NHS E benchmark. Clinical performance in general continued to improve and returned a Combined Clinical KPI of 81.6% which was 17% better than the NHS E national average.

3.2.12. As winter pressures remain, KMSS 111 continues to work closely with other services and commissioners via attendance at A&E Delivery Boards and integrated care forums/workshops whilst also supporting other providers to seek improvements in the patient journey across the system. The insights and learnings from the Christmas and New Year period have been fed in to a comprehensive Christmas look-back report which has been submitted to commissioners and should help improve service and system resilience during periods of peak demand. KMSS 111 is presently undertaking

planning for the expected increased call activity during the Easter period (14th – 17th April) including the recruitment of new, fully supported Health Advisor training cohorts.

3.2.13. Please note KPI the "Calls Abandoned - Intro Message" is no longer a key performance measure so the data has been omitted.

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	66%	**65.5%**	72.0%		**64.5%**	73.4%
999-2	Red 2 response <8 min	55%	**47.7%**	62.8%		**53.0%**	70.4%
999-3	Red 19 Transport <19 min	90%	**85.8%**	93.5%		**89.2%**	94.8%
999-4	Activity: Actual vs Commissioned	68998	**71738**	70326	660016	**688789**	653077
999-5	Hospital Turn-around Delays (Hrs lost >30 min.)	2715	**7950**	4583	23884	**57514.1**	36232.3
999-6	Call Pick up within 5 Seconds	90%	**88.1%**	91.6%		**75.3%**	87.7%
999-7	CFR Red 1 Unique Performance Contribution	1.3%	**1.4%**				
999-8	CFR Red 2 Unique Performance Contribution	1.0%	**1.5%**				
111-1	Total Number of calls offered		**96799**	111134		**962615**	975672
111-2	% answered calls within 60 seconds	85%	**83.7%**	74.7%	85%	**77.9%**	84.2%
111-4	Abandoned calls as % of offered after 30 secs	6.0%	**2.9%**	4.8%	6.0%	**4.5%**	**2.7%**
111-5	Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)	77%	**81.6%**	82.3%		**74.7%**	**87.7%**
PTS-1	PTS Activity (Surrey)	10889	**9736**	11750	118452	**105610**	**149178**

PTS-2	Arrival - % patients to arrive <= 15 min after appt. time. (Surrey)	95%	**87.0%**	83.8%	95%	**86.5%**	**83.7%**
PTS-3	Departure - % patients collected <= 60 min of planned collection time (Surrey)	95%	**87.2%**	87.1%	95%	**86.3%**	**84.2%**
PTS-4	Discharge - % patients collected <= 120 min of booked time to travel (Surrey)	95%	**80.3%**	79.3%	95%	**79.9%**	**76.1%**

3.4. Operational Performance Charts

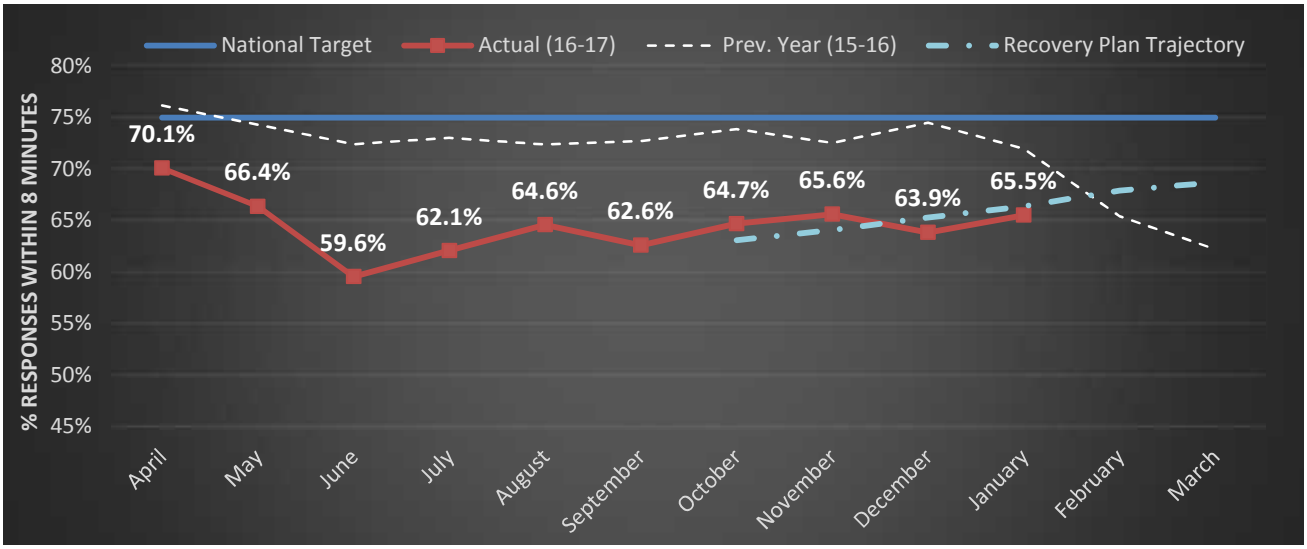

Figure.999-1 - Red 1 response <8 min

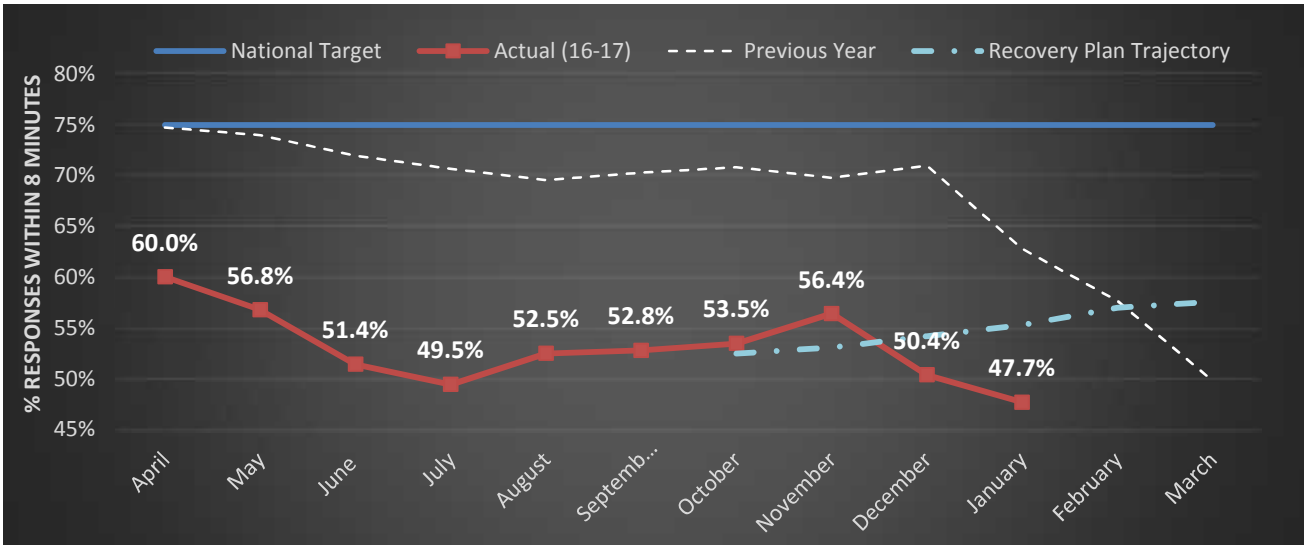

Figure.999-2 - Red 2 response <8 min

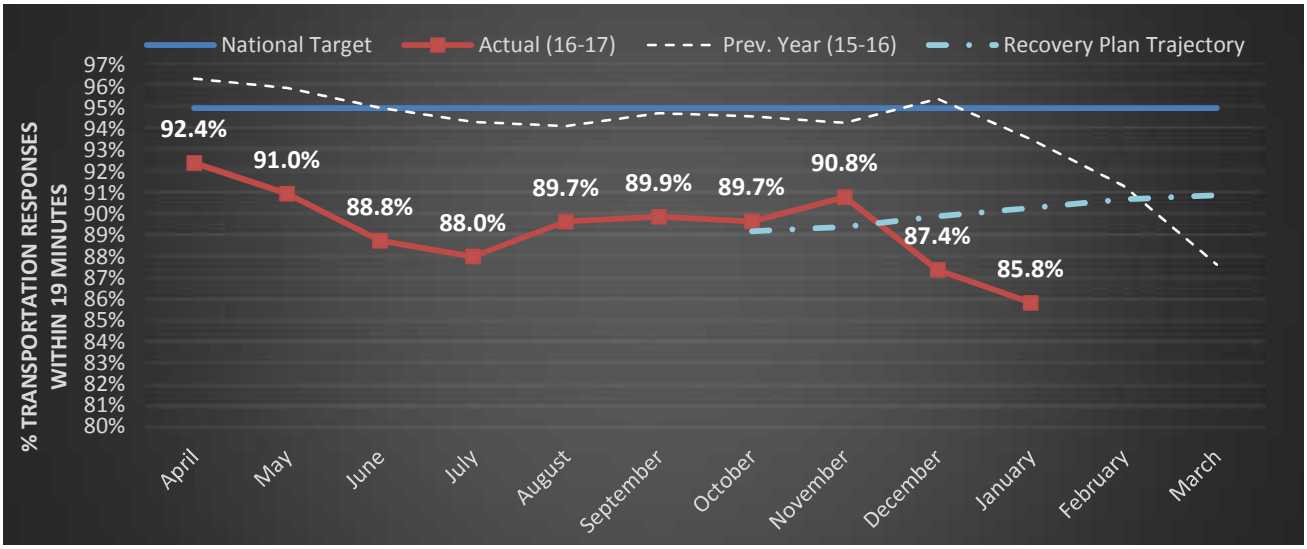

Figure.999-3 - Red 19 Transport <19 min

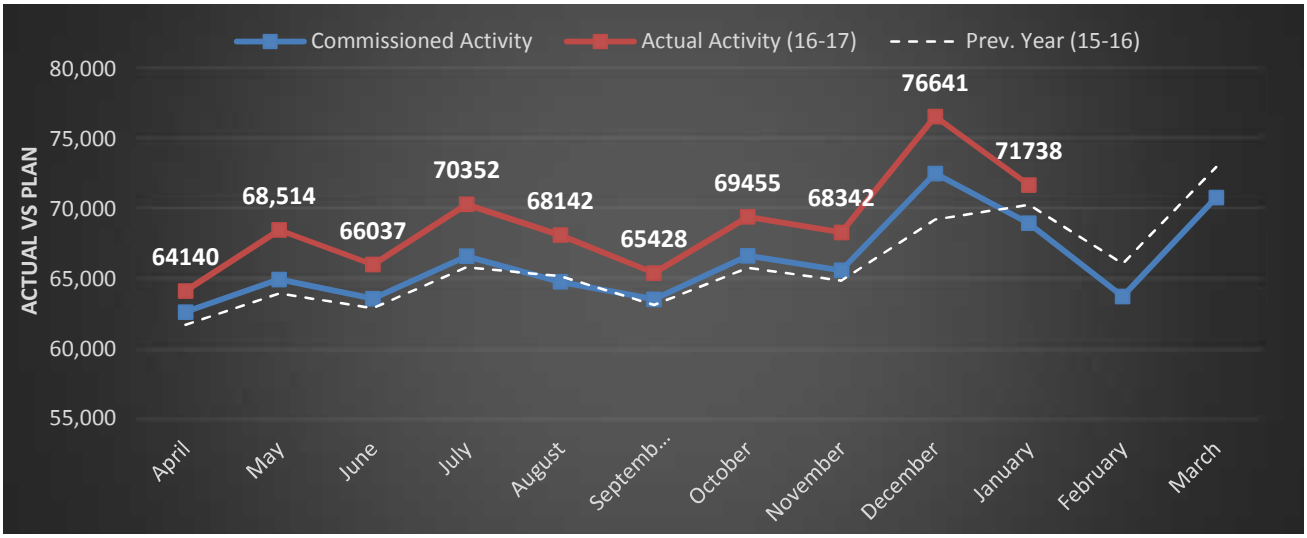

Figure.999-4 - Activity: Actual vs Commissioned

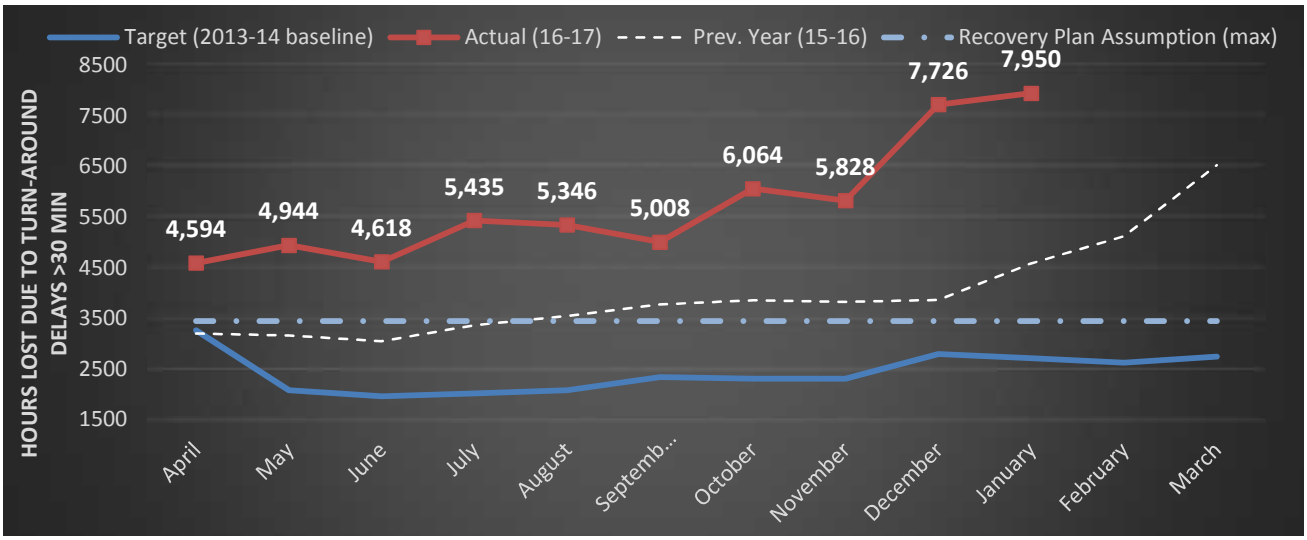

Figure.999-5 - Hospital Turn-around Delays (Hrs lost >30 min.)

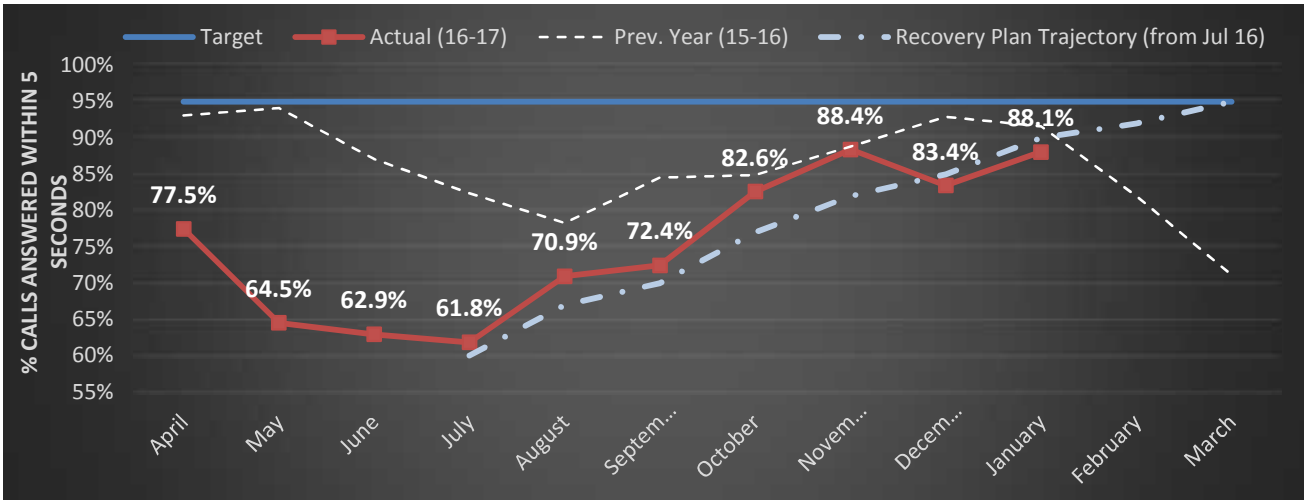

Figure.999-6 - Call Pick up within 5 Seconds

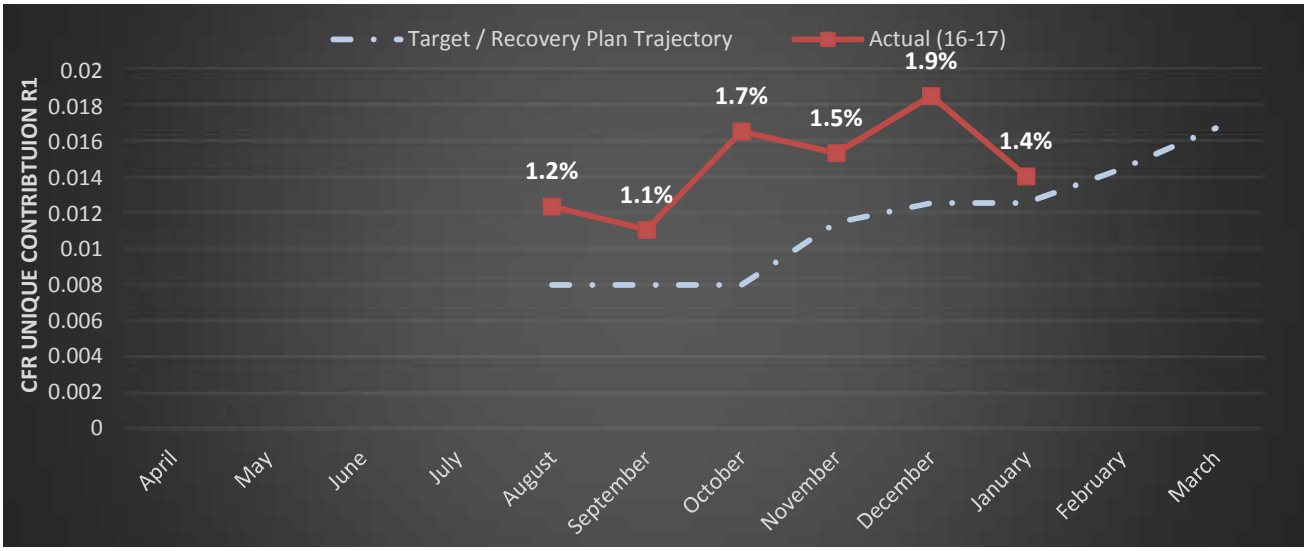

Figure.999-7 - CFR Red 1 Unique Performance Contribution

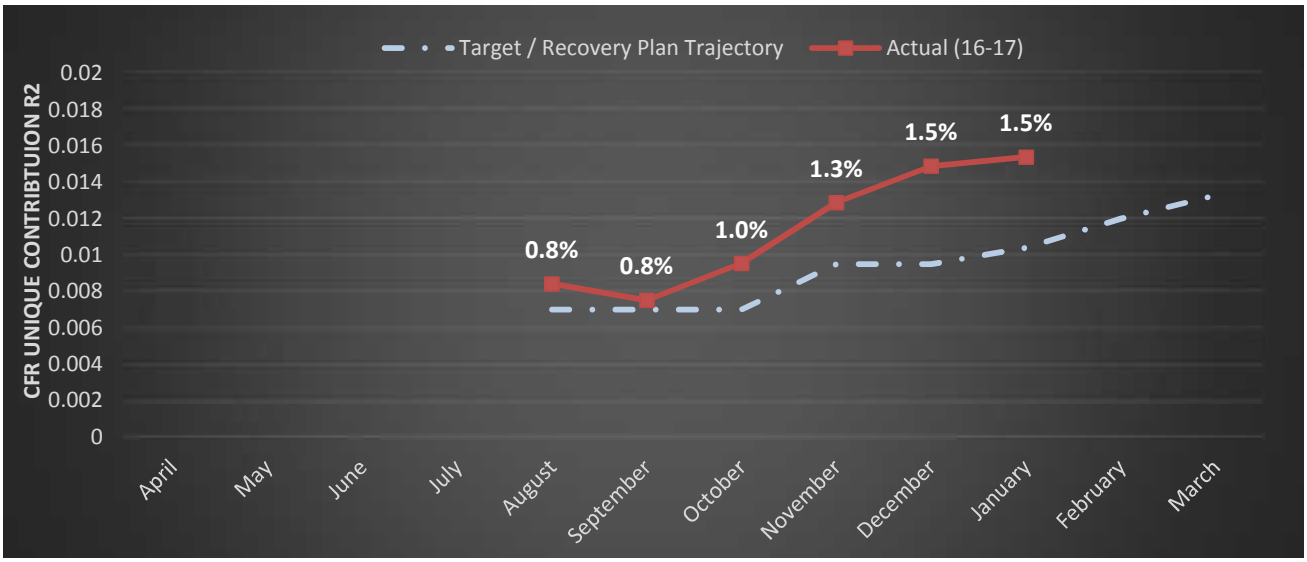

Figure.999-8 - CFR Red 2 Unique Performance Contribution

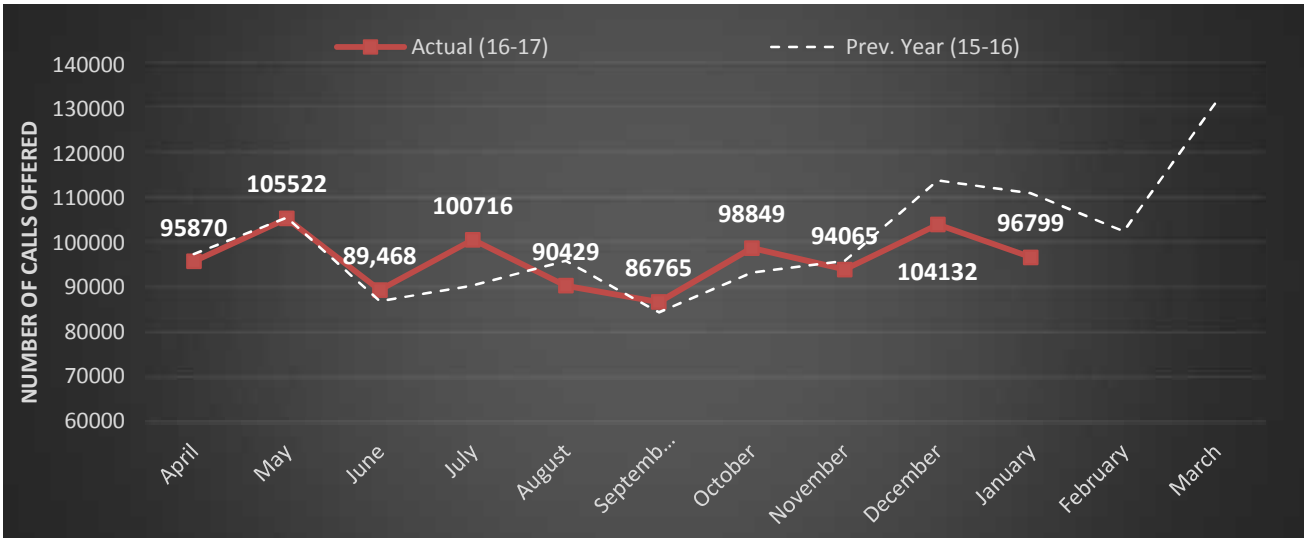

Figure.111-1 - Total Number of calls offered

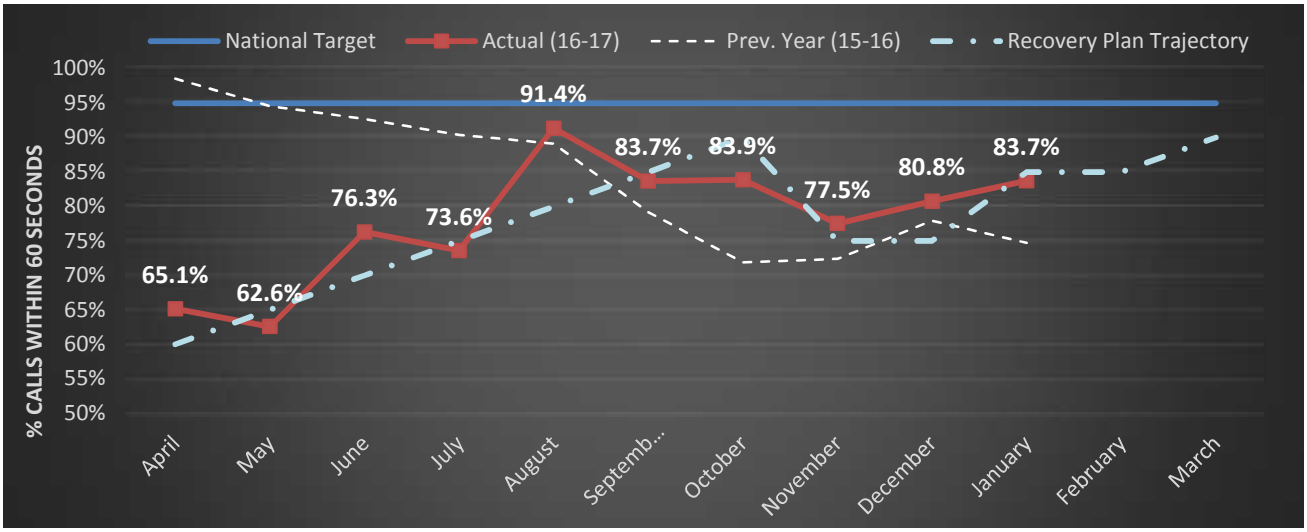

Figure.111-2 - % answered calls within 60 seconds

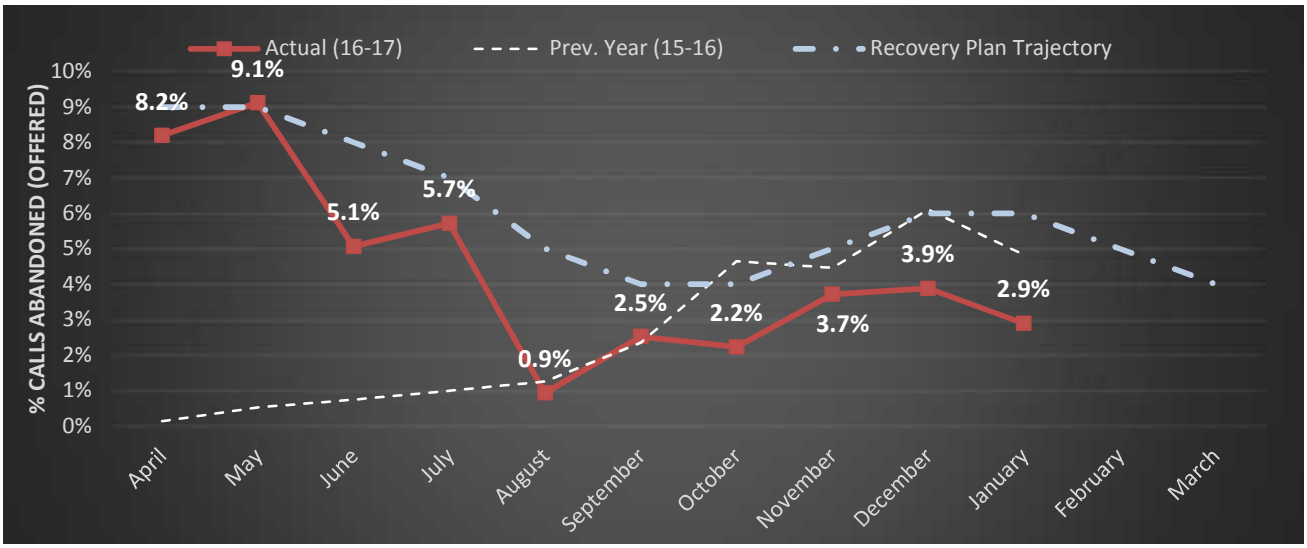

Figure.111-4 - Abandoned calls as % of offered after 30 secs

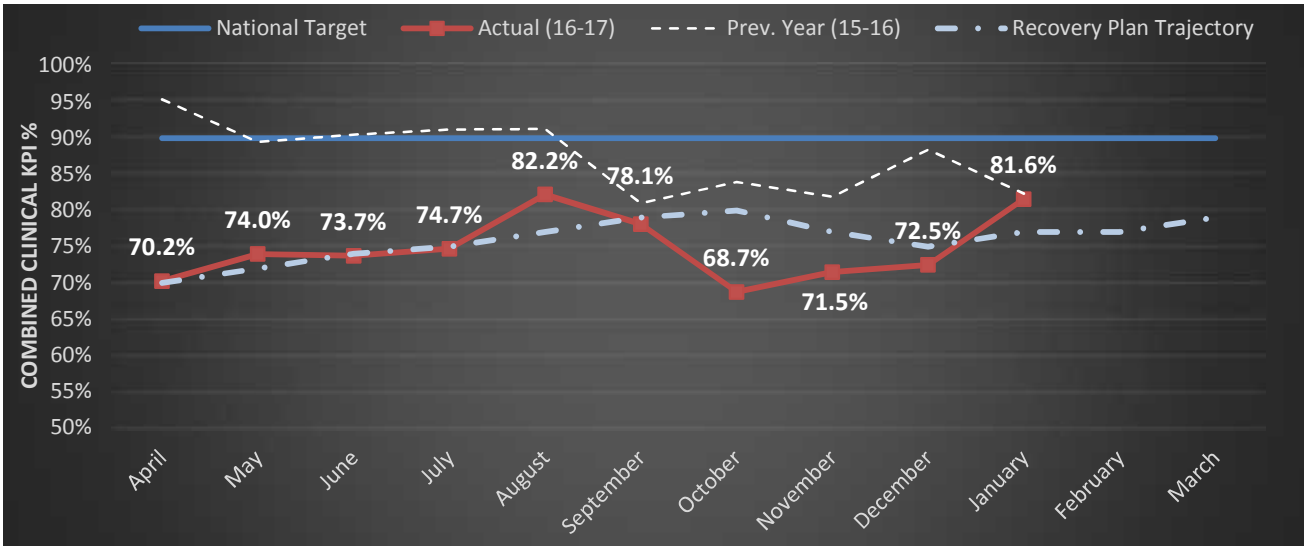

Figure.111-5 - Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)

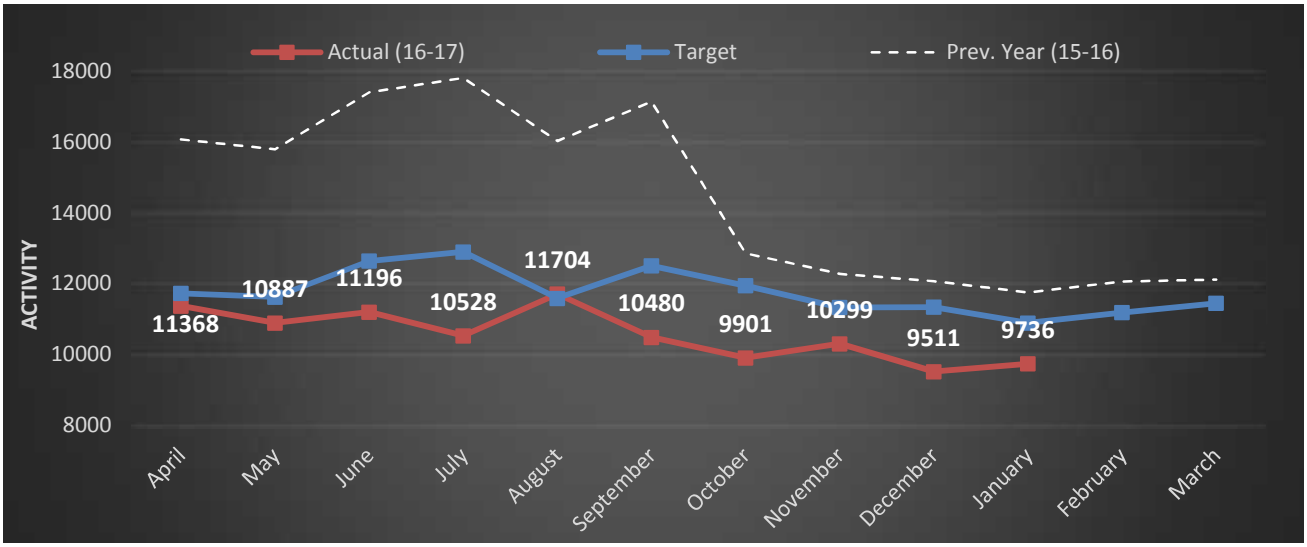

Figure.PTS-1- PTS Activity (Surrey)

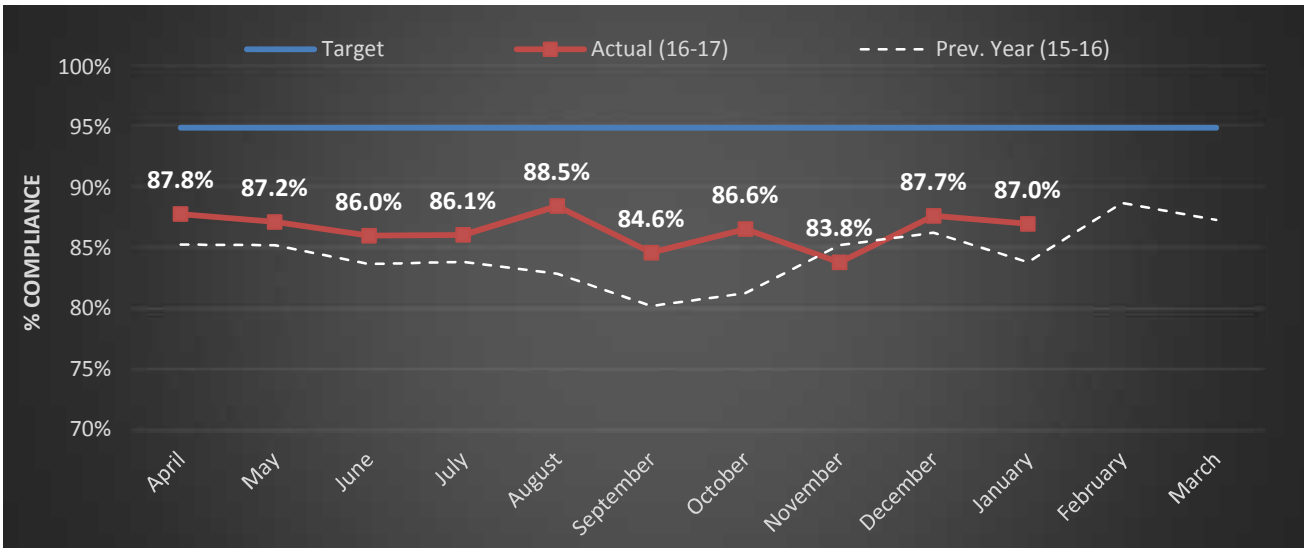

Figure.PTS-2 - Arrival - % patients to arrive <= 15 min after appt. time. (Surrey)

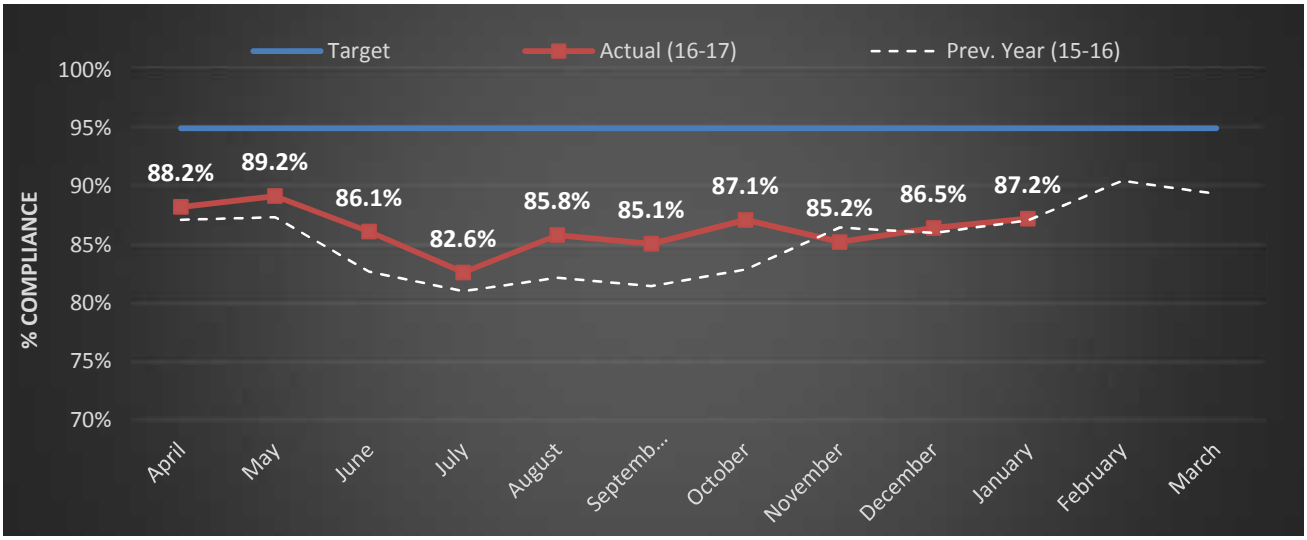

Figure.PTS-3 - Departure - % patients collected <= 60 min of planned collection time (Surrey)

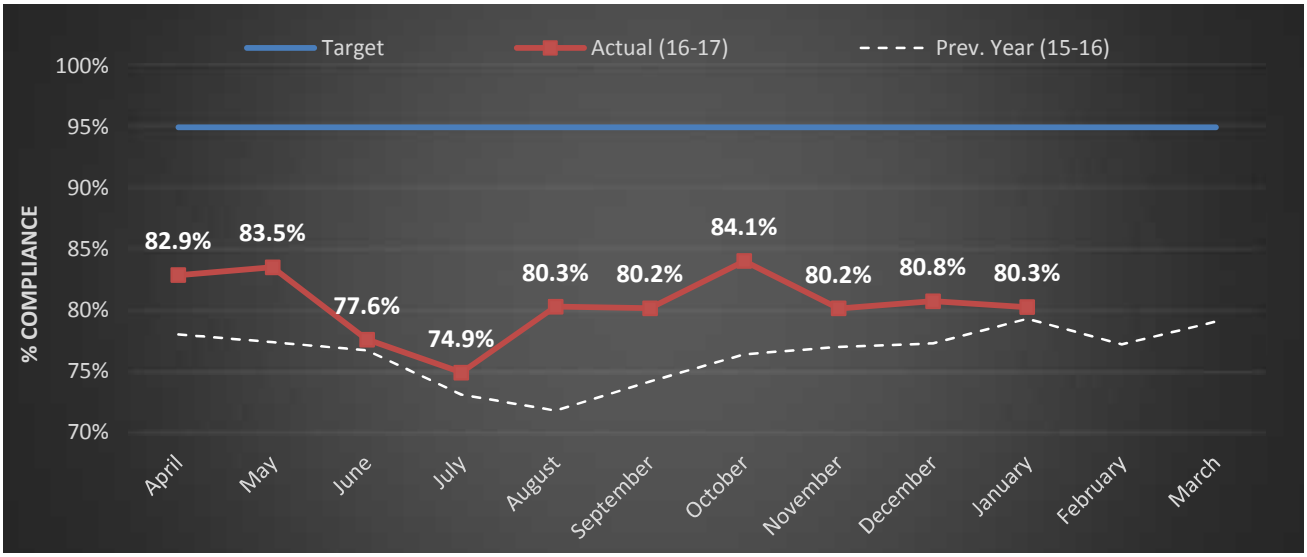

Figure.PTS-4 - Discharge - % patients collected <= 120 min of booked time to travel (Surrey)

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 6 (September 2016). The data continues to show variable standards in delivering patient outcomes.

4.2. Clinical Effectiveness

4.2.1. In September the Trust's performance is better than the national mean for three of the eight *Clinical Outcome Indicators*; Stroke 60 (national ranking 1st), Survival to Discharge (national ranking 6th), Survival to discharge Utstein (national ranking 6th).

4.2.2. The poorest performance is for ROSC Utstein, showing a 5.9% negative variance from the national average. The other indicators which are below the national average are: ROSC, STEMI Care Bundle and Stroke Care Bundle.

<u>In more detail:</u>

4.2.3. **ROSC (All)** – In September 2016, performance has dipped further from the previous two months (July 31.7%; August 26%; September 25.3%), however, performance is more consistent with that at the start of the financial year, and with the same period last year. The further dip in performance has placed the Trust in seventh position nationally.

4.2.4. **ROSC (Utstein)** – In September performance has continued to dip from the previous months (July 69%; August 48.1%; September 44.1%), the Trust has maintained its seventh national position despite the 4% negative variance compare to the previous month's performance. The Trust remains within the national control limits (2 standard deviations).

4.2.5. It must be noted that performance in the Utstein cohort often fluctuates, this is due to the small number on incidents that meet the Utstein inclusion criteria.

4.2.6. **Survival to Discharge (All)** – September performance has slightly improved, bringing the Trust performance above the national average at 9.4%. This has placed the Trust in a higher national ranking (6th) to the previous month, and well within the national control limits (2 standard deviations).

4.2.7. **Survival to Discharge (Utstein)** – September figures shows deteriorated performance following observed improvements in August (August 34.8%; September 30%). However, the Trust remains significantly above the national average with a 4.4% positive variance.

4.2.8. **STEMI 150** – In September performance has taken a further dip from the previous months (July 95.2%; August 89.9%; September 86.7%), this has put the Trust below the national average, however with only 0.1% negative variance.

4.2.9. **STEMI Care Bundle** – Performance for this indicator is consistently below the national average, mainly due poor recording of two pains scores. In September, performance improved from 72.7% to 76.6%, and this has placed the Trust in a seventh national position (from ninth).

4.2.10. **Stroke 60** – In September 2016, 54% of FAST positive patients in England, assessed face to face, and potentially eligible for stroke thrombolysis arrived at hospitals with a hyperacute stroke unit within 60 minutes of an emergency call connecting to the ambulance service.

4.2.11. Whilst Trust performance deteriorated from the previous two months (July 67.2%; August 66.8%; September 62.6%), it is the best performing Trust nationally, with an 8.5% positive variance on the national average.

4.2.12. **Stroke Care Bundle** - In September, performance has improved from the previous month (August 94.2%; September 95.6%). However, the Trust has a national rating of 9th.

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)	50.0%	**44.1%**	58.6%	52.5%	**54.4%**	47.8%
CE-2	Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)	28.7%	**25.3%**	27.5%	29.0%	**27.9%**	27.1%
CE-3	Cardiac arrest -Survival to discharge - Utstein	25.6%	**30.0%**	37.5%	27.1%	**28.8%**	24.0%
CE-4	Cardiac arrest -Survival to discharge - All	9.3%	**9.4%**	9.0%	9.0%	**8.4%**	8.6%
CE-5	Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)	79.7%	**76.6%**	66.7%	79.6%	**69.2%**	66.8%
CE-6	Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes	86.9%	**86.7%**	90.7%	86.3%	**90.9%**	93.5%
CE-7	% of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes	54.1%	**62.6%**	64.5%	54.9%	**67.3%**	65.3%

CE-8	% of suspected stroke patients assessed face to face who received an appropriate care bundle	97.2%	**95.6%**	96.0%	97.6%	**96.0%**	96.3%

4.4. Clinical Effectiveness Charts

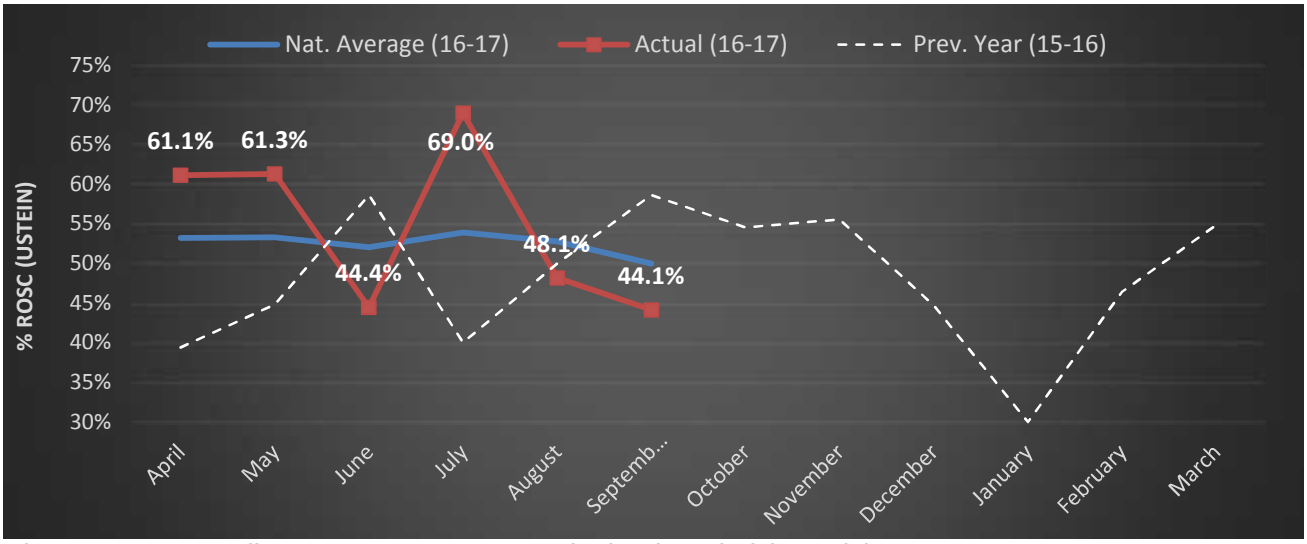

Figure.CE-1 - Cardiac arrest - ROSC on arrival at hospital (Utstein)

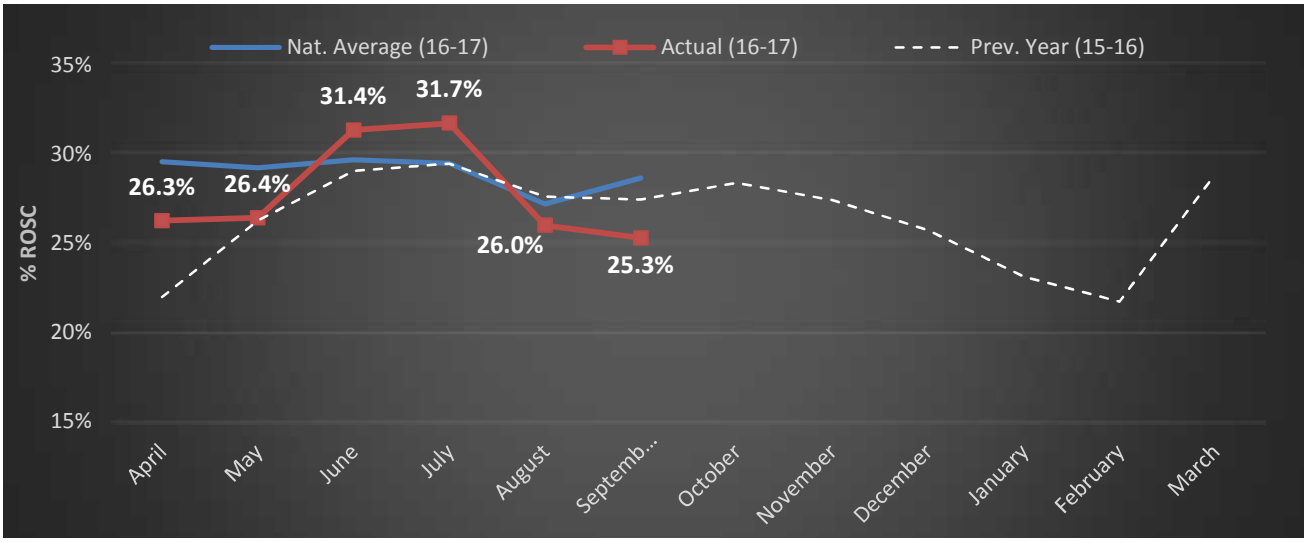

Figure.CE-2 - Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)

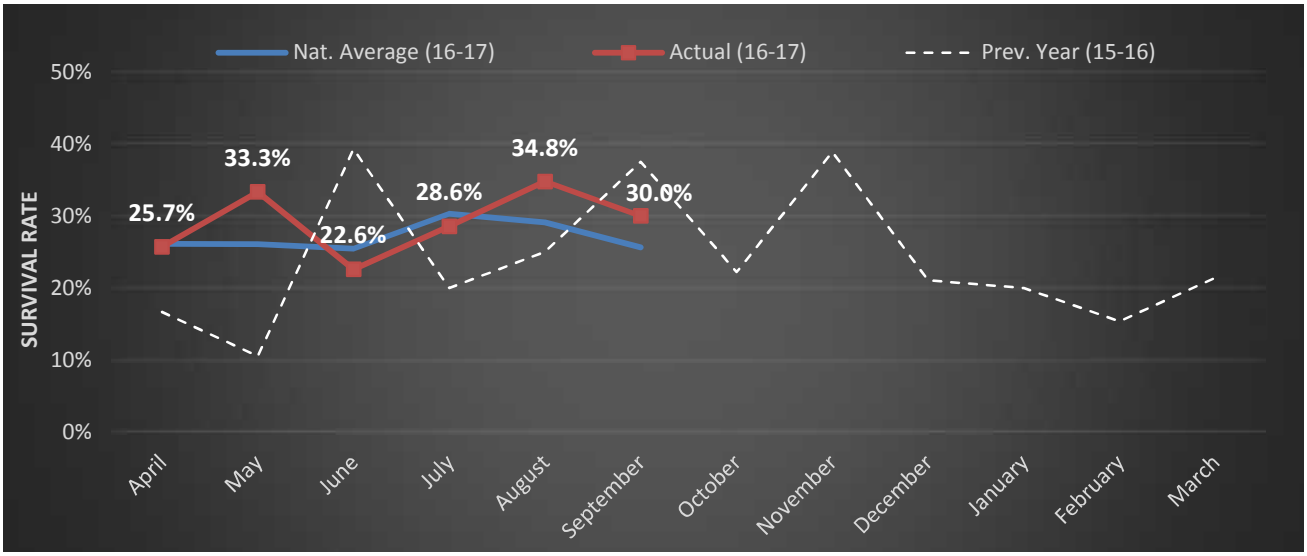

Figure.CE-3 - Cardiac arrest -Survival to discharge - Utstein

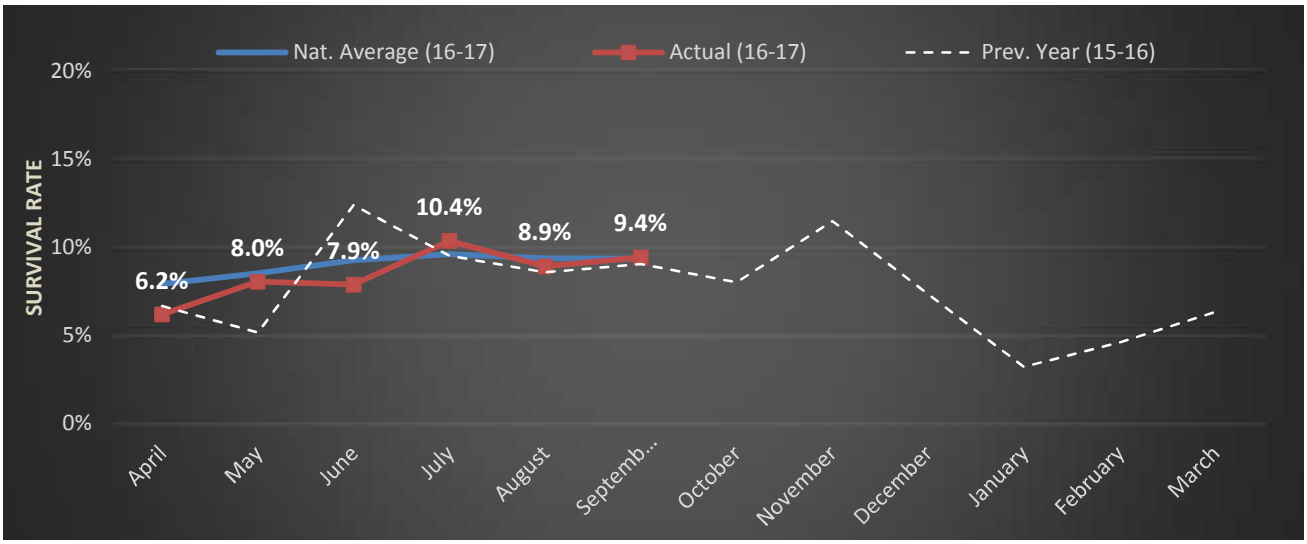

Figure.CE-4 - Cardiac arrest -Survival to discharge – All

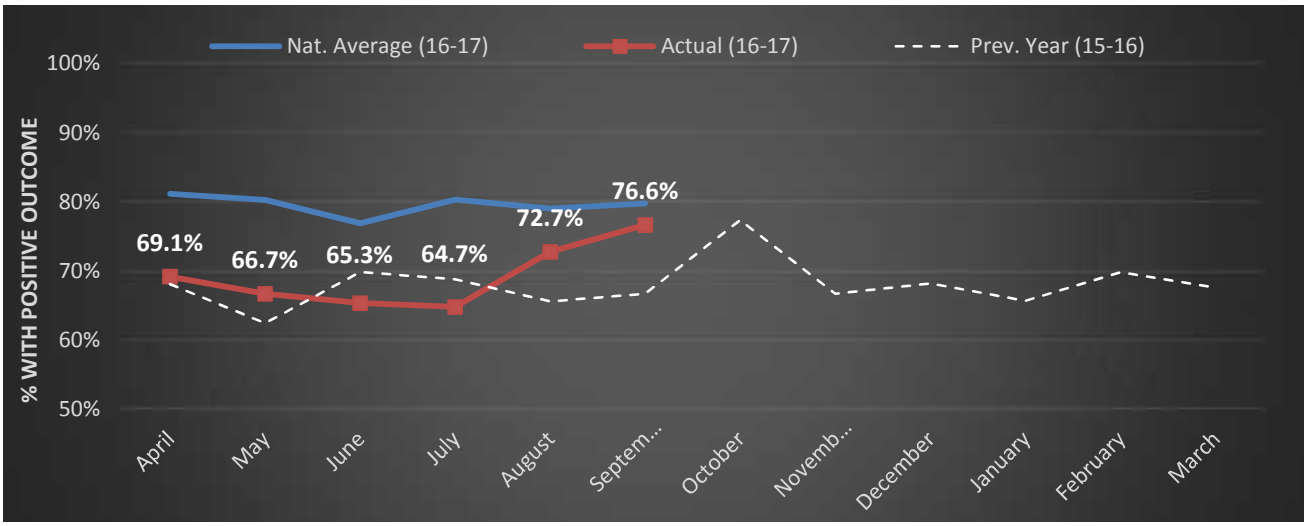

Figure.CE-5 - Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)

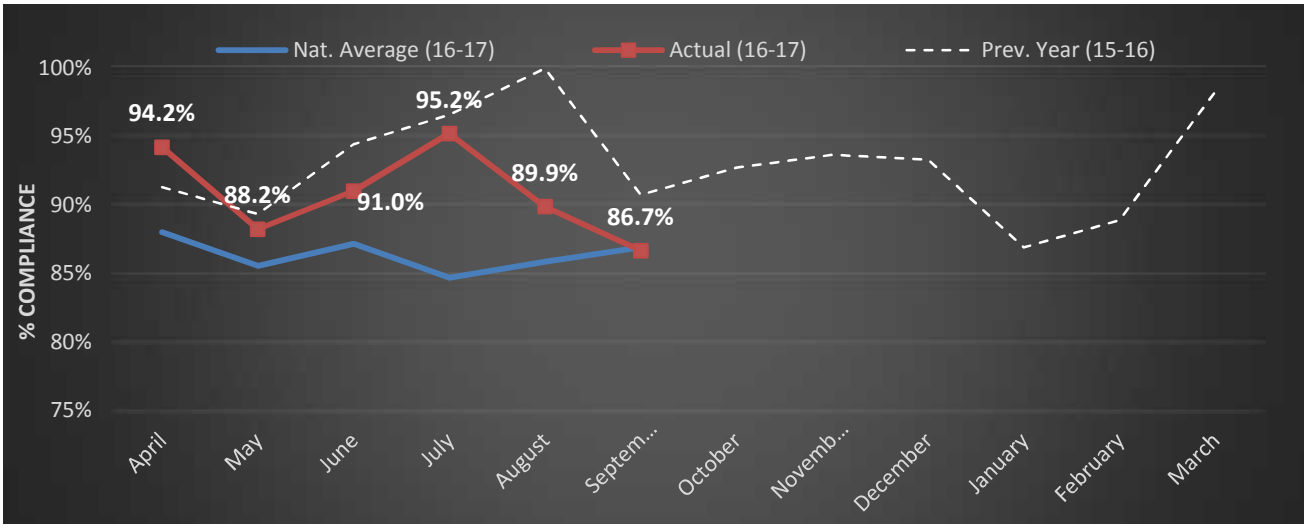

Figure.CE-6 - Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes

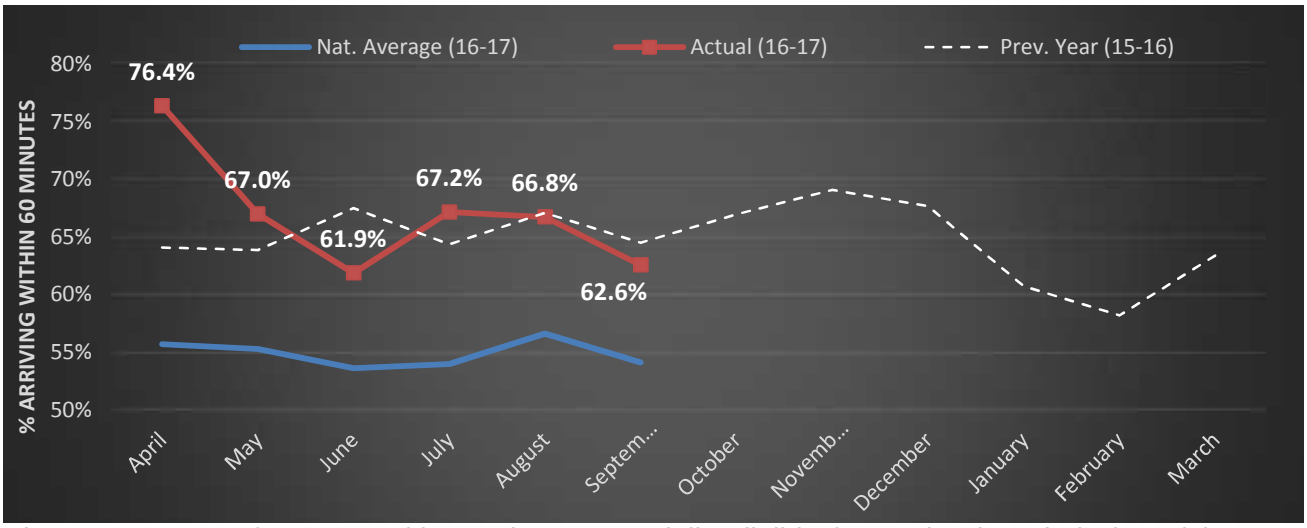

Figure.CE-7 - % of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper acute stroke unit within 60 minutes

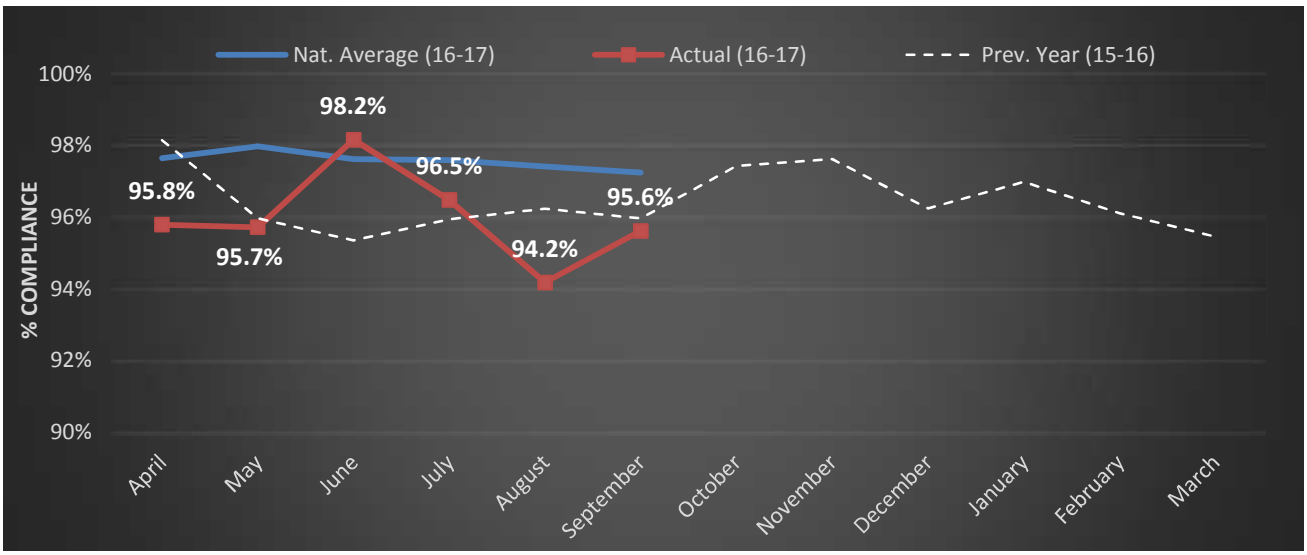

Figure.CE-8 - % of suspected stroke patients assessed face to face who received an appropriate care bundle

5. Quality & Patient Safety

5.1. Quality & Patient Safety Summary

5.1.1. The incident reporting system DATIX has been upgraded and incident categories reviewed in conjunction with service users. Incident reporting remains consistent for the year and has continued to improve and increase in comparison from 2015/16

5.1.2. Safeguarding level 3 training has been introduced and an annual plan for level 3 training developed. Capacity assessments have been developed and are supported with on line mental capacity assessment training to go live in February. Level 1 training is non complaint with trajectory. Level 2 will be the minimum standard training from all staff from April 2017.

5.1.3. The number of incidents reported continues to be above 2015-16 levels. With Serious Incidents (Sis) reporting, there are 30 outgoing investigation reports, with 14 having breached their deadlines.

5.1.4. Of the four Sis' reported in January, three relate to non-conveyance and subsequent deterioration of the patient. Two of the few Sis' in January were reported within 72 hours of occurring.

5.1.5. Duty of Candour currently remains unrecorded across the Trust.

5.1.6. Complaints has demonstrated an in month improvement for "on time return rate" from 72% to 82%, the implementation of a complaint call back initiative have contributed to the timeliness of Returns.

5.2. Quality & Patient Safety Commentary

5.2.1. Over the last month the Incident reporting system has been reviewed with the provider (DATIX) and service users, to include areas of the facility which were underused and significantly rationalising categories for reporting to discourage the use of the "other" category. This change will improve the reporting of themes to allow the Trust to focus on areas of risk and improvement. This upgrade will be piloted end of February with go live targeted for first week in March. Incident reporting remains consistent and above average for the previous year. One serious incident was declared following an incident raised through DATIX. The Incident Management and Reporting Policy remains in consultation end date confirmed as end of February. The policy will need to be shared within the teams to ensure incident reporting compliance is embedded.

5.2.2. Safeguarding – Level 3 training has been introduced to the Trust. The first pilot training started in January 2017 for senior clinical staff. This training will be rolled out to all senior clinical staff in the next year with dates, venues and abstractions agreed. The level 3 training will be validated by an external safeguard lead and will include both adult and children level 3 training, this training will encourage staff to review incidents and give advice on recording and reporting and keep patients safe from harm, giving staff the education needed to act confidentially and consistently in respect of safeguarding.

5.2.3. Level 1 training will continue until April 2017 and subsequently superseded by a minimum level 2 training for all staff after April. Mental Capacity Assessment on line training will become live on February 4th 2017. Supported by the mental capacity

assessment documentation, which has been validated externally by a safeguarding lead. Reporting of incidents for safeguarding throughout the month remain consistent with previous months. For assurance the external safeguard lead will undertake a review of the process for assurance in both 111 and 999 pathways in March to ensure consistency in approach, and propose an audit process moving forward. Level 1 training compliance remains low at 50%, individuals who are non-compliant have been identified and will contacted along with their line manager in February. Level 1 training will be amalgamated with level 2 training from April 2017, ensuring that all staff will be trained at level 2 as a minimum requirement.

5.2.4. One incident was reported in January involving a staff member, this has been reported in accordance with the Trusts procedures.

5.2.5. A 2-day investigation training programme will take place in Feb 2017. 16 senior investigating staff have been given the opportunity to attend the aim of the training will be to introduce standard documentation and reporting. The programme will focus on all aspects of investigation reporting. This training is externally supported by Kent Surrey Sussex Academic Health Science Network with associate CPD accreditation and will have continued support from the Trusts Quality Lead for future investigations. The training will promote a constant and evidence based approach to reporting, the aim will be to improve the Trust formal reporting to provide a clear and concise report to the executive board, commissioners the patients and carers.

5.2.6. Of the 30 SIs are outstanding for submission to the commissioners. 14 have breached their deadlines work has been ongoing the last month to finalise the investigations and get them through the review process so they can be submitted. Two have been through the review stages and should be receiving executive sign-off for submission to the commissioners. Of the 4 serious incidents reported 3 relate to non-conveyance and subsequent patient deterioration and the fourth of an undiagnosed fracture. 50% of the Sis reported in month met the 72-hour reporting. The DATIX system upgrade will support timely reporting and consistent duty of candour being reported.

5.2.7. The Trust has reintroduced the 25-day complainant reporting target (from 30 days). The Trusts performance has improved in month from 72.6 % to 81.8%. 21 late complaints from with EOC or A&E, 2 complaints were overlooked from the complaints and PALs department and one awaiting 3rd party information. A call back to complainant initiatives has been introduced. This initiative identifies with the complainant what are the key issues, time frames and how they would like their concern responded to, this can focus the individual teams in their lines of enquiry. The aim will be to reduce complaints returned and improve patient satisfaction.

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%	50.0%				

QS1b	SI Investigation timeliness (60 days)	100%		100.0%	100%	**64.3%**	100.0%
QS1c	Number of Incidents reported		**529**	**472**		**5088**	4430
QS1d	Number of Incidents reported that were SI's		**1**	**0**		**20**	21
QS1e	Duty of Candour Compliance		100%				
QS2a	Number of Complaints		**132**	157		**132**	157
QS2b	Complaints reporting timeliness (All Complaints)	95.0%	**81.8%**	80.0%	95.0%	**64.8%**	61.8%
QS3a	Number of Safeguarding Referrals		**823**	914		**8817**	8768
QS3b	Safeguarding Referrals relating to SECAmb staff or services		**1**	2		**4**	4
QS3c	Safeguarding Training Completed (Adult) Level 1		**228**				
QS3d	Safeguarding Training Completed (Children) Level 1		**228**				
QS3e	Safeguarding Training Completed (Adult) Level 2		2962				
QS3f	Safeguarding Training Completed (Children) Level 2		2977				

5.4. Quality & Safety Charts

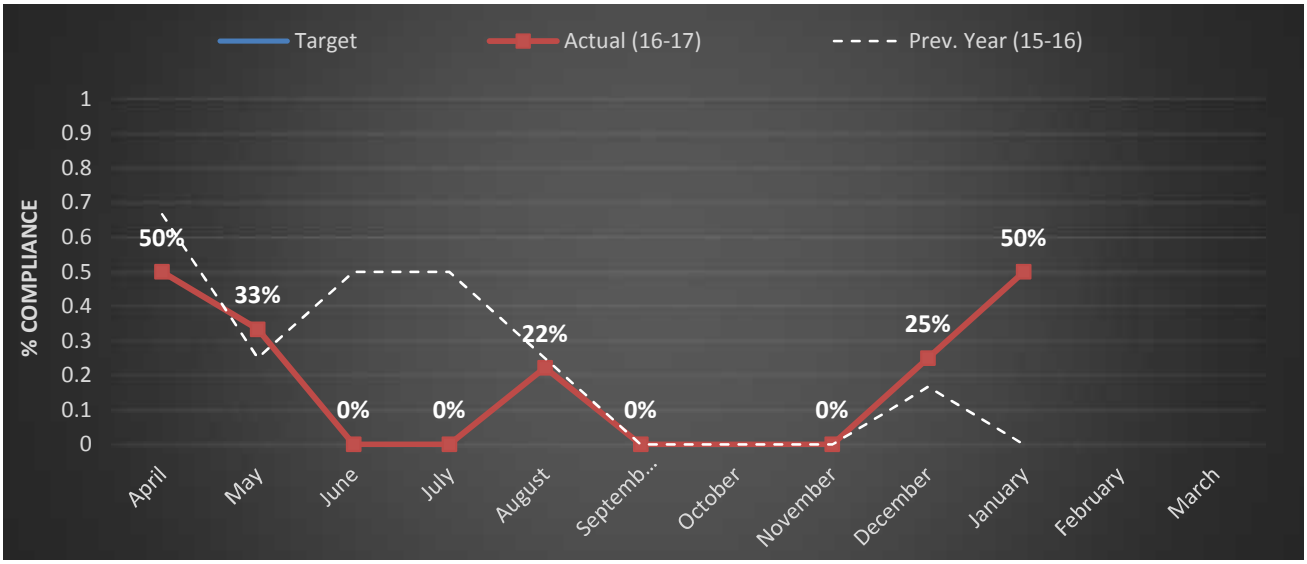

Figure.QS1a - SI Reporting timeliness (72hrs)

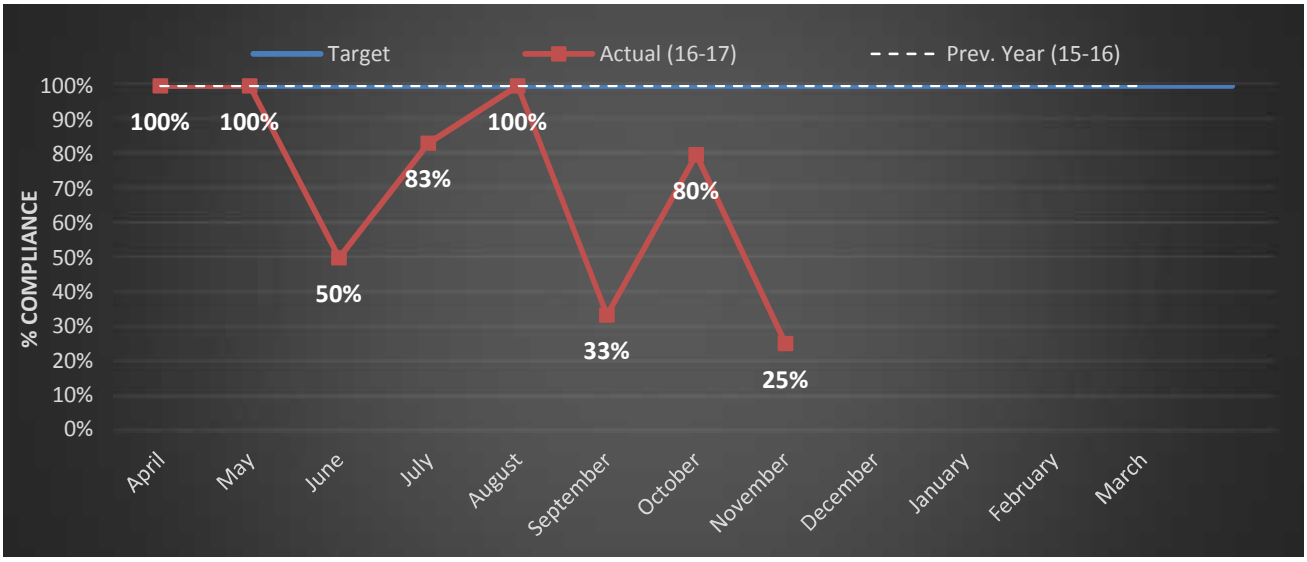

Figure.QS1b - Serious Incident (SI) Investigation timeliness (60 days). Please note that no SI's were due for completion for last month (no data points will be shown)

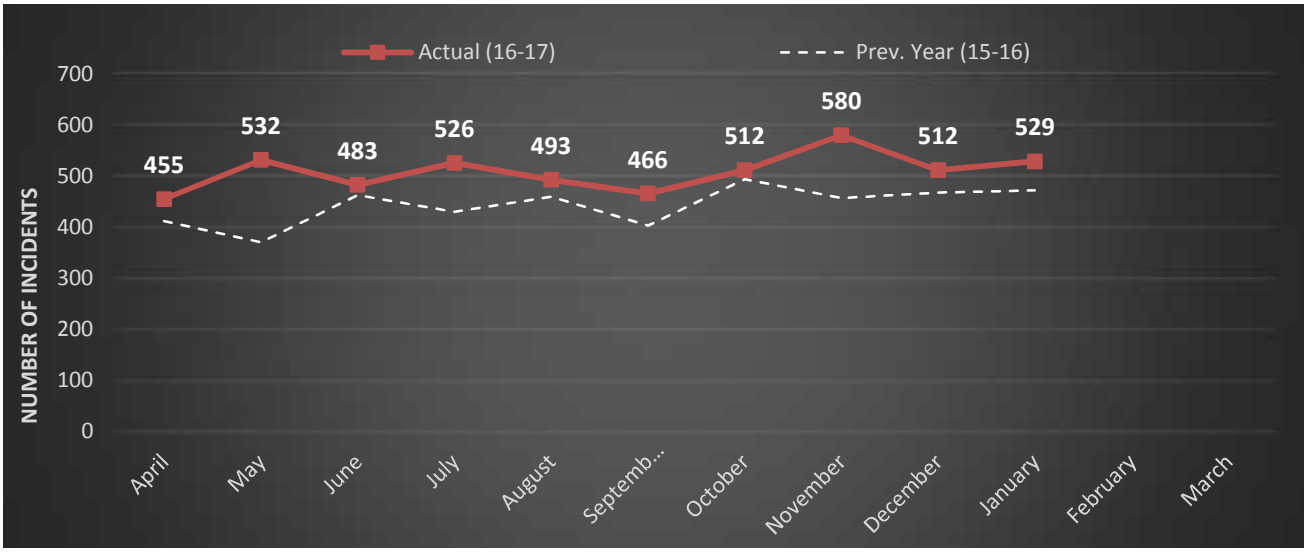

Figure.QS1c - Number of Incidents reported

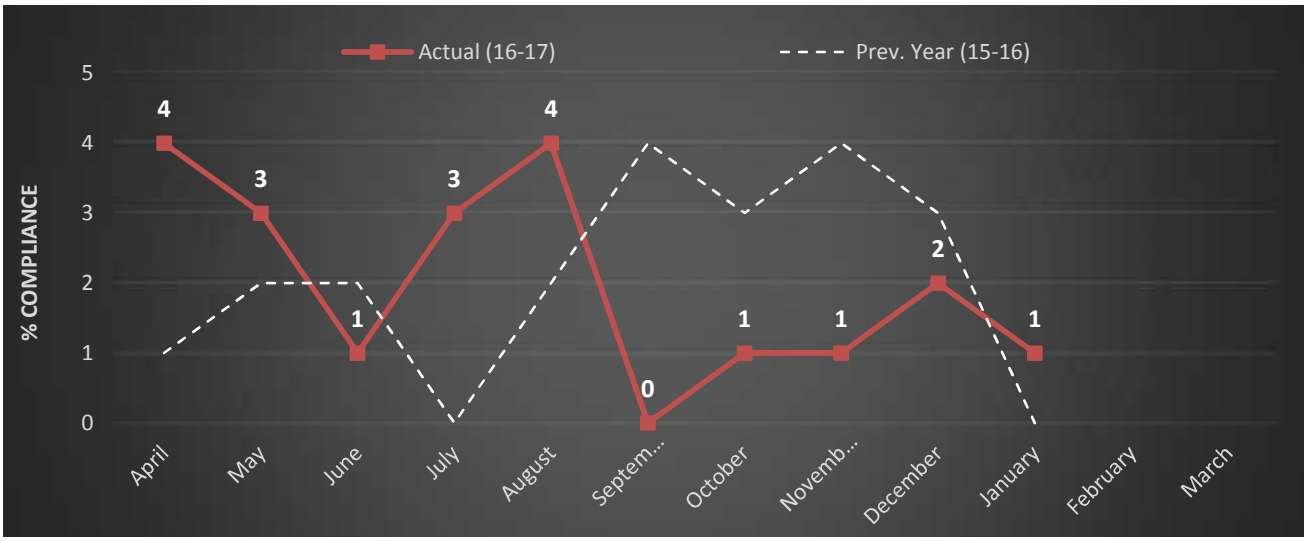

Figure.QS1d - Incidents reported that were SI's

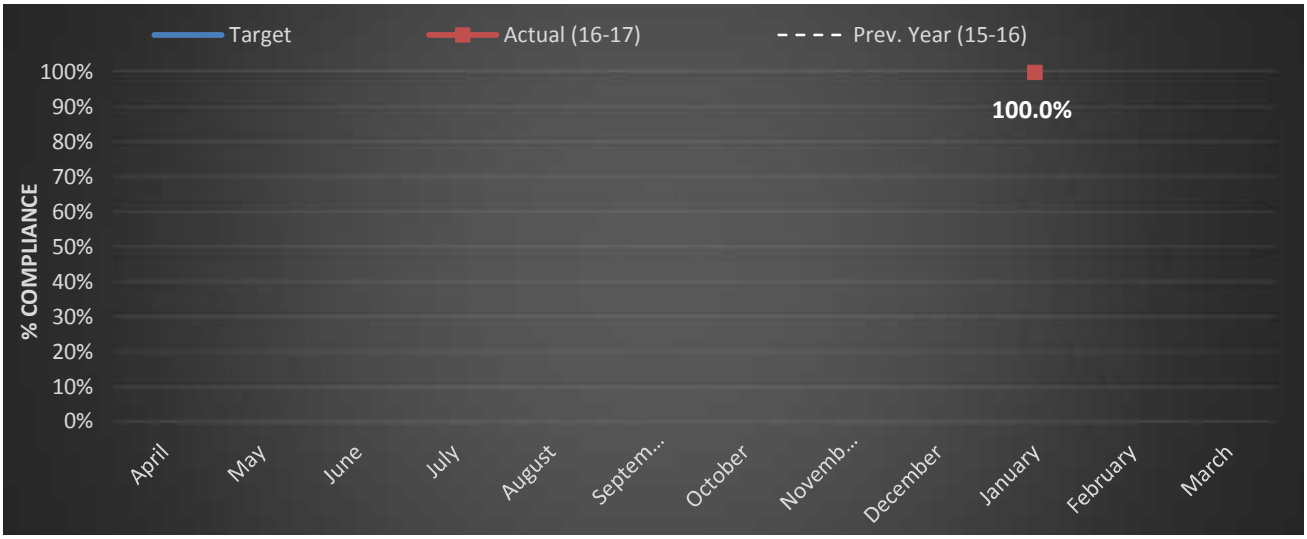

Figure.QS1e - Duty of Candour Compliance

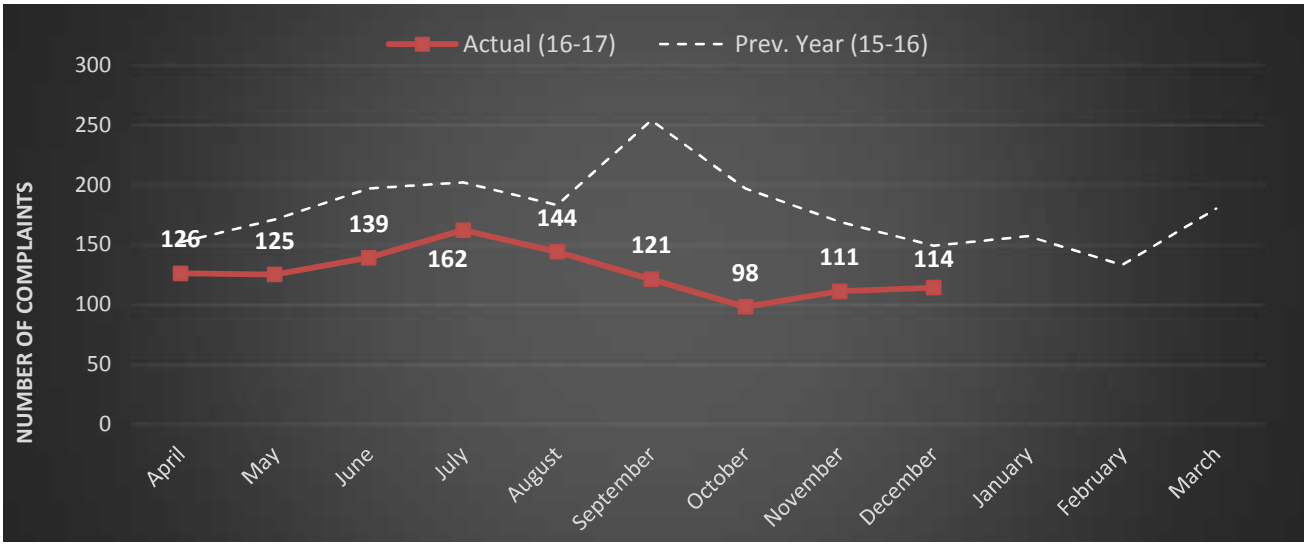

Figure.QS2a - Number of Complaints

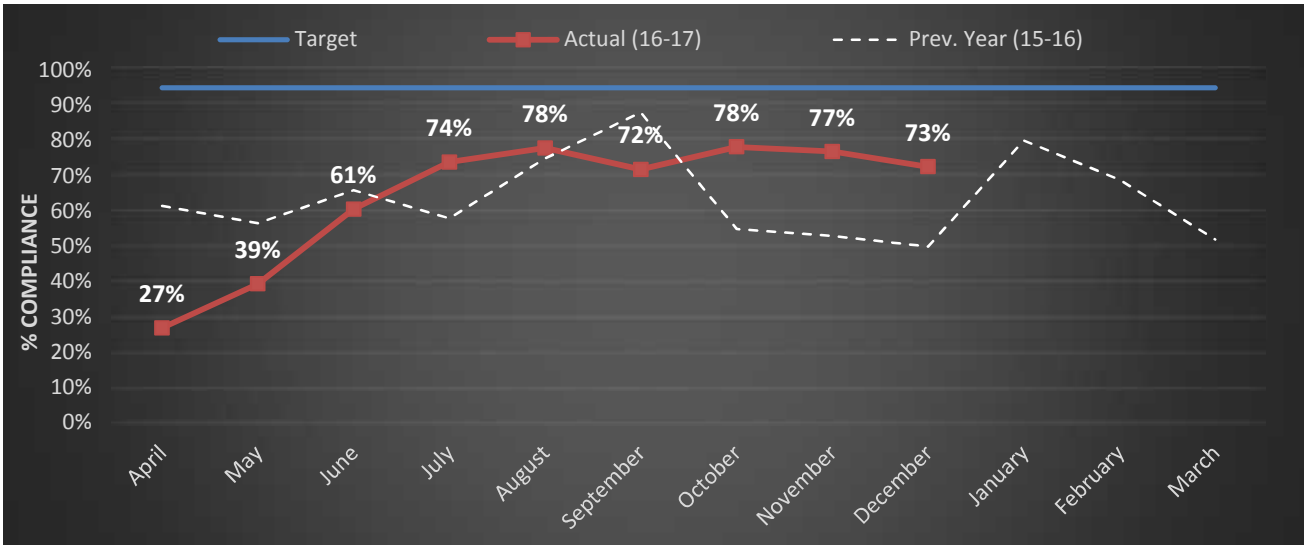

Figure.QS2b - Complaints reporting timeliness (All Complaints)

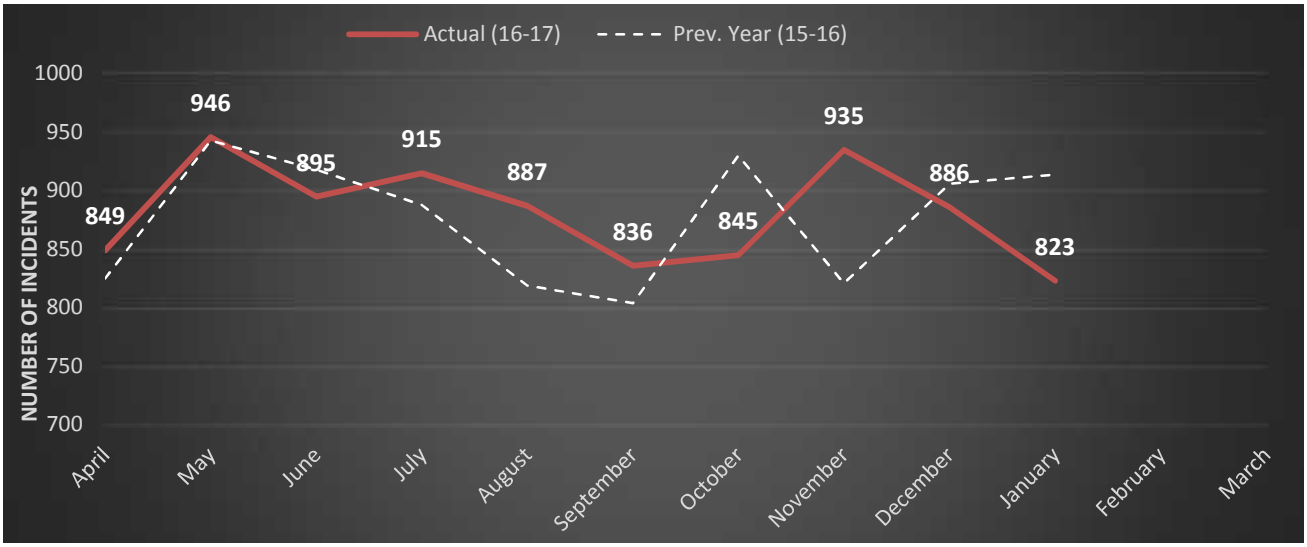

Figure.QS3a - Safeguarding Referrals

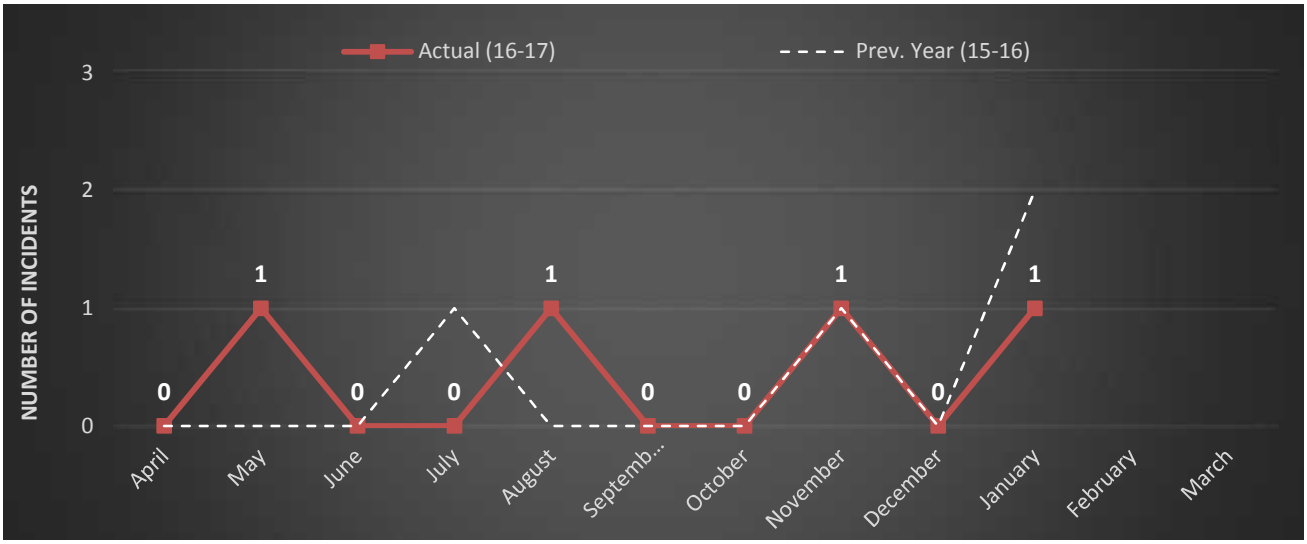

Figure.QS3b - Safeguarding Referrals relating to SECAmb staff or services

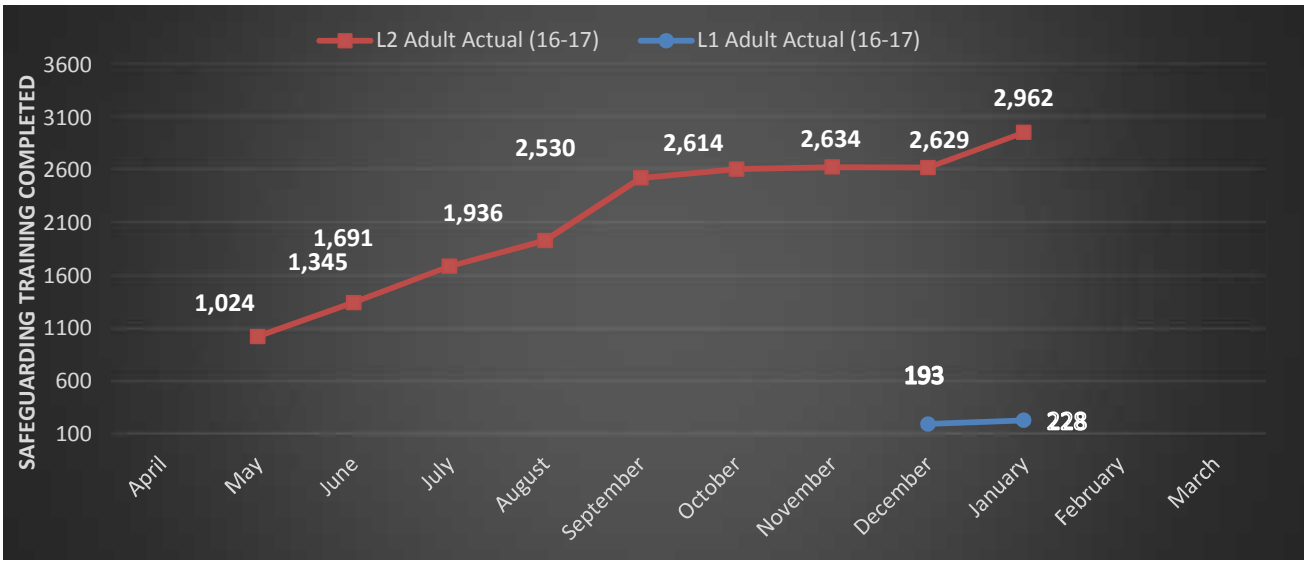

Figure.QS3c and QS3e - Safeguarding Training Completed Adult, Level 1 and 2

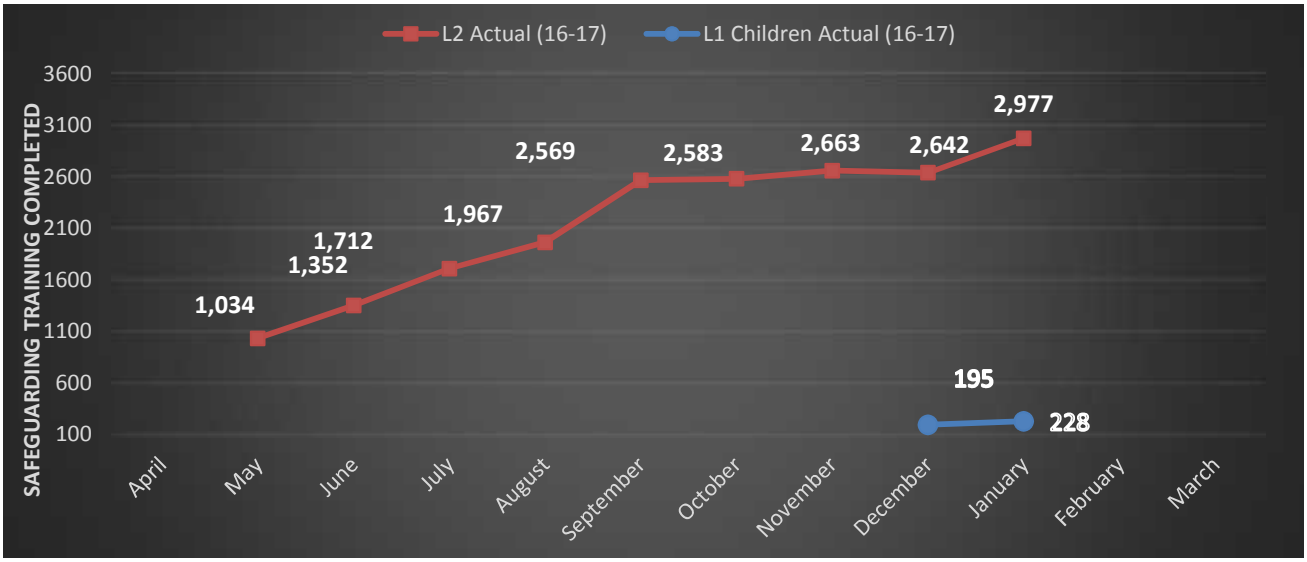

Figure.QS3d and QS3f - Safeguarding Training Completed Children, Level 1 and 2

6. Finance

6.1. Finance Summary

6.1.1. The YTD deficit at M10 of £6.3m means that the Trust remains on track to deliver the £7.1M yearend position declared to NHSI at M3.

6.1.2. Please note, the month 10 cumulative position includes £0.2m of costs relating to the Paramedic re-banding from 5 to 6. This was following a written instruction from NHSI received on 13th February. The Trust has been asked not to include additional income to support these costs (as explicitly instructed by NHSI). In the absence of this income the cost of re-banding changes the FOT deficit adversely from £7.1m to £7.7m. The Trust has been advised by NHSI that discussions are ongoing between Department of Health and NHS England around funding the costs of the Paramedic re-banding, therefore the adverse movement in our FOT is fully expected by NHSI.

6.1.3. The underlying position therefore excluding these costs remains at a £7.1m deficit and the Trust remains hopefully that the funding delay will be resolved quickly.

6.1.4. The Trust continues to be at level 4 using the new NHSI Use of Resources Rating (UOR), which potentially triggers financial special measures. The drivers behind the adverse rating have been the variance against APR largely as a result of agency expenditure. The Trust has addressed spend on temporary staffing and the number agency staff has reduced from 170wte to 110wte in January with further reductions planned. The FOT on agency spend indicates a lower UOR by 31 March 2017. In addition, controls around discretionary spend have been tightened and there is greater scrutiny on all purchase orders, which now require senior manager approval. Other areas being looked at include legal costs, medicines management and training costs.

6.2. Finance Commentary

6.2.1. The YTD adverse variance of £7.1m (excluding paramedic costs) against the APR is across all service lines.

6.2.2. The key drivers within 999 continue to be; the price of hours with costs being higher than planned as the recruitment is lower than the original workforce plan resulting in a higher reliance on PAPS. Hospital handover delays continue to affect job cycle time and remain higher than expected with over 7,950 additional hours lost in January compared to 7,700 hours in December. This is 64% worse than last year and is a situation which is being seen nationwide.

6.2.3. Fleet is overspent by £0.3m YTD mainly on fuel costs.

6.2.4. PTS performance was positive in January however the YTD position is £0.7m adverse against plan. Activity is 22% below expectations resulting in a 17.5% 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.

6.2.5. The financial performance in KMSS111 has improved in recent months, and January reported a £0.1m surplus. The YTD position remains an adverse variance of £0.2m; however, the forecast is expected to improve over the remaining months. The improvement in month is attributable to additional income from the East Kent contract extension and reduction in expenditure on agency spend as agency staff move to permanent contracts.

6.2.6. The YTD capital expenditure of £12.9m is £5.6m below the APR mainly because of delays in the vehicle replacement programme whilst the replacement strategy is developed to support future operating requirements.

6.2.7. The Trust's YTD cash balance of £8.8m is £2.6m lower than the original plan. This has improved from last month's position due to the drawdown of £3.1m of the working capital facility following Board approval in December. This is in line with expectations.

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)	£ 16,212	£ 17,542	£ 17,539	£161,486	£ 164,360	£168,302
F-2	Expenditure (£'000)	£ 16,182	£ 17,614	£ 16,924	£160,615	£ 170,670	£168,617
F-6	Surplus/(Deficit)	£ 30	£ 72	£ 616	£ 871	£ 6,310	-£ 315
ID**	**KPI**	**Current Quarter (Plan)**	**Current Quarter (Actual)***	**Current Quarter (Prev. Yr.)**	**YTD (Plan)**	**YTD (Actual)***	**YTD (Prev. Yr.)**
F-5	CQUIN - Quarterly (£'000)*	£ 1,038		£ 1,013	£ 3,724		£ 3,688
ID**	**KPI**	**Current Month (Plan)**	**Current Month (Actual)**	**Current Month (Prev. Yr.)**	**YTD (Plan)**	**YTD (Actual)**	**YTD (Prev. Yr.)**
F-3	Capital Expenditure (£'000)	£ 1,175	£ 1,261	£ 2,263	£ 18,528	£ 13,621	£ 16,104
F-7	Cash Position (£'000)	£ 11,383	£ 8,770	£ 18,124	£ 11,383	£ 8,770	£ 18,124
F-4	Cost Improv. Prog. (CIP) (£'000)	£ 642	£ 552	£ 949	£ 6,012	£ 6,152	£ 8,231
F-8	Agency Spend (£'000)	£ 336	£ 633	£ 572	£ 3,353	£ 5,674	£ 5,662

** 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).*

6.4. Finance Charts

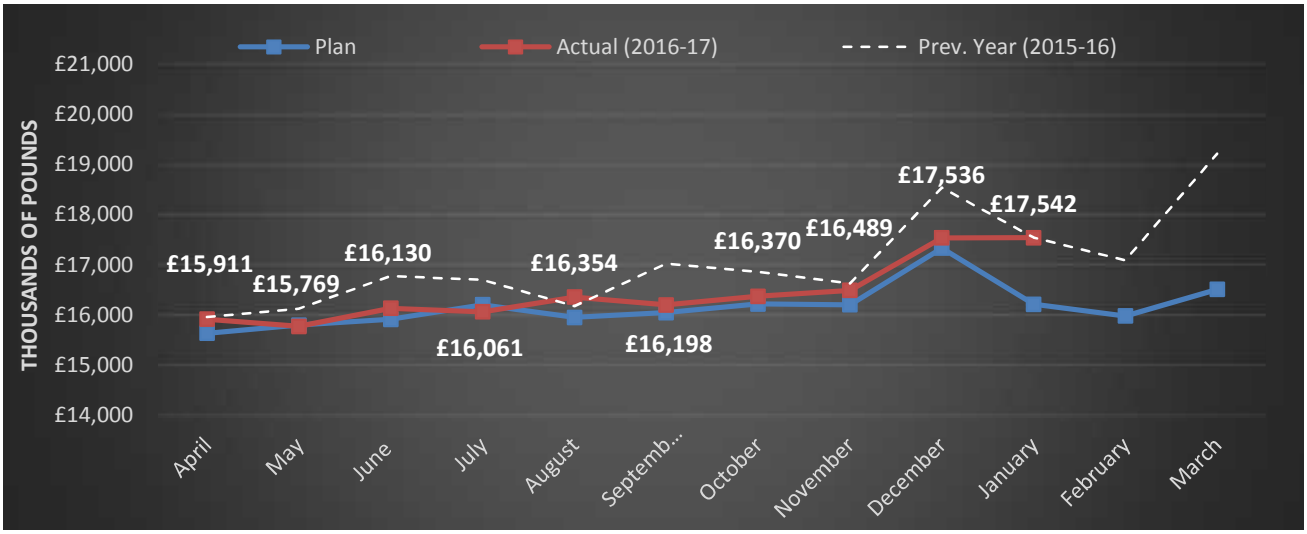

Figure.F-1 - Income (£'000)

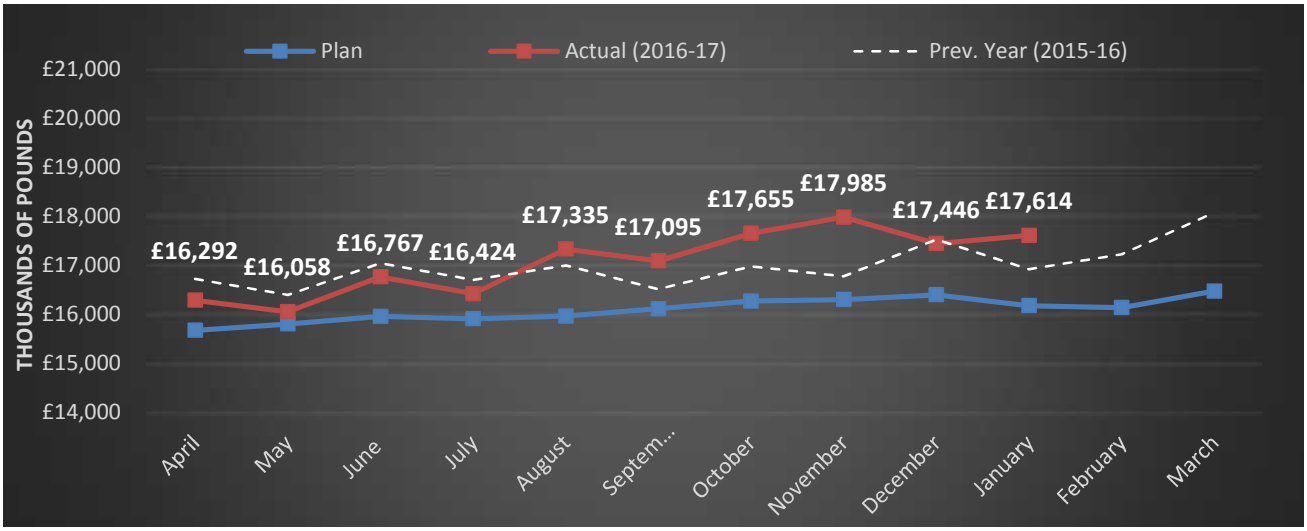

Figure.F-2 - Expenditure (£'000)

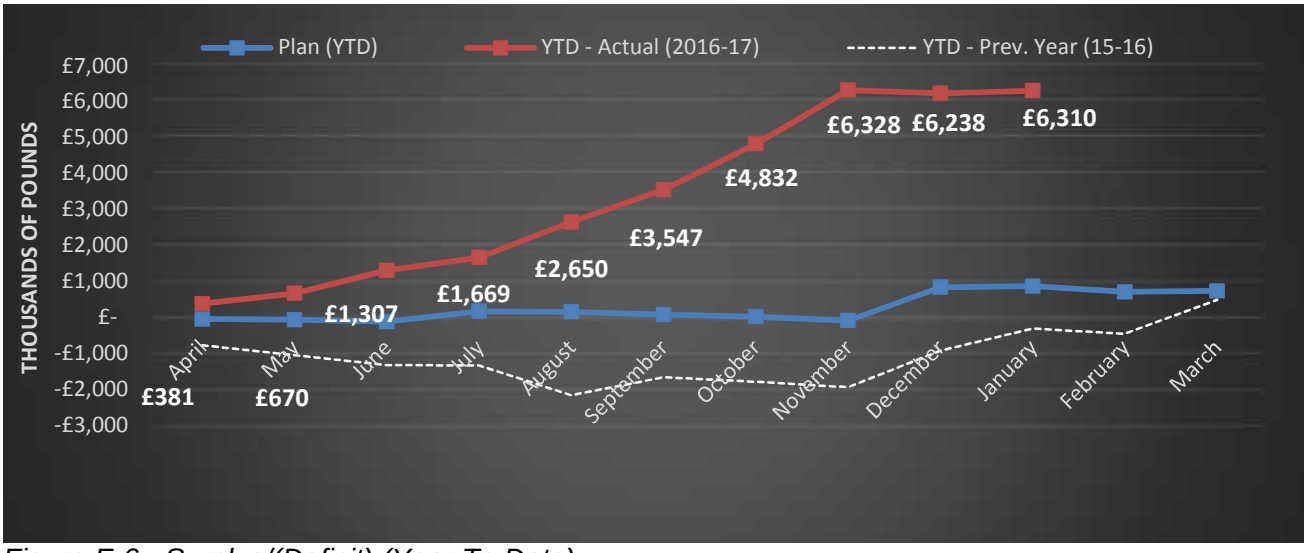

Figure.F-6 - Surplus/(Deficit) (Year To Date)

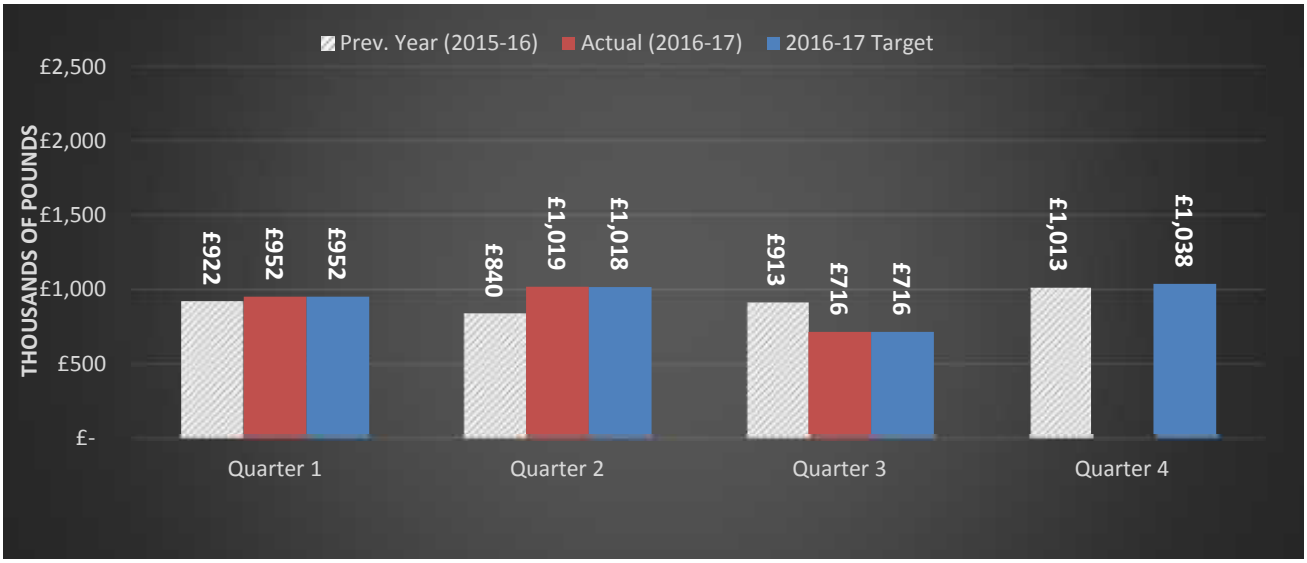

*Figure.F-5 – CQUIN - Quarterly (£'000)**

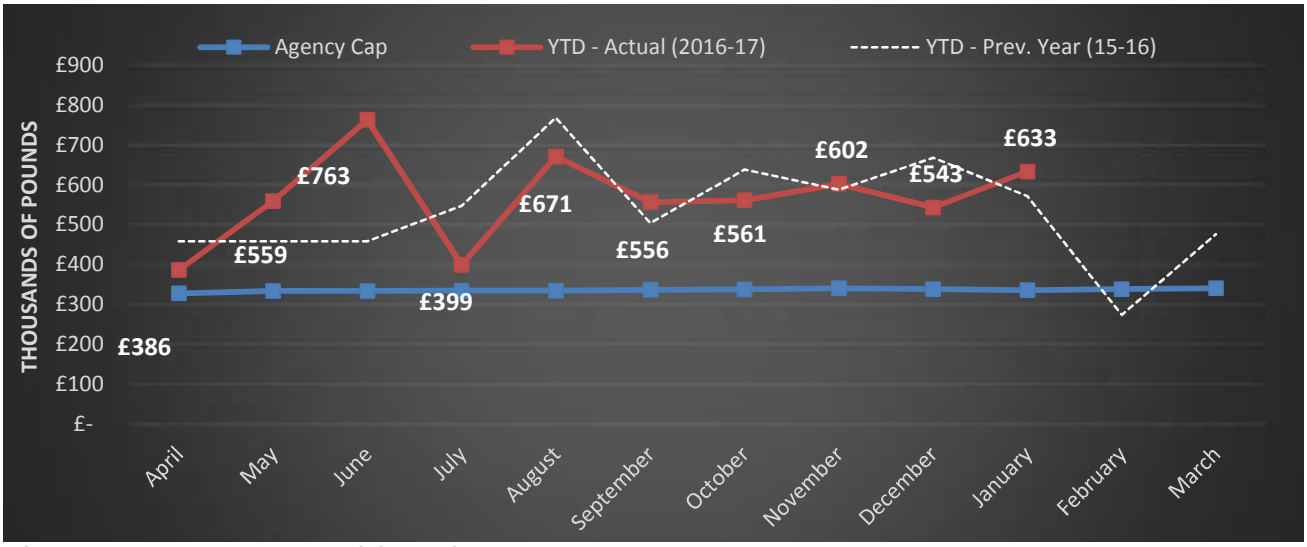

Figure.F-8 – Agency Spend (£'000)

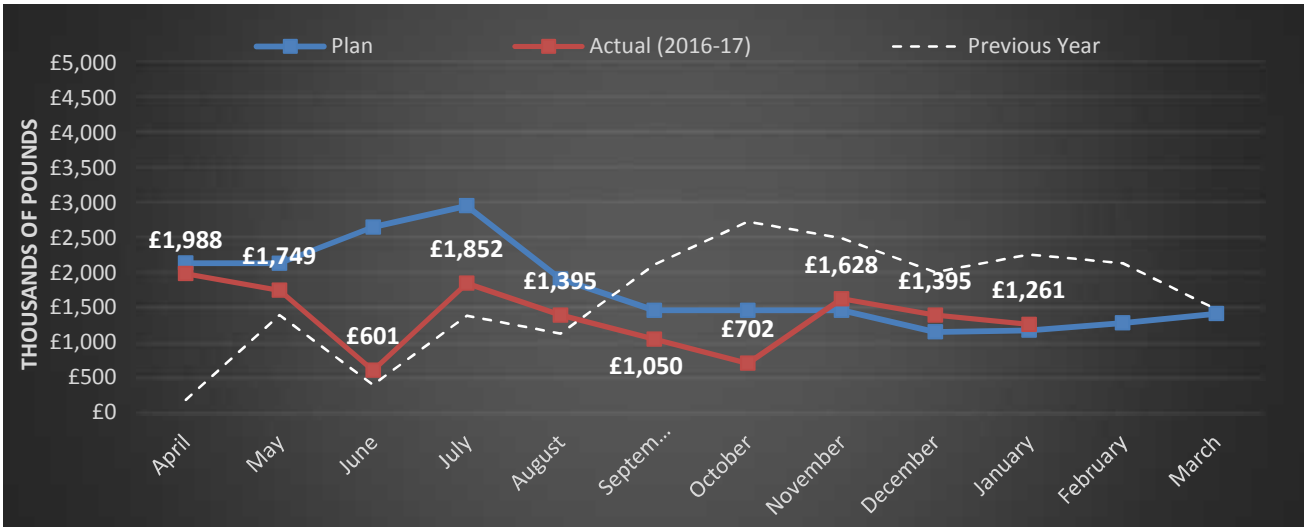

Figure.F-3 – Capital Expenditure (£'000)

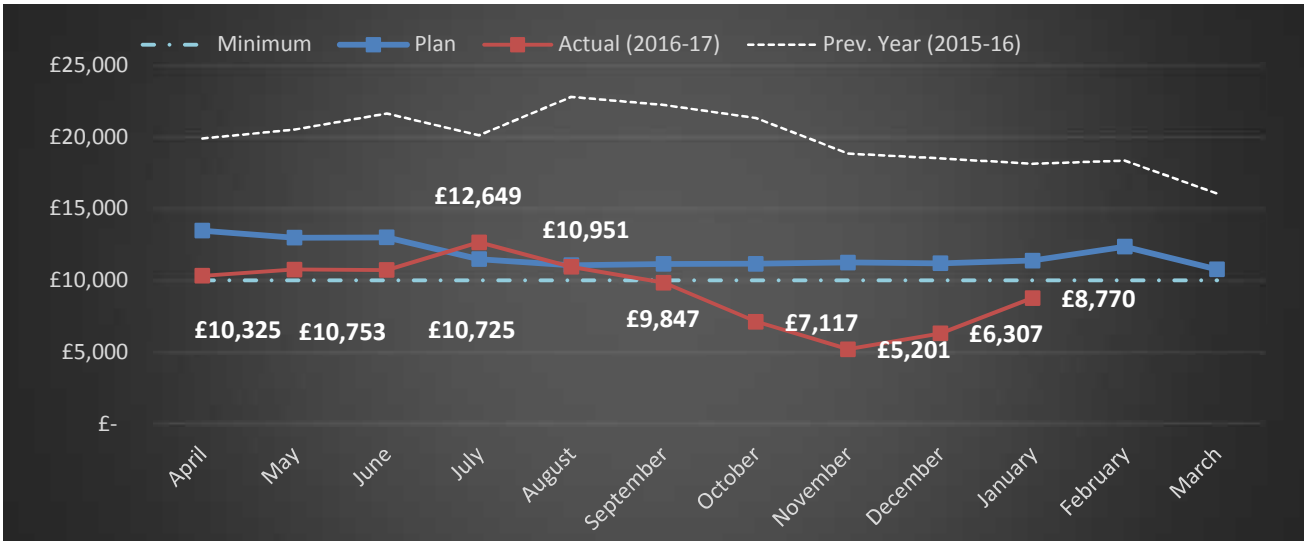

Figure.F-7 – Cash Position (£'000)

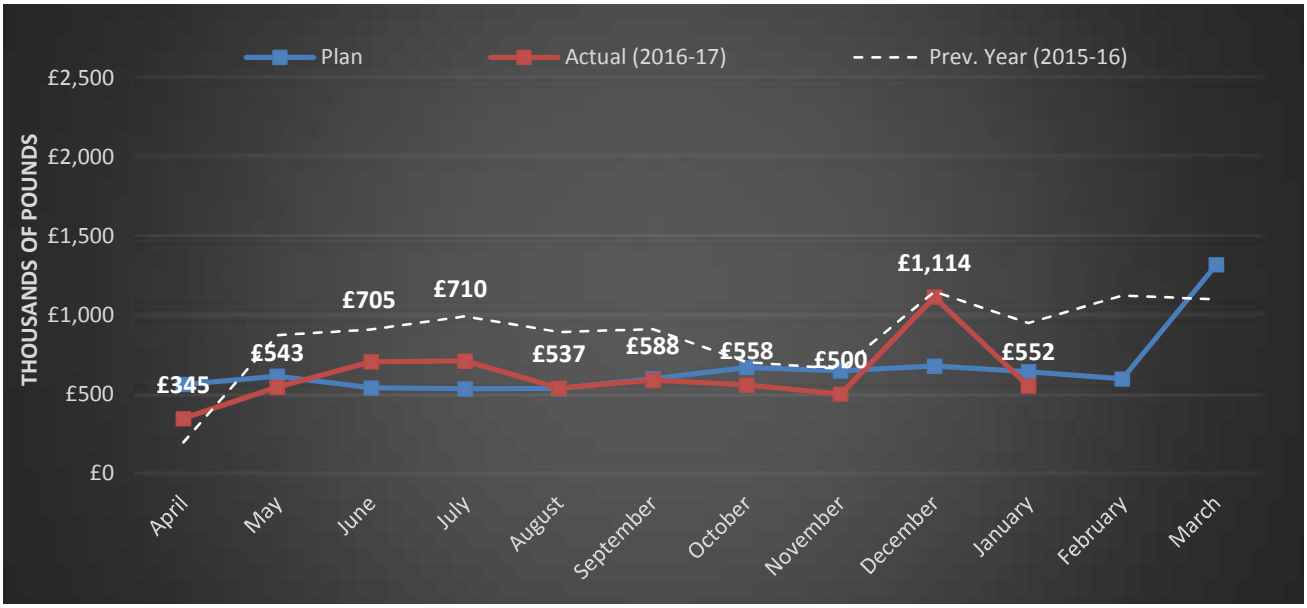

Figure.F-4 - Cost Improv. Prog. (CIP) (£'000)

Appendix 1: Balanced Scorecard

Integrated Performance Dashboard Balanced Scorecard for the February 2017 Board Meeting

Workforce Commentary :- Data from January 2017 and December 2017

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		3.2%	2.7%		3.2%	
Wf-1B	Long Term Sickness - Rate		2.5%	3.6%		2.5%	
Wf-2	Staff Appraisals	75.0%	50.0%	60.6%			
Wf-3	Mandatory Training Compliance (All Courses)	94.0%	78.5%	88.5%			
Wf-4	Total injuries		0	73		550	632
Wf-5	Total physical assaults		14	18		180	163
Wf-6	Vacancies (Total WTE)		323		Not Relevant		
Wf-7	Annual Rolling Staff Turnover		16.9%	14.2%			
Wf-8	Reported Bullying & Harassment Cases		1			14	
Wf-9	Cases of Whistle Blowing		1			3	

Operational Performance Scorecard:- Data From January 2017

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	66.4%	65.5%	72.0%		64.5%	73.4%
999-2	Red 2 response <8 min	55.3%	47.7%	62.8%		53.0%	70.4%
999-3	Red 19 Transport <19 min	90.3%	85.8%	93.5%		89.2%	94.8%
999-4	Activity: Actual vs Commissioned	68998	71738	70326	660016	688789	653077
999-5	Hospital Turn-around Delays (Hrs lost >30 min.)	2715	7950	4583	23884	57514	36232
999-6	Call Pick up within 5 Seconds	90%	88.1%	91.6%		75.3%	87.7%
999-7	CFR Red 1 Unique Performance Contribution	1%	1.4%	0.0%		0.0%	0.0%
999-8	CFR Red 2 Unique Performance Contribution	1%	1.5%	0.0%		0.0%	0.0%
111-1	Total Number of calls offered		96799	111134		962615	975672
111-2	% answered calls within 60 seconds	85%	83.7%	74.7%	85.0%	77.9%	84.2%
111-4	Abandoned calls as % of offered after 30 secs	6.0%	2.9%	4.8%	6.0%	4.5%	2.7%
111-5	Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)	77%	81.6%	82.3%		74.7%	87.7%
PTS-1	PTS Activity (Surrey)	10889	9736	11750	118452	105610	149178
PTS-2	Arrival - % patients to arrive <= 15 min after appt. time. (Surrey)	95%	87.0%	83.8%	95%	86.5%	83.7%
PTS-3	Departure - % patients collected <= 60 min of planned collection time (Surrey)	95%	87.2%	87.1%	95%	86.3%	84.2%
PTS-4	Discharge - % patients collected <= 120 min of booked time to travel (Surrey)	95%	80.3%	79.3%	95%	79.9%	76.1%

** 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 September 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)	50.0%	44.1%	58.6%	52.5%	54.4%	47.8%
CE-2	Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)	28.7%	25.3%	27.5%	29.0%	27.9%	27.1%
CE-3	Cardiac arrest -Survival to discharge - Utstein	25.6%	30.0%	37.5%	27.1%	28.8%	24.0%
CE-4	Cardiac arrest -Survival to discharge - All	9.3%	9.4%	9.0%	9.0%	8.4%	8.6%
CE-5	Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)	79.7%	76.6%	66.7%	79.6%	69.2%	66.8%
CE-6	Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes	86.9%	86.7%	90.7%	86.3%	90.9%	93.5%
CE-7	% of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes	54.1%	62.6%	64.5%	54.9%	67.3%	65.3%
CE-8	% of suspected stroke patients assessed face to face who received an appropriate care bundle	97.2%	95.6%	96.0%	97.6%	96.0%	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 January 2017

ID**	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
F-1	Income (£'000)	£16,211.6	£17,542.0	£17,539.4	£161,485.5	£164,360.3	£168,301.6
F-2	Expenditure (£'000)	£16,181.6	£17,614.0	£16,923.5	£160,614.5	£170,670.0	£168,616.5
F-6	Surplus/(Deficit)	£30.0	£72.0	£615.9	£871.0	£6,309.7	-£314.9
ID**	KPI	Current Quarter (Plan)	Current Quarter (Actual)*	Current Quarter (Prev. Yr.)	YTD (Plan)	YTD (Actual)*	YTD (Prev. Yr.)
F-5	CQUIN - Quarterly (£'000)*	£1,038.0		£1,013.0	£3,724.0		£3,688.0
ID**	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
F-3	Capital Expenditure (£'000)	£1,175.0	£1,261.3	£2,263.0	£18,528.0	£13,621.0	£16,104.0
F-7	Cash Position (£'000)	£11,383.0	£8,770.0	£18,124.0	£11,383.0	£8,770.0	£18,124.0
F-4	Cost Improv. Prog. (CIP) (£'000)	£642.0	£552.0	£948.7	£6,012.0	£6,152.0	£8,230.6
F-8	Agency Spend (£'000)	£335.6	£633.0	£571.8	£3,352.8	£5,673.7	£5,662.1

** 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 January 2017

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%	50.0%				
QS1b	SI Investigation timeliness (60 days)	100.0%		100.0%	100.0%	64.3%	100.0%
QS1c	Number of Incidents reported	0.0%	529	472		5088	4430
QS1d	Number of Incidents reported that were SI's		1	0		20	21
QS1e	Duty of Candour Compliance	0.0%					
QS2a	Number of Complaints		132	157		132	157
QS2b	Complaints reporting timeliness (All Complaints)	95.0%	81.8%	80.0%	95.0%	64.8%	61.8%
QS3a	Number of Safeguarding Referrals		823	914		8817	8768
QS3b	Safeguarding Referrals relating to SECAmb staff or services		1	2		4	4
QS3c	Safeguarding Training Completed (Adult) Level 1		228				
QS3d	Safeguarding Training Completed (Children) Level 1		228				
QS3e	Safeguarding Training Completed (Adult) Level 2		2962				
QS3f	Safeguarding Training Completed (Children) Level 2		2977				

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. February Board Changes:

- The KPI the "Calls Abandoned - Intro Message" is no longer a key performance measure so the data has been omitted.

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.

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

7.6.1. February Board Changes:

- Duty of Candour KPI now has data available.

7.6.2. January Board Changes:

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

7.7. Finance Section:

7.7.1. February Board Changes:

- The CIP figure for December has been corrected to match December's finance pack, the variation was due to an input error.

7.7.2. No other changes of note for finance.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	194

Name of meeting	Trust Board
Date	23/02/2017
Name of paper	Medicines Management
Responsible Executive	Emma Wadey Interim Chief Nurse & Director of Quality
Author	Emma Wadey Interim Chief Nurse & Director of Quality
Synopsis	This papers follows on form last month's board paper on medicines management to provide an update on actions taken to-date.
Recommendations, decisions or actions sought	The Board is asked to consider the issues arising from medicines management and note the immediate actions to help ensure patient safety.

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**

Medicines Management

Medicines Management

1. Introduction

1.1. This report follows last month's board paper about the issues arising from medicines management and the corrective action being taken.

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 poor compliance with medicines management standards requires urgent action.

2.4. Several internal and external reviews of the Trust's medicine's management have been undertaken in the past three months. These reviews have highlighted significant weaknesses in the system of internal control.

2.5. A 'root and branch' diagnostic has been agreed by the executive and the scope is currently being established.

3. Identified risks

- Lack of effective leadership in medicines management
- Capacity within current medicines management team
- Inappropriate storage of medicines at Paddock wood
- Lack of safe storage of medicines on vehicles
- Inappropriate ordering of medicines, including over-ordering and ordering unauthorised items
- Inappropriate storage of pharmacy waste

- Inappropriate Storage and disposal of controlled drugs
- Inconsistent compliance with controlled drug administration, reporting and audit completion
- Administration of medication outside of Scope of Practice
- Use of medication not labelled in English
- Over labelling of medication
- Lack of medicines management training and competency assessments.

4. Summary of immediate Actions taken

- Interim Chief Pharmacist appointed to work until substantive Chief Pharmacist starts in April.
- Transfer of medicines management oversight to Interim Chief Nurse and Director of Quality & Safety, until the new Medical Director is in post (early March).
- Scope of practice and current PGDs reviewed against current medicine formulary
- Immediate removal of all medicines not labelled in English
- Immediate cessation of over labelling on all medicines
- Immediate removal of 3 medicines not covered by the Scope of Practice following QIA determining no patient impact as safe and effective alternatives available.
- A Medicines management audit tool, developed in collaboration with NHSI has been tested and revised following the first unannounced medicine's inspection at paddock wood on 10th February.
- Reviews of all 99 locations - 30 stations; 8 MRCs and 1 Omnicell at Cox Health and 60 response posts is underway for completion by 22 February
- Work is underway for completion in March to replace all locks on vehicles medicines cupboards.
- Current procurement processes have been reviewed and amended with single oversight and final approval by the Executive Director of Quality and safety
- All medicines ordering to be reviewed by Interim chief pharmacist and will follow the SBS approval process
- A revised disposal system of out of date medicines

- Immediate action taken to label all pharmacy waste with Trust name and date in preparation for removal, ensuring all containers are locked

- Arrangements have been made for the removal of containers and a review of waste management including the removal of control drugs is underway.
- As part of the medicines management review we are reviewing the CD registers and reporting the number of times CDs have been signed out by one person only

- Communication to all staff sent via MDT, line management cascade and bulletins

- All staff have been written to setting out current changes and reminding them of their responsibilities and registration accountability.

- All issues have been reported as Incidents

5. Next Steps

- Review of all PGDs and policies and procedures in relation to medicines management by CCG pharmacy leads in collaboration with SECamb medicines management team

- Review of medicines management team capacity and capability to undertake actions as required

- Scope of independent review of identified incidents to be agreed and then commissioned

- Review of current medicines formulary

- Business case for safe storage at Paddock wood to be approved and actioned

Summary

Following an initial review of medicine's management at the request of the Quality & Patient Safety Committee, an unannounced medicines management inspection was undertaken at Paddock wood. This inspection discovered a number of significant concerns in relation specifically to medicines storage, disposal, over labelling, use of medication not in English and medication anomalies in relation to ordering.

As a consequence, a number of immediate actions as summarised above were undertaken and our regulators and commissioners informed. The medicines management improvement plan has been updated as a result and will continue to be monitored by the Quality Steering Group. Further updates will also be provided to the Quality and Patient Safety Committee.