South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

29 March 2017

10:00-13:00

Board Room Lewes

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
197/16	10.00	Chairman's introduction	-	-	PD
198/16	10.01	Apologies for absence	-	-	PD
199/16	10.02	Declarations of interest	-	-	PD
200/16	10.03	Minutes of the previous meeting: February 2017	**Y**	Decision	PD
201/16	10.05	Matters arising (Action log)	**Y**	Discussion	PD
Organisational culture					
202/16	10.10	Patient story	-	Set the tone	
203/16	10.15	Chief Executive's report	**Y**	Information	DH
Trust strategy					
204/16	10.30	Unified Rcovery Plan (Incl. CQC improvement plan)	**Y**	Assurance	JA
205/16	10.50	Bullying and Harrassment Update	**Y**	Assurance	SG
206/16	11.00	Workforce Wellbeing Enabling Strategy	**Y**	Decision	SG
207/16	11.10	Urgent and Emergency Care Handover Delays	**Y**	Assurance	JA
208/16	11.20	Risk Management Strategy & Policy	**Y**	Decision	EW
Allocating resources to achieve plans					
209/16	11.30	Financial Recovery 16/17 and CIPs development 17/18	**Y**	Assurance	DH
Ten minute Break					
Monitoring performance					
210/16	11.40	Medicines Management	**verbal**	Assurance	FM
211/16	11.50	Integrated performance report	**Y**	Assurance	DH
Holding to account					
212/16	12.10	Escalation report; Quality & Patient Safety Committee	**Y**	Information	LB
213/16	12.20	Escalation report; Audit Committee	**Y**	Information	AS
214/16	12.30	Escalation report; Workforce & Wellbeing Committee	**Y**	Information	TH
215/16	12.40	Escalation report; Finance & Investment Committee (Including approval of a lease)	**Y**	Information / Decision	GC
Governance					
216/16	12.45	Lampard Report (Saville Enquiry) Annual Update	**Y**	Assurance	EW

217/16	12.50	CQC Registration	**Y**	Decision	EW
218/16	12.55	Any other business	**-**	Discussion	PD
219/16	-	Review of meeting effectiveness	**-**	Discussion	ALL
Close of meeting			**-**		

Date of next Board meeting: 27 April 2017

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 23 February 2017

Ashford 111
Minutes of the meeting, which was held in public.

Present:

Graham Colbert	(GC)	Independent Non-Executive Director & Deputy Chair (Chair)
Geraint Davies	(GD)	Acting Chief Executive
Alan Rymer	(AR)	Independent Non-Executive Director
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
Lucy Bloem	(LB)	Independent Non-Executive Director
Richard Webber	(RW)	Acting Executive Paramedic Director
Terry Parkin	(TP)	Independent Non-Executive Director
Tim Howe	(TH)	Independent Non-Executive Director
Angela Smith	(AS)	Independent Non-Executive Director

In attendance:

Steve Graham	(SG)	Interim Director of Human Resources
Janine Compton	(JC)	Head of Communications
Peter Lee	(PL)	Trust Secretary

181/16 Chairman's introductions

GC welcomed members, and staff, governors and members of the public observing the meeting.

GC also welcomed AS to her first meeting of the Board of Directors having joined the Trust in February.

182/16 Apologies for absence

The following apologies were noted;

Sir Peter Dixon	(PD)	Chairman

183/16 Declarations of conflicts of interest

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

184/16 Minutes of the meeting held in public January 2017

The minutes were approved as a true and accurate record.

185/16 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.

186/16 Patient story

The video was played, and related to a patient who had broken his leg and experienced some delay in receiving treatment. The Board reflected on this experience and GD confirmed that it helped to highlight the pressure the Trust is under. Specific details of this story are being picked up via the incident process. The Board agreed that this patient story was helpful in setting some of the context regarding system-pressures and what we can do internally and what support is needed.

187/16 Chief Executive's report.

GD highlighted the following;

- We are in the process of securing a new medical director starting from 6 March 2017. In meantime, we have covered responsibilities of the medical director among the executive and via the appointment of an interim Chief Pharmacist. Our substantive Chief Pharmacist starts in April.

- The CQC has confirmed that they are carrying out a comprehensive inspection of all our services in May 2017. Our hope is that all the work we have done to ensure improvement is recognized when tested by the inspection team. GC asked if we are doing anything special for the inspection. GD explained we are as far as possible approaching it as business as usual. EW added that the CQC action plan is monitored closely by the Quality Steering Group and we have started our quality reviews which cover all fundamental standards, not just the 'must dos.' EW went on to explain that these reviews constitute our business as usual internal assurance process.

Action:
The findings from the Quality Reviews to be shared with the Board in April

- Medicines Management is a separate agenda item, but GD reinforced that the issues identified were established by our own governance process, which was positive. He felt that this helps to demonstrate that we are getting a better grip on understanding what we do well, not well, and what needs to be improved.

- We have engaged much needed support to support our work to improve our culture and, in particular, concerns about bullying and harassment. GC asked about a timeline for this and SG confirmed that there will be a report in June arising from the work we do.

Action:
The findings from the bullying and harassment work to be shared with the Board in June 2017

GD reinforced the need to use this work as an opportunity to ensure we better understand why staff don't always feel able to raise concerns through the internal systems that exist. GC agreed that we really need to get on the front foot with this.

- GD reminded the Board of the regular monthly engagement with NHSI and other external stakeholders in which we are held to account against the URP.

- The positive news was noted about the progress to date in our financial recovery plan; we are still on track to achieve our forecast outturn of £7.1m.

- GD ended his summary by mentioning Kimberely Alexander and the positive news regarding her award.

GC asked how the executive was responding to the recent National Audit Office report. JA explained that we are expecting more detailed feedback in the next month or so, and will then feedback to the Board via the Audit Committee in due course.

GC asked about the move to Crawley. DH confirmed that the building is almost complete and is the infrastructure and so we are slightly ahead of plan. In terms of people, SG explained that the HR team are conducting a number of 1:1s with staff as part of the consultation and these should be concluded by early April. GC asked whether this meant all staff will know what is happening by early April, and SG confirmed this would be the case.

188/16 Unified Recovery Plan

JA reminded the Board about the refresh of the Program Management Office (PMO) since January and confirmed that this has enabled the development of a more robust structure. There is still some more work to do to align reporting and workloads across the three Steering Groups, for example, some quality aspects need to transfer from Recovery to Quality.

The structure is set out in Appendix A and JA outlined how this works, e.g. meeting weekly to manage in real time issues as they arise.

Appendix B sets out wider structure and external links. We still need to address the alignment with board committees which will happen over next couple of weeks.

AR confirmed that he has spent time in the PMO and was reassured that his experience reflects JA's summary. He asked about governance and a potential issue that the only time in the structure currently for board oversight is at board meetings; so agrees the need to align to the Board committees to ensure the right level of NED involvement and oversight.

GC agreed and noted that there are some obvious homes for some of this, e.g. quality through the Quality and Patient Safety Committee and Finance through the Finance and Investment Committee. So the main issue is likely to be how the Recovery steering group aligns. There was then a discussion about the 'turnaround' work and 'business as usual' running at a different pace, which needs to be considered too.

LB's concern was that the Quality steering group has wide remit and wondered whether there should be a separate steering group on workforce and culture. EW responded to this suggestion by assuring the Board that there is sufficient capacity in the Quality steering group due to some re-balancing of the work-streams, incl. 999 which is moved across in to the Recovery steering group. EW was therefore confident that workforce can be adequately covered under Quality. There was a discussion too about the cross-cutting nature of workforce and culture and governance and finance. All of this will be considered by the PMO.

The steering groups meet at least weekly, typically on a Wednesday, with escalation the same day to the 'turnaround executive'. These meeting review and scope the outcomes and risks, and are now starting to look at project closures; transferring to business as usual which is always considered using a defined process, which the Recovery steering group will continue to test.

The Dashboard picks up where we are on delivery, week on week. Going forward we will show a monthly view too. The key issues highlighted are as set out in the report commentary and currently five areas are flagged as red.

GC clarified that areas rated red are mitigated to amber. JA confirmed this is right and we review this at least weekly. GC asked if there is anything the Board needs to do anything about. JA suggested the main issue relates to hospital handover delays, which is being picked up later in the agenda.

TH asked why the HQ move is rated red given the assurances given earlier in the meeting (item 187/16). JA explained this is because the paper sets out the position as of 2 weeks ago and so is a timing issue of the paper. The progress made since is what DH and SG set out earlier. DH and SG agreed.

GD explained that the pace in running this project means that when issues are red they are escalated in real time and staff are held to account for very quick rectification. The HQ move is an example of this.

AR noted concern about this confusion. GD reinforced the timing of papers and changing nature of risks, but acknowledged this is a challenge for the executive to ensure we can ensure more up to date information to Board/committees.

TP suggested that to overcome this it might be more helpful in these circumstances for an update on all key projects such as the HQ move, to be picked up by the Chief Executive Report, even if this means sometimes receiving it verbally rather than via a paper. GC agreed that all we need at board is a real time update from the executive about issues they are concerned about.

LB commented that it is positive some projects are rated red, as it demonstrates the interdependency with other projects. This integration with projects should be assuring to the board. LB also noted the improvement in the format of this report which she considered was really helpful.

On call handling, GC asked JG if he is content that the mitigation reduces the risk to amber. JG confirmed that he is and explained the progress being made with call handling performance. And with response ratio where there has been some positive improvement as a result of the initiatives we are taking forward.

TP felt there was inconsistency between this paper and the handover paper, regarding use of policy. Also, that we have heard about time on scene in past, but this is not in either paper. JG explained regarding time on scene that we have seen a 6 min improvement on time to clear at scene. One min equates to 10 whole time equivalents across the year. So this is a significant improvement. There is similar improvement in turnaround time at hospital, and JG felt this is evidence that we are getting better control.

On TP's point about policies, JA explained this is because we are talking about two different policies.

In light of this discussion, TP asked whether the external assurances from stakeholders to support us reduce handovers is being followed through. GD confirmed the difficulty translating the commitments in to action.

GC suggested that we indicate clearly where delays occur.

DH talked about the Finance steering group confirming that there is a segmented approach between 2016/17 and then 2017-2019 and the 3 years beyond. DH highlighted a typographical error in the paper on meal break payments; the paper excludes the word "not" when referring to disturbing crews.

The focus on 2016/17 has been on reducing the run rate. Staff across the Trust have helped enormously with this and at month 10 we are on track so hopeful we will achieve the £7.1 outturn.

In terms of 2017-19, the steering group will drive sustainability plans. Our control total is £1m deficit and we have a significant proportion of CIPs in train and/or already well embedded. 70% are detailed plans. QIA

process ensures we don't put money before quality and the effectiveness of this process is being tested by the Quality and Patient Safety Committee.

GC felt that the challenge is to give assurance to the Board without necessarily the level of detail provided in this paper. It is difficult for the board to have clear view of control total until we know the outcome of negotiations.

189/16 CQC Action Plan Update

EW chairs the Quality steering group, which challenges executive leads in the progress against the action plan and tests the evidence. There are four main areas of concern where we haven't evidenced progress and/or pace include;

1. Operational performance
   JG explained that 999 performance in January was disappointing. Some of the reasons are clear, e.g. levels of activity and handover delays. The areas we have control over, call cycle time for example, is improving as stated earlier. Red acuity has grown exponentially over the past two months and we are analysing why this is and we working hard to mobilise the resource we have available.

2. Medicines Management
   This is a separate agenda item so discussion deferred to then

3. Clinical Audit
   This sits with EW until the new medical director is in post. The action plan has been revised which has helped provide more focus and pace. The hope is that by the Board in March the actions taken will move this from red to amber.

4. Patient Care Records
   JG explained the issues highlighted by the Quality and Patient Safety Committee. We have utilised the existing audit tool to ensure more PCR completion. We are also looking at management of records to ensure this is more robust, and some active trials with different solutions are being piloted.

In summary, EW confirmed that the increase in the number of actions is positive, as it reflects a better understanding of what needs to be improved. In our recent meeting with CQC, some assurance was received around some of the foundations we have put in place, for example in safeguarding, but there was concern about medicines management, as we will pick up later.

LB referred to clinical audit and stated that we have given much effort in past to get this on an even keel, so it is disappointing to see the comment regarding resource. EW reflected that it isn't that no action was taken but in our review of actions we have found that in some areas we have completed actions but missed the point.

TP asked what role the Board can play in areas still red after mitigation. GD suggested that future papers will aim to more clearly set out the actions rated red and what needs to be done. GC reflected that some are clear, for example the national targets (which are red) we simply won't achieve for well-rehearsed reasons.

190/16 Handover Delays

JA started this discussion by stating that some areas are within our control and some are not. The support the system committed to hasn't yet materialised. The paper sets out the current position and the number of lost hours. A number of actions have been requested of us by NSHI, which we have done, as set out in

section 3 of the paper. The incident command hub is being put in place to help manage delays as they occur, and to provide a consistent approach with hospitals and the wider system.

We have agreed work with NHSI about how we capture the data to avoid data being a blocker to progress. GC asked what was in dispute. JA confirmed that it varies, between 0-30%. So even if we take hospital data it is still a significant problem. Appendix 1 illustrates the growth in delays 70% year on year - despite us reducing conveyance. JA confirmed that some hospitals are really engaged in helping to find solutions, some aren't.

The Board discussed how we use the data to best effect.

AS felt that we need to take clear actions and the paper should include this for the board to note. GD agreed. The conversation today should be about how we take this forward. It should be for the executive to come up with a proposal for the Board to consider.

RW brought the discussion back to clinical risk. Noting that we can have 6-8 ambulances waiting at hospitals at any one time, which impacts on patients directly, both those in hospital corridors and those waiting for ambulances in the community. So whatever solution we agree, it must have patient safety at the heart of it. LB agreed but reinforced that this is also a significant issue for staff who are effectively being asked to nurse patients at hospital.

Action:
A paper on handover delays to come back to Board in March with a proposal from the executive on what action we should take to resolve this. To include the pros and cons for the Board to endorse.

Comfort break

191/16 Financial Recovery Plan

AS asked whether we are confident we have identified all costs in meeting infrastructure needs. DH explained at a high level this divides in to; 1) income; 2) cost of recovery in which much of this year's deficit relates; and 3) sustainability, e.g. do we have the right model.

GD added that when we get to the next item on our contract, this will help us identify what resources we need to enable us to provide a safe service. So this is fundamental.

192/16 2017/18 Contract Update

JA updated the Board that things have moved on since this paper was written. We have set out a series of next steps and key outputs of the independent review, the procurement of which is not expected until 20 March. This means there is no chance in meeting the contract precedent deadline of 31.03.17 so we need to agree how we manage this.

In terms of options we don't yet know what these might be. We need to talk to NHSI and NHSE to understand their view. DH suggested we do this and once we understand the options convene an exceptional board, if required.

The Board acknowledged how extremely serious this is. At the moment we have gap between the resources being provided and what is needed to develop statutory standards. It also has implications on what CQC

expect of us. The Board noted that we have escalated this to NHSI. RW reminded directors that the NAO report drew a conclusion that activity for ambulance trusts is double the increase in investment.

193/16 IPR

Performance

JG confirmed that Red 1 is 65.5% against a 66% target. Red 2 is 47.7% against a 55% target and Red 19 is 85.8% against a 90% target. So the area of Red 2 (8 min response) has been the focus of much scrutiny. We have improved call cycle time as stated earlier and reduced time to clear at hospital by up to 8 minutes. We are looking at all areas of resource down time and changing the ratio of double crewed ambulance to cars. Also, in the context of pressure of increased activity, we have focused on maintaining the wellbeing of our workforce by ensuring rest breaks and reducing shift overruns.

GC noted that one of the disappointing aspects is call answering. JG agreed, although confirmed that it is better than in previous months. We are at establishment numbers, but with shift in activity this has compounded performance. In other words, we are being out-paced by activity.

RW added that when we are holding calls with handover delays the number of ring-backs increase, which impacts on call handling performance.

AS had two comments. On the 'tail' he asked if more information could be provided. And on efficiency, asked how efficient are we in using hours we are resourced to provide. DH confirmed that the work over next few months will establish the efficiency metrics. And that we must also be sighted on all assumptions, not just activity.

EW responded to the question about the 'tail' and explained that we are monitoring how long people are waiting by looking at the 95th and 99th percentile. JG added that we are strengthening CFR by de-centralising recruitment in to operating units so there is local ownership about where the need is.

GC felt that it was important to acknowledge that some progress is being made, including in the 111 service.

Clinical Effectiveness

RW confirmed that the survival to discharge is above the national average. There are concerns around the care bundle, although there is some improvement as shown in the report. Key Skills starts in April/May and we will reinforce not just the care provided but how it is documented.

Action:
A deep dive in to clinical outcomes for the Board in March to include longer term trends.

Workforce

This section was taken as read.

LB confirmed that we need to agree a NED whistleblowing lead– Action.

Action:
Board to confirm who the NED will be aligned to whistleblowing / freedom to speak up.

Finance

DH confirmed that we were instructed by NHSI to include the cost of the B6 Paramedic re-banding, but not off-set the income. Our deficit is therefore showing as £7.7m. But this will be offset once agreed. TP asked about confidence in this. DH explained this is a national issue and we have it in writing that it will happen, and so this is just a delay.

DH also confirmed that we have drawn down from the working capital facility £4m, which is in line with the plan. The aim is to repay this by Q2 of 2017/18.

AR asked if the delivery of forecast outturn is dependent on the delivery of the additional savings identified in the financial recovery plan. DH confirmed that it was, but it is about delivery not identifying schemes, as these have been identified.

194/16 Medicines Management

EW confirmed this is update from January on actions taken to date. This remains a significant concern. The main issues are as highlighted in the paper. A number of actions have been taken, and most are complete. This has very close oversight by the executive and there are daily calls and meetings at least weekly. It is therefore rated red in the URP given gaps in assurance identified through our internal assurance structure.

LB confirmed that she went out on an audit yesterday and noted the good progress being made. We are getting to the detail now and notwithstanding the link to previous governance failings, this is a good example of how our current governance has worked in identifying previously unidentified issues. LB also commented on the positive response by the executive. EW confirmed that she is now the executive lead for medicines management until the medical director is in post.

195/16 Any other business

None

196/16 Review of meeting effectiveness

Questions from observers

There were no questions from observers/members of the public

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

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

Date _____

Meeting Date	Agenda item	Action Point
27.10.2016	132/16	The output from the M&M Group to be monitored via the quality and patient safety committee
27.10.2016	134/16	Paper on 111 to come to the Board after consideration by the Executive
26.01.2017	168/16	Risk Strategy & Policy to be received by the Audit Committee in March and then to Board for decision
23.02.2017	187/16	The findings from the Quality Reviews to be shared with the Board in April
23.02.2017	187/16	The findings from the bullying and harassment work to be shared with the Board in June 2017
23.02.2017	190/16	paper on handover delays to come back to Board in March with a proposal from the executive on what action we should take to resolve this. To include the pros and cons for the Board to endorse.
23.02.2017	193/16	A deep dive in to clinical outcomes for the Board in March to include longer term trends.
23.02.2017	193/16	Board to confirm who the NED will be aligned to whistleblowing / freedom to speak up.

ılance Service NHS FT action log

Owner	Target Completion Date	Report to:	Status: (C, IP, R)
Peter Lee	Q4	Board	C
David Hammond	Q4	Board	C
PL	28.03.2017	Board	C
EW	27.04.2017	Board	IP
SG	29.06.2017	Board	IP
JA	29.03.2017	Board	C
RW	29.03.2017	Board	IP
PD	29.03.2017	Board	IP

Comments / Update
M&M Group has been established as part of the management (working group) governance structure reporting directly to the Quality & Safety Group chaired by the Executive Director of Quality & Safety.
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. JA explained we need to give 12 months notice on contract so need to do something at March Board. On the Agenda 29.03.2017
Recived by the Audit Committee on 01.03.2017 and on the Board agenda 29.03.2017
Added to Board Agenda for 27.04.2017
Added to Board Agenda for 29.06.2017
On agenda
Added to Board Agenda for 27.04.2017
To be picked up under matters arising on 29.03.2017

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	203/16

Name of meeting	Trust Board
Date	26.03.2017
Name of paper	Chief Executive's Report
Executive sponsor	Acting Chief Executive
Author name and role	David Hammond
Synopsis (up to 120 words)	The Chief Executive's Report provides an overview of the key local, regional and national issues involving and impacting on the Trust and the wider ambulance sector.
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.
Why must **this** meeting deal with **this** item? (max 15 words)	To receive a briefing on key issues, as noted above.
Which strategic objective does this paper link to?	2. Culture

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

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S REPORT TO THE TRUST BOARD

March 2017

1. Introduction

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

2. Local issues

2.1 Changes at Director/Senior Management level

2.1.1. Following a robust recruitment and selection process and appointment by the Council of Governors, Richard Foster was confirmed on 14th March 2017 as the new Trust Chairman.

2.1.2 Richard has held senior positions in the public and voluntary sectors and his career has seen him serve as Chair, CEO, Trustee, Executive Director and Non-Executive Director of a variety of large, complex, public, voluntary and private sector bodies. He will start with the Trust on 31st March 2017.

2.1.3 On 6th March 2017, Dr Fionna Moore joined the Trust as Medical Director, following the departure of the previous Interim, Dr Andy Carson, on ill-health grounds.

2.1.4 On 9th March 2017, Geraint Davies announced his decision to bring forward his leaving date from 31st March to 9th March 2017. David Hammond is currently Acting Chief Executive, ahead of Daren Mochrie joining the Trust on 1st April 2017.

2.1.5 On 24th March 2017, Director of Nursing & Urgent Care/Chief Nurse, Professor Kath Start, also confirmed that she will be leaving the Trust in March to pursue other interests.

2.2 Revised Executive portfolios

2.2.1 As reported previously, in order to clarify clinical responsibilities and otherwise address issues identified by various external reviews of the Trust, a review of Executive Director portfolios has recently concluded.

2.2.2 Following consultation, there will be changes made to the number of Executive Directors on the Trust Board and to their portfolios. The new Director roles will be:

- Chief Executive
- Executive Director of Finance & Corporate services
- Executive Director of Quality & Patient Safety/Chief Nurse
- Executive Medical Director
- Executive Director of Operations

- Executive Director of Strategy
- Director of HR

2.3 Care Quality Commission (CQC) inspection

2.3.1 As reported previously, the Trust has received confirmation that the CQC will be re-visiting the Trust between 15th & 18th May 2017. Requests for information in preparation for this inspection are already coming into the organisation.

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

2.4 Staff Award ceremonies

2.4.1 On 23rd February and 9th March 2017, I was very proud to join more than 300 members of staff and their guests at our two Staff Awards Ceremonies, held in Maidstone and Cobham. At each event, we celebrated both the long service and the outstanding commitment of our staff and volunteers and were very pleased to be joined by the Deputy Lord Lieutenants of Kent and Surrey respectively, to present Queens Medals to those staff who had completed twenty years' front-line service.

2.4.2 During what are difficult times for the Trust, it was extremely heartening to be part of such positive events and hear the fantastic stories of our staff and volunteers who have 'gone the extra mile' to support their patients and colleagues.

2.5. NHS Staff Survey

2.5.1 On 7th March 2017, the results of the latest Staff Survey results were published for al NHS organisations.

2.5.2 The results for SECAmb are extremely disappointing but reflect, to a great extent, the challenges that the Trust has faced during the last year and the impact that these have had on staff.

2.5.3 We are committed to responding to the results and will take a full diagnostic of the survey outcomes to the Executive Team for discussion. We will then agree with the whole Board the key areas we will be focussing on addressing.

2.5.4 Much has already been done to address some of the issues the survey highlights but we still have a long way to go.

2.6 Paramedic banding

2.6.1 The national development of the Band 6 paramedic profile has now been finalised and, in adherence to the national agreement, we are getting ready to move eligible paramedics across to Band 6.

2.6.2 As per the national agreement, those paramedics who were trained, registered and in paramedic roles before 1st September 2016 are eligible to have their role matched to the new profile. Those joining on or after 1st September 2016 will remain on Band 5 as a newly qualified paramedic (NQP) and will enter a 24-month preceptorship programme.

2.6.3 Local panels, consisting of representatives from both management and staff-side, have successfully job matched and consistency checked the job description against the profile. Our first focus is on transitioning those who joined prior to 1st September 2016 and whose roles match to the new Band 6 profile, across to the higher pay band. Any changes that need to be made will be back-dated to take effect from 31st December 2016.

2.7 New HQ/EOC up-date

2.7.1 As the fit out of the new building at Crawley nears completion, final details of the move are being worked through and shared with those staff affected. Details around the process for moving and familiarisation and induction for staff are being developed.

2.7.2 Dates for the move have been finalised and shared with staff as follows:

- 1st May to 19th May 2017 – re-location of Lewes corporate staff to Crawley
- 22nd May to 12th June 2017 – re-location of Banstead and Lewes EOC staff to Crawley
- By 30th June 2017 – re-location of remaining corporate staff completed and de-commissioning of Lewes site completed

3. Regional Issues

3.1 Contract negotiations

3.1.1 The Trust, working in partnership with CCGs has agreed terms for an independent review of the structural gap and the internal and system actions needed to address this in the short and longer term. The review is expected to report by the end of April 2017.

3.2 Potential changes to acute provision at Kent & Canterbury Hospital

3.2.1 On 20th March 2016 we were informed by East Kent Hospitals University NHS Foundation Trust that, following a visit to the Kent & Canterbury Hospital site by Health Education Kent Surrey and Sussex to assess junior doctor training, changes may need to be made to the provision of acute services at the Kent & Canterbury site.

3.2.2 No decisions have been made as yet but we will ensure that we work closely with the hospitals Trust and the CCG to ensure that the impact on SECAmb of any changes made is fully understood and accounted for.

4. National Issues

4.1 Implementation of Ambulance Response Programme (ARP)

4.1.1 Evidence to the Public Account Committee on 20th March 2017 has confirmed that a final national report on the Ambulance Response Programme is expected in April.

4.1.2 Separately, a letter from the Chief Executives of NHS England and NHS Improvement has confirmed the plan to implement this nationally by October 2017.

4.2 National Audit Office (NAO) report into ambulance services

4.2.1 Following publication of the NAO report earlier this year, the Trust has now received the Trust-specific follow-up report.

4.2.2 A comprehensive report will be taken to the Audit Committee in due course, addressing both the public report and this supplementary information but key highlights relating to SECAmb from the follow-up report include (information related to 2015/16 data):

- Incidents per head of population are high (second highest nationally)
- Private provider costs are high but most other non-pay costs benchmark well
- Handover delays have grown, whilst crew clear delays have decreased
- We perform well on see and treat but less well on hear and treat
- Despite high see and treat rate, re-contact rates are low

5. Recommendation

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

David Hammond, Acting Chief Executive

21st March 2017

Unified Recovery Plan ("URP") Dashboard - ORSG
Extract from Improvement Tracker

Current period of reporting to 15 March 2017
Previous period of reporting to 15 February 2017

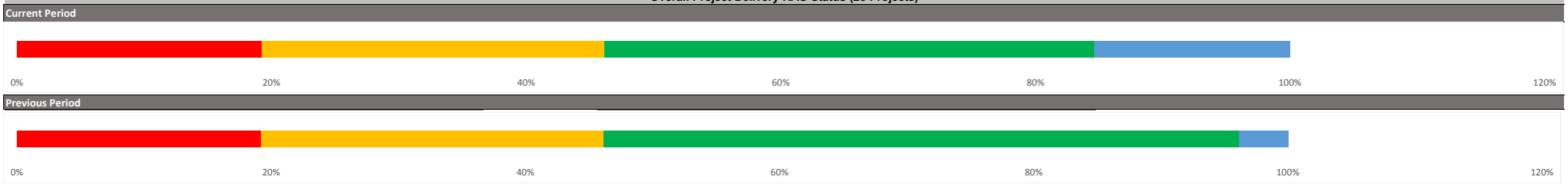
Last updated 17/03/2017

Key:
Red
Amber
Green
Blue (Project officially closed)

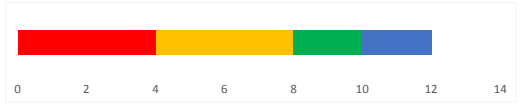
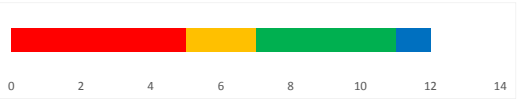
South East Coast Ambulance Service NHS
NHS Foundation Trust

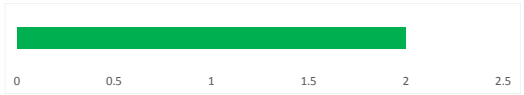
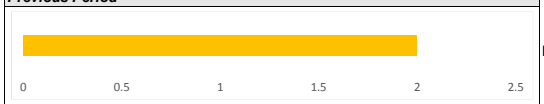
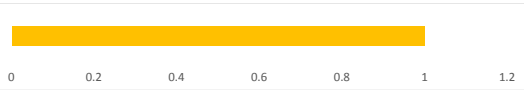
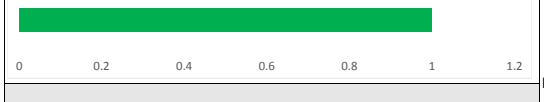
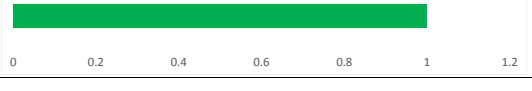
Overall Dashboard

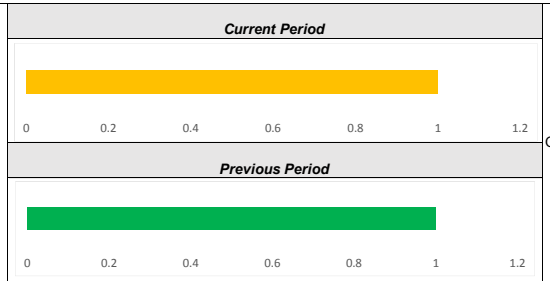
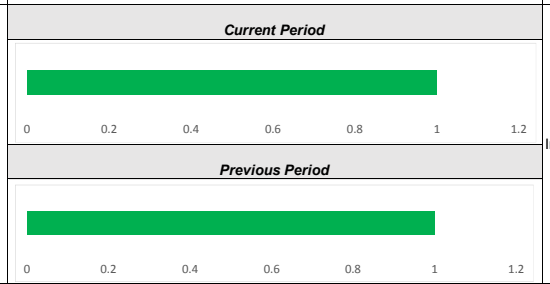
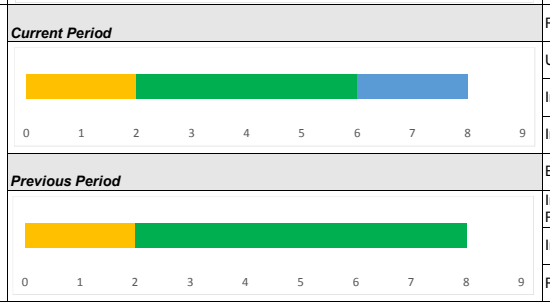
Overall
Overall Project Delivery RAG Status (26 Projects)



Workstream Level Dashboards

Workstream Level			*Project Breakdown*					
Workstream	Overall No. of Projects	Overall Delivery Status (RAG)	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	High-level Commentary
999	***12***	***Current Period*** 	Improve Supply and Effectiveness of Private Ambulance Providers ("PAPs")	Green	Green	Giovanni Mazza	Joe Garcia	PAPs has delivered significant efficiency improvements from 1.9% to 2.5% through efficiency improvements in mobilisation time and non conveyance rates. Initial target of 3% was not realised due to reduction in PAPs hours as part of financial recovery plan. The PAPs project was agreed for closure during the steering group meeting on 15 March 2017. There has been an increase in performance contribution from CFRs from 1% to 2.5%, however, the target for this project is 3% hence the amber RAG rating. There are ongoing discussions with Executive Sponsor to reprioritise energy and focus from those projects which have not realised intended benefits to new methods of improving performance improvement. In some instances, existing projects will be rescoped or closed accordingly. Please see below for further details to all 'Red' projects.
			Forecasting and scheduling process reviewed and action plan delivered	Red	Red	Greg Walsh	Joe Garcia	
			Implement nature of call and dispatch on disposition. (Phase 1 ARP)	Blue	Blue	Rob Mason	Joe Garcia	
			Manpower and recruitment	Blue	Green	Sue Skelton	Joe Garcia	
			Improved effectiveness of Community First Responders ("CFRs")	Amber	Green	Sue Skelton	Joe Garcia	
			Revised demand management plan implemented	Red	Red	Sue Skelton	Joe Garcia	
		Previous Period 	Improved call answer service	Amber	Red	Rob Mason	Joe Garcia	
			Reduced response ratio	Green	Red	Sue Skelton	Joe Garcia	
			Zoned Cars	Amber	Green	Chris Stamp	Joe Garcia	
			Increased Hear and Treat responses	Amber	Amber	Karen Lillington	Joe Garcia	
			Improved Performance Management	Red	Amber	Lynda Pegler	Joe Garcia	
			Reduced hospital turnaround time	Red	Red	Dave Hawkins	Joe Garcia	

111	***2***	***Current Period*** 	Effective operational performance management	Green	Amber	John O'Sullivan	Joe Garcia	Closure forms have been developed and presented to the Organisational Recovery Steering Group ("ORSG") on 15 March 2017. Both projects have delivered tangible improvements and have been successfully embedded into BAU. Project RAG ratings will turn to 'Blue' following approval of forms at Turnaround Executive meeting on 22 March. One new project will be established focusing on integrating governance between 111 and EOC. A short term objective will focus on meeting statutory requirements for 999 audits.
		Previous Period 	KMS 111 Recruitment and Retention	Green	Amber	John O'Sullivan	Joe Garcia	
HQ	***1***	***Current Period***  ***Previous Period*** 	HQ Move / EOC Move	Red	Amber	Ibrahim Razak	Steve Graham	Significant progress has been made with this project over the last month. The 'People' workstream was at risk due to lack of clarity regarding numbers moving. The Trust now has full visibility on the number of 'Yes', 'No' and 'Maybes'. However there is still more urgent work in some areas, particularly in relation to furniture procurement and business continuity, which needs to be done in order to progress this project back on track. Further details are outlined below.
EPCR	***1***	***Current Period***  ***Previous Period*** 	Electronic Patient Clinical Records ("EPCR").	Green	Green	Karen Mann	Jon Amos	The final delivery of IPADs was on 16 March 2017. The delays in IPAD deliveries in January have been resolved through double deliveries during February meaning the overall delivery schedule is on track. The project will go through the PMO Closure process before being formally closed. In addition, a new project will be developed to realise the benefits of the IPADs (phase 2) and this will go through a project mobilisation session in the next two to three weeks.

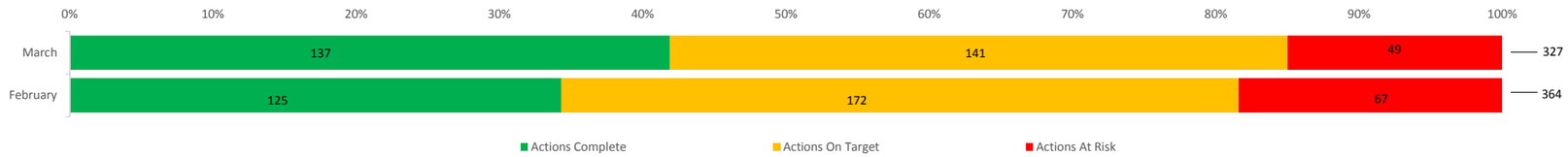
OU Restructure	***1***		OU Restructure (formerly "OU Leadership")	Amber	Green	Sonia Belsey	Joe Garcia	A number of staff concerns have been raised in response to the intended team restructure. If staff concerns are not resolved, this would delay the planned date for implementation of the new team structure. The Executive Sponsor has held discussions with the concerned staff in order to reach an agreement and resolve the issue accordingly. The latest meeting on 15 March was successful and was evidenced through the number of reductions in staff concerns.
New CAD	***1***		Implementation of new CAD	Green	Green	Phil Smith	David Hammond	The project is currently on track to deliver within the agreed timescales, however it is recognised that the timeline is tight. As this project carries a huge risk to the organisation, a weekly Programme Board Meeting has been established in order to monitor and drive progress so that a greater level of grip and control is maintained. Following the first Programme Board meeting on 8 March, the 'Go Live' timetable has been updated in order to build in an additional timing buffer in particular to training requirements.
Culture / Workforce	***8***		Refreshing Values (formerly Improving Staff Engagement)	Amber	Green	Steve Singer	Steve Graham	Great progress has been made in terms of reducing the vacancy rates and reducing the value of overpayments. Vacancy rates have been reduced to 9.15% (below the initial project target of 10%) and the value of overpayments has reduced by c.£119k. Reducing temporary staffing and agency costs was presented for closure to the Finance Steering Group on 14 March 2017 - this project will be officially closed during w/c 20 March following approval from the Turnaround Executive Meeting.
			Updating HR Policies & Procedures	Amber	Amber	Barbara Macanas	Steve Graham	
			Improving Recruitment Rates	Blue	Green	Clare Irving	Steve Graham	
			Improving Service Centre Processes	Blue	Green	Samantha Pearce	Steve Graham	
			Establishing Workforce Information Systems	Green	Green	Adam Van Huet	Steve Graham	
			Implementing New Appraisal System (formerly) Improving Performance Management	Green	Green	Steve Singer	Steve Graham	
			Improving Leadership Management	Green	Amber	Steve Singer	Steve Graham	
			Reducing temporary staffing and agency costs	Green	Green	Clare Irving	Steve Graham	

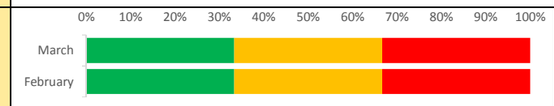
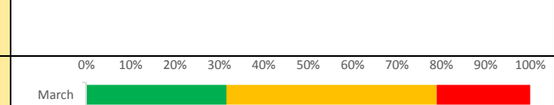
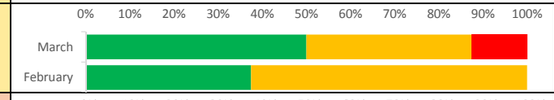
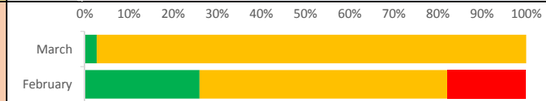
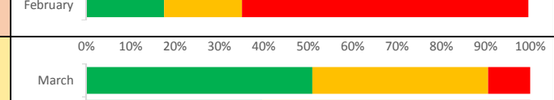
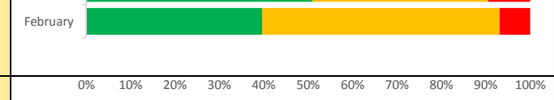
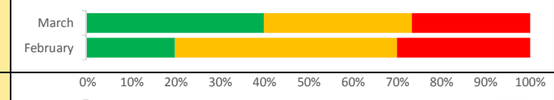
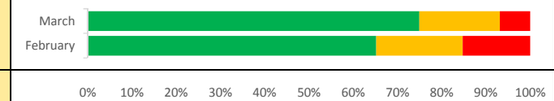
Exceptional Reporting

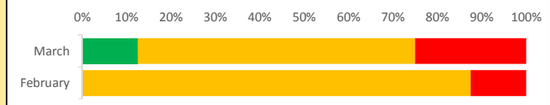
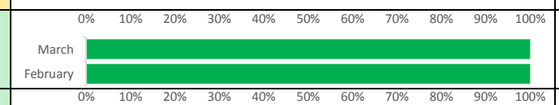
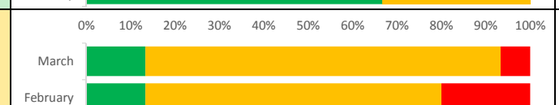
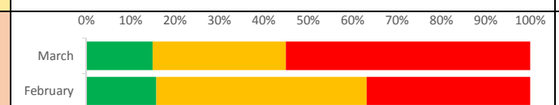
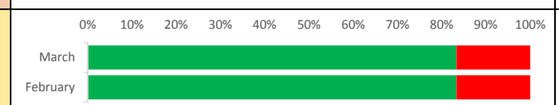
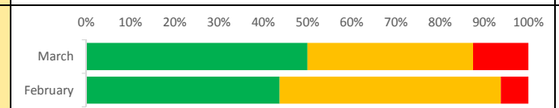
Workstream	Project	Executive Sponsor	Current RAG	Previous RAG	Rationale	Mitigating actions	Owner	RAG post mitigating action
HQ	New HQ and EOC West	Steve Graham	Red	Amber	At risk primarily due to three workstreams: People, Business Continuity and EOC. These areas are at risk due to an insufficient business continuity plan, lack of visibility over number of staff relocating and a delay in procuring EOC furniture for new HQ	A weekly Programme Board has been established whereby priority areas are discussed and action points agreed. The increase in the number of one-to-one meetings has accelerated progress in the 'peoples' workstream meaning the Trust now has full visibility over the individuals and teams who are moving to Crawley. Discussions have been held during w/c 13 March to redesign the EOC continuity plan. A new resource has been allocated to the EOC workstream and a supplier for EOC furniture has been selected	Steve Graham	Amber
999	Reduced hospital turnaround time	Joe Garcia	Red	Red	At risk as hospital handover policy has not gained support required from Commissioners and Acute Trusts	Implementation of the Conveyance Handover and Transfer of Care procedure will be rolled out across the Acute Trusts over the next month. There will be a specific focus on four Trusts initially. There is a mitigation plan in place which looks at establishing an incident command hub in order to gain greater grip and control. The incident command hub location and resource have been agreed and it is expected that the hub will be fully up and running by the 31 March 2017.	Chris Stamp	Amber
999	Forecasting and scheduling	Joe Garcia	Red	Red	At risk due to delayed decision as to whether the scheduling team would be relocated to Crawley. In addition there is uncertainty as to whether the function will be centralised or structured as local teams.	High level process maps has been developed which outlines the current structure of the forecasting and scheduling team. In addition, an external consultant is conducting a review of the forecasting team. There will be a discussion with the Project Manager and Exec Sponsor, to determine whether this project should be rescoped in order to reflect new circumstances; primarily the move the Crawley and findings following the consultant's review	Sue Skelton	Amber
999	Improved Performance Management	Joe Garcia	Red	Amber	At risk due to lack of funds available to finance Lightfoot to implement the IDA process at Level 3 and 4	There are ongoing discussions as to whether the IDA process level 3 & 4 can be completed in house. The project team will review the new scorecards which are being developed as part of the OU Restructure project, to understand if these are fit for purpose for this project	Joe Garcia	Amber
999	Revised demand management plan implemented	Joe Garcia	Red	Red	The demand management plan cannot currently be implemented because there has been a delay in obtaining final executive sign off to the proposed plan	The plan was discussed during Senior Management Team meeting ("SMT") on 24 February. During the meeting it was agreed that amendments needed to be processed and that the Medical Director should review the plan prior to official sign off. Following official executive sign off, the plan can be implemented once training strategy has been agreed	Sue Skelton	Amber

South East Coast Ambulance Service - Quality/CQC Must Do Improvement Plan Board Report

CQC Dashboard - 15 March 2017



Domain	CQC Work stream	CQC Must Do	Confidence of delivery on time and realising benefits	Progress against actions%	Number of at risk items	Project lead	Executive lead	Progress summary
Safe	Security	2. Security Improvement Plan	On Target		4	Dan Garret	Joe Garcia	Good progress is being made to improve security across the Trust with almost 50% of actions complete. Actions at risk pertain to delays in delivery due to a lack of capacity. A key focus for the next period is on updating policies and embedding local ownership of security
	IT	3.0 CAD Improvement Plan	On Target		1	Mark Chivers	David Hammond	Ongoing work is taking place on two key fronts, stabilising the current CAD and installing the new CAD. At risk actions relate to initial delays with stabilising the current CAD. Sufficient progress is now being made on this. New CAD installation is on track. This Must Do action is being managed within the Organisational Recovery Steering Group. For more detail on progress and risks please refer to the Organisational Recovery Dashboard
	Incidents	7. Incident and SI Reporting Improvement Plan	On Target		4	Sara Songhurst	Emma Wadey	The increase in actions at risk from previous month is related to capacity constraints, with recent sickness and resignations. An interim Risk Manager has been appointed who has taking action to address the risks. Funding has also been approved for additional temporary personnel to cover the backlog of incidents
	Infection prevention	10.0 Infection Prevention and Control Improvement Plan	On Target		1	Aide Hogan	Emma Wadey	The majority of improvement actions taken within this work stream have been embedded as BAU. A risk has arisen in relation to training compliance. This is being actively managed with the operational team and should be addressed within the next period
	Medicines	14.0 Medicines Management Improvement Plan	At Risk		0	Fiona Wray	Fionna Moore	A significant amount of work has been undertaken to address immediate concerns and develop a comprehensive action plan to tackle Trust wide systemic issues related to medicines management. A key risk for this now is delivery capacity, which is discussed in more detail below
	Patient records	15.0 Patient Records Improvement Plan	At Risk		5	Fiona Wray	Fionna Moore	This period has seen a number of actions close with 60% of the plan delivered. However, this lacks sustainability at present as the project has lost its project lead. This is due to be addressed in the next period as Fionna Moore takes over Executive sponsorship - discussed further below
	Safeguarding	1. Safeguarding Improvement Plan	On Target		5	Sara Songhurst	Emma Wadey	While the delivery of the action plan is on track, there is currently heavy reliance on interim positions with only one substantive role delivering training and having oversight of strategy, and BAU activities. A business case to grow the current team and enable effective safeguarding service delivery has been submitted to the executive team for approval
Effective	Operational performance 999	8.0 Take action to ensure that national performance targets are met	On Target		8	Sue Skelton (Lynda Pegler)	Joe Garcia	This Must Do action is being managed within the Organisational Recovery Steering Group. For more detail on progress with the operational improvement projects please refer to the Organisational Recovery Dashboard
	Operational performance 111	16. NHS 111 Improvement Plan	On Target		3	John O'Sullivan	Joe Garcia	This Must Do action is being managed within the Organisational Recovery Steering Group. For more detail on progress with the operational improvement projects please refer to the Organisational Recovery Dashboard
	Outcomes	9.0 Outcomes Improvement Plan - Take action to improve outcomes for patients who receive care and treatment	On Target		1	Andy Collen	Richard Webber	Good progress has been made on a number of key areas including reducing frequent callers, and increasing falls and hypo's referrals. The focus for the next period shifts to improving AQI performance through collaborative working with clinical audit and operations, and reducing task cycle time

Domain	CQC Work stream	CQC Must Do	Confidence of delivery on time and realising benefits	Progress against actions%	Number of at risk items	Project lead	Executive lead	Progress summary
Responsive	Scheduling	13. Safe Resource Dispatch	On Target		2	Chris Stamp	Joe Garcia	The increase in at risk actions within this project relate to the new agreed policy on policies, which requires every policy to have a 30 day staff consultation period. This will cause a two month delay in sign off and implementation of the deployment policy, but no issues are anticipated with this as other relevant guidance (scope of practice policy) has been published to support safe deployment
	HART	4.0 HART Improvement Plan	Complete		0	Andy Cashman	Richard Webber	This action plan is complete and evidence to support this is in the process of being collated and validated
		12.0 HART Staffing Improvement Plan	Complete		0	Andy Cashman	Richard Webber	This action plan is complete and evidence to support this is in the process of being collated and validated
Well-led	Governance	6.0A Corporate Governance	On Target		1	Peter Lee	David Hammond	Good progress has been made with developing the Corporate governance of the Trust including agreement of the management governance and meeting structures, appointment of a substantive chairman, and agreement of the internal audit schedule. Many actions are on target and due to be completed at the end of March. Further work is required on establishing effective governance over sub-contracted service providers
		6.0B Clinical Audit	At Risk		11	Fiona Wray	Fionna Moore	The vacancy of the Head of Clinical Audit role has led to significant slippage of this action plan. However, the Clinical Audit Lead role has now been filled substantively, and a complete review of the action plan has been undertaken to prioritise immediate actions. This action plan will receive further review and scrutiny as Fionna Moore takes over Executive sponsorship - further detail below
	PTS	5.0 PTS Improvement Plan	On Target		1	Sue Skelton	Joe Garcia	This action plan is almost complete, with one outstanding action relating to understanding the impact of the loss of PTS services in Surrey. An impact assessment is currently being developed and will be completed by next month. The Trust has gone through a similar process for the loss of PTS services in both Kent and Sussex
	Resourcing	11.0 Staff and resourcing improvement plan	On Target		2	James Pavey	Joe Garcia	The increase in at risk actions within this project relate to the new agreed policy on policies, which requires every policy to have a 30 day staff consultation period. This has caused delays with sign off of the new meal break policy, but no adverse consequences are expected from this due to close monitoring of meal break adherence as per the current policy

Summary exception report

Domain	CQC Work stream	Risk Description	Current RAG	Previous RAG	Mitigating action	Risk after mitigation	Owner	Date for resolution
Safe	14.0 Medicines Management Improvement Plan	A number of the risks identified in the previous month have been addressed. However a new risk has arisen with the limited capacity currently available to deliver on the medicines management action plan. While external resource has been identified to provide delivery support, it is not clear if the expectations regarding the type of support (delivery) to be provided have been understood. Without the additional resource, slippage in the delivery of the action plan is likely	Red	Red	The Interim Chief Pharmacist has been contacted to expedite conversations with external parties providing the additional resource and confirm the level of support available and potential start dates. A task and finish group will be established comprising of key individuals responsible for driving the delivery of the medicines management plan. The frequency of this meeting will be at least once weekly and will be chaired by the interim Medical Director. For further assurance, progress against the delivery of the medicines management plan will be reported through to Drug and Therapeutics Committee (DAT)	Amber	Fionna Moore	24/03/2017
Well-led	6.0B Clinical Audit	There is a risk of not being able to demonstrate actions taken to address findings of the CQC within Clinical Audit in time for the re-inspection in mid-May. There has been significant slippage on the delivery of the action plan due to vacancies in the Head of Clinical Audit and Medical Director roles, and limited capacity within other directorates to provide support. These positions have now both been filled, and a complete review of the action plan has been undertaken to prioritise immediate actions	Red	Red	The interim Medical Director will support the Clinical Audit Lead develop and progress with a short term plan to address immediate concerns. This will be followed by a review of the Clinical Audit service and development of a longer-term action plan to establish an effective delivery model that will support both the assurance of clinical quality and continuous quality improvement.	Amber	Fionna Moore	14/04/2017
Safe	15.0 Patient Records Improvement Plan	The Patient Records action plan does not have a project lead. While progress has been made on the delivery of the action plan with now 60% of actions complete, it is not clear to what extent these actions have resolved the issues identified by the CQC, or how sustainable these potential improvements are.	Red	Red	There is a need to identify an interim project lead and establish the appropriate project governance to support with reviewing the actions completed to date, and embedding improvements made so far. Given that patient records impacts on many other elements of the Trust eg, operations and clinical development, having a project working group with appropriate representation will be pivotal to embedding the necessary change.	Amber	Fionna Moore	31/03/2017
Safe	7. Incident and SI Reporting Improvement Plan	Good progress has been made with the delivery of this Must Do action plan. However, current concerns with the capacity and capability of the personnel within the team puts this at action plan at risk. Two significant HR issues exist, and a back log of incidents that need to be cleared.	Red	NA	As discussed above, an interim Risk Manager has been appointed who has taking action to address the capacity and capability concerns identified. Funding has also been approved for additional temporary personnel to cover the backlog of incidents. The risk team is also being supported by personnel from within the Quality Directorate to ensure necessary traction with the action plan is maintained	Amber	Emma Wadey	28/04/2017

FIMS Graphs

South East Coast Ambulance Service NHS

Validated / Unvalidated FIMs

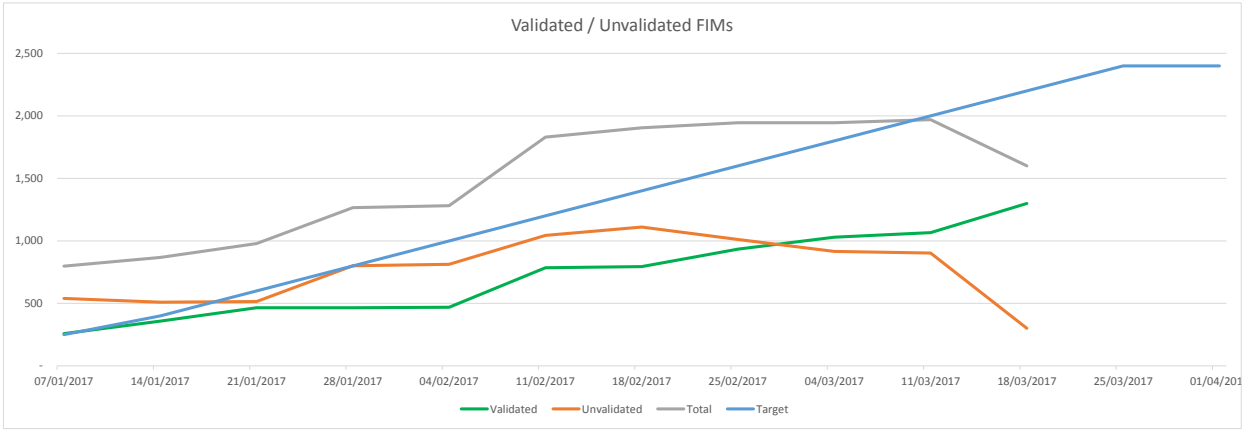
20/03/2017

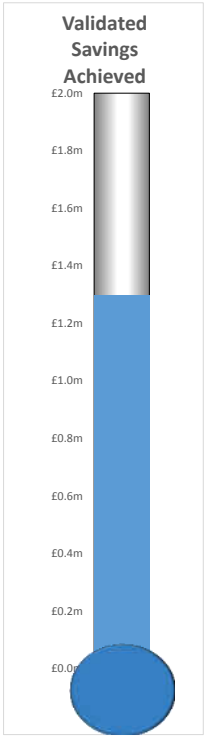
	07/01/2017	14/01/17	21/01/17	28/01/17	04/02/17	11/02/17	18/02/17	25/02/17	04/03/17	11/03/17	18/03/17	25/03/17	01/04/17	08/04/17	15/04/17
Validated	258	358	465	465	469	785	794	934	1,029	1,067	1,299				
Unvalidated	540	510	514	801	813	1,044	1,111	1,011	916	903	301				
Total	**798**	**868**	**979**	**1,266**	**1,281**	**1,830**	**1,905**	**1,945**	**1,945**	**1,970**	**1,600**				
Target	250	400	600	800	1000	1,200	1,400	1600	1800	2000	2200	2400	2400	2400	2400

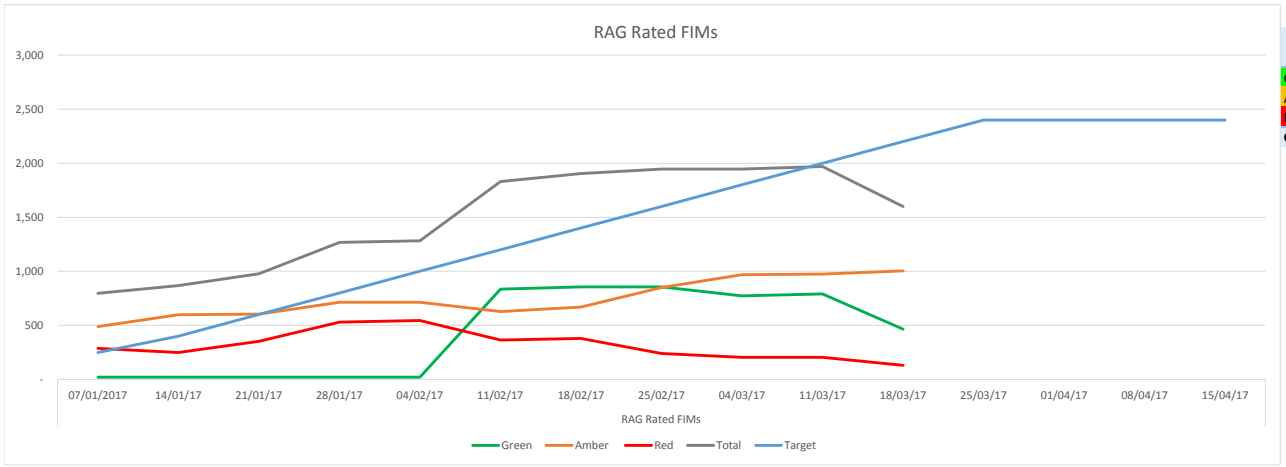
RAG Rated FIMs

20/03/2017

	07/01/2017	14/01/17	21/01/17	28/01/17	04/02/17	11/02/17	18/02/17	25/02/17	04/03/17	11/03/17	18/03/17	25/03/17	01/04/17	08/04/17	15/04/17
Green	20	20	20	20	20	836	856	856	773	790	464				
Amber	490	598	605	715	715	629	670	849	968	975	1,006				
Red	288	250	354	531	546	365	379	240	204	204	130				
Total	**798**	**868**	**979**	**1266**	**1281**	**1,830**	**1905**	**1945**	**1945**	**1970**	**1600**				
Target	250	400	600	800	1000	1200	1400	1600	1800	2000	2200	2400	2400	2400	2400







RAG	Total Validated & Unvalidated
Green	464
Amber	1,006
Red	130
Grand Total	**1,600**

South East Coast Ambulance Service NHS Trust

Financial Immediate Measures Dashboard

No	Initiative	Proposed Executive Lead	Project Lead	Target Saving £k	Benefits Target £k	Validated Level 1 Savings £k	Unvalidated Savings £k	Total Validated & Unvalidated	RAG Rating	Narrative	Progress To Date	Next Action	Due By	Potential QIA Impact considered/ (Yes/No)
1a	Overtime Preapproval -operational	Joe Garcia	Sue Skelton	400	250	213	100	313	Green	Tighter controls on operational overtime payments through monitoring and focus on pre-authorisation of all spend. Recall Clinical staff on secondment and CCPs back on the road	Communication from Operations Director sent out advising that overtime authorisation will be at Regional Operations Manager (ROM) level only. Planned hours have been removed from rotas i.e. 16 Jan and a weekly Tracker has been put in place to monitor progress. CCPs and other Clinical staff have been required to return to front line duties to reduce requirements for overtime and use of Private Ambulance Providers.	Tracking the weekly overtime hours to confirm savings. Ongoing monthly validation	14.4.17	Drafted
1b	Overtime Preapproval - non operational	Steve Graham	Carol Lenz	15	50	7	-	7	Red	Tighter controls on non-operational overtime payments through monitoring and focus on pre-authorisation of all spend.	Communication sent by HR Director regarding tighter approval process to stop non-operational overtime. Overtime authorisation process to be reviewed and use of overtime to be restricted to critical issues only .	Overtime measures implemented and being tracked	14.4.17	Drafted
1c	Overtime Preapproval -Paramedics	Richard Weber	Kirsty Booth	58	58	21	17	38	Amber	Tighter controls on paramedic overtime payments through monitoring and focus on pre-authorisation of all spend. Recall Clinical staff on secondment and CCPs back on the road	CCPs and other Clinical staff have been required to return to front line duties to reduce requirements for overtime and use of Private Ambulance Providers.	Measures agreed and now being implemented	14.4.17	Requested
2	Meal Break Payments	Joe Garcia	James Pavey	400	250	120	13	133	Amber	Change in procedures re lower urgency calls	Communication sent from Operations Director to restrict meal break disturbances to Red 1 calls. Daily meal break disturbance log in place and being reported and reviewed by ROMs. Meal break report/dashboard is currently available on Info.com	Continue to review report and validate target against agreed trajectory	14.4.17	Requested
3	Shift overruns	Joe Garcia	Chris Stamp	100	60	41	19	60	Amber	To reduce the quantum of shift overruns through more rigid implementation of the rules around the need to require shifts to run over allotted times.	Directive issued and Union agreement has been given. Tracking report has been established. New operational instructions implemented from 1 February 2017.	Tracking Dashboard on a weekly basis and validating savings monthly	14.4.17	Drafted
4	PO Controls	David Hammond	Paul Ranson	250	100	62	5	67	Amber	Grip on Trust's commitment to spend - unlikely to deliver original target - enabler	Forensic PO & Non PO review undertaken and communication sent out to required End users. Agency discipline being enforced through questioning at FSSG meetings	Benefits recognised under other FIMs - PO controls FIM acts as an enabler	14.4.17	n/a
5	PO and SFI levels	David Hammond	Paul Ranson	250	5	-	-	-	Amber	Ensure adequate governance & management controls in place	Financial Compliance declaration form distributed and signed by band 8Cs and above	Benefits recognised under other FIMs - PO and SFI levels FIM acts as an enabler	14.4.17	n/a
6	Meeting expense/Room Hire	David Hammond	Paul Ranson	50	30	19	11	30	Amber	Stop non essential room hire and all associated costs. No further away days in hotels	Directive issued and monitoring spend	Benefits tracked against month end accounts	14.4.17	n/a
7	Agency costs and controls	Steve Graham	Clare Irving	500	300	66	17	83	Amber	Reduce agency overspends to address breaches on Agency cap Conversion of temps to perm and tighter controls on recruitment.	New procedures established and communicated, HR working collaboratively with Budget leads to establish savings	Plan and trajectory in place. Tracking to ensure agreed dates are met re transfers and leavers	14.4.17	Drafted
8a	Training Costs & Course Fees - clinical	Steve Graham	Sally James	155	120	108	1	109	Amber	Tighter controls on training related spend such as hotels etc. Stop on discretionary training	Courses moved in-house where appropriate and driver training to be delivered locally using local vehicles. Actively sourcing cost effective hotel and venue hire for training. Reviewing daily travel tickets to move to weekly and monthly train tickets to avoid waste	Benefits agreed against forecast trajectory - tracking against month end accounts	14.4.17	Drafted
8b	Training Costs & Course Fees - non clinical	Steve Graham	Steve Singer	45	80	54	10	64	Amber	Tighter controls on training related spend such as hotels etc. Stop on discretionary training	All non essential training stopped and authorisation of training moved to Head of Learning and Organisation Development. Validation process in progress	Review target against required benefit and assure delivery against month end accounts	14.4.17	n/a
9a	Fleet Fuel	Joe Garcia	John Griffins	308	75	-	25	25	Red	Tighter controls around use of fuel	Review mileage and use of Bunkered fuel and communication sent re use of forecourt fuel. Mileage workstream established to be led by Sue Skelton.	Complete installation of Telematics (currently 60% roll out) regarding Steady Speed limiters. Validate benefits on a monthly basis. Understand the standard system reports requirements for monitoring i.e. idle times	14.4.17	n/a
9b	Fleet Maintenance - External	Joe Garcia	John Griffins	92	50	36	-	36	Red	Tighter controls and review of maintenance cycle time	Reviewed maintenance service cycle/inspection - reduction on use of materials - oil, filters. Issued instruction to maximise use of internal maintenance and minimising reordering (holding stock). Review of obsolete stock	Monitoring stock levels - 22% reduction in call off orders for Q4 and tighter PO approval. Validate benefits on a monthly basis.	14.4.17	n/a
9c	Fleet Maintenance - Internal	Joe Garcia	John Griffins	75	25	-	18	18	Red	Tighter controls and review of maintenance cycle time	see above	see above	14.4.17	n/a
10	IT Costs	David Hammond	Mark Chivers	150	100	92	-	92	Amber	Efficient utilisation of resources to minimise waste. Cut out non essential spend	Reviewed and restricted to critical spend	Validate against agreed delivery target through monthly accounts	14.4.17	n/a
11a	CQUIN payments assurance	Jon Amos	Andy Collen	1,000	-	-	-	-	Amber	Reassure full delivery - no reduction assumed in original forecast	Circa 90% achievement of Q1 & Q2 agreed	Await agreement of Q4 benefits	14.4.17	n/a
11b	Other income generation - recharges & recovery	David Hammond	Priscilla Ashun-Sarpy		70	67	10	77	Green	Improved recovery of income/recharges and overpayments	Agreed repayment plans re overpayments. Confirmed recharges for established work done by Paramedics for KSSAAT.	Assure delivery through monthly accounts	14.4.17	n/a
12	Stock and issue Uniforms	David Hammond	Paul Ranson	100	40	31	5	36	Red	Tighter controls on replacement and changes in policy.	Liaison with Operations leads to review policy	Agree short term measures and utilise existing stock in view of policy review	14.4.17	n/a
13	Tea Coffee	Jon Amos	Paul Ranson	15	5	-	2	2	Red	No free supply and shift back to Maxwell House	Lewes office supplies from petty cash stopped. Procurement providing supplies for all offices and monitoring stock levels	Assure Benefits in monthly accounts	14.4.17	n/a
14	Legal costs	Peter Lee	Lyande Kaikai	50	30	3	10	13	Red	Value for money - clearly define what can be done in house and external	All Legal spend to go through the Company Secretary - communication to go in the next edition of Finance matters.	Assure Benefits in monthly accounts	14.4.17	Requested
15a	Medicine Management - drugs	Fionna Moore	Fiona Wray	160	10	-	3	3	Red	Efficient utilisation of resources to avoid wastage including over ordering	Reviewed/established current drugs that are not required or a more cost effective alternative.	Assure Benefits in monthly accounts	14.4.17	Requested
15b	Medicine Management - Medical equipment	Joe Garcia	Chris Haines	204	110	100	-	100	Amber	Efficient utilisation of resources to avoid wastage including over ordering	Reviewed use of large cylinders and purchases of medical equipment	Assure Benefits in monthly accounts	14.4.17	Drafted
15c	Medicine Management - gases	Joe Garcia	Paul Ranson	36	10	-	5	5	Amber	Efficient utilisation of resources to avoid wastage including over ordering	Efficient utilisation of resources to avoid wastage including over ordering	Reviewed use of large cylinders and purchases of medical equipment Assure Benefits in monthly accounts	14.4.17	Drafted
15d	Medicine Management - consumables	Joe Garcia	Paul Ranson	100	42	30	-	30	Amber	Efficient utilisation of resources to avoid wastage including over ordering	Efficient utilisation of resources to avoid wastage including over ordering	Assure Benefits in monthly accounts	14.4.17	n/a
16	External Contractors	Steve Graham	Clare Irving	200	30	27	2	29	Red	Grip on spend to justify value for money. Risk assess non coverage	Reviewing spend to establish potential savings	Check the trajectory re agency and contractors. Assure benefits	14.4.17	n/a
17	Taxi and Vehicle Hire	Joe Garcia	Sue Skelton	50	40	54	-	54	Green	Reduction in spend and vehicle hire	Reviewing spend to establish potential savings	Check delivery against agreed trajectory	14.4.17	n/a
18	Furniture & Fittings	Jon Amos	Paul Ranson	30	50	59	24	83	Green	Cut in spend and replacement	Communication sent to cease further procurement of furniture in Q4. Capitalisation of new MRCs/RPs furniture under review	Review Target against required benefit and assure delivery	14.4.17	n/a
19	Phones and calls	David Hammond	Mark Chivers	100	10	23	-	23	Red	Improvement in VFM	Restrictions on the allocation of new iPhones. Batch purchases of Laptops to facilitate capitalisation	Review Target against required benefit and assure delivery	14.4.17	n/a
20	Corporate Recruitment	Steve Graham	Clare Irving	12	15	-	10	10	Amber	Tighter controls - value for money	Reviewing spend to establish potential savings	Being tracked on a weekly and monthly basis	14.4.17	n/a
21	Public Relations Expenses	Peter Lee	Janine Crompton	20	20	29	- 9	20	Green	Taken out unnecessary spend	Reviewed and stopped non essential printing and design work	Check delivery re month end	14.4.17	n/a
22	Books Journals & Subscriptions	Peter Lee	Sally James / Lyande Kaikai	30	40	36	4	40	Green	Review to ensure value for money	Subscriptions/books/licences cancelled where not required and recycling reusable materials	Assure delivery through monthly accounts	14.4.17	n/a
23a	Travel & Subsistence - operational	Joe Garcia	Sue Skelton	100	-	-	-	-	Red	Unlikely to get much delivery in short term but potential CIP	Reviewing travel spend to establish potential savings	Check Target, Scope and assure delivery for 2017/18	14.4.17	n/a
23b	Travel & Subsistence - non operational	Steve Graham	Carol Lenz			-	-	-	Red	Grip on spend - potential policy changes	Reviewing travel spend to establish potential savings	Check Target, Scope and assure delivery for 2017/18	14.3.17	n/a
	Total			5,055	2,075	1,299	301	1,600						-
				Target		**2,000**	**2,000**	**2,000**						
	Period 8 Forecast Baseline			% of Target Achieved		**65%**	**15%**	**80%**						

South East Coast Ambulance Service NHS
NHS Foundation Trust

	Agenda No	

Name of meeting	Trust Board
Date	29 March 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 improving the Programme Management Office (PMO) and updates to the governance structure to oversee programme delivery. There is also a summary of the current state of each of the three Steering Groups; Organisational Recovery, Financial Sustainability and Quality (i.e. CQC must do's), which form the Unified Recovery Plan (URP). This is provided through three separate dashboards.
Recommendations, decisions or actions sought	• To note the progress made in relation to the PMO improvements • To review the dashboards to be fully sighted on the current progress of the URP and to consider the risks highlighted.
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 key processes implemented through the Programme Management Office (PMO) and describes a number of changes introduced to the governance structure to oversee Programme delivery.

1.2. There is also a summary of the progress of the three Steering Groups; Organisational Recovery, Financial Sustainability and Quality (i.e. CQC must do's), which form the Unified Recovery Plan (URP). This is provided through three separate dashboards to show what has been achieved since the last reporting period, up to 15 March 2017.

1.3. The purpose of the paper is to ensure the Trust Board is sighted on the changes being made through the PMO and to provide assurance of the governance structures being implemented.

2. Changes to the Governance Structures and PMO

2.1. The three Steering Groups have been running for over two months and are working well, with much better visibility of projects. A number of projects within the Workforce and 999/111 workstreams have been closed having followed a clear closure process (see below). The focus continues to be on project level delivery and risk management, and ensuring interdependencies are mapped and tracked.

2.2. There are Terms of Reference (ToR) for each Steering Group and these have recently been refreshed in line with the work being undertaken by the Company Secretary to refresh all Corporate Governance. The ToRs will be taken through the Turnaround Executive for sign off and then to the Risk and Assurance Executive Group.

2.3. Building on the Governance information flow map which was reviewed by the Board last month, there has been agreement with the Non-Executive Directors as to which projects will be reported to each board committee, as illustrated below, and in appendix A. Highlight reports will be provided for each committee to enable review and discussion on progress.

The below structure illustrates the current Steering Groups and Committees that the Projects report to.

2.4. A new Programme Board has been introduced with focus on the HQ/EOC move, CAD and Informatics projects. This will occur on a weekly basis with attendance by the Executive team and key PMO leads. This will enable priority risks to be effectively managed and any issues to be dealt with in a timely manner. A further key purpose of the Programme Board is to ensure that the interdependencies between these projects are closely monitored given the critical importance of delivering them.

2.5. The revised governance structure highlighting how the new Programme Board feeds in to the overall process is illustrated in Appendix A.

2.6. In addition to the Governance structure, a document articulating the roles and responsibilities of key stakeholders has been circulated to all executive sponsors, programme and project managers, project leads and project teams. The purpose is to ensure everyone is clear on their role in delivering projects and that accountabilities and ownership are fully understood.

2.7. A review of the governance structures at a project level is underway to ensure that it is fit for purpose and functioning as required for the different projects.

2.8. There have been a number of new processes introduced to the PMO to improve the controls to better manage and oversee project delivery. These are briefly described below and all have a clear documented Standard Operating Processes (SOP).

2.8.1. Quality Impact Assessment (QIA) – this process has been revised and includes two stages (summary and full) with formal sign off by the Medical Director and Chief Nurse. The purpose is to ensure all projects have given sufficient consideration to the impact on quality for patients and staff from an implement stage. There will be a QIA for all new projects across the three Steering Groups and these will be revisited during the life cycle of the project.

2.8.2. Project Closure – all leads now have to follow a clear process for closing down projects and complete a comprehensive form. This includes articulating demonstrable objectives achieved, being clear on benefits realised with supporting evidence and also requires a handover plan with agreed escalation

points should business as usual (BAU) veer off track. Closed projects are signed off by the Executive Sponsor, Steering Group chair, and Turnaround Executive if the latter is deemed appropriate due to scale for example.

2.8.3. Project Lifecycle – there is now a clearly mapped step by step process for the formulation and running of a project. This will be key to ensuring all projects are established correctly with agreed objectives, scope, benefits, resource requirements, risk assessment and delivery plan.

2.8.4. Risk management – all project boards and steering groups maintain an up to date risk log which is reviewed on a weekly/fortnightly basis. The Steering Group Logs inform the overarching Programme Risk Log which has recently been revised and fully reviewed by the Executive to ensure it is up to date and accurately reflects progress and concerns. A session has been held with the PMO to upskill regarding risk management and ensure all are aware of the importance and the process. A copy of the Programme Risk Log will be provided as part of the integrated reporting suite received on a monthly basis.

2.8.5. Escalation process – each week the steering group chairs identify appropriate escalations that have arisen in the meetings. These are recorded on a log and raised at the weekly Turnaround Executive for discussion and resolve. Introducing this has ensured that issues are dealt with in a timely manner and delays avoided wherever possible.

2.9. These controls describe continue to be embedded in the PMO and through the organisation. They are clearly documented and will form part of a SharePoint repository for ease of access.

3. URP Progress and Risks

3.1. The move to integrated highlight reporting, consistent across the three Groups, has been broadly successful. The alignment of the projects to the steering groups has been implemented and is working well.

3.2. It has been decided to maintain production of three individual dashboards at present (with Finance always intended to be separate). The CQC re-inspection is not too far away and merging the Quality and Organisation Recovery dashboards is not going to yield much benefit, especially given they are measuring different things (actions vs project delivery). The two dashboards have, however, been reworked to look similar in format and level of content. Appendix B includes the following:

3.2.1 Organisational Recovery Dashboard and exception report

3.2.2 Quality (CQC Must Do) Dashboard and exception report

3.2.3 Financial Sustainability Immediate Measures Dashboard.

3.3. Any comments as to the functionality and content of the dashboards is welcomed to enable further improvements.

4. Summary

4.1. This paper provides the Trust Board with updates to the Programme Governance and PMO controls. Successful implementation will require continued support from the organisation to fully embed.

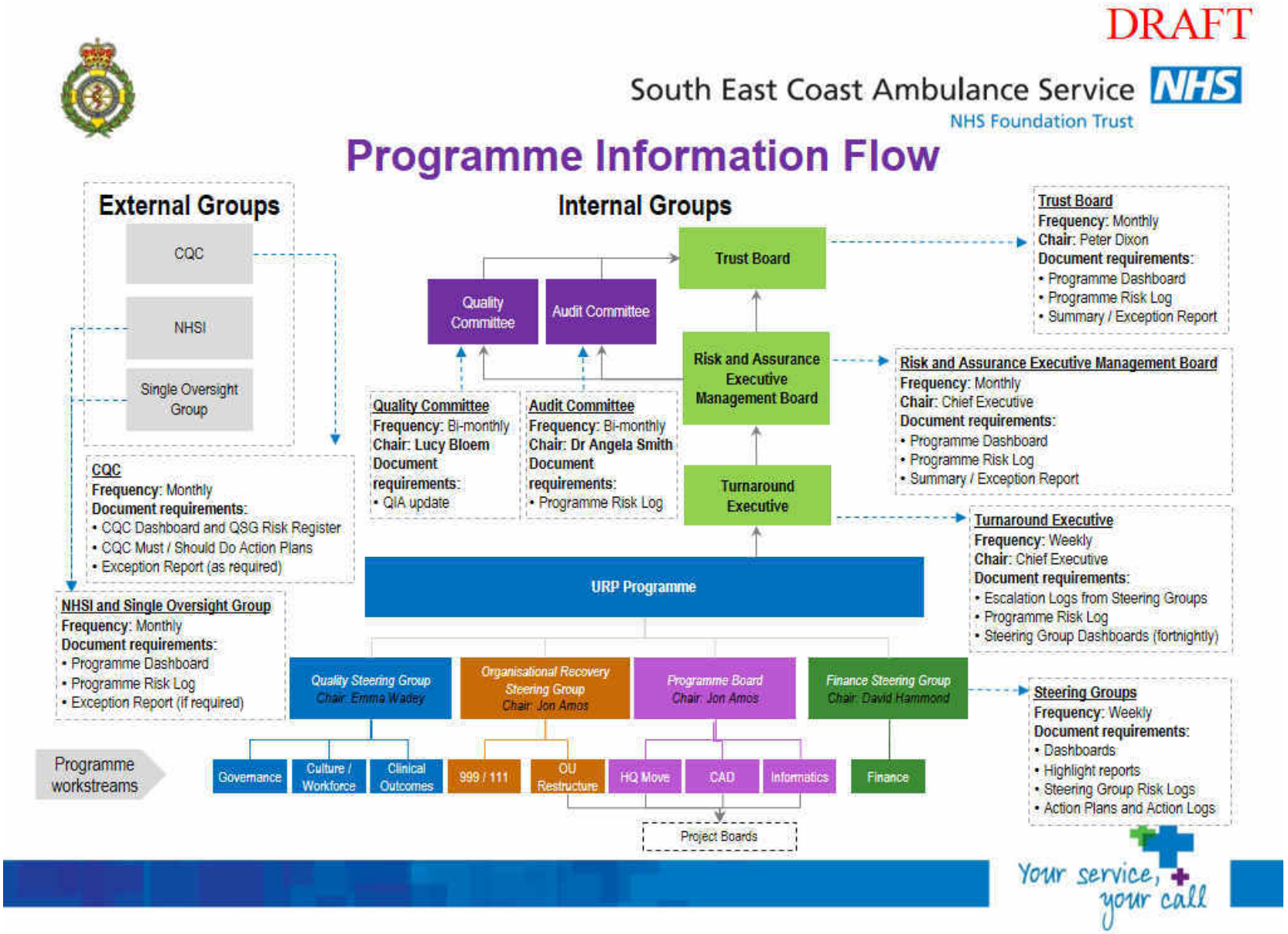
4.2. The Board has been provided with a suite of dashboards to provide a status update of the Programme across the three Steering Groups with supporting narrative to expand upon risk areas.

5. Recommendation

5.1. The Board is asked to note the paper and discuss the appendices with specific attention to the URP Dashboards and Exception Reports.

5.2. The Board is asked to support the controls introduced to provide enhanced grip and provide assurance on delivery.

Appendix A

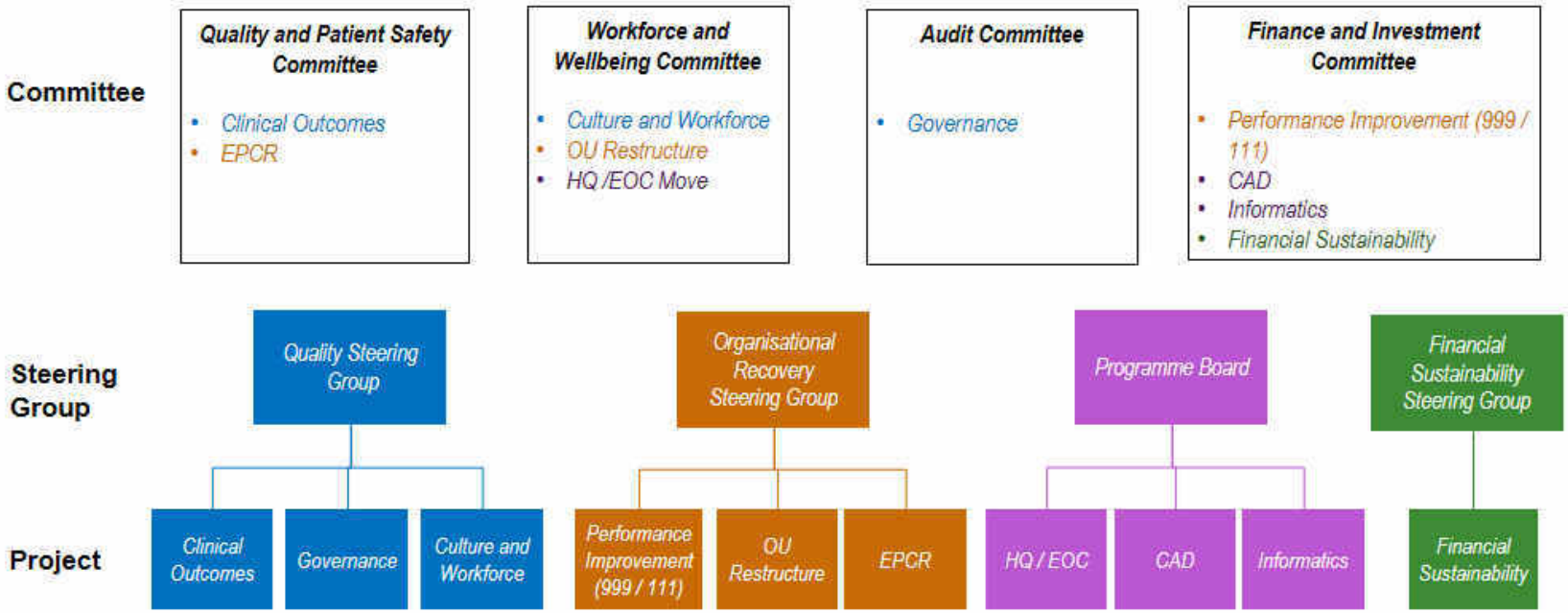

DRAFT
South East Coast Ambulance Service NHS
NHS Foundation Trust
Programme Information Flow
External Groups
CQC
NHSI
Single Oversight Group
Internal Groups
Trust Board
Quality Committee
Audit Committee
Risk and Assurance Executive Management Board
Turnaround Executive
URP Programme
Trust Board
Frequency: Monthly
Chair: Peter Dixon
Document requirements:
• Programme Dashboard
• Programme Risk Log
• Summary / Exception Report
Risk and Assurance Executive Management Board
Frequency: Monthly
Chair: Chief Executive
Document requirements:
• Programme Dashboard
• Programme Risk Log
• Summary / Exception Report
Quality Committee
Frequency: Bi-monthly
Chair: Lucy Bloem
Document requirements:
• QIA update
Audit Committee
Frequency: Bi-monthly
Chair: Dr Angela Smith
Document requirements:
• Programme Risk Log
CQC
Frequency: Monthly
Document requirements:
• CQC Dashboard and QSG Risk Register
• CQC Must / Should Do Action Plans
• Exception Report (as required)
Turnaround Executive
Frequency: Weekly
Chair: Chief Executive
Document requirements:
• Escalation Logs from Steering Groups
• Programme Risk Log
• Steering Group Dashboards (fortnightly)
NHSI and Single Oversight Group
Frequency: Monthly
Document requirements:
• Programme Dashboard
• Programme Risk Log
• Exception Report (if required)
Quality Steering Group
Chair: Emma Wadey
Organisational Recovery Steering Group
Chair: Jon Amos
Programme Board
Chair: Jon Amos
Finance Steering Group
Chair: David Hammond
Steering Groups
Frequency: Weekly
Document requirements:
• Dashboards
• Highlight reports
• Steering Group Risk Logs
• Action Plans and Action Logs
Programme workstreams
Governance
Culture / Workforce
Clinical Outcomes
999 / 111
OU Restructure
HQ Move
CAD
Informatics
Finance
Project Boards
Your service, your call

DRAFT

South East Coast Ambulance Service NHS
NHS Foundation Trust

Governance

The below structure illustrates the current Steering Groups and Committees that the Projects report to.



Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Agenda No	205
Name of meeting	Trust Board		
Date	29 March 2017		
Name of paper	Bullying and Harassment Update		
Responsible Executive	Steve Graham, Interim Director of HR		
Author	Steve Graham, Interim Director of HR		
Synopsis	This paper provides a summary of the progress made in relation to the delivery of the diagnostic study into Bullying and Harassment in SECAmb		
Recommendations, decisions or actions sought	• To note the progress made in delivery of the project which is on track • To note the expected timelines and the delivery date of the outcome report		
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	

Bullying and Harassment Diagnostic Study Board update

1. Introduction

1.1 The purpose of this paper is to provide the Trust board with assurance on the progress of the independent diagnostic study initiated in relation to the reported culture of bullying and harassment in the Trust.

1.2 The staff survey over several years has reported high numbers of staff declaring incidences of bullying and harassment, which was also reported to the CQC, however this level of bullying and harassment has never been reflected in the formally reported cases which can be investigated.

1.3 After discussions with NHS HRD colleagues, a replica of the work Professor Duncan Lewis of Plymouth University carried out at Barts Health was seen as a good model for SECAMb to adopt. This diagnostic study was well received in Barts and became an important tool in the design of programmes to tackle and resolve the cultural issues facing Barts.

1.4 The funding for the review has come from the HEKSS funding made available to us to support cultural development aspects of the workforce.

2. Progress of the diagnostic study

2.1 The wider Bullying and Harassment project (of which the diagnostic study is the first phase) is a project within the Project Management Office. The project follows the governance processes as part of the Unified Recovery Plan and CQC “should do” action plan.

2.2 This study is broken down into 4 parts as shown in Appendix 1 and is currently on track and hitting key milestones.

2.3 Currently around 1,700 staff members have completed the survey is Phase 1 and the focus groups are currently being arranged with a maximum of 8 randomly picked individuals (this will include 1 Exec and 1 Senior Manager).

3. Next steps

3.1 Progress of the study through the phases will continue to monitored with key issues escalated.

3.2 Professor Lewis is will not emerging share themes of the study until all the data has been collected and triangulated so it is unlikely we will be able to provide outcomes much before Phase 4. However at that stage, and when the key areas of concern have been identified we will confirm the initiatives that we will use to respond to the study.

4. Summary

4.1 The procurement of a diagnostic study of bullying and harassment in SECAMb has been well received by the workforce with over 1700 completed studies to date with 2 weeks left in phase 1.

4.2 The study is on track to deliver against the key milestones.

4.3 Publication of the summary report will be in summer and will be followed by appropriate initiatives to support a cultural change.

5. Recommendations

5.1 The Trust Board are asked to:

- Note the content of the paper and the progress of the study
- Note the dates of delivery of the next phases of the study

Steve Graham

Interim Director of HR

March 2017

Appendix 1: Key Milestones

Key Milestones					
	Milestone	**Planned date**	**Projected date**	**Current RAG**	**Previous RAG**
1	Part 1: A survey of all Trust members of staff. This will be administered in the first instance using specialist software (Qualtrics).	01/02/17	31/03/17	Green	Green
2	Part 2: Following discussions, it is planned to hold a total of 14 focus groups	01/04/17	31/05/17	Not due	Not due
3	Part 3: A number of interviews with Trust employees will be undertaken. The survey will include a 'write-in' section where any employee wishing to discuss bullying and harassment can provide their contact details for call-back by the researcher(s)	01/04/17	31/05/17	Not due	Not due
4	Outputs: One executive level report outlining background information, findings of the research, methodology and data analytics. Report to include conclusions and recommendations on any necessary actions.	01/06/17	31/07/17	Not due	Not due

		Agenda No	206/16

Name of meeting	Trust Board
Date	29/03/17
Name of paper	Employee Wellbeing Strategy
Responsible Executive	Steve Graham, Interim Director of HR Emma Wadey - Interim Director of Quality and Safety/Chief Nurse
Author	Angela Rayner, Inclusion Manager
Synopsis	This paper asks the Board to approve an employee Wellbeing Strategy for the Trust. It provides the Trust with information on the process undertaken to develop a meaningful Wellbeing Strategy. It outlines the benefits expected from improved employee wellbeing and the risks associated with poor employee health. The strategy is attached in full.
Recommendations, decisions or actions sought	The Board is asked to approve this strategy.
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).	**Yes - attached**

South East Coast Ambulance Service NHS Foundation Trust

Trust Board

Employee Wellbeing Strategy

1. Introduction

1.1. The Board has recognised that our employees need better support and care from us as an employer, in order to provide the best possible care to our patients.
1.2. The Trust has listened to and learned from our workforce in order to shape a Wellbeing Strategy to meet their needs.
1.3. This paper outlines the headline benefits expected from improved employee wellbeing and the risks associated with poor employee health.
1.4. The strategy is attached in full.

2. The case for improved employee wellbeing

2.1. In writing this paper, we assume that the benefits for Trust employees of personal and individual wellbeing are obvious and do not need to be stated.
2.2. The Trust has a duty as an employer, and specifically as an NHS employer, to promote the wellbeing of employees. The evidence supporting the link between employee wellbeing and organisational effectiveness is set out in the strategy, as are references to NHS commitments to making the NHS a healthy employer.

2.3. **Financial case**

2.4. Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4 billion per year – around £1 in every £40 of the total budget. This excludes the cost of agency staff to fill gaps, as well as the cost of treatment.
2.5. Sickness absence cost the Trust between £340,000 and £460,000 per month during 2016. The table below shows monthly costs for staff reporting via GRS.

Period	No of Episodes	Salary Cost Per Day	Abs (FTE)	Abs (FTE) Adjusted)	Salary Based Absence Cost	Employers Cost	Estimated Cost
2016 01	760	£60.09	6,039.72	5,605.38	368,065.84	89,258.88	£457,324.72
2016 02	730	£58.86	5,527.02	5,154.66	332,313.40	80,008.38	£412,321.77
2016 03	785	£59.44	5,889.80	5,484.37	354,672.33	85,000.79	£439,673.12
2016 04	615	£60.69	4,910.53	4,501.63	295,022.51	70,844.51	£365,867.01
2016 05	592	£60.33	4,523.08	4,112.74	275,935.11	66,017.14	£341,952.25
2016 06	587	£62.77	4,501.73	4,187.47	289,377.00	70,014.70	£359,391.70
2016 07	612	£65.18	4,928.83	4,615.42	322,795.90	78,362.95	£401,158.85
2016 08	640	£64.60	4,863.71	4,479.03	307,799.04	74,123.39	£381,922.43
2016 09	583	£61.45	4,696.07	4,413.86	295,225.87	70,557.12	£365,782.99
2016 10	712	£60.81	5,398.32	5,123.40	341,006.39	82,156.78	£423,163.17
2016 11	702	£62.38	4,891.94	4,654.91	316,055.95	78,184.64	£394,240.59
2016 12	866	£62.14	5,655.11	5,440.69	368,424.69	91,158.93	£459,583.62

2.6. Most support staff do not record sickness absence on GRS, so actual costs will be significantly higher.
2.7. Costs relating to Occupational Health have steadily increased over the same period.
2.8. Between 2007 and 2008, Price Waterhouse Coopers reviewed seven employee wellbeing case studies from various sectors, including the public sector. They reported a return on investment in terms of the benefit/cost ratio of employee wellbeing programmes. Found

that the return on every unit of cost expenditure was £4.17 in programme benefits for every £1 spent.

2.9. It was clear that successful wellbeing programmes were those designed specifically to meet employees' needs as wellbeing is not a one size fits all offering.

2.10. Achieving payment of national CQUIN measures in 2016/17 relies on us demonstrating investment in staff health and wellbeing initiatives. In 2017/18 and 2018/19 further monies are available for achieving:

2.10.1. An increase in the proportion of employees saying their organisation takes positive action on health and wellbeing;

2.10.2. A decrease in the proportion saying they have experienced MSK problems in the last 12 months as a result of work activities; and

2.10.3. A decrease in the proportion saying they have felt unwell in the last 12 months as a result of work-related stress.

3. Supporting employees to deliver better care

3.1. The CQC found that SECAmb staff did not feel cared for and noted the absence of a Health and Wellbeing Strategy. The development of a strategy is an action in the Unified Recovery Plan.

3.2. Staff who feel cared for are more likely to identify the Trust as an employer of choice, including in the staff Friends and Family test. The comments from staff in relation to numerous FFTs demonstrate that staff do not feel cared for.

3.3. In a survey undertaken in November 2016 to set a benchmark level of staff feeling cared for, 95% of the 143 respondents reported that they did not feel cared for. Only 7 respondents did feel SECAmb cared about their health and wellbeing.

4. The strategy

4.1. The strategy document sets out how we worked with staff to identify their needs, and used sickness absence data to clarify the priority areas where we should seek to focus our activities.

4.2. Our vision, aims and objectives are set out in the strategy.

5. Recommendation

5.1. The Executive Team is asked to:

5.1.1. Review the strategy;

5.1.2. Approve the strategy to progress to the March Board for ratification.

Prepared by: Angela Rayner, Inclusion and Wellbeing Manager

Presented by: Steve Graham and Emma Wadey

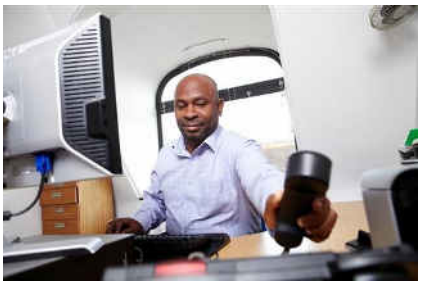
South East Coast Ambulance Service NHS
NHS Foundation Trust

WELLBEING STRATEGY
2017 - 2022

Creating a healthy workplace where everyone feels their health and wellbeing is supported





We would like to thank the staff from across the Trust who helped develop this strategy and shared their views with us.

Contents

Foreword

'NHS staff have some of the most critical but demanding jobs in the country. Creating healthy and supportive workplaces is no longer a nice to have, it's a must do for employers'
Simon Stevens, Chief Executive, NHS England

Our vision is for South East Coast Ambulance Service (SECAmb) to become a healthy workplace where everyone feels their health and wellbeing is supported.

Our services to patients are delivered through and by our workforce. The health and wellbeing of employees is not only important for individuals' personal wellness, but also has a direct impact on our ability to care for our patients.

The evidence is clear that by looking after all employees, we in turn can support our patients to best effect. It is vital that we invest in our individuals and our teams, and provide opportunities and support so that the wellbeing of all SECAmb's employees is valued.

The partnership of personal responsibility for health and the duty of care we have as an employer is one that came out strongly in the conversations during the development of this work. As an employer we step forward to play our part whilst supporting each person to make their own health and wellbeing a priority.

I would like to thank all those who have engaged in the development of this strategy, by joining the focus groups held in November 2016 or writing in and responding to surveys so we could really hear what the priorities are from right across the organisation.

I commend our strategy to, and for, you all.

Steve Graham
Interim Director of HR

Emma Wadey
Chief Nurse

Summary

Health and wellbeing is vitally important for all individuals at SECAmb, and is intimately linked to our ability to provide the best possible patient care.

This strategy has been created with input from staff and reference to best practice in the NHS and nationally. It sits as an enabling strategy under an overarching Workforce Strategy to address the lifecycle of employees, which is currently in development.

Our vision is of a healthy workplace where everyone feels their health and wellbeing is supported.

We have eight strategic objectives to enable us to achieve this vision:

1. Provide a clear, accessible entry point (Wellbeing Hub) for employees to obtain wellbeing advice, signposting and access to appropriate services in a timely manner

2. Provide an effective Occupational Health and Employee Assistance Programme

3. Establish effective communication and promotion of opportunities for employees to enhance their wellbeing

4. Ensure Trust policies and procedures support wellbeing

5. Establish a mechanism for providing ill or injured employees with appropriate alternative duties, where this will improve wellbeing

6. Ensure managers are equipped to support employee wellbeing

7. Develop a culture where staff feel cared for

8. Monitor outcomes and revise our strategy and action plans accordingly

Implementation will be monitored through the HR Group and reported to the Executive Management Board.

Introduction and context

What is health and wellbeing?

"Health and wellbeing is about being emotionally healthy as well as physically healthy. It is feeling able to cope with normal stresses, and living a fulfilled life. It can be affected by things like worries about money, work, your home, the people around you and the environment you live in. Your wellbeing is also affected by whether or not you feel in control of your life, feeling involved with people and communities, and feelings of anxiety and isolation."

National Institute for Health and Clinical Excellence (NICE)

For the purposes of this strategy employee wellbeing is seen as embracing the whole person – physical and mental health both inside and outside of the workplace. Wellbeing is greater than simply the absence of ill health and disease, it is a feeling of physical, emotional and psychological wellness.

The national context

In 2015, NHS England announced investment of £5 million in improving staff health and wellbeing, an initiative that was warmly welcomed as an important step towards understanding employee wellbeing and recognising people as their most important organisational asset.

The NHS is the UK's largest employer with 1.38 million employees. Whilst people who work in health care are valued highly by the general public, health service workers are more stressed and unhappy than the general workforce. The reasons for this are not entirely clear, but are usually attributed to the complexity of the working environment, combined with the fact that many work processes in health care have not been purposefully designed, but have evolved over time.

The nature of the work itself – which involves dealing with physically and emotionally challenging tasks, and providing care in increasingly financially stretched environments to people at their most vulnerable – also takes a significant emotional toll. Dealing with patients and their loved ones, witnessing suffering, pain, grief and dying, is part of the daily routine for many people working in the NHS.

The need to take a better approach to the wellbeing of NHS staff was evident in the 2015 staff survey in England, where only 50% of staff were happy with flexible working opportunities (this was only 29% at SECAmb in 2015) and 37% of staff (49% at SECAmb) reported feeling unwell due to work related stress and pressure. Additionally, 63% of staff (69% at SECAmb) reported coming to work despite feeling unable to carry out their duties or the requirements of their role.

Public Health England puts the cost to the NHS of staff absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget, and the total would be significantly higher if the costs of agency staff cover were included. Evidence from the staff survey and elsewhere shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients.

The benefits of health and wellbeing to employees as individuals are obvious, and employee wellbeing is also recognised as a key part of good business practice. Corporations and organisations recognise the established link between promoting a culture of employee wellbeing and increasing performance and productivity. Proactively managing sickness absence to reduce costs is common, and good, practice.

In the context of rising pressures on the NHS as a whole, and so on all employees, there has never been a better time to focus on the wellbeing of employees.

The link between staff wellbeing and organisational effectiveness

The link between good staff wellbeing and clinical outcomes has been clearly articulated in a number of significant publications since 2009 and provides evidence of the need for attention and action on health and wellbeing in the workplace.

Dr Steve Boorman's 2009 report on the *Health and Wellbeing of NHS Staff* provided clear evidence that good staff wellbeing is vital to enable the NHS to meet the productivity challenge it faced then and continues to face. He identified clear links between staff health and wellbeing and the three key areas of service quality:

- Service user safety
- Service user experience
- The effectiveness of care

The Secretary of State endorsed the Boorman Review and set out three clear messages for the NHS:

- To be an exemplar employer in ensuring the health and wellbeing of its staff, so as to make a real impact on wider public health
- Staff wellbeing improves the quality of services and care for our patients
- Reducing sickness absence and improving staff wellbeing makes a significant contribution to productivity.

More recently, the *NHS Operating Framework* and *NHS Constitution* have formalised recommendations around staff wellbeing. The NHS Constitution created two pertinent pledges. All NHS organisations should be committed to:

- Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability
- Provide support and opportunities for staff to maintain their health, wellbeing and safety.

The Department of Health recognised the role healthcare staff play in the delivery of safe, effective and efficient care for patients in its 2011 publication *Healthy Staff, Better Care for Patients*. The title speaks clearly of the contents.

The *NHS Health and Wellbeing Improvement Framework* (2011 from the DoH) described five high-impact changes for NHS organisations to focus on giving their staff a healthy and positive experience of work. These are:

- Develop a local evidence-based improvement plan
- Strong viable leadership
- Support by improved management capability
- Access to better, local high quality accredited occupational health services
- All staff are encouraged and enabled to take more personal responsibility.

It is worth noting that mental health figures strongly in these reports and frameworks, but in addition in 2012 the Government produced a *National Framework to Improve Mental Health and Wellbeing* which set expectations of organisations to deliver six objectives to improve mental health and wellbeing as defined in the *No Health without Mental Health Strategy* of 2011.

There is a current Health and Wellbeing CQUIN (Commissioning for Quality and Innovation) aimed at improving the support available to NHS Staff to help promote their health and wellbeing, in order for them to remain healthy and well. The Health and Wellbeing CQUIN encourages improvements

to staff health by offering a share of £450m to NHS organisations. To achieve the incentive for 2016/17, trusts are encouraged to take steps, such as introduce health and wellbeing initiatives, increase healthy food choices on premises and increase uptake of front line staff receiving the flu vaccine. Further CQUIN measures relating to improving staff health and wellbeing are in place for a further two years (2017/18 and 2018/19).

Our staff and sickness

Wellness is not only about the absence of illness, but sickness monitoring can provide a proxy measure for the staff health issues that should be addressed, as well as a way of monitoring the impact of our interventions.

Sickness absence at SECAmb

Table 1:
Sickness absence episodes and Full-time Equivalent absences (days lost) 2016 (source: SECAmb HR department)

Period	No of Episodes	Absence (Full-Time Equivalent)
Jan-16	760	6,039.72
Feb-16	730	5,527.02
Mar-16	785	5,889.80
Apr-16	615	4,910.53
May-16	592	4,523.08
Jun-16	587	4,501.73
Jul-16	612	4,928.83
Aug-16	640	4,863.71
Sep-16	583	4,696.07
Oct-16	712	5,398.32
Nov-16	702	4,891.94
Dec-16	866	5,655.11
2016	**8184**	**61,825.86**

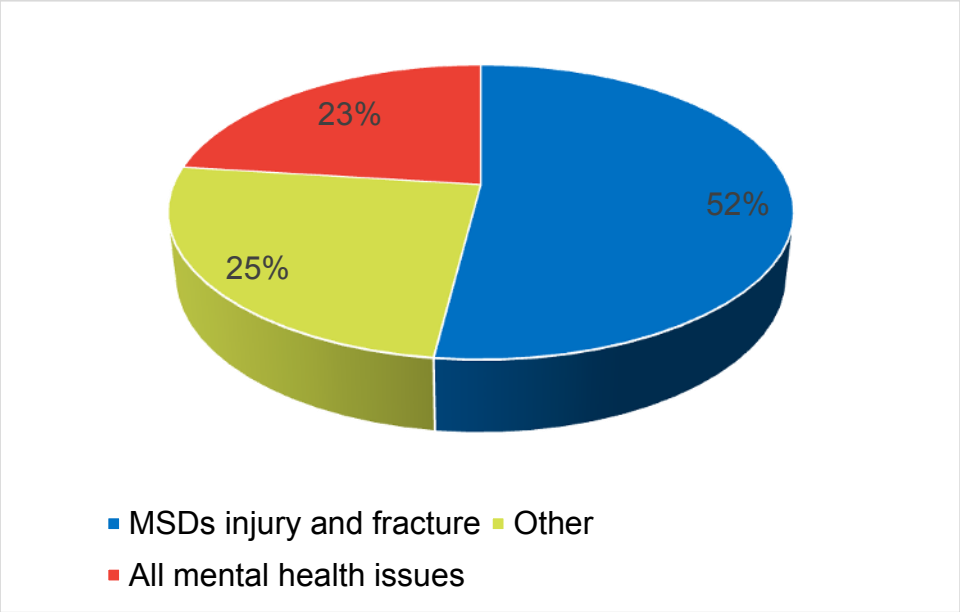
Causes of ill health at SECAmb

Table 2:
Top three reasons for referral to Occupational Health among employees off work (source: TeamPrevent) % are of total staff sickness that month

Period	Musculo-Skeletal Disorders	Stress	Depression
Jan-16	52%	16%	10%
Feb-16	53%	18%	3%
Mar-16	45%	28%	6%
Apr-16	59%	21%	
May-16	50%	17%	6%

Jun-16	63%	15%	2%
Jul-16	57%	26%	2%
Aug-16	55%	16%	6%
Sep-16	62%	17%	7%
Oct-16	63%	27%	
Nov-16	52%	15%	2%
Dec-16	58%	10%	7%

Table 3:
Reasons for all OH referrals 2016 (employees at work and off work)
(source:TeamPrevent)



The data clearly indicates a need to focus on injury prevention and to support those struggling with stress and other mental health issues.

While the data from OH is stark, we have conducted additional research to understand staff health and wellbeing in SECAmb. Appendix 1 sets out the research and development undertaken to inform the strategy and includes additional evidence based on a wellbeing survey and focus group work.

The strategy

Our vision

To become a healthy workplace where everyone feels their health and wellbeing is supported.

Our aims

1. Create an environment where we all take responsibility for our own wellbeing;
2. Support each other so we can provide the best possible care for our patients; and
3. Deliver on our responsibilities as an employer to prioritise everyone's wellbeing.

Our objectives

1. Provide a clear, accessible entry point (Wellbeing Hub) for employees to obtain wellbeing advice, signposting and access to appropriate services in a timely manner
In order to:

- Provide fast access to appropriate services
- Signpost to the most effective intervention for the individual for the best outcomes
- Create clarity and avoid confusion
- Ensure consistency and control

2. Provide an effective Occupational Health and Employee Assistance Programme
OH ensures employees are fit for work, keeps staff healthy in work, and provide access to OH advisers and physicians (including access to Musculoskeletal Disorder services) as well as administering vaccinations and providing advice about reasonable adjustments. The EAP provides 24/7 support on a wide range of personal issue including access to confidential and free counselling, by phone or face to face.

3. Establish effective communication and promotion of opportunities for employees to enhance their wellbeing
In order to:

- Raise awareness to support prevention and early intervention
- Be a caring employer and take the wellbeing of employees seriously
- Encourage employees to take responsibility for themselves and each other's wellbeing

4. Ensure Trust policies and procedures support wellbeing
In order to:

- Ensure the impact of policies and procedures on employees is considered
- Focus on what employees can do rather than can't do
- Ensure a fair and equitable approach to wellbeing

5. Establish a mechanism for providing ill or injured employees with appropriate alternative duties, where this will improve wellbeing
In order to:

- Support employees' transition back into work or keep people in work where appropriate and possible
- Ensure a fair and equitable process for managing alternative duties

6. Ensure managers are equipped to support employee wellbeing
In order to:

- Raise confidence, awareness and skills in supporting good mental and physical health.

7. Develop a culture where staff feel cared for
The process of working towards these objectives, and achieving them, will contribute to changing our culture. By investing in employee wellbeing we put our values and those of the NHS into practice, and in doing so we change perceptions. We will improve employee experience and contribute to making SECAmb a better place to work.

8. Monitor outcomes and revise our strategy and action plans accordingly
We will do this through:

- Annual monitoring of outcomes using sickness data, staff survey feedback, friends and family survey responses, and data and satisfaction reports from Occupational Health and the Employee Assistance Programme
- Surveying employees using our benchmarking wellbeing questionnaire on an annual basis

- Monitoring engagement in wellbeing initiatives and views of their effectiveness
- Quarterly reporting to the HR Group and through that to the Executive Management Board

Our priorities

Based on sickness absence data and feedback during the employee consultation, in delivering our objectives we will prioritise the following to address the most significant risks to wellbeing in the Trust:

- Reducing the incidence and impact of stress and mental illness, and breaking down the stigma relating to mental health
- Preventing injury and providing fast access to treatment for musculoskeletal injuries
- Providing access to the Trauma Risk Management (TRiM) process for everyone
- Promoting better sleep through access to advice and support
- Promoting nutrition and exercise

Implementation and monitoring

In year one we aim to get the basics right, to take deliberate but considered action to achieve our first ambition to make sure every member of our organisation knows what is available to them to support their health and wellbeing, and how to be signposted to other support where appropriate.

Employee wellbeing is one component of the Trust's relationship with its employees. The Wellbeing Strategy sits as an enabling strategy under an overarching Workforce Strategy to address the lifecycle of employees. The Workforce Strategy is currently in development.

Its implementation will be monitored by the HR Group, which reports to the Executive Management Board of the Trust. The Workforce and Wellbeing Committee of the Board will no doubt seek assurance of the effective implementation and monitoring of the strategy.

A draft year one implementation plan is attached as Appendix 2. This sets out proposed activities in relation to the three of the strategic objectives, how achievements will be monitored and what success looks like. The action plan will be further developed with staff and through the HR Group prior to implementation, and action plans for subsequent years will be developed in the same way.

This a five-year strategy and will be implemented in a staged way as it represents a wholesale change in the way we support, signpost and commit to employee wellbeing.

Through this strategy we will bring to life our vision of SECAmb as a healthy workplace where everyone feels their health and wellbeing is supported.

Appendix 1 - Implementation plan April 2017 – 18

Strategic objective(s)	Initiative	Purpose	Monitoring	Measure of Success
1. Provide a clear, accessible entry point (Wellbeing Hub) for employees to obtain wellbeing advice, signposting and access to appropriate services in a timely manner	Set up an in-house Wellbeing Hub	Triage to the right wellbeing pathway and signposting – single point of access Manage and provide access to Trauma Risk Management (TRiM) services Set up and manage an effective process for alternative duties Organise a calendar of appropriate physical and mental wellbeing activities and provide wellbeing advice, such as better sleep, better nutrition, relaxation	Quarterly reporting to the HR Group Submit annual report of activity for 1st year to Board, including: • Activity report • Sickness absence comparison reports • Staff evaluation of services • Priorities for next 12 months	Increased uptake of health and wellbeing initiatives, with positive feedback from staff in wellbeing surveys TRiM available across the Trust with effective referral processes, trained practitioners and coordinators in place. Increase in number of staff who say they 'feel cared for' over previous year Improvements in sickness absence levels (NB target to be discussed and timeframe agreed for improvements)
2. Provide an effective	Procure and	Provide employees with	Quarterly reporting	More effective use of OH

Occupational Health and Employee Assistance Programme	manage an Occupational Health and Employee Assistance Programme	access to a safe, effective, quality occupational health service, which includes rapid access to physiotherapy where clinically required Provide access to counselling services, support and information through the Employee Assistance Programme	to the HR Group Annual activity report to Board	services, due to better triage through the Hub. Well-reputed service - staff report that it meets their needs Contract KPI'S met
3. Establish effective communication and promotion of opportunities for employees to enhance their wellbeing	Design and deliver proactive and engaging wellbeing communications	Continue to promote wellbeing through a regular Bulletin and assess appropriate mechanisms for promoting wellbeing services Staff engagement to assess value of Wellbeing e-bulletin, eliciting recommendations for improvement Continue to promote offers and discounts available to employees	Quarterly reporting to the HR Group Annual activity report to Board	Increase in staff awareness of services available to them over previous year Evidence that staff are providing feedback and accessing/involved in events Increased staff take up of wellbeing activities

Appendix 2 - How we developed our strategy

Executive discussion
To ensure the shape of the strategy aligned with the overall direction and plans of the Trust, the Executive Directors met in October 2016 to engage in a conversation around their thoughts and views of the needs in this area. The cost of sickness absence was discussed and the plans the Executive Team had for some operational realignment were felt to be potentially helpful, but most of all, the key to the strategy, was to listen to the staff and focus on what was being asked for - either for individuals to take action themselves or for the Trust to help them. The Acting Chief Executive saw the need to 'include, support and engage' with staff and that this focus on health and wellbeing was a way to achieve this. The interim Medical Director also shared his perspective that 'in order to look after our patients safely we need to look after our staff' and that staff need to feel better cared for.

Focus Groups
To develop the strategy itself, 5 focus groups were held across SECAmb (in Horley, Brighton, Tangmere, Epsom and Coxheath) in November 2016. More than 70 staff members joined the discussions, shared their views, engaged in the assessments, and undertook;
- Mental wellbeing checklists (designed specifically for ambulance staff);
- Holistic wellbeing questionnaire (on physical, mental, emotional and spiritual wellbeing);
- Word association tests (based on Jung's attitude work).

Staff also responded to examples of other organisations' strategies and what learning could be taken from these, and brainstormed 'wish lists', highlighting the areas participants felt were within SECAmb's duty of care as an employer.

The outcome of the focus groups is shown below.

Mental Wellbeing Checklist
This checklist identified factors that might affect mental wellbeing for those in the ambulance service, and was a simple 'yes/no' questionnaire in response to positive statements around physical activity, sleep, relaxation, helping others, making time for enjoyment, friendships, nutrition and knowing where to turn in times of need.

Of those who undertook the Mental Wellbeing Checklist only 23% felt they were able to say that they had no issues with their mental wellbeing in any category. Those with a single issue were either in the area of eating or physical activity. Those who had two issues were a combination of making time to look after the self, physical activity or being kind to oneself about who I am. Just over 30% identified three or more issues and these were all in the top 5 areas of need, namely:
- Sleep
- Being kind to oneself
- Looking after oneself
- Nutrition
- Physical Activity

Wellbeing Checklist
Within the focus groups, a four-dimensional checklist was undertaken asking about the domains of physical, mental, emotional and spiritual wellbeing. Despite the known

prevalence of MSD injuries among employees, emotional and mental wellbeing were clearly the areas of most concern to employees who participated.

Physical Wellbeing
Employees reported the lowest satisfaction in relation to achieving daily relaxation, having energy and vitality, taking part in physical exercise, and gaining satisfying sleep. Notably, relaxation and sleep scores bear an obvious relationship to mental and emotional wellbeing. A lack of regular, balanced meals and poor nutritional habits were the next two lowest responses.

Emotional Wellbeing
Responses indicated that only a few individuals found they had the '*capacity to reach out for help when needed'*. Anecdotally, this was because individuals did not feel they would get the support, or would be perceived as diminished in some way. Whether or not this is the case is not the issue, the issue is that this can be addressed through supportive action, genuine listening and responding, and shifting to a culture where asking for help is seen as a strength.

Mental Wellbeing
This category had the least positive outcomes although there was some spread in views. The lowest scores were around long-term financial wellbeing, with the second lowest around '*clarity of purpose in career and life*'. The next two lowest scores were for '*ongoing development of talents*' and '*stimulation in my career*'. It was clear that many respondents wished for more opportunities to develop and progress in their working life.

Spiritual Wellbeing
This category shows a significantly high score in the '*unconditional love and regard for others*' and '*leads a life of integrity'* category. This is interesting as in itself it shows that there is a care and consideration for others even when the self is stressed or not being looked after. There is an additional consideration here as the role of those working in the NHS, and in our organisation specifically, is to care for other's needs, and whilst there is a strong correlation between that intent and the measurements here, what one should also be aware of is that the resource is being emptied and at the same time not 'filled up' again so this is a warning sign for potential burnout.

Respondents scored negatively in relation to having '*unconditional love and regard for self*' which is markedly contrasting with the high regard for others noted above.

A number of conversations in the focus groups noted the benefits of the chaplaincy, whatever religious or spiritual denomination, and this naming of the need for pastoral care is something to which the organisation should give regard.

Jung's Word Association (Stimuli / Response) Test
During the local focus groups, a Jungian work association test was undertaken as one of assessments so that each individual could respond to a stimulus of single words which required a response to show the deeper levels of thinking the individuals had around health and wellbeing.

The word association assessment itself revealed something of a person's subconscious mind (as it shows what things they associate together) as the 100 words (in this exercise) were shared in quick succession and the responses noted, and then compared

through analysis, to ascertain the most common and the outlier words that came to people's minds through the test.

From the responses, we can see that overall, people associate the concept of health and wellbeing as a positive state of being and that their view of the overall picture around the subject is positive. However, when we move to analyse this by physicality, although some people see this as positive and desirable, there were some clear views that this was 'boring' or 'mad' at the negative end of the spectrum. Further, when exploring the mental health aspect of the association we can see very clearly how the current unconscious response from the participants saw the mental state to be important and that happiness, calmness, peace etc. are worthwhile and positive attributes. There is also a considerable distance for some from this state, and stress, sad and lonely are words that came up with enough regularity to be of note.

Clearly the test was not undertaken in clinical conditions, the participants were self-selecting, and therefore has some margin for error built in, but the essence of what this test indicates is that there is, as has been outlined, a real need in the organisation for a focus on health and wellbeing as a positive intent, and this needs to be with a significant emphasis on mental wellbeing.

On line survey (staff poll)
Once all the local focus group data had been collected and collated, the key themes were tested through a survey accessible to all staff, to enable anyone unable to attend the focus groups to have their say. 23 responses were received, and there was overwhelming support for the themes and priorities identified through the focus groups.

Appendix 3 - Equality Analysis Record

1. Trust policies and procedures should support the requirements of the Equality Duty within the Equality Act:	• Eliminate discrimination, harassment and victimisation; • Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; • Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.	When designing the processes in your document, have you taken care to support the requirements of the Equality Act? **Yes**

2. When considering whether the processes outlined in your document may adversely impact on anyone, is there any existing research or information that you have taken into account?	For example: • Local or national research • National health data • Local demographics • SECAmb race equality data • Work undertaken for previous EAs	If so, please give details: Numerous existing health and wellbeing policies from other Trusts were reviewed, along with best practice guidance from across the NHS. Research was undertaken with a diverse group of employees face to face and through an online survey.

3. Do the processes described have an impact on anyone's human rights?	If so, please describe how (positive/negative etc): The strategy is neutral in terms of the human rights act, but does reinforce workers' rights to a safe and healthy working environment.

4. What are the outcomes of the EA in relation to people with protected characteristics?			
Protected characteristic	**Impact** Positive/Neutral/ Negative	**Protected characteristic**	**Impact** Positive/Neutral/ Negative
Age	Neutral	Race	Neutral
Disability	Positive (mental health)	Religion or belief	Neutral
Gender reassignment	Neutral	Sex	Neutral
Marriage and civil partnership	Neutral	Sexual orientation	Neutral
Pregnancy and maternity	Neutral	**Date the EA was undertaken: 10.02.17**	

5. Mitigating negative impacts:
If any negative impacts have been identified, an Equality Analysis Action Plan must be completed and attached to the EA Record. A template for the action plan is available in the Equality Analysis Guidance on the Trust's website. Please contact inclusion@secamb.nhs.uk for support and guidance.

South East Coast Ambulance Service NHS
NHS Foundation Trust

	Agenda No	207/16

Name of meeting	Trust Board
Date	29 March 2017
Name of paper	Urgent and Emergency Care Letter from Simon Stevens and Jim Mackay
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 letter received from Simon Stevens and Jim Mackay on the 9 March 2017 (Gateway 06600) in relation to urgent and emergency care. It provides an assessment of the implications the proposed changes will have for SECAmb
Recommendations, decisions or actions sought	The Trust Board is asked to note this briefing, the appended letter and the actions agreed by the Executive Team. The implications arising from this letter will be considered within the strategy 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**

Urgent and Emergency Care Letter from Simon Stevens and Jim Mackay

1. Introduction

1.1. Following the spring budget announcement of additional funding for specific areas of health and social care a letter was received from Simon Stevens and Jim Mackay outlining a number of expected changes (Appendix 1). This briefing summarises these and considers the impact for SECAmb. The letter also makes reference to the NHS Delivery Plan which is due to be published before the end of March.

2. Impact on 999 Services

2.1. The letter sets out the intention to ensure that the Ambulance Response Programme is implemented by October 2017.

ACTION: Director of Operations to liaise nationally and lead roll-out plans for ARP with support from the PMO and informatics team.

2.2. Investment of £100m is being made this year to support capital projects in A&E departments with plans to have streaming models in place in all A&E departments by October 2017. This aims to remove lower acuity patients from A&E to free up capacity. SECAmb is already rolling out plans across the region to support streaming of patients conveyed to hospital who can be seen in minor injuries areas. This process should also be used to stream to any new services put in place.

ACTION: OUMs and Account Managers to ensure roll out of streaming for conveyed patients at all acute sites as soon as possible and by October 2017 at the very latest.

3. Impact on 111 Services

3.1. Increase the number of NHS 111 calls receiving clinical assessment by one third. The current target of 30% has caused national debate as clear definitions have not been provided. KMSS 111 is currently delivering 29% clinical assessment with a cautious set of assumptions on measurement definition so further increase is likely to be possible. The letter does not make clear the definition, measurement or baseline for a further third but the implication appears to be that 40% of patients receive clinical assessment. This does not appear to be funded to provide further clinical hours though conversations are already occurring to reprioritise clinical workload to do more ‘in-line’ assessment without the need for further clinical hours. This action should reduce both A&E and 999 dispositions and support performance improvement

ACTION: Head of NHS 111 Service and Director of Strategy to work with commissioners to define and measure

3.2. The letter sets out plans to strengthen support to care homes, building on pilots in London to use NHS 111 as a clinical support and advice service for care homes in order to reduce admissions to hospital from care homes. £30m has been set aside to roll this model out, which based on percentage share of NHS 111 activity nationally could mean up to £2m being made available to NHS 111 services provided by SECAmb.

ACTION: Head of NHS 111 Service to work with national leads and commissioners to understand requirements and service model. Consideration to be given to how this may support care home calls received via 999

4. Wider System Changes

4.1. Additional funding of £1bn has been made available for social care in 2017/18 and a further £1bn across 2018/19 and 2019/20. It is expected that this will in part be targeted to decreasing delayed transfers of care. Exit block from A&E due to high bed occupancy is the main cause of handover delays so this should be positive for 999 services. The letter also highlights the variance in discharge practices within acute hospitals and the need to improve these.

4.2. Standardisation of Walk-in-Centre, Minor Injuries Unit and Urgent Care Centres replacing them with a single standardised offering. This should support alternative conveyance and provide clearer alternative dispositions for both 999 Hear and Treat and NHS 111.

4.3. Roll out evening and weekend GP appointments to 50% of the public by March 2018 and 100% by March 2019. If achieved this should offer alternative dispositions for both 999 Hear and Treat and NHS 111.

4.4. Acute Trusts will be expected to deliver A&E four-hour performance of 90% by September and 95% by March 2018. This may increase pressure on handover in some A&E departments where benefit may be gained from not releasing crews and booking patients into A&E swiftly.

5. Governance

5.1. The implementation of shared leadership of urgent and emergency care issues between NHS England and NHS Improvement from the 1 April. This is to occur through ‘STP A&E Delivery Boards’ which will hopefully remove some of the current duplication being created nationally by dual reporting requests for urgent and emergency care.

6. Recommendations

6.1. The implications of this letter will be included within the Trust strategy review and specific actions are proposed to take forward actions within 999 and NHS 111.

All NHS Provider Trust Chief Executives
All CCG Accountable Officers
All CCG Clinical Leaders
Copy to Local Authority Chief Executives

Gateway Reference: 06600

9th March 2017

Dear colleague,

Action to get A&E performance back on track

We are writing to thank you and your staff for your work over what has been a highly pressurised winter, and - following the Chancellor's Budget statement yesterday - to let you know about the action now needed to turnaround A&E performance in 2017. Further detail will be provided in the NHS Delivery Plan being published in three weeks' time.

Throughout this winter, there have been three consistent themes relating to urgent and emergency care: difficulties in discharging inpatients when they are ready to go home; rising demand at A&E departments, with the fragmented nature of out-of-hospital services unable to offer patients adequate alternatives; and complex oversight arrangements between trusts, CCGs and councils.

To avoid a repeat next winter of this past winter, we need to make concrete changes on all three fronts.

Freeing up hospital bed capacity

First, we know that difficulties with discharging emergency inpatients has reduced the effective availability of beds in which to care for both emergency patients presenting in A&E, as well as patients needing planned surgery. It is therefore vital that, together with our partners in local government, we ensure that the extra £1 billion the Chancellor has made available for social care is in part used to free-up in the region of 2000-3000 acute hospital beds. We would ask that you immediately now engage with the senior leadership of your local adult social care departments to discuss how those patients stuck in hospital needing home care or care home places can access those services.

It is also, however, indisputable that there are places which have still not adopted best practice to enable appropriate flow, including better and more timely hand-offs between A&E clinicians and acute physicians, discharge to assess, 'trusted assessor' arrangements, streamlined continuing healthcare processes, and seven day discharge capabilities. You now need to ensure these happen everywhere, and well before October 2017.

Managing A&E demand

Some estimates suggest that between 1.5 and 3 million people who come to A&E each year could have their needs addressed in other parts of the urgent care system. They turn to A&E because they are unclear about the alternatives or are unable to access them.

You therefore now need to:

- Ensure every hospital implements a comprehensive front-door streaming model by October 2017, so that A&E departments are free to care for the most urgent patients. Yesterday's Budget has made available an extra £100 million of capital to be deployed in the next six months to support this. Proposals will need agreement with the Department of Health and we will be letting you know proposed allocations of this within the next six weeks.
- Strengthen support to your Care Homes so as to ensure that they have direct access to clinical advice, including where appropriate on-site assessment. We are making available £30 million to support universal roll-out of this model via 111, in order to reduce the risk of care home residents being admitted to hospital.
- Implement the recommendations of the Ambulance Response Programme by October 2017, freeing up capacity for the service to increase their use of Hear & Treat and See & Treat, thereby conveying patients to hospital only when this is clinically necessary.
- Proceed with the standardisation of Walk-In-Centres, Minor Injury Units and Urgent Care Centres, so that the current confusing array of options is replaced with a single type of centre which offers patients a consistent, high quality service.
- Roll out evening and weekend GP appointments, to 50% of the public by March 2018 and 100% by March 2019.
- Increase the number of 111 calls receiving clinical assessment by a third by March 2018, so that only patients who genuinely need to attend A&E, or use the ambulance service, are advised to do this.

Aligned national support and oversight

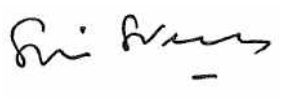
Given the national importance of improving NHS urgent and emergency care performance, we intend to simplify the focus of the 30% performance element of the Sustainability and Transformation Fund (STF) for 2017/18, so that it will focus on A&E rather than requiring providers to focus on multiple objectives. For individual trusts it will be linked to effective implementation of the actions set out above as well as achieving performance before or in September that is above 90%, sustaining this, and returning to 95% by March 2018.

In order to ensure complete alignment between NHS England and NHS Improvement in supporting and overseeing urgent implementation of the above actions, we have appointed Pauline Philip as the single national leader accountable to us jointly.

Furthermore, from 1st April we are nominating a single, named Regional Director drawn from NHSI and NHSE to support this implementation work and hold accountable both CCGs and trusts through their local STP's A&E Delivery Boards. Each RD will therefore act with the delegated authority of both NHSI and NHSE in respect of urgent and emergency care.

Thank you for your ongoing leadership on this critical part of what the NHS does for the people of this country.

Yours sincerely



Simon Stevens
CEO, NHS England

Jim Mackey
CEO, NHS Improvement

South East Coast Ambulance Service NHS
NHS Foundation Trust

	Agenda No	207/16

Name of meeting	Trust Board
Date	29 March 2017
Name of paper	Handover Delays
Responsible Executive	Jon Amos, Acting Director of Strategy and Business Development
Author	Rory Collinge, Surrey Customer Account Manager
Synopsis	This paper provides a summary of the current handover delay challenges, regional and national focus on the urgent care system and handover delays and sets out actions being taken to address this issue by the Trust and at system level
Recommendations, decisions or actions sought	The board is asked to note the current delays being experienced, note the national changes and regional action plan. The board is asked to endorse the approach being taken by the Trust in addressing delays

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 are known to cause risk to patients who receive a delayed response, due to lack of available ambulance resource. They present poor patient experience for patients awaiting handover for extended periods, they impact staff and waste resource in a financially constrained system.

1.2. New national guidance issued jointly by the Association of Ambulance Service Chief Executives, NHS Improvement and The Royal College of Emergency Medicine clearly supports this view and makes clear the role of acute trusts in accepting responsibility for patient handover within 15 minutes. In particular the new guidance highlights that:

1.2.1. Leaving patients waiting in ambulances or in a corridor supervised by ambulance personnel should not be seen as an option

1.2.2. Processes should be developed to enable crews to take patients directly to the most appropriate location in the hospital, thereby avoiding ED where safe and appropriate

1.2.3. If patients are cohorted then extra nurses are required

1.3. The actions required from this new national guidance and the regional action plan developed following the November regional workshop recognise a clear role for the system as whole, the acute hospitals and the ambulance service. The focus appears to be shifting away from the majority of actions being the responsibility of the ambulance service to an acceptance of the wider system and acute Trust responsibility. This positive shift allows the focus for SECAmb to move from raising the profile of this issue to working with systems to implement change, whilst maintaining the profile.

1.4. This paper provides the Board with a summary of key metrics in relation to handover delays highlighting the persistent problem. The paper also sets out actions being taken by the Trust and actions planned by the system to assist in addressing these issues following national and regional changes in the approach to handover delays.

2. Current Position

2.1. Ambulance handover delays reduced in the month of February, losing 5,464 hours down from 7,950 in the previous month. It should be noted that February is a shorter month and conveyances have dropped significantly, as shown in appendix 1.

2.2. Areas to note for the month of February (compared to previous February) were:

2.2.1. Sussex saw a 13% increase from the same point last year this appears to be a county wide problem with specifically Eastbourne District Hospital (EDH) causing SECAmb long delays.

2.2.2. Delays at Kent hospitals increased by 8%. The William Harvey Hospital in particular is facing challenges.

2.2.3. Surrey hospitals handover delay decreased by 2%. The Royal Surrey County hospital has now shown 2 months of continued reduction and is currently on track to maintain this new position.

2.3. 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.

2.4. Data by acute site, for handovers taking over 15 minutes and handovers taking over 60 minutes, between December and February are shown in appendix 3.

3. Actions

3.1. A trust-wide approach is being taken to ensure consistency and to share good practice. The PMO is leading the co-ordination of actions, with weekly calls in place with workstream leads and key managers.

3.2. Account Managers, supported by the Operational Unit Managers are:

3.2.1. Ensuring that handover, including recent national and regional system letters and associated actions plans are on the agenda at all local A&E Delivery Boards.

3.2.2. Ensuring joint completion of a self-assessment tool by SECAmb and each acute Trust site. This will facilitate internal reporting, reporting to A&E Delivery Boards and identification of best practice examples. An example is included in appendix 4.

3.3. 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.

3.4. 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.

3.5. 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.

3.6. There are a number of local trials being led and developed by Account Managers and OUMs, which will be used to share best practice and lessons, including:

3.6.1. Streaming into UCCs without physical handover (Ashford St Peters)

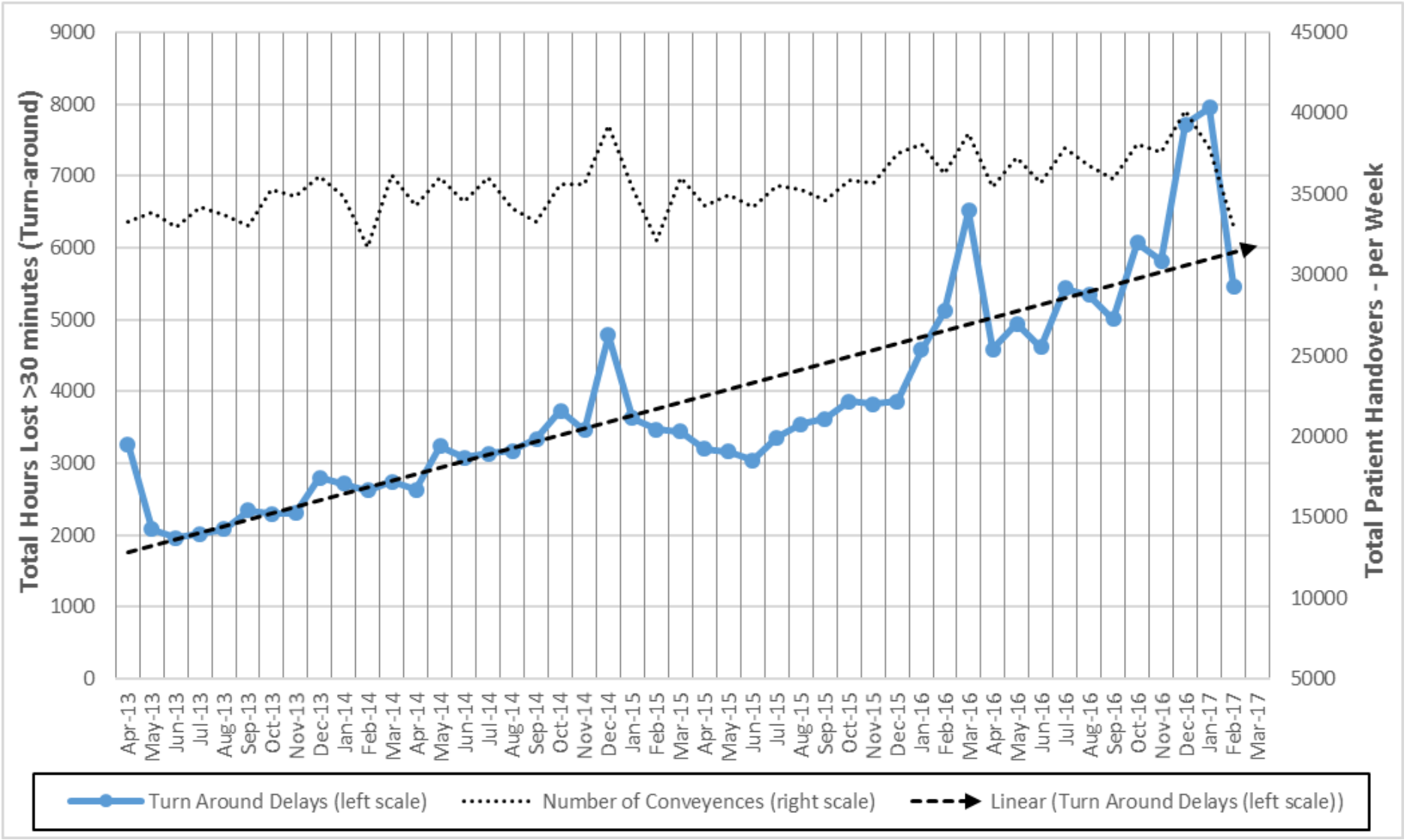
3.6.2. Ambulance receiving nurses (Royal Surrey County Hospital & Frimley Park Hospital)

3.6.3. Streaming into departments other than A&E (Darent Valley)

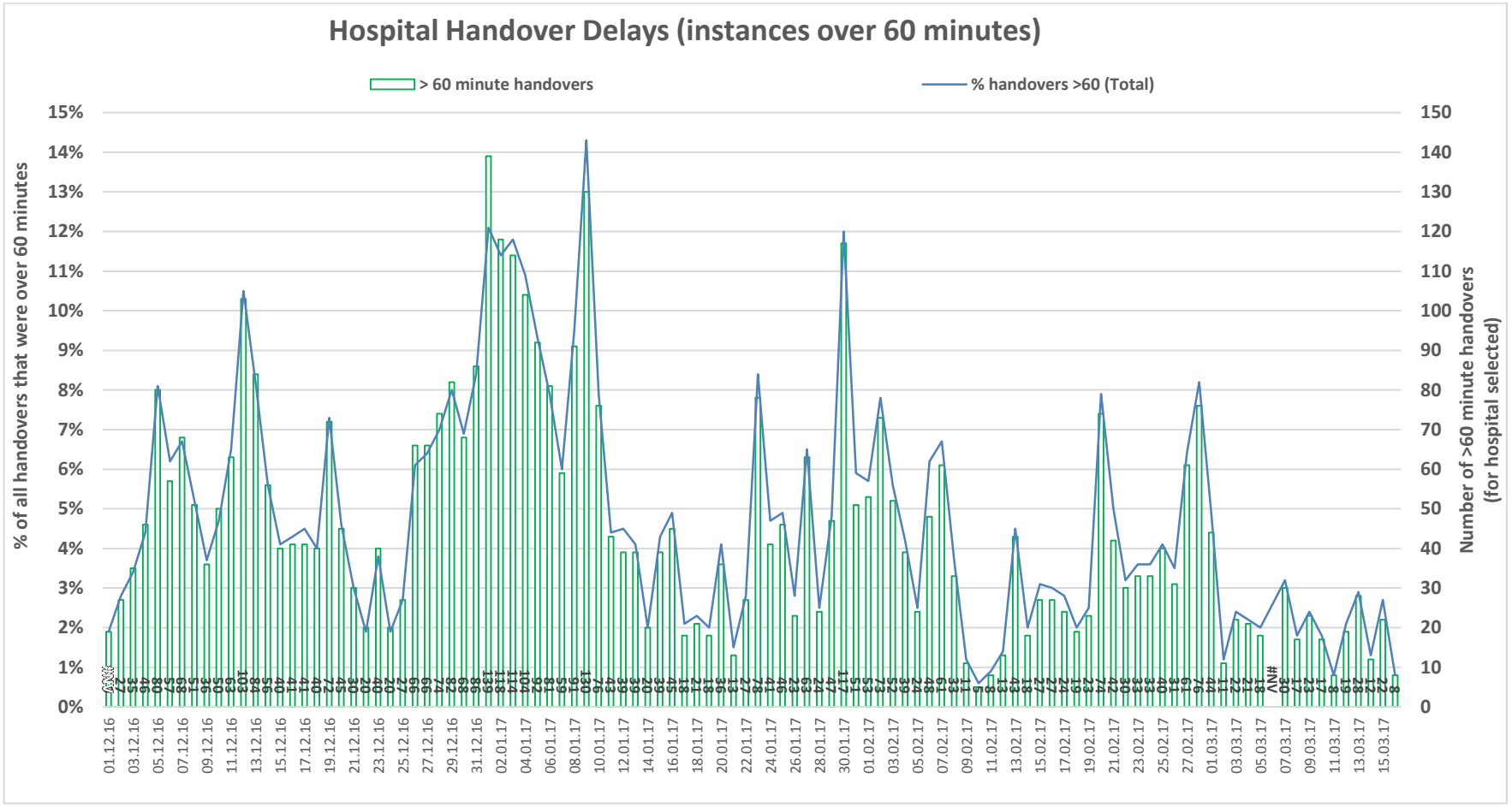
4. Recommendation

4.1. The Board is asked to note the current data and system actions and endorse the actions being taken by the Trust to address these issues.

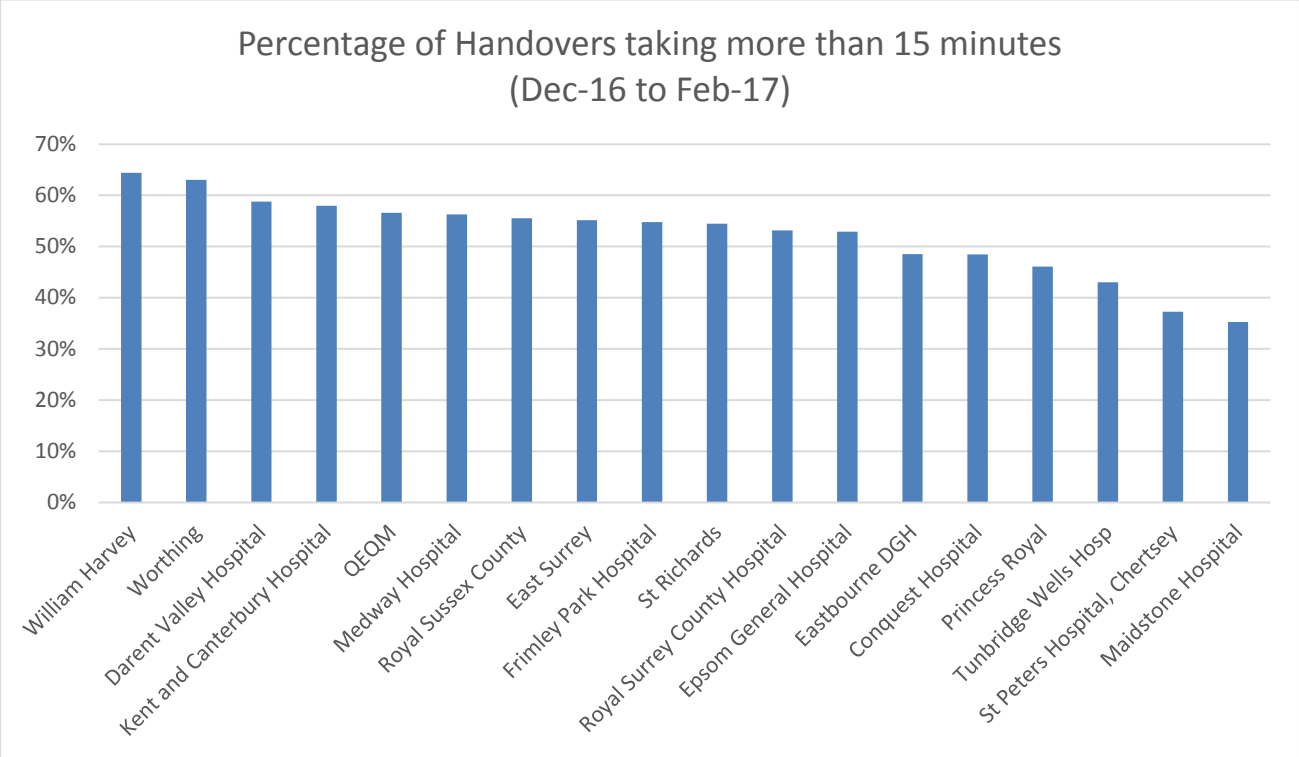
Appendix 1 – Hours Lost (over 30 minute turnaround) and Numbers of Handovers

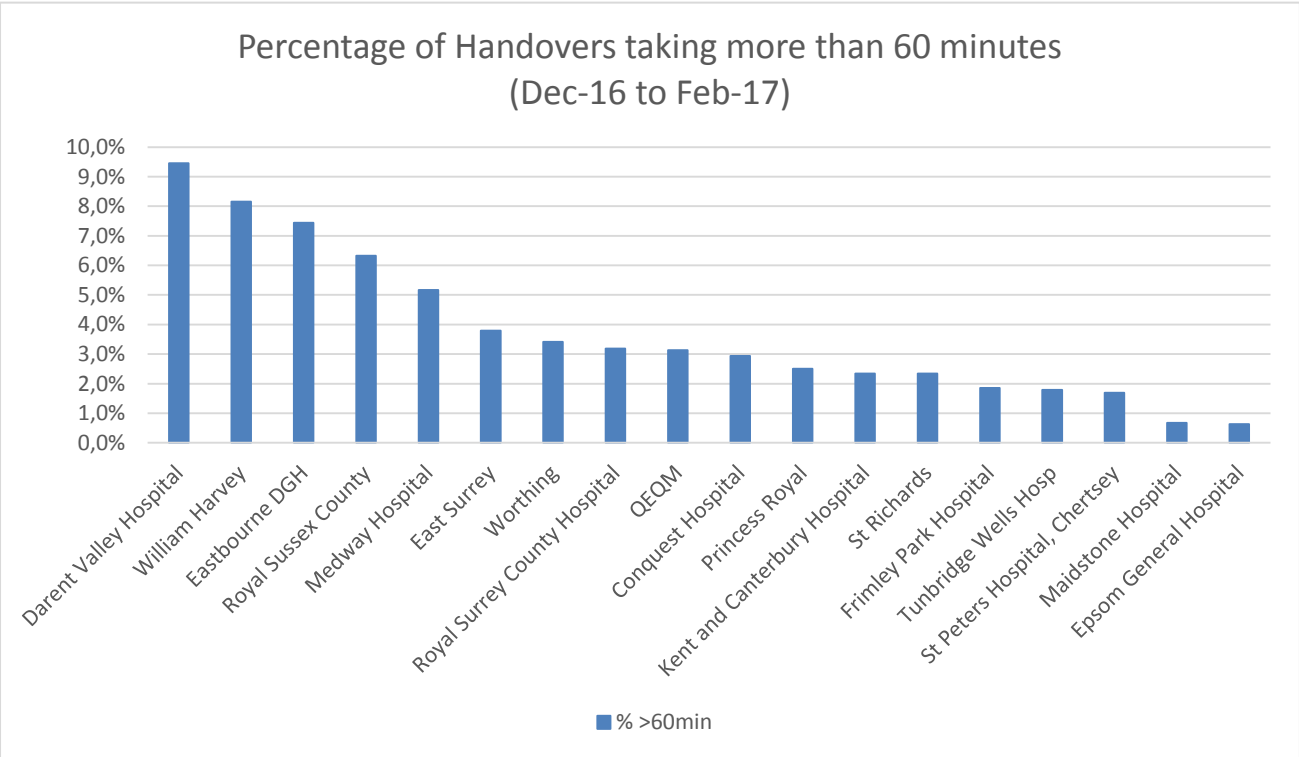


Appendix 2 – Handovers >60min by week



Appendix 3 – Handover by Hospital





Appendix 4 – Self Assessment Tool

	LA DEV BOARD COMPLIANCE:	…….		Last complete	02/03/2017
	Letter ref: Keith Willet, Kathy Mclean (23/02/2017),			Compliant	**50%**

		Description	Further description	Compliant	Comments
Tactical advice to hospitals and ambulance services	1	**Emergency departments must work to the principle that they will always accept handover of patients within 15 minutes of an ambulance arriving.**	*Supervised by ambulance service in corridors is not acceptable*	**Non compliant**	In January 17% of the patients were handed over within 15 mins.
	2	**Implement rapid assessment for ambulance arrivals.**	*Prompt assessment by trained clinician and active management to ensure queues for assessment do not form.*	**Non compliant**	If a stack occurs the rapid assessment consultant will assess those in the stack to prioritise and ensure patient safety.
	3	**Streaming, avoid A&E where possible and appropriate.**		**Compliant**	Streaming is now in place at the ….. The ARN will stream ambulance patients into the correct stream to avoid delays.
	4	**Hospitals should implement a 'Full Capacity Protocol' as part of escalation to create space in crowded emergency departments**	*e.g. protocol may allowpatients to be 'pushed' automatically to wards between predetermined times (e.g. 11am – 4pm) to create space in the emergency department*	**Non compliant**	Trust escalation plan includes operation stack and a internal reposnse to the immediate handover delay. There is also agreement for wards to accept one additional patients (Boarding) if appropriate and agrred by their gold command.
	5	**Use Nurse Cohort as temporary measure**	*this should not be done by the ambulance service*	**Compliant**	……... has a handover nurse, the nurse is funded by the CCG and the hospital until March 31st 2017. We are agreeing how we make this BAU.

LA DEV BOARD COMPLIANCE:		Last completec	02/03/2017
Letter ref: Michael Wilson (28/02/2017)		Compliant	**16%**

	Objective	**Action**	**Status**	**Comments**
1	**Improve alternate pathways for pre-hospital care**	Directory of services (DOS) review	**Non compliant**	
		Ensure commissioned services are being utilised	**Non compliant**	
		Explore pathways for higher/mid acuity cases	**Non compliant**	
		Check usage of 'ranking' and 'capacity tool' (re availability)	**Non compliant**	
		Clear SOP for pre-hospital clinician access (e.g. GP's, HCP's, Ambulance)	**Non compliant**	
2	**Improving flow of patients (reducing system batching)**	As a system, review data and processes to look at pattern for GP home visits and 'peaks' of demand upon both the ambulance service and the receiving acute trust for GP expected patients.	**Compliant**	Data has been reviewed by ……. and …….
		Implement appropriate booking system and home visiting following data review.	**Non compliant**	
		Improve response to mental health, a development in line with the National MH Concordat. 2 proposals, the first develop a pre-hospital response model to crisis care then 2nd to look at streaming to MH liaison (Site) (blue phone)	**Non compliant**	
		Access to alternate departments for ambulance cases MIU, AEC etc. Patients referred by GPs to named team/ward	**Non compliant**	As a system …….. have a MIU, AEC is part of the ED and Patients are streamed into the AEC by assessming nurse/consultant.
		Manage frequent users	Plan in place with timeline	There is a Frequent users of A&E group managed by the CCG, [still need to develop plans for Frequent Callers of Ambulance service.
		Care documents upload onto IBIS as an information sharing tool	**Compliant**	……. are in the top three highest number of patients registered on IBIS with 4651.
3	**Improving information flow**	Ambulance screens in more locations e.g. MAU/regularly attended departments	**Non compliant**	Screens are available in majors,resus, minors and EAU assessment.
		Ambulance/Trust ED data activity to be reviewed to spot trends and potential spikes	**Compliant**	There is a specific ambulance group (SECAmb, ……..., CCG, monthly) who review ambulance activity and "lost hours" for spikes and trends.
		Ambulance service to assist with activity modelling for acute trusts, in particular around staffing models	Plan in place with timeline	Ambulance service assisted in the modelling for the "Handover nurse" role.
		SHREWD review regarding data consistency.	**Non compliant**	Do not use SHREWD in this area…. [BEN PLEASE FILL IN…..]
		Explore technology to enable identification of the provider (acute trusts/ MIU/ UCC) with the quickest handover in the setting that is clinically appropriate.	**Non compliant**	
		Improve digital connections between providers e.g. MIU and acute provider.	**Non compliant**	MIU at ……. uses the sam PACS system so ……. are able to advise on patients X Rays.
4	**System Escalation**	Joint escalation – consistency of process across Trusts (acute, community and ambulance)	**Non compliant**	System escalation plan is in place and has been aligned to the new OPEL document. Both acute and community providers have also aligned their plans to the OPEL Guidance.
		Development of joint SOP across Trusts to include pre- hospital to acute access.	**Non compliant**	

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	208

Name of meeting	Trust Board
Date	29/03/2017
Name of paper	Risk Management Strategy and Policy
Responsible Executive	Emma Wadey Interim Chief Nurse/ Director of Quality & Safety
Author	Emma Wadey Interim Chief Nurse/ Director of Quality and Safety
Synopsis	The Risk Management Strategy and Policy has had a lengthy period of consultation and approved by the Audit Committee and Executive team. The Risk Management Strategy provides an integrated framework, which encompasses strategic, financial, quality, reputational, compliance and health & safety risks. Its aim is to ensure the safety of patients, staff and the public and to deliver quality, patient centred services that achieve excellent results, promoting the best possible use of public resources, through an integrated approach to managing risks. The strategy is integral to the achievement of the Trust's strategic goals and vision. This is further supported by the Trust Board Assurance Framework. The Risk Management Strategy is a dynamic document that needs to be refreshed and updated periodically to reflect changes in both internal and external circumstances. In light of this, the current strategy will be reviewed in 6 months to encompass any new developments. Thereafter it will be reviewed annually or when changes in circumstances trigger a review.
Recommendations, decisions or actions sought	The Trust board is asked to approve the Risk Management strategy and Policy

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**

South East Coast Ambulance Service NHS
NHS Foundation Trust

Risk Management Strategy & Policy

Document Number	[To be inserted by CRA if this is a new document]
Version:	1
Name of originator/ author:	Risk Manager/ Interim Chief Nurse

Policy:	
Approved by:	Trust Board
Date approved:	

Procedure:	
Approved by:	N/A
Date approved:	N/A

Date issued:	[To be inserted by CRA]
Date next review due:	October 2017
Target audience:	All Staff
Replaces:	Risk Management Strategy and Policy 2016

Equality Analysis (EA) Record

Approved EA submitted	Dated:	

Table of Contents

1 Governance of Risk Management

1.1 Introduction

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

The Trust's vision is *proposed* as:

We will always aim to make consistent and sustainable improvement in order to be able to provide good quality care for the patients and carers we work with. We will listen to and work with our patients, staff and partners in doing so.

The Risk Management Strategy is a dynamic document that needs to be refreshed and updated periodically to reflect changes in both internal and external circumstances. In light of this, the current strategy will be updated in 6 months to encompass developments. Thereafter it will be reviewed annually or when changes in circumstances trigger a review.

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

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

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

1.1.4. The strategy applies to all areas and activities of the Trust and to all individuals employed by the Trust including contractors, volunteers, students and agency staff.

1.1.5. The strategy is supported by the Risk Management Procedure which provides the overarching framework of processes to support staff in implementing this strategy.

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

1.1.7. The Trust seeks to eliminate unlawful discrimination against colleagues, potential employees, patients or clients on the grounds of sex, marital status, disability, sexual orientation, gender identity, age, race, ethnic or national origin, religion, pregnancy/ maternity, political opinion, or trade union membership and to promote equality of opportunity and good relations between employees and clients.

1.1.8. Employees must at all times indicate an acceptance of these principles and fulfil their responsibilities with regard to equality legislation and the Trust's Equality Diversity and Human Rights Policy and protocols.

1.2. Legislative, Regulatory and Guidance Framework for Risk Management

Legislation

The Trust has statutory responsibilities for assessing and reducing risks under the Health and Safety at Work Act 1974; and Management of Health and Safety at Work Regulations 1999.The responsibilities under the legislation are outlined in the Trust Health and Safety Policy and supporting documents.

Care Quality Commission

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

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

NHS Improvement

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

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

Best Practice

1.2.4. The strategy is based on good practice from the National Patient Safety Agency and the Risk Management Standard ISO 31000.

1.3. Purpose

1.3.1. The purpose of the strategy is to present a systematic and effective multidisciplinary approach to the management of risk which is underpinned by a clear accountability and reporting structure from Board to Practitioner level. The strategy recognises the need for robust systems and processes to support continuous programmes of risk management. This approach enables staff to integrate risk management into their daily activities, and support better decision making through a good understanding of risks and their likely impact.

1.4. Risk Management Objectives

1.4.1. The strategy facilitates the identification, management and reporting of risks which may prevent the achievement of the Trust's strategic goals and the delivery of safe, high quality care. The Trust has the following risk management objectives:

- **Clearly communicate the risk appetite** of the Trust;
- **Minimise the potential harm** for patients, staff and visitors to a level as low as reasonably practicable, thereby providing a safe environment in which patients can be cared for and staff can work;
- **Risks are identified and managed** protecting the reputation of the Trust and items of value;
- **Maximise** resources available for patient services and care;
- **Minimise** financial liability;
- **Raise awareness** to all staff through ongoing training which is appropriate to specific roles and responsibilities;
- **Develop an 'open culture'** which encourages staff, patients and members of the public to report adverse events in a just and fair environment, so that potential trends and lessons may be identified and support offered to those reporting;
- **Embed an integrated approach** where risk management is visible and fully integrated across all Trust business;
- **Ensure appropriate structures are in place** to identify and manage risks with clear escalation levels and processes;
- **Risks are regularly reviewed and updated** by accountable managers and supported with a robust action plan;

- **Assurance on the operation of controls is** provided with gaps in controls identified and action plans proactively managed;
- **Create a system which is user friendly** and allows the prompt assessment and mitigation of risk;
- **Our approach to risk and opportunity taking** and how that affects our decisions is communicated with internal and external stakeholders

1.4.2. The strategy will be delivered by linking the Trust's strategic goals to local objectives and by delivering a focused training programme as reflected in the Trust's Training Needs Analysis.

1.5. Risk Management Policy Statement

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

1.5.2. All staff are responsible for their own health and safety, and the health and safety of other staff, patients, visitors and others who attend our premises and this is the main component of much health and safety legislation, as identified within the Health and Safety Policy.

2 Risk Management Framework

This section describes the framework for the management of risk. Operational instructions for risk management, health and safety, investigation of incidents, complaints and claims are detailed in separate procedural documents.

Definitions

Board Assurance Framework	The Board Assurance Framework (BAF) host risks which may affect the achievement of the Trust's strategic goals. Risks on the BAF are owned by the Trust Board of Directors and managed by the Executive Management Team. BAF risks are monitored by the Quality & Patient Safety Committee, Finance & Investment Committee, Workforce & Wellbeing Committee and Audit Committee.
Consequence	A measure of the impact that the predicted harm, loss or damage would have on the people, property or objectives affected.
Control	Current (not aspirational) resource put in place to control and reduce the risk
Directorate	Directorate risks are risks that if realised could threaten the way in

Risks	which the Trust operates at a local/ departmental/ directorate level. Directorate risks have a residual risk assessment score of **1 to 6 (low to moderate)** but are unlikely to directly impact strategic goals. Directorate risks are owned and managed by Heads of Service and Managers. Directorate risks are monitored by the Directorate Senior Management Team.
Operational Risks	Operational risks are risks that if realised could threaten the achievement of Trust wide business/ service objectives. Operational risks have a residual risk assessment score of **8 to 12 (high)** and are owned and managed by Trust Senior Managers. Operational risks are monitored by the Trust Senior Management Team and the relevant committee (Quality & Patient Safety Committee, Finance & Investment Committee or Workforce & Wellbeing Committee.)
Hazard	Anything that has the potential to cause injury, loss, damage or harm.
Inherent Risk	The risk prior to the application of controls
Lessons Log	A log of all the lessons captured during incident investigation, to reduce the likelihood of incidents re-occurring.
Likelihood	A measure of the probability that the predicted harm, loss or damage will occur
Mitigating Action	Actions which cannot be implemented immediately to control the risk, but which are required to control the risk in the longer term.
Residual Risk	The risk remaining following the application of controls.
Risk	The combined likelihood and consequence of harm, injury, damage or loss occurring or impacting the achievement of the Trusts objectives or strategic goals.
Risk Appetite	The purpose of risk appetite is to provide clear consistent guidance on the boundaries, levels of risk, and opportunity to take in achieving the Trust's strategic goals. In the absence of a defined risk appetite, there is an increased potential for the Trust to underperform against its goals through lack of scope, clarity and management of expectations.
Risk Assessment	The process of what can cause uncertainty or harm, and how. Assessments can be either general or specific, but will be undertaken by competent persons who have received the appropriate degree of information, instruction and training. The Trust uses the risk assessment matrix issued by the National Patient Safety Agency.
Risk Management	The systematic application of management policies, procedures and practices to identify, analyse, assess, treat, report and monitor risk.
Risk Assessment	The tool used to prioritise risks and determine overall risk level.

Matrix	
Risk Mitigation	The systemic reduction in the extent of exposure to a risk and/or the likelihood of its occurrence.
Risk Register	A log (captured in Datix) of all the risks that may threaten the success of the Trust in achieving its goals, aims and objectives. The Trust Risk Register consists of the following risks: - BAF - strategic - operational - directorate
Strategic Risks	Strategic risks threaten the way in which the Trust exists or operates. These risks have a direct detrimental effect on the achievement of the strategic goals outlined in the Five Year Strategic Plan. Strategic risks have a residual risk assessment score of **15 or higher (extreme)** and are owned and managed by Trust Executive Directors. Strategic risks are monitored by the Executive Management Team and accompany the BAF at Trust Board.
Tolerable Risk	The risk that has been identified, assessed and evaluated and does not require any further mitigating actions.

3 Risk Management Structure

3.1.1. The Committee structure at Appendix A outlines the Risk Management & Assurance Framework. The framework identifies the Trust's risk management structure, detailing those committees and groups which have responsibility for risk. The structure provides assurance that risk management processes are in place and are effective.

3.1.2. BAF risks, strategic risks, operational risks and directorate risks together form the Trust wide Risk Register.

3.1.3. The BAF is reviewed at least quarterly by the Trust Board, Quality & Patient Safety Committee, Finance & Investment Committee, Workforce & Wellbeing Committee and Audit Committee. Risks on the BAF are owned by the Trust Board of Directors.

3.1.4. Strategic risks are monitored and managed by the Executive Management Team on a monthly basis. Strategic risks are owned by the Trust Executive Directors and host risks with a residual risk rating of **15 or higher (extreme).** Strategic level risks accompany the BAF at Trust Board.

3.1.5. Operational risks are monitored by the Senior Management Team on a monthly basis and owned and managed by Trust Senior Managers. Operational risks have a residual risk rating of **8 to 12 (high)**.

3.1.6. Directorate risks are monitored on a monthly basis by Directorate Senior Management Teams and owned and managed by Heads of Service and Managers. Directorate risks have a residual risk rating of **1 to 6 (low to moderate)**.

3.1.7. The Trust Board conduct an annual review of the effectiveness of the Trust's system of internal controls which is reflected in the Annual Governance Statement that is published in the Annual Report. The Board receive the Audit Committee minutes and Audit Committee Annual report which provides assurance to the Board on the effectiveness of risk management in the Trust.

4 Responsibilities

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

4.1. Individual Responsibilities

4.1.1. The **Chief Executive**, as Accountable Officer, has overall responsibility for ensuring the Trust has a Risk Management Strategy and infrastructure in place to provide a comprehensive system of internal control and systemic and consistent management of risk. This includes the duty to protect the health, safety and welfare of Trust employees and other people who might be affected by Trust business as far as reasonably practicable. The Chief Executive will delegate specific roles and responsibilities, as required, to ensure risk management is co-ordinated and implemented equitably to meet the Trust's objectives.

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

The Director Quality and Safety / Chief Nurse has responsibility for quality, patient experience and health and safety in relation to risk management processes. The Director also holds responsibility for non-compliance with CQC fundamental standards, decontamination and infection prevention/ control. As the Senior Information Risk Owner (SIRO), the Director of Quality and Safety/ Chief Nurse is responsible for information governance.

4.1.2.1. **The Medical Director**

The Medical Director has the delegated Board level responsibility for providing assurance on medical leadership throughout the Trust. The Medical Director is responsible for informing the Trust Board of the key risks emanating from

clinical activity throughout the Trust. As the CDAO, the Medical Director is responsible for providing the Board with assurance around medicines management. The Medical Director is also the Trust Caldicott Guardian.

4.1.3. **The Chief Pharmacist**
The Chief Pharmacist has the responsibility delegated from the Medical Director for ensuring that risk and assurance processes in relation to medicines use across the whole medicines pathway are devised, implemented and embedded. The Chief Pharmacist reports to the Medical Director and the Drugs & Therapeutics Committee any significant issues arising from the implementation of this strategy, including evidence of non-compliance or lack of effectiveness arising from the monitoring process so that remedial action can be taken.

4.1.4. The **Director of Finance and Corporate Services** has the delegated Board level responsibility for financial constraints and balances competing financial demands and for coordinating the audit programme within the Trust.

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

4.1.6. The **Director of Strategy & Business Development** has the Board level responsibility for implementing an effective Programme Management Office and for Change Control Processes. They are responsible for ensuring that risks relating to delivering service transformation and re-design are identified, mitigated and managed through robust business case and change control processes.

4.1.7. The **Director of Human Resources** has the Board level responsibility for implementing effective workforce planning, staff welfare, recruitment and retention and organisational development strategies. They are responsible for ensuring that risks relating to workforce and organisational development are identified, mitigated and managed.

4.1.8. **All Executive Directors** are accountable for the delivery of quality services in the areas within their remit and lead on the delivery of the Trust's strategy with responsibility for ensuring that risks are appropriately identified and controlled through the Board Assurance Framework and strategic level risks. They will ensure the quality agenda is effectively co-ordinated, resourced and implemented across the Trust in an integrated way; ensuring actions to improve the quality of service delivery are completed, measured and shared to identify lessons and areas for improvement and best practice. Executive Directors are accountable for ensuring that the potential effect on the quality of service delivery is risk assessed prior to approval of any new business proposal. They will ensure that the infrastructure to enable staff to deliver high quality care within their areas of responsibility continues to be in place. Executive Directors are responsible for risk management leadership and for ensuring sufficient resources have been allocated to undertake effective risk management.

4.1.8.1. The Executive is jointly responsible for:

- Ensuring the Trust is compliant with risk management strategies, policies and processes;
- Managing service risks;
- Escalating risks, issues or requests to the Board of Directors.
- Managing, implementing and tracking mitigating actions, plans and lessons identified.

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

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

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

4.1.10. The **Company Secretary** is responsible for coordinating the Board Assurance Framework and ensuring the Board follows due process.

4.1.11. The **Head of Risk Management** is responsible for:

- The development of the Risk Management Strategy, ensuring it is effectively coordinated, implemented and monitored across the Trust;
- Maintaining the Trust Risk Register as an active document and monitor mitigation and action plans.
- Monitoring the risk and safety requirements of external agencies, including, but not limited to:
    - NHS Improvement Patient Safety Division (Formally National Patient Safety Agency);
    - Medicines and Healthcare Products Regulation Authority;
    - Health and Safety Executive; and
    - Care Quality Commission.
- Developing and implementing a suitable and sufficient risk management training provision across the Trust, ensuring role specific training is provided; and

- For the governance process relating to risks and monitoring compliance with the policy framework.

4.1.12. The **Information Governance Manager** is responsible for:

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

4.1.13. The **Head of Procurement** is responsible for:

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

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

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

4.1.15. **Heads of Service and Managers** have responsibility for managing risks within the services within which they work and for ensuring that they have attended the appropriate risk management training commensurate to their role. Heads of Service and Managers are responsible for managing directorate level risks.

4.1.16. The **Named Nurses for Safeguarding** report to the Director Quality and Safety/ Chief Nurse and Deputy Chief Nurse to ensure that comprehensive and robust arrangements are in place for safeguarding adults and children (including learning disabilities). The Named Nurses work within the clinical governance/risk management framework of the Trust and assist in the

development of robust clinical governance arrangements for safeguarding children and vulnerable adults.

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

4.2. Committee Responsibilities within the Organisation

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

4.2.1. The **Trust Board** is responsible for establishing the principal strategic goals and for driving the organisation forward to achieve these. It is also responsible for ensuring that there are effective systems in place to identify and manage the strategic risks associated with the achievement of these objectives through the Board Assurance Framework. The Trust Board is responsible for endorsing the organisation's system of internal control, including risk management.

The Trust Board has reserved for itself the adoption of the Trust Risk Management Strategy and has collective responsibility for:

- Providing leadership on the management of risk;
- Ensuring risk management systems within the Trust are effective and fully operational across the whole organisation;
- Directing the reduction, elimination and exploitation of risk in order to increase resilience;
- Determining and communicating the risk appetite statement for the Trust;
- Ensuring the consistent approach to the application of the risk management strategy;
- Ensuring that the Trust has a programme in place for managing all types of risk at all levels;
- Reviewing and requesting assurances to demonstrate that risks have been identified, assessed and all reasonable steps have been taken to manage them effectively and appropriately;

- Receiving assurance that resources are available to support the risk management system and to manage risk within the agreed risk appetite;

- Protecting the reputation of the Trust and correctly scoring risks to the achievement of the Trust's strategic goals via the Board Assurance Framework and regular review of such;

- Ensuring all members of the Trust Board attend Board development and awareness training in relation to risk management.

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

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

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

4.2.5. The **Workforce & Wellbeing Committee** has delegated responsibility on behalf of the Board to seek assurance that there are suitable arrangements and controls in place for the management, performance and wellbeing of the workforce, as such the committee is responsible for ensuring the effective management of risks relating to the workforce and their wellbeing.

4.2.6. The **Executive Management Team** is responsible for monitoring and managing the strategic risks, providing assurance to the Trust Board that they are being monitored and managed through the Board Assurance Framework. The Executive is also responsible for reviewing and monitoring strategic risks escalating any risks to the Trust Board, as necessary.

4.2.7. The **Quality Working Group** is responsible for ensuring the management of the Trust's quality governance, including risk management procedures and practices. The Quality Working Group is supported by a number of subject-specific sub groups, which are responsible for risks within a defined area as identified within the management governance structure and the group's terms of reference.

4.2.8. The **Senior Management Team** will;

- Review operational level risks on a monthly basis, escalating risks as required to the Executive Management Team;
- Ensure systems are in place to support delivery and compliance with legislation, mandatory NHS standards and relevant bodies;
- Monitor the delivery of action plans to ensure gaps in controls are closed and to identify robust assurance mechanisms;
- Undertake critical reviews of services; and
- Encourage and foster greater awareness of risk management throughout the Trust.

4.2.9. **Directorate Senior Management Teams** will;

- Review directorate level risks on a monthly basis, escalating risks as required to the Senior Management Team;
- Ensure systems are in place to support delivery and compliance with legislation, mandatory NHS standards and relevant bodies;
- Monitor the delivery of action plans to ensure gaps in controls are closed and to identify robust assurance mechanisms;
- Encourage and foster greater awareness of risk management throughout their directorates.

5 Principles and Methods of Risk Management

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

5.1. Key Principles

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

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

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

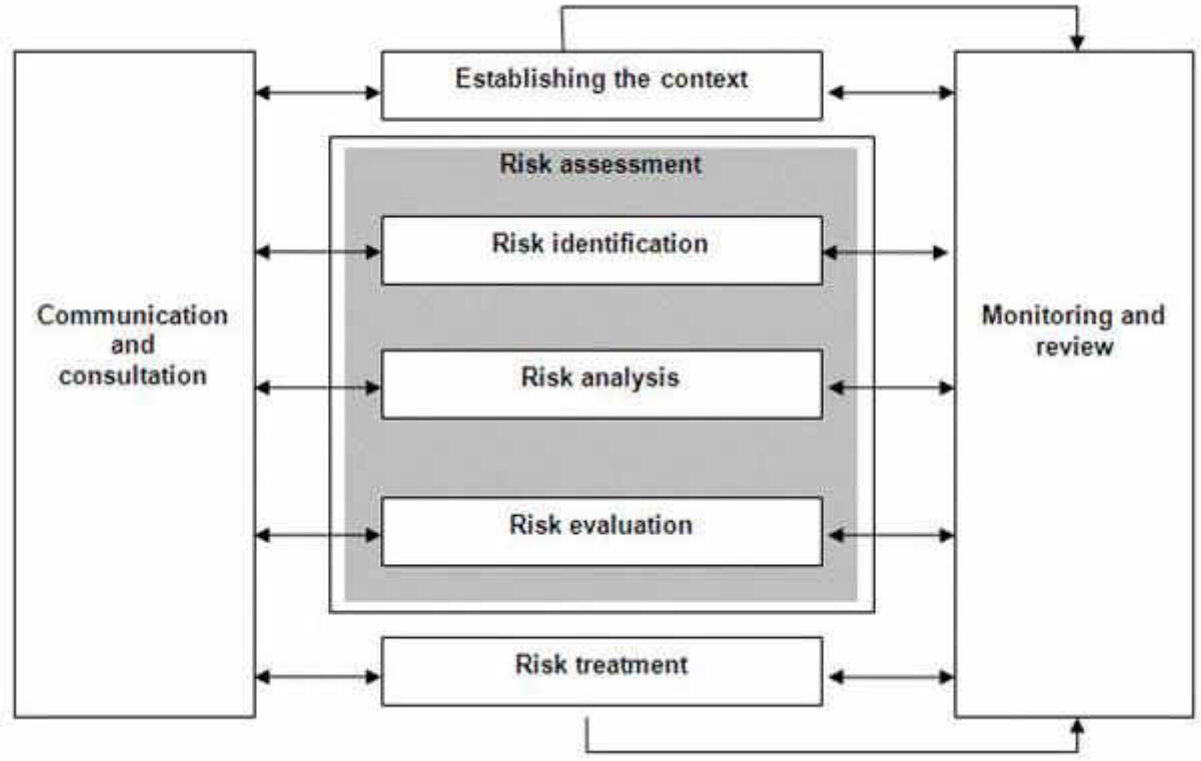
5.1.3. The key sources of risks to those groups include, but are not limited to:

- Acts or omissions by staff and contractors;
- Information systems and the reports they generate (information governance);

- Trust estates and environmental impact;
- Work force planning;
- Business Continuity i.e. the unexpected failure of systems, which may have a wide impact on the continued delivery of services;
- Internal change control
- Healthcare system pressure; and
- Changes to the commissioning / political environment.

5.2. Risk Management Process

The Trust risk management process is outlined below. Additional guidance is available in the Risk Management Procedure.



Risk Identification

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

- Analysis of key performance indicators;
- Capital and service development projects;
- Change control processes.
- Claims, incidents, serious incidents and complaints;
- Clinical Risk Assessments;
- Contingency/Disaster recovery planning and exercising;

- Coroners reports;
- Medicines management;
- Environmental and workplace risk assessments;
- Equipment and system malfunction or failure;
- Equipment purchase/modification;
- Information Governance Toolkit;
- Internal and External reviews, visits, inspections, audits and accreditation;
- National recommendations;
- New legislation and guidance;
- Preventative maintenance issues;
- Risk assessment of everyday operational activities, especially when there is a change in working practice or environment;
- Safety alerts (e.g. Central Alerting System and NHS protect)
- Staff and patient surveys; and
- Raising Concerns Policy;

5.2.2. Each risk identified should be clearly defined using simple and unambiguous language.

Risk Analysis and Evaluation

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

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

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

Risk Scoring

5.2.6. The risk score will be based upon the consequence of a risk and the likelihood of it being realised. The Trust uses the risk scoring matrix issued by the National Patient Safety Agency;

Consequence x Likelihood = Risk Score

5.2.7. Three risk scores are used for the management of risks;

- **Inherent Risk Score** – Score of the risk before the application of controls. The inherent risk score quantifies total control failure- the worse case scenario.

- **Current Residual Risk Score** - Score following the application of controls. Effective controls should always reduce the inherent risk score. The current residual risk score is taken at the time the risk was last reviewed in line with the set review dates. It is expected that the current risk score will reduce and move toward the Target Risk Score as action plans and mitigating actions are developed and implemented.

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

Scoring the Consequence

Consequence must be scored using the Table of Consequences.

Table of Consequences					
	Consequence Score and Descriptor				
	1	2	3	4	5
Domain:	Negligible	Minor	Moderate	Major	Catastrophic
Injury or harm Physical or Psychological	Minimal injury requiring no / minimal intervention or treatment No Time off work required	Minor injury or illness requiring intervention Requiring time off work < 4 days Increase in length of care by 1-3	Moderate injury requiring intervention Requiring time off work of 4-14 days Increase in length of care by 4-14 days RIDDOR / agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident leading to fatality Multiple permanent injuries or irreversible health effects
Quality of Patient Experience / Outcome	Unsatisfactory patient experience not directly related to the delivery of clinical care	Readily resolvable unsatisfactory patient experience directly related to clinical care.	Mismanagement of patient care with short term affects <7 days	Mismanagement of care with long term affects >7 days	Totally unsatisfactory patient outcome or experience including never events.
Statutory	Coroners verdict of natural causes, accidental death or open No or minimal impact of statutory guidance	Coroners verdict of misadventure Breech of statutory legislation	Police investigation Prosecution resulting in fine >£50K Issue of statutory notice	Coroners verdict of neglect/system neglect Prosecution resulting in a fine >£500K	Coroners verdict of unlawful killing Criminal prosecution or imprisonment of a Director/Executive (Inc. Corporate Manslaughter)
Business / Finance & Service Continuity	Minor loss of non-critical service Financial loss of <£10K	Service loss in a number of non-critical areas <6 hours Financial loss £10-50K	Service loss of any critical area Service loss of non-critical areas >6 hours Financial loss £50-500K	Extended loss of essential service in more than one critical area Financial loss of £500k to £1m	Loss of multiple essential services in critical areas Financial loss of >£1m
Potential for patient	Unlikely to cause complaint,	Complaint possible	Complaint expected	Multiple complaints / Ombudsmen inquiry	High profile complaint(s) with

complaint or Litigation / Claim	litigation or claim	Litigation unlikely Claim(s) <£10k	Litigation possible but not certain Claim(s) £10-100k	Litigation expected Claim(s) £100-£1m	national interest Multiple claims or high value single claim .£1m
Staffing and Competence	Short-term low staffing level that temporarily reduces patient care/service quality <1day Concerns about skill mix / competency	On-going low staffing level that reduces patient care/service quality Minor error(s) due to levels of competency (individual or team)	On-going problems with levels of staffing that result in late delivery of key objective/service Moderate error(s) due to levels of competency (individual or team)	Uncertain delivery of key objectives / service due to lack of staff Major error(s) due to levels of competency (individual or team)	Non-delivery of key objectives / service due to lack/loss of staff Critical error(s) due to levels of competency (individual or team)
Reputation or Adverse publicity	Rumours/loss of moral within the Trust Local media 1 day e.g. inside pages or limited report	Local media <7 days' coverage e.g. front page, headline Regulator concern	National Media <3 days' coverage Regulator action	National media >3 days' coverage Local MP concern Questions in the House	Full public enquiry Public investigation by regulator
Compliance Inspection / Audit	Non-significant / temporary lapses in compliance / targets	Minor non-compliance with standards / targets Minor recommendations from report	Significant non-compliance with standards/targets Challenging report	Low rating Enforcement action Critical report	Loss of accreditation / registration Prosecution Severely critical report

Scoring the Likelihood

Likelihood must be scored using the Table of Likelihood-

Description	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
Frequency (How often might it / does it occur)	This will probably never happen/recur Not expected to occur for years	Do not expect it to happen/recur but it is possible it may do so Expected to occur at least annually	Might happen or recur occasionally Expected to occur at least monthly	Will probably happen/recur, but it is not a persisting issue/circumstances Expected to occur at least weekly	Will undoubtedly happen/recur, possibly frequently Expected to occur at least daily
Probability	Less than 10%	11 – 30%	31 – 70 %	71 - 90%	> 90%

Risk Score and Grading (Risk Assessment)

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

Likelihood

1	2	3	4	5

Impact	Rare	Unlikely	Possible	Likely	Almost certain
Catastrophic 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
Negligible 1	1	2	3	4	5

5.2.9. For grading risks, the scores obtained from the risk matrix are assigned grades as follows:

	15 to 25 Extreme Risk
	8-12 High Risk
	4-6 Moderate Risk
	1 to 3 Low Risk

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

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

Risk Rating - Action Table							
Score	**Risk Grade**	**Action**	**Risk Owner ***	**Governance/ Monitoring****	**Trust Risk Register Level*****	**Escalation Route**	**Assurance**
1-3	Low	Entered onto Datix	Head of Service / Manager	Directorate Senior Management Team	Directorate	Trust Senior Management Team	Quality & Patient Safety Committee, Finance & Investment Committee, Workforce & Wellbeing Committee and Audit Committee
4-6	Moderate						
8-12	High		Senior Manager	Trust Senior Management Team	Operational	Executive Management Team	
15-25	Extreme		Executive Director	Executive Management Team	Strategic	Trust Board	

* The Risk Owner has the over-arching organisational responsibility for the risk; however, they may delegate the management of the risk through the implementation of controls and production of action plans as appropriate.
** The committee, group or meeting responsible for Governance and Monitoring will validate scoring and undertake the monitoring / review of action plans and any tolerated risks. They are also responsible for escalating risks as appropriate.
*** The Trust wide Risk Register is held on Datix and broken down by BAF risks, strategic risks, operational risks and directorate risks.

Risk Treatment

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

Accept

5.2.12.1. The risk may be accepted without the need for any further mitigating action. For example, if the risk is rated low; or if the Trust's ability to mitigate the risk is constrained; or if taking action is disproportionately costly. Accepted risks must still be assessed and reviewed at least annually to identify any change in circumstances or scoring.

Reduce

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

5.2.12.3. It is important to ensure that mitigating actions are proportionate to the identified risk and give reasonable assurance that the risk will be reduced to an acceptable level. Risks are considered for closure once the accepted risk level has been reached **(target risk score)** and the Chair of the appropriate monitoring group agrees with the proposal for risk closure, (e.g. Chair of the Trust Board, Executive Management Team, Senior Management Team or Directorate Management Team).

Transfer

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

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

Avoid

5.2.12.6. In some circumstances, the only way to reasonably prevent the risk is to avoid (or terminate) the activity giving rise to the risk, or by changing the way in which the activity is undertaken.

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

Risk Review

5.2.13. The BAF is reviewed at least quarterly by the Trust Board, Quality & Patient Safety Committee, Finance & Investment Committee, Workforce & Wellbeing Committee and Audit Committee.

5.2.14. Strategic risks are reviewed monthly by the Executive Management Team.

5.2.15. Operational risks are reviewed monthly by the Senior Management Team.

5.2.16. Directorate risks are reviewed monthly by the Directorate Management Team.

Process for Review

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

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

Risk Documentation

5.2.17. All risks are entered onto the Trust Risk Register held on Datix. As such the Trust has one centrally held risk register which is organised by risk level:

- BAF
- strategic
- operational
- directorate

Trust Risk Register

5.2.17.1. **Board Assurance Framework**

The BAF host risks which may affect the achievement of the Trust's strategic goals. Risks on the BAF are owned by the Trust Board of Directors and managed by the Executive Management Team. BAF risks are monitored by the Quality & Patient Safety Committee, Finance & Investment Committee, Workforce & Wellbeing Committee and Audit Committee.

5.2.17.2. **Strategic Risks**

Strategic risks threaten the way in which the Trust exists or operates. These risks have a direct detrimental effect on the achievement of the Strategic Goals outlined in the Five Year Strategic Plan. Strategic risks have a residual risk assessment score of **15 or higher (extreme)** and are owned and managed by Trust Executive Directors. Strategic risks are monitored by the Executive Management Team and accompany the BAF at Trust Board.

5.2.17.3. **Operational Risks**

Operational risks impact on the achievement of Trust wide business and service objectives. Operational risks have a residual risk assessment score of **8 to 12 (high)** and are owned and managed by Trust Senior Managers. Operational risks are monitored by the Trust Senior Management Team and the relevant committee (Quality & Patient Safety Committee, Finance & Investment Committee or Workforce & Wellbeing Committee.)

5.2.17.4. **Directorate Risks**

Directorate risks are risks that if realised could threaten the way in which the Trust operates at a local/ departmental/ directorate level. Directorate risks have a residual risk assessment score of **1 to 6 (low to moderate)** but are unlikely to directly impact strategic goals. Directorate risks are owned and managed by Heads of Service and Managers. Directorate risks are monitored by the Directorate Senior Management Team.

Health and Safety Risks

5.2.17.5. Due to their specific nature, health and safety related risks must be recorded on the Trust Health & Safety Risk Assessment Form. Health

and safety related risk assessments must be retained locally. Health and safety risk assessments scoring 8 or higher will be included as part of the Trust's operational level risks.

Patient Clinical / Individual Risks

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

5.2.17.7. Systematic clinical risks (with a residual risk assessment score of 8 or higher) will be added to the Trust's operational risks on Datix.

Project / Programme Risks

5.2.17.8. Project / Programme risks will be recorded using the projects own internal documentation, typically a risk log. Project and programme risks which impact outside the project itself (with a residual risk assessment score of 8 or higher) will be added to the Trust's operational risks on Datix.

Risk Ownership, Escalation and Assurance

5.2.18. Risk owners are responsible for their risks, ensuring these are correctly scored, that suitable and effective controls are implemented and action plans produced and monitored.

5.2.19. The quality governance structure enables risks to be managed at the appropriate level within the Trust, ensuring there is a monitoring committee/ group with responsibility for providing assurance that risks are:

- effectively identified;
- assessed;
- monitored;
- managed;
- escalated and de-escalated as appropriate.

5.2.20. It is the responsibility of the monitoring committee/ group to ensure that risks are escalated appropriately, including escalating themes where they are observed by a number of similar low level risks.

6 Training

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

6.2. A Training Needs Analysis (TNA) has been developed to identify the training requirements for the implementation of this strategy.

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

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

7 Risk Management Work Programme

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

7.2. The Quality & Safety Working Group is responsible for approving the Risk Management Work Programme and for monitoring its development and delivery.

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

- Delivery of internal risk management training for staff undertaking risk management and assessment;
- Delivery and roll out of an integrated risk management data system on Datix;
- Enhanced analysis and reporting to monitor the completion of action plans against timescales;
- Triangulation of data to identify trends and themes;
- 95% of all risks on the Trust Risk Register to be reviewed within the required timescales.

8 MONITORING

8.1. The Audit Committee will monitor compliance with this strategy.

MONITORING OF IMPLEMENTATION	MONITORING LEAD	MONITORING PROCESS
Managers, Heads of Service and Trust Board receive the relevant training as per the Training Needs Analysis	Director Quality & Safety (Chief Nurse)	Quarterly exception reporting
Internal Auditors carry out an audit programme to provide assurance regarding elements of the risk management process	Director Quality & Safety (Chief Nurse)	Annual internal audit report to the Audit Committee
Compliance with the Trust	Director Quality	Quarterly report of compliance to the

Risk Register process is monitored	& Safety (Chief Nurse)	Audit Committee
The Trust Board monitors the BAF & strategic risks	Director Quality & Safety (Chief Nurse)	Quarterly review
Compliance with the Risk Management Process	Director Quality & Safety (Chief Nurse)	Annual audit of risk management process.

9 AUDIT & REVIEW

9.1. The Audit Committee will review this strategy annually or sooner if new legislation, codes of practice or national standards are introduced.

~~9.2.~~ The Head of Risk Management will monitor compliance with this strategy and report compliance to the Audit Committee

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

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

10 ASSOCIATED DOCUMENTS

- Risk Management Procedure
- Serious Incident Reporting and Management
- Health & Safety Policy
- Claims Procedure
- Complaints Policy
- Safety Alerts Procedure

11 REFERENCES

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- NHS Foundation Trust Code of Governance, Section C2. Risk Management and Internal Control
- Compliance Framework, Section 3 Risk Assessment.
- Health and Safety at Work Act 197
- Management of Health and Safety at Work Regulations 1992 (amended 1999

- CQC Fundamental Standards.
- National Patient Safety Agency Risk Managers Matrix

Document Control

Manager Responsible

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

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

Draft/Evaluation/Approval (Insert stage of process)

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

Circulation

Records Management Database	Date:
Internal Stakeholders	
External Stakeholders	

Review Due

Manager		
Period	Annually	Date:

Record Information

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

Supports Standard(s)/KLOE

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

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	209/16

Name of meeting	Trust Board
Date	29 March 2017
Name of paper	Financial Recovery 2016/17 and CIPS 2017/18
Executive sponsor	David Hammond – Acting Chief Executive (and substantive Finance Director)
Author name and role	Kevin Hervey – Deputy Director of Finance
Synopsis (up to 120 words)	This report is presented for information and covers: i) the steps taken to address financial recovery in the current financial year and the outcomes arising ii) the actions to formulate and address Cost Improvement Plans (CIPs) for 2017/18.
Recommendations, decisions or actions sought	The Board is asked to note: i) the actions taken to drive financial recovery in 16/17 and the successes achieved ii) the CIP actions for 2017/18.
Why must **this** meeting deal with **this** item? (max 15 words)	The Board needs to be aware of the financial issues facing the Trust and actions taken by Management to address them.
Which strategic objective does this paper link to?	Financial Sustainability

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

Financial Recovery 2016/17 and CIPs 2017/18

1. Background

1.1. At the end of June 2017, the Trust reported a forecast outturn (FOT) deficit of £7.1m for 2016/17, against a budget surplus of £0.7m. The 2017/19 Plan submitted to NHSI at the end of December 2016 is a £1.0M deficit which is in line with the control total set by NHSI. It includes £4.7m of established Cost Improvement Plan (CIPs) schemes for 2017/18 and a further £10.4m of CIP schemes related to the Unified Recovery Plan.

1.2. This report is presented for information and covers:

1.2.1. the steps taken to address financial recovery in the current financial year and the outcomes arising

1.2.2. the actions to formulate and address CIPs for 2017/18.

2. Financial Recovery 2016/17

2.1. In order to address the apparent loss of grip and control over expenditure, the Trust embarked on a series of financial challenge meetings in October 2016 with individual Directors. During these meetings Directors presented their directorate results and revised FOTs to the CEO and DoF to enable the latter to challenge the Directors on all aspects of their actual and forecast spend. The meetings were attended by the Finance Business Partners, Head of Finance Business Partnering and the Deputy DoF, and a list of actions to address spend were agreed, documented and followed up with the Director at a later stage. The financial challenge meetings continued into Quarter 4 of 2016/17.

2.2. In addition to the financial challenge meetings, a number of initiatives were undertaken through the Programme Management Office (PMO). An Improvement Director and an Assistant Improvement Director were engaged to provide traction on the resolution of CQC issues and to manage the delivery of expenditure savings. The Financial Controller was seconded from Finance to the PMO to provide costing expertise. Twenty-three initiatives were identified as requiring immediate focus and were summarised on a Financial Improvement Measures (FIMs) document. An initial savings stretch target of £2m was allocated to the FIMs. Each initiative was assigned a FIM lead and Executive lead. A team from Ernst & Young was engaged to provide further leadership within the PMO.

2.3. A Financial Sustainability Steering Group (FSSG), reporting to the Turnaround Executive Group, was formed to drive achievement of the FIM initiatives; chaired by the DoF, with permanent members of the group totalling nine, including senior

personnel from the PMO, Finance, Quality and Safety, and Communications. Twice weekly meetings have taken place at which the FIM leads are mandated to attend and present actions and progress to achieve the savings. All actions are recorded and ongoing weekly or fortnightly attendance by FIM leads is required according to circumstances. Achievements of savings are financially validated on an ongoing basis by the Financial Controller.

2.4. A weekly dashboard of progress in achieving the financial targets is brought to the FSSG, together with a Risk Log and an Actions Log. A Quality Impact Assessment (QIA) document is required for all the cost savings initiatives which is sent to the Turnaround Executive Group for assessment. The current Dashboard (Appendix 1) reflects validated savings of £1.3m against the initial target of £2m. The work is ongoing, with a further £0.3m pending validation, and will continue into 2017/18 in the form of CIPs targeting and monitoring.

3. CIPs 2017/18

3.1. As stated above, the 2017/19 Plan submitted to NHSI at the end of December included £4.7m of established CIP schemes and a further £10.4m of CIP schemes related to the Recovery Plan for 2017/18. These schemes are set out in Appendix 2. The same disciplines and routines in use within the FSSG for 2016/17 will be applied for the 2017/18 CIPs in that the CIP leads will be mandated to attend regular meetings with the FSSG to formulate and report on plans to progress their CIPs. The CIPs will be financially evaluated by the PMO and monitored for achievement. A formal governance process will be applied based on the slide pack at Appendix 3. The methodology will be agreed with Ernst & Young.

3.2. In addition, meetings will be held with the PMO, Finance and Budget Holders to discuss their budgets in detail, in the form of a line by line scrutiny of pay and non-pay expenditure, for the purpose of identifying costs that could be reduced, eliminated or deferred. Any CIPs identified will become subject to the same routines described above.

4. Recommendation

4.1. The Board is asked note:

4.1.1. the actions taken to drive financial recovery in 2016/17 and the successes achieved

4.1.2. the proposed CIP actions for 2017/18

Kevin Hervey, Interim Deputy Director of Finance

March 2017

South East Coast Ambulance Service - Financial Immediate Measures Dashboard

Appendix 1

No	Initiative	Proposed Executive Lead	Project Lead	Validated Savings £k	Narrative	Progress To Date	Next Action	Due By	
1a	Overtime Preapproval -operational	Joe Garcia	Sue Skelton	213	Tighter controls on operational overtime payments through monitoring and focus on pre-authorisation of all spend. Recall Clinical staff on secondment and CCPs back on the road	Communication from Operations Director sent out advising that overtime authorisation will be at Regional Operations Manager (ROM) level only. Planned hours have been removed from rotas i.e. 16 Jan and a weekly Tracker has been put in place to monitor progress. CCPs and other Clinical staff have been required to return to front line duties to reduce requirements for overtime and use of Private Ambulance Providers.	Tracking the weekly overtime hours to confirm savings. Ongoing monthly validation	14.4.17	
1b	Overtime Preapproval - non operational	Steve Graham	Carol Lenz	7	Tighter controls on non-operational overtime payments through monitoring and focus on pre-authorisation of all spend.	Communication sent by HR Director regarding tighter approval process to stop non-operational overtime. Overtime authorisation process to be reviewed and use of overtime to be restricted to critical issues only .	Overtime measures implemented and being tracked	14.4.17	
1c	Overtime Preapproval -Paramedics	Richard Weber	Kirsty Booth	21	Tighter controls on paramedic overtime payments through monitoring and focus on pre-authorisation of all spend. Recall Clinical staff on secondment and CCPs back on the road	CCPs and other Clinical staff have been required to return to front line duties to reduce requirements for overtime and use of Private Ambulance Providers.	Measures agreed and now being implemented	14.4.17	
2	Meal Break Payments	Joe Garcia	James Pavey	120	Change in procedures re lower urgency calls	Communication sent from Operations Director to restrict meal break disturbances to Red 1 calls. Daily meal break disturbance log in place and being reported and reviewed by ROMs. Meal break report/dashboard is currently available on Info.com	Continue to review report and validate target against agreed trajectory	14.4.17	
3	Shift overruns	Joe Garcia	Chris Stamp	41	To reduce the quantum of shift overruns through more rigid implementation of the rules around the need to require shifts to run over allotted times.	Directive issued and Union agreement has been given. Tracking report has been established. New operational instructions implemented from 1 February 2017.	Tracking Dashboard on a weekly basis and validating savings monthly	14.4.17	
4	PO Controls	David Hammond	Paul Ranson	62	Grip on Trust's commitment to spend - unlikely to deliver original target - enabler	Forensic PO & Non PO review undertaken and communication sent out to required End users. Agency discipline being enforced through questioning at FSSG meetings	Benefits recognised under other FIMs - PO controls FIM acts as an enabler	14.4.17	
5	PO and SFI levels	David Hammond	Paul Ranson	-	Ensure adequate governance & management controls in place	Financial Compliance declaration form distributed and signed by band 8Cs and above	Benefits recognised under other FIMs - PO and SFI levels FIM acts as an enabler	14.4.17	
6	Meeting expense/Room Hire	David Hammond	Paul Ranson	19	Stop non essential room hire and all associated costs. No further away days in hotels	Directive issued and monitoring spend	Benefits tracked against month end accounts	14.4.17	
7	Agency costs and controls	Steve Graham	Clare Irving	66	Reduce agency overspends to address breaches on Agency cap Conversion of temps to perm and tighter controls on recruitment.	New procedures established and communicated, HR working collaboratively with Budget leads to establish savings	Plan and trajectory in place. Tracking to ensure agreed dates are met re transfers and leavers	14.4.17	
8a	Training Costs & Course Fees - clinical	Steve Graham	Sally James	108	Tighter controls on training related spend such as hotels etc. Stop on discretionary training	Courses moved in-house where appropriate and driver training to be delivered locally using local vehicles. Actively sourcing cost effective hotel and venue hire for training. Reviewing daily travel tickets to move to weekly and monthly train tickets to avoid waste	Benefits agreed against forecast trajectory - tracking against month end accounts	14.4.17	
8b	Training Costs & Course Fees - non clinical	Steve Graham	Steve Singer	54	Tighter controls on training related spend such as hotels etc. Stop on discretionary training	All non essential training stopped and authorisation of training moved to Head of Learning and Organisation Development. Validation process in progress	Review target against required benefit and assure delivery against month end accounts	14.4.17	
9a	Fleet Fuel	Joe Garcia	John Griffins	-	Tighter controls around use of fuel	Review mileage and use of Bunkered fuel and communication sent re use of forecourt fuel. Mileage workstream established to be led by Sue Skelton.	Complete installation of Telematics (currently 60% roll out) regarding Steady Speed limiters. Validate benefits on a monthly basis. Understand the standard system reports requirements for monitoring i.e. idle times	14.4.17	
9b	Fleet Maintenance - External	Joe Garcia	John Griffins	36	Tighter controls and review of maintenance cycle time	Reviewed maintenance service cycle/inspection - reduction on use of materials - oil, filters. Issued instruction to maximise use of internal maintenance and minimising reordering (holding stock). Review of obsolete stock	Monitoring stock levels - 22% reduction in call off orders for Q4 and tighter PO approval. Validate benefits on a monthly basis.	14.4.17	
9c	Fleet Maintenance - Internal	Joe Garcia	John Griffins	-	Tighter controls and review of maintenance cycle time	see above	see above	14.4.17	
10	IT Costs	David Hammond	Mark Chivers	92	Efficient utilisation of resources to minimise waste. Cut out non essential spend	Reviewed and restricted to critical spend	Validate against agreed delivery target through monthly accounts	14.4.17	
11a	CQUIN payments assurance	Jon Amos	Andy Collen	-	Reassure full delivery - no reduction assumed in original forecast	Circa 90% achievement of Q1 & Q2 agreed	Await agreement of Q4 benefits	14.4.17	
11b	Other income generation - recharges & recovery	David Hammond	Priscilla Ashun-Sarpy	67	Improved recovery of income/recharges and overpayments	Agreed repayment plans re overpayments. Confirmed recharges for established work done by Paramedics for KSSAAT.	Assure delivery through monthly accounts	14.4.17	
12	Stock and issue Uniforms	David Hammond	Paul Ranson	31	Tighter controls on replacement and changes in policy.	Liaison with Operations leads to review policy	Agree short term measures and utilise existing stock in view of policy review	14.4.17	
13	Tea Coffee	Jon Amos	Paul Ranson	-	No free supply and shift back to Maxwell House	Lewes office supplies from petty cash stopped. Procurement providing supplies for all offices and monitoring stock levels	Assure Benefits in monthly accounts	14.4.17	
14	Legal costs	Peter Lee	Lyande Kaikai	3	Value for money - clearly define what can be done in house and external	All Legal spend to go through the Company Secretary - communication to go in the next edition of Finance matters.	Assure Benefits in monthly accounts	14.4.17	
15a	Medicine Management - drugs	Fionna Moore	Fiona Wray	-	Efficient utilisation of resources to avoid wastage including over ordering	Reviewed/established current drugs that are not required or a more cost effective alternative.	Assure Benefits in monthly accounts	14.4.17	
15b	Medicine Management - Medical equipment	Joe Garcia	Chris Haines	100	Efficient utilisation of resources to avoid wastage including over ordering	Reviewed use of large cylinders and purchases of medical equipment	Assure Benefits in monthly accounts	14.4.17	
15c	Medicine Management - gases	Joe Garcia	Paul Ranson	-	Efficient utilisation of resources to avoid wastage including over ordering	Efficient utilisation of resources to avoid wastage including over ordering	Reviewed use of large cylinders and purchases of medical equipment Assure Benefits in monthly accounts	14.4.17	
15d	Medicine Management - consumables	Joe Garcia	Paul Ranson	30	Efficient utilisation of resources to avoid wastage including over ordering	Efficient utilisation of resources to avoid wastage including over ordering	Assure Benefits in monthly accounts	14.4.17	
16	External Contractors	Steve Graham	Clare Irving	27	Grip on spend to justify value for money. Risk assess non coverage	Reviewing spend to establish potential savings	Check the trajectory re agency and contractors. Assure benefits	14.4.17	
17	Taxi and Vehicle Hire	Joe Garcia	Sue Skelton	54	Reduction in spend and vehicle hire	Reviewing spend to establish potential savings	Check delivery against agreed trajectory	14.4.17	
18	Furniture & Fittings	Jon Amos	Paul Ranson	59	Cut in spend and replacement	Communication sent to cease further procurement of furniture in Q4. Capitalisation of new MRCs/RPs furniture under review	Review Target against required benefit and assure delivery	14.4.17	
19	Phones and calls	David Hammond	Mark Chivers	23	Improvement in VFM	Restrictions on the allocation of new iPhones. Batch purchases of Laptops to facilitate capitalisation	Review Target against required benefit and assure delivery	14.4.17	
20	Corporate Recruitment	Steve Graham	Clare Irving	-	Tighter controls - value for money	Reviewing spend to establish potential savings	Being tracked on a weekly and monthly basis	14.4.17	
21	Public Relations Expenses	Peter Lee	Janine Crompton	29	Taken out unnecessary spend	Reviewed and stopped non essential printing and design work	Check delivery re month end	14.4.17	
22	Books Journals & Subscriptions	Peter Lee	Sally James / Lyande Kaikai	36	Review to ensure value for money	Subscriptions/books/licences cancelled where not required and recycling reusable materials	Assure delivery through monthly accounts	14.4.17	
23a	Travel & Subsistence - operational	Joe Garcia	Sue Skelton	-	Unlikely to get much delivery in short term but potential CIP	Reviewing travel spend to establish potential savings	Check Target, Scope and assure delivery for 2017/18	14.4.17	
23b	Travel & Subsistence - non operational	Steve Graham	Carol Lenz	-	Grip on spend - potential policy changes	Reviewing travel spend to establish potential savings	Check Target, Scope and assure delivery for 2017/18	14.3.17	
	Total			1.299					
				2.000					

Appendix 2

South East Coast Ambulance Service NHS Foundation Trust

CIPs Schemes 2017/18

Established Schemes

Description	£M TOTAL 2017/18	£M TOTAL 2018/19
CIPs		
Ops Restructure	1.1	0.0
Agency Premiums	1.7	0.0
Reduction in MealBreaks	0.4	0.0
Reduction in Shift overruns (LSOs)	0.3	0.0
Fleet Telematics	0.6	0.0
Reduced Fuel costs from reduced moving of vehicles between sites	0.3	0.0
EPCR (printing)	0.1	0.0
CEO (Consultancy, Subs, Room hire)	0.1	0.0
Estates	0.2	0.0
TBC	0.0	0.0
	0.0	0.0
CIPs Included	**4.7**	**0.0**

Recovery Plan Schemes

	Description	2017/18	2018/19
CIPS	**Additional CIP Schemes to be actioned**		
	Operational Efficiencies (TBC)	1.6	1.0
	Benefits of MRC Program	0.5	0.0
	Facilities Management	0.5	0.0
	Single HQ / EOC	0.8	0.3
	Staff Abstraction Management from Education and Training	1.0	0.0
	Retendering existing contracts: MRC operatives, payroll, legal services, SBS, Occupational health	0.5	0.0
	Strict enforcement of standardised practise and accountability	0.1	0.0
	SOP's for MRC, Fleet maintenance etc.	1.0	0.0
	Benefits realisation followed up and full accountability	1.0	0.0
	Vehicle choices - Vans vs box back vehicles (£1M Capital)	0.2	0.0
	System Status Plan appropriateness	0.5	0.0
	Future clinical model (More Hear and Treat +5%)	1.5	2.0
	Reduced Staff Turnover (EOC)	0.1	0.2
	Reduced Staff Turnover (999)	0.9	0.9
	Releasing Operational Staff from other Directorates to Support Hours	0.2	1.0
Total	**CIPs Other Potential Schemes**	**10.4**	**5.4**
Total	**TOTAL CIPS**	**15.1**	**5.4**

Description	£M TOTAL 2017/18	£M TOTAL 2018/19
CIPs		
Ops Restructure	1.1	0.0
Agency Premiums	1.7	0.0
Reduction in MealBreaks	0.4	0.0
Reduction in Shift overruns (LSOs)	0.3	0.0
Fleet Telematics	0.6	0.0
Reduced Fuel costs from reduced moving of vehicles between sites	0.3	0.0
EPCR (printing)	0.1	0.0
CEO (Consultancy, Subs, Room hire)	0.1	0.0
Estates	0.2	0.0
TBC	0.0	0.0
	0.0	0.0
CIPs Included	**4.7**	**0.0**

South East Coast Ambulance Service NHS
NHS Foundation Trust

Appendix 3

2017/18 Cost Improvement Programme

Your service, your call

Outline

- Overview
- Types of efficiency improvements
- Effective improvement process
  - Planning
  - Identification & Delivery Process
  - Monitoring & Reporting
  - Escalation

Importance of CIPs

- NHS England's *Five-year forward view* makes clear the scale of gap between current spending and resources, (nearly £30 billion a year by 2020/21.
  - NHS facing unprecedented financial challenge – funding constraints and £22b efficiencies required to close the gap by 2021.
- Lord Carter's productivity review found savings possible through changes to the provision of service.
  - Implementing Carter's recommendations is a priority that NHS England and NHS Improvement set out in their July 2016 paper *Strengthening financial performance and accountability in 2016/17*
- NHS organisations expected to deliver year on year efficiency savings. 2017/18 target is 2% - Trust needs circa 7% to meet the £1m deficit control totals.

What is a CIP?

- Purpose of CIPs is to maximise resources by eliminating waste, increasing efficiency and at the same time improving quality and safety.

- **Types of efficiency improvements** *(based on NHS Improvement definitions on cost savings)*

  - **Cost reduction** - providing a service at the same or better quality for a lower unit cost, through new ways of working that eliminate excess costs. ***Savings are generally cash releasing on a recurrent or one off basis.***

Types of efficiency improvements (cont'd)

- **Cost avoidance** is a type of cost reduction but refers specifically to eliminating or preventing future costs arising. Cost avoidance measures should generally not be part of the CIPs but avoid future costs pressures.

- **Income generation –** additional income outside contract funding schemes that provides a contribution for improving services.

- **Service productivity improvements -** changing the way services are delivered such as collaborative working across teams or similar organisations to increase productivity to deliver financial benefits.

Effective improvement process

- Efficiencies should be underpinned by
  - Strong leadership
  - Robust governance
  - Accountability
  - Full stakeholder engagement – buy in
  - Organisation culture that promotes improvement in quality, safety & patient experience
  - Good communication
  - Robust plans

Planning

- Efficiency improvement and waste reduction must be embedded in culture and strategic objectives
- Identify CIPs targets as part of budget process
- Establish target for each directorate and agree exec lead
- Ensure involvement of all relevant stakeholders to promote efficiency opportunities and continuous improvement
- Committees and Board approval of CIPs

Identification & Delivery Process

- Identify CIPs leads for each savings initiative
- Organise CIPs workshop to confirm how CIPs will be managed
- Clarify responsibilities and accountability
- Management of emerging efficiency ideas
- Clarify process of measuring and capturing benefit realisation from business cases
- CIP lead to establish delivery plan for each initiative
  - Define improvement with clear assumptions and calculations
  - Work with Finance & PMO to review/assess effectiveness of each initiative

Identification & Delivery Process (cont'd)

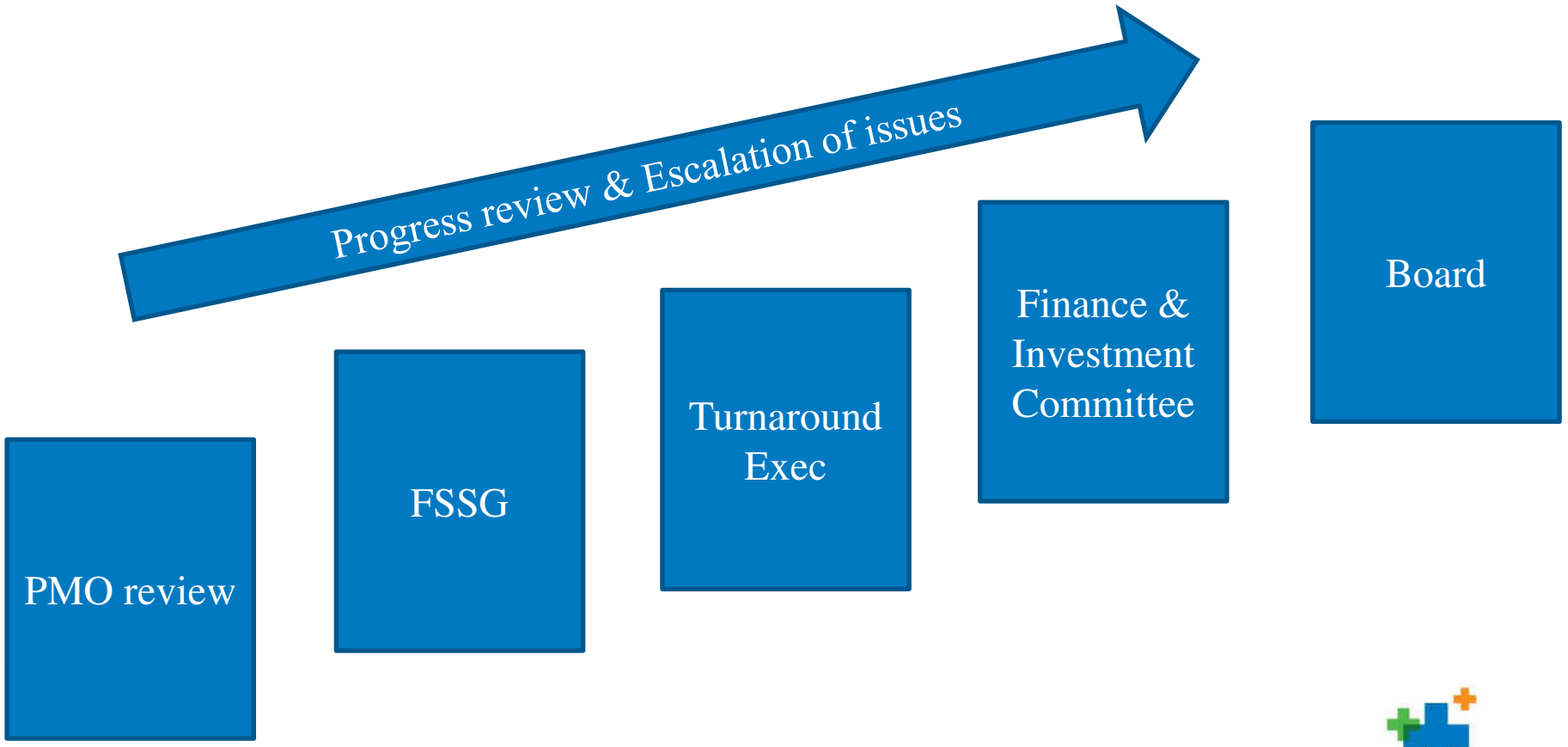
- Agree validation/tracking process
- Define KPIs – (consider benchmarking)
- Develop Dashboard/Tracker for initiative & phasing (PMO/Finance support)
- Define potential risks & mitigation – risk log
- Establish communication requirements (PMO support)
- Assess impact on quality (complete QIA – PMO/DCN support)

- Approval/Sign off of delivery plans
- Removal of approved savings from directorate budget
- Develop overall Financial Improvement Programme Tracker and reporting requirements

Monitoring & Reporting

- Establish CIPs performance reporting at department/directorate/Exec/Committee & Board level (actuals against plan and forecast)
- Weekly review of initiative tracker – CIPs Leads/PMO/Finance
- Fortnightly review – PMO/CIPs leads – attendance at Financial Sustainability Steering Group (FSSG)
- Monthly savings validation – Finance
- Quarterly Exec review – star chamber
- Corrective action taken where necessary
- Half yearly assessment of in – year progress and identification of future years pipeline

Escalation of risks & issues



South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	211/16

Name of meeting	Board Meeting
Date	28th March 2017
Name of paper	Integrated Performance Dashboard
Executive sponsor	David Hammond
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 & Patient Safety 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 response time performance was under the trajectories for Red 1, Red 2 and Red 19 for February. The 999 improvement plan, with the exception of the hospital turnaround performance remains on track. Hospital handover delays continue to affect job cycle time and remain higher than expected. The Trust lost 12% more hours (5,464) in February compared to 4,891 hours compared to the same period last year. This was despite transporting 16% fewer patients to hospital. SECAmb has been working with both commissioners and acute hospitals to strengthen its hospital handover procedures and reduce delays at hospital.

Demand was circa 2.6% lower than that agreed with commissioners for the month but still 3.75% above last year's YTD position. SECAmb has increased its call answer performance in February to the highest position in over 12 months.

KMSS 111 achieved its best monthly operational performance of 2016-17, in returning an "Answered in 60" Service Level Agreement (SLA) KPI of 92.5% in February.

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, at or above the levels attained in the previous year.

For the Clinical Outcome Indicators, the Trust's performance for October 2016 was better than the national average for four of the eight Indicators including ROSC, ROSC Utstein, STEMI 150 and Stroke 60, three of which were are in the top three performing Trusts nationally. The poorest performance was for STEMI 150 with a 15.6% negative variance. Survival to Discharge Utstein also had a 10.3% negative variance against the national average. The other two indicators below the national average were Survival to Discharge and Stroke Care Bundle.

Short term sickness levels have decreased from 3.2% to 2.7% following the negative variance attributable to seasonal illnesses in December and January long term sickness absence remains stable at 2.5%. Appraisals remain below target and Mandatory training has seen an increase but is still below target, however it is expected that Mandatory training compliance will deliver on target.

Complaints have demonstrated an improvement in response rates, the top three most recurrent themes for complaints have remained the same for two months. Incident reporting remains constant with an increase in overall reporting. The DATIX rebuild has remained on track to deliver the new and revised modules which will ensure the system is user friendly to encourage reporting and support better thematic analysis. Serious incident reporting remains consistent, themes for this month, possible incorrect patient pathways. Safeguarding training has shown an improvement in month for level 1 and level 2 training but remains off trajectory for the quarter. The pilots complete in March for level 3 training currently at 64% for February aiming to be 82% in March.

The Trust's financial performance for month 11 reflects a deficit of £0.4m which is in line with the forecast. This takes the YTD deficit to £6.7m compared with the £0.7m surplus position assumed in the plan. The expected outturn at the end of the year is £7.1M as has been forecast since Q1.

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 levels have decreased from 3.2% to 2.7% following the negative variance attributable to seasonal illnesses in December and January Long term sickness absence remains stable at 2.5%.

2.1.2. Appraisals remain below target and Mandatory training has seen an increase but is still below target, however it is expected that Mandatory training compliance will deliver on target.

2.2. Workforce Balanced Scorecard

Workforce Commentary :- Data from Feb 2017 and Jan 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		**2.7%**	2.5%		**2.7%**	2.5%
Wf-1B	Long Term Sickness - Rate		**2.5%**	3.5%		**2.5%**	3.5%
Wf-2	Staff Appraisals	83%	**49.6%**	63.0%			
Wf-3	Mandatory Training Compliance (All Courses)	95%	**81.9%**	89.9%			
Wf-4	Total injuries		**66**	56		**681**	688
Wf-5	Total physical assaults		**14**	12		**194**	175
Wf-6	Vacancies (Total WTE)		**286.8**			Not Relevant	
Wf-7	Annual Rolling Staff Turnover		**16.6%**	14.3%			
Wf-8	Reported Bullying & Harassment Cases		**0**			**14**	
Wf-9	Cases of Whistle Blowing		**0**			**3**	

2.3. Workforce Commentary

2.3.1. The work of the HR Advisor team has seen short term sickness absence figures drop from 3.2% to 2.7% following the negative variance attributable to seasonal illnesses in December and January Long term sickness absence remains stable at 2.5% again managed via the HR Advisor team.

2.3.2. The improvement in the accuracy of establishment figures continues to support better recruitment activity with a further reduction in the vacancy numbers from 323 WTE to 287 WTE and an overall vacancy rate of 8.2% down from 9.3% in January and 9.4% in December. The resourcing are working to clearly defined establishment figures recognised by the managers which has greatly increased the efficiency of the team.

2.3.3. There has been a slight improvement in the turnover rate from the previous month. This figure is likely to remain constant over the next few months until the increased staff engagement activities take effect.

2.3.4. As expected appraisals remain below target. The roll out of the online appraisal system, Actus, will start from April which will support the delivery of the declared target by March 2018.

2.3.5. Mandatory training has seen an increase but is still below target. There is a strong push to get all mandatory training completed by the end of March, with an expectation this will be delivered.

2.3.6. There have been no new formal Whistleblowing or Bullying and Harassment cases. The lack of formal bullying and harassment cases is in contrast to the staff survey figures which shows significant issues in this area. The survey currently underway and facilitated by Duncan Lewis will help us assess the true situation.

2.3.7. SECAmb do not report an agency worker metric but it may be worth bringing to the Board's attention the work in this area. In January the Trust engaged 170 agency workers, this has dropped to 99 at the time of writing and is expected to be below 60 by the end of April. This increased control and rigour has been a joint working effort between the HR and Finance teams.

2.4. Workforce Charts

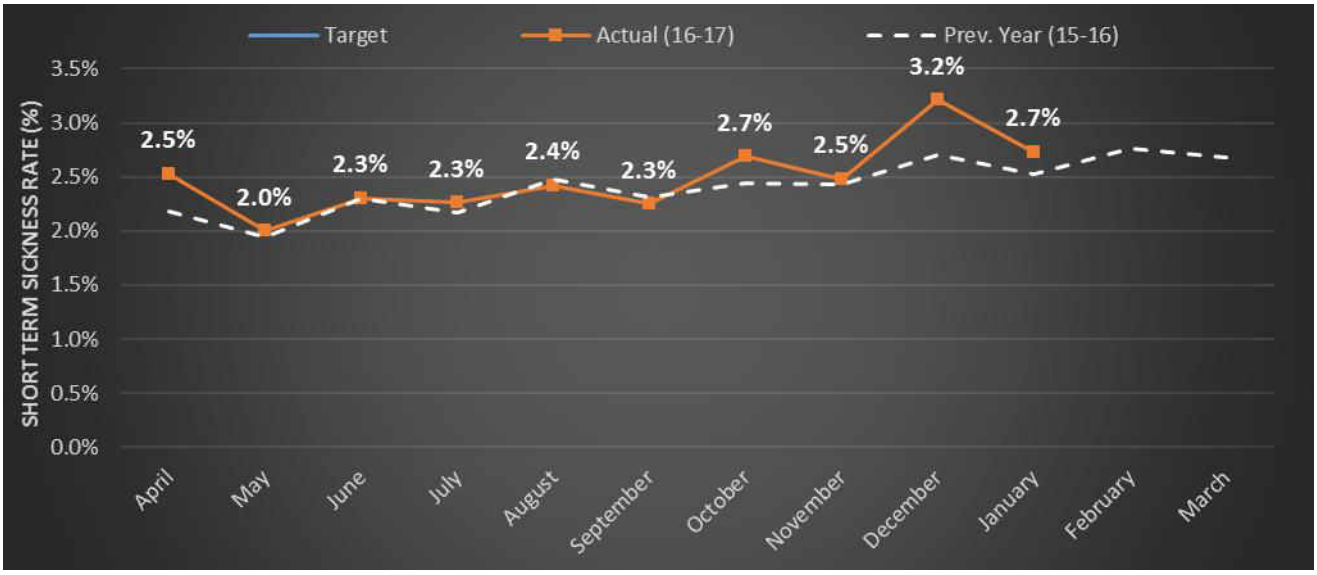


Figure Wf-1A - Short Term Sickness Rate

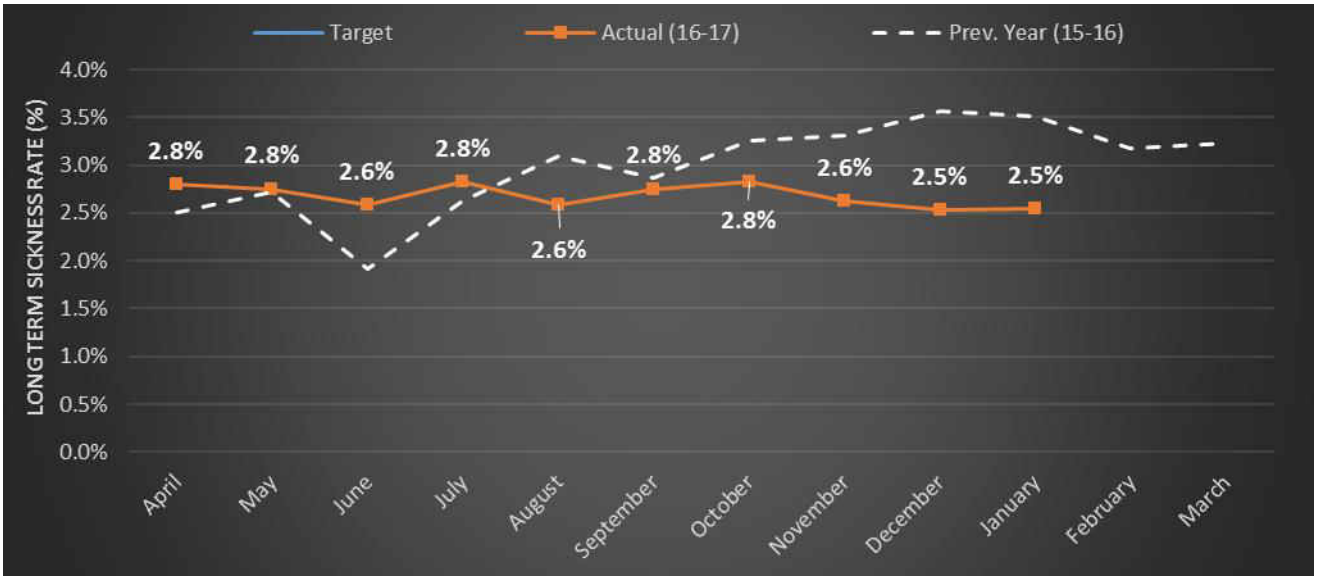


Figure Wf-1B - Long Term Sickness – Rate

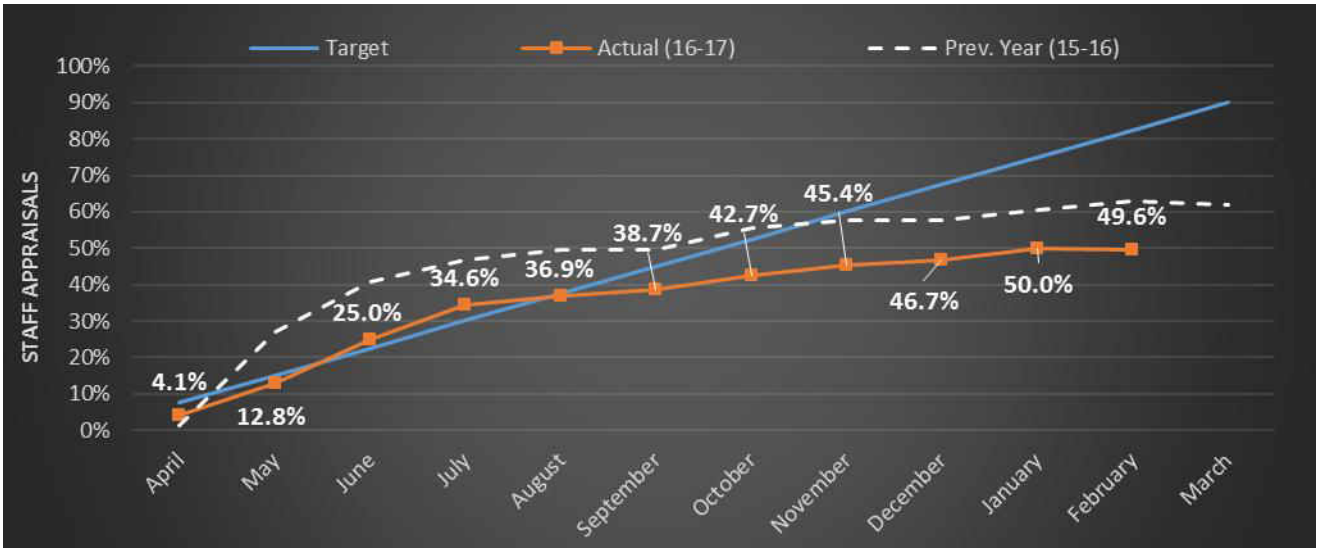


Figure Wf-2 - Staff Appraisals

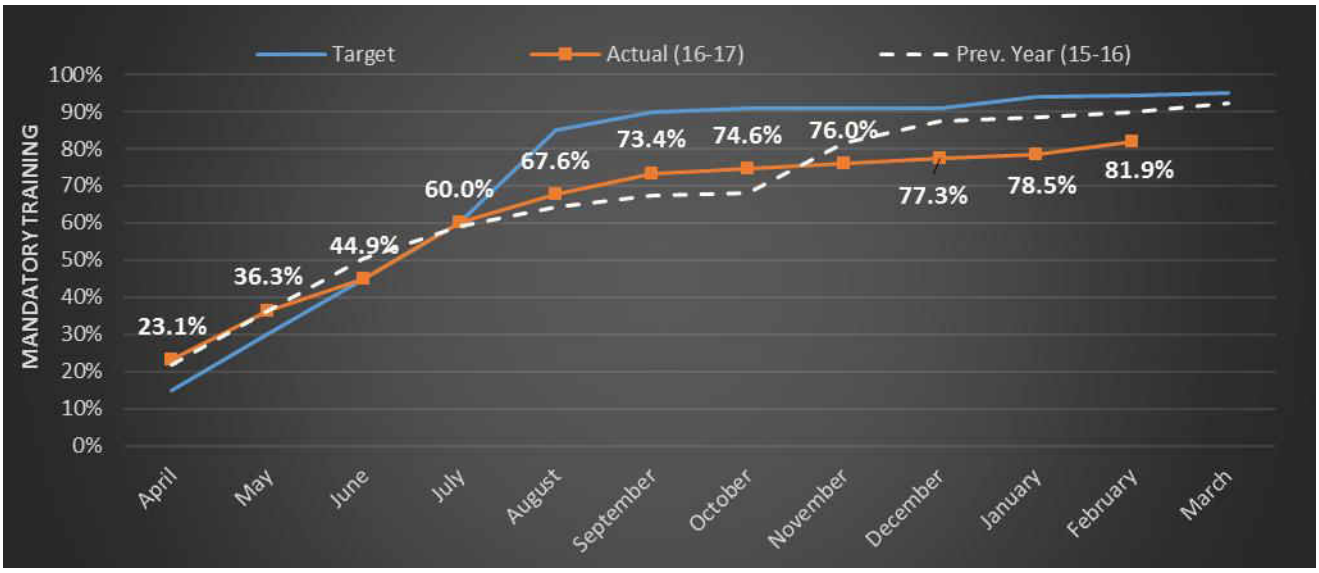


Figure Wf-3 - Mandatory Training Compliance (All Courses)

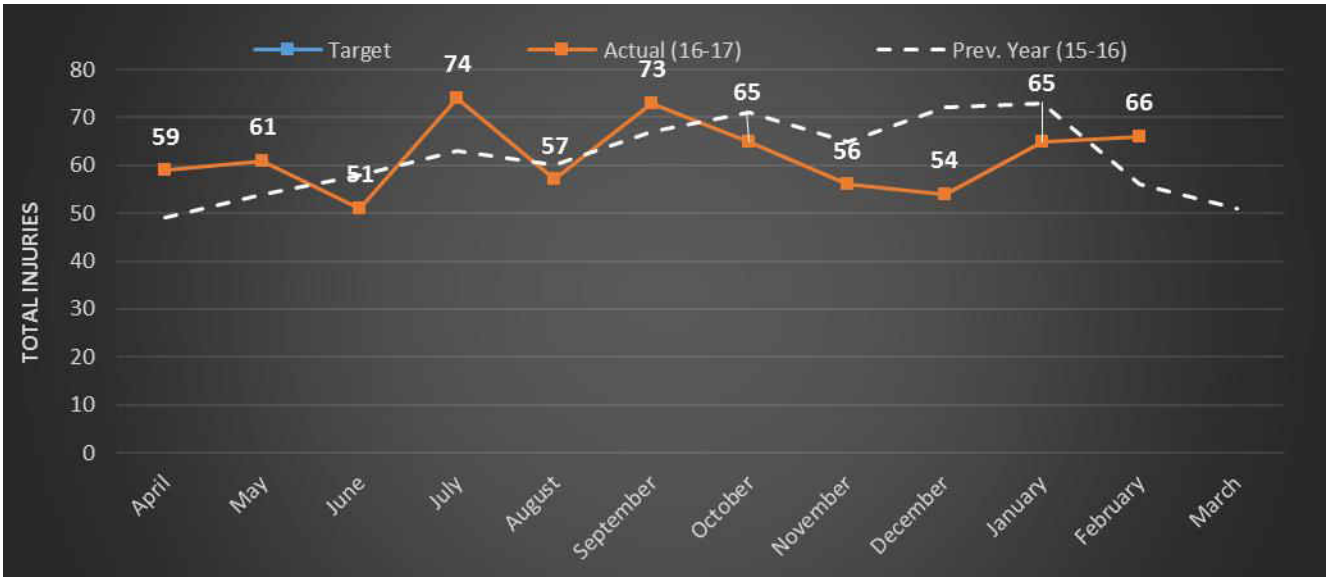


Figure Wf-4 - Total injuries.

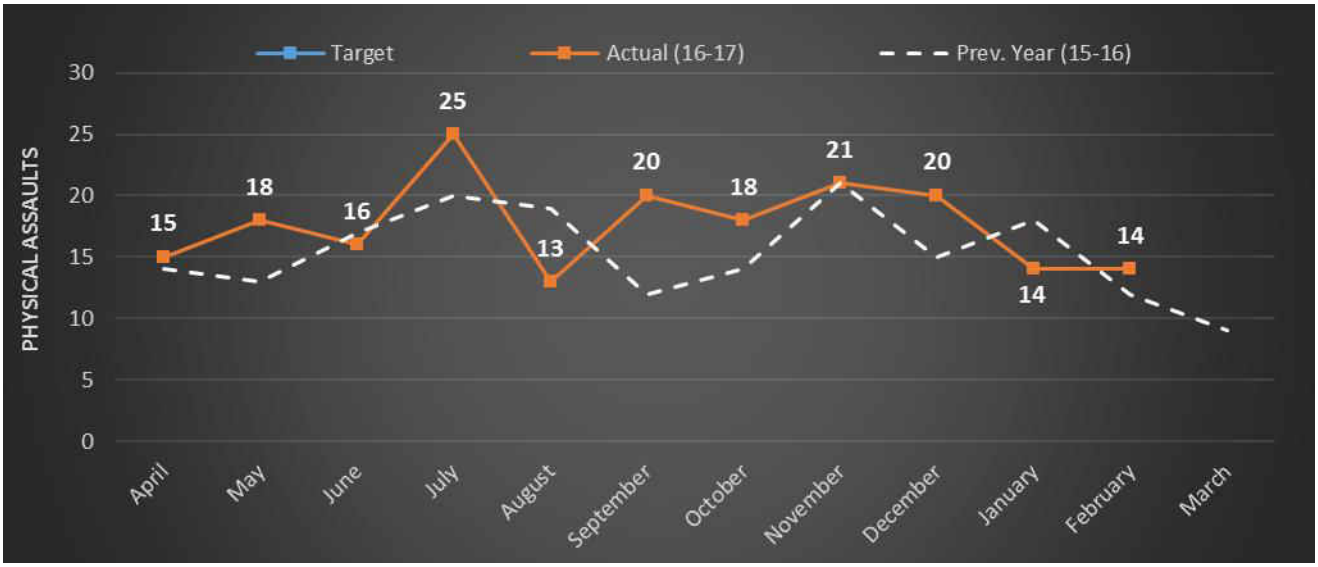


Figure Wf-5 - Total physical assaults.

Figure Wf-6 - Vacancies (Total WTE)

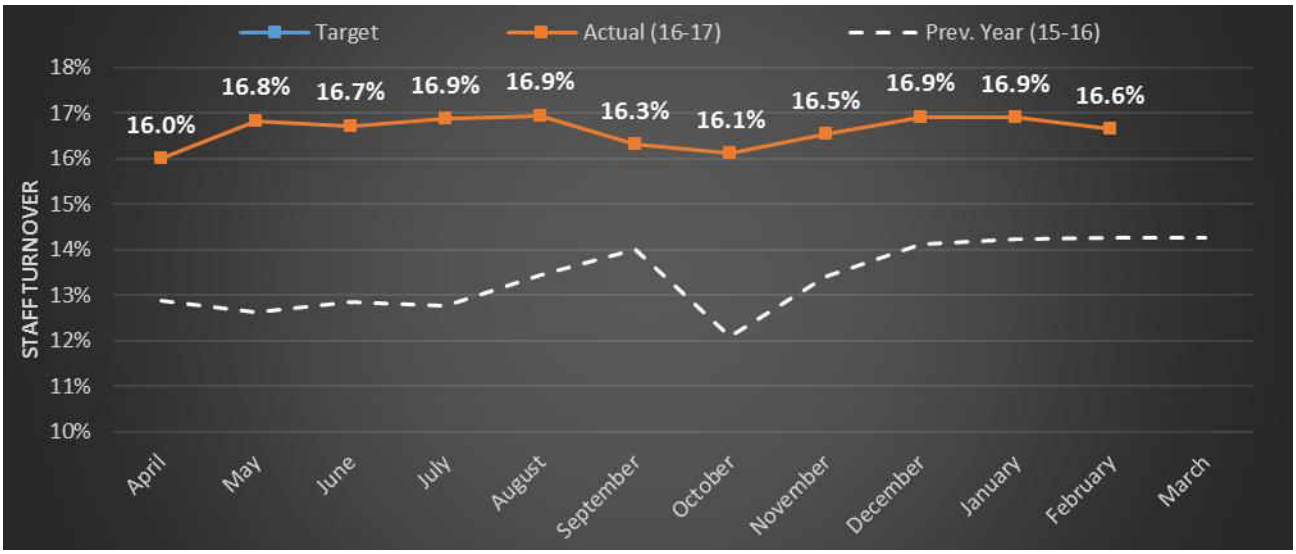


Figure Wf-7 - Annual Rolling Staff Turnover

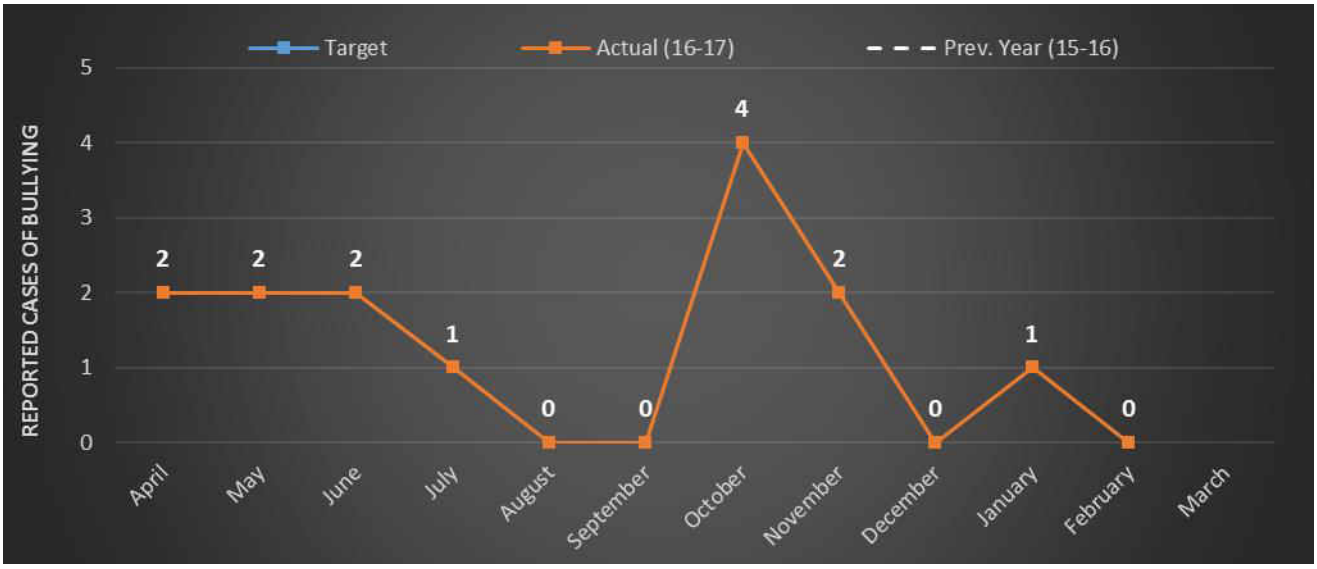


Figure Wf-8 - Reported Bullying & Harassment Cases

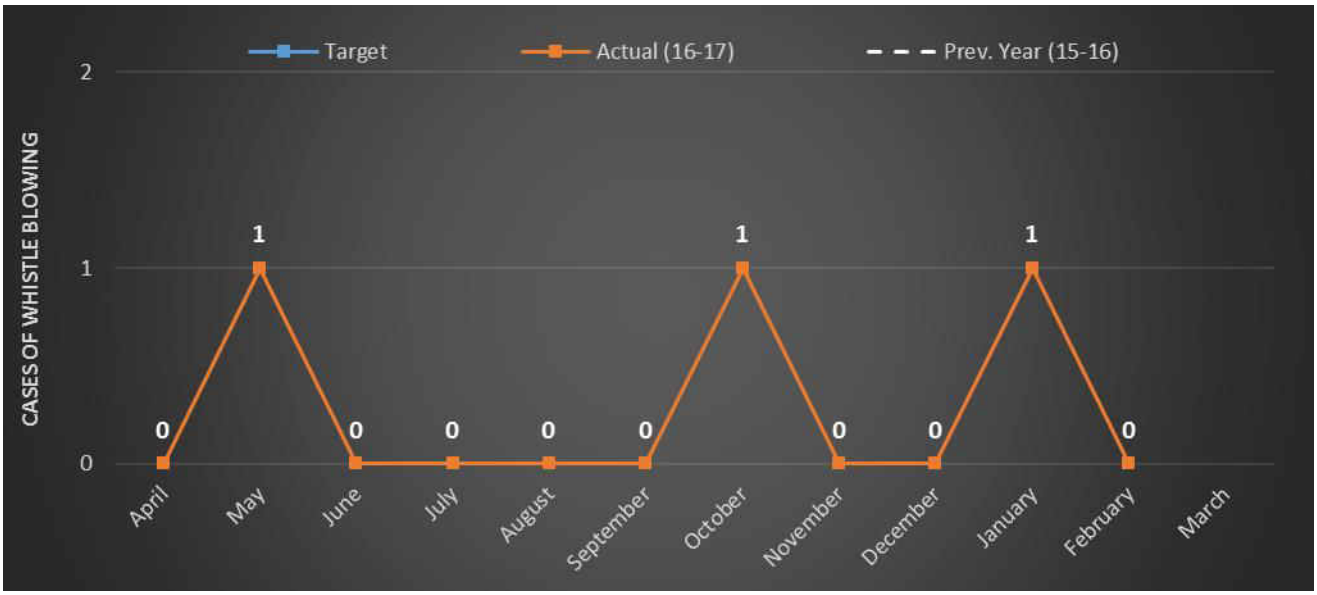


Figure Wf-9 - Cases of Whistle Blowing

3. Operational Performance

3.1. Operational Performance Summary

3.1.1. 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 February.

3.1.1. The 999 Improvement Plan, with the exception of the Hospital Turnaround performance remains on track. Hospital delays in February were better compared with the circa 7700 hours in December and 7950 in January, which were 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.

3.1.2. Demand was circa 2.6% lower than that agreed with commissioners for the month but still 3.75% above last year's YTD position. SECAmb has increased its call answer performance in February to the highest position in over 12 months.

3.1.3. KMSS 111 achieved its best monthly operational performance of 2016-17, in returning an "Answered in 60" Service Level Agreement (SLA) KPI of 92.5% in February. Despite the underlying reduction in like-for-like call volumes compared to the winter surge that was prevalent in February 2016, other NHS 111 service providers have been unable to sustain a similar level of resilience and operational performance, as seen by the NHS England SLA average for February of 89.4%.

3.1.4. 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, at or above the levels attained in the previous year.

3.2. Operational Performance Scorecard

Operational Performance Scorecard:- Data From February 2017

ID	KPI	Current Month (Plan*)	Current Month (Actual)	Current Month (Prev.	YTD (Plan*)	YTD (Actual)	YTD (Prev. Yr.)
999-1	Red 1 response <8 min	68%	65.7%	65.4%		64.6%	72.6%
999-2	Red 2 response <8 min	57%	49.8%	57.7%		52.7%	69.1%
999-3	Red 19 Transport <19 min	91%	87.6%	91.3%		89.1%	94.5%
999-4	Activity: Actual vs Commissioned	63759	62138	66093	723775	750927	719170
999-5	Hospital Turn-around Delays (Hrs lost >30 min.)	2627	5464	5123	26510	62977.6	41355.3
999-6	Call Pick up within 5 Seconds	92%	90.8%	82.0%		76.6%	87.2%
999-7	CFR Red 1 Unique Performance Contribution	1.5%	2.2%				
999-8	CFR Red 2 Unique Performance Contribution	1.2%	1.5%				
111-1	Total Number of calls offered		79876	102628		1042491	1078300
111-2	% answered calls within 60 seconds	85%	92.5%	65.0%	85%	79.0%	82.5%
111-4	Abandoned calls as % of offered after 30 secs	5.0%	0.7%	9.3%	5.0%	4.2%	3.3%
111-5	Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)	77%	73.6%	73.8%		74.6%	86.5%
PTS-1	PTS Activity (Surrey)	11180	8578	12055	129632	114188	161233
PTS-2	Arrival - % patients to arrive <= 15 min after appt. time.	95%	87.2%	88.8%	95%	86.5%	84.1%
PTS-3	Departure - % patients collected <= 60 min of planned collection time (Surrey)	95%	84.3%	90.5%	95%	86.1%	84.7%
PTS-4	Discharge - % patients collected <= 120 min of booked time to travel (Surrey)	95%	76.7%	77.2%	95%	79.9%	76.2%

** 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.*

3.3. Operational Performance Commentary

3.3.1. The Red 1 position was improved on the January position but less than the revised February target. The slight improvement in Red 2 performance compared to January is much lower than anticipated given the significant reduction in activity compared to January. Hospital Turnaround delay would have impacted on this but further investigation is ongoing as to what is generating such a low level of performance.

3.3.2. Demand was circa 2.6% below the plan agreed with commissioners for the month but Year to Date (YTD) was still 3.75% above last year's position. Both activity and performance continues to show a slow but steady improvement based on the March performance to date.

3.3.3. 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.

3.3.4. 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 February are above the planned trajectories for this group of responders.

3.3.5. SECAmb has maintained its Hear and Treat performance for February. There is already an encouraging improvement in the Hear and Treat ratios and further recruitment of clinicians continues, SECAmb has 40 WTE in post and are aiming for a total 45 WTE to support the NHS Pathways activity. The concept of an additional pool of clinicians to undertake a dedicated Clinical Assessment Team for the 2017/2018 year is being put together, this will prepare SECAmb for its phase 2 of the Ambulance Response Programme changes to incident categorisation.

3.3.6. Call answer performance improved from last month's performance despite the February activity and SECAmb achieved 90.8% in 5 seconds compared to a revised trajectory plan of 92%. Despite not meeting the revised target this is the best performance for call answering in over 12 months.

3.3.7. 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 February were better compared with the circa 7950 hours in January which was over double the maximum level agreed with commissioners. February still saw 5464 lost hours which was the single biggest impact on our performance trajectory for February. Hospital Turnaround delay is the single most external 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.

3.3.8. KMSS 111 achieved its best monthly operational performance of 2016-17, in returning an "Answered in 60" Service Level Agreement (SLA) KPI of 92.5% in February. Despite the underlying reduction in like-for-like call volumes compared to the winter surge that was prevalent in February 2016, other NHS 111 service providers

have been unable to sustain a similar level of resilience and operational performance, as seen by the NHS E SLA average for February of 89.4%.

3.3.9. The service continued to achieve the 95% target during weekdays on a routine basis. Although weekends continue to be more challenging, the service only reported six "red" days for the month. The Call Abandonment rate dropped to below 1%, compared to a national benchmark of 2.2% and the formal contractual target of 2%.

3.3.10. Whilst improving and embedding the service's operational performance, KMSS 111 continues to exceed the national average for the Combined Clinical KPI of immediate warm transfer or a clinician call-back within ten minutes. The service year to date for 2016/17 has achieved a Combined Clinical KPI of 74.6%. This has been delivered despite clinical resource being redirected to mobilise the Clinical In-line Support (CIS) function, provided by specifically planned "floor-walking" clinicians which has helped increase KMSS 111's overall clinician contact for its cases (29% for January 2017) and more importantly, has enabled the service to continue returning an Emergency Department referral rate (6.9%), lower than the NHS E average (7.3%).

3.3.11. The Ambulance referral rate was higher than the NHS E average for this month however the service continues to refine its ambulance validation processes and is currently undertaking call profiling modelling work to ensure that KMSS 111 maximises the impact of its CIS when our 999 colleagues (and patients) most need this clinical intervention and support.

3.3.12. The overarching trends for both of these referral rates is downward. Despite its operational improvement, the ED and 999 referrals remain key areas of focus, in line with the recent communication from NHS E relating to "Managing A&E Demand". As agreed with Commissioners, there is also now a greater representation of the KMSS 111 Senior Management Team (SMT) at A&E Delivery Boards and other external forums. The service is developing proposals to mitigate referrals and conveyances to Emergency Departments, especially in relation to how call handlers can maximise their utilisation of services presented on the Directory of Services (DoS). KMSS 111 is also planning to capture an accurate and automatically generated measurement of our clinical contact for cases, which is currently under-reported due to system limitations. An IT solution is due to be implemented in March 2017 that should permit this key (non-contractual) NHS E data-set to be captured and reported on more easily and accurately. This will aid our progress towards realising Simon Stevens' NHS England objective that "the number of 111 calls receiving clinical assessment increases by a third before March 2018." These proposals also form an integral part of ongoing discussions with Commissioners relating to the KMSS 111 Contract Phased Migration, incorporating potential collaboration with other service providers on Integrated Urgent Care pilots and proofs of concept.

3.3.13. KMSS 111 is anticipating a strong finish to the 2016-17 reporting year, representing a successful journey from a very difficult and uncertain operational environment twelve months ago towards now achieving full service stability.

3.3.14. Beyond March, KMSS 111 is planning for Quarter 1 of the new financial year and in particular, the Easter weekend and following Public Holidays in May. Currently there are three large cohorts of Health Advisors in training across both Contact Centres and this new HA resource has predominantly been recruited on a weekend shift basis. The service has acted flexibly and creatively in scheduling and accelerating the training programmes to allow new HA's to achieve full proficiency in time for the pressures and increased call activity of the Easter weekend. With the addition of ongoing clinical

recruitment, we are confident of commencing 2017-18 as one of the highest-performing and innovative NHS 111 services nationally.

3.4. Operational Performance Charts

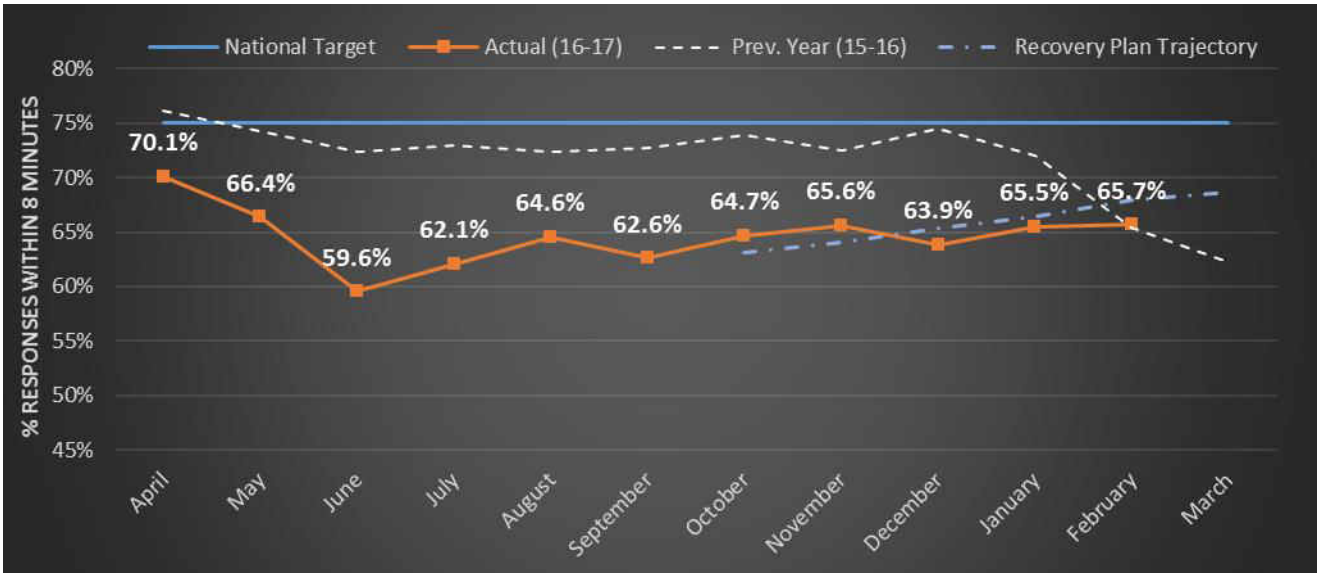


Figure.999-1 - Red 1 response <8 min

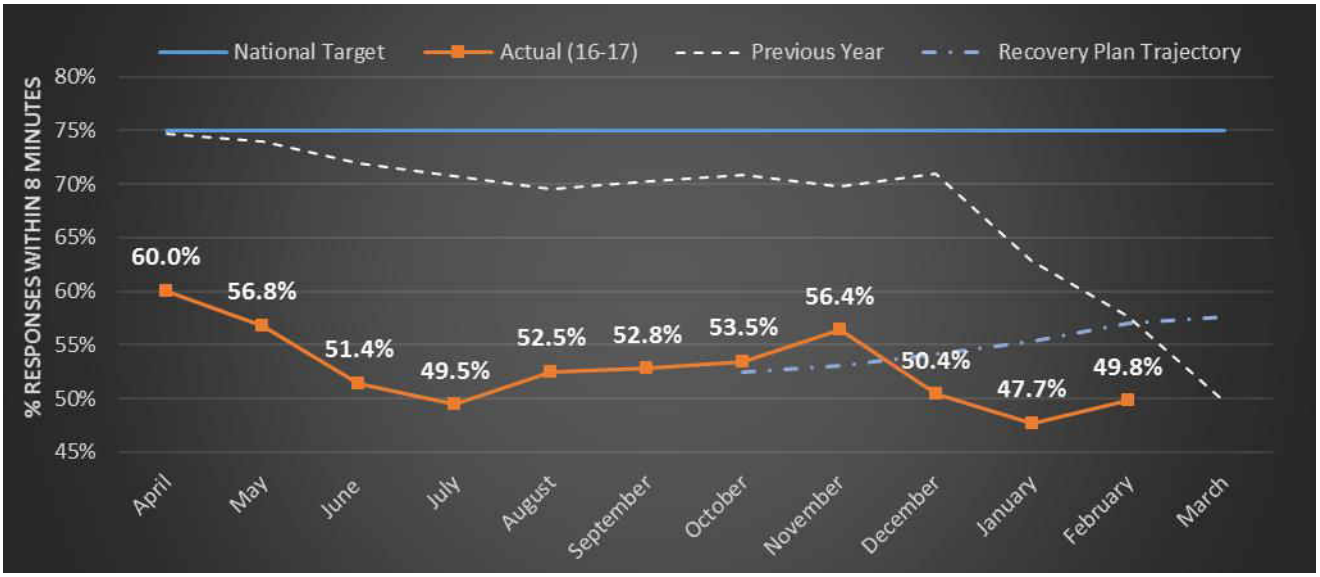


Figure.999-2 - Red 2 response <8 min

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

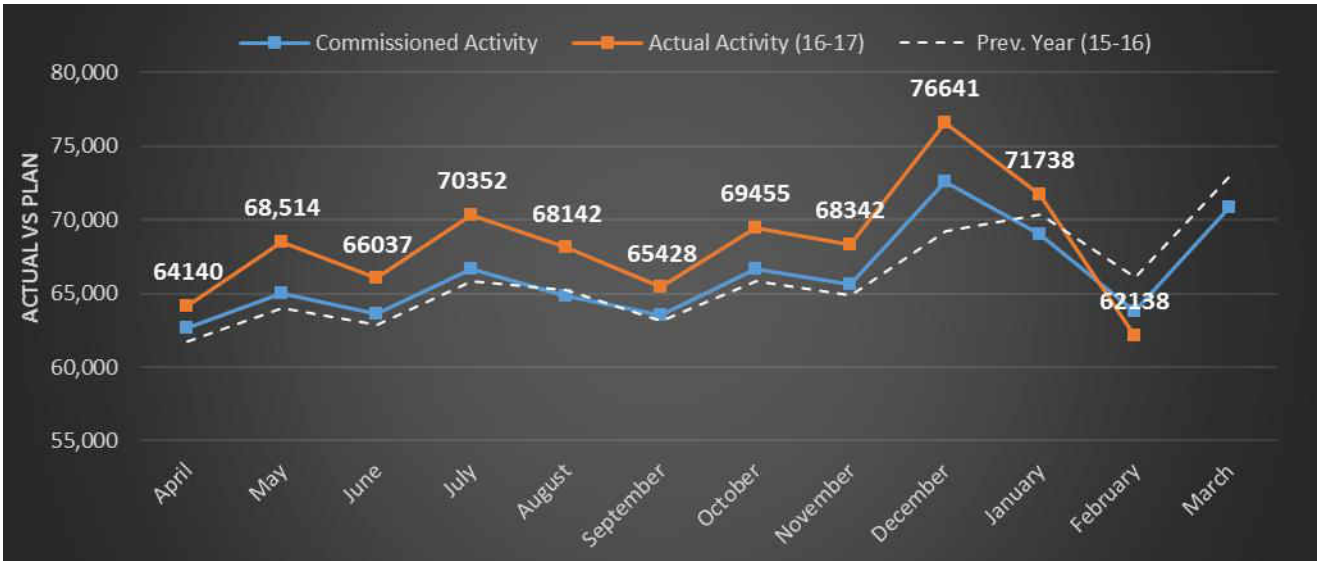


Figure.999-4 - Activity: Actual vs Commissioned

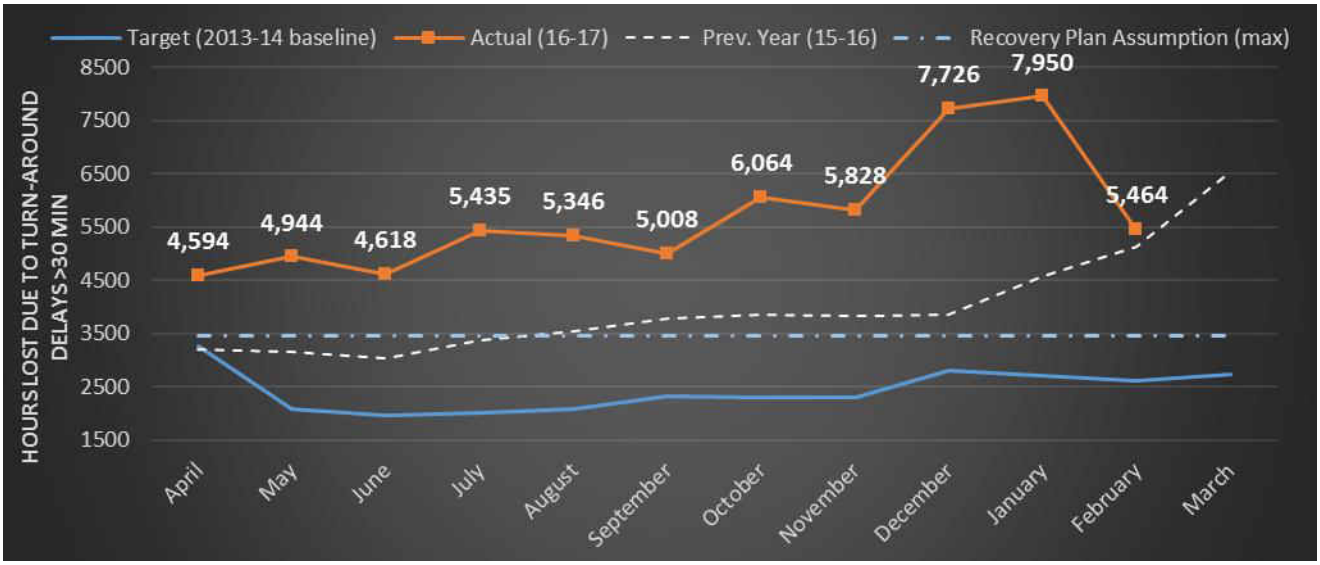


Figure.999-5 - Hospital Turn-around Delays (Hrs lost >30 min.)

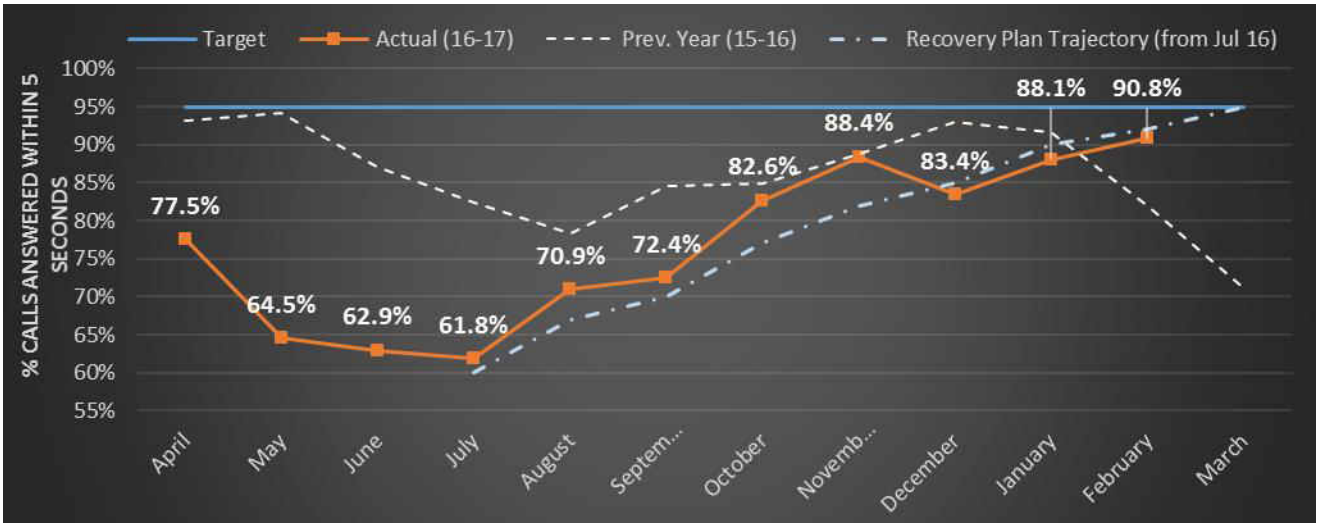


Figure.999-6 - Call Pick up within 5 Seconds

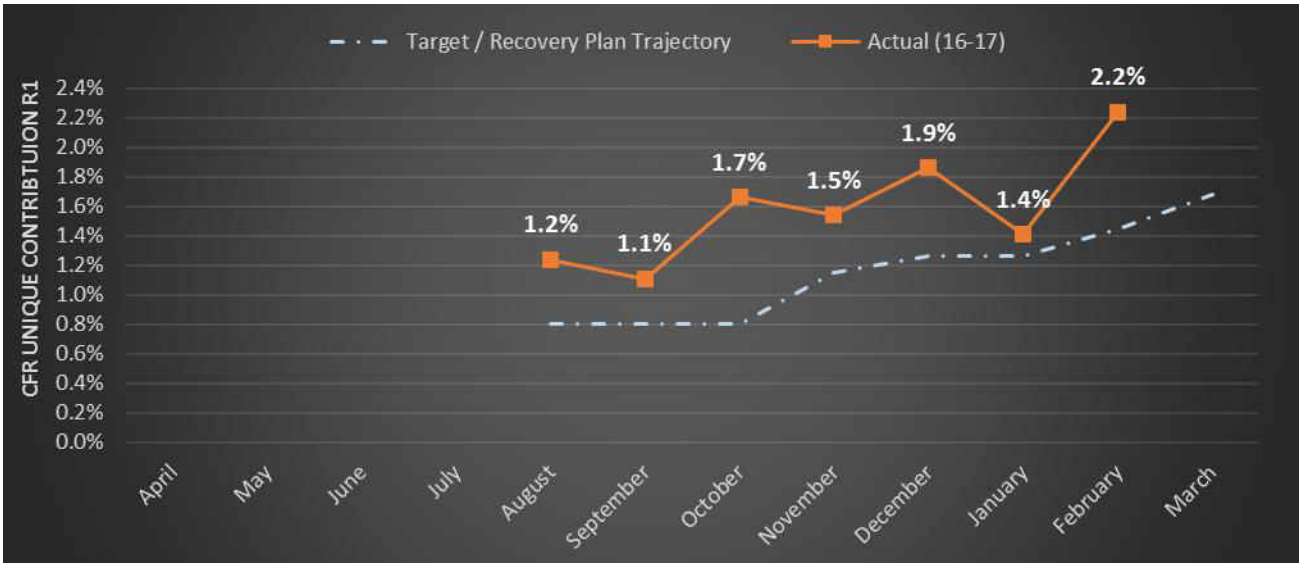


Figure.999-7 - CFR Red 1 Unique Performance Contribution

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

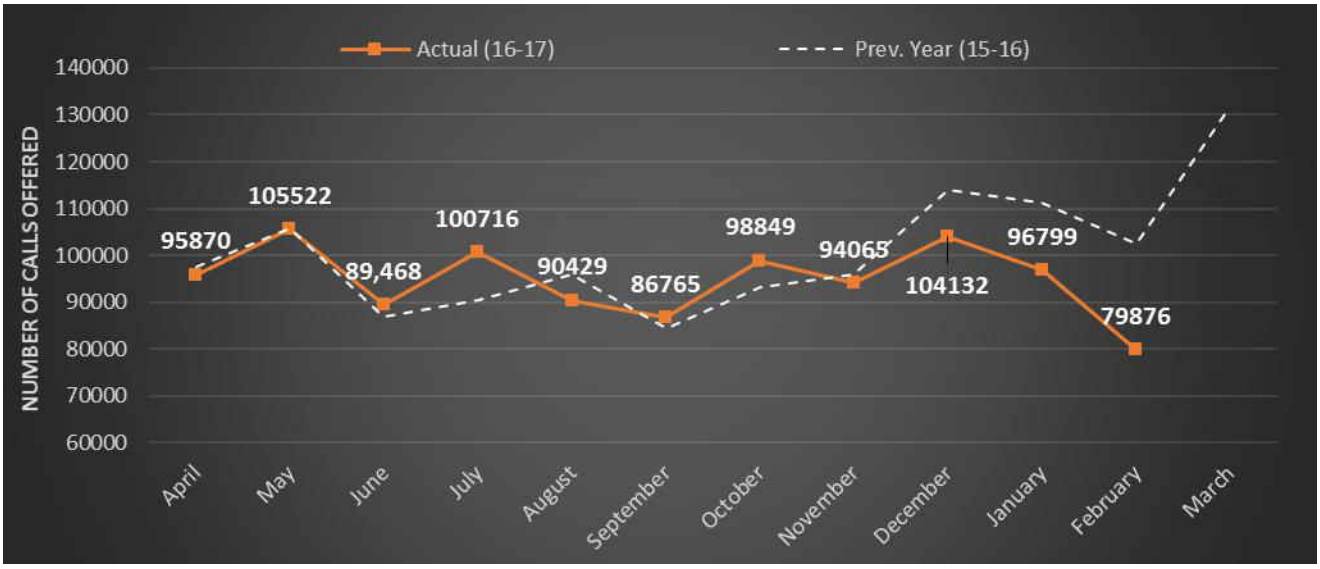


Figure.111-1 - Total Number of calls offered

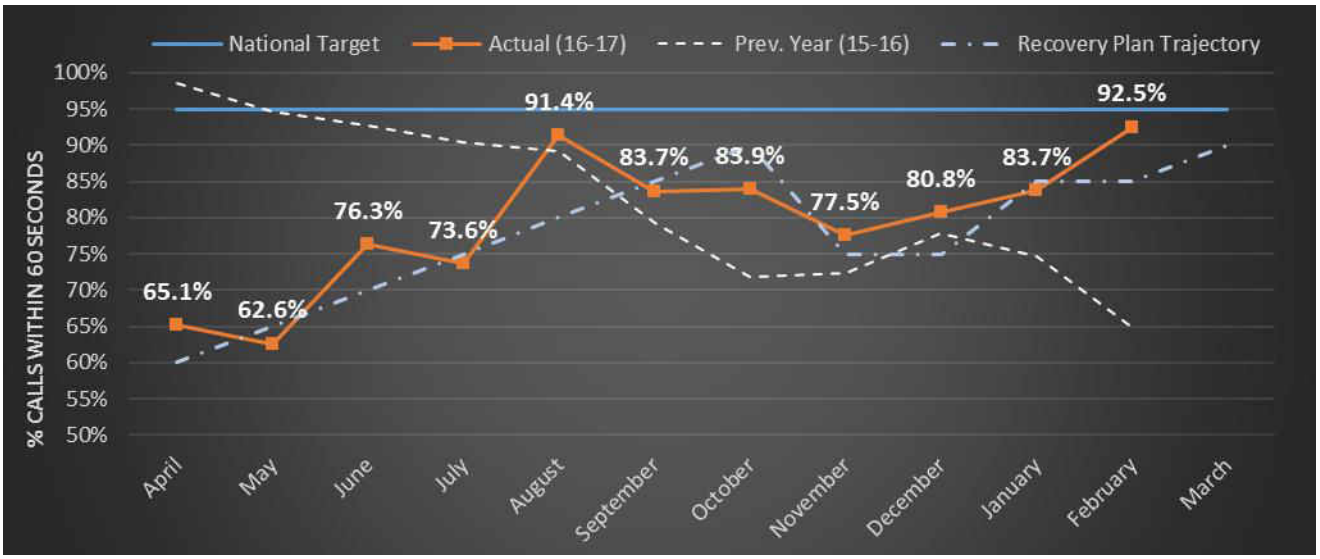


Figure.111-2 - % answered calls within 60 seconds

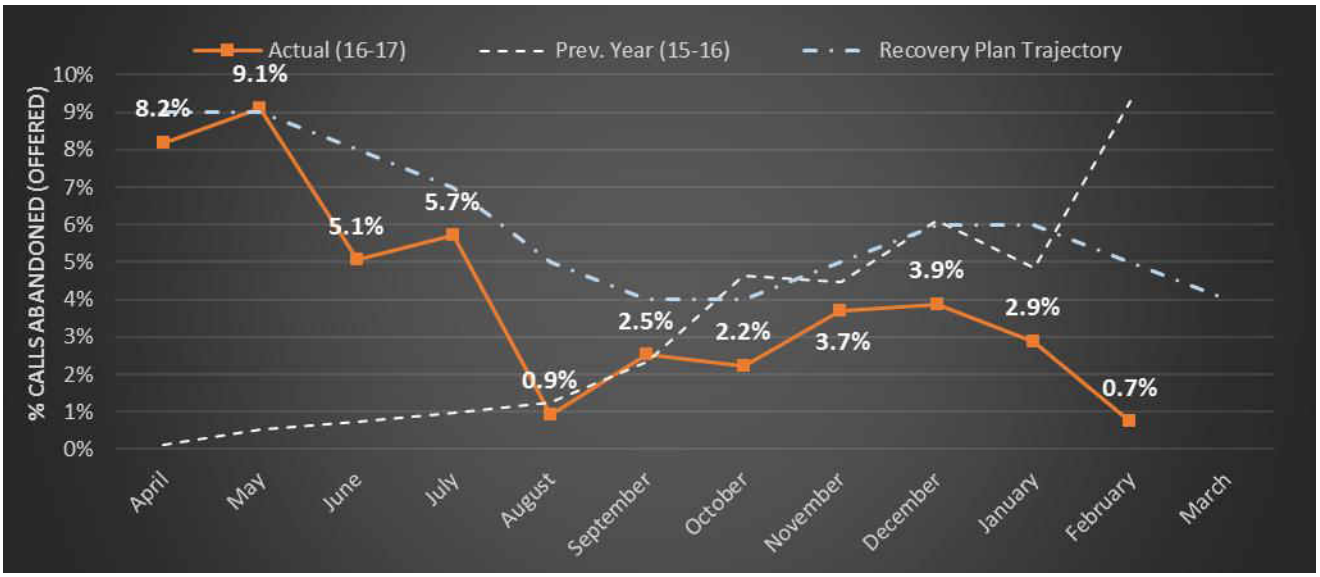


Figure.111-4 - Abandoned calls as % of offered after 30 secs

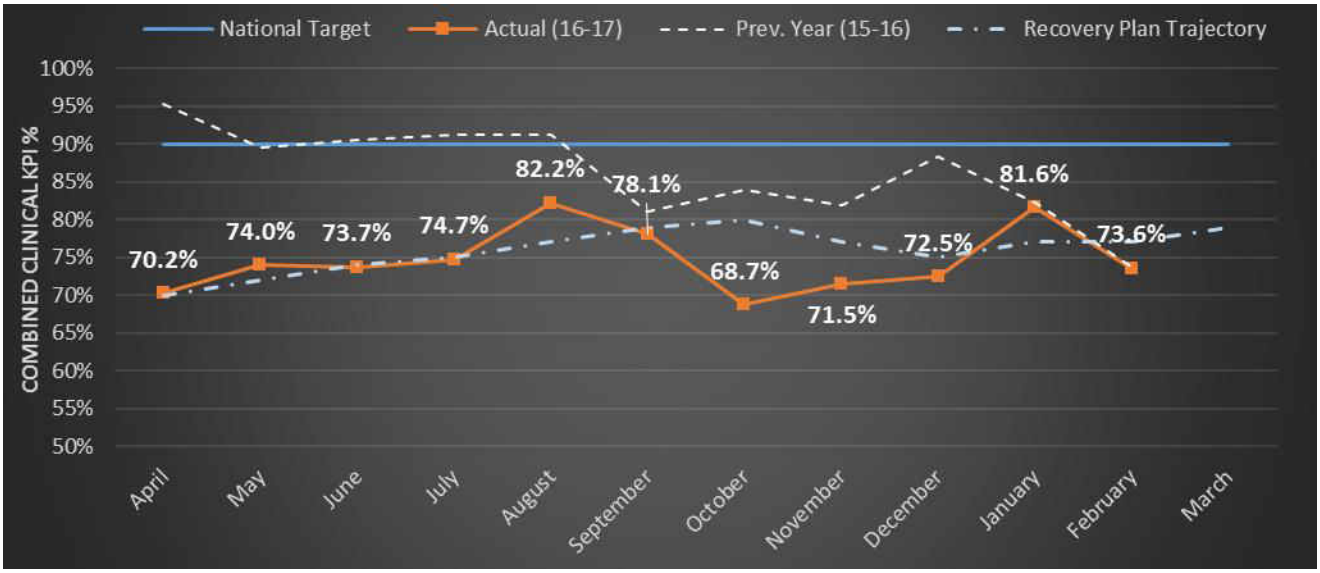


Figure.111-5 - Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)

Figure.PTS-1- PTS Activity (Surrey)

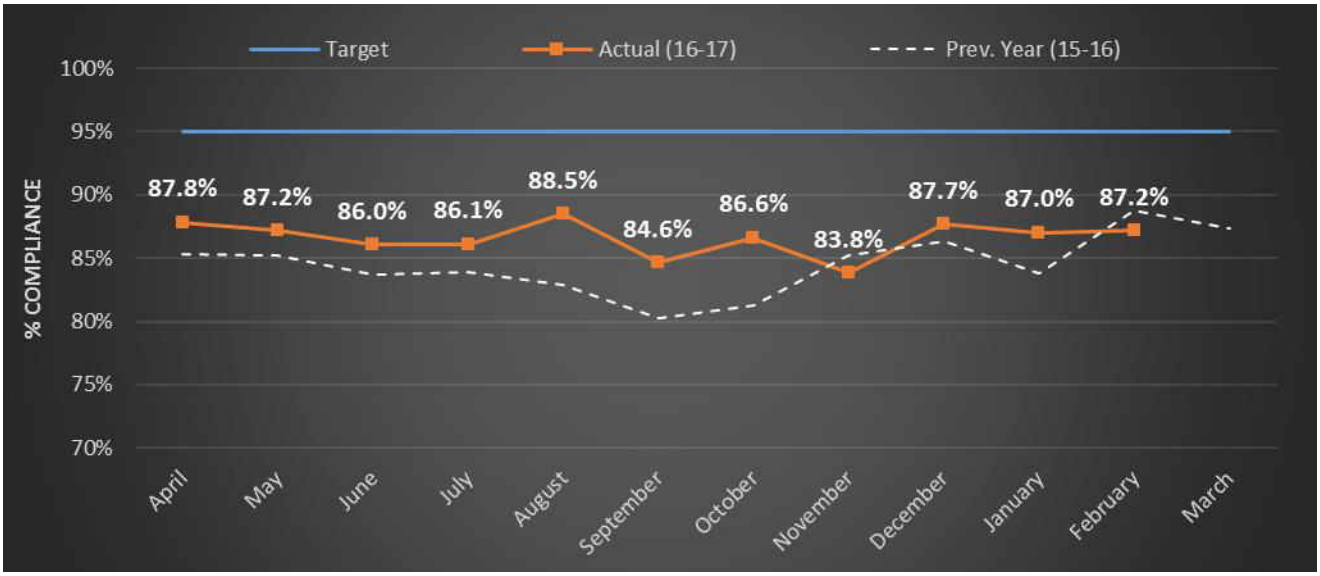


Figure.PTS-2 - Arrival - % patients to arrive <= 15 min after appt. time. (Surrey)

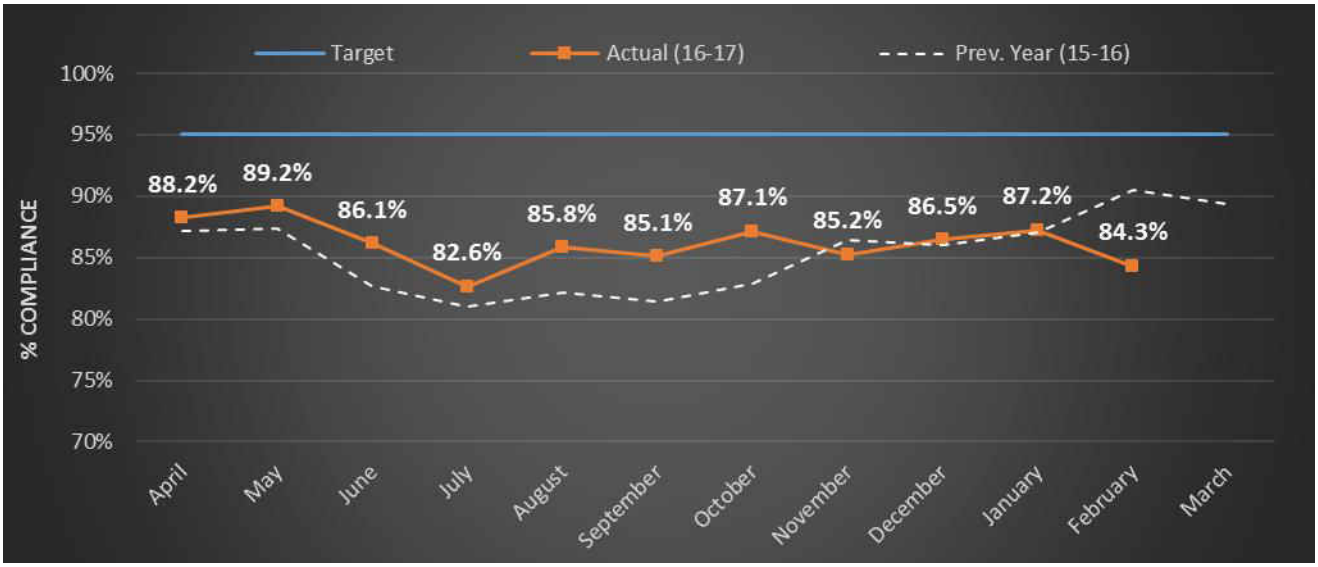


Figure.PTS-3 - Departure - % patients collected <= 60 min of planned collection time (Surrey)

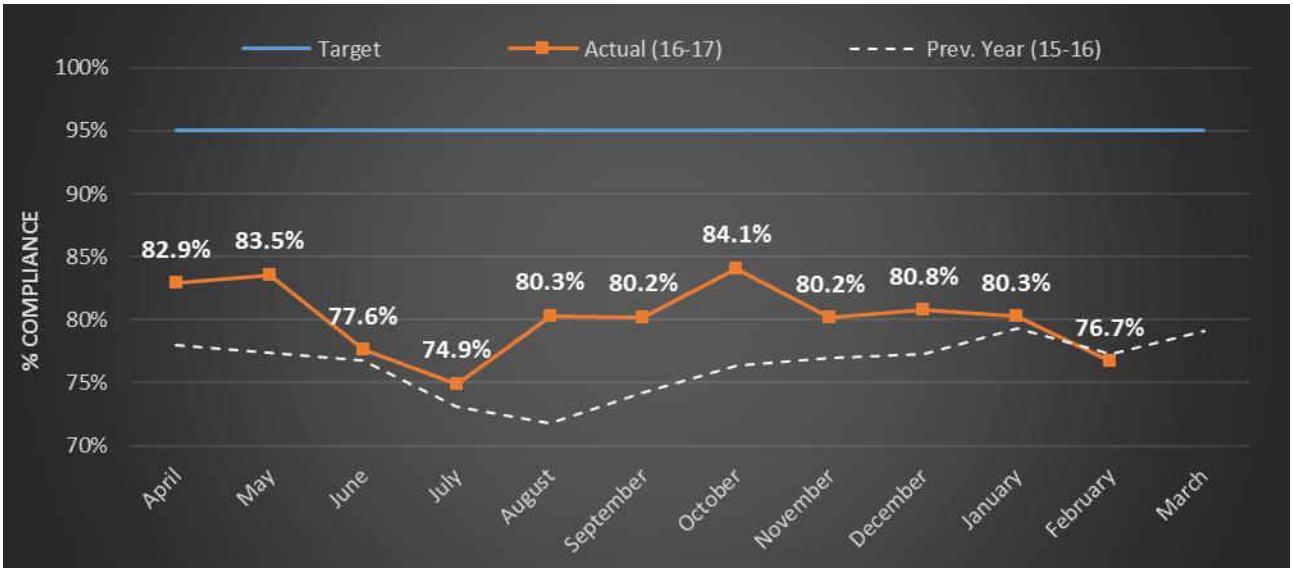


Figure.PTS-4 - Discharge - % patients collected <= 120 min of booked time to travel (Surrey)

4. Clinical Effectiveness

4.1. Clinical Effectiveness Summary

4.1.1. This report describes Trust performance reported against eight Clinical Outcome Ambulance Quality Indicator (AQIs) to NHS England for Month 7 (October 2016). The data continues to show variable standards in delivering patient outcomes.

4.2. 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)	47.6%	**48.1%**	54.5%	51.8%	**53.6%**	48.8%
CE-2	Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)	26.6%	**27.8%**	28.4%	28.6%	**27.9%**	27.3%
CE-3	Cardiac arrest -Survival to discharge - Utstein	25.7%	**15.4%**	22.2%	26.9%	**27.0%**	23.8%
CE-4	Cardiac arrest -Survival to discharge - All	7.8%	**4.3%**	8.0%	8.8%	**7.9%**	8.5%
CE-5	Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)	78.7%	**63.1%**	77.4%	79.5%	**68.3%**	68.3%
CE-6	Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes	86.4%	**96.9%**	92.7%	86.3%	**91.8%**	93.4%
CE-7	% of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes	51.7%	**62.6%**	67.0%	54.4%	**66.5%**	65.5%
CE-8	% of suspected stroke patients assessed face to face who received an appropriate care bundle	97.6%	**95.4%**	97.4%	97.6%	**95.9%**	96.4%

4.3. Clinical Effectiveness

4.3.1. In October the Trust's performance was better than the national average for four of the eight Clinical Outcome Indicators; ROSC, ROSC Utstein, STEMI 150 and Stroke 60, three of which were are in the top three performing Trust.

4.3.2. The poorest performance was for STEMI 150 with a 15.6% negative variance and Survival to Discharge Utstein with a 10.3% negative variance against the national average. The other two indicators below the national average are, Survival to Discharge and Stroke Care Bundle.

In more detail:

4.3.3. **ROSC (All)** – In October 2016, performance improved to 27.8% with a 2.5% positive variance from the previous month. This has placed the trust in a 3rd position nationally, highest ranking for over 3 years, however, this should be treated with caution as overall the national average ~~performance~~ dipped in October.

4.3.4. ROSC (Utstein) – In October performance improved to 48.1%, a 4% positive variance on September's performance, taking the trust above the national average for the first time since July-17. Performance is comfortably within the national control limits of 2 s.d.

4.3.4.1. 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.

4.3.5. Survival to Discharge (StD) – October performance figures for All and Utstein must be treated with caution. Whilst it appears that performance has significantly deteriorated (Std: Sept 9.4%, Oct 4.3%; StD Utstein Sept 30.0%, Oct 15.4%), these figures are skewed as a result of data being extracted from the national spine. Please note, that following the implementation of the new process (national spine), a significant proportion of October survival data is still outstanding from hospitals. An improvement will be evident once all data has been received.

4.3.6. STEMI 150 – In October performance has significantly improved from 86.7% to 96.9%. This has placed the Trust at the top of the national rank.

4.3.7. STEMI Care Bundle – The delivery of the care bundle continues to be a challenge with performance dipping to 63.1%, a 13.5% negative variance on the previous month. The delivery of this outcome indicator continues to be compromised by the failure to record two pain scores.

4.3.8. **Stroke 60** – In October 2016, 52% 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. The largest proportion for October 2016 was 63% for South East Coast.

4.3.9. Stroke Care Bundle - In October, performance has remained stable at 95.4%, however, nationally South East Coast have been in the worst three performing trust for the last four consecutive months. Recording of blood glucose is the element of the care bundle that compromises overall Trust performance.

4.4. Clinical Effectiveness Charts

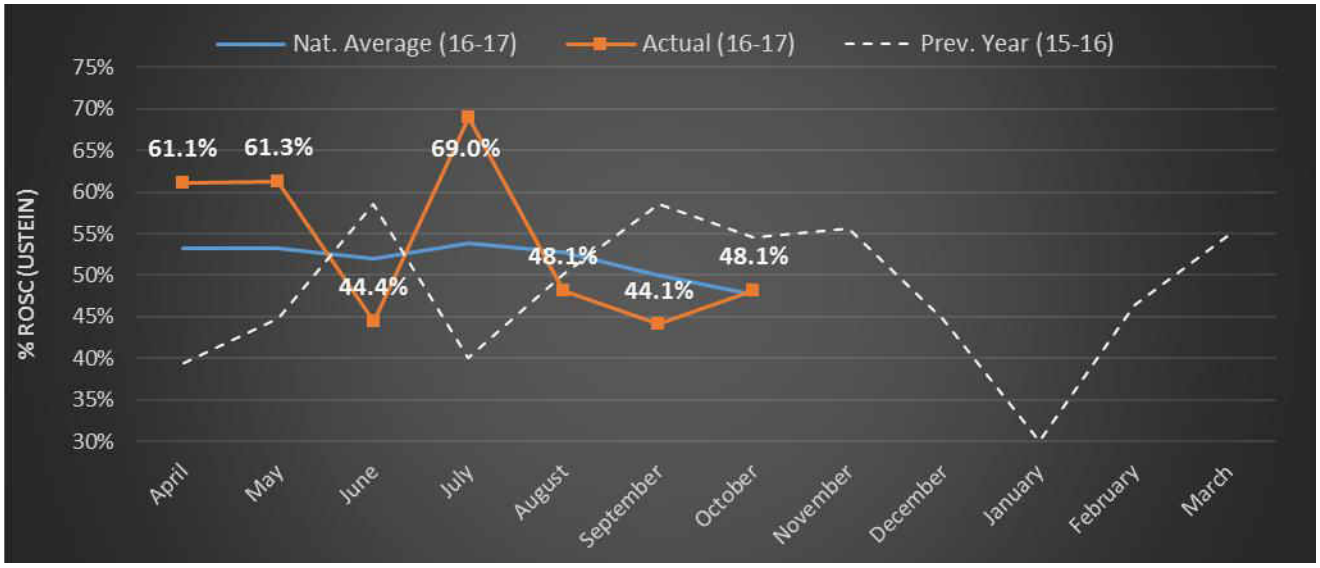


Figure.CE-1 - Cardiac arrest - ROSC on arrival at hospital (Utstein)

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

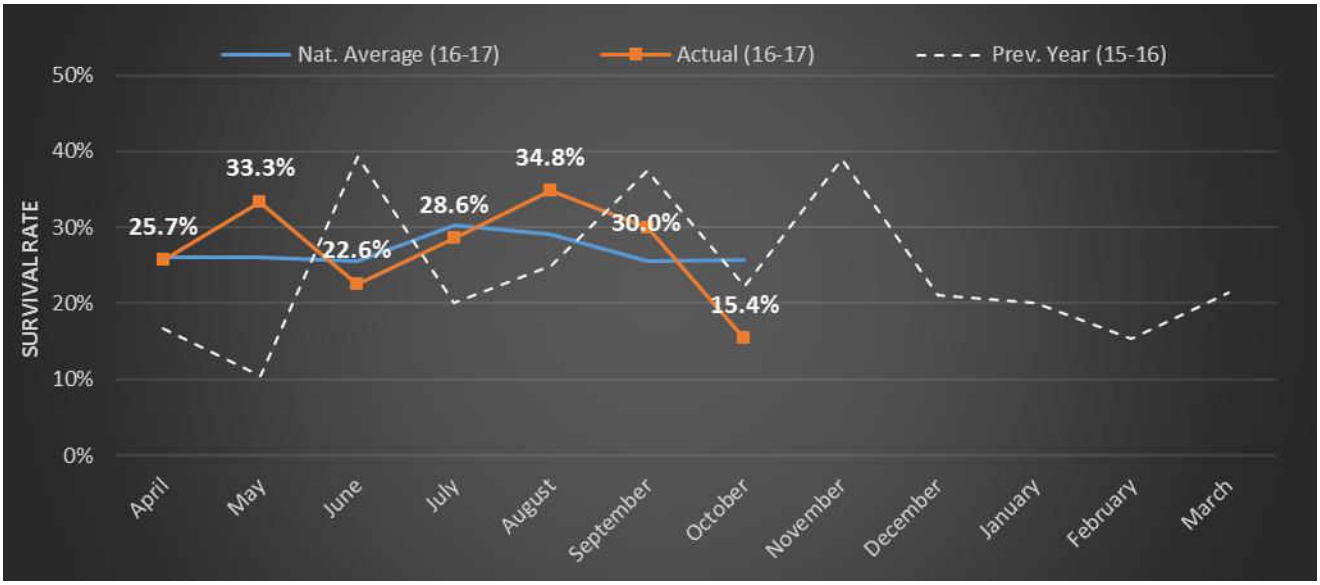


Figure.CE-3 - Cardiac arrest -Survival to discharge - Utstein

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

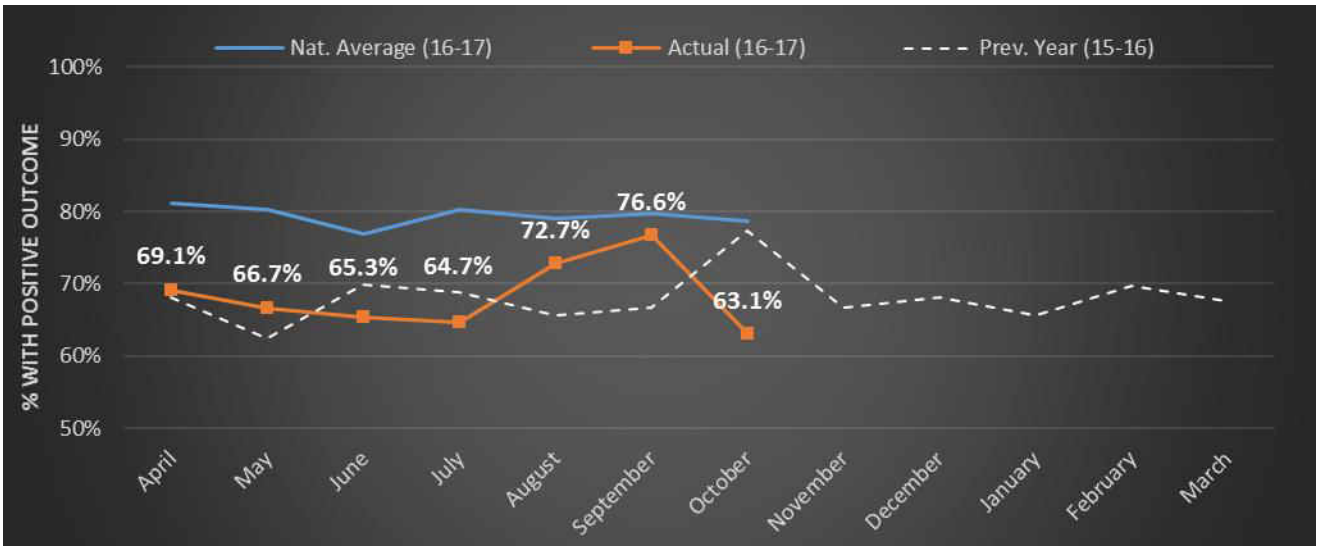


Figure.CE-5 - Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)

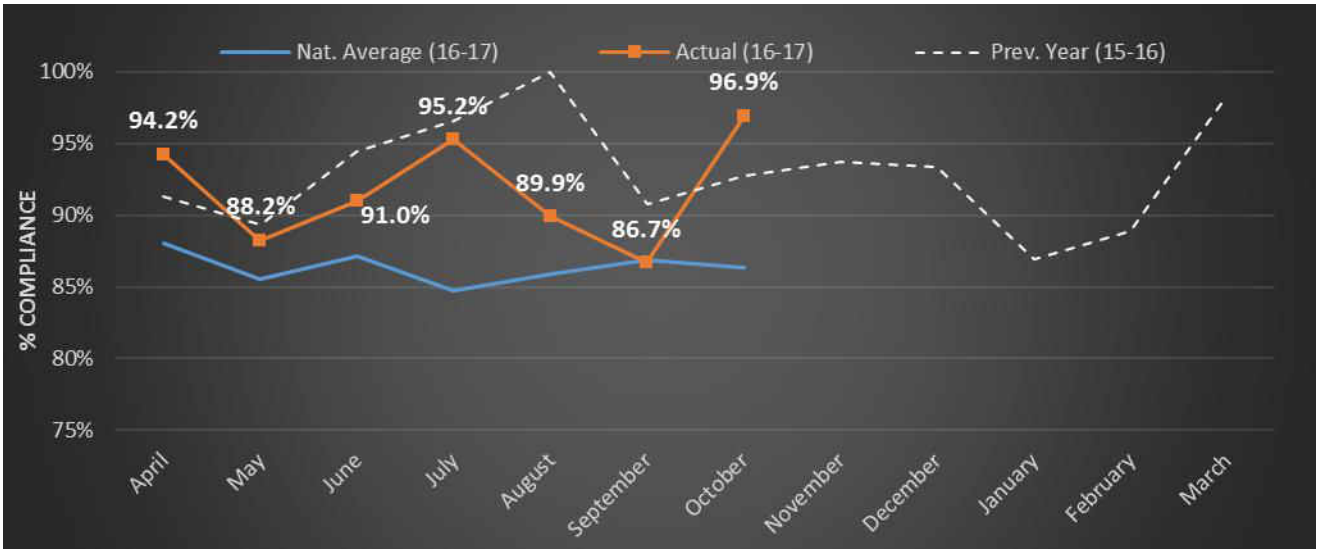


Figure.CE-6 - Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes

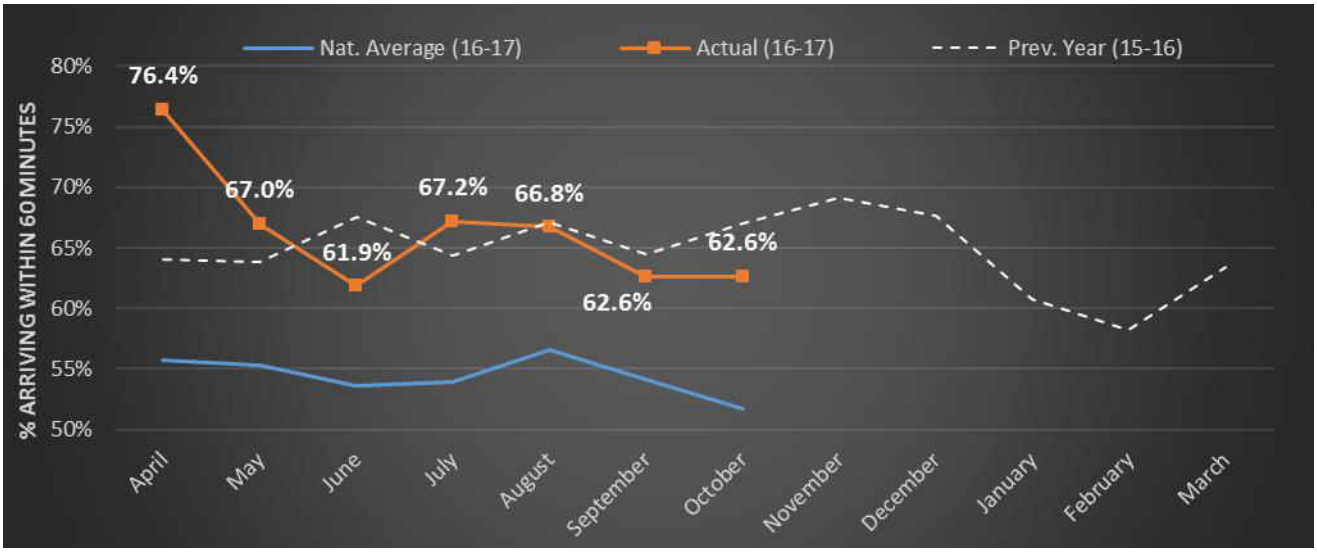


Figure.CE-7 - % of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper acute stroke unit within 60 minutes

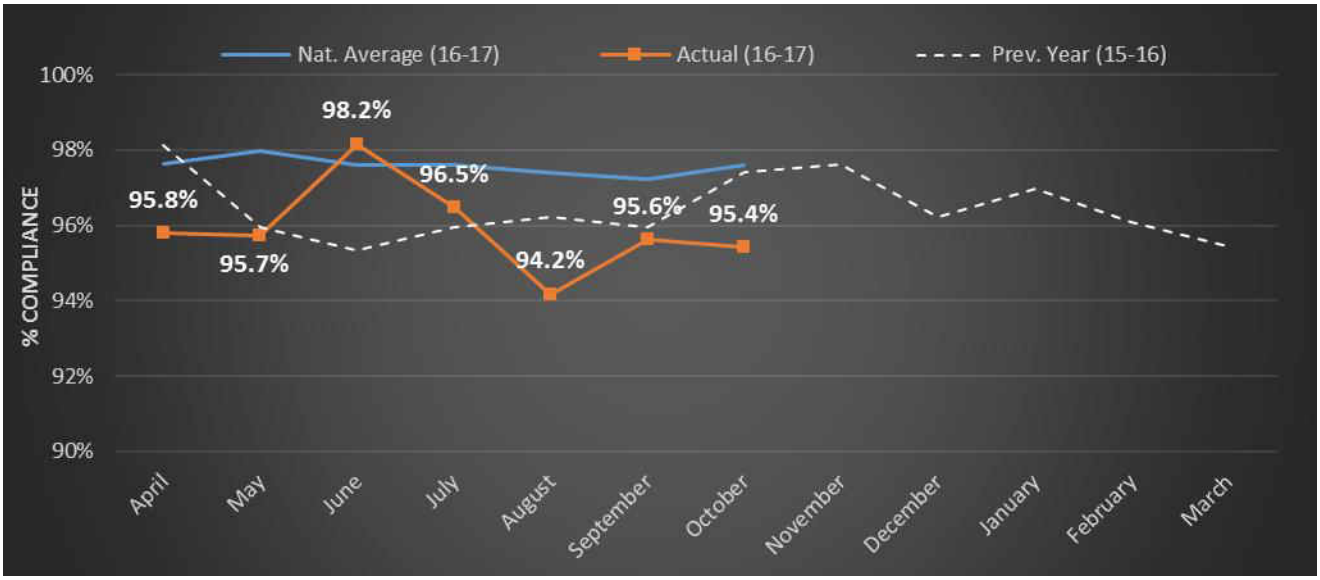


Figure.CE-8 - % of suspected stroke patients assessed face to face who received an appropriate care bundle

5. Quality & Patient Safety

5.1. Quality & Patient Safety Summary

5.1.1. Complaints have demonstrated an improvement in response rates, the top three most recurrent themes for complaints have remained the same for two months, timeliness of emergency response, staff conduct and attitude and pathways. PALS (issues with no clinical concerns or staff identified) remain predominantly driving incidents/ concerns and generic poor staff attitude. Incident reporting remains constant with an increase in overall reporting. Recurrent themes this month have been safeguarding referrals as the highest incident reported, concerns raised by staff attending patients no incidents have been raised this month regarding staff, equipment failures are where the kit fails at point of contact, again there have been no specific kit identified, and patient care primarily delays in arrival at scene times. The DATIX rebuild has remained on track to deliver the new and revised modules which will ensure the system is user friendly to encourage reporting and support better thematic analysis.

5.1.2. Serious incident reporting remains consistent, themes for this month, possible incorrect patient pathways and CAD failure. We continue to have late submissions of Serious incident reviews to the CCG, the longest delay 224 days (hospital delayed handover) families are routinely offered to be engaged in the serious incident process, it is envisaged with the introduction of the new investigation template the timeless will improve.

5.1.3. Safeguarding training has shown an improvement in month for level 1 and level 2 training but remains off trajectory for the quarter. The pilots complete in March for level 3 training currently at 64% for February aiming to be 82% in March

5.2. Quality & Safety KPI Scorecard

Quality & Safety KPI Scorecard:- Data From February 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)	100%	**100.0%**		100%	**34.9%**	
QS1b	SI Investigation timeliness (60 days)	100%	**0.0%**	100.0%	100%	**60.0%**	100.0%
QS1c	Number of Incidents reported		**465**	**390**		**5553**	4820
QS1d	Number of Incidents reported that were SI's		**5**	**4**		**25**	25
QS1e	Duty of Candour Compliance	100%	Data not available	Data not available	0%	Data not available	Data not available
QS2a	Number of Complaints		**96**	133		**96**	133
QS2b	Complaints reporting timeliness (All Complaints)	95%	**93.8%**	69.0%	95%	**66.8%**	61.1%
QS3a	Number of Safeguarding Referrals		**770**	766		**9587**	9534
QS3b	Safeguarding Referrals relating to SECAmb staff or services		**0**	0		**4**	4
QS3c	Safeguarding Training Completed (Adult) Level 1	92%	**70.6%**		92%	**70.6%**	
QS3d	Safeguarding Training Completed (Children) Level 1	92%	**71.4%**		92%	**71.4%**	
QS3e	Safeguarding Training Completed (Adult) Level 2	92%	**89.1%**		92%	**89.1%**	
QS3f	Safeguarding Training Completed (Children) Level 2	92%	**89.8%**		92%	**89.8%**	

5.3. Quality & Patient Safety Commentary

5.3.1. Complaints

5.3.1.1. Following the reintroduction of the 25-day complainant reporting target there is an improvement in the percentage closed within timescale due to improved return rate of reports by operational teams, improved communication with complainants and renegotiation of timescales. The full capability of Datix is being utilised to report consistently on our performance. 62 of the complaints were at least partly upheld – 64.5%. This is consistent with January's figure of 64.8% being at least partly upheld. The year to date (YTD) outcomes (01.04.16 to 28.02.17) 60.8% are at least partially upheld. The past two months have been in excess of 64% showing that there is an upward trend in concerns being upheld.

5.3.1.2. The top three subjects are (same as in January):

- Timeliness of Emergency resources – 29 (30.2%)
- Staff Conduct/attitude – 22 (22.9%)
- Pathways – 15 (15.6%)

5.3.1.3. The YTD subjects are:

- Staff Conduct – 21.4%
- Pathways 17.1%
- Timeliness 14.4%

5.3.1.4. The call back initiative commenced in January continues to receive positive feedback from complainants as issues can be resolved earlier.

5.3.2. Incident reporting

5.3.2.1. Following on from previous months work the reporting system has an additional / enhanced module:

5.3.3. Live modules:

- Risk Register
- Claims
- Complaints (updated)
- Safety Alerts

5.3.3.1. The Incident module goes live on April 1st.

5.3.4. Incidents module

5.3.4.1. Schedule of work:

15 March	SECAmb / Datix review of feedback from test site pilot
20 March	New SECAmb organisational structure due to be announced – this needs to be built in to the Datix hierarchy (discussed with Peter Lee)
22 March	Datix to continue to apply changes obtained from feedback
27 March	Transfer of Hierarchy, Locations and Categories to live site (remote work by Datix)
28 March	Request to NRLS to sign-off mapping (already contacted NRLS to pre-empt this date)
29 March	Datix to provide RR demo to Board (discussed with Peter Lee)

31 March	Switch on all changes to live site ready for 01 April
10 April	SECAmb / Datix post implementation review

5.3.4.2. Training is booked for Heads of service booked for the 20th and 21st March at Paddock Wood. With a further 3 days training to be accessed as part of the rebuild to include the safety alert module, reporting functions and super user training.

5.3.4.3. Specific work being carried out includes improvements such as:

- History marking – addition of a tick box and built-in template / data options to capture everything currently recorded manually when a marker is required; auto-notifications will be issued to the existing history.marking@secamb.nhs.uk email for all incidents that have a tick in this box
- Enquiries – restricted access to the Complaints module will be provided to those who are responsible for handling incident, claims and safeguarding enquiries so that these can be logged and tracked in Datix. This is best practice across the NHS.
- Acronyms – all terms will be spelt in full alongside the acronym
- Reporter feedback will be automatic going forward to allow the reporter to see feedback and actions taken
- Student – will be added to the incident type alongside 'visitor, contractor, member of the public'
- Initial risk grading – will be added to the IWR-1 / the current risk grading will be in the IWR-2 once the investigation has begun – these fields are searchable to help with early identification of any potential Sis.
- SI tick box – once selected this will issue an automated notification to the Head of Risk, Chief Nurse and Deputy Chief Nurse.
- Clinical Education – clinical development / education incidents will be flagged to the Clinical Education team via an automated notification

5.3.4.4. Below are the top five categories

Rank	Category	2015-16	2016-17	Monthly variance Lowest to highest month
1	Safeguarding (formerly Vulnerable Persons)	9195	9162	690-886
2	Equipment	1320	1674	74- 208
3	Patient Care	818	951	56-95
4	Assaults / Aggression	550	640	36-36
5	Accidents	500	494	34-47

5.3.4.5. Staffing within the Datix investigation team has been challenging over the last 2 months with long term sickness and vacancies. Sickness has improved but the vacancy position remains challenging with the withdrawal of the candidate for the Incident Manager post for the third time ,the advert has been reinstated and advert reviewed.

5.3.5. Serious Incidents

5.3.5.1. The National SI Framework identifies the timescales for completing investigations and final reporting to the Clinical Commissioning Group. The Trust breached the Commissioning submission deadlines for 7 incidents in quarter 3 and two were not breached. Of the 7, 1 has been submitted to the commissioners and the remaining 6 have been completed and are progressing through the internal review stages in preparation for submission to the CCGs.

5.3.5.2. There are 49 listed SIs 7 have missed the CCG deadline (5 x A&E, 1 x EOC, 1 x PTS)

Directorate	No. SIs	Stage 1	Stage 2	Stage 3	Ongoing (with IM)	Complete (pending closure)	Closed
NHS 111	5	-	-	-	2	-	3
Ops – A&E	26	1	3	1	9	6	6
Ops – EOC	13	2	-	-	8	3	-
Ops – PTS	2	-	-	-	-	2	-
Not stated	3	-	-	-	3	-	-

5.3.5.3. The new template for serious incident reporting is being used for all incidents in the system currently, following the serious incident and human factors training in February, staff are being supported to complete the documentation from the compliance lead, the feedback for using the standard template has been positive and focuses the investigator on the root causes and recommendations.

5.3.5.4. The Duty of Candour section remains unpopulated until the Datix rebuild is live

5.3.5.5. In Quarter 3, 8 SIs were reported and 13 investigations were submitted to the commissioners. At this time 33 incidents remain open. Of the 33, 18 are ongoing investigations which are either newly reported, or have not yet breached their submission deadlines. Of the remaining 15 which have breached, the reports are either progressing through the review and internal sign off stages or are due to be completed imminently.

5.3.5.6. Learning from closed serious incidents examples:

Initial Grade of harm: Moderate Harm	
Initial Information – pre-investigation: The Trust's Patient Experience Team has received a complaint from the father of a child who was scalded. The complainant says that the crew who attended applied a tea tree bandage and wrapped the patient in cling film. Their advice was to keep the cling film on for 20-30 minutes, to keep the wound open and aired, for the patient to carry out normal activities, and to go home. Four days later the wounds blistered and were weeping. The patient's mother took the patient to A&E, where he was treated and referred to the Burns Unit. He now has to have dressings changed every 3 to 4 days. The complainant says that consultants at both locations advised that the treatment by the crew was wrong and the patient should have been referred to A&E, and they will be submitting complaints too.	

Immediate Action Taken:	The Paramedic involved was been placed on restricted duties and additional training provided. The HCPC informed of his restriction.

Initial Grade of harm: Unknown Harm			
Initial Information – pre-investigation: The Trust has received a complaint from a member of the public who is also a registered nurse. The nurse was witness to an accident involving a 4x4 and a motorcyclist. She was first on scene and was able to administer first aid and make an initial assessment of the motorcyclist. Due to the symptoms and signs - back pain and a thready pulse she was concerned about possible internal bleeding and possible damage to the spine, therefore she immobilised him as best she could and waited for the ambulance. When the crew arrived she explained who she was and gave a basic handover of his condition. The nurse states that following a brief assessment by the crew, they asked him to stand up and get on the stretcher, they then proceeded to move the patient onto the vehicle the wrong way round, and then had to take him off and move him again the right way. She has listed various other points of concerns relating to their general assessment and treatment of him. The nurse states that the patient was taken to hospital where he was found to have numerous serious injuries including damage to his spine and a ruptured spleen. The patient is currently in a neck and back brace awaiting further treatment.			
Immediate Action Taken:	The investigating manager will take restriction/suspension orders out to protect staff/patients if serious concerns are identified from initial review of actions on scene and PCR.		

Initial Grade of harm: Moderate Harm			
Initial Information – pre-investigation: A Technician driving a Single Response Vehicle, was en route to a Red 2 incident when they collided with a car. The driver and passenger of the car were trapped inside it due to the collision causing the car to spin and impact with traffic lights. Both patients were extricated and taken to hospital. The Technician, at this time, is thought to have sustained minor injuries not requiring further treatment.			
Immediate Action Taken:	SECAmb driver removed from driving following the incident and stood down. Consideration will be given to suitability of the SECAmb driver to return to full driving duties on his return to work, this will be conducted by his line manager and he will only return to driving duties if it is found to be appropriate. Welfare support is ongoing with the staff member.		

5.4. Safeguarding

5.4.1.1. Level 1 training figures have improved in month following a targeted campaign on non-compliant individuals and line managers. Both level 1 and level 2 training are below the trajectory agreed. E-mail correspondence has been circulated with a highlight report attached to remind teams to undertake the on line training.

5.4.1.2. Level 3 training package has been approved externally and the final pilot takes place at the end of March. Dates for 2017/18 have been circulated to allow for abstraction throughout the year.

5.4.1.3. A draft training strategy have been developed and will be presented at the March Safeguarding Group for approval. Proactive senior presence at the various safeguarding boards in all of the counties over the last six weeks has been maintained, to share the safeguarding improvement plan and methodology for the quality assurance visits where safeguarding forms part of the key line of enquiry, many of the board members are keen to become observers of the quality assurance visits and have reported positively to the engagement.

5.5. Quality & Safety Charts

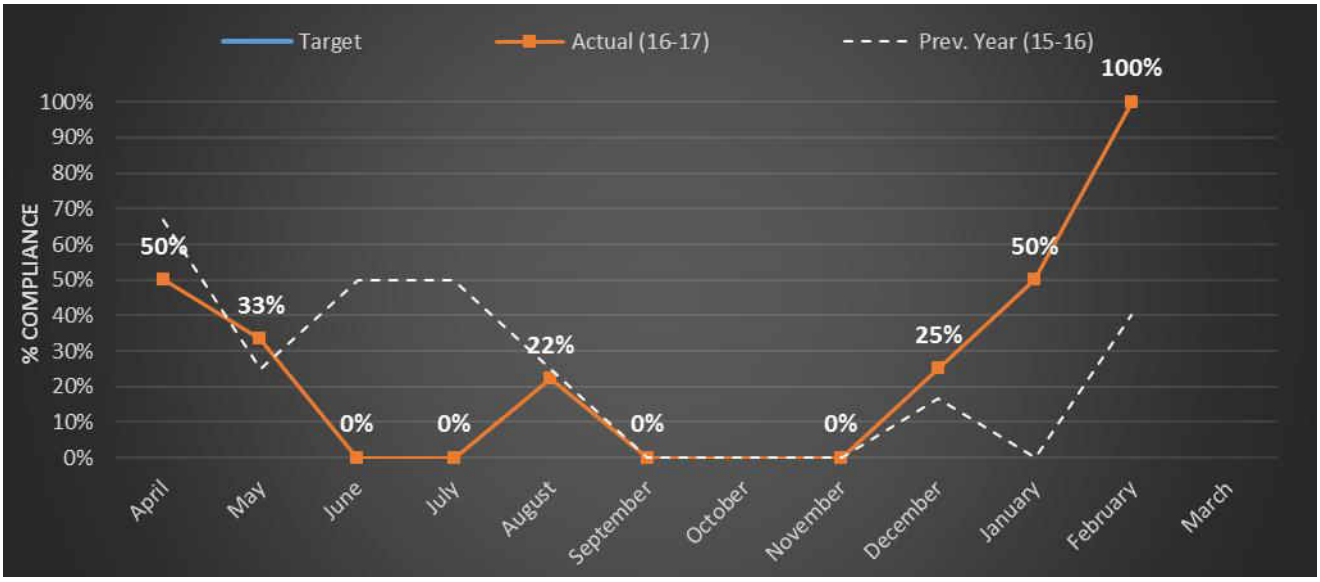


Figure.QS1a - SI Reporting timeliness (72hrs)

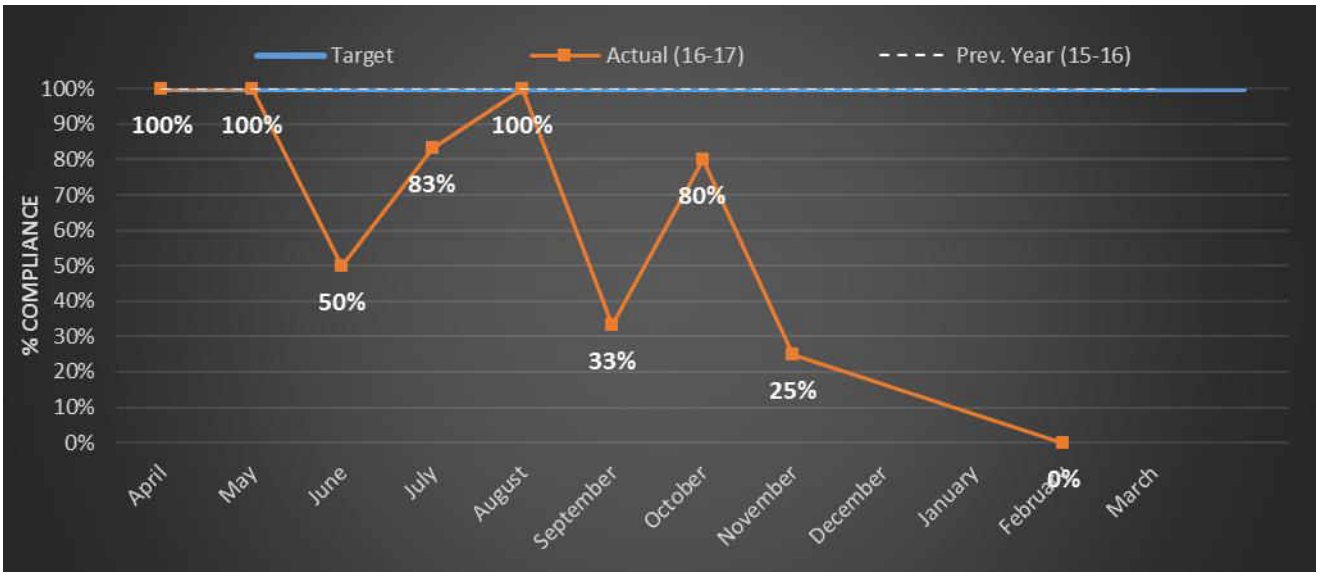


Figure.QS1b - Serious Incident (SI) Investigation timeliness (60 days). Please note that no SI's were due for completion for last month (no data points will be shown)

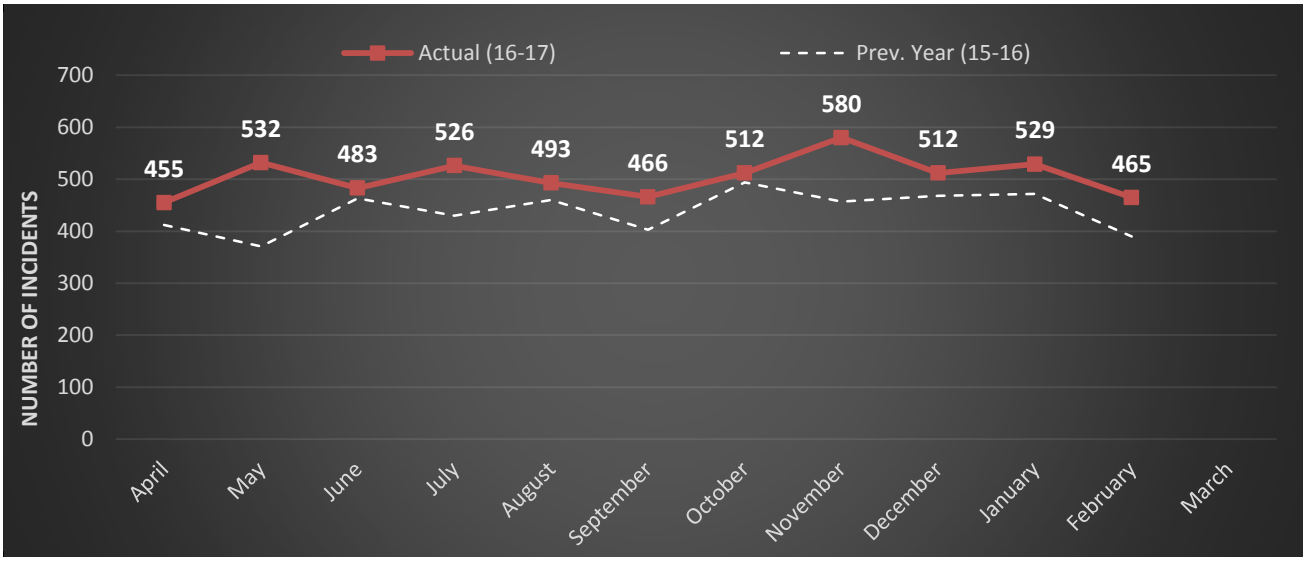


Figure.QS1c - Number of Incidents reported

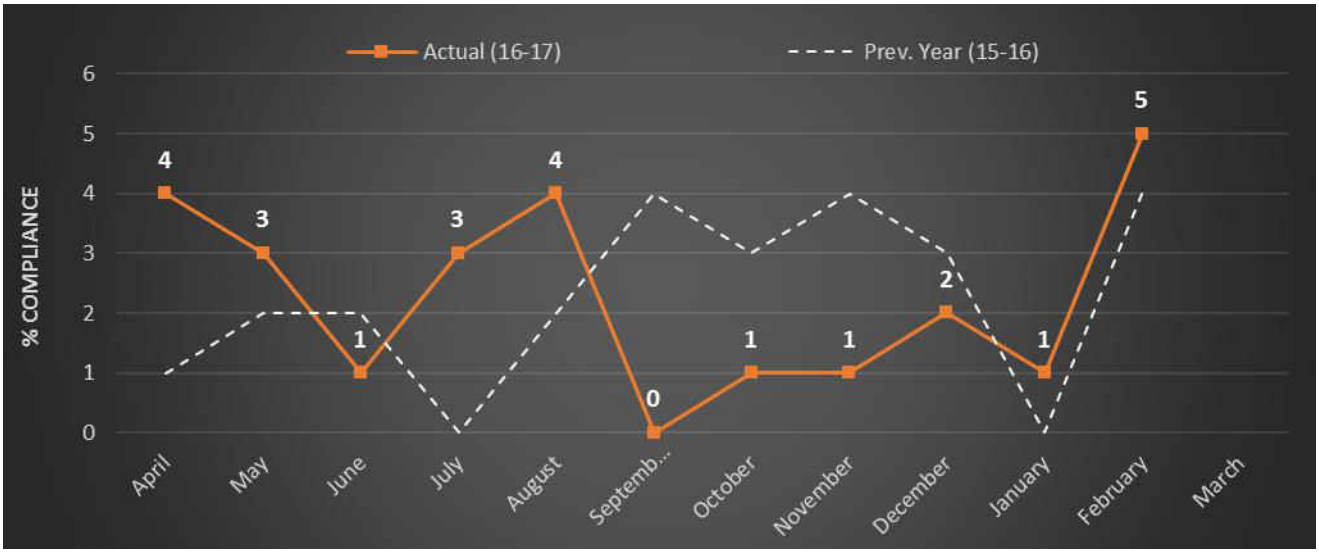


Figure.QS1d - Incidents reported that were SI's

Data not available.

Figure.QS1e - Duty of Candour Compliance

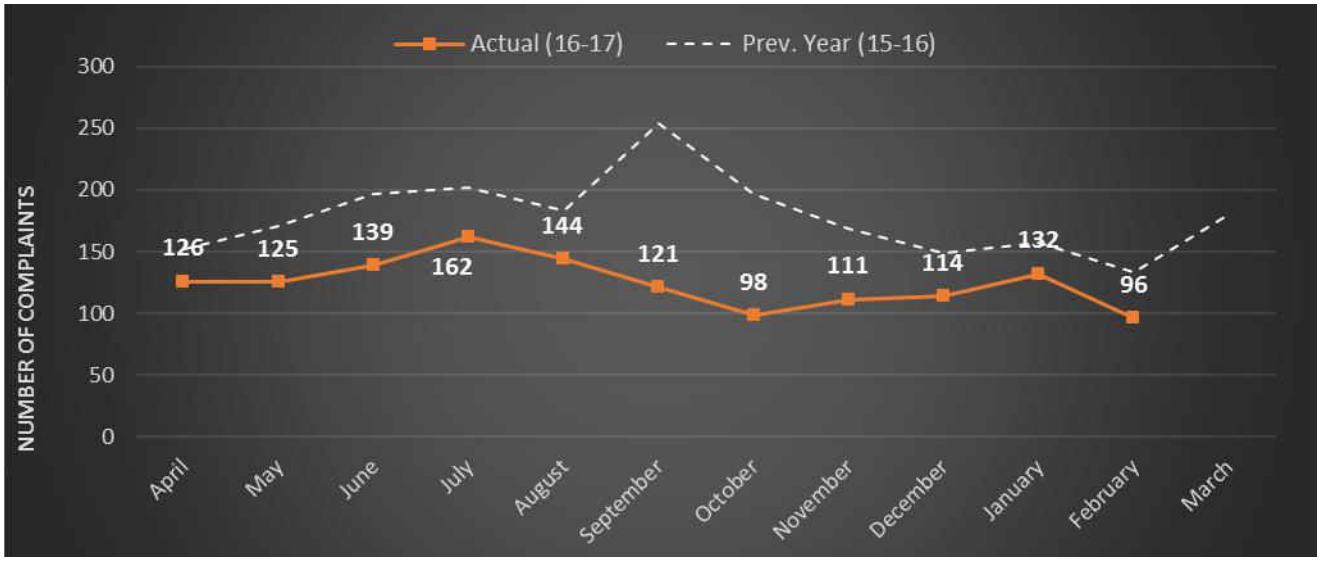


Figure.QS2a - Number of Complaints

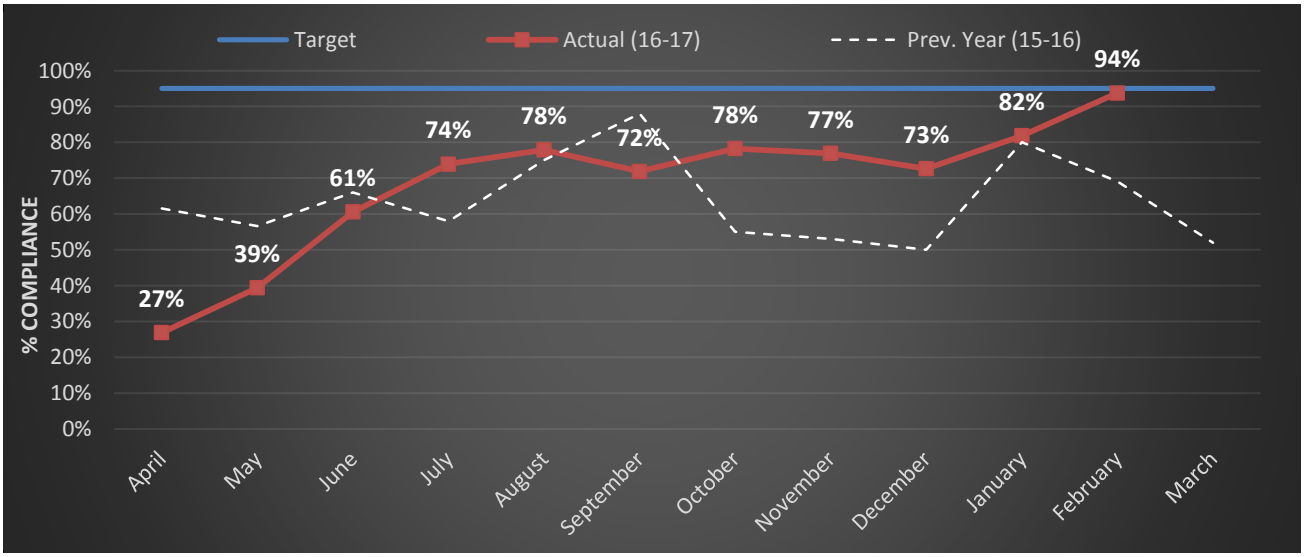


Figure.QS2b - Complaints reporting timeliness (All Complaints)

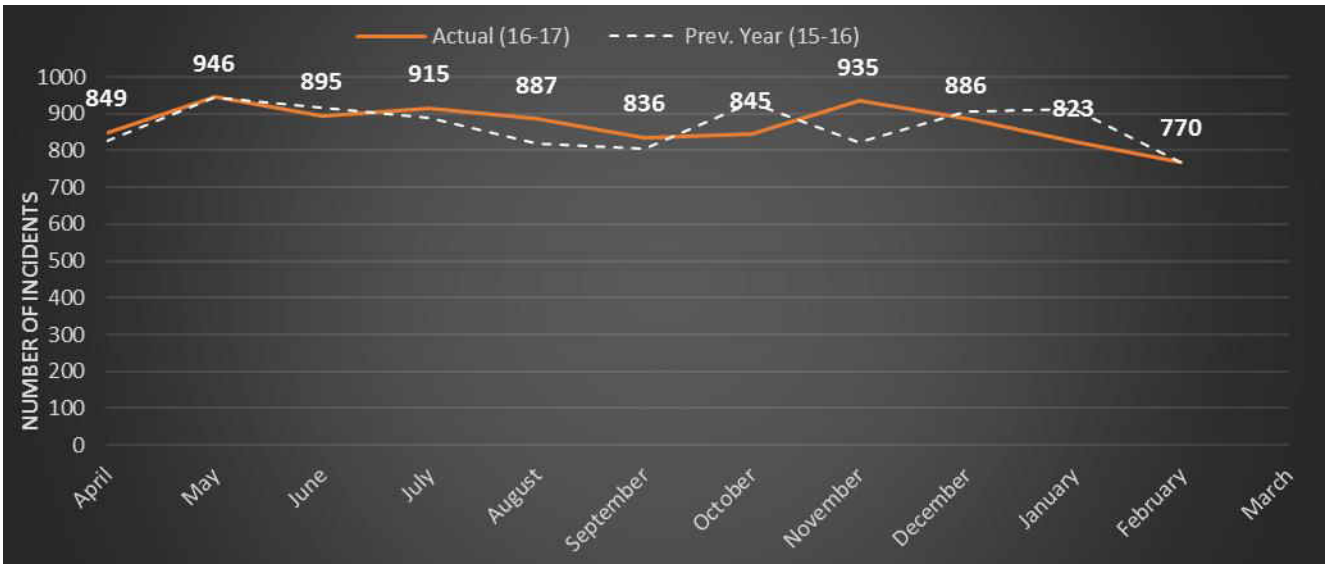


Figure.QS3a - Safeguarding Referrals

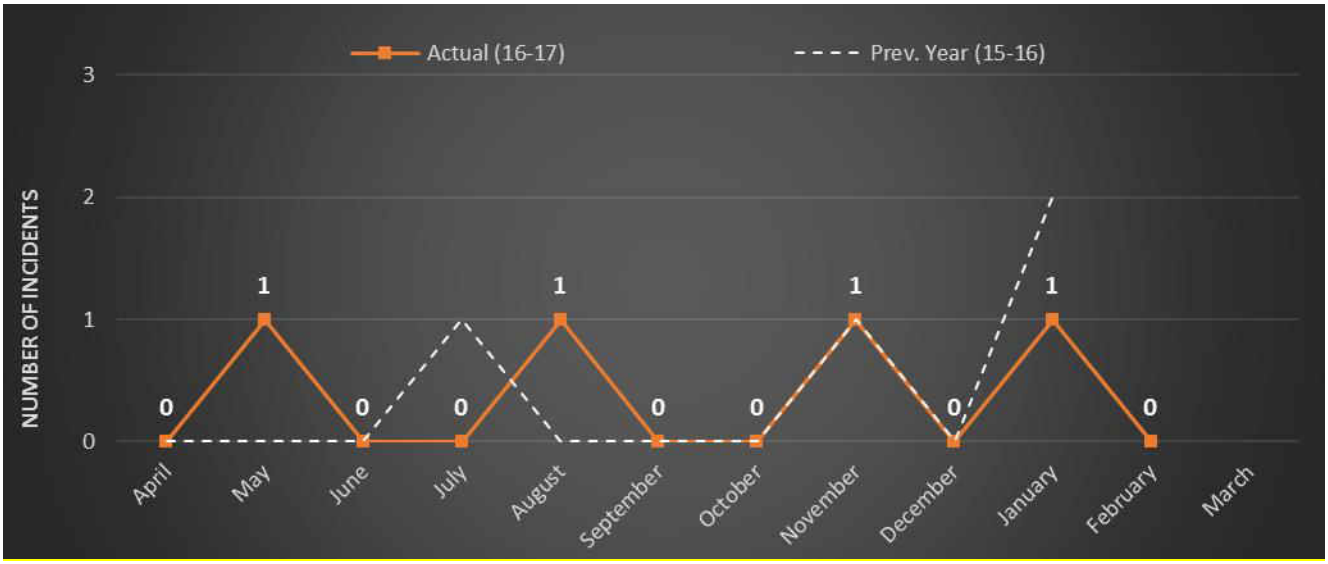


Figure.QS3b - Safeguarding Referrals relating to SECAmb staff or services

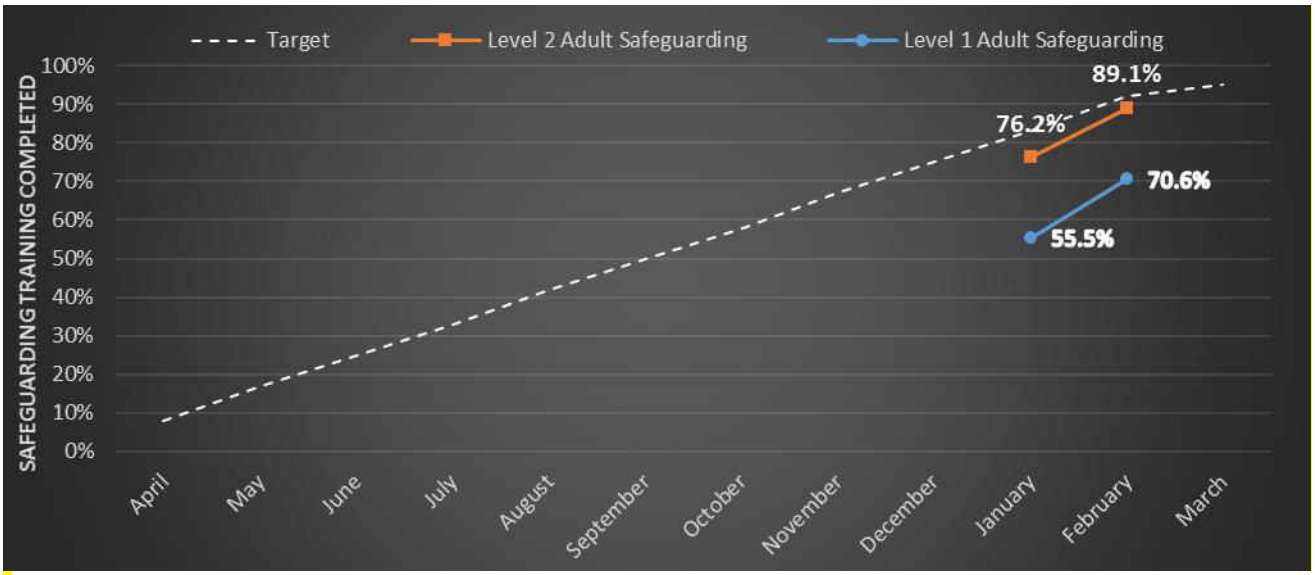


Figure.QS3c and QS3e - Safeguarding Training Completed Adult, Level 1 and 2

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

6. Finance

6.1. Finance Summary

6.1.1. The Trust's financial performance for month 11 reflects a deficit of £0.4m which is in line with the forecast. This takes the YTD deficit to £6.7m compared with the £0.7m surplus position assumed in the plan.

6.1.2. The position includes £0.4m of costs relating to the Paramedic re-banding from 5 to 6 as directed by NHSI. The Trust has now received confirmation from NHS England that there will be additional funding in this financial year to offset these costs; the re-banding will therefore be cost neutral.

6.1.3. The 16/17 FOT deficit has been returned to £7.1m, which the Trust is confident will be achieved. This is supported by the improved outlook on meal break costs, agency spend and non-essential expenditure in the last quarter.

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 tightened up the temporary agency controls by implementing a more robust recruitment and approval process. As a result, the number of agency staff has fallen sharply from 170.0wte to 71.0 wte as of March 2017, saving the Trust £0.3m in this quarter. 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.

6.1.5. The demand in A&E activity continues to track above plan for the year to date, but below plan in month. The activity in February is 1.8% lower than APR (YTD: 2.2% above plan) and 2.5% below the commissioned level (YTD: 3.8% above). Clinical performance remains below the recovery plan trajectory and national targets. The Red 1 performance in February improved slightly compared to January. In February the Trust delivered Red 1 performance of 65.5% (YTD: 64.6%) but Red 2 performance of 48.8% (YTD: 52.8%) against the 75% national targets. The Trust has delivered its YTD CIP target of £6.6m.

6.1. 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)	£ 15,977	**£ 17,179**	£ 17,086	£177,463	**£ 181,539**	£185,387
F-2	Expenditure (£'000)	£ 16,140	**£ 17,576**	£ 17,229	£176,755	**£ 188,246**	£185,845
F-6	Surplus/(Deficit)	-£ 163	**£ 397**	-£ 143	£ 708	**£ 6,707**	-£ 458

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)	£ 1,282	**£ 1,367**	£ 2,140	£ 19,810	**£ 14,988**	£ 18,244
F-7	Cash Position (£'000)	£ 12,353	**£ 11,262**	£ 18,353	£ 12,353	**£ 11,262**	£ 18,353
F-4	Cost Improv. Prog. (CIP) (£'000)	£ 596	**£ 488**	£ 1,124	£ 6,608	**£ 6,640**	£ 9,354
F-8	Agency Spend (£'000)	£ 339	**£ 434**	£ 273	£ 3,691	**£ 6,108**	£ 5,935

** 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).*

6.2. Finance Commentary

6.2.1. The YTD adverse variance of £7.4m against the APR is across all service lines. The financial performance in 999 is £6.5m worse than the APR.

6.2.2. The key drivers are 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. The Trust lost 12% more hours (5,464) in February compared to 4,891 hours compared to the same period last year. This was despite transporting 16% fewer patients to hospital.

6.2.3. In EOC, the management have made some changes in the way in which meal breaks are disturbed which has resulted in a large reduction in the number of claims made from January. The changes are in line with the current policy.

6.2.4. Fleet is overspent by £0.3m YTD mainly on fuel costs. The vehicle maintenance regime has been revised to reduce costs whilst ensuring safe levels are maintained.

6.2.5. PTS performance was a deficit of £0.1m in February due to an excess of costs over income. The YTD position is £0.8m adverse against plan. Activity is 22% below expectations YTD resulting in a 15.0% variance on income, which is the main reason for the adverse variance. The reduction in hours to match this lower activity has not been delivered.

6.2.6. The financial performance in KMSS111 continues to be positive, and February reported a break even position. The YTD position is an adverse variance of £0.1m and it is expected that performance in March will improve the year end position. The improvement in the last quarter is attributable to additional income from the East Kent contract extension and reduction in expenditure. There has been a reduction in agency spend which is attributable to switching agency staff to permanent contracts and strict adherence to agency cap rates.

6.2.7. The YTD capital expenditure of £14.3m.

6.2.8. The Trust's YTD cash balance of £11.2m is £1.2m lower than the original plan. This has improved from last month's position due to the draw-down of £4.6m of the working capital facility. The Trust has secured a total working capital facility of £15m from DoH.

6.3. Finance Charts

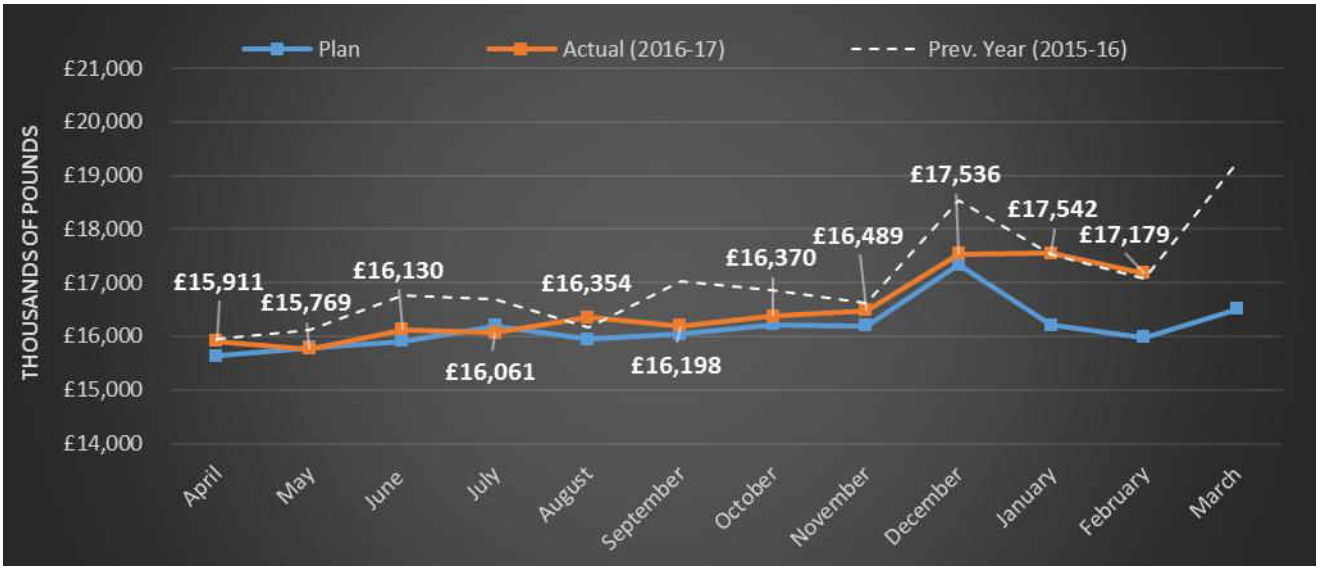


Figure.F-1 - Income (£'000)

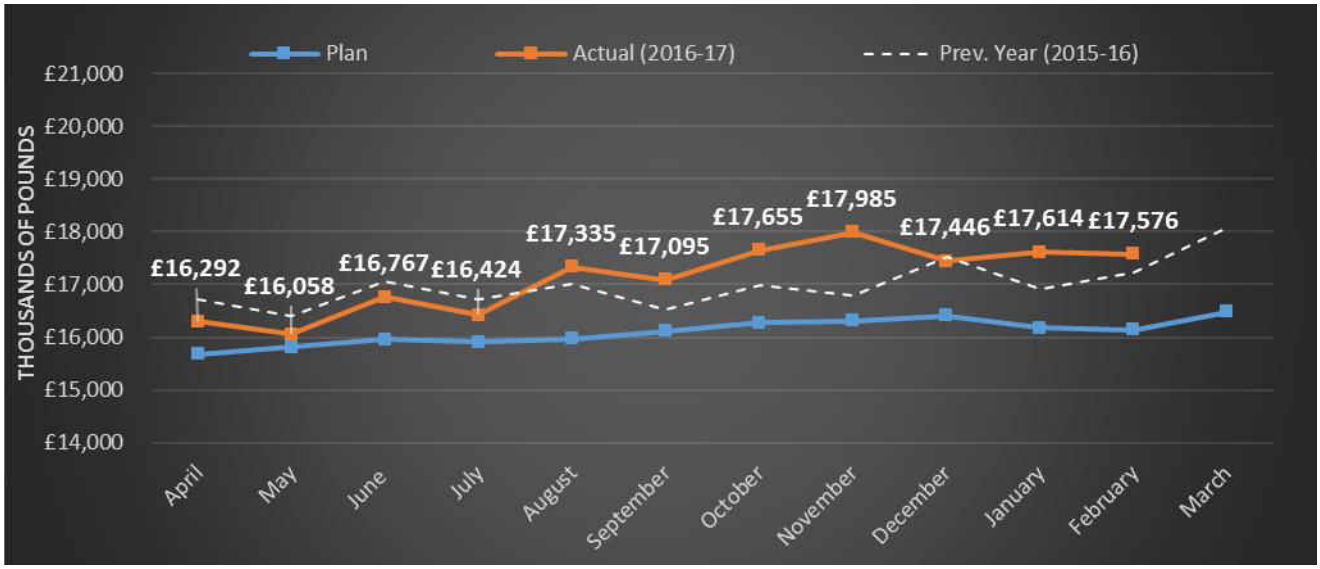


Figure.F-2 - Expenditure (£'000)

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

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

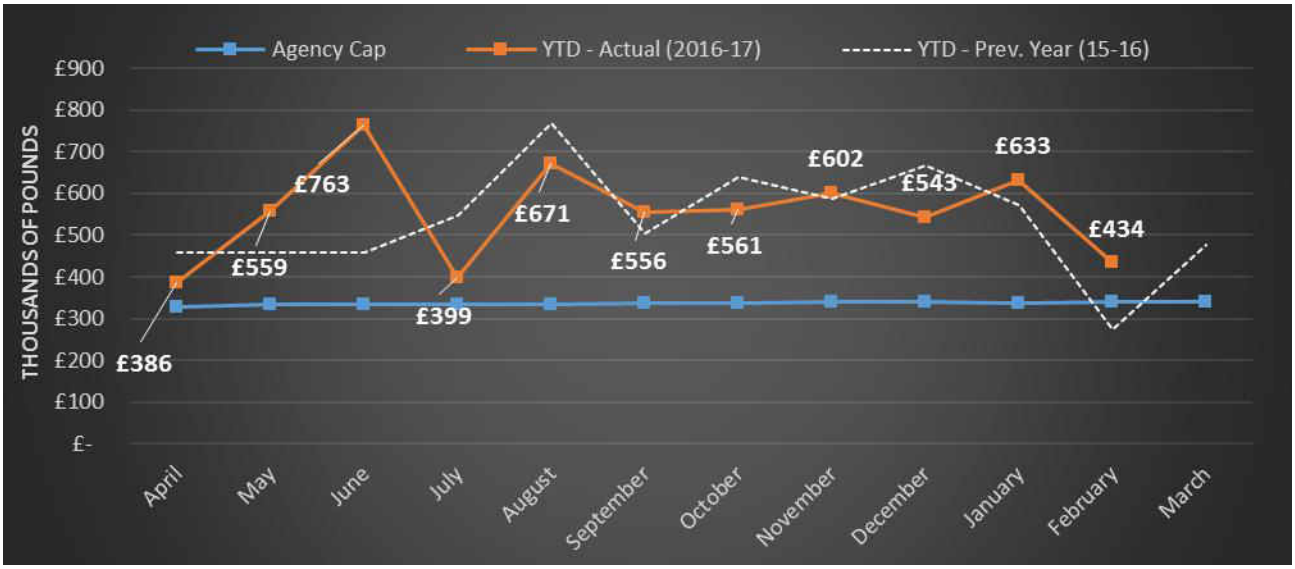


Figure.F-8 – Agency Spend (£'000)

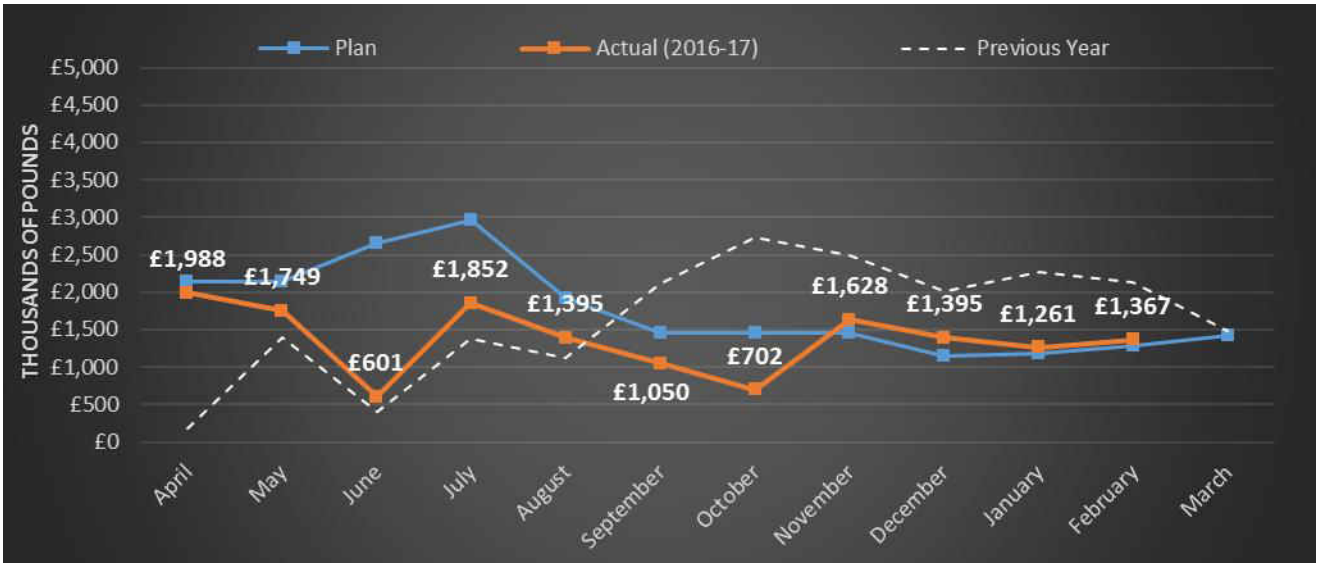


Figure.F-3 – Capital Expenditure (£'000)

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 March 2017 Board Meeting

Workforce Commentary :- Data from Feb 2017 and Jan 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		2.7%	2.5%		2.7%	
Wf-1B	Long Term Sickness - Rate		2.5%	3.5%		2.5%	
Wf-2	Staff Appraisals	82.5%	49.6%	63.0%			
Wf-3	Mandatory Training Compliance (All Courses)	94.5%	81.9%	89.9%			
Wf-4	Total injuries		66	56		681	688
Wf-5	Total physical assaults		14	12		194	175
Wf-6	Vacancies (Total WTE)		287				
Wf-7	Annual Rolling Staff Turnover		16.6%	14.3%			
Wf-8	Reported Bullying & Harassment Cases		0			14	
Wf-9	Cases of Whistle Blowing		0			3	

Operational Performance Scorecard:- Data From February 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	67.9%	65.7%	65.4%		64.6%	72.6%
999-2	Red 2 response <8 min	57.0%	49.8%	57.7%		52.7%	69.1%
999-3	Red 19 Transport <19 min	90.7%	87.6%	91.3%		89.1%	94.5%
999-4	Activity: Actual vs Commissioned	63759	62138	66093	723775	750927	719170
999-5	Hospital Turn-around Delays (Hrs lost >30 min.)	2627	5464	5123	26510	62978	41355
999-6	Call Pick up within 5 Seconds	92%	90.8%	82.0%		76.6%	87.2%
999-7	CFR Red 1 Unique Performance Contribution	1%	2.2%	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		79876	102628		1042491	1078300
111-2	% answered calls within 60 seconds	85%	92.5%	65.0%	85.0%	79.0%	82.5%
111-4	Abandoned calls as % of offered after 30 secs	5.0%	0.7%	9.3%	5.0%	4.2%	3.3%
111-5	Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)	77%	73.6%	73.8%		74.6%	86.5%
PTS-1	PTS Activity (Surrey)	11180	8578	12055	129632	114188	161233
PTS-2	Arrival - % patients to arrive <= 15 min after appt. time. (Surrey)	95%	87.2%	88.8%	95%	86.5%	84.1%
PTS-3	Departure - % patients collected <= 60 min of planned collection time (Surrey)	95%	84.3%	90.5%	95%	86.1%	84.7%
PTS-4	Discharge - % patients collected <= 120 min of booked time to travel (Surrey)	95%	76.7%	77.2%	95%	79.9%	76.2%

** 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 October 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)	47.6%	48.1%	54.5%	51.8%	53.6%	48.8%
CE-2	Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)	26.6%	27.8%	28.4%	28.6%	27.9%	27.3%
CE-3	Cardiac arrest -Survival to discharge - Utstein	25.7%	15.4%	22.2%	26.9%	27.0%	23.8%
CE-4	Cardiac arrest -Survival to discharge - All	7.8%	4.3%	8.0%	8.8%	7.9%	8.5%
CE-5	Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)	78.7%	63.1%	77.4%	79.5%	68.3%	68.3%
CE-6	Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes	86.4%	96.9%	92.7%	86.3%	91.8%	93.4%
CE-7	% of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes	51.7%	62.6%	67.0%	54.4%	66.5%	65.5%
CE-8	% of suspected stroke patients assessed face to face who received an appropriate care bundle	97.6%	95.4%	97.4%	97.6%	95.9%	96.4%

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

Finance Scorecard:- : Data from February 2017

ID**	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
F-1	Income (£'000)	£15,977.0	£17,179.0	£17,085.6	£177,462.5	£181,539.3	£185,387.2
F-2	Expenditure (£'000)	£16,140.0	£17,576.0	£17,228.5	£176,754.5	£188,246.0	£185,845.0
F-6	Surplus/(Deficit)	-£163.0	£397.0	-£143.0	£708.0	£6,706.7	-£457.9
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)	£1,282.0	£1,367.3	£2,140.0	£19,810.0	£14,988.3	£18,244.0
F-7	Cash Position (£'000)	£12,353.0	£11,262.0	£18,353.0	£12,353.0	£11,262.0	£18,353.0
F-4	Cost Improv. Prog. (CIP) (£'000)	£596.0	£488.0	£1,123.7	£6,608.0	£6,640.0	£9,354.3
F-8	Agency Spend (£'000)	£338.6	£434.0	£273.3	£3,691.4	£6,107.7	£5,935.4

** 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 February 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)	100.0%	100.0%				
QS1b	SI Investigation timeliness (60 days)	100.0%	0.0%	100.0%	100.0%	60.0%	100.0%
QS1c	Number of Incidents reported		465	390		5553	4820
QS1d	Number of Incidents reported that were SI's		5	4		25	25
QS1e	Duty of Candour Compliance	100.0%					
QS2a	Number of Complaints		96	133		96	133
QS2b	Complaints reporting timeliness (All Complaints)	95.0%	93.8%	69.0%	95.0%	66.8%	61.1%
QS3a	Number of Safeguarding Referrals		770	766		9587	9534
QS3b	Safeguarding Referrals relating to SECAmb staff or services		0	0		4	4
QS3c	Safeguarding Training Completed (Adult) Level 1	92.0%	70.6%				
QS3d	Safeguarding Training Completed (Children) Level 1	92.0%	71.4%				
QS3e	Safeguarding Training Completed (Adult) Level 2	92.0%	89.1%				
QS3f	Safeguarding Training Completed (Children) Level 2	92.0%	89.8%				

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. March Board Changes:

- Duty of Candour KPI is still under development.
- Safeguarding training is now available as a percentage (rather than number of staff trained).

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.

SECAMB Board

Summary Report on the Audit Committee Meeting of 1st March 2017

Date of meeting	**1 March 2017**
Overview of issues/areas covered at the meeting:	The meeting considered papers covering Financial Reporting, Internal Audit, External Audit Risk Management/Governance and Contra-Fraud items. In summary, key matters were as follows • The committee noted that good progress was being made in Risk Management / Governance matters, albeit that further development was urgent. • The committee approved the preparation of the 2016/2017 accounts on a going concern basis but felt that it was premature to consider the relevant wording to be set out in the accounts at this time. • The committee noted, with surprise, the relatively positive assessment of Internal Controls in the draft head of Internal Audit Opinion for the 2016/2017; however, the Internal Audit team may yet revise this.
Reports *not* received as per the annual work plan and action required	An updated Risk Register was included in the Committee papers at a late stage. Whilst the committee commended the work done, the committee felt that it had insufficient notice to consider the Risk Register properly at this meeting
Changes to significant risk profile of the trust identified and actions required	none
Weaknesses in the design or effectiveness of the system of internal control identified and action required	In view of the number of disappointing Internal Audit Reviews undertaken during 2016/2017, and other well documented shortfalls, the Audit Committee was surprised by the relatively positive draft overall Internal opinion presented to the meeting. Internal Audit explained that their program for 2016/2017 was not yet fully completed and, therefore, that their final opinion may change. The committee emphasised to Internal Audit that it was seeking a proper, fair and, above all independent view of SECAmb's systems of control in order to help the organisation better focus it resources and priorities
Any other matters the Committee wishes to escalate to the Board	**Board Assurance Framework** - the BAF led to significant discussion at the committee. The focus on key "Strategic" risks was supported although there was some doubt as to whether, in practice, the approach proposed would prove sufficient to give the Board definitive confidence in the overall effectiveness of the risk management / controls / governance environment. The committee finally decided to support the proposed approach subject to a review in around 6 months' time

	Risk Management Strategy & Policy - the Committee noted substantial development in this area but was not persuaded that the proposal was sufficiently customised to South East ambulance at this stage. The executive undertook to revise the paper considering points made and to consult with the Audit Chair in view of her particular risk management expertise.

SECAMB Board

Escalation report to the Board from the Finance & Investment Committee

Date of meeting	14 March 2017
Overview of issues/areas covered at the meeting:	This meeting was an exceptional FIC held by conference call to cover the following items: • Progress on PID and 2017/19 Contract following mediation in December 2016 – update to be provide at Board following further meetings with CCG's during March 2017 • Update on potential contract extension for 111 – to be further discussed at part 2 of Board due to commercial sensitivity • Approval of lease for property in Gatwick to house major incident vehicles – to be further discussed at part 2 of Board due to commercial sensitivity
Reports *not* received as per the annual work plan and action required	All reports received as requested
Changes to significant risk profile of the trust identified and actions required	Risks remain as previously identified
Weaknesses in the design or effectiveness of the system of internal control identified and action required	None identified at this meeting
Any other matters the Committee wishes to escalate to the Board	Approval of lease on property in Gatwick as requires Board approval per SFI's.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	216/16

Name of meeting	Trust Board
Date	29 March 2017
Name of paper	Summary of Lampard Inquiry report findings and recommendations
Responsible Executive	Emma Wade. Director of Quality & Safety
Author	June Hopkins Designated Nurse Safeguarding Children
Synopsis	In February 2015 Kate Lampard and Ed Marsden published their report into the themes and lessons learnt from the NHS investigations into matters relating to Jimmy Savile. An assessment tool was developed and all NHS organisations have been required to complete it. This report reviews the assessment carried out on behalf of SECAmb. Overall, the trust meets the requirements set out however, there are actions that could be taken to provide a greater level of assurance, these are covered within section 3.
Recommendations, decisions or actions sought	The Board is recommended to review and discuss the findings, recommendations and implication for the trust

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**

Summary of Lampard Inquiry report findings and recommendations Title of Report

1. Introduction

1.1. This report provides information on the Lampard Inquiry and reviews the trusts recorded evidence in meeting the requirements set out in the self-assessment tool,

2. Back ground and over view of the Process

2.1. On October 3rd 2012 an ITV broadcast identified allegations of abuse toward teenagers had been made against Mr Jimmy Savile. Following this broadcast, the Metropolitan Police launched "Operation Yewtree"

2.2. Over the next 2 years hundreds of people came forward which included a number of allegations against Savile which had reportedly taken place in health provider establishments.

2.3. In October 2012, The Secretary of State requested Kate Lampard to provide independent oversight to the investigations against NHS organisations[1].

2.4. As part of the investigation, calls for evidence from many other providers of care were requested to assess the processes in place today which would reduce the likelihood of such activities being perpetrated in today's system.

2.5. These centred on the following key questions?

- Safeguarding – how policies, procedures and practice take account of and affect patients, visitors and volunteers within NHS settings
- Governance arrangements in relation to fundraising by celebrities and others on behalf of NHS organisations
- The use and value to NHS organisations of association with celebrities, including access, accorded to them by NHS organisations
- Complaints and whistle blowing – how and to what extent do policies and procedures and the culture of NHS organisations encourage or discourage proper reporting, investigation and managements of allegations of the sexual abuse of patients, staff and visitors in NHS settings

2.6. All NHS organisations were required to complete the Lampard Self-Assessment tool and if requested provide additional assurance to CCG's, NHS England and Local Safeguarding Boards.

2.7. The safeguarding Team completed the assessment with input from HR and the complete tool will be reviewed by the Executive Team in March 2017.

[1] K.Lampard (2014) Independent oversight of NHS and Department of Health Investigations into matters relating to Jimmy Savile

3. Lampard Self-Assessment Tool

3.1. For the Trust completed tool see Appendix A

3.2. Update on Actions passed their completion date: Regarding Point V As of the 20th of March 2017 there are 4 cases where there is missing information but in each case the individual is either off on long term sick or have been suspended from duty.

3.3. Further recommended actions

- Review Self-Assessment Tool annually to ensure ongoing compliance
- HR to Audit requirements set out in 1,11,V11 & V111 to provide robust evidence of compliance.

4. Summary

4.1. The completed Self-assessment tool demonstrates that the Trust has systems in place which address the requirements set out by K Lampard. However, there are actions that can be taken to provide a greater level of assurance that the systems in place are effective.

5. Recommendation

5.1 The Board is asked to note this report.

Annex A: REPORT ON TRUST PROGRESS IN RESPONSE TO KATE LAMPARD'S LESSONS LEARNT REPORT

NAME OF TRUST:	South East Coast Ambulance			
Recommendation	**Issue identified**	**Planned Action**	**Progress to date**	**Due for completion**
I. All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors.	All visitors to the service complete an observer declaration	Observer declaration already in place	complete	Complete – standard practice
II. All NHS trusts should review their voluntary services arrangements and ensure that: • They are fit for purpose; • Volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and, • All voluntary services managers have development opportunities and are properly supported.	Volunteers are recruited in line with Trust substantive recruitment – no variation for volunteers	Safe recruitment policy in place	complete	Complete standard practice
III. All NHS hospital staff and volunteers should be required to undergo formal refresher training in safeguarding at the appropriate level at least every three years.	The training strategy for all SECAmb staff including Volunteers is currently being developed.	Training Strategy which will include details of how training refreshers are continually reviewed, updated and delivered. Draft strategy to be presented to safeguarding Group in March 2017.	Draft Strategy being written	Draft March 2017 Sign of by 30th April
IV. All NHS Hospital trusts should undertake regular reviews of: • Their safeguarding resources, structures and processes (including their training programmes); and, • The behaviours and responsiveness of management and staff in relation to safeguarding issues. • to ensure that their arrangements are robust and operate as effectively as possible.	Recent review undertaken. Options paper being developed. Annual report will include information contained within section IV. Bi monthly Safeguarding Meeting monitors compliance, offer challenges and reports directly to the Board. Bi annual completion of CCG's Assurance &	Audit Programme to be developed, and annual reporting to include evidence .	Audit programme	Annual Report due April 2017

	Accountability tool. Bi annual completion of Section 11's for 3 local safeguarding boards.			
V. All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.	Recent review identified missing DBS information on ESR and missing DBS's.	All Service Centre & Resourcing Team retained 22/2/17. Missing information to be added to ESR and completed by 3/3/17.	Started with 173 missing records now 52 and all missing info to be completed by Fri 3/3/17.	Fri 3/3/17
VI. All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.	New Policy issued by communications team for Social Media use on 13/12/17.	This policy is available via the intranet and was issued in the weekly bulletin.	No breaches all social media sites are checked daily.	Ongoing
VII. All NHS hospital trusts should ensure that arrangements and processed for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.	No issues identified, the same recruitment process is followed for agency/interim/contract and permanent staff.	Continue to follow the process.		
VIII. NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.	No issues identified, all recruitment processes sit with the Director of HR	Continue to follow the process.		
IX. NHS hospital trusts and their associated charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect this.	No associated charities	NA	NA	NA

I confirm that this Trust Board has reviewed the full recommendations in Kate Lampard's lessons learnt report:	
SIGNED:	DATE:
CE NAME:	

		Agenda No	217/16
Name of meeting	Trust Board		
Date	29 March 2017		
Name of paper	Changes to CQC Registration		
Responsible Executive	Emma Wadey Interim Chief Nurse/ Director of Quality & Safety		
Author	Emma Wadey Interim Chief Nurse/ Director of Quality and Safety		
Synopsis	The CQC require any changes to a location of a registered service to be approved by the Board prior to the application being made. The Trust's application relates to the new HQ in Crawley.		
Recommendations, decisions or actions sought	The Board are asked to approve these papers for submission to the Care Quality Commission.		
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**	

CHANGES TO REGISTRATION WITH THE CARE QUALITY COMMISSION

1. Introduction

This paper seeks approval of the Board to make a change to the Trust's registration with the Care Quality Commission (CQC), relating to the location of the Trust's HQ. Such applications are made under section 19 of the Health and Social Care Act 2008 and regulation 15 Care Quality Commission (Registration) Regulations 2009.

2. Application to change Location of Trust Headquarters

Currently all our regulated activity is registered under one single location, Trust Headquarters at Banstead. Due to the relocation of the Trust Headquarters to Crawley there is a requirement to add Crawley to the Trust's 'statement of purpose'.

3. Recommendation

The Board of Directors is asked to approve the stated change to the Trust's Care Quality Commission (CQC) registration.

4. Next Steps

Subject to approval, the application will be submitted to the CQC with a revised Statement of Purpose.