South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

27 April 2017

10:00-13:00

Tangmere MRC

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
01/17	10.00	Chairman's introduction	-	-	RF
02/17	10.01	Apologies for absence	-	-	RF
03/17	10.02	Declarations of interest	-	-	RF
04/17	10.03	Minutes of the previous meeting: March 2017	**Y**	Decision	RF
05/17	10.05	Matters arising (Action log)	**Y**	Discussion	RF
Organisational culture					
06/17	10.10	Patient story	-	Set the tone	
07/17	10.15	Chief Executive's report	**Y**	Information	DM
Trust strategy					
08/17	10.25	Unified Recovery Plan Update ▪ Recovery ▪ Quality ▪ Finance	**Y** **Y** **Y** **Verbal**	Assurance	JA JA EW DH
09/17	10.50	Sustainability & Transformation Plan Update	**Y**	Information	JA
10/17	11.00	Board Assurance Framework	**Y**	Decision	PL
11/17	11.15	Staff Survery Results	**Y**	Information	SG
Ten minute Break					
Allocating resources to achieve plans					
12/17	11.35	Finance Plan 2017/18 CIP	**Y**	Assurance	DH
Monitoring performance					
13/17	11.45	Integrated performance report	**Y**	Assurance	DM
14/17	11.55	Q4 Quality Review Visits	**Y**	Assurance	EW
15/17	12.05	Medicines Management	**Y**	Assurance	FM
16/17	12.15	Clinical Outcomes Deep Dive	**Verbal**	Assurance	FM
Holding to account					
17/17	12.25	Escalation report; Quality & Patient Safety Committee	**Verbal**	Information	LB
18/17	12.35	Escalation report; Finance & Investment Committee	**Y**	Information	GC
19/17	12.40	Any other business	-	Discussion	RF
20/17	-	Review of meeting effectiveness	-	Discussion	ALL
Close of meeting					

Date of next Board meeting: Tuesday 30 May

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, Wednesday 29 March 2017

Lewes HQ
Minutes of the meeting, which was held in public.

Present:

Sir Peter Dixon	(PD)	Chairman
David Hammond	(DH)	Executive Director of Finance & Corporate Services / Acting Chief Executive
Alan Rymer	(AR)	Independent Non-Executive Director
Emma Wadey	(EW)	Executive Director of Quality and Patient Safety
Fionna Moore	(FM)	Executive Medical Director
Joe Garcia	(JG)	Executive Director of Operations
Jon Amos	(JA)	Acting Executive Director of Strategy & Business Development
Lucy Bloem	(LB)	Independent Non-Executive 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

197/16 Chairman's introductions

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

198/16 Apologies for absence

The following apologies were noted;

Graham Colbert	(GC)	Independent Non-Executive Director & Deputy Chair

199/16 Declarations of conflicts of interest

The Trust maintains a register of directors' interests. Although on the Register, LB noted her connection with Delloite who have been jointly commissioned by the Trust and CCGs in connection with the contract.

No additional declarations were made in relation to agenda items.

200/16 Minutes of the meeting held in public February 2017

The minutes were approved as a true and accurate record.

201/16 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.

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Resolution:
The Board appointed TP as the independent non-executive lead for Whistleblowing/Freedom to Speak Up.

202/16 Patient story [item taken after 203/16 - 10.24 – 10.31]
The video was played which was about a patient's experience during five different contacts with our services. Each experience was very positive, both with regards to the ambulance service and the service at the hospital they were taken to.

EW reflected that these experiences demonstrate the range of jobs our staff are involved in. PD felt that while the experience was positive, perhaps there was a missed opportunity for the system involved in this patient's care to have agreed a specific care plan, which might have been more proactive rather than reactive.

203/16 Chief Executive's report [10.05 – 10.24]
PD thanked DH for taking agreeing to act in to the role of Chief Executive following Geraint stepping down early.

DH took the report as read and highlighted the following;

- CCQ inspection in May – we appointed Suzanne Rostrum to help support our preparation for the CQC inspection in May and ensure we are well prepared.
- Staff Awards – very important to recognise the good, life-saving, work our staff do every day.
- NHS Staff Survey – disappointing feedback, although not unexpected. We have much work underway to address concerns since the survey was completed last Autumn.

On contract negotiations, TH asked about the implications of any delay on payments. JA confirmed that there was a recent meeting with NHSI when it was agreed that we would move to the new contract from 1 April 2017. Delloite has been appointed to undertake the independent review in to the 'structural gap'. The aim is for the report to be completed by the end of April and so an update will be provided then. The recommendations and next steps arising from the report are to be agreed by the end of June 2017. In the meantime, we have agreed with commissioners an interim approach for Q1.

The Board discussed the risk related to a party(s) not accepting the outcome of the independent review. DH confirmed that NHSI is very clear that there are rules to be followed as this is a formal process, which will ensure we all must follow the outcome of the review. The consequences of any subsequent funding gap will have to be worked through, and this will effectively mean stop doing some things and / or do them differently.

AS asked whether Delloite will look at the quality improvement we are trying to implement. JA confirmed they would be.

TP expressed concern that we seem to be signing up to cost reductions without an agreed financial settlement. DH explained we have segmented between the supply and demand issues (funding versus performance) and the internal efficiencies we should be making anyway. This means we haven't signed up to anything we shouldn't be doing already. TP challenged this by asking why we are signing up to anything without a clear settlement. JA explained this is because if we don't, we will roll over this years' contract which is less beneficial to us. TP acknowledged this.

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PD reminded the Board that while the staff survey was completed in the Autumn, the previous years' survey had a detailed action plan and so we should look back at that to see why it didn't have the expected outcomes. This will help us to avoid repeating anything that hasn't delivered.

On paramedic re-banding PD asked for clarity on the cost implications. SG confirmed that the funding has now be released from the center for the Band 5's who qualify for the uplift. Therefore, there is no expected direct cost to us. DH added that there has been assurance given that this will be the case going forward, but it hasn't yet been fully worked through and so it is still a risk to the organisation.

LB referred to the National Audit Office report and some of the key points for the Board. LB expressed some surprise that we have the second lowest number of calls in country. DH explained that we need to do some sense-checking of this data. JA is completing a detailed review as some Trusts count calls in very different ways which may account for some of these variations. DH confirmed that we will use this report in a way that brings best effect.

204**/16** **Unified Recovery Plan** [10.31 – 11.02]

DH reminded the Board that the URP is updated regularly and so what is in the papers reflects a certain point in time. Red-ratings does not signal failure, but the risk to achievement. At the Board we can't talk about everything so the aim is always to focus on the most significant issues.

URP Progress

JA confirmed the first paper sets out the process and governance to ensure good flow of information and oversight. The revised quality impact assessment has resulted in a more robust process, but we now need to embed this into the culture of organisation. We are coming to the end of year one of the URP and so some projects are coming to a close. Through the PMO we have a formal closure process to ensure smooth transition to business as usual.

PD felt that it still feels a bit clunky. TH disagreed and confirmed from the perspective of the Workforce and Wellbeing Committee it works well. From the executive point of view, DH explained that we live and breathe this and it is actually quite slick.

AR noted the need to address the issue of sustainability, as we are in the PMO still relying on external support (EY). In response to this, JA set out the post-EY plan, which includes the new project managers that have been appointed as part of the transition to a permanent (in-house) team. The Head of PMO joins mid-April and further project managers early May. As we lose a member of EY permanent staff join with a good handover. JA was confident in this transition plan. DH added that we have prepared a draft business case to extend EY for short time. Also, the outcome of the Delloite review may generate some items which will require additional, short-term, PMO support. There may be opportunities to fund some of this through special measures money.

LB felt that the CAD and EOC projects are quite agile. The QIA process isn't perfect (as reflected in the QPS Committee escalation report later in the agenda). LB suggested that as we transition in to a substantive PMO, it would be a good idea to arrange the odd day back through EY, to get their quality assurance view on the team. This will give the Board a different source of assurance that our PMO development is robust.

Recovery

JA highlighted that the key movements from what is in the paper include EOC/HQ. It is still red due to final niggles as we close in on the move, but there is food progress on some of the procurement and business continuity issues which was escalated to the Board last month. The CAD has taken a slight backward step,

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related to training. This is partly resolved by support we have arranged from another Trust who have same CAD. Finally, there is slippage in the roll out of i-pads (on-boarding), which needs focus over the next few weeks to get us back on plan.

JG confirmed that in terms of scheduling, we have sought a third party view on how we forecast. The issue around performance management is about the OU restructure and how we provide accurate and relevant information to first-line leaders about their specific teams. We have basic metrics but need more details, e.g. workforce attendance. Finally, the demand management risk is about needing clinical sign off which will happen shortly.

LB asked about job cycle time. JG confirms it is part of URP and is reducing. Over the past 8 weeks it has reduced by 6 minutes.

AR said it is positive that we are reducing gaps overall across trust, but expressed concern that we are still a bit short on some of the workforce information. Suggesting that the Board should press for the right level of detail about where there are significant gaps. PD confirmed that the granularity of this should be available when needed, but warned against the Board getting too swamped in detail and risk missing the bigger picture.

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Quality

EW set out the main headlines;

- Decrease in areas at risk
- Still three areas at risk which hasn't changed since February's update. These are medicines management; patient care records; and clinical audit. The Clinical Audit plan has had rigorous review.
- In terms of incident management – this is reported by exception to reflect the fragility of the incident management team.
- More positively, is the success of infection prevention and control which has moved to business as usual.

LB asked about clinical audit and suggested we should step back and reflect on this. She reminded the Board that we identified issues prior to the CQC inspection in May 2016 and invested time and resource in improving clinical audit. So to see this now as an area at risk suggests that we have failed collectively. LB asked how we have we let this happen.

FM's initial reflection is that clinical audit doesn't have a very high profile at the Trust and there is very little proper 'clinical' audit going on. We need to focus more on how we are improving outcomes rather than counting numbers. There are also gaps in the team.

205/16 Bullying & Harassment Update [11.02 – 11.04]

SG explained this is to update the Board on where we are with the work being led by Prof. Lewis and provided assurance that the business as usual work is still ongoing. There has been a high degree of engagement (1700 staff responded) to this survey and we are on track to deliver the report in June 2017.

The Board welcomed this work and was impressed with number of staff that have responded to the survey.

206/16 Workforce Strategy [11.04 -11.14]

SG confirmed that this strategy is before the Board for approval, following the work that has been undertaken to develop it since January. The plan is to the get basics right and build from there, as reflected in the year- one objectives. SG corrected an error in the paper at 2.5 that the FTE is hours lost not posts.

EW updated the Board that our mental health nurse consultant has started and will support this program.

TH suggested that it should be the Chief Executive who actually signs the strategy. The Board agreed.

AS asked about the table at paragraph 2.5 in the paper and what proportion of roles are filled. SG explained we have an 8% vacancy rate, so when you add to this the sickness rate, training and annual leave, this helps to explain the pressure on services. AS suggested that this needed to part of the consideration of the review being undertaken by Delloite, to demonstrate what we can reasonably provide.

PD summarised that this strategy is fundamental, especially in the context of number of staff assaulted.

Resolution:
The Health and Wellbeing Strategy was approved and will be signed by the Chief Executive

207/16 Urgent & Emergency Care / Handover Delays [11.15-11.39]

JA introduced these papers explaining that they set out the impact and key actions we are taking. In terms of handovers we have received national and regional guidance. The paper describes the number of actions we are taking with A/E delivery boards. Appendix 4 is the self-assessment tool which we are working through with hospitals and A/E delivery boards.

DH confirmed that at the meeting on Friday 24.04.2017 with NSHI he reiterated that the current way in which the STF is constructed for acute trusts in some ways is a disincentive to the work needed to address handover delays; if they achieve the 4-hour target they get STF and there is no penalty for delaying ambulances.

TH felt that management is doing what it can, and we as a Board need to help as we are making little progress.

TP agreed this is a recurrent problem and noted that handover delays aren't mentioned in STPs and so STP leads should be challenged on how they are considering this. We should also raise through the Chief Executive of acute trusts to ask what action they are taking and what we can do to help.

DH reminded the Board that Delloite's work will help to support our position further as handovers consist a significant part of the structural gap.

PD added that while this is a recurring issue, the good news is that it has moved up the national agenda. He asked what ACE is doing. JA confirmed the guidance from ACE has come out but we need to ensure action is being implemented.

The Board agreed a need to be more proactive as there have been too many words and not enough action. The new Chief Executive and Chair are scheduled to have a series of high-level meetings with this center of the on agenda.

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AR asked whether there was any update on the ambulance response program. JG explained that the final research report is due in April. The aim is to implement it by October 2017. The first phase for us is to map data trends across the new category of response Cat 1 – 4. This will require us to adapt to meet the changing profile of activity. When report is ready the Board will consider it given the implications on what we do. FM noted though that ARP is unlikely to have any significant impact on handover delays.

Resolution / Action:
On behalf of the Board, the new Chief Executive and Chair will increase the pressure to ensure action, working with local MPs / Acute Trusts

208/16 Risk Management Policy [11.39-11.47]
DH reminded the Board of our journey and the need to have something in place which helps to support improved risk management.

AS expressed her view on risk management and concern that the strategy can be improved to give greater chances of success.

AR asked about a section on how to articulate a risk. EW confirmed this will be included.

Resolution
Strategy & Policy approved with a 6-month review

209/16 Financial Recovery Plan [11.47-11.59]
DH confirmed that we are on track and cautiously optimistic we will meet our forecast end of year position of £7.1m (deficit). The response from staff to help our financial recovery since the turn of the year has been excellent. The Board acknowledged this.

DH reflected that much of the good work has been about better grip and control. We must maintain this momentum as business as usual, going in to 2017/18 and beyond.

For 2017/18, we are looking at a stretched target of £17-18m, to achieve the £14m CIP. The PMO is assisting us with some of this work and we have a system in place to support delivery. NHSI has been well engaged in terms of assurance and is comfortable with our approach. DH noted caution that some schemes will deliver, but some won't, and where this is the case new schemes will be identified. Our QIA process which is embedding, builds on the process we have had in place before.

AS was concerned that through PID negotiations we don't squeeze ourselves too much, which impacts on our reasonable ability to deliver the money and quality.

LB confirmed that the QPS Committee will be seeking assurance that the impact on quality is properly mitigated before the cost improvement schemes are approved.

Comfort break 11.59 – 12.08

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210/16 Medicines Management [12.08-12.10]

FM confirmed the amount of work done since the CQC inspection last May, and updated the Board on the external review commissioned to ensure further learning. Regular updates will be provided to the Board and this is a standing agenda item for the QPS Committee. The external review is phased with phase one due to report at the end of April.

211/16 Integrated Performance Report [12.10 – 12.30]

Workforce

SG referred to some of the data set out in the paper. On stat/man training the push over last few weeks has resulted in an improved position to just over 90%. There has been good work too on the reduction of agency workers. A significant number have moved in to permanent roles. There are fewer requests for agency so culturally we are seeing a shift in our approach to agency.

Operations

JG confirmed that February was a challenge, as set out in the paper. Red 1 had improved and was the best since April 2016, but we are still under our agreed trajectory. There has also been a reduced resource-to-incident ratio, and time-to-clear has improved too.

DH added that there is much work through the URP on performance. As we unpack this other issues are exposed, but all this helps to put us in a stronger position to make sustained improvement.

AR asked whether call cycle time should be added as a KPI. Exec will review this as part of its work on the integrated performance report.

Clinical Effectiveness

FM drew out from the report the key issues, including the potential discrepancy in how we report data and the work we need to do in improving care bundles.

Quality

EW highlighted that we are now completing 72-hour reports for all SIs in month. The number of incidents is increasing which is what we planned for and is a positive sign. However, there is much work to do to improve the timeliness of investigations and ensuring we implement learning. EW noted the real success story around complaints, despite this showing in the report as red. 93.8% is the highest response rate for some time. It is red because we imposed a really challenging target of 95%.

PD asked how we demonstrate learning from complaints and other feedback including compliments. EW confirmed that we struggle to demonstrate this in many areas, not just complaints, but this continue to be a focus going forward.

On compliments, LB asked how we manage these. EW explained that we are introducing a survey monkey to ask staff how they want compliments recorded/shared. To include how it links to individual records for appraisals.

AR asked about duty of candor and whether we are meeting this requirement. EW confirmed that we are not meeting it consistently, especially relating to incidents of moderate harm. For severe harm we have much more confidence, mostly because these incidents are much clearer. The issue with incidents of

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moderate harm is related to interpretation. QPS Committee is testing our compliance with duty of candor at its meeting in April.

Finance

DH confirmed that this was covered in the earlier item. The only addition is to note the cash position and being on track with the drawdown and plan to pay back in Q2 of 2017/18.

212/16 Quality & Patient Safety Committee [12.30-12.39]

LB highlighted the PCR issue as set out in the paper and the need to get assurance in this area. PD confirmed that we need to start disciplining staff if we don't get papers, which are also of good quality, on time, otherwise it adversely impacts on board governance. LB confirmed PCR will be covered in April's QPS meeting.

In terms of quality impact assessments, the Committee was not assured that the process is consistently applied, which is concerning given this is an important safeguard. DH explained that the executive reviewed the QIA process immediately following the QPS Committee meeting and through the PMO amended it to reflect the feedback from the Committee. LB confirmed this.

On medicines management the Committee is assured this is getting the right focus, although still much work to do to put things right.

The Committee was also assured of the plans to develop the Quality Account and the new quality and safety report was positively received. This helps the Committee, on behalf of the Board, really get a sense from the data the quality of our services.

213/16 Audit Committee [12.39-12.40]

Much of the discussion on risk management considered by the Committee has been discussed earlier (item 208/16) and so AS drew from the report the challenge the Committee gave to the draft internal opinion, believing it might be too favorable given where we are and, on the Board Assurance Framework, confirmed that the Committee agreed to proceed with the current structure, and if doesn't quite work we can revise it.

214/16 Workforce and Wellbeing Committee [12.40-12.44]

TH informed the Board of the Committee's concern about the issue it considered as part of the review of the risk register, relating to the Disability Act. SG confirmed that a stair-lift has since been approved and will be fitted shortly.

TH also highlighted the concern about having an incomplete workforce plan. Despite this, reasonable assurance was gained about the progress being made. The concern is more about there not being a formal document. SG confirmed that the HR business partners have been working up a workforce plan to cover 3-5 years. In hindsight, this was a bit too optimistic and so have been re-tasked to develop a one-year plan.

DH noted that in the past we have been good at drafting a plan but without it being based on robust data; this time it will be.

215/16 Finance and Investment Committee [12.44-12.45]

The Board noted this escalation report.

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216/16 Lampard Report – Annual Update [12.45-12.46]
EW explained that this is before the Board as an annual update to note the progress on the actions, as set out in the paper. EW confirmed all DBS checks are now completed.

The Board noted this update

217/16 CQC Registration [12.46-12.46]

Resolution
The Board approved this amendment to the CQC registration

218/16 Any other business [12.46-12.53]
On behalf of the Board, DH thanked PD for his chairmanship over the past 12, difficult, months. And wished him well for the future.

PD reflected on his time at the Trust and thanked Geraint, the whole executive and Board for the work in trying to ensure the Trust's recovery.

219/16 Review of meeting effectiveness
Members content with timeliness of papers / discussion

Questions from observers

One question was received in advance of the meeting:

Given the amount of money being spent on the new CEO and Chair can we be guaranteed that they will 'manage' a turnaround in SECAmb? If not, why are we paying them so much?

PD responded by confirming that nothing can be guaranteed. But our recruitment process has been robust in getting the right people to take us forward. The rate of pay is in line with other Trusts. We need to support them both in delivering what will be a tough task.

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

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

Date _____

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South East Coast Ambulance Service NHS FT action log

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
23.02.2017	187/16	The findings from the Quality Reviews to be shared with the Board in April	EW	27.04.2017	Board	C	**On agenda**
23.02.2017	187/16	The findings from the bullying and harassment work to be shared with the Board in June 2017	SG	29.06.2017	Board	IP	**Added to Board Agenda for 29.06.2017**
23.02.2017	193/16	A deep dive in to clinical outcomes for the Board in March to include longer term trends.	RW	29.03.2017	Board	IP	**FM to provide verbal update on 27.04.17 with a paper to come to Board in May**
23.02.2017	193/16	Board to confirm who the NED will be aligned to whistleblowing / freedom to speak up.	PD	29.03.2017	Board	C	**Board agreed in March that this would be TP**
29.03.2017	207/16	On behalf of the Board, DM and RF will increase the pressure to ensure action on hospital handover delays, working with local MPs / Acute Trusts	DM / RF	Q1 2017/18	Board	IP	

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	07/17

Name of meeting	Trust Board
Date	27.04.2017
Name of paper	Chief Executive's Report
Executive sponsor	Chief Executive
Author name and role	Daren Mochrie
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

April 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. I was pleased to start with the Trust on 1st April 2017 and have been made very welcome by all those staff I have met so far. I have been working through my induction programme, which includes visiting as many Trust locations as possible, as well as meeting key external stakeholders.

2.1.2 New Chairman, Richard Foster, also started with the Trust on 31st March 2017 and is working through his induction programme.

2.1.3 The Trust also announced on 13th April 2017 that Director of Workforce Transformation, Francesca Okosi, has left the Trust to pursue other interests.

2.2 Care Quality Commission (CQC) inspection

2.2.1 As reported previously, the CQC will be re-visiting the Trust between 15th & 18th May 2017.

2.2.2 The Trust has now completed and submitted the Provider Information Return (PIR) to the CQC as part of the pre-inspection process and is continuing to prepare for the visit, which will be hosted at the new HQ/EOC at Crawley.

2.2.3 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.

2.3 Paramedic banding

2.3.1 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 national Band 6 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.

2.3.2 In SECAmb, the process for migrating eligible paramedics onto Band 6 is now underway, as agreed with staff side representatives and all eligible staff have now been contacted.

2.4 New HQ/EOC up-date

2.4.1 The final fit out of the new building at Crawley is now virtually complete and furniture and fittings are being installed.

2.4.2 Dates for the move have been finalised and shared with staff and will take place between 1st May and 12th June 2017.

2.4.3 The re-location of staff and the de-commissioning of the Lewes site will be completed by 30th June 2017.

2.4.4 The Trust has commissioned a company called Ignite to support the move and they are working closely with us to support the move, induction and familiarisation of staff at the new site.

2.5 Performance over Easter period

2.5.1 Performance in both 999 and 111 over the Easter period was strong. The Operational Team had worked hard to plan for sufficient resources to respond to predicted demand and were supported by no significant issues in the broader system.

2.5.2 I would like to thank all the staff involved on the road, in the control rooms and in support areas for their hard work during this period.

3. Regional Issues

3.1 Contract negotiations

3.1.1 Following agreement by the board in March the Trust is working with commissioners to finalise an extension to the current NHS 111 contract until March 2019, providing the Trust and commissioners with a transition year between the current contract and the procurement of Integrated Urgent Care contracts.

3.1.2 This will allow new models of care to be tested, building on the strong performance being delivered by the current NHS 111 contract.

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 The Trust is continuing to work closely with the Hospitals Trust and local commissioners regarding potential changes to acute provision over coming months.

3.2.3. However, changes were made to the provision of stroke services at the Kent & Canterbury Hospital on 11th April 2017, requiring a diversion of acute stroke patients conveyed by ambulance to alternative sites. The Trust is

continuing to work closely with local partners to manage the impact of this change.

4. Recommendation

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

Daren Mochrie QAM, Chief Executive

19th April 2017

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	08/17

Name of meeting	Board of Directors
Date	27 April 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 brief update on the progress made in relation to improving the Programme Management Office (PMO) and governance structure to oversee programme delivery. There is also a summary of the current position of each of the three Steering Groups; Organisational Recovery, Quality (i.e. CQC must do's) and Financial Sustainability, which form the Unified Recovery Plan (URP). More detail is provided through separate dashboards on the URP and CQC.
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).	**Yes/No** **NO**

Unified Recovery Plan Delivery Progress

1. Introduction

1.1. This paper provides the Board with a summary of the progress of the Programme Management Office (PMO) and highlights a number of updates in relation to governance for noting; Programme Risk management, Quality Impact Assessment Process (QIA), and Turnaround Executive.

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 a summary within this paper and separate dashboards, for Organisational Recovery and Quality, to show what has been achieved since the last reporting period up to 13th April 2017.

1.3. The purpose of the paper is to ensure the Executive Management Board is sighted on a number of key governance updates, the progress of the URP and in particular notable risk areas.

2. PMO and Governance update

2.1. The three Steering Groups have been running for over three months and are working well, with much better visibility and grip of the projects. The focus continues to be on driving delivery through greater accountability and management of issues and risks. The highlight report system has been fully implemented and are being successfully utilised, which is supporting effective project management and assurances through the governance structures.

2.2. There continues to be a focus on ensuring the Programme is comprised of projects that will improve performance and enable the Trust to be sustainable going forward. This has involved closing and re-scoping a number of projects, particularly within the Organisational Recovery workstream to ensure active projects are effective and outcome driven. More information is provided in the Organisational Recovery Dashboard for project closures that have occurred (Appendix 1).

2.3. Through the recently introduced HQ/CAD/Informatics Programme Board there is much greater visibility and management of the interdependencies between these projects. A critical path across the projects is being developed to ensure full sightedness of the dependencies and milestones. The project boards for HQ and CAD have increased in frequency as the projects move into critical delivery stages.

2.4. The Turnaround Executive which occurs weekly is proving very beneficial in ensuring that escalations from the Steering Groups are managed in a timely and

responsive manner. This is having a huge impact on the pace and progress of the projects. It is also being used to ensure that Programme risks are actively reviewed on a regular basis with a clear process in place for being sighted on key risks. There is a comprehensive programme risk log which is primarily fed from the risk logs of the steering groups ensuring there is a bottom up view.

2.5. The revised QIA process produced through the PMO has been formally approved by the Turnaround Executive with a paper going to the Quality and Patient Safety Committee on the 25th April for consideration. See appendix B for an outline of the QIA process. This process has also been shared at the Senior Management Team (SMT) meeting. It was very positively received and there is wide recognition of the value and requirement to follow such a process. Through the PMO, there will be continuous focus to ensure the process is fully embedded within the wider organisation.

2.6. The focus for the coming month will be to continue to embed the PMO processes, including the QIA to support effective management of the URP projects. Furthermore work is underway to develop a sharepoint site which will be used as a repository for information, tools and guidance, enabling the wider organisation to access and utilise best practice materials.

2.7. Communications relating to the URP has been in place for the past two months with regular 'matters' newsletters for Finance, Quality and People. There is also ongoing targeted communications in relation to the HQ/EOC moves, which is proving very effective. A communications plan for the programme is being finalised and will be taken to the Turnaround Executive for consideration.

3. URP Progress and Risks

3.1. The move to integrated highlight reporting, consistent across the three Groups, continues to be beneficial and is being used across the Programme. Risks and issues are being highlighted in progress update discussions which is enabling more rapid resolution and better mitigation to keep projects on track.

3.2. A programme plan mapping milestones across the projects is being finalised for review by the Turnaround Executive. This will be key to connecting interdependencies across the projects and for highlighting pressure points in terms of delivery. This will enable the organisation to be consider phasing where appropriate to mitigate risk to delivery. An example of this has been the re-phasing of the HQ/EOC moves to support the milestones of the new CAD go live milestones.

Organisational Recovery:

3.3. Within the Organisational Recovery Steering Group a number of 999 and 111 projects have been closed, following the, now embedded, project closure process which requires benefits, evidence and handover plans to be clearly documented and

approved. These are summarised on the dashboard, which is included in the appendices, with the Private Ambulance Provider example. The focus for this workstream going forward, as agreed with Joe Garcia, Director of Operations, is on Hospital Handover and Hear and Treat. This will allow resource to be targeted to drive improvements in areas which are likely to have a high impact performance.

3.4. Particular focus this month has been on the EPCR project and re-scoping this given it has not fully met the timescales for full deployment of the iPads. This has led to the project being turned red and closer scrutiny being applied. The project level governance is currently being reviewed and will see an increase in the regularity of project boards, revised membership including ensuring appropriate input from operations and a new project team. A revised plan is being produced which will be reviewed by the Executive Sponsor at the end of April for approval.

3.5. The programme board for HQ/EOC move, CAD and Informatics has been running for a month now and is working well to ensure progress is maintained at pace, and interdependencies actively monitored. The first corporate moves are due in early May, with the first EOC move towards the end of May. Both milestones are currently on track and there is now targeted focus on day one readiness to ensure risks are effectively mitigated. Ignite (an external company) has been engaged to deliver a workforce change piece relating to culture and new ways of working. They will work closely with the PMO communications lead to engage staff in the lead up to the moves.

Quality:

3.6. Significant work has been underway in relation to the must and should do CQC areas. A stocktake of the must do areas was undertaken by the Medical Director, Chief Nurse and PMO in March to assess delivery against milestones, with a clear plan of immediate actions produced to drive further improvements during April.

3.7. Particular focus has been on medicines management, which is undergoing an external review and will have a task and finish group established to drive progress. In addition there has been a lot of work on the patient records and clinical audit action plans with good progress made in both areas.

3.8. The clinical outcomes project has recently been reprioritised to focus on task cycle time and ACQI performance. A thorough working session has been undertaken to ensure the projects are fully scoped with clear actions and outcomes to get traction on delivery.

3.9. With the impending CQC inspection, significant efforts will be directed to ensuring the preparations are completed. External support has been secured to support this process and information returns are being managed through the PMO.

Financial Sustainability:

3.10. The focus of the steering group until very recently has been on short term measures to reduce spend in the last quarter of 2016/17. Good progress was made and the final position is currently being validated. The final position will be confirmed following closure of the 2016/17 year-end accounts and validation of the savings achieved through the short term measures.

3.11. The focus going forward will be on developing and delivering the 2017/18 cost improvement plan (CIP). Additional resource has been secured to support the development of a comprehensive CIP governance framework and the first planning session took place on 11th April 2017. Communications will go out to budget holders regarding the CIP programme with a briefing meeting to be held on 27th April 2017 allowing staff to engage in the process and ask questions.

3.12. As part of the governance framework, an end to end CIP process will be embedded with a 'how to' guide including supporting documentation produced to ensure sustainability of the CIP approach in future years.

3.13. A series of budget review meetings will be undertaken in April and early May to identify potential CIP opportunities which will build upon the initial plan proposed for 2017/18. Thereafter budget holders will be engaged through the steering group to rapidly identify and develop their CIP schemes. A key focus will be on the development of robust delivery plans to ensure the success of the programme.

4. URP dashboards

4.1. Further detail for each of the steering groups is provided through a series of dashboards;

4.1.1. Organisational Recovery Dashboard and exception report (Appendix 1)

4.1.2. Quality (CQC Must Do) Dashboard and exception report (Appendix 2)

4.2. The above two dashboards now include a summary section for project closures, as requested by the Trust Board. Any further comments as to the functionality and content of the dashboards is welcomed to enable further improvements.

5. Summary

5.1. This paper provides the Board with a summary of notable updates in relation to the PMO and progress against the URP. Progress continues to be made with increased control and grip over delivery.

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

5.3. From May there will be an additional dashboard to provide an update on the programme for 2017/18 CIPs as it develops.

6. Recommendation

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

6.2. The Board is asked to continue to support the programme governance and controls introduced to provide enhanced grip and provide assurance on delivery.

Unified Recovery Plan ("URP") Dashboard - ORSG

Extract from Improvement Tracker

Current period of reporting to 12 April 2017
Previous period of reporting to 15 March 2017

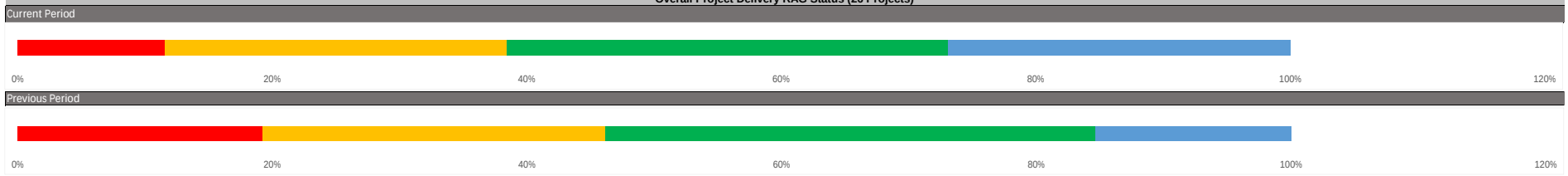
Last updated 13/04/2017

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

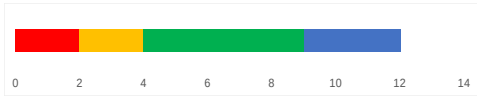
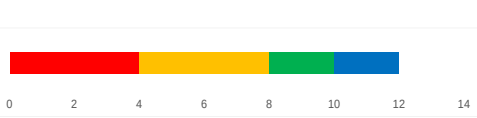
South East Coast Ambulance Service NHS
NHS Foundation Trust

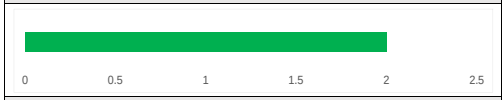
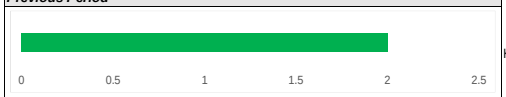
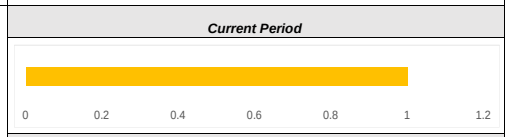
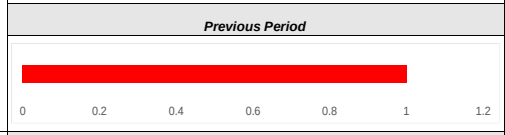
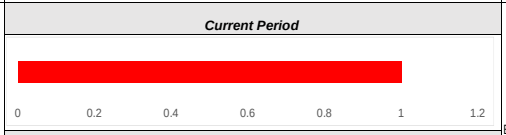
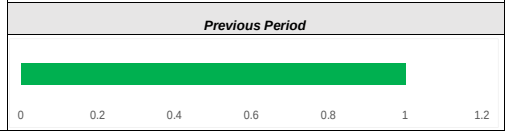
Overall Dashboard

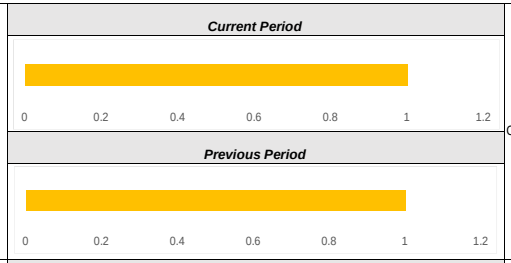
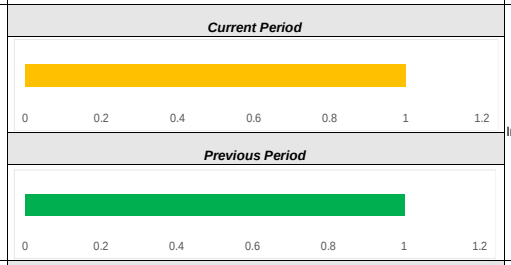
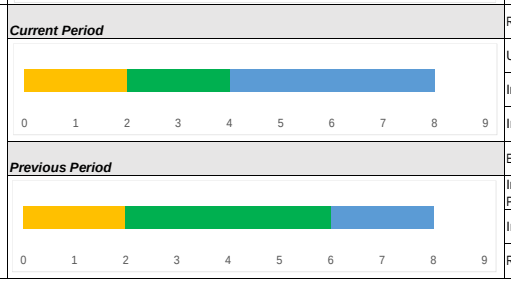
Overall
Overall Project Delivery RAG Status (26 Projects)



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")	Blue	Green	Giovanni Mazza	Joe Garcia	There have been a number of successes since the last board report. The incident command hub has been set up in Coxheath which will help reduce hospital turnaround time by providing co-ordination support to operational staff. The Conveyance and Handover Transfer of Care procedure has been issued to hospitals which will also drive a reduction in hospital turnaround time. As a result the project RAG status has changed from 'Red' to 'Amber'. In addition the response ratio project has successfully reduced the response ratio from 1.28 to 1.21 meaning the number of resources dispatched to calls has reduced. There has also been an increase in performance contribution for CFRs from 0.8% to 2.5% which has improved the effectiveness of the CFRs. During the Organisational Recovery Steering Group ("ORSG") on 28 February 2017, it was agreed with the executive lead and ORSG chair that a number of 999 projects will be closed down in order to refocus priorities to specific impact areas in order to improve operational performance.
			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	Blue	Sue Skelton	Joe Garcia	
			Improved effectiveness of Community First Responders ("CFRs")	Green	Amber	Sue Skelton	Joe Garcia	
			Revised demand management plan implemented ("Surge plan")	Amber	Red	Sue Skelton	Joe Garcia	
		Previous Period 	Improved call answer service	Green	Amber	Rob Mason	Joe Garcia	
			Reduced response ratio	Green	Green	Sue Skelton	Joe Garcia	
			Zoned Cars	Green	Amber	Chris Stamp	Joe Garcia	
			Increased Hear and Treat responses	Green	Amber	Karen Lillington	Joe Garcia	
			Improved Performance Management	Red	Red	Lynda Pegler	Joe Garcia	
			Reduced hospital turnaround time	Amber	Red	Dave Hawkins	Joe Garcia	

111	***2***	***Current Period***  ***Previous Period*** 	Effective operational performance management	Green	Green	John O'Sullivan	Joe Garcia	A draft project mandate and a high-level project plan has been completed for the new project which will be focusing on integrating governance between 111 and EOC. A short term objective will focus on meeting statutory requirements for 999 audits. Closure forms were presented to the ORSG on 15 March 2017. These are pending formal approval at Turnaround Exec once additional information requests have been completed. This is planned to be resubmitted by and will then turn blue in next month's update. During the ORSG both projects were commended due to number of successes. For example KMS 111 clinical performance has consistently been c.8% above the national 111 NHS target and the abandoned call rate has improved from 17% from March 2016 to 0.74% in February 2017, which is below the national rate of 2.24%.
			KMS 111 Recruitment and Retention	Green	Green	John O'Sullivan	Joe Garcia	
HQ	***1***	***Current Period***  ***Previous Period*** 	HQ Move / EOC Move	Amber	Red	Ibrahim Razak	Steve Graham	Good progress has continued to be made against the 'People' workstream as formal letters, including T&Cs, have been sent out to staff who have confirmed their intent to move to Crawley. In addition 60 EOC desks have been delivered to the new site ensuring provision for the Lewis EOC move at the end of May is on track, and continue to be delivered on a staggered basis. External consultants have been engaged to help drive forward the 'Day 1 Readiness' including focus on the communications and cultural aspects of the move. The project continues to be reviewed weekly under the 'Programme Board' which which provides a high level of scrutiny from the Exec and continues to drive forward overall project delivery.
EPCR	***1***	***Current Period***  ***Previous Period*** 	Electronic Patient Clinical Records ("EPCR").	Red	Green	Edyta Suszek	Jon Amos	This project is now reported as 'Red' as the initial project completion date of 31 March has now slipped due to software issues and a delay in on-boarding operational clinicians. It was agreed with the Executive Sponsor that the current project plan is not fit for purpose and that the best way forward to resolve the outstanding issues and to deliver EPCR clinical auditing as BAU by 28 February 2018, will be to set up a new project. During the period, activities and resource requirements have been identified and a initial draft project plan has been completed.

OU Restructure	***1***		OU Restructure (formerly "OU Leadership")	Amber	Amber	Sonia Belsey	Joe Garcia	The main success during the period is due to the fact that staff concerns have now been resolved through consistent engagement with the Executive Sponsor. Following resolution, 118 people have slotted into new clinical team leader ("CTL") roles which has left 35 vacancies. As at 13 April 132 applicants have applied for these vacancies. The focus over the coming weeks will be to finalise the new rotas. However the implementation of the team structure is still at risk of delay should more staff concerns arise, however, this is being closely monitored by the project team.
New CAD	***1***		Implementation of new CAD	Amber	Green	Phil Smith	Jon Amos	Good progress has been made during the period as training plans have been created for Coxheath and Crawley. In the addition the final IT systems infrastructure and solution design has been reviewed and signed off. The project continues to tracks as 'Amber' primarily due to the delay in agreeing the EOC training plan. However the EOC task & finish group continues to operate well on a weekly basis and has helped drive delivery. The project continues to be reviewed weekly under the 'Programme Board' which continues to provide a high level of scrutiny and continues to drive forward overall project delivery.
Culture / Workforce	***8***		Refreshing Values (formerly Improving Staff Engagement)	Amber	Amber	Steve Singer	Steve Graham	There has been a reduction in the number of agency staff which has reduced the cost avoidance by c.£269k (see closure report below for more information). The Finance Steering Group ("FSG") continues to review and monitor the level of agency expenditure on a fortnightly basis. The 'Establishing Workforce Information Systems' project has delivered its objective of establishing a robust ESR system which now provides better visibility over vacancy rates, staff turnover and staff absences. Given the nature of the remaining live Culture projects, it was agreed that these projects would now report into the Quality Steering Group ("QSG") in order to improve the level of scrutiny from a culture perspective.
			Updating HR Policies & Procedures	Amber	Amber	Barbara Macanas	Steve Graham	
			Improving Recruitment Rates	Blue	Blue	Clare Irving	Steve Graham	
			Improving Service Centre Processes	Blue	Blue	Samantha Pearce	Steve Graham	
			Establishing Workforce Information Systems	Blue	Green	Adam Van Huet	Steve Graham	
			Implementing New Appraisal System (formerly) Improving Performance Management	Green	Green	Steve Singer	Steve Graham	
			Improving Leadership Management	Green	Green	Steve Singer	Steve Graham	
			Reducing temporary staffing and agency costs	Blue	Green	Clare Irving	Steve Graham	

Exceptional Reporting

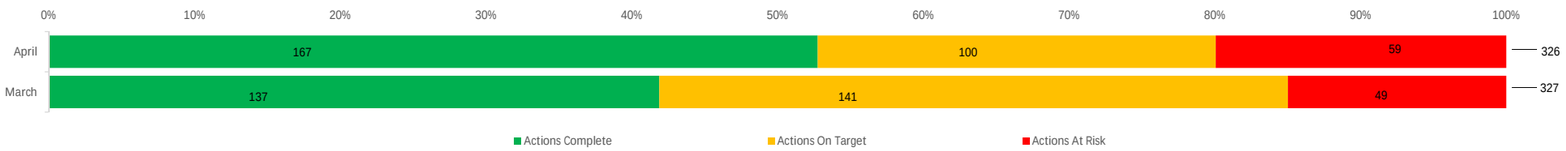
Workstream	Project	Executive Sponsor	Current RAG	Previous RAG	Rationale	Mitigating actions	Owner	RAG post mitigating action
EPCR	Electronic Patient Clinical Records ("EPCR").	Jon Amos	Red	Green	At risk as there has been a software issue which is causing some IPADs to crash when certain application updates are selected on the IPADs. In addition there has been slippage with on-boarding operational clinicians with the IPADs which was expected to complete on 17 March.	It was agreed with the Executive Sponsor that the current project plan is not fit for purpose as it does not incorporate sufficient activities to resolve the software issues nor does it outline an appropriate plan to on-board the remaining clinicians. It has therefore not met the original project milestones. A new project team has been established and has created a new draft project plan which identifies and incorporates the significant activates and outcomes needed to be achieved in order to resolve the current issues.	Jon Amos	Not applicable - change process will be implemented
999	Forecasting and scheduling	Joe Garcia	Red	Red	Overall project delivery rated as 'Red' 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. Consequently these delays have caused slippage in the project meaning the original project end date has been missed. Therefore the overall project delivery RAG status has not changed since the last board submission.	There were ongoing discussions at the start of the period explaining that the current project is no longer fit for purpose, given the change in Trust's circumstances, mainly including the external review of the Trust's forecasting system. It was agreed between the Executive Sponsor and ORSG chair during the ORSG on 28 March 2017 that the project would be closed down and handed over to BAU so that effort and energy could be refocused on other areas to improve operational performance.	Joe Garcia	Not applicable - project will be closed
999	Improved Performance Management	Joe Garcia	Red	Red	Overall project delivery rated as 'Red' due to lack of funds available to finance Lightfoot to implement the IDA process at Level 3 and 4 meaning overall project objectives cannot be achieved meaning the project has been unable to move forward. Therefore the overall delivery RAG status as remained unchanged in 'Red'.	During the ORSG on 28 March 2017, it was recognised that the current project is no longer fit for purpose as the Lightfoot programme could not be implemented due to financial restrictions. The Executive Sponsor and ORSG chair agreed that the project would be closed down and handed over to BAU in order to focus on high impact areas to improve operational performance.	Joe Garcia	Not applicable - project will be closed

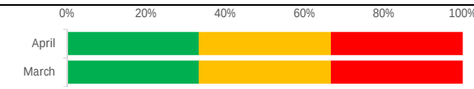
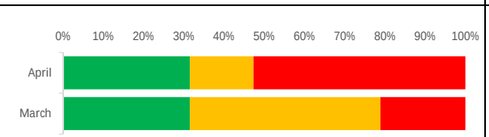
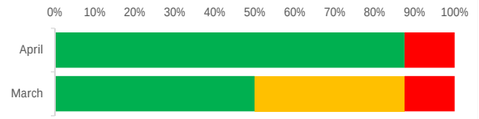
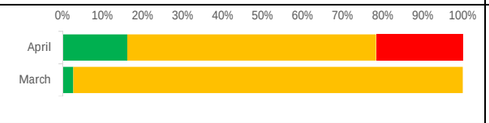
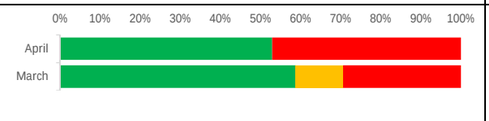
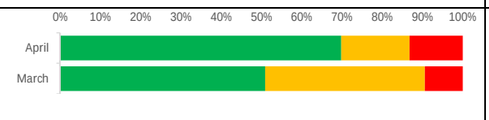
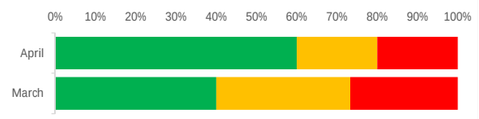
Closure Reporting

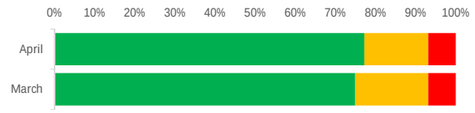
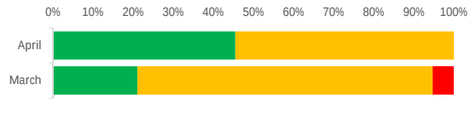
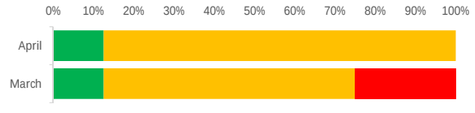
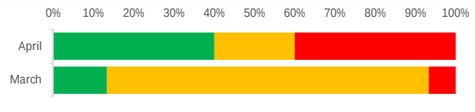
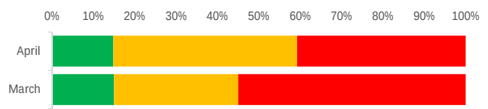
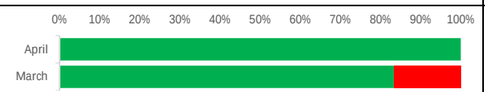
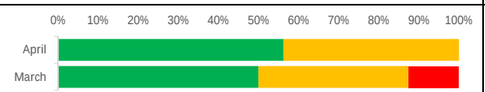
Workstream	Project	Executive sponsor	Project lead	Date project officially closed	Review date	Rationale for closure	Handover to BAU
999	Improve Supply and Effectiveness of Private Ambulance Providers ("PAPs")	Joe Garcia	Giovanni Mazza	05/04/2017	10/05/2017	This project has achieved significant efficiency improvements and was completed on time and within budget. The efficiency improvements in mobilisation time and non conveyance rates have meant that there was a performance contribution improvement from 1.9% to 2.5%.	The PAPs operations team will continue to monitor and actively manage performance against KPIs. A weekly update for both PAP Operational Performance and PAP Shift Delivery will be sent to all EOCs, ROMs and UOMs. Performance deterioration of more than 0.5% for two consecutive period will be escalated to SOLT.
Culture	Establishing Workforce Information Systems	Steve Graham	Adam Van Huet	29/03/2017	30/04/2017	This project has delivered a robust ESR system which has improved the process for managing recruitment, staffing levels and vacancy rates. The new and improved ESR system is ready to be handed back to BAU.	The process of updating budget and ESR date must be pro-actively managed on an ongoing basis to maintain accuracy. The project review will test whether sufficient maintenance has been provided.
Culture	Reducing temporary staffing and agency costs	Steve Graham	Clare Irving	22/03/2017	30/04/2017	The project objectives were achieved as the Trust now has revised guidelines to support the process of recruiting interims and has greater visibility over interims which has contributed to the financial saving.	The resourcing team will continue to monitor agency levels and will provide monthly reports to the Resourcing summit and Workforce & Wellbeing Committee. Reports will be escalated to the FSG if interim figure goes over an agreed threshold.

South East Coast Ambulance Service - CQC Must Do Improvement Tracker

CQC Dashboard - 15 April 2017



Domain	CQC Work stream	CQC Must Do	Confidence of delivery on time and realising benefits	Progress against actions% Complete On Target At Risk	Number of at risk items	Project lead	Executive lead	Progress summary	Project completion date
Safe	Security	2. Security Improvement Plan	On Target		4	Paul Cloves	Joe Garcia	Good progress continues to be made in improving security across the Trust with almost 60% of actions complete. A key priority for the following period is to continue embedding local ownership for security at EOCs and stations through audit and feedback, and ongoing communications. Unannounced CQC mock visits have highlighted security breaches at a number of stations, which are being acted on, and lessons learnt shared across the Trust	01/05/2017
	IT	3.0 CAD Improvement Plan	On Target		1	Mark Chivers	David Hammond	The new CAD installation continues to progress on track. This project has a dedicated project board and delivery team, and is closely monitored through the PMO. However, ongoing challenges remain with stabilising the current CAD. A number of issues were identified with the installation of the new gazetteer into a test environment, so this has been returned to the supplier for further work	01/10/2017
	Incidents	7. Incident and SI Reporting Improvement Plan	At Risk		10	Sara Songhurst	Emma Wadey	Continued growth in at-risk actions relate to ongoing capacity constraints within the risk team slowing delivery against timeframes. The interim risk manager has made good progress with reviewing the incident management process and policy, and temporary personnel have been appointed to support with clearing the backlog of incidents. The new Datix system has gone live, and a number of teething problems have been identified, these are being acted on immediately and contingency planning for risk management has begun in case significant changes are required	31/05/2017 (Date revised as original completion date no longer deemed achievable)
	Infection prevention	10.0 Infection Prevention and Control Improvement Plan	Complete		1	Aide Hogan	Emma Wadey	With all the improvement actions being embedded as BAU, this project has successfully been closed. There is one at risk action relating to 95% compliance with all infection control training. While the Trust is compliant with Level 2 training (96%), it is currently sitting at 67% for Level 1 training. This is believed to be caused by a system fault in counting online training figures, and is being actively managed through BAU. Progress with this is being monitored through internal governance, and monthly through the CQC reporting requirements	31/03/2017
	Medicines	14.0 Medicines Management Improvement Plan	At Risk		8	Fiona Wray	Fionna Moore	Slow progress is being made in the delivery of this action plan as a result of ongoing capacity constraints in the delivery team, and competing priorities with the external review of foreign medicines starting. These are discussed in more detail below. The Trust now has a Chief pharmacist in post, who is supporting this work, and further temporary resource is being sought through agency and local CCGs	31/08/2017
	Patient records	15.0 Patient Records Improvement Plan	At Risk		8	Fiona Wray	Fionna Moore	While this project remains at risk, there has been a significant increase in momentum with the appointment of a project lead and delivery support. A review of current processes with patient records has identified some concerns regarding security and governance of missing PCRs. However, some 'quick win' solutions have been identified, which should be implemented following initial testing. This is discussed in further detail below	01/05/2017
	Safeguarding	1. Safeguarding Improvement Plan	On Target		7	Sara Songhurst	Emma Wadey	Good progress is being made on the delivery of the action plan. The business case to bolster the capacity and capability of safeguarding team has been approved, and progress made on implementation. A key focus for the next period is to implement an effective audit and feedback process for safeguarding referrals to support ongoing quality improvement and ensure appropriate decision making around rejection of referrals	01/06/2017
Effective	Operational performance 999	8.0 Take action to ensure that national performance targets are met	At Risk		6	Sue Skelton	Joe Garcia	Projects to improve operational performance have recently undergone rationalisation to support targeted improvement of high impact areas such as hospital handover. While the current projects have delivered some improvement, the Trust will not achieve national performance targets, putting this project at risk. Re-prioritising focus has been agreed by Joe Garcia to target activities appropriately to improve performance, and has been discussed through the Steering Groups and Executive Turnaround meeting. Please refer to the Organisational Recovery Dashboard for further detail on next steps with operational improvements	31/03/2017

Domain	CQC Work stream	CQC Must Do	Confidence of delivery on time and realising benefits	Progress against actions% Complete On Target At Risk	Number of at risk items	Project lead	Executive lead	Progress summary	Project completion date
Responsive	Operational performance 111	16. NHS 111 Improvement Plan	Complete		3	John O'Sullivan	Joe Garcia	The key actions within this project have been completed. This has focused on improving operational and resourcing management within the service in order to improve performance and sustain effective service delivery. Key improvements have been embedded into BAU. These are detailed further within the Organisational Recovery Dashboard. Key outstanding actions refer to the current structure of the 111 service and improving the contractual terms with CareUK. These elements will be managed within the operations directorate	31/12/2017
	Outcomes	9.0 Outcomes Improvement Plan - Take action to improve outcomes for patients who receive care and treatment	On Target		0	Andy Collen	Emma Wadey	Ongoing work continues with reducing frequent caller rates and increasing referrals for falls and hypo's to support demand management. However, the key focus for this period has been on developing effective plans to improve performance on the national AQIs. A workshop was held with key commissioners and colleagues across clinical development and operations directorates within the Trust to identify priority areas for improvement and agree tangible actions. The focus for the next period will be to further develop and begin implementing plans	30/03/2018
	Scheduling	13. Safe Resource Dispatch	On Target		0	Chris Stamp	Joe Garcia	Progress continues with the sign off process for the revised deployment policy, which ensures that appropriate crew are deployed to jobs that align with their capability. Dates within the action plan have been revised to align with the new sign off process outlined in the policy on policies. The intention is to hand this project over to BAU, and continue to monitor through internal governance processes and monthly CQC reporting	30/09/2017
	HART	4.0 HART Improvement Plan	Complete		0	Andy Cashman	Joe Garcia	This action plan is complete. Formal closure documentation is underway and will be signed off at the Quality Steering Group within the next reporting period	31/03/2017
		12.0 HART Staffing Improvement Plan	Complete		0	Andy Cashman	Joe Garcia	This action plan is complete. Formal closure documentation is underway and will be signed off at the Quality Steering Group within the next reporting period	31/03/2017
Well-led	Governance	6.0A Corporate Governance	On Target		6	Peter Lee	Daren Mochrie	Key achievements for this period include the approval of the Trust-wide risk management strategy, and initial review of the draft organisational strategy. Growth in the number of at-risk actions relate to delays in updating out of date policies, and potential risks associated with the recent roll out of the new Datix system. These will be a key focus for the next period in preparation for the CQC re-inspection in mid-May	31/03/2018
		6.0B Clinical Audit	At Risk		11	Joe Emery	Fionna Moore	With the appointment of the clinical audit lead, a significant amount of planning work has been undertaken to support the development of an effective recovery plan for the clinical audit service. A key achievement has been the revision of the clinical audit procedure to support more consistent and accurate ways of working across the team. However, a key risk for this project is the ongoing vacancy in the Head of Clinical Audit post, to provide the subject matter expertise required. This is discussed further below	31/12/2017
	PTS	5.0 PTS Improvement Plan	Complete		0	Sue Skelton	Joe Garcia	This action plan is complete. PTS services have been decommissioned as of 31.03.17. Formal closure documentation is underway and will be signed off at the Quality Steering Group within the next reporting period	01/02/2017
	Resourcing	11.0 Staff and resourcing improvement plan	On Target		0	James Pavey	Joe Garcia	Progress continues with the sign off process for the revised meal break and abstraction management policies. Dates within the action plan have been revised to align with the new sign off process outlined in the policy on policies. The intention is to hand this project over to BAU, and continue to monitor through internal governance processes and monthly CQC reporting	01/03/2018

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	While some additional capacity has been provided to support the delivery of the action plan, through the Chief Pharmacist and interim supporting pharmacist, slow progress continues to be made on the delivery of this action plan. This is due to capacity constraints within the medicines management team, and competing priorities with the external review of foreign medicines starting	Red	Red	Conversations with the CCGs who may potentially be able to provide additional resource are ongoing, and a decision on this is expected by 21/04/2017 HR related matters are currently preventing recruitment to posts within the medicines management team. However, recruitment of additional interim personnel to support delivery is under way With the current resourcing available, prioritisation of actions has had to occur. The key focus at present is the external review, which is slowing progress on the delivery of the action plan	Amber	Fionna Moore	27/04/2017

Domain	CQC Work stream	Risk Description	Current RAG	Previous RAG	Mitigating action	Risk after mitigation	Owner	Date for resolution
Well-led	6.0B Clinical Audit	With the appointment of the Clinical Audit Lead, a plan to address the findings of the CQC regarding clinical audit has been developed, and progress is starting to be made on addressing immediate concerns. However, a key risk for this project is the ongoing vacancy in the Head of Clinical Audit post, to provide the subject matter expertise required	Red	Red	The medical directorate is working with HR to expedite the recruitment for the Head of Clinical Audit position. However, in the interim the Medical Director is providing closer scrutiny and oversight, and an informal relationship with LAS has been initiated to provide buddying support	Amber	Fionna Moore	31/05/2017
Safe	15.0 Patient Records Improvement Plan	There has been a significant increase in momentum with the appointment of a project lead and delivery support. However, a review of current processes within patient records has identified some additional concerns regarding security and governance of missing PCRs. These include compliance with the use of the new PCR storage boxes, and practicalities of continuing to audit PCRs locally if the new boxes are in use. Additionally, accuracy of information regarding missing PCRS, and the governance to manage these requires review	Red	Red	The project team will continue to develop proposed solutions to the risks identified, and take the necessary action to implement these A working session has been held with operational unit managers to identify quicks wins that will enhance compliance with the PCR boxes, and support ongoing audits of PCRs A pilot study is also underway to implement an incident shift log that will enable tracking of PCRs by paramedic, and improve the governance of missing PCRs The project team currently meets once weekly, and reports through to the Quality Steering Group on a fortnightly basis to provide an update on progress, key risks and issues, and seek approval to progress with proposed solutions	Amber	Fionna Moore	15/05/2017
Safe	7. Incident and SI Reporting Improvement Plan	Continued growth in at-risk actions relate to ongoing capacity constraints within the risk team slowing delivery against timeframes and minimising the team's ability to reduce the backlog of incidents. An additional number of issues have been identified which further increase the risk profile of this project: - The recently appointed Datix manager has withdrawn from the position, leaving this vacant - The new Datix system has gone live, and a number of teething problems have been identified, while the system is still usable, these issues need to be addressed	Red	Red	Temporary personnel have been recruited to support the reduction of the incidents backlog The Datix Manager position is currently being re-advertised. Consideration is being given to broadening the job role to make it potentially more appealing to candidates A meeting has been organised with the Datix team (20/04/2017) to understand the issues that have arisen, drivers behind this, and length of time to reach a resolution. Contingency planning is also currently underway in case the solution will require a longer period of time	Amber	Emma Wadey	28/04/2017

Summary of project closures

Domain	CQC Work stream	Executive sponsor	Project lead	Date of closure	CQC findings	Rationale for closure	Handover plan to BAU	Next review date
Safe	10.0 Infection Prevention and Control Improvement Plan	Emma Wadey	Aide Hogan	31/03/2017	Take action to adequately manage the risk of infection prevention and control. This includes: - Ensuring consistent standards of cleanliness in the ambulance stations and vehicles - Improving staff hand hygiene practices - Increasing capacity within the IPC Team to provide a more local IPC presence for staff	The following actions have been taken to address the findings of the CQC : - The development of a new IPC audit programme and supporting governance framework to ensure compliance with IPC is adhered to and actively monitored - Establishment of IPC champions in each OU to support the IPC team with training and embed changes in practice - New IPC audit tool for environmental use agreed, and monthly IPC Audit Tracker developed to monitor compliance - New IPC Practitioner joined the team on 5th January 2017, this has enhance capacity of the team and increased the monitoring and quality assurance capacity	Enhancing the capacity of the team through establishing operational IPC champions, and recruiting an IPC practitioner is key in sustaining the improvements made. These posts are supported with a clear work programme containing: - a comprehensive training plan using multiple different platforms, including e-learning on iPads - a robust audit schedule with a clear feedback loop through IPC champions - a clear governance framework where audit findings and IPC training compliance are discussed and actively monitored - New tools and techniques to support improved IPC	30/09/2017

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	09/17

Name of meeting	Trust Board
Date	27th April 2017
Name of paper	Sustainability and Transformation Plans (STP) - Update
Responsible Executive	Jon Amos, Acting Director of Strategy and Business Development
Author	Jayne Phoenix Associate Director of Strategy and Business Development
Synopsis	This paper provides an update on the STPs recent developments, key work streams, and actions underway.
Recommendations, decisions or actions sought	The Board are asked to note the update

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

Sustainability and Transformation Plans (STP) - Update briefing on the key developments in STPs and impact on South East Coast Ambulance Service NHS Foundation Trusts (SECAmb)

1.0 Introduction

1.1 This paper provides an update on the STPs recent developments, key work streams, implications for SECAmb, and actions underway. This is an update to the January Executive and Board papers.

2.0 Background

2.1 STPs continue to be the core-planning vehicle to develop place based plans that aim to take forward a sustainable care system across organisations. This was further reinforced in the most recent NHS policy guidance "Five year Forward View: Next Steps ", published on 31st March 2017. In order to ensure traction and ownership STPs are now required to appoint permanent leaders. The guidance has also reinforced that access to transformation funds and capital will be influenced by STPs. In addition, we have a CQUIN that requires proactive involvement with each STP.

3.0 Update

3.1 **Progress by STP –** each of our 4 STPS are at differing stages of development as regards progress and outputs. The key issues and challenges remain as follows: -

- Acute reconfiguration
- Urgent and Emergency Care
- Primary Care, Community Services and Clinical Hubs
- Workforce
- Accessing transformation funds
- Attendance and meaningful participation in all work streams
- Signing off submissions

3.2 **Kent and Medway STP** – SECAmb are partners and sit on the programme board, and relevant working groups. In March 2017 the STPs published a case for change, which can be found on the STP website www.kentandmedway.nhs.uk. There is also a newsletter. Work continues on all the work streams at pace. Kent and Medway have advertised the STP lead full time post in March 2017 to be appointed in April 2017. They also advertised a finance and commissioning lead post. We are finalising the STP CQIUN expectations for this STP

3.3 **Surrey Heartlands STP** – SECAmb are partners and sit on the programme board and relevant working groups. Work continues at pace and the latest on all areas was shared at two recent stakeholder events in February and March 2017. The STP has also developed a devolution proposal which looks to be able to take control of the use of all local NHS and social care funding to be able to spend it on local priorities. The STP now has a website and monthly newsletter, at www.nwsurreyccg.nhs.uk/surreyheartlands/Pages. The current lead officer is leaving to take up another job and a part time lead role is being sought to replace this post. We have an agreement on the STP CQIUN expectations for this STP

3.4 **Sussex and East** Surrey STP – SECAmb are partners and sit on the programme board. We are now sitting on some of the work streams and establishing which we need to be at. We are finalising the STP CQIUN expectations for this STP

3.5 **Frimley Health and Care STP** - SECAmb only serve a small part of this area, and so are partners and attend relevant work streams. Work continues at pace and this area is identified in the Five Year Forward View Next steps as one of the next 9 likely accountable care organisations. The STP now also has a newsletter and website: - www.fhft.nhs.uk/about-us/a-better-future-for-health-and-care/our-local-sustainability-and-transformation-plan-stp

4.0 Board level engagement

4.1 During January - March 2017- we had meetings with three of our STP leads with our CEO, Director of Strategy and STP representative- Associate Director of Strategy. This will be replicated for all areas with the new CEO, and Chairman.

4.2 We will continue to have the STP representative on the programme boards and other appropriate for consistency.

5.0 STP alignment to our developing strategy

5.1 Our developing strategy fully aligns with the STPs, noting what can be delivered locally and what needs to be delivered at a larger scale. In developing this we recognise the rapidly changing landscape of the wider health and social care economy, particularly in the light of STPs. As such our strategy will be dynamic and will focus at this stage on delivery in the first two 2 years, including as a core component further development of the component parts of our emerging strategy. This will ensure it is sustainable and built on firm foundations in dealing with current and future challenges, and has alignment to wider economy plans as they emerge.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	10/17

Name of meeting	Board of Directors
Date	27 April 2017
Name of paper	Board Assurance Framework
Responsible Executive	Executive Team
Author	Peter Lee, Company Secretary
Synopsis	The Board Assurance Framework (BAF) sets out the principal risks facing the Trust, the mitigation, and actions to be taken. It also confirms the current risk rating, and the target risk rating post treatment. The BAF does not, as is typical in the NHS, align to the Trust objectives (which align to the strategic goals) given the current strategy refresh underway. Once this is complete the BAF will be re-aligned accordingly. In addition to the BAF, this paper sets out the Trust's risk profile in the context of the new Risk Management Strategy & Policy approved by the Board in March, outlining the actions required to increase risk maturity and to strengthen risk management across the Trust.
Recommendations, decisions or actions sought	The Board is asked to consider the BAF and confirm its tolerance of the target risk scores as set out and form a view as to the adequacy of the arrangements in place to establish and maintain a sound system of risk management.

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

1. Background

The Trust has made some good progress towards the development of a stronger risk management framework. In March, the Risk Management Strategy & Policy was approved by the Board, outlining the objectives, structure and accountabilities for risk management. The strategy sets out the hierarchy of risks recorded on the Risk Register within the Trust and aligns the grading of all risks to the National Patient Safety Agency (NPSA) model for consistency and best practice. Other key developments within the period also saw the migration of risks from SharePoint to Datix to improve the reporting, monitoring and triangulation of risks.

Table 1: NPSA Risk Grading

NPSA Risk Level	Risk Score
Low	1-3
Moderate	4-6
High	8-12
Extreme	15-25

Table 2: Hierarchy of Risks

Risk Level	Risk Score
Strategic	15-25
Operational	8-12
Directorate	1-6

This Board Assurance Framework (section 3 below) sets out the principal risks currently facing the Trust and describes the mitigating controls and assurances, and is structured against the following objectives;

1. Recovery through the URP
2. Sustainable Workforce
3. Financial Sustainability
4. Strategic Direction
5. Consistent application of the Fundamental Standards
6. Achieving Statutory Performance Targets

Objective 6 is an addition to version 1 of the revised BAF received by the Board in January, and was included following feedback from the Board.

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

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

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

2. Risk Profile

Including the BAF, the Trust has 62 open risks recorded on the Risk Register (Datix). This number will increase as part of the migration to Datix of the locally held risks registers; for example, those relating to projects.

Strategic level risks (Appendix 1) represent 11% of all risks, operational level 60% and directorate level 29%.

87% of risks have been reviewed within the last month (100% of strategic risks, 92% of operational risks and 72% of directorate risks). As part of risk reviews, all strategic level risk owners were asked to review corresponding risk scores. Risk owners were challenged in instances where the initial risk score (pre-controls) was similar to the current risk score (post controls). In some instances, current risk scores were reduced to reflect the effectiveness of controls. However, there remains several strategic level risks where both initial and residual risk scores remain the same. The risk owners in this category believe the controls are mostly effective, but the current risk is influenced by external factors.

3. Recommendation

The Board is asked to confirm the extent to which is believes that the BAF;

i. Adequately describes the principal risks
ii. Accurately reflects the risk scores with the stated controls in place
iii. Includes sufficient actions to meet the target risk score
iv. Target risk score is tolerable and stretching

4. Next Steps

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- The Head of Risk Management will continue to work with risk owners (at all levels) on the visibility of risks by strengthening risks descriptions, controls, action plans and assurances.

- The nature of aged risks will be explored in more detail with risk owners to establish the effectiveness of risk management and to determine if the correct risk has been identified.

- A full account of risk movement will be undertaken for the next review taking into consideration risk escalation, de-escalation and risks transferred.

- Training Needs Analysis will be written to support the implementation of the Risk Management Strategy.

- A Risk Management Procedure will be written in April to support the Risk Management Strategy and roll out of Datix.

- The Datix risk register module will be configured to facilitate the effective triangulation and horizon scanning of risks with incidents, claims, safety alerts and complaints.

5. **The Board Assurance Framework**

Dashboard

Objective	Principal Risk(s)	Initial Score		Current Score		Target Score		Target Date
		C	L	C	L	C	L	
(Chief Executive) **Recovery through the URP**	Weakness in the governance structure which supports the oversight and delivery of the URP	4x4 = 16		4x3 = 12		4x2 = 8		Sept 17
(HR Director) **Sustainable Workforce**	Insufficient capacity and capability within key departments across the Trust	4x4 = 16		4x3 = 12		4x2 = 8		March 18
(Director of Finance) **Financial Sustainability**	Capability & Capacity of staff to own and manage budgets effectively and deliver required saving plans	4x4 = 16		4x3 = 12		4x2 = 8		October 17
	Size of CIP programme 7% of turnover							
	Uncertainty within commissioning (contract / identified structural gap)							
(Director of Strategy) **Strategic Direction**	No up-to-date strategy	4x5 = 20		4x2 = 8		4x1 = 4		July 17
(Director of Quality & Safety) **Consistent application of the Fundamental Standards**	Non-compliance with the Fundamental Standards (section 2 of the Heath & Social Care Act 2008 (Regulated Activities) Regulations 2014)	5x4 = 20		5x3 = 15		5x2 = 10		March 18

(Director of Operations) **Consistently Achieving Statutory Performance Targets**	Commissioning gap to supply sufficient hours	4x4 = 16	4x3 = 12	4x2 = 8	March 19
	Cost Improvement Plan				
	Increase in activity beyond forecast				
	Lost hours, e.g. sickness, hospital handover delays.				

Objective 1	Recovery through the Unified Recovery Plan		
Principle Risk	Weakness in the governance structure which supports the oversight and delivery of the URP	**Executive Lead**	Chief Executive
		Initial Risk	C4 x L4 = 16
Potential Impact	➢ Insufficient grip, pace and accountability ➢ Lack of understanding as to how the recovery programme is functioning ➢ False assurance being received about the progress being made ➢ Losing sight of strategic priorities through focus on current issues/actions	**Current rating**	C4 x L3 = 12
		Risk Treatment (avoid, reduce, transfer, accept)	**REDUCE**
		Target risk score	C4 x L2 = 8

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

- From 1 January 2017 a new assurance structure has been established to help ensure programme leads are held to account for delivery of the URP and to collate the evidence which demonstrates the same.
- Focus on the CQC must do actions (dashboard gives overview)
- EY has been commissioned to develop greater capacity and capability within the PMO
- Established improved reporting mechanisms through the governance structure, project to board. For example, highlight reports help the Steering Groups assess progress from the tracker.

Gaps in Control

- Ability to consistently ensure capacity with senior management and executive team to respond to both strategic priorities and immediate recovery.

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(- & +) CQC/URP dashboard shows a number of completed actions, but some which are at risk (- & +) Performance Review Meetings with NHSI demonstrate some areas of good progress, but lack of pace in others. (-) Steering Group still highlighting gaps in project-level controls (+) Quality Assurance Reviews to date broadly positive	▪ The pace of recruitment of substantive staff [e.g. Datix manager and PMs] ▪ Clearly defined metric(s) to measure benefit realisation ▪ Alignment of Programme Risk Register with new Trust-wide Risk Register ▪ Quality Assurance Reviews have covered only a few sites ▪ Quality Impact Assessments – process still embedding ▪ Interdependencies map between projects (to ensure nothing falls through the gaps between individual pieces of work)

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Develop greater capacity and capability within the PMO 2. Quality Assurance Reviews 3. PMO working through each action plan and project to re-test outcomes / benefits 4. Quality Impact Assessments process implementation	1. Recruitment to PMO 2. Paper setting out the plan for quality assurance reviews considered by the Executive and the annual schedule of reviews has begun 3. New reporting structure has been established 4. QIA process has been approved and engagement with staff underway to ensure it is well understood and embedded

Update	April 2017	Date discussed at Board	January 2017

Objective 2	Sustainable Workforce		
Principle Risk	Insufficient capacity and capability within key departments across the Trust	**Executive Lead**	Director of HR
		Initial Risk	C4 x L4 = 16
Potential Impact	➢ Lack of consistent leadership ➢ Insufficient ownership and pace re improvement ➢ Stop / start nature of interims ➢ Poor staff morale: ▪ sickness ▪ turnover ▪ patient care	**Current rating**	C4 x L3 = 12
		Risk Treatment (avoid, reduce, transfer, accept)	**REDUCE**
		Target risk score	C4 x L2 = 8

Controls in place (to manage the risk)

- Resourcing to the current funded establishment (vacancy rate currently below 10% target)
- Recruitment plan to recruit to all operational posts during 2017/18
- Moved from 170 to 70 agency workers, transferring many to substantive contracts
- Substantive Chief Executive & Chairman in post
- £0.5m to fund workforce-related initiatives provided by Health Education Kent Surrey & Sussex
- Two posts created with HR Directorate to focus on staff engagement started
- Board succession plan has been agreed
- Monthly resourcing summit between HR/Finance/Ops managers to track delivery of recruitment in operational services
- Restructure of executive team complete
- H&W strategy approved by the Board

Gaps in Control

- Corporate Department/Directorate workforce plans still in development
- Leadership development programme
- Board development programme

Actual Assurances: Positive (+) or Negative (-)	Gaps in assurance
(+) Integrated Performance Report showing 10% vacancy rate target being met (-) Workforce and Wellbeing Committee (-) Appointment & Remuneration Committee (ARC) (+) URP closed recruitment rate project as now business as usual (-) 2016/17 staff survey	

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.

1. HR Business Partners to develop workforce plans for each corporate department/directorate 2. Substantive Executive recruitment 3. Bullying & Harassment diagnostic review underway. 4. Leadership development programme in development 5. Purchase and roll out of an on-line appraisal system	1. Plans being developed; target is now end of May 2017 2. First posts to be advertised in May 2017 3. Review underway and to report in July 2017 4. Met with Kings Fund and a leadership development business case scheduled to be considered by the executive in Q1. 5. Roll out to whole Trust started in April 2017

Update	April 2017	**Date discussed at Board**	January 2017

Objective 3	**Financial Sustainability**		
Principle Risk	Capability & Capacity of staff to own and manage budgets effectively and deliver required saving plans Size of CIP programme 7% of turnover Uncertainty within commissioning (contract / identified structural gap)	**Executive Lead**	Director of Finance
		Initial Risk	C4 x L4 = 16
Potential Impact	➢ Not achieving financial plans and control total ➢ Inadequate cash reserves leading to borrowing ➢ Adverse impact on improvement plans and future investment strategy ➢ Adverse impact on quality / recovery	**Current rating**	C4 x L3 = 12
		Risk Treatment (avoid, reduce, transfer, accept)	**REDUCE**
		Target risk score	C4 x L2 = 8

Controls in place (to manage the risk)

- Finance team restructure
- Financial Sustainability Steering Group
- Executive challenge sessions
- Reinforcement of monthly budget (challenge) meetings
- Financial business partner model established
- Contract negotiations provided £3-4m improvement on initial offers
- Independent review jointly commissioned with CCGs to identify the commissioning gap
- Overdraft facility secured from NHSI
- QIA process reviewed

Gaps in Control

- Finance team restructure - initial aim was to implement the new structure in April but now will be end of June 2017
- All 2017/18 budgets and CIP schemes not yet established
- Investment Strategy based on current situation, instead of longer terms sustainability

Actual Assurances: Positive (+) or Negative (-)	Gaps in Assurance
(-) (+) Internal Audit (-) (+) FIC (-) NHSI	Budgets / Cost Improvement Plans (and associated QIAs) for 2017/18 not agreed/ signed off Currently there is no agreed plan on which to develop an investment strategy

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Following mediation work to address structural gap jointly commissioned by with the 22 CCGS – 2. Finance team restructure 3. CIP planning / QIAs / budgets	1. To be concluded by 29.04.2017 2. Planning started and aim to put in place by June 17 3. All plans to be agreed by the end of April with QIAs overseen by QPS Committee.

Update	April 2017	Date discussed at Board	January 2017

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

Controls in place (to manage the risk)

- Recruitment of a deputy director of strategy to lead the substantial refresh of the Trust's strategy
- Engagement of internal and external stakeholders to ensure their views are considered and fed-back to decision-makers in real time
- Sessions held with the Board, Council of Governors, Executive and Senior Management Team

Gaps in Control

- Although some work has started, there are a number of enabling strategies to review and / or develop
- Agreement of the clinical model
- Delay from March to May 2017

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

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Clinical Directors in the process of developing the new clinical model 2. Executive Strategy Group established to oversee the drafting and implementation of the strategy 3. Substantive recruitment to deputy director of strategy	Strategy Group considered the new clinical model at its meeting in April. The draft to be considered by the Board in April. New deputy director has been appointed.

Update	April 2017	Date discussed at Board	January 2017

Objective 5	Consistent application of the Fundamental Standards		
Principle Risk	Non-compliance with the Fundamental Standards (section 2 of the Heath & Social Care Act 2008 (Regulated Activities) Regulations 2014)	**Executive Lead**	Director of Quality & Patient Safety
		Initial Risk	C5 x L4 = 20
Potential Impact	➢ Inappropriate and unsafe provision of care and treatment ➢ Suspension or cancellation of our CQC registration to provide services ➢ Breach of contract with commissioners ➢ Regulatory, criminal and / or civil sanctions ➢ Poor use of resources	**Current rating**	C5 x L3 = 15
		Risk Treatment (avoid, reduce, transfer, accept)	**REDUCE**
		Target risk score	C5 x L2 = 10

Controls in place (to manage the risk)

- A quality and compliance work plan and strategy is being implemented to concentrate on the quality and compliance with the CQC Fundamental Standards (launched from February 2017).
- CQC Fundamental Standards staff handbook, developed in consultation with a wide range of internal stakeholders
- Quality Steering Group established to ensure improvement in standards
- Recruitment to key governance roles
- Staff training
- Upgrade to incident and risk management database
- Quality Assurance visits
- Revised clinical governance structure providing greater focus on monitoring of fundamental standards / escalation of issues

Gaps in Control

- Quality Strategy
- Vacancies / Interim staff within key roles, including risk and clinical audit teams
- Fundamental Standards self-assessment tool

Assurances: Positive (+) or Negative (-)	Gaps in assurance
(-) CQC comprehensive inspection and related s.29a Warning Notices (+) & (-) Board Assurance Committees – in particular negative assurance re medicines management, clinical audit, risk management, patient records. (-) NHSI diagnostic (safeguarding, incident and risk management) (+) Quality Assurance Reviews – x4 to-date (-) Internal Audit – incident management	▪ CQC re-inspection scheduled for May 2017 ▪ External well-led review – date to be confirmed

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Quality Assurance Reviews 2. Staff training workshops (safeguarding, SI and risk management) 3. Self-Assessment tool kit 4. Quality Strategy in development 5. Recruitment – Head of Risk / Datix Manager / H&S Manager / Head of Legal Services / Head of	1. Reviews ongoing – 2017/18 schedule agreed – 4 every month. 2. Started February 2017 and ongoing. 3. Due to start in Q2 (originally February 2017) 4. Included in overall Trust strategy development,

Safeguarding			with enabling quality strategy to be developed for Q2 5. Recruitment plan in place, aim to appoint to the key posts by Q3
Update	April 2017	**Date discussed at Board**	January 2017

Objective 6	**Statutory Performance Targets (Red 1, 2 & 19 plus call answering 95%)**		
Principle Risk	Commissioning gap to supply sufficient hours Cost Improvement Plan Increase in activity beyond forecast Lost hours, e.g. sickness, hospital handover delays.	**Executive Lead**	Director of Operations
		Initial Risk	C4 x L4 = 16
Potential Impact	➢ Failure to meet statutory targets ➢ Reduction in budgeted hours' output ➢ Adverse impact on patient safety and experience ➢ Adverse impact on staff health and wellbeing	**Current rating**	C4 x L3 = 12
		Risk Treatment (avoid, reduce, transfer, accept)	**REDUCE**
		Target risk score	C4 x L2 = 8

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

- Private Providers used to increase hours' output
- Overtime contingency
- Demand Management Plan
- Application of the Sickness Absence Policy
- Incident Command Hub provides consistent approach to hospital handover delays and other lost hours
- Independent Review on commissioning gap and agreed interim contract/trajectory for Q1
- Operational efficiencies related to call cycle time (change in vehicle mix to 70/30 split between DCA and SRVs has helped to achieve 6-minute reduction in call cycle time to clear during Q4 of 16/17)

Gaps in Control

- Surge Management Plan
- Formal clinical assessment team to enhance hear and team activity
- Agreed contract which sets out what performance we are commissioned to achieve
- Agreed budget / CIP - Quality Impact Assessment to help reduce the impact of CIPs

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**

(-) IPR showing that we are not meeting current trajectories (-) Forecasting tools showing comparison between forecast and actual activity (-) Lost hour reports showing volume of lost hours against output	▪ Data quality concerns ▪ Forecasting accuracy

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. To agree budget / CIP 2. Implementation of a Surge Management Plan 3. Clinical assessment team staff numbers identified (part of budget planning – in place by Q1) 4. Independent review of commissioning gap 5. Data quality being reviewed externally (6. Forecasting accuracy review	1. Budget / CIP to be agreed April 2017 2. Surge Management Plan out for consultation 3. Staff numbers identified for clinical assessment team – in place by end of Q1 4. Review to be concluded April 2017 5. outputs by Q1 to align with the introduction of the new CAD 6. External review commissioned to look at our forecasting accuracy to be concluded by Q1

Update	April 2017	Date discussed at Board	N/A

Appendix 1: Strategic Level Risks (Residual Score 15-25)

ID	Date Identified	Risk Area	Accountable Executive	Title	Description of Risk facing SECAmb	Lead Manager	Existing Controls in Place	Inherent Risk Rating	Current Risk Rating	Target Risk Rating	Action Points Addressing the Risk: Comments for increasing or decreasing ratings should be S.M.A.R.T.	Modified
254	31/08/2015	Operations	Chief Operating Officer	GP Out Of Hours	Risk that KMSS 111 is currently unable to operate effectively because of the persistent failure of the main GP OOH's service provider to deliver an acceptable service level, especially at periods of peak operational activity (i.e. weekends). This is caused by external pathway providers being unable to react to the volume of demand, resulting in increased Average Handling Time (AHT) causing: reduced operational efficacy; increased patient dissatisfaction; multiple call-backs into KMSS 111; elevated clinical risk with KMSS 111 referrals not being handled appropriately; a greater risk of financial exposure to the financial plan; and reputational damage through poor service provision.	John O'Sullivan;#4671	1. Operational performance reviewed on a daily basis and detailed reports (Inc. OOH's failings) submitted to Commissioners. 2. Staff resourcing reviewed daily and additional resource planned for anticipated OOH's failings. 3. Additional scripts created for staff handling calls from failing main GP OOH's service provider. 4. Additional clinician floor walkers put in place to support call handlers. 5. Current clinical performance is excellent and manages clinical risk effectively. 6. Monthly meetings held with main GP OOH's provider and weekly conference calls with Commissioners.	20	20	4	1. Detailed escalation plan (inc. coping with GP OOH's issues) has been created, submitted to and accepted by Commissioners. In addition, Winter Plan also created and accepted by Commissioners, giving assurance and mitigating risks. 2. Monthly meetings in place with main GP OOH's service provider to improve operational performance and communication. 3. Operational support given to GP OOH's providers to create a robust escalation plan. 4. Significant Administration team put in place at weekends in Ashford to manage call backs and GP OOH's issues. 5. Performance of GP OOH's provider monitored and data supplied to Commissioners as requested. 6. Concerns regarding GP OOH's service failings formally raised with Commissioners.	07/04/2017 13:33
259	06/01/2016	Clinical Operations	Chief Operating Officer	CAD threat to operational effectiveness	Threat to operational effectiveness due to instability of CAD software.	Rob Mason;#444	1. Complete review of CAD during Q4, potential rebuild following review during Q1 and implementation of new system during Q2 aimed at improving functionality and stability of system. 2. CAD Replacement Project is monitored by PMO and CAD Project Board. 3. Training Plan has been developed. 4. Migration Plan and business continuity plans have been developed with a view of reducing risk to 999 service as a minimum(untested). 5. Weekly checkpoint progress call with all operational stakeholders. of system.	16	16	4	1. Configure CAD so it meets the functionality required of the business and improves the stability. 2. Replacement of CAD in progress. 3.Roll out of new CAD planned for 4th July 2017 within the Coxheath EOC	13/04/2017 12:05
278	05/07/2016	Clinical Operations	Chief Operating Officer	Introduction of Ambulance Response Programme (ARP)	There is a risk that the CAD platform is not responsive to the changes of the Ambulance Response Programme (ARP) impacting on commissioning.	Joe Garcia;#5946;#Rob Mason;#444;#Sue Skelton;#90;#Richard Webber;#5637	1. Engagement in national forums for horizon scanning 2. Early engagement with commissioners	16	16	15	1. Exec strategy session planned for early August to develop action plan 2. Deployed and adopted nature of call and dispatch dispositon (ARP Phase 1) 3. Boarder risks around phase 2 of implementation	07/04/2017 13:42
319	26/09/2016	Workforce Transformation	Director of Workforce Transformation	No clear apprenticeship strategy	The absence of a Trust wide Apprentice Strategy due to poor planning, may lead to loss of income, reduced recruitment from a wider population, reputation damage and benefits relating to retention being missed.	Steve Graham;#5265;#Steve Singer;#5781	1. Head of Learning and Organisational Development has been assigned to write Trust Apprentice Strategy.	16	16	4	1. Strategy due for completion by end April 2017. 2. Strategy implementation. 03/11/16 - No update and score updated. 28/11/16 - No further update. Score remains unchanged.	06/04/2017 14:15
324	23/03/2017	Chief Executive	Chief Executive	Exec Team capacity and stability	Perceived continuity and stability of the Trust Executive Team due to organisational change at senior level.	Steve Graham;#5265;#Daren Mochrie;#6054	1. Chief Executive and Chair in post.	16	16	6	03/04/17 - Director of Workforce to present Recruitment Plan to Chief Executive for approval in April. 23/03/17 - Plan currently being developed to recruit substantive Directors and introduce Leadership Development for execs.	06/04/2017 14:59
147	21/06/2010	Operations	Chief Operating Officer	Turnaround Delays at hospitals within the SECAmb area	Loss of hours to deliver an operational service due to handover delays may adversely impact on patient care and have a detrimental affect on the achievement of performance.	Sue Skelton;#90;#Chris Stamp;#103;#Gerraint Davies;#10;#James Pavey;#197;#Rob Mason;#444;#Richard Webber;#5637	between the Trust and acute hospitals. 2) Daily review of turnaround times and subsequent deployment of local managers to affected hospitals. 3) Whole system turnaround policy. 4) Written agreement and monthly monitoring raised with Commissioners. 5) Developed and implemented best practice guidelines. 6) Prioritised actions for longest delays at hospitals with LHE. 7) Delays are monitored by the on call EOC Silver (Tactical) Manager who liaises with the Trust and escalates to Gold (Strategic) Manager if appropriate. 8) Handover flow chart produced to be signed off by commissioners. 9) Determine best practice and build into new policy agreement signed up by commissioners and external stakeholders. 10) Additional trolley used for co-horting. 11) HALOs in place as required/funded. 12)Immediate Handover - Standard Operating Procedure has been developed and implemented from 15th December 2014. In order to standardise the secamb approach to hospital delay we are implementing as of 3 aril and incident command hub to ensure that a tactical manager is on duty and available over a 24/7 period to provide consistency and approach to our	20	15	6	1) Ongoing monitoring of metrics for total time spent at hospital. 2) Regular reports on progress including clarity of targets and performance. 3) No diverts, unless agreed at whole health system level in exceptional circumstances. 4) SECAmb will not undertake co-horting of patients in emergency departments as a normal response to handover delays 5) HALOs (duty CTLs/Bronze managers) deployed to hospital sites in response to emerging handover delays. 6) Implementation of Immediate Handover as instructed by Silver and authorised by Gold. 7) Transfer of care agreement to be fully implemented in the three locations with the highest % of delays before consideration for wider roll out 8) PMO to have oversight of issue and monitor progress 9) Formation of task and finish group to explore further options 10) Conveyance and Transfer of Care procedure developed but not yet implemented	13/04/2017 16:11
260	01/04/2016	Commissioning	Director of Commissioning	Non-delivery of projected income and threat to service provision (16/17)	Non-delivery of projected income (2016/17 contracts) and threat to service provision due to loss of funding through fines of up to £15m and withholding of CQUIN income. Withholding of funding will impact on patient care and quality of services provided.	Jon Amos;#2130;#Jayne Phoenix;#5975	Monthly contract review meetings with commissioners to review performance against contractual standards. Performance penalties measured against improvement trajectory rather than national standards within the 16/17 contract. Removal of performance penalties in 17/19 contracts as part of the move to national STF funding. Monthly income review between commercial and finance to review expected income and debt recovery. Monitoring of expected CQUIN income through Finance Steering Group	20	15	12	1. Agreement of revised trajectory with commissioners (signed off Jan-17). Agreement from commissioners to reinvest fines 2. Operational Performance recovery projects, with monthly monitoring with commissioners 3. Income assurance process for CQUIN and planning process for more robust CQUIN assurance for 17-19 4. Renegotiation of NHS 111 contracts for 2017-19 to increase income per call	13/04/2017 10:40

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	11/17

Name of meeting	Trust Board
Date	20.04.2017
Name of paper	Staff Survey Results
Executive sponsor	Steve Graham, Interim Director of HR
Author name and role	Steve Singer, Head of Learning and OD Steve Graham, Interim Director of HR
Synopsis (up to 120 words)	This report informs the board of the key outcomes of the 2016 staff survey and updates the action plan from the 2015 survey to reflect the on-going work
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.
Why must **this** meeting deal with **this** item? (max 15 words)	To receive a briefing on key issues, as noted above.

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

2016 Staff Survey Report and Action plan update

Introduction

The 2016 SECAmb staff survey was conducted between 17 October and 01 December 2016. It was a paper exercise in which 1,334 staff (40%) participated. The results, with few exceptions, are worse than in 2015. The overall staff engagement score for the trust is 3.22 out a possible score of 5.00, compared with an overall engagement score of 3.30 in 2015 and a national ambulance service average of 3.41.

Structure and scoring

There are nine themes within the staff survey:

- Appraisals and support for development
- Equality and diversity
- Errors and incidents
- Health and well-being
- Working patterns
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and bullying

The report summarises the key findings for each of these sections. Responses are presented in two ways:

- as percentage scores;
- scale summary scores, converting responses into a five point scale, with a minimum of 1 and maximum score of 5 to each response

Reported year-on-year comparisons are with the 2015 SECAmb staff survey and the national average referred to is for ambulance trusts across the country.

Results

Appraisals and support for development

The percentage of staff appraised in the past 12 months was 78%, higher than the national average for ambulance trusts (76%), but lower than our 2015 score of 87%.

There is no year on year perceived difference in the quality of our appraisals, but the quality of our training, learning and development has decreased and is below the national average (a satisfaction score of 3.61 compared to an average of 3.90).

Equality and diversity

There are no significant year in year changes in the percentage of staff experiencing discrimination at work or in those who believe we provide equal opportunities for career development, although in both area we are worse than the national average: 27% of staff experienced discrimination against an average of 20% nationally with 64% believing that there are equal career opportunities compared with a national average of 70%.

Errors and incidents

There is no year on year change to numbers of staff witnessing potentially harmful errors, near misses or incidents, or to those reporting such incidents, with SECAmb being rated as similar on this dimension when compared with other trusts. However, we scored below the national average on both perceptions of the fairness and effectiveness of incident reporting procedures along with confidence in reporting unsafe clinical practice. On both these measures we also scored less well than in 2015.

Health and well-being

On the three key measures of health and wellbeing we scored worse than in 2015 and were also below the national average:

- The number of staff feeling unwell due to work-related stress has increased from 49% to 58% against a national average of 48%;
- The number of staff who felt pressured into coming to work despite feeling unwell has increased from 69% to 74% against a national average of 64%;
- Perceived organisation and management interest and action on health and wellbeing issues has decreased form a rating of 3.15 in 2015 to 2.98 in 2016 against an average national rating of 3.21

Working patterns

There are no year-on-year changes in numbers of staff satisfied with the opportunities for flexible working patterns (29%) or in the number of staff working extra hours (89%), although on both these measures we performed below average: 34% national satisfaction with flexible working opportunities and 85% of staff nationally work extra hours.

Job satisfaction

On all key measures of job satisfaction we scored below the national average and on four key measures we showed a year-on-year decrease in our ratings: staff motivation is rated at 3.48 against a 2015 score of 3.51 and a national average of 3.66; the percentage of staff able to contribute towards improvements at work has reduced fr0m 45% to 39% (national average – 46%); staff satisfaction with levels of responsibility and involvement is rated at 3.42 compared to a 2015 rating of 3.52, and staff satisfaction with resourcing and support has reduced from a score of 3.02 to one of 2.86.

Managers

On all key questions relating to managers we scored worse than in 2015 and were also below the national average on all questions. Recognition and value is rated at 2.74 against a national average of 3.02; only 12% of staff consider communication between managers and staff to be good, compared with 15% in 2015 and an average of 19% across all trusts, and perceived levels of support from immediate managers has gone from a score of 3.40 to 3.22 (national average – 3.44).

Patient care and satisfaction

We scored better in this section when compared with others such as 'managers' and health and wellbeing'. We were average on percentage of staff agreeing that their role makes a difference to patients / service users (87%), and there is no change in the perceived use if patient / service user feedback (2.95). However, in terms of perceived satisfaction with the quality of work and care they are able to deliver, we scored below the national average (3.65 against 3.84) and less well than in 2015 (3.65 against 3.76).

Violence, harassment and bullying

We have shown a year-on-year improvement in the percentage of staff reporting the most recent experience of harassment, bullying or abuse (up from 33% to 38%) and on a number of key measures there is no statistically significant year-on-year change in our results: percentage of staff experiencing violence from other staff is at 4%; number of staff who report violence is at 62%; and

the percentage of staff who have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months remains at 56%. However, although out year-on-year results show no real improvement or deterioration, we do score below the national average on a number of key measures relating to violence, bullying and harassment.

Survey Action Plan

The survey action plan developed in response to the survey reported in 2015 and 2016 is shown in Appendix 1. There were 5 major themes identified as those we should focus following those surveys, they are

- *Strengthen Leadership at every level*
- *Improve performance and access to development*
- *Encourage greater two-way Communication and increased staff engagement*
- *Promote and improve employee health and well-being*
- *Create a more inclusive and diverse workforce*
- *Enhance patient safety and the patient experience*

The majority of actions in the plan relate to issues also raised in the recent survey published in 2017 and an updated action plan is shown in Appendix 2. Some of the original actions have been replaced and some completed. There has also been a change in many of the leads for the actions

Conclusions

There are few surprises in the survey; rather it confirms what we already knew, and indeed action plans are already in place in a number of areas such as appraisal, wellbeing, and bullying & harassment. With a continued focus on improvement in these and other areas, the 2016 staff survey may well prove to be a turning point in the relationship between SECAmb and its most valuable asset; its people.

Recommendations

The Board are asked to:

1. Note the contents of the report
2. Note the updated action plan
3. Agree that focus continues on the 5 areas already identified

South East Coast Ambulance Service NHS
NHS Foundation Trust

Appendix 1: **2016 Staff Survey Action Plan**

Workforce Transformation Directorate

April 2016

The 2015 staff survey saw a total response rate of 40%, which is a 6% improvement on the 2014 survey results and 5% better when compared with the national average for ambulance services. Although the picture for 2015 is more positive than in the previous year, it is imperative that the Trust not only addresses the areas of continued concerns but also further consolidate the areas where improvements have been made following the 2014 survey.

There are five overarching themes in the 2016 Staff Survey Action plan and they are:

- ***Strengthen Leadership at every level - 2015***
- ***Improve performance and access to development - 2015***
- ***Encourage greater two-way Communication and increased staff engagement - 2015***
- ***Promote and improve employee health and well-being - 2016***
- ***Create a more inclusive and diverse workforce – 2016***
- ***Enhance patient safety and the patient experience 2016***

Proposed Work Stream	Action	Responsible	Executive Owner	What 'success' would look like	Date of Completion
Consolidation of actions from the 2015 Staff Survey Action Plan					
Strengthen leadership at every level	Continued rollout of the Band 8 Leadership programme	Marcia Daigo	Francesca Okosi	Managers will increase their confidence and effectiveness when managing and supporting their staff.	Mar 2017
	Establish and rollout the Band 7 Management Leadership programme	Marcia Daigo	Francesca Okosi		Mar 2017
	Support managers to develop competence in communicating and interpreting core briefs to their staff.	Marcia Daigo	Francesca Okosi		Sept 2016

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Improving Performance and access to Development	Maintain access to and attendance levels to Key skills training (95%)	Sally Wentworth-James	Andy Newton	Attendance at KST will meet or exceed the 95%	Mar 2017
	Improve the number of people receiving appraisals from 72% in 2015 to 85% in 2016/2017	Marcia Daigo	Francesca Okosi	Staff appraisals will meet of exceed 85%	Jan 2017
	Improvements the quality of appraisals to be monitored through pulse surveys.	Marcia Daigo/HRBPs	Francesca Okosi	Staff will feel their appraisal is not a tick box exercise	Mar 2017
Encourage two-way communication and increased staff engagement	Complete the rollout of the whiteboards across the whole Trust and ensure they are being actively used	Marcia Daigo	James Kennedy/ Francesca Okosi	Staff will feel informed and involved in making decisions at a local level to be determined by the the pulse survey.	Jun 2016
	The Communications team to send out 'message of the week' Communications team to ensure staff are regularly informed of corporate priorities	Janine Compton	Janine Compton		Weekly
	Improve communication capability at a local level to improve two-way communication between staff and local managers	HR Business Partners (HRBPs)	Francesca Okosi		Monthly
	Carry out Pulse Surveys to assess and monitor improvements and issues	Marcia Daigo/HRBPs	Francesca Okosi		Quarterly
	Encourage staff to treat each other with professional respect at all times	Senior Managers	Francesca Okosi		On-going

	Launch a new process to promote staff involvement through the 'voice of the employee'	Marcia Daigo	Francesca Okosi		Bi monthly

Work streams resulting from the 2016 Staff Survey *40% of staff, which is a (6%) increase, completed the 2015 staff survey.*					
Encourage two-way communication and increased staff engagement Improve the 2016 staff survey submission rate by 20% to a total of 60%.	Re-tender service to include National NHS Staff Survey and SECAmb local Pulse Surveys for 2016/2017 Develop a communications and engagement plan to encourage staff to complete the 2016/17 survey with "You Said, We Did" narrative Deliver workshops and 1:1 sessions to encourage and support managers and staff to complete the survey.	Marcia Daigo Marcia Daigo/HRBPs HRBPs	Francesca Okosi Francesca Okosi Francesca Okosi	The staff survey submissions will meet or exceed the target of 65%.	Apr 2016 Aug 2016 Sept – Nov 2016
16% of staff, which is a (2%) increase indicated that in the last 12 months they had personally experienced discrimination at work from, patients / service users, their relatives or members of the public.					
Create a more inclusive & diverse workforce Work with the Inclusion team to ensure equality and diversity awareness raising is incorporated into the culture change programme being rolled out across the Trust	Monitor discrimination complaints across the Trust Deliver equality and diversity training across the Trust Ensure all staff new to the Trust receive the Equality and Diversity handbook when	Marcia Daigo Angela Rayner OD Team Angela Rayner	Francesca Okosi Francesca Okosi Francesca Okosi	Reducing the number of discrimination complaints by 5% across the Trust is met or exceeded.	Quarterly May – Jan 2017 Apr 2016

	they attend the Corporate Induction Carry out a pulse survey to gauge whether staff feel they are being treated fairly regarding career progression / promotion, irrespective of ethnic background, gender, religion, sexual orientation, disability?	Angela Rayner	Francesca Okosi		Jul 2016
61% of staff, which is a (2%) increase indicated that in the last 12 months they have personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or members of the public.					
Create a more inclusive and diverse workforce Roll out the signed off Dignity at Work Framework across the Trust to address the culture change needed to reduce the number of bullying and harassment cases in the next 12 months.	Refresh the Bullying and Harassment policy Commission external expertise to deliver training and appropriate development interventions to all levels leadership levels in the Trust, with a view to facilitate an improved climate across SECAmb Communicate the Dignity at Work Framework to staff Carry out pulse surveys to better understand what might force staff, including 111, to make the decision to leave SECAmb	Marcia Daigo Robert Ivey Robert Ivey Marcia Daigo Marcia Daigo	Francesca Okosi Francesca Okosi Francesca Okosi Francesca Okosi	Reducting the number of bullying and harassment complaints by 5% is met or exceeded.	Apr 2016 May 2016 May – Jun 2016 May and Sept 2016
40% of staff, which is a (1%) increase indicated that in the last 12 months they have personally experienced physical violence / harassment, at					

work from patients / service users, their relatives or members of the public.					
Promote and improve employee health and well-being Develop a zero tolerance protocol across the Trust regarding violence against staff	Set up a small task and finish group (6-8 front line staff) to develop the protocol. Promote the protocol across the Trust Monitor complaints submitted by staff indicating they have experienced violence Design and deliver workshops to support managers and staff to address violence / harassment more effectively.	Robert Ivey HRBPs Rob Parsons Senior OD Consultant	Francesca Okosi Francesca Okosi Francesca Okosi Francesca Okosi	Reducing the number of complaints by 5% is met or exceeded.	Apr 2016 Jun – Aug 2016 Quarterly Jun & Sept 2016
21% of staff, which is a (2%) decrease, indicated they would not feel secure raising concerns about unfair clinical practice. 26% of staff indicated they neither agreed nor disagreed with this question.					
Enhance patient safety and the patient experience Encourage an environment where more staff are able to raise concerns and improve patient safety at all levels of SECAmb	Commission PCaW to deliver Raising Concerns at Work training for the Board and Executives Roll out the PCaW training across the Trust to promote the culture change and encourage staff to feel secure in reporting concerns.	Marcia Daigo Marcia Daigo	Francesca Okosi Francesca Okosi	The Executive Board will promote the strapline of 'Our People Our Priority' to underpin the culture change needed across the Trust.	Apr 2016 Apr 2016 – Mar 2017

34% of staff, which is a (5%) decrease, indicated that in the month prior to completing the survey, they had seen errors, near misses or incidents that could have hurt patients / service users.					
Improve patient safety and the patient experience Support a 4% reduction in errors, near misses or incidents in the next 12 months.	Monitor IR1 reports on a quarterly basis Produce an action plan when the emerging themes have been identified and analysed and ensure that lessons learnt and improvements made are regularly communicated back to frontline / 111 / clinical staff	Colin Taylor Richard Webber	Andy Newton Dr Rory McCrae	Reducing the number of incidents by 4% is met or exceeded.	Apr 2016 and quarterly
89% of staff, which is a (1%) increase, indicated they are working additional hours each week.					
Promote and improve employee health and well-being Monitor meal breaks and late overruns and take necessary action to ensure staff well-being is promoted	Actively monitoring the impact on lack of meal beaks and late over runs staff well-being Produce evaluation reports to inform the Executive Management Team of meal beaks and late over runs	Senior Operations Leadership team	James Kennedy	Regular reports are presented to the Exec team and actions taken where necessary.	Monthly Bi monthly

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20% of staff, which is a (1%) increase indicated they were dis-satisfied with the care they gave to patients / service users.					
Improve patient safety and the patient experience Support a 5% reduction in the level of staff dis-satisfaction related to patient care.	Carry out pulse surveys to assess staff dis-satisfaction 2 times over the next 12 months Report on the pulse survey results in the Staff engagement Dashboard.	Marcia Daigo Kullie Bangar	Francesca Okosi	Reducing the number of staff dis-satisfaction related to patient care by 5% is met or exceeded.	Sept 2016 Mar 2017
71% of staff indicted they were satisfied with the way the Trust dealt with their health and well-being. This would suggest nearly 1/3 of the staff who submitted the survey either did not answer the question or did not feel able to answer positively.					
Promote and improve employee health and well-being Take positive action on Health and Well-being to demonstrate that the physical and mental health of staff across the Trust will be a key priority.	Develop a trust-wide Health and Well-being Strategy Establish a working group to monitor and evaluate the implementation of the Health & Well-being Plan 2016/2017 HR Business Partner to work with the Senior Operations Leadership team to determine a variety of approaches to address meal breaks and long service overrun.	Gary Sharp Gary Sharp Gary Sharp	Francesca Okosi	The H&W working group is established and staff across the Trust feel supported to access health and well-being services if required.	Apr 2016 May 2016 Aug 2016

Marcia Daigo, Associate Director OD & Improvement
13/4/2016

South East Coast Ambulance Service NHS
NHS Foundation Trust

Appendix 2: **2017 Staff Survey Action Plan**

Human Resources Directorate

April 2017

The last two staff surveys have seen a total response rate of 40%. This is above average response rate for ambulance service and is the 3rd best response in the service, however the latest survey placed SECAmb bottom in many of the key themes.

There are five overarching themes that formed the action plan in 2016 Staff Survey Action plan and these will continue to be the focus in 2017. They are:

- ***Strengthen Leadership at every level***
- ***Improve performance and access to development***
- ***Encourage greater two-way Communication and increased staff engagement***
- ***Promote and improve employee health and well-being***
- ***Create a more inclusive and diverse workforce***
- ***Enhance patient safety and the patient experience***

Proposed Work Stream	Action	Responsible	Executive Owner	What 'success' would look like	Date of Completion
Strengthen leadership at every level	Recruit to substantive executive team	Steve Graham	Daren Mochrie	Roles filled	Sept 2017
	Continued rollout of the Band 8 Leadership programme	Complete			
	Establish and rollout the OTL assessment process in operations	Steve Singer	Joe Garcia		June 2018
	Support managers to develop competence in managing	Steve Singer	Steve Graham		March 2018

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Improving Performance and access to Development	Maintain access to and attendance levels to Key skills training (95%) Improve the number of people receiving appraisals to 85% in March 2018 Improvements the quality of appraisals to be monitored through pulse surveys.	Sally Wentworth-James Steve Singerr Steve Graham	Steve Graham Steve Graham Steve Graham	Attendance at KST will meet or exceed the 95% Staff appraisals will meet of exceed 85% Staff will feel their appraisal is not a tick box exercise	Mar 2018 Mar 18
Encourage two-way communication and increased staff engagement	The Communications team to send out 'message of the week' Improve engagement capability at a local level to improve two-way communication between staff and local managers Carry out Pulse Surveys to assess and monitor improvements and issues Increased use of technology Develop an engagement plan to encourage staff to complete the 2016/17 survey with "You Said, We Did" narrative Deliver workshops and 1:1 sessions to encourage and support managers and staff to complete the survey.	Janine Compton Steve Singer Steve Singer Steve Singer	Daren Mochrie Steve Graham Steve Graham Steve Graham	Staff will feel informed and involved in making decisions at a local level to be determined by the the pulse survey asnd increased staff survey response July 2018 Nov 2018.	Weekly Quarterly On-going

Create a more inclusive & diverse workforce	Monitor resourcing outcomes Development strategies for under represented groups Develop role of Diversity Champions Understand nature of bullying and harassment Communicate the Dignity at work Frasmework	Clare Irving Clare Irving Angela Rayner Robert Ivey	Steve Graham	Increased representation in the workforce at all levels	June 2017 September 2017 September 2017 July 2017
Promote and improve employee health and well-being	Develop a zero tolerance protocol across the Trust regarding violence against staff Monitor meal breaks and late overruns and take necessary action to ensure staff well-being is promoted Monitor mesal breaks and long hours of corporate staff in new HQ Take positive action on Health and Well-being to demonstrate that the physical and mental health of staff across the Trust will be a key priority.	Adam Graham Sue Skelton Clare Irving Angela Rayner	Emma Wadey Joe Garcia Steve Graham Steve Graham		Ongoing Ongoing Ongoing Mar 2018
Enhance patient safety and the patient experience	Encourage an environment where more staff are able to raise concerns and		Steve graham		

	improve patient safety at all levels of SECAmb via whistleblowing, speak in confidence and line management		Emma Wadey		

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South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	12/17

Name of meeting	Trust Board
Date	27 April 2017
Name of paper	2017/18 CIPs
Executive sponsor	David Hammond, Director of Finance
Author name and role	Kevin Hervey, PMO Head of Financial Efficiency
Synopsis	The Trust submitted a schedule of potential CIPs (Cost Improvement Plans) schemes to NHSI as part of the 2017/19 Plan totalling £15.1m for the year ending 31 March 2018. £4.7m related to established schemes and £10.4m related to additional schemes. Further potential CIPs totalling £10.3m have since been identified. The CIPs are broadly summarised under the following themes: New HQ £0.8m Fleet £2.5m Estates £0.7m Operational efficiencies £15.9m Property revaluation benefits £2.1m Other (including agency and re-tendering of contracts) £3.4m Operational efficiencies include MRC program benefits, CCPs contribution to performance, better staff abstraction management, future clinical model (more hear & treat), hand over delays, job cycle time improvements). Detailed work on the evaluation of all these schemes will be commencing shortly. Further CIPs schemes will be explored with budget holders through a line by line assessment of the 2017/18 budgets. The current disciplines and governance around the CIPs process require improvement and therefore the PMO (supported by EY) and Finance are working to establish and implement rigid disciplines to identify, evaluate and report on CIP schemes going forward, including the QIA (Quality Impact Assessment) process. All CIPs schemes will be reviewed by the Finance & Investment Committee. Cost savings covering a number of schemes were realised through work undertaken in the PMO with various Trust leads during the last quarter of the 2016/17 financial year totalling some £2m. It is expected that the annualised equivalent of some £8m covering similar schemes will be achievable in 2017/18 subject to detailed evaluation as stated above. The same Trust leads will continue to be actively involved. As a result of the property valuation exercise (subject to audit) carried out by Montagu Evans at 31 March 2017, we believe that £2.1m of savings relating to PDC dividends and depreciation on buildings will be eminently achievable. All schemes will undergo a thorough QIA process to be signed off by the Medical Director and Director of Nursing; this will ensure that patient safety concerns are taken into account and addressed where applicable.
Recommendations, decisions or actions sought	The Trust Board is asked to note the updates to 2017/18 CIPs, including the governance process.
Why must **this** meeting deal with **this** item? (max 15 words)	NHSI and governance requirement
Which strategic objective does this paper link to?	Financial Sustainability

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

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	14/17

Name of meeting	Board of Directors
Date	19.04.17
Name of paper	Quality Assurance Visit Report (Q4)
Executive sponsor	Emma Wadey, Director of Quality and Safety and Chief Nurse
Author name and role	Jo Habben- Lean Clinician Quality and Compliance
Synopsis (up to 120 words)	This paper is presented in order to update and provide assurance to the Board on the progress to date in demonstrating compliance with the Fundamental Standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Recommendations, decisions or actions sought	This report had been discussed at the Quality Working Group.

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.

South East Coast Ambulance Service NHS Foundation Trust

Quality Assurance Visit (QAV) Update Report

March 2017

1. Introduction

1.1 This paper is presented in order to update the Board on the progress to date in demonstrating compliance with the Fundamental Standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

1.2 The duty to ensure each of the Fundamental Standards is met rests with the organisation. Currently the evidence is tested by unannounced inspection visits undertaken by a quorate specialist team led by the Deputy Director of Nursing and the Lead Clinician of Quality & Compliance.

1.3 The Board must continue to assure itself that the systems in place provide robust evidence of compliance. Using a triangulation approach to correlate the information and intelligence data reported via the operational Unit (OU) dashboard, the Section 29A Warning Notice issued to the Trust by the CQC (Care Quality Commission), the SECAmb corporate action plan (*must do improvement plan*); and feedback from the staff survey, a quality assurance template using the CQC 13 Fundamental Standards of Care as the quality baseline, has been developed.

1.4 The developed tool assesses the 13 CQC Fundamental Standards of Care to form the evidence to appraise and inform the ratings of the CQC Key Lines of Enquiry (KLOEs):

- **Safe** by safe, we mean that people are protected from abuse and avoidable harm.
- **Effective** by effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.
- **Caring** by caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
- **Responsive** by responsive, we mean that services are organised so that they meet people's needs.
- **Well-led** by well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

1.5 The tool has been designed to encourage local ownership of issues relating to quality and safety whilst enabling the development of a thematic review and action plan to present to the Executive Board. In future all services will be expected to complete a 6 monthly self-assessment and rate themselves as either outstanding, good, requires improvement or inadequate for each domain (safe, effective, caring, responsive and well led). They also need to provide an example of good practice and identify any areas of concern that have been escalated but remain unresolved for each domain. Where standards are not met, teams are required to develop improvement plans to address this which should be monitored via local governance systems.

1.6 An immediate risk assessment matrix has been developed to allow for any risks to be managed and escalated appropriately. Following each visit, a service specific action log is developed collaboratively with the teams and monitored following a 3 monthly review process (including a scheduled re-visit if deemed necessary). A corporate tracker is being produced in order for the action logs to be collated and monitored effectively with assurance provided on the progress of the actions.

2. Current Position

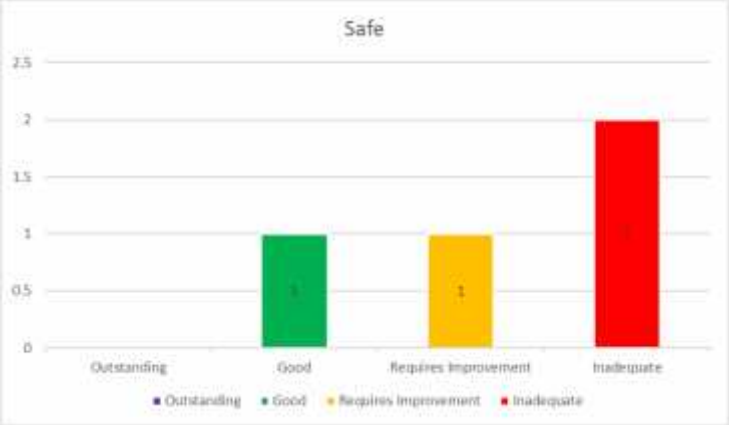
2.1 Following an inaugural pilot testing process and announced quality assurance visit at Tangmere Make Ready Centre, in February 2017 (Q4) SECAmb introduced a programme of unannounced Quality Assurance Visits (QAV).

2.2 To date (Q4) 4 unannounced Quality Assurance Visits have been completed:

1) Chertsey Make Ready Centre
2) Coxheath Emergency Operations Centre
3) Lewes Emergency Operations Centre
4) Brighton Ambulance Station

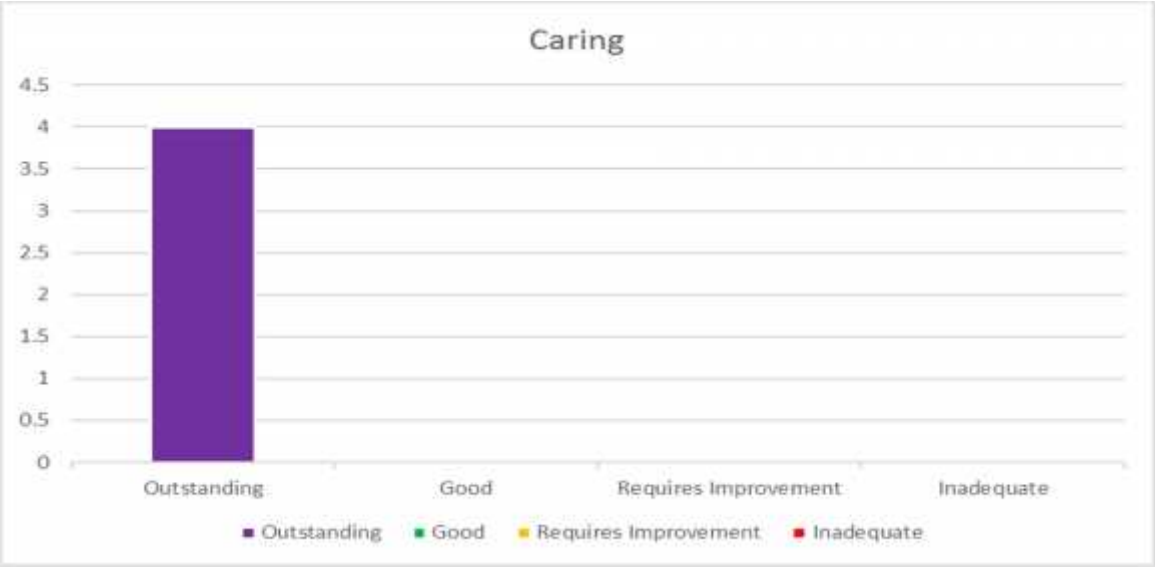
2.3 In order to assess the services accurately and consistently, the quorate inspection group rate the services from the documentation and evidence provided, and the observations and interviews/discussions experienced on the day of the visit. This rating with be service specific, and not necessarily reflect or match what the overall CQC rating of the organisation would achieve. For example, '*well-led*' will represent the exclusive service team leadership only, not the senior management, corporate or executive responsibility or accountability.

The findings per KLOE are as follows:

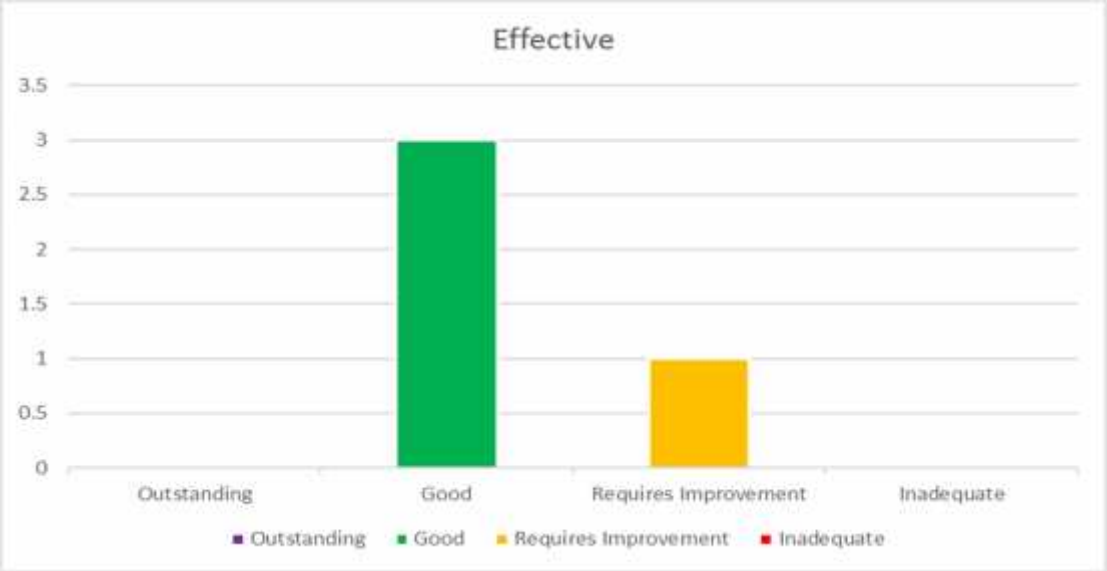


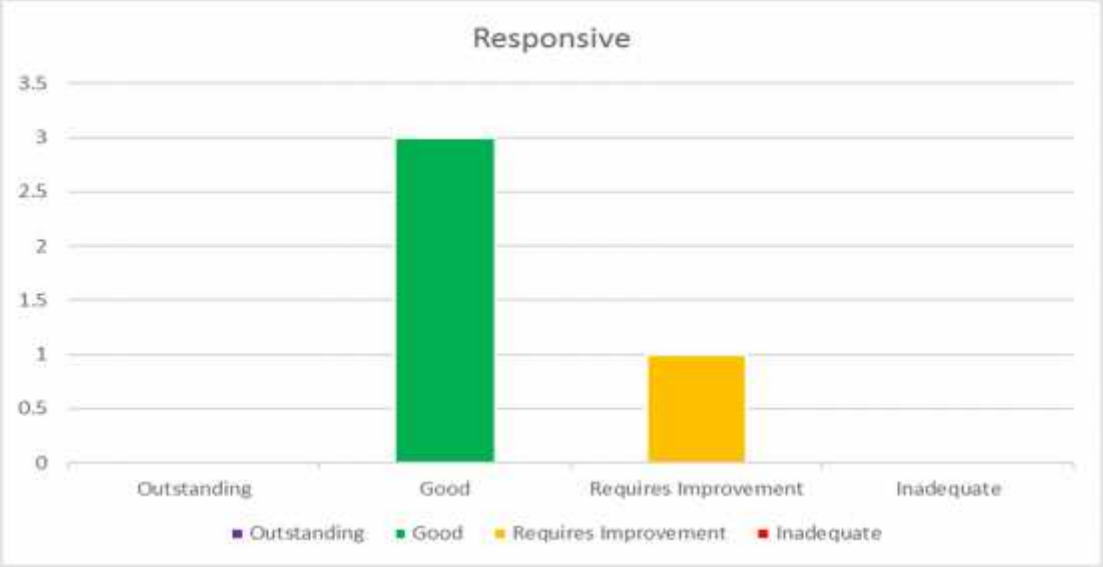
2.4 The safety rating of inadequate was scored based on the evidence seen on the day and interviews with staff. The high risk themes identified were regarding site security, estates management, fire safety (including management of sub-contractor Churchill), business continuity planning, medicines management and compliance with infection control. These safety themes were assessed as requiring immediate action, and cascaded to the management team on the day of the visit.

2.5 The updated action log will be tracked by the compliance team and owned by the Operating Unit Managers. The Lead Clinician for Quality and Compliance has also cascaded the issues to the Regional Operating Managers, the estates department, the security team, the Head of Risk, contract management (Churchill) and the resilience team.



2.6 The caring rating of outstanding was also externally ratified and endorsed on two occasions by invited observers and representatives from East Sussex Heathwatch and Brighton and Hove CCG.

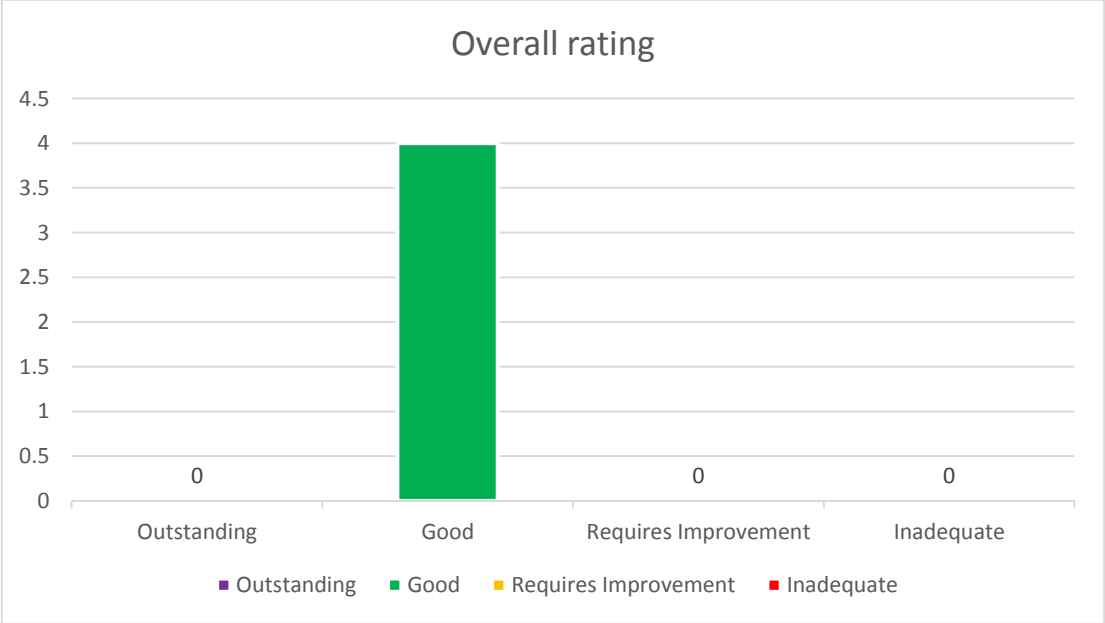




2.7 The ratings of effective and responsive identified themes with staff understanding of the complaints process and Duty of Candour, and understanding and knowledge of safeguarding vulnerable adults and children.

2.8 All teams felt that the mandatory and statutory training data was inaccurate and lower than anticipated.

2.9 Two teams expressed the requirement for increased HR support when dealing with staff performance and disciplinary.



2.10 The SECAmb supporting services of estates, HR, security management, medicines management and learning and development have also been informed of the themes that are being identified in the visits. The action log includes the actions for supporting services and will be updated accordingly.

3. Conclusion

3.1 In summary a total of four unannounced Quality Assurance Visits have taken place during the last quarter (the pilot *announced* visit was at Tangmere MRC). Three of these visits have been externally observed by both Healthwatch and Clinical Commissioning Group quality leads.

3.2 Feedback from staff has been extremely positive in response to the inspection teams, areas of good and outstanding practice to date are in the KLoE domains of both ‘caring’ and ‘well-led’.

3.3 Areas for improvement are noted in the KLoE domains of ‘safe, responsive and effective’.

3.4 Immediate areas for improvement are noted with site security, estates management, fire safety, business continuity planning, medicines management and compliance with infection control (also relates to sub-contractor Churchill staff).

4. Recommendation

4.1 The Board is asked to note the current compliance with all Fundamental Standards.

4.2 To consider if further action is required to support compliance from services.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Finance & Investment Committee

Date of meeting	20 May 2017
Overview of issues/areas covered at the meeting:	• The financial outturn for 2016/17 which was confirmed at a deficit of £7.1M net of all year-end accounting adjustments. • Included within the formally reported outturn is an charge of £XXM as a result of revaluing assets on to a new basis (subject to audit signoff). • Progress on PID and 2017/19 Contract following mediation in March 2017 – update to be provide at Board following the outcome of the external review expected late April • Updates were provided on elements of the URP including the key enabling projects. Further assurance will be provided to FIC and the Board following the Executive review of progress next week • The operational performance against trajectories were reviewed in detail and a further analysis of the underlying shortfalls will be provided at the next meeting • Business cases for vehicle replacement will be presented at a conference call in May
Reports *not* received as per the annual work plan and action required	All reports received as requested. Verbal updates were received on key enabler projects within the URP.
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	The committee noted the delay in roll out of IPADs and the variation in hospitals approaches to receiving the information in an electronic format.