South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

30 May 2017

10:00-13:00

Crawley HQ

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
21/17	10.00	Chairman's introduction	-	-	RF
22/17	10.01	Apologies for absence	-	-	RF
23/17	10.02	Declarations of interest	-	-	RF
24/17	10.03	Minutes of the previous meeting: April 2017	**Y**	Decision	RF
25/17	10.05	Matters arising (Action log)	**Y**	Decision	RF
Organisational culture					
26/17	10.10	Patient story	-	Set the tone	
27/17	10.15	Chief Executive's report	**Y**	Information	DM
Trust strategy					
28/17	10.30	Unified Recovery Plan Delivery Progress Update ▪ Organisational Recovery Dashboard ▪ Quality Dashboard ▪ Financial Sustainability Dashboard	**Y** **Y** **Y** **Y**	Assurance	JA JA EW DH
29/17	11.10	Cyber Security	**Y**	Information	DH
Ten minute Break					
Allocating resources to achieve plans					
30/17	11.20	PMO Transition	**Y**	Assurance	JA
Monitoring performance					
31/17	11.35	Integrated Performance Report	**Y**	Information	DM
32/17	11.55	Medicines Management	**Verbal**	Assurance	FM
Holding to account					
33/17	12.05	Escalation report; Audit Committee	**Y**	Information	AS
34/17	12.10	Escalation report; Quality & Patient Safety Committee	**Y**	Information	LB
35/17	12.20	Escalation report; Workforce & Wellbeing Committee	**Y**	Information	TH
36/17	12.25	Any other business	-	Discussion	RF
37/17	-	Review of meeting effectiveness	-	Discussion	ALL
Close of meeting					

Date of next Board meeting: Thursday 29 June 2017

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

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, Thursday 27 April 2017

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

Present:

Graham Colbert	(GC)	Independent Non-Executive Director & Deputy Chair
Daren Mochrie	(DM)	Chief Executive
Alan Rymer	(AR)	Independent Non-Executive Director
Angela Smith	(AS)	Independent Non-Executive Director
David Hammond	(DH)	Executive Director of Finance & Corporate Services
Emma Wadey	(EW)	Executive Director of Quality and Patient Safety
Fionna Moore	(FM)	Executive Medical Director
Joe Garcia	(JG)	Executive Director of Operations
Lucy Bloem	(LB)	Independent Non-Executive Director
Terry Parkin	(TP)	Independent Non-Executive Director
Tim Howe	(TH)	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

01/17 Chairman's introductions

In RF's absence, GC welcomed members, and staff, governors and members of the public observing the meeting.

02/17 Apologies for absence

The following apologies were noted;

Richard Foster	(RF)	Chairman
Jon Amos	(JA)	Acting Executive Director of Strategy & Business Development

03/17 Declarations of conflicts of interest

The Trust maintains a register of directors' interests. No additional declarations were made in relation to agenda items. Although LB reminded the Board that she is a partner at Deloitte.

04/17 Minutes of the meeting held in public March 2017

The minutes were approved as a true and accurate record.

05/17 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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06/17 **Patient story** [10.03 – 10.12]

JC reminded the Board that we rotate stories between positive and negative experiences of services. This month's story was about a patient in mental distress who had taken an overdose and needed the assistance of the ambulance service. Her concern was about the approach staff took to her gender; recording male on the patient care record, despite referring to her correct gender during their interaction. This resulted in patient becoming increasingly distressed, feeling staff has unnecessarily made an issue of her gender.

JG outlined some of the work we are doing to ensure staff are more aware of issues for people with protected characteristics. DM supported this and referred to the work EW was leading to ensure we learn from incidents and complaints. This story related to a person with mental health issues and EW confirmed the training we are providing for staff through our mental health consultant. She believed that this story illustrated the impact on patients when we get it wrong.

07/17 **Chief Executive's report** [10.12 – 10.18]

DM took his report as read, highlighting the following;

- Paramedic Banding - plans are in place to ensure smooth transition.
- HQ/EOC – we are on target.
- Easter performance - this was positive, despite the challenges. DM thanked staff for their efforts, also the wider system for working well together.
- Contract negotiations – confirming that it was good news that we extended the 111 contract to 2019.

GC asked DM to comment on the national picture and how its evolving. DM confirmed that we are doing some benchmarking work with other trusts and comparing quite well. Key themes include financial sustainability and workforce transformation.

08/17 **Unified Recovery Plan** [10.18 – 11.24]

DH reminded the Board about the way the URP is arranged, and the governance structure which supports it through the three Steering Groups (quality, recovery and finance). He explained that we've moved on from delivery of sets of actions, to ensuring plans are integrated through the Trust with clear interdependencies. We are aware of the quality impact of all the work we are doing and we have introduced a more robust quality impact assessment process.

DH highlighted electronic patient care records (ECPR) confirming that we are behind with this, primarily due to slower roll out of i-pads. This was discussed at the executive management board recently and plans are in place over the next few weeks to accelerate the roll out/on-boarding. Once ECPR is deployed, we need to ensure we realise the benefits.

GC explored further what steps we are taking with ECPR. JG explained the solution is to maximize the opportunities of on-boarding. The initial plan was to bring staff in to sit with a super-user, but instead we will have a specialist in each operating unit and to spend two hours with crews on duty; avoiding the issue we had experienced with overtime.

DM added that his initial observations are that we clearly had hoped to make more progress, and so he has helped the team re-align oversight of this project. JA is now leading and he is refreshing plans and revising trajectories. The first issue is training, and the second is connectivity with our partners. Therefore, we need to work with IT department at hospitals to reduce reliability of paper records.

Action:
Finance Committee to hold an exceptional meeting to consider revised ECPR roll out plan.

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LB expressed her view that the CAD project board works well, with good infrastructure, and felt that ECPR is lacking such infrastructure. DH agreed this is probably right and confirmed that we are refreshing project teams to support this.

DM agreed that if you don't have attention to detail then things can go awry, and acknowledged the context we are working on, with so many significant projects that are ongoing con-currently. GC was sympathetic to this and stated that this is why prioritisation is so important.

AS asked about financial sustainability and whether we can be confident that we allow for the cost of running projects fully; having a clear budget to ensure completion of transformation programes. DH confirmed that each project is operating within the approved business case and is in the bottom line position. It is therefore part of the negotiations with commissioners.

On Datix, and the issues relating to the recent upgrade, TP reminded the Board that we had assurances that this was routine and so concerned that recent issues may indicate that we can't manage routine projects and aren't delivering promises to the Board. He reinforced the importance of investing in teams to ensure delivery of projects. DM explained that over the last four weeks we have taken stock on all projects. A huge amount of governance, systems and processes are in place, embedding in the organisation. It is about resourcing all projects adequately; at the moment it seems we do this mostly, but not always. DH confirmed that any concerns going forward about projects being under-resourced will be brought to the Board.

TH felt that part of problem is that the Board is promised delivery of all projects on time despite so much to be delivered, and so questioned whether are we realistic enough. DM agreed that we don't want any surprises. If we are slipping, we need to be open with management and then with the Board.

LB reminded the Board that we have used funds really well to bring in external support, e.g. PMO, evidenced by the good quality of some of the board papers. But this isn't sustainable, so we need assurance as a Board about how we are going to ensure in-house capability. DH confirmed that the majority of funding for this has come from 'special measures' money to support our recovery. All business cases for this support has been predicated on plan to transition to in-house capability.

TP clarified that he isn't saying we don't deliver, and gave examples of where we have, e.g. MRC Tangmere, and expressed that much credit needs to go to the executive for taking on the high number of key projects we have ongoing to support the Trust's recovery.

<u>Recovery</u>

JG confirmed that the trajectory for 2016/17 was predicated on activity and the position with hospital handover delays, as at September 2016. We have managed to reduce from 1.28 resources per incident to 1.21 which is really significant. We have also reduced incident cycle time by 6 minutes, which is really good progress. Lost hours from hospital handover delays is increasing, which impacted our ability to deliver trajectories. We have started to turn the corner though with 999 performance. In the last couple of weeks we have significantly surpassed the last quarter trajectories; this was helped by accurate forecasting of activity, good planning over Easter, and reduction of the 99th percentile of green incidents, falling from 5 hours to 1.5 hours. At the same time, we have taken steps to improve staff welfare by reducing disturbed rest periods. In March 257 rest periods were disturbed compared to 360-400 per-day earlier in the year. We also reduced end of shift overtime by 700 hours a week.

AR felt that it was good to hear the positives and we can see this coming through in the numbers. In terms of forecasting/scheduling, she asked about what we are doing to improve this. JG explained that we have got a colleague from another trust to help analyse this. One of the key early pointers is that we need to review

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process of resource utilization; it isn't just about forecasting and getting more hours in. The balance therefore is between ensuring enough staff and using them in the right way. The priority is to get this balance right then look in more detail and forecasting/scheduling.

DM confirmed that he has looked at this too and how we assure ourselves that we have the right staffing levels. Looking at our shift levels it is always high (90%-100%) which is positive and demonstrates that we are resourcing what we are budgeted for.

FM referred to shift overruns, rest breaks, and job cycle time being the most intransient areas in ambulance trusts and so the progress made can't be underestimated. TP echoed this and was very impressed with the progress in operations, especially getting a grip on what we have control over. On hospital handover delays, this is largely outside our control and so asked about the confidence of the executive that this will be adequately addressed. DM felt this requires working closely with partners to help each other understand the issues and how they can be fixed. For example, looking at the data and focusing on areas of most concern rather than trying to fix the whole problem.

TP noted that some trusts do well, e.g. Medway have improved significantly, and so how do we learn from acute partners who have found some solutions. DM agreed.

AR asked about the CAD work stream going from Green to Amber asking whether we could break down the reports, as the one for culture. JA explained it is Amber because at time of the report, we hadn't yet fully defined one of the training plans. These plans are now agreed. DH confirmed there is robust governance supporting the CAD, including twice weekly meetings of the project board, scrutiny by the executive, and significant issues escalated to the Finance & Investment Committee. Therefore, assured the Board that it would become aware of any significant issues/risks through one of these routes. The Board agreed that it is adequately sighted on risks.

<u>Quality</u>
On Datix, EW confirmed that there will be a review of why the upgrade went wrong on 31.03.17. This related to one specific upgrade; other upgrades have happened as planned. The glitches found were addressed really quickly with good support by the team.

EW noted that while there are red areas on the action plan, progress has been made overall. Another 30 actions were completed in the last four weeks. Risk areas haven't changed significantly and much work being done to address these, for example;

Incident / SI reporting – work to ensure we demonstrate learning and improve timeliness of investigations.

Medicines Management – FM confirmed set out the focus areas identified during the CQC inspection in May 2016, and the issues established following the audits of all ambulance stations/MRCs during Q4. FM was confident that progress is being made. AR asked whether we are safe. FM confirmed her belief that we are, but we need to further improve governance. The external review is helping us to ensure issues are not repeated and avoid making the same mistakes.

Clinical Audit – FM confirmed there is much work to do in this area, with the aim of providing greater focus on clinical outcomes.

PCRs – we are understanding the life cycle of PCRs and this links to clinical audit. Some improvements have been made in terms of storage etc. but improvements in the process of scanning is still needed.

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GC summarised by stating that much has been achieved, but we are still behind where we want to be. EW agreed; we can demonstrate much improvement but lots to do, and we have a plan to get there.

AR asked about the feedback from external partners, e.g. NHSI Improvement Director. DM confirmed he meets weekly with the NSHI Improvement Director and the feedback is much the same; lots of good progress but behind where we would like to be.

Finance

DH confirmed that we achieved the £7.1 deficit plan. There was much good work from staff at all levels to help in our financial recovery plan and we are still getting lots of good ideas about how we can make better use of resources. Our use of resources rating is 3 out of 4; which is improved from 4. The key metrics were as expected. In terms of financial sustainability, we have a URP work-stream focusing initially on 12-24 months.

TH asked what the projected financial risk rating is for 2017/18. DH confirmed it is unlikely to move from 3 to 2.

09/17 STP Update [11.24 – 11.28]

DM explained that we are doing a huge amount to engage across all four STPs, as outlined in the paper.

TP asked whether STPs would be considered a failure if they don't include hospital handover delays in the planning. DM confirmed that we have discussed this internally. The key focus currently is as listed in section 3.1 of the paper; these appear to be bigger issues to STPs than handover delays. But we will do what we can to get this included as a greater focus. More broadly, we need to get better at articulating our offering to wider system. The Board agreed.

10/17 Board Assurance Framework [11.28 -11.40]

PL set out the BAF structure and the process which supports its development and review.

AS felt the BAF focusses on the right things in the context of last 12 months and our recovery (URP and feedback from CQC etc.). As the Trust moves in to business as usual the BAF will need to address different things, and will need to ensure we are realistic about how we set out our risks in achieving objectives.

JG challenged that we need to provide as safe a service for as many people as possible.

DM added that we do need to do more to manage risk at all levels and reminded the Board that there is a session for directors planned for early May.

AR referred to the risk related to a sustainable workforce, and this being more about the ability to recruit; currently the risk stated is more the impact.

Action:
Audit Committee to oversee how the Trust plans to improve its approach to risk management

Comfort break 11.40 – 11.50

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11/17 Staff Survey Results [11.50-12.03]

SG confirmed that the themes from the staff survey are pretty much the same as last year. Our actions are set out in the paper. Some of the actions from last year were long-burn and so not expected to make immediate impact, but over the next 12 months we do expect more improvement.

TH felt that a number of issues are longer term, e.g. culture. The plans are fine but we need to start demonstrating some results. SG confirmed this year there are more tangible things happening, such as end of shift overtime / meal breaks. JG agreed. All these things are inter-related, including things like rota patterns, unsocial hours and relief. All these being core elements which will support improved staff wellbeing.

AS added that we need more resource into management and supervision, so when there is increased financial pressure, this doesn't get pushed back. JG explained how the management restructure deals directly with this, giving 50% of time to management-issues.

GC asked if there is a plan to get a real pulse check. SG that confirmed there is; the plan is to develop a quarterly friends and family test to ensure it is more relevant. This will indicate on a quarterly basis where we are, which the Board will have sight of.

AL referred to the action to improve engagement at a local level, explaining that we need to ensure there is more ability for staff to have 1:1 time with managers/supervisors. DM agreed and felt that we are ahead of curve with the OU restructure and giving the time to ensuring better quality management and supervision. Really important to be visible and understand front line leadership roles.

TH stated that the OU restructure helps give accountability and authority to the workforce, moving away from command and control. This is the cultural piece which will take longer to improve.

GC summarised that we have a plan and will monitor progress.

12/17 Finance Plan [12.03-12.11]

DH referred the Board to the paper which outlines where we are financially. The detail is considered by the Finance and Investment Committee.

The CIP target is £15.1m and we have schemes totaling £24m some of which we know won't deliver. £12m are fully worked up schemes; some medium-high risk. £3m are in various stages of development, supported through the PMO. CIP is taken out of agreed budgets and this is effectively our contribution to the structural gap; pour efficiencies.

GC asked for a bit more clarity on specific schemes, which will come via the Finance and Investment Committee, to better understand which relate to existing projects such as HQ and whether these will deliver the stated benefits.

EW confirmed the QIAs that have been undertaken which themselves are fluid to take account of any changes to impact or risk.

13/17 Integrated Performance Report [12.11 – 12.14]

DM introduced this report, the detail which has been considered already during previous agenda items.

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LB raised an anecdotal concern about support staff and gaps in key roles and asked whether in the next report we can set out the position in corporate services. DM explained that we are reviewing the IPR and over the summer will look to be making significant revisions to improve it.

14/17 Q4 Quality Review Visits [12.14 – 12.26]

EW explained that this is a high level summary of the quality review visits we undertake as part of our quality assurance framework, introduced in February. These are unannounced visits by a team of internal experts and external partners (CCG/Health Watch). They assess each area under the CQC key lines of enquiry and triangulate against available data. Inspection team observe practitioners too. Since this report we have undertaken a further two visits; averaging 3-4 each month. Some areas of concern have been identified and actions are taken immediately, which are owned by operational teams. Two areas had some safety concerns relating to security and awareness around fire safety. Staff took immediate actions in these areas which is positive.

TP felt it is really good to talk about something that is business as usual. He felt the Board needs to be conscious of the weakness in the grading system. EW agreed that these are assessments of specific sites, and at a point in time. But it is still helpful to get a sense of how we are meeting the fundamental standards and this empowers staff to be able to make a difference in improving standards.

AS asked about the graph in 2.3 in the paper, where we show inadequate and requires improvement under safe in 3 of 4 sites inspected. The Board discussed that this reflects where we are and we know there is still much work to do. It commended this approach.

15/17 Medicines Management [12.26 – 12.29]

FM reminded the Board that at its last meeting she confirmed that we had initiated an externally led medicines management review. This has slowed down a bit as the independent lead has been unwell, although we are still progressing the specific case files. FM felt that it was important to reflect that legislation re use of drugs for ambulance trusts is complicated and inconsistent, as it is not always applicable to ambulance trusts. For example, the amount of Morphine that can be carried at any time has changed. We are moving further forward with being more consistent with national practice.

LB confirmed that this is being followed closely at the Quality and Patient Safety Committee which is assured that we are doing what we need to be doing to ensure proper focus.

16/17 Clinical Outcomes Deep Dive [12.29 – 12.34]

FM apologised that there is no report and confirmed that we have set up a clinical outcomes group focusing on this. AQIs are under review nationally, and we are aware some indicators are showing red. Really significant changes are on survival to discharge which we think relates to how we capture data; as we focus only on those who definitely have died rather than those who have survived. Getting this data is difficult hence the time-lag on reporting. What we report is therefore the worst possible picture and so very likely to be better.

A written paper will come to the June Board meeting.

DM felt that we need to talk more about clinical outcomes, but with confidence in the data. JG agreed; our ability to deliver timely and accurate data is something we need to get right.

17/17 QPS Escalation Report [12.34 – 12.38]

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LB confirmed that we were assured about the quality impact assessment process (not assured before). The committee also looked at the governance supporting the use of private ambulance providers and were assured by this. With PCRs, however, it is clear this area has a number of issues both in quality and the life cycle of the record. The committee has asked for an urgent review in to this to understand the problems.

Duty of Candour provided partial assurance. We are compliant with incidents of serious harm/death, but no compliant with incidents of moderate harm, so work to be done.

On the Quality Account, the committee was concerned that we are behind our plan, but assurance from EW that we will get there in end.

DM confirmed that the executive met yesterday to ensure we pick up the pace in some of these areas.

18/17 Finance & Investment Committee Escalation Report [12.38 – 12.40]
GC explained that the only item to add to what is set out in the paper relates to asset evaluation. Within the profit and loss account we have £600k of benefit due to lower depreciation and PDC; this is a technical accounting adjustment.

19/17 Any other business [12.40-12.43]
TH updated the Board on the recent exceptional meeting of the workforce and wellbeing committee. This meeting explored the workforce plan and gained assurance about the HQ move. On culture and staff engagement, there was some evidence that we are making progress. Recruitment and retention plans are good, and we can answer sufficiently resource question, i.e. we will resource to level of funding we have. The committee was not fully assured on retention but actions appear to be in right direction.

20/17 Review of meeting effectiveness
Members content with timeliness of papers / discussion

Questions from observers

No questions

There being no further business, the meeting closed at 12.43pm

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 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	29.06.2017	Board	IP	**FM provided a verbal update on 27.04.17 confirming that a paper will come to Board in June**
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	
27.04.2017	08 17	Finance Committee to hold an exceptional meeting to consider revised ECPR roll out plan.	DH	June	FIC	IP	
27.04.2017	10 17	Audit Committee to oversee how the Trust plans to improve its approach to risk management	AS	TBC	AuC	IP	

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	27/17

Name of meeting	Trust Board	
Date	30.05.2017	
Name of paper	Chief Executive's Report	
Executive sponsor	Chief Executive	
Author name and role	Daren Mochrie, Chief Executive	
Synopsis (up to 120 words)	The Chief Executive's Report provides an overview of the key local, regional and national issues involving and impacting on the Trust and the wider ambulance sector.	
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.	
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

May 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 Care Quality Commission (CQC) inspection

2.1.1 During the week commencing 15th May 2016, the CQC undertook their planned inspection of the Trust. A team of 30 inspectors visited stations, NHS 111, Make Ready Centres, fleet teams and EOCs, as well as going out with crews on ambulances and observing staff in A&E Departments.

2.1.2 The inspection team also carried out more than 40 interviews with a range of different staff, as well as holding focus groups with union representatives, Governors and Non-Executive Directors.

2.1.3 At this stage, the Trust only receives limited, high-level feedback from the inspection team, however the CQC have recognised that the Trust is moving in the right direction and has made real improvements in a number of key areas, although there remains much still to do.

2.1.4 The feedback for 111 was especially positive and they also commented positively on how well received they had been by staff, who had engaged with them in an honest and open way.

2.1.5 Although the CQC team have now concluded their planned visits to the Trust, there may well be further unannounced visits during coming weeks.

2.1.6 The Trust is unlikely to receive the report from the CQC until the Autumn.

2.2 New HQ/EOC up-date

2.2.1 On 1st May 2017, staff began formally moving into the new HQ/EOC at Manor Royal, Crawley. To date, about half of our support teams have re-located to Crawley, with the remainder due to move during the next couple of weeks. I have really enjoyed welcoming staff into the fantastic new premises.

2.2.2 24th May also saw the first 999 calls taken in the new EOC, as the first teams from Lewes started their shifts at Crawley. We have now seen all of the teams from Lewes move to Crawley, with their colleagues from Banstead following in September as part of the phased move.

2.2.3 The Trust is continuing to work closing with 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.

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

2.3 Revised Executive Director portfolios

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

2.3.2 The new Executive Director portfolios can be seen on our website here http://www.secamb.nhs.uk/about_us/our_organisational_structure.aspx but, in brief and in addition to the Chief Executive, the new Executive Director roles are:

- Executive Director of Finance & Corporate services
- Executive Director of Quality /Chief Nurse
- Executive Medical Director
- Executive Director of Operations
- Executive Director of Strategy & Business Development

2.3.3 Recruitment to the substantive posts of Director of Operations, Director of HR, Director of Quality/Chief Nurse and Director of Strategy & Business Development has now started.

3. National issues

3.1 Increase in threat level

3.1.1 Following the terrible events in Manchester on 23rd May 2017, the threat level to the UK has been raised from 'Severe' which is defined as 'an attack is highly likely' to 'CRITICAL' – meaning an attack is expected imminently. This is to the UK as a whole and does not necessarily mean the Trust area.

3.1.2 The Trust has a plan in place to support the additional requirements under these circumstances, which will be co-ordinated through Mission Control.

3.1.3 In the event of a Major Incident (MI), the Trust MI plan will be activated along with additional specialist response plans as required.

3.1.4 Communications have been issued to staff remind them of a number of precautions, including the security of estate and vehicles.

3.2 Cyber attack

3.2.1 I am sure everyone is already familiar with the cyber-attack that took place on 12th May, that saw computers affected in 150 countries.

3.2.2 In the UK, although 47 NHS Trusts were affected, SECAmb were not. Thank you to the IT team for their response to this. However, we are not complacent and have already taken action in a number of areas.

3.2.3 Areas that we are looking at already, to ensure that we protect our systems and patient safety as far as possible include:

- Reviewing the wide area network and its firewalls – we currently rely heavily on NHS N3 connections to connect sites yet it cannot be considered a fully secure network
- Tightening controls on how systems are accessed from home or non-Trust devices, including remote access to emails
- Formal controls on the transfer of data between the Trust and third parties, ensuring only certified secure methods are used

4. Recommendation

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

Daren Mochrie QAM, Chief Executive

25th May 2017

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	28/17

Name of meeting	Board of Directors
Date	30th May 2017
Name of paper	Unified Recovery Plan Delivery Progress
Responsible Executive	Jon Amos, Acting Director of Strategy and Business Development
Author	Ellie Wilkes, Interim Head of PMO
Synopsis	This paper provides a summary on key updates in relation to 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, Financial Sustainability and Quality (i.e. CQC must do's), which form the Unified Recovery Plan (URP). More detail is provided through three separate dashboards.
Recommendations, decisions or actions sought	) To note the progress made in relation to the PMO and functionality) To be fully aware of the CIP governance framework and processes that has been implemented) To review the dashboards to be fully sighted on the current progress of the URP and to consider the risks highlighted.)

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

Unified Recovery Plan Delivery Progress

1. Introduction

1.1. This paper provides the Board with a summary of notable updates with regard to the Programme Management Office (PMO) and key governance areas; programme risk management, recruitment and the Financial Sustainability Steering Group (FSSG).

1.2. There is also a summary of the progress of the three Steering Groups; Organisational Recovery, Financial Sustainability and Quality (the latter primarily on the CQC must do's), which form the Unified Recovery Plan (URP). This is provided through a summary within this paper and three separate dashboards to show what has been achieved since the last reporting period up to 12th May 2017.

1.3. Given the instigation of a new CIP end to end process, additional detail is provided regarding this and also the governance structure implemented.

1.4. The purpose of this paper is to ensure the Trust Board is sighted on key updates, the progress of the URP and in particular notable risk areas.

2. PMO and Governance update

2.1. The revised PMO has now been running for almost five months and is driving delivery of key projects and priority areas through greater accountability and management of issues. Through the standardised use of highlight reports, discussions at Steering Groups are focused and productive, whilst also enabling timely and responsive reporting throughout the organisation and to external stakeholders.

2.2. The focus of the PMO is on continuing delivery progress but also to fully embed the systems and processes to ensure a sustainable function going forward. This has been partially impacted by difficulties with recruiting to a number of substantive roles within the PMO (these are being re-advertised). However the permanent Head of PMO joined the Trust at the end of April and is working closely with EY colleagues, and the PMO team to ensure a robust handover and a continuity plan.

2.3. The FSSG has been relaunched to focus on developing the Cost Improvement Programme (CIP) at pace and commenced from 2nd May occurring twice weekly. Significant work has been undertaken to develop the governance structure, end to end process and documentation. This is described in more detail in the following section.

2.4. The PMO Programme risk logs have been updated to reflect the changes made to the Risk Management Strategy in relation to risk scoring and categorisation.

Furthermore the main risks from the Programme have been transferred to the Datix system where all future risks will be recorded going forward.

2.5. The Turnaround Executive continues to be a useful forum for escalation to, and management of, issues requiring review and resolve. This is also where the top Programme risks are reviewed weekly via an exception report. A deep dive into all risks across the Programme is now carried out on a monthly basis to ensure sufficient oversight and discussion.

2.6. Work is now underway to develop the PMO SharePoint which will be a repository of information and provide an opportunity to publish a toolkit and guidance for the project lifecycle. The aim is to have a suite of best practice based templates and processes accessible across the organisation. Already representation from the PMO has been requested to support a departmental training day which is very positive and will support upskilling and knowledge transfer.

2.7. 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 999 projects, to ensure active projects are effective and outcomes driven. More information is provided in the Organisational Recovery Dashboard for closures that have occurred.

2.8. Communications relating to the URP has been in place for the past few months with regular ‘matters’ newsletters for Finance, Quality and People. This has been lessened slightly over the past month in support of the CQC specific communications ahead of the inspection. The overarching communications plan for the Programme has been shared with the Executive and is being finalised by the Communications team for further review.

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 in most areas 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. There is now a programme plan mapping milestones across the projects and this will be finalised in the coming period. Key interdependencies across the projects have been identified and it is clear where the pressure points for delivery are. These are being actively managed.

3.3. Capacity within the organisation continues to be a challenge to drive all the projects, particularly in operations. However the operational teams are working hard to identify appropriate resource and there will be two secondment opportunities to the PMO. These will support delivery of operational projects whilst also providing a development opportunity to upskill in project management.

Organisational Recovery:

3.4. Within the Organisational Recovery Steering Group a number of 999 projects have been closed (requiring a project closure form to be completed and approved by the Executive Sponsor), having been comprehensively reviewed by the Steering Group. The details of the closed projects are summarised on the Organisational Recovery dashboard which is included in the appendices. Closure forms can be provided for further detail on request. As highlighted previously, the focus for this workstream going forward, as agreed with Joe Garcia, Director of Operations, will be on Hospital Handover and Hear and Treat, the latter requiring a re-scoping be undertaken to confirm scope, approach and benefits.

3.5. Of note this month is the successful 'go live' of the Headquarters (HQ) at Crawley with a number of corporate functions now relocated. Feedback has been very positive although there continues to require significant work on the cultural aspects (including areas such as ways of working and team building). The next big more will be the Lewes EOC to Crawley at the end of May and this remains on track. The focus of the project whilst continuing with fully establishing the HQ, will also turn to the vacation of Lewes and decommissioning plan for Banstead.

3.6. There has been continued focus on the EPCR project and getting momentum behind it. The project plan has been reworked and will be considered at the next project board on 23rd May. There are a number of interdependencies identified with the CAD and Informatics projects which require careful monitoring through the established governance. There has been some progress with securing resources relating to the project team and the deployment of IPads has increased (up to 51%) although not yet at the pace required. There has now been an operational link lead identified to work with the project manager to drive deployment and this is already having a positive effect in engaging with the Operating Units.

Quality:

3.7. Significant work has continued in relation to the must and should do CQC areas. It is important to note that this report does not include any updates with respect to the inspection preparation or visit as this has been managed outside of the PMO, aside from evidence collation and submission.

3.8. A further stocktake of the must do areas was undertaken by Chief Nurse and PMO in the week commencing 15th May to consider progress and assess whether projects are near closure, require re-scoping and/or need to maintain. This will be complete over two working sessions and, whilst will be informed post the CQC visit, is helpful to ensure prioritisation remains correct and that sufficient focus and support is being targeted to the right areas.

3.9. Medicines Management continues to be a key priority and the permanent Chief Pharmacist has now joined the Trust and is focusing on priority issues, as supported by the Programme Manger in terms of prioritisation and project management. Further details regarding the issues and progress are summarised in the Quality Dashboard and reported in more detail through the Quality and Patient Safety Group and Committee.

3.10. The first Culture workstream working session to map out the projects and priorities was held on 18th May and was well attended by project leads and the Director of HR. Significant activities impacting culture are already underway but not clearly mapped into a coherent work plan. An output from the session is to produce a plan on a page and high level programme plan to include milestones and KPIs. This will support further discussions around the key activities that will support the Culture workstream and ensure alignment with priorities from the staff survey.

Financial Sustainability:

3.11. The focus of the steering group has recently been overhauled to focus on developing the CIP programme at pace. A revised governance framework and CIP end to end process was presented to the Executive on 26th April 2017 and approved for implementation (see Appendix A). Detailed communications were then circulated to key stakeholders advising of the approach. The first FSSGs with the CIP focus commenced on 2nd May 2017.

3.12. The week prior, an in depth briefing session with supporting documentation was held on 27th April for all budget holders and other key stakeholders. It was very well attended with positive feedback. The end to end process (and revised documentation) aligns with the existing PMO processes but has been tweaked to be CIP appropriate. The end to end process is designed to be robust and includes a significant focus on adherence to the QIA.

3.13. Since the beginning of May a series of budget reviews have taken place with budget holders to progress CIPs and identify new opportunities. The engagement with this process has been good.

3.14. A positive meeting was held with NHSI to share content of the CIP Programme, governance and ‘end to end’ process, with positive feedback. NHSI wish to return in June to focus on a number of selected CIP schemes, most likely targeted to workforce impact ones.

3.15. A CIP pipeline tracker has been produced to track the development of schemes through a series of stages ahead of being transferred and monitored through a CIP delivery tracker, the latter of which is in final development. Only once a scheme has met all the process requirements and has been validated and fully approved will it be rated ‘green’ and move to the delivery tracker.

3.16. Positive progress has been made already and is detailed within the Financial Sustainability dashboard. There is however, a significant amount of work still to do to achieve the minimum £15.1m target and reach the £25m stretch target.

3.17. There will be an ongoing focus on developing robust delivery plans to ensure the success of the programme. Progress will be tracked on a weekly basis through the FSSG and a monthly report provided for the Trust Board.

4. URP dashboards

4.1. Further detail for each of the steering groups is provided through the suite of URP dashboards (see Appendix B):

4.1.1. Organisational Recovery Dashboard and exception report

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

4.1.3. Financial Sustainability CIP Dashboard

4.2. The first 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. In particular the paper includes an update section with regards development and progress of the CIP Programme.

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

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.

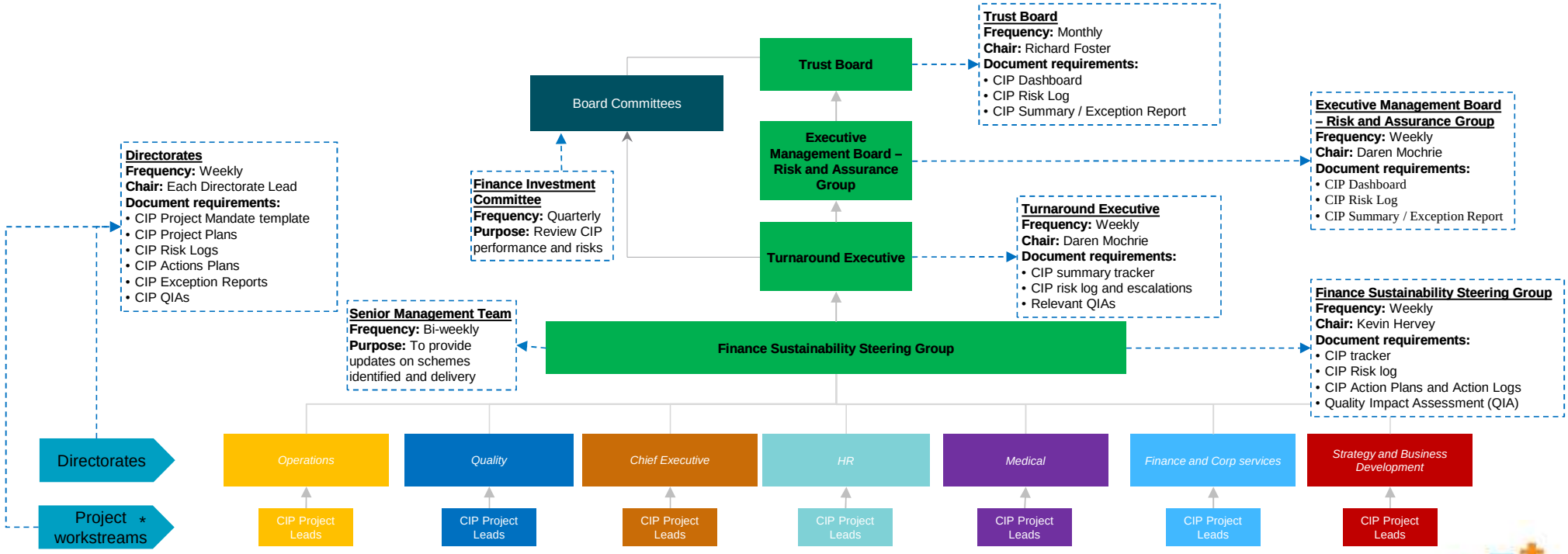
South East Coast Ambulance Service NHS
NHS Foundation Trust

CIP Governance information flows

Your service, your call

Governance information flows

The structure below, is an illustrative diagram of the governance and process relating to CIP. We drafted this initial structure to assist in mapping out the meetings required throughout the CIP process as well as the meeting requirements and frequencies. In addition, this structure will assist in mapping out who are the key stakeholders within the CIP Governance at SECAmb



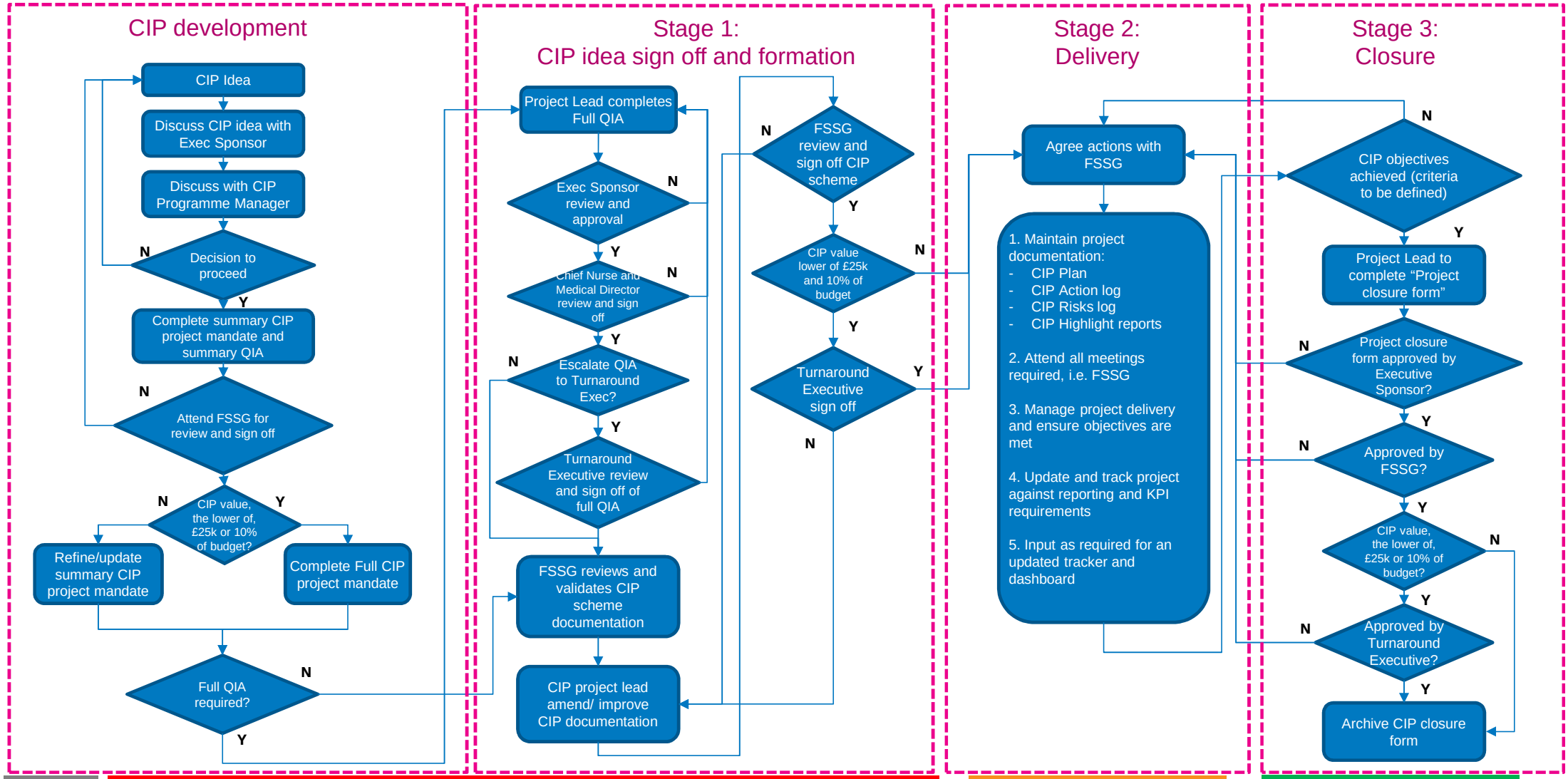
* To be agreed

South East Coast Ambulance Service NHS
NHS Foundation Trust

CIP end to end process

Your service, your call

CIP end to end process



Stage RAG | RED | AMBER | GREEN

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

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

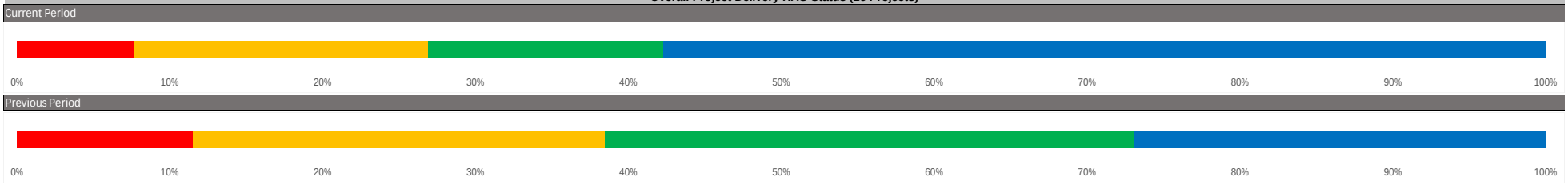
Last updated 23/05/2017

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

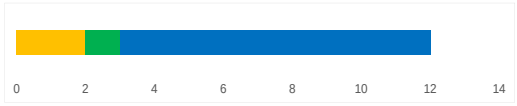
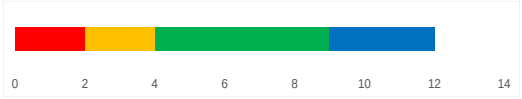
South East Coast Ambulance Service NHS
NHS Foundation Trust

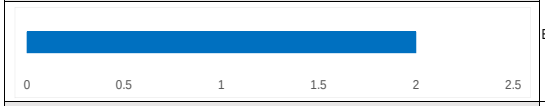
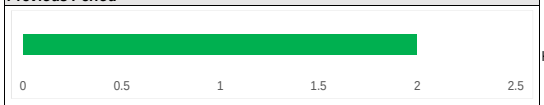
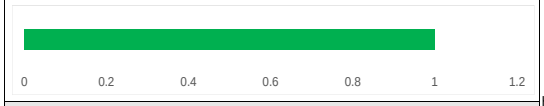
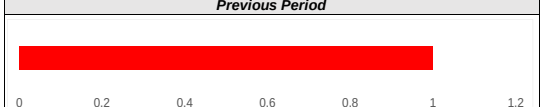
Overall Dashboard

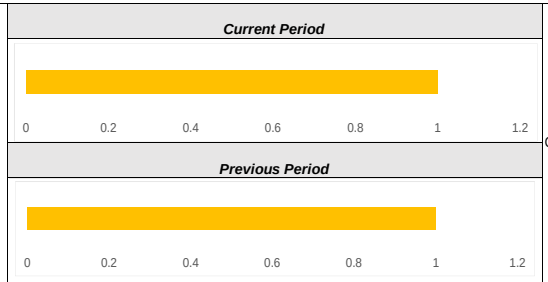
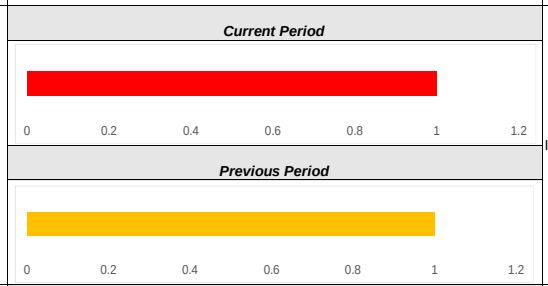
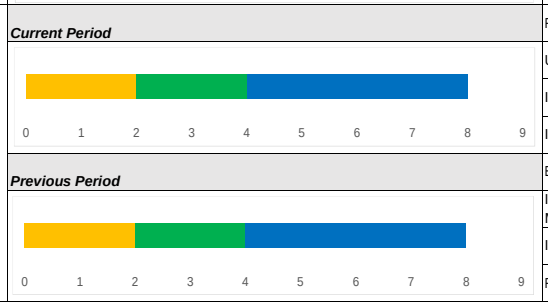
Overall
Overall Project Delivery RAG Status (26 Projects)



Work stream Level Dashboards

Work stream Level			*Project Breakdown*					
Work stream	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	Blue	Giovanni Mezza	Joe Garcia	There has been increase in the number of calls answered in five seconds, since the 'Improve call answer time' project started in August 2016, from 63% to 90%; which has helped drive an improvement in performance. Since the last Board report there have been a number of 999 project closures and handovers to BAU following the agreement to refocus efforts on high impact projects to help improve operational performance. A new plan has been developed for Hospital Turnaround and there has been good progress over the last few weeks to help drive towards the objective of achieving 100% of A&E's on boarding by the end of May 2017; with performance monitoring to continue through to the end of September 2017. The Hear & Treat project has been paused and will be re scoped, planned and mobilised in order to increase the number of clinicians who can undertake H&T tasks but also to improve the way in which H&T data is monitored and used for performance review.
			Forecasting and scheduling process reviewed and action plan delivered	Blue	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")	Blue	Green	Sue Skelton	Joe Garcia	
			Revised demand management plan implemented ("Surge plan")	Blue	Amber	Sue Skelton	Joe Garcia	
		Previous Period 	Improved call answer service	Blue	Green	Mark Bailey	Joe Garcia	
			Reduced response ratio	Blue	Green	Sue Skelton	Joe Garcia	
			Zoned Cars	Green	Green	Chris Stamp	Joe Garcia	
			Increased Hear and Treat responses	Amber	Green	Karen Lillington	Joe Garcia	
			Improved Performance Management	Blue	Red	Sue Skelton	Joe Garcia	
			Reduced hospital turnaround time	Amber	Amber	Dave Hawkins	Joe Garcia	

111	***2***	***Current Period*** 	Effective operational performance management	Blue	Green	John O'Sullivan	Joe Garcia	Both projects were formally approved for closure during Turnaround Exec. During the closure process both projects were commended due to the 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%. The focus going forward will be on integrating governance between 111 and EOC, which is currently being managed through BAU.
		Previous Period 	KMS 111 Recruitment and Retention	Blue	Green	John O'Sullivan	Joe Garcia	
HQ	***1***	***Current Period*** 	HQ Move / EOC Move	Green	Amber	Ibrahim Razak	Steve Graham	Excellent progress has been made to the overall project; the new HQ in Crawley is operational and a number of Directorates, including Corporate Governance and Quality & Safety, have successfully relocated to the new HQ. Much of the focus since the last board report has been on progressing the 'Day 1 Readiness' workstream with the Lewes EOC staff due to relocate on 24 May 2017. The project has continued to be monitored through the weekly Programme Board which has helped improve scrutiny and drive forward project progress. A particular focus over the next few weeks will be on decommissioning of the Lewes site in advance of the 30 June 2017 deadline.
		Previous Period 						
EPCR	***1***	***Current Period*** 	Electronic Patient Clinical Records ("EPCR").	Red	Red	Edyta Suszek	Jon Amos	During the period functional testing has been completed in order to increase the size of the app to resolve the software issues. In addition there has been an increase in the level of ePCR / IPAD on-boarding from 43% at the of March 2017 to 53% as at 18 May 2017. A new project plan has been developed which includes milestones to complete 90% of iPAD / ePCR on boarding by 21 July 2017. The project is still rated as 'Red' as the project has not secured appropriate resource from an operational perspective, following the restructure of the project team at the end of March 2017. Furthermore the project is significantly behind the track.
		Previous Period 						

OU Restructure	***1***		OU Restructure (formerly "OU Leadership")	Amber	Amber	Sonia Belsey	Joe Garcia	Following resolution of the staff concerns raised, HR are now managing the process in order to recruit into the outstanding vacancies. As at 16 May 2017 there have been 147 applicants for the 35 vacancies. During the period assessment centres have been arranged, assessors have been trained to manage the assessment centres and communications have been made with candidates. The first assessment centre is due to start at the end of the month and will continue to operate 1 - 2 times each week afterwards. The project is still tracking as 'Amber' as the implementation of the team structure is still as risk of delay if staff concerns are raised.
New CAD	***1***		Implementation of new CAD	Red	Amber	Phil Smith	Jon Amos	Good progress has made during the period as the first training course was completed with 100% pass rate. In addition Core system Infrastructure builds (across Coxheath and Banstead) are 90% complete and on track with the remaining work scheduled to be completed on time. However work on setting up the TEST interfaces has fallen behind schedule which has pushed the overall delivery RAG status from 'Amber' to 'Red'. Please refer to 'Exceptional Reporting' below for further details.
Culture / Workforce	***8***		Refreshing Values (formerly Improving Staff Engagement)	Amber	Amber	Steve Singer	Steve Graham	Four key projects currently exist within the Culture and Workforce workstream, although it is likely this will grow in scope following a recent work planning session to scope out the Trust's priorities for improving organisational culture. Refreshing values is currently on hold until an Executive decision is made on the approach that will be taken to complete this work. Progress continues to be made with updating the HR policies. Superuser and line manager training for the new appraisal system are underway, and roll out of the system has commenced. Leadership development continues with first level managers through the OU restructure.
			Updating HR Policies & Procedures	Amber	Amber	Karen Lavender	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	Blue	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	Blue	Clare Irving	Steve Graham	

Exceptional Reporting

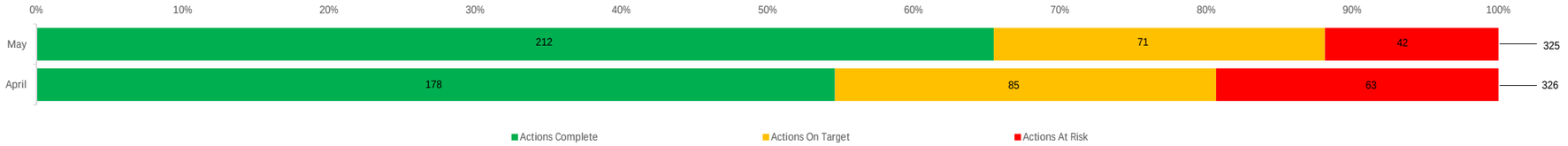
Workstream	Project	Executive Sponsor	Current RAG	Previous RAG	Rationale	Mitigating actions	Owner	RAG post mitigating action
New CAD	Implementation of new CAD	Jon Amos	Red	Amber	At risk because there has been a delay in setting up the TEST interfaces meaning any ongoing delays could have a knock on effect on live testing and handing back the system to EOC.	This risk was escalated during project board on 15 May 2017 and discussed further during Programme Board on 17 May 2017. The project plan has been amended in order to take into account the slippage and revised dates which will provide certain individuals within the project team with more time to complete the interface configurations. However it has been noted that the any further slippage could delay the GO LIVE 1 date (4 July 2017).	Mark Chivers	Amber
EPCR	Electronic Patient Clinical Records ("EPCR")	Jon Amos	Red	Red	At risk as there has been difficulty in securing the appropriate resources needed to drive forward project progress, following the change of the project team structure at the end of March 2017.	The project team have secured resource from Operations to lead the on-boarding element of the project. In addition clinical resource has been secured which will start at the beginning of June 2017. There is now ongoing work to retain the ePCR project operational lead.	Adrian Johnson	Amber

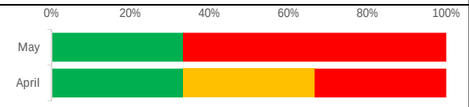
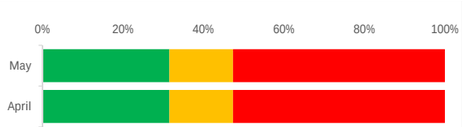
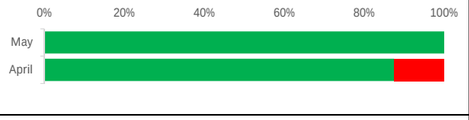
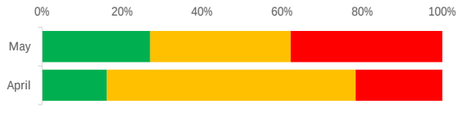
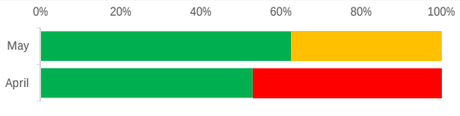
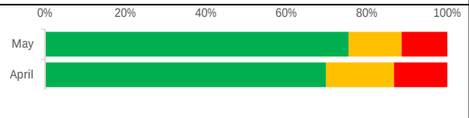
Closure Reporting

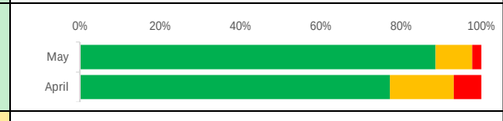
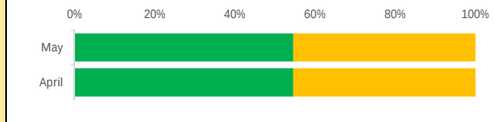
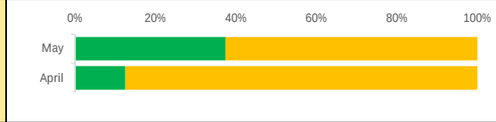
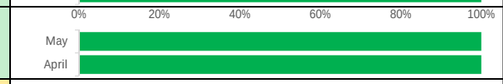
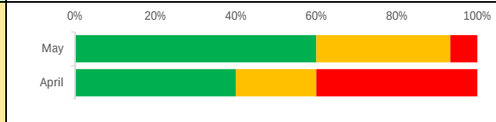
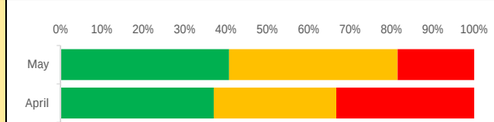
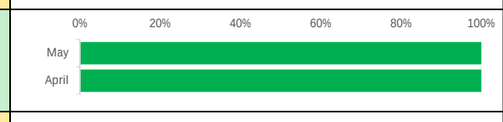
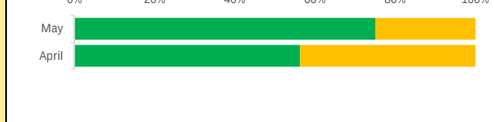
Workstream	Project	Executive sponsor	Project lead	Date project officially closed	Review date	Rationale for closure	Handover to BAU
111	Effective operational performance management	Joe Garcia	John O'Sullivan	26/04/2017	05/05/2017	This project has been achieved its objectives and has been a significant success story, the team have worked hard to develop the team ethos to improve the performance metrics to the point that the SECAMB 111 service is place top of the 5 Ambulance 111 providers in comparative data.	The team will continue to monitor the use of RTA reports to drive operational performance and understand key issues and the ongoing adherence to performance meetings through documenting minutes as evidence
111	KMS 111 Recruitment and Retention	Joe Garcia	John O'Sullivan	26/04/2017	05/05/2017	The recruitment & retention issues within 111 have materially changed since the commencement of this project, with the approach to move to more employed staff compared with Agency staff. The initiatives to ensure new staff are supervised more closely during their shifts has greatly enhanced the retention rates.	The team will continue to use the KMS 111 recruitment tracker to monitor the level of agency and to ensure visibility is maintained over recruitment and attrition to enable a more effective management of workforce turnover
999	Improved effectiveness of Community First Responders ("CFRs")	Joe Garcia	Sue Skelton	26/04/2017	30/06/2017	There has been a increase in performance contribution for CFRs from 0.8% to 2.5% delivered through this project which has helped improve the effectiveness of the CFRs. Despite not reaching the initial target of 3%, the strategy for the CFR expansion will move into the individual Operating Units to provide a more localised focus to CFR placement and engagement.	The CFR Project has matured into a key element of the Trust's BAU as monitoring and regular reviews of contribution and performance are discussed during the SOLT review meetings.
999	Revised demand management plan implemented ("Surge plan")	Joe Garcia	Sue Skelton	26/04/2017	26/06/2017	This project has delivered the product of the initiative in providing a revised Demand Management Plan now termed a Surge Management Plan. This has now been reviewed by the new Medical Director and been shared with Commissioner stakeholders for review.	The completion of policy and sign off has transferred to BAU as part of the handover plan. In addition training and implementation plans will be managed through BAU.
999	Improved call answer service	Joe Garcia	Mark Bailey	26/04/2017	01/08/2017	The 999 Call answering performance has consistently improved month on month over the past 12 month and call answering performance, whilst not yet at 95% was the most consistent and positive during that period. Much closer scrutiny is being applied through BAU to recruitment and retention to ensure that the rate of attrition does not create a similar 'boom and bust' scenario from an EMA numbers perspective.	Performance will be actively monitored and any issues or risks will be escalated to SOLT accordingly. In addition work has commenced to help improve the integration of 111 & 999 which will introduce new concepts to the 999 service in order to help improve quality, retention and productivity rates
999	Reduced response ratio	Joe Garcia	Sue Skelton	18/04/2017	18/07/2017	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. It was recognised that the original 1.18 target was deemed to be a challenging target when benchmarked against NWAS levels (1.58).	The Response Ratio will remain an item on the SOLT performance dashboard where any unexpected deteriorating performance will be monitored and investigated. Implementation of the new CAD will help improve performance through the auto dispatch functionality.
999	Improved Performance Management	Joe Garcia	Sue Skelton	19/04/2017	01/10/2017	This project was designed and scoped to implement a performance management system with the use of an external provider. However with the Trust in financial recovery, it was not possible to obtain the level of funding needed to support the roll out and therefore the project was previously tracking as 'Red'.	The Trust will be utilising internal resources to develop performance data dashboards that support the new operating unit structure which is currently being managed through BAU.
999	Improving Forecasting and Scheduling processes	Joe Garcia	Greg Walsh	11/05/2017	01/09/2017	This project has been unable to achieve its objectives within the original timeline because the Operations Restructure has required a pause to the scheduling restructure which will be recommenced by September 2017. During this time an independent review of the scheduling and forecasting activity has been undertaken and a further project will be initiated to effect the changes necessary.	No handover has been completed as there will be a new project which will be initiated in September 2017 once the Operating Restructure is complete and will incorporate the new findings of the independent review.

South East Coast Ambulance Service - CQC Must Do Improvement Tracker

CQC Dashboard - 15 May 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		2	Dan Garratt	Joe Garcia	With over 80% of actions complete, a number of improvements have been made to site and vehicle security within the Trust. Key highlights include, enhancing EOC security, implementing a quarterly site security audit programme, and enhancing communications regarding learnings and awareness of the importance of security. The objective for the next period is to publish the updated policies and procedures, publish quarter four audit findings, and transition the improvements made into BAU while embedding further local ownership. These actions are at-risk due to a slippage in timeframes by approximately one month, with no material impact envisaged.	01/05/2017 *Estimated to now be complete by 30/05/2017*
	IT	3.0 CAD Improvement Plan	At Risk		2	Mark Chivers	David Hammond	The challenges associated with replacing the gazetteer within the existing CAD continue. However, the replacement of the gazetteer will be superseded with the implementation of the new CAD system. The new CAD is understood to have a gazetteer that is fit for purpose. Over the next period a formal handover of this project will be made to the new CAD implementation. This project is flagging at risk due to delays with live testing of the new CAD, discussed further in the ORSG Board Report.	01/10/2017
	Incidents	7. Incident and SI Reporting Improvement Plan	At Risk		10	Sara Songhurst	Emma Wadey	While no further actions have been closed within the period, work has continued on the delivery of this project. Progress has been slow due to a combination of ongoing capacity constraints within the risk team, an inability to recruit temporary personnel at this moment to support with clearing the backlog of incidents, and initial teething problems with the new Datix system that have now been resolved. A Datix Manager is due to join the Trust at the end of May, which should significantly assist with progressing some actions. Additional capacity from within the risk team has also been sought to assist with clearing the incidents backlog. This is discussed in more detail below.	01/05/2017 *Estimated to now be complete by 29/07/2017*
	Infection prevention	10.0 Infection Prevention and Control Improvement Plan	Complete		0	Aide Hogan	Emma Wadey	This project is complete and improvements embedded into BAU. Monitoring will continue to be provided through directorate governance.	31/03/2017
	Medicines	14.0 Medicines Management Improvement Plan	At Risk		14	Fiona Wray	Fionna Moore	The increase in the number of at-risk actions is due to ongoing delays with the delivery of this project related to continued capacity constraints in the delivery team. The newly appointed associate medical director is providing additional oversight, and a senior pharmacy technician has been recruited to start in early June. The key priorities for the following period include reviewing and improving controlled drugs handling and management procedures, updating all patient group directives and improving medicines waste management processes. Please see below for further detail.	31/08/2017
	Patient records	15.0 Patient Records Improvement Plan	At Risk		0	Fiona Wray	Fionna Moore	Momentum with the delivery of this project continues, with a revised action plan developed to incorporate the findings of the end to end process review and realistic completion dates set. All stations are now understood to be using PCR boxes with ongoing monitoring taking place locally. The focus has shifted to reducing the lag time for PCRs to be processed, and embedding a standardised PCR audit process Trust wide. Despite the delivery of this project being on track, it remains at risk due to challenges with reconciling approximately 9% of PCRs with an incident number on a monthly basis. This is discussed in more detail below.	01/05/2017 *Estimated to now be complete by 04/08/2017*
	Safeguarding	1. Safeguarding Improvement Plan	On Target		6	Sara Songhurst	Emma Wadey	Good progress continues to be made on the delivery of the project. Recruitment of the new post is underway with an appointment expected in the near future. An audit process of safeguarding referrals has been implemented to support quality improvement. The key priorities for the next period is to further expand the type of audits undertaken, and establish an effective feedback process for operational teams to enable learning.	01/06/2017

Domain	CQC Work stream	CQC Must Do	Confidence of delivery on time and realising benefits	Progress against actions%	Number of at risk items	Project lead	Executive lead	Progress summary	Project completion date
Effective	Operational performance 999	8.0 Take action to ensure that national performance targets are met	Complete		0	Sue Skelton	Joe Garcia	Following the rationalisation of projects within the operational improvement workstream, and submission and approval of all closure forms through the ORSG, all actions within this plan have been closed. All further monitoring and reporting of continued, re-scoped and new projects will occur within the ORSG. Please refer to the Organisational Recovery Dashboard for further detail on next steps with operational improvements.	31/03/2017
	Operational performance 111	16. NHS 111 Improvement Plan	Complete		1	John O'Sullivan	Joe Garcia	This project is complete and improvements embedded into BAU. Monitoring is being provided through directorate governance and meetings with commissioners. 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		2	Andy Collen	Emma Wadey	Despite no further closure of actions, progress continues to be made with the delivery of the frequent caller project with potential opportunities to expand this in collaboration with operational teams. Challenges with IBIS staffing have impeded progress with the falls and hypo's referrals project. However, recruitment for vacant posts are currently underway. Discussions are also taking place regarding opportunities to re-scope this project given the interest of commissioners on improving the management and prevention of falls. There have been minor delays in finalising the improvement plan for AQIs, with this being a key priority for the following period to start with implementation.	30/03/2018
Responsive	Scheduling	13. Safe Resource Dispatch	On Target		0	Chris Stamp	Joe Garcia	The remaining actions within this project relate to publishing and implementing the revised incident and resourcing deployment and management policy and SOP that is focused on supporting the safe deployment of staff, with particular emphasis on new joiners. This is currently under consultation and due to be finalised within the next period in order to begin training and implementation.	30/09/2017
	HART	4.0 HART Improvement Plan	Complete		0	Andy Cashman	Joe Garcia	This project is complete and improvements embedded into BAU. Monitoring is being provided through directorate governance.	31/03/2017
		12.0 HART Staffing Improvement Plan	Complete		0	Andy Cashman	Joe Garcia	This project is complete and improvements embedded into BAU. Monitoring is being provided through directorate governance.	31/03/2017
Well-led	Governance	6.0A Corporate Governance	On Target		1	Peter Lee	Daren Mochrie	With 60% of actions now complete, progress continues to be made with the Corporate Governance improvement plan. Key achievements for this period include the formal sign off of Executive portfolios, and development of the risk management procedure. Key priorities for the next period include publication and implementation of the risk management procedure, and maintaining progress with the key at risk action of updating out of date policies.	31/03/2018
		6.0B Clinical Audit	On Target		5	Joe Emery	Fionna Moore	Consistent delivery against the clinical audit project plan has seen this shift from 'at risk' to 'on target'. A key achievement this period is the implementation of weekly work plans and KPIs for the clinical audit team to support productivity. Ongoing work continues with two key actions including, finalising the clinical audit plan for FY17/18 and the annual audit report for FY16/17. These are expected to be finalised within the next period. Two additional priorities include the establishment of effective communication channels between incidents and clinical audit to inform identification of priority audits, and between operations and clinical audit to support the provision of feedback and enable learning.	31/12/2017
	PTS	5.0 PTS Improvement Plan	Complete		0	Sue Skelton	Joe Garcia	This project is complete. No further monitoring is required due to PTS services being decommissioned as of 31.03.17.	01/02/2017
	Resourcing	11.0 Staff and resourcing improvement plan	On Target		0	James Pavey	Joe Garcia	This project is nearing closure with almost 80% of actions complete. Two key remaining actions relate to the sign off of the revised meal break and abstraction management policies, with these on track to be finalised within the next period. Additionally, a review of operational staff rosters is required to ensure adequate administration and training time is provided. However, this aligns with the work being undertaken on roster reviews through the OU restructure, and may potentially be handed over to avoid duplication. This will be confirmed within the next period.	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	Delays with the delivery of the medicines management improvement plan continue due to ongoing capacity constraints in the delivery team. Potential options with CCGs have been explored but with limited success. The ongoing capacity constraints are impacting on the ability to make the required progress.	Red	Red	The newly appointed associate medical director is providing additional oversight to the project. Additionally, a senior pharmacy technician has been recruited to start in early June. The PMO will provide direct project management support to the Chief Pharmacist to enable more effective prioritisation of actions, monitoring of progress and escalation of key risks and issues.	Amber	Fionna Moore	30/06/2017
Safe	15.0 Patient Records Improvement Plan	Despite the delivery of this project being on track, it remains at risk due to challenges with reconciling approximately 9% of PCRs with an incident number on a monthly basis. This has the potential to compromise the governance of patient information, and restricts the ability to accurately analyse and report national performance data.	Red	Red	A three pronged approach will be taken to understanding the underlying causes of the inability to reconcile some PCRs: - A review of the current methodology used to calculate the number of PCRs that cannot be reconciled to an incident, to ensure this is accurate. - A review of the current PCR data validation process undertaken by the health records team, to understand the error rate and likely impact on the total percentage of PCRs that cannot be reconciled. - An independent internal audit of the back office reporting and linkages between the Formic scanners, used to transfer PCR information onto a database, and Info.Secamb, the database storing CAD information. This is to ensure information is accurately and successfully being transferred between the two systems.	Amber	Fionna Moore	15/05/2017
Safe	7. Incident and SI Reporting Improvement Plan	Progress with this project has been slow due to a combination of ongoing capacity constraints within the risk team, an inability to recruit temporary personnel to support with clearing the backlog of incidents, and initial teething problems with the new Datix system that have now been resolved.	Red	Red	The Datix Manager is due to join the Trust at the end of May, which should significantly assist with progressing actions relating to improvements to the system itself and assessing Trust wide training needs. Ongoing work continues to reduce the backlog of incidents through two approaches: - Utilising capacity within the wider risk team to support with processing incidents - Direct follow up and monitoring of progress for operations staff holding a backlog in their respective areas of responsibility - Initial review and triage of incidents within the backlog to identify those with moderate, severe and death harm scores for escalation directly to the Serious Incident Declaration Group (SID) for a decision on whether declaration of a serious incident is required.	Amber	Emma Wadey	28/04/2017

Summary of project closures

No project closures to report in this period. For further detail on project closures within 999 please refer to the ORSG dashboard.

South East Coast Ambulance Service: CIP Workstream

Programme for 2017/18 to deliver a minimum of £15m savings to achieve the planned £1m control total

Programme Summary:

- Good engagement and buy in achieved at CIP process workshop delivered to budget holders. Execs have assumed leadership and accountability of the new CIP governance process presented to them
- New CIPs Governance framework and processes favourably received by NHSI during visit to the Trust
- Completed comparison of 17/18 budgets and 16/17 spend and initiated budget review meetings with budget holders to identify additional CIP schemes.
- Developed pipeline tracker to monitor development and validation of schemes. Meetings with budget holders to establish delivery plans for existing schemes.
- Delivery tracker in development to monitor CIP project achievement of savings against plan. Initial review of schemes shows £0.89m savings in Month 1 against an in month plan of £1m.

Programme Risks

	Risk	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Failure to scope fully and deliver the entire planned value (£15m) CIPs schemes, impacting on the Trust's ability to achieve 2017/18 year-end control total of £1m.	Holding twice weekly FSSG meetings coupled with several budget reviews to support budget holders to drive the development and delivery of 2017/18 CIP schemes. CIP pipeline and delivery tracker in use to monitor CIP delivery in line with governance framework.	Kevin Hervey	Red	Red	30/03/2018
2	No formal process in place to ensure that investment projects are operating within the original budget or delivering the planned financial benefits.	Develop and implement a structured process to track programme costs and finance benefits. New business case template being developed and the review of the last 2 years business cases is underway to align the proposed financial benefits to the CIPs programme.	Kevin Hervey	Amber	Amber	16/06/2017

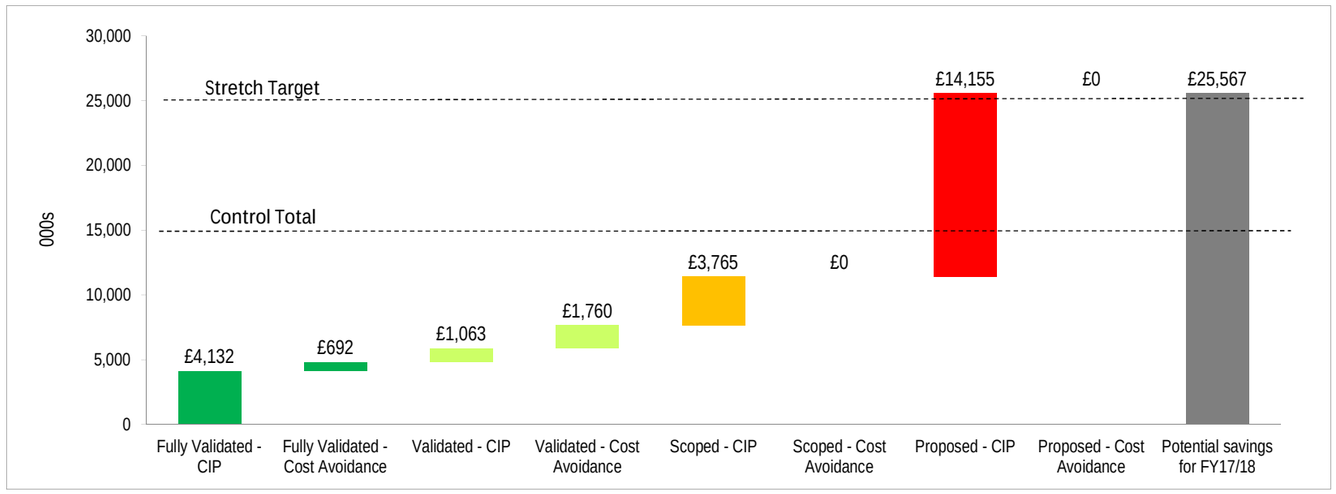
Programme Issues

	Issue to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Time taken to identify and agree CIPs schemes as budget leads juggle with conflicting priorites	CIP team is set up to provide support to budget / CIP project leads. Email will be sent by DoF to CIP leads reinforcing the need to address CIPs requirements with the PMO.	Kevin Hervey	Amber	Amber	30/06/2017

CIP Opportunity Classification and Pipeline Summary

Opportunity Status	Description	Key
Fully Validated	Scheme with confirmed savings calculation prior to delivery tracking	
Validated	Scheme with identified benefits under development	
Scoped	Scheme to be scoped for further development	
Proposed	Proposed CIP idea in analysis	

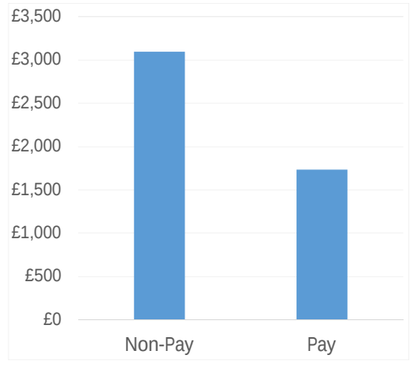
Category	Fully Validated	Validated	Scoped	Proposed	Grand Total
CIP (000s)	£4,132	£1,063	£3,765	£14,155	£23,115
Cost Avoidance (000s)	£692	£1,760	£0	£0	£2,452
Grand Total	£4,824	£2,823	£3,765	£14,155	£25,567



Fully Validated Schemes

CIP / Cost Avoidance	Busines Area / Cost Centre	Exec Sponsor	Scheme Title	Scheme Description	Spend Category	Planned Savings (000s)	YTD Savings Delivered (000s)
CIP	EOC	Joe Garcia	Reduction in Meal Breaks (old policy)	Continued work on the Meal Break Policy in relation to the disturbance of staff to RED1 etc.	Pay	£1,560	£177
CIP	Corporate Expenditure	David Hammond	Reduction in PDC Dividend	Resulting from reduction in Net Relevant Assets of £36,889k due to property revaluation	Non-Pay	£1,275	£106
Cost Avoidance	Corporate Expenditure	David Hammond	Reduction in Buildings depreciation	Resulting from reduction in building values of £20,366k due to property revaluation	Non-Pay	£692	£75
CIP	Fleet	Joe Garcia	Fleet Telematics	Decreased fuel consumption through telematics and speed restrictions & reduction in idling	Non-Pay	£500	£28
CIP	Estates	David Hammond	Facilities Management renegotiation	£96k Minor Works, £112k Staff	Non-Pay	£208	£17
CIP	Fleet	Joe Garcia	Maintenance - Spares	Reduction in owned spares stock and increase in Impress Stock	Non-Pay	£200	
CIP	PMO, Performance and Information	Jon Amos	Non-recurrent Vacancy Factor	Non-recurrent CIP of Vacancies in Strategy and Business Development	Pay	£171	£293
CIP	EOC	Joe Garcia	Reduction in Meal Breaks (new policy)	Work on the Meal Break Policy in line with the new policy and the delivery of savings over and above the old policy	Non-Pay	£100	
CIP	Corporate Governance	Daren Mochrie	CEO (Consultancy, Subs, Room hire)	Reductions in spend for consultancy, legal fees and room hire	Non-Pay	£68	£6
CIP	Fleet	Joe Garcia	Bunkered Fuel vs Fuel Cards	Increased use of bunkered fuel vs fuel cards	Non-Pay	£50	
Total						£4,824	£702

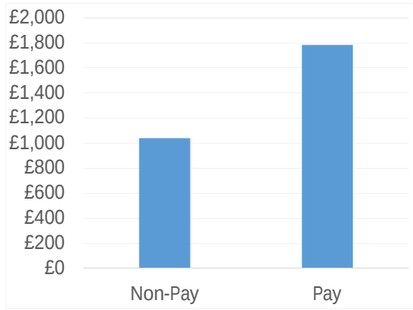
Total Fully Validated Savings Profile (000s)



Validated Schemes (greater than £50k)

CIP / Cost Avoidance	Busines Area / Cost Centre	Exec Sponsor	Scheme Title	Scheme Description	Spend Category	Planned Savings (000s)	YTD Savings Delivered (000s)
Cost Avoidance	Trust Wide	Steve Graham	Agency Premiums	Recruitment of Permanent Staff to posts currently being filled by Agency Employees	Pay	£1,400	£117
CIP	Corporate	David Hammond	NHSLA Contribution	Reduced CNST Contributions - should be £1,577k for the year, not £1,956k,	Non-Pay	£380	£32
Cost Avoidance	KMSS 111	Steve Graham	Agency Premiums (111)	Recruitment of long term agency employees, retention to increase % of core staff vs. agency	Pay	£300	£25
CIP	Corporate	David Hammond	Vehicle Insurance	Sale of PTS Vehicles to reduce insurance premium	Non-Pay	£274	£23
CIP	EOC	Joe Garcia	Reduction in Meal Breaks (new policy)	Additional efficiencies realised from updated Meal Break Policy in relation to the disturbance of staff to RED1 etc.	Non-Pay	£100	
CIP	Medical	Fionna Moore	Clinical Governance and Standards POST	TBC	Pay	£83	
Cost Avoidance	Medical	Fionna Moore	Omnicell contract	Omnicell Contract review	Non-Pay	£60	
CIP	Comms	Daren Mochrie	General spend reduction	Photography costs, SECamb news, DOD Monitoring, Media Monitoring, Survivors event	Non-Pay	£50	
Total validated schemes (including less than £50k)						£2,823	£197

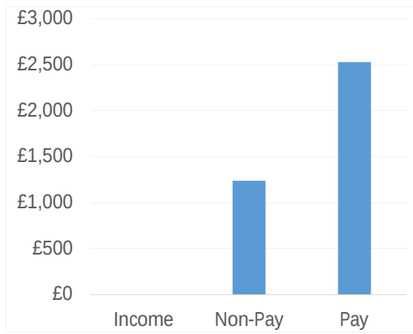
Total Validated Savings Profile (000s)



Scoped Schemes (greater than £50k)

CIP / Cost Avoidance	Busines Area / Cost Centre	Exec Sponsor	Scheme Title	Scheme Description	Spend Category	Planned Savings (000s)
CIP	Operations	Joe Garcia	Ops Restructure	Net effect of CTL moving back to Paramedic roles (Note: Pay protection has been added to budget which this saving pays for, for 2 years)	Pay	£986
CIP	HR / Operations	Joe Garcia	Reduced Staff Turnover (999)	Reduced the need for PAP hours to backfill vacancies in rota c. 20 less wte leaving	Pay	£850
CIP	EOC / Operations / Fleet	Joe Garcia	System Status Plan appropriateness	Deactivating the SSP during the night, requiring lower fleet movements	Non-Pay	£500
CIP	Operations / EOC	Joe Garcia	Reduction in Shift overruns (LSOs)	Continuing work to allocate responses to vehicles able to complete job without running over shift	Pay	£311
CIP	Trust Wide	Steve Graham	Releasing Operational Staff from other Directorates to Support Hours	Review of all clinical staff in support function roles; appropriateness and promotion of bank (overtime) work to keep up clinical skills etc.	Pay	£200
CIP	Quality and Safety	Emma Wadey	Quality Efficiencies	Reduced requirement from external contractors / resources	Non-Pay	£155
CIP	Procurement	David Hammond	Staff Uniforms	Rationalisation of staff required to wear uniform/ quantum of uniforms issued/ returns policy/ badges	Non-Pay	£150
CIP	Operations	Joe Garcia	EOC	Reduced requirement to use external resource to advise on EOC direction / engagement	Non-Pay	£120
CIP	HR / EOC	Joe Garcia	Reduced Staff Turnover (EOC)	Less training costs to fill vacancies + increased efficiencies from more experienced staff	Pay	£100
CIP	Operations	Joe Garcia	IBIS	Reduced requirement to develop / manage software	Non-Pay	£68
CIP	Operations	Joe Garcia	PAP Contract	use of current management to manage the PAP contract / framework rather than using external resource	Pay	£60
CIP	Clinical Education	Steve Graham	External driving training instructors	If the Trust recruit 4 new driving instructors costing c£160k pa, a net saving of at least £50k is anticipated (incl. renegotiation with FTS and Mstar)	Non-Pay	£50
Total scoped schemes (including less than £50k)						£3,765

Total Scoped Savings Profile (000s)



Proposed Schemes (greater than £50k)

CIP / Cost Avoidance	Busines Area / Cost Centre	Exec Sponsor	Scheme Title	Scheme Description	Spend Category	Planned Savings (000s)
CIP	Operations	Joe Garcia	Job Cycle Time Improvements (JCT)	Lightfoot report indicates average JCT has increased by 13mins since 2013/14; this equates to around 158k hours of additional staff hours	Pay	£2,700
CIP	Operations	Joe Garcia	Hand Over Delays	Reduction to 2013/14 levels would save around 37k hours of vehicle time (74k Staff Hours) - needs Commissioner Support to work with hospitals.	Pay	£2,400
CIP	Operations	Joe Garcia	CCP's contribution to Performance	CCPs Hours (1,300) x 50wte = 65k hours saved = £2.1m	Pay	£1,600
CIP	EOC / Operations	Joe Garcia	Future clinical model (More Hear and Treat +5%)	Every 1% of activity moved from Frontline (8k activation) means c.22k hours saved £0.7m	Pay	£1,500
CIP	Fleet / Estates	David Hammond	SOP's for MRC, Fleet maintenance etc.	Increasing maintenance cycles; better purchasing of consumables; management of Churchill contracts etc.	Non-Pay	£1,000
CIP	L&D (enabler)	Joe Garcia	Staff Abstraction Management from Education and Training	Using on the job training / coaching / mentoring equating to c.31k hours saved in frontline abstractions	Pay	£1,000
CIP	Trust Wide	Daren Mochrie	Benefits realisation followed up and full accountability	Review of Business Cases approved within past twelve months, with all benefits accounted for.	Non-Pay	£1,000
CIP	Estates / EOC / Trust Wide	Steve Graham	Single HQ / EOC	Per Business Case	Non-Pay	£800
CIP	Estates	David Hammond	Facilities Management	TBC	Non-Pay	£500
CIP	Operations / Fleet / Estates	Joe Garcia	Benefits of MRC Program	Frontline staff able to be available to respond for longer due to vehicles ready	Pay	£500
CIP	Procurement	David Hammond	Procurement / Contracts Review	Review of all existing contracts, to deliver better value through re-tendering	Non-Pay	£280
CIP	Fleet/Production Desk	Joe Garcia	Reduced moving of vehicles between sites	Reduced movement of vehicles / better planning of maintenance schedules	Non-Pay	£275
CIP	Procurement	David Hammond	Procurement / Contracts Review	Reduced costs of providing ancillary equipment to staff by standardisation / use of discounts	Non-Pay	£110
CIP	Paramedics	Joe Garcia	Clinical Co-Ordinator External contracts	Rationalisation of requirements for external contractors	Non-Pay	£100
CIP	Fleet	Joe Garcia	Vehicle choices - Vans vs box back vehicles (£1M Capital)	TBC	Non-Pay	£100
CIP	Procurement	David Hammond	Stationery	Ratonalisation of stationery procurement	Non-Pay	£100
CIP	Operations	Joe Garcia	Crew Clear	15mins saved on each current breach of Crew Clear >30mins would save around 4k staff hours	Pay	£100
CIP	IT	David Hammond	EPCR (printing)	As per Business Case, reduced requirement to have paper Patient Care Records	Non-Pay	£80
Total proposed schemes (including less than £50k)						£14,145

Total Proposed Savings Profile (000s)

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Item No	20/17
Name of meeting	Trust Board		
Date	30.05.2017		
Name of paper	SECAmb Cyber Security		
Executive sponsor	David Hammond - Director of Finance and Corporate Services		
Author name and role	Mark Chivers, Head of IT		
Synopsis (up to 120 words)	Report outlining the impact to SECAmb of the worldwide cyber-attack of May 12th and the future recommended actions.		
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.		
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**	

SECAmb Cyber Security

1 Introduction

1.1 On 12 May 2017 a global cyber event saw 200,000 machines in 150 countries infected with a ransomware component that encrypted files on the host machine and servers. This event included 47 NHS Trusts and led to widespread and very public disruption which in turn has resulted in questions being raised about NHS Security in general. Reputational damage has probably been limited purely by the scale of the attack and the fact that a number of private sector organisations have been impacted.

2 Description of the issue

2.1 The actual source of the outbreak is largely in dispute but there have been reports of it being packaged within a Word document attached to an email. The actual delivery method for these attacks is usually via an email attachment or an innocent looking link clicked by the user that takes them to a website that then downloads the infection.

2.2 Most viruses use known exploits in computer operating systems or applications. An exploit is essentially a bug in the code that once known can be used by 'hackers' to either gain access to systems or plant other software on the system which then causes more damage. This particular piece of ransomware (known by various names including Wanna Decryptor and WannaCry) is designed to encrypt the files on a machine and then offer to release them for a fee and it replicates itself using a fault in a file transfer program called SMB which is part of many Windows operating systems – both laptop/desktop and servers.

2.3 These bugs in the operating systems are usually there from day one but it's only when they're found that they become dangerous because that is when people learn how to exploit them. It is usually at this stage when the vendor (e.g. Microsoft) develops a 'patch' to fix the problem which is then made available to customers to implement.

3 Impact to SECAmb

3.1 As of Monday afternoon (May 15th) there have been no reported incidents within SECAmb and the threat level of being hit by this issue is now medium to low due to the implementation of an anti-virus patch and the ongoing patching of servers against the vulnerability that allows the issue to spread.

3.2 There is always a risk that a variation of this ransomware could be developed specifically designed to defeat the protections put in place could be developed but that risk is probably no greater than previous.

3.3 It would also appear that no other ambulance services have been significantly impacted either. The Scottish Ambulance Service reported around six machines affected and others reported some disruption but this was due more to other services shutting down their systems and 111 interfaces either as a precaution or because they were impacted.

3.4 The CAD has very minimal connections to the outside world and has traditionally a high level of controls imposed on the machines that access it, specifically to guard against such attacks. It sits on its own network to prevent cross-contamination and these controls must be enforced with the introduction of Cleric. To date there have been several requests to allow external connections directly into the Cleric system such as the CAD Online add-on used for Hospital Inbound screens. IT is and will continue to challenge these requests and insist that best practice is adhered to such as the use of a secure DMZ between the CAD Online system and the CAD itself. A DMZ (De-Militarised Zone) acts as a buffer in the event someone breaches the firewall.

4 Timeline of this event

4.1 Indications are the attack started mid-morning on Friday. IT Security companies reported receiving calls from customers that they had a ransomware outbreak and it quickly escalated.

4.2 Some Trusts felt they had little choice but to shut down systems and disconnect from the outside world in order to protect themselves so even where machines were not affected there was significant disruption to patient facing services. SECAmb IT did not agree with that assessment and instead monitored network and server activity whilst a resolution was found.

4.3 CareCERT, the NHS Digital Cyber Security Programme, started issuing advice to Trusts around 5pm. The perception within IT is that they were quite behind the private security companies in responding to the threat. It was highlighted fairly soon how the infection was spreading and which security patch needed to be applied so Trusts would have started that process as soon as possible.

4.4 At around 7pm the Sophos anti-virus company issued a new virus definition that prevented infection but could not repair any existing damage. This was installed by the Trust IT department on Friday evening who then spent the rest of the weekend ensuring all systems had the update rolled out to them and that the critical Microsoft security patches were installed.

4.5 As an additional precaution, the SECAmb backup servers were checked and turned off as ransomware attacks have been known to specifically target backup services in order to make restoring systems and data more difficult and increase the chance of victims having to pay to decrypt files.

4.6 In summary this meant that two components are needed to prevent this attack – the anti-virus update that identifies and quarantines the malware and the Microsoft patch to prevent the bug in the operating systems being used to replicate it if it or another variant did get past the anti-virus.

4.7 Organisations that had infected/encrypted machines were faced with the additional task of wiping and rebuilding any infected machines and restoring any data from the last clean backup.

5 What happens next?

5.1 For some time it has been stated that NHS security is lacking significantly behind other industries and indeed other parts of the public sector. Last year the Head of IT presented a paper to the IT Working Group outlining areas that should be addressed to improve security based on previous exposure to local government organisations that have to complete an annual compliance process in order to connect to central government networks. Many actions from this paper still need to be addressed.

5.2 There are several reasons why IT security in the NHS is often lagging behind others:

- **Lack of funding to keep systems up to date.** As hardware ages it sometimes is unable to run the latest versions of software and old software doesn't get patched thus creating vulnerabilities.
- **Lack of supplier engagement.** The NHS seems to be particularly bad at holding its software suppliers to account when they don't update the systems they supply. As a result some common NHS systems will not run on the current supported versions of software. For example it was only last year that SBS was able to run on Internet Explorer 11 and could only run on IE7 – a long out of date system with known vulnerabilities. The current version of Datix will not run alongside the newer version of Microsoft Office, and so forth.
- **No dedicated security resources within the IT team.** There are some skills and knowledge within the team but they have little time to focus on security issues.
- **Lack of necessary maintenance windows.** Security patches are essential to keep servers protected and with over 250 servers within the Trust, that inevitably means downtime for many systems whilst the patches are applied and traditionally it is difficult to get departments to agree to regular downtime.

- **Lack of regulation.** There is no regulated requirement from NHS Digital or any other part of the NHS for Trusts to comply with an agreed set of security standards. Even the CQC doesn't concern itself with how well organisations manage the systems upon which it depends to deliver its services and instead only focusses on persistent issues reported by staff, such as the CAD gazetteer. Without this there is little external pressure to maintain security practices all year round when faced with other pressures.
- **Over-reliance on policies.** Instead of having robust controls in place the Trust tends to rely on having policies and asking staff to comply with them. The issue with this is that in any security situation the weakest link tends to be the staff. This is not necessarily due to wilful intent but usually because they don't understand the risk or feel it doesn't apply to them.
- **Lack of appetite for enforcement.** Whilst there are many ways to implement security controls and not be overly restrictive, it is inevitable that putting proper systems in place will impact the way people go about their daily work. For example, they may be required to use a separate token to log in to systems remotely or forced to use an encrypted USB stick rather than *asked* to. Part of the key to doing this properly is to explain and educate staff as to why these restrictions are necessary and what the correct ways are to achieve their goals.

5.3 The events of May 12th must serve as a catalyst to placing more serious emphasis on making significant improvements to the Trusts cyber security. It has to have adequate and appropriate controls in place to prevent accidental infection of its systems and have sufficient resources to consistently assess threats and vulnerabilities and to act on them.

5.4 Education will play a significant part and consideration should be given to expanding the annual training but the reality is that many of the improvements will inevitably be technology solutions to combat technological threats.

5.5 The implementation of security controls rather than policies is vital to prevent further attacks. However will take time to do this properly without simply locking down systems to the point where staff are unreasonably hindered from doing their jobs.

6 Recommendations

6.1 The events of May 12th have been a timely reminder on the importance of good cyber security. Whilst there was already a plan to review this once the move into Crawley and migration to the new CAD were complete, it is recommended that the work is brought forward.

6.2 Whilst general IT security principles are adhered to it is recommended that:

6.2.1 The Trust undertakes a full IT Health check annually from a recognised external security company. This includes an internal vulnerability scan and an external penetration test with the key output being a published remedial action plan.

6.2.2 The Trust adheres to a recognised industry security standard such as PSN, NIST or CIS 20 in order to provide focus and metrics with compliance reported through normal governance to the Trust Board.

6.2.3 A process is started to significantly tighten the starters and leavers process and changes to system access when staff change roles.

6.2.4 The Trust reviews the wide area network and its firewalls. The Trust heavily relies on NHS N3 connections to connect sites yet it cannot be considered a secure network. As it approaches end of life we should consider putting a more secure private service in place, retaining one active and one backup N3/HSCN link for accessing core services such as SBS, ESR, DOS etc. This in turn reduces the number of firewalls, making them easier to manage and spot potential attacks.

6.2.5 The Trust implements controls for data loss prevention (e.g. forced encryption of removable media) and automatically logging network events such as failed login attempts.

6.2.6 Consideration is given to implementing dual factor authentication to improve remote access security and guards against compromised passwords by adding a separate constantly changing token.

6.2.7 There is a tightening of controls on how systems are accessed from home or non-Trust devices. This includes remote access to email as the current systems allows attachments to be uploaded and downloaded to and from remote machines.

6.2.8 Formal controls are established on the transfer of data between the Trust and third parties, ensuring only certified secure methods are used (i.e. limitation of third party file sharing tools).

6.2.9 Third party access to Trust systems is reviewed. This includes access to systems such as IBIS by other NHS organisations as the Trust should not automatically consider other NHS bodies as secure and trusted.

6.2.10 Significant improvement is made to data backups. The current system is basic in functionality and does not provide the level of granularity needed to restore systems and files quickly.

6.2.11 Consideration is given to backing up systems to the Cloud as a disaster recovery standby.

6.3 It is also recommended that the Board note the contents of the report and that further outputs are managed through the normal governance routes with a further Board update to be provided in due course.

6.4 Agreeing and implementing any such future controls will require clear support from both Executive and Non-Executive Directors.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	30/17

Name of meeting	Board of Directors
Date	30th May 2017
Name of paper	PMO Transition
Responsible Executive	Jon Amos, Acting Director of Strategy and Business Development
Author	Eileen Sanderson, Head of PMO Ellie Wilkes, Interim Head of PMO
Synopsis	This paper provides an overview of the PMO structure following the departure of Ernst and Young (EY), and a view of the current risks that may have an impact on the running of the PMO
Recommendations, decisions or actions sought	To note the proposed structure going forward for the PMO and actions to mitigate the risks highlighted

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

1.0 Background

In January 2017, EY management consultancy was commissioned by the Trust to review and improve the Programme Management Office (PMO) in terms of its governance, policies and processes. The existing PMO was not functioning effectively and there was limited visibility of programme progress and inadequate reporting.

A rapid maturity assessment was carried out by EY which highlighted a series of recommendations and an improvement work-plan. A small team has been working as part of the PMO, led by the Interim Head of PMO to implement the improvements and there have been significant improvements during that time.

2.0 Transition Plan

Since March 2017, the majority of the roles within the PMO team have been covered by EY Consultants to drive and enable change in the organisation (one Head of PMO and three Programme Managers). Recruitment commenced at the end of January with the successful appointment of four substantive posts (Head of PMO, two Programme Managers and one Project Manager). Unfortunately, a further two Project Managers who had accepted permanent positions withdrew shortly prior to their start dates, and subsequent recruitment efforts have not been successful. This has resulted in a number of gaps that are being actively managed but present a risk when the additional support by EY ceases at the end of June.

2.1 However, to mitigate against these risks, there are a number of immediate actions that are taking place to ensure the impact is reduced. These include; interviews for PMO support to be held on 22nd May 2017, Operational Project Leads secondees being advertised and Project Managers being re-advertised. Pending successful appointments into these roles will ensure there is sufficient capacity within the PMO.

2.2 The table in page two and three outlines the plan on how the PMO posts will be filled following the phased departure of EY in the coming weeks.

URP area	Role	Remit	Substantive / Vacant	EY filled	Transition period
Overarching	Head of PMO	Overarching PMO leadership	Substantive	EY Consultant in supportive role until 30 June 2017 (also providing support on HQ/EOC, CAD, Informatics from beginning of May)	Head of PMO started on 27 April and so will have a significant handover period
	PMO support	Administrative support to the running of the PMO	Substantive	No	EY has provided management support, which will be taken over by Head of PMO by the end of May
	PMO support	Administrative support to the running of the PMO	Vacant	No	Substantive post being recruited to - interviews on 22nd May 2017
Quality	Quality Programme Manager	Quality Steering Group including CQC Must/Should do's, Culture, Clinical Outcomes and Governance	Substantive	EY Programme Manager in post until 15 June 2017	Will have a short handover period with the EY Programme Manager following a robust process to ensure knowledge and skills transfer
	Project Manager	Support to culture/ workforce projects to drive delivery	Job currently being re-advertised. Proposed interviews on 9 June 2017	No	The project manager currently supporting HQ/EOC moves will have the capacity to take up this role once Lewes has been decommissioned at the end of June 2017
	Project Manager	Support to clinical outcomes' projects to drive delivery	Substantive	No	EY provides oversight and upskilling as part of Programme Manager role. This will be handed over to the Quality Programme Manager
Organisational Recovery	Organisational Recovery Programme Manager	Work streams including 999/111, EPCR, CAD, HQ and Informatics	Substantive	EY Programme Manager providing targeted support to HQ/EOC moves, CAD and Informatics projects from 03/04/17 until 30/05/17	One-month handover completed to ensure knowledge transfer - focus initially was on 999/111 projects and EPCR. EY Programme Manager will hand over remaining projects by the end

					of May
	Project Manager	Support to EPCR / CQUIN	Substantive	No	Organisational Recovery Programme Manager has taken on responsibility of overseeing this project manager
	Project Manager	Support to HQ/EOC moves & Culture and Workforce	Substantive	Oversight by EY	This will be overseen by the Organisational Recovery Programme Manager at the beginning of June 2017
	Project Manager	Support to 999/111	Job is now out to advert for 2 x Operational staff to enable them to develop their skills within PMO (talent management) on a 6 months rolling contract	No	
Financial recovery	Project Manager	Develop and deliver 2017/18 CIP plan	Vacant. Unable to appoint following recent interviews	EY Consultants providing support until 30 June 2017 to Interim Head of PMO Finance	Discussions taking place for a potential candidate to take on this role who will also oversee internal PMO interfaces

3.0 Key Risks

The key risks identified are listed below with mitigating actions:

Key risks identified	Risk	Mitigation
Project Manager for Financial Recovery	Once EY Consultants leave at end of June 2017, there will be no Project Manager assigned to this work stream	Potential candidate has been identified and discussions are underway.
Sustainability once EY departure at end of June 2017	Embedding and adhering to PMO practices and policies	Head of PMO is now in post. Objective setting to include best practice within the PMO and linking in with performance. Continue to be actively engaged with the Executive Team via Turnaround Exec Board meetings

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	31/17

Name of meeting	Board Meeting
Date	30th May 2017
Name of paper	Integrated Performance Dashboard
Executive sponsor	Daren Mochrie
Author name and role	Executive Team
Synopsis (up to 120 words)	The monthly Integrated Performance Dashboard gives the board oversight of the key performance indicators for the Trust, together with explanatory commentary to give suitable context and what actions are being taken to address any shortfalls. The dashboard includes score cards for each area (Workforce, Performance, Clinical Effectiveness, Quality & Patient Safety and Finance), suitable supporting commentary and charts with historic performance for trending purposes. The Integrated Performance Dashboard is an evolving item and is expected to undergo continuous improvement and change going forward.
Recommendations, decisions or actions sought	For Discussion
Why must this meeting deal with this item? (max 15 words)	Overview of the Trusts key performance indicators including patient outcome KPIs, AQI and associated performance KPIs, finance KPIs, and workforce KPIs.
Which strategic objective does this paper link to?	All

Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	Yes / **No** If yes and approval or ratification is required, a completed EA Record must be attached.

Executive Summary

999 response time performance remains under the nationally set targets, however SECAmb did achieve a level of performance that was above the trajectories commissioned by the local CCGs for Red 1, Red 2 and Red 19. The 999 Improvement Plan initiatives, with the exception of the Hospital Turnaround performance and fire co-responders, remains on track to delivering beyond the incremental elements set within the recovery plan trajectories. Hospital delays in April were still over double the maximum level agreed with commissioners. Demand was circa 3.4% above the agreed plan with commissioners for the month and above last year's position for the same month.

KMSS 111 achieved its best monthly operational performance for over a year.

As reported in previous months, the Trust continues to perform below the expected levels for the Clinical Quality Indicators and work continues to deliver improvements. Other quality and patient safety indicators are also being closely monitored and the improvement actions continue as previously reported. Training sessions are being offered and rolled out across the operating units to ensure integration of learning.

Workforce metrics have remained constant from the previous months and the re-set of the financial year and the introduction of the online performance management and appraisal system will be reviewed on an on-going basis by the Organisational Development team.

The Trust's financial performance in month 1 was a deficit of £0.9m, which was £0.1m behind plan. The forecast for the full year is unchanged from the plan, a deficit of £1.0m

1. SECAMB Regulation Statistics

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

2. Workforce

2.1. Workforce Balanced Scorecard

Workforce Commentary :- Data from Apr 2017

ID	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
Wf-1A	Short Term Sickness - Rate		**2.0%**	2.5%		**2.0%**	2.5%
Wf-1B	Long Term Sickness - Rate		**2.5%**	2.8%		**2.5%**	2.8%
Wf-2	Staff Appraisals	7.5%	**53.9%**	4.1%			
Wf-3	Mandatory Training Compliance (All Courses)	15.0%	**88.5%**	21.8%			
Wf-4	Total injuries		**52**	59		**52**	59
Wf-5	Total physical assaults		**18**	15		**18**	15
Wf-6	Vacancies (Total WTE)		**-**			Not Relevant	
Wf-7	Annual Rolling Staff Turnover		**16.7%**	16.0%			
Wf-8	Reported Bullying & Harassment Cases		**1**			**1**	
Wf-9	Cases of Whistle Blowing		**0**			**0**	

2.2. Workforce Commentary

2.2.1. We have decided not to publish a figure for vacancies this month. This is for data validation reasons whilst we correlate the newly released budget with the workforce establishment. The monthly figure prior to the budget increase was 9.2% - it is therefore anticipated that the revised figure will be higher than previous months.

2.2.2. The HR Advisor team, working closely with managers, has again reduced the monthly sickness absence figure.

2.2.3. The turnover rate has remained constant over the past month. This figure is likely to remain relatively high over the next few months until the increased staff engagement activities take effect.

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

2.2.5. A new year for mandatory training has commenced and a new process for recording training has been introduced to ensure robust and timely reporting. A new e-learning platform is being introduced to allow the provision of more engaging e-learning packages.

2.2.6. The diagnostic review of Bullying and Harassment is on track to deliver a report by July.

2.2.7. Work has continued to reduce the number of Agency workers within the Trust and this has now dropped to 59.

2.2.8. The Friends and Family Test (FFT) has been re-designed and re-launched as a quarterly Pulse Survey, covering the key themes of the staff survey as well as the FFT questions. The first survey was released a week ago and already has had over 500 responses, compared with the 200 received in total for the Q4 FFT survey.

2.2.9. The move of staff to Nexus House as the new HQ and West EOC is well underway.

2.3. Workforce Charts

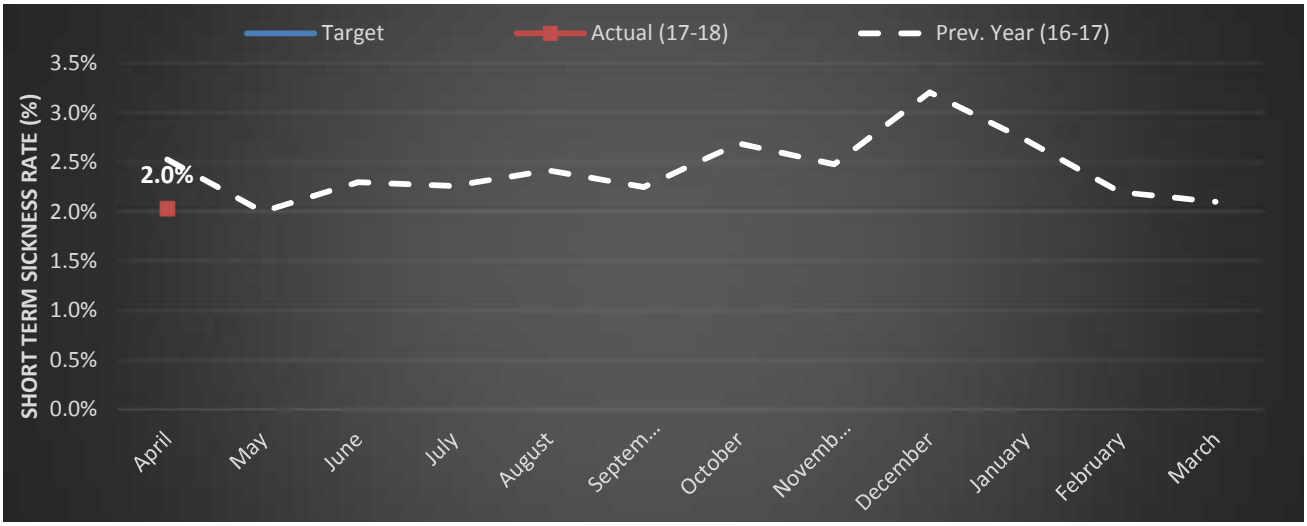


Figure Wf-1A - Short Term Sickness Rate

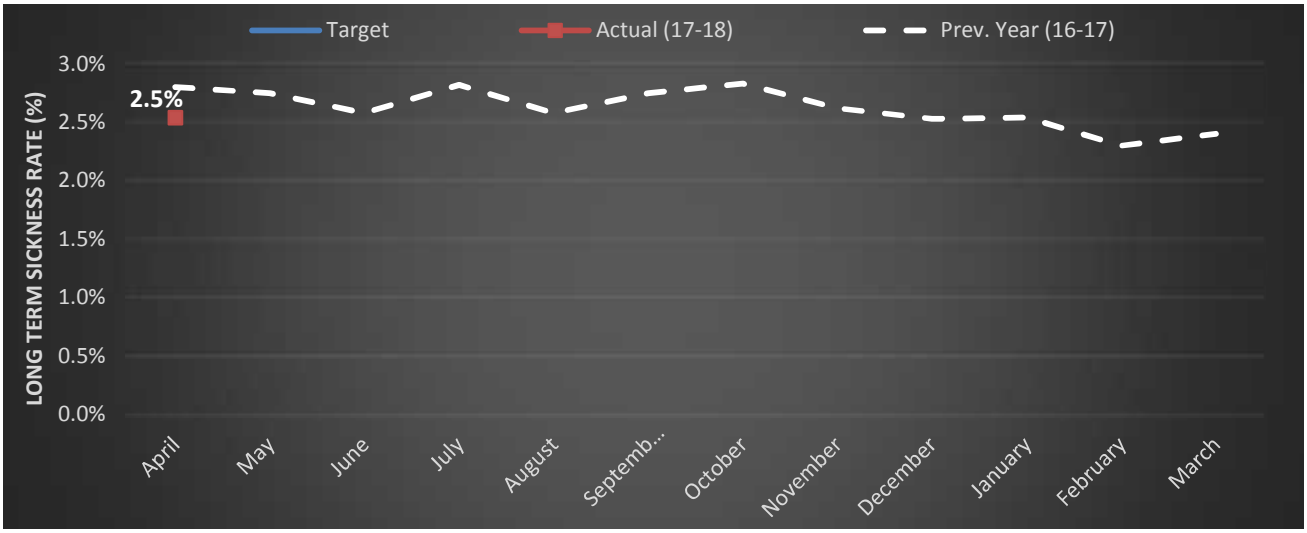


Figure Wf-1B - Long Term Sickness – Rate

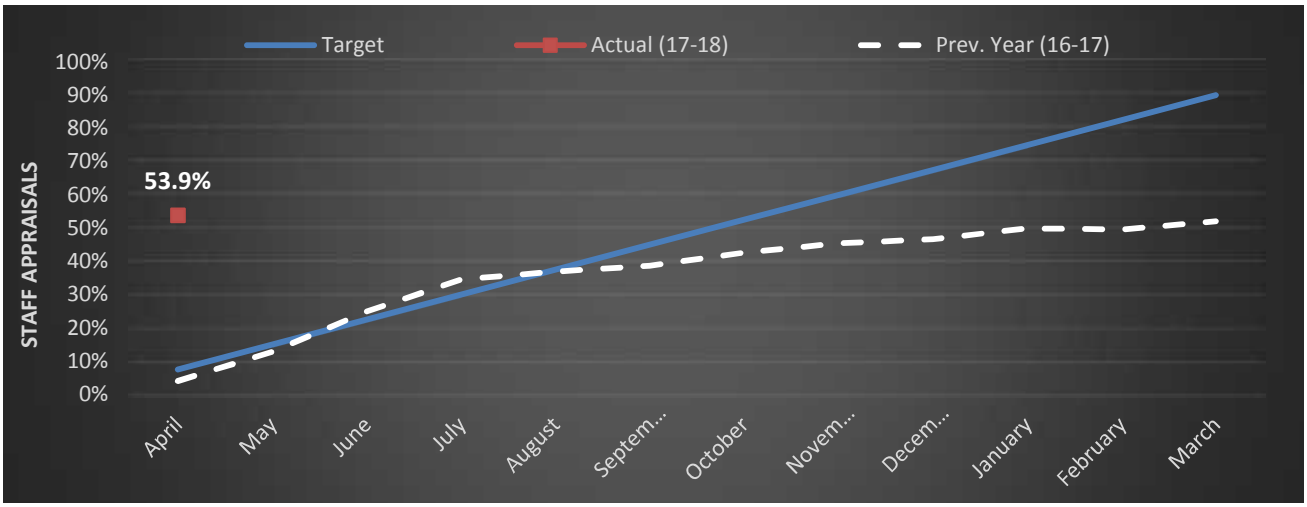


Figure Wf-2 - Staff Appraisals

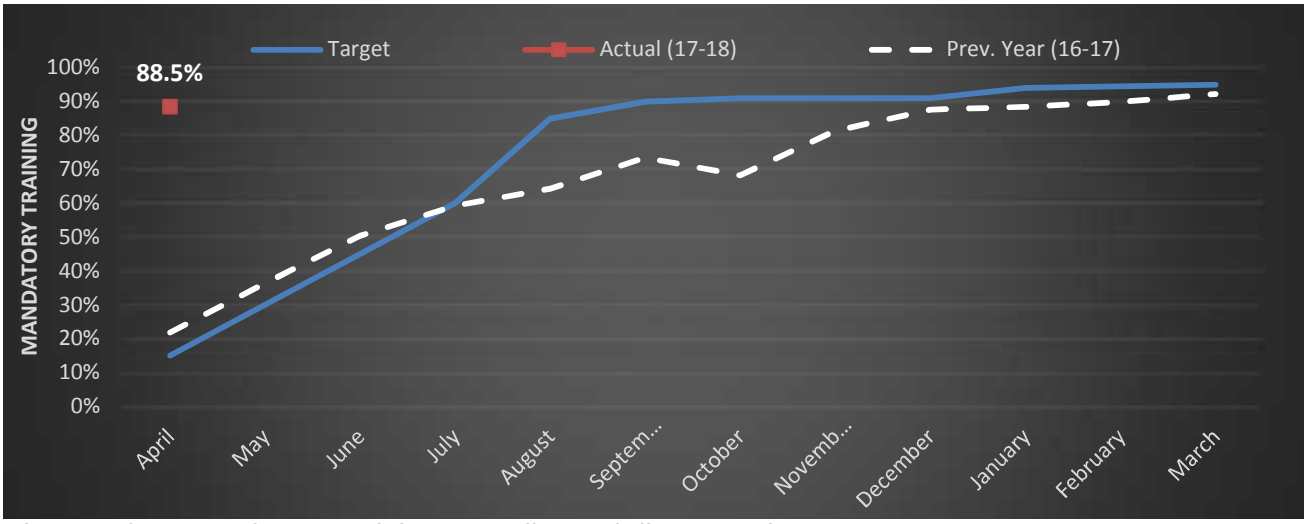


Figure Wf-3 - Mandatory Training Compliance (All Courses)

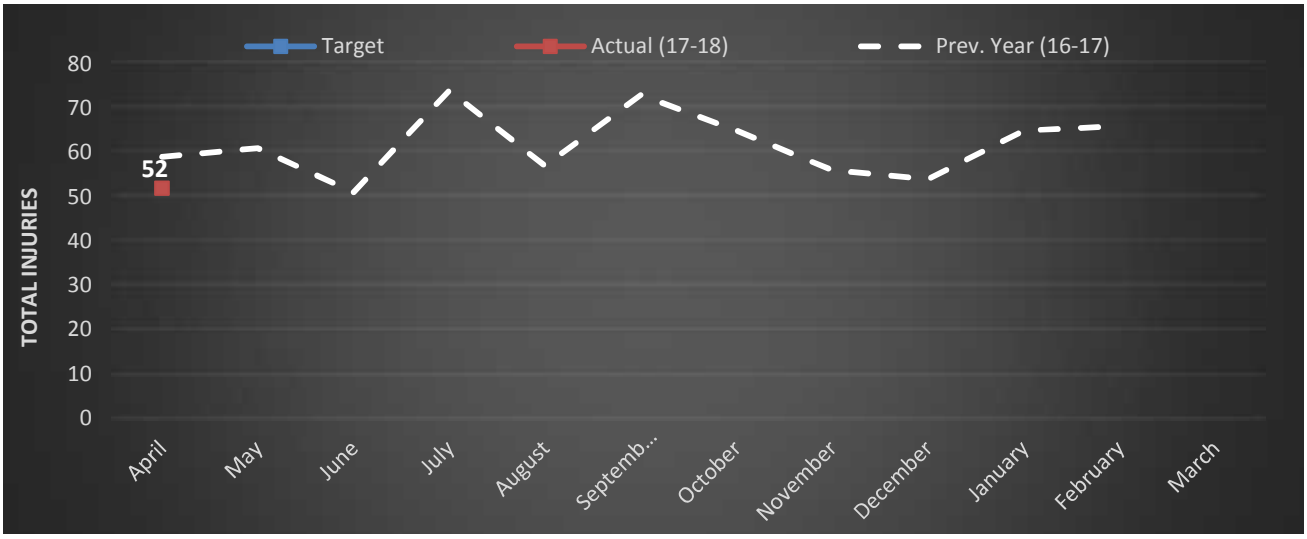


Figure Wf-4 - Total injuries.

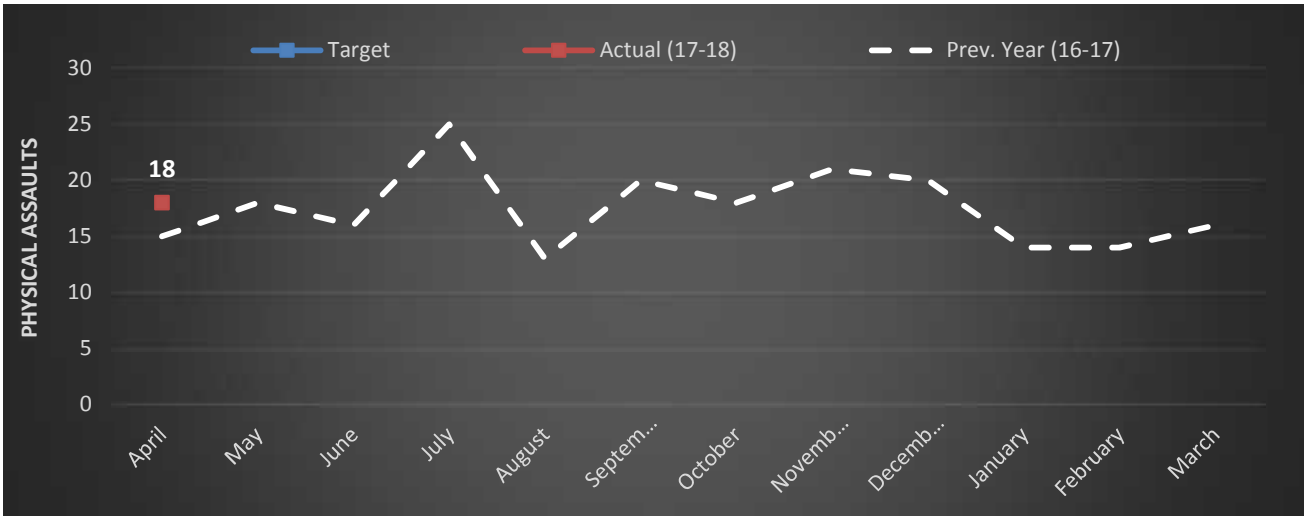


Figure Wf-5 - Total physical assaults.

Unavailable

Figure Wf-6 - Vacancies (Total WTE)

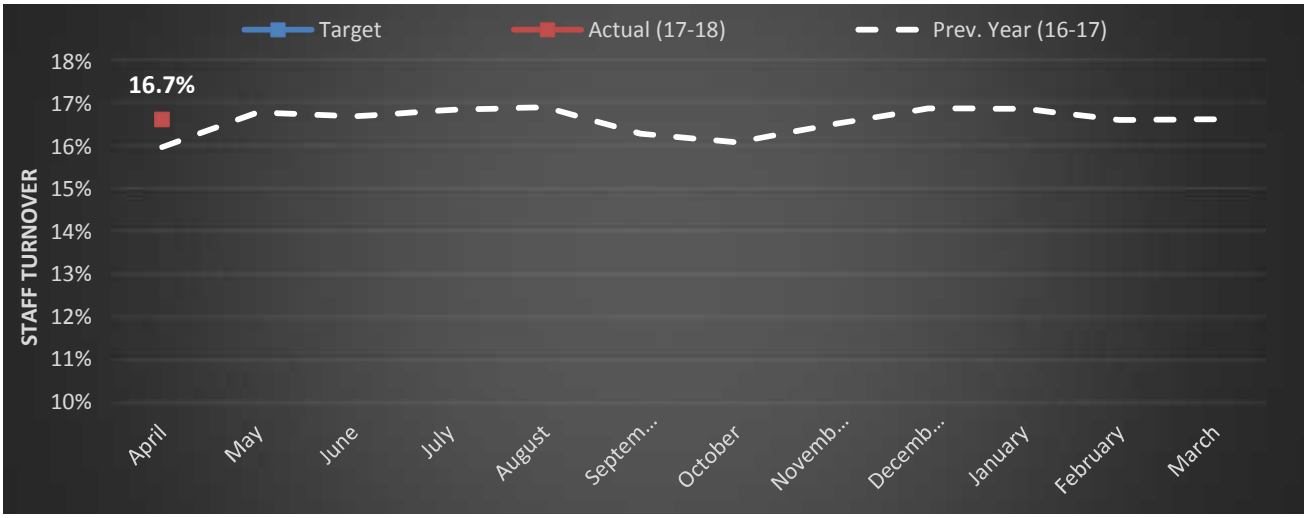


Figure Wf-7 - Annual Rolling Staff Turnover

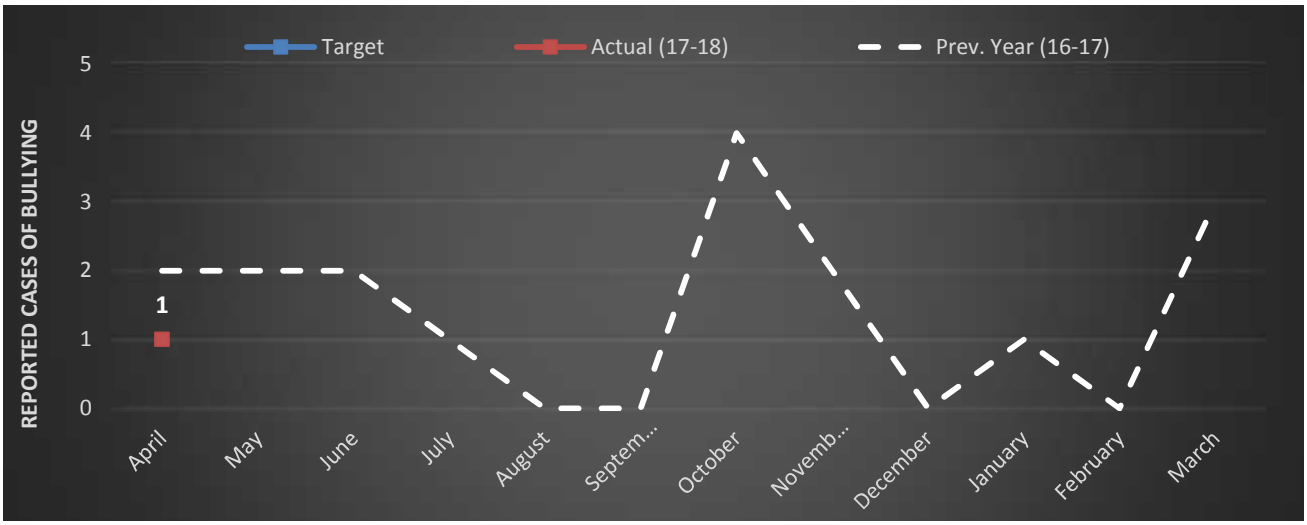


Figure Wf-8 - Reported Bullying & Harassment Cases

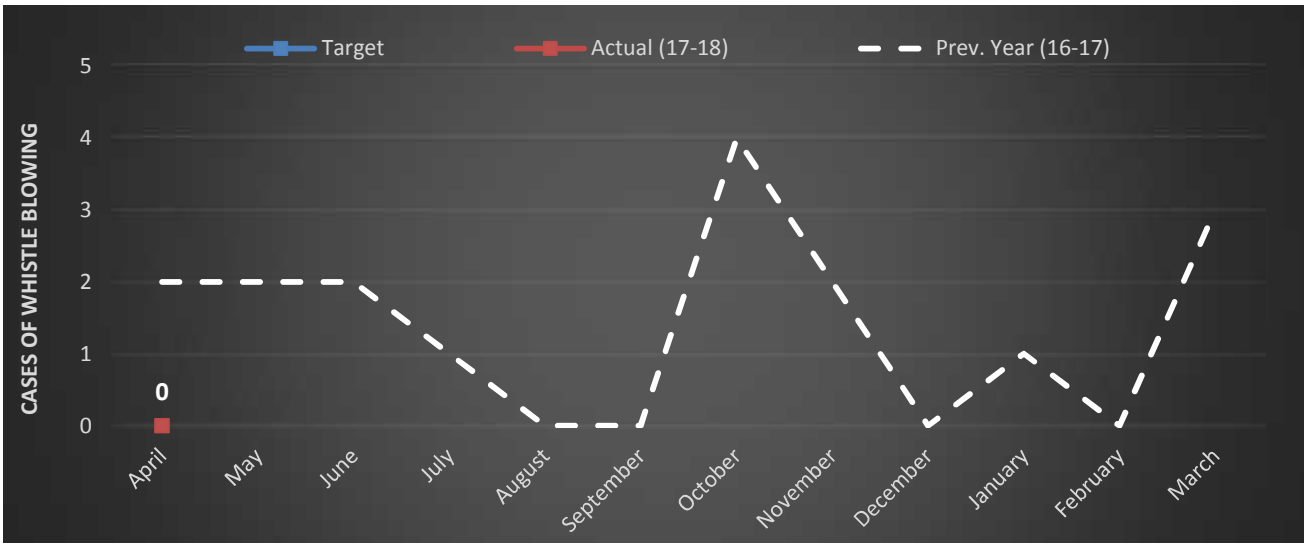


Figure Wf-9 - Cases of Whistle Blowing

3. Operational Performance

3.1. Operational Performance Summary

3.1.1. SECAmb's 999 response time performance was under the national targets, however SECAmb did achieve a level of performance that was above the new trajectories for Red 1, Red 2 and Red 19 for April, which was agreed with SECAmb commissioners for April 2017.

3.1.2. The 999 Improvement Plan initiatives, with the exception of the Hospital Turnaround performance and fire co-responders, remains on track to delivering beyond the incremental elements set within the recovery plan trajectories. Hospital delays in April were slightly better compared with the March level of delays, but still over double the maximum level agreed with commissioners. SECAmb has been working with both commissioners and acute hospitals to strengthen its hospital handover procedures and reduce delays at hospital.

3.1.3. Demand was circa 3.4% above the agreed plan with commissioners for the month and above last year's YTD position for the same month. SECAmb has maintained its call answer performance in April, closely matching that of March, to maintain the highest consistent position in over 12 months.

3.1.4. KMSS 111 achieved its best monthly operational performance for over a year, returning an "Answered in 60" Service Level Agreement (SLA) KPI of 95.5% in April. Despite the underlying reduction in like-for-like call volumes compared to the winter surge that was prevalent in March 2016, other NHS 111 service providers have been unable to sustain a similar level of resilience and operational performance, as seen by the NHS England SLA average for April of 90.9%.

3.2. Operational Performance Scorecard

Operational Performance Scorecard:- Data From April 2017

ID	KPI	Current Month (Plan*)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan*)	YTD (Actual)	YTD (Prev. Yr.)
999-1	Red 1 response <8 min	Not available	70.9%	70.1%		70.9%	70.1%
999-2	Red 2 response <8 min	Not available	56.2%	60.0%		56.2%	60.0%
999-3	Red 19 Transport <19 min	Not available	91.4%	92.4%		91.4%	92.4%
999-4	Activity: Actual vs Commissioned	62627	64833	64140	62627	64833	64140
999-5	Hospital Turn-around Delays (Hrs lost >30 min.)	3267	4915	4594	3267	4915	4594
999-6	Call Pick up within 5 Seconds	Not available	90.3%	77.5%		90.3%	77.5%
999-7	CFR Red 1 Unique Performance Contribution	Not available	2.3%	Not available		2.3%	Not available
999-8	CFR Red 2 Unique Performance Contribution	0.0%	1.5%	Not available		1.5%	Not available
111-1	Total Number of calls offered		99575	95870		99575	95870
111-2	% answered calls within 60 seconds	60%	95.5%	65.1%	60%	95.5%	65.1%
111-4	Abandoned calls as % of offered after 30 secs	9.0%	0.5%	8.2%	9.0%	0.5%	8.2%
111-5	Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)	70%	80.4%	70.2%		80.4%	70.2%

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

3.3. Operational Performance Commentary

3.3.1. The Red 1 position was improved again on the March position and above that of the revised April target which has been re-set by commissioners for the Quarter 1 period. The slight improvement in Red 2 performance compared to March was again higher than anticipated trajectory position, given the increase in activity compared to forecast, and this was circa 2000 incidents more than March. Hospital Turnaround delay would have been a material impact on this.

3.3.2. Demand was circa 3.4% above the plan agreed with commissioners for the month and still circa 800 incidents above last year's MTD position. Both activity and performance continues to show a slow but steady improvement based on the March performance to date.

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

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

3.3.5. SECAmb has maintained its Hear and Treat performance for April. There is already an encouraging improvement in the Hear and Treat ratios and further recruitment of clinicians continues. SECAmb has 40 WTE in post and are aiming for a total 45 WTE to support the NHS Pathways activity. The concept of an additional pool of clinicians to undertake a dedicated Clinical Assessment Team for the 2017/2018 year is being actively worked on now by a multi-disciplinary team from both the 999 & 111 management teams; this will prepare SECAmb for its phase 2 of the Ambulance Response Programme changes to incident categorisation.

3.3.6. Call answer performance generally matched that from last month's performance, despite the April increase in activity and SECAmb achieved 90.3% in five seconds compared to a revised trajectory plan of 92%. Despite not meeting the revised target, this is the best consistent level of performance for call answering in over 12 months.

3.3.7. SECAmb has been working with both commissioners and acute hospitals to strengthen its hospital handover procedures and reduce delays at hospital. These improvements are built into the improvement trajectories. Hospital delays in April were marginally better compared with the hours lost in March, however they were over double the maximum level agreed with commissioners. April saw 4,915 lost hours which was the single biggest impact on our performance trajectory for April. Hospital Turnaround delay is the single biggest external factor which impacts SECAmb performance and the one which we have least control of. A recent instruction from NHSI to increase the prompts to Acute Hospital Directors On-Call for every patient delay over 1 hour is being developed into a robust Operational Plan to ensure consistency across the region.

3.3.8. The KMSS 111 service finished the 2016-17 reporting year very strongly and this has carried over to the new financial year, with the service delivering its best monthly KPI dataset for over two years. This was despite the challenge of April having twelve days falling on either a weekend or public holiday, when the spike in demand activity is always higher. In stark contrast to the Easter of 2016, the service delivered a particularly high level of performance over the Easter weekend, 14th – 17th April.

3.3.9. Based on a call volume of 99,575, the service answered 95.5% of its calls offered within 60 seconds (NHS E national average of 91.4%). The rate of Call Abandonment fell to 0.6% (NHS E national average of 1.9%). Throughout the month KMSS 111 achieved 23 "green" and five "amber" days with respect to the operational Service Level Agreement (SLA). On only two days during April did our service level drop below 90%, despite ongoing challenges from downstream OOH providers in some parts of Kent, Medway, Surrey and Sussex.

3.3.10. In a clinical context, KMSS 111 increased its proportion of Clinician Call Backs within 10 minutes and/or a Warm Transfer to a clinician. This fed into a Combined Clinical performance exceeding 80% for the first time since January 2017 (almost 16 percentage points ahead of the NHS E national average for April). KMSS 111 continues to focus on "admissions avoidance" as evidenced by the sustained low referral rates to A&E and Ambulance despatches; both of measures show the KMSS 111 rate as being 0.6% lower than the National benchmark. The service continues its Clinical In-line Support to proactively increase clinician intervention and to validate "Green" non-emergency ambulance dispositions. In addition, over the Easter weekend, members of the Senior Leadership Team were on site in each contact centre to encourage the optimum usage of the Directory of Services in making appropriate referrals to Walk-in Centres, NUMSAS pharmacies, and Extended Hours GP practices to ease pressure upon SECAmb 999 and the Emergency Departments across the region.

3.3.11. Our staff continue to deliver a high quality service whilst improving their productivity, as measured by the service's Average Handling Time (AHT). The latest cohort of new Health Advisors (HAs) was transitioned into the HA rota successfully with minimal staff attrition; the HAs are now at full proficiency.

3.3.12. KMSS 111 continues to work with commissioning groups and partner providers at an operational and strategic level. We are exploring opportunities for the Proof of Concept of collaborative integrated working and potentially innovative clinical operating models, to improve the patient experience for each patient with a clinical intervention. Longer-term, we are supporting the consultation with NHS E on Digital Roadmaps and the development workshops within Integrated Urgent Care.

3.4. Operational Performance Charts

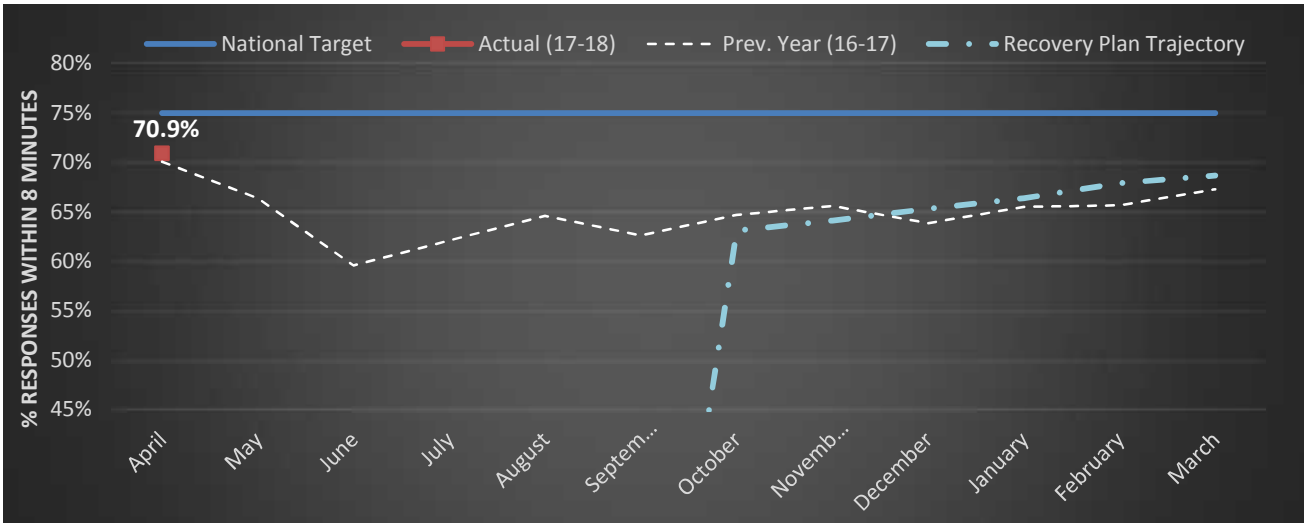


Figure.999-1 - Red 1 response <8 min

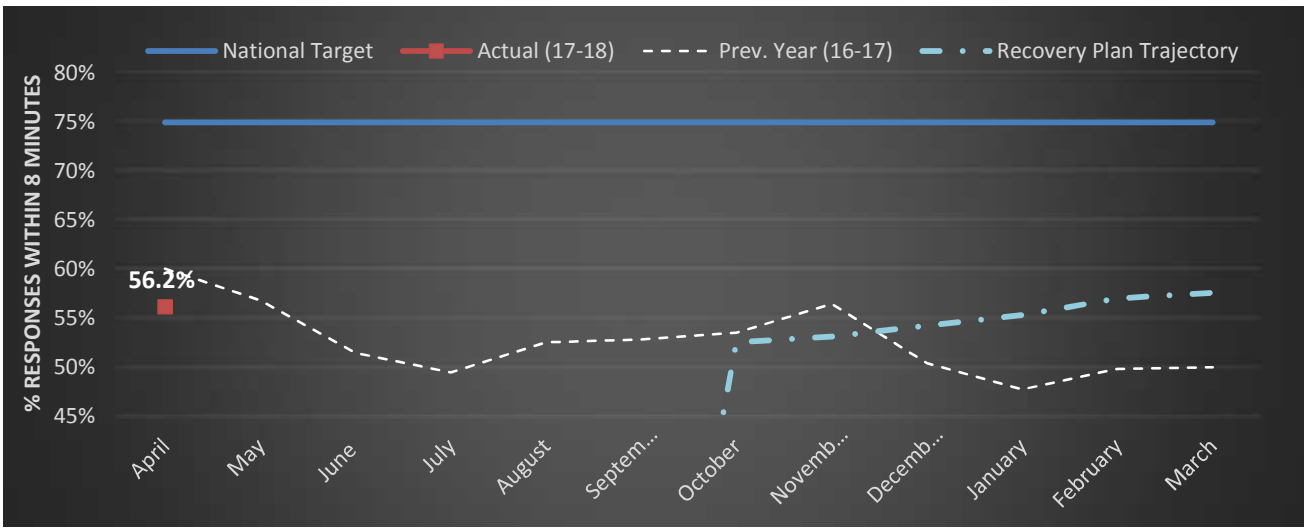


Figure.999-2 - Red 2 response <8 min

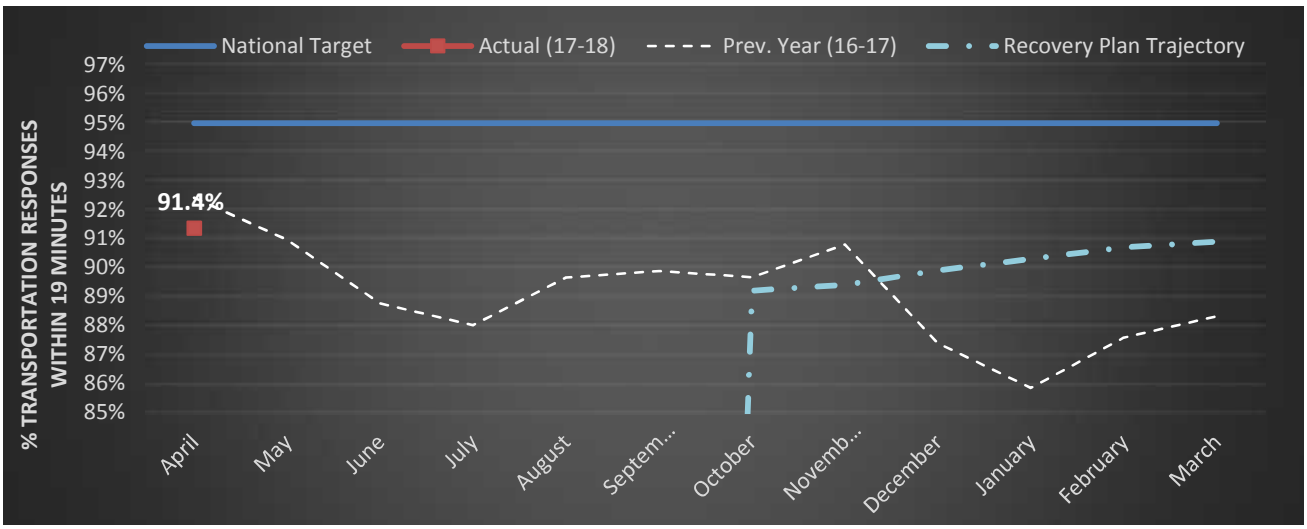


Figure.999-3 - Red 19 Transport <19 min

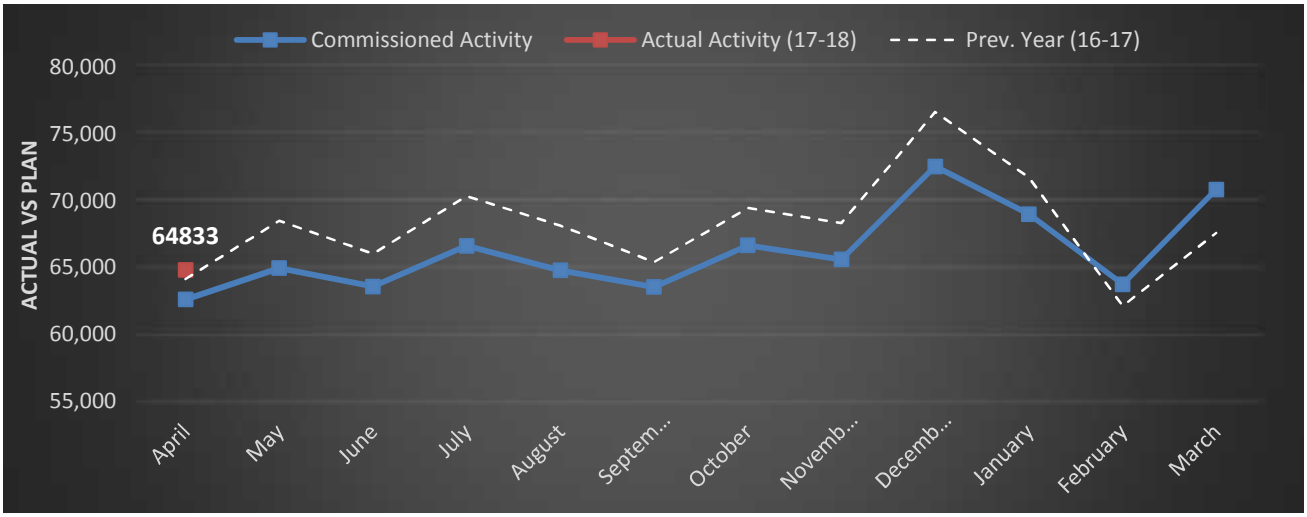


Figure.999-4 - Activity: Actual vs Commissioned

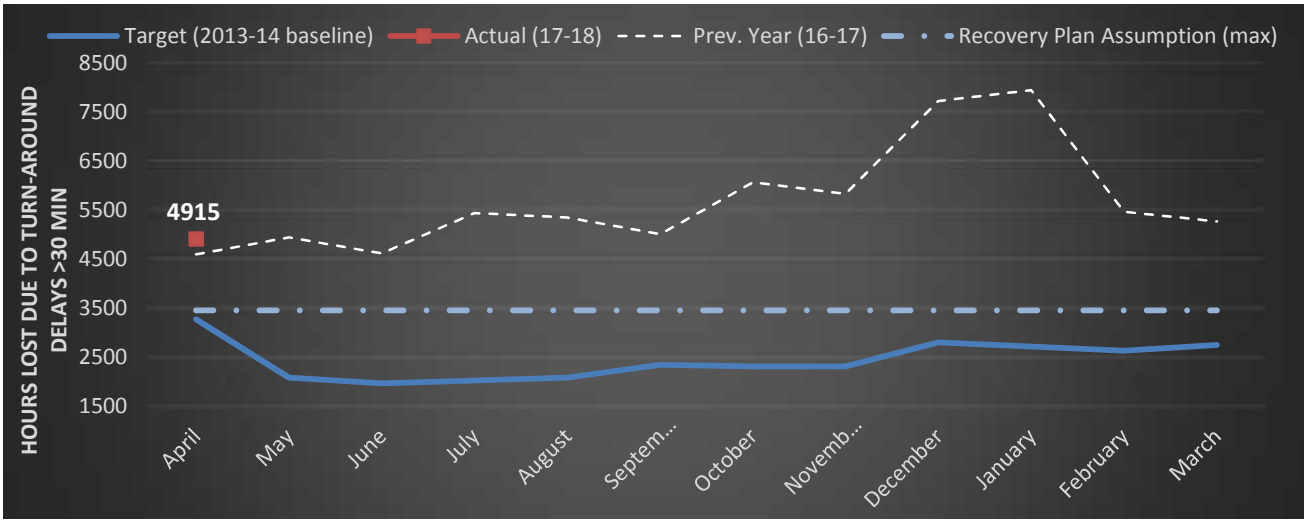


Figure.999-5 - Hospital Turn-around Delays (Hrs lost >30 min.)

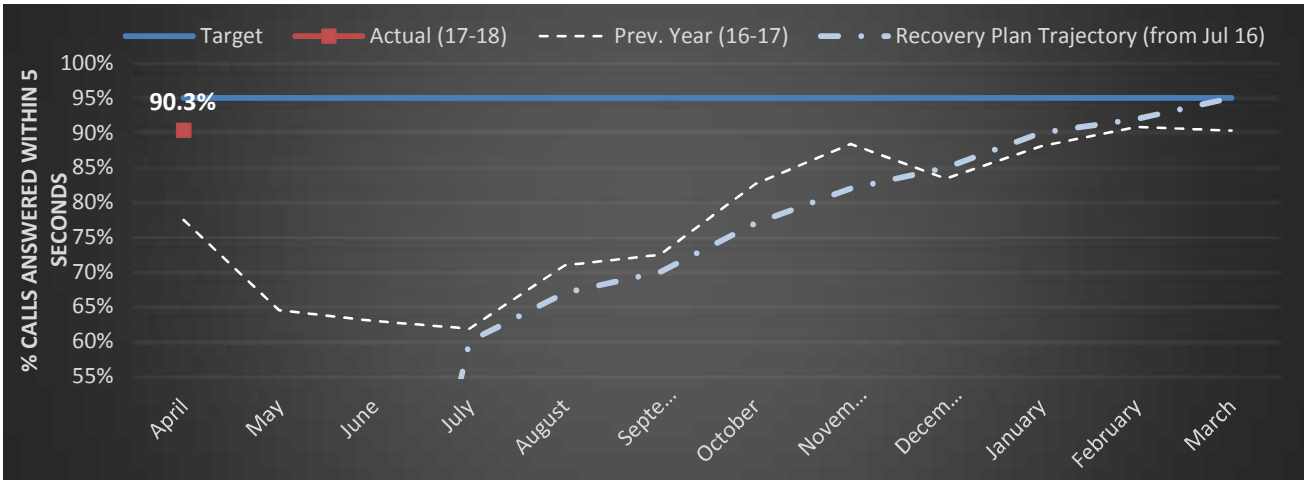


Figure.999-6 - Call Pick up within 5 Seconds

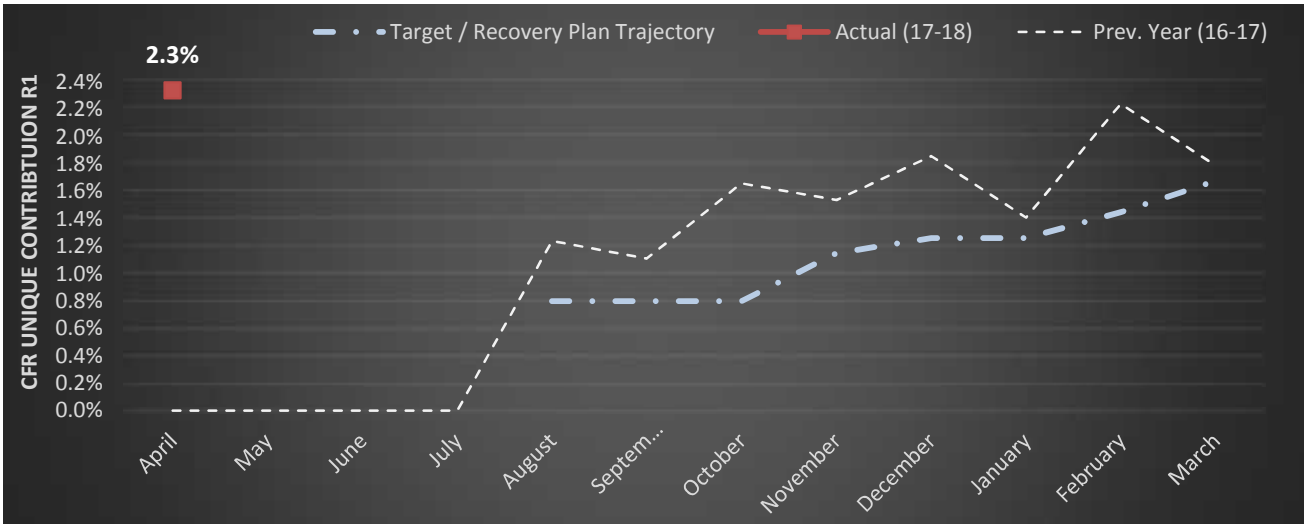


Figure.999-7 - CFR Red 1 Unique Performance Contribution

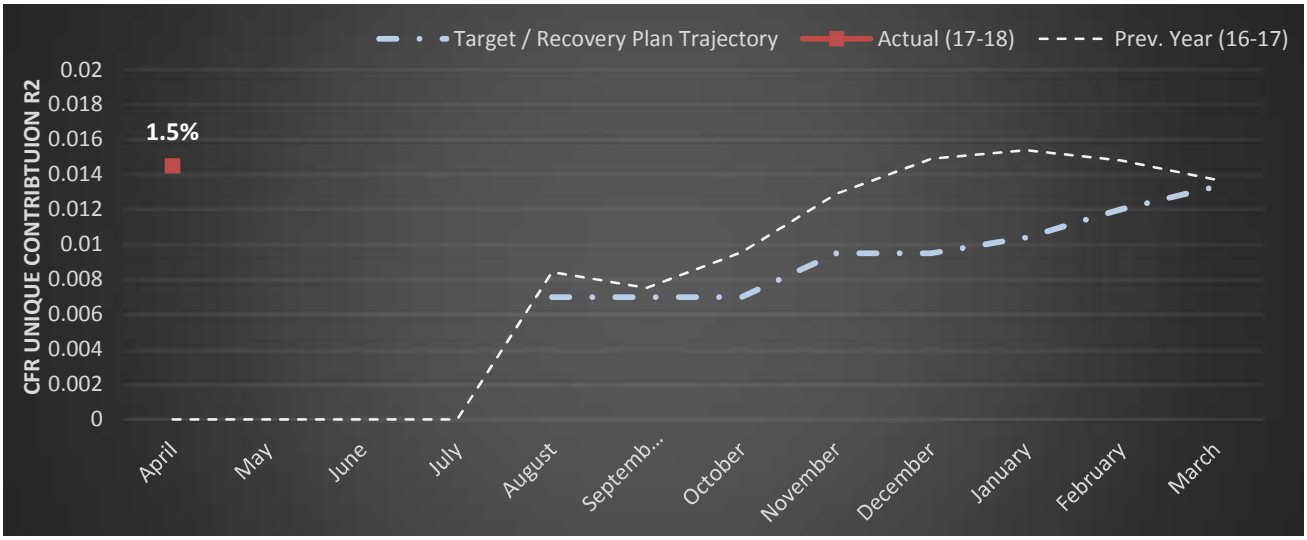


Figure.999-8 - CFR Red 2 Unique Performance Contribution

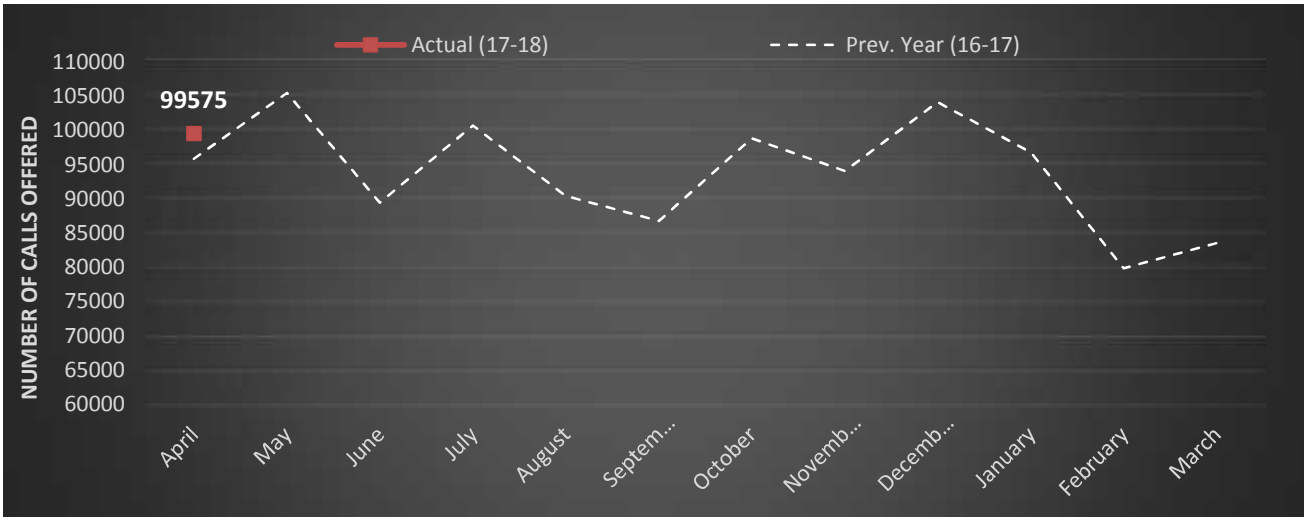


Figure.111-1 - Total Number of calls offered

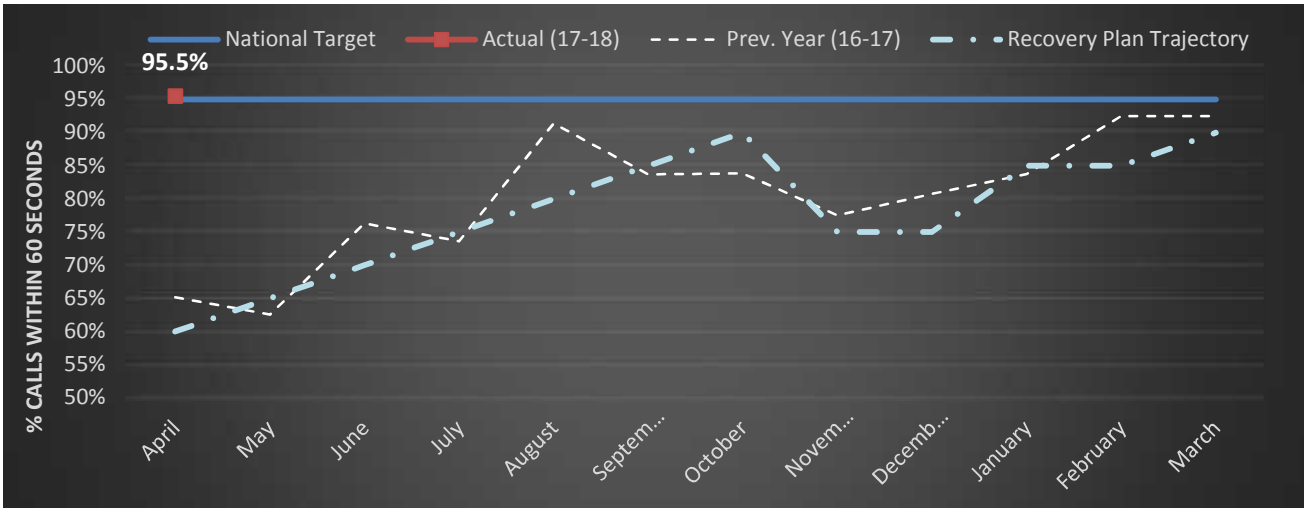


Figure.111-2 - % answered calls within 60 seconds

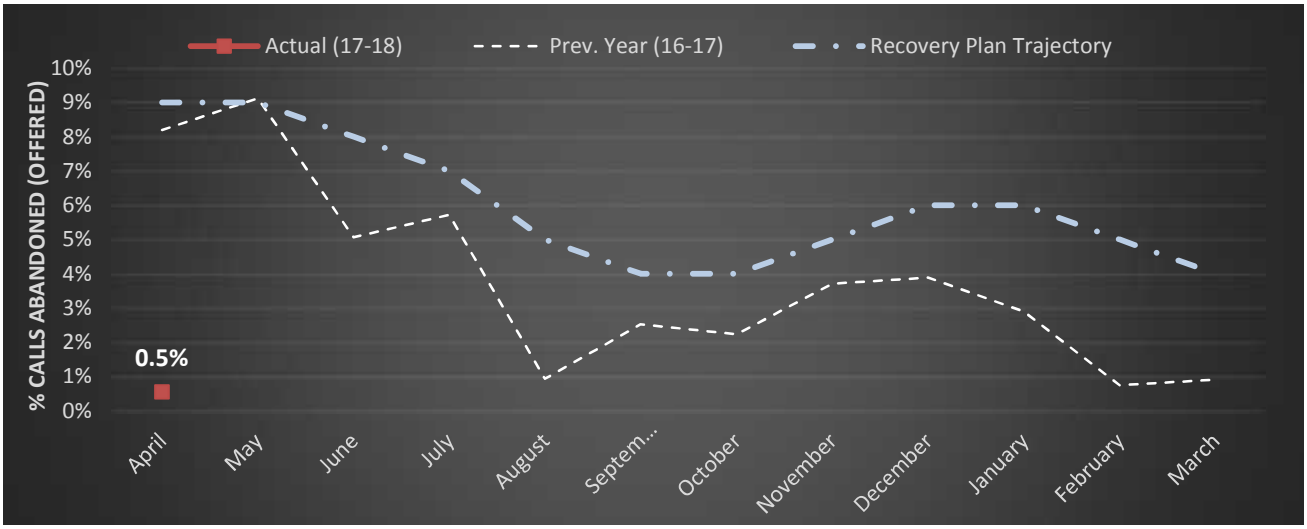


Figure.111-4 - Abandoned calls as % of offered after 30 secs

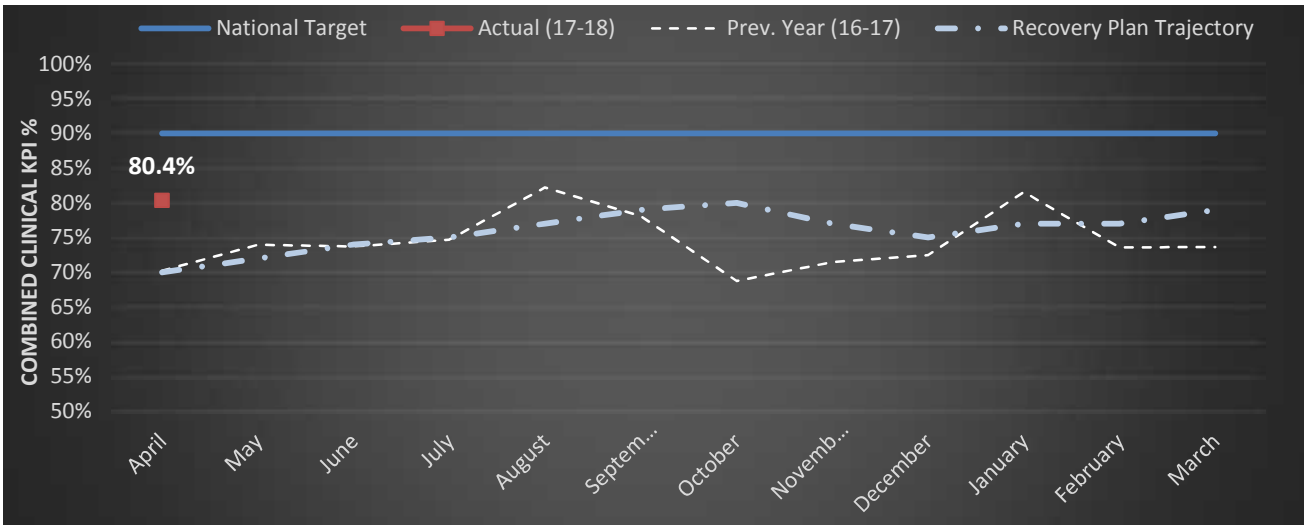


Figure.111-5 - Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)

4. Clinical Effectiveness

4.1. Clinical Effectiveness Summary

4.1.1. This report describes Trust performance reported against eight Clinical Outcome Ambulance Quality Indicator (AQIs) to NHS England for Month 9 (December 2016). The data continues to show variable standards in delivering patient outcomes.

4.2. Clinical Effectiveness KPI Scorecard

Clinical Effectiveness KPI Scorecard:- Data From December 2016

ID	KPI	Current Month (Nat. Av.*)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Nat. Av.*)	YTD (Actual)	YTD (Prev. Yr.)
CE-1	Cardiac arrest - ROSC on arrival at hospital (Utstein)	44.4%	**48.6%**	44.7%	51.2%	**52.2%**	48.7%
CE-2	Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)	27.2%	**28.5%**	25.7%	28.4%	**27.7%**	27.1%
CE-3	Cardiac arrest -Survival to discharge - Utstein	21.7%	**8.8%**	21.1%	26.4%	**22.7%**	24.5%
CE-4	Cardiac arrest -Survival to discharge - All	6.7%	**3.7%**	7.3%	8.4%	**6.7%**	8.7%
CE-5	Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)	81.4%	**62.8%**	68.1%	79.6%	**67.5%**	68.1%
CE-6	Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes	85.2%	**86.9%**	93.3%	86.1%	**91.3%**	93.4%
CE-7	% of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes	50.7%	**58.9%**	67.7%	53.8%	**64.9%**	66.1%
CE-8	% of suspected stroke patients assessed face to face who received an appropriate care bundle	97.8%	**95.6%**	96.2%	97.6%	**95.9%**	96.5%

4.3. Clinical Effectiveness

4.3.1. The data detailed above shows the Trust's clinical performance for the month of December 2016. These are the most up to date figures published to the Department of Health (DH).

4.3.2. Out of the eight clinical effectiveness markers, four are currently below the national average expected for this month.

4.3.3. As per last month the Clinical Audit team (CAT) are working on ensuring that all the data that has been published to the DH is accurate by ensuring appropriate adherence to a new and updated procedure for the Clinical Audit Coordinators to use as the main document for adherence to the national technical guidance for ACQI reporting. Following on from this program of work, the data may change as the Audit Team revalidate previous submissions ensuring that all national guidance has been matched.

4.3.4. The main awareness required for this report is for the CE 3 and CE 4 sections relating to Cardiac Arrest Patients and the Survival to Discharge KPI. This is significantly lower than expected due to a change in procedure within the Trust. The Clinical Audit team (CAT) previously requested all data from the receiving hospital units for this output for both survival and deceased patients. In this month the team gained confirmation of the patient's outcome directly from the NHS Spine. This enabled the CAT to correctly identify the deceased patients, but for the survivors the CAT are still waiting for replies from the receiving hospitals. This gave the CAT a 100% return on the negative patients without confirmation of the positive patients (patients who survive to discharge). This had an additional delay due to the internal CAT process being changed from weekly requests to the hospitals to monthly. This has proved catastrophic for the return as there are many hospitals that have outstanding responses to the team's emails.

4.3.5. The Clinical Audit Lead (CAL) has been working with the Clinical Audit Supervisor in ensuring that the processes are supporting better data entry along with enhanced updates for the receiving hospitals. Once the CAT have all the appropriate responses, the CAL will be able to produce internal updates to the Quality and Safety committee once this has been complete.

4.3.6. To ensure full and accurate reporting, the CAL has introduced processes to ensure that all non-compliance care is clinically appropriate for the DH care bundles. This will mainly be for the Stroke and STEMI indicators; this will give the Trust assurance on full adherence to the national requirement for each indicator. Any abnormalities in trends or reporting will be highlighted appropriately through the Trust governance groups.

4.4. Clinical Effectiveness Charts

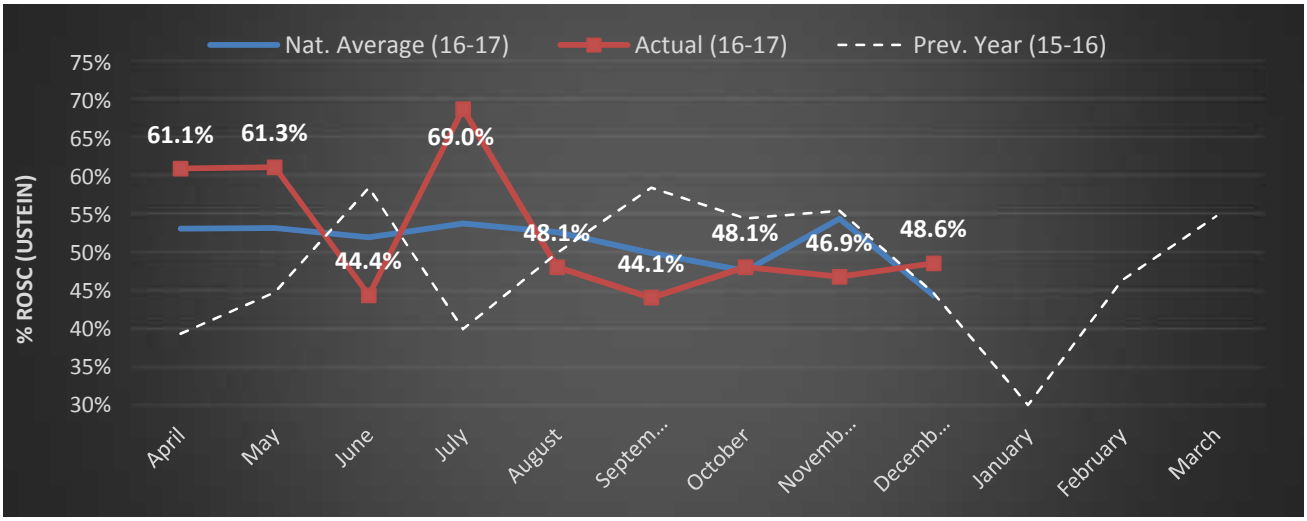


Figure.CE-1 - Cardiac arrest - ROSC on arrival at hospital (Utstein)

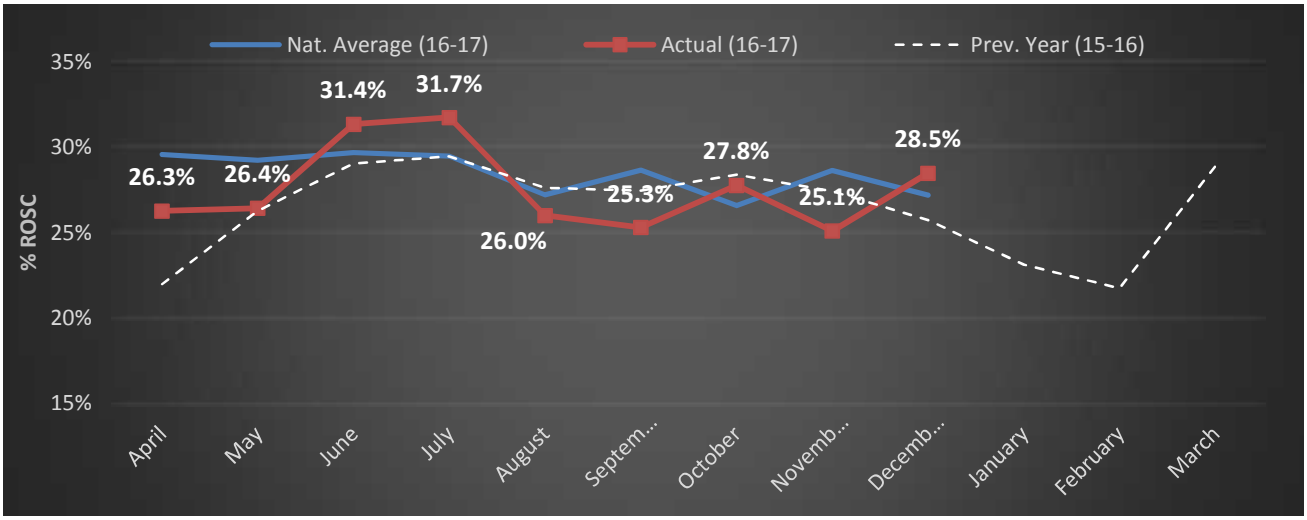


Figure.CE-2 - Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)

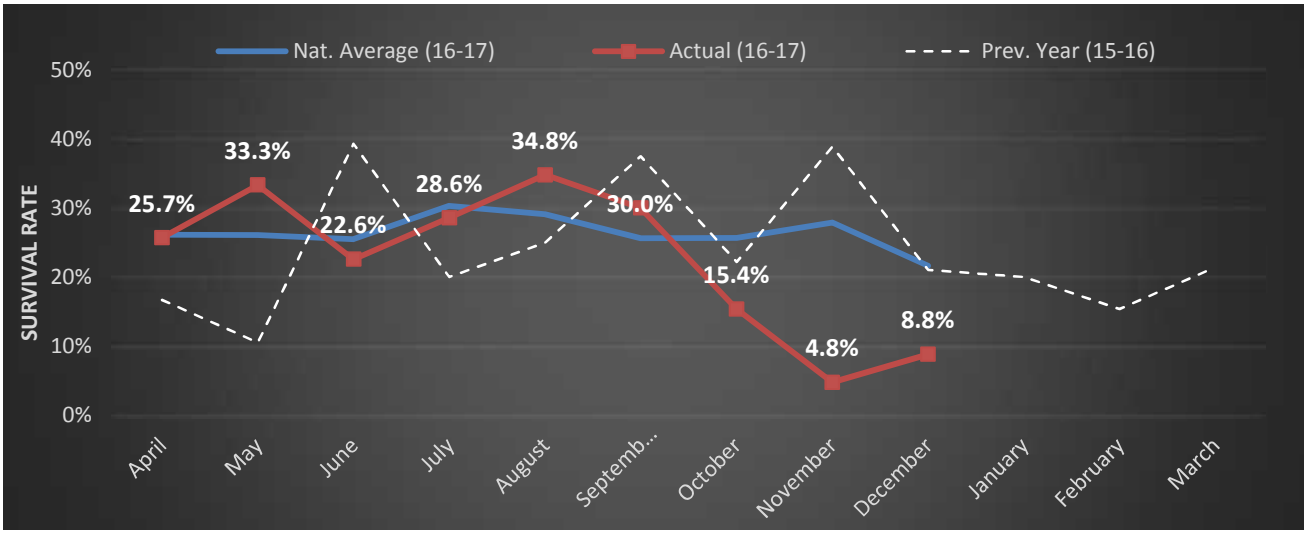


Figure.CE-3 - Cardiac arrest -Survival to discharge - Utstein

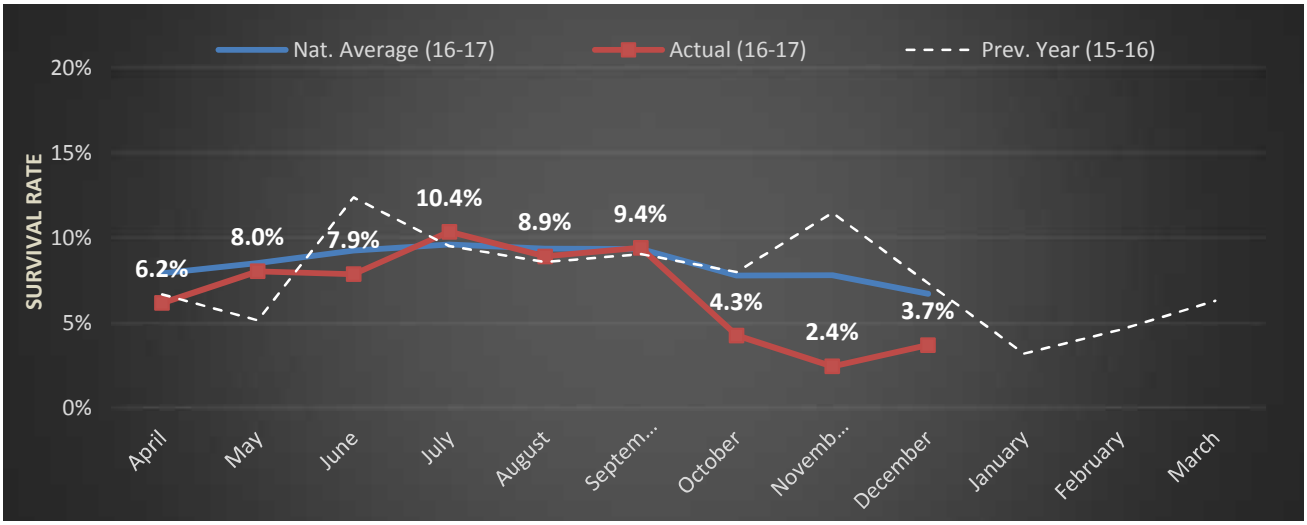


Figure.CE-4 - Cardiac arrest -Survival to discharge – All

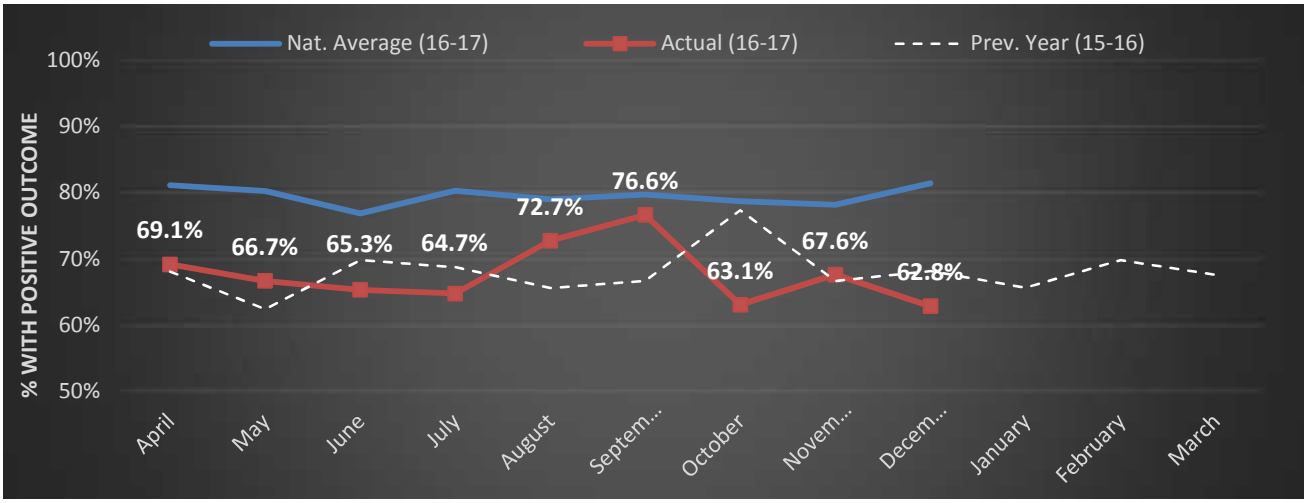


Figure.CE-5 - Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)

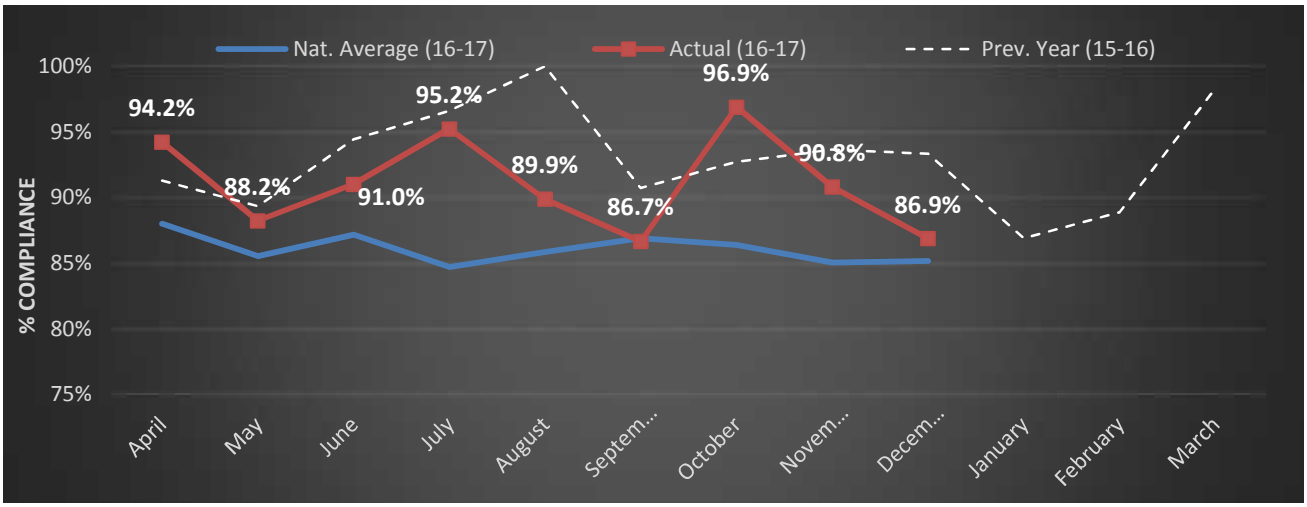


Figure.CE-6 - Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes

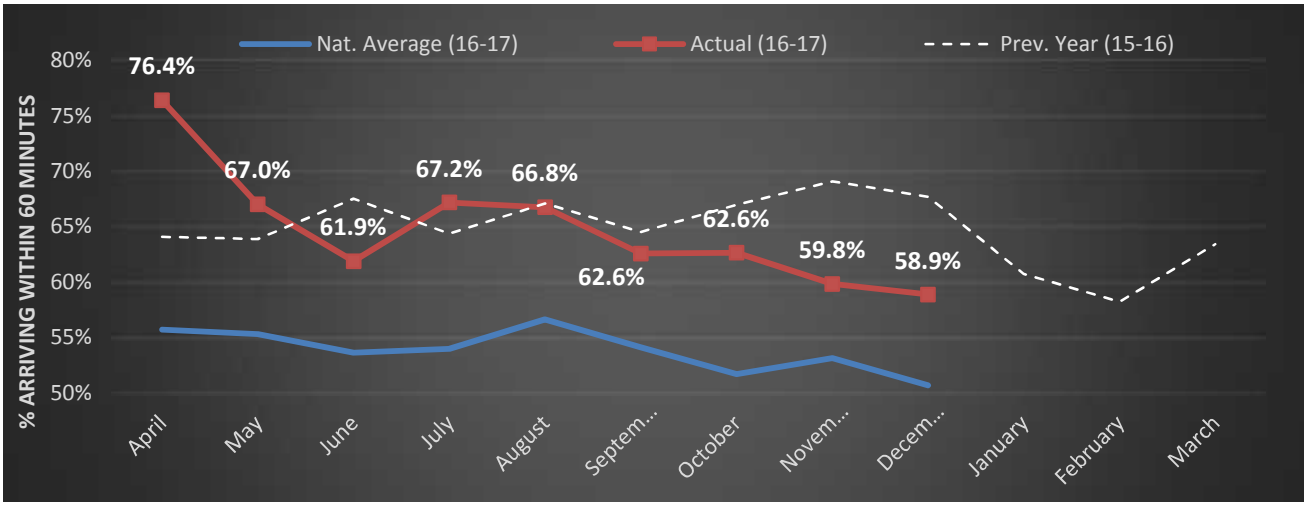


Figure.CE-7 - % of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper acute stroke unit within 60 minutes

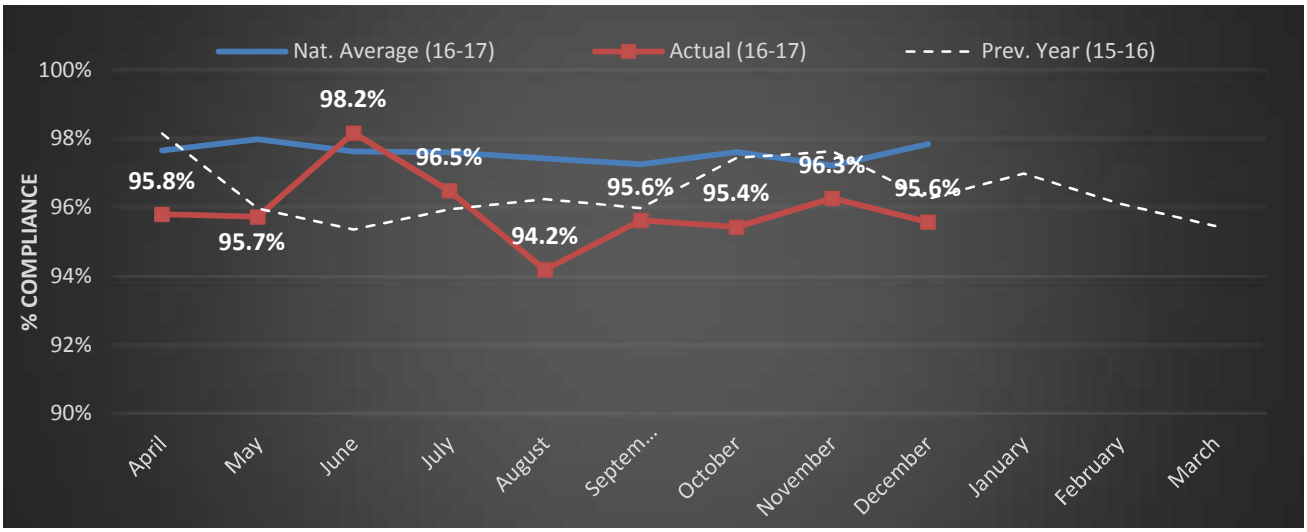


Figure.CE-8 - % of suspected stroke patients assessed face to face who received an appropriate care bundle

5. Quality & Patient Safety

5.1. Quality & Patient Safety Summary

5.1.1. The Trust can demonstrate an overall increase in reporting during the month of April of 21.4%. The IRW1 has been updated and now moderate, severe and death harms are mandatory fields. Historically these fields were not mandatory, in essence it is too early to compare no harm to harm ratios. This will both trigger the handler to record duty of candour and upload the evidence and will provide potential serious incident information to the serious incident decision group on a weekly basis.

5.1.2. Five new serious incidents were reported in April, although there was zero compliance with 72 hour reporting to the CCG. This has been attributed to the lack of capacity within the professional standards team. The partnership model business case has been completed and is ready to present to senior management team (SMT). The four reports due for submission also breached, reaching a total of 30 breached serious incidents YTD.

5.1.3. Duty of candour compliance was 66% for the serious incident reporting. The duty of candour compliance for incidents moderate and severe incidents will be audited in June as the mandatory field went live early May 2017. Five serious incidents were reported in April, two incidents did not require duty of candour as no direct patient contact/ harm was identified, two were compliant with candour and one breached (our internal 10-day compliance target) due to the investigating officer unable to make contact with the patient (the contact is being pursued). The directive for contact for duty of candour has changed nationally to “when reasonably possible” At SECamb we have agreed to maintain the 10-day compliance standard to maintain focus on candour.

STEIS Reference Number	Date Reported	DOC Internal Deadline	DOC Contact Made	Deadline Met
2017/9216	05/04/2017	28/04/2017	No	No
2017/10468	20/04/2017	12/05/2017	TBC	Yes
2017/10471	20/04/2017	N/A	N/A	N/A
2017/10988	27/04/2017	N/A	N/A	N/A
2017/11171	28/04/2017	19/05/2017	15/05/2017	Yes

5.1.4. Responsiveness to complaints, although below the 95% target for on time, continues to demonstrate improvement. April reached compliance of 91% response. Staff conduct, compliance with pathways and timeliness are the top three themes for complaints for the months.

5.1.5. Safeguarding training level 3 training is off trajectory due to the non-attendance at the training session. This resulted in two training session (50 places) not booked by scheduling. Compliance to attend training was escalated and supported by the Director of Operations, receiving a positive response from the operations team. Dates have been set and circulated for the year to plan abstraction. For the Level 1, level 2 and MCA the trajectory has been reset as of 1st April and will be covered in key skills, transition to practice and new starters. Local management will drive the on line training

for all other substantive staff. To date no clinicians have attended from the EOC. 11 Clinicians from 111 have attended the training to date 189 in total for the Trust.

5.2. Quality & Safety KPI Scorecard

Quality & Safety KPI Scorecard:- Data From April 2017

ID	KPI	Current Month (Target)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Target)	YTD (Actual)	YTD (Prev. Yr.)
QS1a	SI Reporting timeliness (72hrs)	100%	**0.0%**	50.0%	100%	**0.0%**	50.0%
QS1b	SI Investigation timeliness (60 days)	100%	**0.0%**	100.0%	100%	**0.0%**	100.0%
QS1c	Number of Incidents reported		**545**	**455**		**545**	455
QS1d	Number of Incidents reported that were SI's		**5**	**4**		**5**	4
QS1e	Duty of Candour Compliance	100%	66%		100%	66%	
QS2a	Number of Complaints		**71**	126		**71**	126
QS2b	Complaints reporting timeliness (All Complaints)	95.0%	**91.5%**	26.9%	95.0%	**91.5%**	26.9%
QS2c	Mental Capacity Assessment Training		**23.0%**			**23.0%**	
QS3a	Number of Safeguarding Referrals Adult		**644**	708		**644**	708
QS3b	Number of Safeguarding Referrals Children		**134**	141		**134**	141
QS3c	Safeguarding Referrals relating to SECAmb staff or services		**0**	0		**0**	0
QS3d	Safeguarding Training Completed (Adult) Level 1	8.0%	**0.1%**		8%	**0.1%**	
QS3e	Safeguarding Training Completed (Children) Level 1	8.0%	**0.1%**		8%	**0.1%**	
QS3f	Safeguarding Training Completed (Adult) Level 2	8.0%	**0.4%**		8%	**0.4%**	
QS3g	Safeguarding Training Completed (Children) Level 2	8.0%	**0.6%**		8%	**0.6%**	
QS3h	Safeguarding Training Level 3 (Adult/Child)	8.0%	**6.0%**			**6.0%**	

5.3. Quality & Patient Safety Commentary

5.3.1. Incident Reporting

5.3.1.1. Incident reporting has increased from the previous years' data with a minimal reduction in reporting from the previous month from 575 to 545 this month. Previous year's average per month being 491 reported incidents.

5.3.1.2. The backlog for closure continues to decrease alongside the incident team continuing to support areas with overdue reviews and reviews in progress.

5.3.1.3. Changes made within the system in the month consist of a mandatory field for level of harm to be reported alongside a mandated field for duty of candour. The level of harm will inform the serious incident decision (SID) group currently on a weekly basis, the plan for next month is to add an instant alert via email to the SID as the incident is logged where moderate, severe and death are triggered.

5.3.1.4. The duty of candour section is also triggered with the same prompts; going forward this will ensure ease of reporting and ensure compliance with duty of candour. The prompt was switch on in May so a full month's compliance will be available for June performance report.

5.3.2. Serious Incident reporting

5.3.2.1. For April the number of serious incidents declared was five, which is consistent with the previous month's declaration of four.

5.3.2.2. The compliance with duty of candour is at 66% for April. Five serious incidents were reported in April, two incidents did not require duty of candour as no direct patient contact/ harm was identified, two were compliant with candour and one breached (our internal 10-day compliance target) due to the investigating officer being unable to make contact with the patient; the contact is being pursued. The directive for contact for duty of candour has changed nationally to "when reasonably possible" At SECamb we have agreed to maintain the 10-day compliance standard to maintain focus on candour.

5.3.2.3. This compliance tracking will be supported by the mandatory field for duty of candour, which has been added to the incident report system this month.

5.3.2.4. In the month there has been zero compliance with 72-hour reporting to the CCGs due to lateness in submission from the investigating team and more recently, examples of administration omissions to submit within the time frame. There remain three reports outstanding for the professional standards to complete. The team are aware but due to their reduced capacity and annual leave there is no resilience built into the team with the current WTE.

5.3.2.5. Capacity within the professional standards team has diminished over the year, resulting in delays in their capacity to report both 72 and serious incident reports within timeframes. All four reports due to be returned in April have breached the deadline, with 26 reports in the back log for completion. The Paramedic Consultant has escalated capacity to the Medical Director following the realignment of Executive portfolios.

5.3.2.6. It is envisaged the capacity will increase within the professional standard team with the approval of the proposed partnership model; this is due to be presented to the senior management team in May for support and approval. The backlog and average monthly 4.5 serious incidents declaration will require additional support to achieve the 72-hour compliance for reporting to CCG and subsequent 60-day submission for closure

5.3.3. Complaints

5.3.3.1. Of those that were outside the agreed time frame to respond, three were due to unexpected staff sickness, one due to a late report from A&E operations and two were unfortunately missed by the complaints team. This has been remedied going forward, with a daily electronic calendar visible to all, profiling each member of staff's workload.

5.3.3.2. Response times are still below our 95% target at 91% but demonstrating an improving response rate. This has been due to some changes in reporting, but also due to a decrease in overall complaint numbers, meaning the team are able to focus on their existing caseload. 51 were either fully or partially upheld which is 71.8%, and is above trend for the proportion upheld.

5.3.3.3. The top three categories are:
Staff conduct – 20 (28%)
Pathways (disposition) – 18 (25%)
Timeliness - 16 (23%)

5.3.3.4. There has been a significant reduction in the number of timeliness complaints. The reasons for this are multifaceted such as crew cover (rota compliance and vehicle ratio shifts), and handover times in the emergency department.

5.3.3.5. The complaints were spread across the organisation:
EOC – 28 (39%)
A&E – 27 (38%)
NHS111 – 9 (14)
PTS – 6 (8%)
Corporate - 1

5.3.3.6. Duty of candour compliance (contact within the first 10 days as set by our internal procedure) is 100%, due to the initial letter sent to the complainant and call made following receipt of the complaint. All patients receive a call where the contact number is available, all receive a letter of acknowledgment offering an apology for their experience, supported by an information leaflet giving a more detailed explanation of duty of candour.

5.3.3.7. The complaints team now have the same incident reporting data within the complaints module to report harm and going forward these reports will be discussed at the serious incident decision (SID) group held weekly. An additional alert needs to be added to the datix module which automatically inform the SID group of moderate and severe harms as they are reported.

5.4. Safeguarding

5.4.1.1. The L3 training trajectory is not on target. All training dates publicised have been delivered in line with the training schedule however, attendance figures are below the required numbers (50 per week). In the first week in April, no staff were abstracted to attend either of the dates scheduled. This was not known ahead of the day training was due to be delivered.

5.4.1.2. Operational staff are now being offered overtime to attend the sessions which has meant that courses are now being attended. The training trajectory identified that 8.5% of staff should have attended a session by the end of April 2017, the actual figure was 6%. With a shortfall of 16 staff each week during May, it is unlikely that the proposed 17% compliance rate will be achieved by the end of May.

5.4.1.3. Capacity in the safeguarding team has been increased with the support of one interim WTE member of staff. Their primary focus has been to ensure the training, policies and procedures are fit for purpose. The enhanced team business case will increase the team's capacity in the second half of the year following consultation with staff.

5.4.1.4. 12% Mental Capacity Assessment on line training has been completed in month 1.

5.4.1.5. Level 1 training has historically been a trust wide training course, going forward this will be provided for induction only. Level 2 training is for support staff only during2017/18; the compliance percentage has not been calculated for April data but will be available for May. Learning and development have been unable to provide the new breakdown.

5.5. Quality & Safety Charts

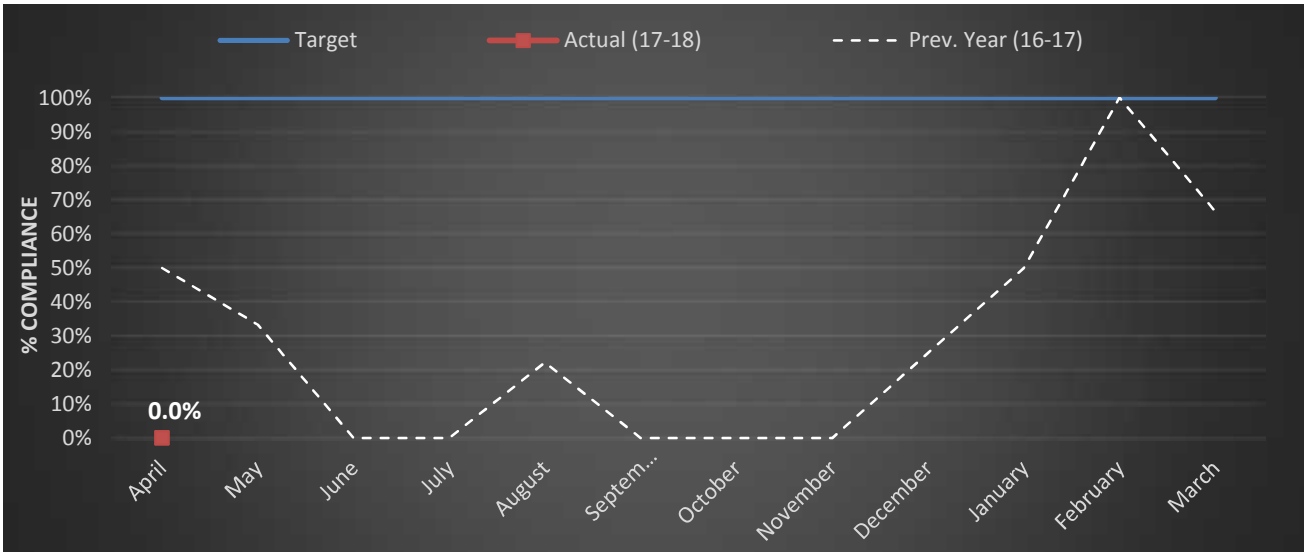


Figure.QS1a - SI Reporting timeliness (72hrs)

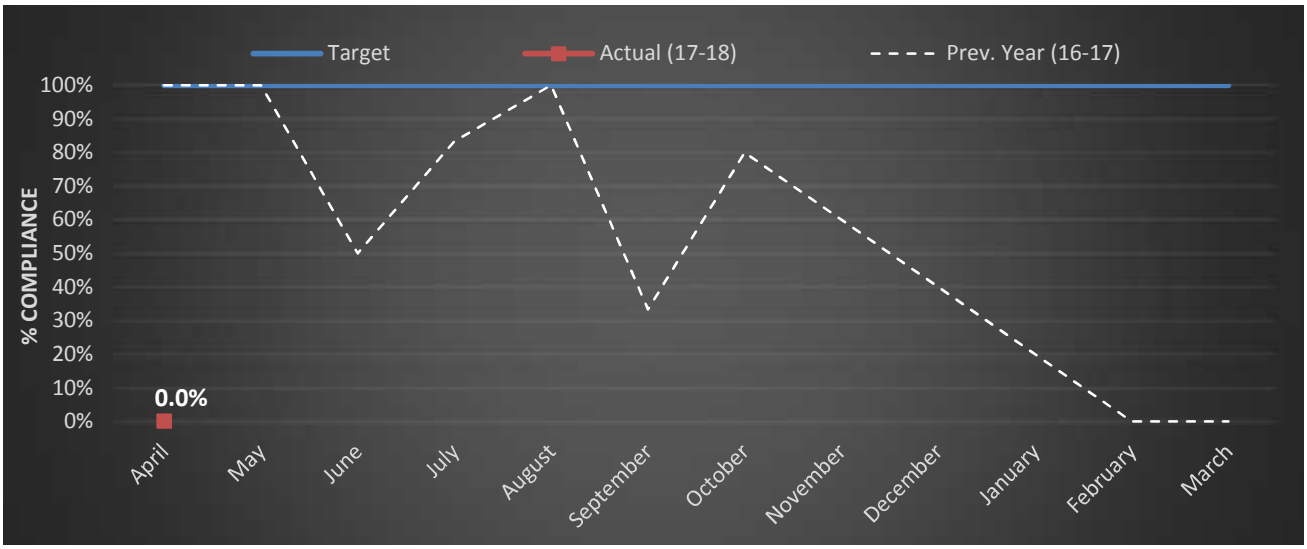


Figure.QS1b - Serious Incident (SI) Investigation timeliness (60 days).

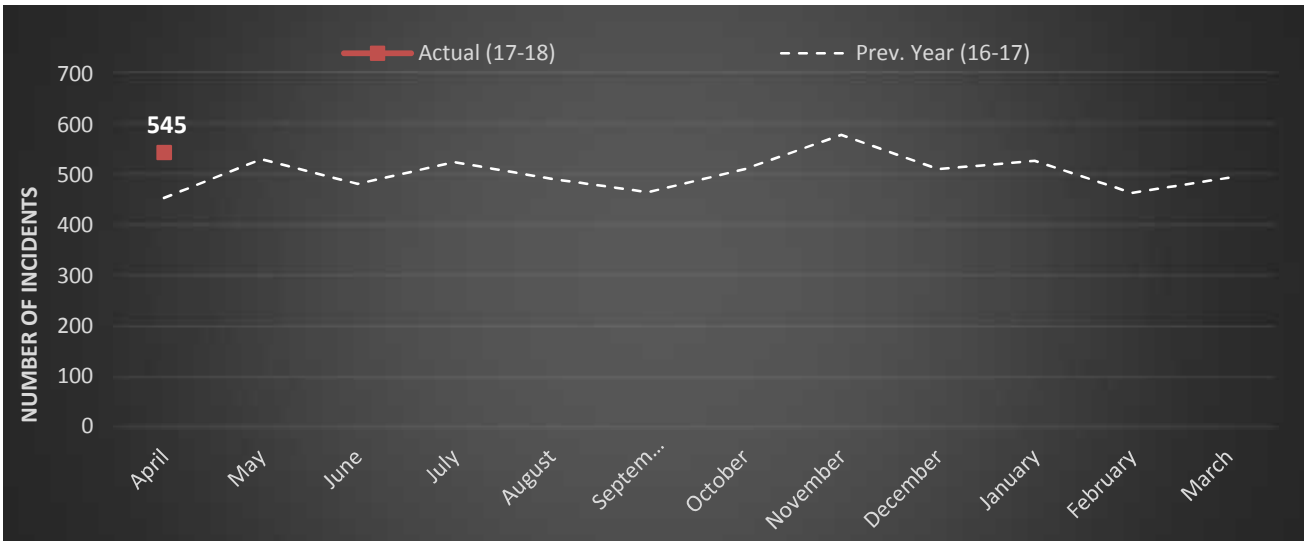


Figure.QS1c - Number of Incidents reported

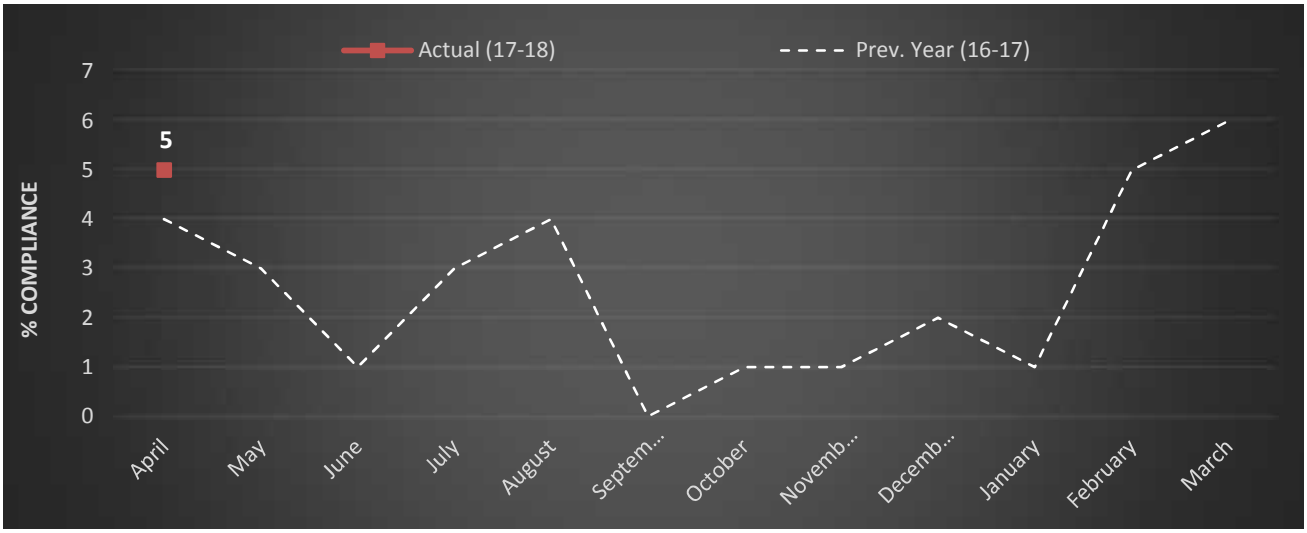


Figure.QS1d - Incidents reported that were SI's

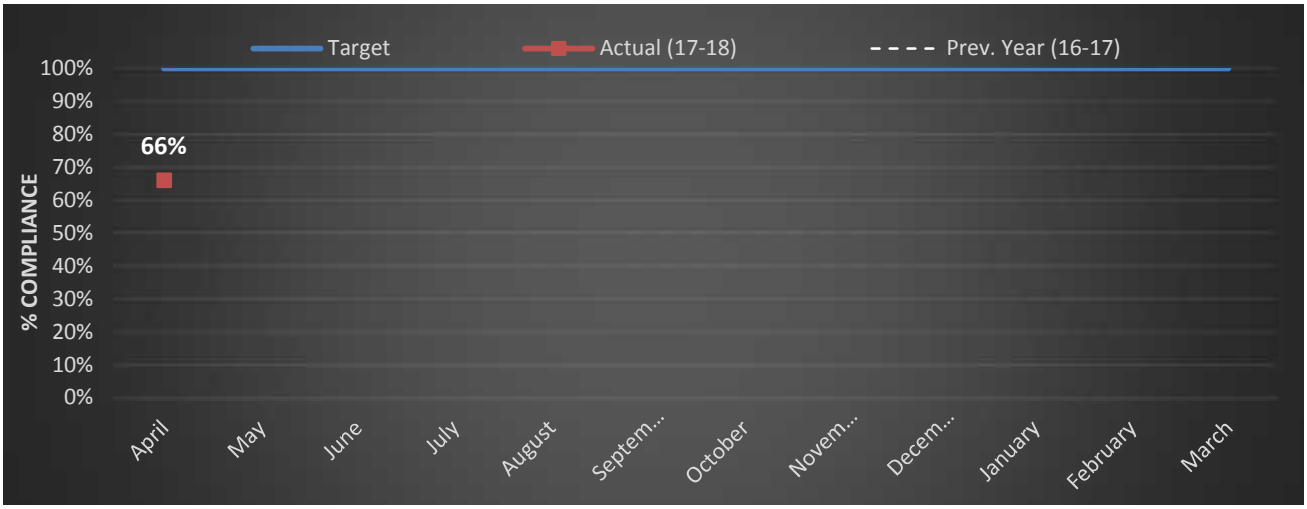


Figure.QS1e - Duty of Candour Compliance

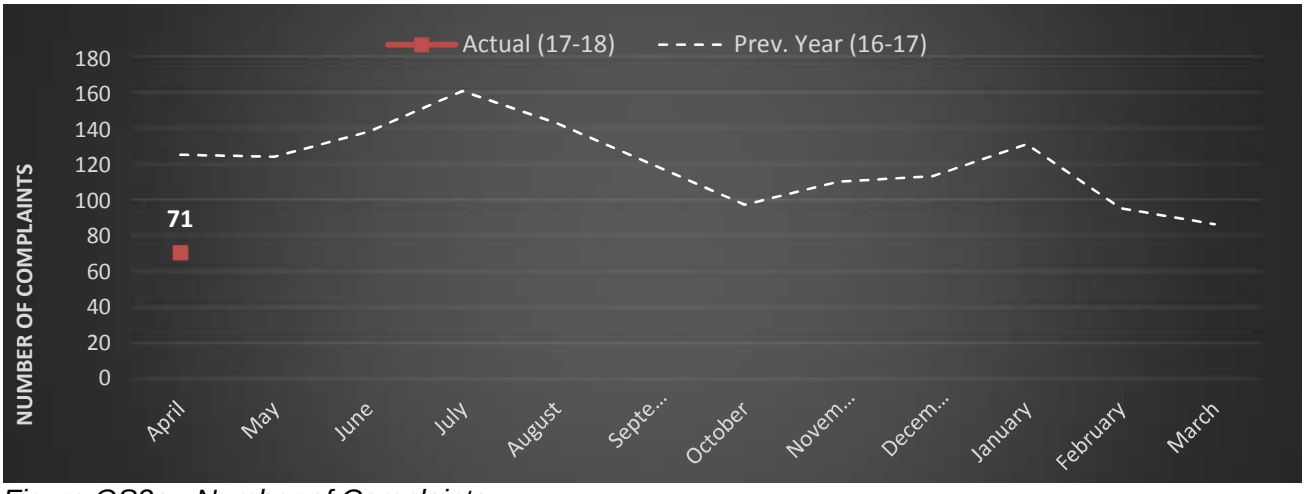


Figure.QS2a - Number of Complaints

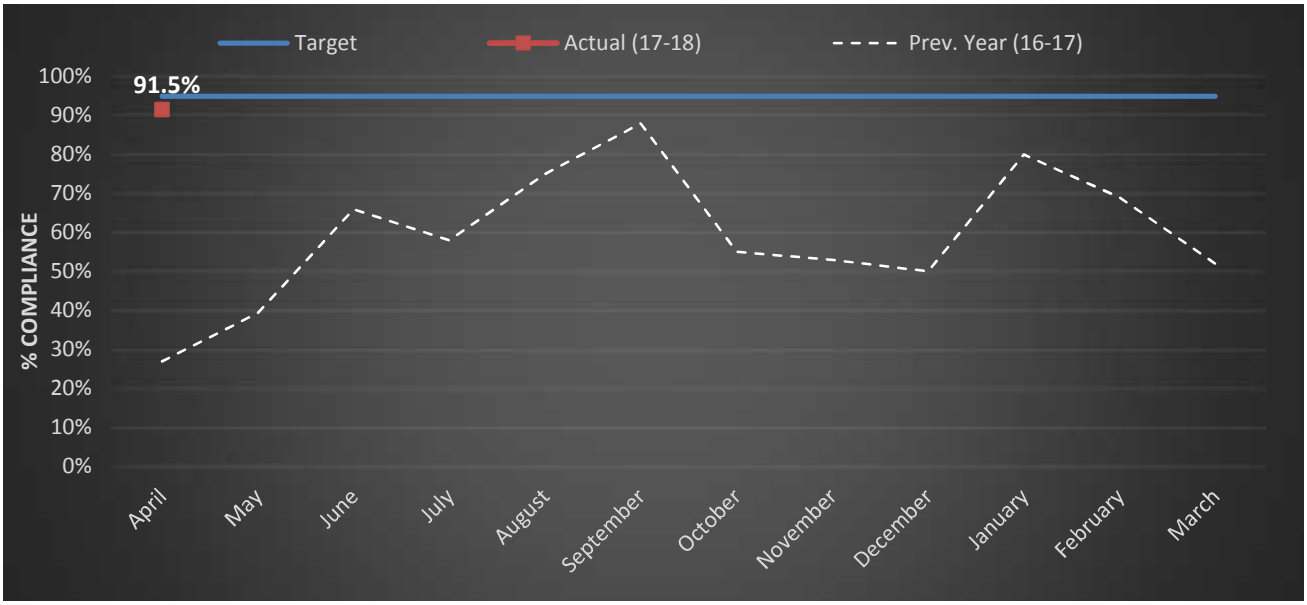


Figure.QS2b - Complaints reporting timeliness (All Complaints)

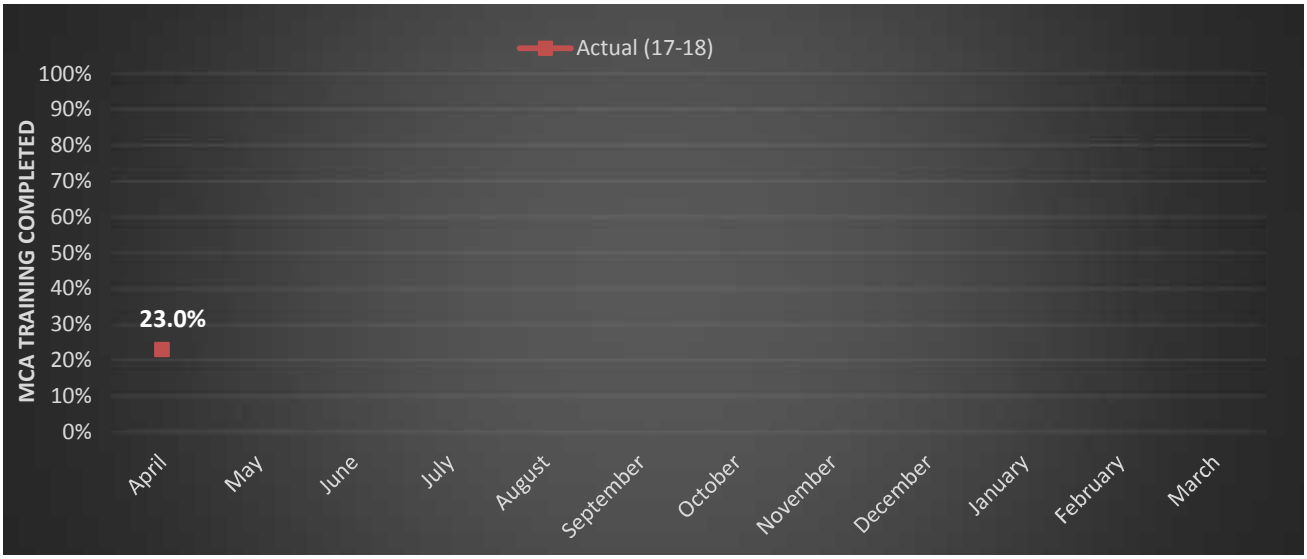


Figure.QS2c – Mental Capacity Assessment Training

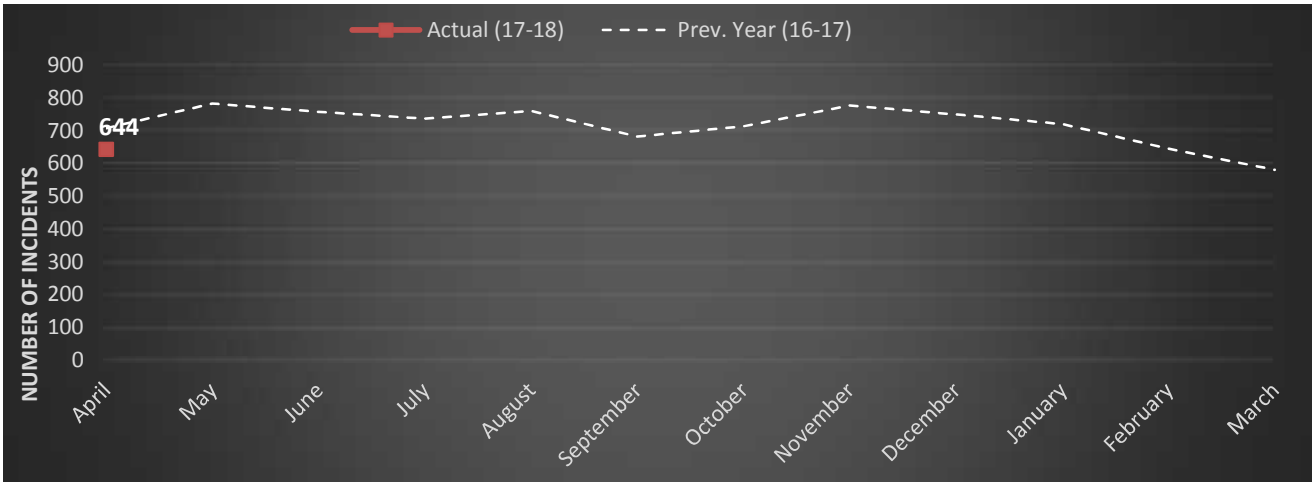


Figure.QS3a - Safeguarding Referrals Adult

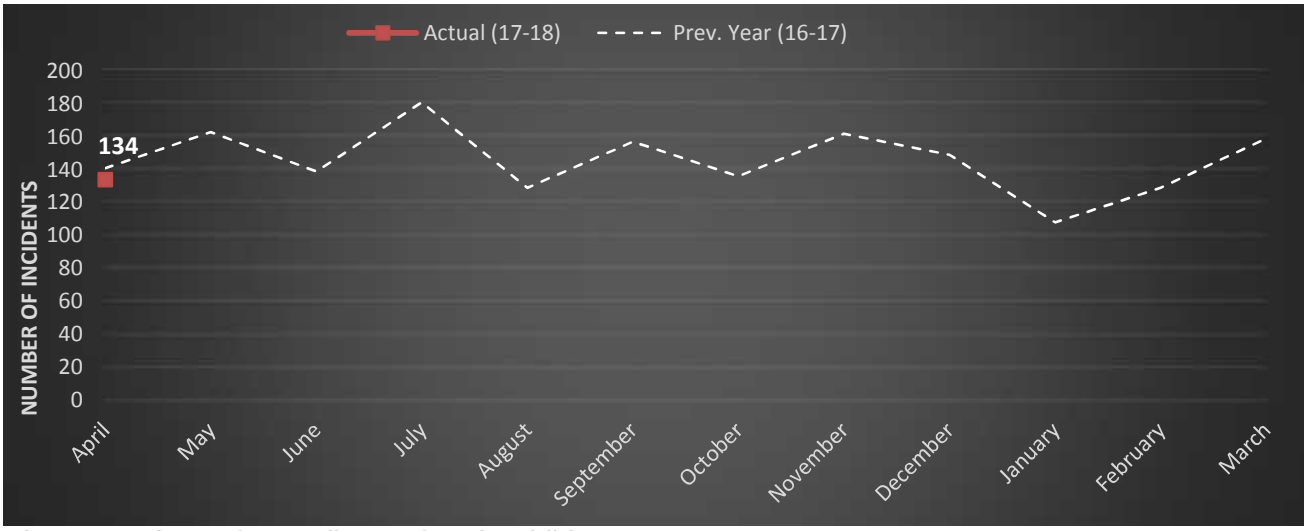


Figure.QS3b - Safeguarding Referrals Children

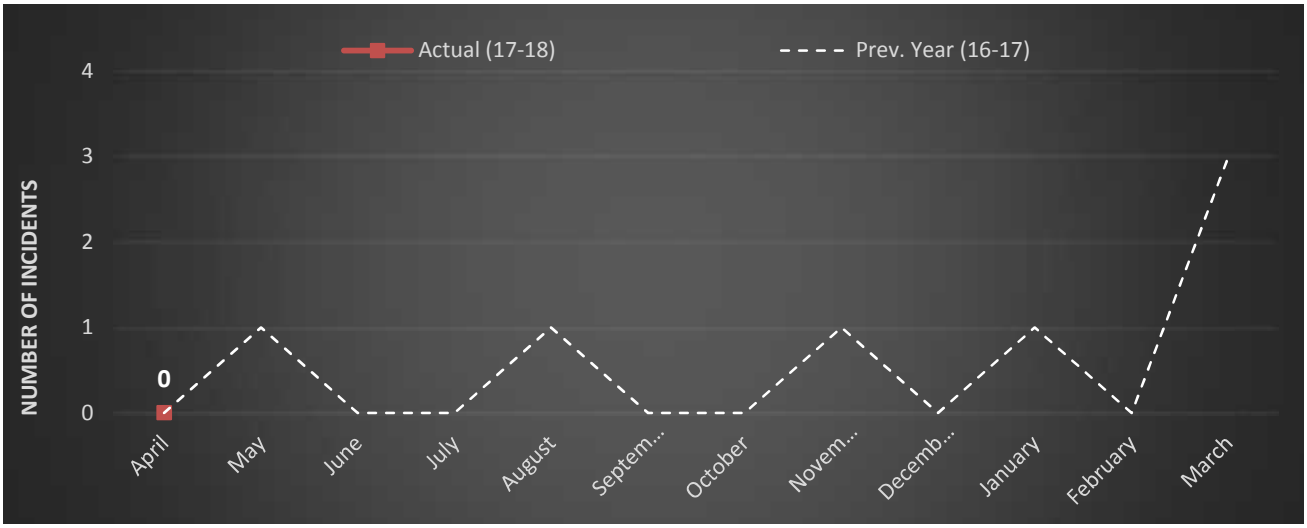


Figure.QS3c - Safeguarding Referrals relating to SECAmb staff or services

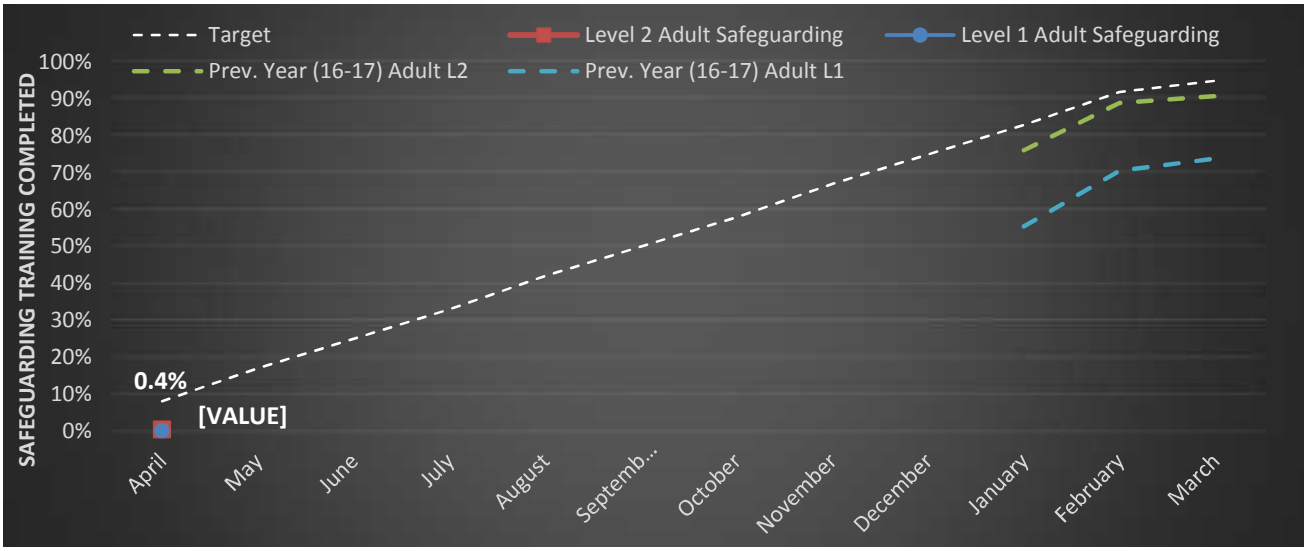


Figure.QS3d and QS3f - Safeguarding Training Completed Adult, Level 1 and 2

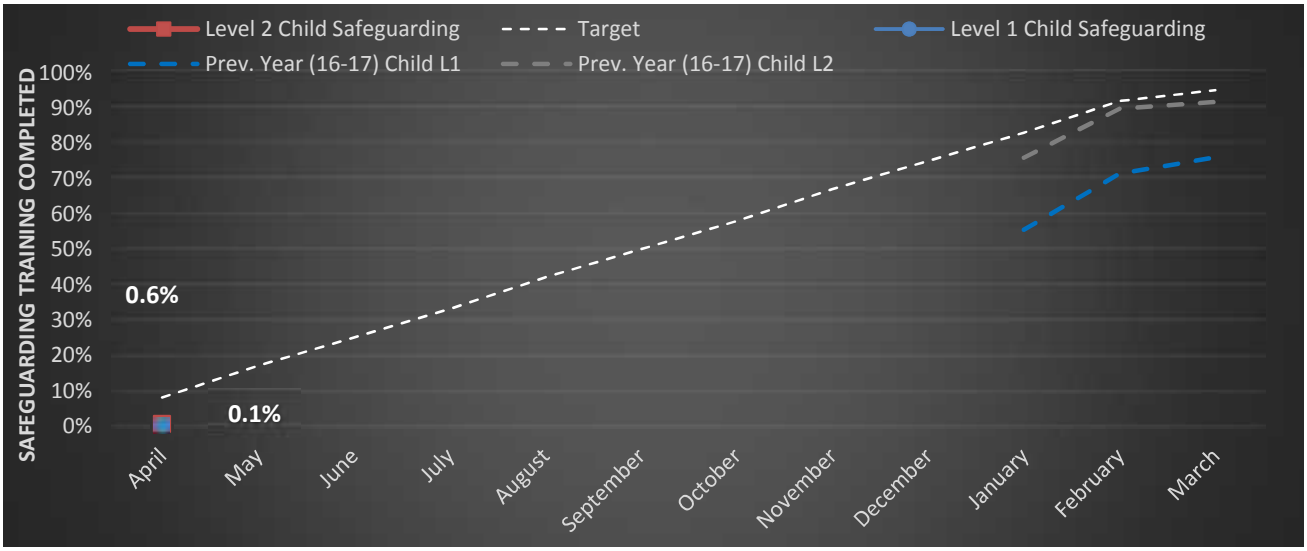


Figure.QS3e and QS3g - Safeguarding Training Completed Children, Level 1 and 2

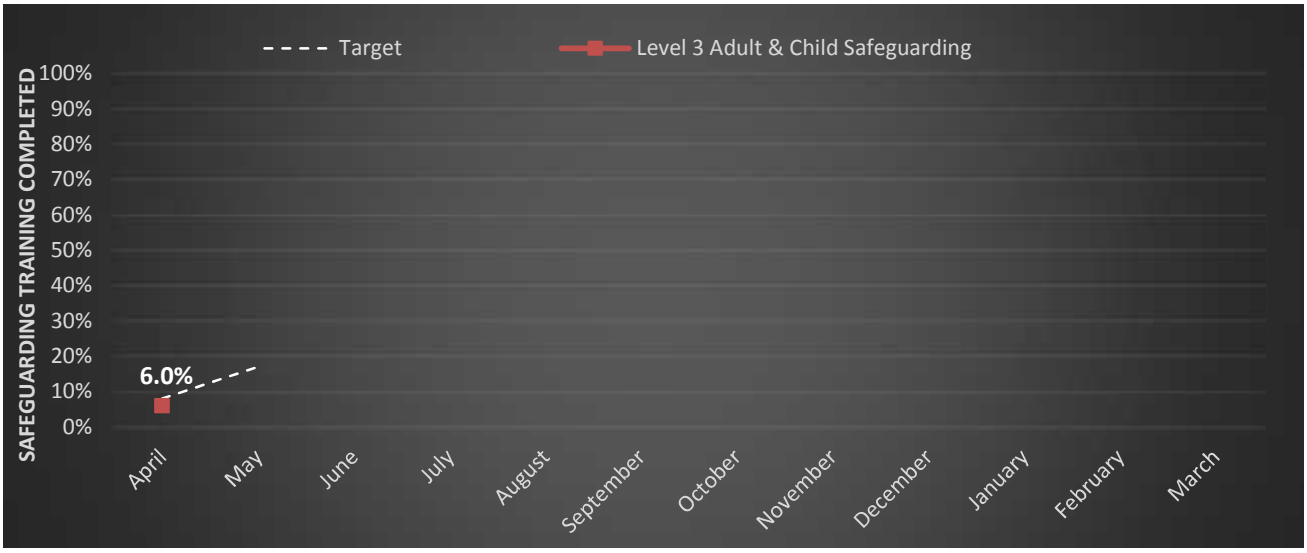


Figure.QS3h - Safeguarding Training Completed Adult & Child Level 3

6. Finance

6.1. Finance Summary

6.1.1. This commentary highlights the key messages arising from the month 1 financial position.

6.1.2. The Trust's financial performance in month 1 was a deficit of £0.9m, which was £0.1m behind plan. The forecast for the full year is unchanged from the plan, a deficit of £1.0m

6.1. Finance Scorecard

Finance Scorecard:- : Data from April 2017

ID**	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
F-1	Income (£'000)	£ 17,676.3	£ 15,230.7	£ 15,911.4	£ 17,676.3	£ 15,230.7	£15,911.4
F-2	Expenditure (£'000)	£ 18,432.6	£ 16,126.1	£ 16,292.4	£ 193,233.0	£ 16,126.1	£16,292.4
F-6	Surplus/(Deficit)	-£ 48.0	£ 895.4	£ 381.0	£ 739.0	£ 895.4	£ 381.0
ID**	**KPI**	**Current Quarter (Plan)**	**Current Quarter (Actual)***	**Current Quarter (Prev. Yr.)**	**YTD (Plan)**	**YTD (Actual)***	**YTD (Prev. Yr.)**
F-5	CQUIN - Quarterly (£'000)*	£ 283.0	£ 283.0	£ 952.0	£ 283.0	£ 283.0	£ 952.0
ID**	**KPI**	**Current Month (Plan)**	**Current Month (Actual)**	**Current Month (Prev. Yr.)**	**YTD (Plan)**	**YTD (Actual)**	**YTD (Prev. Yr.)**
F-3	Capital Expenditure (£'000)	£ 3,343.0	£ 268.0	£ 1,988.0	£ 3,343.0	£ 16,187.0	£ 1,988.0
F-7	Cash Position (£'000)	£ 5,929.0	£ 9,421.0	£ 10,325.0	£ 5,929.0	£ 9,421.0	£10,325.0
F-4	Cost Improv. Prog. (CIP) (£'000)	£ 1,293.0	£ 619.0	£ 345.0	£ 1,293.0	£ 619.0	£ 345.0
F-8	Agency Spend (£'000)	£ 344.0	£ 156.2	£ 386.1	£ 344.0	£ 6,346.0	£ 386.1

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

6.2. Finance Commentary

6.2.1. There was an expected income shortfall of £2.0m arising from the structural deficit, partly offset by a directly related £1.5m of expenditure not required pending outcome of mediation and Deloittes review. This resulted in an adverse EBITDA of £0.5m as a result of the structural deficit.

6.2.2. A&E Contract Income was £0.4m down on plan in the month, due to activity being below plan, even though income was marginally above that earned in the same period last year.

6.2.3. Pay expenditure was underspent by £0.3m, due to operational hours being slightly lower than plan combined with a high level of vacancies and a favourable level of CIPs. Although hours were below plan, Unit Hour Utilisation (UHU) at 0.343 was below the plan of 0.363, due to activity being further below plan than hours.

6.2.4. In Operating Units there were 115 vacancies, a rate of 5.5%, and overtime was down on plan, giving a favourable variance on Trust operational staff of £0.3m, partly offset by an overspend on Private Ambulance Providers of £0.1m

6.2.5. Non pay expenditure was underspent by £0.3m and non-operating expenditure by £0.2m. The latter was mainly due to the cost improvement benefit of estate revaluation at 31 March.

6.2.6. CIP delivery for the month was £0.9m compared to the planned level of £1.0m.

6.2.7. Capital expenditure for the month was just £0.3m against a plan of £3.3m. The full year programme is £15.8m.

6.2.8. The Trust's cash balance at the end of April was £9.4m, down from £13.0m at year end. This was after repaying £3.0m of the working capital loan previously drawn, reducing the loan balance outstanding to £3.2m. No further draw down or repayment is planned in the foreseeable future. There is a £15m working capital facility with the Department of Health.

6.2.9. Financial performance in the month fell slightly below plan. The adverse impact of the structural deficit was partly offset by a favourable operating position, despite income being down against plan.

6.3. Finance Conclusion

6.3.1. Financial performance in the month fell slightly below plan. The adverse impact of the structural deficit was partly offset by a favourable operating position, despite income being down against plan.

6.4. Finance Charts

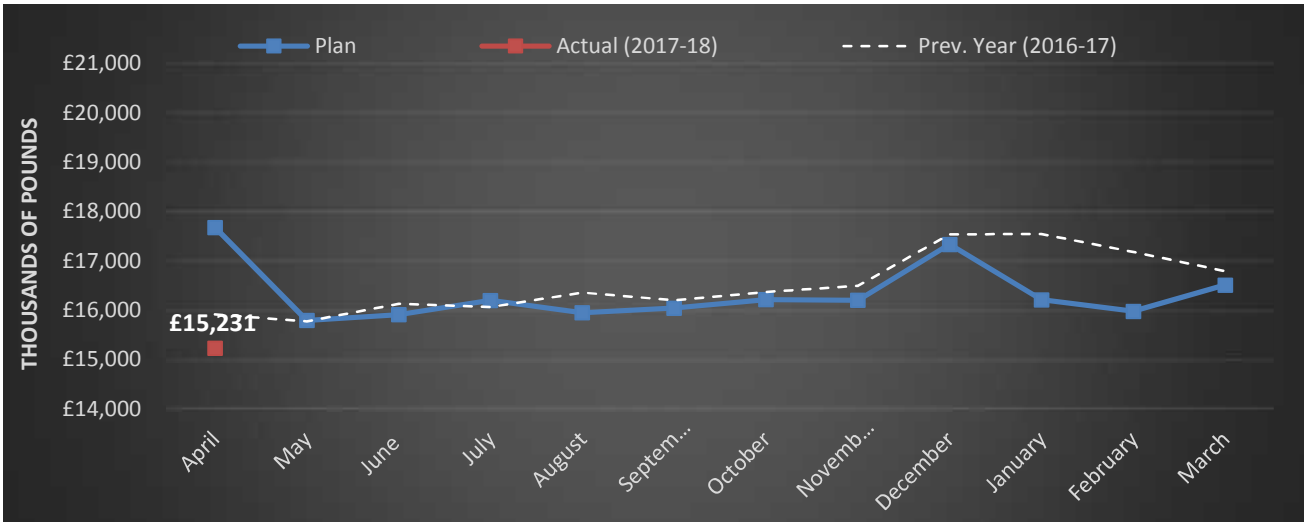


Figure.F-1 - Income (£'000)

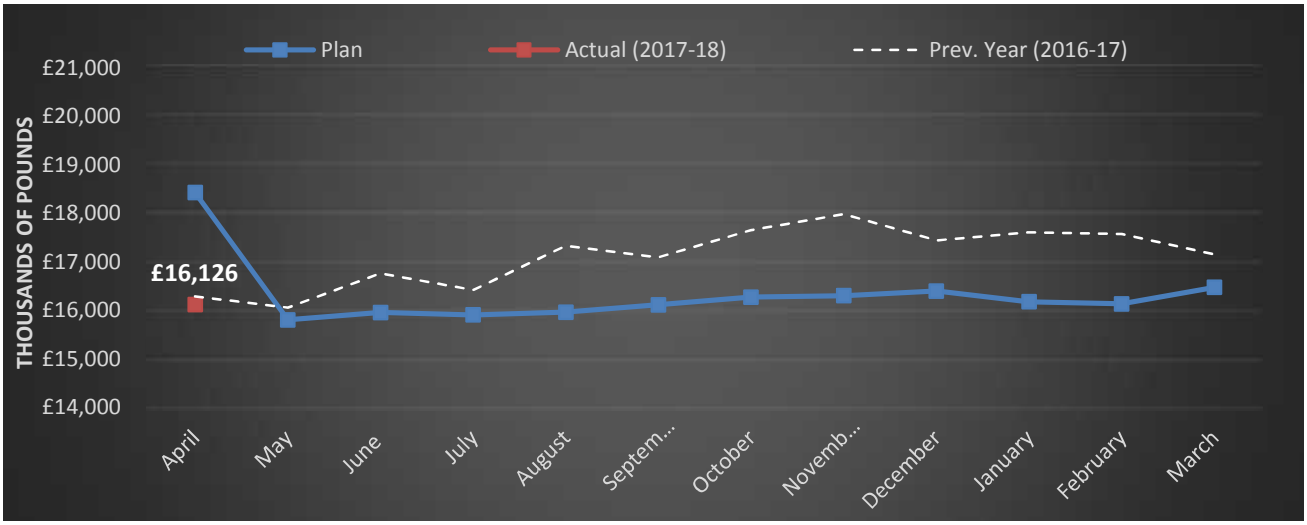


Figure.F-2 - Expenditure (£'000)

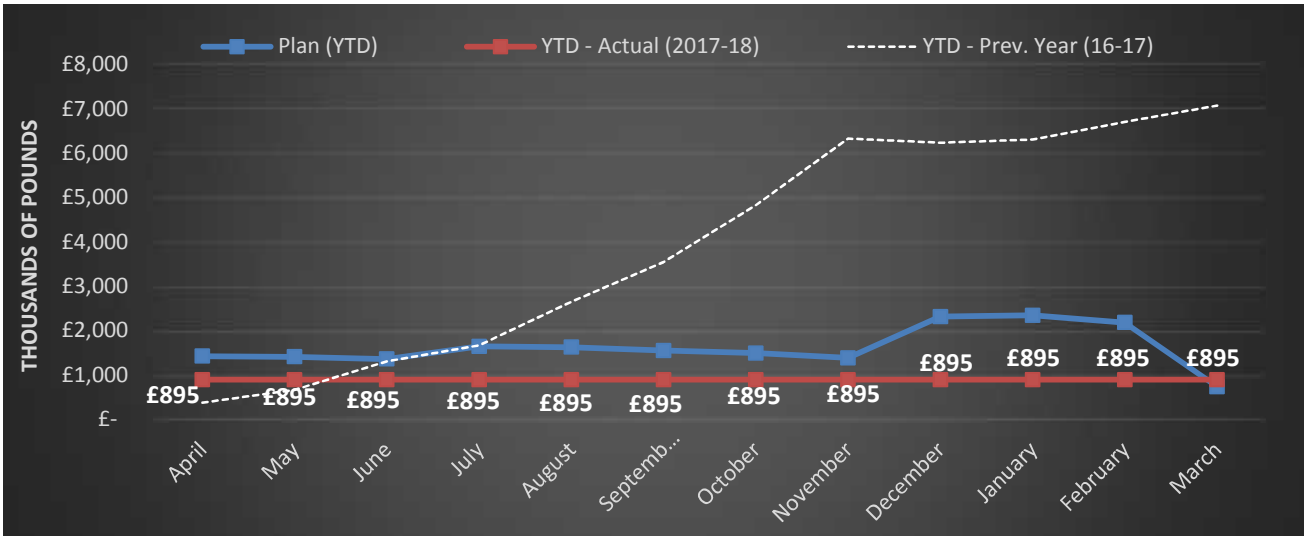


Figure.F-6 - Surplus/(Deficit) (Year To Date)

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

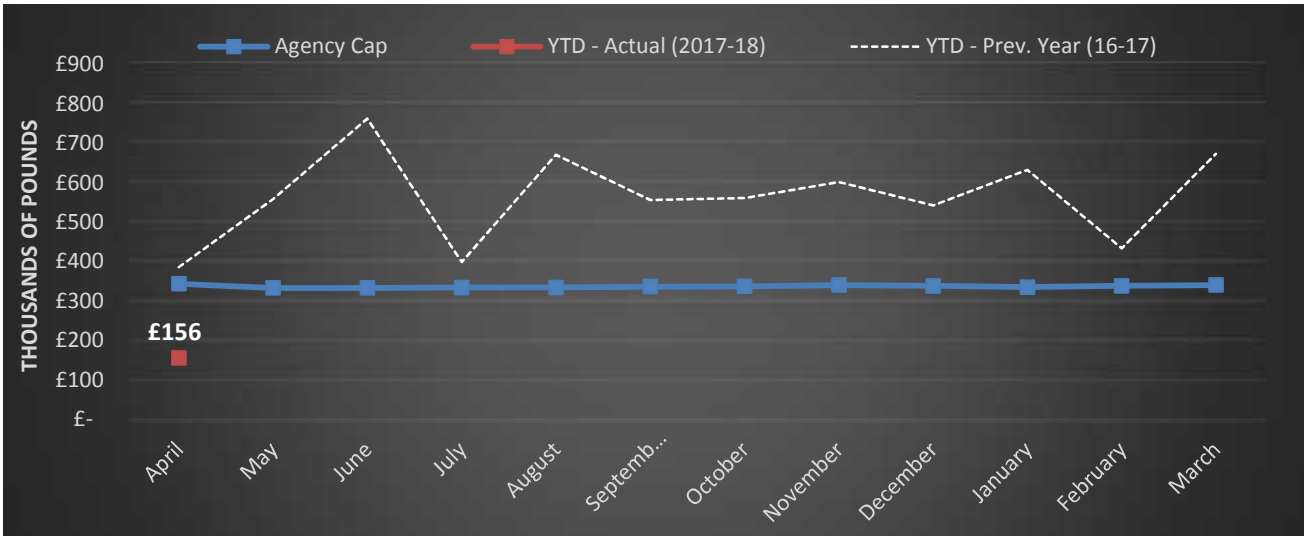


Figure.F-8 – Agency Spend (£'000)

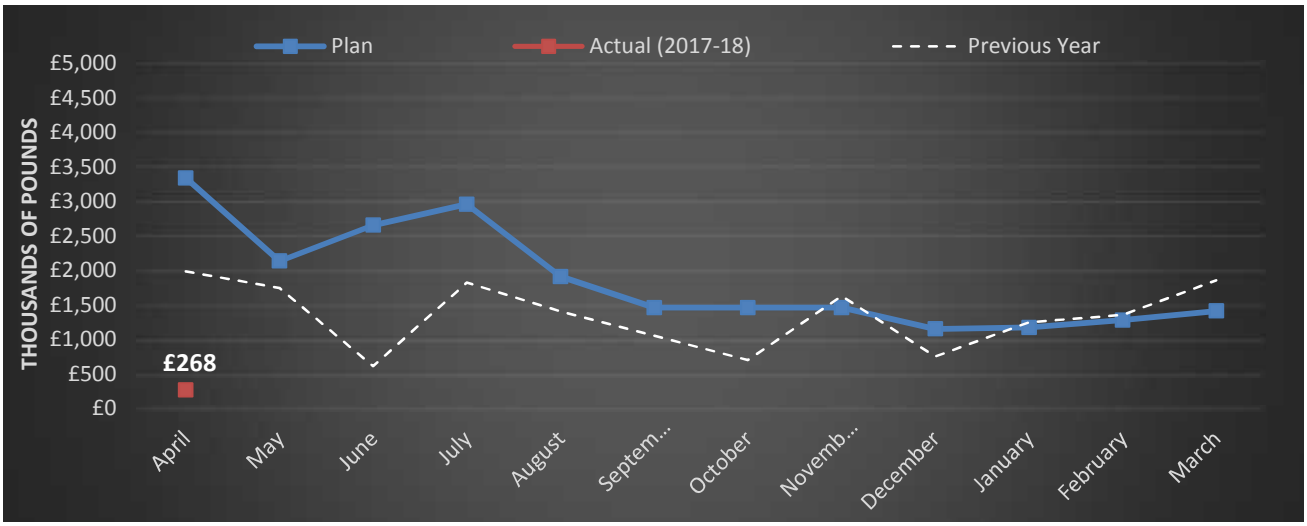


Figure.F-3 – Capital Expenditure (£'000)

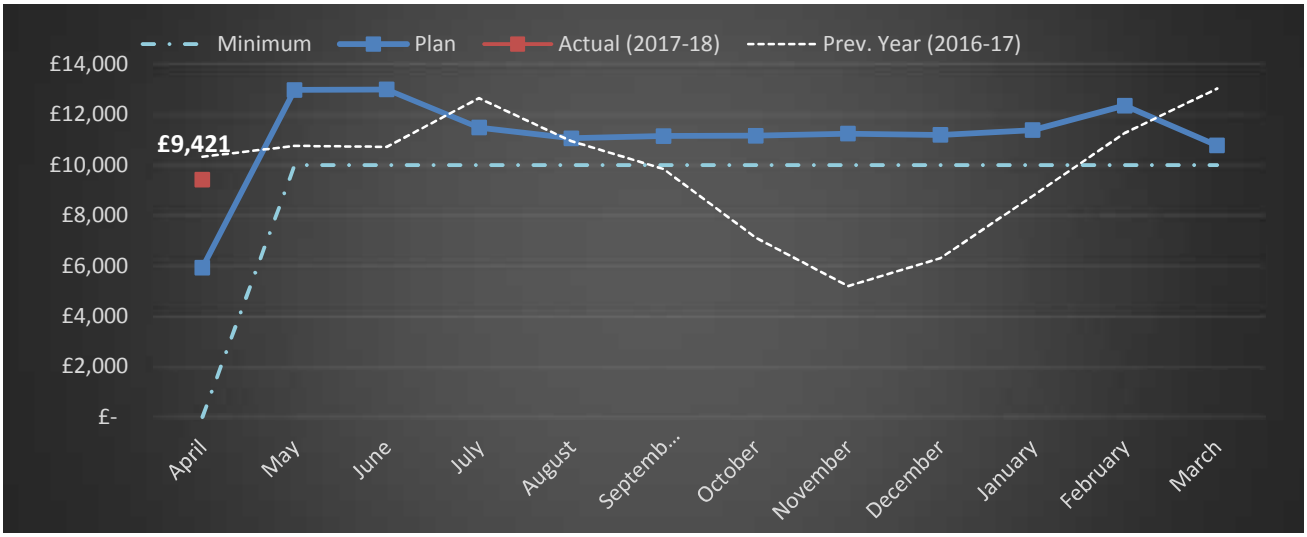


Figure.F-7 – Cash Position (£'000)

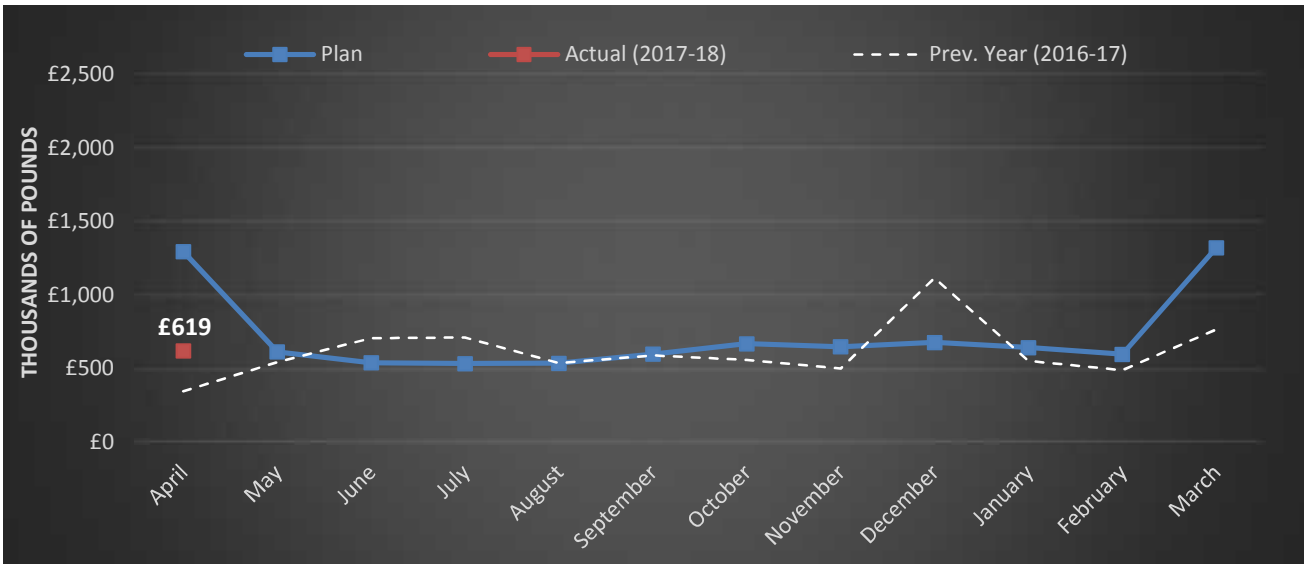


Figure.F-4 - Cost Improv. Prog. (CIP) (£'000)

Integrated Performance Dashboard Balanced Scorecard for the May 2017 Board Meeting

Workforce Commentary :- Data from Apr 2017

ID	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
Wf-1A	Short Term Sickness - Rate		**2.0%**	2.5%		**2.0%**	
Wf-1B	Long Term Sickness - Rate		**2.5%**	2.8%		**2.5%**	
Wf-2	Staff Appraisals	7.5%	**53.9%**	4.1%			
Wf-3	Mandatory Training Compliance (All Courses)	15.0%	**88.5%**	21.8%			
Wf-4	Total injuries		**52**	59		**52**	59
Wf-5	Total physical assaults		**18**	15		**18**	15
Wf-6	Vacancies (Total WTE)		**0**				
Wf-7	Annual Rolling Staff Turnover		**16.7%**	16.0%			
Wf-8	Reported Bullying & Harassment Cases		**1**			**1**	
Wf-9	Cases of Whistle Blowing		**0**			**0**	

Operational Performance Scorecard:- Data From April 2017

ID	KPI	Current Month (Plan*)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan*)	YTD (Actual)	YTD (Prev. Yr.)
999-1	Red 1 response <8 min	Not available	**70.9%**	70.1%		**70.9%**	70.1%
999-2	Red 2 response <8 min	Not available	**56.2%**	60.0%		**56.2%**	60.0%
999-3	Red 19 Transport <19 min	Not available	**91.4%**	92.4%		**91.4%**	92.4%
999-4	Activity: Actual vs Commissioned	62627	**64833**	64140	62627	**64833**	64140
999-5	Hospital Turn-around Delays (Hrs lost >30 min.)	3267	**4915**	4594	3267	**4915**	4594
999-6	Call Pick up within 5 Seconds	Not available	**90.3%**	77.5%		**90.3%**	77.5%
999-7	CFR Red 1 Unique Performance Contribution	Not available	**2.3%**	Not available		2.3%	Not available
999-8	CFR Red 2 Unique Performance Contribution	0%	**1.5%**	Not available		1.5%	Not available
111-1	Total Number of calls offered		**99575**	95870		**99575**	95870
111-2	% answered calls within 60 seconds	60%	**95.5%**	65.1%	60.0%	**95.5%**	65.1%
111-4	Abandoned calls as % of offered after 30 secs	9.0%	**0.5%**	8.2%	9.0%	**0.5%**	8.2%
111-5	Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)	70%	**80.4%**	70.2%		**80.4%**	70.2%
0	0	0	0	0	0	0	0
0	0	0%	0.0%	0.0%	0%	0.0%	0.0%
0	0	0%	0.0%	0.0%	0%		0.0%
0	0	0%	0.0%	0.0%	0%	0.0%	0.0%

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

SECAMB Regulation Statistics

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

Clinical Effectiveness KPI Scorecard:- Data From December 2016

ID	KPI	Current Month (Nat. Av.*)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Nat. Av.*)	YTD (Actual)	YTD (Prev. Yr.)
CE-1	Cardiac arrest - ROSC on arrival at hospital (Utstein)	44.4%	**48.6%**	44.7%	51.2%	**52.2%**	48.7%
CE-2	Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)	27.2%	**28.5%**	25.7%	28.4%	**27.7%**	27.1%
CE-3	Cardiac arrest -Survival to discharge - Utstein	21.7%	**8.8%**	21.1%	26.4%	**22.7%**	24.5%
CE-4	Cardiac arrest -Survival to discharge - All	6.7%	**3.7%**	7.3%	8.4%	**6.7%**	8.7%
CE-5	Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)	81.4%	**62.8%**	68.1%	79.6%	**67.5%**	68.1%
CE-6	Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes	85.2%	**86.9%**	93.3%	86.1%	**91.3%**	93.4%
CE-7	% of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes	50.7%	**58.9%**	67.7%	53.8%	**64.9%**	66.1%
CE-8	% of suspected stroke patients assessed face to face who received an appropriate care bundle	97.8%	**95.6%**	96.2%	97.6%	**95.9%**	96.5%

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

Finance Scorecard:- : Data from April 2017

ID**	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
F-1	Income (£'000)	£17,676.3	**£15,230.7**	£15,911.4	£17,676.3	**£15,230.7**	£15,911.4
F-2	Expenditure (£'000)	£18,432.6	**£16,126.1**	£16,292.4	£193,233.0	**£16,126.1**	£16,292.4
F-6	Surplus/(Deficit)	-£48.0	**£895.4**	£381.0	£739.0	**£895.4**	£381.0
ID**	**KPI**	**Current Quarter (Plan)**	**Current Quarter (Actual)***	**Current Quarter (Prev. Yr.)**	**YTD (Plan)**	**YTD (Actual)***	**YTD (Prev. Yr.)**
F-5	CQUIN - Quarterly (£'000)*	£283.0	**£283.0**	£952.0	£283.0	**£283.0**	£952.0
ID**	**KPI**	**Current Month (Plan)**	**Current Month (Actual)**	**Current Month (Prev. Yr.)**	**YTD (Plan)**	**YTD (Actual)**	**YTD (Prev. Yr.)**
F-3	Capital Expenditure (£'000)	£3,343.0	**£268.0**	£1,988.0	£3,343.0	**£16,187.0**	£1,988.0
F-7	Cash Position (£'000)	£5,929.0	**£9,421.0**	£10,325.0	£5,929.0	**£9,421.0**	£10,325.0
F-4	Cost Improv. Prog. (CIP) (£'000)	£1,293.0	**£619.0**	£345.0	£1,293.0	**£619.0**	£345.0
F-8	Agency Spend (£'000)	£344.0	**£156.2**	£386.1	£344.0	**£6,346.0**	£386.1

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

Quality & Safety KPI Scorecard:- Data From April 2017

ID	KPI	Current Month (Target)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Target)	YTD (Actual)	YTD (Prev. Yr.)
QS1a	SI Reporting timeliness (72hrs)	100.0%	**0.0%**		100.0%	**0.0%**	
QS1b	SI Investigation timeliness (60 days)	100.0%	**0.0%**	100.0%	100.0%	**0.0%**	100.0%
QS1c	Number of Incidents reported		**545**	455		**545**	455
QS1d	Number of Incidents reported that were SI's		**5**	4		**5**	4
QS1e	Duty of Candour Compliance	100.0%	66%		100.0%	66%	
QS2a	Number of Complaints		**71**	126		**71**	126
QS2b	Complaints reporting timeliness (All Complaints)	95.0%	**91.5%**	26.9%	95.0%	**91.5%**	26.9%
QS2c	Mental Capacity Assessment Training		23.0%			23.0%	
QS3a	Number of Safeguarding Referrals Adult		644	708		644	708
QS3b	Number of Safeguarding Referrals Children		**134**	141		**134**	141
QS3c	Safeguarding Referrals relating to SECAmb staff or services		**0**	0		**0**	0
QS3d	Safeguarding Training Completed (Adult) Level 1	8.0%	**0.1%**		8.0%	**0.1%**	
QS3e	Safeguarding Training Completed (Children) Level 1	8.0%	**0.1%**		8.0%	**0.1%**	
QS3f	Safeguarding Training Completed (Adult) Level 2	8.0%	**0.4%**		8.0%	**0.4%**	
QS3g	Safeguarding Training Completed (Children) Level 2	8.0%	**0.6%**		8.0%	**0.6%**	
QS3h	Safeguarding Training Level 3 (Adult/Child)	8.0%	**6.0%**			6.0%	

Appendix 2: Notes on Data Supplied in this Report

7.1. Preamble:

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

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

7.2. Executive Summary:

7.2.1. No changes to note.

7.3. Workforce Section:

7.3.1. No changes to note.

7.4. Operational Performance Section:

7.4.1. No changes to note.

7.5. Clinical Effectiveness

7.5.1. No changes to note.

7.6. Quality and Patient Safety Section:

7.6.1. May Board Changes: Added two new KPI's:

- Duty of Candour KPI added.
- Level 3 Safe Guarding Training
- Mental Capacity Assessment Training

7.7. Finance Section:

7.7.1. No changes to note.

SECAMB Board

Summary Report on the Audit Committee Meeting of 22 May 2017

Date of meeting	**30 May 2017**
Overview of issues/areas covered at the meeting:	The meeting was focussed on the annual report and accounts, which included; • Internal Audit's Annual Report and Head of Internal Audit Opinion • External Audit Findings Report • External Audit's Report on the Quality Report and their Limited Assurance Opinions on the Quality Report Indicators. The report and accounts will be considered by the Board in part 2 of its meeting, where it will receive a recommendation by the Audit Committee to approve both the Annual Report and Accounts. The Committee thanked executive colleagues for the evident hard work that they had put into the Annual Report and Accounts.
Reports *not* received as per the annual work plan and action required	None
Changes to significant risk profile of the trust identified and actions required	None
Weaknesses in the design or effectiveness of the system of internal control identified and action required	The Committee noted the pressure of time in drafting the annual report and accounts, and asked management to think about the planning for next year, so that the Committee has earlier sight, acknowledging some aspects will still need significant revision right up to the Board meeting in May.
Any other matters the Committee wishes to escalate to the Board	The Committee considered the reports of both Internal and External Audit in relation to the Quality Report, but the Quality & Patient Safety Committee considered the detail and will make its recommendation to the Board separately.

SECAMB Board

QPS Escalation report to the Board

Date of meeting	22 May 2017
Overview of issues/areas covered at the meeting:	The main focus of this meeting was to review the Quality Report, which will be considered by the Board in part 2 of its meeting. The committee was unable to recommend the Quality Report to the Board at the meeting, due to significant gaps and readability of the document. It was agreed a re-write would be undertaken and the document submitted to the QPS Chair for review on Wednesday 24 May 2017. In addition, the Committee considered the following; *Management Response* • Duty of Candour • Patient Care Records *Scrutiny Item* • Patient Experience - **assured** The committee scrutinised the design and effectiveness of the Trust's system of internal control for patient experience. It was assured with the processes that have been implemented and recognised that they are still being embedded. The committee requested a management response for later in the year to clarify further the process of ensuring quality complaints investigations / reviews and how we involve patients in the complaints process to ensure positive outcomes.
Reports *not* received as per the annual work plan and action required	None
Changes to significant risk profile of the trust identified and actions required	
Weaknesses in the design or effectiveness of the system of internal control identified and action required	**Duty of Candour** As escalated to the Board in April, the Committee was assured that we are compliant with the Duty of Candour in respect of incidents of serious harm and death, but not with regards incidents of moderate harm. The management response described the action being taken to implement systems which ensures compliance going forward. The Committee was assured that these systems are robust, but would need time to embed fully and therefore asked for a further management response in June to explore how management will know we are compliant and how this will be demonstrated.

	Patient Care Records This is an area the Committee will continue to monitor until it is assured that all the issues are identified and sustained improvement is made. The Committee received a progress update, which provided assurance that both the director of operations and medical director have gripped this issue and the immediate action is being undertaken where identified. The Committee will receive an update in June on the progress against the rectification plan being put in place.
Any other matters the Committee wishes to escalate to the Board	**Complaints** It became clear in committee that the basis on which complaint timeliness is calculated and how complaints are classified has been changed and that the Board should be aware of this when reviewing the figures presented in to Integrated Performance Report. The Committee has asked an audit of the figures to be undertaken to provide assurance. **Life Pak 12** Following on from a discussion at the April QPS the Committee received a briefing on the use of Life Pak 12 in the Trust. As a result of this the Committee has asked for a review of their use to confirm any safety issues. In addition, it was agreed a replacement strategy should be put in place and reviewed by the Finance and Investment Committee. **Call Recording** The Committee also received an update on the issue recently highlighted with call recording. It has asked for a progress update at its meeting in June to ensure the system we use records clearly every call received.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	25th May 2017
Overview of issues/areas covered at the meeting:	**Review of outstanding actions on** **a. Policies and procedures –** In January **assurance** was received that adequate processes are in place to both update and disseminate Trust policies. However, the Committee was **not assured** on any follow up about understanding or compliance. This is still outstanding. Assurance has been requested for July meeting. b. **Move to Crawley** – Phased move to Crawley now under way. Essentially everything is going to plan (putting to one side expected normal snagging issues). Major outstanding issues remain the adoption of the cultural change by staff and business continuity plans for new building. Committee received **assurance** that both are in hand which will be confirmed at the July meeting. c. **NED Induction and Training** – This had been identified as an issue by Audit Committee. Agreed a paper will be produced at July meeting. d. **Committee Framework** – Item outstanding but anticipate proposal at July meeting **Well-being Strategy –** The Committee received a paper on the new well-being strategy being implemented throughout the Trust. There was **overall assurance** on this topic and an update on impact was scheduled for September meeting. **Critical vacancies –** The Committee reviewed a paper on resourcing action around a range of critical positions throughout the Trust. There was **assurance on the actions around operational jobs** but only **partial assurance on some crucial positions in non-operational positions** – particularly those related to the clinical directorates. The Director of HR will circulate a clarification of the current situation within the next 2 weeks (09/06) and will identify any issues where a lack of resource or capability is a cause for concern. This is also an issue identified by the CQC. **CFR's –** The Committee reviewed a paper which dealt largely with the **training and development of CFR's and were assured** about his part of the process. However it was acknowledged that there also needed to be a broader **consideration of the recruitment, engagement and integration** of this important group. Therefore there was **no assurance** on this aspect and a paper was requested for the July meeting. **CQC Issues** – The Committee discussed three workforce related issues raised by the CQC in their initial feedback session. a. Appraisals – The Committee acknowledged that this was a known issue and that the Executive had already commenced plans to address the matter. Reports on the roll-out of the new system are already scheduled for Committee meetings in July (non-operational staff) and September (operational staff). The Committee recorded a level of **partial assurance** on the topic – being satisfied with the plans in place but it had not yet seen any evidence as to their effectiveness (being too early in the process) and therefore reserved judgement.

	b. Change Management – The Committee acknowledged that in any major change it is likely that there will be some disquiet among employees. Nothing so far has suggested that the move to the new HQ is anything more than normal levels of uncertainty and disquiet. However the Committee was **unable to gain assurance that the Trust had an effective process for supporting staff through the implementation of major change**. This will be addressed in the July meeting. c. Corporate vacancies – See under comments above. Issue already identified as a concern. **Risk Register –** The Committee reviewed the top risks relating to workforce. Some work is needed on consistency of moderation across directorates to ensure there is a common understanding of top workforce risks. However the Committee was **assured that plans were in place to mitigate the top workforce risks** and these appeared adequate and were on track as far as these were within the control of the Trust.
Reports *not* received as per the annual work plan and action required	) All reports requested were received on time
Changes to significant risk profile of the trust identified and actions required	No changes to previously reported risk profile – significant risks remain about sufficient manpower; culture; move to Crawley; and appraisal completion. While the move to Crawley is still a significant risk (and will be until EOC move complete) the Committee felt that everything appeared to be on track.
Weaknesses in the design or effectiveness of the system of internal control identified and action required	Previously identified weaknesses around dissemination of policies and establishing an accepted set of measured outcomes on the progression of culture initiatives identified in January still remain. See above for action. The question of potential weaknesses on how the Trust manages major change highlighted through the CQC visit will be initially addressed and scrutinised through a report on process at the July Committee meeting.
Any other matters the Committee wishes to escalate to the Board	The most significant issue remains the **incomplete nature of the Workforce Plan.** With the recent clarification of structure and internal agreement on budgets, this should begin to be resolved. A paper on overall strategic direction will be presented in July. It was acknowledged that a planning process is being discussed by the Executive and will be in place in order to guide the budgets/plans for 2018/19. This does mean that a formal workforce plan for 2017/18 is unlikely to be produced.