South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

29 June 2017

10:00-13:00

Tangmere MRC

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
38/17	10.00	Chairman's introduction	-	-	RF
39/17	10.01	Apologies for absence	-	-	RF
40/17	10.02	Declarations of interest	-	-	RF
41/17	10.03	Minutes of the previous meeting: May 2017	**Y**	Decision	RF
42/17	10.05	Matters arising (Action log)	**Y**	Decision	RF
Organisational culture					
43/17	10.10	Patient story	-	Set the tone	
44/17	10.15	Chief Executive's report	**Y**	Information	DM
Trust strategy					
45/17	10.30	Unified Recovery Plan Delivery Progress Update ▪ Organisational Recovery Dashboard (Including CAD Update) ▪ Quality Dashboard ▪ Financial Sustainability Dashboard	**Y** **Y** **Y** **Y**	Assurance	JA JA SL DH
Ten minute Break					
Allocating resources to achieve plans					
46/17	11.30	Independent Governance Review	**Verbal**	Information	PL
47/17	11.35	Certification on Training for Governors	**Y**	Decision	PL
48/17	11.40	Corporate Governance Statement	**Y**	Decision	PL
Monitoring performance					
49/17	11.50	Integrated Performance Report	**Y**	Information	DM
50/17	12.10	Medicines Management Progress Update	**Y**	Assurance	FM
51/17	12.20	Clinical Outcomes Deep Dive	**Y**	Assurance	FM
52/17	12.30	Defib Patient Impact Review	**Y**	Information	JG
Holding to account					
53/17	12.40	Escalation report; Audit Committee	**Y**	Information	AS
54/17	12.45	Escalation report; Quality & Patient Safety Committee	**Y**	Information	LB
55/17	12.55	Escalation report; Finance Committee	**Y**	Information	GC
56/17	13.00	Any other business	-	Discussion	RF
57/17	-	Review of meeting effectiveness	-	Discussion	ALL

Close of meeting

Date of next Board meeting: 25 July 2017

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

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	**C**	**On Agenda**
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	**C**	**Ongoing - as discussed in May**
27.04.2017	08 17	Finance Committee to hold an exceptional meeting to consider revised ECPR roll out plan.	DH	June	FIC	**C**	**Held on 5 June**
27.04.2017	10 17	Audit Committee to oversee how the Trust plans to improve its approach to risk management	AS	TBC	AuC	C	**On-going - discussed at meeting in June**
30.05.2017	29 17	Finance & Investment Committee will review the controls in place for IT security at its meeting in July	DH	18.07.2017	FIC	IP	**Added to FIC agenda for July**
30.05.2017	31 17	A report to the Board in Autumn setting out how the Trust is ensuring learning from complaints, incidents, SIs etc.	SL / FM	October	Board	IP	
30.05.2017	32 17	Medicines Management Progress Update paper to Board in June, to be presented by the Chief Pharmacist	FM	29.06.2017	Board	C	**On agenda**

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 30 May 2017

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

Present:

Richard Foster	(RF)	Chairman
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
Jon Amos	(JA)	Acting Executive Director of Strategy & Business Development
Graham Colbert	(GC)	Independent Non-Executive Director & Deputy Chair
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

21/17 Chairman's introductions

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

RF acknowledged the lateness of the papers for the meeting. He reinforced the importance of timeliness and asked the executive to ensure going forward that papers are received a week in advance.

22/17 Apologies for absence

None

23/17 Declarations of conflicts of interest

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

24/17 Minutes of the meeting held in public April 2017

Subject to amending some minor typographical errors confirmed by JA and AR, the minutes were approved as a true and accurate record.

25/17 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.

26/17 Patient story [10.04 – 10.10]
RF confirmed that the Board receives a patient story at each meeting, alternating between positive and negative; this month we have a positive story.

The story related to a carer's experience with SECAmb. They fed back that staff had involved her in decisions for mother. She was very positive about the experience both as a carer and in her professional capacity.

27/17 Chief Executive's report [10.10 – 10.15]
DM reflected what a busy month it has been. He highlighted a number of areas from his report;

- The initial feedback from the CQC was that they had undertaken a positive inspection, especially for our 111 service.

- The new HQ went live a few weeks ago; EOC moved in last week and is now fully operational.

- New executive portfolios and objectives have been agreed and are published on the website.

- In terms of national issues, we had implemented robust plans while we were at critical level, following the terrorist attacks; now reduced to severe. And DM confirmed that the Trust responded very well to the recent cyber-attack.

LB noted the positive impact of moving to the new HQ, describing a different feeling now all support services are together.

With regards the CQC, RF added that he also attended the initial feedback session and confirmed that it was clear the CQC think we are doing the right things and that things are getting better. But it is hard to read where they think we might be in terms of ratings. There were some concerns expressed about the pace of change. DM agreed; it was a better inspection than last time and CQC noted a number of positives but also said there is much to do.

28/17 Unified Recovery Plan [10.15 – 10.57]
JA took paper as read which sets out where we are with the governance of the programmes and the three work-streams.

AR noted the difficulty recruiting to substantive roles and felt that we need as a Board to keep focus on ensuring we continue to have an effective PMO. RF explained there are two sides to this; ensuring enough people and then matching those people against programmes. JA agreed and reinforced the focus on mitigating risk as outlined in the paper later on the agenda.

<u>Finance</u>:
DH set out the governance flow for the cost improvement (CIP) schemes, confirming that NHSI are cautiously assured with our plans. Some schemes are well established and some are about making efficiencies; most of the savings come through toward the end of the year.

GC asked what NHSI are worried about and why do they need to come back in. DH explained the size of the CIP is 7%, which in itself is a significant risk. Also, NSHI just want full assurance and no surprises. GC asked whether NHSI are putting enough pressure on commissioners to ensure we get sufficient funding. DH explained where we are with negotiations and the aim to conclude these by the end of June. TH asked about the confidence in meeting this target given the first deadline was March. DH explained the mediation process which includes this timeframe so this is what we are working to. Our position is that we can't go in

to Q2 without agreement. TH asked what our Plan B is. DH confirmed this would be formal arbitration. He outlined the steps we are taking to try and avoid this and reminded the Board that we currently have a contract variation for Q1 which we are content with.

In the context of the negotiations with commissioners, there was a discussion about CIPs and the size of the challenge, with the Board concluding that regardless of what the Trust's part is in closing the gap, being as efficient as we can be, is something we need to do anyway.

LB added that at the extraordinary meeting in May, the Quality & Patient Safety Committee considered the quality impact of the CIP. Not all schemes were established at that point and so the plan is to test this again in July.

AS noted how tough it must be to take out 7% of the cost base and felt that this doesn't take in to account that the Trust is in a period of transformation needing to improve quality which all costs money. DH clarified that we aren't aiming for anything higher than £15m. The additional schemes help toward this figure given the risk in some of the schemes. AS acknowledged this but felt we must allow for some contingency given the improvements we need. DH agreed.

In summary, RF confirmed that we are all in this together. There is a real concern about targets being so stretching given the quality improvement needed. On the gap, this has been ongoing for a while now and we must bring it to conclusion, which will include arbitration if needed.

Recovery:
JA explained that we have made good progress over the last month with 999 and 111 projects, bringing a number to a close. The report sets out the detail of these closures. Good progress also with HQ/EOC. The challenges include ECPR in terms of i-pad roll out. The Finance & Investment Committee next week will scrutinise the recently revised plans which help to ensure full roll out by July. Also the new CAD; this will move to 'amber' next week once the IT challenges resolve. We have re-scoped the order of when we do things to ensure go live on 4 July 2017, but there are some risks to this. Finally, culture and workforce will become its own work-stream.

TP asked about the CAD risk and the need to ensure we deliver given how much relies on this. He asked for assurance that the deadline will be met. DH confirmed that despite the risks, there is high confidence it will. Some of the recent issues related to IT focusing on moving to the new HQ, but the executive is overseeing delivery of the CAD at its weekly meeting. Also, LB will be joining the Programme Board. TP asked then whether the risk outlined in the report was about the move to HQ? DH confirmed it was, plus the cyber-attack.

DM assured the Board that we do have a close grip on this reinforcing the weekly meetings to oversee delivery. The IT team are working really hard and he is not concerned at this stage about not delivering. DH added that we have almost concluded discussions with the current CAD company, with a positive outcome.

LB reiterated that she attends all programme board meetings and is convinced there is a grip and focus. However, there is not the same grip on EPCR.

DM stated that we all acknowledge where we are with EPCR, but this can't de-rail EOC/CAD. So if EPCR needs to slow to ensure delivery of EOC/CAD we will give this priority. DM also noted the smoothness of which the move to Crawley has gone.

In summary, RF confirmed we are cautiously confident. There is much going on and so we need to priortise accordingly.

Quality:
EW confirmed that, despite a very busy month, an additional 34 actions were completed and the number at risk has reduced. Although the same areas have been off target for a number of months. EW explained the steps being taken in some of these areas, such as incident management, where there have been a number of recruitment issues. As this is a specialist area it has been difficult to fill posts, even on an interim basis. Having said that, incidents have increased by 20% in the last month, which is positive.

EW set out the governance which supports the closure of projects.

LB asked about capacity-issues in support roles, which this report reinforces. And asked how soon we can address the timeliness issues regarding serious incidents. Some of these key posts are stopping us moving forward and have quality/safety implications.

TH confirmed that the Workforce & Wellbeing Committee has asked for an update on the critical support roles currently vacant.

With regards, serious incidents, FM explained that she is now responsible for this and is reviewing how we manage them. This includes consideration to whether we continue with a central team.

TH asked about how management is prioritising as we can't do everything at once. DM explained the revision of executive portfolios and the steps he is taking, working with EW and FM, to ensure we have the resource in the right places.

In summary, RF noted that we want the executive to save money and deliver all things. We need to get to have a realistic view on what can be achieved.

29/17 Cyber Security [10.57 – 11.10]
DH explained that this paper sets out the issues and at the end lists the things we should be doing. Little of this is new and the recent cyber-attack has simply brought them in to sharper focus. We fared well as a result of having up-to-date systems and reasonable infrastructure. However, there was also an element of good fortunate and so the recommendations point to things we need to do over the next few months to ensure we are as resilient as possible. The IT team is small, but worked hard over the weekend of the attack to ensure we weren't affected.

DH confirmed the recommendations in the paper will form part of the IT strategy and business cases will go through the usual governance processes, with assurance through the Finance & Investment Committee.

On behalf of board, RF thanked the IT team for all they did.

TH asked about timescales. DH confirmed that the draft IT strategy will be complete by the end of June, but it will be an ongoing series of work.

AR asked whether we have an IT policy which covers these things. DH confirmed that all IT policies are up to date and that we have introduced a new role to deal with IT security. There will be a review of policies to ensure they reflect up to date guidance.

TP refereed to 5.2 in the paper, which lists the reasons why the NHS is prone to risk of cyber-attack, and asked whether this relates specifically to SECAmb. DH confirmed the answer is probably yes for all of them, to varying degrees. But assured the Board that we are in top quartile of NHS Trusts. TP felt that some of the issues listed are within management control and the paper doesn't set out how we are managing these.

Action:
Finance & Investment Committee will review the controls in place for IT security at its meeting in July

TH expressed concern about our IT strategy and wondered if we are doing enough. He asked about the Board's appetite which the board needs time to consider. LB agreed; as a board we need a heat map of risk setting out all our IT systems, which would underpin our IT strategy.

DH confirmed that this paper was intended to generate this discussion. We have to priortise investment and IT is huge enabler.

RF summarised that if we are clear we have governance in place via the Finance & Investment Committee we should allow this to flow through to ensure visibility of risk and how we prioritise investment.

Comfort break 11.10 – 11.22

30/17 **PMO Transition** [11.22 -11.24]
JA explained that this paper updates where we are with the transition from EY to a permanent PMO. There are two risks highlighted relating to the project manager for finance, and sustainability of the PMO post EY. We talked at last Board about a follow up assessment by EY, which we have planned for within the budget.

31/17 **IPR** [11.24-12.02]
DM introduced report.

Workforce:
SG confirmed that we have 600 staff friends and family test responses in the last four weeks, which is really positive. We will use this as an indicator of staff engagement. The plan over the next two months will be to ensure better data, especially relating to training and appraisals. RF asked whether recruitment will be easier at Crawley than in Banstead. SG felt anecdotally, it might be.

Performance:
JG expressed disappointed that we aren't currently able to achieve national targets, but the trajectories agreed with commissioners for Q1 were exceeded in April against a backdrop of increased activity. Red 1 was 70.9% and the first time it has been over 70% for many months. Red 2 is 56.2% against the target of 50.3%. Red 19 is 91.4% against a target of 87.7%. These are positive achievements against the revised trajectories, especially while also maintaining the reduction in shift overruns/meal breaks.

AS asked whether we could add to the IPR the actual trajectories we are working to. JG confirmed that the report will be revised accordingly, and noted that while we aren't commissioned to provide national targets this will always be our aim.

GC agreed, asking for the KPIs to mirror what management is trying to achieve, e.g. cycle time / sending right resource first time etc.

TP asked where we are with hospitals improving handover delays. JG confirmed that he has seen Michael Wilson and a further visit is planned to see the Matron at East Surrey Hospital. We have additional support through the emergency care improvement programme, to help deep dive on particular hospital sites. We are

trying to find angles to do things differently, for example using a clinical navigator, where we and hospital trusts liaise to ensure patients are brought to the right place.

DM confirmed that he is doing much work with other Chief Executives and NHSI, exploring different solutions using Darzi fellows, and targeting work in East Kent, for example. We need a whole-system approach, including primary care so it is quite complex.

In summary, first and foremost, RF asked JG to feedback to his team thanks for the improvements we have made. It is obviously frustrating to have targets we aren't commissioned to achieve, but staff must remain positive that we are meeting trajectories.

DM added that the speed of response is only one measure of success. We need to look more at outcomes going forward.

Finally, AR noted that 111 performance is good. JG explained the work this services has done in the past 12 months to make such good progress.

Clinical Effectiveness:
FM explained that this section focusses on AQIs, and going forward the dashboard will consider more areas than stroke and STEMI. Also, the data is 6 months old. It is disappointing that four measures put us below the national average. With cardiac arrest, there is a disconnect to how we are collecting the data. We are failing to get outcome data from hospitals, so we get it from a source that only includes when patients have died; not those that have survived. With the stroke care bundle we are delivering well. We were successful in bringing in a consultant paramedic to look at how we are managing STEMI and relations with heart attack centers and our response to stroke patients.

Quality:
EW explained that the training data does not show the true picture. SIs in month missed the target, although in 4 out of 5 cases we met duty of candour. The one we missed was due to a delay in getting the contact details. For complaints, EW confirmed we are 100% compliant with the duty.

The number of complaints has reduced, possibly due to the loss of PTS. Our responsiveness of complaints is on an upward trajectory. Eight cases went to the PHSO, with only one being upheld.

TP asked about the risk in not completing SIs in a timely manner. EW felt this was more reputational than any patient risk, because when an SI is declared, it is considered via weekly meetings and immediate actions are taken. Some delays in concluding the investigations relate to the need to ensure the right quality and engagement.

TP asked about how the Board could better understand how we are ensuring learning. LB explained that the Quality & Patient Safety Committee is exploring this.

Action:
A report to the Board in Autumn setting out how the Trust is ensuring learning from complaints, incidents, SIs etc.

LB added that in terms of complaints the committee has identified some concerns about the way we calculate some of the data reported, which we are looking in to.

TH expressed disappointment in the non-attendance of safeguarding training. JG explained the issue was in the first week in April when his operational team prioritised improved performance. Since then, however, steps have been taken to ensure maximum attendance, either via abstraction or overtime. EW confirmed that since April over 200 operational staff have been trained.

Finance:
DH summarised this section by explaining we are slightly under income levels, but had adjusted resources accordingly. The phasing of the plan is such that he is not overly concerned with being £100k off plan art month 1. The challenge to the team is to ensure constant monitoring to avoid surprises at the end of each month. With regards cash we are on trajectory.

Capital is behind plan, but this is to do with phasing. GC noted that this was quite significantly behind and asked whether it really was just phasing or something else delaying things. DH confirmed it is a bit of both. GC felt that if we were delayed in fleet replacement that would be a concern. DH gave assurance that it wasn't fleet specifically.

32/17 Medicines Management [12.02-12.07]
FM assured the Board that we are moving in the right direction. We now have a Chief Pharmacist in post and staffing is improved, for example we have recruited a technician and one other is back from long term sick-leave. Unfortunately, the external review has slowed as the independent lead been sick, but 7 of 9 case files are complete. One other is near completion and the final case relies on information from a Coroner. More specifically, FM highlighted to the Board the following;

- Overlabelling – this is now being done legally, through a contract with another trust.
- PGDs - these have been reviewed and renewed. There are some relating to CCPs which FM has granted a 6-week extension.
- Breakages - these are still high and linked to how we carry drugs.
- Review of formulary is under review.
- Waste management continues to be a focus. We currently carry 4 months of stock.

RF met the new Chief Pharmacist last week and thought she was getting to grip with things very quickly. In terms of the external review delay RF asked if the independent lead is due to return this week. FM confirmed she was.

LB asked about the PDG 6-week extension. FM confirmed this was because these were more complex and needed an external reviewer to support the review.

Action:
Progress Update paper to Board in June, to be presented by the Chief Pharmacist

33/17 Audit Committee Escalation Report [12.07 – 12.13]
AS set out the timing of the accounts and the challenge this brings. A huge amount of work goes in to these end of year reports. In terms of the accounts themselves, the numbers didn't change which is positive. At the meeting we were able to scrutinise the report and accounts and recommend to board their approval.

34/17 QPS Escalation Report [12.13 – 12.17]
QPS met after the Audit Committee. It was unable at the meeting to recommend the quality report to the Board and a significant amount of work has been undertaken subsequently to get it to place it can be recommended. The Committee will help to ensure improvements are made in the way the quality report is brought together next year.

The issues from the Committee are as set out in the paper. Good management responses were received and swift actions are being taken regarding PCRs and call recording.

35/17 WWC Escalation Report [12.17 – 12.18]
TH confirmed the issues set out in the paper.

36/17 Any other business [12.18-12.19]
LB confirmed that a few months ago we had a NAO report and asked how this was being considered. JA confirmed that this will be taken at next meeting of the Audit Committee as previously agreed by the Board.

DM reflected on the achievements during May, i.e. end of year report; response to the cyber-attack; EOC/HQ move; in addition to maintaining business as usual. He thanked staff for all their efforts. This was endorsed by RF who expressed that we are moving in the right direction.

37/17 Review of meeting effectiveness

Questions from observers

Question 1 (from Mr G)

"Given that critical care paramedics were introduced by SECAmb over 10 years ago, what clinical audit or other evidence is available on their effectiveness in terms of outcome improvements, either over a period of time or in comparison with other ambulance services in England; whether such evidence has been or is being published in a peer-reviewed journal (as opposed to the report by Dr Ashok Jashapara); and whether other ambulance services have introduced critical care paramedics in the light of SECAmb's experience?"

I'm prompted by the recent public event in Tangmere, and I'd like to stress that I'm not doubting the usefulness of CCPs, only trying to establish the strength of the evidence base.

Response:
FM confirmed that CCPs have been introduced at approx. 8 per year. There has been no audit to test outcomes, although there is a database where all their interactions are logged. Some feedback from the recent trauma networks has been positive; they feel care/outcomes have improved by the intervention of CCPs. Recently, a survey of staff asked whether they felt CCP had benefit. There were 1000 responses and

the feedback was that they think CCPs are there to support them when patients need it, and they would like CCPs to engage more in teaching and reviewing incidents. So in terms of formal audit; no. But we will look at this going forward. In terms of numbers, we have far more CCPs than any other Trust, probably by in excess of 100%.

Mr G was in audience and thanked FM for such detailed response.

Question 2 (Mr N)

"I have just been reading the vision and Strategy section on the web-site and it appears to be way out of date. It refers to three documents.

1. Strategic Plan and Summary Plan 2014-2019
   It is only in draft form, appears to have no owner and an un-controlled document.
2. Clinical Strategy
   It was written by Jane Pateman and Andy Newton and approved by Paul Sutton.
3. Operational Plan 2014-15

In view of the CQC inspections and change in governance procedures this vision and strategy policy is clearly out of date.

My question for the next board meeting is simply in view of the above when can we expect this documentation to be revised.

Response:
JA confirmed that the Operating Plan is agreed annually and will be published soon. The strategy will be published in July which will include clinical aspects.

There being no further business, the meeting closed at 12.30pm

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

Date _____

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	44/17

Name of meeting	Trust Board
Date	29 June 2017
Name of paper	Chief Executive's Report
Executive sponsor	Chief Executive
Author name and role	Daren Mochrie
Synopsis (up to 120 words)	The Chief Executive's Report provides an overview of the key local, regional and national issues involving and impacting on the Trust and the wider ambulance sector.
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S REPORT TO THE TRUST BOARD

June 2017

1. Introduction

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

2. Local issues

2.1 Changes to the Executive Team

2.1.1 On 7th June 2017, the Trust announced that Emma Wadey had decided not to extend her secondment with SECAmb. She is taking an agreed period of study leave to work on her PhD, ahead of returning to a Director role at Sussex Partnership Trust. I would like to thank Emma for the significant contribution she has made during her secondment with us.

2.1.2 The advert for the permanent Director of Nursing & Quality is now live. However, in the interim, I am pleased that, following an interview process, Steve Lennox has agreed to take on the role until a substantive appointment is made, with effect from 12th June 2017. Steve is experienced nurse, has previously worked as Director of Nursing and Quality at London Ambulance Service and most recently, was part of the team working at Hounslow & Richmond Community Healthcare, helping the Trust to significantly improve their CQC rating.

2.1.3 Recruitment to the substantive posts of Director of Operations, Director of HR, Director of Nursing & Quality and Director of Strategy & Business Development is now underway. Interviews are due to take place during July/August 2017.

2.2 New HQ/EOC up-date

2.2.1 Staff have continued to move into the new Trust HQ/EOC at Manor Royal, Crawley during June and the re-location of support staff is now largely complete.

2.2.2 All of EOC teams from Lewes have now moved 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. The first meeting of the Staff User Group for staff based at Crawley has now taken place and is looking to find solutions to any issues with the new building and develop new ways of working.

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 Thefts from Trust vehicles

2.3.1 During June, the Trust has suffered a spate of thefts of equipment from stations and vandalism of vehicles across Kent. We are working closely with Kent Police as they investigate these incidents; at this time, arrests have been made and I would like to thank Kent Police for their support.

2.3.2 In each case, concerted efforts were made by the thieves to break into the premises as they had been left locked and secure. But, especially in light of recent terrorist incidents, all staff have been reminded of the need for extra vigilance around station and vehicle security.

2.4 New Computer Aided Dispatch (CAD) system

2.4.1 Work is continuing on final testing and training on the Trust's new CAD system; the CAD is the system used by Emergency Operations Centre (EOC) staff to assess, prioritise and if necessary dispatch ambulance crews to 999 calls.

2.4.2 Staff at the Trust's Coxheath EOC in Kent will be the first to begin using the new system in early July. Staff in the Trust's new Crawley EOC will be next to begin using the new system from 18th July onwards, with staff currently based in Banstead due to start using the new CAD at the same time as moving to the new Crawley EOC in early September.

2.4.3 The Trust has been using its current CAD system for more than 10 years. A decision was taken by the Trust Board last year to upgrade to a new system in order to improve reliability and performance. A competitive tendering exercise led to Cleric Computer Services being awarded the new contract to implement the new CAD early this year. Feedback from staff training on the new system has been very positive.

2.4.4 In addition to improved reliability and performance, other key benefits of the new system include its ease and speed of use and its flexibility to meet any future needs.

3. Regional issues

3.1 Changes to provision of services at the Kent & Canterbury Hospital

3.1.1 19th June 2017 will see the temporary transfer of trainee (junior) medical doctors from the Kent & Canterbury Hospital, following concerns raised about their training by Health Education England and the Royal Colleges. This means that acute in-patient medical services will also move on 19th June 2017 to the William Harvey Hospital (WHH) at Ashford and the Queen Elizabeth The Queen Mother Hospital (QEQM) at Margate

3.1.2 SECAmb has received additional initial funding to support the need for extra ambulance resources and is working closely with the acute Trust and local commissioners to manage the changes as safely as possible.

4. National issues

4.1 Recent incidents in London

4.1.1 Following the recent terrorist incidents at London Bridge/Borough Market and Finsbury Park and the dreadful fire at Grenfell Tower, I have written to the Chief Executive of London Ambulance Service (LAS), passing on our thoughts and support. SECAmb stood up response teams and were ready to provide support if needed to LAS at the time of each incident, although this was not required.

4.1.2 In light of recent events, we have also continued to review our own major incident and emergency plans, to ensure we are able to respond as needed to any incidents within our area.

5. Recommendation

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

Daren Mochrie QAM, Chief Executive

20th June 2017

Unified Recovery Plan ("URP") Dashboard - ORSG

Extract from Improvement Tracker

Current period of reporting to 16 June 2017
Previous period of reporting to 15 May 2017

Last updated

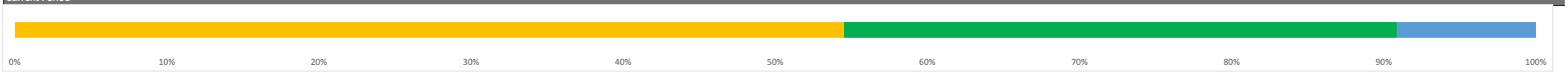
Key:
- Red
- Amber
- Green
- Blue (Project officially closed)

South East Coast Ambulance Service NHS
NHS Foundation Trust

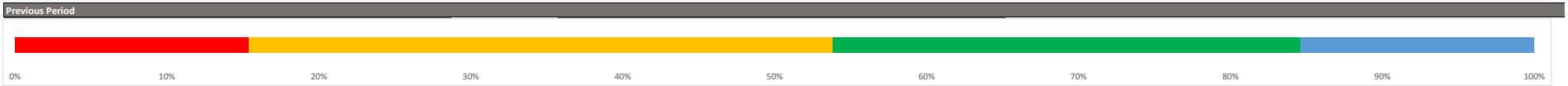
Overall Dashboard

Overall Project Delivery RAG Status (11 Projects)

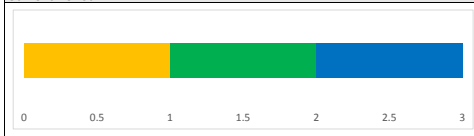
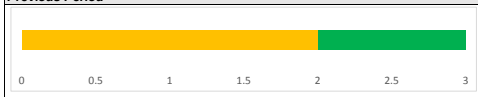
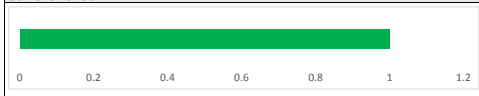
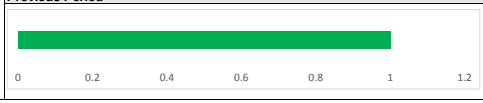
Current Period

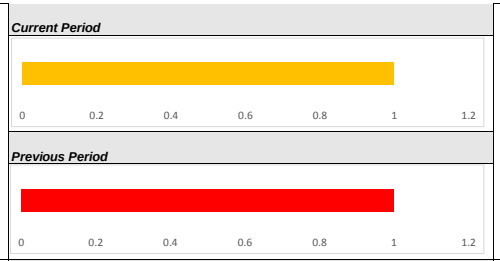
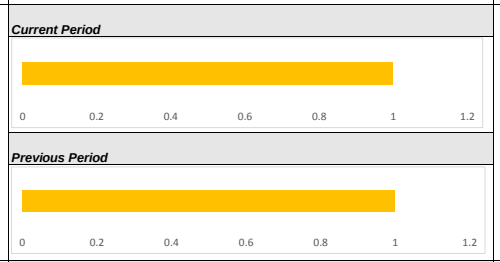
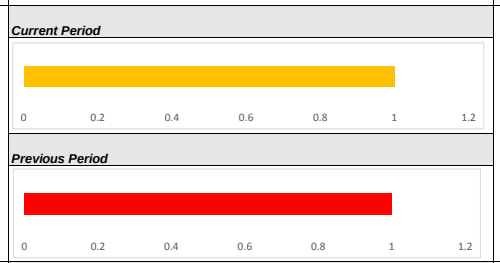
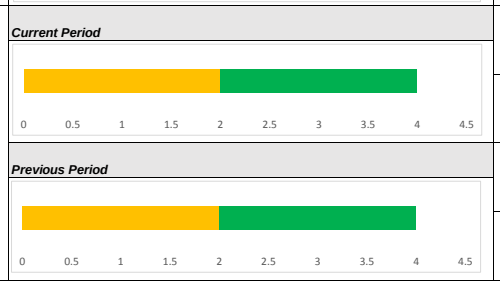


Previous Period



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**	**Completion date**	**High-level Commentary**
999	***3***	*Current Period*  *Previous Period* 	Zoned Cars	Blue	Green	Chris Stamp	Joe Garcia	26/04/2017	The Zone cars project is now officially closed and has proved beneficial to operational performance and will be adopted across the entire Trust in due course. The Increased Hear & Treat project is now in the process of being re scoped with a number of revised initiatives to be included in the new plan; a project lead has been assigned and will be supported by the Programme Management Office during the complete project lifecycle. The Reduced Hospital Turnaround project has progressed well with all A & E's except for East Surrey adopting the new policy; further actions to monitor improvements from the policy will continue through to September and beyond and will report on improvement data next period.
			Increased Hear and Treat responses	Amber	Amber	Scott Thorney	Joe Garcia	To be re scoped	
			Reduced hospital turnaround time	Green	Amber	Richard Harker	Joe Garcia	29/09/2017	
HQ	***1***	*Current Period*  *Previous Period* 	HQ Move / EOC Move	Green	Green	Ibrahim Razak	Steve Graham	31/10/2017	Project has progressed at pace and has focused on the relocation of corporate and Lewes EOC staff. 97% of corporate staff have now been relocated 2 weeks ahead of schedule. Lewes EOC operations moved into Crawley on 24th May and were fully functional with no significant issues or risks to patient safety. EOC is fully operational with no issues to report. Work has started on the decommissioning of Lewes and is due to complete on 30th June.

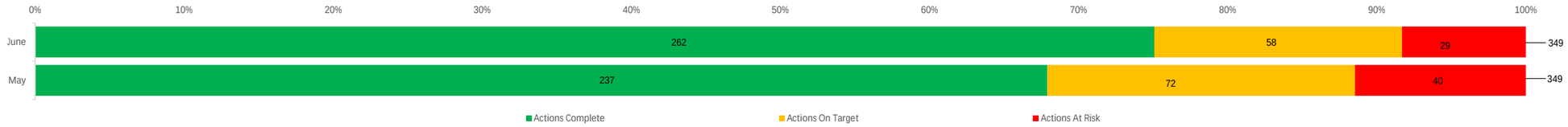
EPCR	***1***		Electronic Patient Clinical Records ("EPCR").	Amber	Red	Edyta Suszek	Jon Amos	29/03/2018	Core project team is now in place which has moved the project status from Red to Amber. In addition, the onboarding of ipads has increased from 53% in last reporting period to 73%. Additional roadshows and drop in sessions will be held in June and July to help achieve the target of to 90% by 27th July. Testing of the new App is continuing with a target for deployment of the upgrade scheduled for 27th June.
OU Restructure	***1***		OU Restructure (formerly "OU Leadership")	Amber	Amber	Sonia Belsey	Joe Garcia	30/11/2017	It is anticipated that the project will be closed and handed over to BAU. A Project Board will be held on 19 June to discuss next steps .
New CAD	***1***		Implementation of new CAD	Amber	Red	Phil Smith	Jon Amos	01/10/2017	Core system Infrastructure builds (across Coxheath and Banstead EOC's) and a session for internal 'Cleric' testing of Infrastructure builds have now been completed. Good progress being made with the core system functionality with minimal issues being reported through testing and training, Cleric continue to work to provide amended or new functionality. The next system update has been released to the Trust and is currently in test. Go Live for Coxheath decision to be made 28/06/17 and Go Live plan to be approved by 23/06/17. The Project has moved from Red to Amber following a re-baselining of the Project Plan; however all contingency time has now been utilised.
Culture / Workforce	***4***		Refreshing Values (formerly Improving Staff Engagement)	Amber	Amber	Steve Singer	Steve Graham	tbc	Good progress made for the reporting period in developing a draft programme of work around Culture and Organisational Development with an OD Steering group established and chaired by the Director of HR. It is envisaged that current projects will be reviewed to align with the overarching plan within the next period. Progress on the refreshing values project has stalled pending agreement on the approach. Updating HR policies progress impacted by team capacity constraints. Good progress made with embedding the appraisal system. Work continues with the Leadership development programme; likely to be embedded into BAU next period
			Updating HR Policies & Procedures	Amber	Amber	Karen Lavender	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		

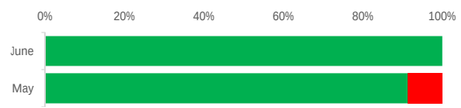
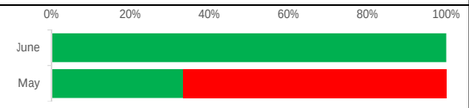
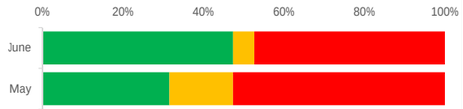
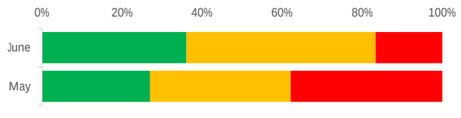
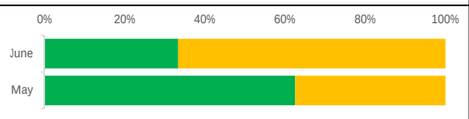
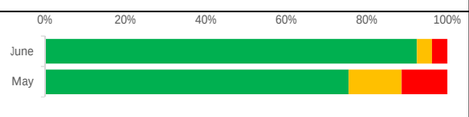
Closure Reporting

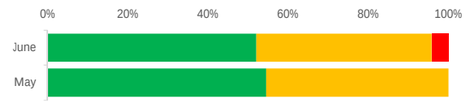
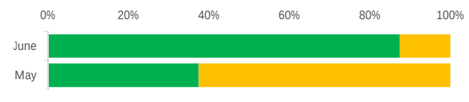
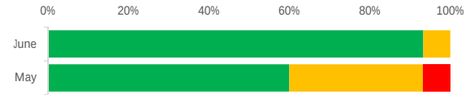
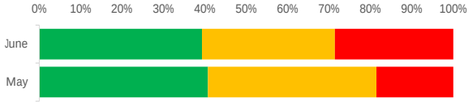
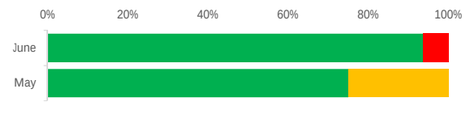
Workstream	Project	Executive sponsor	Project lead	Date project officially closed	Review date	Rationale for closure	Handover to BAU
999	Zoned Cars	Joe Garcia	Chris Stamp	26/04/2017	05/05/2017	This project has demonstrated that when the resource remains in the response zone the intended benefits to operational performance are realised and will be adopted across the entire Trust in due course. This project has provided the framework for further Zoned car use and should be reassessed for implementation of further Zoned cars as the new CAD, ARP and altered system plan come to fruition.	Weekly meetings are held by the Regional Operations Managers ("ROM's"), Zoned cars are discussed including local plans for deployment and review of performance. Expand capability of monitoring performance in order to capture performance contribution directly attributed by zonal cars and review Zonal cars as individual performance contributing level through reviewing performance against normal SRV.

South East Coast Ambulance Service - CQC Must Do Improvement Tracker

CQC Dashboard - 15 June 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
Safe	Security	2. Security Improvement Plan	Complete		0	Adam Graham	Joe Garcia	All actions within the security improvement plan have now been completed. The key objectives for this period have been to publish the findings of the 2016/17 quarter four site security audits and finalise the revised draft security procedures ready for consultation. The consultation and approval process for the security procedures will be managed outside of the programme and within the security service. This action plan will be submitted for formal closure within the next period.	01/05/2017 *Estimated to now be complete by 30/05/2017*
	IT	3.0 CAD Improvement Plan	Handed over to the New CAD project		0	Mark Chivers	Jon Amos	Efforts to stabilise the gazetteer within the current CAD have not been successful. However, this is being superseded with the implementation of the new CAD system, which will resolve the issues currently being experienced. On these grounds implementation of the new CAD system is being prioritised. As a result, this action plan has been closed and a formal handover to the New CAD Implementation project has taken place. For further detail on progress with the installation of the new CAD, please refer to the ORSG Board Report.	01/10/2017
	Incidents	7. Incident and SI Reporting Improvement Plan	At Risk		9	Sara Songhurst	Steve Lennox	Steady progress has been made with the delivery of this improvement plan. Key drivers behind this include the development of a serious incident policy and supporting procedure, and the Datix Manager commencing employment with the Trust. The Datix Manager has provided the much needed capacity and expertise to resolve the challenges being experienced with the Datix system. Key at-risk actions relate to delays with resolving the incidents backlog and maximising the functionality of the Datix system. A key priority for the next period will be to re-scope this action plan, splitting Datix from the incidents and SIs improvements required. This is discussed in more detail below.	01/05/2017 *Estimated to now be complete by 31/08/2017*
	Medicines	14.0 Medicines Management Improvement Plan	At Risk		6	Carol-Anne Davis-Jones	Fionna Moore	With recent appointments to vacant posts, the medicines management team has had more capacity to deliver on the improvement plan. However, ongoing capacity constraints within the medicines packing team. Key areas of progress within the period include reviewing the controlled drugs policy, updating the patient group directives, enhancing key management of drug cabinets on vehicles and improving medicines waste processes. The increase in on-target actions relates to a review of timeframes undertaken to establish a more realistic timeline for completion. While progress is being made, this area remains at-risk due to the fragility of the service and the volume of issues identified that require improvement. This is discussed in more detail below.	31/08/2017 Estimated to now be complete by 30/11/2017
	Patient records	15.0 Patient Records Improvement Plan	At Risk		0	Fiona Wray	Fionna Moore	A priority for this period has been resolving the challenges associated with reconciling approximately 9% of PCRs with an incident number. A snapshot audit has identified challenges with the accuracy of recording incident numbers and the validation process used for reconciling PCRs to incident numbers. To understand these issues further an independent internal audit is being commissioned. In the meantime, the project team has rolled out shift incident envelopes across the Trust as a tool to securely record and store all PCRs. The increase in on-target actions relate to the re-scoping of parts of this project to ensure all issues are appropriately addressed. The risks and mitigating actions for this project are discussed in more detail below.	01/05/2017 *Estimated to now be complete by 31/08/2017*
	Safeguarding	1. Safeguarding Improvement Plan	On Target		2	Sara Songhurst	Steve Lennox	With over 90% of actions completed, this project is nearing closure. Remaining actions relate to the development of a work plan for the implementation of the safeguarding strategy and working with HR to finalise the Managing Allegations Against Staff policy. These actions are expected to be completed within the next period, along with formal closure of the project.	01/06/2017

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
Effective	Outcomes	9.0 Outcomes Improvement Plan - Take action to improve outcomes for patients who receive care and treatment	On Target		2	Andy Collen	Fionna Moore	This action plan continues to evolve with the key priorities for the Trust around clinical outcomes. Within this period a number of key areas have been successfully closed relating to End of Life Care and CQUIN (see below for more detail). The growth in on-target actions relates to re-scoping of the AQI project, with the Trust appointing a cardiac arrest consultant paramedic to lead on improvements in this space. The at-risk actions relate to delays with the implementation of the ASHICE process (clinician to clinician patient handover using radio). However, this is driven by the need to clarify the governance and audit around the process change.	30/03/2018
Responsive	Scheduling	13. Safe Resource Dispatch	On Target		0	Chris Stamp	Joe Garcia	A key element of this action plan has been the revision of the Incident and Deployment policy, which has been approved by JPF and is due to be published in the near future. The project lead is working with the communications team and operational colleagues to plan the roll out of the policy. However, this will be managed through BAU. The only outstanding action relates to finalising the intermediate tier policy, which has been submitted to JPF for comment. It is expected that this project will be submitted for formal closure within the next period.	30/09/2017
Well-led	Governance	6.0A Corporate Governance	On Target		0	Peter Lee	Daren Mochrie	Over 90% of actions of the original plan are now complete, with key achievements for this period including the completion of the Trust Strategy, and the development of the risk management implementation plan. The only remaining action relates to ongoing Director recruitment, which will be managed through BAU. However, given issues identified with the management of out of date policies, and the need to ensure successful implementation of the risk management strategy, this project will be re-scoped and continued.	31/03/2018
		6.0B Clinical Audit	At Risk		8	Joe Emery	Fionna Moore	This action plan has shifted back into at-risk this month due to capacity constraints within the team delaying further progress on delivery of actions, with a number of deadlines being missed. A key priority for the next period will be to resolve these matters, and move forward with finalising the clinical audit policy, the annual report for 2016/17, and work plan for 2017/18. The risks and mitigating actions for this project are discussed in more detail below.	31/12/2017
	Resourcing	11.0 Staff and resourcing improvement plan	On Target		1	James Pavey	Joe Garcia	This project is nearing closure with over 90% of actions complete. The revised meal break policy has been submitted to JPF for approval, with the final publication being managed through BAU. There are only two outstanding actions, one of which relates to the abstraction management policy, which is at-risk due to delays in progress driven by constrained capacity. The other relates to a review of operational staff rosters which is likely to be managed through BAU in order to align with the revised OTL rosters, established as part of the OU restructure. Confirmation of this will occur through submission of a formal closure document 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	While progress is being made with the medicines management improvement plan, this has been slow due to constraints in capacity which are starting to resolve. However, the action plan remains at-risk due to the fragility of the service and the volume of issues identified that require improvement.	Red	Red	Further action is being taken to bolster the capacity of the medicines team . An additional part-time senior technician is being recruited, and agency staff are being used to support the medicines packing team. In addition to this, a further request has gone out to CCGs for resources to support the required service improvements. The PMO is providing the Chief Pharmacist with project management support to enable the effective management and delivery of this project. Timeframes have been revised to provide realistic objectives to work towards, and progress is being closely monitored through the Quality Steering Group.	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 associated 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. A high-level audit has identified challenges with the accuracy of recording incident numbers and the current validation process used for reconciliation of PCRs to incident numbers	Red	Red	The project lead has reviewed the current methodology used to calculate the number of expected PCRs, and is looking to make some adjustments to provide a more accurate reflection of the unreconciled number. An independent internal audit of the back office reporting within the health records team is due to be commissioned within the next period. The scope has been agreed, and is awaiting final sign-off to proceed. The Trust has rolled out shift incident envelopes as a tool to securely record and store all PCRs. The project team has visited a neighbouring ambulance Trust to understand their processes for validating the accuracy of information on PCRs and are working with operational staff to potentially adopt improvements.	Amber	Fionna Moore	11/08/2017
Safe	7. Incident and SI Reporting Improvement Plan	The Trust still has a significant backlog (~1700) of incidents that have not been finalised. Additionally, ongoing challenges are being experienced with Datix that make the system less user friendly and potentially restrict the volume of incidents logged.	Red	Red	The Datix Manager has commenced employment with the Trust, providing the much needed capacity and expertise to resolve the challenges being experienced with the Datix system. A current state assessment of the system is underway with a report summarising the findings to be submitted the Chief Nurse within the next period. The PMO will provide project management support to the Datix Manager to establish a separate project focused solely on improving the Datix system and rolling this out successfully across the Trust. 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 An initial review and triage of incidents within the backlog continues. This is to identify any incidents 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	Steve Lennox	31/08/2017
Well-led	6.0B Clinical Audit	Capacity constraints within the team have delayed further progress in the delivery of actions, with a number of deadlines being missed. This places the clinical audit action plan at risk of not being delivered and the necessary improvements not being made.	Red	NA	The Medical Director is working with the team to identify a short-term resource to support the delivery of the action plan. Action is also being taken to recruit to the Head of Clinical Audit post, which is currently vacant.	Amber	Fionna Moore	28/07/2017

Summary of project closures

Domain	CQC Work stream	Executive sponsor	Project lead	Date of closure	CQC findings	Rationale for closure	Handover plan to BAU	Next review date
Safe	9.0 Outcomes Improvement Plan - CQUIN	Fionna Moore	Andy Collen	31/05/2017	Take action to improve outcomes for patients who receive care and treatment	In response to the CQC findings, a programme of work was developed to improve the outcomes for patients who come in contact with the Trust. The clinical outcomes programme includes 10 projects, two of which have been closed with the rationale outlined below: CQUIN - actions agreed with commissioners for all four quarters in 2016/17 have now been delivered, with some variance to the original plans agreed in year to align to CQC priorities. End of Life Care - through the use of the IBIS system, end of life care plans are now accessible to paramedics on the road. This includes the DNACPR status of patients, ensuring care provided respects their wishes. This tool has been supported with active education and awareness raising to staff.	CQUIN - Given the overlap between the CQUIN indicators for 2016/17 and that of 2017/18, a new project will be established to support the delivery of objectives. However, this will sit outside of the CQC Improvement Plan moving forward. End of Life Care - With a two year contract agreed with commissioners for the use of IBIS, this service will continue to be available for all staff to use, informing the care they deliver to patients. The project lead will also continue to provide education to clinical staff as part of their permanent post within the Trust.	30/11/2017

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:

1. Good engagement and buy in from Execs and CIP Project Leads. Execs and Project Leads are making time to participate in Financial Sustainability Steering Group meetings, and engaging with the CIP Programme and processes

2. Follow-up to CIPs Governance framework and processes meeting held with NHSI on 14 June to conduct CIP pipeline review and CIP scheme deep-dive. Positive feedback received on progress made in-month (£3.3m increase in fully validated schemes), recognising the further work to be undertaken to develop detailed plans for complex schemes. NHSI plan to return in 3 weeks to review progress. Next Steps from meeting are to:
 a. Agree schemes on the CIP Pipeline Tracker to the Delivery Tracker, where scheme has been fully validated and documentation complete
 b. Complete validation, project mandates and QIA process for schemes with a current status of validated and scoped (excluding those complex schemes noted below)
 c. Engage with senior Operations and Estates personnel to progress Operations, Estates and Make Ready Centre CIP schemes (c.£8.5m).
 d. Ensure that all CIP schemes on the Delivery Tracker include a forecast monthly profile
 e. Continue engagement with CIP Leads to identify additional CIP schemes and support the completion of appropriate documentation (project mandates and QIAs)
 f. Monitor achievement of approved schemes on the Delivery Tracker against month end accounts

2b. Update: Positive meeting held to discuss benefits realisation from the Make Ready and HQ Relocation Programmes. Agreed plans in place for each programme to work through and deliver the savings

3. Delivery tracker in development to monitor CIP project achievement of savings against plan. Initial review of schemes shows £1.8m savings in Month 2 against an a plan of £2.1m.

CIP Opportunity Classification - KEY

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	

Programme Risks

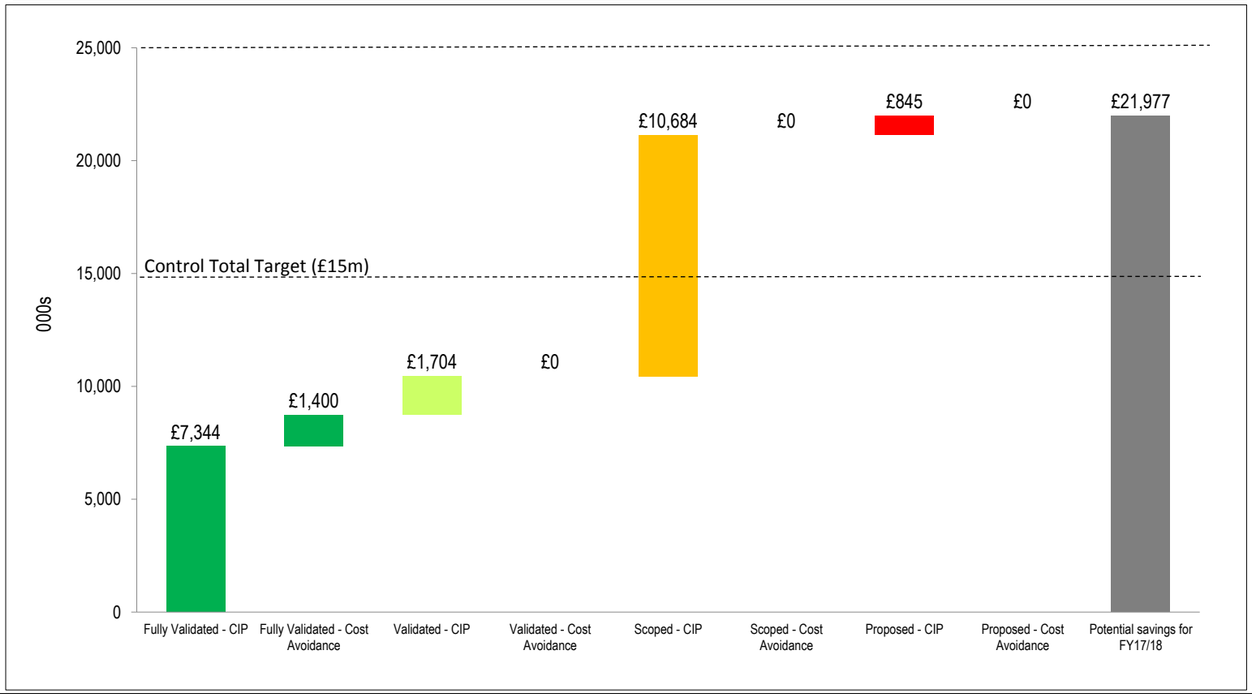
	Risk	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Failure to identify and scope fully the entire planned value (£15m) CIPs schemes, impacting on the Trust's ability to achieve 2017/18 year-end control total of £1m.	Holding twice weekly FSSG meetings coupled with several budget reviews to support budget holders to drive the development and delivery of 2017/18 CIP schemes. CIP pipeline tracker in use to monitor CIP development in line with governance framework.	Kevin Hervey	Amber	Amber	30/06/2017
2	Failure to achieve / deliver the planned entire planned value (£15m) of CIPs schemes, due to part-year effect of some schemes, impacting on the Trust's ability to achieve 2017/18 year-end control total of £1m.	Aiming to identify and validate £19m of full year CIP savings to support achievement / delivery £15m of savings in year.CIP delivery tracker in use to monitor delivery of individual CIP schemes	Kevin Hervey	Red	Red	TBC
3	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 has been developed and signed off by the Execs and SMT. Review of the last 2 years business cases is underway to align the proposed financial benefits to the CIPs programme.	Kevin Hervey	Amber	Amber	30/06/2017

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 sent by DoF to CIP leads reinforcing the need to address CIPs requirements with the PMO. Exec Sponsort and CIP Project Leads have been responsive and engaged with the CIP Programme and processes	Kevin Hervey	Amber	Amber	30/06/2017
2	Impact on FSSG and CIP Quality Assessment Process due to departure of Deputy Chief Nurse	Flagged to Interim Chief Nurse and Exec Team as an issue. Looking to rapidly replace Deputy Chief Nurse to provide input to CIP Quality Assessment and Process	Steve Lennox	Amber	Amber	30/06/2017
3	N/A	N/A	N/A	N/A	N/A	N/A

CIP Pipeline Summary

Category	Fully Validated	Validated	Scoped	Proposed	Grand Total
CIP (000s)	£7,344	£1,704	£10,684	£845	£20,577
Cost Avoidance (000s)	£1,400	£0	£0	£0	£1,400
Grand Total	**£8,744**	**£1,704**	**£10,684**	**£845**	**£21,977**



Fully Validated Schemes (greater than £100k)

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	Meal break payment - implementation of existing policy	Continued work on the Meal Break Policy in relation to the disturbance of staff to RED1 etc.	Pay	£1,560	£352
Cost Avoidance	Trust Wide	Steve Graham	Agency Premiums	Recruitment of Permanent Staff to posts currently being filled by Agency especially senior management posts. Also to resolve those on long term sick.	Pay	£1,400	£99
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	£1,278	£213
CIP	Finance	David Hammond	PTS vehicles	Sale of PTS Vehicles to reduce insurance premium and a reduction in depreciation on PTS vehicles	Non-Pay	£910	£133
CIP	Corporate Expenditure	David Hammond	Reduction in Buildings depreciation	Resulting from reduction in building values of £20,366k due to property revaluation	Non-Pay	£692	£115
CIP	Trust wide	David Hammond	Non-clinical vacancy	Vacancies in non-clinical posts for all or part of the financial year	Pay	£508	£272
CIP	Fleet	Joe Garcia	Fleet Telematics	Decreased fuel consumption through telematics - continued rollout of speed restrictions when not on blue light / emergency calls and reduction in idling	Non-Pay	£500	£83 *
CIP	Trust Wide	Joe Garcia	External Contractors	Savings on external contractor costs	Non-Pay	£418	£70
CIP	Corporate	David Hammond	NHSLA Contribution	Reduced NHSLA contributions covering CNST, LTPS and PES	Non-Pay	£379	£63
CIP	Estates	David Hammond	Facilities Management Contract Renegotiation	£96k Minor Works, £112k Staff	Non-Pay	£208	£35
CIP	KMS 111	Steve Graham	Agency Premiums (111)	Recruitment of long term agency employees, retention to increase % of core staff vs. agency	Pay	£110	£50
CIP	Procurement	David Hammond	Stationery	Rationalisation of stationery procurement	Non-Pay	£110	£18
CIP	Trust Wide	David Hammond	Clinical vacancy	Vacancies in clinical posts for all or part of the financial year	Pay	£107	£57 *
CIP	Combined	Combined	Combined value of fully validated schemes with planned savings of less than £100k)	Combined value of validated schemes with planned savings of less than £100k)	Combined	£564	£130
Total Fully Validated Schemes						**£8,743**	**£1,690**

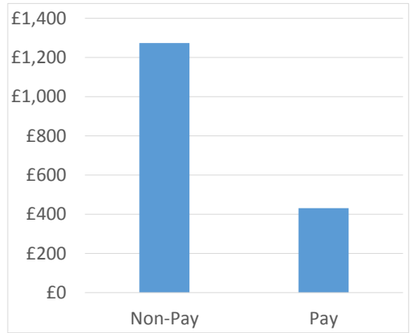
Calculated as proportion of total vacancies on CIP Schedule*

Total Fully Validated Savings Profile (000s)

Validated Schemes (greater than £100k)

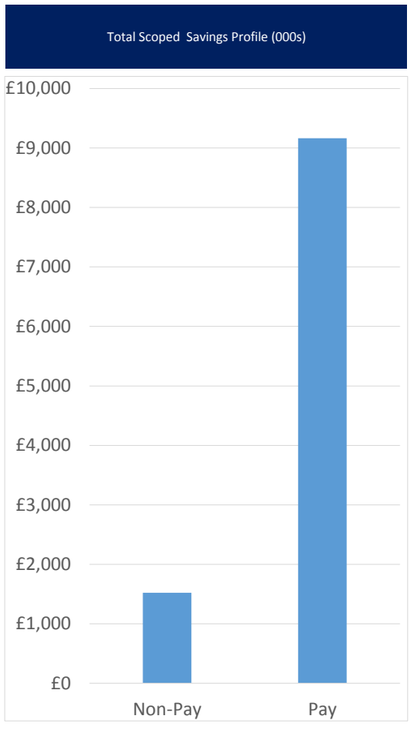
CIP / Cost Avoidance	Busines Area / Cost Centre	Exec Sponsor	Scheme Title	Scheme Description	Spend Category	Planned Savings (000s)	YTD Savings Delivered (000s)
CIP	Fleet / Estates	David Hammond	MRC Churchill contract	Renegotiation of the Churchill Make Ready Contract	Non-Pay	£300	-
CIP	Finance	David Hammond	Top Slice - 1%	Percentage top slice - non pay 1%	Non-Pay	£250	-
CIP	EPCR	David Hammond	EPCR staff cost capitalisation	EPCR staff cost and time to be capitalised and therefore to be removed from IT budget	Pay	£241	-
CIP	Fleet	Joe Garcia	Maintenance - Spares: increase in Imprest Stock	Reduction in owned spares stock from £1.2m in-house to c. £600k in house, therefore reducing stock holding	Non-Pay	£200	-
CIP	KMS 111	Steve Graham	Operational Efficiencies	Reduction in AHT from 507 secs to 472 secs means less Health Advisor resource / Agency staff made permanent eliminating Agency Premium / Better management of sub-contract with Care UK.	Pay	£190	£54
CIP	Procurement	David Hammond	Staff Uniforms - move to national contract	Implementation of the national ambulance uniform on the national contract, which will reduce costs	Non-Pay	£150	-
CIP	Combined	Combined	Combined value of validated schemes with planned savings of less than £100k)	Combined value of validated schemes with planned savings of less than £100k)	Combined	£373	£64
Total Validated Schemes						**£1,704**	**£118**

Total Validated Savings Profile (000s)



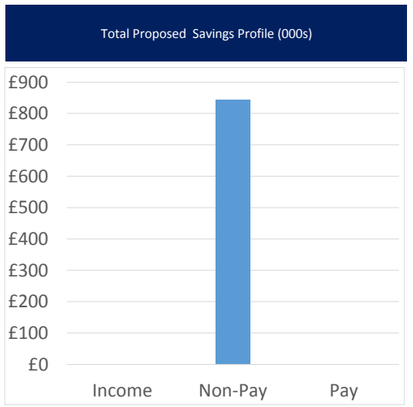
Scoped Schemes (greater than £100k)

CIP / Cost Avoidance	Busines Area / Cost Centre	Exec Sponsor	Scheme Title	Scheme Description	Spend Category	Planned Savings (000s)
CIP	Operations	Joe Garcia	Vacancy factor - non-use of PAPs and overtime	Not to cover vacancies with PAPs and overtime hours. Restrict the use of PAPs to 5%	Pay	£3,816
CIP	Operations	Joe Garcia	Reduction in Job Cycle Time	Reduce job cycle time by 6 and a half minutes (from 71.5 to 65)	Pay	£1,500
CIP	Operations / Fleet / Estates		Benefits of MRC Program	Benefits realisation as outlined in original business cases in respect to Chichester, Polegate and Gatwick	Pay	£1,177
CIP	Operations	Joe Garcia	Allocation and response ratios	Review and reduce allocation and response ratios	Pay	£1,100
CIP	Operations	Joe Garcia	Vacancy Factor - 44 CAT staff	Reduction in CAT staff numbers	Pay	£720
CIP	Estates	David Hammond	Single HQ / EOC: Benefits realisation from ongoing HQ move.	Per Business Case; Reduced Travel; EOC duplication of Posts; Staff Time Efficiencies (not detailed in case). Business case saving of £598k	Non-Pay	£598
CIP	Operations	Joe Garcia	Move PAPs hours to overtime	Reduce PAPs hours and increase overtime	Pay	£450
CIP	Procurement	David Hammond	Contracts management	Renegotiation of contracts to ensure compliance and value for money	Non-Pay	£200
CIP	Procurement	David Hammond	Internal supply chain	Move internal logistics to a just in time process where goods are delivered directly to the requesting location	Non-Pay	£200
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	Operations	Joe Garcia	HART at Gatwick gate	Rent and rates reduction following the vacation of the Gatwick Gate bulling	Non-Pay	£186
CIP	Procurement	David Hammond	Staff Uniforms - review allocation	Review the allocation of staff uniforms with the view to reduce the number and range of items provided to staff as standard	Non-Pay	£100
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	Operations / Fleet / Estates		Benefits of MRC Program - Ashford	Benefits realisation at Ashford	Pay	£100
CIP	Operations / Fleet / Estates		Benefits of MRC Program - Paddock Wood	Benefits realisation at Paddock Wood	Pay	£100
CIP	Combined	Combined	Combined value of scoped schemes with planned savings of less than £100k)	Combined value of scoped schemes with planned savings of less than £100k)	Combined	£137
Total Scoped Schemes						**£10,684**



Proposed CIP Schemes with indicative planned savings

CIP / Cost Avoidance	Busines Area / Cost Centre	Exec Sponsor	Scheme Title	Scheme Description	Spend Category	Planned Savings (000s)
CIP	Trust wide	Daren Mochrie	Benefits realisation followed up and full accountability	Thorough review of Business Cases approved within past twelve months, with all benefits accounted for.	Non-Pay	£500
CIP	Finance	David Hammond	Dilapidations provision	Dilapidations provision - Lewes office. Ensure no duplication with HQ benefits	Non-Pay	£170
CIP	Procurement	David Hammond	Procurement / Contracts Review	Review of all existing contracts, especially where none exists, to deliver better value through re-tendering:	Non-Pay	£100
CIP	EOC	Joe Garcia	EOC office equipment	Reduction in EOC office equipment	Non-Pay	£40
CIP	EOC	Joe Garcia	EOC external consultancy	EOC external consultancy	Non-Pay	£25
CIP	Procurement	David Hammond	Procurement / Contracts Review	Equipment purchase reduction	Non-Pay	£10
Total proposed schemes						£845



South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	

Name of meeting	Trust Board
Date	23 June 2017
Name of paper	Unified Recovery Plan Delivery Progress
Responsible Executive	Jon Amos, Acting Director of Strategy and Business Development
Author	Eileen Sanderson, Head of PMO
Synopsis	This paper provides a brief update on the progress made in relation to improving the Programme Management Office (PMO) and governance structure to oversee programme delivery. There is also a summary of the current position of each of the three Steering Groups; Organisational Recovery, Quality (i.e. CQC must do's) and Financial Sustainability, which form the Unified Recovery Plan (URP). More detail is provided through separate dashboards on the Organisational Recovery, Finance and CQC Programmes.
Recommendations, decisions or actions sought	What is the board / committee being asked to consider and/or decide? • To note the continued progress made in relation to the PMO improvements • To review the dashboards to be fully sighted on the current progress of the URP and to consider the risks highlighted.

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

Unified Recovery Plan Delivery Progress

1. Introduction

1.1 This paper provides the Board with a summary of the progress of the Programme Management Office (PMO) and highlights a number of updates in relation to governance.

1.2 There is also a summary of the progress of the three Programmes; Organisational Recovery, Financial Sustainability and Quality (i.e. CQC must do's), which form the Unified Recovery Plan (URP). Additional information is provided within three separate dashboards, for Organisational Recovery, Finance and Quality, to show what has been achieved since the last reporting period up to 16th June 2017.

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

2.0 PMO and Governance update

2.1 The three Steering Groups continue to work well, with much better visibility and grip of the projects. The focus continues to be on driving delivery through greater accountability and management of issues and risks. The highlight report system has been fully implemented and is being successfully utilised, which is supporting effective project management and assurances through the governance structures. Best practice of PMO is now beginning to be recognised across the Trust and the PMO team are supporting other teams to improve project governance broader than the URP.

2.2 The Trust wide strategy is currently being refreshed and work will continue in the coming weeks to ensure that the programmes are aligned to the strategy to ensure that the projects deliver the required benefits. This will also include the review of the governance structure for each of the Steering Groups.

2.3 The HQ/CAD/Informatics Programme Board no longer meets due to 90% of corporate staff now moved into Crawley. Progress on the last phase of the Trust HQ project will be reported through the Organisational Recovery Steering Group to ensure that focus is given to areas to ensure appropriate ownership and accountability. The capturing of lessons learnt is underway and will be ready to be shared in the coming weeks through the Trust HQ Project Board.

2.4 The Trust HQ Project Board will continue to meet to ensure plans are put in place in terms of Business Continuity post February 2018. A workshop was recently held with stakeholders to explore options and the recommendations put forward after the event is to be discussed at the Trust HQ Project Board on 20th June 2017.

2.5 The CAD and Informatics projects are now moving into implementation phase, the reporting of progress will continue on a weekly basis to the Turnaround Executive to ensure any risks and issues are managed appropriately.

2.6 The Programme Risk Log for all the URP programmes has now been migrated to Datix, which is the software the Trust has adopted to use to monitor and track risks. The Turnaround Executive will continue to review top key risks on a weekly basis which are escalated via the Steering Groups.

2.7 A Culture and Organisational Development project plan has now been developed and the Steering Group first meets on Thursday 22nd June 2017 to track and monitor progress.

3.0 URP Progress and Risks

Organisational Recovery Programme

3.1 Significant progress has been made with the Hospital Turnaround project. All hospitals have now gone live as of Monday 19th June 2017 except for East Surrey Hospital. A project closure form will be developed in the coming weeks to move this project into Business As Usual.

3.2 The EPCR project has been re-scoped to take into consideration the outstanding elements from the original project, transition into BAU and the iPad benefits realisation which were two supplementary mandates. The Change Control Form has been completed for review by the Executive Sponsor and then will go to Organisational Recovery Steering for formal sign off.

3.3 The deployment of iPads is making good progress and is in line to meet the planned trajectory of 90% by 21st July 2017 and 98% by 30th November 2017. The onboarding of ipads has increased from 53% in last reporting period to 73%. The Project Board now meets on a regular basis with good representation from key stakeholders, including Operations.

3.4 After a period of pause due to capacity, progress is now being made with the Hear and Treat Project. A Clinical Lead has now been appointed to take on a six month contract to move this project forward, with support from the PMO. The focus will be to rapidly establish a project board and understand project requirements.

CAD

3.5 The CAD project board, now meet weekly, is sighted on all outstanding deliverables and risks and is confident that appropriate mitigations are in place. The final go-live plan for the Coxheath implementation on the 4 July 2017 will be approved on 23 June 2017 with the go/no-go decision taken for ratification by the Board on 28 June 2017. The project does however remain on a tight timeline to achieve the first go-live and any new risks or delays could impact this.

3.6 The previous risk in relation to support from 3TC beyond the 26 July 2017 has now been resolved with a support agreement in place until October 2017.

Whilst the CAD implementation will support future efficiency and improved performance there will be a series of dips in performance during Q2 as a result of each of the three

go-live periods. This is estimated to be in the range of 3.8-5.0% impact on R2 for each dip in performance based on time to dispatch increasing between 15-45 seconds. Plans are in place to mitigate this impact for each go-live.

3.8 Good progress is being made with the core system functionality, resulting in minimal issues being reported through testing and training. Cleric continue to work to provide amended or new functionality. The next system update has been released to the Trust and is currently in test phase. Staff training is on track with most staff passing the course. Training for Crawley go live has now commenced and will be completed by end of June 2017.

Quality Programme

3.9 Progress continues to be made in relation to the 16 CQC must and should dos. From the 16 identified, 10 will be put forward to the Steering Group later this month for formal closure, with some of the remaining six potentially being re-scoped to ensure that the projects continue to deliver the desired outcomes and benefits.

4.0 Over the last few months, the Clinical Outcomes scope of work has made significant process with the programme now having 9 'live' work streams, 4 projects going through project closure and 3 projects nearing completion. The focus moving forward will be around reduction in activity of Frequent Callers and AQI Improvements.

Financial Sustainability

4.1 Formal meetings of the Financial Sustainability Steering Group (FSSG) have continued to take place on a weekly basis with CIP Leads to report on delivery progress as well as to ensure achievement of designated CIP schemes. Other meetings with CIP Leads and budget holders take place outside the FSSG sessions in order to identify and progress CIP ideas.

4.2 A CIP Delivery tracker is currently in development to monitor CIP project achievement of savings against plan. Initial review of schemes shows £1.8m savings in Month 2 against the plan of £2.1m. Programme risks and issues are summarised in the dashboard.

5.0 URP dashboards

5.1 Further detail for each of the steering groups is provided through a series of dashboards (see appendix B); Organisational Recovery, Financial Sustainability (CIP focus) and Quality (CQC Must Do) together with exception reports.

6.0 Summary

6.1 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.

6.2 The Board has been provided with a suite of dashboards to provide a status update of the Programme across the Organisational Recovery, Quality and Financial Sustainability Steering Groups with supporting narrative to expand upon risk areas.

7.0 Recommendation

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

7.2 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

		Item No	47/17
Name of meeting	Board of Directors		
Date	29 June 2017		
Name of paper	Certification on Training for Governors		
Executive sponsor	Company Secretary		
Author name and role	Peter Lee, Company Secretary		
Recommendation	The Board is asked to confirm the statement set out below, which is recommended following consultation with the Council of Governors.		

Certification on Training for Governors

Introduction
Foundation Trusts are required by their License to make an annual self-declaration in relation to the legal obligation to ensure that Governors receive appropriate training. The wording of the declaration is:

*The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their r*ole.

Until this year, this declaration was submitted to NHS Improvement. However, Foundation Trusts are now only required to publish the statement on its website.

Proposed declaration: Confirmed

Rationale: In order to ensure that prospective Governors understand the role, responsibilities and commitments, and have a chance to ask questions and meet Trust leaders, pre-nomination drop in sessions have been held for prospective Governors in different areas of the region. These sessions provided an introductory overview of the Trust, the role, and in particular the time commitment and expectations of Governors.

Once elected/appointed, Governors attended a one-day induction with the Corporate Governance Team, welcoming Governors to the Trust, setting out the key challenges, risks and opportunities for the Trust, and exploring the role of the Governor and the Council in more detail.

Governors were offered the opportunity throughout the year to observe in our Emergency Operations Centres and/or on our vehicles, in order to meet and hear from staff and learn more about the Trust's services and how they are delivered.

The Trust utilises the NHS Providers GovernWell training, offering all Governors the chance to attend courses of their choice. In addition, the Trust offered a bespoke training session, attended

by around 10 Governors, which was structured around holding to account and effective questioning. Feedback about all GovernWell events has been very positive. In addition, two Governors took up a place at the annual NHS Providers Governor Focus Conference and provided a report back to the full Council about the presentations and discussions held.

The Trust has established a Governor Development Committee, which meets six times a year and provides Governors with a forum to raise any issues or concerns with their training, the information they are provided with, or the support they get from the Trust. This gives the Trust a degree of comfort about whether Governors feel content with the training and support offered, and enables Governors to raise any issues in a timely manner.

Finally, discursive sessions were held after each general Council meeting. These typically involve sessions with Non-Executive Directors to explore issues relating to performance and improvement. Annual planning and strategic discussions were also held in this forum.

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Item No	48/17
Name of meeting	Audit Committee		
Date	21 June 2017		
Name of paper	Corporate Governance Statement		
Executive sponsor	Chief Executive		
Author name and role	Peter Lee, Company Secretary		
Recommendation	The Board is asked to confirm / not confirm the statements, as set out below.		

Corporate Governance Statement 2017-18

Introduction
Foundation Trusts are required by their License (FT condition 4) to make an annual self-declaration in relation to a number of statements – the Corporate Governance Statement. Until this year, this declaration was submitted to NHS Improvement. However, Foundation Trusts are now only required to publish the statement on its website.

Unlike the annual governance statement which narrates what has been in place during the financial year, the corporate governance statement confirms the position against at the point in time it is considered. The executive has carefully considered the proposed submissions as set out below and recommends the same to the Board for approval.

Corporate Governance Statement (declaration 4)
This declaration consists of *six statements* and the Board is required to either state 'Confirmed' or 'Not confirmed' for each, describing any related risks and mitigations.

Statement 1.
The Board is satisfied that the Trust applies those principles, systems and standards of good governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

Proposed declaration: Confirmed

Rationale: In 2016 the Board did not confirm this statement on the basis that NHSI imposed an additional licence condition on the Trust in respect of 'Improved Governance'. However, over the past 12 months, despite there still being some weaknesses in our governance arrangements, the steps taken to improve governance are considered sufficient to be able to confirm this statement. For example, the Board committee structure has been revised to ensure much clearer emphasis on assurance, testing areas against the framework agreed by the Board (the assurance purview).

A number of examples during the year demonstrates the effectiveness of this committee structure, e.g. medicines management and patient care records.

In addition, steps were taken to ensure better focus by the executive supported through the introduction of an Executive Management Board, Executive Risk and Assurance Group, and Executive Strategy Group. The management structure which supports the executive was also revised and overlaying this was the introduction of a 'turnaround executive' supported by a much enhanced PMO; ensuring improved grip and control of the Unified Recovery Plan.

Statement 2.
The Board has regard to such guidance on corporate governance as may be issued from time to time.

Proposed declaration: Confirmed

Rationale: In 2016 the Board did not confirm this statement on the basis that whilst it did have regard to such guidance, the application was insufficiently robust. However, for some of the reasons described above, the Trust now applies such guidance more robustly, in particular the Code of Governance, and in-year guidance such as that relating to use of agency and consultants.

Statement 3.
The Board is satisfied that the Trust implements:
a. Effective Board and committee structures;
b. Clear Responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
c. Clear reporting lines and accountabilities throughout its organisation

Proposed declaration: Confirmed

Rationale:
a. The Board agreed a new committee structure in July 2016, which has been increasingly effective as outlined above.
b. The role of the Board Committees was clarified ensuring focus on assurance, and drawing a clear distinction between this function and the function of management.
c. As a result of a. and b. the reporting lines for the Board and its committees is clear – there is no longer any board sub-committees which in the past caused confusion between the role and reporting lines of the Board and management. The executive is now clearly accountable to the Board and to the independent non-executive directors through the board committee structure. Accountabilities were also clarified through the executive restructure and revision to portfolios, and the Board has updated Standing Financial Instructions / Scheme of Delegation.

Statement 4.
The Board is satisfied that the Trust effectively implements systems and/or processes:
(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) To ensure compliance with healthcare standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions;
(d) For effective financial decision making management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);

(e) *To obtain and disseminate accurate, comprehensive and timely and up to date information for Board and Committee decision-making;*
(f) *To identify and manage (including but not restricted to managing through forward plans) material risks to compliance with the conditions of its license;*
(g) *To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery;*
(h) *To ensure compliance with all applicable legal requirements.*

Proposed declaration: Not Confirmed

Rationale: Although some aspects of this statement could be confirmed, taken in the context of some of the current challenges in meeting healthcare standards, as set out in the URP (resulting in the Trust's continued special measures status), this statement cannot be confirmed.

Statement 5.
The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and or processes to ensure:
(a) *That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;*
(b) *That the Board's planning and decision making processes take timely and appropriate account of quality of care considerations;*
(c) *The collection of accurate, comprehensive and up to date information on quality of care;*
(d) *That the Board receives and takes into account accurate, comprehensive and up to date information on quality of care;*
(e) *That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources;*
(f) *That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.*

Proposed declaration: Not confirmed

Rationale: In addition to statement 4, the Trust continues to be challenged on its data as demonstrated through the current work to improve the integrated performance report.

Statement 6.
The Board is satisfied that there are systems to ensure that the Trust has personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with its NHS provider licence.

Proposed declaration: Not Confirmed

Rationale to be included as explanation: Despite the systems in place, gaps and capacity at senior management level continues to be a challenge.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	49/17

Name of meeting	Board Meeting
Date	29th June 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

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

The Trust'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 May agreed with the SECAMB commissioners for Quarter 1 of 2017. Our performance dashboard has been realigned to measure against this agreed performance trajectory, though national performance targets continue to be shown on charts for reference.

The Trust had a challenging month for call answer, seeing an in month drop to 79.2%, a worse position than recent months. This drop was driven primarily by a short term resourcing demand as a result of training for our Computer Aided Dispatch (CAD) system. This performance is expected to improve in line with the transition to the new CAD. Demand in 999 continued to be below the expected activity plan for the month but continued to be above the demand seen last year.

KMSS 111 saw a decrease in call answer performance, in line with services nationally but saw low number of abandoned calls and good clinical performance.

The Trust continues to perform at above national average for cardiac arrest return of spontaneous circulation but below national average for survival to discharge from hospital. Work continues to review the quality of data for our clinical outcome reporting.

Incident reporting saw an increase in May of 5.7%, which demonstrates an improvement in reporting culture, however, the Trust continues to perform poorly in respect of review and closure of incidents, although overall the backlog has reduced from 2000 to 1600 in month. Harm is now a mandatory field to trigger escalation to the weekly serious incident decision group. 1.9% of incidents have been reported to the National Reporting and Learning System (NRLS). Serious incident reporting remains consistent at 6 reported incidents for the month, 1 did not have direct patient contact. 5 were patient related of these 4 breached our internal duty of candour target of 10 working days primarily due to the lateness to assign the incident. There has been zero compliance for 72 hour reporting to the CCG for the same reason.

Safeguarding level 3 compliance reached 14% against a trajectory of 17%.

82.5% of complaints have been responded to on time. 11 actual complaints breached the 25 days. Patient care, staff concern and timeliness remain the top 3 complaint themes.

Vacancies have increased in month as a result of plans to increase the operational establishment and some corporate and support service posts being on hold pending restructures. Appraisal and mandatory training metrics are being revised to reflect new systems and methods of counting. Continued positive progress has been made in reducing agency staff.

The Trust incurred a deficit of £0.5m in the month, which was £0.1m favourable to plan. The structural deficit produced an expected shortfall of £0.6m but this was more than offset by the £0.7m favourable position on actual performance. In the year to date the deficit is £1.4m, in line with plan. The cumulative impact of the structural gap is an adverse variance to plan of £1.1m. This has been fully offset by other net favourable variances. The forecast for the full year is unchanged from the plan, a deficit of £1.0m.

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1. SECAMB Regulation Statistics

ID	KPI	Value
R1(b)	Use of Resources Metric (Financial Risk Rating)	3
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 May 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		**2.1%**	2.0%		**2.1%**	2.0%
Wf-1B	Long Term Sickness - Rate		**2.9%**	2.8%		**2.9%**	2.8%
Wf-2	Staff Appraisals	15.0%	Data unavailable	12.8%			
Wf-3	Mandatory Training Compliance (All Courses)	30.0%	Data unavailable	36.4%			
Wf-4	Total injuries		Data unavailable	61		Data unavailable	120
Wf-5	Total physical assaults		Data unavailable	18		Data unavailable	33
Wf-6	Vacancies (Total WTE)		**415**	381		Not Relevant	
Wf-7	Annual Rolling Staff Turnover		**20.6%**	16.8%			
Wf-8	Reported Bullying & Harassment Cases		**1**			**2**	
Wf-9	Cases of Whistle Blowing		**0**			**0**	

2.2. Workforce Commentary

2.2.1. Vacancies for this month have risen to give an overall vacancy rate of 11.85%, with the vacancy rate in the operational services showing the greatest increase to 10.85%. This is due to an increased in establishment responding to the anticipated increase in activity.

2.2.2. The activity in the recruitment team continues to map the gaps in the operational team and are on track to deliver the required recruits during this year.

2.2.3. There are a couple of planned re-structures within the corporate services areas, following which recruit into those vacancies will be targeted.

2.2.4. There is an increase in the turnover rate following the transfer of the PTS service, with this team removed from the figures turnover remains constant at 16.34%.

2.2.5. The roll out of the online appraisal system, Actus, continues with the expectation that all of the workforce will be live on the system by the end of June 2017. However, the introduction of the system has impacted on our ability to report on completion rates for the following reasons:

a. Not all staff are live on Actus, although we expect this to happen before the end of June.
b. There are a combination of paper and online appraisals being completed (approximately 150 of each) but not all are complete. Actus allows for various stages of progress from draft through agreed to completed. We currently only report on completed appraisals but this may not capture the level of activity taking place.
c. Appraisal and Objectives are independent modules within Actus. To give a true flavour of activity, we may need to report on both.
d. Similarly, it is possible to have mass uploads of objectives for a particular role (e.g. call handler) which will appear as published objectives for all call handlers but not necessarily mean a conversation has taken place. We need to work round this scenario.
e. We can also publish data for 1-2-1 activity, learning and development and career progression data, but at present we only report on whether an appraisal has been completed or not.

2.2.6. We will revise the reporting methodology over the next month to reflect the best way to accurately report to the Board.

2.2.7. A new year for mandatory training has commenced and a new process for recording training has been introduce. This has led to some reporting problems, so we have not reported statutory and mandatory training for this month. The issues will be resolved in time for reporting next month.

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

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

2.2.10. The Friends and Family Test 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 has now closed with over 600 responses and a response rate of 19%, compared with the 200 received in total for the Q4 FFT survey. An analysis of the data is underway and will be reported to staff.

2.2.11. The move of HQ staff to Nexus House is now complete. The Banstead EOC staff are on track to move in September 2017.

2.3. Workforce Charts

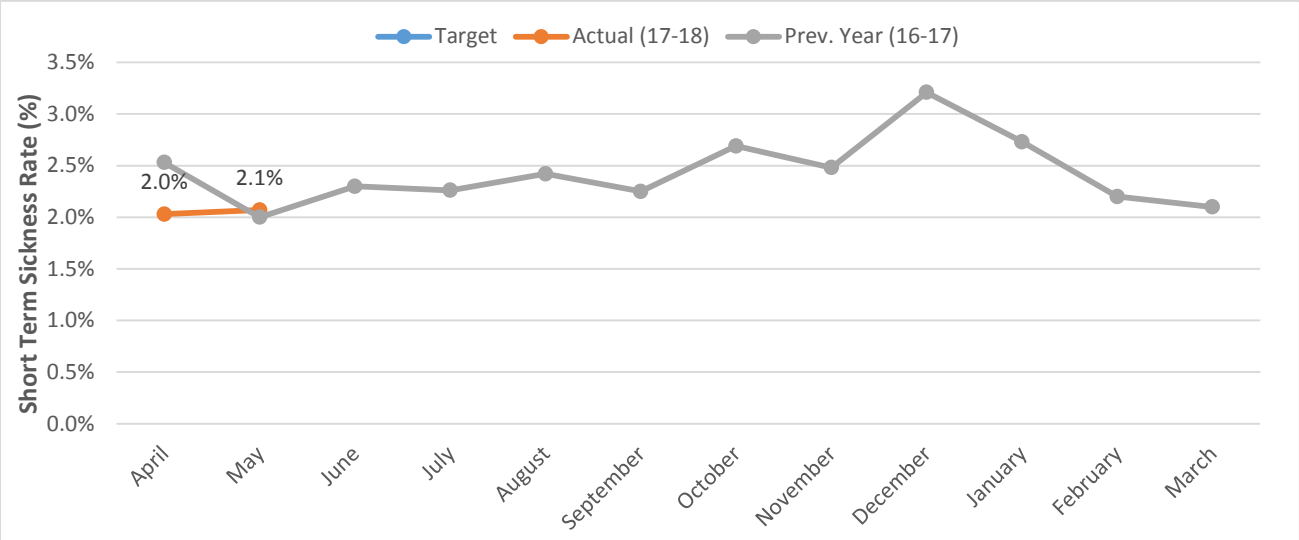

Figure Wf-1A - Short Term Sickness Rate

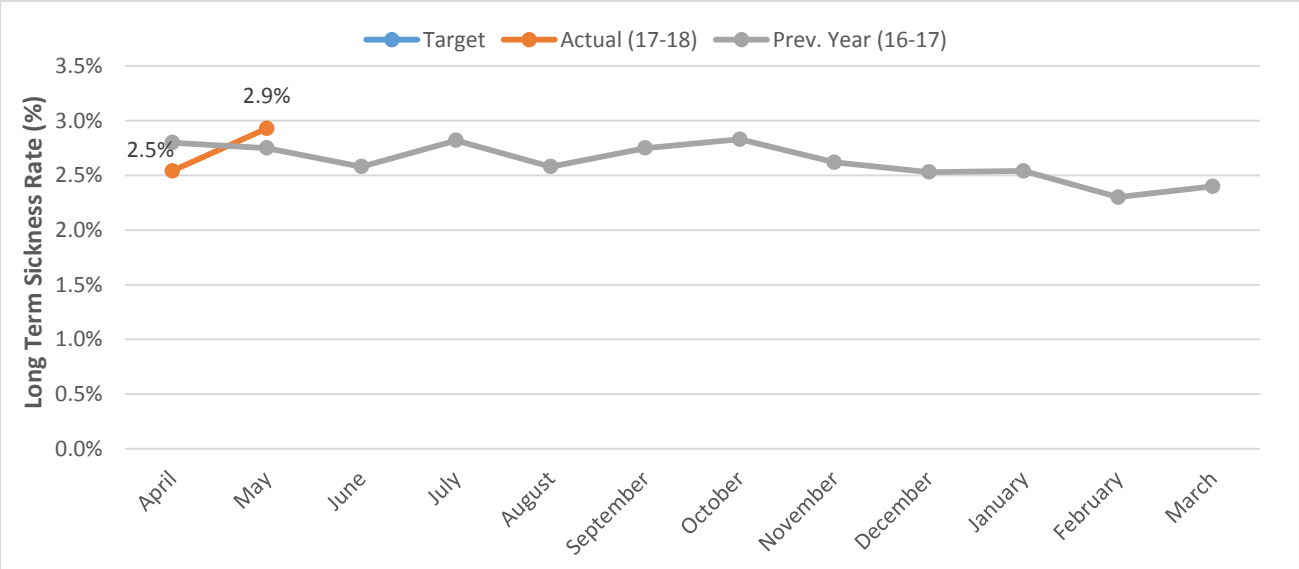

Figure Wf-1B - Long Term Sickness – Rate

Unavailable
Figure Wf-2 - Staff Appraisals

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

Unavailable
Figure Wf-4 - Total injuries.
Unavailable
Figure Wf-5 - Total physical assaults.

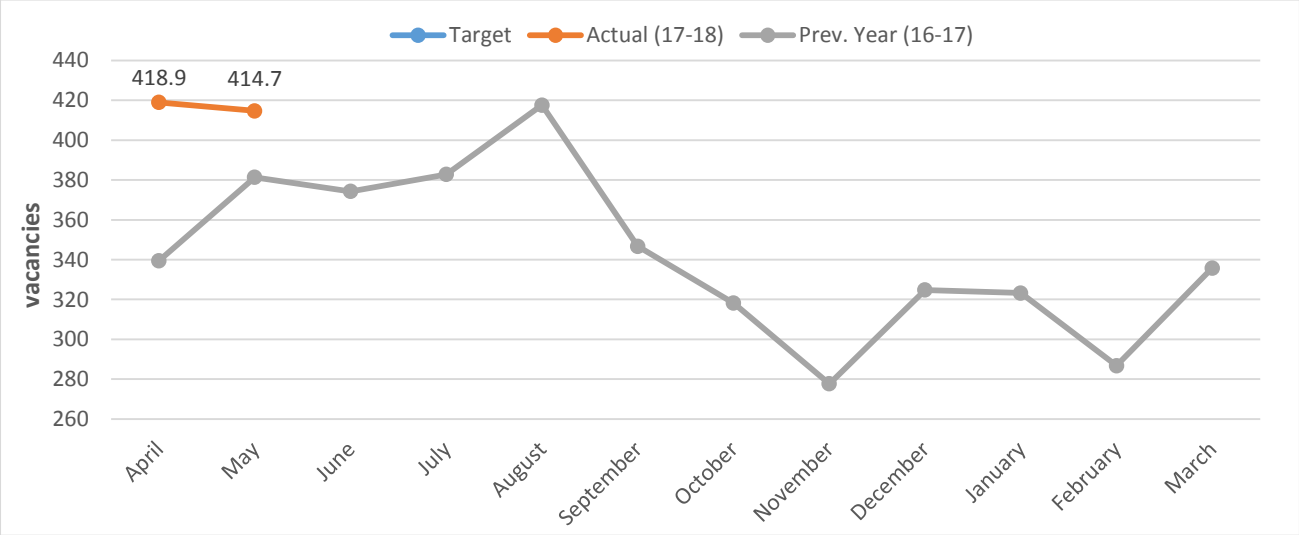

Figure Wf-6 - Vacancies (Total WTE)

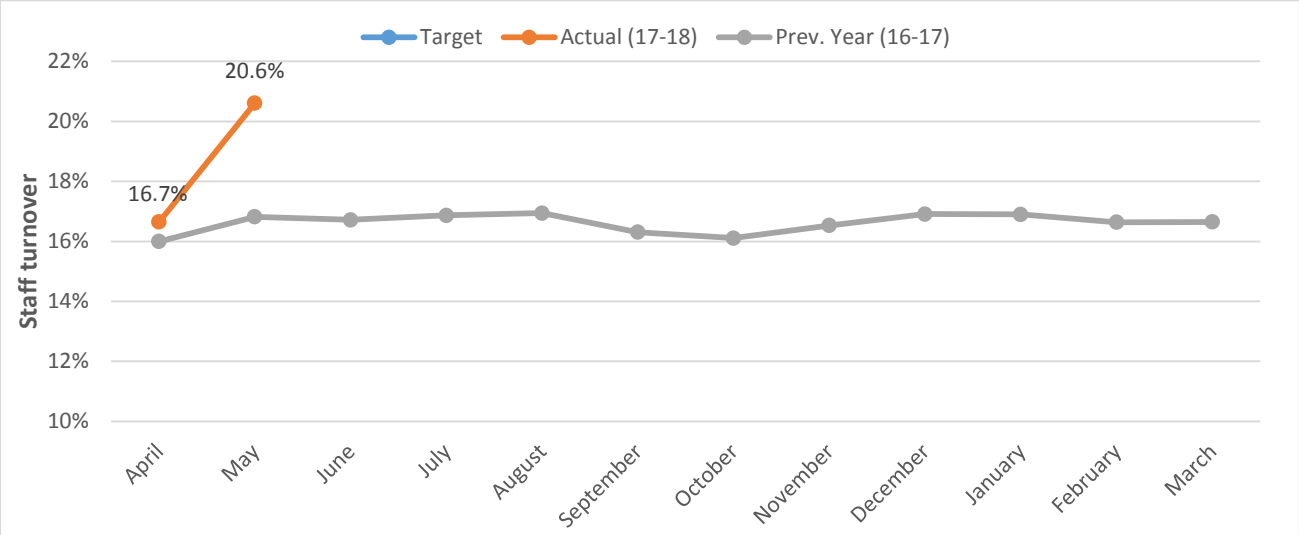

Figure Wf-7 - Annual Rolling Staff Turnover

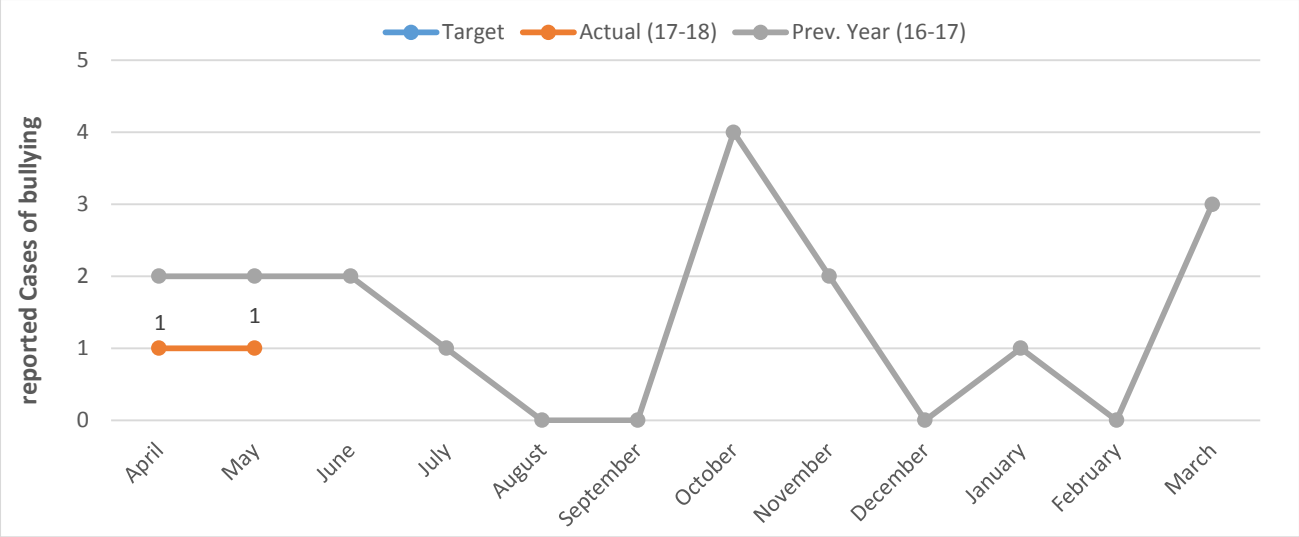

Figure Wf-8 - Reported Bullying & Harassment Cases

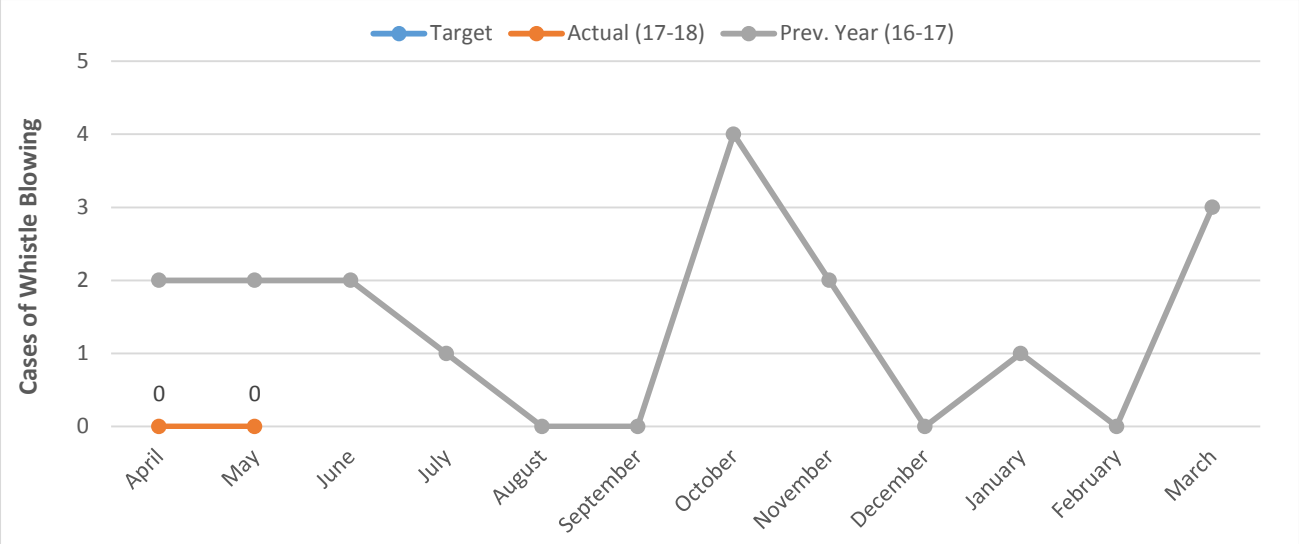

Figure Wf-9 - Cases of Whistle Blowing

3. Operational Performance

3.1. Operational Performance Summary

3.1.1. SECAmb's 999 response time performance was under the national targets however SECAmb did achieve a level of performance that was above the new trajectories for Red 1, Red 2 and Red 19 for May agreed with the SECAMB commissioners for Quarter 1 of 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 May were slightly worse when compared with the April level of delays, and still well 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 0.85% below the agreed plan with commissioners for the month and above last year's YTD position for the same month. SECAmb has had a difficult month with its call answer performance in May, the key challenge being the need to abstract staff on two sites at once to prepare for the new Command & Control Computer Aided Dispatch (CAD) platform delivery that commences in July. There is no reduction in the workforce numbers and this is considered to be a transitory resourcing pressure until the CAD is fully deployed at the beginning of September.

3.1.4. KMSS 111 has also had a more challenging month with its monthly operational performance, returning an "Answered in 60" Service Level Agreement (SLA) KPI of 91.1% in May. Despite the underlying increase 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, KMSS 111 still remain the front runner compared with the 5 reference organisations that provide a similar 999/111service.

3.2. Operational Performance Scorecard

Operational Performance Scorecard:- Data From May 2017

ID	KPI	Current Month (Plan*)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan*)	YTD (Actual)	YTD (Prev. Yr.)
999-1	Red 1 response <8 min	67.20%	**68.1%**	66.4%		**69.4%**	68.3%
999-2	Red 2 response <8 min	51.10%	**52.4%**	56.8%		**54.2%**	58.4%
999-3	Red 19 Transport <19 min	88.10%	**89.6%**	91.0%		**90.4%**	91.7%
999-4	Activity: Actual vs Commissioned	70408	**69812**	68514	137824	**134645**	132654
999-5	Hospital Turn-around Delays (Hrs lost >30 min.)	2082	**5462**	4944	5349	**10377**	9538.2
999-6	Call Pick up within 5 Seconds	90.1%	**79.2%**	64.5%		**84.5%**	70.7%
999-7	CFR Red 1 Unique Performance Contribution	Not available	**1.3%**	Not available		**1.3%**	Not available
999-8	CFR Red 2 Unique Performance Contribution	Not available	**1.3%**	Not available		**1.3%**	Not available
111-1	Total Number of calls offered		**91789**	105522		**191364**	201392
111-2	% answered calls within 60 seconds	95%	**91.1%**	62.6%	65.0%	**93.4%**	63.8%
111-4	Abandoned calls as % of offered after 30 secs	9.0%	**1.0%**	9.1%	9.0%	**0.8%**	**8.7%**
111-5	Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)	72%	**74.0%**	74.0%		**77.2%**	**72.2%**

** 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 less than the level achieved for the April position but above that of the revised May target which has been re-set by commissioners for the Quarter 1 period. The slight reduction in Red 2 performance compared to April was again higher than anticipated trajectory position given the increase in activity compared to the April volume, and this was circa 5000 incidents more than April. Hospital Turnaround delay has been the factor that has had a material impact on this performance position, producing a worsening position to that of April.

3.3.2. Demand was circa 0.85% below the plan agreed with commissioners for the month and still circa 1300 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. No serious clinical incidents have been reported since go live, we have improved to circa 60% plus of Red 1's are being identified during this manual 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, we anticipate an improvement on this position with the introduction of the new Cleric CAD platform.

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 May are above the planned trajectories for this group of responders.

3.3.5. SECAmb has struggled to maintain its Hear and Treat performance for May. This is again an additional pressure brought on by the new CAD development and training and is anticipated to be resolved by September once the CAD has gone live. 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 has fallen significantly compared to that from last month's performance primarily due to the May increase in activity and the additional abstraction necessary to prepare for the deployment of the new CAD platform in July. SECAmb achieved 79.2% in 5 seconds compared to a revised trajectory plan of 92%.

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 May were however worse compared with the hours lost in April, and still remain over double the maximum level agreed with commissioners. May saw 5462 lost hours which was the single biggest impact on our performance trajectory for May. Hospital Turnaround delay is the single most external factor which impacts SECAmb performance and 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, some significant improvements have taken place in some acute Trust's but the changes are not consistent.

3.3.8. May 2017 presented several challenges to Urgent Care providers, including two public holidays and the “malware” cyber-attack which adversely affected so many healthcare providers across the country. As a consequence, KMSS 111’s performance declined in comparison to April, however KMSS 111 returned a Service Level better than the National 111 average for the fourth consecutive month.

3.3.9. On a “Calls Offered” volume of 91,789 KMSS 111 achieved an “Answered in 60 seconds” Service Level Agreement (SLA) of 91.13%. This compared to a service level of 95.51% in April, but KMSS 111 still outperformed the NHS E average of 88.87% for May 2017. The KMSS 111 Abandonment rate of 1.04% also compared favourably with the national rate of 2.31%.

3.3.10. Amongst the operational challenges faced internally KMSS 111 saw emerging rota fill issues, especially in the last week of May which was exacerbated by unusually high levels of sickness. It should be noted that there has been a period of intense call activity recently with four public holidays in the last seven weeks. This was particularly prevalent over the Whitsun weekend when on Saturday 27th and Sunday 28th May, KMSS 111 experienced call demand in excess of 20% above the predicted forecast. This spike in demand was reflected across all 111 providers nationally. The administration of Planned Learning Time (PLT) events by some CCGs continues to cause significant challenges with regards to resource planning; a large PLT closure in late May was deferred by 24 hours without any notification to 111. Although KMSS 111 did subsequently discover this change only 48 hours prior to the PLT, the service managed to adapt its resource with no risk to patient safety. However, the potential risk is evident, and this also had an impact on staff productivity.

3.3.11. The global cyber-attack on Friday 12th May did not directly affect either our operations or infrastructure. Steps were taken to minimise potential disruption; KMSS 111’s system security defended the service successfully against the virus and further IT patches were implemented to increase our resilience. However, the service was adversely affected by a late surge of patient demand on Friday 12th, possibly as a result of media messages prompting patients to call 111 (200 calls above forecast for the day). Over the following week Derbyshire Health United (DHU), a large 111 service provider had persistent IT issues and had to rely upon invoking the NHS E National Contingency, which redirected calls for DHU through other providers. KMSS 111 has formally requested clarity from NHS E with regards to the proportion of calls it should have received following the activation of the NHS E National Contingency, given that the proportion of “national “unknown” calls handled by the service during this period appeared to be disproportionately high. KMSS 111 is still awaiting confirmation that the appropriate proportion of calls was allocated to the service. Following the cyber-attack the service also participated in national 111 conference calls in the week after the attack, co-ordinated by NHS E to provide re-assurance to the Department of Health. Separately North West Ambulance Service (NWAS) activated the NHS E National Contingency in the early evening of 22nd May, for which we again handled an increase in call activity.

3.3.12. In a clinical context, KMSS 111’s Combined Clinical KPI of 73.98% continued to significantly out-perform the NHS E national average clinical KPI by circa 10%. Although KMSS 111’s 999 referral rate climbed to 10.57%, the actual volume of ambulance despatches is on a downward trend. It was also reassuring that the service’s A&E referral rate of 7.24% was again approximately 0.5% below the national average.

3.3.13. In mid-May the Care Quality Commission (CQC) inspected the KMSS 111 service across both contact centres. Although the full reports are expected in July/August (for

both organisations), the initial feedback from the lead inspectors was very positive, citing the significant improvement in “timely access” for patients to the service since the 2016 inspection, when the service was found to Require Improvement overall. The feedback was also positive in the context of the CQC Key Lines of Enquiry (KLOE) domains of Safe, Effective, Responsive, Well Led and Caring, the service being identified as “caring for its staff and patients”.

3.3.14. As part of the KMSS 111 contract transition, in May the clinical Joint Commissioner Provider (JCP) Working Group was initiated, working with representatives of the associate CCG’s, NHS E and other providers to develop pilot projects as we move towards a more integrated care system. These initiatives seek to act as Proofs of Concept for Integrated Urgent Care (IUC) models across the region. Six potential work-streams are currently being scoped and risk assessed. Within the Terms of Reference of the Working Group, KMSS 111 is committed to further innovation in order to improve the Patient Experience and enhance quality care.

3.4. Operational Performance Charts

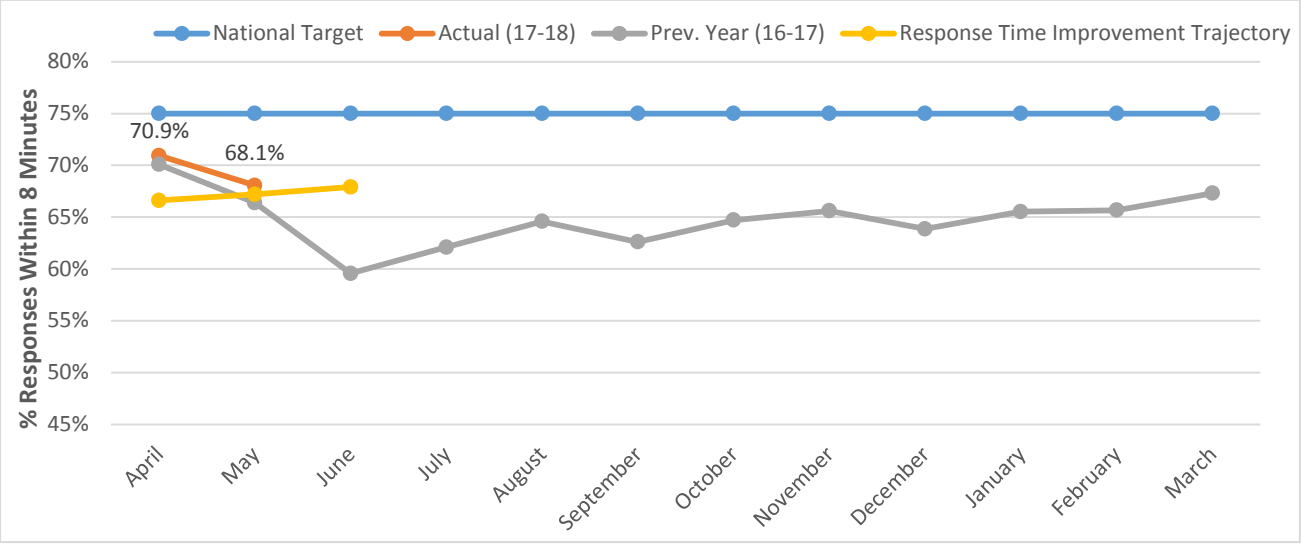

Figure.999-1 - Red 1 response <8 min

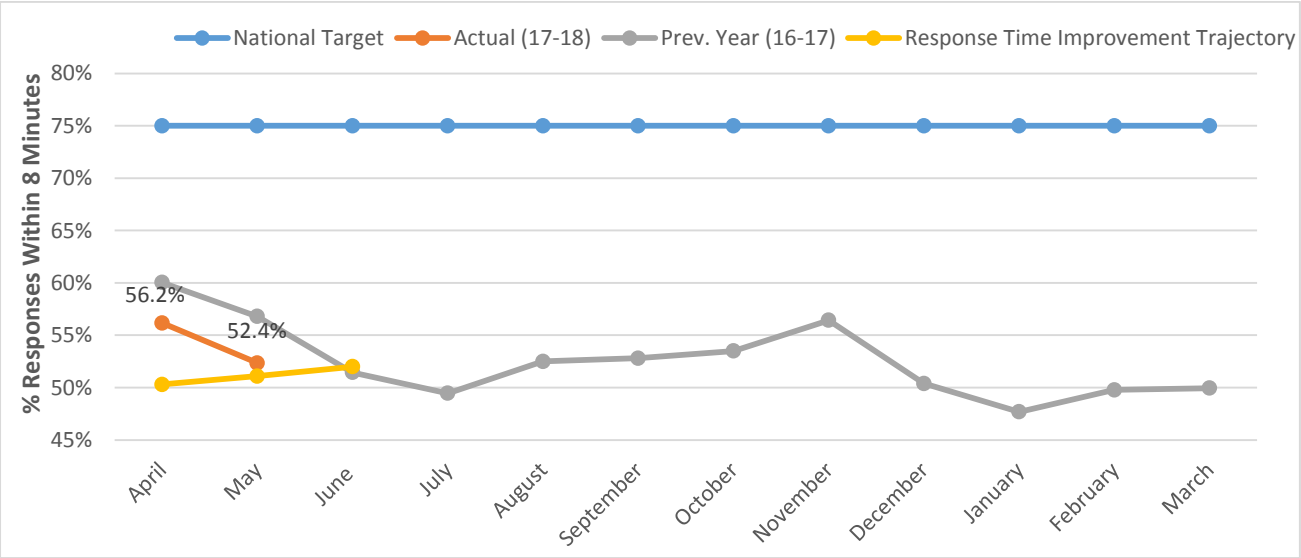

Figure.999-2 - Red 2 response <8 min

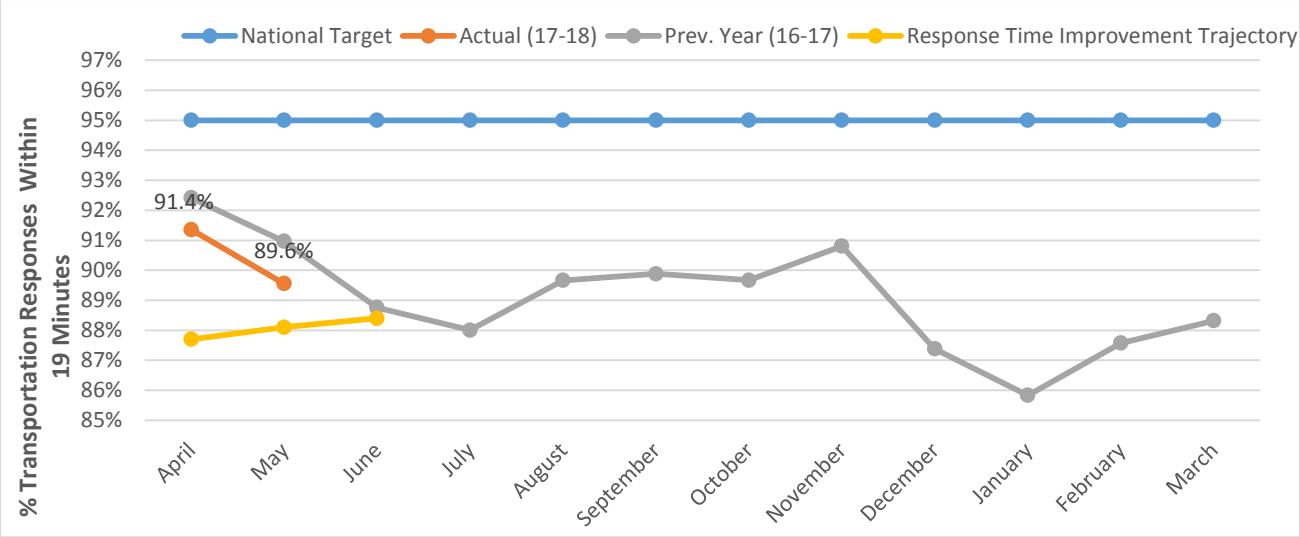

Figure.999-3 - Red 19 Transport <19 min

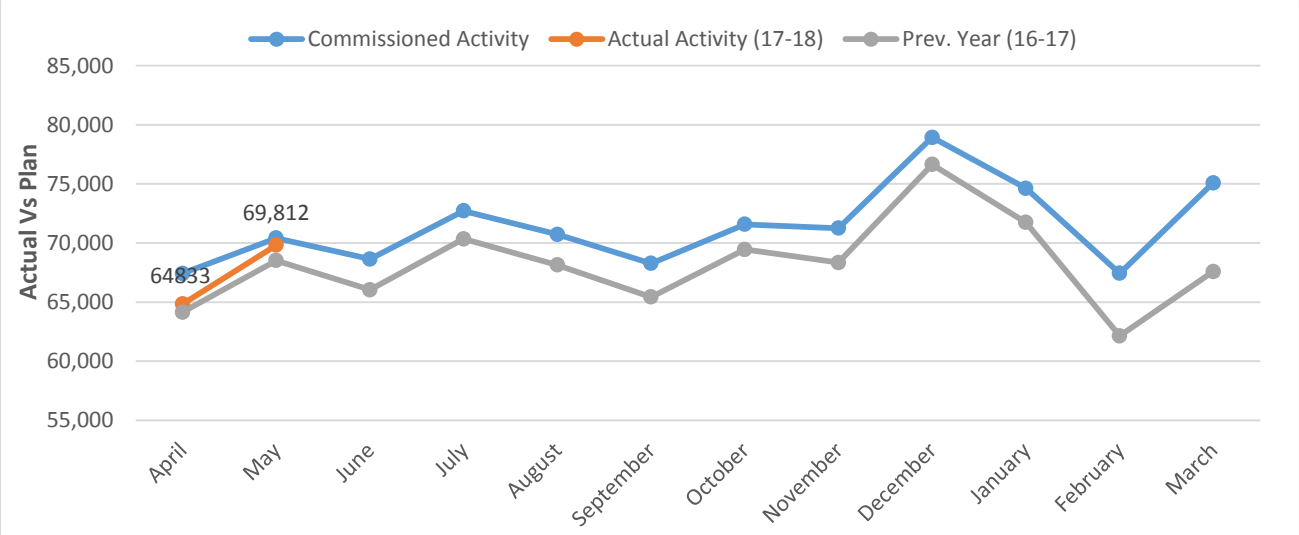

Figure.999-4 - Activity: Actual vs Commissioned

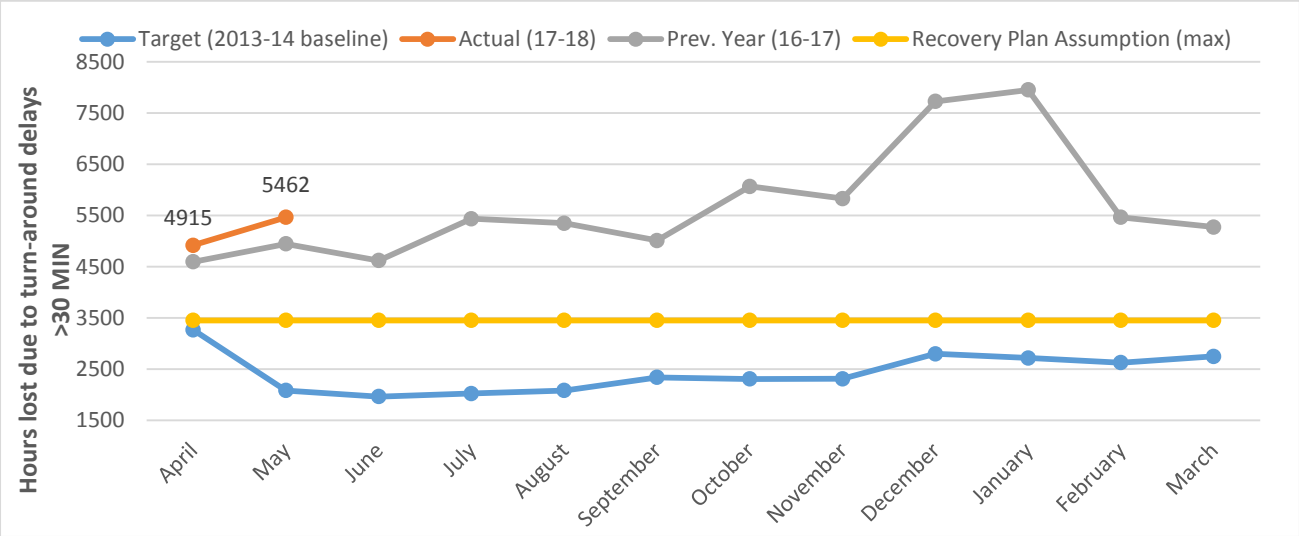

Figure.999-5 - Hospital Turn-around Delays (Hrs lost >30 min.)

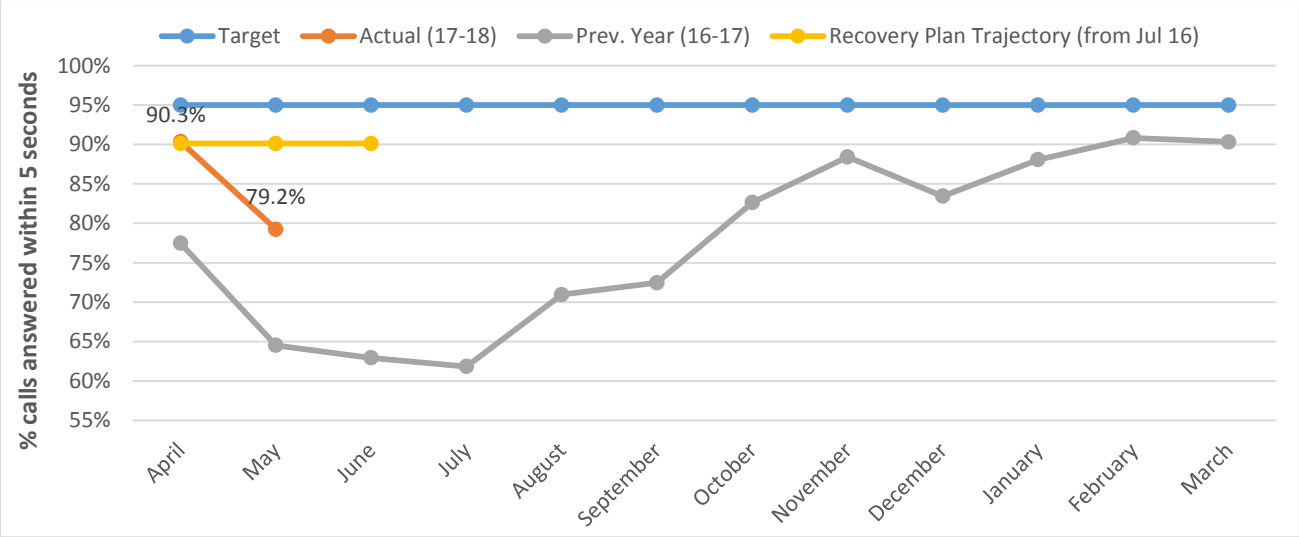

Figure.999-6 - Call Pick up within 5 Seconds

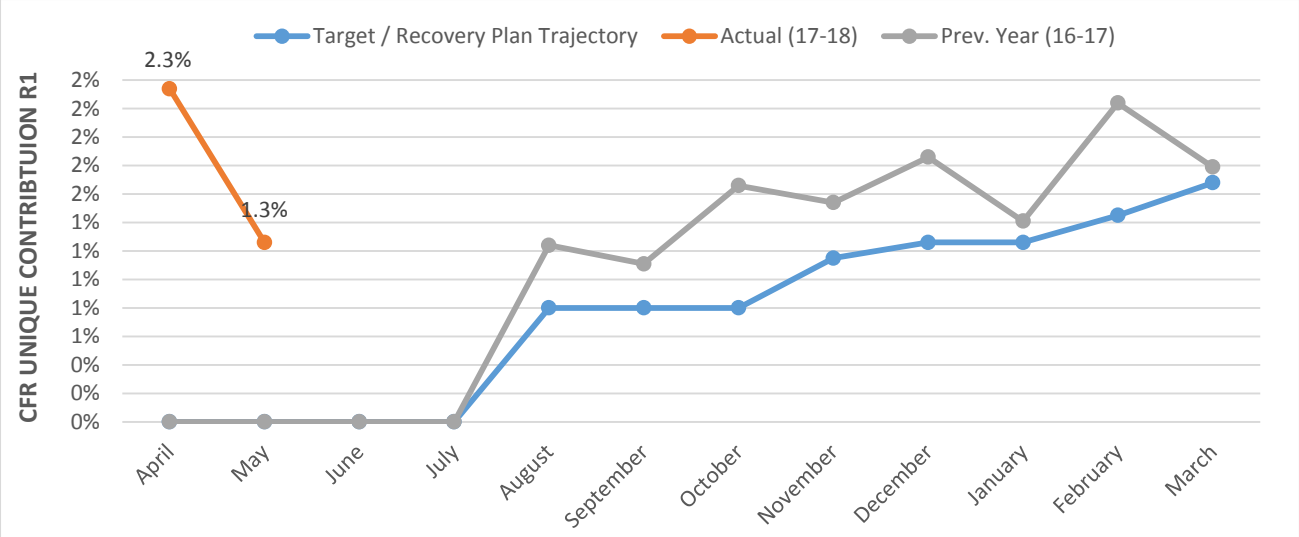

Figure.999-7 - CFR Red 1 Unique Performance Contribution

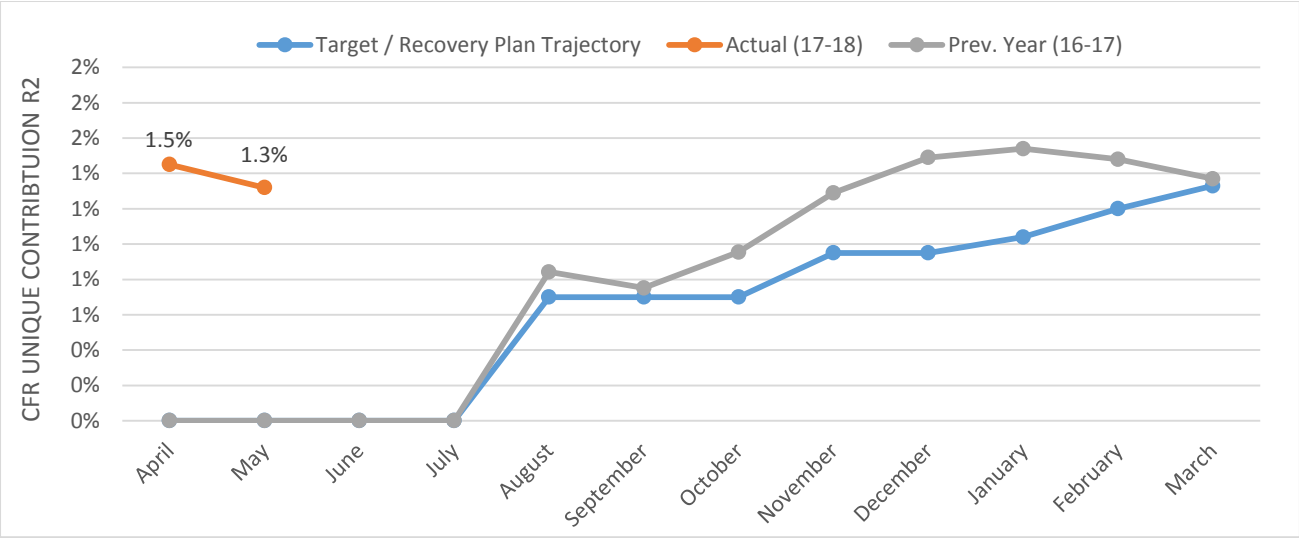

Figure.999-8 - CFR Red 2 Unique Performance Contribution

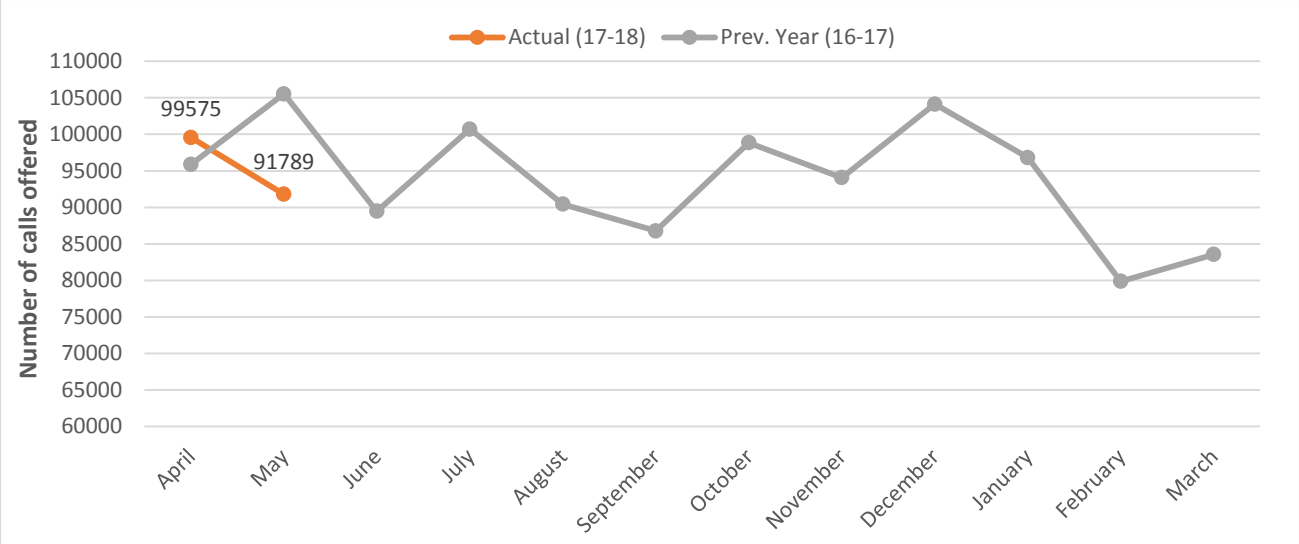

Figure.111-1 - Total Number of calls offered

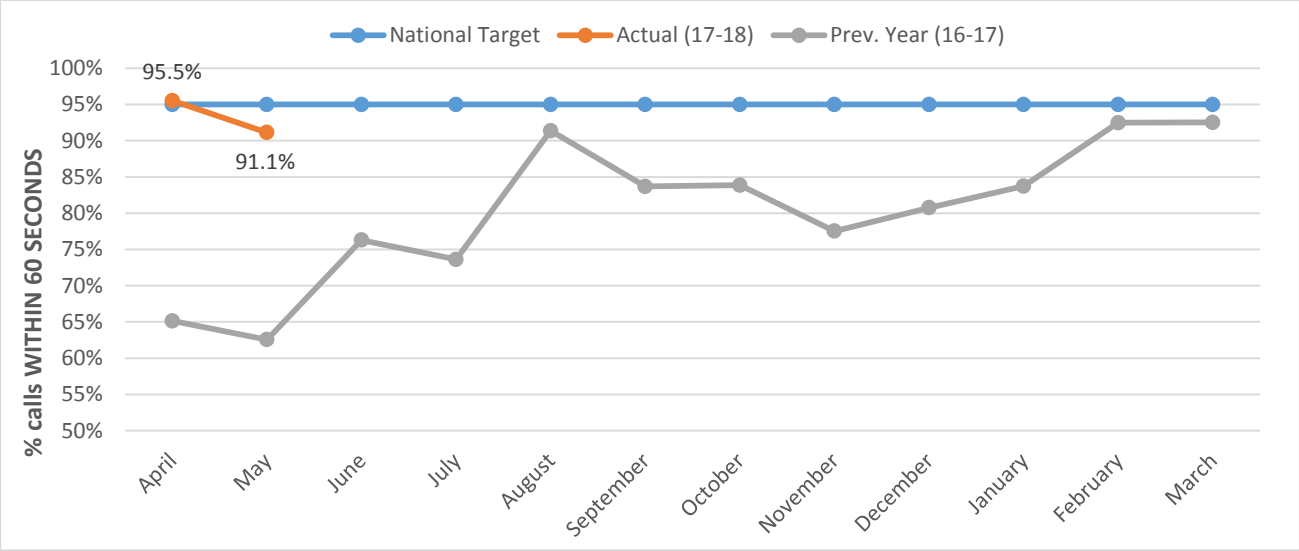

Figure.111-2 - % answered calls within 60 seconds

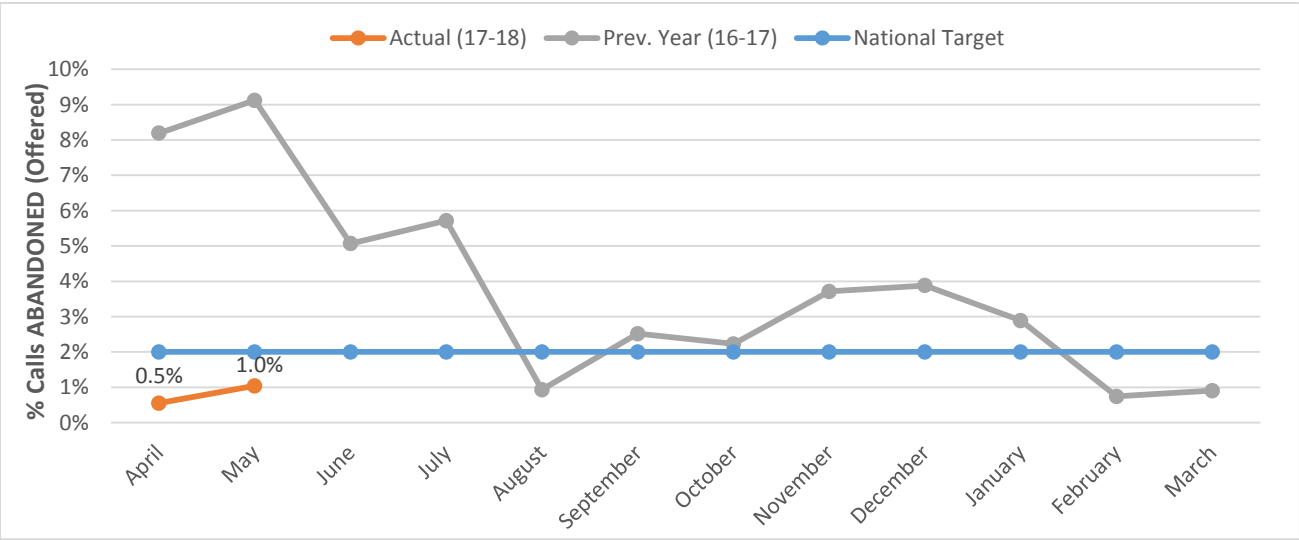

Figure.111-4 - Abandoned calls as % of offered after 30 secs

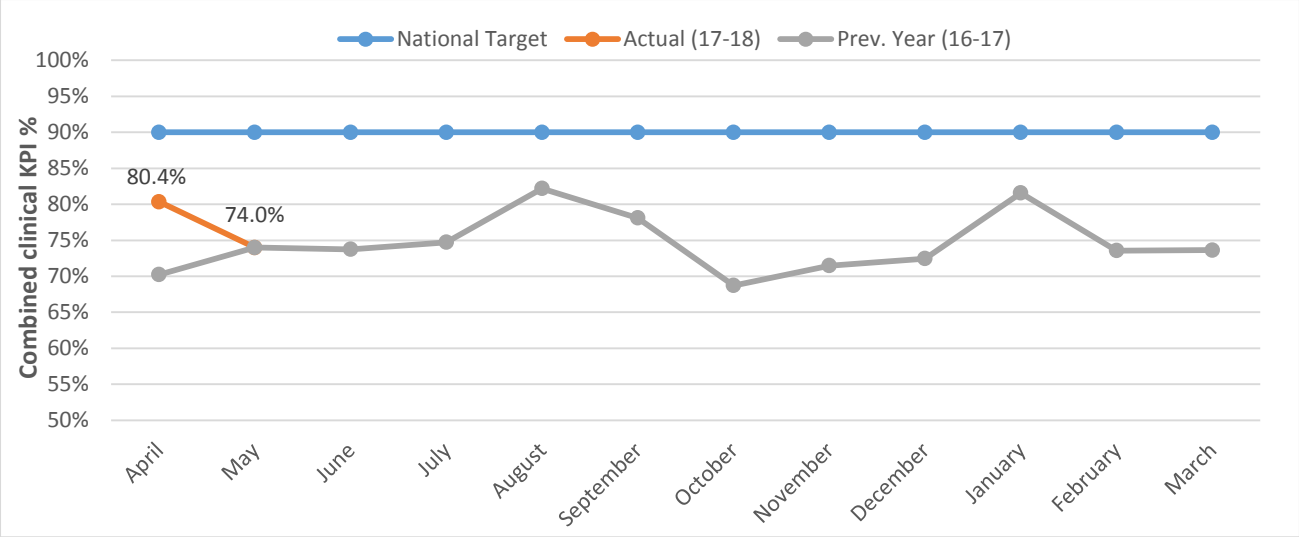

Figure.111-5 - Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)

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 10 (January 2017). The data continues to show variable standards in delivering patient outcomes.

4.2. Clinical Effectiveness KPI Scorecard

Clinical Effectiveness KPI Scorecard:- Data From January 2017

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)	49.9%	**51.5%**	30.0%	51.0%	**52.2%**	46.8%
CE-2	Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)	27.5%	**28.8%**	23.1%	28.3%	**27.8%**	26.7%
CE-3	Cardiac arrest -Survival to discharge - Utstein	24.8%	**10.7%**	20.0%	26.2%	**21.5%**	24.0%
CE-4	Cardiac arrest -Survival to discharge - All	6.9%	**3.4%**	3.2%	8.2%	**6.3%**	8.1%
CE-5	Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)	79.1%	**65.6%**	65.7%	79.5%	**67.3%**	67.9%
CE-6	Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes	81.0%	**76.8%**	86.9%	85.5%	**89.7%**	92.6%
CE-7	% of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes	52.1%	**59.0%**	60.7%	53.6%	**64.3%**	65.6%
CE-8	% of suspected stroke patients assessed face to face who received an appropriate care bundle	97.6%	**94.9%**	97.0%	97.6%	**95.8%**	96.5%

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

4.3. Clinical Effectiveness

4.3.1. The data detailed above shows the Trusts clinical performance for the month of January 2017. These are the most up to date figures published to the Department of Health (DH).

4.3.2. Out of the 8 clinical effective markers 5 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. There continues to be a disconnect with Trust data collection for cardiac arrest outcomes.

4.3.5. Work continues with the Medical Directorate, health records and the clinical audit team to provide robust data collection to allow matching of incident to patient care record to defibrillation download this is essential to allow accurate ROSC and patient outcome data to be reviewed and submitted.

4.3.6. Patient outcomes i.e. those patients who survived their cardiac arrest as well as those where resuscitation was unsuccessful should be reported. Currently only patients who did not survive are reported, this leads to inaccurate outcome data being submitted.

4.4. Clinical Effectiveness Charts

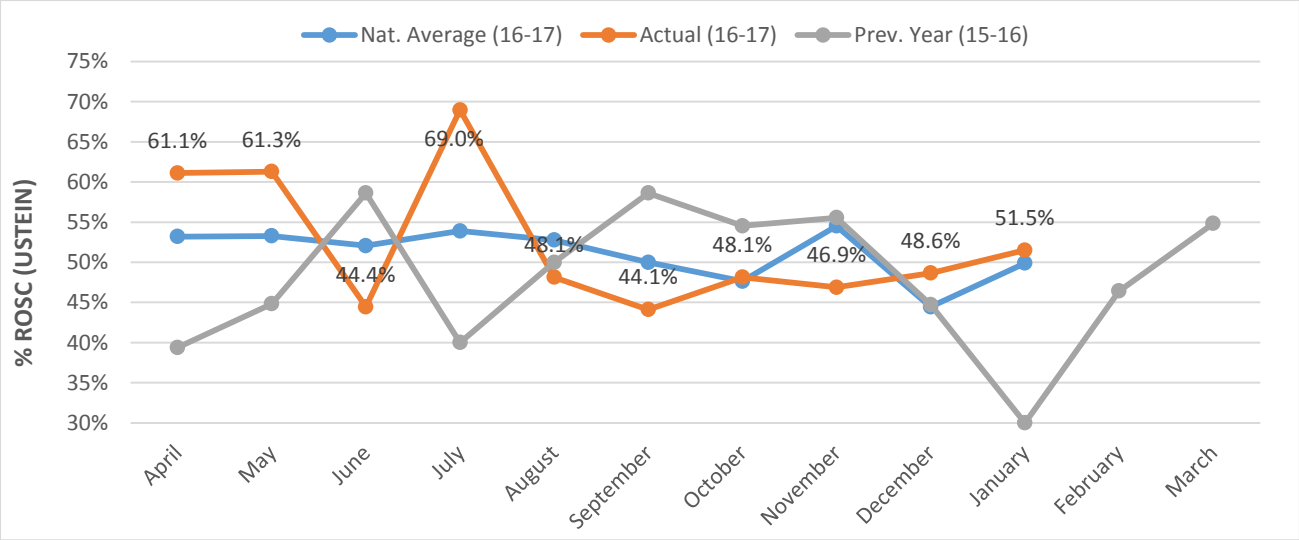

Figure.CE-1 - Cardiac arrest - ROSC on arrival at hospital (Utstein)

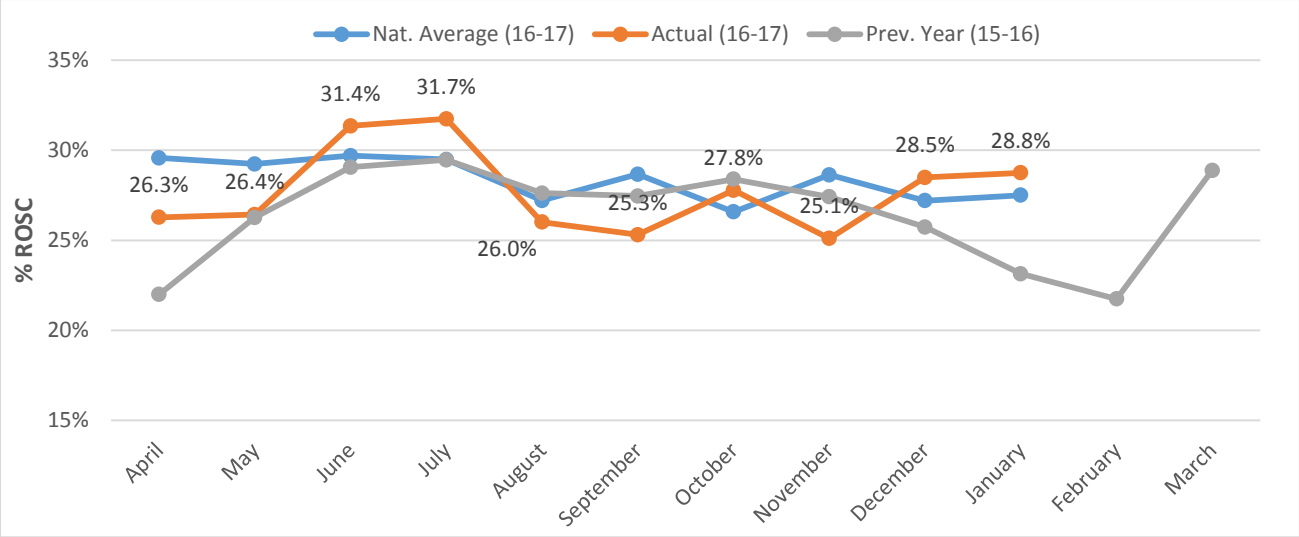

Figure.CE-2 - Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)

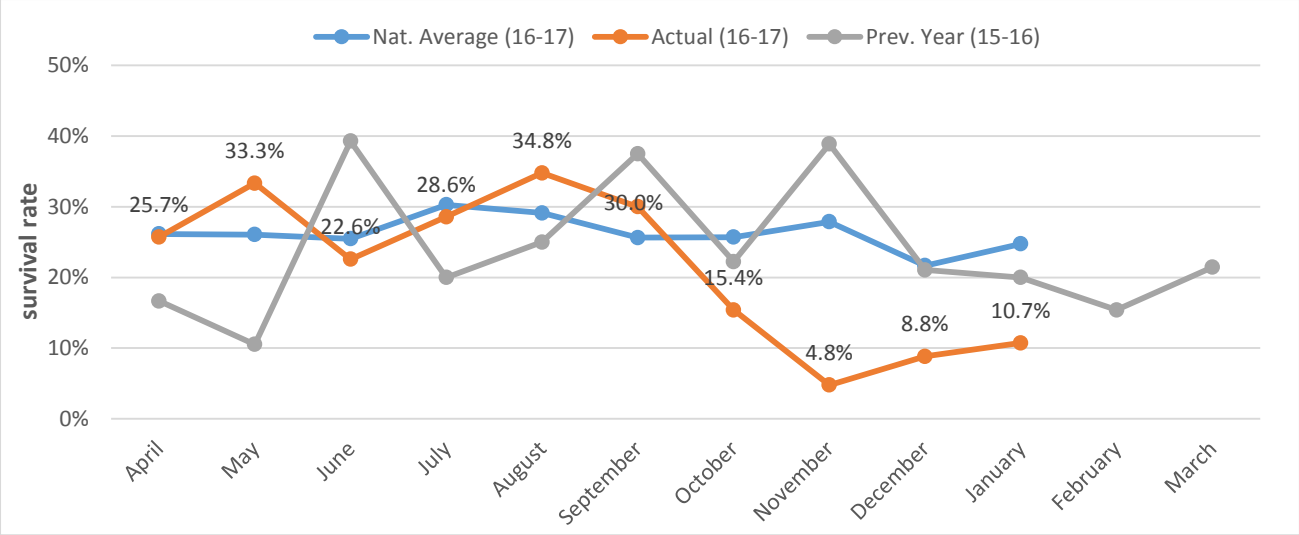

Figure.CE-3 - Cardiac arrest -Survival to discharge - Utstein

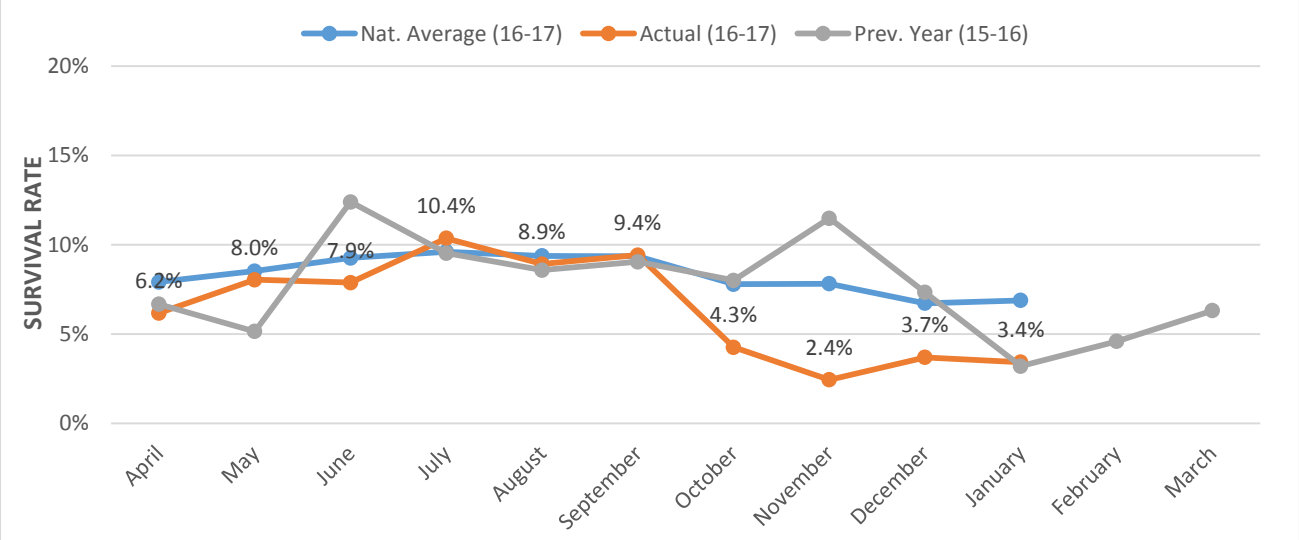

Figure.CE-4 - Cardiac arrest -Survival to discharge – All

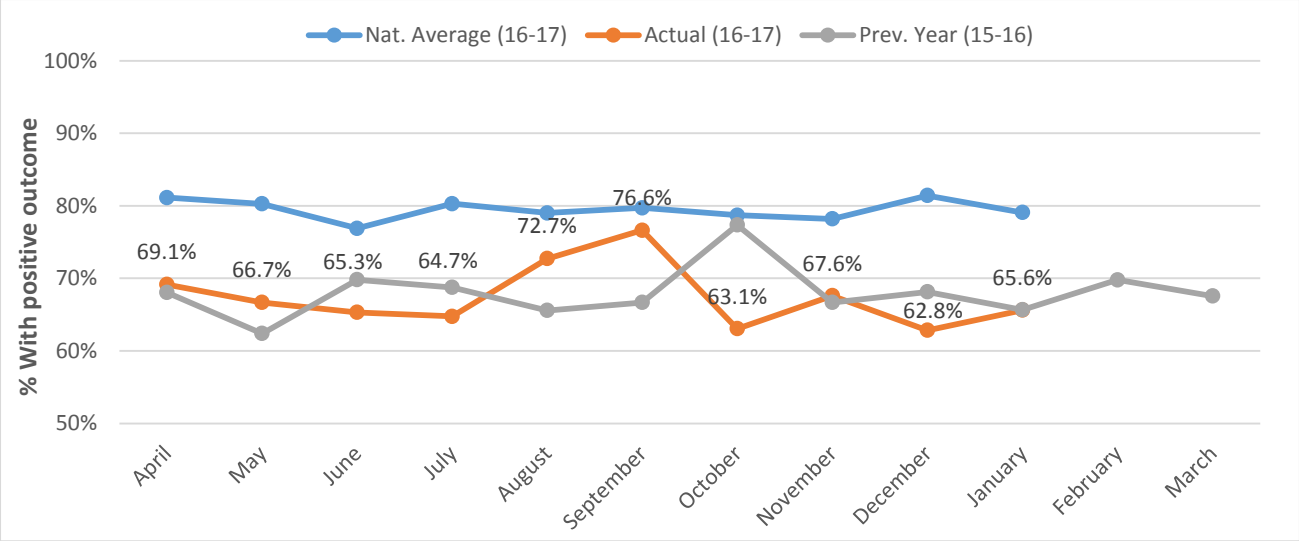

Figure.CE-5 - Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)

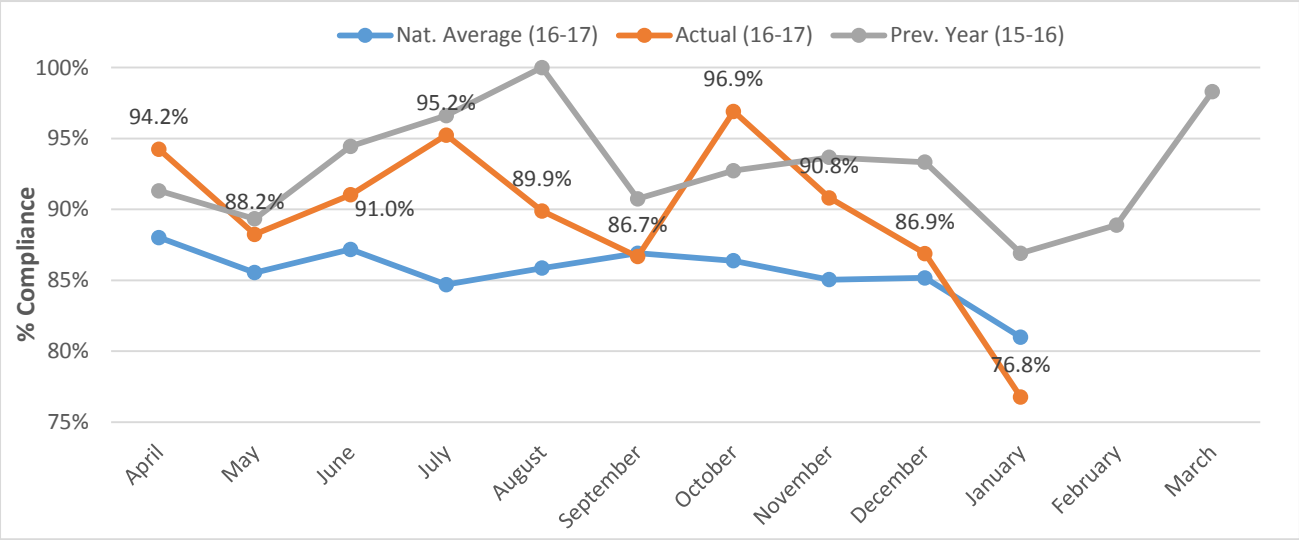

Figure.CE-6 - Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes

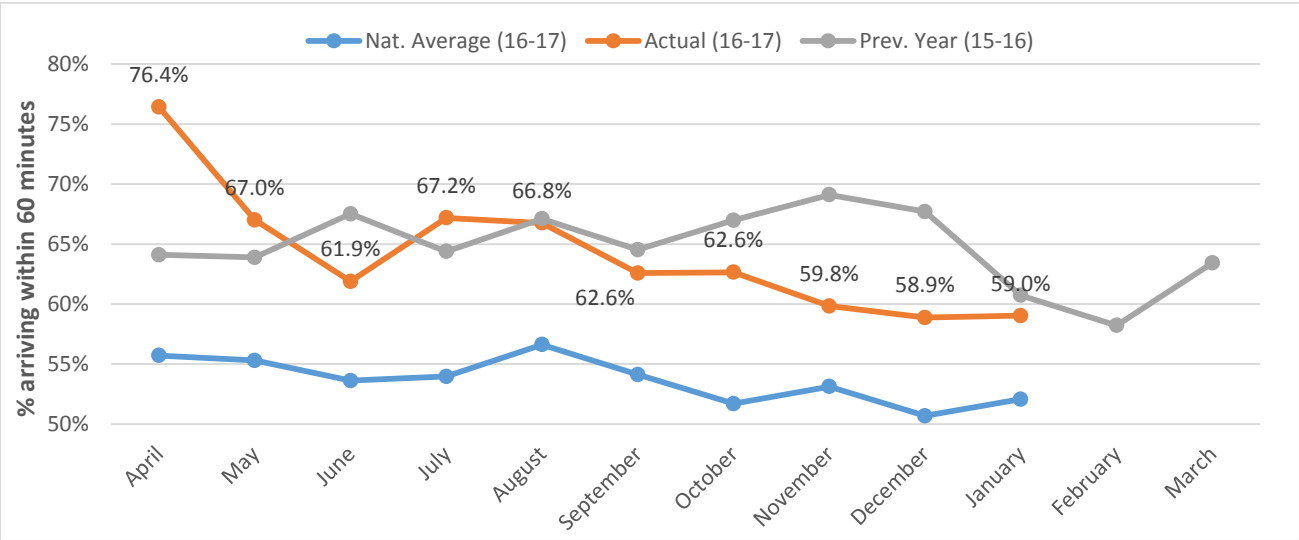

Figure.CE-7 - % of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper acute stroke unit within 60 minutes

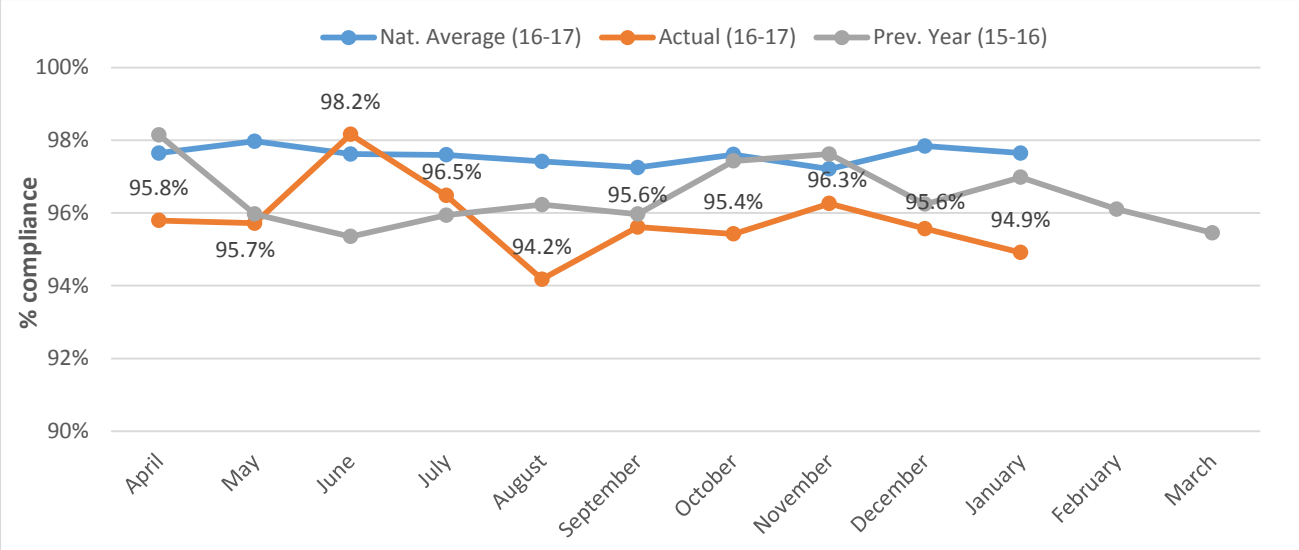

Figure.CE-8 - % of suspected stroke patients assessed face to face who received an appropriate care bundle

5. Quality & Patient Safety

5.1. Quality & Patient Safety Summary

5.1.1. Incidents reporting can demonstrate an overall increase in reporting during May of 5.7%. The Trust continues to perform poorly in respect of review and closure of incidents, although overall the backlog has reduced from 2000 to 1600 in month. Harm is now a mandatory field to trigger escalation to the weekly serious incident decision group. 1.9% of incidents have been reported to the National Reporting and Learning System (NRLS).

5.1.2. Serious incident reporting remains consistent at 6 reported incidents for the month, 1 did not have direct patient contact. 5 were patient related of these 4 breached our internal duty of candour target of 10 working days primarily due to the lateness to assign the incident. There has been zero compliance for 72 hour reporting to the CCG for the same reason. Capacity within professional standards remains challenged.

5.1.3. Safeguarding level 3 compliance reached 14% a trajectory of 17%. An options paper is in progress to be presented to board within the next 2-3 weeks to review initial decision to train all staff at level 3

5.1.4. Complaints 82.5% of complaints have been responded to on time. 11 actual complaints breached the 25 days. Patient care, staff concern and timeliness remain the top 3 complaint themes.

5.2. Quality & Safety KPI Scorecard

Quality & Safety KPI Scorecard:- Data From May 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%**	33.3%	100%	**0.0%**	40.0%
QS1b	SI Investigation timeliness (60 days)	100%	**60.0%**	100.0%	100%	**30.0%**	100.0%
QS1c	Number of Incidents reported		**576**	**532**		**1121**	987
QS1d	Number of Incidents reported that were SI's		**6**	**3**		**11**	7
QS1e	Duty of Candour Compliance	100%	20%		100%	20%	
QS2a	Number of Complaints		**63**	125		**134**	251
QS2b	Complaints reporting timeliness (All Complaints)	95.0%	**82.5%**	39.4%	95.0%	**87.3%**	32.2%

QS2c	Mental Capacity Assessment Training		**35.0%**			**35.0%**	
QS3a	Number of Safeguarding Referrals Adult		**678**	783		**1322**	1491
QS3b	Number of Safeguarding Referrals Children		**149**	163		**283**	304
QS3c	Safeguarding Referrals relating to SECAmb staff or services		**0**	1		**0**	1
QS3d	Safeguarding Training Completed (Adult) Level 1	17.0%	Unavailable		17%	Unavailable	
QS3e	Safeguarding Training Completed (Children) Level 1	17.0%	Unavailable		17%	Unavailable	
QS3f	Safeguarding Training Completed (Adult) Level 2	17.0%	**20.0%**		17%	**20.0%**	
QS3g	Safeguarding Training Completed (Children) Level 2	17.0%	**21.0%**		17%	**21.0%**	
QS3h	Safeguarding Training Level 3 (Adult/Child)	17.0%	**14.0%**			**14.0%**	

5.3. Quality & Patient Safety Commentary

5.3.1. Incident Reporting

5.3.1.1. There has been an increase in reporting during May of 5.7%. On average 75% of reports breach the 7-day initial review deadline and 87% breach the action and request for closure / further investigation deadline. With the organisational restructure within operations and the incorporation of administration time, it is envisaged these response times will improve. Overall final closure back log continues to decrease from 1300 incidents to 800 in June. The caveat to this is that several incidents are being rejected for closure due to incomplete actions and lessons identified, other incidents have been redirected into the serious incident decision group for consideration, this process ensures there is good documentation around decision making.

5.3.1.2. The IRW1 has been updated and now moderate, severe and death harms are mandatory fields. Historically these field 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.

5.3.1.3. There were 5 moderate harms identified in May all 3 related to patient harms were compliant with duty of candour, these moderate harms did not result in serious incident but required further investigation.

5.3.1.4. 11 incidents (1.9% of all incidents reported) were reported as a Patient Safety Incident (PSI) on the National Reporting and Learning System (NRLS). The NRLS a Patient Safety Incident as Any unintended or unexpected incident(s) that could have or did lead to harm for one or more person(s) receiving NHS funded healthcare. [Data Quality Standards (2009) Data Quality Standards | guidance for organisations reporting to the NRLS.]

5.3.2. Serious Incident reporting

5.3.2.1. Duty of candour compliance was 20% 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.

5.3.2.2. 6 serious incidents were reported in May; 1 incident did not require duty of candour as no direct patient contact/ harm identified. Of the remaining 5, 4 breached (our internal 10-day compliance target) due to there being a delay in being able to assign the SIs to investigating managers. This has been caused by serious capacity issues within the Professional Standards Department and difficulty in locating alternative appropriate investigators.

5.3.2.3. 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
2017/11722	05/05/2017	26/05/2017	No	No
2017/11737	05/05/2017	26/05/2017	17/05/2017	Yes
2017/12779	17/05/2017	N/A	N/A	N/A
2017/13180	22/05/2017	13/06/2017	No	No
2017/13405	25/05/2017	16/06/2017	No	No
2017/13476	25/05/2017	16/06/2017	No	No

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. For May there remains 29 reports outstanding for completion, the majority of which are being managed by the Professional Standards Department. 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. Of the 7 reports due to be submitted in May, 4 have breached the deadline and 3 were submitted on time.

5.3.3. Complaints

5.3.3.1. The number of complaints closed in time was 82.5%. 91% of breaches were due to late submission of the investigation. 8% due to administration delays within the complaints team. With 5 working days available between the report due date and the response due date, even a delay of one day can cause issues. The Medical Director is also now reviewing a proportion of responses which involve complex clinical care prior to sending.

Late responses

A&E	4
EOC	3
PTS	2
NHS111	1

Complaints by Operational Area (Complaints may cover more than one operational area, hence the increase in the total to 70)

EOC	28	40%
A&E	26	37%
NHS111	13	18.5%
PTS	3	4.5%

5.3.3.2. Complaints about patient transport can be taken for up to 12 months from the date of any incident or from when the complainant becomes aware of the reason for a complaint. There is a nominated investigator in the Trust who investigates these matters.

Complaints by Category

5.3.3.3. Patient care, concern about staff and timeliness continue to be the highest proportion of complaint subjects.

5.3.3.4. Upheld patient care complaints, always result in actions involving change to practice, where the need has been identified as a failing across the organisation. Individual staff involved in complaints about patient care, where gaps in their knowledge/skills is identified receive the necessary training and ongoing support and mentoring where needed. Complaints may have more than one subject, so the numbers differ. The actions following complaint outcomes are currently not monitored through any Trust forum.

Patient Care	28
Concern about staff	25
Timeliness	18
Communication Issues	3
Administration errors	2
History marking issues	1

5.3.3.5. A patient experience session has now been added to KEY Skills training for frontline staff to improve awareness of language use, attitude issues and patient anxieties.

Outcome of Complaints

Upheld	29
Partly Upheld	11
Not Upheld	*21*
Withdrawn	2

5.3.3.6. Therefore 63.4% of complaints were upheld in some aspect.

5.3.3.7. Complaints about patient transport can be taken for up to 12 months from the date of any incident or from when the complainant becomes aware of the reason for a complaint. There is a nominated investigator in the Trust.

5.4. Safeguarding

5.4.1.1. The L3 training trajectory is currently still not on target and has been added to the Corporate Risk Register. All training dates publicised have been delivered in line with the training schedule, however, attendance figures remain below the required numbers (50 staff per week), although there is an improvement on figures in April have been noted. The training trajectory identified that 17% of all Trust staff should have attended a session by the end of May 2017, the actual figure was 14%. With a focus on staff with a professional registration attending the Level 3 training, separate figures for registrants are now being collated. The figure for registered staff is also 14% to the end of May.

5.4.1.2. Capacity issues remain within the Safeguarding Team and possible solutions, including use of recovery monies to commission additional trainers, increase staff hours and utilisation of agency staff are being explored.

5.4.1.3. Mental Capacity Assessment training has seen 35% of staff having completed the online module for 2017/2018 which is double the projected trajectory figure. Level 1 training is being delivered as part of the Trust Corporate Induction programme. Currently 62 new members of staff have completed Corporate Induction since the start of the financial year although the total number of staff who have commenced employment within this period is not available.

5.4.1.4. Level 2 training is for support staff only 2017/18 with 21% of staff having completed safeguarding child training and 20% having completed safeguarding adult training on line by the end of May.

5.4.1.5. In June the safeguarding lead will prepare an options paper in respect of safeguarding level 3 training. The current proposal / work programme is for all clinical facing and senior managers to complete level 3 training, following external review it has been identified this exceeds any others organisations expectations for training, the team will be proposing a revised training programme for board consideration.

5.5. Quality & Safety Charts

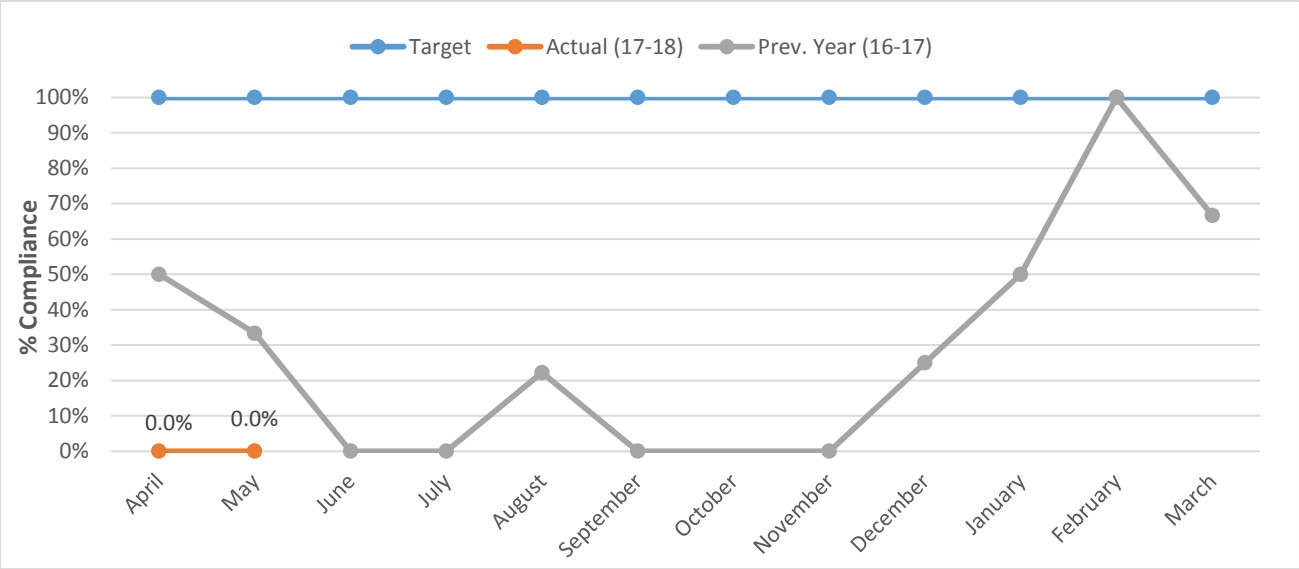

Figure.QS1a - SI Reporting timeliness (72hrs)

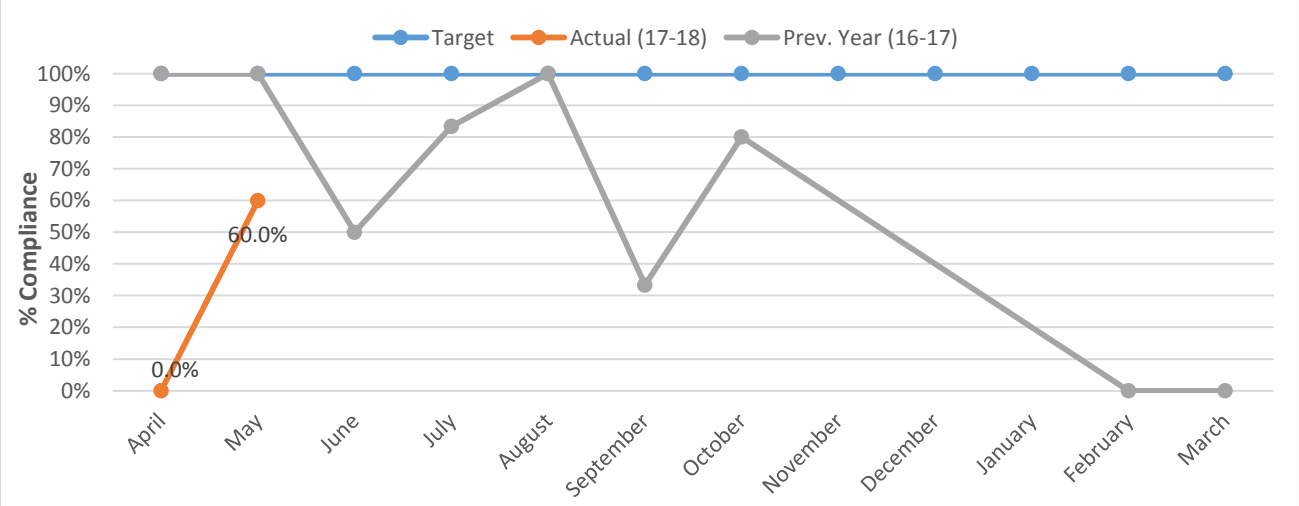

Figure.QS1b - Serious Incident (SI) Investigation timeliness (60 days).

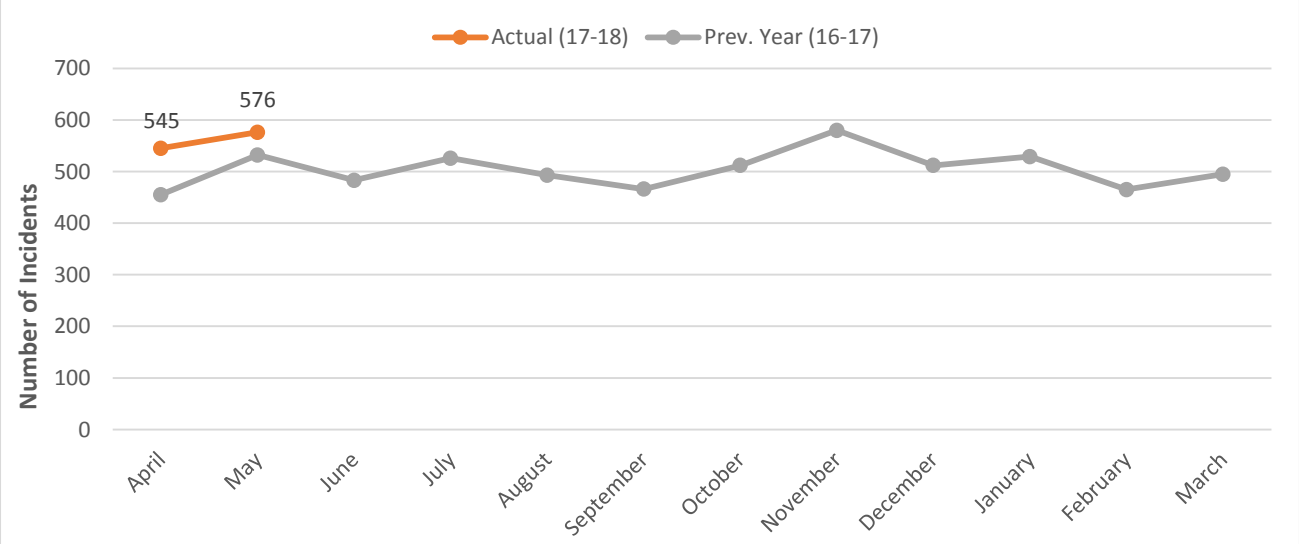

Figure.QS1c - Number of Incidents reported

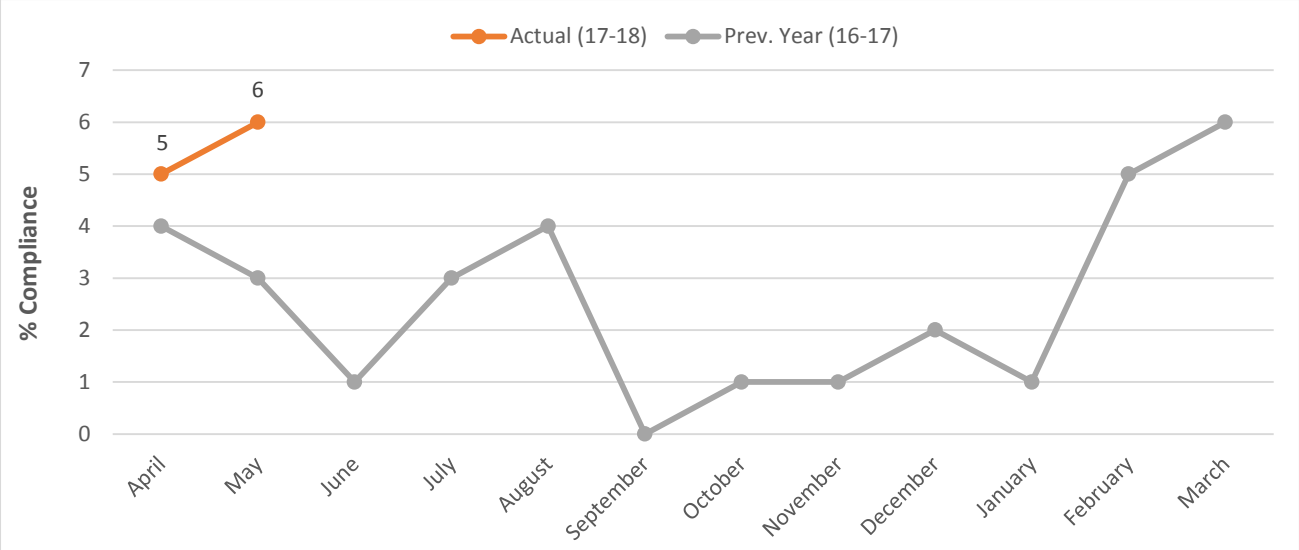

Figure.QS1d - Incidents reported that were SI's

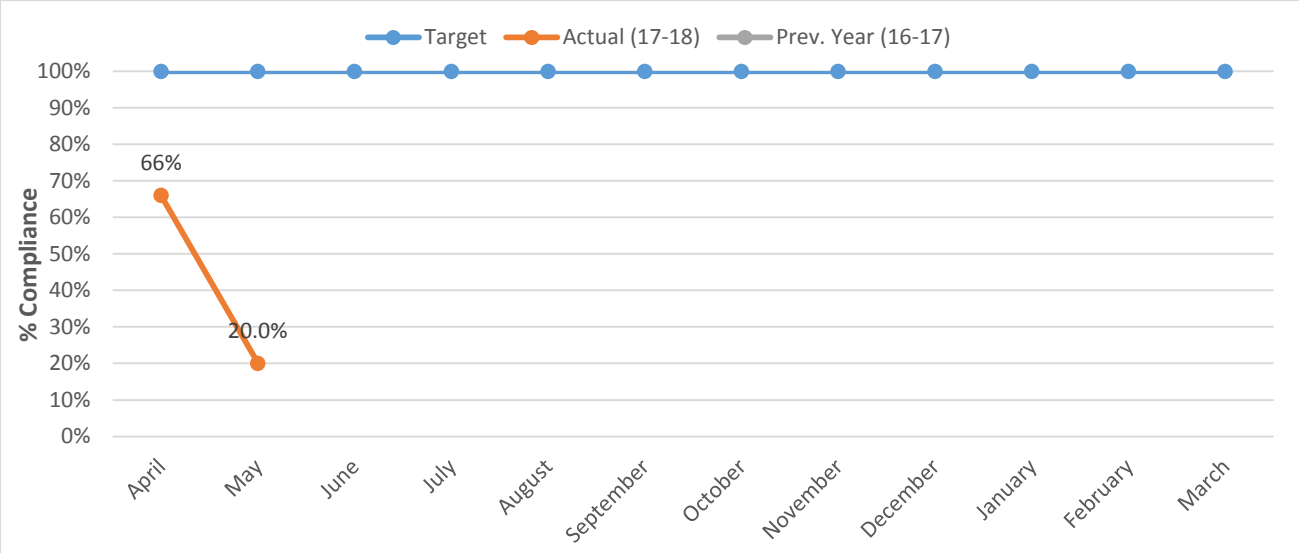

Figure.QS1e - Duty of Candour Compliance

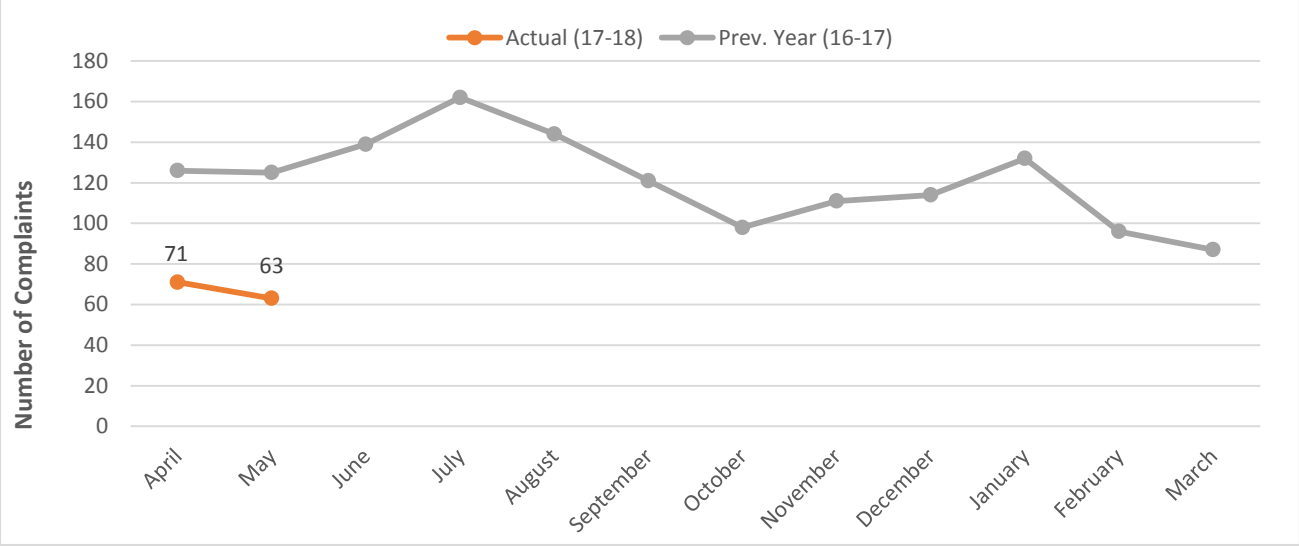

Figure.QS2a - Number of Complaints

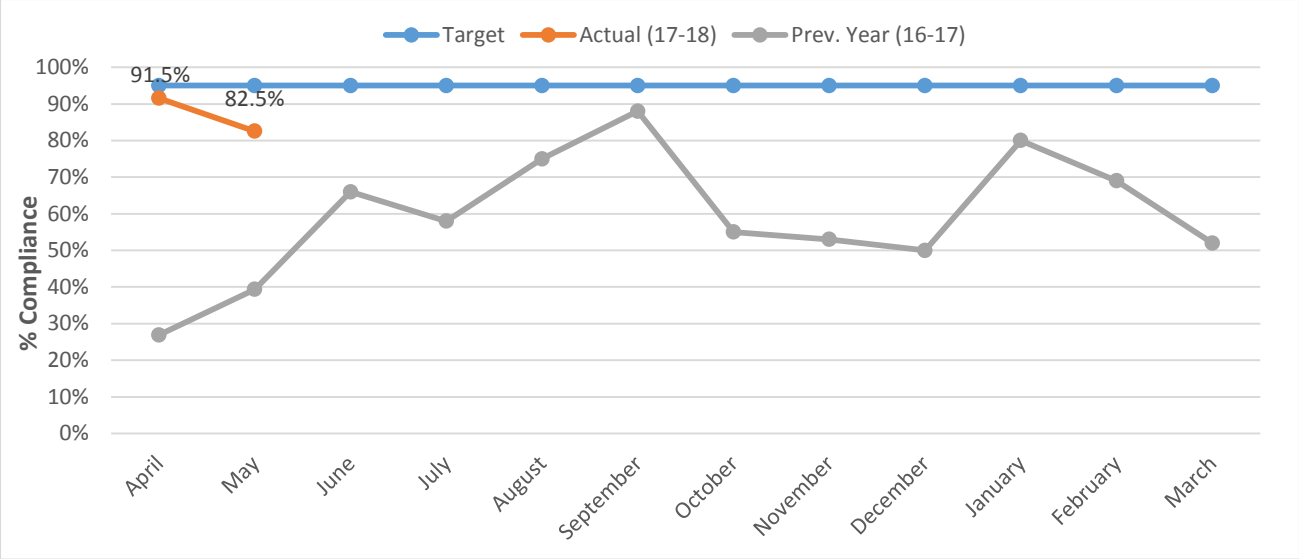

Figure.QS2b - Complaints reporting timeliness (All Complaints)

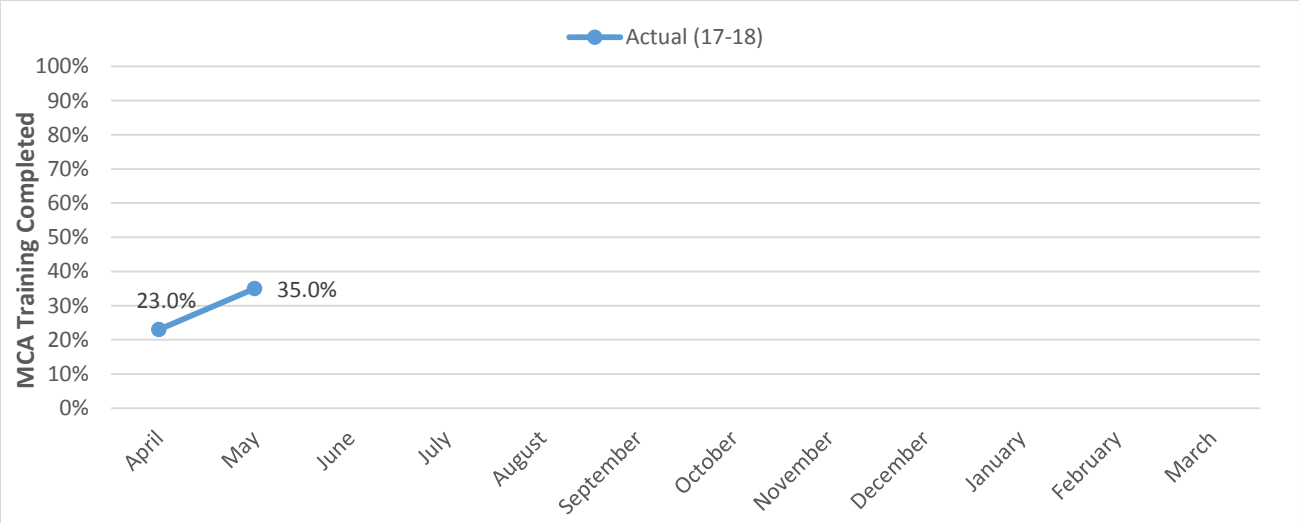

Figure.QS2c – Mental Capacity Assessment Training

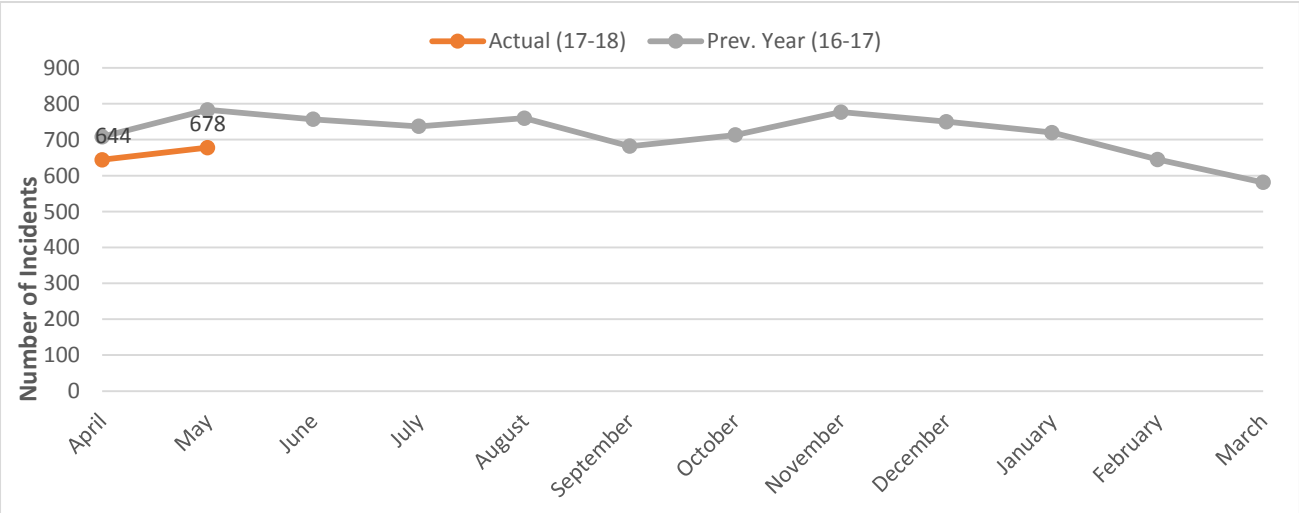

Figure.QS3a - Safeguarding Referrals Adult

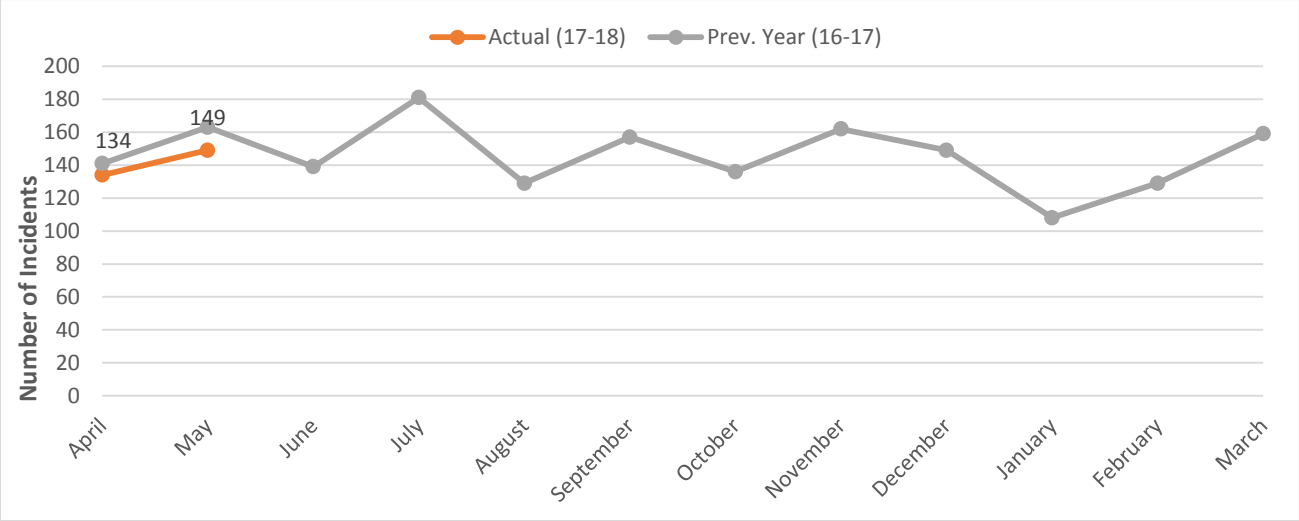

Figure.QS3b - Safeguarding Referrals Children

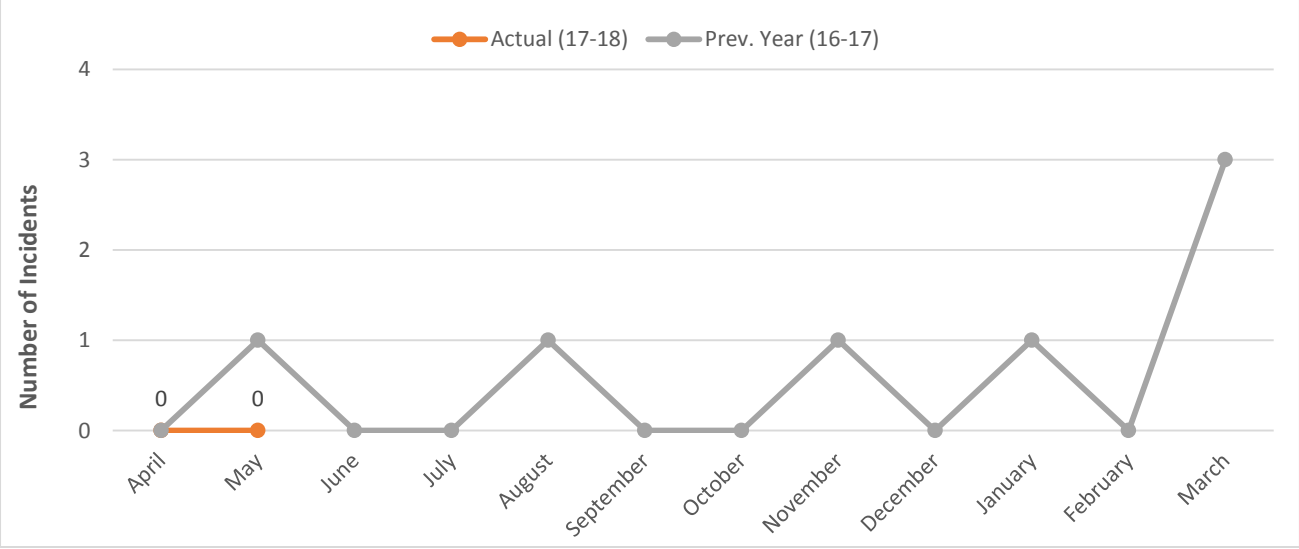

Figure.QS3c - Safeguarding Referrals relating to SECAmb staff or services

Unavailable

Figure.QS3d - Safeguarding Training Completed Adult, Level 1

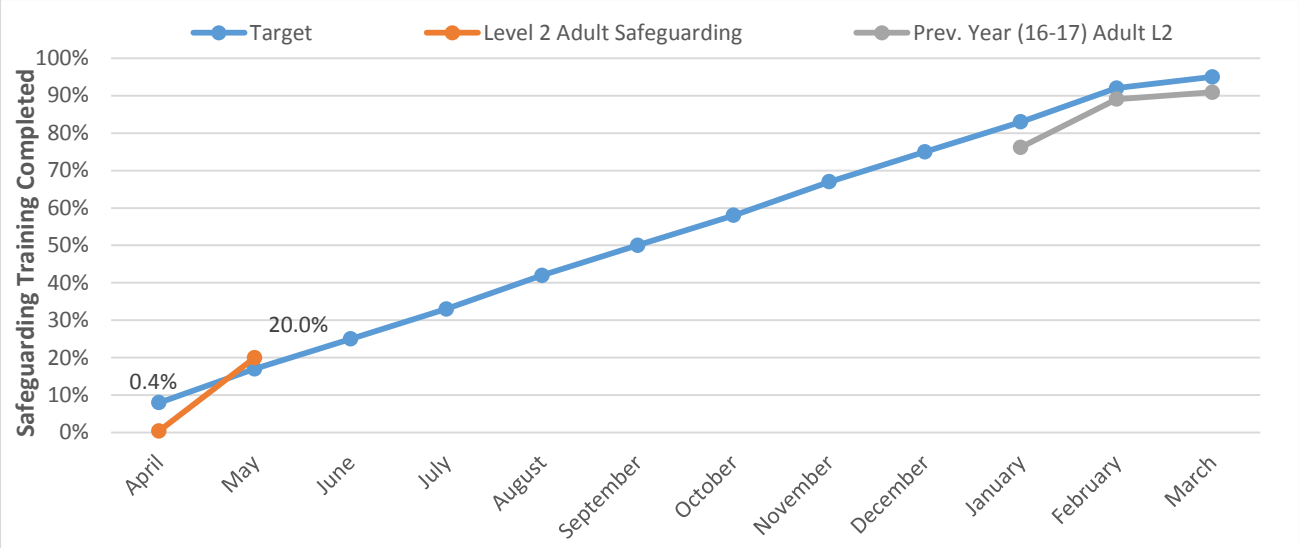

Figure.QS3f - Safeguarding Training Completed Adult, Level 2

Unavailable

Figure.QS3e - Safeguarding Training Completed Children, Level 1

Figure.QS3g - Safeguarding Training Completed Children, Level 2

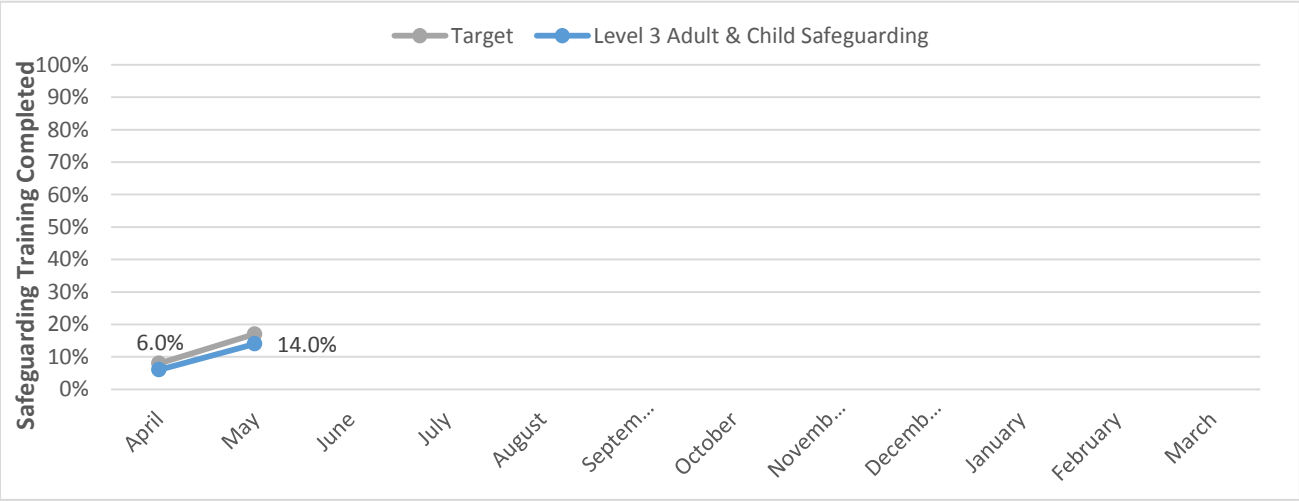

Figure.QS3h - Safeguarding Training Completed Adult & Child Level 3

6. Finance

6.1. Finance Summary

6.1.1. This commentary highlights the key messages arising from the month 2 financial position

6.1.2. The Trust incurred a deficit of £0.5m in the month, which was £0.1m favourable to plan. The structural deficit produced an expected shortfall of £0.6m but this was more than offset by the £0.7m favourable position on actual performance.

6.1.3. In the year to date the deficit is £1.4m, in line with plan. The cumulative impact of the structural gap is an adverse variance to plan of £1.1m. This has been fully offset by other net favourable variances.

6.1.4. The forecast for the full year is unchanged from the plan, a deficit of £1.0m.

6.1. Finance Scorecard

Finance Scorecard:- : Data from May 2017

ID**	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
F-1	Income (£'000)	£ 18,367	**£ 16,175**	£ 15,769	£ 36,043	**£ 31,406**	£31,680
F-2	Expenditure (£'000)	£ 19,014	**£ 16,674**	£ 16,058	£ 37,447	**£ 32,801**	£32,350
F-6	Surplus/(Deficit)	-£ 647	**-£ 499**	-£ 289	-£ 1,404	**-£ 1,394**	-£ 670
ID**	**KPI**	**Current Quarter (Plan)**	**Current Quarter (Actual)***	**Current Quarter (Prev. Yr.)**	**YTD (Plan)**	**YTD (Actual)***	**YTD (Prev. Yr.)**
F-5	CQUIN - Quarterly (£'000)*	£ 849	**£ 567**	£ 952	£ 849	**£ 567**	£ 952
ID**	**KPI**	**Current Month (Plan)**	**Current Month (Actual)**	**Current Month (Prev. Yr.)**	**YTD (Plan)**	**YTD (Actual)**	**YTD (Prev. Yr.)**
F-3	Capital Expenditure (£'000)	£ 2,048	**£ 670**	£ 1,749	£ 5,391	**£ 938**	£ 3,737
F-7	Cash Position (£'000)	£ 5,369	**£ 10,313**	£ 10,753	£ 5,369	**£ 10,313**	£ 10,753
F-4	Cost Improv. Prog. (CIP) (£'000)	£ 1,067	**£ 909**	£ 543	£ 2,100	**£ 1,808**	£ 888
F-8	Agency Spend (£'000)	£ 342	**£ 331**	£ 559	£ 686	**£ 541**	£ 945

** 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

Activity, Income and Expenditure

6.2.1. There was an expected income shortfall in the month of £2.2m However, contracted income was in line with plan. For the year to date actual income was £4.6m below plan, of which just £0.4m related to a shortfall in contracted activity.

6.2.2. No Sustainability & Transformation Funding has been assumed in the position to date. The amount potentially available for the full year is £1.3m. This assumption will be revisited at the end of Quarter 1.

6.2.3. EBITDA was marginally behind plan in the month but is £0.3m adverse to date.

6.2.4. A&E contracted activity was 2% down on plan in the month and contracted income £0.2m down, although nearly 2% above that earned in the same period last year.

6.2.5. After 2 months A&E activity is 3.4% below plan.

6.2.6. Pay was underspent by £1.7m in the month and £3.5m for two months. Operational hours were managed in line with activity in the month. Unit Hour Utilisation (UHU) at 0.364 was marginally above the plan of 0.363. The reduced resourcing requirement in the month enabled the Trust to make a 20.8% hours saving (£0.2m) on private ambulance provision. Cumulatively, the hours saving is just 1.5% (£0.1m).

6.2.7. The whole time equivalent (substantive) staffing level in the month was 201 or 5.4% lower than establishment. At month 2 there were 158 vacancies, 4.8% of establishment.

6.2.8. Non pay expenditure in the month was £0.4m below plan and non-operating expenditure £0.2m below. After two months these variances are £0.7m and £0.4m respectively. The main areas of favourable operational variance were Fleet £0.3m, IT £0.1m, Procurement £0.1m and Voluntary Services £0.1m. Some of these will be issues of timing/plan profiling and may be reversed in later months. The favourable variances on non-operating cost were mainly due to the current year cost improvement benefit of estate revaluation at 31 March 2017.

Cost Improvement Programme

6.1.1. CIP delivery for the month of £0.9m was just £0.1m below plan. The year to date achievement of £1.8m is £0.3m behind plan. An action plan is in place to ensure the full year target is delivered.

Capital Expenditure

6.1.2. Capital expenditure for the month was £0.7m against a plan of £2.0m. To date the spend is £0.9m against a planned £5.4m. The shortfalls in spend are mainly due to timing and comprise Fleet £3.0m, New HQ £1.2m and CAD £0.3m. A Fleet business

case is being presented to the Board. The full year programme is £15.8m and at this relatively early stage it is anticipated that the programme will be completed in full.

Cash and Financing

6.1.3. The cash balance at the end of May was £10.3m, significantly higher than the planned £5.4m. The improved position is partly due to the timing of capital spend.

6.1.4. The working capital loan balance stands at £3.2m. There is a £15m working capital loan facility in place.

Use of Resources Rating

6.1.5. The Trust's URR after two months is 3, in line with plan. The forecast for the year remains at 3, as planned.

6.2. Finance Conclusion

6.3.1. Financial performance and risk ratings are in line with expectations to date. The underlying commissioning gap is being managed. CIP plans are progressing well but present an ongoing challenge. The capital programme is behind schedule but is expected to catch up. The overall position to date is satisfactory and work is underway to improve controls and embed the efficiencies.

6.3. Finance Charts

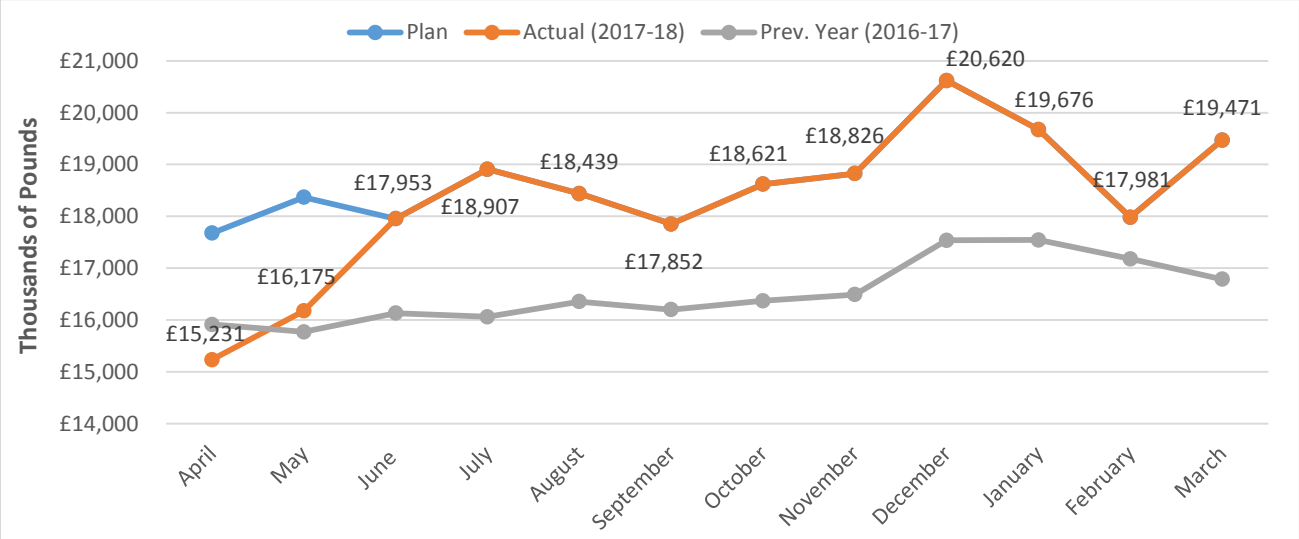

Figure.F-1 - Income (£'000)

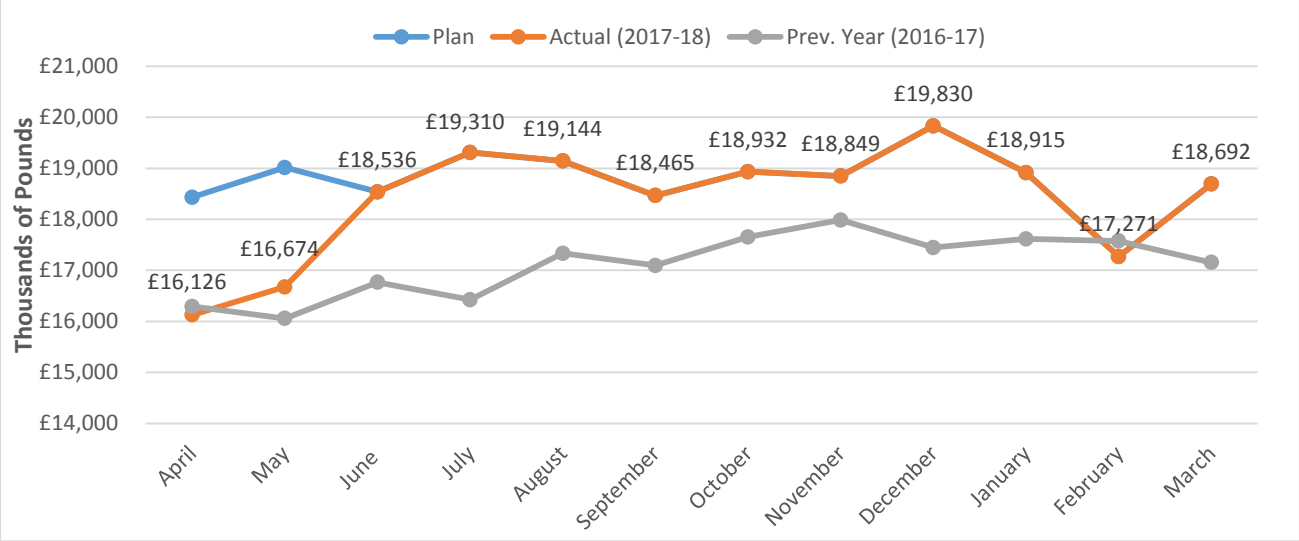

Figure.F-2 - Expenditure (£'000)

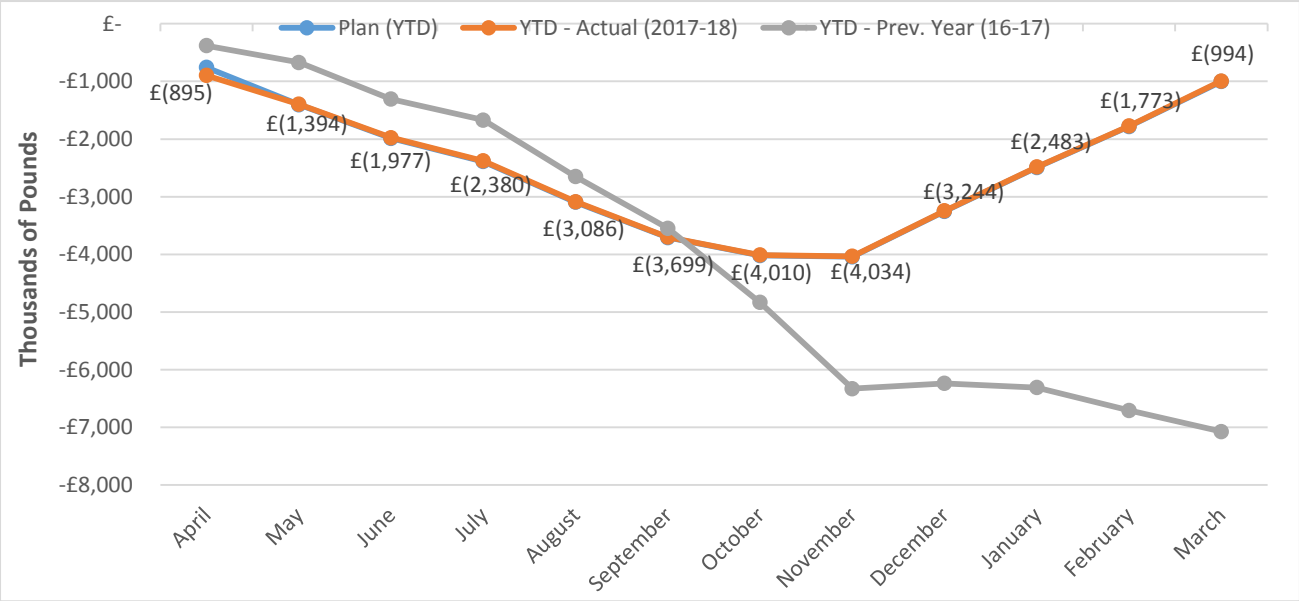

Figure.F-6 - Surplus/(Deficit) (Year To Date)

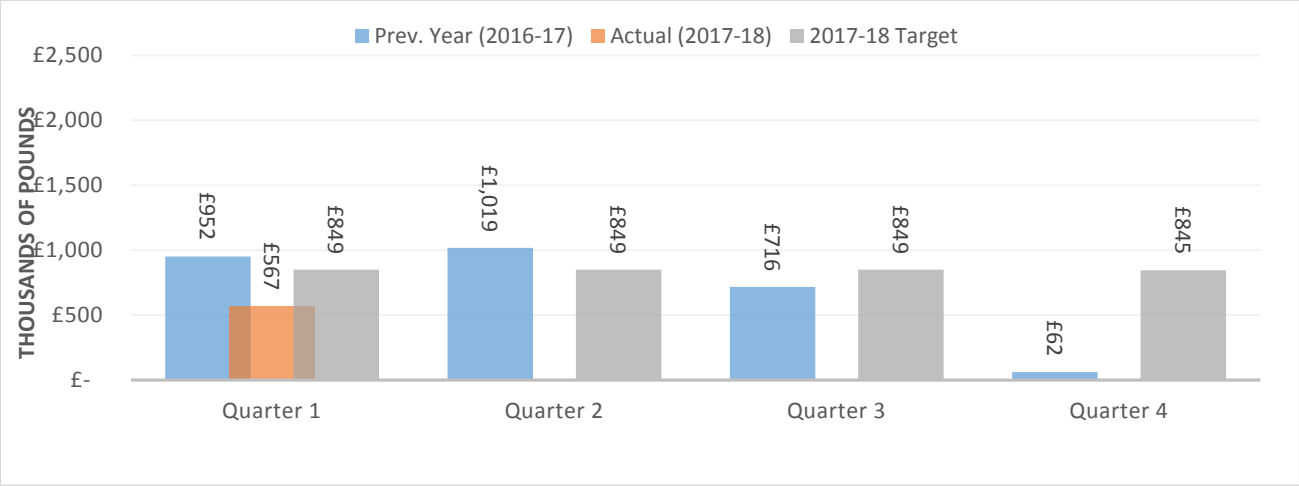

*Figure.F-5 – CQUIN - Quarterly (£'000)**

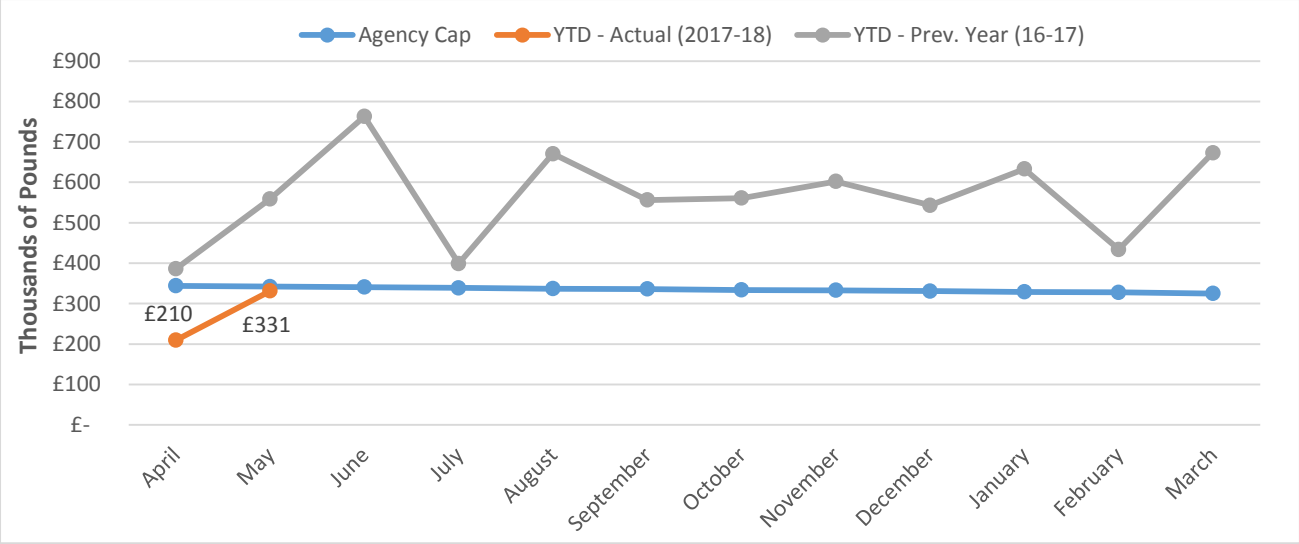

Figure.F-8 – Agency Spend (£'000)

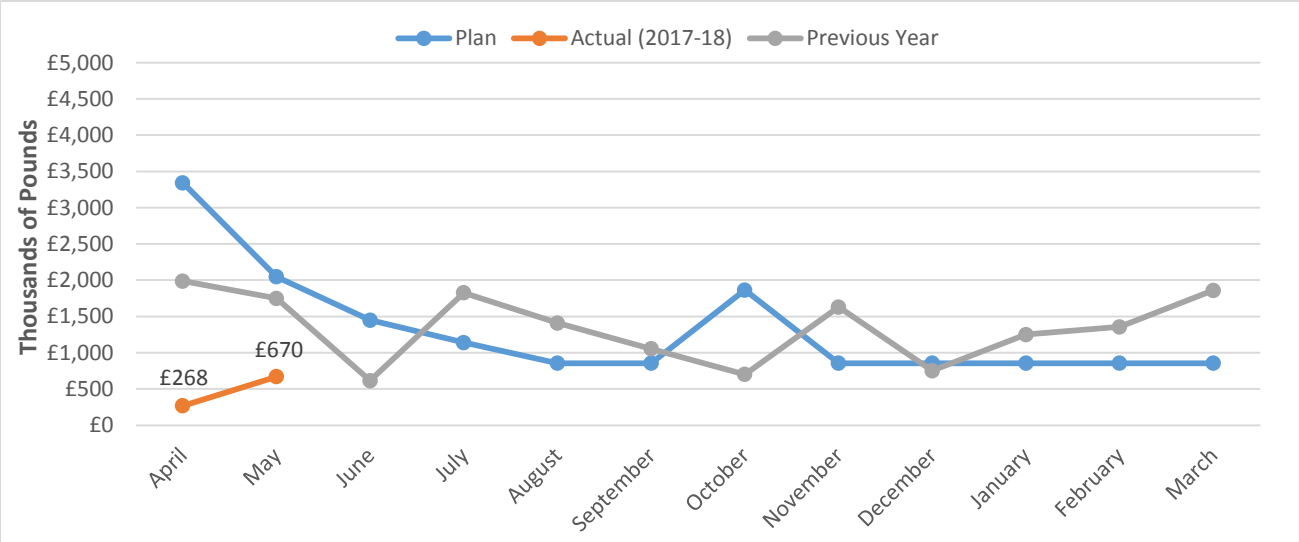

Figure.F-3 – Capital Expenditure (£'000)

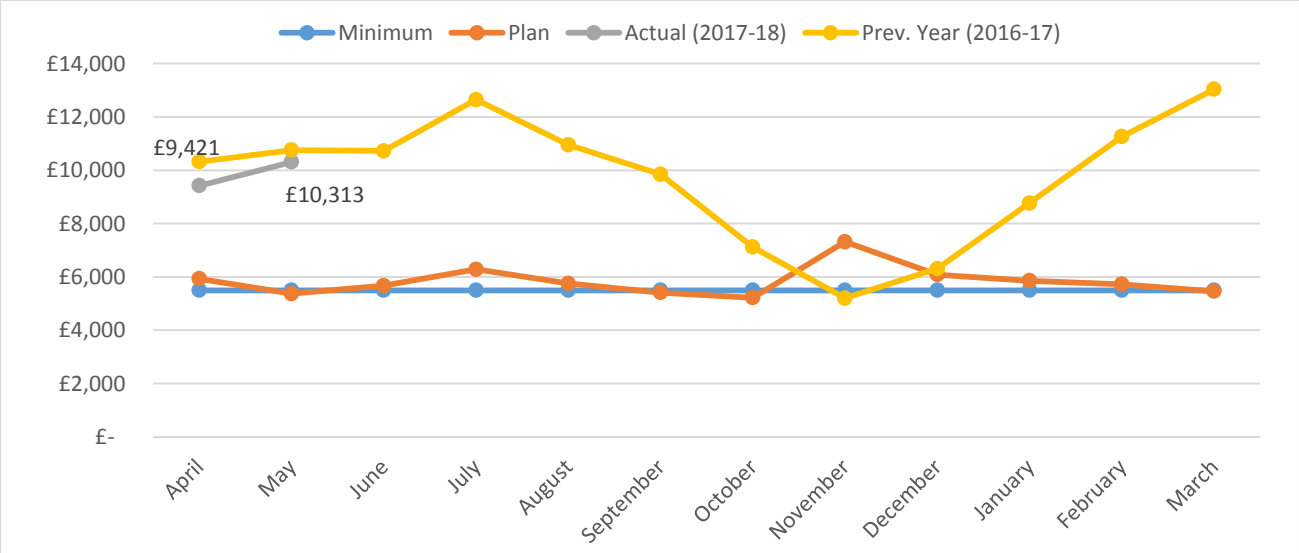

Figure.F-7 – Cash Position (£'000)

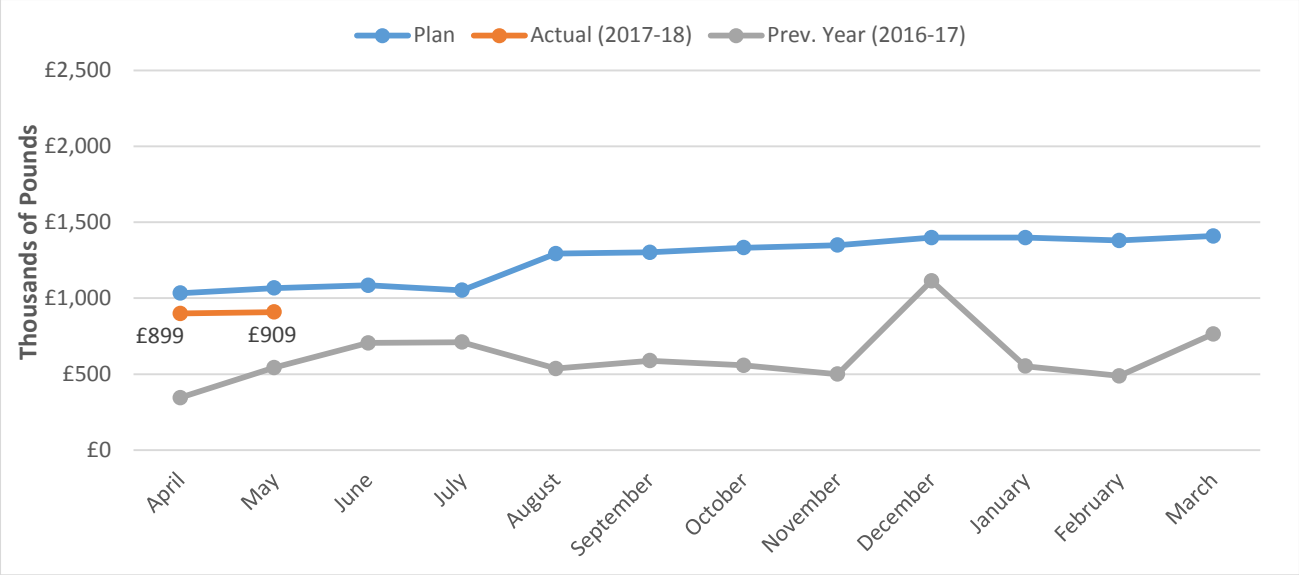

Figure.F-4 - Cost Improv. Prog. (CIP) (£'000)

Integrated Performance Dashboard Balanced Scorecard for the June 2017 Board Meeting

Workforce Commentary :- Data from May 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		2.1%	2.0%		2.1%	
Wf-1B	Long Term Sickness - Rate		2.9%	2.8%		2.9%	
Wf-2	Staff Appraisals	15.0%	Data unavailable	12.8%			
Wf-3	Mandatory Training Compliance (All Courses)	30.0%	Data unavailable	36.4%			
Wf-4	Total injuries		Data unavailable	61		Data unavailable	120
Wf-5	Total physical assaults		Data unavailable	18		Data unavailable	33
Wf-6	Vacancies (Total WTE)		415	381			
Wf-7	Annual Rolling Staff Turnover		20.6%	16.8%			
Wf-8	Reported Bullying & Harassment Cases		1			2	
Wf-9	Cases of Whistle Blowing		0			0	

Operational Performance Scorecard:- Data From May 2017

ID	KPI	Current Month (Plan*)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan*)	YTD (Actual)	YTD (Prev. Yr.)
999-1	Red 1 response <8 min	67.2%	68.1%	66.4%		69.4%	68.3%
999-2	Red 2 response <8 min	51.1%	52.4%	56.8%		54.2%	58.4%
999-3	Red 19 Transport <19 min	88.1%	89.6%	91.0%		90.4%	91.7%
999-4	Activity: Actual vs Commissioned	70408	69812	68514	137824	134645	132654
999-5	Hospital Turn-around Delays (Hrs lost >30 min.)	2082	5462	4944	5349	10377	9538
999-6	Call Pick up within 5 Seconds	90.1%	79.2%	64.5%		84.5%	70.7%
999-7	CFR Red 1 Unique Performance Contribution	Not available	1.3%	Not available		1.3%	Not available
999-8	CFR Red 2 Unique Performance Contribution	Not available	1.3%	Not available		1.3%	Not available
111-1	Total Number of calls offered		91789	105522		191364	201392
111-2	% answered calls within 60 seconds	65%	91.1%	62.6%	65.0%	93.4%	63.8%
111-4	Abandoned calls as % of offered after 30 secs	9.0%	1.0%	9.1%	9.0%	0.8%	8.7%
111-5	Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)	72%	74.0%	74.0%		77.2%	72.2%
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 January 2017

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)	49.9%	51.5%	30.0%	51.0%	52.2%	46.8%
CE-2	Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)	27.5%	28.8%	23.1%	28.3%	27.8%	26.7%
CE-3	Cardiac arrest -Survival to discharge - Utstein	24.8%	10.7%	20.0%	26.2%	21.5%	24.0%
CE-4	Cardiac arrest -Survival to discharge - All	6.9%	3.4%	3.2%	8.2%	6.3%	8.1%
CE-5	Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)	79.1%	65.6%	65.7%	79.5%	67.3%	67.9%
CE-6	Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes	81.0%	76.8%	86.9%	85.5%	89.7%	92.6%
CE-7	% of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes	52.1%	59.0%	60.7%	53.6%	64.3%	65.6%
CE-8	% of suspected stroke patients assessed face to face who received an appropriate care bundle	97.6%	94.9%	97.0%	97.6%	95.8%	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 May 2017

ID**	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
F-1	Income (£'000)	£18,366.8	£16,175.4	£15,769.0	£36,043.1	£31,406.1	£31,680.4
F-2	Expenditure (£'000)	£19,014.0	£16,674.4	£16,057.8	£37,446.6	£32,800.5	£32,350.2
F-6	Surplus/(Deficit)	-£647.2	-£499.0	-£288.8	-£1,403.5	-£1,394.4	-£669.8
ID**	**KPI**	**Current Quarter (Plan)**	**Current Quarter (Actual)***	**Current Quarter (Prev. Yr.)**	**YTD (Plan)**	**YTD (Actual)***	**YTD (Prev. Yr.)**
F-5	CQUIN - Quarterly (£'000)*	£849.0	£567.0	£952.0	£849.0	£567.0	£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)	£2,048.0	£670.0	£1,749.0	£5,391.0	£938.0	£3,737.0
F-7	Cash Position (£'000)	£5,369.0	£10,313.0	£10,753.0	£5,369.0	£10,313.0	£10,753.0
F-4	Cost Improv. Prog. (CIP) (£'000)	£1,067.0	£909.0	£543.0	£2,100.0	£1,808.0	£888.0
F-8	Agency Spend (£'000)	£342.0	£331.5	£559.1	£686.0	£541.0	£945.2

** 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 May 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%	33.3%	100.0%	0.0%	
QS1b	SI Investigation timeliness (60 days)	100.0%	60.0%	100.0%	100.0%	30.0%	100.0%
QS1c	Number of Incidents reported		576	532		1121	987
QS1d	Number of Incidents reported that were SI's		6	3		11	7
QS1e	Duty of Candour Compliance	100.0%	20%		100.0%	20%	
QS2a	Number of Complaints		63	125		134	251
QS2b	Complaints reporting timeliness (All Complaints)	95.0%	82.5%	39.4%	95.0%	87.3%	32.2%
QS2c	Mental Capacity Assessment Training		35.0%			35.0%	
QS3a	Number of Safeguarding Referrals Adult		678	783		1322	1491
QS3b	Number of Safeguarding Referrals Children		149	163		283	304
QS3c	Safeguarding Referrals relating to SECAmb staff or services		0	1		0	1
QS3d	Safeguarding Training Completed (Adult) Level 1	17.0%	Unavailable		17.0%	Unavailable	
QS3e	Safeguarding Training Completed (Children) Level 1	17.0%	Unavailable		17.0%	Unavailable	
QS3f	Safeguarding Training Completed (Adult) Level 2	17.0%	20.0%		17.0%	20.0%	
QS3g	Safeguarding Training Completed (Children) Level 2	17.0%	21.0%		17.0%	21.0%	
QS3h	Safeguarding Training Level 3 (Adult/Child)	17.0%	14.0%			14.0%	

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. Total Staff Vacancies: April & May Board data: the newly released budget is still in the process of being triangulated and finalised with finance and may, therefore, be subject to change.

7.3.2. Staff Appraisals, Mandatory Training & Total Physical Assaults performance reporting is currently being reviewed. See points 2.2.6 & 2.2.7.

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. Safe Guarding Training Level 1 Adult & Child performance reporting is currently being reviewed.

7.7. Finance Section:

7.7.1. No changes to note.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	50/17

Name of meeting	Trust Board
Date	29 June 2017
Name of paper	Medicines Management
Responsible Executive	Dr Fionna Moore, Medical Director
Author	Fiona Wray, Associate Director, Medical Directorate Carol-Anne Davies Jones- Chief Pharmacist
Synopsis	The Quality and Patient Safety Committee has been scrutinising the system of internal control relating to medicines management This paper sights the Board on the current issues and progress made to address these known issues.
Recommendations, decisions or actions sought	The Board is asked to consider the issues arising from medicines management and seek assurance that the appropriate remedial action is being taken

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

Medicines Management

1. Introduction

1.1. This report provides an overview of the issues relating to medicines management in the Trust and the progress made addressing these. The actions described aim to provide assurance that the Trust is taking appropriate action to mitigate the risks associated with the identified medicine management issues.

2. Background

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

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

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

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

2.5. In March 2017 an external independent medicines management review at South East Coast Ambulance Service NHS Foundation was commissioned by the Trust, and approved by NHSI. Phase one of the Review, which will review specific elements of medicines management, is expected to be completed by the end of June 2017, this has been delayed by six weeks due to the chair Professor Ann Jacklin having a period of sick leave.

2.6. Following the recent CQC follow up inspection in May 2017, high level feedback was provided to the Trust Executives which included some immediate medicines management actions.

3. Medicines Management issues and action taken to-date

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

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

3.1.2. Phase one of the external independent medicine review aims to explore the Trust's governance systems and processes in relation to medicines management. The group agreed that this would be achieved through the development of case files relating to specific identified issues.

3.2. **Progress to date**

3.2.1. We are reviewing the medicines used in the Trust and removing duplicate drugs that are used for the same conditions to ensure we are adhering to best clinical practice.

3.2.2. The external independent medicines'' review terms of reference and outcomes of the review have been agreed and the internal support group identified

3.2.3. All eight case files that explore the Trust's governance structures, compliance with the relevant regulatory and legal requirements and form the basis of phase one of the Review have been completed and are being used to inform the interim report that will be shared with the Trust's Chief Executive.

3.2.4. The project management team are providing the Chief Pharmacist with support to deliver the CQC 'must do' action plan including facilitating problem solving and prioritising issues.

4. Controlled Drugs

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

4.2. The standard operating procedure (SOP) for controlled drugs is out of date, unclear and too long.

4.3. We identified that crews are routinely carrying four ampoules of morphine. Legally they are only allowed to carry and have two x 10mg= 20mg of morphine in their possession.

4.4. A review of ampoule breakages identified one of the possible root causes of the high number of breakages was the case used to carry these drugs.

4.5. **Progress to date**.

4.5.1. The clinical instruction advising staff of the changes to the amount of morphine they can carry has been circulated and the revised practice implemented on 20 April 2017. The Chief Pharmacist receives an alert if any member of staff withdraws more than two ampoules of Morphine, this is then followed up with the individual's manager. In the past month very few alerts have been generated demonstrating staff are adhering to this change.

4.5.2. The Chief Pharmacist is working with our account manager at Omnicell to develop an audit trail that will account for all CDs, returned, broken or administered. The Trust CDAO, (Fionna Moore) has agreed to this change allowing more monitoring of CDs to take place in the organisation.

4.5.3. An alternative method for carrying CDs has been identified, this approach will be personal issue with the drugs carried in a case on the individual's belt. This device has been costed and discussed with the Unions, who are supportive. The next steps are to develop and submit a business case for this development.

4.5.4 The Trust's current CD license expires on 05 September 2017, the Chief Pharmacist is in direct contact with the Home Office in relation to the application process and possible need for a Home Office compliance visit.

4.5.5 Work has commenced on updating and drafting the controlled drugs policy and associated SOPs. A workshop was chaired by the Chief Pharmacist attended by staff from logistics and a range of operational staff to map the processes for ordering, distributing and handling CDs. This work will inform the policy and supporting processes

4.5.6 The Trust has obtained a T28 waste exemption license which allows the sorting and denaturing of CDs for disposal at 41 sites in the Trust

4.5.7 The Medical Director is now formally identified as the CDAO. The Care Quality Commission (CQC) have been informed of this and an application made to include this information on the information held by CQC.

4.5.7 The CDAO and Chief Pharmacist are booked onto a nationally recognised two day Accountable Officers Course in July 2017.

5. Staffing

5.1. There are currently 2.5 WTE vacant medicines support workers with another member of staff due to leave the packing unit on the 23 June 2017, increasing the

vacancy rate to 50% This is impacting on the ability of the team to meet station medicine orders.

5.2. The medicines' management lead has recently left the Trust; it has been identified that due to capacity in the team additional support is required to ensure the action plans are implemented in a timely manner. However, as the Trust is unclear at the present time how this service will be provided in the near future, it was decided to cover the post with a temporary member of staff.

5.3. **Actions completed to date**

5.3.1 To cover the vacant medicine support worker posts until a decision has been made about how the Trust provides its medicines management service we have recruited 2 WTE agency staff. To ensure continuity of the service and retain staff we are currently exploring the possibility of recruiting staff to six months fixed term contract to cover the vacancies.

5.3.2 On the 06 June 2017, a temporary, part-time, Senior Pharmacist Technician commenced in post to support the Chief Pharmacist develop the medicines dash board and other specific improvement work linked to the CQC action plan.

6. Patient Group Directives (PGDs)

6.1. All PGDs expired at the end of May 2017, there was no identified plan with timescales for the updating of these PGDs.

6.2. All the medicines administration protocols (MAPS), protocols for specific medicines used by identified groups of staff who have completed training and have been assessed as competent are due to expire in July 2017. These all need to be reviewed and updated to ensure they are reflect best practice.

6.3. **Progress to date**

6.3.1. A review of the majority of the Patient Group Directives (PGD), has been completed to ensure they reflect best evidence based practice, and the staff groups identified to use them, are legally authorised to do so. These have now been published on the Trust intranet and staff have provided electronic signatures to confirm they have read and understood these revised PGDs. The only outstanding revised PGDs are those used by our Critical Care Paramedics and nurses.

6.3.2. The CCP PDGs have been revised and are currently being shared with external medical experts to ensure they reflect best practice. It is anticipated that these PGDs will be ready for publication by the end July 2017.

6.3.3. A review of the PGD for tranexamic acid is under way, this is being undertaken following the publication of WOMAN study.

6.3.4. The PGDs used by nursing staff employed by the Trust are currently also under review, this work is expected to be completed by July 2017.

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

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

7.2. **Progress to date**

7.2.1 Building work is now complete on the mezzanine area of Paddock Wood Make Ready Centre and there is a new secure air conditioned medicines store room, ensuring that medicines are stored securely in line with legal guidance.

8. Trust estate and temperature control

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

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

8.3. All areas used to store medicines must have the ambient room temperature monitored to ensure drugs are stored at recommended temperatures. This is done either by an active monitor installed into an Omnicell or by a standalone unit which will alarm should the parameters be breached. Currently we have medicines stored outside in areas that do not have effective temperatures monitoring.

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

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

8.6. **Progress to date**

8.6.1 An escalation procedure for when temperatures are outside the recommended range has been introduced and to date this procedure has been used 23 times in the Summer of 2016 and never in 2017.

8.6.2 To ensure there is clarity of the temperature each drug used in the Trust should be stored at we are currently compiling an in-house database with information from drug companies in relation to the stress/stability testing performed at extremes of temperatures.

8.6.3 We have completed a baseline exercise of all stations and reviewed the temperatures of the areas used to store drugs. This information has been uploaded onto the dashboard and will be monitored to ensure compliance.

9. Overspent Medicines Budget

9.1. The year end 2017 spend on medicines was £883,008 against a budget of £428,016. The budget for 2017/18 is £850,752

9.2. The spend on associated budgets for medical gases and consumables have not increased at the same rate as the medicine's budget and are not significantly overspent. On investigation of the rationale for this it was noted that all stations are supported by either a Make Ready Centre (MRC) or a Vehicle Preparation Programme (VPP) for gases and consumables.

9.3. The medicine's budget was previously managed by the Head of Procurement (Finance) despite not having any direct control on how the budget is spent. It is anticipated that this budget will be transferred to the Medical Directorate in 2017/18.

9.4. **Progress to date**

9.4.1 The medicine's budget has been transferred to the medical directorate.

9.4.2 The Chief Pharmacist is planning to undertake a review all medicines used in the Trust and the amount wasted to ensure effective usage of medicines..

10.0 **Over labelling of drugs**

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

10.2 **Progress to date**

10.2.1 The Trust's process for over labelling the Paramedic Practitioners drugs is now provided by an external NHS Trust to ensure practice is in line with national guidance. It is planned that this will continue until a review of the most effective and efficient approach to medicines management in the Trust is agreed.

13.0 No contract for the removal of medicines waste

13.1 It has been identified that the current clinical waste contract does not include removal of medicines waste. The medicines management team have discussed this with estates who have confirmed the removal of medicines waste such as out of date medicines and fluids is not included in their budget.

13.2 In discussion with Mark Cottenham, Estates Contracts Manager it has been identified that we are spending on average £1,110 per month on the removal of medicines waste from Paddock Wood. The contractor removing this waste has raised concerns about the amount of medicines waste the Trust is generating.

13.4 Progress to date

13.4.1 Work has commenced on the drafting of the Trust waste management policy; this work is expected to be completed by July 2017.

13.4.2 The Chief Pharmacist has commenced an exercise to investigate the amount of medicines used across the trust and the amount of medicine waste that is generated. this work is expected to be completed by August 2017.

14 Drug labels

14.4.1 The Trust's drug labels have been identified as not in line with national guidance, they are not the right colours and the crown is not the correct size or position. Staff have informed us that they had previously raised this as an issue by staff to medicines management team but their concerns were not taken into account prior to the introduction of labels. The labels will be withdrawn and a supplier of correct labels identified.

14.5 Progress to date

14.5.1 We are piloting the use of new drug labels with the CCPs to ensure they are fit for purpose. This group was chosen as they are a smaller group of staff and therefore implementation was easier.

14.5.2 We are in discussions with other staff groups to identify which labels they require and will then request procurement source these.

15 Medicines dashboard

15.1 At the present time there is no effective medicines dashboard to monitor and drive improvement.

15.2 Progress to date

15.2.1 The Chief Pharmacist is commencing work on the development of a medicines dashboard in June 2017.

16 Omnicell

16.1 It has been identified that the Trust is not utilising the Omnicell systems to realise maximum benefits.

16.2 Progress to date

16.2.1 Training Dates have been arranged with Omnicell Ltd for key staff to attend a two-day training programme to assist us realise Omnicell's full potential. This training is planned for the 10 and 11 July 2017. This training will then be cascaded to operational staff who use Omnicell as part of their role.

16.2.2 The need for a SOP to guide staff on the process they should follow in the event of Omnicell failing or malfunctioning has been identified. This SOP is currently being drafted and the work is expected to be completed by July 2017

Fiona Wray- Associate Director, Medical Directorate

Carol-Anne Davies Jones- Chief Pharmacist

June 2017

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	51/17

Name of meeting	Trust Board
Date	29 June 2017
Name of paper	Clinical Outcomes Deep Dive
Responsible Executive	Dr Fionna Moore – Executive Medical Director
Author	Kirsty Booth – Business Support Manager, Medical Directorate
Synopsis	This report will look at the clinical outcomes that we report to NHS England and how we collate and use this data to inform quality improvements.
Recommendations, decisions or actions sought	The board is asked to discuss the report.

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

Clinical Outcomes

1. Introduction

1.1. This report will look at the clinical outcomes that we report to NHS England, looking specifically at the long term trends that we are seeing on the integrated performance dashboard which is reviewed every month by the Trust Board.

1.2. On 27 April 2017 a verbal update was given by the Executive Medical Director which detailed where we are in relation to the eight Ambulance Clinical Quality Indicators (ACQI).

1.3. The Trust is continuing to work with our Commissioners to agree the improvements required and it is envisaged that this will form part of a two-year plan.

1.4. This report will look into how we are obtaining the data and the criteria we are using to report from.

2. CQC Must/Should do action plan

2.1. Improving clinical outcomes forms part of the CQC Must/Should Do action plan, the plan is comprehensive and includes not only the ACQIs but any workstreams where the clinical outcome for our patients could be improved.

2.2. The CQC Must/Should Do tracker includes

2.2.1. Improving clinical leadership

2.2.2. Confident and competent to provide end of life care

2.2.3. Reduction in conveying patients to hospital by 0.5%

2.2.4. Improving the ASHICE process (Procedure for pre-alerting hospitals for serious ill patients)

2.2.5. Increasing falls & hypo referrals

2.2.6. Improving outcomes from Out of Hospital Cardiac Arrest (OHCA)

2.2.7. Reduction in Task Cycle time

2.2.8. Frequent caller process

2.2.9. The use of audit data to inform practice development

2.2.10. Improve clinical outcomes for patients through optimised ACQI performance.

3. Current Position

3.1. On 11 June 2017 the National figures for the ACQIs were published and showed that although there was an improvement seen in ROSC at hospital with the Trusts performance being above the National average, the same picture as seen in previous months showed our performance for Stroke and STEMI care bundles and Survival to Discharge (StD) all below the National average.

3.2. Figure 1 below shows the published ACQI

		Cardiac Arrest - ROSC		STEMI 150		Stroke		Cardiac Arrest - StD	
		All patients	**Utstein comparator group**					**All patients**	**Utstein comparator group**
		Proportion of those who were resuscitated who had return of spontaneous circulation on arrival at hospital	Proportion of those who were resuscitated who had return of spontaneous circulation on arrival at hospital, where the arrest was bystander witnessed and the initial rhythm was VF or VT	Number of patients with initial diagnosis of definite STEMI for whom primary angioplasty balloon inflation occurred within 150 minutes of emergency call connected to ambulance service, where first diagnostic ECG performed is by ambulance personnel and patient was directly transferred to a designated PPCI centre as locally agreed	Proportion with suspected STEMI confirmed on ECG who received an appropriate care bundle	Number of FAST positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines arriving at hospitals with a hyperacute stroke centre within 60 minutes of call connecting to the ambulance service	Proportion of suspected stroke or unresolved transient ischaemic attack patients assessed face to face who received an appropriate care bundle	Number of patients who had resuscitation commenced/ continued by ambulance service following an out-of-hospital cardiac arrest, who were discharged from hospital alive	Number of patients who had resuscitation commenced/continued by ambulance service following out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was VF or VT, who were discharged from hospital alive
England	Apr-16	29.8%	53.5%	88.3%	80.7%	54.3%	97.6%	8.2%	27.2%
Trust		26.1%	60.5%	94.2%	66.7%	63.7%	95.2%	6.5%	27.0%
England	May-16	29.2%	54.0%	85.5%	80.0%	55.1%	98.0%	8.9%	27.7%
Trust		26.0%	60.6%	88.2%	65.1%	66.3%	95.9%	8.8%	36.4%
England	Jun-16	29.6%	51.9%	86.3%	76.9%	53.5%	97.6%	9.5%	27.2%
Trust		30.3%	45.9%	91.0%	65.7%	58.8%	98.2%	9.1%	28.6%
England	Jul-16	29.7%	53.3%	85.3%	80.3%	54.0%	97.6%	9.7%	31.0%
Trust		32.3%	67.9%	95.2%	64.7%	67.0%	96.5%	10.3%	29.2%
England	Aug-16	27.2%	52.3%	86.0%	79.0%	56.7%	97.3%	9.1%	29.5%
Trust		25.3%	46.2%	89.9%	72.5%	66.8%	94.2%	9.2%	32.0%
England	Sep-16	28.7%	49.9%	86.9%	79.7%	53.8%	97.2%	9.5%	25.9%
Trust		25.3%	44.1%	86.7%	76.6%	62.6%	95.6%	9.4%	30.0%
England	Oct-16	26.6%	47.6%	86.4%	78.7%	51.7%	97.6%	7.8%	25.7%
Trust		27.8%	48.1%	96.9%	63.1%	62.6%	95.4%	4.3%	15.4%
England	Nov-16	28.6%	54.5%	85.0%	78.2%	53.1%	97.2%	7.8%	27.9%
Trust		25.1%	46.9%	90.8%	67.6%	59.8%	96.3%	2.4%	4.8%
England	Dec-16	27.2%	44.4%	85.2%	81.4%	50.7%	97.8%	6.7%	21.7%
Trust		28.5%	48.6%	86.9%	62.8%	58.9%	95.6%	3.7%	8.8%
England	Jan-17	27.5%	49.9%	81.0%	79.1%	52.1%	97.6%	6.9%	24.8%
Trust		28.8%	51.5%	76.8%	65.6%	59.0%	94.9%	3.4%	10.7%

Figure 1 - Shows the published ACQI by NHS England (11 June 2017)

4. Cardiac Arrest

4.1. The Trust is currently undertaking a deep dive into cardiac arrest, this is being led by the Consultant Paramedic – Critical Care & Resuscitation.

4.2. The review so far has found areas where there is significant improvement work needed, some areas are detailed below:

4.2.1. The Trust attends approximately 300 cardiac arrests per month. Of this figure 50% of the downloads are made available for audit, this is due to the ECG download submission being voluntary. We are exploring the benefits of making the download submission mandatory to assist with the audit of the data to inform quality improvements and patient outcomes. (This is higher than any other UK ambulance trust, and we are looking to share the information gathered with front line staff.)

4.2.2. The criteria that the Trust uses for the submission of cardiac arrest data needs to be reviewed, as we only submit data where we have received a Patient Clinical Record (PCR) linked to an incident. The ACQI data requirements allow a larger sample to be considered.

4.2.3. A review of the content in the Trust PCR to incorporate the cardiac arrest form as the data on the Cardiac Arrest form is not regularly audited.

4.3. A full update and presentation is planned to be given to the Executive Management Board in early July 2017.

5. STEMI

5.1. The Trust consistently performs below the National average in the STEMI care bundle, this is due to the second pain score not being completed. However, Time from Call to Balloon is within the national parameters.

6. STROKE

6.1. Although the Trust consistently performs below the National average in the Stroke care bundle, due to the operational staff not recording a BM score, the overall score is in excess of 90%. We are looking at areas in the Trust where through geographical issues, patients may experience a long delay from call to hospital, to try and improve the overall time to hospital.

7. Reporting to NHS England

7.1. All future ACQI data that is required to be submitted to NHS England will be reviewed at meetings held on a monthly basis, chaired by our Consultant Paramedic – Critical Care & Resuscitation and approved by the Assistant Director – Medical before submission to ensure accurate reporting.

8. Clinical Education

8.1. All new staff undergo training that is commensurate to their clinical grade. A review of the lesson plans and feedback from the higher education providers has identified that the underpinning knowledge of the ACQIs is not covered in any of the modules.

8.2. A review of the clinical education plans will be undertaken to ensure staff awareness of the ACQIs is embedded in all clinical education programmes.

9. Summary

9.1. This report has highlighted areas for improvement in all of the six ACQIs.

9.2. The report also shows areas of good practice that should be further developed and shared to improve our overall compliance and performance.

9.3. The CQC Must/Should do action tracker was developed post the 2015 CQC inspection, the Clinical outcomes section was updated to incorporate the agreements made at a workshop with our Commissioners on 10 April 2017.

9.4. Out of Hospital Cardiac Arrest outcomes remain a key priority for the Trust, with targeted work led by our Consultant Paramedic – Critical Care & Resuscitation.

9.5. A review of the Operating Unit performance dashboard on its effectiveness in driving improvements and trust wide reporting.

9.6. The Board is asked to discuss this report.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	52/17

Name of meeting	Trust Board
Date	29 June 2017
Name of paper	Defib Patient Impact Review
Responsible Executive	Joe Garcia, Executive Director of Operations
Author	Joe Garcia, Executive Director of Operations
Synopsis	This paper sets out the findings of the review into the patient impact of the inability of the Computer Aided Dispatch (CAD) system to consistently identify in real time the location of the nearest Public Access Defibrillator, and the use of the 'Webdefib' call sign to 'stop the clock'.
Recommendations, decisions or actions sought	Acknowledging that this review has been overseen on its behalf by the Quality & Patient Safety Committee, the board is asked to discuss the findings, and agree the steps taken by management to ensure the Trust establishes and then maintains an accurate and up to date defibrillator database.

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**

Patient Impact Review – Defibrillators

1. Introduction

1.1 In 2015, following whistle-blowing cases and associated media coverage, the Trust Board commissioned a review by the Trust's Internal Auditors, RSM, which considered the reporting, governance and technical issues associated with the 'Webdefib' call-sign and the inability of the Trust's current Computer Aided Dispatch (CAD) system to consistently record the location of the nearest Public Access Defibrillator (PAD).

1.2 The 'Webdefib' call-sign was a call-sign added manually and retrospectively to 999 calls recorded on the Trust's Computer Aided Dispatch (CAD) system in the Emergency Operations Centre (control room), indicating that a defibrillator was in the vicinity of the patient at the time of the call.

1.3 Following this review in early 2016 it was agreed that a high-level Patient Impact Review would be undertaken to understand any impact on the issues relating to Public Access Defibrillators.

1.4 The Terms of Reference for the Patient Impact Review looked at two specific areas to assess potential impact:

1. The inability of the Trust's current Computer Aided Dispatch (CAD) system to consistently identify in real time the location of the nearest Public Access Defibrillator (PAD).
2. Use of the 'Webdefib' call sign to 'stop the clock'.

In terms of time periods, the review considered:

- All Red 1 calls covering the period 1st November 2015 to 30th June 2016 plus.
- It also included the 32 incidents allocated a 'Webdefib' call sign between 1st April 2014 and 30th November 2016 that were identified in the RSM Review.

These time periods were chosen to take account of:

- Publication of guidance by AACE for Ambulance Trusts on interpretation of the national Ambulance Quality Indicators (AQIs) – February 2014 and July 2015.
- Cessation of use of the 'Webdefib' call-sign – November 2015.
- Introduction of new national AQIs – January 2016.

1.5 The internal review was undertaken by a multi-disciplinary team from within the Paramedic and Medical directorates. It also had oversight from NHS Improvement through its Improvement Director and Head of Quality.

2. Methodology

2.1 To attempt to identify the impact on patients, each call falling into the time periods detailed in 1.4 above was reviewed, in terms of both the CAD record and the accompanying Patient Clinical Record (PCR).

2.2 Using the RSM Review as a basis, each call was assessed in terms of:

- Whether or not the 'Webdefib' call-sign was applied correctly (in terms of meeting the AQI requirements in place at the time).
- Whether or not there was a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place for that patient at the time.
- The presenting condition of the patient (as far as this was able to be ascertained from the records) at the time of the call.
- The Public Access Defibrillator (PAD) database.

2.3 As part of the process, a workshop was held in January 2017, which included representatives from NHS Improvement as well as members of the Trust Board, to consider the early findings.

3. Patient Impact

3.1 In terms of the inability of the CAD system to consistently identify the nearest PAD at the time of the call, it proved difficult to comprehensively assess the impact on patients of this, due to:

- The PAD database being a 'live' document i.e. defibrillator sites are added and removed from the database on a frequent basis, without the date being consistently recorded. Therefore, when reviewing retrospectively, it is impossible to robustly confirm whether a PAD was recorded on the system at the time of any call or not.
- The limited information provided by 999 callers in terms of the presenting condition of the patient.
- The difficulty in determining, for each call, whether or not the use of a defibrillator would have resulted in a better outcome for the patient, due to:
    - Patients who collapse often have multiple conditions, so it is impossible to identify whether or not the patient was suffering a cardiac arrest and use of a defibrillator would have been appropriate and/or beneficial.
    - The 'shock' from a defibrillator is only proven to be of benefit in less than 25% of cardiac arrest cases (the application of chest compressions is of far more benefit).

3.2 Given the constraints as noted above, it was not possible to fully assess the impact on patients, although there was no evidence of harm from the data reviewed.

3.3 However, the review did recommend that one case (from March 2016) should be subject to a further clinical review.

3.4 This review has concluded that for this case:

- The national AQIs were not correctly applied to this incident in performance terms, primarily because the national acceptance to record a defibrillator in attendance needed to happen at the time of call and not retrospectively.

However:

- The incorrect performance reporting of this call did not change the dispatch of resources to this incident.
- The Emergency Medical Advisor (EMA) did ask the 999 caller if a defibrillator was available and was informed that there was one and it was being retrieved.
- The defibrillator was used on the patient prior to the arrival of the crew, although unfortunately it was not successful.

Therefore, the reviewer concluded that there was no adverse patient impact in this case.

3.5 No adverse impact on patients was identified through application of the 'Webdefib' call-sign for performance reporting, whether this was applied correctly or not. As the application was undertaken retrospectively, it did not change or slow down the response to the patient in any sense for any of the 999 calls reviewed.

4. Current situation and moving forwards

4.1 The 'Webdefib' call-sign ceased to be used by the Trust in November 2015. Since then, the Trust has chosen not to permit the presence of a defibrillator to 'stop the clock' for any 999 calls in terms of performance reporting, although this is permitted under the national Ambulance Quality Indicators (AQIs) in line with specified criteria.

4.2 The Trust's current CAD system still cannot consistently identify the location of defibrillators in the community and this is logged on the Trust's Risk Register.

4.3 The Trust is currently in the process of implementing a new CAD system, which will 'go live' in stages from July 2017 onwards. The new CAD will be able to accurately identify the location of defibrillators, although this is dependent on the defibrillator database being maintained and kept up to date.

4.4 Establishing and maintaining an accurate and up to date defibrillator database is an issue for all Ambulance Trusts and there are a range of different, locally-applied solutions in place. The Trust is already exploring a range of potential options and is looking to replicate best practice from elsewhere.

4.5 In addition, recognising that this is a national issue, the British Heart Foundation (BHF) is currently funding a £5m project to create and support a national database of defibrillators for a period of three years. The Trust is looking forward to fully supporting this initiative.

5. Conclusion

5.1 The historic use of the ‘Webdefib’ call-sign within the Trust has now been subject to a number of different reviews covering the technical, performance and patient impact aspects of the process.

5.2 The reviews have identified a number of issues including:

- Historic incorrect application of the ‘Webdefib’ call-sign that was not consistently in line with AQI guidance.
- Poor governance processes previously around changes to performance reporting.
- The inability of the Trust’s CAD system to consistently identify the location of defibrillators.
- On-going issues with creating and maintaining an accurate and up-to-date defibrillator database.

5.3 Within the limitations of the review, no adverse impact on patients has been identified, although as we cannot comprehensively analyse all of the data, it cannot be ruled out completely.

5.4 The Trust regrets that, through the issues identified at 5.2 above, it did not put the best systems in place to manage this risk, even taking account of the technical limitations of the CA. These have been material factors in the Trust reaching a decision to replace the Computer Aided Dispatch platform.

SECAMB Board

Audit Committee Escalation Report

Date of meeting	**21 June 2017**
Overview of issues/areas covered at the meeting:	The meeting considered papers covering Financial Reporting, Internal Audit, External Audit Risk Management/Governance and Counter-Fraud items. In summary, the key matters were as follows; **Preparation for Committee Meetings** It was emphasised to the Executive that Minutes of previous meetings, updated actions and sending out papers on time are essential (unless with prior agreement of the chair) to enable the Committee to execute its detailed work on behalf of the Board as a whole. Papers should have a clear purpose and articulation of executive opinion/actions proposed/intended together with sufficient evidence for the Committee to add constructive challenge and support. The committee emphasised that in normal circumstances, all papers submitted should have the support of the Chief Executive **Counter Fraud** In consideration of the Annual Report the committee was assured that the Trust has raised awareness of counter fraud and through the self-review tool demonstrated good adherence to the relevant criteria/regulations. The related action plan aims to ensure this is maintained through 2017/18. The committee agreed to adopt the Counter Fraud 2017/18 work-plan. **Internal Audit** The committee received the progress report. Internal Audit highlighted the upcoming changes to the data protection regulations. Internal Audit raised an emerging concern that some of the actions in the audit tracker were starting to slip. The executive agreed to work with internal audit to ensure action is taken. The committee agreed at this stage to note the emerging concern and will review progress in dealing with actions again at its next meeting. **Annual Corporate Governance Statement** The committee commended the work done to get this paper to committee but felt that the paper needed further executive development and explicit support from the Chief Executive **Board Assurance Framework & Risk Register** The committee discussed the risks and challenged the way some of the risks are articulated and some of judgments on the risk ratings. It acknowledged that the BAF will be reviewed in the autumn. The BAF is not consistent with the risk register. The Risk Register (and therefore) Risk Management mechanisms clearly have some way to go but the committee was positive about the progress being made.

	NAO Benchmark A Summary paper was presented. The committee was unable to endorse priorities but noted the paper on the understanding that implications from the NAO benchmark would be brought into plans & strategy to be presented to the Board meeting
Reports *not* received as per the annual work plan and action required	Due to the lack of minutes and updated actions, the reports and papers deferred to this meeting from the meeting at the end of May were not available. Consideration of External Audit recommendations and a review of Q4 Internal Audit Reports will be covered at Audit Committee meetings later in the year
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	**Risk Management** - although the committee acknowledged the progress being made on the Risk Register, there is still some way to go to ensure adequate systems and culture of risk management. In particular, at a minimum, the BAF and Risk Register need to be consistent. Due to the misunderstanding about agenda items for this meeting, the Committee was unable to consider the Internal Audit review of the BAF and Risk Management conducted in Q4. This will be considered later this year
Any other matters the Committee wishes to escalate to the Board	**Policies** In the context of the current board committee/governance structure, the committee discussed its role in assuring the Board that the 'major' policies are in place, are clear about what is expected, who is responsible and the mechanisms for understanding the extent and nature of compliance. It was agreed that: - The committee will receive at its next meeting a list of all formal SECAmb policies (for which Executive Committee members are accountable) together with their last review dates - The executive would arrange for Chair to review a small number of policies to test the current policy template. **Integrated Performance Report** At the meeting in September the committee will facilitate an executive-led discussion about the IPR and how it can be improved to ensure it has the right balance of information for the Board.

SECAMB Board

QPS Escalation report to the Board

Date of meeting	19th June 2017
Overview of issues/areas covered at the meeting:	This meeting considered: ***Management Responses*** *(response to previous items scrutinised by the committee)* • **Medical Equipment**- The committee was **assured** by the additional evidence that was provided to give assurance in this area. It was agreed later in 17/18 that a sampling of equipment will be done to demonstrate the consistency of testing. • **Private Ambulance Providers** - The committee was **assured** by the additional evidence (e.g. CQC Certificates) subject to evidence of external checks being completed. The committee will ask the finance and investment committee to scrutinise procurement in the next quarter given some of the issues identified. • **Use of LifePack12** – The committee was **assured** that use of LP12s presented no patient safety issues but have asked that a 'Defibrillator Strategy' is developed with a view to retiring the LP12s over an agreed period. • **Duty of Candour** - The committee was informed that the Duty of Candour field is now mandatory in Datix. A further management response will be brought in July to demonstrate the process/system in place to demonstrate we are compliant. • **Patient Care Records** – There is executive grip and focus in this area, with work being undertaken to identify the issues both internally as well as RSM being asked to undertake a review of Health Records. It was agreed a rectification plan would be brought in September. ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas)* **Clinical Audit – Not assured** The committee was briefed on the current status of clinical audit and it is clear that the Trust does not have the resources in place to execute even a basic clinical audit plan. This is particularly disappointing given the effort and focus in the area in Q1-3 2016. The committee was assured that this has focus from the Chief Executive and his executive team. **Vehicle Infection Control – Assured** The committee scrutinised the design and effectiveness of the Trust's system of internal control for Vehicle Infection Control. It was assured that the processes are in place, although a tighter grip on managing the outcome to achieve targets is needed; assurance was given this will be put in place. It was agreed that the clean at shift start/deep clean/swab test would be included in the Quality & Patient Safety Report. **Mortality and Morbidity** - **Assured** The committee was assured that the new proposal for Morbidity and Mortality would comply with the March 2017 'National Guidance on Learning from Deaths' and the mandatory reporting required for the 2018 Quality Account. The previous process that was put in place in 16/17 was not fit for purpose. The above is subject to the Trust putting a policy in place by September 2017. The outcome of the process will be included in the Quality & Patient Safety Report. **Safeguarding Annual Report 2016/17** The Safeguarding Annual Report was accepted by the committee as meeting the

	requirements of an annual report. It was noted that progress had been made in some areas though the year particularly in relation to managing safeguarding allegations policy and procedures. **Quality and Patient Safety Reporting** • **Quality Improvement Plan/CQC Inspection Finding** The committee received an update on the Quality Improvement Plan and noted progress in many areas, and the areas rated 'red' which include Patient Care Records, Clinical Audit and Clinical Outcomes. The committee also discussed the preliminary CQC inspection findings and any areas the committee was not cited on and the action to be taken. • **MDT Review** The committee noted an excellent and clear report (External Serious Incident Review) into the patient impact of the Mobile Data Terminal Misuse. This related to 16 incidents and the findings were that patient harm did not occur although there may have been a detrimental impact on the experience of the patients. Also, of the 16 patients there were two cases where harm could have resulted, but on balance the clinical outcome would not have changed. The committee has asked for a Management Response on the recommendations made by the review to be bought to the July meeting.
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	There is no Clinical Audit Plan in place for 2017/18. Alongside the concerns about clinical audit the Trust does not currently have a clear strategy/plan on how to improve the Clinical Outcome Indicators and the committee asked this be considered alongside the Clinical Audit work.
Weaknesses in the design or effectiveness of the system of internal control identified and action required	Clinical Audit Patient Care Records
Any other matters the Committee wishes to escalate to the Board	The Committee also received an update on the issue recently highlighted with **call recording**. It was assured that this is progressing to resolution and explored why this issue had occurred and what could be done to prevent it in the future. The committee received an update on **medicines management** and the outcome of the Discovery Phase of the External Review that is being undertaken. Although this phase of the review found significant weaknesses in governance, it established that there has been no patient harm and that the governance supporting medicines management from March 2017 is now much improved, due to the leadership of our new Medical Director and Chief

	Pharmacist. Lastly, the committee noted the quality and timeliness of papers submitted and the work and preparation that had gone in behind this, which enabled a full agenda to be dealt with efficiently and effectively. Well done!

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Finance & Investment Committee

Date of meeting	5th June 2017
Overview of issues/areas covered at the meeting:	1. Vehicle replacement business cases – for support 2. Datix implementation lessons learned 3. Updated plans for ePCR roll out 4. Update on the new CAD implementation
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	Once signed, the support contracts being put in place for Visicad for 12 months from July 2017 will reduce operational risks with the new CAD.
Weaknesses in the design or effectiveness of the system of internal control identified and action required	1. Fleet lease agreements
Any other matters the Committee wishes to escalate to the Board	1. Financing of fleet decision still to finalised (lease /buy). 2. Relative prioritisation of ePCR to be confirmed