South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

25 July 2017

10:00-13:00

Crawley HQ

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
58/17	10.00	Chairman's introduction	-	-	RF
59/17	10.01	Apologies for absence	-	-	RF
60/17	10.02	Declarations of interest	-	-	RF
61/17	10.03	Minutes of the previous meeting: June 2017	**Y**	Decision	RF
62/17	10.05	Matters arising (Action log)	**Y**	Decision	RF
Organisational culture					
63/17	10.10	Patient story	-	Set the tone	
64/17	10.15	Chief Executive's report	**Y**	Information	DM
Trust strategy					
65/17	10.25	Unified Recovery Plan Delivery Progress Update ▪ Organisational Recovery Dashboard ▪ Quality Dashboard ▪ Financial Sustainability Dashboard	**Y** **Y** **Y** **Y**	Assurance	JA JA SL DH
66/17	11.00	Trust 5-Year Strategy	**Y**	Decision	DM
67/17	11.10	Board Assurance Framework	**Y**	Decision	PL
Ten minute Break					
Monitoring performance					
68/17	11.20	Integrated Performance Report	**Y**	Information	DM
69/17	11.30	Medicines Management Progress Update	**Y**	Assurance	FM
70/17	11.40	Serious Incident Management Update	**Y**	Assurance	FM
Annual Review					
71/17	11.50	Infection Prevention & Control Annual Report	**Y**	Assurance	SL
72/17	12.00	Workforce Race Equality Standard Annual Report	**Y**	Assurance	SG
Holding to account					
73/17	12.30	Escalation report; Workforce Committee	**Verbal**	Information	TH
74/17	12.35	Escalation report; Quality & Patient Safety Committee	**Y**	Information	LB
75/17	12.40	Escalation report; Finance Committee	**Y**	Information	GC
76/17	12.45	Any other business	-	Discussion	RF
77/17	-	Review of meeting effectiveness	-	Discussion	ALL

Close of meeting

Date of next Board meeting: 29 September 2017

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

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	64/17

Name of meeting	Trust Board
Date	25 July 2017
Name of paper	Chief Executive's Report
Executive sponsor	Chief Executive
Author name and role	Daren Mochrie
Synopsis (up to 120 words)	The Chief Executive's Report provides an overview of the key local, regional and national issues involving and impacting on the Trust and the wider ambulance sector.
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.
Why must **this** meeting deal with **this** item? (max 15 words)	To receive a briefing on key issues, as noted above.
Which strategic objective does this paper link to?	2. Culture

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

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S REPORT TO THE TRUST BOARD

July 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 Recruitment to the Executive Team

2.1.1 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 taking place during late July and early August 2017.

2.2 New Computer Aided Dispatch (CAD) system

2.2.1 The first stage of the 'go live' of the Trust's new CAD system took place in the early hours of 6th July 2017, when the Emergency Operations Centre (EOC) at Coxheath (East) moved successfully onto the new Cleric system.

2.2.2 I am pleased to say that the move happened safely, with no interruption to service provision. This is down to a great deal of hard work in terms of planning and training during recent months.

2.2.3 The team are now working hard planning for the next phase of the CAD roll-out, which will see the West EOC at Crawley also move onto the new Cleric CAD. This successful took place on 18th July 2017.

2.2.4 The final stage will see the remaining staff based at Banstead move into the West EOC; this will take place in September 2017.

2.3 Operational Performance

2.3.1 The Executive Team are continuing to closely monitor 999 performance following the down-turn that has been seen during recent weeks. A number of factors are thought to have contributed to this, including the recent hot weather and the go-live of the new CAD. The team are continuing to drive forwards improvements in our own operational efficiencies, including job cycle time and response ratio, although it is disappointing to see that hospital turnaround times across the Trust are not improving; this obviously has an impact on patient safety, as well as placing additional pressure on our EOC and road staff.

2.3.2 The lack of progress in addressing the identified gap in funding and the impact this has on response time performance, the quality of care we are able to provide and on our patients and staff remains a serious concern for myself and the Board.

2.4 Success at enei Awards

2.4.1 On 11th July 2017, SECAmb was been awarded the 'Gold Standard' for the fourth year running at the Employers Network for Equality & Inclusion (enei) awards, held in London. SECAmb was recognised alongside big national companies like Santander and Zurich Insurance.

2.4.2 The awards acknowledge and celebrate those organisations who are committed to good practice in equality and diversity, above and beyond legal compliance and who utilise innovative approaches that will inspire other employers.

2.4.3 I would like to thank the Trust's Inclusion Manager Angela Rayner for her on-going hard work in this area and everyone who is involved in our work around equality, diversity and inclusion for the benefit of both staff and patients.

3. Regional issues

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

3.1.1 The Trust is continuing to work hard to support the changes made on 19th June 2017 to the provision of services at the Kent & Canterbury Hospital, which saw acute in-patient medical services move to the William Harvey Hospital (WHH) at Ashford and the Queen Elizabeth The Queen Mother Hospital (QEQM) at Margate

3.1.2 SECAmb is continuing to provide additional support in East Kent in order to help the system safely manage the implications of the changes at the Kent and Canterbury Hospital. This is being reviewed on a regular basis with partners and CCGs.

3.2 Sustainability and Transformation Partnership (STP) up-date - Kent

3.2.1 The Trust has received notification of the intention to formally consult on the future configuration of acute stroke services across Kent and Medway, emergency services in East Kent and elective orthopaedic care in East Kent.

3.2.2 The Trust continues to work with and support all STP areas to design their models of care and will provide updates and recommendations to the board as these plans progress and as options are formally consulted upon.

4. National issues

4.1 Ambulance Response Programme (ARP)

4.1.1 On 13th July 2017, NHS England announced that the Ambulance Response Programme (ARP) will be rolled out to all English ambulance Trusts over coming months.

4.1.2 The final roll-out of ARP to all Trusts follows the programme being piloted by firstly three, and then a further two ambulance Trusts during the past 18 months. The results from these pilots have been analysed by the University of Sheffield and used to influence the final design of the programme.

4.1.3 The changes outlined focus on making sure that the best, most appropriate response is provided for each patient, first time and are designed to change the rules

on performance standards, so that they are met by doing the right thing for the patient rather than trying to ‘stop the clock’.

4.1.4 The new standards will feature four categories of call:

- Category one is for calls about people with life-threatening injuries and illnesses. These will be responded to in an average time of seven minutes
- Category two is for emergency calls. These will be responded to in an average time of 18 minutes
- Category three is for urgent calls where patients may be treated in their own home. These types of calls will be responded to at least nine out of 10 times within 120 minutes
- Category four is for less urgent calls where patients may be given advice over the telephone or referred to another service such as a GP or pharmacist. These less urgent calls will be responded to at least 9 out of 10 times within 180 minutes.

4.1.5 Results and experience from the ambulance trusts who have been part of the pilot have shown that ARP necessitates a different operational model than many Trusts have adopted since the introduction of ‘call connect’. One key area is a change in the ratio of ambulances to cars - with the introduction of far more ambulances than cars.

4.1.6 We have started to plan for the local implementation of ARP, which will take place after the final stages of the roll-out of the new CAD.

5. Recommendation

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

Daren Mochrie QAM, Chief Executive

19th July 2017

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	

Name of meeting	Trust Board
Date	17 July 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) and the recent established Culture and Organisational Development Steering Group. 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 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, visibility and grip of the projects continues. The focus on the coming weeks will be to align the programmes with the Trust wide strategy which sets out strategic direction for the next five years and our objectives for the next two years. The impact this has on the PMO is that the existing governance will need to be adapted to ensure that the programmes of work are aligned so that projects continue to deliver the desired benefits.

2.2 The proposed governance going forward will see the current Organisational Recovery Steering Group feeding into the Quality Steering Group which will focus on Governance, 999/111, Clinical Service Model and Clinical Outcomes and Performance work streams. The Culture Steering Group will continue to focus on Organisational Development, Health and Well Being and Clinical Education. The existing Financial Sustainability Steering Group will become the Sustainability Steering Group which will encompass Digital, Fleet and Estates (Appendix A illustrates the proposed governance structure).

2.3 New and existing Project Boards will be aligned to the Steering Groups to ensure that the focus continues on driving delivery through greater accountability and management of risks and issues.

2.4 Programme Risks for all the URP programmes are actively being monitored via Datix with the Executives having sight of the top risks on a weekly basis.

3.0 URP Progress and Risks

Organisational Recovery Programme

3.1 Good progress has been made with the three CQC 'Must and Should Do's projects; Security Improvement Plan, Safe Resource Dispatch and Staff and Resourcing Improvement Plan. All three projects will be successfully closed in the coming weeks.

3.2 The deployment of iPads continues to make good progress. The on boarding of ipads has increased from 73% to 83.5% in last reporting period with the target of 90% to be reached by 21st July 2017. Focus is now on ensuring that all priority hospitals are on boarded to ensure that this does not have a negative impact on job cycle time.

3.3 A number of pre mobilisation workshops have now taken place to capture and understand the requirements for the Hear and Treat Project so over the coming weeks, a project mandate will be developed which outlines the key milestones.

3.4 CAD went 'live' at Coxheath on 6th July 2017 with no major issues with 'go live' proceeding as planned on the 18th July 2017. The reporting of progress will continue on a weekly basis to the Turnaround Executive to ensure any risks and issues are managed appropriately.

Quality Programme

3.5 Work continues on progress against the CQC 'Must and Should Do's'. In the coming weeks, a stock take of the areas of focus will be undertaken by the Director of Quality to ensure that momentum continues on the areas of most need.

3.6 Particular focus will be given on Medicine Management to ensure a Medicines Optimisation Action plan is submitted to the CQC by 22nd July 2017 and that areas of concern highlighted by CQC are resolved by 22nd September 2017.

Financial Sustainability

3.7 Good engagement with Execs and CIP Project Leads continues. Progress in some areas have been impacted due to availability largely due to annual leave commitments. £11.4 million of fully validated savings have now been identified. A positive meeting held with NHS Improvement to review progress on identification and delivery of 2017/18 CIP schemes. Over the coming weeks, engagement will continue to develop detailed plans to fully validate for Operations schemes.

Culture and Organisational Development

3.8 The Steering Group now meets on a fortnightly basis and progress has been made in identifying key areas of focus to ensure projects are effective and outcome driven. Over the coming weeks, Project Mandates will be developed for each project and signed off by the Steering Group.

To support effective project management and assurances thought the governance structures, highlight reports will be also be produced on a weekly basis. In the next reporting period, a dashboard for Culture and Organisational Development together with exception reports will be produced moving forward.

4.0 URP Dashboards

4.1 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. These will be revised over the summer to reflect new governance and the Strategy Delivery Plan.

5.0 Summary

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

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

6.0 Recommendation

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

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

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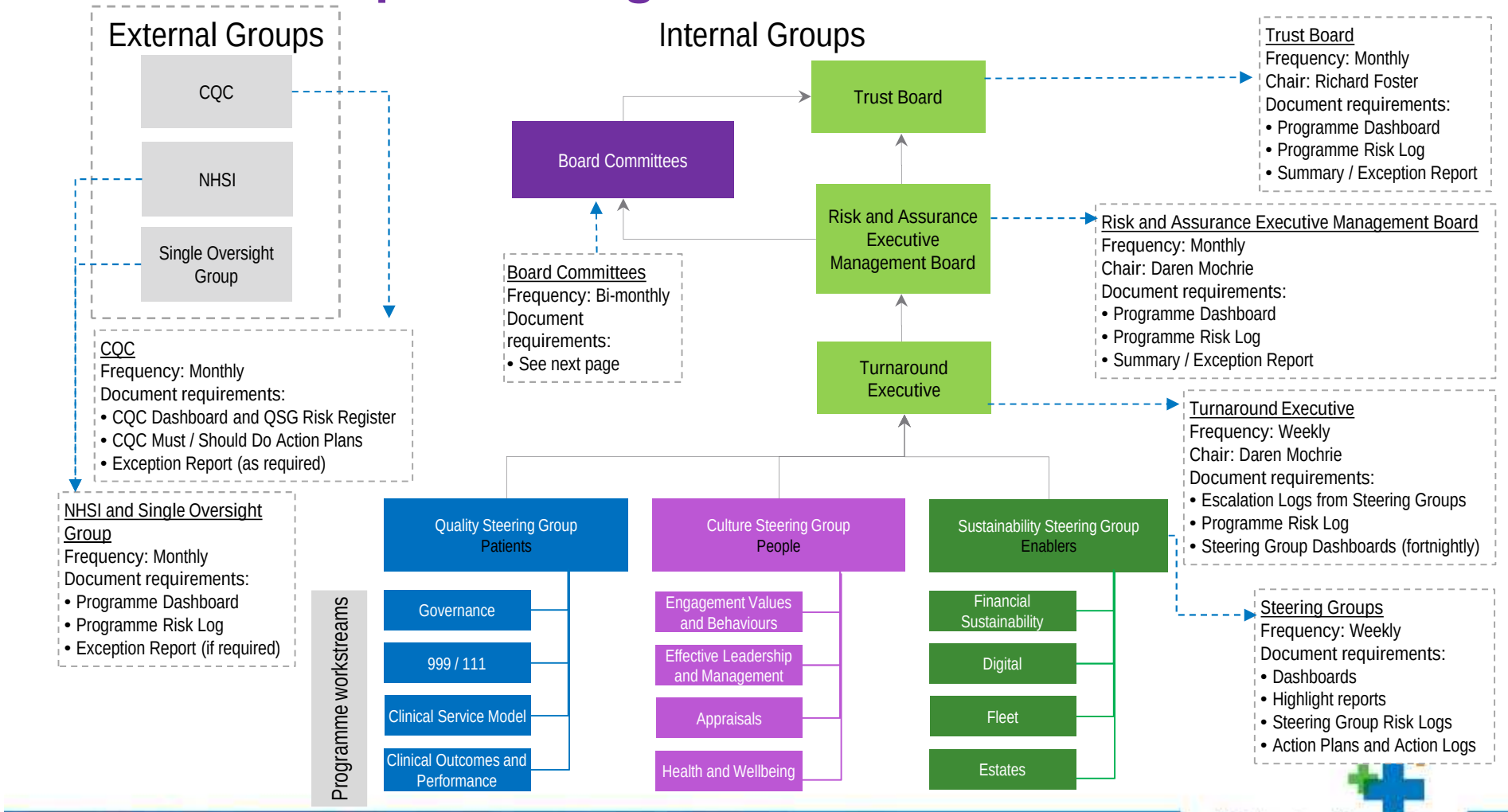
Proposed Programme Information Flow



Your service, your call

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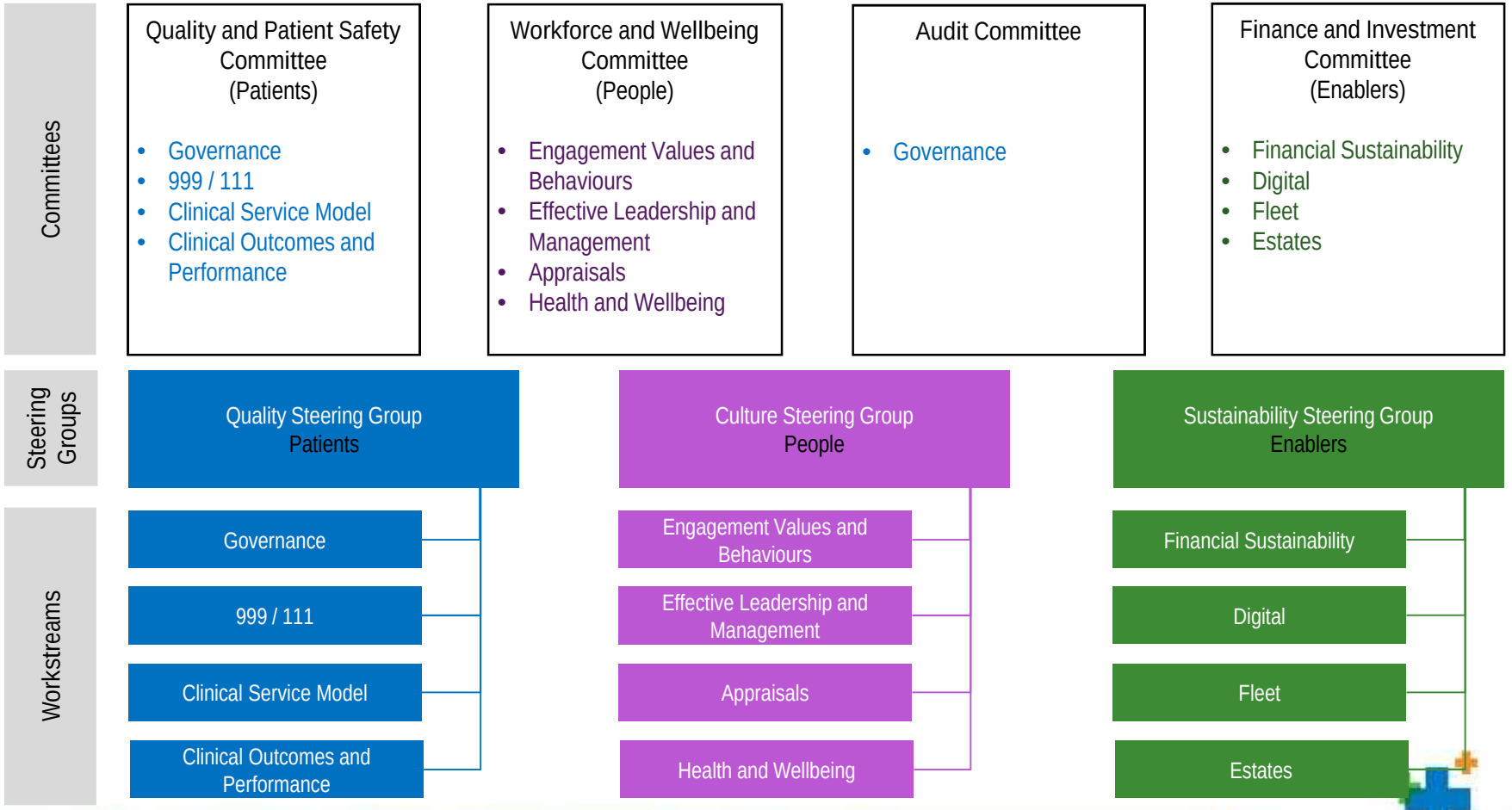
Governance

The below structure illustrates how the proposed Steering Groups will align to the Committees



Your service, your call

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

Current period of reporting to 14 July 2017
Previous period of reporting to 16 June 2017

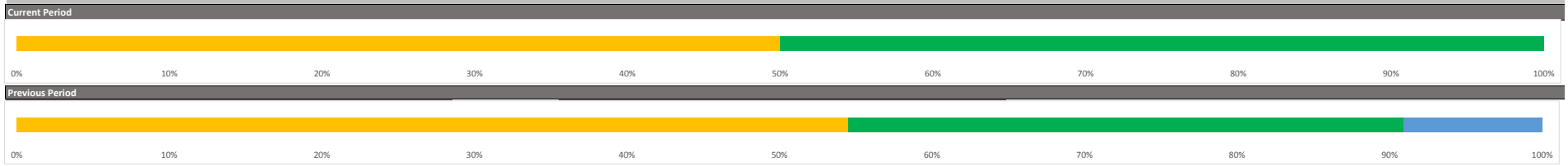
Last updated

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

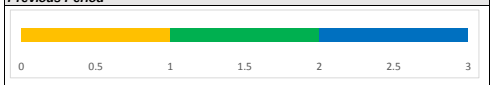
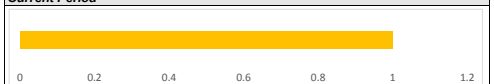
South East Coast Ambulance Service NHS
NHS Foundation Trust

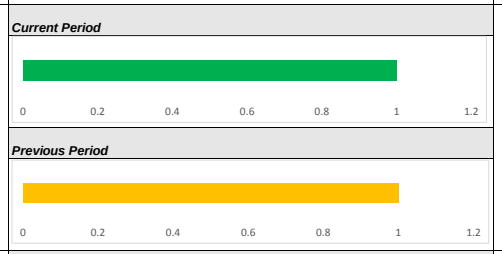
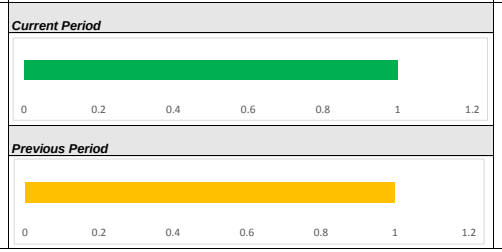
Overall Dashboard

Overall Project Delivery RAG Status (6 Projects)



Work stream Level Dashboards

Work stream Level			*Project Breakdown*						
Work stream	**Overall No. of Projects**	**Overall Delivery Status (RAG)**	**Project Name**	**Project RAG Current Period**	**Project RAG Previous Period**	**Project Lead**	**Executive lead**	**Completion date**	**High-level Commentary**
999	***2***	*Current Period* 	Increased Hear and Treat responses	Amber	Amber	Scott Thowney	Joe Garcia	To be re scoped	The Increased Hear & Treat project is progressing well with re scoping sessions taking place. It is planned to present a Project Mandate for approval at the next Organisational Recovery Steering Group on 26/07/17.
		Previous Period 	Reduced hospital turnaround time	Green	Green	Richard Harker	Joe Garcia	29/09/2017	The Reduced Hospital Turnaround project has progressed well; however there are some outstanding concerns on the procedure which are being addressed. Performance monitoring continues and will provide data to prove 100% of Acute Trusts and A & E's are using the New Conveyance, Handover and Transfers of Care Procedure by 29/09/17.
HQ	***1***	*Current Period* 	HQ Move / EOC Move	Amber	Green	Ibrahim Razak	Steve Graham	31/10/2017	Staff relocation to the new Crawley HQ and the Decommissioning and handback of the Lewes building completed on 30/06/17. Actions are in place to secure a Building Officer to enable handover of the New-HQ-EOC building from Estates Programme Manager to BAU. Project currently reporting as Amber due to outstanding Business Continuity Plans to be produced and agreed; scheduled completion for the respective plans is 21/07/17. A Phase 2 project has been outlined with requirements and scope to be agreed at Project Board on 18/07/17.
		Previous Period 							

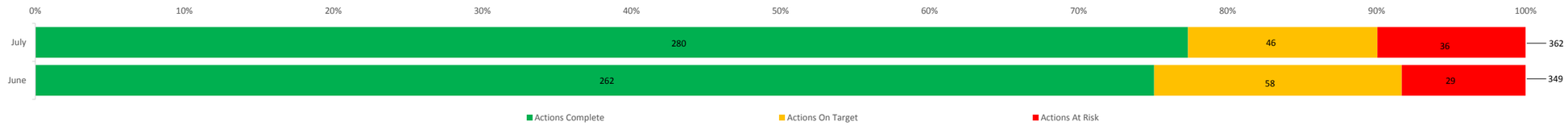
EPCR	***1***		Electronic Patient Clinical Records ("EPCR").	Amber	Amber	Edyta Suszek	Jon Amos	29/03/2018	Good progress on ePCR/iPad user onboarding moving from 73% to 85% during the period helped by additional roadshows and drop in sessions; aiming for 90% by 27/07/17. A focused push to onboard hospitals is progressing well. Testing of the new 1.2 App is continuing although some configuration issues identified and being addressed by the software developers. A revised target for deployment of the 1.2 App upgrade is 27/07/17. Overall project completion date of 29/03/18 unchanged.
OU Restructure	***1***		OU Restructure (formerly "OU Leadership")	Green	Amber	Sonia Belsey	Joe Garcia	30/11/2017	It has been agreed to close this project. Formal closure to be completed by 28/07/17.
New CAD	***1***		Implementation of new CAD	Green	Amber	Phil Smith	Jon Amos	01/10/2017	The Project is now being reported as GREEN, following a successful first go live at Coxheath following an agreed delay of 24 hours to complete NHS 111 testing. Completed successful testing and the live link was switched over late afternoon 06/06/17. Care UK completed testing next day against the live system following issues with the test system configurations. Crawley EOC planned go live is 19/07/17 with a Go / No go decision to be made 14/07/17 . This go-live will have reduced risk with prior use of the infrastructure and new CAD software.

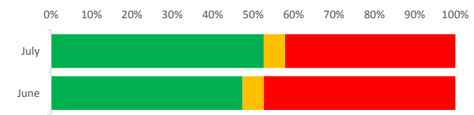
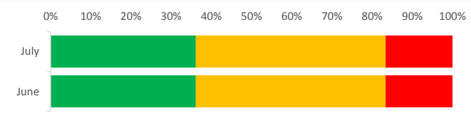
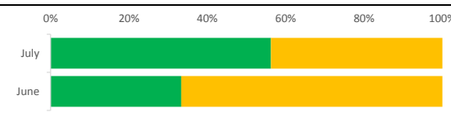
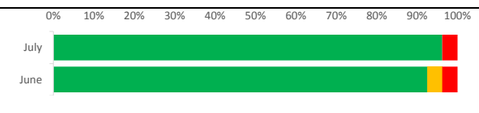
Closure Reporting

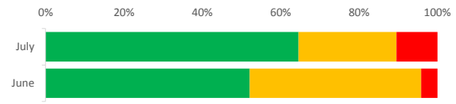
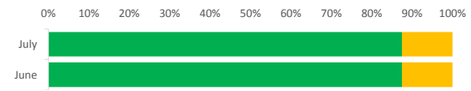
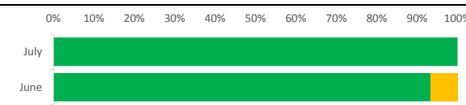
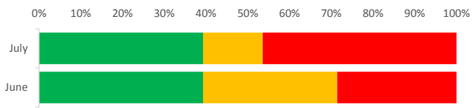
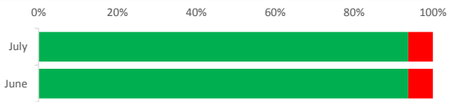
Workstream	Project	Executive sponsor	Project lead	Date project officially closed	Review date	Rationale for closure	Handover to BAU
	No project closures for period						

South East Coast Ambulance Service - CQC Must Do Improvement Tracker

CQC Dashboard - 15 July 2017



Domain	CQC Work stream	CQC Must Do	Confidence of delivery on time and realising benefits	Progress against actions% (Complete / On Target / At Risk)	Number of at risk items	Project lead	Executive lead	Progress summary	Project completion date
Safe	Security	2. Security Improvement Plan	Complete		0	Adam Graham	Joe Garcia	This project has been formally closed. More detail on achievements and plans to sustain improvements are provided within the closure section below.	01/05/2017 *Delayed to 30/05/2017*
	Incidents	7. Incident and SI Reporting Improvement Plan	At Risk		8	Jason Bryan	Steve Lennox	Progress continues with improvements to the incidents management and reporting process. Visibility of the issues and risks with the Datix system has increased with weekly reporting through to the interim Chief Nurse. A separate Datix project has been scoped and is currently undergoing the required approvals. The Serious Incidents policy is in its final stages of consultation, and is expected to be ratified within the next period. Changes within the policy should alleviate the bottle necks with reviewing and reporting on SIs moving forward. The Incident Management policy has been drafted and will undergo the required consultation within the next period. The key risk for this project continues to be the backlog of incidents, which 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	Following the CQC re-inspection in May 2017, the Trust is required to take a set of immediate actions to resolve the concerns raised with medicines management. Work on delivering the action plan has paused and efforts reprioritised to provide a response to the CQC by 22/07/17 on how the Trust will address the concerns identified. The largest risk associated with this is the ability to deliver the improvements by 22/09/17 as required by the CQC. This is discussed in further 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	Kirsty Booth	Fionna Moore	The priority for this action plan continues to be resolving the challenges associated with reconciling approximately 9% of PCRs with an incident number. Two key drivers are understood to be causing the reconciliation issues; transcription errors by the operational teams and processing inaccuracies within the Health Records team. Possible solutions have been identified for both of these challenges and are currently being progressed. These are in part reliant on the IT team within SECAmb, who are currently at max capacity with CAD implementation. The risk and mitigating actions surrounding 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	TBC	Steve Lennox	Following the development and approval of the work plan to implement the Safeguarding strategy, the majority of actions within this project have now closed. This excludes finalising the policy on managing allegations against staff, which will be completed within BAU. On these grounds this project was submitted for formal closure. However, through this process, a decision has been made to keep Safeguarding under the monitoring of the QSG due to recent personnel changes which risk slowing progress with the implementation of the Safeguarding Strategy. The project is paused until an interim Head of Safeguarding is identified	01/06/2017 *Decision to be taken on Safeguarding project*

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		5	Andy Collen	Fionna Moore	The clinical outcomes workstream continues to progress, with the ASHICE process being approved for implementation and is expected to be completed within the next reporting period. The Frequent Caller project has recruited a new lead to support project delivery, and benefits of the project are being monitored more closely following the development of an agreed reporting tool. Scoping of the AQI project continues under the guidance of the cardiac arrest consultant paramedic. Closure of the Falls and Hypo's referrals project is going through the closure process following agreement that the project has delivered the benefits realistically achievable within the current environment – discussed in more detail below.	30/03/2018
Responsive	Scheduling	13. Safe Resource Dispatch	Complete		0	Chris Stamp	Joe Garcia	This project has been formally closed. More detail on achievements and plans to sustain improvements is provided within the closure section below.	30/09/2017
Well-led	Governance	6.0A Corporate Governance	On Target		0	Peter Lee	Daren Mochrie	All actions within the Corporate Governance project are now complete, with this expected to be approved for formal closure within the next reporting period. While a new process has been established to ensure policies remain up to date as part of this project, progress with updating policies will continue to be monitored through the QSG to ensure sufficient pace around this. A decision needs to be taken as to whether a new 'risk management' project will be established.	31/03/2018
		6.0B Clinical Audit	At Risk		13	Joe Emery	Fionna Moore	This project remains at-risk due to ongoing capacity constraints within the clinical audit team delaying further progress on delivery of actions. Steps have been taken to resolve the capacity constraints, with recruitment for both an interim Head of Clinical Audit and Substantive Head of Clinical Audit underway. This is discussed in more detail below. Progress with actions continues at a slow pace with the clinical audit policy being sent to JPF for approval, the annual audit report has been re-drafted for review by the Medical Director, and the clinical audit work plan is in its final stage of development.	31/12/2017
	Resourcing	11.0 Staff and resourcing improvement plan	Complete		1	James Pavey	Joe Garcia	This project has been formally closed. More detail on achievements and plans to sustain improvements are provided within the closure section below.	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	There is a risk that the Trust will be unable to address the findings of the CQC re-inspection by the 22/09/2017 as required by the CQC. This is due to a combination of resource and financial constraints.	Red	Red	The Chief Pharmacist, with support from the PMO, has drafted a high-level action plan to address the findings of the CQC, including the resource requirements and potential financial implications. This has been presented at both the Turnaround Executive meeting and Single Oversight meeting to provide awareness of the complexity of the problem and indicative implications for investment required to achieve the deadlines, while also receiving guidance on what is realistically achievable within the current challenging funding and operating environment. Early engagement and guidance from the CQC will be sought to understand expectations and the level of support that can be provided to achieve the improvements required within the timeframes outlined. A meeting has been set up wtih the Medical Director to discuss the governance requirements and response.	Red	Fionna Moore	22/07/2017
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	An independent internal audit of the back office reporting within the Health Records team is due to start on the 17/07/17. This will support the Trust to further understand the challenges with reconciliation that exist. The project team have identified possible solutions to addressing the challenges identified through the high-level audit: - Improving the validation process within the Health Records team through increasing the use of the existing software capability to support automatic validation of PCRs. This is currently constrained by IT capacity due to implementation of the new CAD. However, this is expected to resolve by the 18/07/17 following the final CAD implementation date. - Options to reduce the length of the CAD incident number or implement a validation step of PCRs while still on stations are being considered. Exploring the likelihood of reducing the length of the CAD incident number is once again dependent on IT capacity.	Amber	Fionna Moore	11/08/2017
Safe	7. Incident and SI Reporting Improvement Plan	The Trust still has a significant backlog 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 PMO is supporting the establishment of a new Datix project with clear milestones and timeframes to resolve the ongoing challenges with Datix. This is currently in development stage having been through an initial scoping exercise. The timescales for completion will be confirmed as part of this. As an interim strategy, the key risks and issues associated with the Datix system are being reported to the Chief Nurse on a weekly basis to ensure sufficient oversight and escalation as required. 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. Close monitoring of the backlog is occurring at Executive level to ensure the issue is addressed at the pace 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	Red	Personnel within the Medical Directorate have been supporting the ongoing delivery of the action plan, while alternative resource can be brought in to support the Clinical Audit team. Recruitment is underway for both a interim and substantive Head of Clinical Audit. Shortlisting and interviews for the interim position have commenced with the aim of having this post filled within the next reporting period.	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	2. Security Improvement Plan	Joe Garcia	Adam Graham	12/07/2017	In the 2016 CQC report, the following findings were documented with regards to security: - Site security (Make Ready Centres, ambulance stations etc.) was not being routinely monitored. - All Emergency Operations Centre (EOC) premises containing confidential data and critical equipment were not secure. - Lack of robust security measures identified at Dorking Station - keys left in a vehicle and station left unlocked.	In response to the CQC findings, a programme of work was developed to improve security across the Trust, which included the following key areas: - Establishment of a quarterly site security assessment, owned and completed by OUs, but with review and critique from the Security Lead. This is reported through to CHSWG and Q&S Working Group for sufficient oversight and governance - Development of a live strategic-level security action plan that addresses Trust-wide security risks, informed by the quarterly site security assessments - Implementation of a vehicle and site security campaign to enhance awareness among operational staff and improve compliance with security procedures - Ongoing review and updating of site security procedures to increase transparency of security requirements	The quarterly site security assessments that have been established will continue to run through OUs with oversight from the Security Lead and monitoring through the business as usual governance structures CHSWG and Q&S Working Group. The live strategic-level security action plan will continue to be updated by the Security Lead and progress with implementation monitored through the CHSWG. Site security procedures will continue to be updated by the Security Lead and taken through the business as usual governance processes required. It was agreed as part of the agreement to close the project, that roles and responsibilities regarding resolve of security issues is clear and	12/12/2017
Effective	9.0 Outcomes Improvement Plan - Falls and Hypo's referrals	Fionna Moore	Andy Collen	18/07/2017	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. Within the programme, one project has focused on improving referrals for patients who call 999 due to having an avoidable fall or episode of hypoglycaemia. Through this project there has been a Trust-wide increase of 20.4% in falls referrals and 60.2% in hypoglycaemia referrals. While this is lower than the intended target of 75%, assumptions were made in the development phase of the project on the availability of software through the iPad to support increased referral rates. However, this has not available during the life of project. For this reason, the project will be closed and managed within BAU, providing the opportunity to reallocate project resources to key organisational priorities requiring progress in the short term.	Falls and hypoglycaemia referrals will continue to be managed by the Senior Practice Development lead who has been leading the project. This will be incorporated within the key priorities of the practice development team to continue to progress as part of their continuous quality improvement agenda.	12/12/2017
Responsive	13. Safe Resource Dispatch	Joe Garcia	Chris Stamp	12/07/2017	Ensure that ambulance crews qualifications, experience and capabilities are taken into account when allocating crews to ensure that patients are not put at risk from inexperienced and unqualified crews working together.	In response to the CQC finding this project has focused on reviewing and updating the deployment policy to ensure: - Appropriate grades and experience of staff are crewed together to ensure that patients are not put at risk. - A safe and effective resource deployment process exists that it is adhered to and audited to optimise patient outcomes. The deployment policy has been through the required governance processes and is now finalised. There have been delays with implementation due to a decision to wait until the roll out of the new CAD, to avoid the risk associated with multiple changes at once. Implementation of the revised deployment policy will be managed through BAU.	The Regional Operations Manager leading on the update of the deployment policy will maintain responsibility for rolling this out Trust-wide when it is deemed appropriate. Progress with this will be monitored through the Senior Operational Leadership Team meeting.	12/12/2017

Safe	11.0 Staff and resourcing improvement plan	Joe Garcia	James Pavey	12/07/2017	Take action to ensure there are always sufficient numbers of staff and managers to meet patient safety and operational standards requirements. This should include ensuring there are adequate resources for staff to usually take their meal breaks, finish on time, undertake administrative and training	In response to the CQC finding this project has focused on the following key objectives: - Embedding a process which delivers a schedule that matches forecast demand and is proactively managed. This has been implemented and embedded into BAU with operational managers attending six-weekly meetings to review forecasts and make the necessary adjustments. - Actively recruiting to funded establishment and maintaining vacancy rates at 5%. Monthly meetings have now been established, which are attended by ROMs to monitor recruitment as part of BAU. Currently showing 5% vacancy rate - Ensure staff receive adequate meal breaks and finish shifts on time to maintain their welfare. Review and update of policies have been completed. These are currently out to staff for consultation, with ratification to follow. In the interim, operational instructions are in place to more effectively enable staff to take meal breaks and finish on time. Once policies have been finalised, they will be implemented within BAU.	The processes established for scheduling and recruitment have been embedded into BAU and will continue following closure of this project. The Regional Operations Manager leading on the updates of the policies will maintain responsibility for finalising and implementing these. Progress with this will be monitored through the Senior Operational Leadership Team meeting	12/12/2017

South East Coast Ambulance Service: CIP Workstream

CIP Delivery Dashboard

Reporting Month Jun-17

Programme for 2017/18 to deliver a minimum of £15.1m savings to achieve the planned £1m control total

Programme Summary: (See Pipeline Tracker for Risks and Issues)

1. CIP delivery tracker introduced to monitor progress against CIP targets throughout the financial year. Achieved YTD Month 3 delivery of £3.1m CIP savings vs Target of £3.2m. Reviewing corrective action required for CIPs with YTD underachievement.

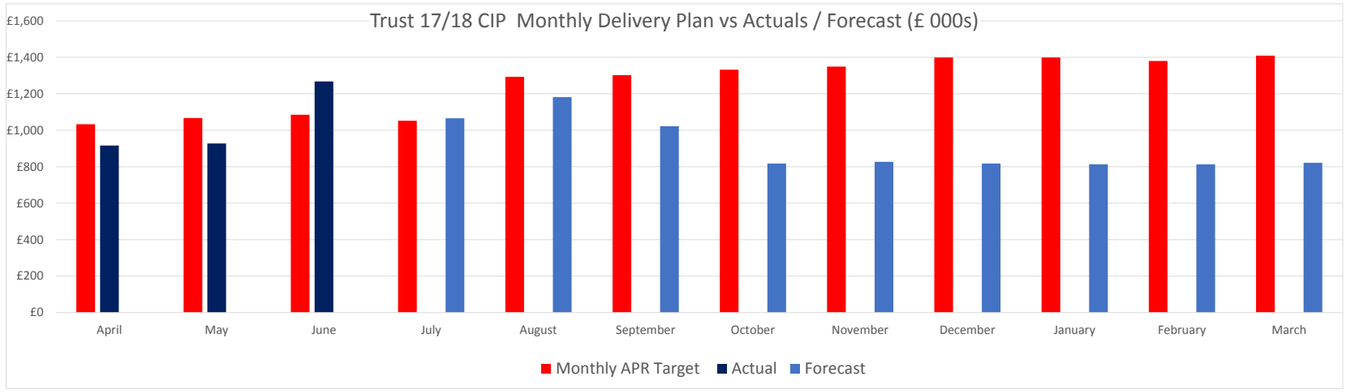
2. £11.2m of fully validated savings transferred to delivery tracker as at 12 July 2017, resulting in £3.9m variance to 17/18 target of £15.1m
   - £9.8m CIP moved to delivery tracker (a further £200k is to be added to delivery tracker)
   - £1.4m cost avoidance moved to delivery tracker

3. Work underway to develop detailed plans for c. £4.0m of complex Operations schemes currently "validated" on the pipeline tracker. CIP translates to a target hours reduction in 17/18 of 148,000. Sign-off of underway for part-year phased delivery of schemes .

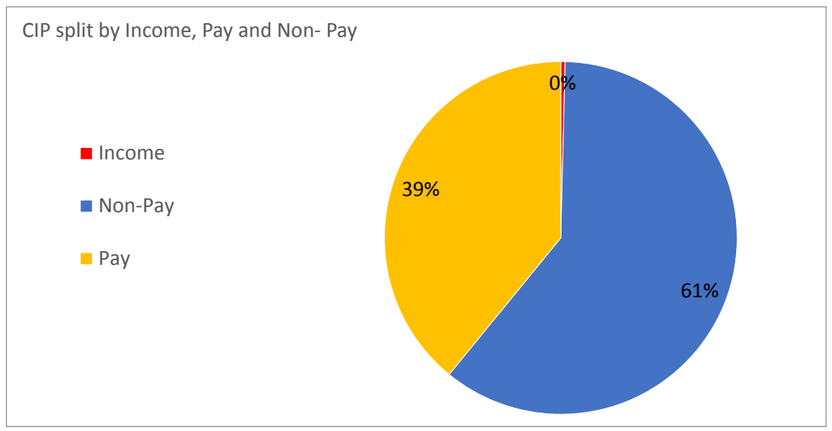
4. Positive meeting held with NHSI to review progress on identification and delivery of 2017/18 CIP schemes. Date of next CIP meeting suggested as September, subject to confirmation, due to the need allow delivery of schemes

1. Monthly CIP Trust Profile - as at 5 July 2017. Actual savings as at June '17

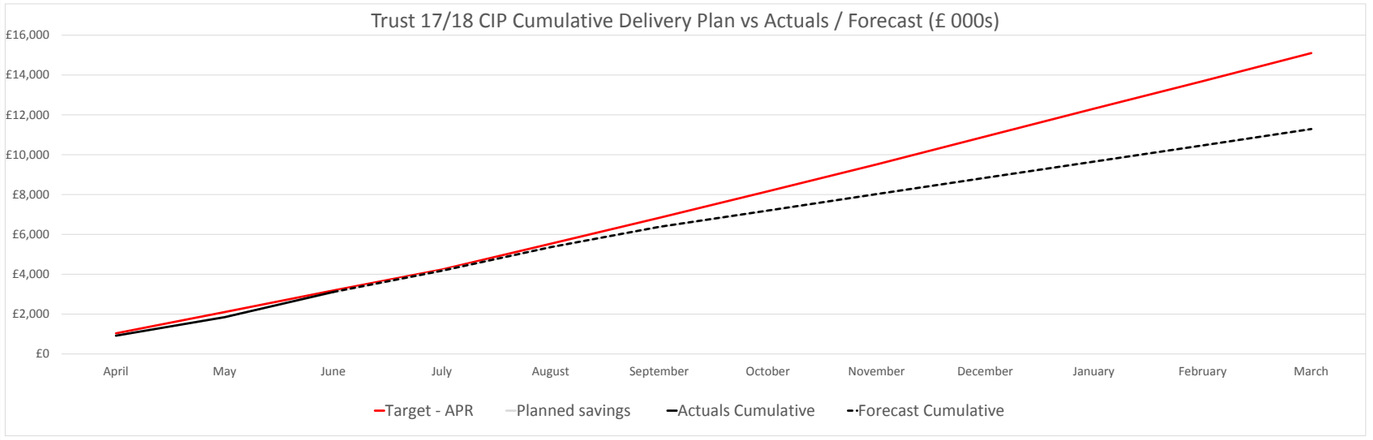
CIP Target for 17/18 £000's	Total planned savings on delivery tracker £000's - as at 5 July	Total risk adjusted savings on delivery tracker £000's - as at 5 July	YTD Jun '17 - Target Savings £000's	YTD Jun '17 - Actual Savings £000's	YTD Jun '17 - variance £000's
15,100	11,273	10,221	3,185	3,111	-74



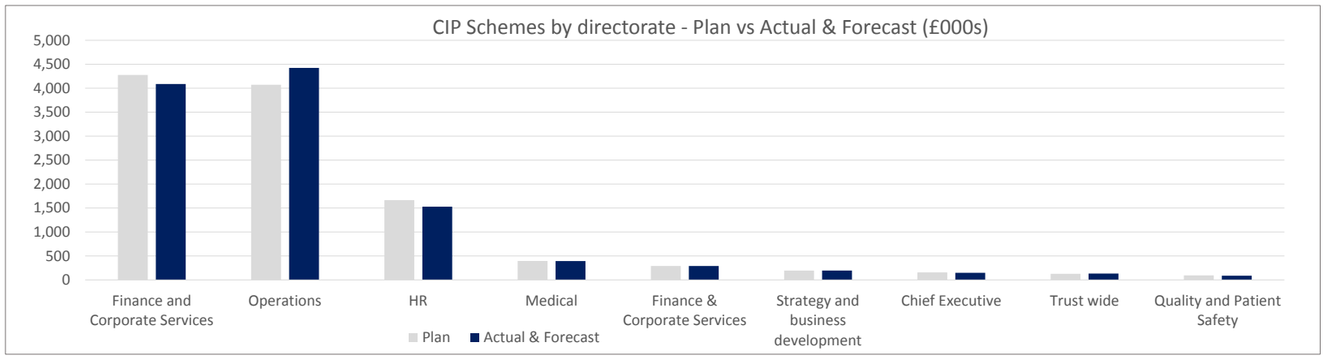
2. CIP - Planned savings split by income, pay and non-pay - as at 5 July



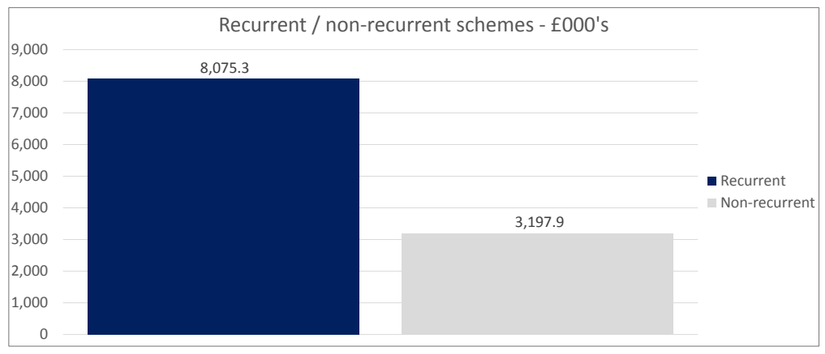
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2017/18



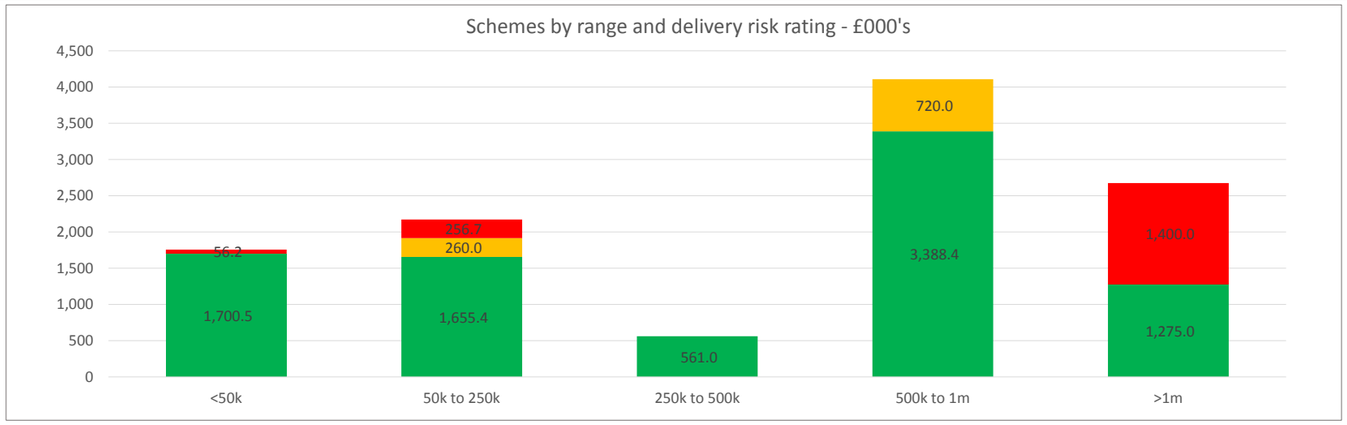
4. CIP schemes by directorate - Plan vs Actual & Forecast 2017/18 - as at 5 July



5. Value of planned recurrent and non-recurrent savings - as at 5 July



6. Planned savings by scheme size and delivery risk rating £000's - as at 5 July



7. Operations Hours CIP: Effective from June Reporting Period

	Full Year (forecast)	YTD - June '17
Budgeted Staff Hours (including OTLs and CAT hours)	3,178,321	569,462
Target Hours - Projected hours after CIPs* (TCT Reduction, Allocation and Response Ratio, Vacancy Productivity)	3,030,725	569,462
Actual Hours Used	3,030,725	551,508
Variance to CIP Target (Target - Actual Hours)	0	17,954

Commentary* - The hours currently reported above include YTD OTL and CAT staff hours = 149,381. These hours will be taken out of frontline hours from June '17, resulting in 3,028,940 budgeted frontline hours. This is a budget adjustment and not a CIP

The target CIP hours reduction for FY17/18 relates to the TCT Reduction, Allocation and Response Ratio and Vacancy Productivity CIP schemes, which assume a 148,000 operations hours reduction in 17/18.

Delivery for these schemes is phased from June '17 resulting in 2,881,344 projected target hours for 17/18.

8. YTD Identified CIPs to Date and Savings - June Reporting Period

Scheme Category	2017/18 Value of Identified Schemes - £000	2017/18 Value of Risk Adjusted Savings Schemes - £000	YTD Planned / Identified Savings (Month 3): £000	YTD Actuals (Month 3): £000	Variance	Comments (+/- £20k variance)
Accounting efficiency	£3,539	£3,539	£868	£729	(£139)	Underachievement - Lower than expected PDC savings for Q1 - under investigation
Meal break payment	£1,560	£1,560	£390	£527	£137	Overachievement - Q1 additional averge monthly savings of £46k
Agency Premiums	£1,510	£810	£378	£347	(£31)	Underachievement - 8.1% variance to planned cost avoidance during Q1
Vacancies - clinical	£827	£683	£265	£465	£200	Phasing - quarter to date savings. Expected to align with plan
Vacancies - non clinical	£608	£551	£426	£412	(£14)	-
External consultancy & contractors	£551	£551	£138	£120	(£18)	-
Fleet telematics & bunkered fuel	£550	£550	£138	£138	(£0)	-
MRC efficiency	£494	£394	£73	£69	(£4)	-
EPCR efficiency	£310	£310	£78	£39	(£38)	Phasing - expected to deliver to plan
Facilities management	£208	£208	£52	£52	(£0)	-
Staff Uniform	£153	£123	£38	£38	(£1)	-
IT costs and Phones	£149	£149	£37	£21	(£17)	-
Furniture & Fittings	£133	£133	£33	£38	£5	-
Stationery	£110	£88	£28	£15	(£13)	-
Meeting room hire	£97	£97	£24	£19	(£6)	-
Medicines Management - Consumables	£93	£93	£23	£1	(£22)	Phasing - expected to deliver to plan
Medicines Management - Equipment	£90	£90	£15	£10	(£5)	-
Training courses & accomodation	£75	£75	£21	£21	£0	-
Books & Subscriptions	£55	£55	£14	£14	(£0)	-
Public relations	£47	£47	£12	£12	£0	-
Legal cost	£40	£40	£10	£0	(£10)	-
Events Income	£35	£35	£17	£17	£0	-
Discretionary non-pay spend	£26	£26	£6	£6	(£0)	-
Travel & subsistence	£16	£16	£4	£3	(£0)	-
Variance to YTD Target	-	-	£98	-	(£98)	Variance between YTD Identified Schemes and Control Total Target
Grand Total	£11,273	£10,221	£3,185	£3,111	(£74)	

South East Coast Ambulance Service: CIP Workstream Pipeline Dashboard

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. Progress in some areas impacted by availability, largely due to annual leave commitments.

2. £11.4m of fully validated savings as at 12 July 2017 - c. £10.0m CIP and £1.4m cost avoidance moved to delivery tracker. CIP schemes moved to delivery tracker once

3. Work underway to develop detailed plans and fully validate complex Operations schemes currently indicated as "validated"
- Reducton in Task Cycle Time, Ops Vacancy Factor, Allocation and Response Ratios, PAPs to Overtime Ratio

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	

CIP Pipeline and Delivery: Risks and Issues

	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. C. £15m of CIPs Fully validated / Validated.	Kevin Hervey	Amber	Amber	31/07/2017
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. Sign-off of c. £4.0m of complex Operations schemes underway. Delivery of schemes to be closely monitored due to complex and interdependent nature (see delivery tracker section 7)	Kevin Hervey	Amber	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	31/07/2017

	Issue to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	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. Summary QIAs currently being signed off by AD in the Medical Directorate.	Steve Lennox	Green	Amber	30/06/2017
2	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 Sponsors and CIP Project Leads have been responsive and engaged with the CIP Programme and processes	Kevin Hervey	Amber	Amber	31/07/2017
3	Time taken to develop and scope MRC benefits realisation schemes with detailed analysis to ensure there is no duplication with other operational efficiency schemes.	CIP team working with Finance Business Partners and identified leads to complete validation of savings information. Follow up meeting being scheduled with Operations and Leads to review and agree benefits to be realised	Sue Skelton	Amber	N/A	31/07/2017

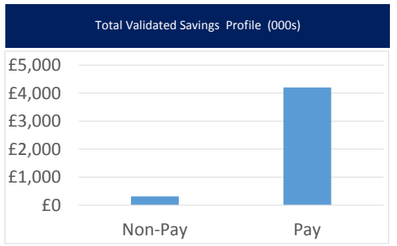
CIP Pipeline Summary

Fully Validated	Validated	Scoped	Proposed	Cost Avoidance	Grand Total
£9,963	£4,515	£2,351	£710	£1,400	£18,939

Top 20 Validated Schemes

Validated
(Multiple Items)

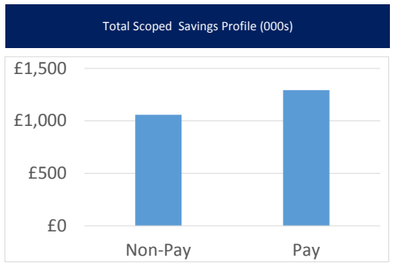
CIP / Cost Avoidance	Business Area / Cost Centre	Exec Sponsor	Scheme Title	Scheme Description	Spend Category	Planned Savings
CIP	Operations	Joe Garcia	Reduction in Task Cycle Time	Task cycle time reduction from 71.5 to 65	Pay	£1,536
CIP	Operations	Joe Garcia	Ops - Vacancy factor	Ops vacancy factor with restricted PAPs and overtime	Pay	£1,339
CIP	Operations	Joe Garcia	Allocation and response ratios	Review and reduce allocation and response ratios	Pay	£1,100
CIP	Finance	David Hammond	Top Slice - 1%	Percentage top slice - non pay 1%	Non-Pay	£250
CIP	Operations	Joe Garcia	Move PAPs hours to overtime	Reduce PAPs hours and increase overtime	Pay	£228
CIP	Corporate Governance	Daren Mochrie	In-House Legal Post	Reduction in legal spend by creating in-house legal post	Non-Pay	£37
CIP	HR Operations	Steve Graham	E-payslips	E-payslip provision via ESR self service	Non-Pay	£25
						£4,515



Top 20 Scoped Schemes

Scoped
(Multiple Items)

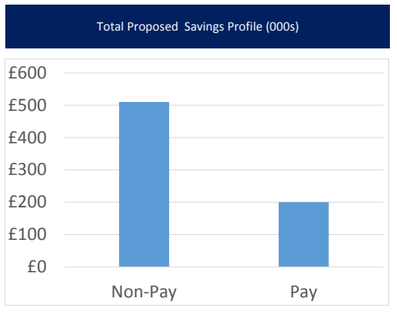
CIP / Cost Avoidance	Business Area / Cost Centre	Exec Sponsor	Scheme Title	Scheme Description	Spend Category	Planned Savings
CIP	Operations / Fleet / Estate	Joe Garcia	Benefits of MRC Programme	Benefits realisation as outlined in business cases	Pay	£1,093
CIP	Estates	David Hammond	Single HQ / EOC: Benefits realisation	Per Business Case - Travel; Duplication of Posts etc.	Non-Pay	£598
CIP	Procurement	David Hammond	Contracts management	Renegotiation of contracts to ensure compliance	Non-Pay	£210
CIP	Procurement	David Hammond	Internal supply chain	Move internal logistics to a just in time process	Non-Pay	£200
CIP	Operations / Fleet / Estate	Joe Garcia	Benefits of MRC Programme - Ashford	Benefits realisation at Ashford	Pay	£100
CIP	Operations / Fleet / Estate	Joe Garcia	Benefits of MRC Programme - Paddock Wood	Benefits realisation at Paddock Wood	Pay	£100
CIP	Procurement	David Hammond	Staff Uniforms - review allocation	Review the allocation of staff uniforms	Non-Pay	£50
CIP	EOC	Joe Garcia	Reduction in Meal Breaks (new policy)	Additional efficiencies realised from Meal Break Policy	Non-Pay	£0
Cost Avoidance	HR	Joe Garcia	Overtime: Non-operational	Tighter controls on non-operational overtime payments	Pay	£0
						£2,351



Top 20 Proposed Schemes

Proposed
(Multiple Items)

CIP / Cost Avoidance	Business Area / Cost Centre	Exec Sponsor	Scheme Title	Scheme Description	Spend Category	Planned Savings
CIP	Trust Wide	Daren Mochrie	Business Case Benefits realisation	Review of Business Cases approved within past year	Non-Pay	£500
CIP	Trust Wide	Steve Graham	Releasing Operational Staff from other Directorates to Sup	Review of all clinical staff in support function roles	Pay	£200
CIP	HR Operations	Steve Graham	E-expenses	Transition from paper expenses	Non-Pay	£10
CIP	Medical	Fionna Moore	LIfePaks	Review of LifePaks 15 and 1000 in SRVs and DCAs.	Non-Pay	£0
CIP	HR	Steve Graham	Reduction in oversees relocation expenses (e.g. Australian	Overseas relocation expenses (e.g. Australian paramedics)	Non-Pay	£0
CIP	Estates	David Hammond	Rates rebate	Rates rebate and completion of the expected schedule	Non-Pay	£0
CIP	Estates	David Hammond	Utilities, non-recurrent opportunity	Non-recurrent efficient review from utilities payments	Non-Pay	£0
CIP	Estates	David Hammond	Facilities Management - Business Case	Business Case for Facilities Management showed a £0.4m saving, this	Non-Pay	£0
Cost Avoidance	Corporate	David Hammond	Review Building Lives	Review by Montagu Evans to consider building life and extension. Sav	Non-Pay	£0
(blank)	Finance	David Hammond	Review of Provisions	Review of Provisions in the Annual Accounts as of 31/03/2017	Non-Pay	£0
(blank)	Finance	David Hammond	Liaison with other Ambulance Services	Aim is to identify potential further CIPs based on experience of other	Non-Pay	£0
						£710



South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	66/17

Name of meeting	Trust Board
Date	25 July 2017
Name of paper	Trust Strategy
Responsible Executive	Jon Amos, Acting Director of Strategy & Business Development
Author	Jon Amos, Acting Director of Strategy & Business Development Jayne Phoenix, Associate Director of Strategy & Business Development
Synopsis	This paper is the final draft of the Trust Strategy (2017-2022). It sets out the five year goals and two year objectives for the Trust and highlights the required next steps to develop and deliver the strategy over the next two years
Recommendations, decisions or actions sought	The Board is asked to approve this Strategy for launch with our staff, public, partners and stakeholders
Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**

South East Coast Ambulance Service NHS Foundation Trust

Five Year Strategic Plan 2017-2022

Version 1 FINAL DRAFT

Aspiring to be **better today and even better tomorrow** for our people and our patients

About Us

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) was formed in 2006 from the merger of Kent, Surrey and Sussex ambulance services and in 2011 became a Foundation Trust.

We receive and respond to 999 calls from the public, urgent calls from healthcare professionals and receive and respond to calls to NHS 111 as well as providing the regional Hazardous Area Response Team (HART).

We are led by a Unitary Trust Board composed of Chair, Non-Executive Directors, Chief Executive and Executive Directors. We are held to account by our Council of Governors composed of publically-elected, staff elected and appointed governors.

Our 3,499 staff, 85% of whom are patient facing, provide services to 4.7 million people over the 9,400 square kilometres of Kent, Medway, Surrey, Sussex and North East Hampshire.

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Foreword

The last few years have been a time of significant change for South East Coast Ambulance Service (SECAmb), many of our partners and the context in which we operate. Demand, driven by an aging and growing population, is increasing faster than funding. This requires a new approach to continue to balance patient safety, outcomes and experience, staff satisfaction and financial sustainability.

It is therefore timely to set out our strategic direction for the next five years and our objectives for the next two years. It is important, in doing this to recognise the pace of external change, in particular the challenging financial context, the growing role of Sustainability and Transformation Plans, the implementation of the Ambulance Response Programme and the progress of our recovery plan over the last year in response to requirements from the Care Quality Commission and NHS Improvement. This strategy therefore recognises the need to be dynamic in response to internal and external change over the coming years and sets out a process for delivery and monitoring as well as criteria for further review or refresh of the strategy to respond to changes.

Our focus remains on delivering care to our patients, but recognises that this is dependent upon retaining the best staff through the support and development provided to them. This strategy recognises the work still needed to further develop our culture to provide support and development for our people (staff and volunteers), to allow them to provide the best possible care to our patients. This strategy recognises the further improvement and consolidation needed over the next two years. In recognising the work still to do, this strategy has a simple mission, relevant to all areas of our work in the coming months but also as we move our focus from our current recovery to a future of continuous improvement:

‘Aspiring to be better today and even better tomorrow for our people and our patients’

This mission aims to recognise the excellent care provided to patients on a daily basis whilst recognising there is always more to do to improve safety, quality and experience for our people and our patients. The entire board, our governors, our staff and our volunteers are committed to working with our partners across the health and social care system to achieve this aim through a process of continuous learning and improvement.

Daren Mochrie QAM

Chief Executive Officer

Richard Foster CBE

Chairman

1.0 Introduction

SECAmb worked closely with its staff, patient representatives and partners during 2016-17 to develop its Unified Recovery Plan, which set out the recovery trajectory for the Trust following the outcome of our May 2016 Care Quality Commission inspection and subsequent inadequate rating. This approach was built around eight objectives focussed on service delivery and improvement:

1. Governance
2. Culture
3. 999 and 111 Performance Improvement
4. Clinical Outcomes
5. Financial Sustainability
6. Operational Restructure
7. Electronic Patient Care Record
8. New Headquarters and Emergency Operations Centre

This strategic plan, developed after several months of consultation, builds on this work, recognising the areas in which further improvement and consolidation is necessary to ensure sustainable change. It recognises that there is on-going work across the organisation in developing plans for our future and that further work is needed to revise the Trust values and to set out further detail of our clinical model and enablers. Recognising these gaps, and setting out plans to address these within the delivery plan over the next two years, this documents sets out our vision and goals for the next five years and our objectives for the next two years.

As an organisation we must continue to learn from feedback from our staff, our volunteers and our patients and embed organisation wide change as a result of this learning. Our simple mission embodies this approach. To achieve this mission, the strategic plan for the next five years is focussed on delivery of our four strategic themes:

- Our people – supporting and developing our staff and volunteers
- Our patients – ensuring timely quality care, in the right place by the right people
- Our enablers – fit for purpose technology, fleet and estates, underpinned by sustainable financial performance
- Our partners – working with health, blue light and education partners

Recognising our current position, the significant pace of change in the wider health system and the impact of demographic growth, coupled with constrained public spending, this plan will be reviewed at least annually and revised to take account of significant external and internal changes.

This strategic plan demonstrates how the Trust will ensure the provision of safe, quality care to its communities, acknowledging that it is in the process of improvement and consolidation to get back to consistent provision of quality care whist delivering financial balance. This will require continuation of a journey that moves through the stages of recovery, improvement and consolidation, using agreed improvement methodologies. We will strive to deliver sustainable services, secure the best possible outcomes for our patients and meet fundamental standards, whilst achieving best value for taxpayers' money.

We acknowledge that to do this we need to work in increasing partnership with other agencies across health, social care, blue light, third sector, and local communities, including our regulators. We must also, to standardise care and deliver more efficiently, do things

‘once for the region’ where possible. We will work with our commissioners and partners to explore areas in which greater standardisation can be achieved.

2.0 Our Vision, Goals and Objectives

The Trust recognises that there is significant work needed to improve quality for patients, deliver improved performance against targets, meet financial targets and in doing this support and develop our staff. This balancing of priorities must be delivered in a fast changing economic and health policy context. Recognising these challenges, the focus of the strategy is on delivery of improvement and consolidation in the first two years with a view to the longer term strategic goals. The strategy aims to set our long-term aspiration whilst focussing on clear two year objectives that deliver improvement and support our progress towards these goals. It will be reviewed at least annually, as part of a new annual business planning cycle and revised where key external or internal triggers are met, as set out in section 8.

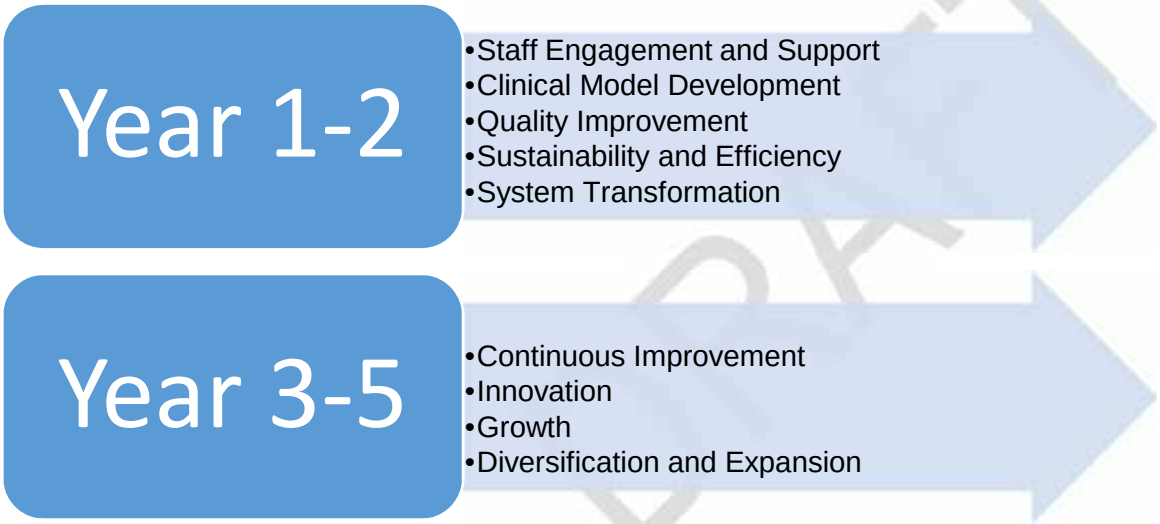


Figure 1 – Strategic Focus

2.1 Vision

SECAmb delivers the majority of its services in the heart of the communities it serves. Our vision supports our plan to build upon our expertise in call centre management and urgent and emergency care over the next five years in order that we can:

'Support our staff to provide a caring, high quality and efficient urgent and emergency care service to our communities'

This is underpinned by our mission, which focusses on a continuous improvement approach to reaching our vision:

'To deliver our aspiration of being better today and even better tomorrow for our people and our patients'

2.2 Strategy Overview

The Trust places supporting people and delivering care for our patients care at the heart of its plans, recognising that delivery of high quality care is reliant upon skilled, motivated and engaged staff.

Our Vision	Support our staff to provide a caring, high quality and efficient urgent and emergency care service to our communities			
Our Mission	To deliver our aspiration of being better today and even better tomorrow for our people and our patients			
Our Themes	Our People	Our Patients	Our Enablers	Our Partners
Our five year goals	We will respect, listen to and work with our staff and volunteers to provide development and support that enables them to provide consistent, quality care to our patients	We will develop and deliver an integrated clinical model that meets the needs of our communities whilst ensuring we provide consistent care which achieves our quality and performance standards	We will develop and deliver an efficient and sustainable service underpinning by fit for purpose technology, fleet and estate	We will work with our partners in STPs and blue light services to ensure that our patients receive the best possible care, in the right place, delivered by the right people
Our two year objectives	With the support and engagement of staff and volunteers, refresh the Trust values and behaviours	Develop and deliver a clinically led process to prioritise patient need at the point of call, increasing referral to alternative services where clinically appropriate	Ensure our services are efficient and sustainable and that they are supported by appropriate levels of funding	Work with STPs to achieve the best care for our patients through emerging local out of hospital care systems
	Develop effective leadership and management at all levels, through our new selection, assessment and development processes	Further integrate and share best practice between NHS 111 and 999 services, striving for Integrated Urgent Care service where this is considered viable	Develop and deliver a digital plan which supports integration with the health system and enables the clinical model and our approach to continuous improvement	Work with STPs to design and deliver generalist and specialist care pathways for patients requiring an acute hospital attendance
	Ensure all staff and volunteers have clear objectives, and a plan for their development, set through regular appraisal	Further improve and embed governance and quality systems across the organisation, building capacity and capability for continuous improvement	Ensure that our fleet is fit for purpose and supports the clinical model	Work with education and STP partners to develop career pathways that support our staff to make effective clinical decision making
	Improve staff and volunteer health and wellbeing	Improve clinical outcomes and operational performance, with a particular focus on life threatening emergencies	Ensure that our estate is fit for purpose and supports the clinical model	Work with blue light partners to ensure collaboration supports patient outcomes and efficient service delivery

Table 1 – Vision, Mission, Themes, Goals and Objectives

3.0 Context

This section provides a brief summary of the key internal and external context which has been taken into account in developing the strategy, more detailed context and analysis including our SWOT, PESTLE, benchmarking and market assessment is maintained internally by the strategy team.

3.1 Governance

As an NHS Foundation Trust SECAmb has a Unitary board formed of the Chair, Non-Executive Directors, Chief Executive and Executive Directors as well as a Council of Governors who help to ensure we are accountable to the public we serve, our staff and all stakeholders. The Council has two core statutory duties:

- To hold the Non-Executive Directors individually and collectively to account for the performance of the Board; and
- To represent the interests of members and the wider public.

The Council recruits, appoints and appraises the Chair and other NEDs to ensure they are providing the support and scrutiny necessary to the Executive part of the Board. The Council also participates in staff and public engagement groups and feeds insight from these groups, and from their own interactions with staff, patients and the public, to the Board. The Council has participated actively in the development of this strategy.

3.2 Risk Management

The Trust has a risk management strategy, refreshed in 2017 in recognition that the existing policy, system and controls for risk management were not robust. As a result, risk management is variable across the Trust at the time of publication. Embedding this process will be a core part of our quality and governance improvement work.

Our Board Assurance Framework sets out the principle strategic risks to the delivery of our strategy and describes the mitigating controls and assurances.

3.3 The Local Population

SECAmb provides services across Kent, Medway, Surrey, Sussex and a part of North East Hampshire, serving a combined population of over 4.7million people. With such a large population and a geographical area of 9,400 square kilometres the population and their needs are extremely diverse. The following issues are key to SECAmb planning:

Deprivation	The areas are generally affluent, with some key areas of significant deprivation including Thanet and Hastings
Age profile	Is mainly above the England average for over those aged over 65 and 85 years. Only Medway, Brighton and Crawley have younger populations
Life expectancy	Is generally above the England average, but varies widely being lowest in areas of deprivation.
Health needs	Are on a par with England averages with deprived areas generally having more lifestyle issues
Population growth	All areas are growing rapidly, with differing levels of growth within counties including the creation of new towns in Kent
Ethnicity	All areas have a lower ethnic diversity than the England and South East (SE) average excepting North West Surrey and Crawley

Table 2 – Local Population

3.4 Strategic Policy Context

The NHS in England has set a five-year strategy, the Five Year Forward View, underpinned by specific work on Urgent and Emergency Care, including the Ambulance Response Programme.

3.4.1 Delivering the Five Year Forward View

Delivering the Forward View: NHS planning guidance 2016/17-2020/21 set out nine must do actions for the NHS including the development of 7 day services. Those of most relevance to an ambulance trust are the requirements to:

- Get back on track to achieve targets for A&E and Ambulance waits
- Develop a Quality Improvement plan and publish avoidable mortality rates
- Working with the Sustainability and Transformation Plans (STPs) to return system to aggregate financial balance

This also moved all NHS providers to two year contracts, supporting a longer planning horizon, our strategy mirrors this in setting objectives for a two-year period until March 2019.

In March 2017 the Five Year Forward View – Next Steps was published. The document provided a summary of the challenges and paradoxes facing the NHS in 2017, identifying the need to face three improvement opportunities health, quality and financial sustainability. It builds on the Five Year Forward View (5YFV), specifically resetting priorities recognising that there have to be trade-offs as there is finite amount of resource.

In April 2017 this was followed by the Urgent and Emergency Care (UEC) Delivery plan of the Five Year Forward View: Next Steps. It provides detail on the offer, specification, delivery plan, expected costs and benefits of seven UEC priorities to deliver transformation care. STPs are expected to deliver this through UEC networks. The seven priorities in summary are:

- Innovative new service models
- Develop NHS 111
- Access to evening and weekend GP appointments
- Standardisation of Urgent Treatment Centres
- Improved Ambulance Response
- New approaches in Emergency Departments including improving ambulance handover
- Speed up assessment and flow in hospitals

In January 2015 NHS England established the Ambulance Response Programme (ARP) which aims to improve response times to critically ill patients and improve outcomes for all patients who contact the ambulance service. It will also increase the operational efficiency of ambulance services whilst maintaining a clear focus on the clinical need of patients. There has been significant input from Ambulance Trusts, Commissioners, professional bodies and patient groups.

The programme was approved in July 2017 and the Trust will be working to roll these changes out as part of our new clinical model and performance improvement in the coming months as details and national timelines are finalised.

3.4.2 Emergency Preparedness, Resilience and Response (EPRR)

As a category one responder under the Civil Contingencies Act we work closely with our partners to prepare for and respond to major incidents. SECAmb operational services are structured to respond to major incidents of all kinds accordingly, and clear plans and policies are in place for Major Incidents and Business Continuity. Our plans include staff awareness of PREVENT as part of the UK counter terrorism programme.

3.5 Commissioning Intentions

SECAmb works with 22 Clinical Commissioning Groups (CCGs) across the region, through lead commissioner arrangements. In addition to national policy, the CCG strategies and commissioning intentions as well as our two year contract with CCGs, have informed the development of our strategy. The items identified are summarised as follows:

- In all areas reduce A&E and acute demand, increase care at home or close to home, through a reduction in conveyance to hospital and an increases in Hear and Treat and See and Treat outcomes. Includes working with partners to develop alternative pathways.
- Ensure delivery of quality and staff satisfaction improvement
- Improve delivery against performance targets
- Work with partners to reduce handover and turnaround times
- Local urgent and emergency care development and involvement in networks
- Support work to develop system wide digital solutions
- Alignment with relevant STP plans, including local integrated care models, and sustainable service delivery plans

4.0 Our People

'We will respect listen to and work with our staff and volunteers to provide development and support that enables them to provide consistent quality care to our patients'

SECAmb values its workforce and recognises that our people are the central and integral element of delivering services for our patients. The Trust therefore aspires to develop an organisation where every person feels supported, engaged, well managed, healthy and happy at work. We believe that this will create an organisation that is a great place to work and that this improvement for staff will lead to a better patient experience. We recognise that this is not how staff have viewed the Trust in recent years and the Trust leadership pledges to engage with staff to develop values and behaviours to ensure that SECAmb is the best it can be for our people and for our patients.

The Trust operates within a range of challenged health economies where challenges with workforce recruitment are a common factor, however SECAmb has significantly improved its ability to attract and recruit staff over the last year. In improving our recruitment, the Trust continues to embrace changing workforce and operational models**.** It has established Operating Units as our model to deliver a mobile healthcare service that will improve clinical response times, reduce A&E attendances, improve staff skills and integrate work with new workforce initiatives with partner organisations as part of our commitment to support the STP, and other joint workforce programmes. The HR and OD functions, along with other corporate and support services, are aligning themselves to the new Operating Unit structure to ensure that staff and managers are fully supported.

We recognise that in developing workforce plans we need to consider a range of aspects. Our approach is based on the employee lifecycle model and our strategic priority focuses on the areas in which we need to make the most improvement.

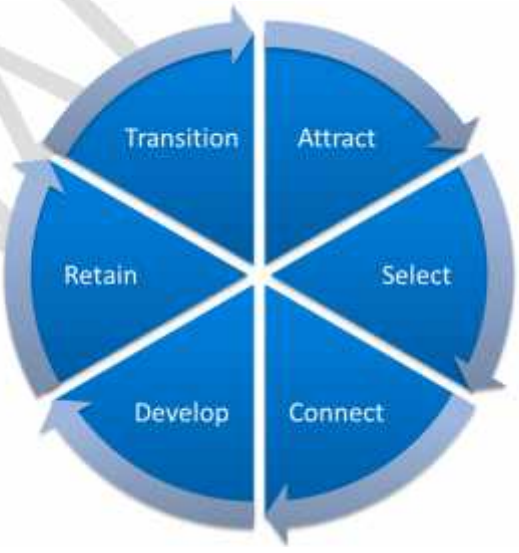


Figure 2 – Employee Lifecycle

4.1 Organisational Values and Staff Engagement

Success for any organisation depends upon a motivated and satisfied workforce. Staff engagement is key to this and it is recognised that this has been limited historically. In order to improve engagement a team of engagement champions linking across the organisation

will facilitate communication to ensure contribution to the future direction and development of our organisation.

Our organisational values should underpin value based recruitment, appraisal and behaviours. The Trust has a set of published values however during the summer of 2016 some qualitative research was undertaken to test the place of these in the hearts and minds of our staff. Although staff largely agreed with the values the view was that they were not introduced or developed with staff and therefore are not meaningful to all or universally supported. Engagement of staff in creating our new values is key to developing our culture. Therefore, in the first six months of our strategic work there will be a work programme to redefine and launch these with staff, and thereafter work to embed them within the organisation.

4.1.1 Equality and Diversity

SECAmb believes in fairness and equity, and values diversity in its role as both a provider of services and as an employer. This is reflected in the Trust document "Our Commitment to equality, diversity and inclusion". This identifies that SECAmb aims to provide accessible services that respect the needs of individuals and exclude no one. The Trust is committed to eliminating discrimination on the basis of the Equality Act 2016, and to doing so for all protected characteristics as shown in the following table:

Age	Religion and Belief	Sex
Disability	Gender reassignment	Marriage and Civil Partnership
Race	Sexual Orientation	Pregnancy and Maternity

Table 3 – Protected Characteristics

The commitment is reinforced in the Inclusion Strategy 2016-19, which includes the development and support of an Inclusion Hub Advisory Group. This brings together Trust members including staff, patients, public and stakeholders; including those we work with who have protected characteristics.

4.2 Developing Leadership

Our Learning and Organisational Development (OD) approach aims to develop effective leadership at all levels from team leader to board, and ensure a sustainable talent pipeline.

The Trust is developing its work using the NHS Academy healthcare leadership model. This is made of nine leadership dimensions which provide competencies to underpin leadership effectiveness. These will be embedded through three key areas of activity:

- Selection – choosing the right person for the job, using competency and values based assessment processes.
- Assessment – measuring and managing performance, including induction, objective setting, identifying and managing talent, learning and development needs, succession planning, and appraisal.
- Development – Active, future planning including formal management development programmes, developing business skills, and offering coaching, mentoring, secondment opportunities, and acting up opportunities.

The executive leadership team are key in this by committing to and modelling their own development, and inclusive compassionate leadership. Also by championing, promoting and offering learning and development opportunities including mentoring and recognising and

rewarding staff committed to learning and development. The OD programme will support organisational, team and individual development at all levels of the organisation.

4.2.1 Operating Unit Model

For our operational staff, the new Operating Unit Model provides accessible team leadership for all staff, ensuring that team leaders have sufficient time to support and develop their team members. Work continues to develop our operational managers and operating unit managers.

4.2.2 Trust Board

The Trust Board is led by the Chair and Chief Executive. They are supported by a team of eight non-executive directors, including the Chair and seven executive directors including the Chief Executive. With many recent changes to board appointments a development programme for the board will be implemented.

4.2.3 Executive Management Team

The Executive Management Board (EMB) is made up of the seven Executive Directors, and is supported by the Company Secretary and the Head of Communications. The EMB meet weekly to support their key functions and this team will be developed through both the board development programme and through joint work with the Senior Management Team.

4.2.4 Senior Management Team

The Trust has established a Senior Management Team (SMT) of senior managers at the level below and reporting to the EMB. Recent appointments at this level have used the new selection and assessment process and a joint development plan for SMT and EMB is being developed.

4.2.5 Support for Governors

SECAmb has 25 Governors on its Council: 14 Public Governors, four Staff Governors and seven Appointed Governors. Governors serve three year terms of office and are able to stand for election to three consecutive terms.

The Trust utilises the Governor training programme provided by NHS Providers. For example, two new members of the Nominations Committee attended NHS Providers training on NED recruitment this year prior to taking their positions on the committee. Governor workshops are held following formal Council meetings to provide opportunities for in-depth discussion with NEDs in relation to key issues for the Trust.

The Trust holds a programme of public events each year to enable Governors to meet and recruit members of the wider public.

4.3 Supporting and Developing Staff through Appraisal

The introduction of the new Actus online appraisal system will enable recording of all staff/manager interactions including formal appraisal, development needs and tracking of progress against objectives for all staff. This will be rolled out over the coming months to all staff, in parallel with the new Operational Team Leader structure for operational staff.

4.3.1 Volunteers

SECAmb proudly works with over 650 Community First Responders (CFRs) from the local community who form a vital part of the ambulance response. CFRs are trained to respond to

emergency calls in conjunction with SECAmb. They respond in the local areas where they live and work, and are able to attend the scene of an emergency within a few minutes, and often before Trust clinicians arrive. They are able to offer life-saving first aid further increasing the patient's chances of survival.

To support our staff SECAmb also has a recognised ambulance chaplaincy. There are 40 volunteer chaplains with cover for every Trust location. The Chaplaincy service is offered on a non-denominational basis, but staff and volunteers accessing the service do have the option to seek support from someone of their own faith as well. Chaplains have a very visible presence within the Trust.

In parallel with the new Operating Unit Model we are aligning our volunteers to local teams to provide them the best possible opportunities for engagement, support and development alongside the teams they support.

4.4 Health and Wellbeing

SECAmb recognises that the health and wellbeing of staff is vital, and that the staff survey identified that our staff need better care and support. As a result, the Health and Well Being strategy was developed and launched in March 2017. It is focused on creating a heathy workplace where everyone feels their health and wellbeing is supported.

It aims to:

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

It is focused on delivery of eight objectives summarised as follows:

The priorities are:

- Mental health promotion and illness reduction
- Injury prevention and faster treatment
- Access to Trauma Risk Management (TriM)
- Better Sleep
- Nutrition and exercise

In addition, the staff survey identified significant issues regarding Bullying and Harassment, and an independent review is underway which will further shape our plans to address this.

4.5 Clinical Education

Our approach to clinical education and development is aligned with our partners and is set out in the 'Our Partners' section, below.

5.0 Our Patients

'We will develop and deliver an integrated clinical model that meets local needs whilst ensuring we provide consistent care which achieves our quality and performance standards'

5.1 Ensuring Patients Get the Right Care

The ambulance service is an integral part of the healthcare system, providing the first point of contact for people in distress whether for an injury, sudden illness or an exacerbation of an existing condition. The ambulance service also acts as the provider of last resort for some patients when other services are not immediately available. It is essential that the ambulance service focusses on providing the care that cannot be delivered by other parts of the NHS and limit duplication of service provision to provide both best care and to contribute to an efficient and sustainable system.

Demand for our services continues to increase, however, we recognise the role we have to play in ensuring that patients receive the right care, at the right place in a clinically appropriate timeframe. We must also recognise that patients access 999 and NHS 111 as these recognisable numbers provide a consistent service, with no exclusion criteria and are accessible 24/7. Though a patient has accessed the NHS via 999 or NHS 111 their need may not be best met by the ambulance service and referral to another service or provider may provide more appropriate care for a patient.

The vast majority of patients who contact the ambulance service receive a referral to another service including those who are transported to hospital for their on-going care. It is therefore essential, in ensuring coordinated person centred care, that the service utilises existing care plans to provide continuity of care and builds the technological capability to electronically refer patients and share ambulance care records with other providers, as set out in section 6.

Our clinical model, builds upon our current approach to telephone advice (Hear and Treat), responding to a patient and managing their care needs through treatment or referral (See and Treat) or taking them to hospital for further care (See and Convey). Increasing emphasis will be placed on developing and improving referral pathways, ensuring that patients are cared for by the most appropriate part of the NHS or social care system as set out below.

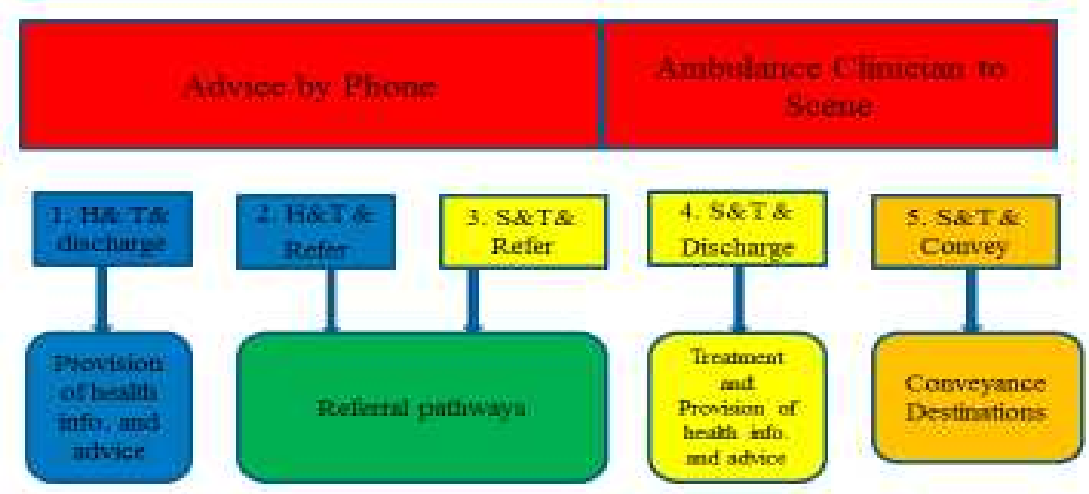


Figure 3 – Clinical Model

5.1.1 The 999 Emergency Operations Centre (EOC) and NHS 111 Contact Centre

Ensuring the right care, at the right place in the right time begins at the point of the 999 or NHS 111 call. Triaging the patient appropriately at this stage ensures that the most appropriate response is provided. It is essential that as a part of the wider healthcare system we ensure that every contact counts and that patients are directed to the most appropriate service to meet their needs, whether this need is met by the ambulance service or another part of the health and social care system.

We will be building our Hear and Treat capacity and capability through recruitment of additional clinical staff as well as the development of an incident command hub to provide advice and management of more complex incidents. A new Computer Aided Dispatch (CAD) system in the control room and our new Electronic Patient Clinical Record (EPCR) will provide the foundations for future technical developments including sharing of care plans and care records and electronic referrals to other services for our staff whether assessing a patient by phone or face to face.

In parallel with formalising referrals to other providers we will define the skills required within our inter-disciplinary clinical hub, preferring where possible to refer to other providers or develop ways of sharing skills and workforce across providers. Successful delivery will require increased responsiveness from partners and the emerging local clinical models in meeting the needs of these patients. The development of the technology and skills to support call answering and triage will drive an increase in Hear and Treat as well as referrals to more appropriate care for patients who do not require an urgent or emergency response from the ambulance service.

5.1.2 Responding to Patients

Historically ambulance services have focussed on providing emergency care, against a time based target. Whilst this remains important for those patients with life-threatening conditions these patients make up around 8% of our workload. It is important to ensure balance between a timely response and the most appropriate response for all patients. The introduction of the Ambulance Response Programme has helped to prioritise care for those with immediately life-threatening conditions and the implementation of the next phase will support more clinically focussed prioritisation for those needing emergency and urgent responses. This is a substantial change and a demand and capacity review, based on the new Ambulance Response Programme rule will help shape the detail of our future clinical model.

5.1.3 Emergency Care

Responding to the needs of patients with life-threatening conditions remains our first priority. Timely responses to patients with life-threatening condition, and those in cardiac arrest in particular, requires the quickest possible intervention and we will continue to build on the work done by our Community First Responders and fire service co-responders in support of our staff to ensure that these patients receive timely basic life support in addition to advanced intervention.

We will work with STP partners to highlight the system and whole pathway response required to improve outcomes for those who experience out of hospital cardiac arrest building on the pioneering work in places such as Seattle and Edinburgh. We will continue to develop our clinical workforce and utilise our critical care paramedics to ensure that we have

the right skills to deliver effective, evidence based care to those patients with a life threatening condition.

Increasingly hospital services are being reorganised to provide specialist care for patients with life-threatening conditions. This has already happened for heart attacks and major trauma and is occurring for stroke. Section 7 sets out how we will work closely with STPs to ensure alignment of care through these pathways to improve clinical outcomes.

5.1.4 Urgent Care

SECAmb has increased care provided at home or out of hospital through both its ambulance and NHS 111 services over recent years. SECAmb transports or refers some of the lowest proportions of patients calling 999 and NHS 111 to hospital when compared to other English services. Delivering the right care, in the right place at the right time requires an approach focussed on shared decision making with specialist clinicians both within SECAmb, based in our EOC, and in the wider healthcare system. Speed of access and a willingness to proactively support these conversations and accept referrals is crucial to limiting the numbers of patients who end up in hospital as the place of last resort rather than as the right place for their care. We will work with STPS and education partners, as set out in section 7, to ensure that we are developing the right referral pathways and clinical skills, including skills for specialist and advanced paramedic roles, to support appropriate triage, treatment and referral for these patients.

Despite the low proportion of patients which SECAmb transports to hospital, when compared to the national position, the emerging Sustainability and Transformation Plans (STPs) across the region recognise that patients are still unnecessarily referred or transported to the acute hospital setting due to gaps in responsiveness or provision out of hospital services. Plans to address this, through local care models, are emerging in each STP area and SECAmb will continue to work closely with each STP to develop alignment with these emerging models as set out in section 7. This requires a balance between regional consistency and local integration which will require support from STPs as they design their models of local care. With this support we believe that further reduction in the number of patients that need to be taken to hospital to have their care needs met is achievable.

5.2 Integration of 999 and NHS 111

SECAmb delivers the 999 service for the whole region and NHS 111 service for much of the region. As well as the direct referrals made from NHS 111 to 999 there are a number of interdependencies and synergies between the two services. We intend to capitalise on these synergies, sharing best practice between the two services and where feasible beginning to integrate and share functions between the two services. An integrated region wide approach provides clearer pathways for patients, reduced handovers between providers and a more efficient and resilient service. We will therefore explore opportunities to engage in delivery of new Integrated Urgent Care Services and align these with the 999 clinical hub as these opportunities emerge.

5.3 Governance and Quality Systems

Quality and Patient Safety is key to the development and implementation of our strategy. A key part of this is the attainment of fundamental standards to improve patient care and to ensure we meet our regulatory standards.

5.3.1 Defining Quality

These three elements in the following diagram are key to us continually improving the quality of the services.

Figure 4 – Quality Elements

5.3.2 SECAmb Quality Priorities

There are several components to the SECAmb quality programme. These are covered by the quality component of the URP, the Quality Account components, and the clinical outcomes. In all cases SECAmb is working to improve and consolidate quality, and ensuring a continued cycle of improvement and SECAmb wide learning.

Quality Programme	
Medicines Management	Consolidating and continued improvements to the secure storage and safe administration of medicines. This will be measured by audits of compliance, incident type and deep dives into any specific issues arising.
Safeguarding	Consolidating and continuing to improve safeguarding capability, response and processes.
Serious Incident investigation and subsequent learning and action	To improve the handling, recording, investigation of and learning from all incidents based on a human factors approach. Continued improvement will be measured via achievement of an effective reporting trajectory, levels of response satisfaction and audits reported to the Quality Working Group and Quality and Patient Safety Committee.
Health Records	The safe and secure handling of patient records - both paper and electronic has been identified as an area requiring improvement. In summary the areas of

	focus are as follow: • Improvement of safe and secure storage • Reduction of loss records between completion and scanning by the records department • Improvement in the consistency of records completion and quality of clinical entries • Clear audit and compliance plan Development and move to electronic patient records
Clinical Audit	The Trust had an approved three year Clinical Audit plan, which due to other changes requires revision. This is being reviewed and refreshed.
Other Quality Initiatives	
Information Governance	The Trust has met the national standard level 2 (satisfactory) of the Information Governance Toolkit for 2016-17. Our digital ambitions for the next two years will require development Information Asset Owners and a Trust wide approach to Information Governance through the new Information Governance Working Group
Patient Experience	During 2017 the Trust will continue to work in partnership with Health Watch and wider stakeholders to develop our approach to patient experience. Patients and carers will be directly involved in this. The focus will be on ongoing co-design, involvement and collaboration in future work. Work will also be focused on increasing the quality, focus and range of patient and carer feedback.

Table 4 – Quality Priorities

5.4 Clinical Outcomes and Operational Performance

The Trust is committed to equality and diversity as per section 4.1.1. This includes ensuring our services are accessible to all of our population, and that they take account of specific needs across protected characteristics as well as vulnerability, language and cultural needs.

We recognise that for many patients a timely response is also important for their care. We will continue to work with commissioners and partners to monitor and improve the timeliness of our response.

Whilst the Trust performs well on stroke, heart attack and some cardiac arrest outcome measures there is more to do to ensure that we have timely accurate data to support further improvement in these measures and can begin the process of measuring clinical outcomes for other conditions such as sepsis.

Our new Electronic Patient Records (EPCR) will support the development of more timely and accurate data collection and analysis through the clinical audit plan. This will allow not only more timely reporting but will allow us to begin some reporting at a more granular level so

that in future we can support our operating units, teams and staff to better understand their performance against these clinical outcomes.

6.0 Our Enablers

'We will develop and deliver an efficient and sustainable service underpinning by fit for purpose technology, fleet and estate'

6.1 Financial Sustainability

The Trust has been set a national target to deliver services in 2017-18 with a deficit of no more than £1m. This follows a deficit of £7.1m in 2016-17 as a result of a gap in funding and investment required to address concerns raised by the CQC. Following the contract settlement for 2017-19 an independent review was commissioned and delivered by Deloitte which confirmed that even with significant internal efficiencies and savings it was not possible to meet operational performance targets within the current funding.

The Trust has committed to make significant savings and efficiencies over the coming years, £15m in 2017-18 alone, to contribute to closing this gap and conversations are on-going with regulators and commissioners to agree the level of operational performance improvement to be commissioned from the Trust, recognising that there is a ceiling below 75% operational performance that can be achieved within current funding.

Once the clinical model and resulting preferred fleet and staff mix are finalised then a detailed Long Term Financial Model will be developed to support this. The capital plan may need to be reprioritised to support digital, fleet and estates in a different way to deliver this plan within our financial means. The Trust aims to repay its working capital facility within 2017/18, and will start to generate small surpluses from 2019. This means that any new investment decisions (which are not replacement of existing assets), will need to be funded by disposals or loans.

6.2 Digital

SECAmb will develop and deliver a digital plan which covers both IT and Business Intelligence. This will support integration with the wider health system through sharing of information and will enable the clinical model supporting more effective patient referral. Developing our management of business information and clinical information will underpin our approach to delivering continuous improvement in both clinical outcomes and operational effectiveness.

This work will build upon our existing network of systems and system owners, defining our key reference systems for specific information. For example, consolidating staff lists and hierarchies held in numerous systems, into a single 'point of truth' on staff information from our ESR system. This will be enabled by timelier update of information through self-service portals, reducing delays and administrative duplication.

We are currently implementing a new Computer Aided Dispatch System (CAD) in our 999 control room. This will provide the foundation, alongside a new clinical decision support system, for improved collection of patient data using NHS number, access to care plans and easier referral to other services where this is most appropriate for patients. This will support more integrated and seamless care for patients and aid our staff in their decision making.

Our new Electronic Patient Care Record (EPCR) provides a foundation for the collection of patient information at the scene of an incident electronically and allows us to develop future approaches that reduce duplicate information entry, enable access to care plans and support

sharing of information with hospitals and other care providers as appropriate to the needs of our patients.

This new approach to data collection will be supported by the development of an enhanced business intelligence function and tools to support local managers and corporate functions with more timely access to actionable information and intelligence. This will support both performance management and continuous improvement.

6.3 Fleet

SECAmb have a draft fleet strategy that will be completed in the light of this overarching strategy and the demand and capacity review following announcement of the ambulance response programme. It will describe the vehicle mix required to deliver our clinical model, as well as the organisations approach to fleet replacement and maintenance

6.4 Estates

SECAmb have an estates strategy that will be revised in the light of this overarching strategy. It will describe the organisations approach to estates development, modernisation, optimisation and carbon reduction. This will ensure that our estate is fit for purpose now and into the future.

7.0 Our Partners

'We will work with our partners in STPs and blue light services to ensure that our patients receive the best possible care, in the right place, delivered by the right people'

STPs are now the core-planning vehicle to develop place based plans that aim to take forward a sustainable care system across all NHS and social care organisations. Local areas are expected to work together, which requires some changes to organisational sovereignty. Of the 44 national STP areas, four align with the SECAmb area, as follows:

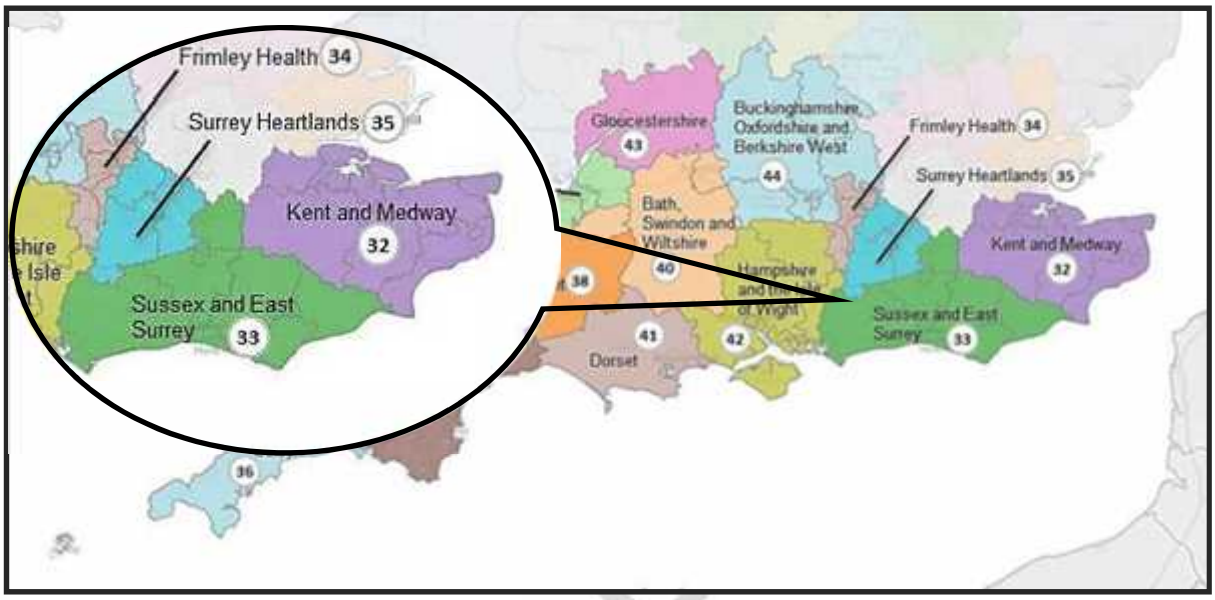


Figure 5 – Sustainability and Transformation Plan Footprints

Each areas plans are developing at differing paces with Surrey Heartlands having recently been supported to take a devolution approach. SECAmb is working with all STPs to support and influence plans ensuring alignment with our strategy.

As a regional provider we are able to provide consistent clinical care across a wide geographical area. In working with STPs we need to take into account what can be realistically delivered locally as determined by communities of practice, and what needs to be delivered at a regional or STP level to deliver consistent and efficient care.

7.1 Local Care

Working with local communities of practice – geographical clusters of out of hospital services such as primary and community care – we will seek to develop improved referral pathways for use both at the point of call to 999 or NHS 111 or following a face to face assessment by an ambulance clinician. These improved referral pathways and associated improvements in information sharing, both care plans shared with the ambulance service and referral information shared by the ambulance service, will support the drive to keep patients out of hospital unless hospital is the most appropriate place for care.

This will require support from STPs to standardise information sharing, digital systems, available services and referral criteria, whilst recognising the need for local variation to meet the needs of different populations. The Trust will work with STPs to support them in developing consistent approaches to support regional approaches, to ensure the most

appropriate care is available or patients and that this care is timely and not delayed by navigating numerous referral options.

7.2 Acute Care

Increasingly patients with complex clinical need following incidents such as a heart attack or major trauma are taken to specialist centres where they can receive the best possible care. This move away from closest place of care to most appropriate place of care is shown to improve clinical outcomes and similar work is underway for stroke care across the region. SECAmb will work to support these pathways but must ensure that sufficient resource and the right skills are available to safely manage these longer journeys to specialist centres.

For those patients who need an investigation or assessment in hospital but may not require admission we will work with providers to make direct referrals to ambulatory care, or other alternatives to A&E departments to support timely care for these patients.

7.3 Blue Light Collaboration

The Policing and Crime Bill (2016) places a statutory duty on Police, Fire and Ambulance services to work in collaboration. At the present time this is the extent of the duty, it is not known at present if this will be extended.

SECAmb works closely with local Fire and Rescue and Police services across the area to optimise joint working and shared resourcing opportunities. Most notably for SECAmb, all of our Fire Services are now working with us to provide a first response to life threatening calls. We will continue to work closely with blue light partners to seek opportunities for collaboration and efficiency.

7.4 Clinical Education

As the needs of patients get more complex and the role of the ambulance service continues to evolve, particularly in light of the recently announced Ambulance Response Programme, we need to ensure that our staff have the appropriate skills and education to effectively support patient needs. We will work with Health Education England, Higher Education and STP partners to evaluate our educational pathways for all clinical grades. In particular we will work to introduce apprenticeship routes for our band 3 and 4 clinical staff and review opportunities to support clinicians working in a telephone triage role.

8.0 Annual Business Planning and Delivery

Alongside our strategy we have published a two year operating plan (2017-2019) in line with NHS guidance and the new two year contract round, this sets our the details the high level financial, workforce and quality plans based on our previous strategic direction but not a clear plan for delivery of the new strategy. To ensure that planning remains current we will develop a delivery plan to monitor delivery of the first two years of the strategy. We will operate an annual business planning cycle within the Trust to constantly review our strategy and ensure continued alignment with national policy, and local priorities. This will ensure that we focus our resources and ensure alignment between our strategic plan and other annual deliverables such as the workforce plan, finance plan, quality account and contractual relationships.

8.1 Delivery Approach

Delivery has to take account of what can be appropriately delivered SECAmb wide, STP wide, county wide and at a more local level. Where possible to optimise resources and delivery consistency our approach will be SECAmb wide. This will vary to smaller footprints where determined by local or specific population based needs.

SECAmb has a Programme Management structure and approach to delivering our core strategic programmes. The Trust has implemented a standard system of project documentation and an agreed procedure for the approval of proposed improvement schemes. This approach and the programme governance structures employed in delivering the Unified Recovery Plan will be revised to support delivery of the strategy. The Trust has implemented a standard Quality Impact Assessment (QIA) which staff proposing and delivering improvement schemes must complete with support from the programme team.

8.1.1 Quality Impact Assessment

The Quality Impact Assessment (QIA) is used to assess any potential impact of changes or developments on patient safety, clinical effectiveness, and patient experience. This includes ensuring appropriate mitigations are put in place for any risks, and agreed mechanisms to provide measurement and assurance of any impacts.

Following approval, the scheme can proceed to implementation, with regular ongoing review of quality impact as the project progresses.

We have developed an integrated performance report that that now reports on and triangulates key metrics of quality, performance, finance, and workforce. This is a process we are continuing to refine and develop. The QIA process also provides this triangulation. Additional scrutiny of triangulation takes place at the audit committee.

8.1.2 Measuring Performance and Delivery

SECAmb reports on all performance monthly to the executive and the Board via the Integrated Performance Report and on progress against strategic programmes. This will be revised in the first half of 2017 to improve the priority for measurement and to include strategy and delivery plan objectives.

8.2 Triggers for Review or Refresh

In line with NHS Improvement guidance on strategy development we will review our strategic direction at least annually, as part of the business planning cycle. To enable an annual

review that aligns with other annual processes and requirements this cycle will begin in September with any revisions published annually by the following March.

We will use the triggers below to review whether consideration of changes to the strategy are required:

8.2.1 Internal Triggers

- Changes in Trust performance considering all metrics (Scorecard, dashboard, CQC rating, staff survey.) May be one significant change or a combination of them
- Workforce – unable to safely staff a service component, or all services, or any new development
- Significant variation in achievement of the strategic goals and implementation of the strategy or enabling strategies
- Significant/ serious incident or significant issues found following an incident or complaint investigation
- Adverse findings from a governance review
- Losing business
- Unexpected or unintended impact on delivery of a significant strategic change or plan

8.2.2 External Triggers

- Significant change to commissioner plans
- Changes in commissioning landscape and structure
- Significant change to national or local policy
- Significant changes in regulatory / governance policy
- Significant changes in national targets
- External financial instability, including the move into special measures of CCGs and partner providers

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	67/17

Name of meeting	Board of Directors
Date	25 July 2017
Name of paper	Board Assurance Framework
Responsible Executive	Executive Team
Author	Peter Lee, Company Secretary
Synopsis	The Board Assurance Framework (BAF) helps the Board assess the risks in achieving its strategic goals. It sets out the principal risks in achieving the Trust's 16 objectives, which align to the four strategic goals, and includes the controls currently in place, any gaps, and the actions to be taken. It also describes the assurances, and confirms the current risk rating, and the target risk score post treatment.
Recommendations, decisions or actions sought	The Board is asked to consider the BAF and confirm its tolerance of the target risk scores, as set out. The risks of achieving objectives 3, 11 & 16 will be confirmed in version 2 which is due to be considered by the Audit Committee in September.

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

1. Background

In June the Board of Directors approved the trust's five-year strategic goals and the related two-year objectives (Appendix 1). Aligned to the 16 objectives, the Board Assurance Framework sets out the principal risks to their achievement.

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

The risks are quantified in accordance with the risk score matrix in Figure 1 below:

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

Low	**Moderate**	**High**	**Extreme**

Figure 1

2. Board Assurance Framework (version 1)

As illustrated in Figure 1, risks are categorised from low to extreme. Figure 2 sets out the risk score for each objective post controls:

	Low 1	**Moderate 2**	**High 8**	**Extreme 2**
Objectives	**12**	**1** **15**	**2** **4** **5** **6** **7** **8** **10** **14**	**9** **13**

Figure 2

In consideration of the Board Assurance Framework, the executive has considered it appropriate to tolerate the current risks identified against objectives 12 and 15.

'Capacity' is a theme across several of the objectives and this is consistent with discussions at recent board meetings about the need to ensure robust prioritisation.

3. Recommendation

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

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

4. Board Assurance Framework

Our Strategic Goals

Our People	Our Patients	Our Enablers	Our Partners
We will respect, listen to and work with our staff and volunteers to provide development and support that enables them to provide consistent, quality care to our patients	We will develop and deliver an integrated clinical model that meets the needs of our communities whilst ensuring we provide consistent care which achieves our quality and performance standards	We will develop and deliver an efficient and sustainable service underpinning by fit for purpose technology, fleet and estate	We will work with our partners in STPs and blue light services to ensure that our patients receive the best possible care, in the right place, delivered by the right people

Dashboard

Objectives		Principal risk(s) to achievement of objectives		Initial Score		Current Score		Target Score		Target Date
				C	L	C	L	C	L	
1	With the support and engagement of staff and volunteers, refresh the Trust values and behaviours	Lack of engagement from staff / volunteers		3	3	3	2	3	1	31.03.2019
2	Develop effective leadership and management at all levels, through our new selection, assessment and development processes	Not following the NHS leadership academy framework for all appointments. Inability to support development plans.		4	4	4	3	4	2	31.03.2019
3	Ensure all staff and volunteers have clear objectives, and a plan for their development, set through regular appraisal									31.03.2019
4	Improve staff and volunteer health and wellbeing	Insufficient resources to deliver on aspects of the strategy, e.g. wellbeing hub. Lack of awareness and understanding of how to access the support available, e.g. OH services		3	4	3	3	3	2	31.03.2019
5	Develop and deliver a clinically led process to prioritise patient need at the point of call, increasing referral	Capacity in the clinical hub. Inability to consistently manage call handling times.		3	5	3	4	3	3	31.03.2019

	to alternative services where clinically appropriate									
6	Further integrate and share best practice between NHS 111 and 999 services, striving for Integrated Urgent Care service where this is considered viable	111 leadership capacity to help drive the integration and sharing of best practice.		4	4	4	3	4	2	31.03.2019
7	Further improve and embed governance and quality systems across the organisation, building capacity and capability for continuous improvement	Insufficient capacity and competing priorities through the whole cascade of governance. Resourcing for IT infrastructure to allow reliable data collection from multiple sources.		4	3	4	2	4	1	31.03.2019
8	Improve clinical outcomes and operational performance, with a particular focus on life threatening emergencies	Inability to provide enough hours to meet demand within the current systems and resources available		4	5	4	3	4	2	31.03.2019
9	Ensure our services are efficient and sustainable and that they are supported by appropriate levels of funding	CIP target is over 7% of the budget. Insufficient capacity to deliver this stretching CIP target in the context of recovery etc. (most acute within operations). Current residual commissioners gap. Capacity within PMO to support once EY exit.		5	5	5	4	5	2	31.03.2019
10	Develop and deliver a digital plan which supports integration with the health system and enables the clinical model and our approach to continuous improvement	Prioritising between internal and external requirements and maintaining delivery within scope.		3	4	3	3	3	2	31.03.2019
11	Ensure that our fleet is fit for purpose and supports the clinical model									31.03.2019
12*	Ensure that our estate is fit for purpose and supports the clinical model	Financial investment needed to implement our estates strategy (future investment in estate will need to come from disposals of surplus locations).		3	2	3	1	3	1	31.03.2019
13	Work with STPs to achieve the best care for our patients through emerging local out of hospital care systems	Capacity and ability to engage and influence given such a high number of different pathways		4	5	4	4	4	3	31.03.2019
14	Work with STPs to design and	Capacity to ensure proactive engagement		3	4	3	4	3	3	31.03.2019

	deliver generalist and specialist care pathways for patients requiring an acute hospital attendance	Insufficient influence								
15*	Work with education and STP partners to develop career pathways that support our staff to make effective clinical decision making	Insufficient internal capacity to design and deliver appropriate modules. A reduction in external resource		4	3	4	1	4	1	31.03.2019
16	**Work with blue light partners to ensure collaboration supports patient outcomes and efficient service delivery**									31.03.2019

*Risk Accepted

Objective 1	**With the support and engagement of staff and volunteers, refresh the Trust values and behaviours**

Our People			
Principal Risk	Non-engagement from staff & volunteers	**Director responsible**	**Director of HR**
		Initial Risk	C3xL3 = 9
Potential Impact	Lack of ownership of the values and behaviours and, therefore, insufficient impact.	**Current rating**	C3xL2 = 6
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C3xL1= 3

Controls in place (what are we doing currently to manage the risk)
Staff Engagement Advisors are in place An Engagement Plan has been developed

Gaps in Control
Clever Together System Business Case to be approved (this system is designed to help enable engagement) The engagement plan is yet to be implemented (pending outcome of the business case)

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
None	Values and Behaviours Project Plan (part of Culture and OD steering group) yet to report through the steering group

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Clever Together System Business Case 2. Implement the Values and Behaviours Project Plan	1. In the approval process 2. Due to begin pending the outcome of business case decision

Update	12.07.2017	**Date discussed at Board**	Due 25.07.2017

Objective 2	**Develop effective leadership and management at all levels, through our new selection, assessment and development processes**

Our People			
Principal Risk	Not following the NHS leadership academy framework for all appointments. Inability to support development plans	**Director responsible**	**Director of HR**
		Initial Risk	C4xL4 = 16
Potential Impact	Lack of understanding of staff development needs. Not supporting their leadership development, which will affect staff morale.	**Current rating**	C4xL3 = 12
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C4xL2 = 8

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

We have assessment centres established, and recruitment tools, which are based on the NHS leadership academy framework
The system 'Actus' has been introduced to support managers identify development needs and establish associated plans
The Actus Project Plan has begun, with the aim of ensuring consistent use of this system
Limited internal and external capacity is in place to support some interventions, such as coaching / mentoring

Gaps in Control

Additional internal and external capacity is required to ensure demand is met to support interventions, such as coaching and mentoring
Actus is not fully embedded / used by staff
The performance management culture needs to be improved

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) Data on career conversations / objective setting	Staff survey (results scheduled for Q4) Pulse surveys (next survey in Q2 is to include questions on career conversations)

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Development of a leadership programme 2. Procurement of the support needed to increase internal / external capacity to support interventions 3. Implementing the Actus Project Plan, which includes training managers to hold career conversations.	

Update	12.07.2017	Date discussed at Board	Due 25.07.2017

Objective 4 Our People	Improve staff and volunteer health and wellbeing		
Principal Risk	Insufficient resources to deliver on aspects of the strategy, e.g. wellbeing hub. Lack of awareness and understanding of how to access the support available, e.g. OH services	**Director responsible**	**Director of HR**
		Initial Risk	C3xL4 = 12
Potential Impact	If materialised these risks will increase the time for staff to access the right intervention(s).	**Current rating**	C3xL3 = 9
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C3xL2 = 6

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

The H&W strategy and delivery plan is in place (approved by the Board)
We have re-tendered OH services - Communication / engagement to staff has included posters etc. on the services available
Management training has been provided on how to access services / request referrals
We have approved a 12-month dedicated resource to support implementation of the strategy
HEKSS funding is in place to support implementation of TrIM – the trauma management programme
Initiatives introduced such as Pilates.
Increased focus on minimising shift over-runs and ensuring meals breaks
Mental Health Nurse Consultant supports the triage of staff experiencing mental health issues

Gaps in Control

Wellbeing hub is not yet implemented
Further development is needed to increase healthy activities across trust, such as Pilates which is in place at Crawley HQ.

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) Referrals to OH (+) Referrals to TrIM (+) Reduction in shift over runs and increase in (uninterrupted) meal breaks	Progress against the H&W strategy yet to be reported. It will be overseen by management via the HR Group and on behalf of the Board by the WWC.

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Implementation of the wellbeing hub 2. Business Case for the hub	

Update	12.07.2017	Date discussed at Board	Due 25.07.2017

Objective 5 Our Patients	Develop and deliver a clinically led process to prioritise patient need at the point of call, increasing referral to alternative services where clinically appropriate		
Principal Risk	Capacity in the clinical hub. Inability to consistently manage call handling times.	**Director responsible**	**Executive Medical Director**
		Initial Risk	C3 X L5 = 15
Potential Impact	Slower response times and adverse impact on quality and/or patient safety	**Current rating**	C3 X L4 = 12
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C3 x L3 = 9

Controls in place (what are we doing currently to manage the risk)
NHS Pathways is clinically-led; QA is in place Education and supervision of call handlers Recruitment

Gaps in Control
Currently no decision software support available to (hear and treat) clinicians Introduction of QA of hear and treat ARP – which will help respond to fewer Cat A patients giving more resource for lower priority patients and more time to identify patients suitable for hear and treat.

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) complaints and incidents data (-) Call handling behind target (-) % patient for hear and treat low (+) low non-conveyance rates	Not completing non-conveyance audit

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Recruitment to the clinical hub 2. Decision support tool with QA 3. LAS support for staff 4. Audit non-conveyed patients (not yet started – although have head of clinical audit)	

Update	18.07.2017	**Date discussed at Board**	Due 25.07.2017

Objective 6 Our Patients	Further integrate and share best practice between NHS 111 and 999 services, striving for Integrated Urgent Care service where this is considered viable		
Principal Risk	111 leadership capacity to help drive the integration and sharing of best practice.	**Director responsible**	**Executive Director of Operations**
		Initial Risk	**C4xL4 = 16**
Potential Impact	Quality control of 999 call handling would deteriorate, as audits are led by 111. Anticipated volume of hear and treat activity would not be realised, as recruitment of clinicians and their education and training is currently led by 111.	**Current rating**	C4xL3 = 12
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	4x2 = 8

Controls in place (what are we doing currently to manage the risk)
Expanded remit of the head of quality to include both 111 and 999 services. A short term interim appointment has been made (until Q3) to increase capacity / capability. The JD for the substantive appointment of a senior clinical operations manager is complete and being evaluated. The quality audit team within 999 is being maintained and strengthened by leadership through the 111 service.

Gaps in Control
JD for the senior clinical operations manager yet to be approved and so substantive recruitment not yet started.

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) There has been a significant increase in 999 call handling audits, and subsequent increase in quality / compliance. (- / +) Audit feedback is being provided to 999 call handlers, which is positive, but some staff are negative about the feedback, indicating a need to improve delivery of the feedback. (- & +) Less 999 referrals from 111 (reported as a percentage against a national target) – currently trend is above national average. But still better than other ambulance trusts providing 111 services.	Should receive less referrals back to 111 (not yet reporting)

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Recruitment to the senior clinical operations manager 2. Recruitment to 44 clinician posts	1. Due to start in August 2. Due to start end of Q2

Update	17.07.2017	**Date discussed at Board**	Due 25.07.2017

Objective 7 Our Patients	Further improve and embed governance and quality systems across the organisation, building capacity and capability for continuous improvement		
Principal Risk	Insufficient capacity and competing priorities through the whole cascade of governance. Resourcing for IT infrastructure to allow reliable data collection from multiple sources.	**Director responsible**	**Executive Director of Nursing & Quality**
		Initial Risk	C4xL3 = 12
Potential Impact	The pace of improvement will be slower	**Current rating**	C4xL2 = 8
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C4xL1 = 4

Controls in place (what are we doing currently to manage the risk)
Succession plan in place to ensure all key posts are filled (currently there is a mixture of vacancies and interim appointments) PMO support is helping to ensure focus and priority of the actions to support of recovery / improvement plan Datix Manager is in post to ensure this system is maximised to support continuous improvement

Gaps in Control
Some key posts are currently vacant and some are filled on an interim basis. Clarity and informed cross-directorate decision making in competing priorities; for example, the abstraction needed to ensure appropriate training versus the need to ensure improved performance.

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(- / +) IPR / Quality and Patient Safety Report currently shows a mixed-picture (- / +) CQC findings – the initial feedback from the recent inspection was positive about some of the improved systems of governance and weaknesses in others.	Dashboard that gives better clarity on key metrics and levels of performance. An external Governance Review has been commissioned and is due to report in September 2017. A review is being completed which sets out the critical posts and related succession plan to give assurance that plans are in place when posts become vacant.

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Vacant posts are being recruited to 2. The quality management group structure is being re-focussed around standards; practice and; effectiveness. 3. Extending EY support through the PMO 4. Improving the use of Datix	1. On-going 2. This has started and requires some revision to terms of reference and rescheduling meetings to align to the new structure 3. A business case is being developed 4. This is one of the new Datix Manager's principal objectives over the coming weeks and months.

Update	13.07.2017	Date discussed at Board	Due 25.07.2017

Objective 8 Our Patients	Improve clinical outcomes and operational performance, with a particular focus on life threatening emergencies		
Principal Risk	Inability to provide enough hours to meet demand within the current systems and resources available.	**Director responsible**	**Executive Director of Operations**
		Initial Risk	C4 x L5 = 20
Potential Impact	Adverse impact on patient safety	**Current rating**	C4 x L3 = 12
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C4 x L2 = 8

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

Mediation with commissioners to provide appropriate levels of funding.
Internal initiatives to minimise lost hours, such as call cycle time and resources per incident.
External initiatives with partners to minimise lost hours, such as hospital handover delays, and exploration of alternative pathways.
High degree of specialist practice education to minimise the volume of patients transported to hospital (relatively high see and treat ratio).
Proprietary forecasting tool used to help understand the required resource to meet demand.
Continued investment in specialist practitioners

Gaps in Control

Mediation still ongoing – no additional resources been offered to date
Hospital handover delays not improving in sustainable way

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) Low conveyance rates (+) call cycle time has shown a sustained improvement since Dec/Jan (+) resources per incident – as above (-) actual activity is not consistently as predicted (- & +) Ambulance Quality Indicators	Data capture means we aren't properly measuring all Ambulance Quality Indicators correctly.

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
Conclude mediation Continue working with partners on initiatives such as hospital delays Continue focus on call cycle time Improve forecasting model (seeking external support end of Q2)	

Update	17.07.2017	Date discussed at Board	Due 25.07.2017

Objective 9 Our Enablers	Ensure our services are efficient and sustainable and that they are supported by appropriate levels of funding		
Principal Risk	CIP target is over 7% of the budget. Insufficient capacity to deliver this stretching CIP target in the context of recovery etc. (most acute within operations). Current residual commissioners gap. Capacity within PMO to support once EY exit.	**Director responsible**	**Executive Director of Finance & Corp. Services**
		Initial Risk	C5xL5 = 25
Potential Impact	Adverse impact on performance. Adverse impact on quality / patient safety/experience. Sustainability of the improved governance we have introduced through the PMO and delivery of CIP.	**Current rating**	C5xL4 = 20
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C5xL2 = 10

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

We have identified CIP schemes circa £20m to deliver the target of £15.1m. These have been developed within a robust governance process with support of PM0 and following the established QIA process.
Process of regular reviews of the QIAs given the risk associated with the 7% efficiency target.
The mediation process confirmed a residual gap in health economy of up to £30m. NSHI, NSHE and CCGs are working on closing this gap, however, the Trust acknowledges that until this happens there won't be the appropriate level of finding to provide a quality service.
A Business Case has been developed to extend the contract of EY which we consider crucial in order to sustain the focus on delivery.
A Financial Sustainability Steering Group (FSSG) is well-established and meets at least weekly, to ensure grip and focus.

Gaps in Control

Not all CIP schemes are fully validated.
We haven't concluded the mediation process with commissioners.
The urgency of both commissioners and regulators to address the residual gap is not as we would have liked (the initial aim was to conclude this by 1 April 2017)
There is a lack of clarity and direction from the 22 CCGs as to how to resolve the residual gap.

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) FSSG is providing positive assurance on the governance supporting the development and implementation of CIP schemes. (+/-) NHSI have been very close to the detail of our CIP development and are assured with the process, but concerned about the risks and size of the target	Currently not all schemes are fully validated to test their deliverability and the CIP progress plan is in development

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Business Case to extend EY 2. Conclusion of Mediation 3. To conclude validation of all CIP schemes	1. To be approved by the Board and then NHSI 2. We have engaged both regulators 3. All CIP schemes to be validated by the end of July 2017

Update	14.07.2017	**Date discussed at Board**	Due 25.07.2017

Objective 10 Our Enablers	**Develop and deliver a digital plan which supports integration with the health system and enables the clinical model and our approach to continuous improvement**		
Principal Risk	Prioritising between internal and external requirements and maintaining delivery within scope.	**Director responsible**	**Executive Director of Strategy & Business Development**
		Initial Risk	C3xL4 = 12
Potential Impact	Inadequate or inaccurate information to inform decision making. Information governance breaches. Additional resources and costs.	**Current rating**	C3xL3 = 9
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C3xL2 = 6

Controls in place (what are we doing currently to manage the risk)
CAD and EPCR projects are developed and being implemented

Gaps in Control
CQUIN delivery plan to be agreed/approved. The scope of the digital plan is to be defined. There are currently some gaps in the informatics team.

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) CAD and EPCR Project Boards are currently providing positive assurance in their implementation.	We are still unable to provide detailed information to local teams

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. CQUIN delivery plan is in development 2. The Digital project mandate is to be developed which defines the scope of the digital plan 3. Recruit to six vacant posts in Informatics team 4.	1. Commissioners due to approve the CQUIN plan in August 2017 2. No progress to date 3. Two posts are covered on interim basis. Adverts are out for the other four vacancies.

Update	12.07.2017	**Date discussed at Board**	Due 25.07.2017

Objective 12 Our Enablers	Ensure that our estate is fit for purpose and supports the clinical model		
Principal Risk	Financial investment needed to implement our estates strategy (future investment in estate will need to come from disposals of surplus locations).	**Director responsible**	**Executive Director of Finance & Corp. Services**
		Initial Risk	C3xL2 = 6
Potential Impact	Inability to invest in our estate	**Current rating**	C3xL1 = 3
		Risk Treatment (tolerate, treat, transfer, terminate)	**Tolerate**
		Target risk score	C3xL1 = 3

Controls in place (what are we doing currently to manage the risk)
We currently have an estate that is fit for purpose, which includes 8 MRCs and a new HQ, plus significant investment in ambulance community response posts. Estates team continue to manage the estate via external contractors, ensuring the key requirements of compliance / maintenance. Where opportunities arise we will consider 'land-banking', such as in Brighton where couldn't afford the build costs, but bought the land.

Gaps in Control
The Estate Strategy is not yet developed

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) Estates Return Information Collection return provides positive assurance re the condition of our estate	Until the Estates Strategy is in place we can't monitor the implementation plan.

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. The Estates Strategy to be approved / implemented.	1. to be approved as scheduled by October 2017

Update	14.07.2017	**Date discussed at Board**	Due 25.07.2017

Objective 13 Our Partners	Work with STPs to achieve the best care for our patients through emerging local out of hospital care systems		
Principal Risk	Capacity and ability to engage and influence given such a high number of different pathways.	**Director responsible**	**Executive Director of Strategy & Business Development**
		Initial Risk	C4xL5 = 20
Potential Impact	Crews longer on scene seeking non-conveyance pathways or increased conveyance through lack of pathway.	**Current rating**	C4xL4 = 16
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C4xL3 = 12

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

We are engaged through account managers and local operations managers in STP meetings.
County-level pathway review workshops have been held.
Increased provision of hear and treat as per URP.

Gaps in Control

We are not always able to provide the right person at each of the STP meeting.
We need to be more proactive in the proposals for the design of the care pathways.
We don't have all the detailed data, e.g. delays in accessing pathways and in evidencing potential gaps in a pathway, such as those in primary care.
We aren't using the directory of services.
Further increase needed as planned, in the provision of hear and treat

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) The current data demonstrated positively the on-scene time and conveyance rates	None

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Review how we engage with STP-leads to ensure we are more proactive and use conversations to build consistency across the region. 2. Use of directory of services 3. Increasing hear and treat	1. Plan to be developed 2. We are piloting use of directory of services on iPads 3. Project mandate planned for July/Aug

Update	12.07.2017	Date discussed at Board	Due 25.07.2017

Objective 14 Our Partners	Work with STPs to design and deliver generalist and specialist care pathways for patients requiring an acute hospital attendance		
Principal Risk	Capacity to ensure proactive engagement. Insufficient influence.	**Director responsible**	**Executive Director of Strategy & Business Development**
		Initial Risk	C3xL4 = 12
Potential Impact	Geographical spread / no funding for additional journey times. Misalignment of plans. We don't plan the right capacity to respond to reconfigured services and do not secure associated funding.	**Current rating**	C3xL4 = 12
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C3xL3 = 9

Controls in place (what are we doing currently to manage the risk)
We are engaged through account managers and local operations managers in STP meetings.

Gaps in Control
We aren't always able to provide the right person at each of the STP meetings. We need to be more proactive in proposals for the design of the care pathways. We don't have timely availability of clinical outcomes data.

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) We are being relied upon to provide data which demonstrates STP understanding of the role we have. (+) Clinical outcomes data we do have is used to review and measure the impact of changes to pathways	We only have outcomes data for some of the pathways

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Review how we engage with STP-leads to ensure we are more proactive and use conversations to build consistency across the region. 2. Review of clinical outcomes data we are able to provide.	1. Plan to be developed 2. Medical Director reviewing clinical outcomes data

Update	12.07.2017	**Date discussed at Board**	Due 25.07.2017

Objective 15 Our Partners	Work with education and STP partners to develop career pathways that support our staff to make effective clinical decision making		
Principal Risk	Insufficient internal capacity to design and deliver appropriate modules. A reduction in external funding.	**Director responsible**	**Director of HR**
		Initial Risk	C4xL3 = 12
Potential Impact	Inadequate training for clinical staff	**Current rating**	C4xL1 = 4
		Risk Treatment (tolerate, treat, transfer, terminate)	**Tolerate**
		Target risk score	C4xL1 = 4

Controls in place (what are we doing currently to manage the risk)
We currently have fully staffed, established and costed clinical education team, including a consultant paramedic providing input. We have a programme designed for each module across all relevant career pathways. We have facilities in place to deliver the modules / training. Funding from HEKKS is in place for next two years.

Gaps in Control
None

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) Clinical education group	Workforce strategy which shows career pathway flow chart

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
None (all controls in place)	NA

Update	12.07.2017	Date discussed at Board	Due 25.07.2017

Our Themes	Our People	Our Patients	Our Enablers	Our Partners
Our five year goals	We will respect, listen to and work with our staff and volunteers to provide development and support that enables them to provide consistent, quality care to our patients	We will develop and deliver an integrated clinical model that meets the needs of our communities whilst ensuring we provide consistent care which achieves our quality and performance standards	We will develop and deliver an efficient and sustainable service underpinning by fit for purpose technology, fleet and estate	We will work with our partners in STPs and blue light services to ensure that our patients receive the best possible care, in the right place, delivered by the right people
Our two year objectives	With the support and engagement of staff and volunteers, refresh the Trust values and behaviours	Develop and deliver a clinically led process to prioritise patient need at the point of call, increasing referral to alternative services where clinically appropriate	Ensure our services are efficient and sustainable and that they are supported by appropriate levels of funding	Work with STPs to achieve the best care for our patients through emerging local out of hospital care systems
	Develop effective leadership and management at all levels, through our new selection, assessment and development processes	Further integrate and share best practice between NHS 111 and 999 services, striving for Integrated Urgent Care service where this is considered viable	Develop and deliver a digital plan which supports integration with the health system and enables the clinical model and our approach to continuous improvement	Work with STPs to design and deliver generalist and specialist care pathways for patients requiring an acute hospital attendance
	Ensure all staff and volunteers have clear objectives, and a plan for their development, set through regular appraisal	Further improve and embed governance and quality systems across the organisation, building capacity and capability for continuous improvement	Ensure that our fleet is fit for purpose and supports the clinical model	Work with education and STP partners to develop career pathways that support our staff to make effective clinical decision making
	Improve staff and volunteer health and wellbeing	Improve clinical outcomes and operational performance, with a particular focus on life threatening emergencies	Ensure that our estate is fit for purpose and supports the clinical model	Work with blue light partners to ensure collaboration supports patient outcomes and efficient service delivery

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	68/17

Name of meeting	Board Meeting
Date	25th July 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

Workforce vacancies have been reviewed to understand the split by directorate, highlighting a variance between operational vacancies (11%) and other directorates (25%). This is as a result of challenges to recruiting to some corporate and specialist vacancies and ongoing restructures in a number of directorates. Following the move to the new Actus software some appraisal and objective metrics now being reported.

The Trust's 999 response time performance was under the national targets and the revised trajectory agreed with commissioners for June. The Trust saw impacts of a challenging month for call answer performance as a result of CAD training and the impact of the heatwave, whilst the impact of hospital handover delays continues to be high across the region.

KMSS 111 also saw a challenging month for call answer, in line with national NHS111 performance. Despite this clinical performance was maintained at 10% above the national performance.

The Trust continues to review data quality for our clinical outcome indicators. February data shows improvements for stroke and STEMI arrival at hospital times and for survival to discharge as compared to January.

Incident reporting has increased by 1.7% (586 incidents). The backlog has reduced from 1600 to 1535 in June. Serious Incident reporting was 7 Serious Incidents declared (increase of 1 since May). None of the 7 incidents were reported to commissioners within 72 hours. This is due to a constraint with the allocation of a lead investigator which has traditionally set with the Professional Standards Team. The Trust has now trained over 20 additional investigators so we anticipate this will improve as these individuals become investigators. The volume of Serious Incident investigations completed within the 60-day timescale has also decreased from 60% to 12.5%.

Level 2 Safeguarding Children Training compliance reached 21.3% against an expected trajectory of 25% and Safeguarding Adults 21.1% against a trajectory of 25%.

The number of complaints received this month was 102, compared to 79 in May. The top three complaints subjects remain as previously reported 1) patient care, 2) concerns about staff attitude/conduct, and 3) timeliness of response. All three areas have seen an increase; patient care complaints have increased by 46%; timeliness by 12%; and concerns about staff by 83%.

51.7% of complaints due for response within June were responded to within timescale.

The Trust incurred a deficit of £0.6m in the month, which was on plan. This includes the structural gap which is still being negotiated with the Commissioners. In the year to date the deficit is £2.0m, which was on plan. The forecast for the full year is unchanged from the plan, a deficit of £1.0m.

1. SECAMB Regulation Statistics

ID	KPI	Value
R1(b)	Use of Resources Metric (Financial Risk Rating)	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 Jun 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		**2.2%**	2.3%		**2.2%**	2.3%
Wf-1B	Long Term Sickness - Rate		**2.5%**	2.6%		**2.5%**	2.6%
Wf-2A	Staff Appraisals	22.5%	**4.7%**	25.0%	90.0%	**4.7%**	25.0%
Wf-2B	Objectives and Career Conversations		**13.0%**			**13.0%**	
Wf-3	Mandatory Training Compliance (All Courses)	45.0%	**38.6%**	50.4%	45.0%	**38.6%**	50.4%
Wf-4	Total injuries		**59**	51		**181**	171
Wf-5	Total physical assaults		Data unavailable	16		Data unavailable	49
Wf-6	Vacancies (Total WTE)		**433**	374		Not Relevant	Not Relevant
Wf-7	Annual Rolling Staff Turnover		**17.9%**	16.7%		17.9%	16.7%
Wf-8	Reported Bullying & Harassment Cases		**0**	2		**2**	6
Wf-9	Cases of Whistle Blowing		**0**	0		**0**	1

2.2. Workforce Commentary

2.2.1. Vacancies for this month have risen slightly again to give an overall vacancy rate of 12.37%. This is composed of an 11.12% vacancy rate in Operations and a 25% vacancy rate across other directorates.

2.2.2. Within Corporate services there is a 12.95 wte (51%) rate due to the difficulty in recruiting to posts and 35.64 wte (46%) vacancy rate whilst two directorates going through restructure and posts are held.

2.2.3. 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.

2.2.4. Once the corporate restructures are complete recruitment into those vacancies will be targeted.

2.2.5. The overall vacancy number has increased slightly which has driven a slight increase in the turnover rate.

2.2.6. The roll out of the online appraisal system, Actus, continues with 95% of the workforce live on the system. However, the introduction of the system has complicated our ability to report on completion rates:

a. We will report on appraisals completed in the previous 12 months, (currently 38%)
b. Objective/career conversations for year going forward currently 13%

2.2.7. The new year for mandatory training has commenced and a new process for recording training has been introduced. We will continue to review the most accurate way of reflecting statutory and mandatory training.

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

2.2.9. 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.

2.2.10. 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

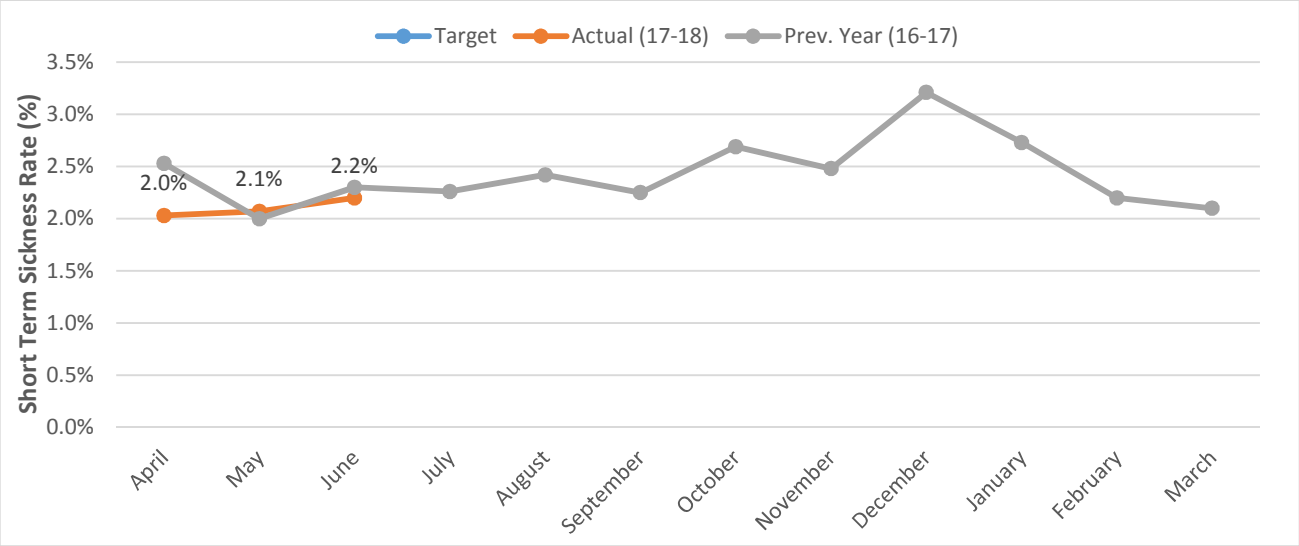


Figure Wf-1A - Short Term Sickness Rate

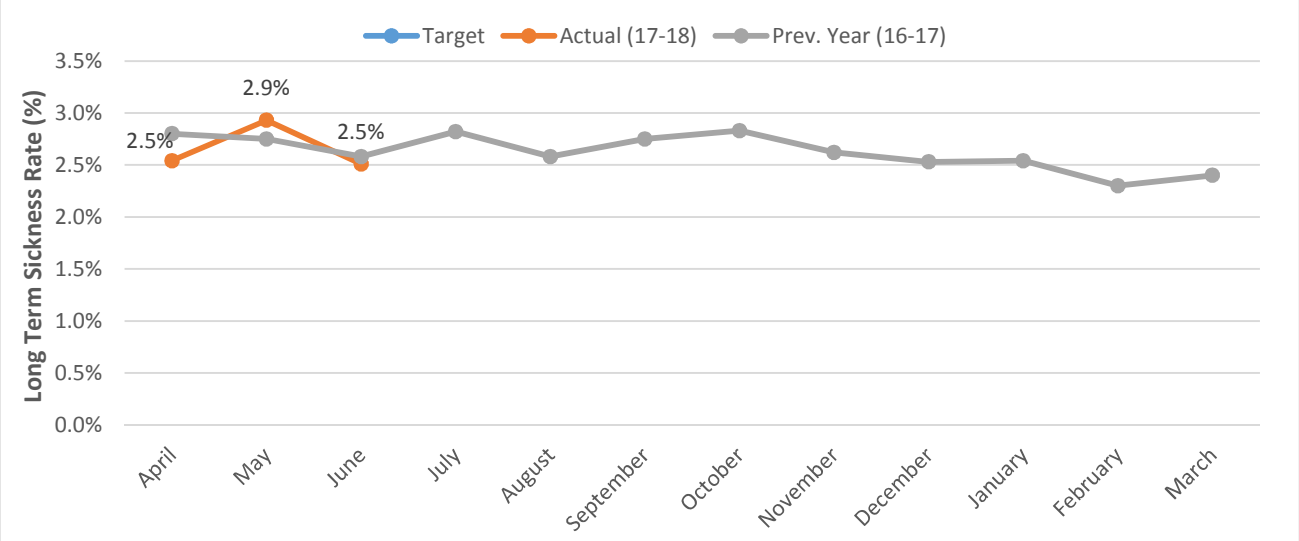


Figure Wf-1B - Long Term Sickness – Rate

Unavailable
Figure Wf-2 - Staff Appraisals

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

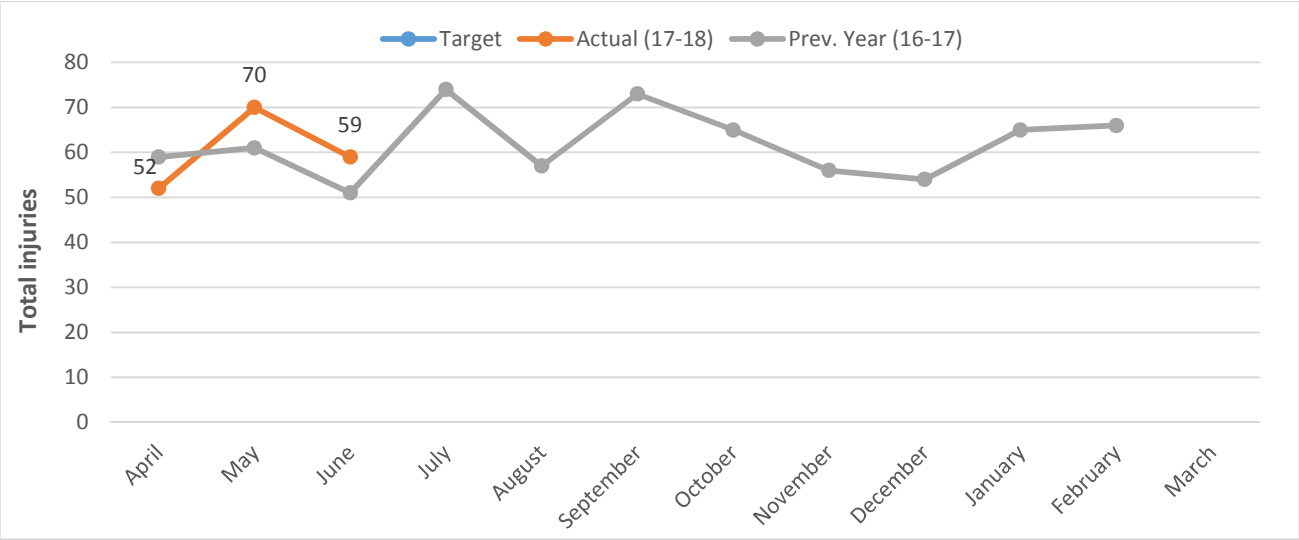


Figure Wf-4 - Total injuries.

Unavailable

Figure Wf-5 - Total physical assaults.

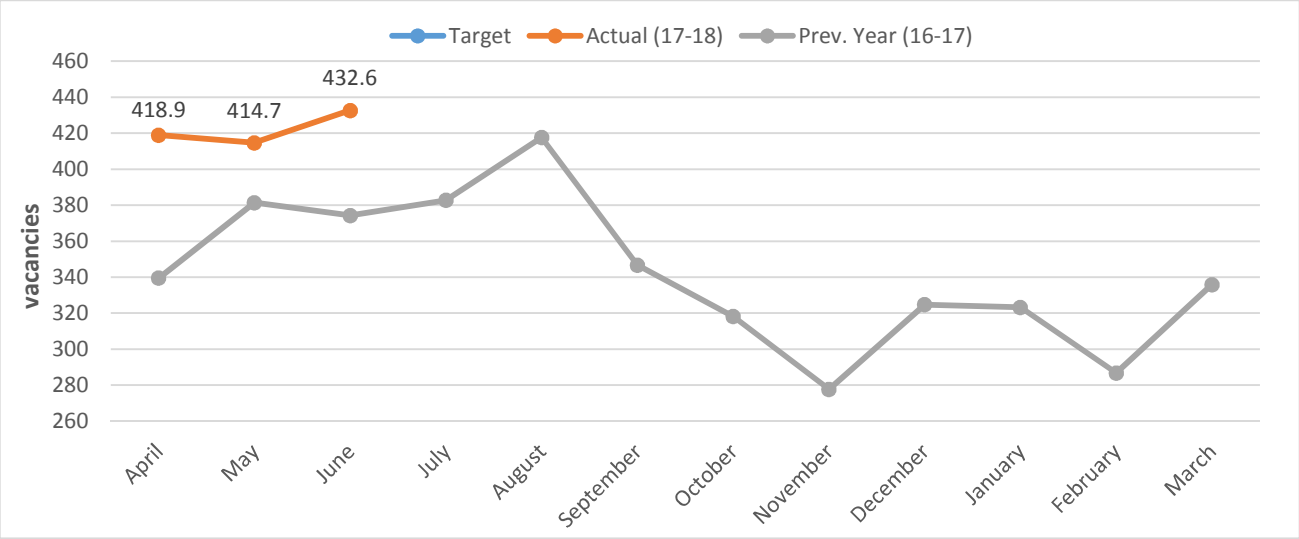


Figure Wf-6 - Vacancies (Total WTE)

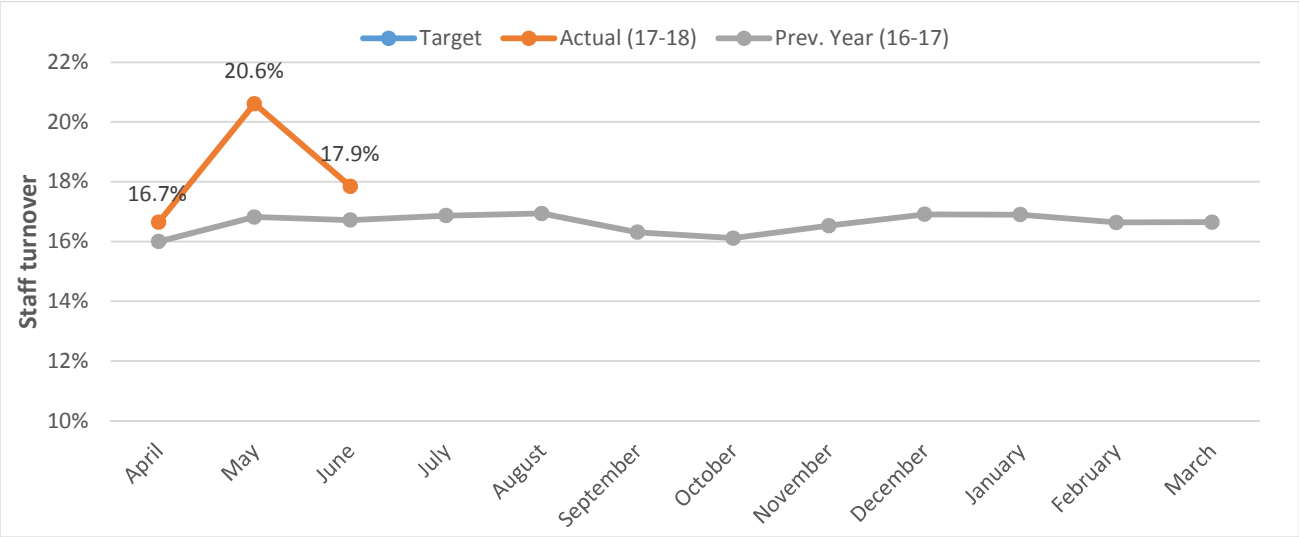


Figure Wf-7 - Annual Rolling Staff Turnover

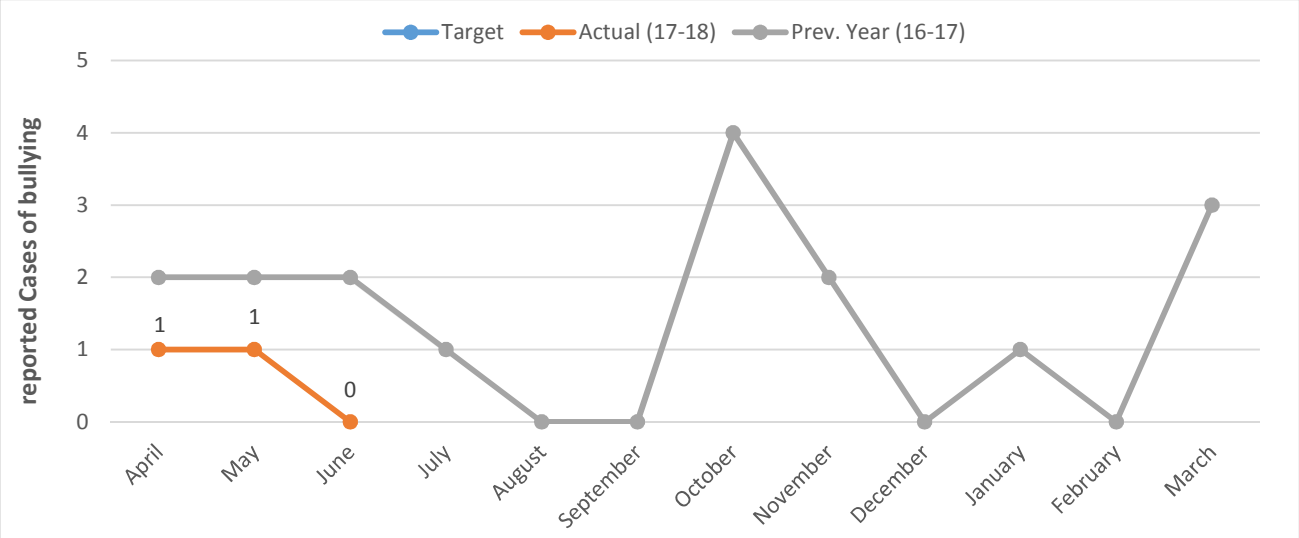


Figure Wf-8 - Reported Bullying & Harassment Cases

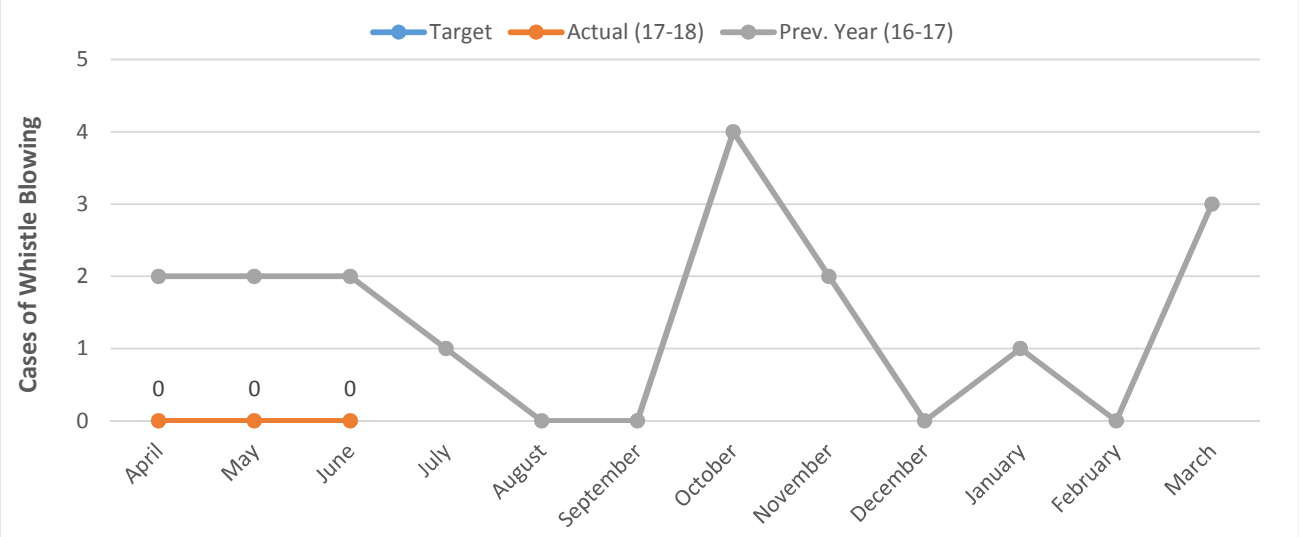


Figure Wf-9 - Cases of Whistle Blowing

3. Operational Performance

3.1. Operational Performance Summary

3.1.1. SECAmb's 999 response time performance was under the national targets and SECAmb did not achieve the level of performance that was above the new trajectories for Red 1, Red 2 and Red 19 for June 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 June still remain high although these are now back in line when compared with 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 June, 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. However, on 5 July the team successfully implemented the new Cleric CAD into Coxheath EOC and the only remaining issues are around reporting of data.

3.1.4. KMSS 111 Expectations for June 2017 were for the onset of three months of relatively low "summer" volumes. This proved to be true for most of June, with the significant exception of week commencing 19th June which saw a heatwave across the south for the entire week, affecting call volumes and profiles, returning an "Answered in 60" Service Level Agreement (SLA) KPI of 88.42% in June.

3.2. Operational Performance Scorecard

Operational Performance Scorecard:- Data From June 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	67.90%	**63.9%**	59.6%		**67.6%**	65.3%
999-2	Red 2 response <8 min	52.00%	**46.4%**	51.4%		**51.6%**	56.1%
999-3	Red 19 Transport <19 min	88.40%	**86.0%**	88.8%		**88.9%**	90.7%
999-4	Activity: Actual vs Commissioned	68640	**68068**	66037	206464	**202713**	198691
999-5	Hospital Turn-around Delays (Hrs lost >30 min.)	1963	**4807**	4618	7313	**15183**	14156.4
999-6	Call Pick up within 5 Seconds	90.1%	**72.0%**	62.9%		**80.1%**	68.0%
999-7	CFR Red 1 Unique Performance Contribution	Not available	1.5%	Not available		**1.5%**	Not available
999-8	CFR Red 2 Unique Performance Contribution	Not available	1.2%	Not available		**1.2%**	Not available
111-1	Total Number of calls offered		**78212**	89468		**269576**	290860
111-2	% answered calls within 60 seconds	95%	**88.4%**	76.3%	95.0%	**92.0%**	67.8%
111-4	Abandoned calls as % of offered after 30 secs	8.0%	**1.2%**	5.1%	8.0%	**0.9%**	**7.6%**
111-5	Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)	74%	**73.0%**	73.7%		**75.9%**	**72.7%**

** 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 May and below the target which has been re-set by commissioners for the Quarter 1 period. The reduction in Red 2 performance in June compared to May was again below the anticipated trajectory position given the increase in activity, with this being circa 1200 incidents more than May. Although both Red 1 and Red 2 performance were lower in June, there were a higher number of calls received but a reduced number of responses due to slightly increased Hear and Treat and See and Treat activity. This was as a result in the spike in temperature from 19 June which saw an activity increase on some days of 22% and the Trust at DMP Level 4. Hospital Turnaround delays have also been the factor that has had a material impact on this performance position, although this has not worsened in June, the level of delays are still well over double the maximum level agreed with commissioners.

3.3.2. Demand was circa 0.85% below the plan agreed with commissioners for the month and still circa 180 incidents above last year's MTD position.

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. However, although benefits are being realised, in June we saw a reduction in performance against the planned trajectory for this group of responders.

3.3.5. SECAmb's Hear and Treat performance has improved for June and has been above the trajectory over recent weeks (at 7.8% compared to 6% in May) mainly due to weather related activity.

3.3.6. Call answer performance has fallen significantly compared to that of last month due to the June increase in activity and the additional abstraction necessary to prepare for the deployment of the new CAD platform from July to September. SECAmb achieved 72% in 5 seconds compared to a revised trajectory plan of 90.1%.

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 June were slightly improved compared with the hours lost in May, but still remain over double the maximum level agreed with commissioners. June saw 4807 lost hours which was one of the biggest impacts on our performance trajectory for June. Hospital Turnaround delays are 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. Monthly performance of KMSS 111 failed to match the preceding month, although remaining broadly in line with national performance.

3.3.9. In a month containing eight weekend days, KMSS 111 received 78212 calls. The "Calls Answered in 60" performance was 88.42%, compared to the national 89.09%. The Abandonment rate of 1.16% was significantly below the national average for the month. Combined Clinical performance of 72.97% continued to out-perform the national clinical measure, by 10 percentage points in June.

3.3.10. The Ambulance referral rate increased to 11.20% in June due to a sustained level of high-acuity cases. The long-term trends point to a downward trajectory in Ambulance referral volumes, supported by the continuation of validation of Green ambulance dispositions. Conversely the validation process has the effect of increasing Emergency Department referral volumes, although the KMSS 111 June ED referral rate of 8.42% remained slightly below the national rate of 8.46%.

3.3.11. The week commencing 19th June saw a heatwave across the south of the country, with peak daytime temperatures in excess of 30°, and (just as significantly) night time temperatures failing to fall below 20°. Due to a combination of symptomatic factors and changed behaviours, that week saw an increase in call volumes of 13% compared to the preceding week. This was compounded by call profiles diverging from our long-established demand distribution curve. Average Handling Times also increased significantly. Managers met regularly throughout the week to address the exceptional demand, and also to support the wider health economy (e.g. SECAmb escalated to DMP Level 4 on 21st / 22nd June). Ultimately the sustained period of high volumes proved stretching, so the service activated the Front End Message at selected periods during 22nd – 25th June, in line with on-call commissioner approval and our Escalation procedures. Our operational performance for the week of 77% compared reasonably with the national 80% for that week. The service has subsequently reviewed its planning procedures to be more pro-active in anticipating volume spikes driven by hot weather.

3.3.12. At a strategic level the service is proceeding with the Joint Commissioner-Provider "Clinical Development Pilots. Meetings took place during June on a plenary and bi-lateral basis. The Mandates and Quality Impact Assessments for the pilots are being finalised, with the expectation that pilot activities will commence during 2017 Q2 – Q3.

3.4. Operational Performance Charts

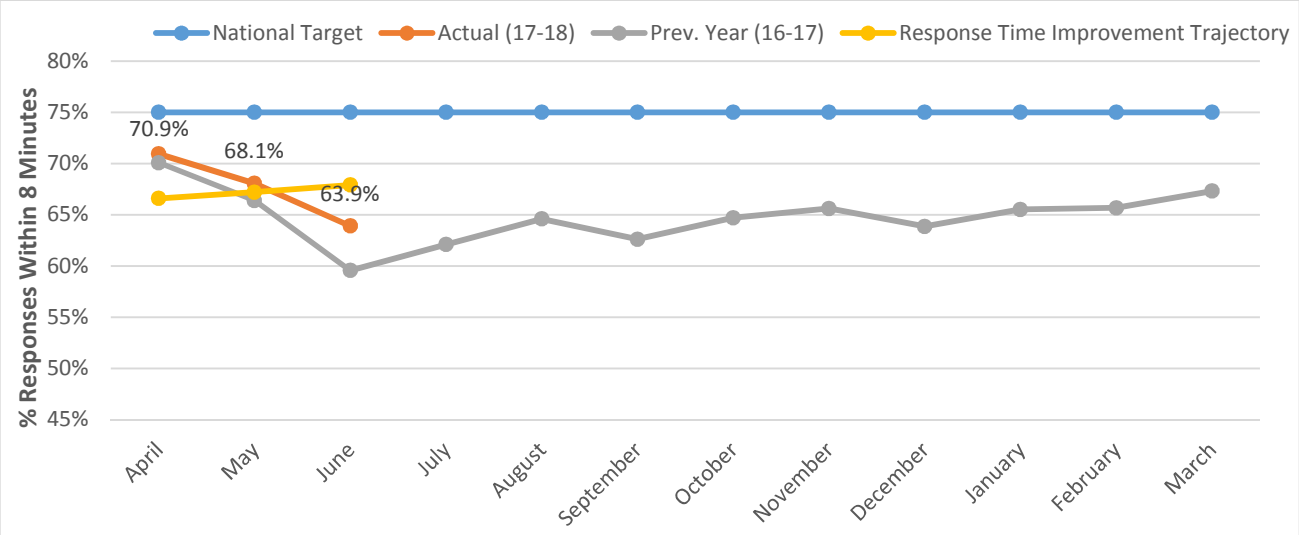


Figure.999-1 - Red 1 response <8 min

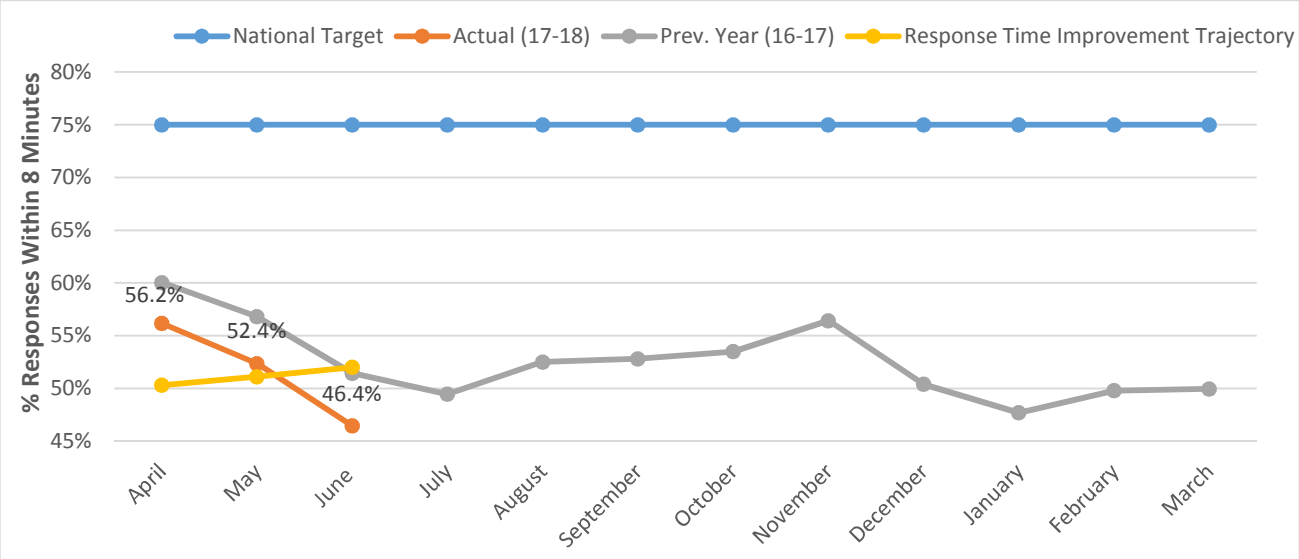


Figure.999-2 - Red 2 response <8 min

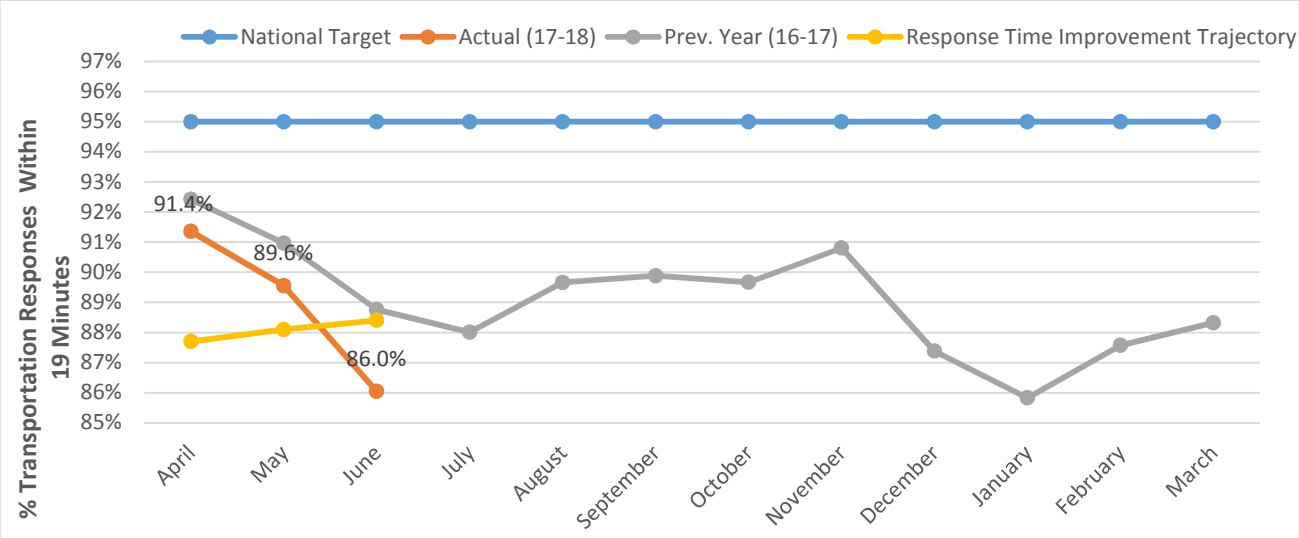


Figure.999-3 - Red 19 Transport <19 min

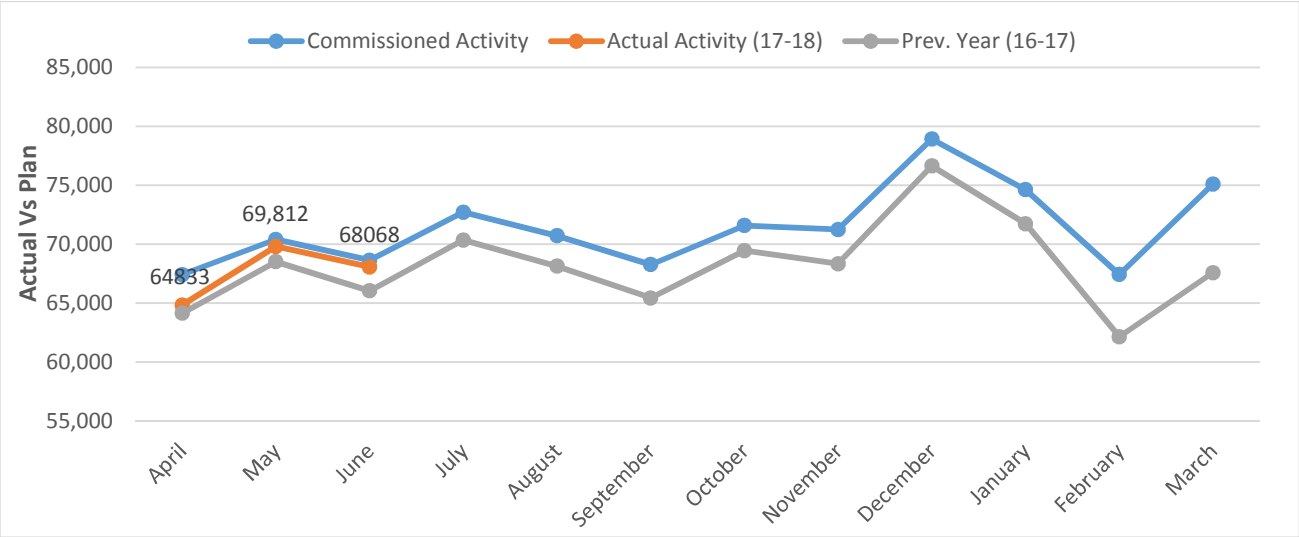


Figure.999-4 - Activity: Actual vs Commissioned

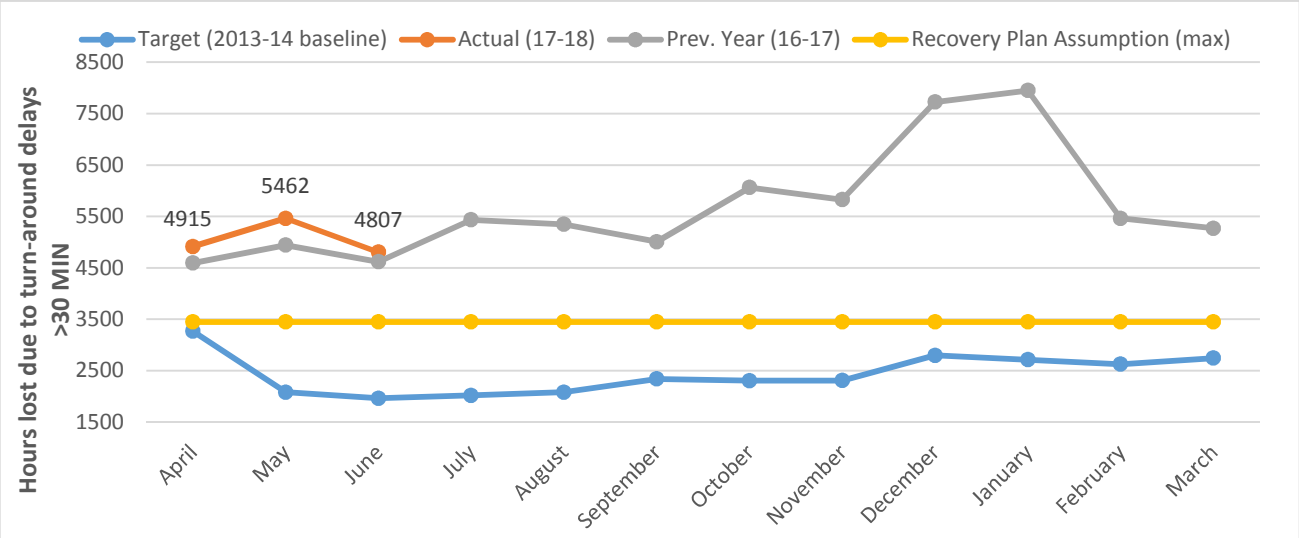


Figure.999-5 - Hospital Turn-around Delays (Hrs lost >30 min.)

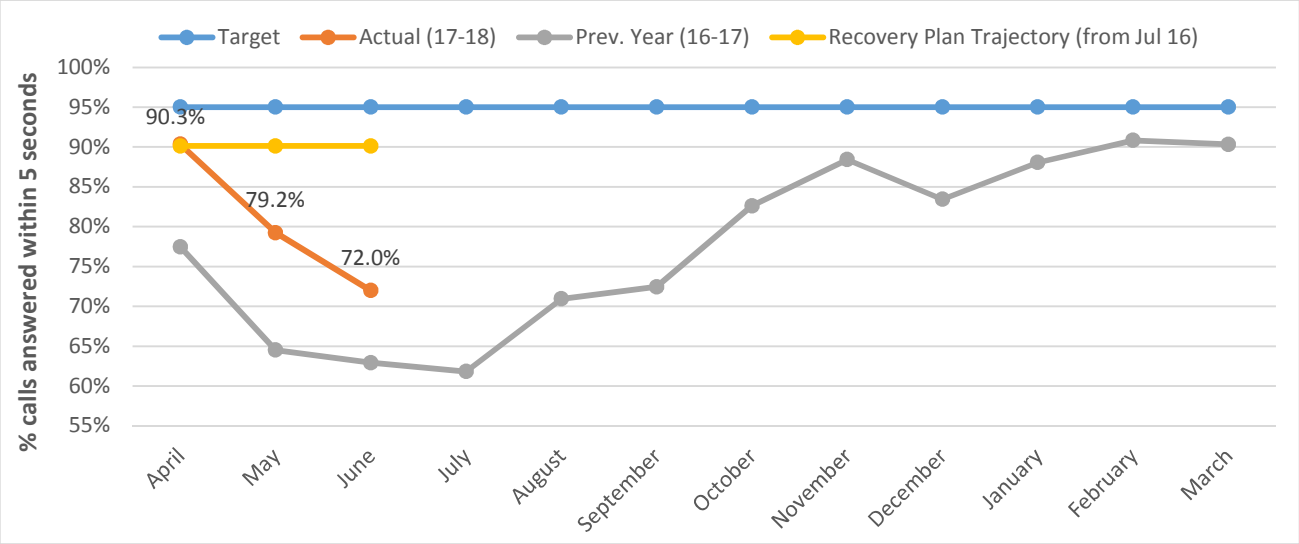


Figure.999-6 - Call Pick up within 5 Seconds

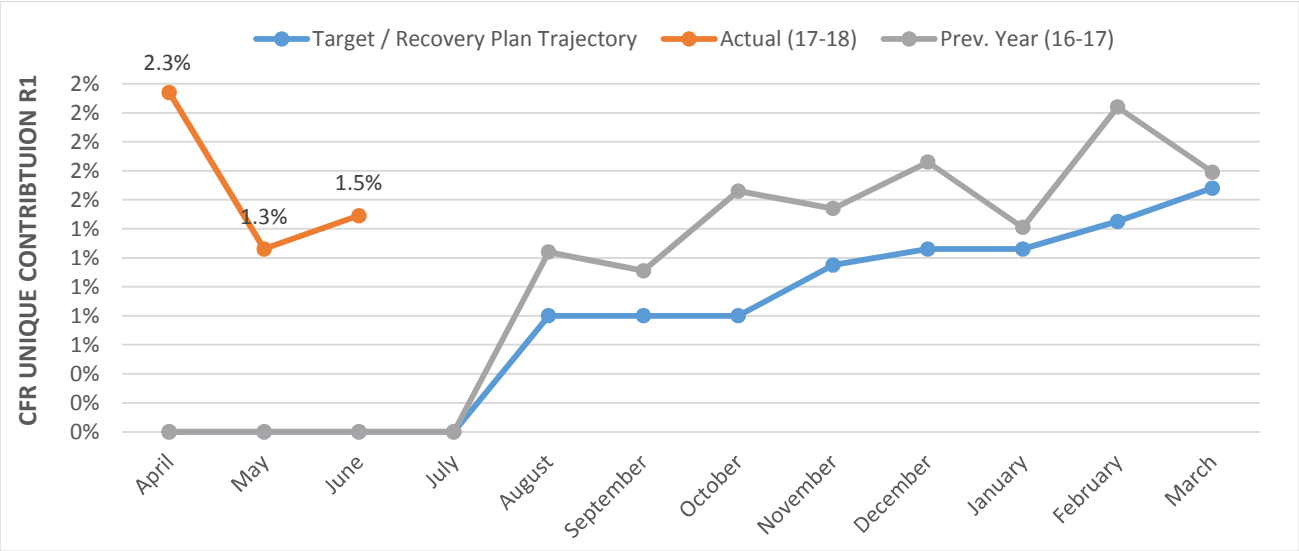


Figure.999-7 - CFR Red 1 Unique Performance Contribution

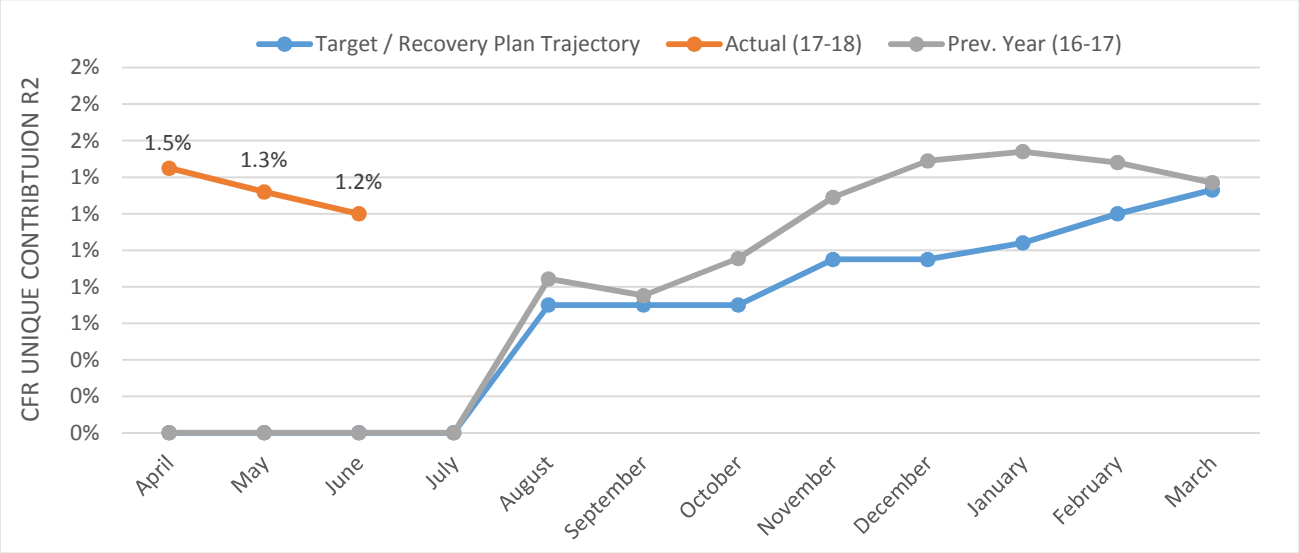


Figure.999-8 - CFR Red 2 Unique Performance Contribution

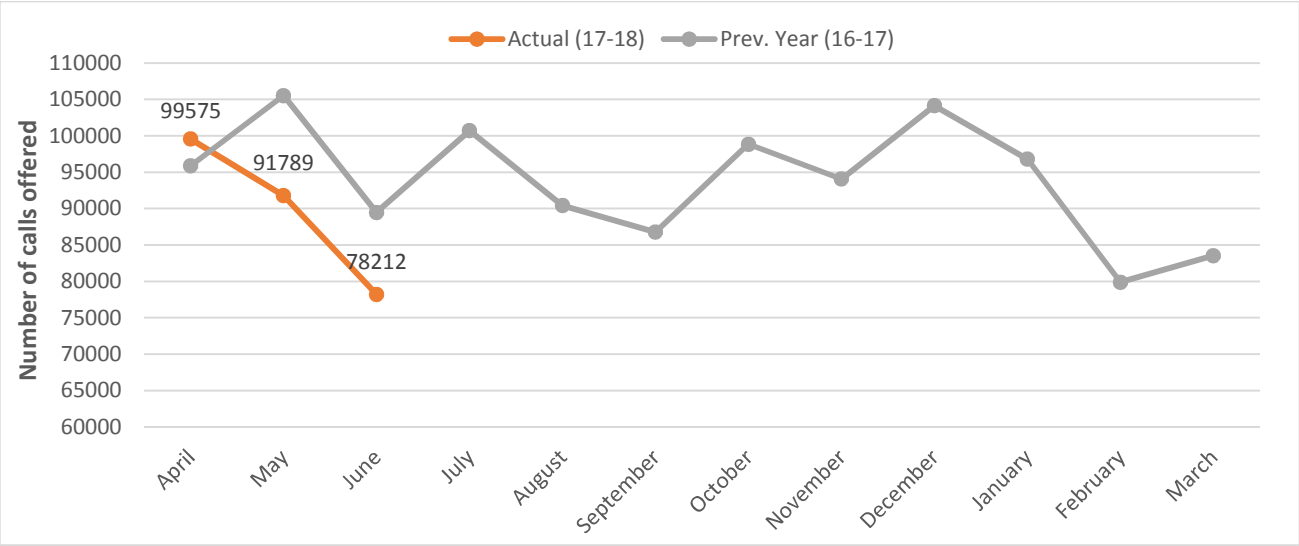


Figure.111-1 - Total Number of calls offered

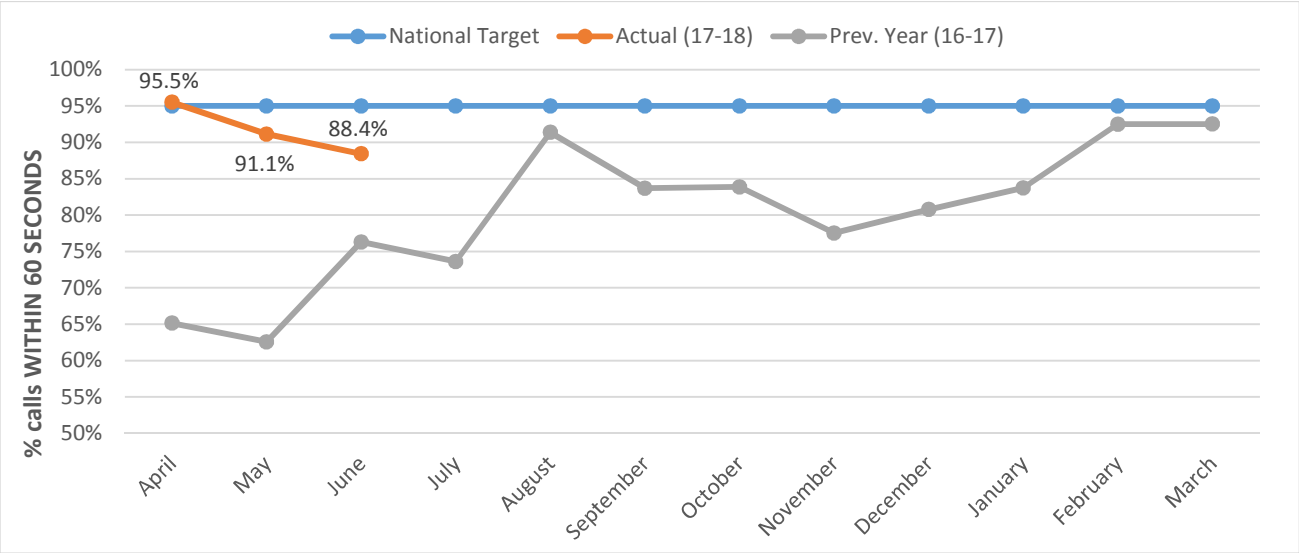


Figure.111-2 - % answered calls within 60 seconds

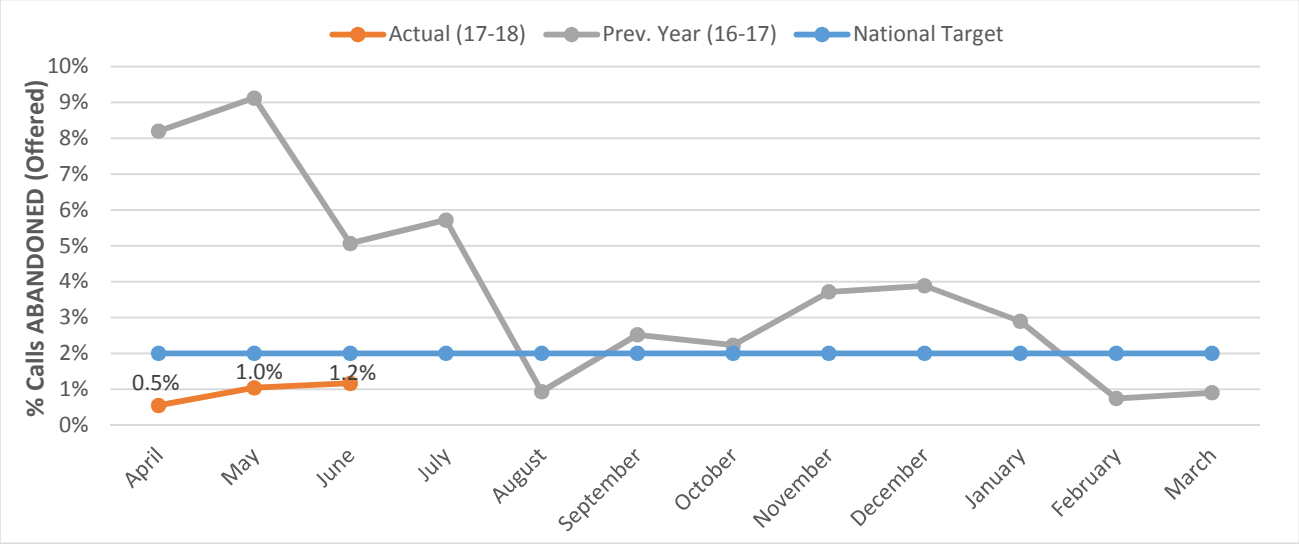


Figure.111-4 - Abandoned calls as % of offered after 30 secs

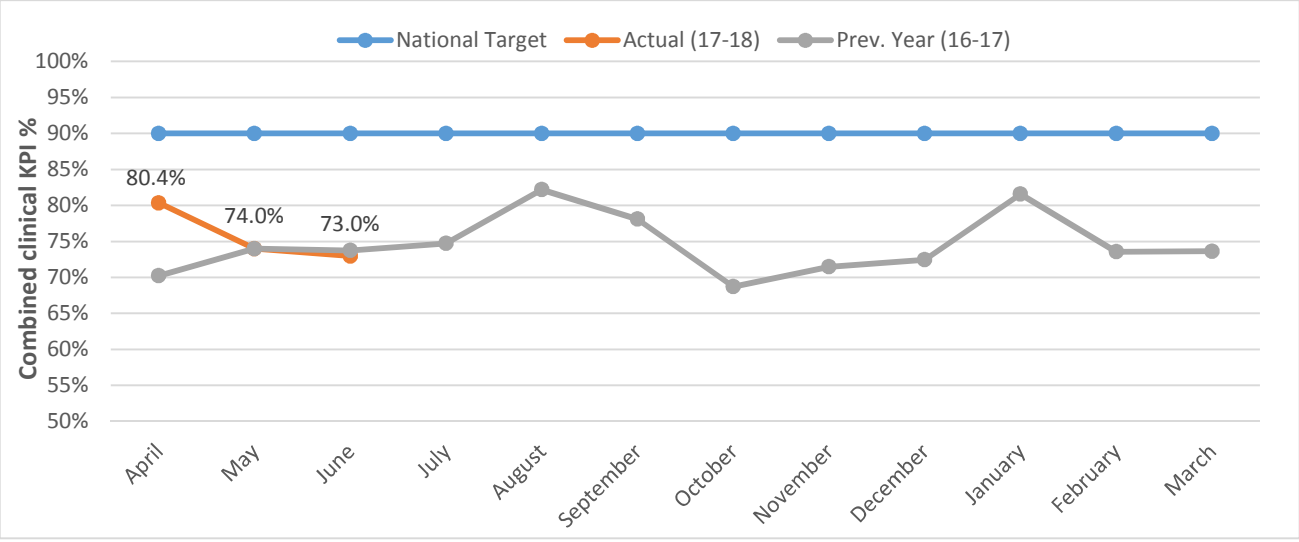


Figure.111-5 - Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)

4. Clinical Effectiveness

4.1. Clinical Effectiveness Summary

4.1.1. This report demonstrates the Trust's performance against the eight Ambulance Clinical Quality Indicator (ACQIs) reported to NHS England for Month 11 (February 2017). The data continues to show variable achievements in delivering patient outcomes in relation to the AQIs.

4.2. Clinical Effectiveness KPI Scorecard

Clinical Effectiveness KPI Scorecard:- Data From February 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)	52.1%	**43.3%**	46.4%	51.2%	**51.4%**	46.8%
CE-2	Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)	28.3%	**28.3%**	21.7%	28.3%	**27.8%**	26.2%
CE-3	Cardiac arrest -Survival to discharge - Utstein	24.9%	**20.7%**	15.4%	26.0%	**21.4%**	23.3%
CE-4	Cardiac arrest -Survival to discharge - All	7.6%	**4.0%**	4.6%	8.1%	**6.1%**	7.7%
CE-5	Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)	80.5%	**68.4%**	69.8%	79.6%	**67.4%**	68.1%
CE-6	Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes	85.4%	**86.9%**	88.9%	85.5%	**89.5%**	92.1%
CE-7	% of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes	53.2%	**64.5%**	58.2%	53.6%	**64.3%**	64.9%
CE-8	% of suspected stroke patients assessed face to face who received an appropriate care bundle	97.9%	**97.3%**	96.1%	97.6%	**95.9%**	96.5%

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

4.3. Clinical Effectiveness

4.3.1. The data above shows the Trust's clinical performance for the month of February 2017. These are the most up to date figures which have been submitted to the Department of Health (DH).

4.3.2. Out of the eight ACQI the data demonstrates for four of the indicators the Trust is below the national average for February 2017.

4.3.3. Compared to the previous month (January 2017), the Trust has seen a 10% increase in survival to discharge, Utstein and a 0.6% increase in all patients who survive to discharge post cardiac arrest.

4.3.4. In February 2017 the Trust's performance for Acute ST-elevation myocardial infarction who received primary angioplasty within 150 minutes has increased by 9% when compared to January 2017. We have also seen an improvement of 4.5% in the ACQI for FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper acute stroke unit within 60 minutes and a 3% increase in suspected stroke patients assessed face to face who received an appropriate care bundle

4.3.5. The Clinical Audit team (CAT) continue to ensure that all data submitted and published by the DH is accurate, this is achieved by the Clinical Audit Coordinators utilising the revised procedure for adherence to the national technical guidance for ACQI reporting. The outcome of this revalidation of previous submissions using the revised procedure may result in changes to the Trust's data but will ensure all national guidance has been matched.

4.3.6. To improve the accuracy of the ROSC and patient outcome data submitted collaborative working between the health records and clinical audit teams continues. This work includes matching and reviewing of incidents to patient clinical records and defibrillation downloads.

4.3.7. It has been identified that the Trust currently only reports data for those patients who survive a cardiac arrest. The Trust should be reporting patient outcomes of individuals both surviving cardiac arrest and unsuccessful resuscitation. Therefore, the data currently submitted is inaccurate and does not reflect patient outcomes.

4.4. Clinical Effectiveness Charts

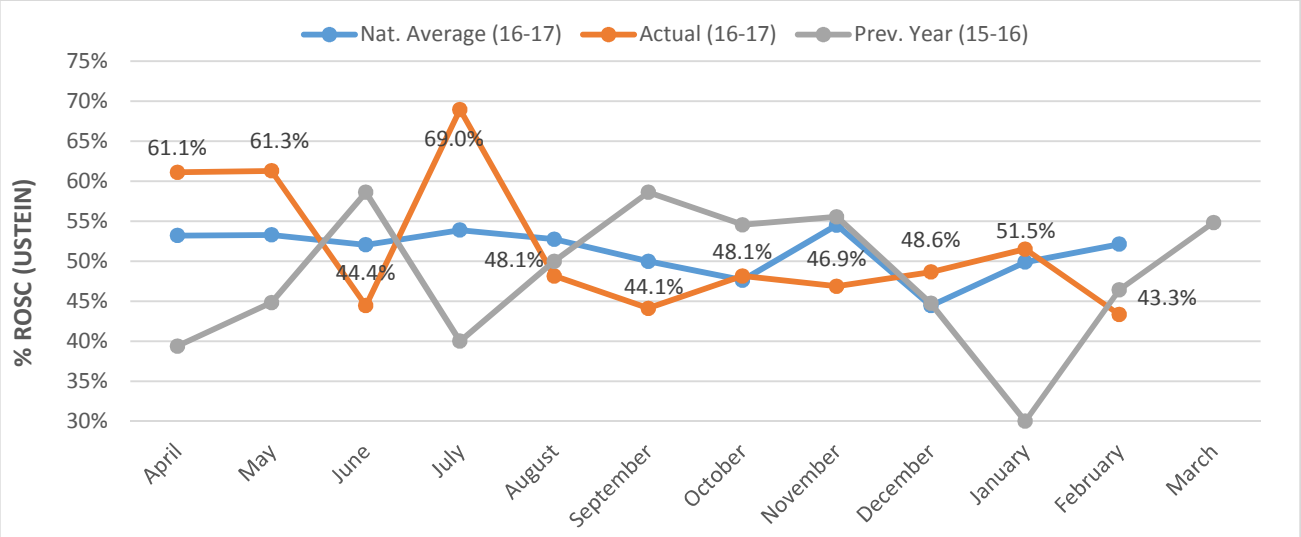


Figure.CE-1 - Cardiac arrest - ROSC on arrival at hospital (Utstein)

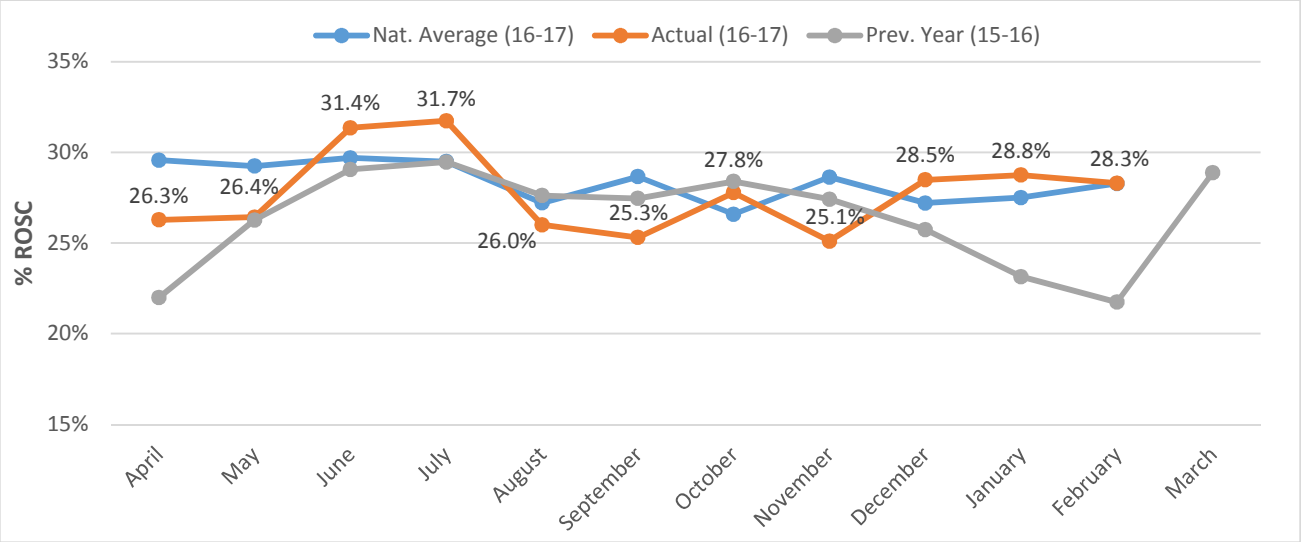


Figure.CE-2 - Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)

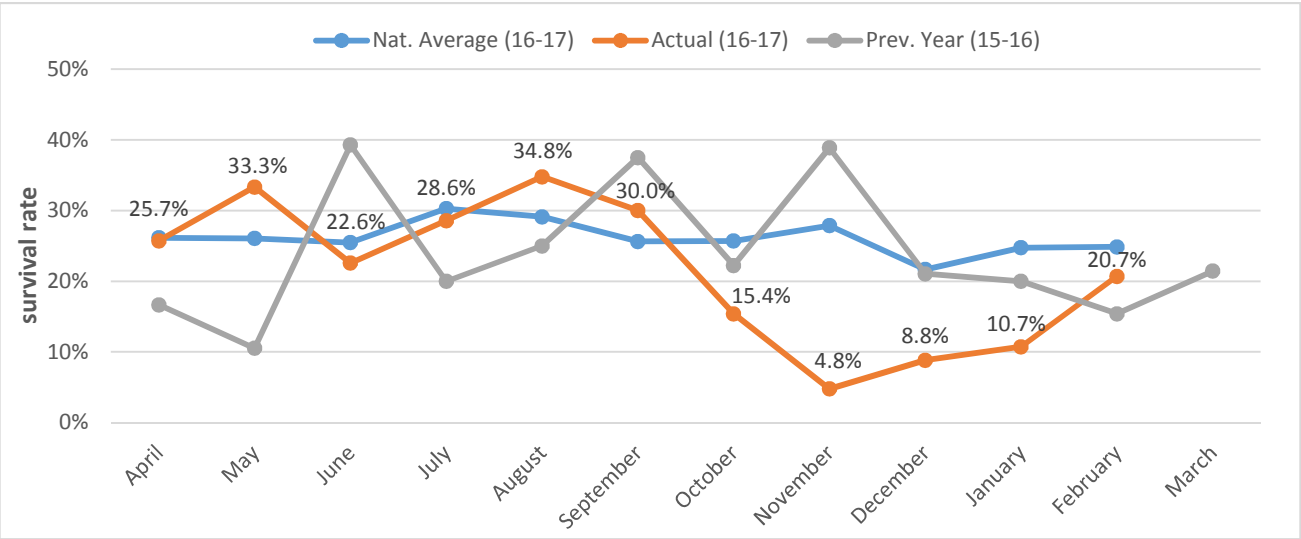


Figure.CE-3 - Cardiac arrest -Survival to discharge - Utstein

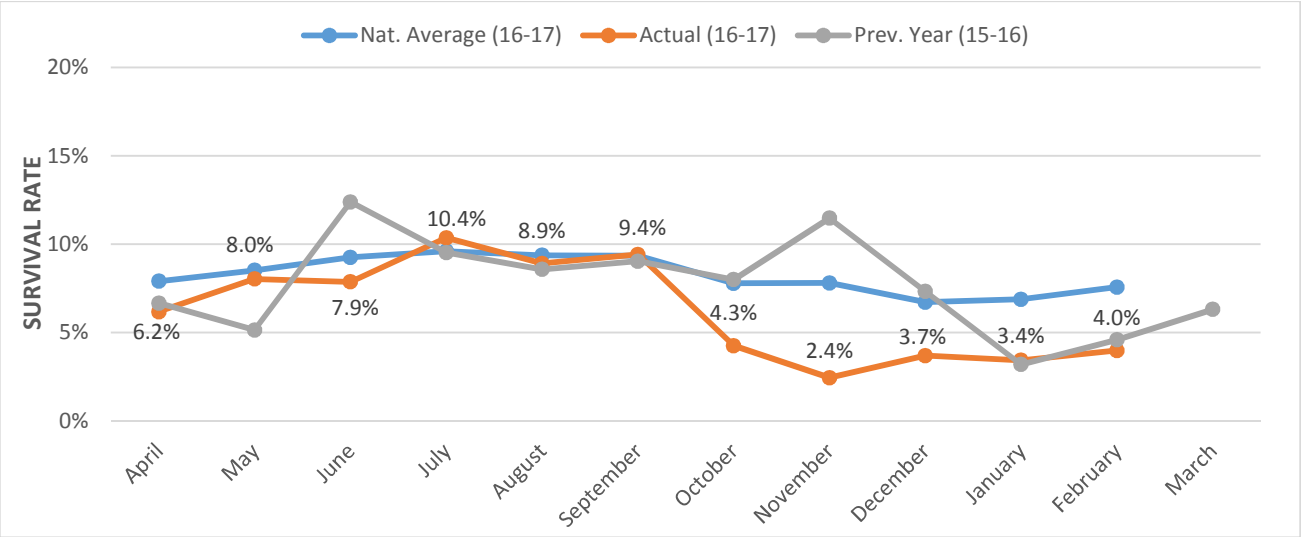


Figure.CE-4 - Cardiac arrest -Survival to discharge – All

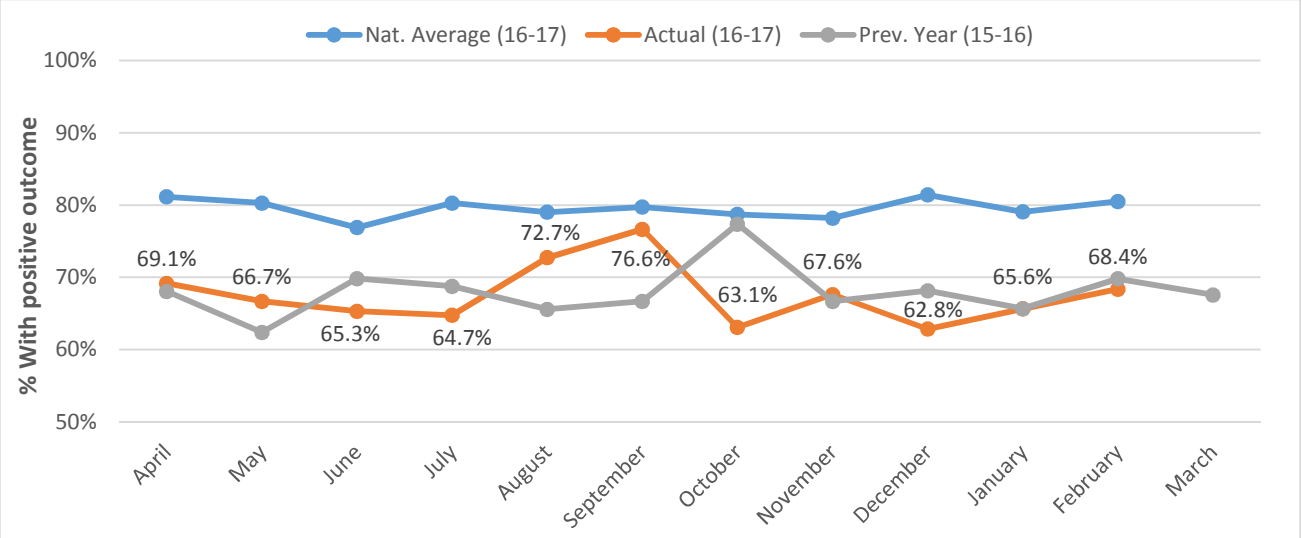


Figure.CE-5 - Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)

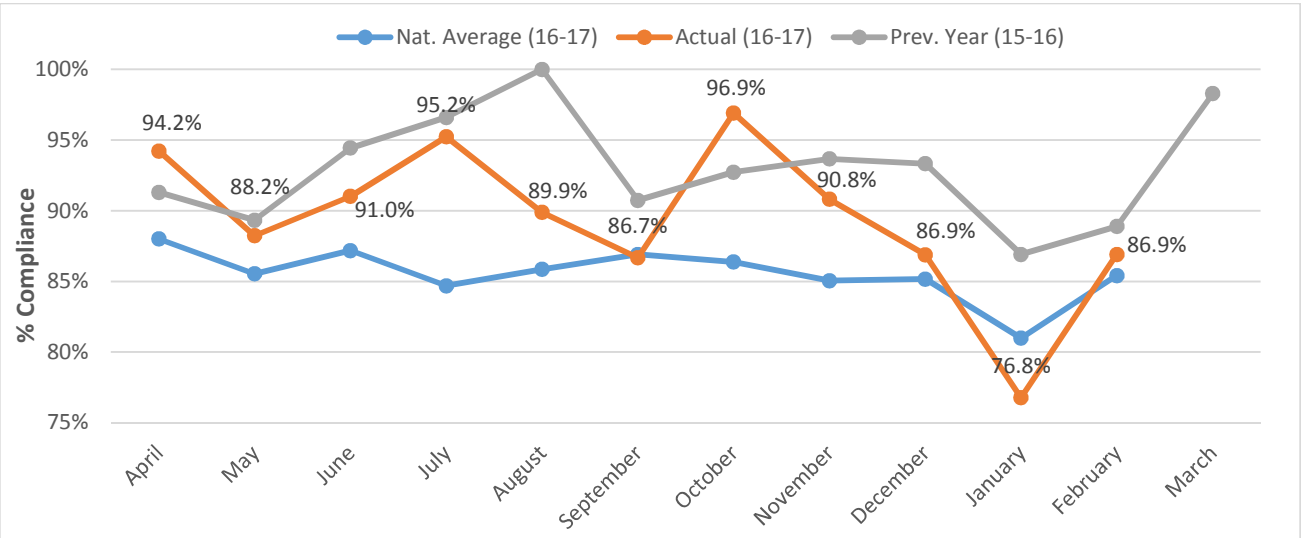


Figure.CE-6 - Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes

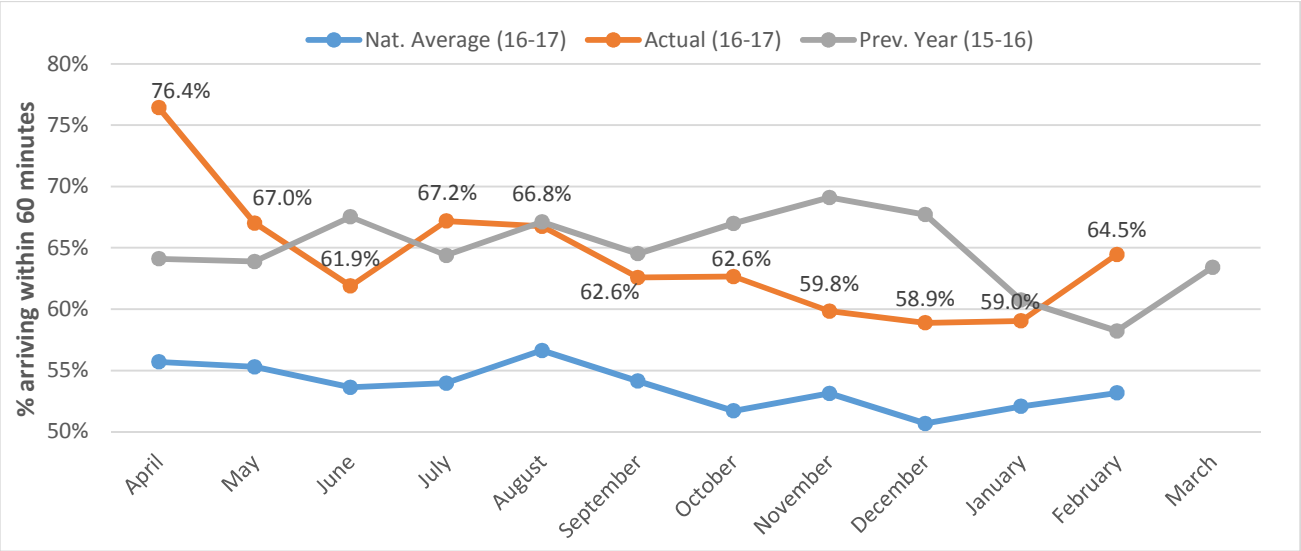


Figure.CE-7 - % of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper acute stroke unit within 60 minutes

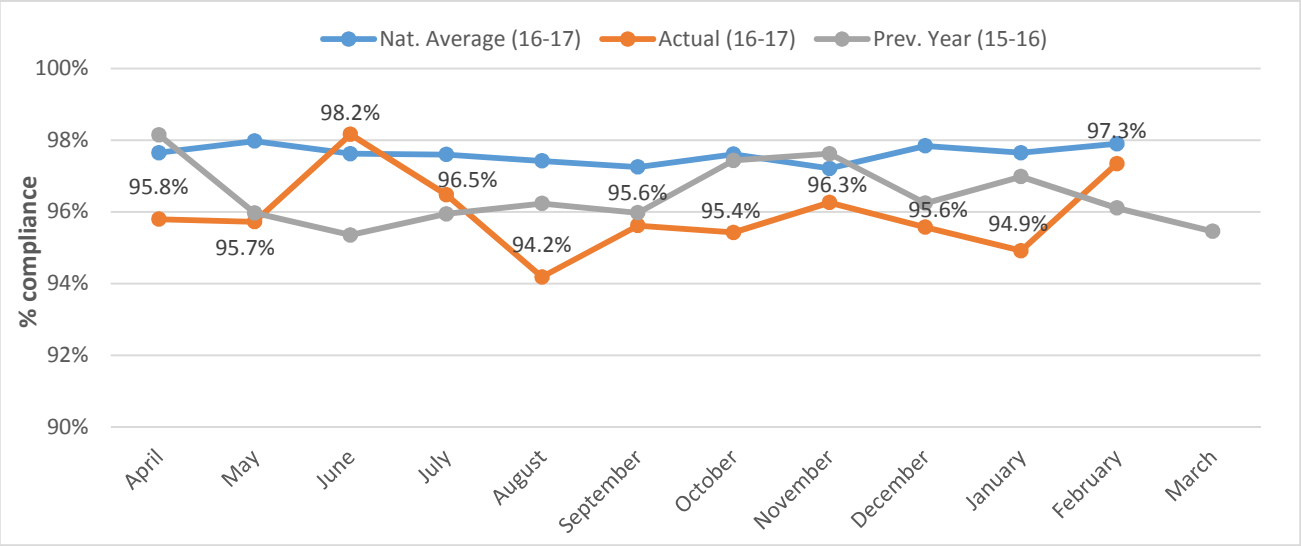


Figure.CE-8 - % of suspected stroke patients assessed face to face who received an appropriate care bundle

5. Quality & Patient Safety

5.1. Quality & Patient Safety Summary

5.1.1. Incident reporting has increased by 1.7% (586 incidents). The backlog has reduced from 1600 to 1535 in June.

5.1.2. Serious Incident reporting was 7 Serious Incidents declared (increase of 1 since May).

5.1.3. None of the 7 incidents were reported to commissioners within 72 hours. This is due to a constraint with the allocation of a lead investigator which has traditionally set with the Professional Standards Team. The Trust has now trained over 20 additional investigators so we anticipate this will improve as these individuals become investigators.

5.1.4. The volume of Serious Incident investigations completed within the 60-day timescale has also decreased from 60% to 12.5%.

5.1.5. Level 2 Safeguarding Children Training compliance reached 21.3% against an expected trajectory of 25% and Safeguarding Adults 21.1% against a trajectory of 25%.

5.1.6. The number of complaints received this month was 102, compared to 79 in May. The top three complaints subjects remain as previously reported 1) patient care, 2) concerns about staff attitude/conduct, and 3) timeliness of response. All three areas have seen an increase; patient care complaints have increased by 46%; timeliness by 12%; and concerns about staff by 83%.

5.1.7. 51.7% of complaints due for response within June were responded to within timescale.

5.2. Quality & Safety KPI Scorecard

Quality & Safety KPI Scorecard:- Data From June 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%**	0.0%	100%	**0.0%**	28.6%
QS1b	SI Investigation timeliness (60 days)	100%	**12.5%**	50.0%	100%	**22.2%**	86.7%
QS1c	Number of Incidents reported		**586**	**483**		**1707**	1470
QS1d	Number of Incidents reported that were SI's		**7**	**1**		**18**	8
QS1e	Duty of Candour Compliance	100%	33%		100%	33%	

QS2a	Number of Complaints		**102**	139		**252**	390
QS2b	Complaints reporting timeliness (All Complaints)	95.0%	**51.7%**	66.0%	95.0%	**73.1%**	39.6%
QS2c	Mental Capacity Assessment Training		**49.9%**			**49.9%**	
QS3a	Number of Safeguarding Referrals Adult		**727**	757		**2049**	2248
QS3b	Number of Safeguarding Referrals Children		**162**	139		**445**	443
QS3c	Safeguarding Referrals relating to SECAmb staff or services		**1**	0		**1**	1
QS3d	Safeguarding Training Completed (Adult) Level 1	25.0%	Unavailable		25%	Unavailable	
QS3e	Safeguarding Training Completed (Children) Level 1	25.0%	Unavailable		25%	Unavailable	
QS3f	Safeguarding Training Completed (Adult) Level 2	25.0%	**21.1%**		25%	**21.1%**	
QS3g	Safeguarding Training Completed (Children) Level 2	25.0%	**21.3%**		25%	**21.3%**	
QS3h	Safeguarding Training Level 3 (Adult/Child)	0.0%	**0.0%**			**0.0%**	

5.3. Quality & Patient Safety Commentary

5.3.1. Incident Reporting

5.3.1.1. There has been an increase in incident reporting during June of 1.7%.

5.3.1.2. On average 86% of reports took longer than the desired 7-day initial review deadline (increase of 11% since May).

5.3.1.3. The closure process for incidents has been enhanced and incidents sent for closure are now rejected if actions are incomplete or lessons are not clearly identified. Despite this enhancement the Trust has decreased the backlog of incidents from 867 in May to 615 in June.

5.3.1.4. The IRW1 has been updated and now moderate, severe and death harms are mandatory fields. This will give greater clarity to the classification of incidents and 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.

5.3.1.5. Seventeen moderate harms were identified in June. 11 were patient related, 5 were staff related and 1 was a Trust issue. None of the moderate harms were escalated as Serious Incidents.

5.3.1.6. Eighteen incidents (3% of all incidents reported in June) were reported as a Patient Safety Incident (PSI) on the National Reporting and Learning System (NRLS).

5.3.2. Serious Incident reporting

5.3.2.1. 7 Serious Incidents were reported in June (1 in May). 6 of the newly declared Serious Incidents involved direct patient contact and one was IG related to a deceased patient.

5.3.2.2. In June due to the constraints of the Professional Standards Team the Trust did not report any within 72-hours to the CCG.

5.3.2.3. However, the Trust has now trained over 20 additional people in Serious Incident reporting so this constraint is expected to resolve. In addition, the Trust has appointed a new Head of Serious Incidents for 12 months to help manage the process, improve quality and identify themes and trends.

5.3.2.4. The volume of Serious Incident investigations completed within the 60-day timescale was 12.5% (60% last month). Again, this will improve as the new Head of Serious Incidents impacts on the portfolio.

5.3.2.5. The NHS England SI Framework March 2015 states 'Serious incidents must be reported without delay and no longer than 2 working days after the incident is identified.'

5.3.2.6. The Trust has been compliant with this throughout June, with all 7 of the Serious Incidents reported, being reported within 2 working days from being declared. This is due to the impact of the newly reformed Serious Incident Review Group weekly meetings.

5.3.2.7. The Trust is able to assure that it is meeting its statutory responsibilities for Duty of Candour for those cases recorded as Severe/Death.

5.3.2.8. There is a 33% compliance with Duty of Candour for Serious Incidents in June. The non-complaint cases are due to the incident awaiting the commencement of the investigation.

5.3.2.9. This data set includes the 10-day timeframe which was recently removed as a national requirement.

5.3.2.10. The Trust has commenced collecting data for Moderate Harm. There was a delay commencing the data collection due to an error in the set up of Datix. This has now been corrected and a report was pulled after one week to test the

process. The data is being collected correctly but there were no cases of moderate harm to report in that test week.

5.3.3. Complaints

Complaints received

5.3.3.1. In June 2017 there were 102 complaints received and opened, compared to 79 in May. These complaints are broken down by service area as follows:

Service area	Number	% of total
EOC	46	45%
A&E	41	40%
NHS111	11	11%
Medical Directorate	2	2%
Chief Executives Office	1	1%
Unknown / Other Directorate	1	1%
Total	**102**	

Complaints by subject

5.3.3.2. Complaints are shown by subject area below. Although there were 102 complaints, some have more than one aspect, e.g. patient care and staff conduct/attitude.

Subject	
Patient care*	41
Concern about staff	33
Timeliness	28
Communication issues	6
Miscellaneous	2
Transport arrangements	1
History marking issue	1
Total	**112**

*Of the complaints about patient care, 30 were about triage (25 EOC and 5 NHS111), 10 about care provided by clinical staff during face to face contact, and one was a complaint about the advice provided by the frequent caller team.

5.3.3.3. The top three complaints subjects remain patient care, concerns about staff attitude/conduct, and timeliness of response. All have seen an increase on the previous month. Patient care complaints have increased by 46%; timeliness by 12%; and concerns about staff by 83%.

Outcome of complaints

5.3.3.4. Of the 89 complaints due to be concluded and responded to during June 2017 (excluding SIs, which have a longer timeframe for completion), 81 had been concluded at the time of writing, with 64% upheld at least in part. The outcome of these complaints was as follows:

Outcome	Number	Percentage
Upheld	37	46%

Partly upheld	15	18%
Not upheld	28	35%
Withdrawn	1	1%
Totals:	81	

Timeliness of response

5.3.3.5. There were 89 complaints (again excluding SIs) due for response, and of these 46 were closed within the Trust's 25 working day timescale, i.e. 51.7%. The most common reason for delay was that the investigation report was received late (nine).

5.4. Safeguarding

5.4.1.1. Level 2 safeguarding children training compliance reached 21.3% against an expected trajectory of 25% and safeguarding adults 21.1% against a trajectory of 25%. The level 3 training trajectory still remains on the Trust corporate level risk register as with capacity issues within the safeguarding team.

5.4.1.2. Safeguarding referrals for adults increased by 7% and by 8.7% for safeguarding referrals for children. The number of safeguarding referrals relating to Trust staff had increased from zero in May to one in June.

5.4.1.3. Mental Capacity Assessment Training has seen 48.85% of staff having completed the online module for 2017/2018.

5.5. Quality & Safety Charts

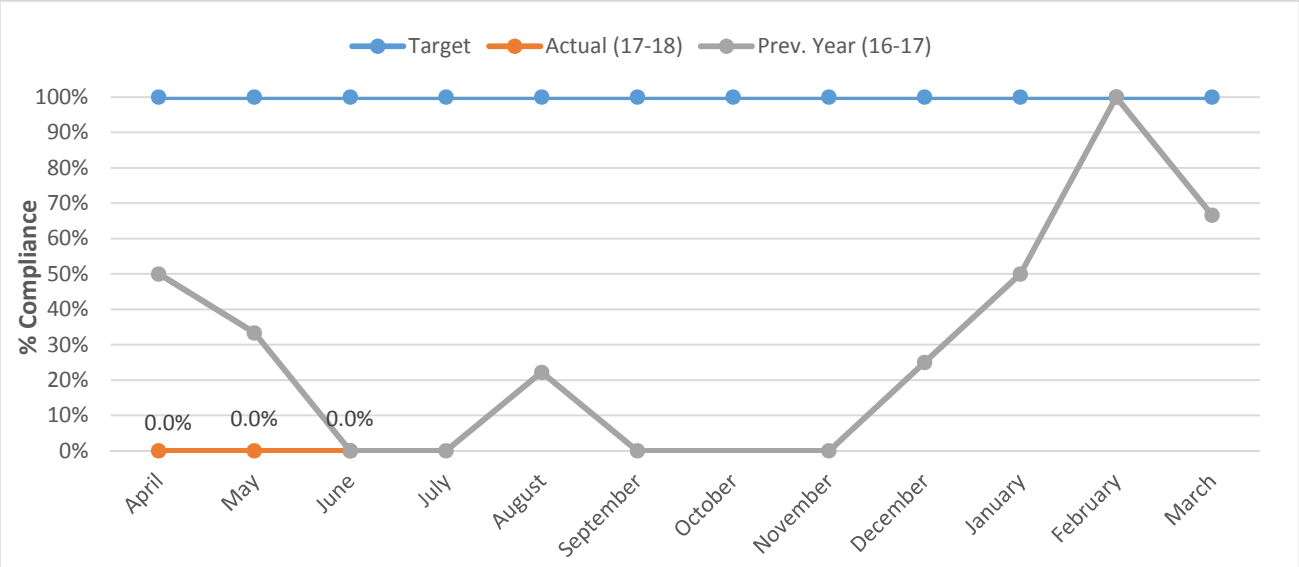


Figure.QS1a - SI Reporting timeliness (72hrs)

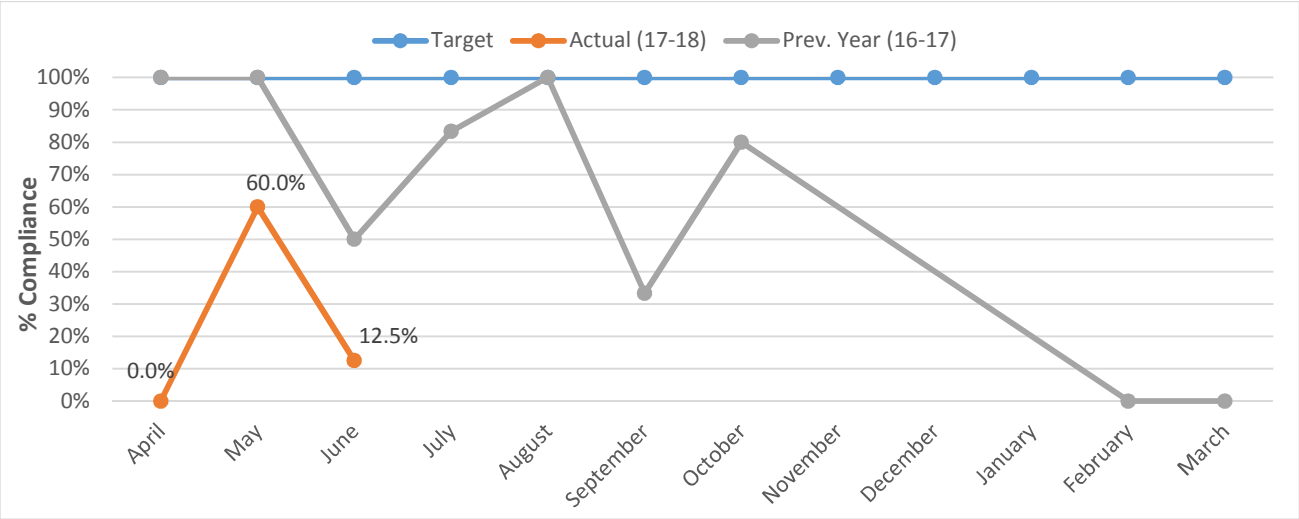


Figure.QS1b - Serious Incident (SI) Investigation timeliness (60 days).

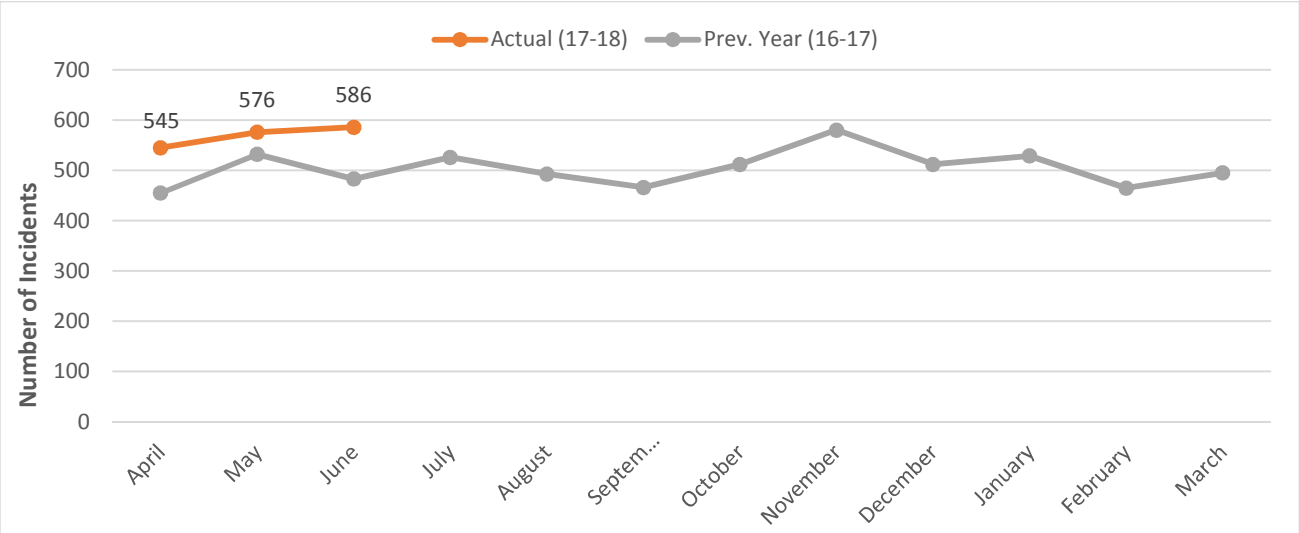


Figure.QS1c - Number of Incidents reported

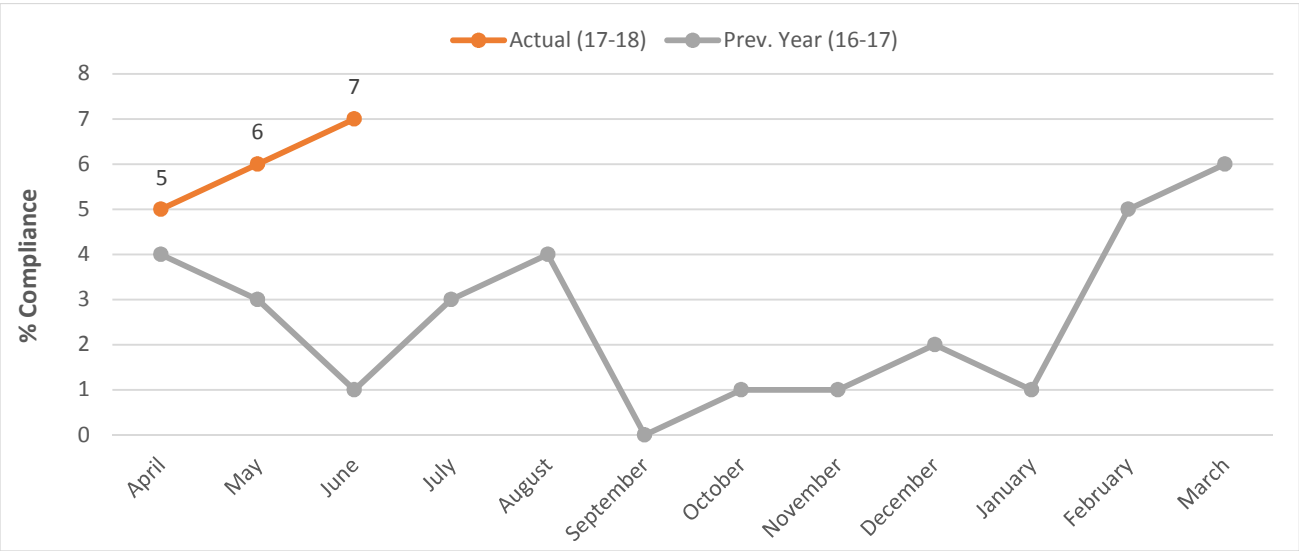


Figure.QS1d - Incidents reported that were SI's

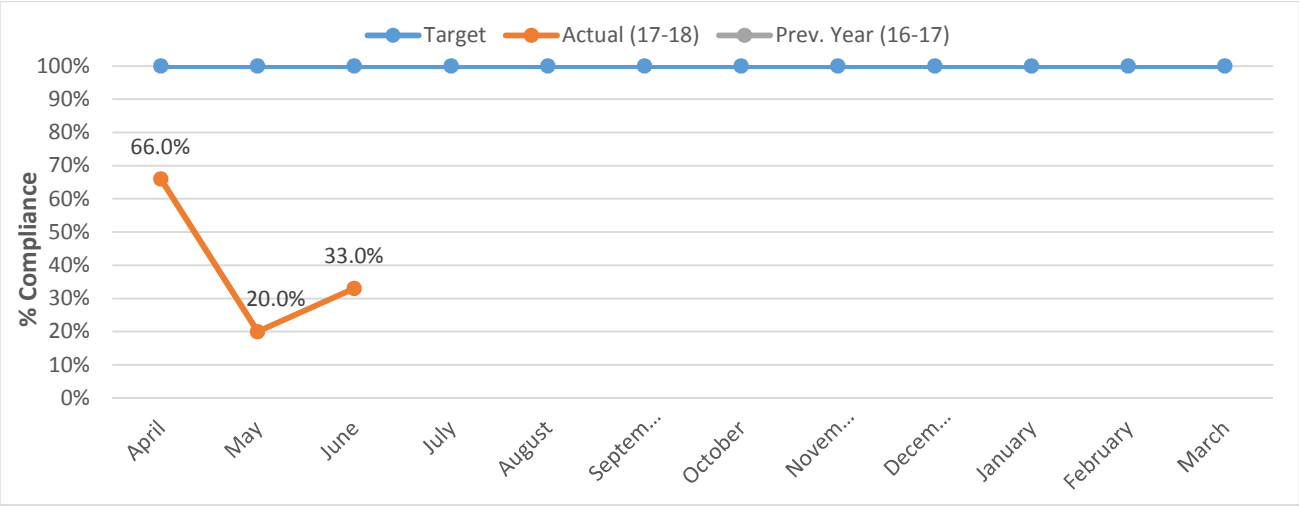


Figure.QS1e - Duty of Candour Compliance

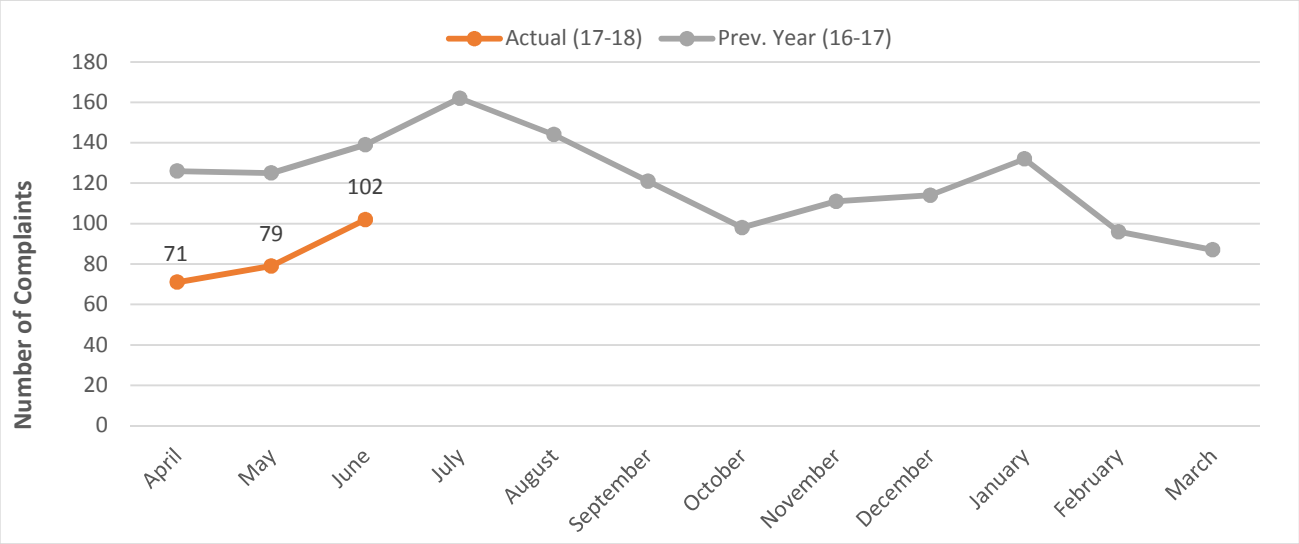


Figure.QS2a - Number of Complaints

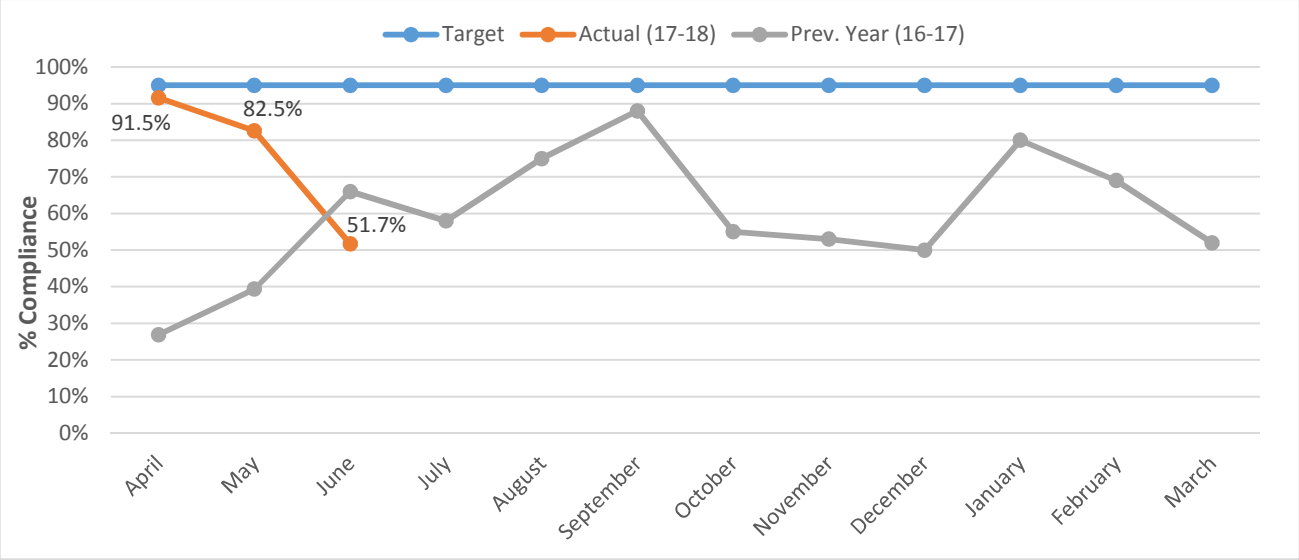


Figure.QS2b - Complaints reporting timeliness (All Complaints)

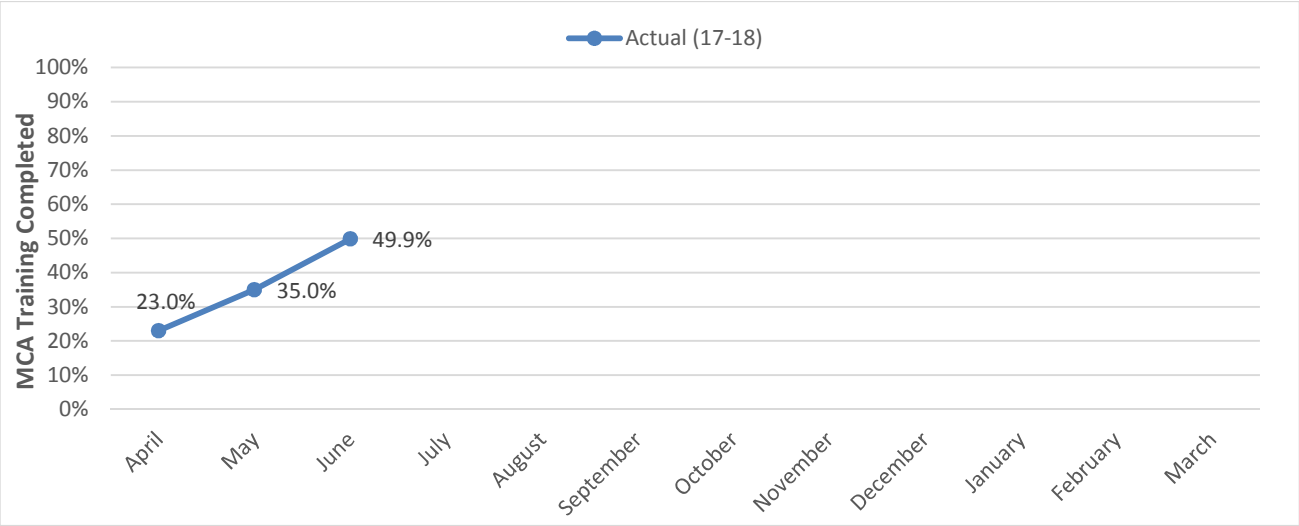


Figure.QS2c – Mental Capacity Assessment Training

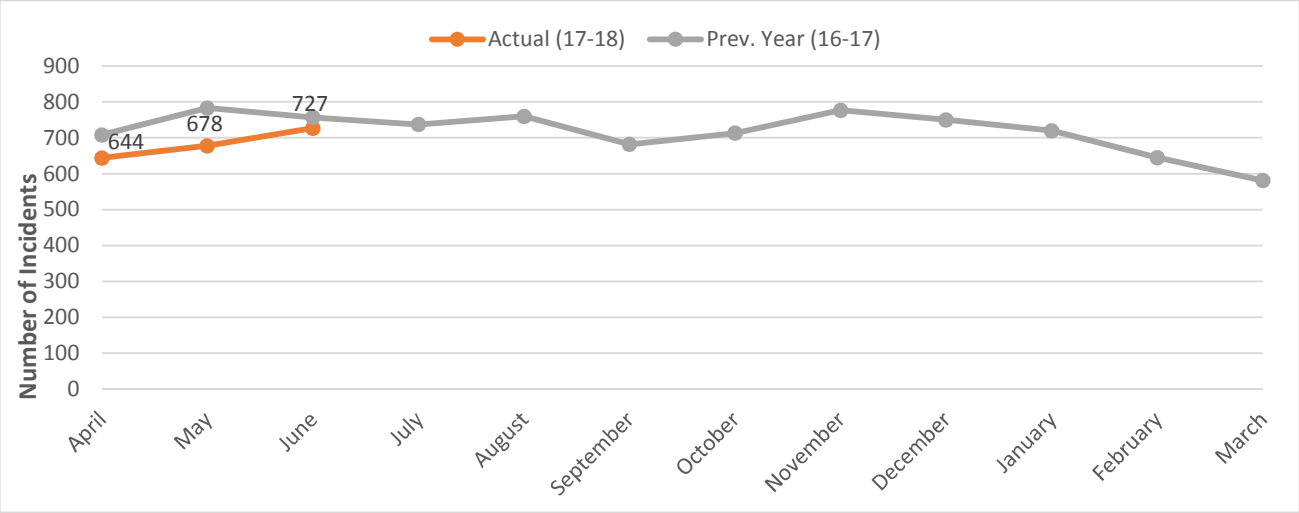


Figure.QS3a - Safeguarding Referrals Adult

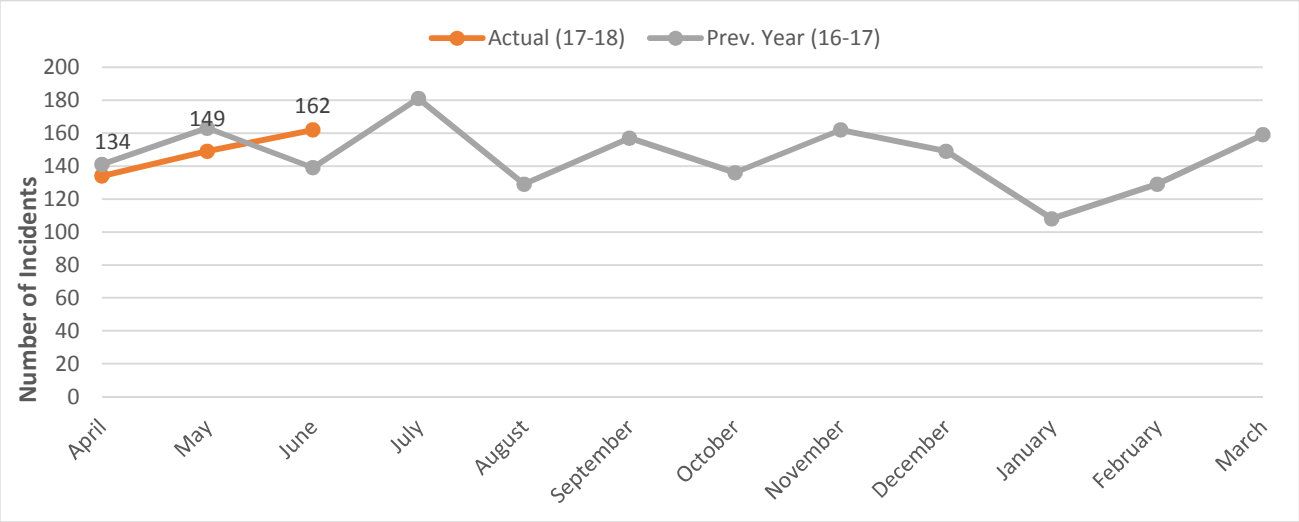


Figure.QS3b - Safeguarding Referrals Children

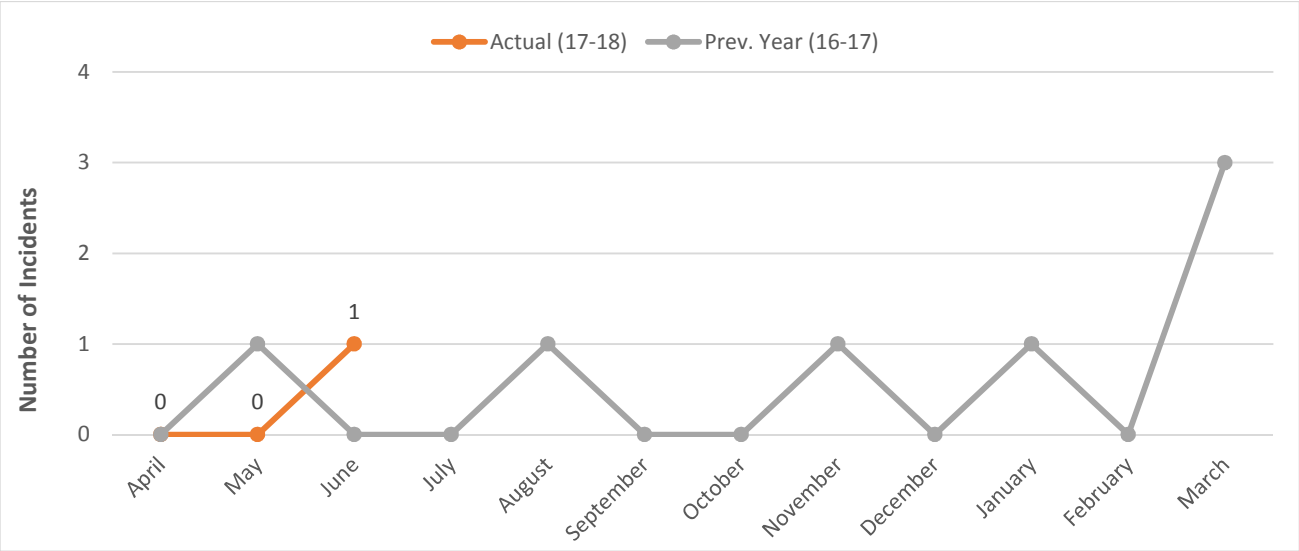


Figure.QS3c - Safeguarding Referrals relating to SECAmb staff or services

Unavailable

Figure.QS3d - Safeguarding Training Completed Adult, Level 1

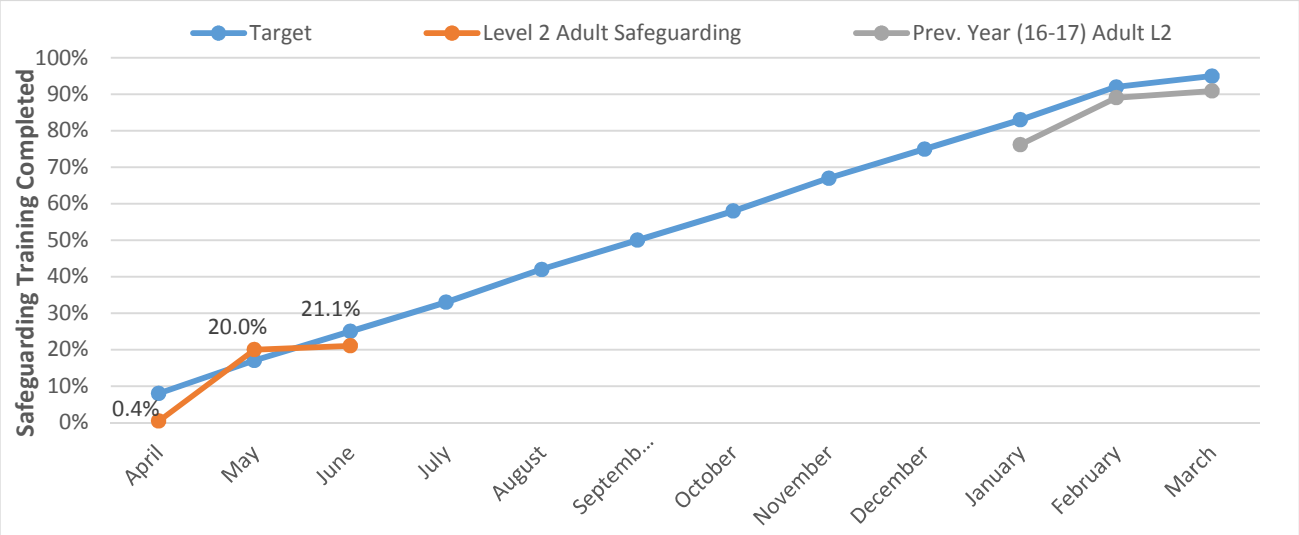


Figure.QS3f - Safeguarding Training Completed Adult, Level 2

Unavailable

Figure.QS3e - Safeguarding Training Completed Children, Level 1

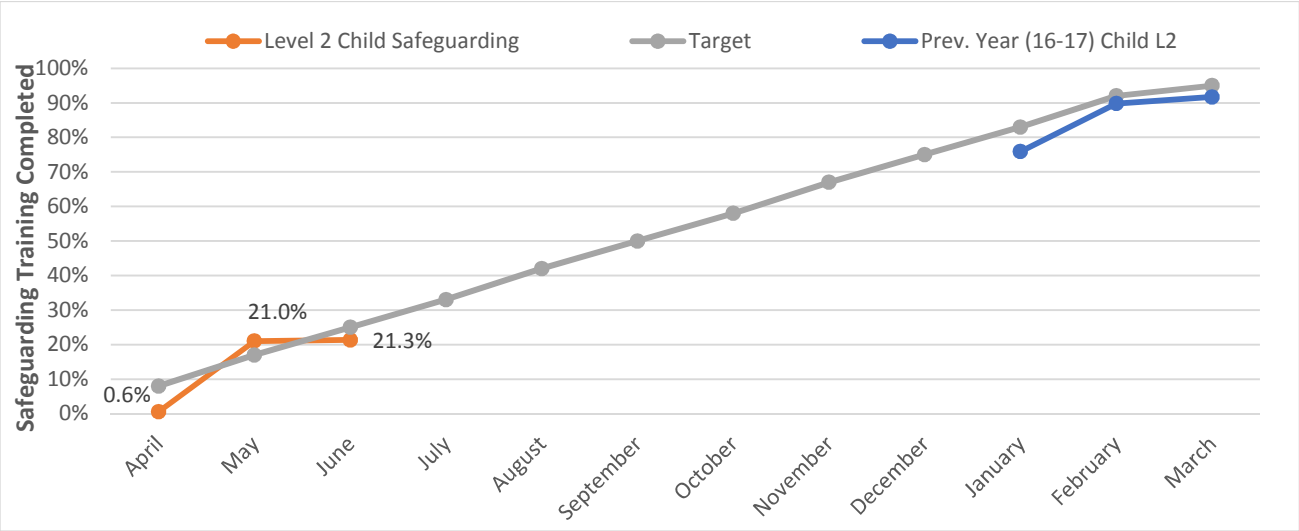


Figure.QS3g - Safeguarding Training Completed Children, Level 2

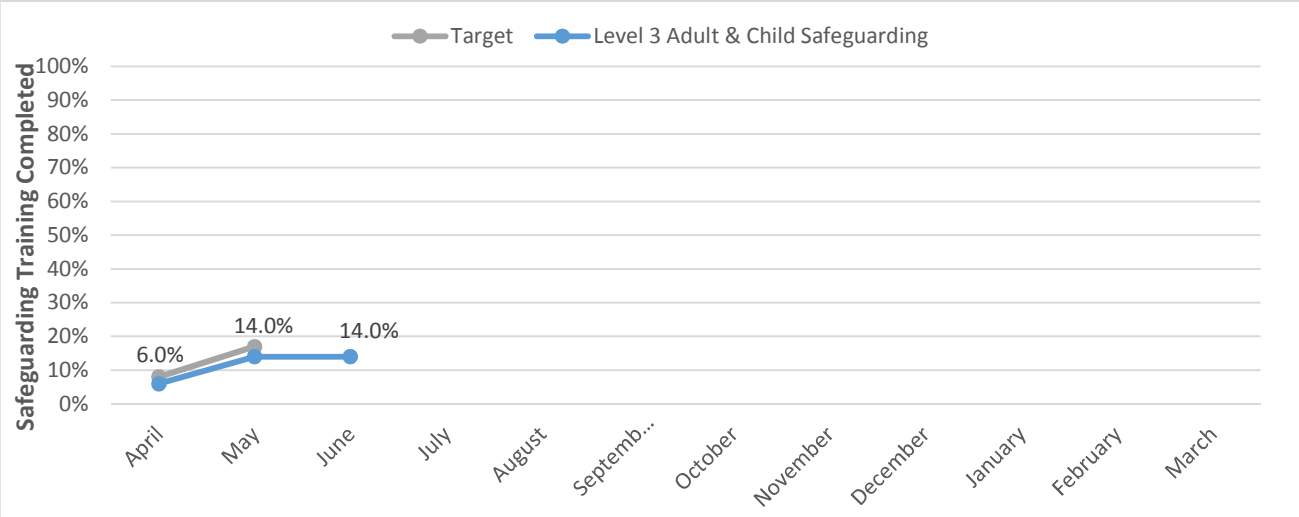


Figure.QS3h - Safeguarding Training Completed Adult & Child Level 3

6. Finance

6.1. Finance Summary

6.1.1. This commentary highlights the key messages arising from the month 3 financial position

6.1.2. The Trust incurred a deficit of £0.6m in the month, which was on plan. This includes the structural gap which is still being negotiated with the Commissioners. The normalised position is being confirmed as will be communicated within this commentary in future months.

6.1.3. In the year to date the deficit is £2.0m, which was on plan.

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

Finance Scorecard:- : Data from June 2017

ID**	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
F-1	Income (£'000)	£ 17,953	£ 16,131	£ 16,130	£ 53,996	£ 47,534	£47,810
F-2	Expenditure (£'000)	£ 18,536	£ 16,703	£ 16,767	£ 55,983	£ 49,502	£49,117
F-6	Surplus/(Deficit)	-£ 583	-£ 572	-£ 637	-£ 1,986	-£ ,968	-£ 1,307

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	£ 850	£ 952	£ 849	£ 850	£ 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)	£ 1,450	£ 582	£ 614	£ 6,841	£ 1,520	£ 4,351
F-7	Cash Position (£'000)	£ 5,674	£ 10,452	£ 10,725	£ 5,674	£ 10,452	£ 10,725
F-4	Cost Improv. Prog. (CIP) (£'000)	£ 1,085	£ 1,302	£ 705	£ 3,185	£ 3,111	£ 1,593
F-8	Agency Spend (£'000)	£ 341	£ 219	£ 763	£ 1,027	£ 580	£ 1,708

** 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).*

6.1. Finance Commentary

Activity, Income and Expenditure

6.1.1. There was an expected income shortfall in the month of £1.9m arising from the 'commissioning gap'. Outside of this, income was slightly better than plan due to the inclusion of STF income. For the year to date actual income was £6.5m below plan, excluding the structural gap this is £0.4m less than plan, mainly from a shortfall of £0.9m due to lower than planned activity (-3.0%), partly mitigating this there was £0.2m of additional income from East Kent CCGs from the diversion of services.

6.1.2. Total Expenditure including Financing costs, are £6.5m better than plan, excluding the structural gap we are £1.8m better than plan, the main areas of underspend are Operational Hours £0.6m, Fleet £0.4m, Estates and Make Ready £0.4m, other Operations Non Pay £0.4m and IT £0.1m, despite some unexpected redundancy payments (£0.3m) and delays in sale of Eastbourne ambulance station (£0.2m).

6.1.3. Some of these will be issues of timing/plan profiling and may be reversed in later months, for example the purchase of Airwave radios for CFRs (£0.1m).

6.1.4. A&E activity was 2.0% down on plan in the month and contracted income £0.2m down, although income was nearly 2.0% above that earned in the same period last year.

6.1.5. After 3 months A&E activity is 3.0% below plan, but 1.9% above last year.

6.1.6. Operational hours were 3.1% below planned matching income, however operational efficiency was less than expected with Unit Hour Utilisation (UHU) at 0.380 was below the panned 0.395.

6.1.7. The whole time equivalent worked was 126 or 3.4% lower than expected, this includes overtime, agency and private ambulance provision. At month 3 there were 432.6 wte in vacancies, 12.37% of establishment, vacancies are partly covered by overtime and external provision (PAPs and Agency).

Cost Improvement Programme

6.1.1. CIP delivery for the month of £1.3m was £0.2m above plan. The year to date achievement of £3.1m which is £0.1m less than 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 £0.6m against a plan of £1.5m. To date the spend is £1.5m against a planned £6.8m. The shortfalls in spend are against Fleet (equipment) £3.1m, New HQ £1.2m and CAD £0.3m. The full year programme is £15.8m. Due to the decision to finance our new fleet through an operating lease means we cannot, the forecast has been reduced to £7.6m.

Cash and Financing

6.1.3. The cash balance at the end of May was £10.5m, significantly higher than the planned £5.7m. 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 through. CIP plans are progressing well but present an ongoing challenge. The capital programme is behind schedule excluding new vehicles 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

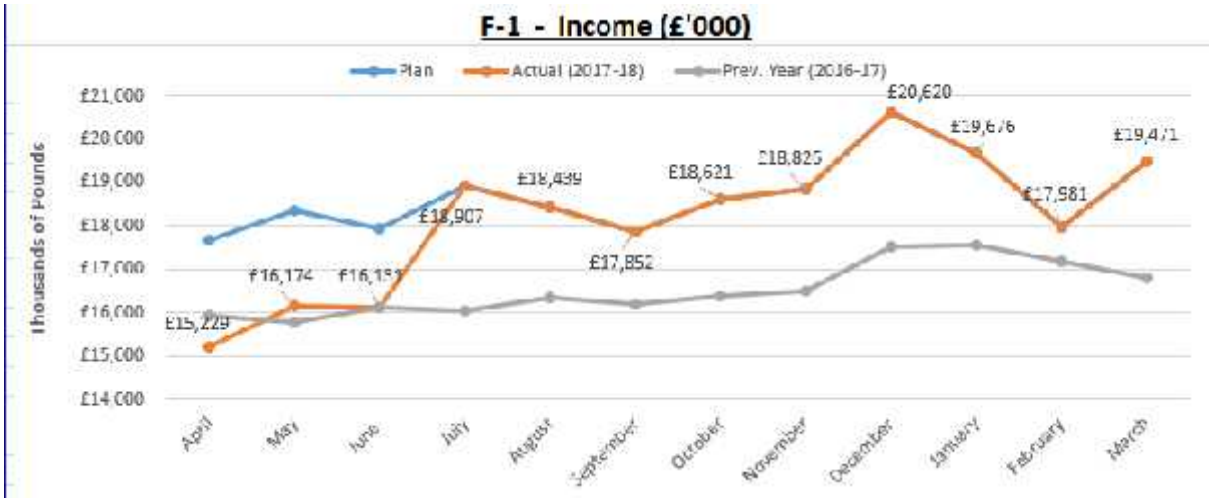


Figure.F-2 - Expenditure (£'000)

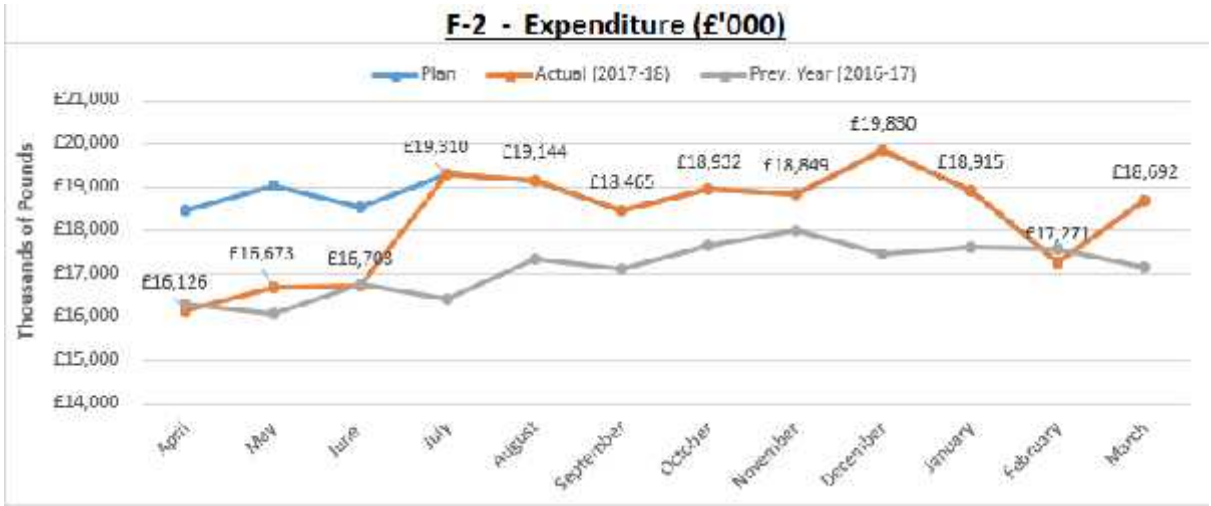


Figure.F-6 - Surplus/(Deficit) (Year To Date)

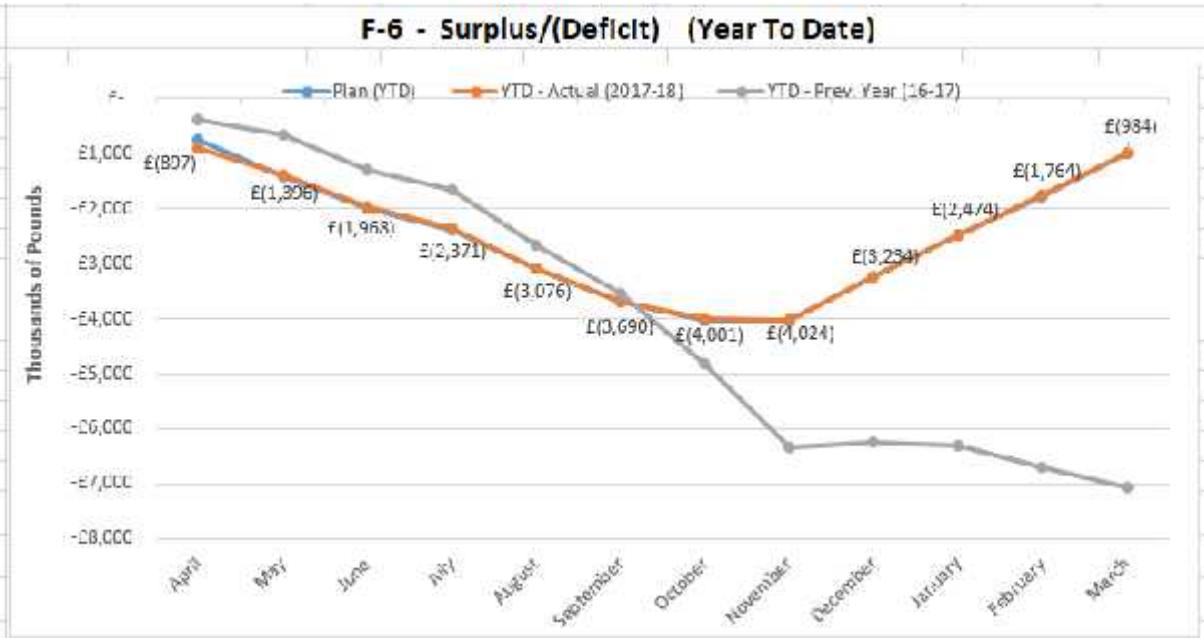


*Figure.F-5 – CQUIN - Quarterly (£'000)**

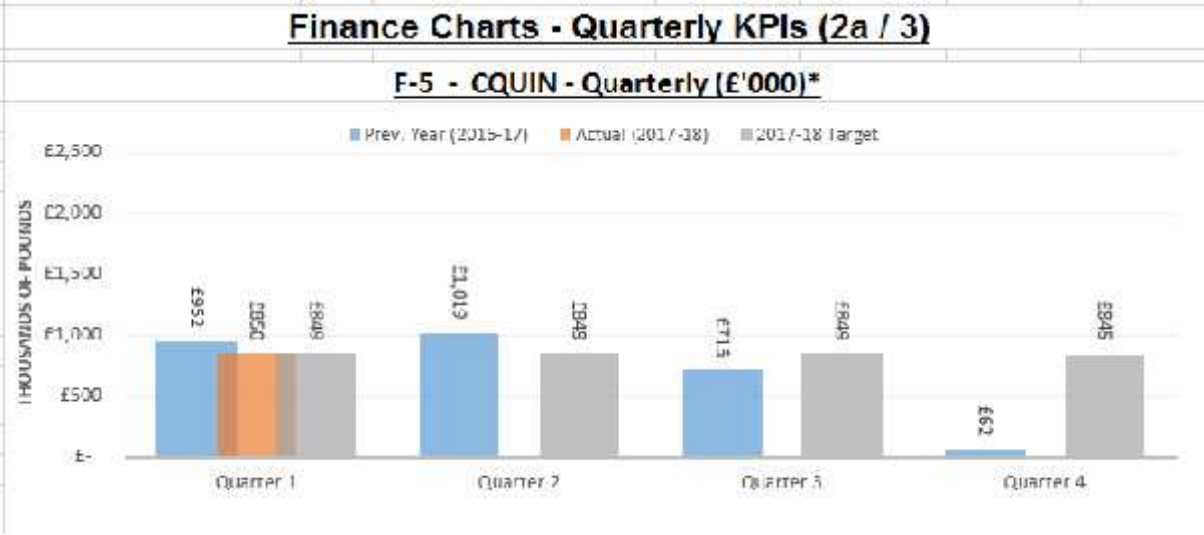


Figure.F-8 – Agency Spend (£'000)

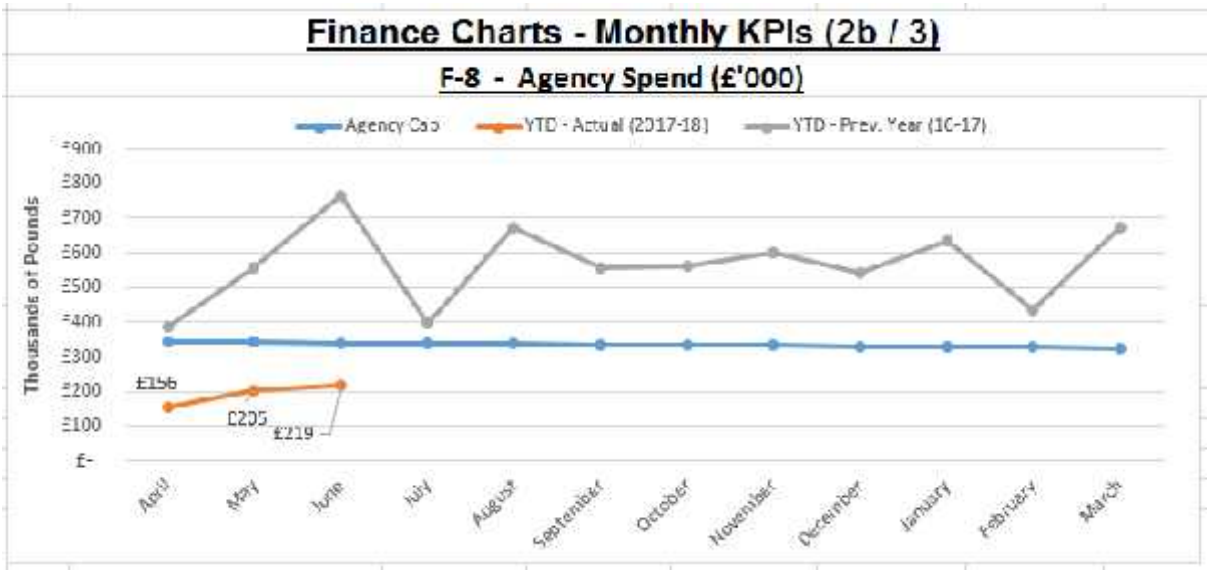


Figure.F-3 – Capital Expenditure (£'000)

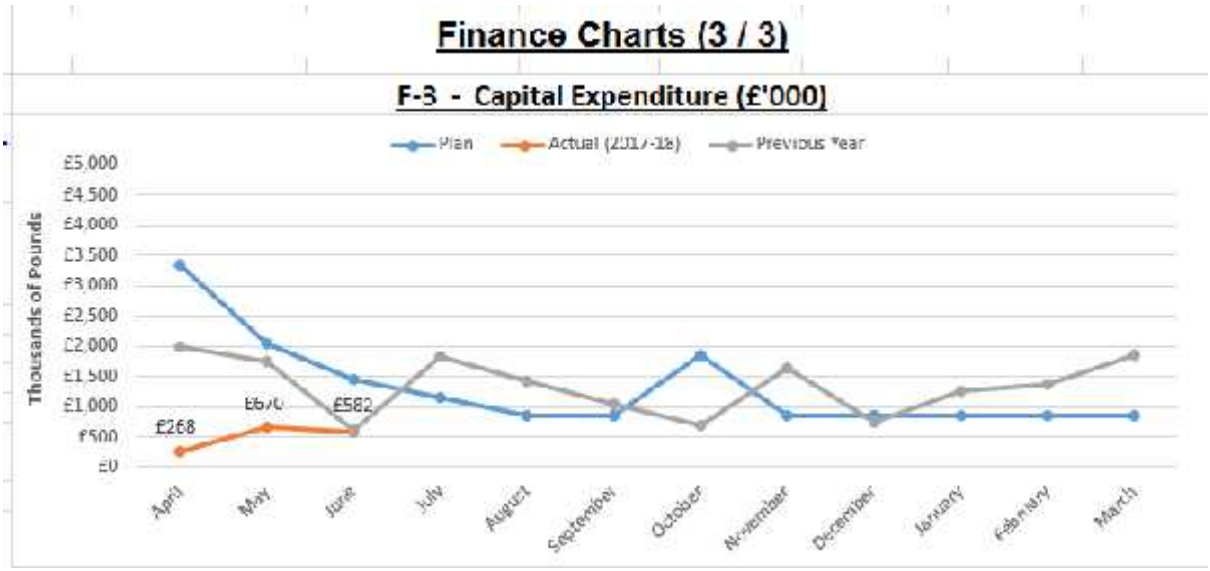


Figure.F-7 – Cash Position (£'000)

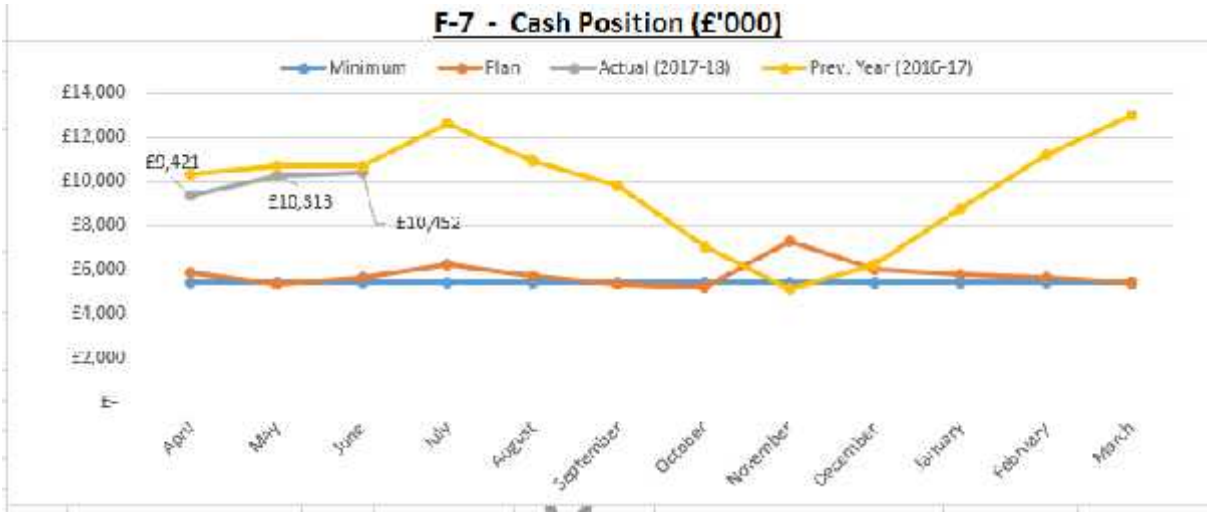
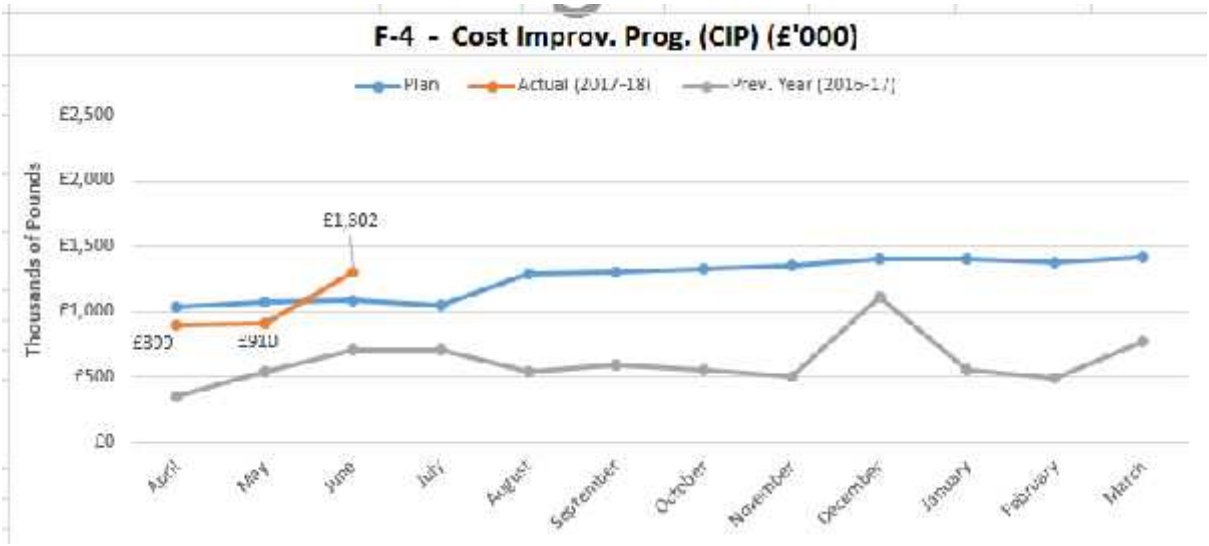


Figure.F-4 - Cost Improv. Prog. (CIP) (£'000)



Appendix 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.

7.3.3. Meeting arranged to review Workforce section.

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	69/17

Name of meeting	Trust Board
Date	25 July 2017
Name of paper	Medicines Governance
Responsible Executive	Dr Fionna Moore, Executive Medical Director
Author	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 had identified other medicine management concerns. The associated risks were explored by the Executive Management Board and shared with the Quality and Patient Safety Committee of the Board. There was consensus that compliance with medicines management standards constituted a high risk and so required 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 12 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 was commissioned by the Trust, and approved by NHSI. Phase one of the Review, reviewed specific elements of medicines management was completed in July 2017.

2.6. Following the May 2017 CQC follow up inspection, high level feedback was provided which included concern about medicines governance that required immediate action.

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 explored the Trust's governance systems and processes in relation to medicines management. Case files were compiled 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. 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 improve practice around medicine governance.

3.2.3. 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. Progress implementing the action plan to address the identified issues is monitored at weekly Quality and Safety group and regular performance meetings with NHSI.

3.2.4. Monthly Medicines Governance's Group meetings are held with membership from operational and corporate functions where a range of medicines issues are discussed and addressed.

4. Controlled Drugs

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

4.2. The policy and associated standard operating procedures (SOPs) for controlled drugs is out of date requires review and update.

4.3. Data from sources such as incident reporting identified that we continue to have a high percentage of ampoule breakages in the trust as a result of a range causes including how staff carry CDs.

4.4. The Trust's current CD license is due to expire on 05 September 2017.

4.5. **Progress to date**.

4.5.1. The Chief Pharmacist is working with our account manager at Omnicell to develop an audit trail that will account for all Controlled Drugs (CDs), returned, broken or administered. This will facilitate full track and trace of CDs. For non-Omnicell locations who store their CDs in lockable CD cabinets a paper version of track and trace will be developed and implemented. 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. A business case is in final stages awaiting comments before submission.

4.5.2. The renewal of the Trust's CD license has been applied for in June 2017, which has included an application to change the named CD Accountable Officer and staff responsible for the destruction of out of date CDs.

4.5.3. Work has commenced on updating and drafting the Controlled Drugs policy and associated SOPs. CD activity in the Trust has been mapped. This work will inform the policy and supporting processes.

4.5.4. 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.

4.5.5. The Medical Director is the identified CDAO with responsibility for all aspects of Controlled Drugs management within the Trust. On 21 June 2017 she completed the nationally recognised CDAO course to assist her to prepare for undertaking this role in line with best practice and national guidance.

4.5.6. To support the CDAO in her role the Chief Pharmacist is booked onto the CDAO course in November 2017.

4.5.7. A meeting has been arranged for 21 July 2017 with the Trust's local CD liaison police officers, chief pharmacist and the local security manager to discuss station inspections and safe handling of CDs and other medicines in the Trust.

5. Staffing

5.1. There are currently 2.5 WTE vacancies in the medicines support workers team.

5.2. **Actions completed to date**

5.2.1. To cover the vacant medicine support worker posts we have advertised internally and externally for fixed term contracts. Six candidates have been short-listed this week. Interview dates to be confirmed.

5.2.2. To assist with the implementation of the CQC action plan an interim Senior Pharmacist Technician commenced in post in June for a three-month period.

6. Patient Group Directives (PGDs)

6.1. All Critical Care Paramedic (CCP) PGDs expire at the end of July 2017.

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 reflect best practice.

6.3. **Progress to date**

6.3.1. A CCP working group was set up to review and update the CCP PGDs to ensure they reflect current evidence based practice. All 15 PGDs for this staff group have been amended as appropriate and reviewed by external medical consultants before being approved by the Trust's Executive Medical Director.

6.3.2. A plan for the implementation of these revised CCP PGDs has been developed and will be introduced to CCPs at their regular clinical training. This exercise is expected to be completed within the next eight weeks.

6.3.3. A PGD working group has been set up as a sub group of the MGG. Terms of reference are in draft form and will be presented to MGG on 10 August 2017.

6.3.4. A review of the PGD for tranexamic acid is currently being undertaken to ensure it reflects the findings of WOMAN study and updated JRCALC guidance to be published in September 2017 due in September 2017.

7. Trust estate and temperature control

7.1. 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.

7.2. 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.

7.3. 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 thermometer which will alarm should the parameters be breached. Currently we have medicines stored outside in areas that do not have effective temperatures monitoring.

7.4. 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.

7.5. 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.

7.6. **Progress to date**

7.6.1. We are currently developing a SOP for temperature monitoring in all areas where medicines are stored and how to escalate in the event of temperatures being outside acceptable ranges.

7.6.2. 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.

7.6.3. There is a schedule of station inspections that will be undertaken by the medicines governance team to identify all areas where medicines are stored, check that temperature is being monitored and issues escalated. The findings of these inspections will be used to update the current medicines dashboard.

8. Overspent Medicines Budget

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

8.2. 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.

8.3. 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. This budget will be transferred to the Medical Directorate in 2017/18.

8.4. **Progress to date**

8.4.1. The medicine's budget has been transferred to the Medical Directorate in April 2017.

8.4.2. 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.

9. Drug labels

9.1. 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.

9.2. **Progress to date**

9.2.1. A supplier of labels that are in line with national guidance and best practice has been identified. The drug label requirements of the CCPs has been identified and new labels introduced for use by this staff group. Initial feedback is positive.

9.2.2. Other staff groups such as Paramedics have been request to identify the drug labels they require. Once this information has been received by the medicines governance team these labels will be ordered.

10. Medicines dashboard

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

10.2. **Progress to date**

10.2.1. The Chief Pharmacist is commencing work on the development of a medicines dashboard.

10.2.2. A new quarterly station checklist has been developed and is in draft form. This checklist will be used to monitor the safe and secure handling of medicines. The findings will be fed back into the medicine's dashboard and reported to MGG.

10.2.3. A New weekly manager checklist is in draft form to monitor the safe and secure handling of medicines on station/sites. This will be monitored by quarterly medicine checks and dashboard and results fed back to MGG.

11. Omnicell

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

11.2. **Progress to date**

11.2.1. Training on use of Omnicell was received on the 10th and 11th July by the medicines team.

11.2.2. Now SOPs to guide staff on the process they should follow in the event of Omnicell failing or malfunctioning can be completed along with other user SOPs that are necessary.

11.2.3. Standardised stock list for Omnicell has been completed and Omnicell adjusted so that there is no confusion over which product to select when withdrawing or returning.

11.2.4. Review of user access rights is underway.

11.2.5. Standard templates for different user access rights is underway.

12. Key for drug cabinets on double crew vehicles (DCAs)

12.1. We currently reviewing the lock used on our DCA drugs cabinets to enable more robust controls to be in place over loss and replacement keys.

12.2. **Progress to date**

12.2.1. Baseline audit of all DCA keys on all sites complete.

12.2.2. Ledger books ordered and SOP in progress around ‘track & trace’ of all these keys.

12.2.3. Head of fleet and chief Pharmacist in discussions with companies around various locking systems to replace current universal lock.

13. Medical gases storage and security

13.1. It was identified during the recent CQC inspection that medical gases storage and security is not line with the Department of Health guidance (2006).

13.2. **Progress to date**

13.2.1. A BOC audit has been complete to ensure all racking and storage facilities in the Trust are in line with BOC recommendations

13.2.2. Quarterly medicines audits check to include medical gases.

13.2.3. Local security manager checks to include medical gases.

13.2.4. CD liaison officer security checks to include medical gases.

13.2.5. Medical gas group to be set up and terms of reference agreed through MGG.

13.2.6. Medical Gas Policy to be implemented at trust – in progress.

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Agenda No	70/17
Name of meeting	Trust Board		
Date	25 July 2017		
Name of paper	Serious Incident Management Update		
Responsible Executive	Dr Fionna Moore, Executive Medical Director		
Author	Kirsty Booth, Business Support Manager		
Synopsis	This paper provides the Trust Board with an update on changes to the Serious Incident reporting, investigation and themes identification.		
Recommendations, decisions or actions sought	The Trust Board is asked to note this 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**	

Serious Incidents Management Update

1. Introduction

1.1. At the June Trust Board an update on progress on Serious Incident (SI) management was requested.

2. Current Position

2.1. There were seven SIs declared in June 2017. This compared to six in May, comparison to last year shows an increase of four over the same period.

2.2. All SIs have been assigned an investigating manager.

2.3. The pool of potential investigating managers has been increased to include operational managers supplementing subject matter experts and using the Professional Standards department for expertise and support.

2.4. The percentage of Serious Incident investigations completed within the 60-day timescale was 12.5% compared to 60% for May 2017.

2.5. The capacity within the Professional Standards Department in June prevented any SIs being reported to the CCGs within the required 72-hours.

2.6. **Table 1** below shows the current status of SIs

Stage of SI	**No.**
Awaiting closure (with CCG)	7
Clock stopped, awaiting closure (with CCG)	2
Clock stopped, collating further response	1
Closure declined, collating further response	8
Downgrade approved	1
Downgrade denied	1
Downgrade requested (with CCG)	1
Investigation complete, being reviewed internally	2
Investigation ongoing	36
Virtual closure, collating response (with CCG)	8
Total	**67**

3. Improvements

3.1. July has seen a change in the way that the Trust manages SI investigations through the Serious Incident Review Group (SIRG) with membership from the Medical, Quality & Safety and Operations directorates. Subject matter experts are invited from other directorates when a SI has been declared in their area.

3.2. A senior manager has been appointed as Serious Incidents Lead (12-month secondment). Their role will be to manage and improve the process and quality and identify themes and trends.

3.3. 20 staff members have now undertaken the Duty of Candour and Serious Incident Investigation training which includes Root Cause Analysis (RCA) training.

3.4. Of the 36 SIs currently under investigation, eight are being undertaken by staff who have completed the Duty of Candour and Serious Incident Investigation training. Each has a Professional Standards Manager assigned to support the investigation.

3.5. The Incident Management process and escalation was agreed at the Executive Management Board in 05 July 2017. Please see below:

20170510 Incident Process Map v3.xlsx

4. Impact

4.1. The changes to the SI system are still being worked through with a larger pool available to undertake SI investigations. It is envisaged the backlog of outstanding incidents will reduce.

4.2. The Serious Incidents Lead will develop processes that will improve the quality and compliance for reporting to ensure we are meeting all the agreed key performance indicators.

5. Further improvements

5.1. The Serious Incident Policy is under review with the SI Lead and will follow the Policy on Policies for implementation.

5.2. Work will continue with the Risk department to manage, improve the quality and ensure timely reporting of SIs.

5.3. Further Duty of Candour and Serious Incident Investigation training is scheduled for September 2017 with a further four places available to SECAmb staff.

5.4. The system of allocating an investigating manager needs to be more robust.

5.5. Working collaboratively with the Quality & Safety Directorate to ensure timely reporting.

6. Summary

6.1. The Serious Incident Policy needs to be reviewed to ensure it is in line with best practice and national guidelines.

6.2. With the appointment of a SI Lead, the expectation is that the quality of SIs will improve.

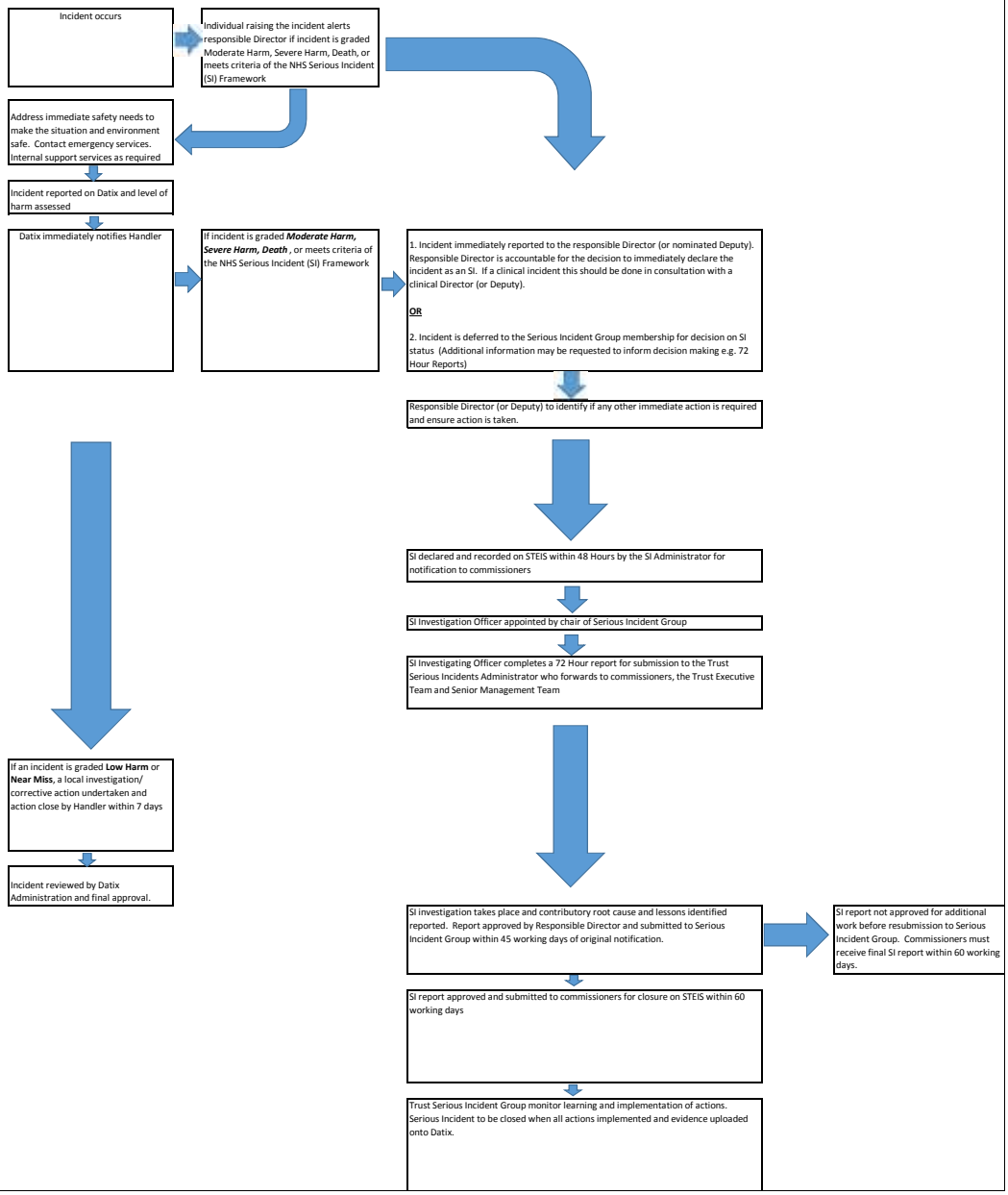
6.3. Further Duty of Candour and Serious Incident Investigation training is scheduled for September 2017

7. Recommendation

7.1. The Board is asked to note this report.

DRAFT INCIDENT MANAGEMENT PROCESS AND ESCALATION: VERSION 0.3

Timescale	Duty of Candour
Immediately	When harm is identified make verbal contact with patient/ family/ relative/ guardian
48 Hours	Telephone call to patient/ family/ relative/ guardian to confirm invitation to meet and discuss. Written confirmation followed up in Duty of Candour letter.
72 Hours	
Within 7 Days	
Within 45 Working Days	
Within 60 Working Days	Findings of investigation shared with patient/ family/ relative/ guardian
Continuous	



		Item No	71/17
Name of meeting	Board of Directors		
Date	25 July 2017		
Name of paper	Infection Prevention & Control Annual Report		
Executive sponsor	Steve Lennox, Executive Director of Nursing & Quality		
Author name and role	Aide Hogan, Infection Prevention and Control Lead		
Synopsis (up to 120 words)	This annual report sets out the steps taken during 2016/17 in establishing and maintaining sounds systems of infection prevention and control. It also includes an outline of the Annual Work Programme for 2017/18.		
Recommendations, decisions or actions sought	The Board is asked to note and discuss this report.		
Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).		**No** If yes and approval or ratification is required, a completed EA Record must be attached.	

South East Coast Ambulance Service NHS
NHS Foundation Trust

South East Coast Ambulance Service NHS Foundation Trust

Infection Prevention & Control Annual Report

2016-2017

1. Executive Summary

The purpose of this report is to inform the Board, staff, patients and members of the public of the progress made against the Care Quality Commissions standards (Outcome 8, Regulation 12) and the Department of Health 'Health and Social Care Act' 2008 during the last 12 months. An outline of the Infection Prevention and Control (IPC) Annual Work Programme for 2015/16 is appended to the report to illustrate the priorities for the forthcoming year (Appendix 1). The report provides information and evidence of the ongoing commitment of the Trust to embed IPC principles and practices throughout the organisation.

As a result of learning and improvement, South East Coast Ambulance Service NHS Foundation Trust (SECAmb) has a workforce that has the knowledge, skills and experience to appropriately minimise infection risk for patients and staff, thereby improving patient safety and staff well-being. The organisation is able to demonstrate compliance with IPC standards and delivery of key strategic objectives including: 'Delivering high quality, patient focused services' and 'Ensuring a highly skilled, motivated and engaged workforce'.

Key achievements are identified along with priorities and risks for 2016/17 as follows:

2. Key achievements

- Following the Care Quality Commission (CQC) inspection in May 2016 and comments from the inspection team about capacity in the Infection Prevention and Control Team (IPCT) funding was made available to recruit a Band 6 IPC Practitioner (IPCP). Following a successful interview Gavin Thompson was appointed and commenced his role on the 5th January 2017.

- The IPCT have continued to maintain a high level of IPC awareness through communications to staff in a variety of formats such as SECAmb News articles, weekly bulletin articles, IPC Alerts, meetings (internal and external), inspections and audits. In February 2017 the IPCP also managed to liaise with the EPCR Team and we now have a dedicated site built into the I-Pads that staff are being provided with.

- Continued audits and inspections carried out by the Infection Prevention and Control Lead (IPCL) and Infection Prevention and Control Champions (IPCC) during the first two quarters of the year were sporadic, but have now improved with the addition of the IPCP. A new audit programme has been developed and a monthly tracker enables the IPCT to review the consistency of audit and inspection results and provided a valuable opportunity for sharing knowledge and best practice at a local level.

- Good communications with local NHS Trusts and Public Health England continue to reap benefits through ensuring that timely information is passed from one organisation to another with regard to health care associated infections. This work and the liaison between other NHS providers are not uniformly in place across all Ambulance Trusts and therefore should be commended.

- Provision of education and information to staff through development of good quality, validated training packages and the IPC Communication Strategy. The team ensures that training materials are well evidenced, are fit for purpose and that communications to staff on IPC matters are concise, accurate and targeted appropriately.

- The IPCL managed the seasonal flu vaccination programme this year and a rise in frontline healthcare staff vaccinated of 5.5% saw the Trusts best ever total reached (66.9%).

3. Introduction

This is the first Annual Report from the Director of Infection Prevention & Control (DIPC). The report is to inform the Board, staff, patients and members of the public of the progress made against the Care Quality Commissions standards (Outcome 8, Regulation 12) and the Department Health 'Health and Social Care Act' 2008 during the last 12 months. An outline of the IPC Annual Work Programme for 2017/18 is appended to the report (Appendix 1) to illustrate the priorities for the forthcoming year.

The report provides information and evidence of the ongoing commitment of the Trust to embed IPC principles and practices throughout the organisation and shows the significant improvement the Trust has made in this respect.

4. Background

Effective infection prevention and control practice requires ownership at every level – from Board to frontline. Success depends on creating a managed environment that minimises the risk of infection to patients, staff and the public and ensures compliance with relevant national and local standards, guidance and policies. Through personal accountability, skilled and competent staff, transparent and integrated working practices and clear management processes a sustained approach to IPC can be achieved.

4.1. The Health and Social Care Act 2008: Code of Practice for Health and Social Care on the Prevention and Control of Infections and related guidance (Department Health).

Section 21 of the Health and Social Care Act (2008) enables the Secretary of State for Health to issue a revised Code of Practice. The Code contains statutory guidance about compliance with the registration requirement for cleanliness and infection control. The Act states that the Code must be taken into account by the Care Quality Commission (CQC) when decisions are made regarding the cleanliness and infection control standards required to achieve registration. The Code, revised in December 2010, focuses on 10 areas which are detailed in Table 1.

	Criteria Requirement	Compliance	RAG
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.	Compliant	
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Compliant	
3	Provide suitable accurate information on infections to service users and their visitors.	Compliant	

4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/ medical care in a timely fashion.	Compliant	
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.	Compliant	
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.	Compliant	
7	Provide or secure adequate isolation facilities.	Not applicable to ambulance Trusts	
8	Secure adequate access to laboratory support as appropriate.	Not applicable to ambulance Trusts	
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	Compliant	
10	Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.	Compliant	

5. Board Assurance

5.1. **Corporate Responsibility**

In December 2003 the Department of Health published 'Winning Ways: Working Together to Reduce Healthcare Associated Infections' which highlighted the requirement for a Director of Infection Prevention and Control (DIPC). The Director of Quality and Safety has been designated as the DIPC with lead responsibility within the Trust for IPC. This post reports directly to the Chief Executive Officer and the Trust Board. The Trust Board holds overall responsibility for ensuring that the Trust is compliant with IPC national guidance. The IPCL has been designated as the Deputy DIPC.

6. Performance Monitoring

6.1. **The Infection Control Sub Group (ICSG)**

The aim of the ICSG is to provide assurance to the Trust Board that all services are provided in a clean and safe environment through the effective performance monitoring of key performance indicators (KPIs). It provides a forum for the co-ordination of any IPC related projects ensuring a consistent approach to IPC throughout the Trust. During 2016 - 2017 the group met bi-monthly (Terms of Reference revised in May 16).

The ICSG is responsible for providing assurance to the Clinical Quality Working Group (CQWG) and upwards to the Risk Management and Clinical Governance Committee (a sub-committee of the Board). It monitors compliance with the Health and Social Care Act 2008 via updates from all areas within SECAmb relating to the IPC audits for vehicles, premises and observed practice, and IPC training compliance is provided at each meeting.

Following the CQC inspection and as part of the Trusts recovery plan the reporting line for the IPCSG changed in September 2016 to the Quality Safety Group and then the Quality Safety Committee.

6.2. **The Infection Prevention and Control Team**

The Trust has a proactive Infection Control Team (which has been enhanced since the recruitment of the IPCP) that is very clear on the requirements necessary to support the Trust in maintaining its commitment to patient safety and quality of care. Equally, it is recognised that infection prevention and control is the responsibility of every member of staff and must remain a high priority for all to ensure the best outcome for patients.

6.2.1. **Director Infection Prevention and Control (DIPC) and Deputy Director of Infection Prevention and Control (DDIPC)**

The responsibilities of the DIPC are outlined in 'Winning Ways' (DH, 2003) and include:

- To be the responsible Executive Lead for IPC within the Trust reporting directly to the Chief Executive
- To ensure that pre-determined targets are met by overseeing the IPC work programme and Annual IPC Audit Programme
- Present regular reports to the Trust Board
- Approve and contribute to the Director of Infection Prevention and Control Annual Report
- The Deputy Director of Infection Prevention and Control manages and oversees the performance of the IPC team

6.2.2. **Infection Prevention and Control Lead (IPCL) / Deputy DIPC**

The responsibilities of the ICL include:

- Performing a self-assessment of the Trust against the Health and Social Care Act 2008 and ensuring plans are appraised by the SIPCG and are implemented to sustain compliance
- Ensuring the Trust policies, procedures and manual reflect the national and local IPC requirements
- Developing and overseeing the delivery of an annual inspection programme and monitor through the ICSG
- Developing and overseeing the delivery of an annual work programme focusing on improving and sustaining compliance with the Health and Social Care Act 2008
- Producing an Annual IPC report
- Developing and updating integrated inspection tools to ensure these are fit for purpose
- Managing the Trusts seasonal flu vaccination programme

6.2.3 **Infection prevention and Control Practitioner (IPCP)**

- Challenges unsafe practice in all levels of staff in order to reduce the risk of health care related infections
- Offer infection prevention advice on patient care in relation to preventing cross infection
- Carry out risk assessments in relation to infection prevention and control including clinical practices to reduce the risk of healthcare related infection
- Assists where appropriate in the management and the control of meningitis, tuberculosis, hepatitis B, hepatitis C, HIV, and major outbreaks of gastrointestinal infection in association with existing personnel.
- Day to day monitoring of infection control incidents within the Trust.
- To assist the ICL with the development of an infection control annual plan, to include audit planning against key performance indicators.
- Provide effective communication of the Trust's infection prevention and control
- Investigates incidents of infection control and produces reports to the relevant groups. Report the lessons learnt and actions via the IPCSG, in order to prevent and control further incidents within the Trust.
- To assist the ICL with specialist training as appropriate such as induction programmes, service specific training and as required in response to risk assessments and incidents.
- Act as, or co-ordinates, mentorship and clinical supervision for Infection Prevention and Control Champions.

6.2.4. **Infection Prevention and Control Champions (IPCC)**

- To liaise between the Infection Control Team (ICT) and their clinical area
- To facilitate the introduction & implementation of new & existing infection control practices
- In conjunction with the ICT to act as a resource for staff concerning IPC related problems in the clinical area
- To assist in the education of staff in their service area in the principles of infection control as it relates to their speciality
- To participate in infection control activities as appropriate
- To participate in teaching patients / staff appropriate aspects of care relating to infection control practices
- To assist the ICT with accurate surveillance/audit as appropriate
- Staff IPDR's (CQC / Health Act Requirements)

6.3. **Infection Prevention and Control Annual IPC Work Programme**

The IPC Annual Work Programme for 2016/17 has been completed. The aim of the annual programme is to provide a framework with which to clearly demonstrate improvements in IPC from Board to Ambulance. The ICSG agreed the new 2017-2018 Annual Work Programme at the May 2017 meeting which focuses on embedding and sustaining good IPC practice across the organisation thereby maintaining compliance with the Health and Social Care Act 2008.

6.4. **Policy Review and Development**

The IPC Policy and Manual were reviewed and updated as appropriate during 2016-2017 in response to national guidance / legislation. They are both available on the Trusts intranet site which has a dedicated IPC page.

6.5. **National Ambulance Service IPC Group (NASIPCG)**

The IPCL continues to attend the quarterly NASIPCG meetings. The role of the group is to provide expert advice on IPC in Ambulance Services to the National Ambulance Quality Governance & Risk Directors (QGARD). During 2016 / 2017 the group commenced a research study into the Deep Clean systems in place at each service and the results of this study are being pulled together at the time of writing this report. Once this is complete the group hope that they will be able to provide an evidenced based paper for the length of time between Deep Cleans for ambulances in the future.

6.6. **South East Regional IPC Forums**

Reporting to the Lead Commissioners: As part of the agreed Quality and Information reporting requirements defined in the Trusts contract for 2016/17, frequent update reports pertaining to IPC within the Trust are also reported to the Lead Commissioners Clinical Quality Review Group meetings. The ICL also attends IPC Forums in Kent, Sussex and Surrey where Infection Control Practitioners from various healthcare settings meet to promote standardisation and consistency of practice related to infection prevention and control. The purpose and objectives of these meeting are as follows:

- Facilitate partnership working between NHS organisations
- Promote shared learning and expertise within the specialist field of infection prevention and control
- Standardise approach to infection prevention and control practice
- Provide valuable resources to infection control teams and associated organisations
- Implement latest guidelines and initiatives related to infection prevention and control
- Improve the patient experience.

6.7. **Corporate Risk Register**

There have been no risks pertaining to the management and delivery of the IPC agenda on the Trusts corporate risk register during 2016/17.

6.8. **Learning and Development**

As a consequence of our large geographical spread, the Trust has utilised a mix of delivery mechanisms to educate and train our staff. This has included ‘face to face’ training, IPC workbooks and communication briefings delivered via email, weekly bulletin articles and IC alert notices.

The IPC Team are responsible for ensuring that all IPC educational material is up to date and reflects current best practice and national guidance. Hand hygiene is a core theme throughout all training packages and compliance is monitored through the Observed Practice Audit Tool.

This year we delivered two levels of training to all staff. Level 1 was a workbook for all support staff to complete and level 2 formed part of the two-day Key Skills training for staff with direct patient contact roles within the Trust. At the time of writing this report level 2 training had been completed by 96% of staff and level 1 training had been completed by 68% of support staff.

The Organisational Learning and Development Team and Clinical Education Team are responsible for the delivery of education to all staff within the Trust. IPC education forms part

of the Trust's Training Needs Analysis programme and Corporate Induction programme for new starters.

6.9. **Third Party Contractors**

Third party providers are required to provide evidence that they are fully compliant with the Care Quality Commission's Essential Standards related to the quality and safety of care. These are set out in the Health and Social Care Act 2008. The IPCT attends relevant meetings with third party providers to capture the aspects of IPC compliance. During 2016/17 this has included working closely with any third party contractors used to support the deep clean programme and that their staffs have received appropriate training and adhere to infection prevention and control standards. The IPCT are part of the Occupational Health contract monitoring mechanism. Third party sub-contractors of A&E work are also monitored for compliance with IPC standards as part of a wider monitoring mechanism. This has involved close working with those organisations which either currently contract or aspire to contract with SECAmb.

6.10. **Annual Inspection Programme 2016 –2017**

The IPC Annual Inspection Programme is recorded and monitored as part of the Key Performance Indicators (KPI) via the Central Health and Safety Working Group (CHSWG) and has been successful in providing Board assurance in order to declare compliance with the Health and Social Care Act 2008.

The inspection schedule is operated on a quarterly basis, with each location reporting their compliance with the results. This has enabled the Trust to identify key trends in non-compliance and take the required action to address these in a timely manner. Following discussions with the Lead for IPC from the NHSI team these audits were changed to monthly until January 2017 so as to seek further assurance that our estate was being managed and cleaned to a good standard. The IPCSG monitored the change for compliance and also carried out audits during the Quality Assurance visits implemented in Q4 of 2016 / 17.

To close the inspection loop all learning outcomes are routinely discussed at the IPCSG and CHSWG. Key issues are then cascaded to all Operating Units (OU) for implementation. This ensures Trust wide learning in a consistent and cohesive way.

6.11. **Audit Tools**

The IPC team has developed its audit tools in line with guidance from the Department of Health and Public Health England. There are seven different audit tools:

- Hand Hygiene Observed Practice
- Bare Below the Elbows Observed Practice
- Aseptic Non Touch Techniques Observed Practice
- A&E vehicle cleanliness
- PTS vehicle cleanliness
- SRV car cleanliness
- Station cleanliness
- ACRP cleanliness

In January 2017 the IPCT reviewed all of the audit tools used and have made changes to them in order to rectify some of the learning outcomes that came out of the CQC inspection and recovery plan. A new monthly tracker for audit completion will be introduced on the 1st

April 2017 along with the revised audit tools and training for OU IPCC staff will be carried out during Q1 of the year.

Monitoring of all audits will take place at the IPCSG and compliance issues will be escalated to the QSG as required. Quality Assurance visits will provide further evidence of compliance and the intention is to carryout secret shopper hand hygiene / BBE audits later in the year once the IPCT can set this up.

6.12. **Deep Clean**

The Trust has recognised that cleanliness in the patient environment is paramount for patient safety and reduces the likelihood of transmission of healthcare associated infections. The Trust has ensured that every OU has access to staff that perform deep cleaning of all vehicles and equipment.

The six weekly cleaning schedules for A/E vehicles, have maintained a high level of cleanliness in our vehicles and the monthly compliance results of the Deep Clean programme are made available to the Trust.

7. Decontamination

The Trust appointed the Head of Logistics as the nominated Decontamination Lead. The Decontamination Lead works in partnership with the IPCT to ensure a comprehensive approach to medical devices management, procurement of equipment and the suitability of cleaning products. The IPCT are members of the Clinical Equipment and Consumables Sub Group.

8. Communications Strategy 2017-2018

The IPC Communications Strategy for this year is detailed below: this will assist in embedding IPC policies and procedures in practice and to be a key mechanism for ensuring the IPC message is conveyed to staff. Key subject areas for the forthcoming year will be:

- Quarterly IPC awareness months; which will include learning outcomes from IPC related incidents, audit compliance issues from across the Trust and any new emerging infections / outbreaks. The content will be produced by the IPCT and communicated to all staff via the Intranet, Weekly Bulletin and on IPads for operational staff.

9. IPC Incident Reporting

All IPC incidents are reviewed by the IPCT and any trends are taken to the IPCSG for discussion and actions.

There is still some additional work to be done on reducing needlestick injuries, which was one of the focuses of last year's education/awareness information sent out to all staff.

A full breakdown and totals for the previous two years IPC incidents are shown in Appendix 2.

10. Seasonal Flu

During 2016/17, the management of the annual flu programme was once again managed by the IPCL and local Flu Leads were once again utilised to provided local flu vaccination clinics within each OU, EOC and at 111 Ashford. Flu Leads completed the PowerPoint training and signed the annual PGD before commencing vaccinations and records for vaccinations were sent to the IPCL on a monthly basis. The Trusts final total for the year was 66.9% an improvement of 5.5% on last year.

11. Serious Incidents and Complaints

SECAmb has reported no Serious Incidents or complaints related to IPC during 2016/17.

12. Key Achievements, Risks and Mitigations

The Trust, in order to grow and learn needs to critically examine what has been achieved, take action where goals have not been reached and examine the reasons for this. Achievements include the embedding of IPC standards from Board to the frontline through auditing of staff, vehicles and premises. This benefits staff by raising IPC issues and themes and providing structured feedback. Patients benefit through the staff being well informed of key IPC issues such as hand hygiene and cleanliness and vehicles and equipment being clean and fit for purpose. The organisation is provided with validated assurances which are shared across the Trust.

The second achievement is improvement of communication with the regions NHS Trusts and Public Health England on outbreak notification, enabling the team to communicate to frontline staff in a timely manner. This results in better informed staff, lower risk of transmission of healthcare associated infections and implementation of the correct actions in the interests of staff and patients.

Provision of education to staff through development of good quality, validated training packages and communications is the third key achievement. This has been achieved by means of a communications plan and IPC work plan. Communicating to staff on matters concerning IPC and providing concise, accurate and targeted information is key to the implementation.

As a result of this learning and improvement we have a workforce that has the knowledge, skills and experience to appropriately reduce infection risk for patients and staff thereby improving patient safety and staff well-being. Patient safety has also been improved by the increased level and quality of information sharing and collaboration between different organisations. As a result, the Trust is able to demonstrate compliance with infection prevention and control standards and delivery of key strategic objectives including: 'Delivering high quality, patient focused services' and 'Ensuring a highly skilled, motivated and engaged workforce'.

The key risks from IPC associated issues include staff using equipment or consumables which are out of date or have damaged packaging which is a risk to patients. This situation arises due to the limitations in time available to check equipment. Examples of the most frequently occurring themes are:

- Dust on equipment including suction machines and defibrillators
- Torn or damaged packaging
- Out of date consumables
- Lack of or out of date cleaning materials

In mitigation, the issues are raised at each ICSG meeting and corrected with staff and their managers at the time of audit inspections. Communication briefings have been circulated to all staff on the most frequently occurring problems to raise awareness.

Inappropriate waste and sharps disposal present a risk including inoculation injury which is monitored through the DATIX reporting system. Communications and education have been focused in this area to mitigate the risk. Fleet design has enabled better compliance with waste, while audit and training continue to raise awareness of sharps bin and disposal protocols.

An outline of the IPC Annual Work Programme for 2014/15 is appended to the report to illustrate the priorities for the forthcoming year (Appendix 1).

13. Summary and Conclusion

Patient safety remains a top priority for the Trust and IPC is integral to maintaining this. The Trust has shown its commitment to IPC by the systems and processes implemented during 2016 – 2017. The key achievements over the year continue to be associated with embedding IPC standards firmly from Board to frontline staff as demonstrated by means of a comprehensive communication plan, continued IPC education for all staff and joint working between IPC and Operational staff.

Appendix 1

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Infection Prevention and Control Annual Programme 1 April 2017 to 31st March 2018

Key Objective: to sustain compliance with the Care Quality Commission (CQC) registration criteria against The Health and Social Care Act 2008 (amended 2010)	**Responsible**	**Deadline for completion**	**Assurance / Progress Report / Evidence**
Ensure the Trust maintains compliance with the CQC registration criteria (i.e. The Health and Social Care Act 2008 (amended 2010) including evidential assurance) and provider compliance assessments.	Infection Prevention and Control Lead	Review of PCA compliance and associated evidence twice yearly	Updated PCA self-assessments Monitored via self-assessment of the Hygiene Code (within the IPCAF) with resultant action plan Infection Prevention and Control Sub Group (IPCSG) Monthly Internal Quality Assurance Visits External reviews and inspections
Development of an annual Infection Prevention and Control Assurance Framework (IPCAF) for 2017/18 and successful completion by year end	Infection Prevention and Control Lead	Quarterly	IPCAF reviewed at every IPCSG and reported to the Quality Safety Group (QSG)
Management and achievement of HCAI standards	Infection Prevention and Control Lead	Quarterly	HCAI plan reviewed at every IPCSG and reported to the QSG

To coordinate the Trusts Infection Prevention and Control Sub group	Infection Prevention and Control Lead	Quarterly	Terms of reference, minutes, action log, HCAI plan, IPCAF and associated reports.
Promote clinical ownership of IPC through the Infection Prevention and Control Champions (IPCC) and staff.	Infection Prevention and Control Lead	Training of new IPCC staff for each Operating Unit, EOC's and 111 by the end of Quarter 1. Ongoing monitoring with quarterly reviews	IPCC representation across the Trust is monitored via the IPCSG.
Review and refresh the Trusts Training Needs Analysis for IPC for the 2017/18 annual training programme delivered by Clinical Education team.	Infection Prevention and Control Lead	Q1 2017/18	Revised TNA for IPC included in training programme for all staff
Contribute to the Clinical Education training agenda by preparing validated IPC information to use in all training forums including workbooks and e-learning.	Infection Prevention and Control Lead	As Required	Annual training programme includes evidence based validated IPC elements which are updated as required on request from Clinical Education team.
Seek funding for two full time staff to assist with IPC work throughout the Trust	Infection Prevention and Control Lead	Q1 2017/2018	To ensure all work streams for IPC are effectively managed by seeking funding for two full time staff to assist with training, audit, investigations, support and data analysis.
Development of, and reporting against a suite of KPIs for IPC (to include compliance with clinical best practice issues such as); hand hygiene, cannulation, accidental inoculations, exposure to infections, seasonal flu vaccination, IPC	Infection Prevention and Control Lead	Q1 2017/18	Data monitored at every IPCSG

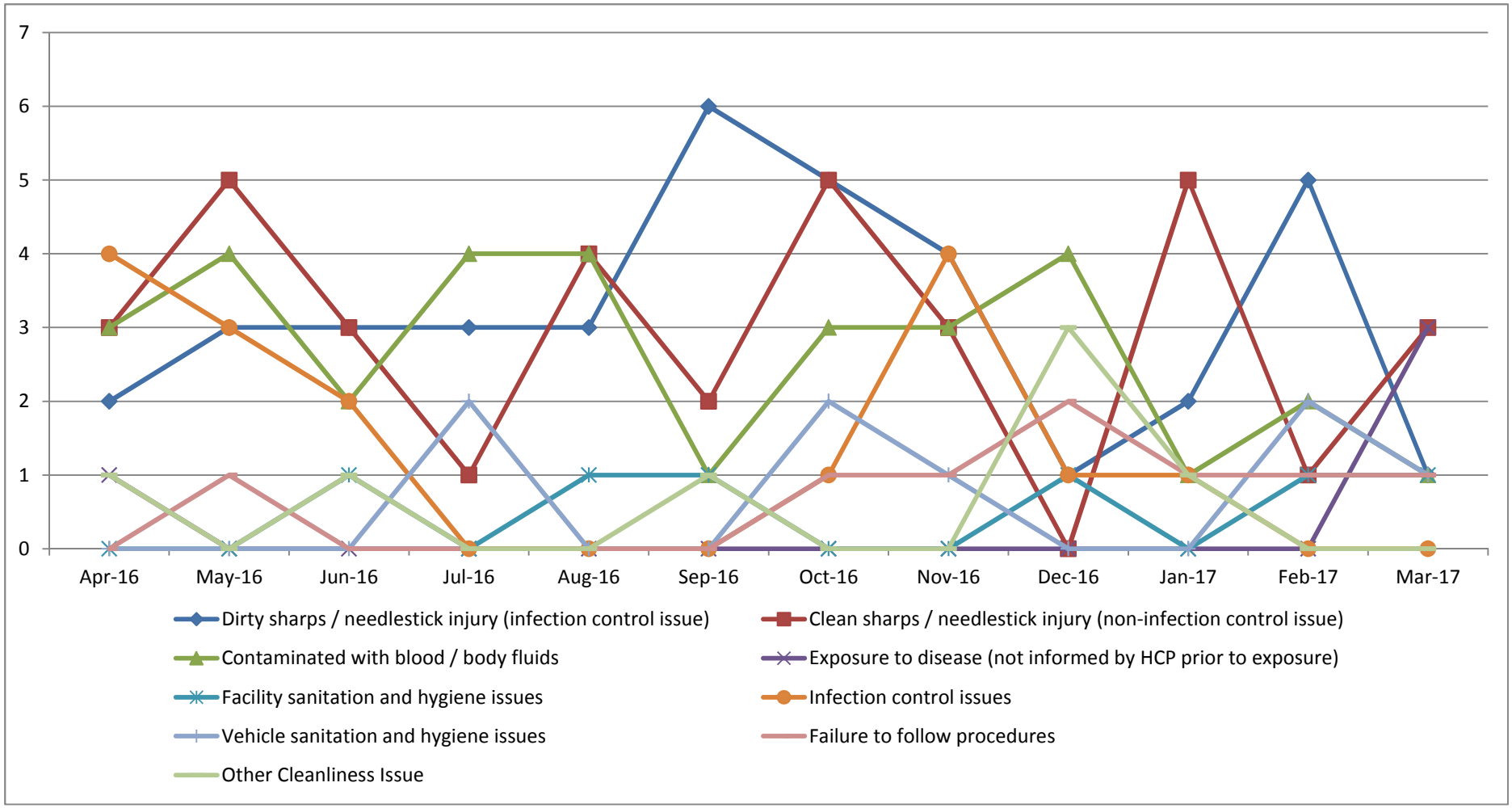
incidents and investigations, environmental cleanliness standards and antimicrobial stewardship programme.			
Regular attendance at Kent, Sussex and Surrey IPC Committees	Infection Prevention and Control Lead	Quarterly	Reported to the IPCSG
Outbreaks effectively tracked, monitored and resolved across organisation.	Infection Prevention and Control Lead	As Required	Reported to the IPCSG
Annual review of IPC Policy and Manual	Infection Prevention and Control Lead	End March 2018	Publication of revised Trust Policy and/or Manual
Production of an Annual IPC Report for 2016/17	Infection Prevention and Control Lead	End June 2017	IPC Annual Report published
Review of quarterly station IPC audits and monthly hand hygiene / Bare Below the Elbow, vehicle and cannulation audit tool kits	Infection Prevention and Control Practitioner	Annual	Reports and action plans to IPCSG
Continued engagement with the National Ambulance IPC Group	Infection Prevention and Control Lead	Quarterly	Reports to IPCSG
To develop and deliver a successful Flu programme for 2017/18	Infection Prevention and Control Lead	Quarterly	Reports to IPCSG

Work with key internal stakeholders and external Quality Assurance Group and the IPCSG to advise and contribute when securing robust contracts for the provision of linen and waste management	Infection Prevention and Control Lead	End March 2018	Monitored via IPCSG.
Provides expertise to inform modelling of vehicle deep cleaning programme and station / environmental cleanliness	Infection Prevention and Control Lead	As required	Monitored via IPCSG.
There is a communications strategy in place to deliver IPC information to SECAmb staff throughout 2017/18	Communications Team / Infection Prevention and Control Lead	Quarter 1 2017 / 2018	Review quarterly at IPCSG meetings
Continue to work with health economy partners to develop effective communications when patients are transferred between healthcare providers and where outbreaks of infections occur in healthcare settings.	Infection Prevention and Control Lead	As required	Monitored at IPCSG meetings quarterly.
Communication with health economy partners to review any HCAI's that have possibly involved SECAmb staff. Including non-compliance with IPC standard universal precautions.	IPC Team	As required	Monitored at IPCSG meetings quarterly.
Work with Clinical Equipment and Consumables Sub Group to identify new products appropriate to delivery of high quality evidence based care in regard to IPC. (Where possible linked to Cost Improvement Plans)	IPC Team	As required, providing IPC view at each CECSG meeting, review quarterly	Clinical Equipment and Consumables Sub CECSG minutes

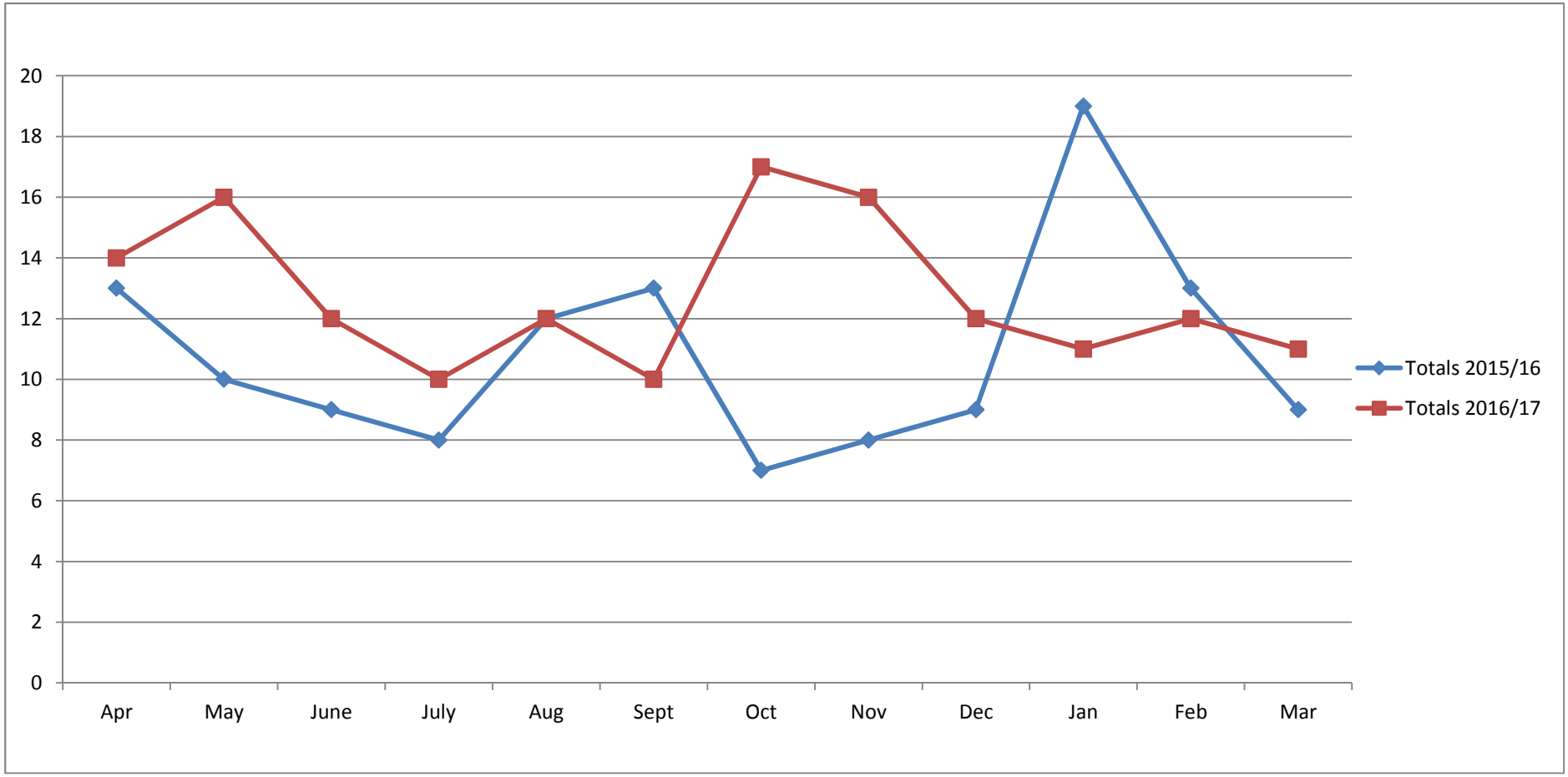
Provide support and specialist advice to Estates Team.	Infection Prevention and Control Lead	As required	Monitored at IPCSG meetings quarterly.
Provide timely and professional advice and support on IPC matters to SECAmb staff where required.	IPC team	Where required	Team log of queries and responses maintained to inform content of future IPC Communications
Provision of specialist advice to SECAmb contract tendering and contract monitoring work, for all third part providers, specifically Occupational Health and third party providers of sub contracted operational work	Infection Prevention and Control Lead	Quarterly	Minutes ICSG meetings which include the OH Clinical Leads updates. Details of reports on sub-contractors to be submitted through ICSG
Oversee the outcomes of the Trust deep cleaning programme	Infection Prevention and Control Lead	Monthly	Monthly reports from contractor on Deep Clean data. Any IPC issues identified to be dealt with as appropriate.

Appendix 2

Breakdown for all types of IPC Incidents – 1st April 2016 / 31st March 2017:



Totals for all IPC Incidents – 1st April 2015 / 31st March 2016 and 1st April 2016 / 31st March 2017:



South East Coast Ambulance Service NHS
NHS Foundation Trust

		Item No	72/17
Name of meeting	Board of Directors		
Date	25 July 2017		
Name of paper	Workforce Race Equality Standard Annual Report		
Executive sponsor	Steve Graham – Director of HR & OD		
Author name and role	Angela Rayner - Inclusion & Wellbeing Manager		
Synopsis (up to 120 words)	This report provides the Board of Directors with information and detail of the Trust's Workforce Race Equality Standard (WRES) submission for 2016. It also includes a copy of a report to the Association of Ambulance Chief Executives 'Strengthening Workforce Race Equality in the Ambulance Sector - Leadership, Approach and Performance'		
Recommendations, decisions or actions sought	The Board is asked to discuss this report		
Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).		**No** If yes and approval or ratification is required, a completed EA Record must be attached.	

South East Coast Ambulance Service NHS Foundation Trust

Trust Board

Workforce Race Equality Standard (WRES)

1. Introduction

1.1. The purpose of this report is to update the Trust Board on the progress achieved in the implementation of the Workforce Race Equality Standard (WRES) which was embedded within the NHS Contract from 2014/15, mandatory for all NHS Trusts.

1.2. It provides the outcomes of the WRES summary which is due for submission to NHS England and Commissioners by 1st August 2017, Appendix 1.

1.3. The Inclusion Working Group (IWG) monitor the overarching action plan which was developed and is updated each year to maintain and deliver progress against the metrics. In particular, the Executive are asked to note the following in the outcomes this year:

1.3.1. The Trust reported an all-White Board in 2016 as only voting members were previously counted. This has been changed for 2017/18 which now looks at Board breakdown by both voting and executive membership. However, in 2017/18 the Trust Board continues to be non-representative of its workforce by both voting membership and executive membership.

1.4. It provides a copy of a report, presented to the Ambulance Association of Chief Executives by Tracy Myhill, CEO Wales Ambulance Service as the Chief Executive lead for Equality and Inclusion. The report 'Strengthening Workforce Race Equality in the Ambulance Sector - Leadership, Approach and Performance' is provided at Appendix 2.

2. Background

2.1. The Workforce Race Equality Standard (WRES) was introduced by the NHS Equality and Diversity Council (EDC) for all NHS Trusts and Clinical Commissioning Groups in April 2015. This was in response to 'The Snowy White Peaks' a report by Roger Kline which provided compelling evidence that barriers, including poor data, are deeply rooted within the culture of the NHS. The report highlights a clear link between workforce diversity of NHS organisations and better patient access, experience, care and outcomes.

2.2. The WRES is a mandatory requirement embedded within the NHS Contract to ensure effective collection, analysis and use of workforce data to address the under-representation of Black Minority Ethnic (BME) staff across the NHS.

2.3. The WRES requires NHS organisations to demonstrate progress against nine indicators specifically focused at Race equality. The nine indicators are shown in more detail in the results of the 2015-16 WRES return, Appendix 1.

2.4. As of the 1 April 2015, the WRES formed part of the standard NHS Contract. From April 2016 it was also included as part of the CQC inspection standards.

The nine indicators cover:

- Four workforce metrics – data provided showing comparison of the experience of Black and Ethnic Minority (BME) employees and candidates
- Four NHS Staff Survey findings – Key Findings 18, 19, 27 and question 23b; all specifically focus on the experience of employees from an Equality and Diversity perspective
- A Board that is broadly representative of the population they serve.

2.5. The WRES has clear links with the Equality Delivery System 2 (EDS2) which also became mandatory for NHS Trusts, including CCG's from April 2015. It also supports the EDS2 goal for representative workforce and the link to inclusive leadership (including the Board) and how organisations are well led and provide support and leadership across their workforce.

3. Summary of Key Findings 2016/17

3.1. The results of the 2017 WRES return detailed in Appendix 1, will be shared with Commissioners as mandated in the contract and published on the Trust website by 1st August 2017.

The key findings of the results are provided below:

3.1.1. There has been an increase in the BME workforce across the Trust with the percentage rising from 2.8% to 3.5%, of the total Workforce.

3.1.2. BME candidates continue to be less likely to be appointed from shortlisting than their White counterparts, however this figure has seen a significant improvement. BME staff in 2015/16 were 3.84 times less likely to be appointed and in 2016/17 this has reduced with BME staff now 1.26 times less likely to be appointed than their White colleagues.

3.1.3. The 2015/16 figures showed a 1.08 likelihood of BME staff being taken through the formal disciplinary process. This fell in 2016/17 to BME staff being 0.82 times more likely to go through the formal disciplinary process than their White counterparts.

3.1.4. BME staff continue to be less likely to undertake non-mandatory training than their White counterparts. The relative likelihood of BME staff accessing non mandatory training and CPD as compared to White staff fell from 1.22 in 2015/16 to 1.36 in 2016/17.

3.1.5. In the last 12 months 59% of BME staff and 62% of White staff experienced harassment, bullying and abuse from members of the public / patients. Both figures have seen an increase which were 39.39% for BME staff and 60.94% for White staff in 2015/16. This equates to an increase of almost 20% for BME staff.

3.1.6. In the last 12 months 44% of BME staff and 39% White staff experienced harassment, bullying and abuse from colleagues. Both figures have seen an increase since 2015/16 with a 14% increase reported by BME staff and 11% increase reported by White staff.

3.1.7. Metric 7 noted a decline in both BME and White staff believing the Trust provides equal opportunities for career progression. In 2015/16 this was 66% for both BME and White staff. In 2016/17 this fell to 48% for BME staff, and 62% for White staff.

3.1.8. There have been increases in both White and BME staff reporting discrimination from a manager/team leader or other colleagues since 2015/16. These were up in 2016/17 from 13.26% to 17.18% for White staff and, 15.63% to 27.27% for BME staff.

3.1.9. The Trust reported an all-White Board in 2015/16 at which time only voting members were could be counted. This has been changed for 2016/17 which now looks at Board breakdown by both voting and executive membership. However, in 2016/17 the Trust Board continues to be non-representative, with voting membership and executive membership all reporting White or undisclosed.

4. Approach

4.1. The IWG monitor and discuss the requirements of the WRES at each meeting, and review progress against an approved action plan to ensure an upward trajectory. Following the most recent IWG meeting on 12 June 2017, based on the recommendations of the WRES Subgroup, the IWG agreed an action plan for the year 2017/18, Appendix 3.

4.2. It is worth noting that the action plan is focussed around three main actions as recommended by the National WRES team. However, there are Trust wide actions on bullying and harassment and culture which are expected to deliver further progress on this agenda. The Inclusion and Wellbeing Manager is part of the steering group overseeing this work.

4.3. In addition, the Trust Equality Objective ‘The Trust will improve the diversity of the workforce to make it more representative of the population we serve’ is supported by an action plan which will also contribute to achieving progress. This is also monitored and reviewed at IWG meetings, with regular reports to go to the HR Group.

5. National Ambulance Diversity Forum (NADF)

5.1. The NADF is working in conjunction with the NHS England WRES Team on an ambulance specific WRES Project, initiated and led by Tracy Myhill.

5.2. The report provided in Appendix 2 proposes a suite of WRES interventions and outlines work that will seek to identify good practice to address some of the key areas for WRES development within the sector. It is anticipated that via AACE, all Ambulance Trusts will sign up to, and commit resources to supporting the delivery of agreed interventions within their Trust. These interventions have already been considered and are achievable through delivery of the various work streams and action plans outlined above.

5.3. There are several proposed interventions provided in Annex A of the report that focus on Trust leadership and governance arrangements and in particular the 'Board-level leadership and ownership' as outlined under the heading 'Leadership and Engagement Strategy'.

6. Recommendation

6.1. The Board is asked to discuss and note this report.

Prepared by: Angela Rayner, Inclusion Manager

Presented by: Steve Graham, Interim Director of HR & OD

	Appendix 1		2015-16	2016 - 17
	Workforce Race Equality Standard Data Report		Headcount	Headcount
1	Staff in each of the AfC bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce	1a) Non-Clinical Workforce (White)	967	1084
		1b) Non-Clinical Workforce (BME)	47	65
		1c) Non-Clinical Workforce (Not stated /Null)		58
		1d) Clinical Workforce (white)	2295	2128
		1e) Clinical Workforce (BME)	52	56
		1f) Non-Clinical Workforce (Not stated /Null)		92
2	Relative likelihood of staff being appointed from shortlisting across all posts	No. of shortlisted applicants (White)	2108	4089
		No. of shortlisted applicants (BME)	289	493
		No. of shortlisted applicants (unknown /Null)	36	80
		No appointed from shortlisting (White)	112	386
		No appointed from shortlisting (BME)	4	37
		No appointed from shortlisting (unknown /Null)	6	10
		Relative likelihood of White staff being appointed from shortlisting compared to BME staff	**3.84**	**1.26**
3	Relative likelihood of	Number of staff in workforce (white)	3285	3212

	staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. Note. This indicator will be based on data from a two year rolling average of the current year and the previous year	Number of staff in workforce (BME)	100	94
		Number of staff in workforce (unknown / NULL))	173	150
		Number of staff entering the formal disciplinary process (White)	152	129
		Number of staff entering the formal disciplinary process (BME)	5	5
		Number of staff entering the formal disciplinary process (not stated / NULL)		3
		The relative likelihood of BME staff entering the formal disciplinary process compared to White staff	**1.08**	**0.82**
4	Relative likelihood of staff accessing non-mandatory training and CPD	Number of staff accessing non-mandatory training & CPD (White)	2177	1874
		Number of staff accessing non-mandatory training & CPD (BME)	54	52
		Number of staff accessing non-mandatory training & CPD (Unknown / Null)		74
		Relative likelihood of White staff accessing non-mandatory	**1.22**	**1.36**

		training and CPD compared to BME staff		
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	% White staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**60.94%**	**62.22%**
		% BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**39.39%**	**58.82%**
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	% White staff experiencing harassment, bullying or abuse from staff in the last 12 months	**32.16%**	**39.48%**
		% BME staff experiencing harassment, bullying or abuse from staff in the last 12 months	**27.27%**	**44.12%**
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion	% White staff believing that trust provides equal opportunities for career progression or promotion	**66.45%**	**62.73%**
		% BME staff believing that trust provides equal opportunities for career progression or promotion	**66.67%**	**48.00%**

8	Q17. In the last 12 months have you personally experienced discrimination at work from an b) Manager/team leader or other colleagues of the following?	% White staff personally experienced discrimination at work from Manager/team leader or other colleagues	**13.26%**			**17.18%**		
		%BME staff personally experienced discrimination at work from Manager/team leader or other colleagues	**15.63%**			**27.27%**		
9	Percentage difference between the organisations' Board membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board Note: this is an amended version of the previous definition of Indicator 9		White	BME	Unknown / Null	White	BME	Unknown / Null
		Total board members - % by Ethnicity	66.70%	6.70%	26.70%	69.20%	0.00%	30.80%
		Voting Board Members - % by Ethnicity	71.40%	0.00%	28.60%	75.00%	0.00%	25.00%
		Non - Voting Board members - % by Ethnicity	0.00%	100.00%	0.00%	0.00%	0.00%	100.00%
		Executive Board members - % by Ethnicity	57.10%	14.30%	28.60%	66.70%	0.00%	33.30%
		Non-Executive Board Members - % by Ethnicity	75.00%	0.00%	25.00%	71.40%	0.00%	28.60%
		Overall Workforce - % by Ethnicity	92.30%	2.80%	4.90%	92.20%	0.00%	4.30%
		Difference (Total Board - Overall Workforce)	**-25.70%**	**3.90%**	**21.80%**	**-23.00%**	**3.50%**	**26.50%**

Appendix 2 – Report to the Association of Ambulance Chief Executives

Strengthening Workforce Race Equality in the Ambulance Sector - Leadership, Approach and Performance

Background

Research and evidence strongly suggest that less favourable treatment of Black and Ethnic Minority (BME) staff in the NHS, through poorer experience or opportunities, has significant impact on the efficient and effective running of the NHS, and adversely impacts the quality of care received by all patients.

We know that across the NHS in England, there is significant variation by Trust type in the treatment and workplace experiences of BME staff.[1] Data and evidence indicates that this, together with employing and retaining a workforce that is reflective of the communities served, are challenges of particular importance to the ambulance sector. [2]

In 2015, the Workforce Race Equality Standard (WRES) was introduced to prompt inquiry and to better understand why it is that BME staff often receive much poorer treatment than White staff in the workplace and to facilitate the closing of those gaps. Following the presentation from Yvonne Coghill and Byron Currie (NHS England WRES Team) to the AACE on 19 July 2016, a national ambulance sector WRES Project has been initiated.

Supported by the national WRES Team, the project is led by Tracy Myhill, CEO Wales Ambulance Service/Lead Chief Executive to the AACE for Equality and Inclusion. To date, the following ambulance sector and HEE staff members have contributed towards this project.

- Kez Hayat – Head of Diversity and Inclusion – Yorkshire Ambulance Service
- Ludlow Johnson – Equality and Delivery Manager – South Central Ambulance Service
- Ricky Lawrence – Chair, BME National Staff Network
- Harminder Bains – Education Transformation Manager – HEE Midlands and East

It is anticipated that further staff from sector will join the project with regard to particular 'task and finish' pieces of work.

Underpinning this project is the notion that concerted attention is required towards understanding and adopting the conditions to help make continuous improvements on this agenda. Each sector within the NHS has unique challenges, and each organisation within the sector having its own unique culture and ways of doing things. With this in mind, it is important that interventions are co-produced with the sector and their implementation tailored to suit local organisations.

Consultation

For consultation and engagement purposes, earlier iterations of this paper have been discussed at the National Diversity Forum Annual meeting and also at the sector HRD network during October 2016. Several key comments received via the consultation process have been integrated into this paper.

[1] West, M; Dawson, J. & Kaur, M. (2015) Making the difference: Diversity and inclusion in the NHS. The King's Fund.
[2] NHS Equality and Diversity Council (2016) NHS Workforce Race Equality Standard: 2015 Data Analysis Report for NHS Trusts.

Remit of the Project

Drawing upon organisation's WRES data and associated action plans, the remit of the project is to co-produce a suite of WRES interventions and identify good practices and processes that can initiate continuous improvement on the workforce race equality agenda across the ambulance sector.

There are several proposed interventions that focus on Trust leadership and governance arrangements. These will be set out in the first instance, followed by specific proposed interventions relating to the prioritised WRES indicators; thus helping to embed and mainstream replicable good practices and processes on the workforce race equality agenda across the ambulance sector.

Leadership and Engagement Strategy

Board leadership should include ensuring that the Chief Executive or another senior Board member leads on the workforce race equality agenda within the organisation, and that the Board regularly and openly reviews its progress or otherwise. Senior leadership accountability for improving race equality should include establishing clear corporate objectives; linking them to organisational values, strategic objectives and individual performance reviews and, where appropriate, reward.

Whilst equality specialists have an important advisory and facilitative role to play, it is senior management whose role is crucial. Board-level leadership and ownership on this agenda, allied with shared ownership across the organisation, is essential to meet contractual and legal requirements, expectations of regulators, the aspirations of staff and the best interests of patients and communities alike.

Leaders at every level need to understand why race equality, and diversity and inclusion in general, is critical. Leaders are encouraged to create a narrative specific to their own organisation and take responsibility for ensuring that middle managers in particular understand that narrative. Leaders should engage with all staff (and BME
staff in particular), staff networks and with local staff-side organisations to help ensure all staff understand the narrative and the approaches being undertaken.

It is proposed that Trust's tailor and implement a nationally agreed template detailing a leadership and communications strategy (with the capacity to insert local elements) wherein all sector Trusts will have an agreed approach to communicating WRES principles and benefits to staff and stakeholders. It is proposed that the project team work with several OD and Communications teams throughout the ambulance sector in developing the detail relating to this strategy.

Management and Support to Local and National BME Staff Network Fora

Staff within the ambulance sector that have local and national positions within BME Staff Networks often struggle to be granted facilitation time to undertake their responsibilities within these networks. It is proposed that Trusts continuously demonstrate their commitment to race equality by supporting staff to fully contribute and attend network meetings, as robust and active BME networks are an excellent way of enhancing staff engagement and involvement. Such involvement is likely to enhance transparency on decision making and play a key role in valuing and empowering staff.

It is proposed that a review of local BME staff networks' Terms of Reference be undertaken to ensure that they are empowered and valued by Trusts, and hardwired into organisational governance arrangements, via Trust Committees or the Board. BME Staff Networks are a key stakeholder for organisational consultation and staff involvement. For example, BME Staff

Networks could be consulted with as a matter of course on issues such as organisational change plans and policy development.

The working group prioritised four WRES indicators for concerted focus, against which the proposed interventions seek to continuously improve organisational, and sector-wide, performance in these areas. These priority areas were identified and agreed, through the undertaking of a detailed analysis of the sector's current WRES performance. It is essential that interventions are developed with the sector in the spirit of co-production. The proposed areas for intervention development are outlined in Annex A.

Benefits to the Sector

There are a wide range of benefits to the sector in implementing interventions that help to improve performance on the workforce race equality agenda, including implementation of the WRES. Several of the key ones are listed below.

1. Improving patient outcomes and patient satisfaction, through increased staff engagement and involvement.

2. Improved sector performance against the mandated WRES indicators, leading to the ambulance service becoming the beacon sector within the NHS for delivery against the WRES.

3. Helping organisational responses to specific legal and regulatory compliance and duties.

4. More effective and efficient use of human and financial resources (e.g. less sickness absence, less agency staffing costs, a reduced number disciplinaries, grievances, employment tribunals, performance reviews).

5. The ambulance sector has a great opportunity to be the lead sector within the NHS on WRES performance in forthcoming years.

6. Enhances the reputation of the ambulance service as an equal opportunities employer with BME communities throughout the country.

Recommendation
It is recommended that the AACE consider the proposals set out within this paper, and provide direction for the co-production of interventions and subsequent implementation, both across the sector and within member trusts.

Annex A

WRES Indicator 1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. (Note: Organisations should undertake this calculation separately for non-clinical and for clinical staff)

WRES Indicator 2. Relative likelihood of staff being appointed from shortlisting across all posts

Proposed Interventions

Recruitment and Selection and promotion

The low levels of recruitment of people from BME communities into the ambulance sector is a known and long-term challenge. This issue was initially reported to the ambulance sector within the 2004 University of Central England Report – Improving the Representation of BME Staff within the Ambulance Service, and 10 years later it was also commented upon within the Snowy White Peaks of the NHS report.

Ambulance staff, generally, do not report favourably within the national NHS Staff Survey (WRES indicator 7) regarding equal opportunities for career progression and promotion. The challenge seems to be three fold:

- Recruitment is unrepresentative and (consciously or unconsciously) sifts out BME staff in ways that require scrutiny
- Interview processes impact unfavourably on BME shortlisted candidates
- The same processes are believed to be unfair at promotion level which may reflect both on development opportunities and encouragement, and the interview process itself.

It is acknowledged that the proposals set out within points 2, 4, 6 and 11 below will bear cost implications that will vary between Trusts. For most of the interventions, the cost is likely to be minimal; indeed, it is considered that the benefits of implementing the proposals within this paper significantly outweigh any potential financial costs.

1. Trusts are to review internal recruitment and selection policies to ensure that recruitment processes are fully diversity managed. This review and improvement to systems should include:

    a. Assurance that all job roles are developed and recruited to in-line with organisational policy and best practice.
    b. Equitable provision of non-mandatory development opportunities to help level the playing field drawing for BME staff, bearing in mind the evidence that opportunities such as secondment, acting up, shadowing and leading projects are key enablers for career progression and development.
    c. Consideration on how and where the job is advertised. Do adverts include relevant positive messages about commitment to having a diverse workforce?
    d. Consideration on how applications are shortlisted, including any screening tests/assessment centres used.
    e. Assessment of psychometric/online tests risks, to ensure that they are not discriminatory. Employers should reconsider using such tests as a pre-screening part of the process and as a part of the selection process, post shortlisting.
    f. Consideration of how references are written and evaluated.
    g. Focus on the structure that interview processes take, their components including what questions are asked, and who is on the panel.
    h. Reflection on how decisions are taken after the interview process.
    i. Focus on the way in which new staff are welcomed into the workplace, their induction process, support, encouragement, and opportunities they are given.
    j. Assurance that all members of the recruitment panel are trained on recruitment and selection with a key focus on equality and diversity as part of this training.

2. Develop internal accreditations for managers to be selection/interview panel members. This accreditation will include training on the Equality Act 2010, and its relevance to fair recruitment and selection management and implementation. The intention is that organisations will set future targets that will ensure that all staff who are responsible for taking part in recruitment panels will be appropriately trained, and have the local accreditation to do so.

3. It is proposed that Trusts promote and articulate their desire to have fully diverse boards when recruiting to director vacancies, and clearly include this requirement when commissioning recruitment consultancies, and also include such statements in the text of any adverts.

4. Ambulance Trust Boards should set stretch targets for the percentage of BME staff in the workforce, and until such time the target is reached, BME applicants who meet the minimum standard for shortlisting are to be guaranteed an interview. This action is lawful under the Equality Act 2010, and would encourage people from BME backgrounds to help them overcome disadvantages in competing with other applicants. The 2015 WRES data report that, for 8 of the ambulance sector Trusts, clear evidence indicates a consistent level of disadvantage in the conversion rate of BME shortlisted applicants into firm job offers.

5. Revise recruitment packs to include a document so that post interview the Chair of the panel sets out the reason why any BME shortlisted candidate has not been selected for appointment. The data gathered from interview panel outcomes are to be reported to the Board each quarter. It may be necessary to implement directorate or corporate positive action programmes in line with current legislation if recruitment performance does not improve such that the workforce does not steadily move towards being representative of the local population.

6. Trust boards to receive quarterly updates on workforce race equality as per the WRES data and its associated annual reporting template.

7. Trusts to sponsor quarterly recruitment fairs targeting BME communities in collaboration with HEI's delivering Paramedic Education (follow or adapt the highly successful YAS model), in order to increase the potential of the sector's workforce demographic being more reflective of the communities it serves.

8. Draw upon expertise from BME networks to be included on recruitment panels where possible and appropriate.

9. Ambulance Trusts to work with HEI's and HEE widening participation agenda to promote career opportunities within Trusts to a wider diverse learner base. (follow or adapt the East Midlands Model) http://www.emascareers.com/

10. Be aware of, and work with, HEE as a pilot site for the Pre-Paramedic experience to encourage positive action in attracting diverse groups to access these opportunities.

11. Ambulance Trusts to intervene with relevant universities regarding their recruitment practices to increase the likelihood that the intakes on paramedic courses are more racially diverse.

12. Trusts that serve communities that consist of 10% BME populations should develop cadet schemes as a further potential point of entry into the sector, with caveats to ensure that they are community based and reflective of the local population.

WRES Indicator 5 – Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

The 2015 NHS Annual Staff Survey evidences that the Ambulance sector is the worst performing sector against this WRES Indicator with 45% of survey respondents experiencing such behaviours during the last 12 months. The next worst performing sector is the Mental Health/Learning Disability Trusts at 32%. The NHS average is 29%.

Proposed Interventions
It is considered necessary to engage with established sector BME networks in the development and rollout of the proposed interventions below.

1. Chief Executives and Boards should aim to re-affirm zero tolerance of abuse, bullying and harassment from patients, relatives and the public (linked to Communications Strategy below).

2. As a policy, Trusts should commission NHS Protect, where relevant, to carry out work to prosecute members of the public who do not comply with the organisational position on this matter. Prosecutions are not to be the responsibility of the staff member.

WRES Indicator 6 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
The 2015 NHS Annual Staff Survey evidences that the Ambulance sector is the worst performing sector against this WRES Indicator with 29% of survey respondents experiencing such behaviours during the last 12 months. The next worst performing sector is the Acute sector at 26%. The NHS Trust average 24%.

Proposed Interventions

1. Chief Executives and Boards are to re-affirm zero tolerance of abuse, bullying and harassment from staff (linked to Communications Strategy below). It is advisable to link communications around this to organisational values. Increased focus is required on reviewing existing policies and procedures on bullying and harassment. Increased focus is required on informal conflict resolution and attention on monitoring and reporting of incidents of bullying and harassment so that patterns and trends can be identified and reported.

2. Develop an Ambulance wide campaign on Dignity and Respect; this has to be a high level campaign in a positive light.

3. Where there is a case to answer, staff will be disciplined through agreed local procedures.

Further Reading

1. NHS England Equality and Diversity Council – NHS Workforce Race Equality Standard: 2015 Data Analysis Report for NHS Trusts
2. University of Central England - Improving the Representation of BME Staff within the Ambulance Services, Summary of Final Report. (Professor Notter, Joy et al. 2004.)
3. Middlesex University London - The “snowy white peaks” of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England. (Kline, Roger. 2014.)

4. Review by Baroness McGregor-Smith on the Issues Faced by Businesses in Developing Black and Minority Ethnic Talent – WRES Team Submission 2016
5. NHS England WRES IT – Workforce Race Equality Standard Report for the Ambulance Sector 2015

Appendix 3 - Workforce Race Equality Standards Action Plan 2017-18

	Proposed action	Sub-actions	Action owner
1	Increase the number of applications and appointments from BME candidates.	Encourage applications from underrepresented groups ensuring information is included in job adverts to specifically encourage applications from underrepresented groups.	Clare Irving
		Apply for funding for a Community Development Worker who will work with external stakeholders to increase applications from BME candidates	Clare Irving
		Undertake a sampling exercise of BME shortlisted candidates who were not appointed to enable identification of reasons for data variance and address any areas of poor practice. This is too include those applications not going via NHS jobs.	Clare Irving
		Undertake detailed data analysis to identify any specific directorates, departments, job roles and pay bands where BME staff are more or less likely to be appointed from shortlisting than white applicants. Use this information as the basis for further action planning	Clare Irving
		Investigate the funding for specific BME places on student paramedic courses	Neil Monery
2	Engage with BME staff to increase participation in programmes designed to		Steve Singer

	create a level playing field for BME staff, providing coaching and mentoring to give those with talent and potential the opportunity to move into senior leadership roles		
3	Ensure that individuals involved in the interviewing of NED's have the agreed SECAmb recruitment, interview & selection training.		Peter Lee / Izzy Allen

SECAMB Board

QPS Escalation report to the Board

Date of meeting	20 July 2017
Overview of issues/areas covered at the meeting:	This meeting considered: ***Management Responses*** *(response to previous items scrutinised by the committee)* - **Duty of Candour –** Although the committee noted that we aren't yet fully compliant with the duty of candour, in particular with regards incidents of moderate harm, it was **assured** that we have the infrastructure which will help to ensure compliance. The committee will continue to monitor compliance levels and escalate any concerns to the Board. - **Mobile Data Terminal** - The committee was **not assured** with the current action plan as it needs to be revised to ensure appropriate priority, and clarity about which of the recommendations from the review we can implement. The committee asked management to bring back the revised plan to the meeting 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 acknowledged the current gaps in the clinical audit team and the impact of this on progressing clinical audit. It was pleased to hear that an interim appointment to the head of department has been made and that the interviews for a clinical audit lead are scheduled for the end of July. The annual plan was considered against this background and some comfort was received by the plan, which will be prioritised appropriately with sufficient flexibility to respond to any emerging issues. **Quality Impact of Cost Improvement Programme (CIP) - Assured** The committee was assured with the process and governance underpinning the quality impact assessments relating to the CIP. It noted that four CIP schemes were rejected due to the assessed impact on quality. It also explored the low number of full QIAs and asked management to look at this to assure itself that there has been sufficient rigour. **Hear & Treat** - **Assured** There was a full discussion about hear and treat, in particular in relation to patient safety. The committee asked for a scrutiny paper in December to check the progress and to seek assurance that we continue to implement this safely. **Q1 Quality & Patient Safety Report** The committee reviewed this report in detail highlighting the following; - a need to understand the plan to clear the backlog of incidents which the committee will review in September. - A need for an 'action tracker' to assure itself that actions arising from serious incident are implemented in a timely way; this will be included in future reports - Infection Prevention and Control audit compliance was low in Q1; the committee will track this to establish any trend. - Data on mental health patients was welcomed by the committee. There was a good discussion about this and a need to collect data for children detained under s.136 of the

	MHA. The committee asked for a scrutiny paper in November on our approach to transporting patients with mental health problems.
Reports *not* received as per the annual work plan and action required	None
Changes to significant risk profile of the trust identified and actions required	**None**
Weaknesses in the design or effectiveness of the system of internal control identified and action required	Clinical Audit remains a concern but the committee acknowledges the steps being taken by management to ensure deliver of the annual plan, as outlined above. The committee will monitor progress with the plan as part of the quarterly report.
Any other matters the Committee wishes to escalate to the Board	The committee received a verbal update on medicines management and was assured by the progress being made. It will consider the medicines optimisation plan in September and was assured that this has weekly executive oversight. Finally, the committee acknowledged the continued improvement in the papers, which members felt reflected a sense of greater management control.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Finance & Investment Committee

Date of meeting	18th July 2017
Overview of issues/areas covered at the meeting:	1. Q2 financial and operating performance 2. Operational Productivity measures 3. CCG contracting 4. CAD go live 5. IT Cyber Controls 6. Financing for vehicle acquisitions 7. Reference costs 8. Lessons learned from Datix Project
Reports *not* received as per the annual work plan and action required	Linkage of Finances and Operational Performance with Key Clinical indicators.
Changes to significant risk profile of the trust identified and actions required	⁾ (-) Lack of agreed funding from CCGs ⁾ (+) CAD implementation on track and being well managed.
Weaknesses in the design or effectiveness of the system of internal control identified and action required	⁾ Weakness in the management structure manifested in 1. Close out of the PTS Contract 2. Implementation of the Datix upgrade
Any other matters the Committee wishes to escalate to the Board	1. Deteriorating operating performance. 2. Lack of resolution to the ongoing contracting discussion and under funding of the Trust.