D – Integrated Performance Report

Executive Summary

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

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

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

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

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

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1. SECAMB Regulation Statistics

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

2. Workforce

2.1. Workforce Balanced Scorecard

Workforce Commentary :- Data from Apr 2017

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

2.2. Workforce Commentary

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

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

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

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

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

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

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

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

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

2.3. Workforce Charts

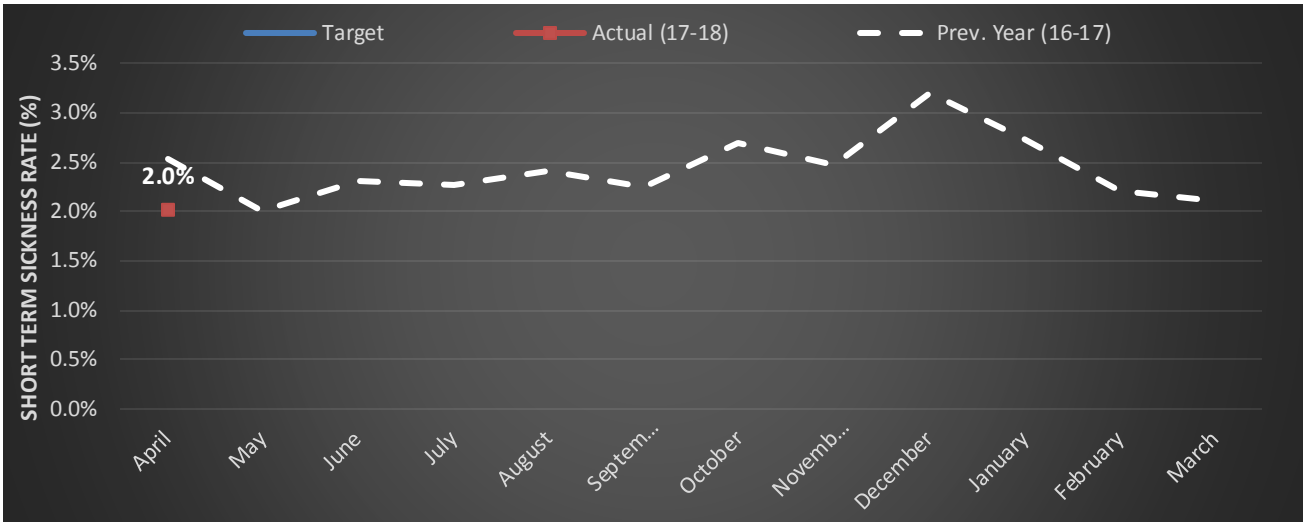

Figure Wf-1A - Short Term Sickness Rate

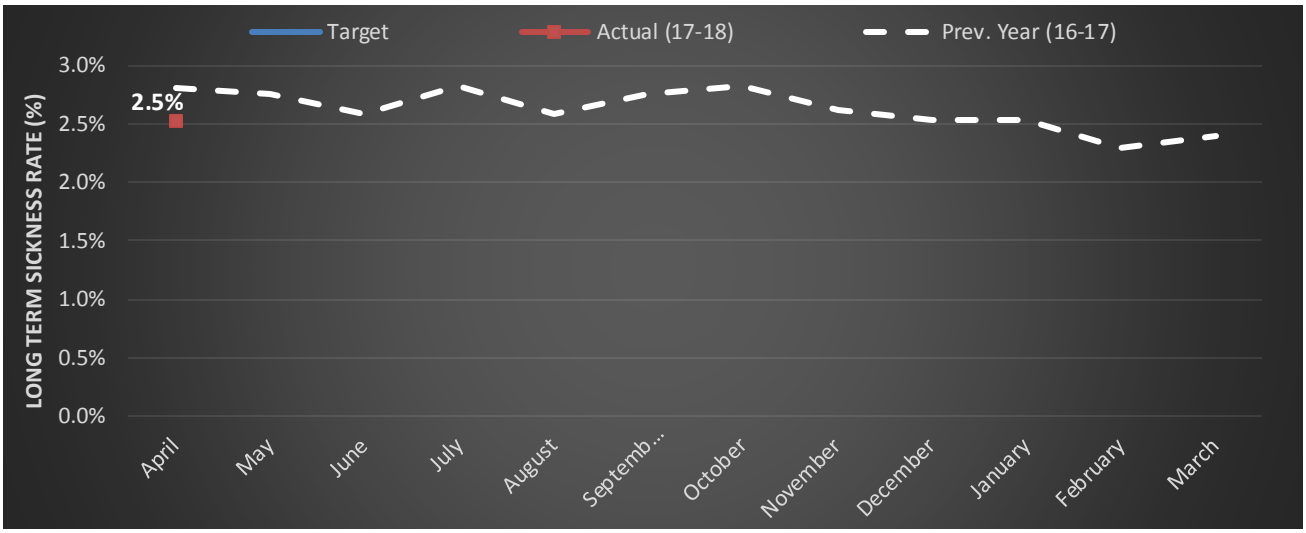

Figure Wf-1B - Long Term Sickness – Rate

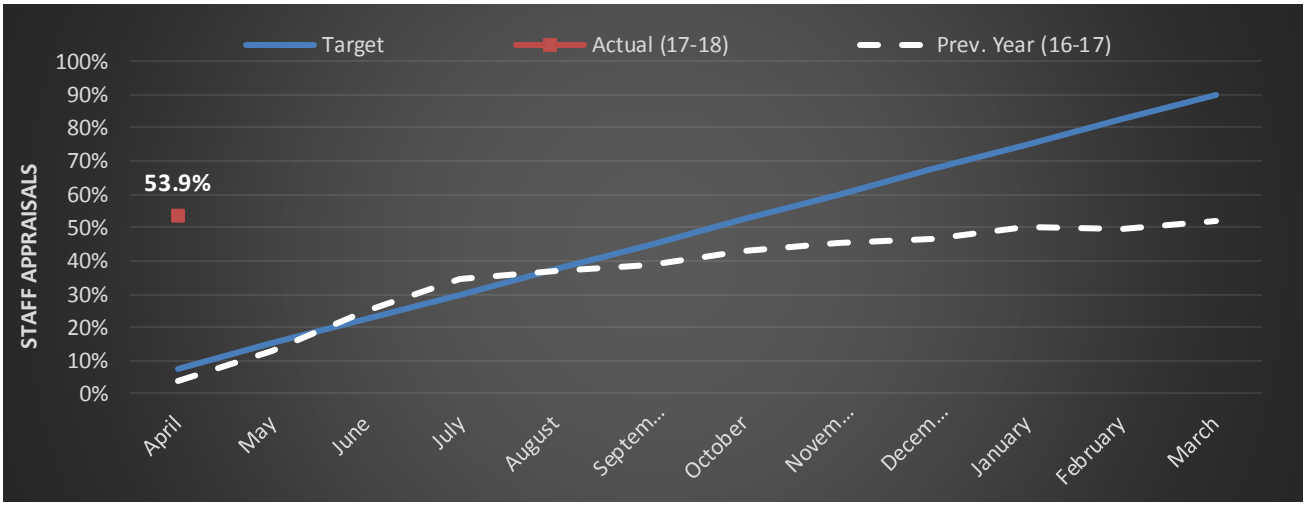

Figure Wf-2 - Staff Appraisals

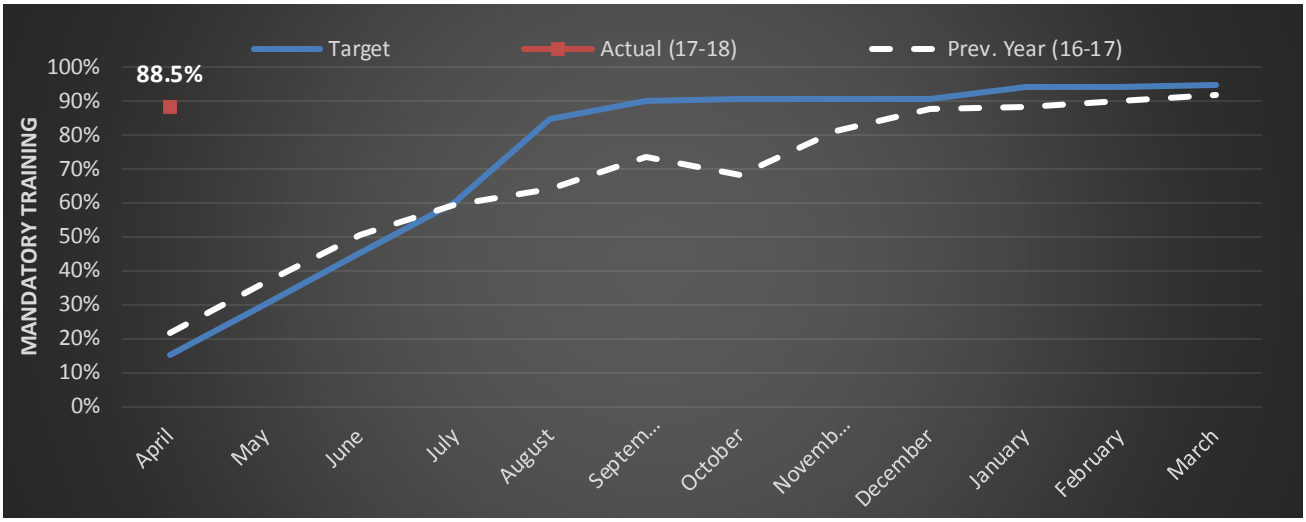

Figure Wf-3 - Mandatory Training Compliance (All Courses)

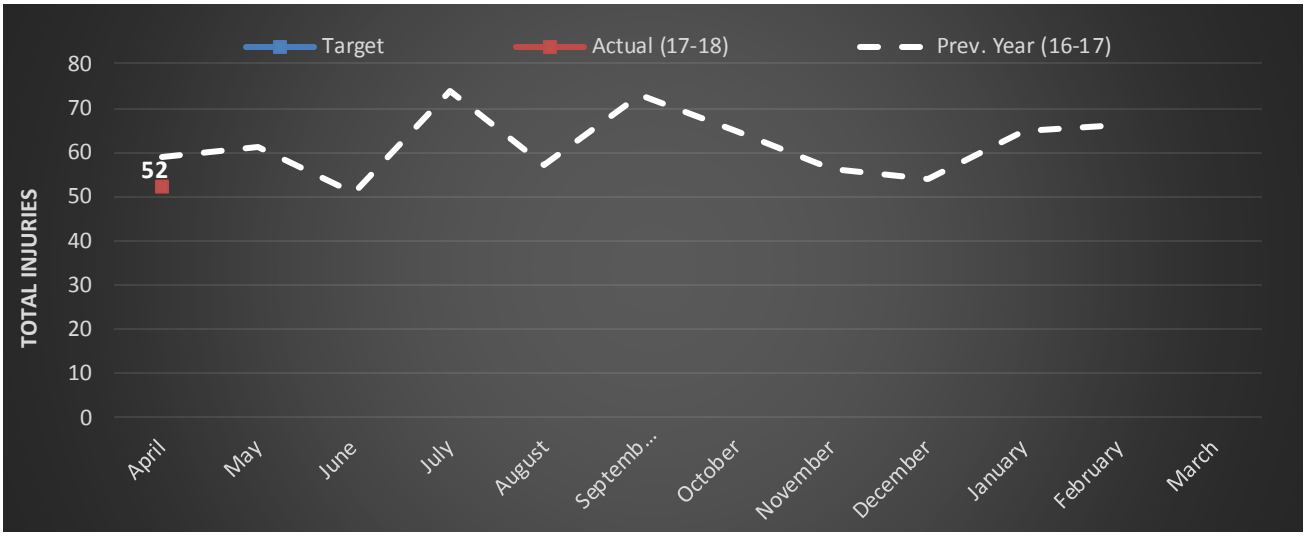

Figure Wf-4 - Total injuries.

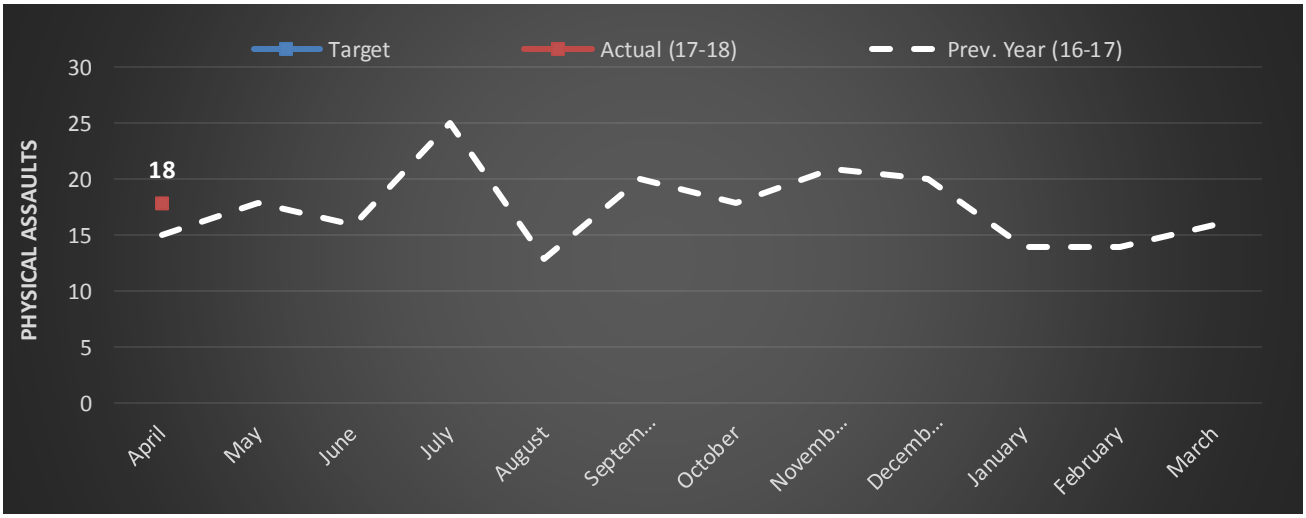

Figure Wf-5 - Total physical assaults.

Unavailable

Figure Wf-6 - Vacancies (Total WTE)

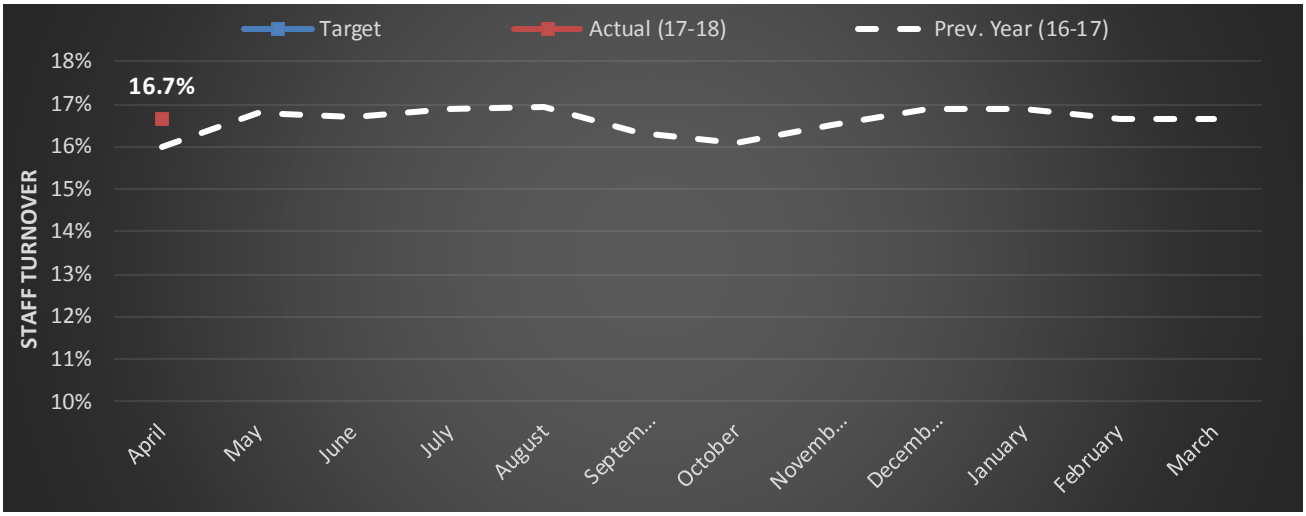

Figure Wf-7 - Annual Rolling Staff Turnover

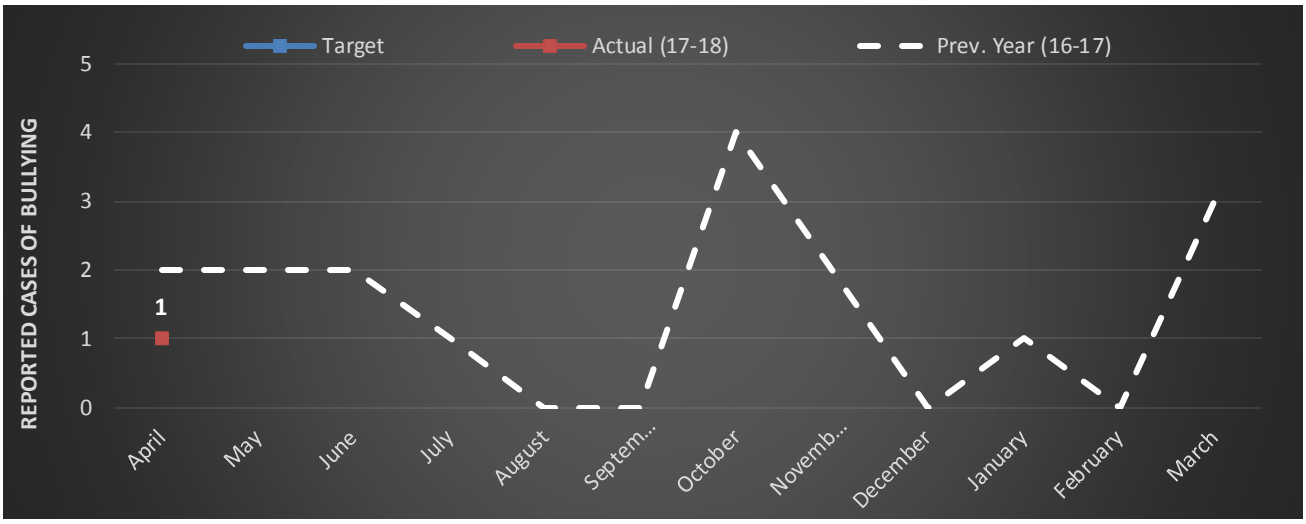

Figure Wf-8 - Reported Bullying & Harassment Cases

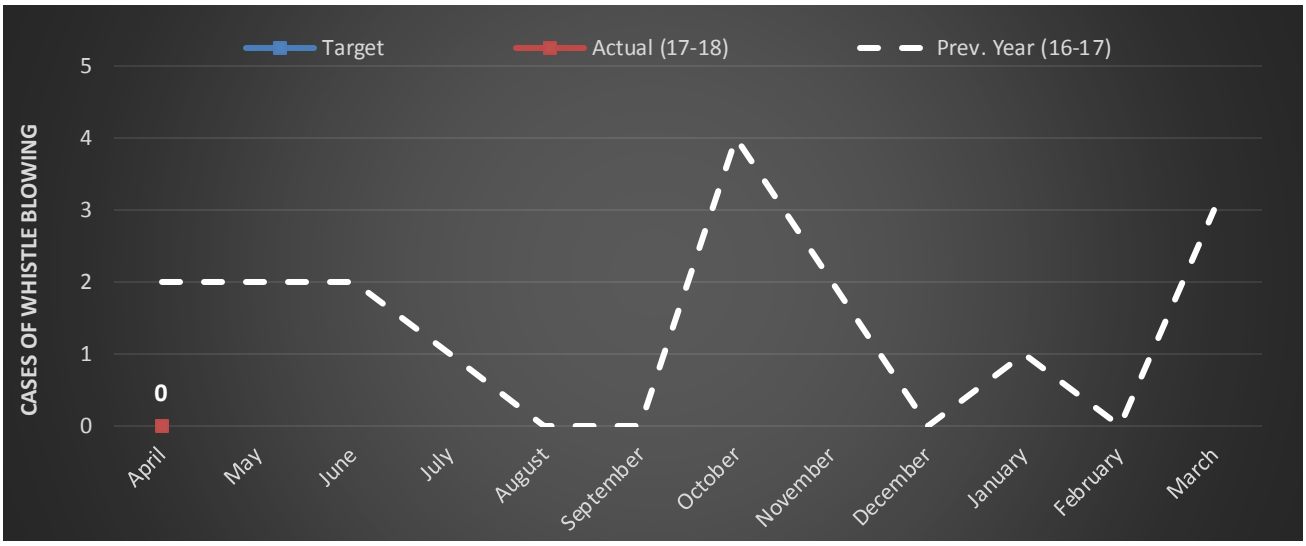

Figure Wf-9 - Cases of Whistle Blowing

3. Operational Performance

3.1. Operational Performance Summary

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

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

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

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

3.2. Operational Performance Scorecard

Operational Performance Scorecard:- Data From April 2017

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

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

3.3. Operational Performance Commentary

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

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

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

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

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

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

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

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

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

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

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

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

3.4. Operational Performance Charts

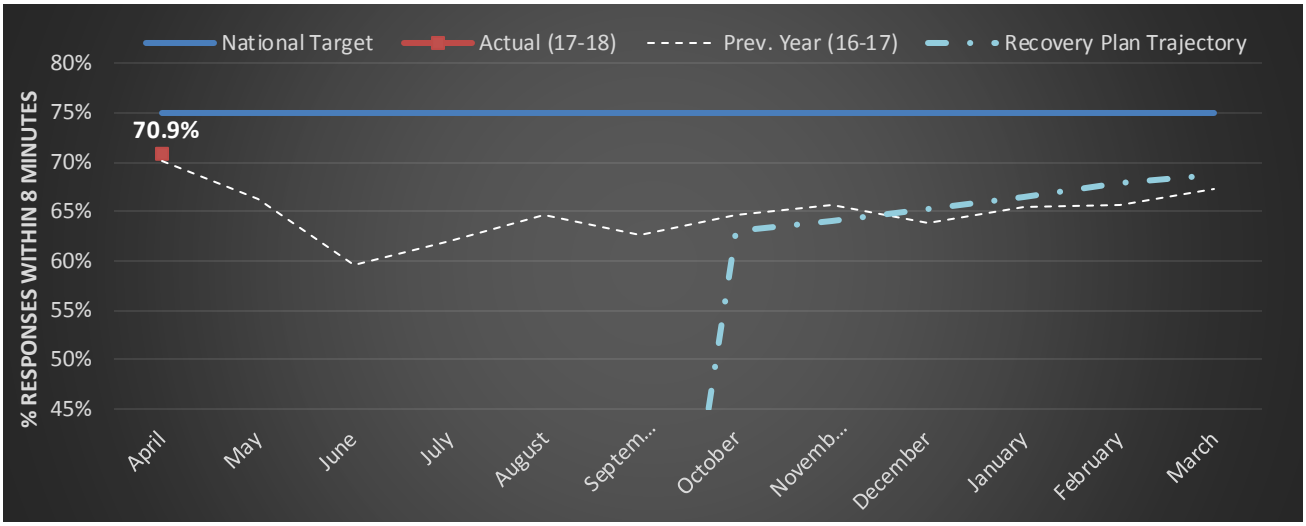

Figure.999-1 - Red 1 response <8 min

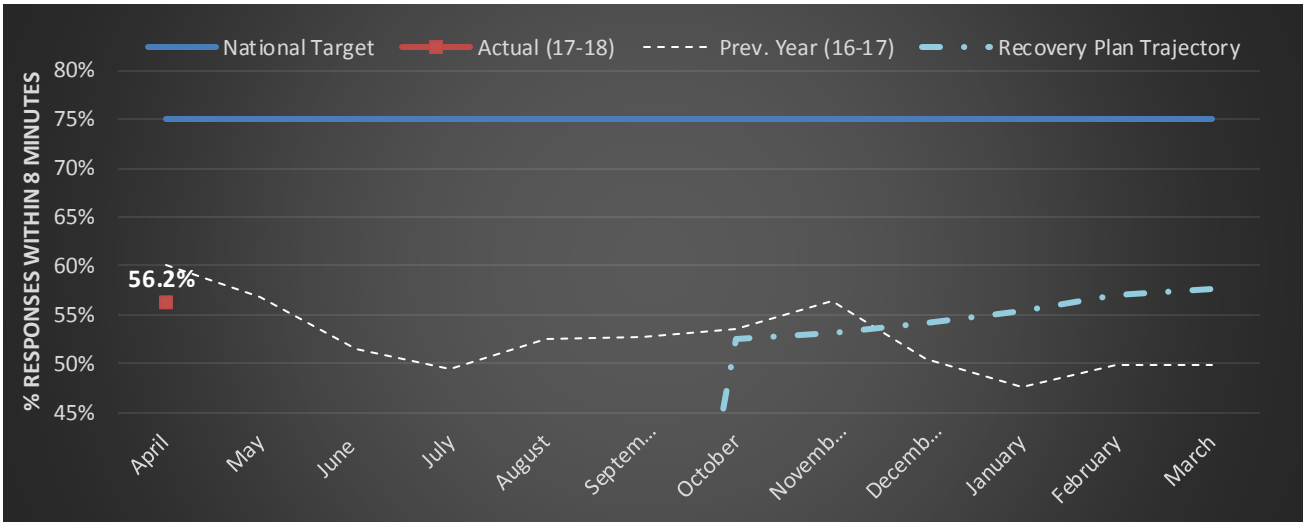

Figure.999-2 - Red 2 response <8 min

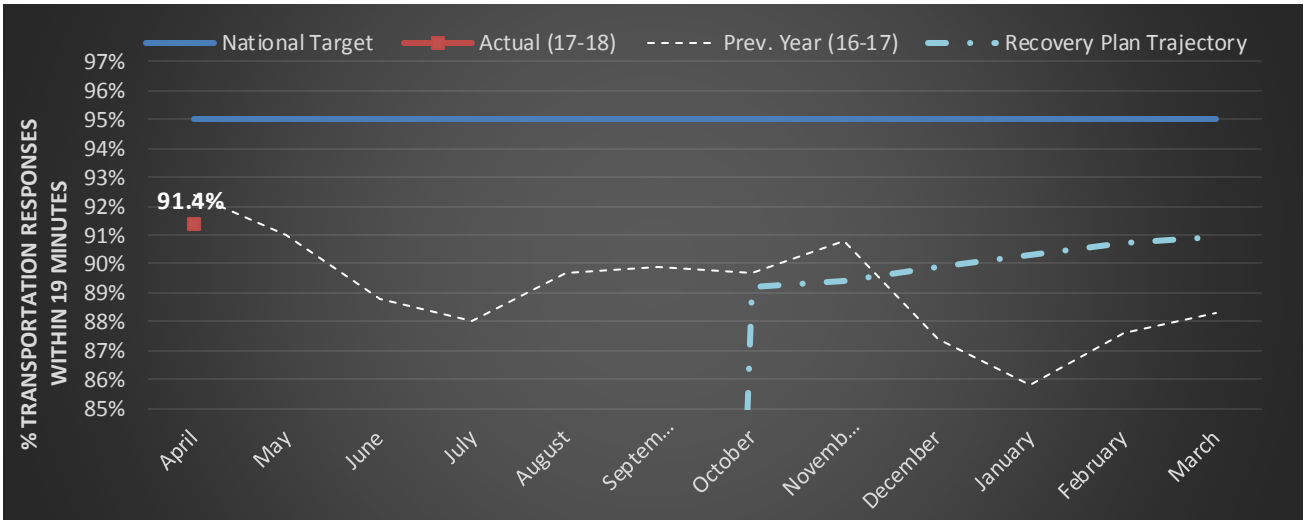

Figure.999-3 - Red 19 Transport <19 min

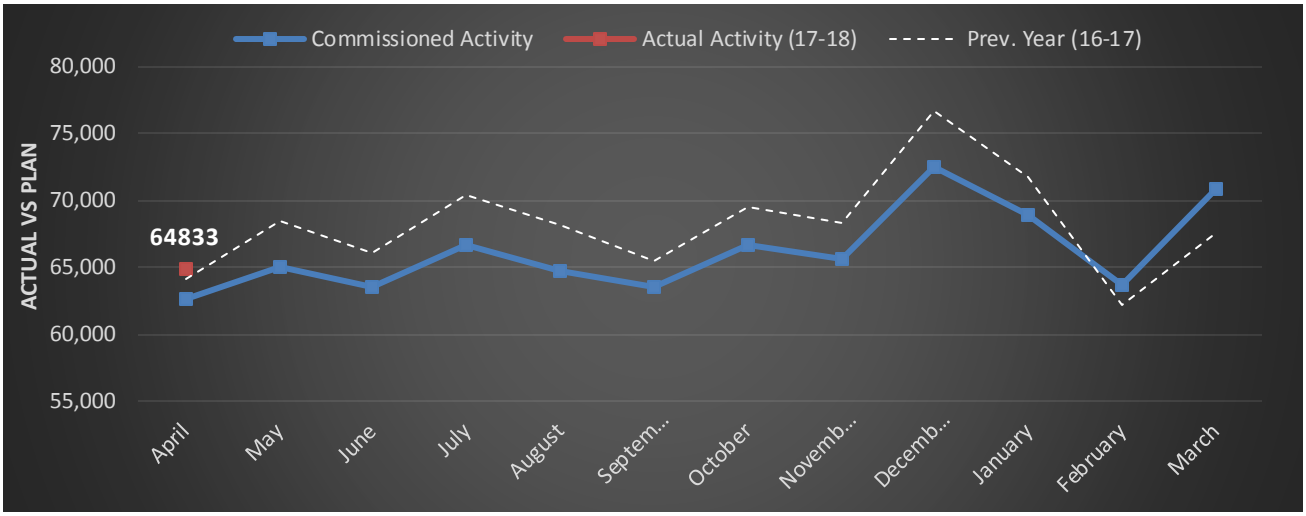

Figure.999-4 - Activity: Actual vs Commissioned

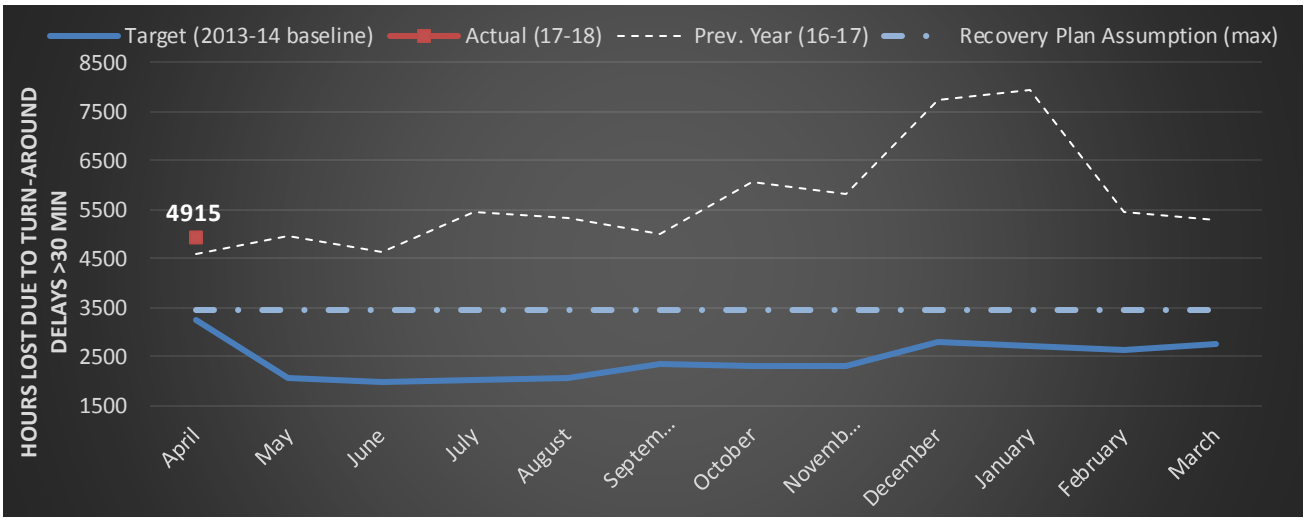

Figure.999-5 - Hospital Turn-around Delays (Hrs lost >30 min.)

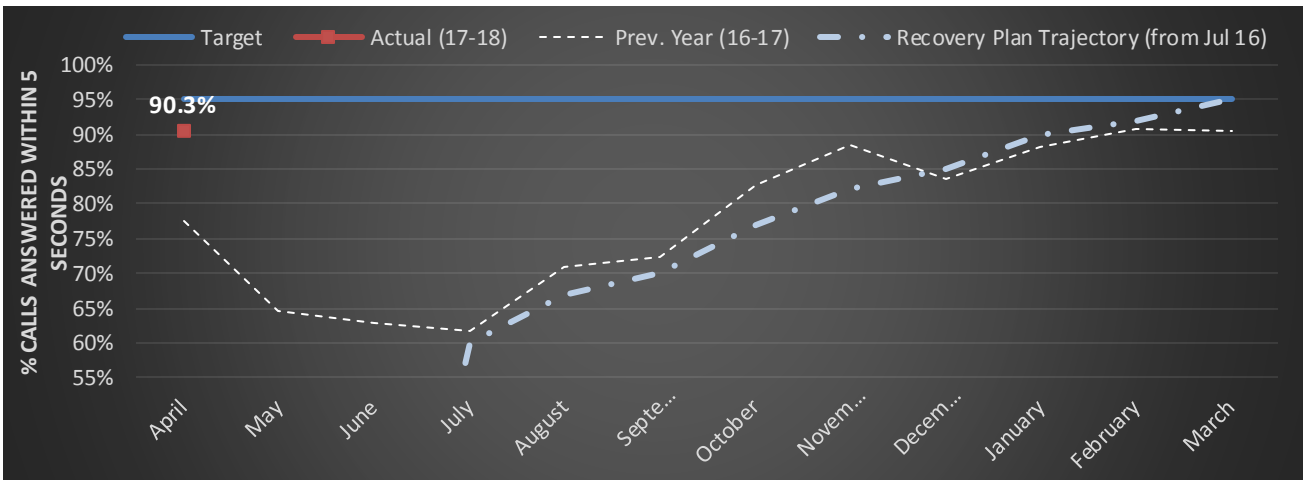

Figure.999-6 - Call Pick up within 5 Seconds

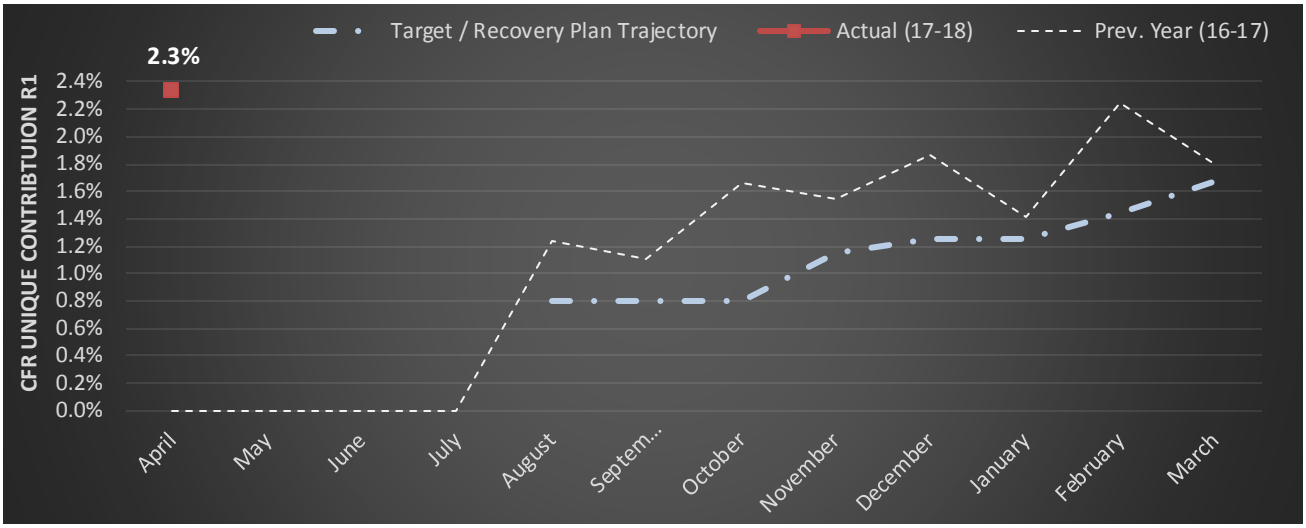

Figure.999-7 - CFR Red 1 Unique Performance Contribution

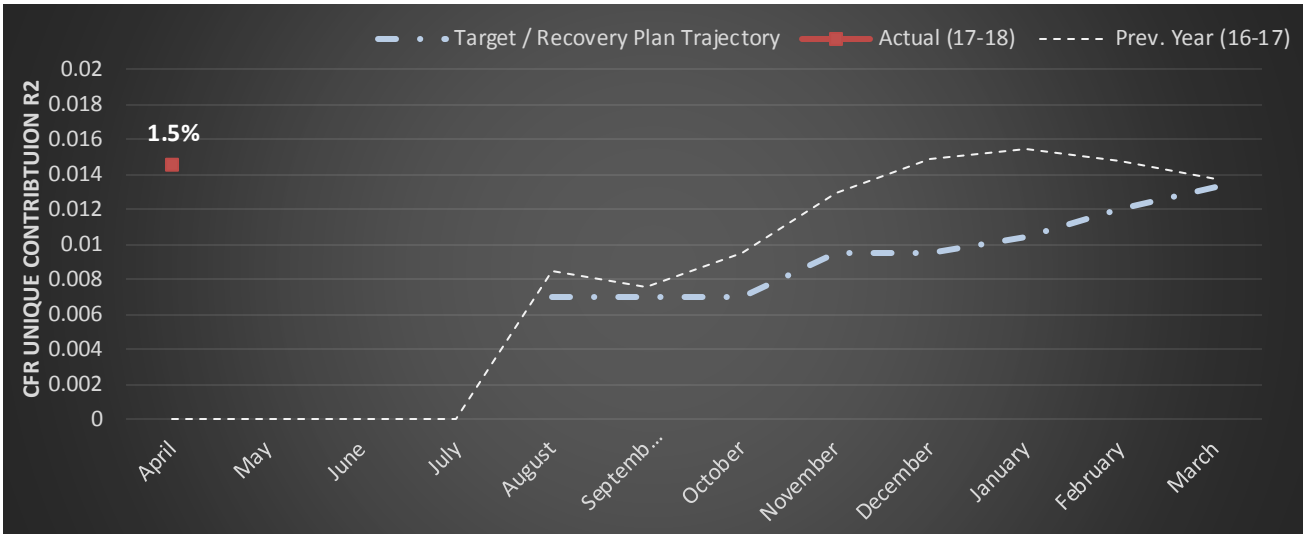

Figure.999-8 - CFR Red 2 Unique Performance Contribution

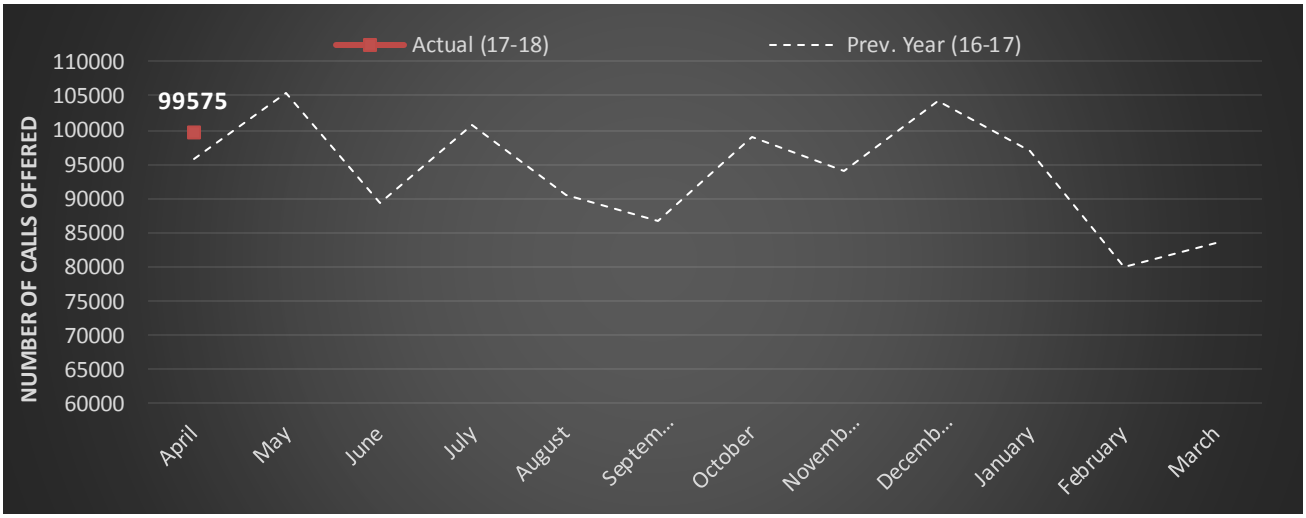

Figure.111-1 - Total Number of calls offered

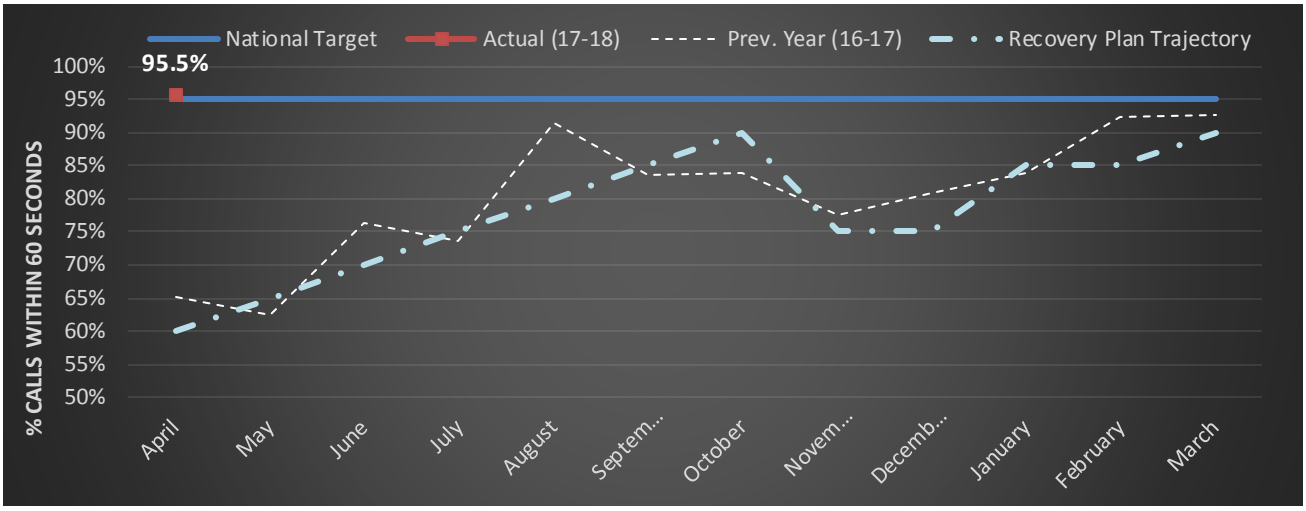

Figure.111-2 - % answered calls within 60 seconds

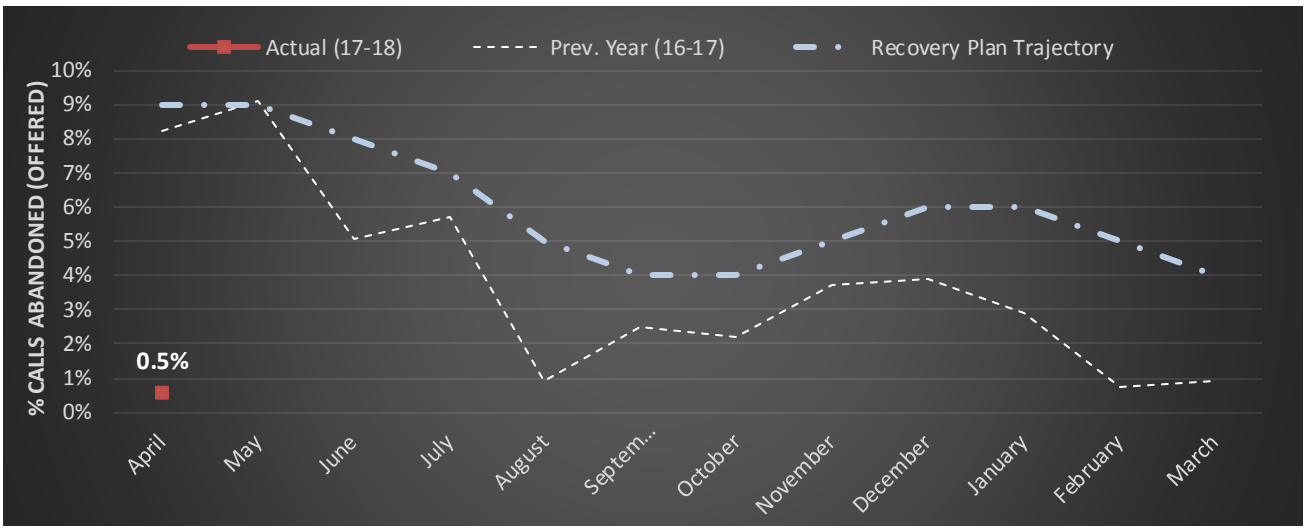

Figure.111-4 - Abandoned calls as % of offered after 30 secs

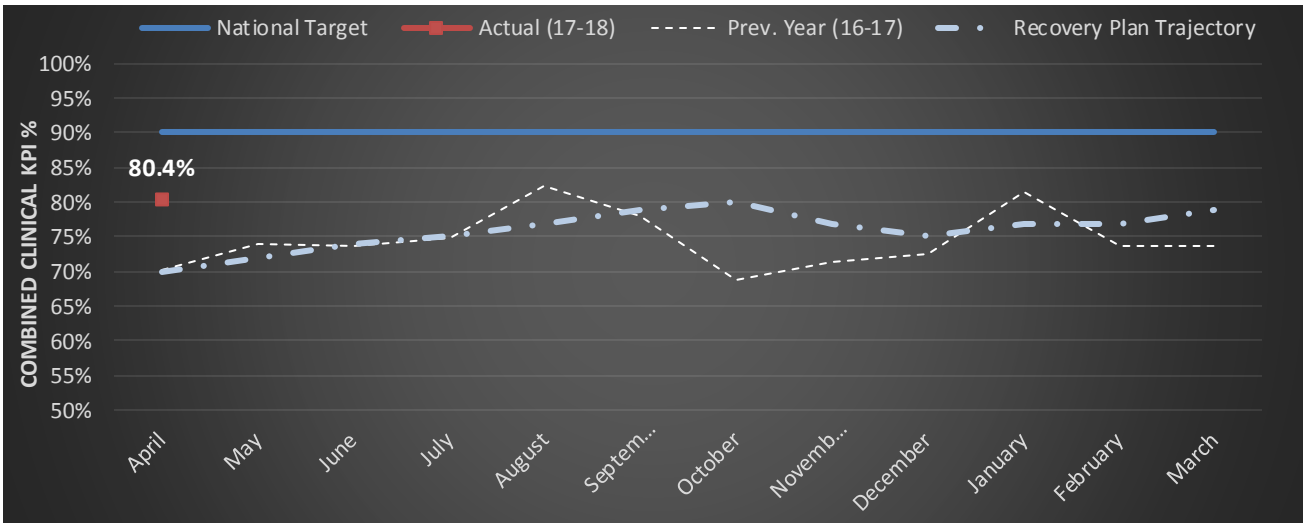

Figure.111-5 - Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)

4. Clinical Effectiveness

4.1. Clinical Effectiveness Summary

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

4.2. Clinical Effectiveness KPI Scorecard

Clinical Effectiveness KPI Scorecard:- Data From December 2016

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

4.3. Clinical Effectiveness

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

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

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

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

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

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

4.4. Clinical Effectiveness Charts

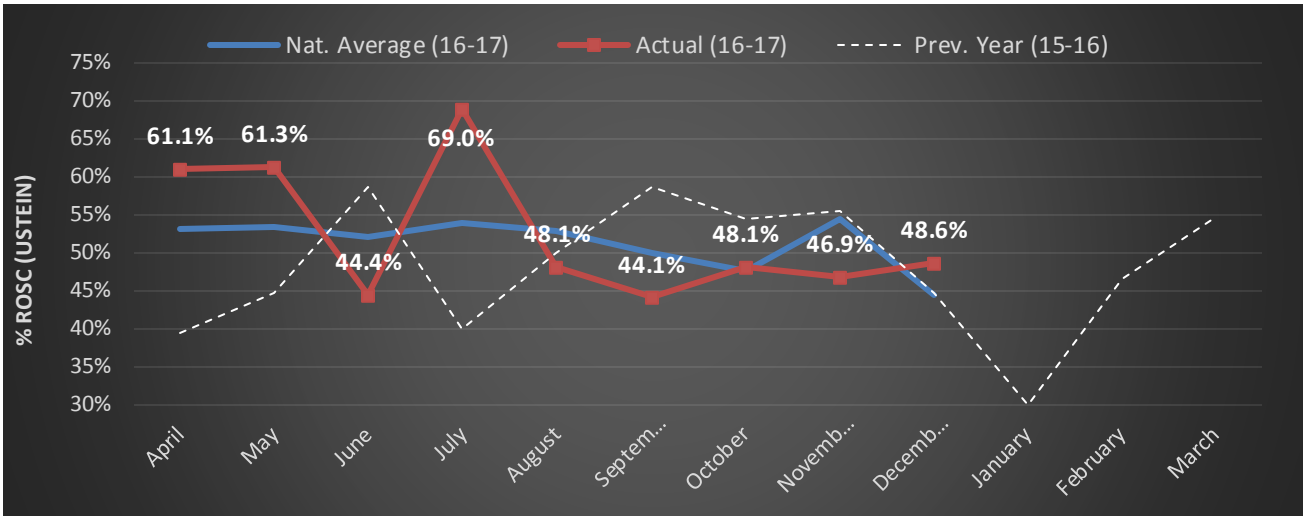

Figure.CE-1 - Cardiac arrest - ROSC on arrival at hospital (Utstein)

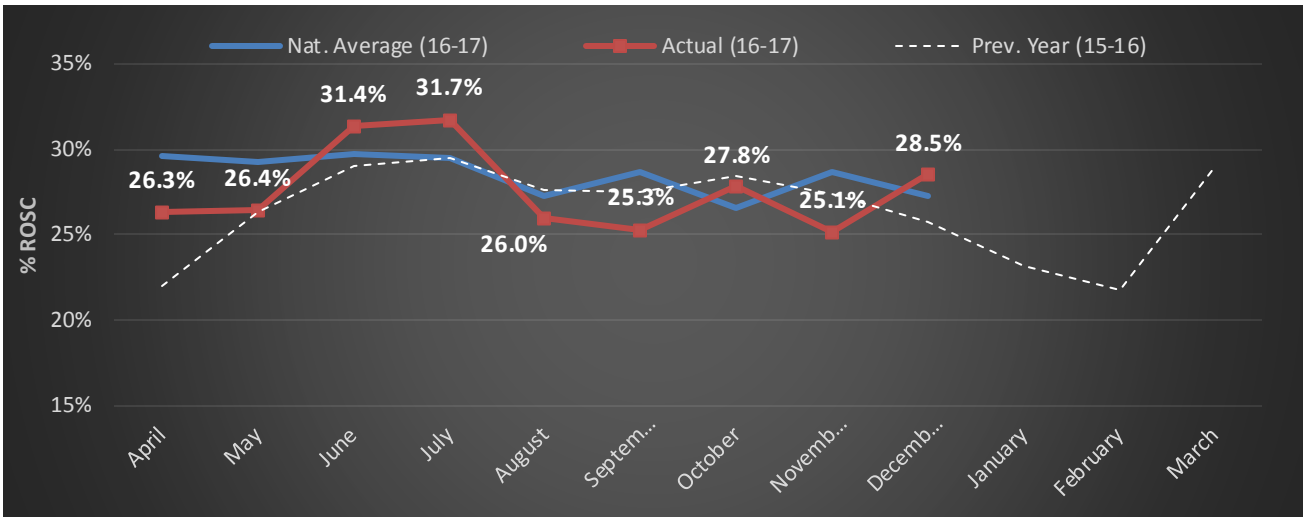

Figure.CE-2 - Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)

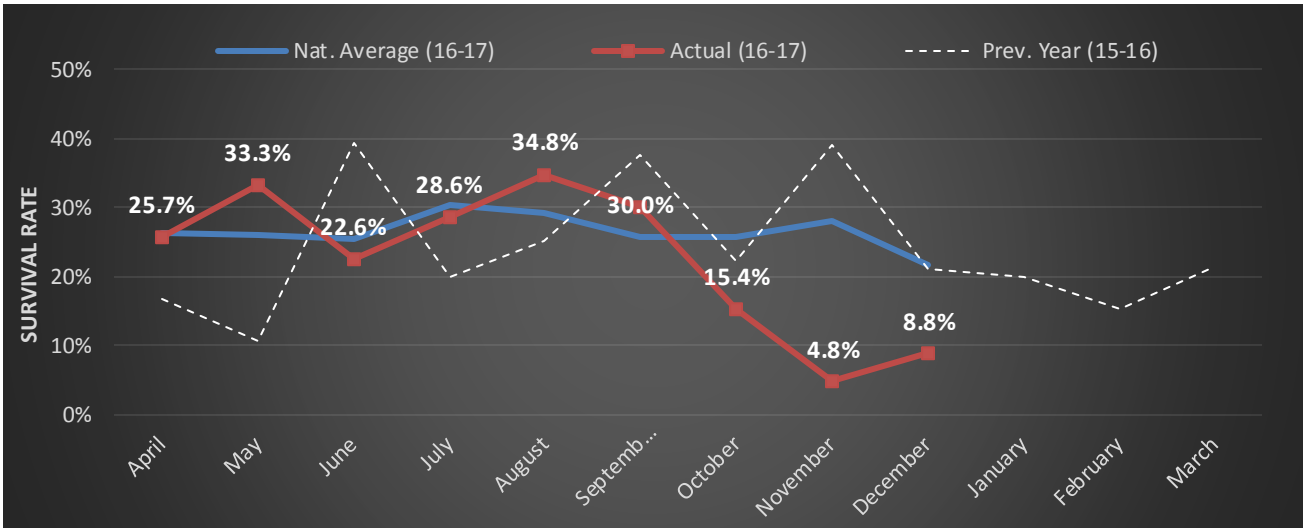

Figure.CE-3 - Cardiac arrest -Survival to discharge - Utstein

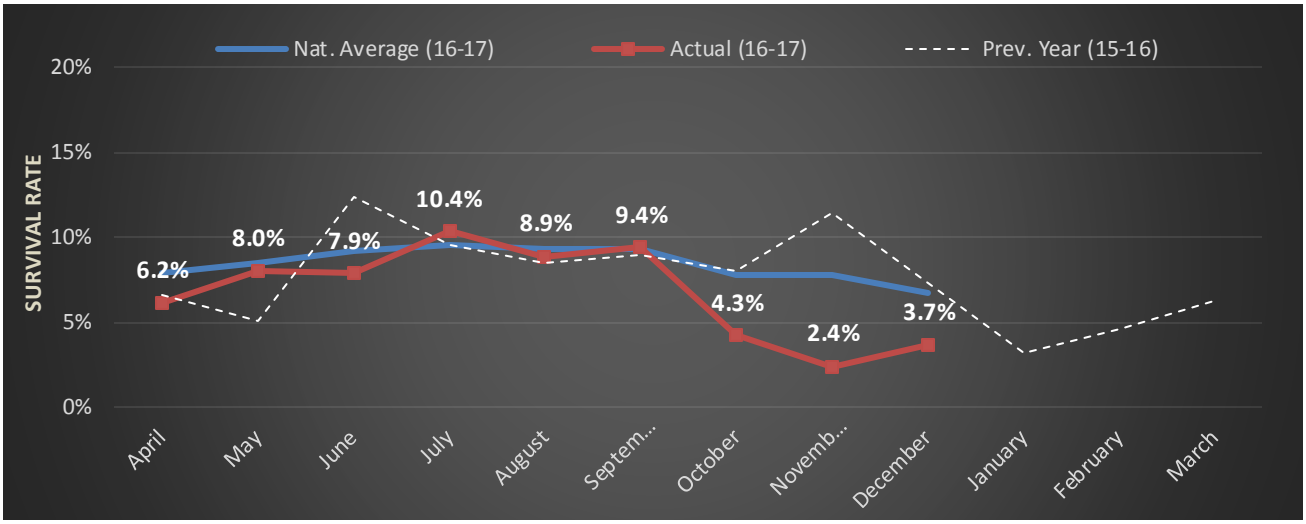

Figure.CE-4 - Cardiac arrest -Survival to discharge – All

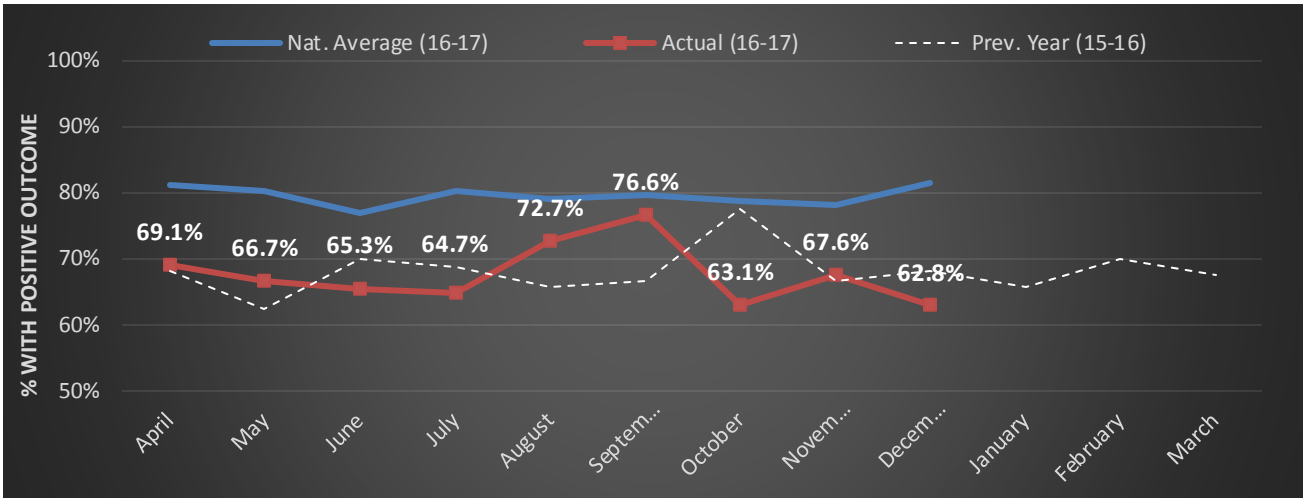

Figure.CE-5 - Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)

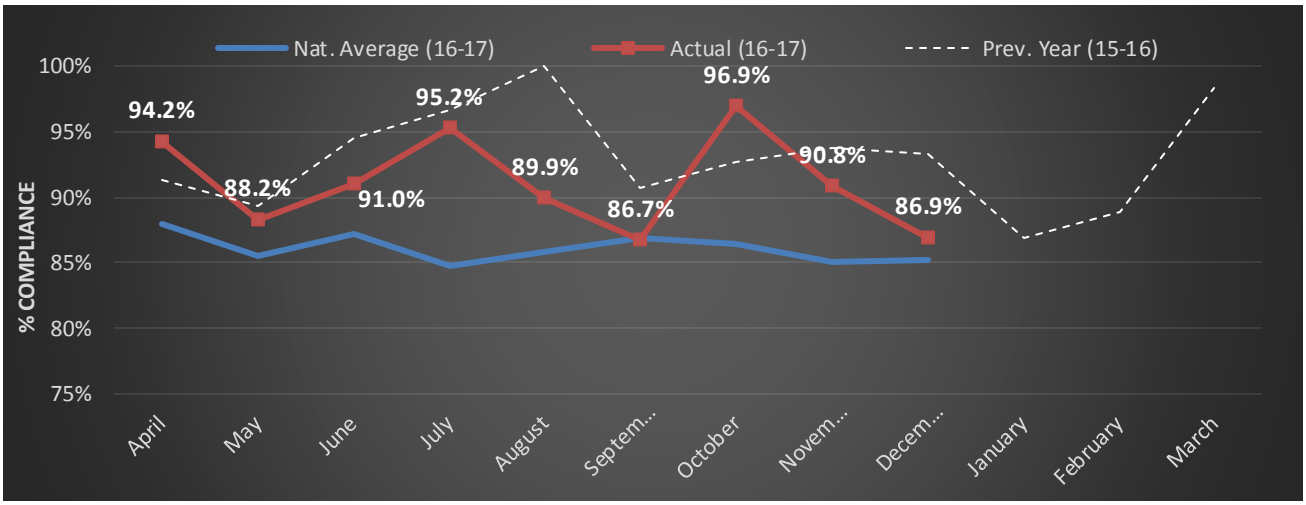

Figure.CE-6 - Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes

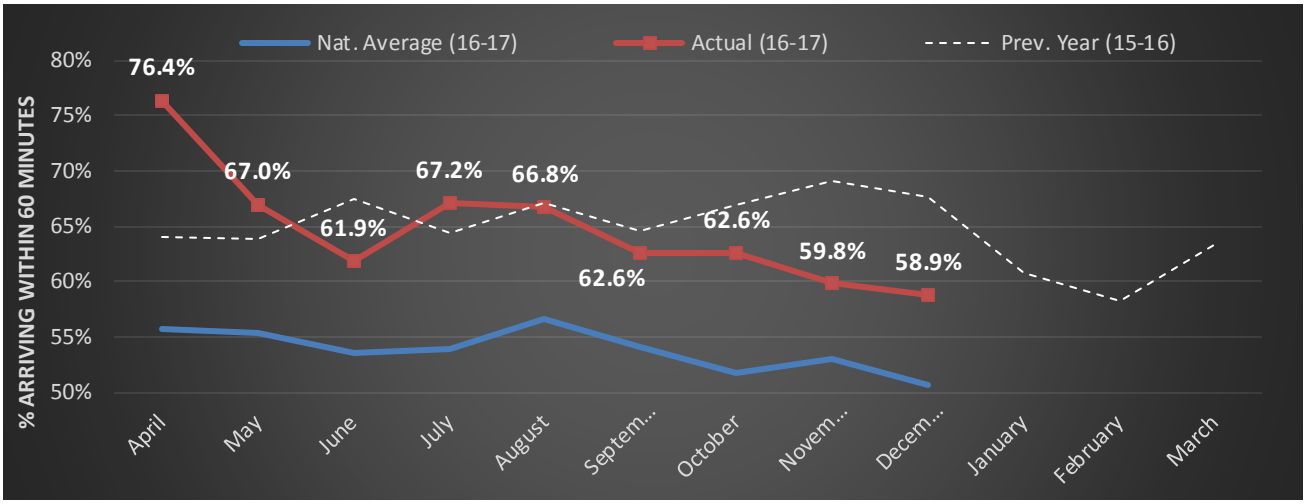

Figure.CE-7 - % of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper acute stroke unit within 60 minutes

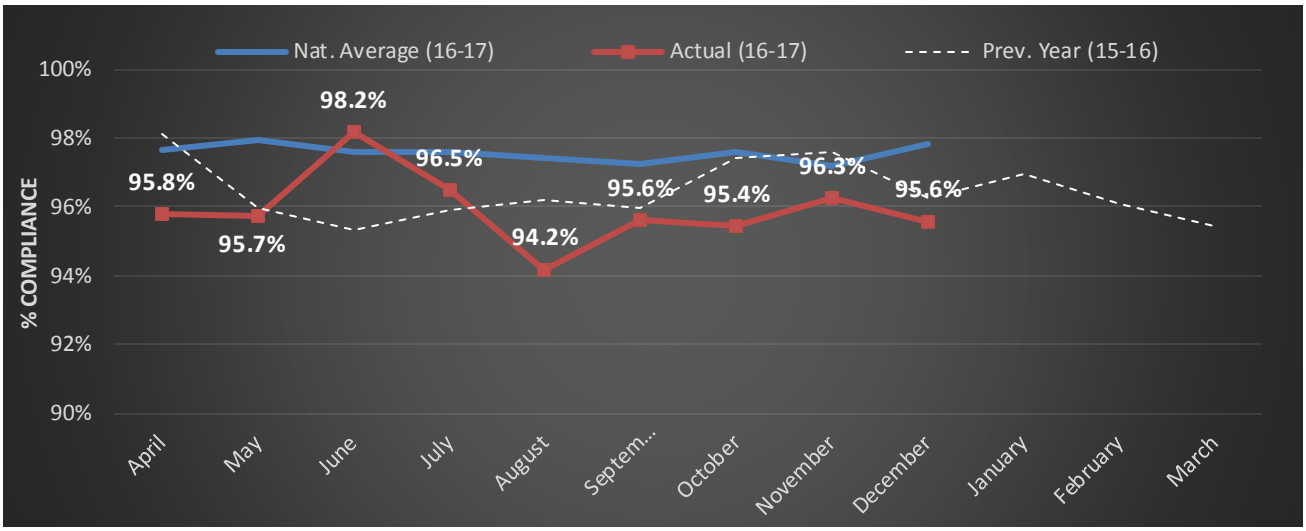

Figure.CE-8 - % of suspected stroke patients assessed face to face who received an appropriate care bundle

5. Quality & Patient Safety

5.1. Quality & Patient Safety Summary

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

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

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

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

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

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

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

5.2. Quality & Safety KPI Scorecard

Quality & Safety KPI Scorecard:- Data From April 2017

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

5.3. Quality & Patient Safety Commentary

5.3.1. Incident Reporting

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

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

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

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

5.3.2. Serious Incident reporting

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

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

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

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

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

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

5.3.3. Complaints

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

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

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

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

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

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

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

5.4. Safeguarding

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

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

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

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

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

5.5. Quality & Safety Charts

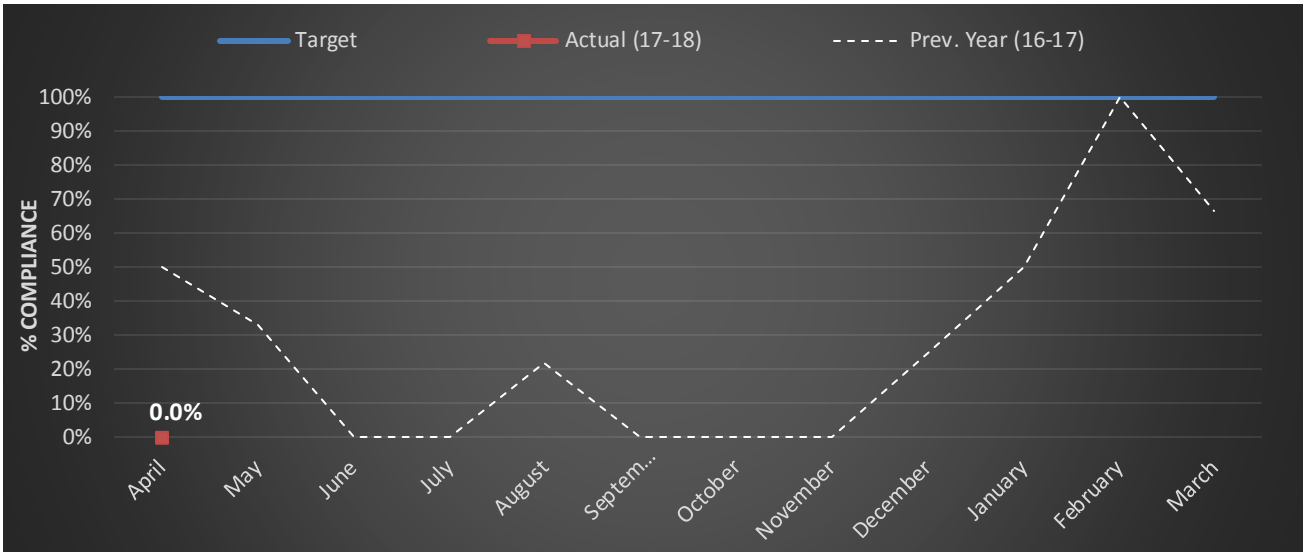

Figure.QS1a - SI Reporting timeliness (72hrs)

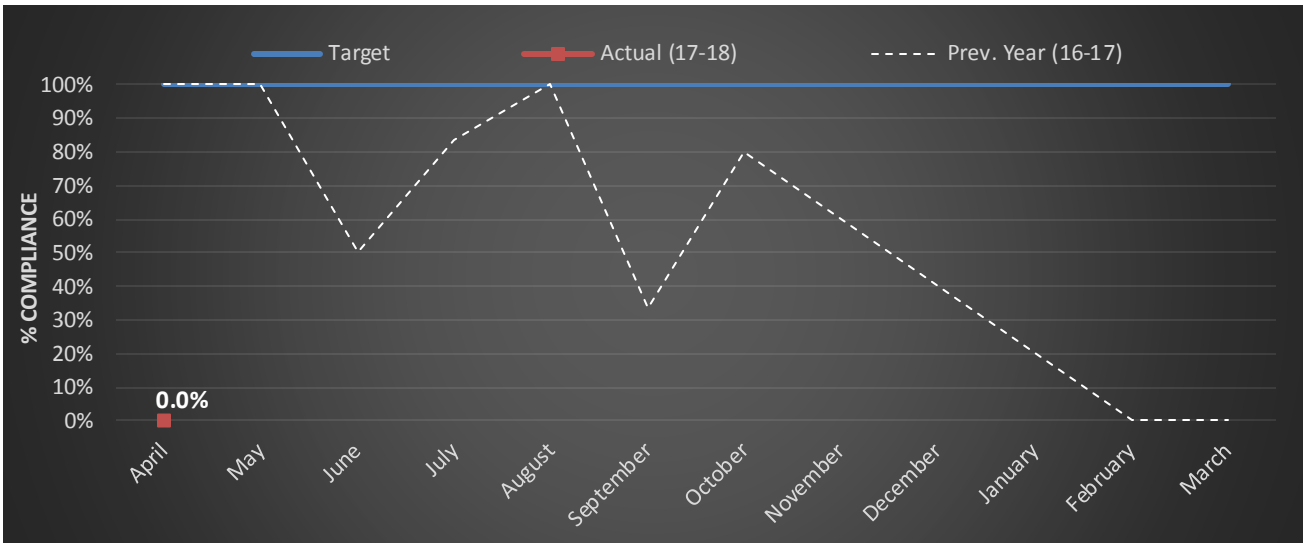

Figure.QS1b - Serious Incident (SI) Investigation timeliness (60 days).

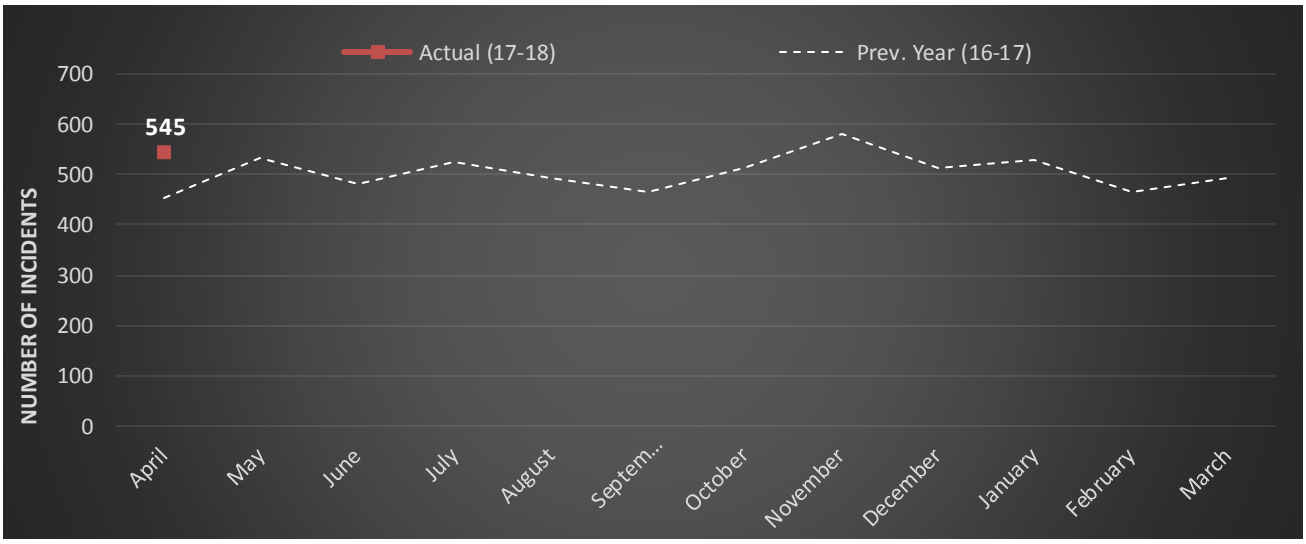

Figure.QS1c - Number of Incidents reported

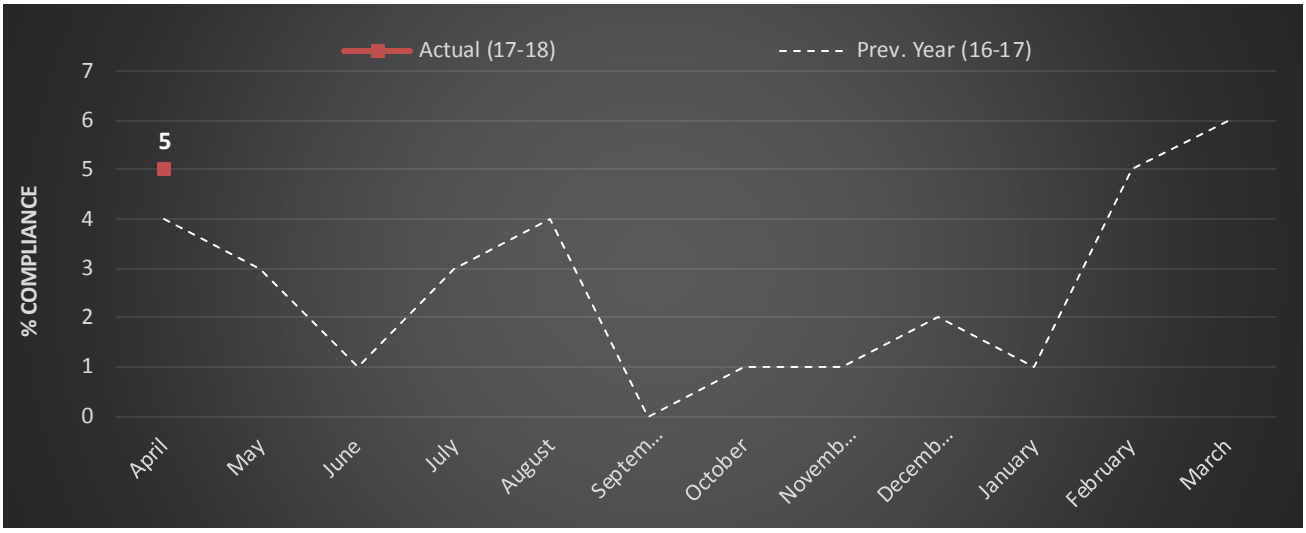

Figure.QS1d - Incidents reported that were SI's

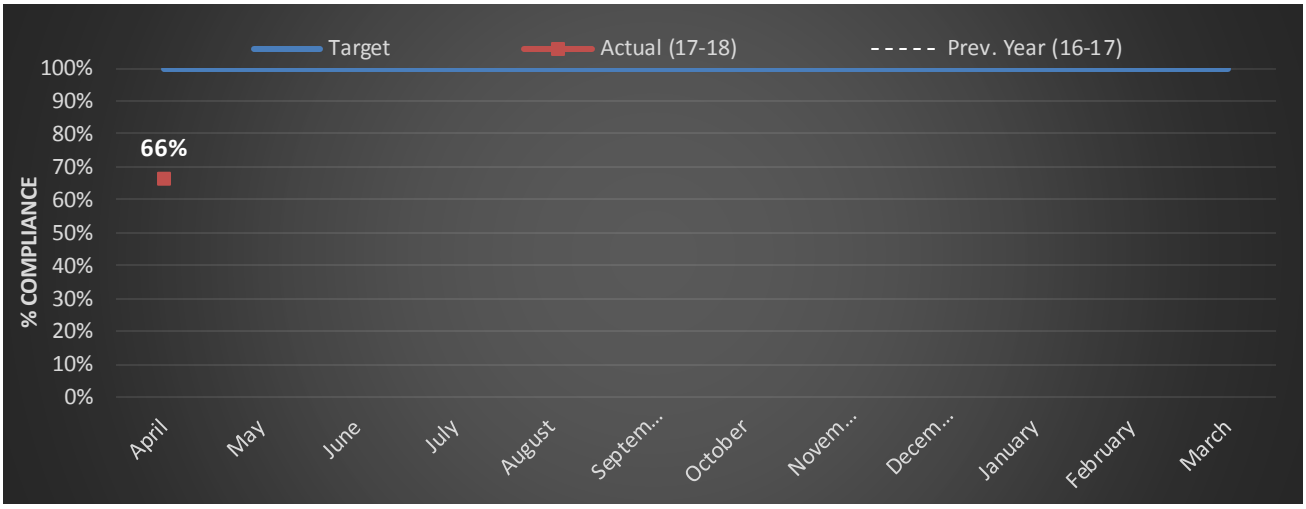

Figure.QS1e - Duty of Candour Compliance

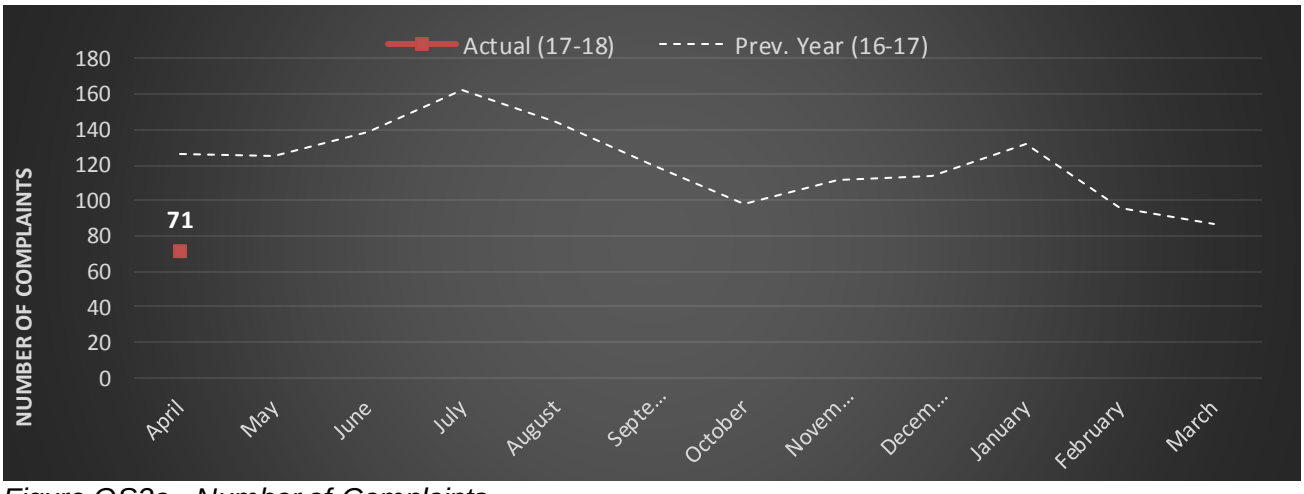

Figure.QS2a - Number of Complaints

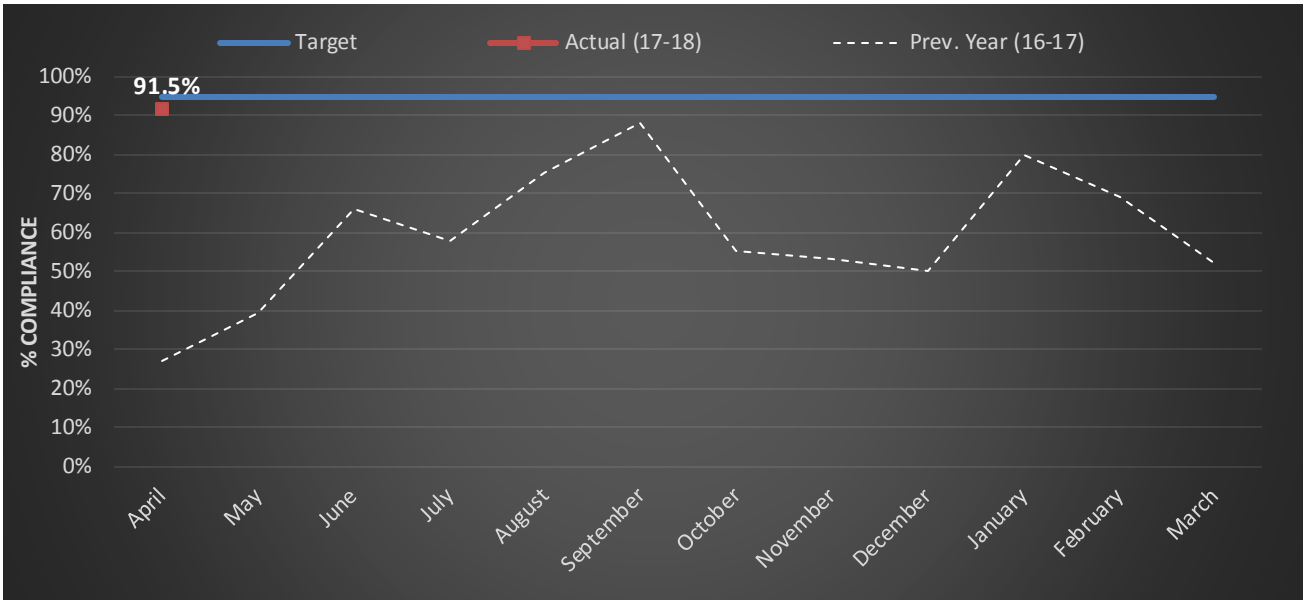

Figure.QS2b - Complaints reporting timeliness (All Complaints)

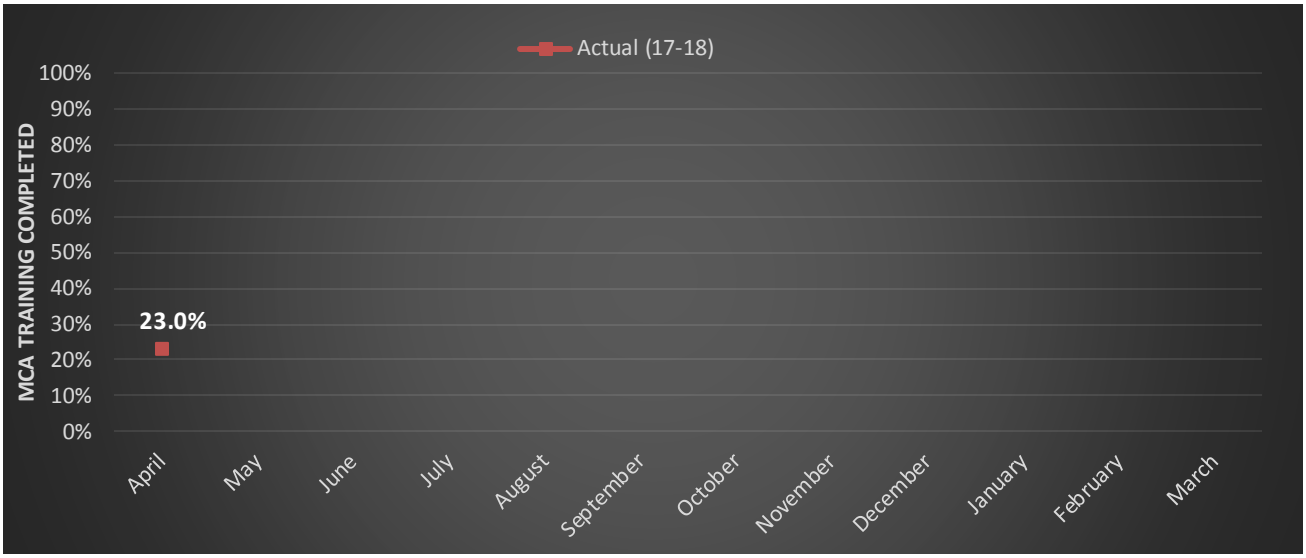

Figure.QS2c – Mental Capacity Assessment Training

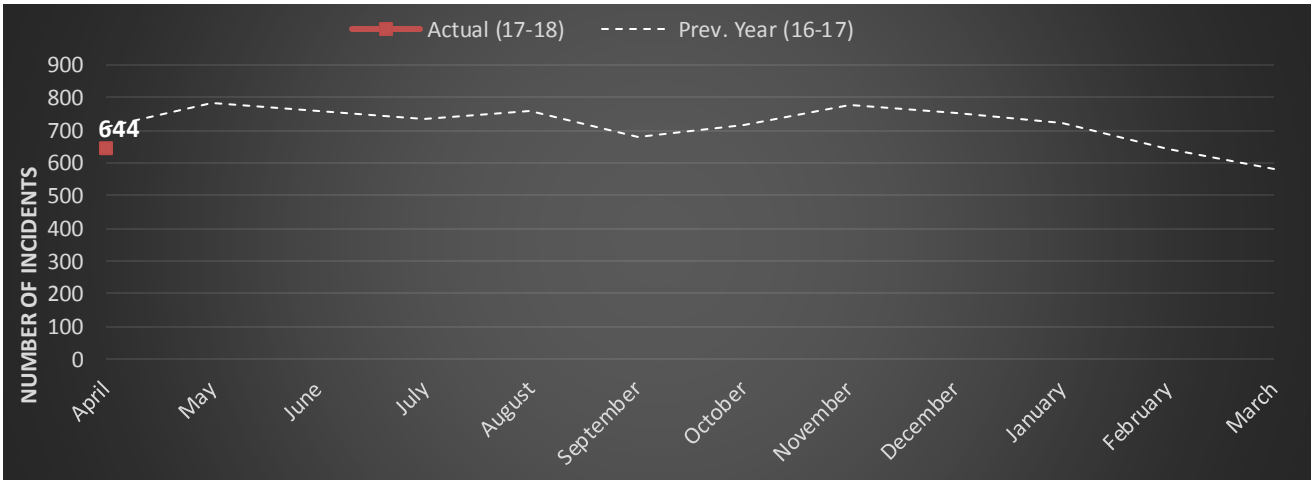

Figure.QS3a - Safeguarding Referrals Adult

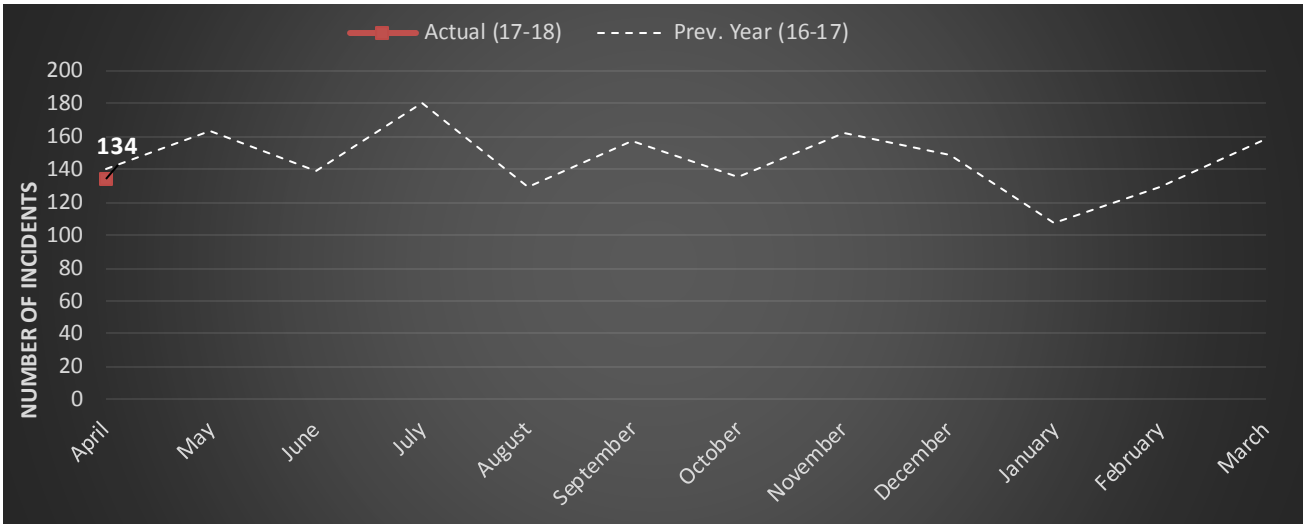

Figure.QS3b - Safeguarding Referrals Children

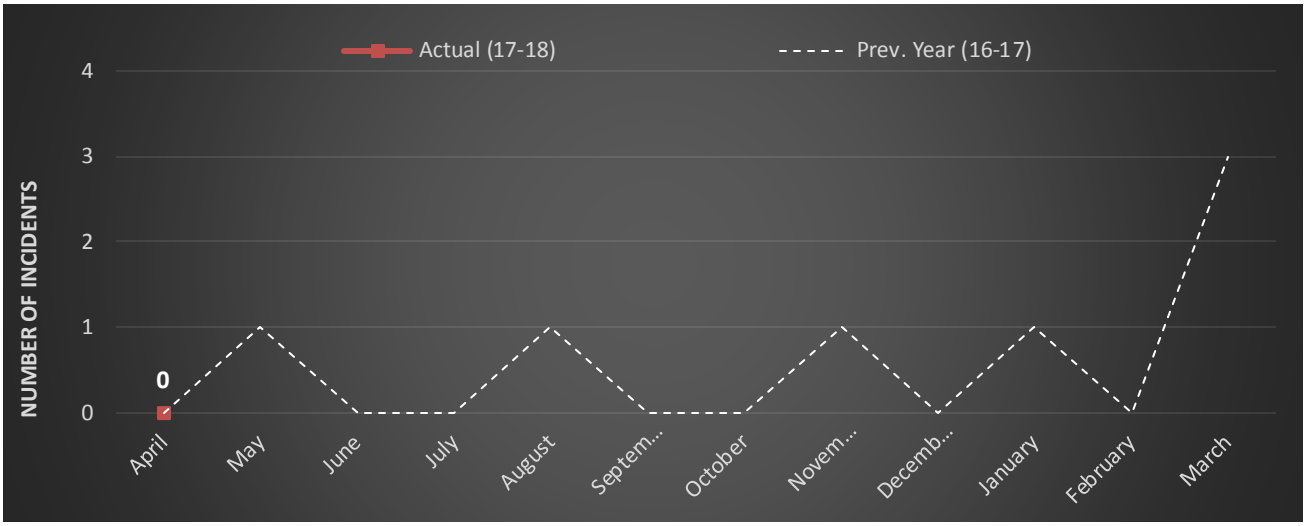

Figure.QS3c - Safeguarding Referrals relating to SECAmb staff or services

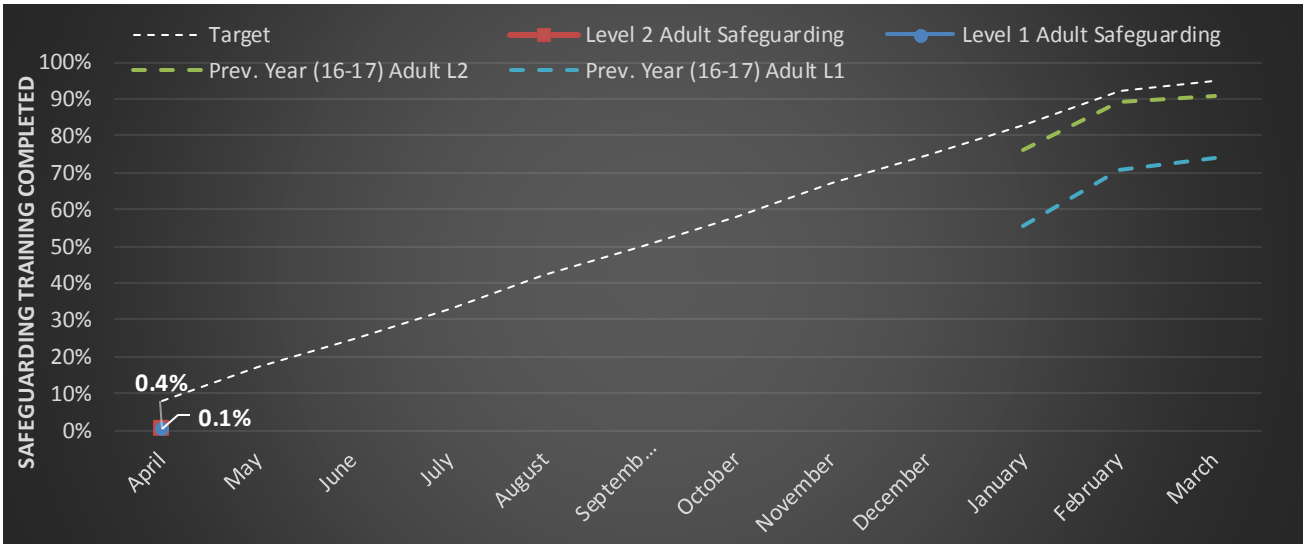

Figure.QS3d and QS3f - Safeguarding Training Completed Adult, Level 1 and 2

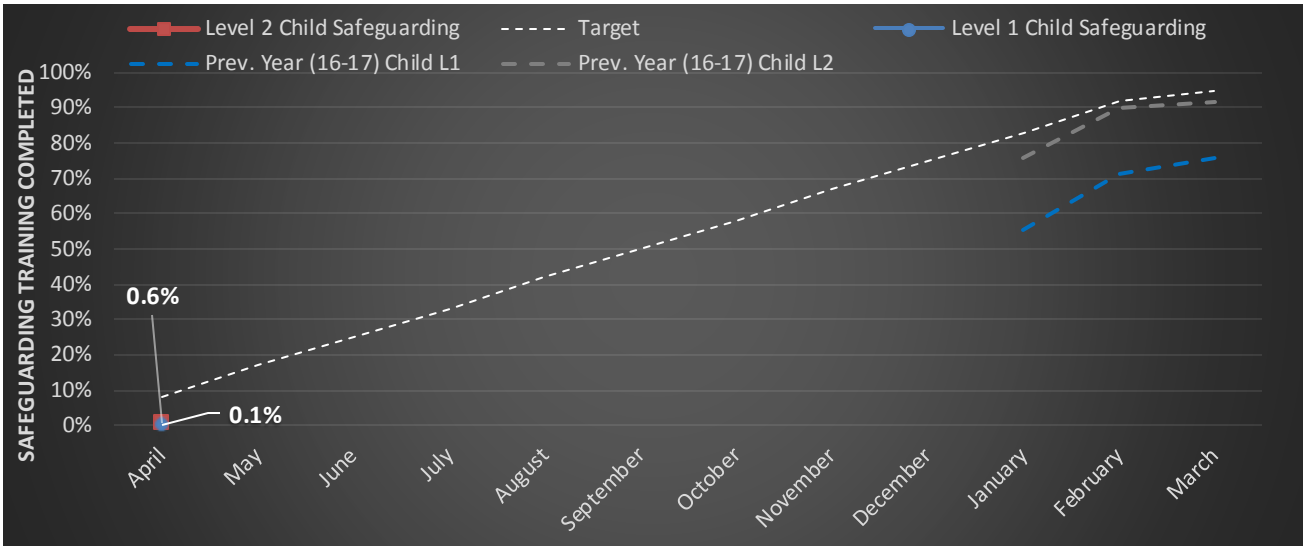

Figure.QS3e and QS3g - Safeguarding Training Completed Children, Level 1 and 2

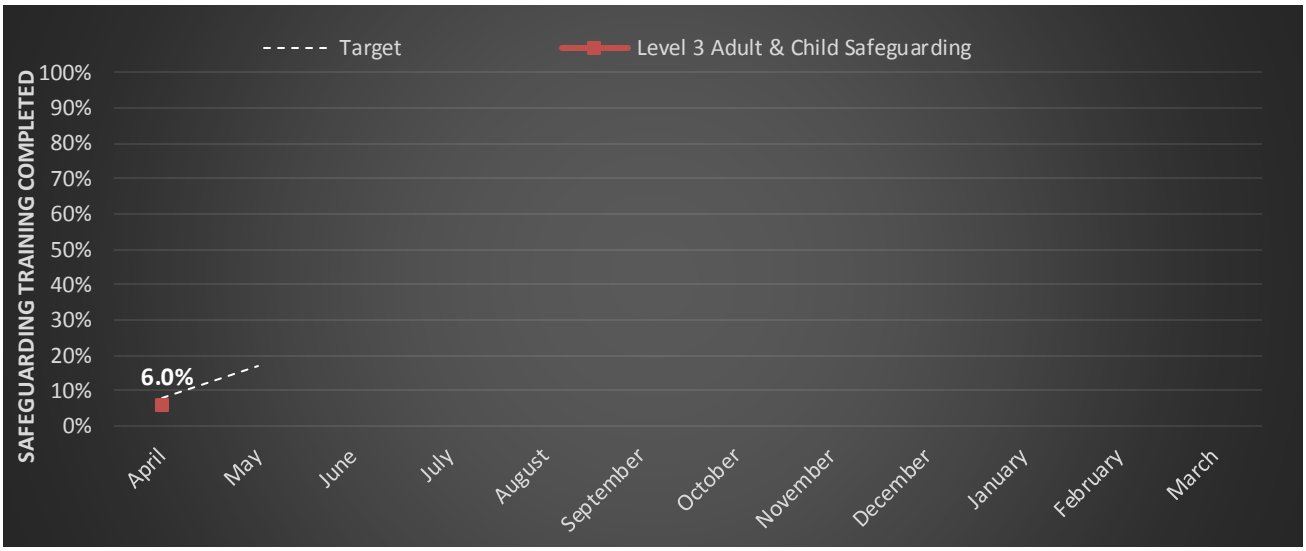

Figure.QS3h - Safeguarding Training Completed Adult & Child Level 3

6. Finance

6.1. Finance Summary

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

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

6.1. Finance Scorecard

Finance Scorecard:- : Data from April 2017

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

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

6.2. Finance Commentary

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

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

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

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

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

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

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

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

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

6.3. Finance Conclusion

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

6.4. Finance Charts

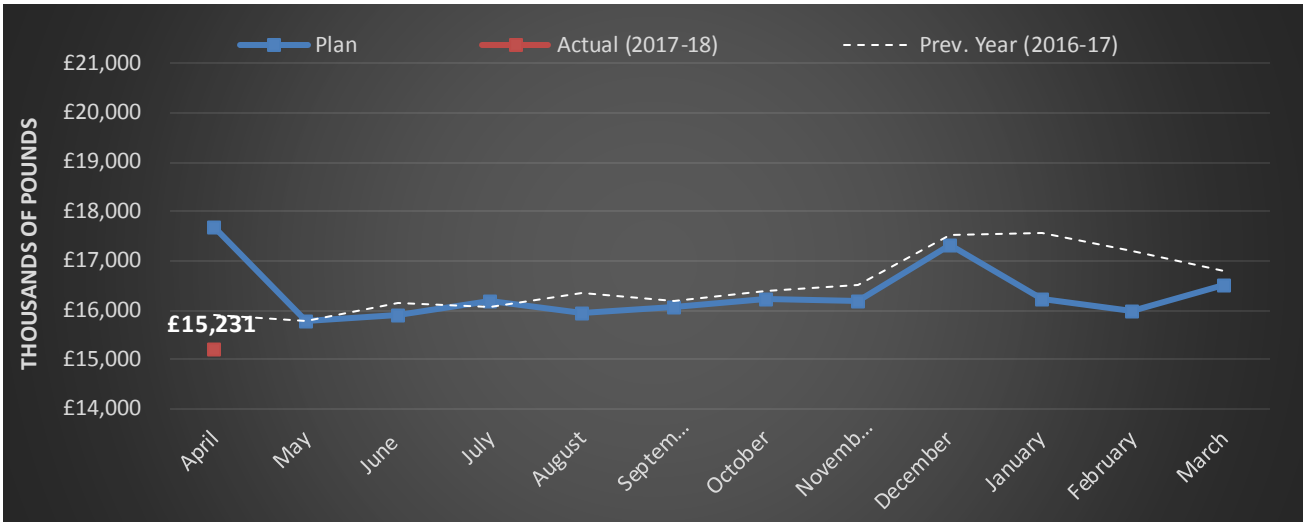

Figure.F-1 - Income (£'000)

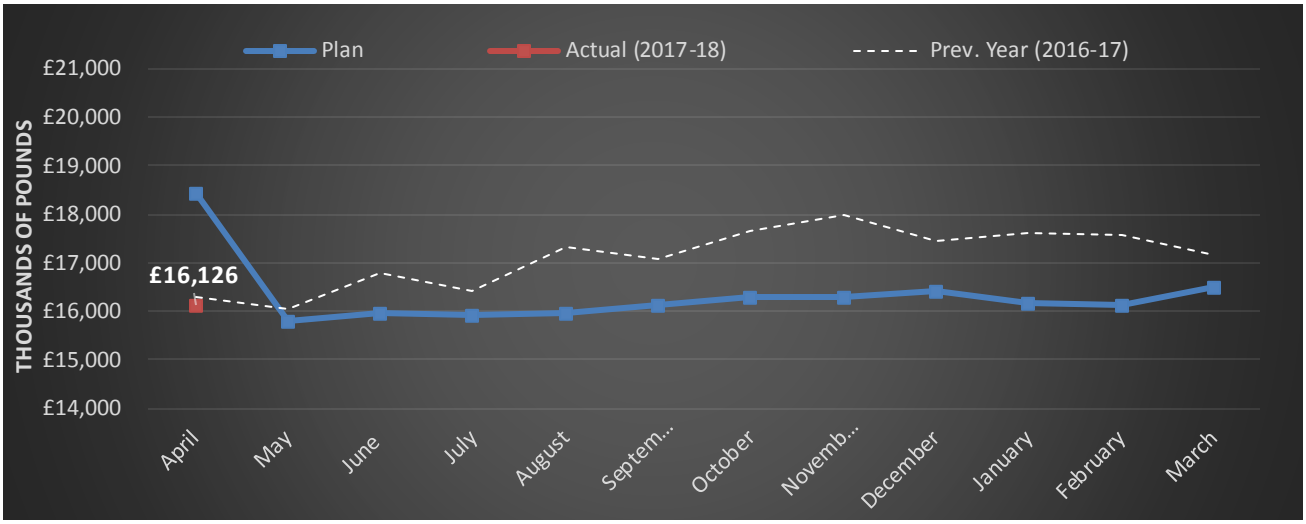

Figure.F-2 - Expenditure (£'000)

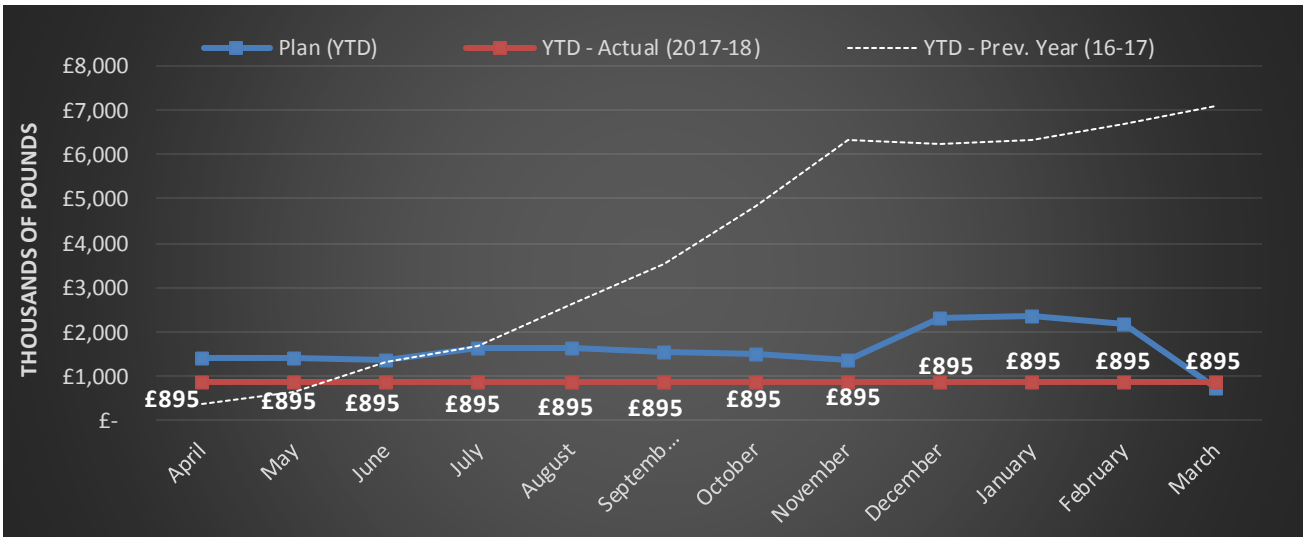

Figure.F-6 - Surplus/(Deficit) (Year To Date)

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

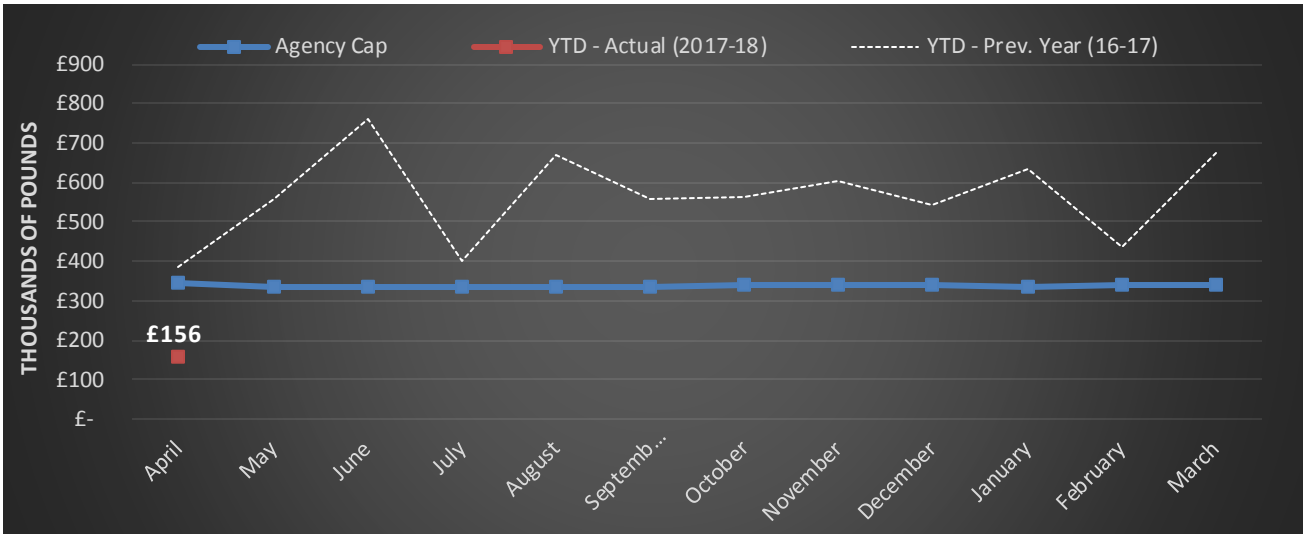

Figure.F-8 – Agency Spend (£'000)

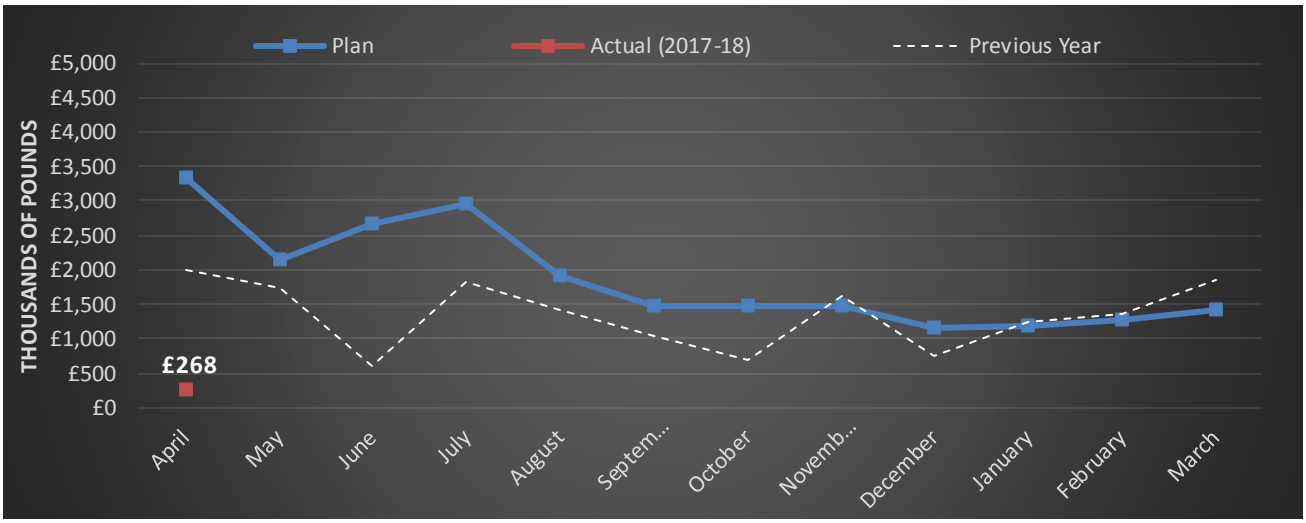

Figure.F-3 – Capital Expenditure (£'000)

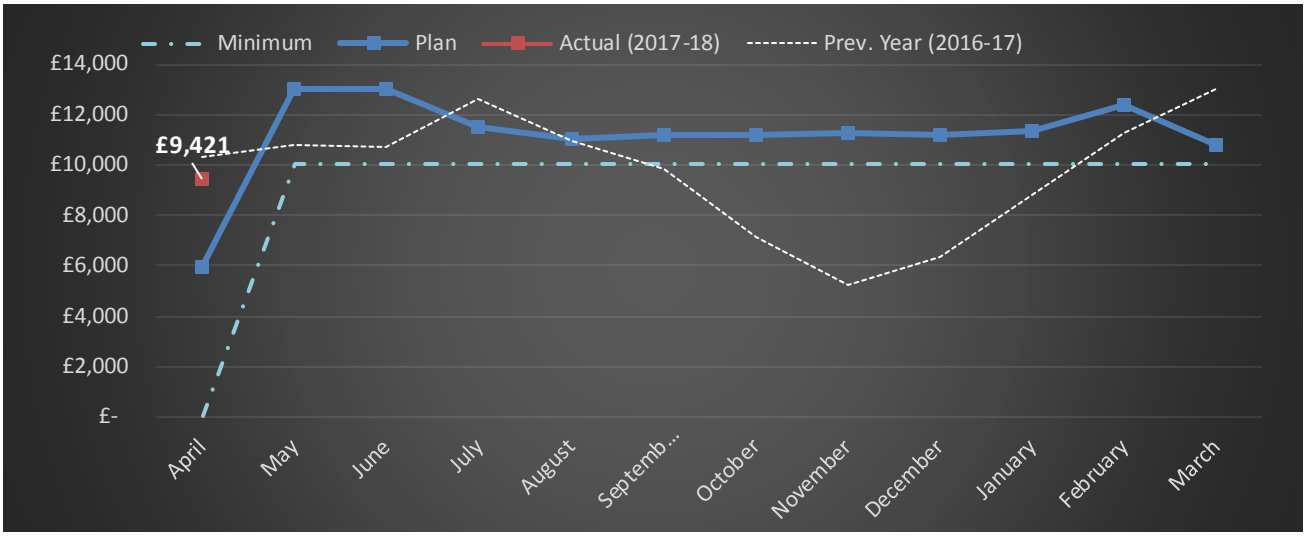

Figure.F-7 – Cash Position (£'000)

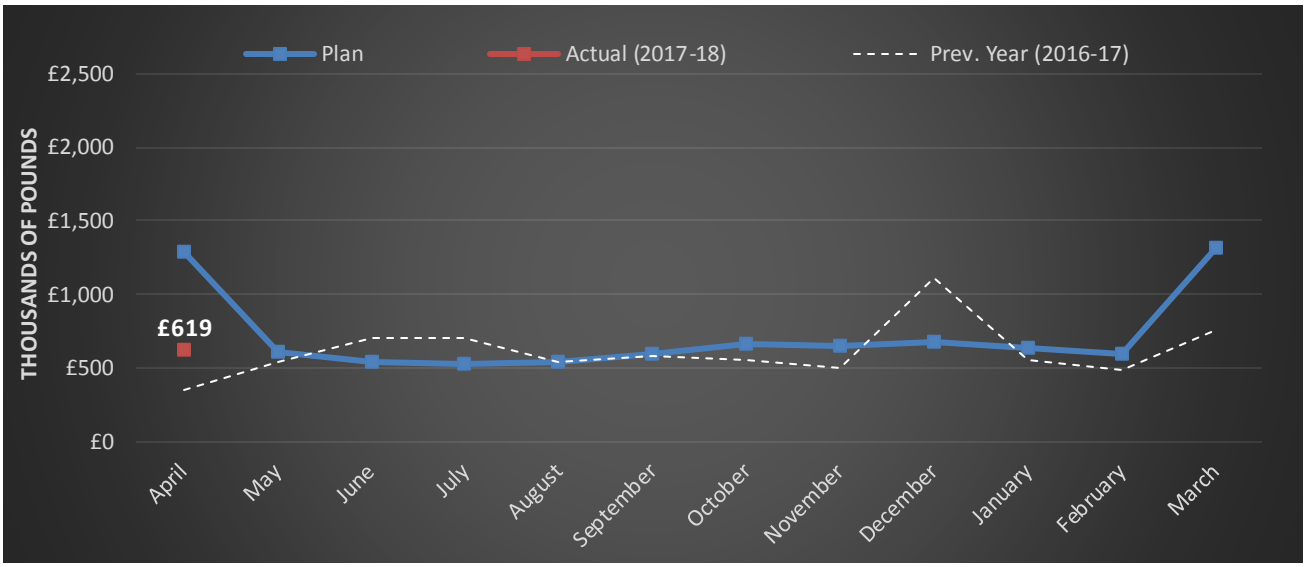

Figure.F-4 - Cost Improv. Prog. (CIP) (£'000)

Integrated Performance Dashboard Balanced Scorecard for the May 2017 Board Meeting

Workforce Commentary :- Data from Apr 2017

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

Operational Performance Scorecard:- Data From April 2017

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

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

SECAMB Regulation Statistics

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

Clinical Effectiveness KPI Scorecard:- Data From December 2016

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

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

Finance Scorecard:- : Data from April 2017

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

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

Quality & Safety KPI Scorecard:- Data From April 2017

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

Appendix 2: Notes on Data Supplied in this Report

7.1. Preamble:

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

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

7.2. Executive Summary:

7.2.1. No changes to note.

7.3. Workforce Section:

7.3.1. No changes to note.

7.4. Operational Performance Section:

7.4.1. No changes to note.

7.5. Clinical Effectiveness

7.5.1. No changes to note.

7.6. Quality and Patient Safety Section:

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

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

7.7. Finance Section:

7.7.1. No changes to note.