South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 29 September2017

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

Present:

Richard Foster	(RF)	Chairman
Daren Mochrie	(DM)	Chief Executive
Alan Rymer	(AR)	Independent Non-Executive Director
Angela Smith	(AS)	Independent Non-Executive Director
Fionna Moore	(FM)	Executive Medical Director
Graham Colbert	(GC)	Independent Non-Executive Director & Deputy Chair
Jon Amos	(JA)	Acting Executive Director of Strategy & Business Development
Joe Garcia	(JG)	Executive Director of Operations
Lucy Bloem	(LB)	Independent Non-Executive Director
Steve Lennox	(SL)	Executive Director of Nursing & Quality
Tim Howe	(TH)	Independent Non-Executive Director

In attendance:

Janine Compton	(JC)	Head of Communications
Peter Lee	(PL)	Trust Secretary
Phil Astell	(PA)	Deputy Finance Director

78/17 Chairman's introductions

RF welcomed members and those observing, including KPMG who were observing as part of a governance review.

79/17 Apologies for absence

Terry Parkin	(TP)	Independent Non-Executive Director
David Hammond	(DH)	Executive Director of Finance & Corporate Services
Steve Graham	(SG)	Interim Director of Human Resources

80/17 Declarations of conflicts of interest

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

81/17 Minutes of the meeting held in public in July 2017

The minutes were approved as a true and accurate record.

82/17 Matters arising (action log)

The progress made with outstanding actions was noted as confirmed in the Action Log and completed actions will now be removed.

83/17 Patient story [10.05 – 10.12]

The video was played which was a compilation of verbal feedback from a number of patients, including positive feedback about a response to a care home and the friendliness and compassion showed by a crew.

RF reflected that this helps to remind the Board of the impact of personal interaction. DM added that this type of feedback is consistent with what he has observed when out with crews. He acknowledged that we don't always get it right, but we do much more often than not. He also mentioned the important role of support staff; it is a whole team effort.

84/17 Chief Executive's report [10.13 – 10.47]

DM talked through the issues listed in his report highlighting, in particular, the following;

- Executive recruitment – DM congratulated JG on his substantive appointment.
- Banstead EOC move to Crawley – DM thanked staff for their efforts to make this happen.
- Prof. Lewis report – DM acknowledged that this was a disappointing report and reiterated that as a Board we will not tolerate the behaviours identified and will learn from this to ensure we effect the necessary change in culture.
- CQC – DM confirmed that the Quality Summit is on 5 October where final CQC inspection reports will be presented.

GC noted that part of the business case to move to Crawley included a need to deliver on the plan for Banstead; this was noted by the Board.

LB asked about risks on moving to ARP. JG described one of the principal risks being abstraction, something we have recently experienced with the change to the new CAD. He explained that we wouldn't have planned to do both back to back, but implementing AR by 22 November is the date imposed from the centre.

In relation to the general point about abstraction for training, which clearly adds to existing pressures, RF asked whether beyond November we have any significant abstraction(s) planned. JG confirmed that we plan for specific pressures, e.g. winter, in a way which minimizes abstraction during these periods. We also profile hours needed against historic trends in demand.

TH noted that we are behind our target for statutory and mandatory training, and asked whether we risk back-loading this to the end of the year, impacting on extraction. JG confirmed that there will be an element of this, but this is how we plan it; balancing the need to ensure we meet demand versus giving training to all our staff to ensure a most effective workforce. The other aspect is staff sickness and JG explained we have started the flu vaccination process this week. It remains to be seen if this is effective, but we are encouraging as many as possible to have the vaccination.

DM reminded the Board that it will be receiving our winter plans in October which are supplemented by detailed local operational plans that plan proactively for pressure points through the winter.

AS asked whether we have enough people and the right type in the right place. Board members agreed to work off line to agree the data that would help to clarify this, to be addressed through the Workforce and Wellbeing Committee. TH added that the workforce plan hasn't been developed due to the outstanding commissioning decisions; although this is in train for April 2018.

DM reassured the Board that we are doing work in terms of the workforce model as part of our strategy and in parallell we are working with commissioners on the demand and capacity review to help ensure we have enough operational staff to meet demand.

In summary RF explained that we know there are some things we must do, firstly to get out of special measures. We have to be a Trust run on simple and clear messages and as a board we need to keep an eye

on both the must dos and the business as usual. On top of all of this, we are a Trust that has been in some disarray over last couple of years, and so some things we aren't as a good at as we should be. The focus must be on the must dos, otherwise we won't be out of special measures.

RF added that the plan for a strategic Board away day is still in the thinking, and the aim is to await the new executive recruitment early in the New Year. GC felt that it is important that we have the output of the demand and capacity review first, beforehand.

Action:
Board away day to discuss our strategic approach to be scheduled for February 2018.

85/17 Unified Recovery Plan [10.47 – 11.37]
JA introduced the papers taking the overall cover paper as read, which includes the refreshed governance structure, to reflect the new compliance areas which focus on the strategic must dos.

AS felt that the highlight report comes across as being too much of an optimistic view of where we are. LB added that although what we see in these papers is significantly improved from where we have been in the recent past, going forward we need to be clearer on the must dos; CQC or otherwise. She therefore asked for the report(s) to be clearer on our targets; key milestones; and a trajectory / timescales for when the targets are to be achieved.

JA confirmed that as an executive we have agreed to do just this; show milestones and what we have achieved and aim to achieve.

DM added that as the paper sets out, we need to be clear on the compliance issues, but we also need to do everything else in a way that is focused. In other words, we can't just focus on the CQC must dos to detriment of other areas.

TH supported what LB and AS are saying and agreed that this is about capacity; we can't do everything. We need to make a deliberate decision about what we are going to do and what we are going to stop or pause.

AR acknowledged that we are in far better place, evident by the task and finish approach. He felt that the PMO is critical to this, but in a supportive role rather than it taking accountability for delivery. Otherwise we risk overloading the PMO and it won't then be able to support improvement.

RF summarised by saying that the compliance areas are the must dos to help get us out of special measures. The transformation areas also include areas we not in good order, so we need to be clear as a Board what they are to ensure we prioritise accordingly.

Compliance:
SL explained that we have a dashboard in the paper which is being revised as per the earlier discussion. We have a good grip of incidents as set out and this demonstrates much improvement to where we have been. On the flip side, however, we are not in such a good position with SIs.

Medicines Management is rated red, because there are some cultural sustainability issues, including embedding SOPs. With patient care records (PCR) there is still much improvement needed in the quality of our documentation.

LB expressed concern about PCR given what the Quality & Patient Safety Committee (QPS) considered at its recent meeting, which included other areas to those in the URP. Therefore, it seems that either the scope of project does not cover all the issues or there is an issue with how it is reported. DM confirmed that this is the action plan based on the 2016 inspection. In light of the draft inspection report from May 2017, we are aligning the actions to ensure we do address all the issues, including clinical record keeping.

Transformation:
JG confirmed that the hear and treat (H&T) project is focused on bringing in additional clinicians to support EOC and improve H&T capability. The rationale being that with enough clinicians, they can assess lower acuity patients and aren't constrained by NHS pathways. It will become a multi-disciplinary clinical advice service in conjunction with 111. The aim is that with APR, all category 3 and 4 calls are assessed by a clinician before tasking to dispatch; increasing utilization of non-urgent transport as a result. DM felt the project is progressing well. We are in the recruitment phase and have two training courses scheduled.

GC asked about the sort of clinicians we are aiming to attract. JG explained these would be from various backgrounds, such as nurses, midwives, i.e. not just paramedics.

RF asked JG to clarify his comment about "not being constrained by NHS pathways". JG explained that this will mean professionals can use their expertise and training to make decisions, but with the support and governance of decision support tools.

On APR JG explained this is a fantastic opportunity to reset how we deliver a service. It allows us to make more rationale decisions and to consider utlisation of different lower acuity options, which could include enabling more scheduling. Categories being promoted through ARP will allow us to offering more ETAs to patients, in turn encouraging more self-help. From a projective perspective the training is under way; the project team is in place; and we are on track to deliver for 22 November. But 22 November is the start of the journey, as over the next 18/24 months we will be reviewing and amending our rota and fleet requirements.

RF asked about those Trusts that piloted ARP, and whether there are arrangements in place to get intelligence from those who are more advanced than us. JG confirmed this is in place, for example, staff are visiting other trusts, and are utilizing training programmes already developed. We are also taking early lessons from their pitfalls and challenges, including how we are likely going to need to re-profile our fleet.

GC asked what are we doing to communicate to the public. JC confirmed we have a communications plan as part of the project group, drawing on learning from the pilot sites and using the national communications which have been developed. There are key stakeholder events planned too.

In terms of the HQ project, JA explained we have moved to Phase 2, which includes the decommissioning of Banstead. There has also been progress with ECPR. Our current contract for ECPR software ends in March and so we will be considering our options over the coming weeks.

RF felt that it was important to acknowledge the smoothness with which some of these projects have been implemented, in the context of everything else management has had to deal with. LB agreed and felt that this applied particularly to the CAD project given the short timeframe this has been implemented.

Finance:
PA confirmed that at month 5 we continue to be on plan with delivery of CIP and noted that we are though slightly under the full requirement for the year; forecast is £14.2m against a plan of £15.1m. He went on to explain that the programme is back-ended. Although this carries some risk the established schemes, save for agency, is low risk of non-delivery. Finally on CIP PA reminded the Board of the risk that a significant proportion of the CIP is non-recurrent, which will put pressure on 2018/19.

AS asked about the list of CIP schemes in the paper and commented that it is difficult to understand. There was then some discussion about how the CIP schemes are pulled together and the fact that they are quite one-dimensional. GC explained that the issue is therefore about whether we are meeting our financial targets.

86/17 Medicines Governance Optimisation Plan [11.37 – 11.46]

FM reminded the Board that there were a number of requirement actions identified by the CQC following its inspection in May, as listed in the paper. FM acknowledged the focus of JG and his operations team is delivering the improvement needed. All the actions have been delivered, save two;

1) We haven't yet collected all the BOC Cylinders, but will have done within the week
2) We haven't yet had delivery of all locks/keys for the safes on the ambulances; these are due on 6 November 2017.

FM explained the daily assurance checks led by team leaders, and overseen by the central hub. And the weekly task and finish group chaired by DM.

AS acknowledged the focus we have given to improving medicines governance, and asked whether we are putting staff in any difficulty by asking them to comply with these standards. FM confirmed that she did not think so, explaining that what we are trying to embed is simply good and safe practice, in particular safe, and secure practice of controlled drugs. FM went on to explain that people coming in to ambulance services are taught about pharmacology (like doctors are) but little about medicines management, so it is something we need to work with universities on to ensure better training and education. In the meantime, our improvement plan aims to ensure our people better understand their responsibilities.

87/17 999 Call Recording [11.46-11.58]

DM reminded the Board this was part of the Notice of Proposal. We took immediate action to bring in suppliers to isolate the issues so they could be fixed. We also carried out audits and went through period of time where no issues were identified. However, a new issue was identified in early September and the executive effectively lost confidence in the platform, hence the steps outlined in the paper. We brought the provider in to upgrade the software which has fixed the issue, but due to its evident instability, we are exploring options to replace the telephony platform. The business case is being developed and will come back to the Board for decision.

RF asked whether the difficulties around telephony are linked to us not using tried and tested system; in other words, have we done our own thing. DM acknowledged that this is in part, true, but the challenges have been the number of single points of failure. JG added that the business case will set out options to introduce a dedicated 999 platform which he feels will improve resilience.

LB asked that the business case includes how we can provide assurance that we choose the right solution, to reinforce the right decision.

In summary, RF confirmed that we have put in yet another fix which as far as we can tell has stabalised the system and so at least for now we are assured it is fixed. But due to the intermittent nature of the issues in the past, the executive would want to introduce a new platform. A business case will come to the Board in due course. In the meantime, the Board is assured that the executive has the issue in its sights and is closely monitoring it.

88/17 Bullying & Harassment Report Update [11.58-12.01]

DM confirmed the steps being taken to review the outputs from the recent staff engagement workshops to inform the strategic narrative and the plan coming to Board in October. In the meantime, any known issues are being taken forward with individuals. We are also reviewing how we ensure staff feel more confident in coming forward to ensure we change the culture and stamp out such behavior.

The were no questions from the Board.

RF added that we are taking this very seriously, and working on our actions. He confirmed that inappropriate behaviour is unacceptable, full stop.

89/17 STP Update [12.01 – 12.10]

JA explained that STPs are now coalescing in the new structures, and there is money now available through STPs, via CQUINS, and other bids as per the paper. We are hosting a workshop to consider a single offer from a regional perspective. Similar work has started on stroke and mental health. Finally, we are using new structures and the four STPs rather than the 22 CCGs to meet some of our challenges.

TH asked about the MOU referenced in 3.3. JA explained this helps to ensure commitment between organisations as part of the STP. He assured members that anything that impacts on funding or structure to the Trust would come to Board.

GC noted that this paper omits 111. JA explained 3 of the 4 STPs have had market events on the procurement of 111 services and the Board will be considering this at its meeting in October.

Comfort break 12.10 – 12.22

90/17 Integrated Performance Report [12.22 – 12.53]

Operations:

JG expressed disappointment that we continue to be unable to achieve constitutional standards. August was the last month where we have been using multiple systems, and with the new CAD we are counting things differently to before.

In activity terms, the actual activity bears little resemblance to the plan. Our crews are still attending the same number of incidents, but the new CAD is counting incidents differently, and showing a 10% variance, which we are exploring.

LB asked about CFR decrease in performance. JG explained some of the reforms in how CFRs function, including having one single CFR dispatch desk. DM added that he has asked for a clear action plan on all the arrangements including how we resource and task CFRs in line with plans for ARP.

AR noted that at the Council of Governors, Governors asked about the tail, and felt the Board should be focused on this too.

GC agreed that clearly operational performance is nowhere near constitutional standards, but it is also below the trajectory agreed with commissioners. He asked whether there are any contractural issues/fines – JA confirmed not.

Workforce:
DM confirmed that career conversations continue to improve; in fact, since this paper was written it has increased to 44%. Stat/Man is 60% and we have good focus on this to ensure all staff are up to date.

RF noted that the Prof. Lewis report shows a high number of bullying and harassment incidents, yet year to date we are showing only 8 cases. He suggested this is evidence of the problem, i.e. staff don't think it is safe to report bullying and harassment or nothing will happen as a result. In other words, in building trust, we have a long way to travel.

TH asked whether we can include in the report themes and timeliness of investigation.

Clinical Effectiveness:
FM tabled a breakdown on cardiac arrest data to better explain what the data is and put it in to better context. This will form part of the IPR going forward. FM explained that this shows the number of cardiac arrests and the number we attempted resus is set out. Of these, we break down in to Ustein as defined in the paper. ROSC sustained to hospital is good and in keeping with the national average. Although the numbers are quite small. The overall survival to discharge is what we report. The additional information helps to compare with the national database.

Quality:
SL highlighted Sis and duty of candour; neither good enough. He explained we are in a period of catch up.

LB noted the reduction in backlog of incident and felt this is positive progress. Duty of candour compliance is concerning, and SL confirmed the issue is about culture and understanding. In terms of SG level 3 training SL explained that we now have an online version of training, which enables us to prioritise who needs face to face and who can do it online. This will help ensure better take up.

Finance:
PA confirmed the month 5 positon is in line with plan. In terms of reduction in activity, this impacts on income, hence the shortfall in-month. The forecast for the year remains unchanged and in line with the control total. In terms of risk, PA explained that the best indication is in figure F6, and we have to watch income and ensure any variance is reflected in expenditure. In summary, so far so good.

In terms of what we know regarding likely future income levels, AS asked if there is anything to cause doubt to these numbers. JA explained there are a number of things; we have secured an additional £1m, plus bids with STPs, and we will be asking for more investment by CCGs. In terms of risk, there is still some work to do on activity. We have until mid-October to reconcile the numbers following the introduction of the new CAD.

TH asked if there are any winter monies. JA confirmed this is in the plan already, although we will be pushing for more.

On capital expenditure GC asked if we on track with delivery of new fleet. JG confirmed we are on track for Q4 (42 vehicles to replace the oldest vehicles). In terms of overall capital position, PA explained the decision to use an operating lease explains some of the shortfall. In terms of cash, we are in a reasonably healthy position and will be repaying the £3.2m loan as planned.

AS reminded the Board that the plan is for the integrated performance report to come to Audit Committee for review.

91/17 Serious Incident Annual Report [12.53 – 13.01]
FM introduced this paper, which looks back to 2015/16 analysing the incidents and giving an overview of where we are with the process of managing serious incidents. FM added that there has been much improvement in the last 5 months or so, ensuring quality of investigations is improved, better timeliness, and learning. In the report is some examples of how we learnt from last year and the plans for this year.

AR asked about section 4.2 in the paper where we described a 66% increase in non-conveyance/condition deteriorated. FM confirmed this is just 6 incident and went on to explain that we pride ourselves on treating people at home wherever possible and the advantage of the clinical hub JG referred to earlier and our investment in specialist paramedics. There was a discussion about the Trust taking considerably less people to hospital than other Trusts and the value this adds to the system which isn't always recognised.

The Board noted this report, acknowledging there have been gaps in implementation of systems, but assured by the current executive focus in this area.

92/17 Clinical Audit Report [13.01 – 13.05]
FM set the context of clinical audit and the difficulty in this area with shortages in staff, for example. We planned to undertake 9 audits in addition to the AQIs. Four were completed.

LB agreed clinical audit has been in a difficult place and this report reflects the work that has been done.

93/17 WWC [13.05 – 13.06]
This paper was taken as read.

The Board had no questions.

94/17 QPS Escalation Report [13.06-13.08]
LB highlighted that there are a number of areas we are not assured on and these areas will remain within the sight of the committee until it is assured.

On EOC, the discussion at the committee highlighted that there is a need to review how we record complaints so as to give a true picture.

The Board has no questions.

95/17 Audit Committee [13.08 – 13.13]
AS noted the need to ensure timeliness of papers.

On the BAF, it sets out strategic risks, but the Committee did not consider it a framework to assure the Board, so in that sense more work to do.

In addition, AS confirmed that the policy review timeframe is courageous. There is already a big agenda, and felt that it will take longer than 31 December 2017 to ensure all policies are up to date.

96/17 Any other business [13.13 - 13.15]
RF asked KPMG in the audience about their review. They confirmed that they are coming to the end of their work, and have been able to attend committees and spend time with crews. There has been really good engagement and cooperation. The plan is to feedback to the Board in October.

97/17 Review of meeting effectiveness

RF will review agenda to ensure sufficient time for items.

Questions from observers

Question 1
I learnt at yesterday's Annual Members Meeting from the Mental Health appointed governor that the respective trusts have no policies/procedures in place for joint serious incident investigations or learning sharing in accordance with the NHS Serious Incident Framework copy attached.

In view of the increase in mental health work especially the recent report into mental health patients in Sussex, does the board share my views that this matter needs addressing?

FM answered that there is no formal agreement but we do work to NHS guidelines. If one incident involves more than one Trust only one can take lead, but there is cooperation. FM added that we are well-placed as one of only a few ambulance trusts with a mental health consultant.

There being no further business, the meeting closed at 13.17pm

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

Date _____

South East Coast Ambulance Service NHS FT action log

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
30.05.2017	31 17	A report to the Board in Autumn setting out how the Trust is ensuring learning from complaints, incidents, SIs etc.	SL / FM	29.11.2017	Board	IP	Learning is covered in various elements of the Unified Improvement Plan and a paper will come to the Board in November pulling this together and confirming the progress made to date
29.06.2017	45 17	Ipad business case to be reviewed by Finance and Investment Committee in October 2017.	DH	18.01.2018	FIC	IP	Added to FIC meeting agenda on 18 January 2018
29.06.2017	51 17	To bring back a deep dive in to clinical outcomes to the Board in November 2017	FM	29.11.2017	Board	C	On agenda
25.07.2017	65 17	JA to review and refine the handover project to include how we measure the impact on patients.	JA	29.09.2017		C	29.09.17 Update: System working group has been established to review quality metrics and resulting actions. Daily, weekly and monthly metrics are being provided to CCGs and regulators. A recent meeting has resulted in a joint action plan.
25.07.2017	65 17	WWC to seek assurance that the workforce plan is established. The plan to come to the Board in October.	SG	26.10.2017		IP	WWC is meeting in 20.10.2017 where the workforce plan will be discussed. The plan will then come to the Board in November.
25.07.2017	65 17	JA to ensure that key external deadlines are included in the dashboard / new delivery plan, for example the deadline for the medicines optimization action plan.	JA	26.10.2017		C	The revised Unified Improvement Plan includes timescales which align to planned CQC deep dives and the Trust's aim to exit special measures
25.07.2017	66 17	Report back to Board in October how the strategy has landed with our internal and external stakeholders.	JA	26.10.2017		C	Included in CEx report
25.07.2017	68 17	Workforce and Wellbeing Committee to scrutinise the training figures reported in the IPR and agree how best to report completion of Appraisals	SG	26.10.2017		C	Considered at the WWC meeting on 20.10.17 - see escalation report
25.07.2017	68 17	IPR to include greater detail about vacancy rates, to ensure clarity on the true number, especially if we are reporting a vacancy when it is covered on an interim/agency basis.	SG	26.10.2017		c	The IPR now includes a pipeline adjusted vacancy rate taking into account those roles that have candidates allocated to them. Further
25.07.2017	68 17	Workforce & Wellbeing Committee to seek assurance that the process for approving the recruitment of vacancies is sufficiently nimble and not too bureaucratic.	SG	26.10.2017		C	Considered at the WWC meeting on 20.10.17 - see escalation report
29.09.2017	84 17	Board away day to discuss our strategic approach to be scheduled for February 2018.	RF	Feb-17		IP	

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	

Name of meeting	Trust Board	
Date		
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

October 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 and Non-Executive Team

2.1.1 Recruitment to the roles of the Director of Human Resources & Organisation Development, the Director of Nursing & Quality and the Director of Strategy & Business Development is underway, with long-listing for each role now taking place.

2.1.2 Depending on the availability of candidates we are looking to hold interviews in mid-November.

2.1.3 Recruitment is also currently underway for two Independent Non-Executive Director posts, one of which is for the vacant 'clinical' NED role. The Council of Governors will hope to make appointments to these roles at their meeting at the end of November 2017.

2.2 CQC

2.2.1 On 4th October 2017 the Care Quality Commission (CQC) published its report into the Trust, following a planned inspection in May 2017.

2.2.2 While the report recognised that progress since the previous inspection in May 2016 has been made in some areas, it concluded that this had not been as rapid or as widespread as it might have been. Therefore, the overall rating for the Trust remained as 'inadequate'.

2.2.3 The CQC report into the NHS 111 service was also published at the same time. This recognised that significant improvements had been made since the previous inspection, resulting in an overall rating of 'good'. This is a fantastic reflection on the hard work of the staff involved.

2.2.4 On 5th October 2017 a Quality Summit was held to consider the findings of the report and how the broader system can help the Trust to address the issues identified. This was led by NHS Improvement and the CQC and was a useful opportunity to gain in-put from a number of local and regional partners.

2.2.5 Since the inspection in May 2017 the Trust has undertaken significant changes, including reconfiguring the EOCs and creating a new EOC and HQ in Crawley, implementing a new Computer-Aided Dispatch (CAD) system and completely re-designing and implementing the approach we take to managing and using medicines.

2.2.6 I believe that the pace of improvement has picked up since the CQC visit in May 2017 but I am very aware, as is our senior team, that there remains a significant amount of work to be done.

2.2.7 In terms of ensuring the Trust continues to make the right progress, we have refreshed our Unified Improvement Plan to now include eleven key areas of focus. Each area has its own Project Plan and Task & Finish Group to ensure that the right actions are taken and we keep making progress.

2.3 Operational Performance

2.3.1 The Executive Team are continuing to closely monitor 999 performance on a weekly basis.

2.3.2 September 2017 was the last month where we were recording data from two separate CAD platforms and we have now migrated fully over to the Cleric Computer Aided Dispatch (CAD) system.

2.3.3 The performance position for September is extremely disappointing, with us not achieving constitutional standards or the revised commissioners' trajectory. This is, in part, due to the on-going abstraction challenges within EOC, particularly with 999 call handlers and the developments necessary to prepare staff for the Ambulance Response Programme changes. This has been particularly challenging within the 999 Emergency Call Handler cohort and means that, in reducing our ability to answer calls in a timely manner, this also impacts on the delivery of Red 1 and Red 2 performance.

2.3.4 In combination with the above challenges, we have also seen a significant rise in the overall acuity of our activity, with Red activity (8-minute response) increasing to some 44% of the overall activity compared to 36% three months ago.

2.3.5 I have asked the Director of Operations to produce a performance improvement plan to address all the areas of concern. This plan covers both EOC and Field Operations activities and is being supported by personnel from other Ambulance Trusts and the Association of Ambulance Chief Executives (AACE).

2.3.6 One of the compounding challenges in the move to the new EOC at Crawley has been an increase in the rate of attrition within the EOC staff group. We have, to date, lost approximately 40 staff within the EOC since April. In order to meet this increasing challenge, we have been working with our colleagues in HR to double the recruitment effort within the EOC, particularly within the EMA cohort, to try and improve the workforce position before the onset of winter.

2.4 Restart-a-Heart awareness campaign

2.4.1 For the second year running, I am very pleased that SECAmb is participating in the Restart-a-Heart awareness campaign where many staff, volunteers and partner organisations have been busy teaching CPR to people across our region.

2.4.2 I'd like to thank all those involved in organising the event and teaching, mainly young people, such an important skill. I understand that this year we saw 16,800 people trained; this is an incredible achievement and everyone involved should be very proud.

2.5 Listen, Learn, Change Conference

2.5.1 On 4th October 2017 the Trust hosted the 'Listen, Learn, Change' Conference at the AMEX Stadium in Brighton. This was a one-day conference on how we use learning to improve patient safety.

2.5.2 It was a fantastic event, with more than 200 attending from the Trust and from a broad range of regional and national organisations.

2.5.3 Feedback from delegates was extremely positive and we will be looking to build on the success of this with a further Conference in 2018.

2.6 Station visit programme

2.6.1 On 25th September 2017 I started phase one of a programme of visits to ambulance stations and Make Ready Centres. This phase, which runs up until the end of October, will see me visit seventeen locations across the Trust to chat with staff and discuss issues which are important to them presently.

2.6.2 This is phase one of the programme and I am aiming to visit as many locations as possible before the end of the year.

2.6.3 The visits have proved extremely useful so far and I have thoroughly enjoyed the opportunity to meet with staff informally, listen to their concerns and discuss the broader issues affecting the Trust.

3. Regional issues

3.1 Trust's Strategic Plan

3.1.1 Since the launch of our Strategic Plan at the July Trust Board, we have actively engaged with a number of internal and external stakeholders building on from a wide-ranging set of engagement activities undertaken when developing the strategy

3.1.2 Internally we have held interactive sessions with a number of operational teams and with support staff across PMO, HR, Fleet and Logistics, and with our Council of Governors, as well as using a range of internal communication mechanisms to raise awareness of the Plan. Further events, materials and articles are planned.

3.1.3 Following a session held with the Trust's Staff Engagement Forum (SEF), we have also agreed that we would ask the SEF to assist us to examine how well staff and volunteers understand and are engaged with the strategy moving forwards, including working to develop and undertake a survey. We will also use this forum to help review the strategy in February 2018.

3.1.4 Externally we have presented the strategy to a range of local STP leads, presented it via stall at the Annual Members Meeting and at a national volunteer's forum. It has also been discussed at the Single Oversight group with commissioners and regulators.

3.1.5 We held a workshop session at the Trust's Inclusion Hub Advisory Group focussed on key external messaging around the strategy.

3.1.6 Support is also being given to those who are leading on developing supporting enabling Trust strategies, such as Workforce, Fleet and Medicines, to ensure these are consistent and link into the overarching Strategic Plan.

3.1.7 To date, the Strategic Plan has been well received with the clear understanding that it is a dynamic document that will be revised in light of changes. In light of the Ambulance Response programme and any other changes this will initially take place in February 2018, with engagement of a range of internal and external stakeholders as regards the current document and incorporating their views into the next version.

4. National issues

4.1 Winter Planning

4.1.1 This year there is significant national focus on preparing for winter which is being led jointly by NHS Improvement and NHS England.

4.1.2 Key areas of national focus include:

- Expanding the national flu vaccination programme
- Providing extra hospital bed capacity by reducing delayed transfers of care
- Increasing the emergency care workforce
- Ensuring a robust, system-wide approach to clinical oversight and risk management through the creation of a national Emergency Pressures Panel

4.1.3 We have developed a Trust-specific Winter Plan, which is being shared with local partners. We will also ensure that we are fully engaged in the regional escalation processes.

5. Recommendation

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

Daren Mochrie QAM, Chief Executive

16th October 2017

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	

Name of meeting	Trust Board
Date	13 October 2017
Name of paper	Unified Improvement 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 how it will support the delivery of the CQC recommendations.
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 note the developments of the CQC Task and Finish Groups • To review the dashboards to be fully sighted on the current progress of the Unified Improvement Plan (UIP)

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 Improvement 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 Unified Improvement Plan (UIP).

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 UIP and in particular notable risk areas.

2.0 PMO and Governance update

2.1 In recent weeks, all projects have now been mapped across to the new Programme Governance and Steering Groups have now been established to monitor progress against project plans.

2.2 Programme Risks for all the UIP programmes will continue to be monitored through the Trust Risk Management system Datix with the Executives having sight of the top risks on a monthly basis.

3.0 UIP Progress and Risks

Compliance Steering Group

The PMO, working with Executive Leads have now established ten Task and Finish Groups to address the recent findings in October's CQC report.

Theme	Director Lead
Incidents (Incidents, Datix, Serious Incidents, Duty of Candour)	Steve Lennox
Medicines Management	Fionna Moore
999 Call Recording	David Hammond
Safeguarding	Steve Lennox
Risk Management	Steve Lennox
Governance, Health Records & Clinical Audit	Fionna Moore
EOC	Joe Garcia
Performance Targets & AQIs	Joe Garcia & Fionna Moore
Complaints	Steve Lennox
Engagement – Staff and Patients	Steve Graham

3.1 Each Task and Finish Group will report weekly to the Compliance Steering Group which progress will be tracked against the Improvement Action Plan. Each group will go through a four phased cycle;

1. Delivery (this is the stage where we ensure the action is right and that it delivers to plan)
2. Assurance (this will form part of the Station Assurance Audits)
3. Scrutiny (this is to ask if the actions delivered are working and releasing the required change)

4. Business as Usual (only once assurance has been provided otherwise the project will go back to the Delivery Phase)

3.2 Annex A shows the 10 projects and when they would need to move to the Scrutiny phase to be ready for CQC Deep Dive. It is anticipated that each project will go into Scrutiny for a month. This group will be chaired by Daren Mochrie and will meet weekly.

3.3 Each Task and Finish group will report weekly to the Compliance Steering Group to ensure pace and traction. Any escalations will feed into the weekly Turnaround Executive meeting.

3.4 The progress update on medicines governance is set out in Appendix 1.

Culture and Organisational Steering

The themes from the focus groups have been analysed and a Phase 1 Action Plan has been drawn up which is due to presented to this month's Board.

To support effective project management and assurances, the Culture and Organisational Steering group will be re-established with cross Trust representation.

Service Transformation & Delivery Steering Group

3.4 Good progress is being made on the Ambulance Response Programme with the emphasis on this phase for training of clinicians 22nd November 2017. Increased Hear and Treat is also making good progress with ensuring that we have sufficient enough clinicians to use the decision support tool.

3.5 Deloitte has recently been commissioned to undertake Demand and Capacity Review to develop our future workforce. A report is expected in the early New Year.

Sustainability Steering Group

3.6 Discussions with Executive Directors/Budget Holders/CIP Project Leads have now identified £15.1m of fully validated CIPs schemes against the target of £15.1m. Further potential schemes have been identified and are in the course of development. Actual achievement of CIPs to the end of month 6 is running ahead of the Plan figure of £6.8m by £0.2m. The CEO has received a letter from Paul Bennett, NHSI Regional Improvement & Delivery Director, advising that NHSI will be looking for assurance on the Trust's budget setting process for 2018/19. Finance are in the course of developing the strategy for budget setting and will agree the approach with the CIPs team and Finance Director following completion of the M6 results.

3.7 The CAD system has now been live across all controls since the beginning of September 2017 and following some initial problems around freezing the system appears to have settled down and is operating as expected. The final elements of the work related to CAD are to now plan the decommissioning of the Banstead datacentre and to relocate the hardware infrastructure into Crawley. It is expected that the work will be completed prior to the end of November 2017.

3.8 The ePCR project is still making good progress, in terms of onboarding, the Trust is at 93.7% with the aim to achieve 98% by 30 November 2011. Project completion

scheduled for 29 March 2018 may be affected by the Trust's decision to deploy ePCR version 1.3 on a new platform but this risk is being closely monitored.

4.0 UIP Dashboards

4.1 Dashboards is provided for Financial Sustainability (CIP focus) and Unified Improvement Plan.

4.2 The Unified Improvement Dashboard captures the high level milestones and associated Key Performance Indicators (KPIs) for this reporting period, extracted from the Project Plans. The Project Plans will continue to be developed to provide assurance to the Executives that there is pace and grip of the projects and they continue to deliver the expected outcomes.

4.3 The Dashboard will continue to be developed with more work on outlining the description of measure, current target, end target and actual targets for each KPI.

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 UIP. Progress continues to be made with increased control and grip over delivery.

6.0 Recommendation

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

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.

Appendix 1

Medicines Governance Optimisation Plan Progress Update

1 Introduction

1.1 Following the inspection by the Care Quality Commission (CQC) in May 2017, a medicines governance optimisation plan was developed to ensure sufficient remedial action and submitted to CQC on the 22nd July 2017.

1.2 12 specific areas were highlighted and the plan aimed to ensure improvement in each of the areas by 22nd September 2017. The Trust has provided the CQC with evidence to support the action that has been taken.

1.3 A task and finish group chaired by the Chief Executive was set up to deliver of the 12 key areas. A medicines hub was set up to oversee operational delivery of the changes in practice and provision of a local assurance framework to identify themes and compliance

1.4 All evidence was submitted to CQC on the designated dates identified by CQC.

1.5 Training of 221 management and operational team leaders in the revised standard operating procedures has taken place over the past month to embed changes in practice and to allow roll out and cascade training to all operational staff.

1.6 The CQC returned for an unannounced inspection on the 29th September 2017 and visited stations both Omnicell and non-Omnicell.

1.7 On 5th October the Trust held a CQC summit with partner organisations to advise of the May 2017 report outcomes and the actions required by the Trust. At this meeting the extent of the work undertaken by the Trust to improve Medicines Governance was acknowledged by the CQC.

1.8 CQC full report has been received and published in September 2017 and medicines governance improvement plan has been drawn up and phase 2 has begun to improve further medicines governance and management in the Trust

1.9 In March 2017 an external independent medicines governance review at South East Coast Ambulance Service NHS Foundation was commissioned by the Trust, and approved by NHSI. Phase one of the Review, reviewed specific elements of medicines governance was completed in July 2017. The findings of this phase have been reported in a draft report. We continue to work with external independent investigator who will write a report on completion of phase 2 of the medicine governance improvement plan.

1.10 The overarching governance arrangements are in place to ensure sustained improvement and monitoring

2 Background and Progress.

2.1 The twelve areas of concern that were raised by the CQC regarding the storage, management, security and administration of medicines have been actioned. There was a delay in the Double Crewed Ambulances (DCA) drug cabinet keys which CQC were sighted on. The DCA have now begun cycling through the make ready centres and universal locks are being replaced with individualised locking system. Full track and trace on these DCA drug cabinet keys has been implemented at all sites.

2.1 CQC visit on the 29th September concluded that there was nothing untoward with medical gases. No out of date medicines were found, recording of temperatures was seen in medicines areas and that staff were fully engaged and aware of the work going on around medicines. Staff were welcoming and supportive.

2.2 Medicines stocked on stations did not match the centrally held stock list was part of phase 1. We now have a master stock list and have identified all authorised medicines on each site depending on which staffing group works out of each site. Medicines are only accessible by the staff authorised to administer them. All stations have a printed copy displayed of their authorised stock list. In Phase 2 we will look at stock levels and management of the ordering processes. We will also look at the procurement processes and drug applications process.

2.3 CQC report identifies the process of tagging medicines bags was not working effectively; while the concept of tagging was right, the governance, control and accountability was lacking. There have been daily assurance checks in relation to this process. As we continue into Phase 2 we will look at the signing sheet for the pouch system as it has been identified during checks that the compliance is poor due to the complicated packing sheet. Talks have already begun with Aseco software company to improve this process.

2.4 CQC report identifies inconsistent management of Controlled Drugs was compromising safety and security. During phase 1 of the plan we introduced new processes around recording, disposal and CD activity checks by Operational Team Leaders (OTLS). We have also introduced personal possession CD pouches to address our CD breakages and increase our governance around CD management. Going into phase 2 we will do trend analysis on breakages and further implement change where necessary. The medicine governance team quarterly inspections have begun and CD liaison police officers are inspecting the Trust both with the medicines team and unannounced. On these inspections we will audit the compliance to OTL weekly CD checks and CD management around CD entries, disposals, administration details and security.

2.5 CQC report identifies a lack of temperature monitoring in all areas that store medicines. All areas that store medicines have been issued with temperature monitoring equipment the daily logs are now electronic on the iPAD and escalation procedure identified as per standard operating procedure (SOP). As we move into Phase 2 the weekly OTL checks and medicines governance quarterly inspections will monitor the adherence to this process.

2.6 CQC reported the current scope of practice for staff outside of those authorised to use a PGD (patient group direction) was sitting outside the Human Medicines Regulations (2012) all medicine administration protocols (MAPs) have been withdrawn where appropriate these have been reintroduced under PGD legislation. Going into Phase 2 a PGD working group has been set up and a PGD SOP and new PGD proposal application form is in draft form. This working group is a sub group of Medicines Governance Group (MGG) chaired by the Medical Director. A report on the PGD working group activity will be presented at MGG.

2.7 Mechanisms for securing ampoules in cardiac pouches has been worked on in phase 1 of the plan and we will continue to monitor in phase 2. We will consider to look at new ways of housing our medicines in our current system more safely and look to alternative options going forward.

2.8 Security codes for medicines rooms were being written on the door to access the medicines seen during our inspection in May continues to be monitored by OTLs and staff are held to account where applicable. As we move into phase 2 the Trust is looking at alternative security methods.

2.9 CQC report that our Medical Gas storage and security did not meet in full the Department of Health (DoH) guidance 2006. Much work has been done to ensure we are compliant with DoH. In our recent inspection on the 29th September CQC had positive feedback in terms of our safe and secure handling of medical gases. A medical gas subgroup of the MGG has been set up and problems identified are been addressed and escalated where appropriate. A report will be presented to MGG.

2.10 CQC reported that lack of safe and secure storage and access to medicines used for purposes of training only. An SOP has been ratified for the use of out of date medicines for training with strict governance controls. Currently there are no medicines used for training purposes. During phase 2 we will scope the requirement and a decision will be made on what is used going forward.

2.11 Medicines Policies are out of date.

2.11.1 Currently a medicine optimisation strategy is in draft format which is aligned to the Trust 5-year Strategy.

2.11.2 Medicine Policy is due to be in draft format by November 2017

2.12 Education and training –a training plan will be in place for all staff in medicines management for key skills deliver 2018/19. PGD training will be required to be completed by all staff. Options for delivery of education e.g. E-learning will be looked at during phase 2 of improvement plan.

3. Assurance Process

3.1 Weekly and monthly assurance checks are in place at station level to measure completion and compliance against a number of parameters in relation to safe and secure handling of medicines.

3.2 These assurance checks are undertaken by Operational Team Leaders (OTL's), via electronic portal developed internally. We are now looking at options for ongoing IT reporting systems and performance dashboards.

3.3 The medicines hub holds a weekly conference call to discuss findings of the station audits, shares best practice and holds teams and other departments to account for delivery against the action plans.

3.4 Quarterly station inspections by the medicines governance team has begun. Feedback is given to OTLs and operating unit managers. Actions are followed up where appropriate by the medicine governance team.

3.5 In addition the Quality Assurance Visits undertaken to do a 'deep dive' on stations using the KLOE approach will continue to include medicines management as part of that process.

4 Governance Processes

4.1 The overarching Governance of Medicines sits with the Medicines Governance Group (MGG).

4.2 There are two sub groups that report into the MGG which are Patient Group Directives and Medical Gasses.

4.3 MGG reports and escalation issues are discussed at the Practice Group which has been established by the Executive Management Board.

4.4 Implementation of any new medicines will now be agreed at the MGG and then go to the New Interventions Group for wider consultation and agreement before implementation.

5 Culture

5.1 The comment from the CQC in the removal of the Notice of Proposal was the shift in culture of our staff that the team witnessed on their unannounced inspection and that they understood and owned the issue, not as a means of getting out of special measures, but as a clinically important issue that impacted on patient care.

5.2 To embed the changes we have undertaken a number of steps to embed change and gain local ownership.

5.3 It was important to set the scene with staff sharing the implications of poor practice by using video messaging and setting clear expectations for improvement

5.4 Face to face educational sessions undertaken with Team Leaders sharing feedback of local audit and workshops to discuss changes to SOPs lead by an executive sponsor to enforce the importance to patients and the organisation

5.5 Influencing future learning of our workforce by engaging educational establishments, teaching on transition to practice courses for new entrants and recently qualified students as well as the ECSW programme and CFR schemes to educate about medicines governance

5.6 Using communications team to reinforce messages to our staff through a weekly medicines management update, clinical newsletter and from the CEO weekly message highlighting learning points from Datix, adverse drug events, sharing breakage and loss figures

5.7 Using innovative ways to provide assurance and development of an IPad system of recording compliance for team leaders which is easy to use and improves working lives and gives immediate feedback

6 Summary

6.1 Significant progress has been made in the management of the project plan to deliver improvements in medicines governance. However, more improvements are still to be made and these will need to be communicated effectively to our frontline staff.

6.2 A structure is now in place to provide Vehicle to Board assurance of both completion and compliance audits completed at local level.

6.3 In addition, there is a series of quality assurance checks at a monthly and quarterly level that are in place to provide board assurance.

6.4 Learning is shared through weekly conference calls, regular updates in the Trust bulletin and face to face learning with OTL's and station management team which is cascaded down to staff. We will continue to improve on our communications to reach the frontline staff through OTLs and their teams.

6.5 Improvement in staff engagement with culture shift and greater accountability at local level

7 Recommendation

7.1 The Board is asked to accept this report as assurance that sufficient progress has been made in addressing the specific issues as listed in section 2.0.

Unified Improvement Plan Dashboard

Progress made to date 10/10/2017

RAG Key:

Red	At significant risk of failure due to circumstances which can only be resolved with additional support
Amber	A risk of failure but mitigating actions are in place and these can be managed and delivered within current capacity
Green	On track and scheduled to deliver on time and with intended benefits
Blue	Complete

South East Coast Ambulance Service NHS
NHS Foundation Trust

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	Project Completion Date	Process / Milestone	Completion Date	RAG	KPI / Outcome	High-level Commentary
Service Transformation & Delivery Steering Group	Increased Hear and Treat Project	Amber	Amber	Scott Thowney	Joe Garcia	31/03/2018	The number of clinical supervisor roles in EOC will be increased to allow compliance with Pathways requirements for clinical supervision and to allow capacity above this for Hear and Treat cases.	01/02/2018	Amber	45 clinical supervisors in post in EOC	Staffing continues to be the predominant challenge within Hear and Treat as attrition has reduced FTE actual to 68.7% of required staffing. This is still based on historic requirement as Work Force Management system and modelling is being reviewed to identify requirement against demand. These two factors when resolved will see the largest improvement in Hear and Treat performance.
							Hear and Treat performance will meet national required standard of 11% whilst ensuring compliance with pathways clinical supervision requirements.	30/11/2017	Amber	Hear and Treat Performance is currently at 6% of overall call volume, the national target is 11%. We will accurately monitor this KPI when the data is readily available - Target to be confirmed	
							The Patient Demographic Service, which allows the look up of patient information by Emergency Operations Centre (EOC) staff, will be improved. This will allow EOC staff to identify patients efficiently at the point of call and access pertinent patient information. This also forms part of an Ambulance enabler CQUIN	31/12/2017	Amber	Improved access to patient information at point of call will increase efficacy of Hear and Treat process. This will be measured in the overall Hear and Treat performance above	
	Demand and Capacity review	Green	First reporting period so no previous RAG	Jon Amos	Jon Amos	01/01/2018	Tendering process completed for the procurement of an external provider to conduct a review of current demand and capacity	29/09/2017	Completed	External provider appointed	Review jointly commissioned with CCGs and provided by Deloitte and ORH. The work has commenced and will provide an interim report in late December and final report at the end of January 2018 The outputs will include: - Review of historic demand and provide a future capacity plan aligned to the ARP standards to include rota profiles and vehicle mix - Case for Change to seek support from the wider system - New contract process and payment model to support the new standards - Timeline and transition plan to move from current state to the new rota profile, fleet mix etc.
							The External provider will have established accurate and current interim reporting procedure	29/12/2017	Green	Unconfirmed during this reporting period	
							Final report submitted with recommendations	30/01/2018	Green	Unconfirmed during this reporting period	
	First Responders and Public Access Defibrillators (PAD)	First reporting period so no previous RAG	First reporting period so no previous RAG	Chris Stamp	Joe Garcia	TBC	Still being scoped	TBC	TBC	Unconfirmed during this reporting period	At scoping stage
							Still being scoped	TBC	TBC	Unconfirmed during this reporting period	
							Still being scoped	TBC	TBC	Unconfirmed during this reporting period	
	Ambulance Response Programme	Amber	Amber	Sue Skelton	Joe Garcia	22/11/2017	A training programme in place to train dispatch and team leaders in new ARP processes and procedures (new call categorisation, automated dispatch)	22/11/2017	Green	Training plan and materials have been developed and training course is underway	ARP is progressing at pace on track to meet the nationally agreed deadline of 22nd November 2017. However ongoing organisation wide issues around training and recruitment/ retention are evident and monitored at Project Board with any escalations to Turnaround Executive on a fortnightly basis
							Dispatch and Team Leaders will be trained in ARP changes identified in the training programme	06/10/2017	Amber	41% of all dispatch staff trained	
							Develop and implement forecasting models that will enable the impact of ARP to be established and allow for accurate forecasting of demand changes.	31/10/2017	Amber	Forecasting models in place, reporting on a monthly basis	
Sustainability Steering Group (see separate Dashboard for Cost Improvement Programme)	HQ Phase 2	Amber	Green	Ibrahim Razak	David Hammond	28/02/2018	Coxheath site is expanded and ready for use as an EOC fall-back site.	31/11/2017	Green	To have two EOC locations with sufficient capacity to provide fall back should an emergency arise	Construction work is underway to increase EOC capacity at Coxheath site. This will provide resilience/ contingency and fall-back for the EOC West (Crawley). This includes the physical Estates, infrastructure, technology and furniture. Options are being evaluated for the long term solution for Clinical Education which currently resides in Banstead site. Similar work is being done for Fleet, Logistics and Production. This will enable the disposal of Banstead.
							All paper documents disposed in accordance with Trust retention policy.	28/02/2018	Green	Inventory of all paper which has been disposed and what needs to be retained	
							Clinical Education, Fleet, Logistics and Production relocated to chosen solution and operational, allowing Banstead to be disposed of.	28/02/2018	Amber	All departments have been fully relocated to chosen solution in agreed timescales.	
	Electronic Patient Clinical Records ("EPCR").	Amber	Amber	Edyta Suszek	Jon Amos	29/03/2018	All hospitals are trained to be able to adopt the new iPad process which will increase efficiency in hospital handover.	30/11/2017	Green	There are 25 hospitals in total to on-board with 11 which have currently gone through the process. These are monitored via a weekly tracker	93.7% of on boarding completed against original iPad stock. Aiming to achieve 98% by 30/11/2017 which is still on track. Release of ePCR version 1.2 has been deployed to live environment on 25th September and caused application crashes which are currently being investigated by Kainos. Apple has also released IOS11 in September and has been successfully adopted by the new ePCR 1.2 application. There has been no progression in hospital ePCR acceptance rollout for this period, but we have 2 Go-live dates scheduled for October. Aiming to achieve. Content Locker management including updates and additions are now running smoothly with minimal delay post request allowing improved Trust communication with frontline staff. Missing ePCR reports and processes are now in place to locate any 'missing' ePCR submissions due to an incorrect Incident number. These processes are ready for Health Records to adopt once they have capacity. Project completion scheduled for 29/03/2018 may be affected by the Trusts decision to deploy ePCR version 1.3 on a new platform.
							ePCR portal is developed and embedded which will allow access to ePCR records and training to all departments.	18/12/2017	Amber	All key departments to be trained and this will be measured through weekly tracking by completion of training	
							All policies, procedures and clinical instructions will be signed off so that ePCR is functioning safely in accordance with trust policy. This will ensure the safety of patient information and ensure that staff are clear on how to use the application.	14/02/2018	Amber	There are currently 14 policies/procedures in draft awaiting approval	
	CAD	Green	Green	Barry Thurston	Jon Amos	05/09/2017	New Computer Aided Dispatch (CAD) system implemented	05/09/2017	Green	Data control centres live with new CAD.	The CAD system has now been live across all controls since the beginning of September and following some initial problems around freezing the system appears to have settled down and is operating as expected. The final elements of the work related to CAD are to now plan the decommissioning of the Banstead datacentre and to relocate the hardware infrastructure into Crawley.
						30/11/2017	Banstead decommissioned to allow data centre relocated to Crawley	30/11/2017	Green	100% of the data centre relocated to Crawley.	

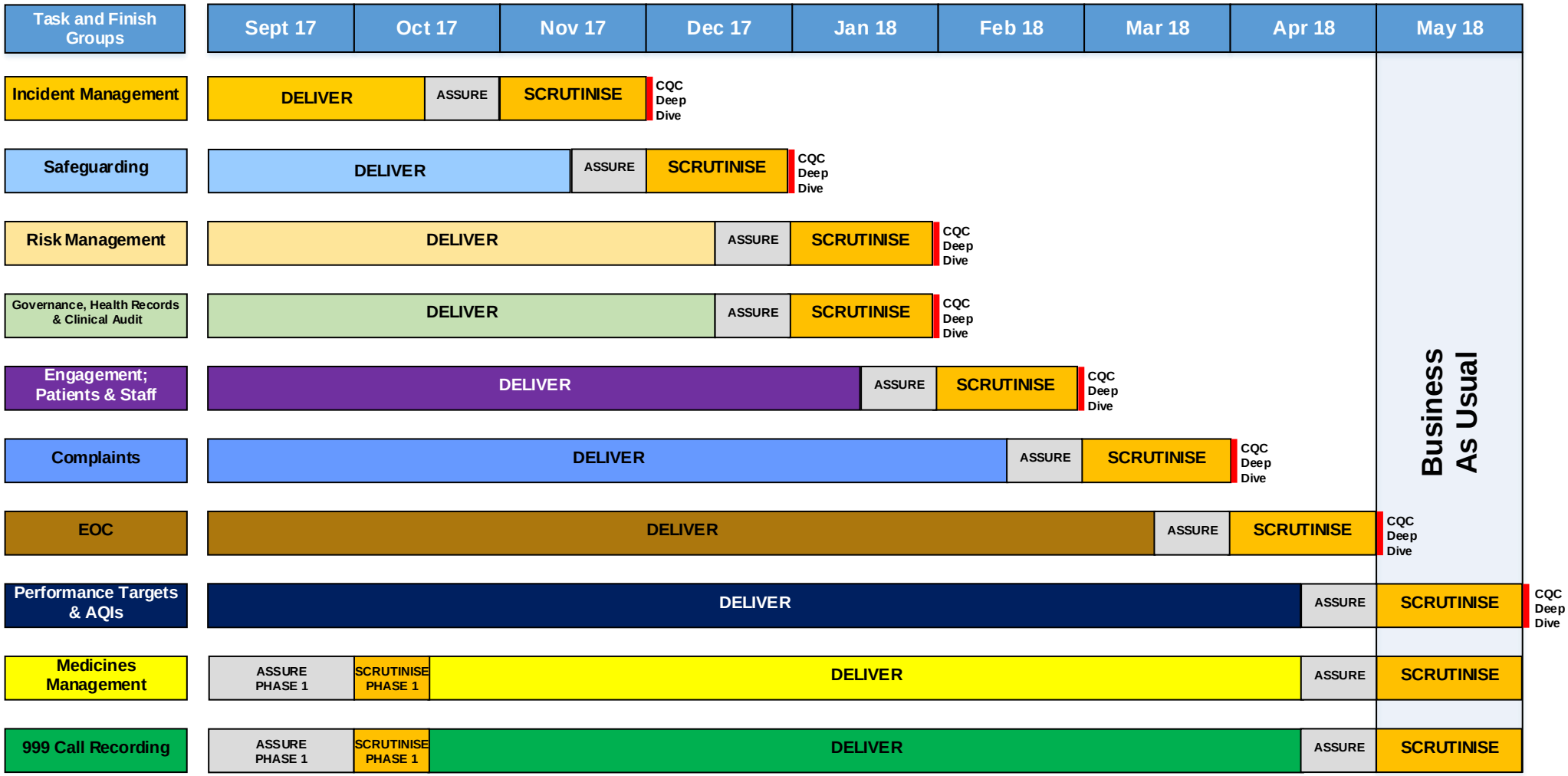
DRAFT

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	Project Completion Date	Process / Milestone	Completion Date	RAG	KPI / Outcome	High-level Commentary
	Informatics	Green	Green	Barry Thurston	Jon Amos	18/12/2017	Design and implement the backend for the database scheme / warehouse.	15/11/2017	Green	Business Case financial KPI (awaiting BC approval)	The Trust are currently continuing with the existing information system and structures which provides a number of challenges to ensuring the timeliness and appropriateness of information provision. The plan to replace the system is being executed with a new server build now complete and West Midlands Ambulance Service (WMAS) agreeing, and commissioned, to provide a new backend database structure. The project has appointed a temporary database administrator (DBA) to support the implementation of the system internally and work progressing on a new interface programme to extract data from the CAD system and upload into the new data warehouse. In addition, the Trust have just approved the business case for the supply of business intelligence (BI) tools to support a self service portal for Trust managers and appropriate tools for the software developers to provide the more complex reporting, for example, ARP, commissioning/commissioners reports. It is expected that the new system will begin to provide reports, dashboards and screen based information before the end the calendar year.
							Develop an interface to lift the data off the existing system and export to the new warehouse.	30/11/2017	Green	Still being scoped	
							Developing tools and people to use the new data warehouse.	18/12/2017	Green	Still being scoped	
	Financial Sustainability	Amber	Green	Kevin Hervey	David Hammond	31/10/2017	CIP schemes totalling £15.1m in line with 2017/18 Plan identified	31/10/2017	Amber	£15.1million schemes fully validated	On track to deliver, some CIP schemes under-delivering, additional CIP schemes under development.
						31/03/2018	Achieved projected financial deficit of £1.0m as agreed with NHSI	31/03/2018	Amber	£1 .0million of projected financial deficit achieved	
						31/03/2018	Identified CIP schemes for 2018/19 Plan - target to be agreed	31/03/2018	Not started	To be confirmed.	
	Incident Management	Green	First reporting period so no previous RAG	Samantha Gradwell	Steve Lennox	22/03/2018	All Trust staff will have received a communication with instructions on what to report and how to report incidents.	31/11/2017	Green	95% of Trust staff will have received instructions what qualifies as an incident and how to report it.	Mandate and QIA have been drafted and awaiting approval at Compliance Steering Group. Improvement Action Plan has been developed, with actions cross referenced back to the CQC Report. Delivery capability will be increased to deliver the plans within agreed timelines. Supporting enabler project underway to improve the Incident Reporting Forms.
							The Trust will have identified and implemented clear roles and responsibilities, with robust processes, for the internal management of incident reporting.	30/12/2017	Green	Governance documentation will show approvals from all JPF and SMT members, as an agreement to adopt and embed the new Incident Management Process for the Trust.	
							The learning of incidents is shared across the Trust and can be evidenced through the quarterly station visits	31/03/2018	Green	During station visits, staff are aware of the learning from incidents (baseline to be agreed)	
							The Trust will identify and merge all incident reporting mechanisms into one system on Datix.	01/01/2018	Green	100% of incidents across the Trust will be logged on Datix only, and the end to process for each incident will be contained within Datix.	
	Safeguarding	Green	First reporting period so no previous RAG	Philip Tremewan	Steve Lennox	23/03/2018	Keeping safe from abuse	31/03/2018	Green	This will be monitored during quality assurance visits.	The Trust's 2016 Care Quality Commission (CQC) report made a number of observations regarding the safeguarding function. This generated an improvement plan and the appropriate actions were completed. The most recent CQC report (October 2017) identified that improvements were required within training for Safeguarding Children level 3 but also identified that further work was still needed to continue this improvement. This project has developed a plan and has a mandate and QIA awaiting sign off.
							All learning from internal and external safeguarding work is captured and appropriately shared across the organisation	31/03/2018	Green	95% of staff, when asked on audit, feel adequately prepared to identify safeguarding concerns and know how to obtain assistance . This will be measured through quality assurance visits and feedback through appraisal bulletins, local governance groups.	
							To ensure appropriate reporting and escalation of incidents that have a safeguarding theme	31/03/2018	Green	This will be measured through quarterly audit checks to ensure compliance with safeguarding policy	
	Risk Management	Green	First reporting period so no previous RAG	Samantha Gradwell	Steve Lennox	24/03/2018	The Trust will have a Datix Risk Management Platform that is fit for purpose and aligns to the organisation's staff hierarchy structure.	08/01/2018	Green	100% risks are managed on Datix, with the end to end process from identification, mitigation and closure of risk contained centrally on one system. A scoping exercise will reveal all other risk registers maintained in the Trust and these will be consolidated onto Datix. The Head of Risk will be able to report on risks across all areas from Datix.	Mandate and QIA have been drafted and awaiting approval at Compliance Steering Group. Improvement Action Plan has been developed, with actions cross referenced back to the CQC Report. Delivery capability will be increased to deliver the plans within agreed timelines. Platform already exists for capturing risks.
							The Trust will have agreed clear roles and responsibilities for the identification, mitigation and management of risk	28/02/2018	Green	Existing risk management policy will be updated with amendments to roles and responsibilities and ratified at Senior Management Team (SMT)	
							The Trust will have communicated a clear set of guidelines on how to identify, report and manage risks at all levels.	31/03/2018	Green	95% of Trust staff will have received guidance on how to identify and manage a risk via guidance which will be shared by email as well as listed on the intranet.	
	Governance, Records & Clinical Audit	Green	First reporting period so no previous RAG	Fiona Wray	Fionna Moore	25/03/2018	Patient Clinical Records will be accurately completed, fit for purpose and stored securely.	31/03/2017	Green	90% of Patient Records will be completed accurately and stored securely	Improvement plan drafted with identified timescales and owners for each action and submitted for approval. Scope of external independent review of clinical audit team drafted and contact made with potential organisations who could undertake this work. Mapped all mandatory audits including time commitment for each audit against resources in audit team. Meeting arranged to discuss minimum data set criteria and supporting processes/guidelines. Task and finish group working on the review of the Patient data and Health Records policy. Commence monthly monitoring of unreconciled PCRs. Criteria used for validation being reviewed.
							The Trust Patient Data & Health Records Policy will always be contemporary and reflect national guidelines and best practice.	10/11/2017	Green	90% of incidents will have Patient Clinical Record linked	
							Incidents will have Patient Clinical Record linked so that we can ensure safe and accurate records.	31/03/2018	Green	90% of all records will have a PCR linked.	
	Engagement - Patients and Staff	Green	First reporting period so no previous RAG	Steve Singer	Steve Graham	26/03/2018	Established local colleague engagement networks	31/05/2018	Green	Monthly meetings established in all Directorates/Units (evidenced by minutes/action plans) by 30/04/2018	Phase 1 of the Action Plan has now been drafted and is due to be presented to the Trust Board this month.
							Staff survey used as a driver of culture change	26/03/2018	Green	Increase of staff morale as evidenced in the staff survey.	
							Local staff suggestions for improvement to be generated.	26/03/2018	Green	Still being scoped.	

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	Project Completion Date	Process / Milestone	Completion Date	RAG	KPI / Outcome	High-level Commentary
Compliance Steering Group	Complaints	Green	First reporting period so no previous RAG	Louise Hutchinson	Steve Lennox	27/03/2018	Improved complaint response times so that complaints are being concluded within the Trust's target of 25 working days.	27/03/2018	Green	By March 2018 90% of complaints should be being concluded within the Trust's target of 25 working days. In 90% of cases complainants will receive their response within the stated timescale, evidenced from Datix, and greater compliance with the target will help to restore complainant confidence in the Trust's systems and processes.	This plan was devised in early October and is progressing within schedule. Mandate and QIA in development.
							Actions are recommended, implemented and learning is generated as a result of complaints, so we can provide evidence of learning from at least 95% of complaints that are upheld in any way	31/01/2018	Green	By January 2018 we will be able to provide evidence of learning from at least 95% of complaints that are upheld in any way, and this will drive improvements to our service.	
							Improved the sharing of learning from complaints, both locally and across the Trust, through discussion of such learning at the newly-established Area Governance Meetings.	27/03/2018	Green	By January 2018 we will have improved the sharing of learning from complaints by utilising a range of different mechanisms to ensure all staff are aware of the lessons that can be learned from others' near misses, errors and misunderstandings. This will also raise staff awareness of the value of complaints and how they are used by the Trust as a useful improvement tool. This will be evidenced via minutes of meetings and by the publications themselves.	
	EOC	Green	First reporting period so no previous RAG	Dean Jarvis	Joe Garcia	28/03/2018	The Trust will have taken action to ensure there are a sufficient number of clinicians in each EOC at all times in line with evidence-based guidelines.	31/03/2018	Green	45 clinical supervisors in post in EOC	The Trusts 2016 Care Quality Commission (CQC) report made a number of observations regarding the Emergency Operations Centre. This generated an improvement plan and the appropriate actions were taken. The most recent CQC report (October 2017) identified that improvements were required in relation to Clinical staffing levels within the EOC, the Trust needs to meet its minimum requirement in relation to auditing 999 calls and although there had been improvements made in call answering, the trusts did not meets the required national standards and further work was still needed to continue this improvement. An improvement plan has been developed to address the latest CQC inspection. Each theme contains a number of strong actions with deliverable timescales that will evidence how measurable outcomes will be achieved and will be used as a benchmark to support the Trust in the areas identified requiring improvements.
							The Trust will have taken action to ensure that the minimum amounts of audits are carried out in line with the requirement needed by pathway to maintain the licence.	31/03/2018	Green	The audits will take place on a monthly basis via an audit function on the info system which was created by SECAmb	
							The Trust will have improved call answering time to align within the national standard	31/03/2018	Green	95% of calls answered within 5 seconds.	
	Performance Targets and AQI's	Green	First reporting period so no previous RAG	Chris Stamp	Joe Garcia	29/03/2018	The Trust meets national performance standards for unit hour supply	29/03/2018	Green	Improvement of unit hour provision against the required baseline of 92% to 100%	Staffing continues to be the predominant challenge within Hear and Treat as attrition has reduced FTE actual to 68.7% of required staffing. This is still based on historic requirement as workforce model system and modelling is being reviewed to identify requirement.
							The Trust meets national performance standards for time at scene - conveyed/ non-conveyed	29/03/2018	Green	Reduction in on scene times (target to be determined)	
							The Trust meets national performance standards for hospital wrap-up times	29/03/2018	Green	Reduction on the time spent waiting for handover and clearing after handover (target to be determined)	
	Medicines Management	Green	First reporting period so no previous RAG	Carol-Anne Davies-Jones	Fionna Moore	31/03/2018	All organisation requirements are reflected in operational framework policies, procedures and plans	31/03/2018	Green	All SOPs, processes and Trust formulary completed, embedded and signed declarations by all relevant Operational staff	First work stream has been achieved surrounding the safe, secure storage of medicines and the culture change around medicines. Continuing work into the next 'phase' to include strengthening governance process, pathways, legislation and on-going education/training as well as implementation of NICE good practice guidance. Mandate and QIA in early draft format.
							The Trust Medicines Management process will ensure that stations are 100% compliant	31/03/2018	Green	The Trust medicines management process will ensure 100% compliance by 31 March 2018	
							A training plan in place for all staff in medicines management	31/03/2018	Green	All staff to have training plans, records and on-going training delivered by 31 March 2018	
	999 Call Recording	Green	First reporting period so no previous RAG	Barry Thurston	David Hammond	31/03/2018	Completed further testing post voice reorder system update to provide assurance that the system is recording all 999 calls.	17/10/2017	Amber	100% of all 999 calls recorded	System upgraded to the latest version which appears, through audit, to have corrected the problem but has, however, introduced a new issue around the quality of calls. Fault has been documented but is not easily repeatable and therefore a full range of testing will be repeated.
							An ongoing robust auditing procedure embedded of the current system to ensure any emerging issues are flagged and escalated in timely manner	19/01/2017	Green	Quality check of calls recorded. 2500 calls audited at a time. Once there are no issues, we will move to sampling around 10%.	
							A business case developed to replace telephony and voice recording systems to prevent further 999 call recording issues	03/11/2017	Green	Business Case sign off by SMT	
	Infection Prevention and Control	Green	First reporting period so no previous RAG	Adrian Hogan	Trevor Hubbard	29/12/2017	Improved station cleaning standards, monitoring/ audit systems and new ATP testing.	29/12/2017	Green	100% compliance evidenced through quarterly audit returns.	
							Awareness raised to improve vehicle cleaning standards with new monitoring/ audit systems and ATP testing.	29/12/2017	Green	100% compliance evidenced through audit returns - 4 per month.	
							Improved hand hygiene, uniform awareness and compliance. New audit tools introduced with partnership working with patients and hospital staff. New hand hygiene equipment for each Operating Unit	29/12/2017	Green	90% uniform compliance achieved. Audit returns and reporting systems for hand hygiene will be evidenced via 10 reports per month.	
	Engagement Values and behaviours	Green	First reporting period so no previous RAG	Steve Singer	Steve Graham	31/03/2018	Definition of organisational values.	31/12/2017	Green	Values defined, agreed and signed off by Board by 31/12/2017	
							SECAmb behavioural framework developed	31/12/2017	Green	Competences and supporting behaviours defined and published by 31/12/2017	
							Values and behaviours embedded in recruitment activity	31/03/2018	Green	100% of recruitment exercises use values and behaviours as part of decision making process by 31/03/2018	
	Effective Leadership and Management	Green	First reporting period so no previous RAG	Steve Singer	Steve Graham	31/08/2018	Competence assessment of all managers across the Trust	31/03/2018	Green	90% managers have attended an assessment event by 31/07/2018	
							PDP's in place for managers	31/03/2018	Green	90% of managers have a current PDP published in Actus as of 31/08/2018	
							MDP2 and Accelerate programmes developed and rolled out	31/05/2018	Green	25 candidates successfully compete each programme by 31/05/2018	

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	Project Completion Date	Process / Milestone	Completion Date	RAG	KPI / Outcome	High-level Commentary
Culture and Organisational Development Steering Group	Appraisals	Green	First reporting period so no previous RAG	Steve Singer	Steve Graham	31/03/2018	Staff undertake an appraisal meeting is recorded in Actus	31/03/2018	Green	80% completion rate by 31/03/2018	
							Actus includes clinical audit module and key skills learning	31/03/2018	Green	100% of individual performance audits and key skills are recorded electronically in Actus	
							Coaching skills rolled out to all line managers	31/03/2018	Green	33% of managers have attended a coaching workshop by 31/03/2018	
	Health and Wellbeing	Green	First reporting period so no previous RAG	Steve Singer	Steve Graham	31/03/2018	A clear, accessible, entry point (Well-Being Hub) provided	31/03/2018	Green	5% year on year increase in staff who feel 'cared for' as measured in the annual staff survey	
							An effective EAP and OH programme provided and managed	31/03/2018	Green	More effective use of OH services; increased uptake and access of EAP (% target to be defined).	
							Effective communication and promotion of opportunities for employees to enhance their well-being is established	31/03/2018	Green	Increase in staff take-up of well-being opportunities (% target to be defined).	
	Clinical Education	Green	First reporting period so no previous RAG	Sally Wentworth-James	Steve Graham	TBC	Trust wide Apprenticeship Plan developed	TBC	TBC	Executive agreement of clinical and non clinical Apprenticeship strategy, action plan, costing, resourcing and numbers across EOC/111 and A&E	
							Level 4 Associate Ambulance Practitioner Programme established	31/03/2018	Green	30 Level 4 Practitioners started course by March 2018	
							NQP Preceptorship programme and B6 TNA and training plan for non graduate paramedics implemented	31/01/2018	Green	200 NQP staff to be using ePortfolio by January 2017. TNA assessment completed by March 2018	

CQC Task and Finish Groups



NOTE:

After the scrutiny phase, the project will move into Sustainability (BAU), with quarterly station visits. Aim is to do every station every quarter. Results feed into Area Governance Meetings and Executive Committee.

If assurance is not provided, project will go back to delivery stage.

South East Coast Ambulance Service: CIP Workstream

CIP Delivery Dashboard

Reporting Month: Sep-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. Achieved YTD half year delivery of £7.05m CIP savings - £0.2m ahead of the NHSI plan. 45.4% of the YTD CIPs relate to recurrent schemes.

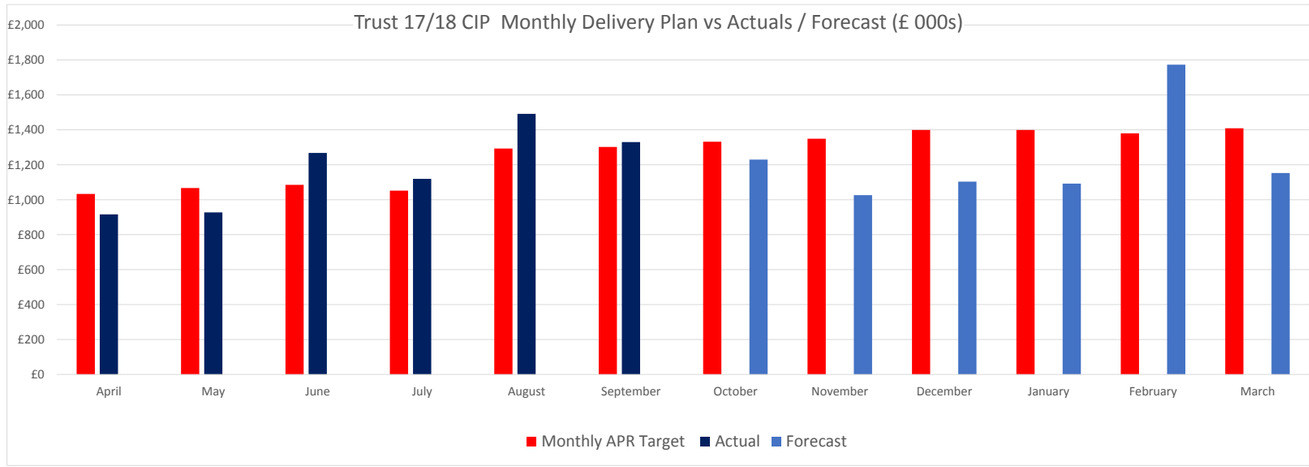
2. £15.1m of fully validated savings transferred to delivery tracker as at 30 September 2017, which now meets the 2017/18 target. This is an improvement of £0.4m compared to figures reported at month 5 (13 September 2017).

3. The full year projection of £14.4m is currently £0.7m below the fully validated total. This is largely due to underachievement in planned Agency premium scheme of £0.5m due to higher than expected Interim staff covering essential established posts while restructures are undertaken in various departments across the Trust. The remaining £0.2m relates to underperformance in computer software, hotel accommodation and task cycle time schemes.

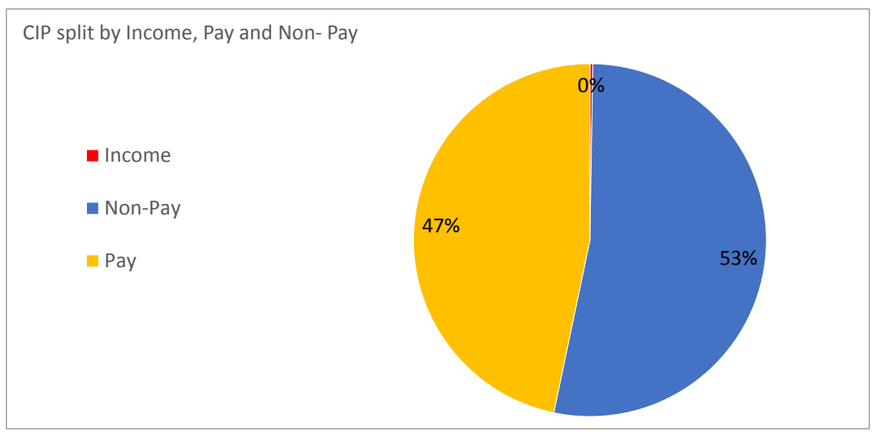
4. Monthly review meetings with Budget leads and Finance Business Partners are on going to devise corrective actions to mitigate delivery of underachievement of YTD CIPs and to identify new schemes to meet the 2017/18 target.

1. Monthly CIP Trust Profile - as at 30 September 17

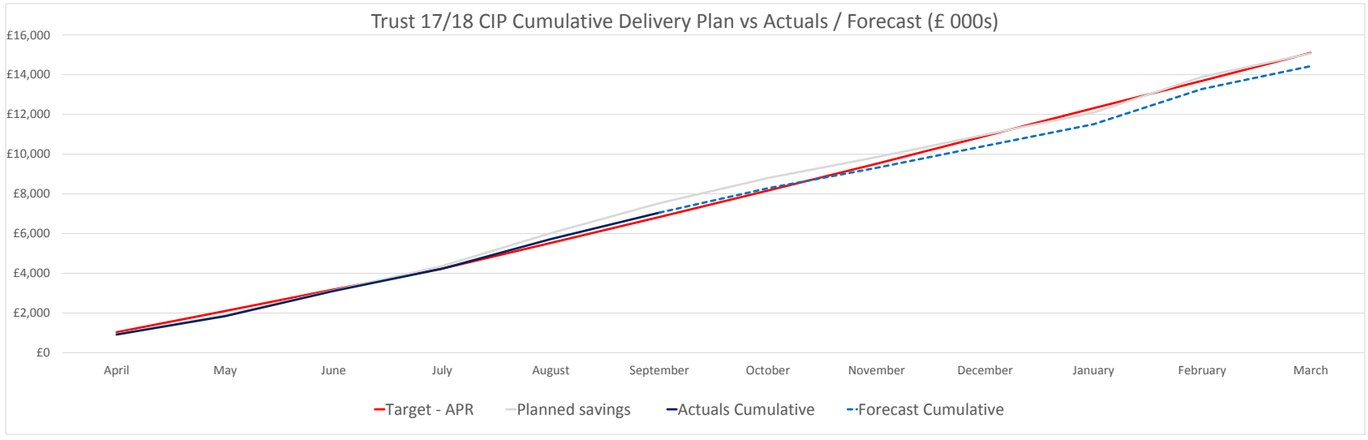
CIP Target for 17/18 £000's	Total planned savings on delivery tracker £000's - as at 30 September	Total forecast savings on delivery tracker £000's - as at 30 September	YTD Sept '17 - Target Savings £000's	YTD Sept '17 - Actual Savings £000's	YTD Sept '17 - variance £000's
15,100	15,071	14,429	6,832	7,052	220



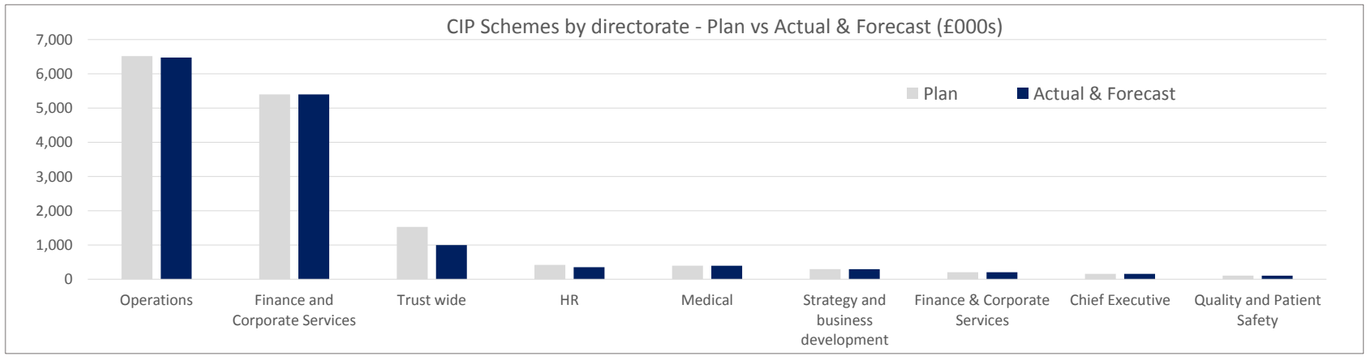
2. CIP - Planned savings split by income, pay and non-pay: as at 30 September



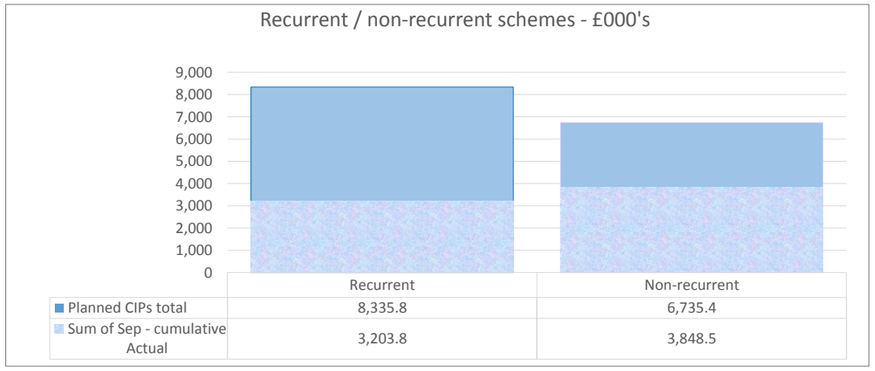
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2017/18



4. CIP schemes by directorate - Plan vs Actual & Forecast 2017/18

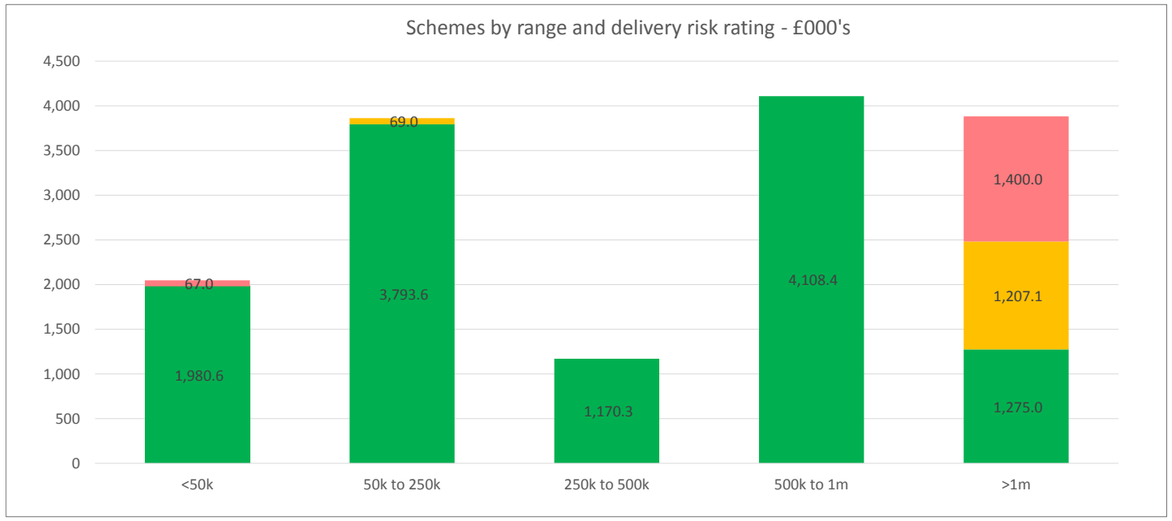


5. Value of planned recurrent and non-recurrent savings - 30 September 2017



	Recurrent	Non-recurrent
Planned CIPs total	8,335.8	6,735.4
Sum of Sep - cumulative Actual	3,203.8	3,848.5

6. Planned savings by scheme size and delivery risk rating £000's



7. Operations Hours CIP: Effective from September

Forecast	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
Planned Staff Hours	1,566,293	261,722	255,185	276,408	257,276	225,734	250,015	**4,415,227**
Planned Staff Hours Reduction (Task Cycle Time)	1,662	3,244	4,812	8,624	8,056	8,078	10,066	**44,542**
Planned Staff Hours after Reduction (Task Cycle Time)	1,564,631	258,478	250,373	267,784	249,220	217,657	239,949	**4,370,685**
Cost Saving	£45,051	£87,912	£130,409	£233,703	£218,313	£218,902	£272,799	**1,207,090**
Cost Saving Running Total	**£45,051**	**£132,964**	**£263,373**	**£497,076**	**£715,389**	**£934,291**	**£1,207,090**	

Actuals	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
Staff Hours Saved	0							**0**
Cost Saving	£0							**0**
Cost Saving Running Total	**£0**							**£0**

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

Scheme Category	2017/18 Value of Identified Schemes - £000	2017/18 Forecast Value £000	Full Year Variance £000	YTD Planned / Identified Savings (Month 5): £000	YTD Actuals (Month 5): £000	YTD Variance £000	Comments (+/- £20k variance)
Accounting efficiency	£4,281	£4,281	£0	£2,026	£2,026	£0	-
Meal break payment	£1,890	£1,890	(£0)	£1,044	£1,044	£0	-
Agency Premiums	£1,510	£980	(£530)	£755	£379	(£376)	YTD Underachievement - ongoing monitoring and corrective action in progress
Operations Efficiency	£1,435	£1,390	(£45)	£121	£76	(£45)	hievement in September due to delays in implementing clinical process - on going monitoring in prog
Vacancies - non clinical	£1,017	£1,017	(£0)	£902	£902	£0	-
Vacancies - clinical	£833	£833	£0	£833	£833	£0	-
Fleet - Fuel: Telematics, Bunkered Fuel & Price Differential	£700	£700	£0	£375	£375	£0	-
External consultancy & contractors	£565	£565	£0	£284	£273	(£11)	Timing - expected to deliver
MRC efficiency	£543	£543	£0	£182	£182	£0	-
Estates and Facilities management	£409	£409	£0	£104	£104	£0	-
EPCR efficiency	£310	£310	£0	£155	£149	(£6)	Under investigation
Staff Uniform	£203	£202	(£0)	£76	£76	(£1)	-
111 Efficiency	£200	£200	£0	£100	£100	£0	-
IT productivity and Phones	£191	£144	(£47)	£87	£63	(£24)	Under investigation
Training courses & accomodation	£160	£140	(£20)	£84	£73	(£11)	Under investigation
Furniture & Fittings	£133	£133	£0	£66	£62	(£4)	Timing - expected to deliver
Meeting room hire	£127	£127	£0	£64	£64	£0	-
Stationery	£110	£110	£0	£55	£55	(£1)	-
Medicines Management - Consumables	£93	£93	£0	£46	£46	£0	-
Medicines Management - Equipment	£90	£90	£0	£40	£40	£0	-
Legal cost	£78	£78	£0	£28	£28	£0	-
Books & Subscriptions	£55	£55	£0	£28	£28	£0	-
Public relations	£47	£47	£0	£23	£23	£0	-
Discretionary non-pay spend	£41	£41	(£0)	£25	£25	£0	-
Events Income	£35	£35	£0	£17	£17	£0	-
Travel & subsistence	£16	£16	£0	£8	£8	£0	-
Variance to YTD Target	-	-	-	(697)	-	£697	Variance between YTD Identified Schemes and Control Total Target
Grand Total	£15,071	£14,429	(£642)	£6,832	£7,052	£220	

South East Coast Ambulance Service: CIP Workstream Pipeline Dashboard

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

Financial Reporting Period: Month 6 - September 2017

Programme Summary:

1. £15.1m of fully validated savings as at 30 September 2017 - c. £13.7m CIP and £1.4m cost avoidance moved to delivery tracker. CIP schemes moved to delivery tracker once QIA signed off and Exec Sponsor approves mandate.

2. Positive engagement and buy in from Execs and CIP Project Leads. CIP Programme and processes are fully embedded in the business and Execs and Project Leads are making time to participate in Financial Sustainability Steering Group meetings.

3. Continuing to work collaboratively with Project Leads and Execs to develop further schemes to mitigate potential gaps in delivery to meet the 2017/18 CIPs target and also to build the pipeline of recurrent schemes for 2018/19.

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	

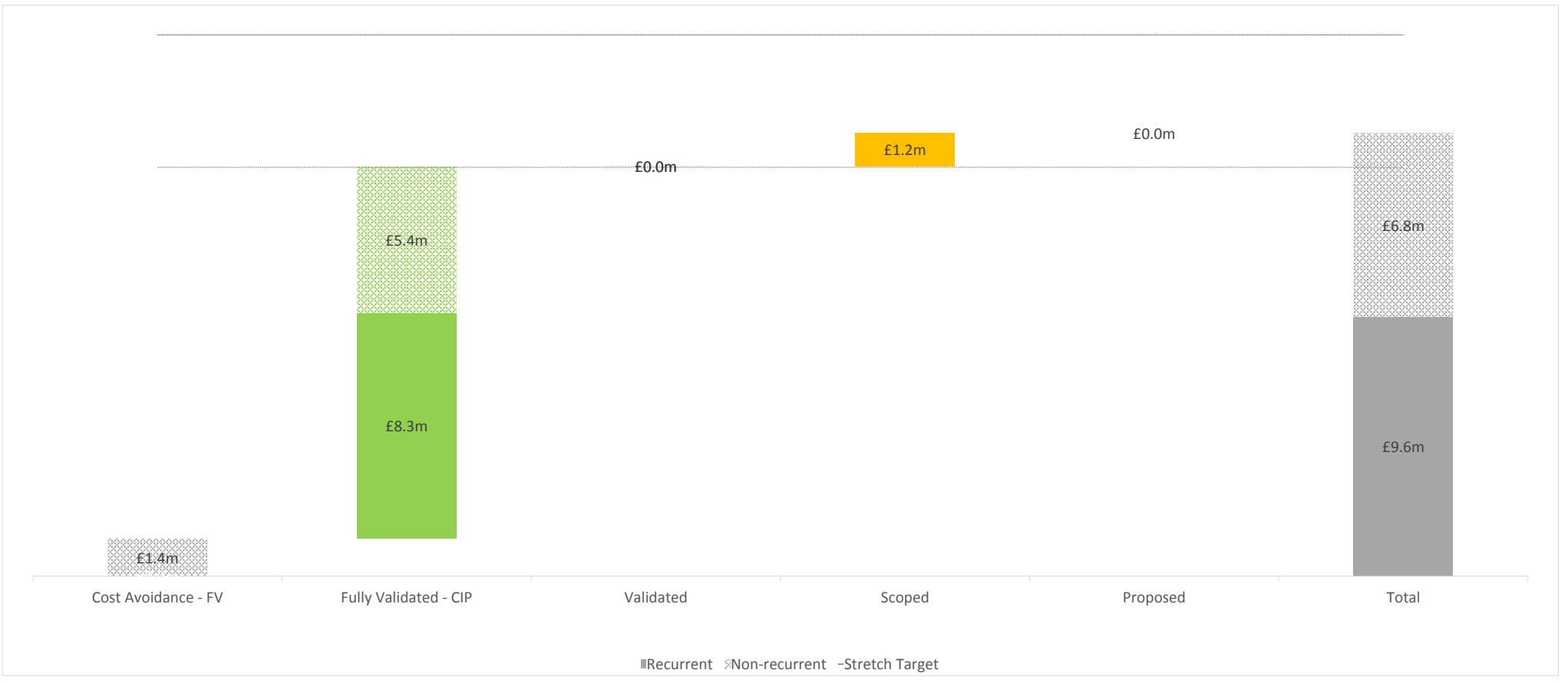
CIP Pipeline and Delivery: Risks and Issues

	Risk	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Failure to identify and scope fully the entire planned value (£15.1m) CIPs schemes, impacting on the Trust's ability to achieve the 2017/18 year-end control total of £1m.	Holding regular FSSG meetings along with 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. £15.1m of CIPs now Fully validated.	Kevin Hervey	Amber	Amber	31/12/2017
2	Failure to achieve / deliver the entire planned value (£15m) of CIPs schemes, due to part-year effect of some schemes and under delivery of fully validated schemes	Aiming to identify £19m CIP savings to mitigate risk. Delivery tracker in use to monitor CIP schemes individually. Monthly financial performance review with Budget leads and FBPs in place to monitor and challenge budgets. Weekly meetings in progress to monitor delivery of transformational scheme due to complex and interdependent nature (see delivery tracker section 7)	Kevin Hervey	Amber	Red	31/02/18
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	Green	Amber	31/10/2017

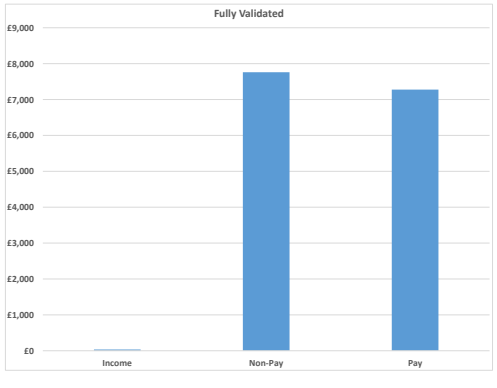
	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Effect of YTD under delivering schemes, in particular agency costs.	Finance Business Partners and CIPs leads to identify and rectify for under delivering schemes. Further schemes under development to compensate.	Kevin Hervey	Amber	Amber	31/10/2017
2	Time taken to identify and agree CIPs schemes as budget leads juggle with conflicting priorities.	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. Monthly financial performance review meetings established to monitor spend and to ensure corrective actions are in place to address schemes that are not delivering.	Kevin Hervey	Amber	Amber	31/10/2017
3	Delays in establishing further frontline Operations efficiencies to reach the £5m target (current shortfall of £2m)	49 potential Operations schemes have been identified and initial risks scoped. CIP team working with Operations leads and relevant Execs to agree likely schemes to develop. Follow up meetings scheduled with Operations leads to review and agree benefits to be realised.	Kevin Hervey	Amber	Amber	31/10/2017

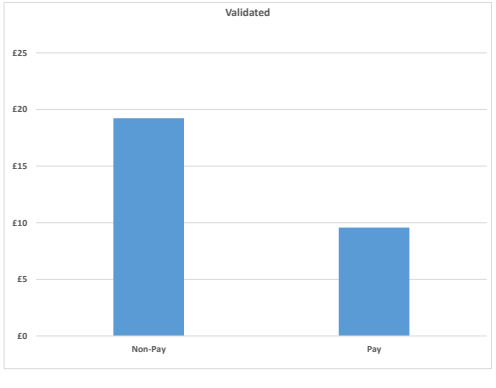
CIP Pipeline Summary

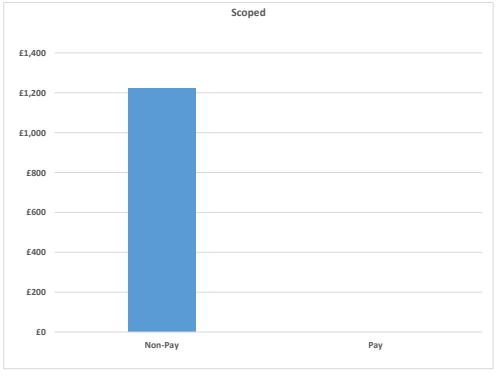
Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£1,400	£13,672	£29	£1,220	£0	£16,321



Pay / Non-Pay / Income Breakdown







Potential schemes under development:

1. Increase Hear and Treat
2. Reduction in Handover delays
3. Ambulance Stations/ACRP review
4. Maintenance contracts renegotiation
5. Response capable vehicle provision
6. Clinical capable staff review - shift contribution
7. Lease car eligiblility review
8. Lease car equipment review
9. Clinical Scheduling review
10. Review of Operations management structure

Agenda No	107/17

Name of meeting	Trust Board
Date	October 2017
Name of paper	Learning from Deaths Policy
Responsible Executive	Dr Fionna Moore, Executive Medical Director
Author	Fiona Wray- Associate Director, Medical Directorate
Synopsis	This paper sights the Board on the draft Learning from Deaths policy, which is a new requirement that all foundation Trusts are required to adopt. This includes the implementation of a standardised and transparent approach to learning from the care provided to patients who die.
Recommendations, decisions or actions sought	The Board is asked to note the policy.

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**Yes**

Learning from Deaths Policy

Document Number	[To be inserted by CRA if a new document]
Version:	V0.00
Name of originator/ author:	

Policy:	
Approved by:	RMCGC
Date approved:	

Date issued:	[To be inserted by CRA]
Date next review due:	
Target audience:	
Replaces:	

Equality Analysis Record

Approved EA submitted	Dated:	

*These patients may only be identified post initial review unless this information is shared during history taking.

Contents

*These patients may only be identified post initial review unless this information is shared during history taking.

1 Statement of Aims and Objectives

1.1 Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality found that the focus on aggregate mortality rates was distracting Trust Boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".

1.2 In 2013 Sir Bruce Keogh published "*Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*" which identified lessons from NHS Trusts where mortality figures were highest. The report highlighted a number of factors which he considered as contributory to the NHS Trust's position.

1.3 In November 2015 the Royal College of Surgeons published a "*Good Practice Guide on Mortality & Morbidity"*. The main purpose was to highlight the benefits of having a structured review of mortality & morbidity and as such shared some basic principles on how to manage mortality & morbidity reviews.

1.4 This was reinforced in 2016 in the Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

1.5 The National Quality Boards (NQB) at the request of the Secretary of State, has developed a Learning from Deaths framework, all foundation Trusts are required to adopt. This includes the implementation of a more standardised and transparent approach to learning from the care provided to patients who die.

1.6 The South East Coast Ambulance Service NHS Foundation Trusts (the Trust) is committed to improving patient care and outcomes. The Trust will utilise the National Guidance on Learning from Deaths (March 2017): https://improvement.nhs.uk/resources/learning-deaths-nhs/ to facilitate learning and improve patient care and outcomes, particularly in relation to the care of vulnerable people.

2 Principles

2.1 The main purpose of the policy is to promote learning and improve how the Trust engages with the families and carers of those who die in our care; it is not to count and classify deaths. It will also;

- Provide assurance at Board level of the quality of patient's final episodes of care.

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- Provide local management teams with information and assurance of quality of care and outcomes within their areas of responsibility.
- Ensure opportunities for learning are always acted upon and that the learning is recorded.
- Provide a clear and documented attention to deaths of patients with Learning Disability.
- Assist in meeting the Trust's requirement that bereaved relatives have been invited to voice any remaining concerns, and that any review has taken such concerns into account. (This is in addition to the statutory Duty of Candour).

2.2 Requirements

2.2.1 The National Quality Board have mandated that all Foundation Trusts must from April 2017 onwards, on a quarterly basis, collect information on deaths, reviews, investigations and resulting quality improvements.

2.2.2. By September 2017 the Trust is required to have published a policy that outlines how we will manage deaths that occur to patients in our care;

2.2.3 From quarter 3 onwards the Trust must publish, quarterly, public Board reports on deaths, reviews and investigations which includes information on any reviews of care provided to those patients with mental health needs or learning disabilities (Appendix A).

2.2.4 From June 2018 the Trust is required to include a more detailed narrative account of the learning from reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year in its Trust's Quality Account.

2.3 Scope

2.3.1 The Trust will consider the following patient deaths to be in scope for review or investigation as the patients were under our care when they died. The episode of care will commence from the time our staff answer the telephone call from the patient or their representative requesting assistance to the time we transfer the patient's care to another healthcare provider.

- Any individual with learning disabilities
- All patients with mental health needs
- All infants and children under 18 years of age
- Any stillbirth
- All maternal death
- Any unexpected death- when a patient is not conveyed to hospital after death.
- All patients who have had an inpatient episode within the last 30 days. *
- Any death where the bereaved family or member of staff raises significant concerns about the care delivered

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2.3.2 The following cases are considered out of scope for case review under this policy and will be considered and investigated under the serious incident policy;

- Any death declared as a serious incident
- Any expected death, for example all patients discharged from hospital or hospice on an End of Life or Amber pathway

3.0 Case Review Process

An overview of the Trust's Learning from Deaths process can be found in appendix B.

3.1 Notification of patient deaths

3.1.1 All patient deaths must be notified through Datix and a review will be undertaken by a member of the Datix Team. If the death is considered to be in scope the case will be moved to the initial review stage.

3.1.2 Where concerns have been raised about a patient's care and treatment i.e. through an incident report or complaint, the initial review should be used to inform any formal serious incident investigation. This immediate action could also include contacting the Police, Coroner and regulators.

3.2 Initial review

3.2.1 All deaths considered in scope will have an initial review completed by staff who have completed a root cause analysis course and a decision made either to review or investigate (appendix D). The purpose of this initial review is to provide sufficient information to be able to determine if there are any areas of concern in relation to the care of the person who has died, or if any further learning could be gained from a single or multiagency review of the death that would contribute to improving practice. It will also provide a timeline of events leading to the individual's death.

3.2.2 On completion of the initial review the rationale for the decision, which is informed by the views of bereaved families and carers, including their views about the sequence of events leading to death, will be documented on the standard template. The initial review will also include identifying if other organisations need to be informed such as the deceased person's GP.

3.3 Case Review

3.3.1 If the initial review identified areas of concern and meets one of the identified trigger criteria (appendix E) a case review will be undertaken. The case review will be undertaken using the structured judgement review (SJR) review methodology. This is based upon the principle that trained staff use explicit statements to comment

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on the quality of healthcare in a way that allows a judgement to be made that is reproducible.

3.3.2 A key element of the case review process is meaningful and compassionate engagement with the bereaved family members and carers. This engagement will include informing them that a case review is taking place and may include offering guidance, if appropriate, on obtaining legal advice.

3.3.3 The purpose of the case review is to identify any avoidable contributory factors and good practice in relation to the person's death. Consideration will be given to if on balance, there were any aspects of care and support that, had they been identified and addressed, may have changed the outcome will also be given.

3.3.4 The case review aims to identify lessons learnt, if there is a need to change local practices as a result of the findings or if there are any wider recommendations that should be made to other healthcare providers. The outcome of the case review will be documented on the standard template and an action plan will be developed and implemented to ensure that it is translated into improvements in the delivery of care.

4.0 Responses to the death of particular patients

4.1 Infant or child (under 18) death

Reviews of these deaths are mandatory and will be undertaken in accordance with *Working together to safeguard children,* using the Department for Education Form C. New child death review guidance is being developed and expected by the end of 2017. The Trust will use this once it is published.

4..2 Perinatal or maternal death

All perinatal deaths will be reviewed, using the new perinatal mortality review tool once available. Maternal deaths and many perinatal deaths are very likely to meet the definition of a Serious Incident and should be investigated accordingly.

5.0 Definitions

Some of the terms used in the Learning from Deaths Policy could be misunderstood, the terms used in this policy have the following specific meaning;

5.1 Case record review:

A structured desktop review of a case record/note carried out by clinicians to determine whether there were any problems in the care provided to a patient. Case

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record review is undertaken routinely in the absence of any particular concerns about care, to learn and improve. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when the bereaved or staff raise concerns about care.

5.2 Investigation:

A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigation draws on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.

5.3 Death due to a problem in care:

A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel the death is more likely than not to have resulted from problems in care delivery/service provision. Note, this is not a legal term and is not the same thing as cause of death'. The term 'avoidable mortality' should not be used as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

5.4 Quality improvement:

A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

6 Responsibilities

6.1 The Trust Board is responsible for the quality of the healthcare the Trust provides, including its safety. The Learning from Deaths policy places particular responsibilities on the Board, including;

- Ensuring effective systems for recognising, reporting and reviewing or investigating deaths where appropriate are in place.
- Ensuring learning identified by reviews or investigations as part of a wider process that links different sources of information provides a comprehensive picture of care provided.
- Ensuring effective, sustainable action to address key issues associated with problems in care are taken.

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- Ensuring the needs and views of patients and the public are central to how the Trust operates.

6.2 The Non-Executive Director identified by the Trust to oversee the Trust's approach to Learning from Deaths is responsible for;

- Understanding the review process: and ensuring the processes for reviewing and learning from deaths are effective and can withstand external scrutiny.
- Championing quality improvement that leads to actions that improve patient safety.
- Assuring published information: accurately reflects the Trust's approach, achievements and challenges.

7.0 Competence

7.1 Any member of staff appointed as the Case Review investigating officer will have received appropriate training. It is recognised that the priority is to ensure the root causes and learning is identified, therefore on occasions a subject matter expert will also be identified to support the investigating officer.

8.0 Monitoring

8.1 The Trust is required to collect and publish information on deaths of both adults and children (under 18s). The data will be collected by the Datix team and included on the Learning from Deaths dashboard. (Appendix C)

8.2 The Learning from Deaths dashboard will be presented on a monthly basis to the serious incident group and to QPS bimonthly., A quarterly report will be presented to the public Trust Board this will include number of deaths, reviews, investigations and any specific quality improvements.

8.3 Learning from deaths will also be reported in the Trust's annual Quality Report.

9.0 Audit and Review

9.1 The Serious Incident Group will undertake an analysis of the deaths that have been considered on a monthly basis and the both the initial review and any case review documentation.

9.2 On a monthly basis this analysis will identify potential theme or subject area for further enquiry known as a "Deep Dive". At the "Deep Dive" any cases where there is evidence it is linked to the case being presented will be presented (where possible

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by the investigator) and thoroughly reviewed. These “Deep Dive” will form the quarterly Mortality & Morbidity Review group meeting.

9.3 If necessary or appropriate these ‘Case Reviews’ will be supported by a commissioned audit or a routine audit and an analysis of complaints. Any other national evidence or benchmarks will also be considered.

9.4 At the end of the “Case Review” any links or adjustments that are required will be identified. The review will also form a view as to the standard of care delivered and will inform Quality Improvement Plans across the service.

9.5 This policy will be reviewed every three years or sooner if new legislation, codes of practice or national standards are introduced.

10.0 Associated Documentation

The following documents are related to this Learning from Deaths Policy.

- Serious Incident (SI) Framework
- Risk Management Strategy Policy and Procedure
- Incident Reporting and Investigation Manual
- Being Open and Duty of Candour Policy
- Safeguarding Policy
- Complaints Policy
- Complaints procedure
- Risk Register and Associated Risk Assessments and Action Plans
- Board Assurance Framework

11.0 References

NQB. (2017). National Quality Board Guidance on Learning from Deaths. https://www.england.nhs.uk/publication/national-guidance-on-learning-from-deaths/

Mazars report - NHS England https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/.../mazars-rep.pdf

CQC. (2016). Care Quality Commission published “Learning, candour and accountability” http://www.cqc.org.uk/publications/themed-work/learning-candour-and-accountability

RCS. (2015). Royal College of Surgeons *Morbidity and Mortality Meetings Good Practice Guide*. https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/morbidity-mortality-guide/

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Keogh. (2013). *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report.* http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

12.0 Resources

Learning from deaths dashboard
https://improvement.nhs.uk/resources/learning-deaths-nhs-national-guidance

Resources from the national patient safety team;
https://improvement.nhs.uk/resources/patient-safety-alerts/

The Improvement Hub
https://improvement.nhs.uk/improvement-hub/

Using the structured judgement review method Data collection form (RCP)
https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrrprogramme-resources

Appendix A: Contents of Quarterly Public Board Papers

Frequency	Information on deaths must be published in the quarter after which the death occurred in the public Board paper. If the review or investigation is on-going this information should be included and updated in subsequent publications.
Contents	• Number of deaths in the Trust's care. • Number of deaths subject to case record review (desktop review of case notes using a structured method). • Number of deaths investigated under the Serious Incident framework (and declared as serious incidents) • number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care • number of reviews/investigations on-going • themes and issues identified from review and investigation (including examples of good practice) • actions taken in response, actions planned and an assessment of the impact of actions taken.

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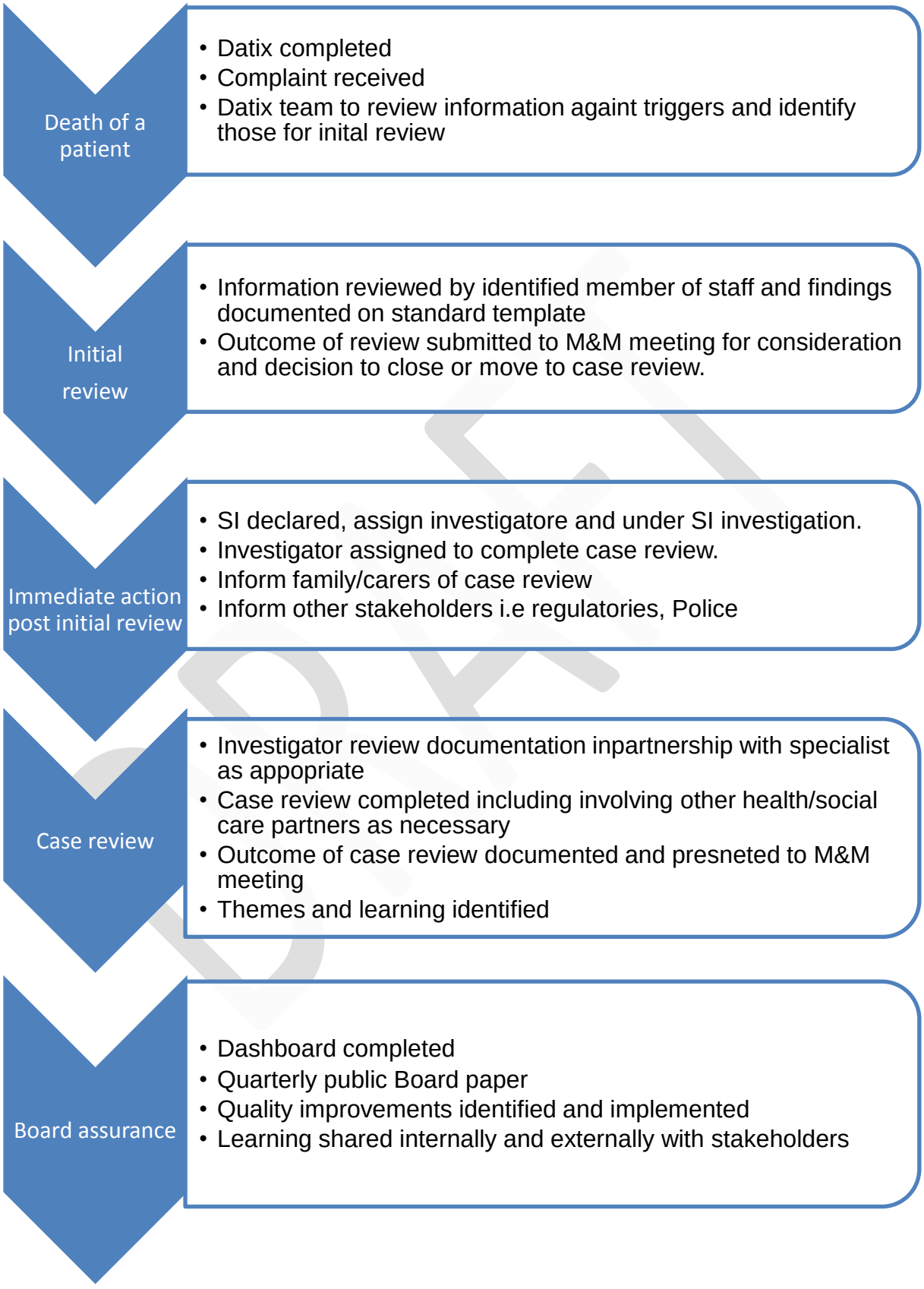
Appendix B- Case Review Process



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Appendix C Dashboard template

learning-from-deaths-dashboard.xlsx

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Appendix D Initial review template

Initial Review- Learning from deaths

Datix ref;		**Date reported:**	
Initial review undertaken by;		**Date of review**	
Incident number:		**PCR/ EpCR**	
Patient:		**D.O.B:**	
Background:			
Date of death:		**Operational area:**	
Clinical presentation:			
Staff present (include name and role):			
Brief summary of events that occurred:			
Timeline of events:			
Outcome:			
☐ Meets criteria for case review		☐ Serious incident declared	
Case closed			

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Rational for closing case:	
Outcome of M&M meeting	
Preventable harm (Yes/No):	
Further investigation required (Yes/No):	
Case Review Investigator identified (Yes/No):	
Family/carer informed of decision to escalate to case review or declare as SI (Yes/No):	
Any additional comments:	
Date;	
Agreed actions or learning	
List of actions	**Individual(s) responsible for implementation**

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Appendix E Triggers for case reviews

If during initial review any of the following triggers are identified a case review will be undertaken.

- Any individual with learning disabilities
- All patients with mental health needs
- All infants and children under 18 years of age
- Any stillbirth
- All maternal death
- Any unexpected death- such were a patient is not conveyed to hospital after death.
- All patients who have had an inpatient episode within the last 30 days.
- Any death where the bereaved family or member of staff raises significant concerns about the care delivered

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Document Control

Manager Responsible

Name:	(optional, if included, will be placed in the public domain)
Job Title:	
Directorate:	

Committee to approve		
Version No. V0.00	Final / Draft	Date: dd/mm/yyyy

Approval

Person/ Committee	Comments	Version	Date

Circulation

Records Management Database	Date:
Internal Stakeholders	
External Stakeholders	

Review Due

Manager		
Period	Every three years or sooner if new legislation, codes of practice or national standards are introduced	Date:

Record Information

Security Access/ Sensitivity	[eg: Official (Public Domain) or Official – Sensitive]
Publication Scheme	Yes / No
Where Held	Records Management database
Disposal Method and Date	

Supports Standard(s)/KLOE

	Care Quality Commission (CQC)	**IG Toolkit**	**Other**
Criteria/KLOE:	Name core service area and CREWS elements		

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South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	108/17

Name of meeting	Trust Board
Date	26 October 2016
Name of paper	**Five-Year Strategic Plan – 'Our People'**
Executive sponsor	Daren Mochrie, Chief Executive
Author name and role	Steve Graham, Director of HR & OD
Synopsis (up to 120 words)	The Board's response to the issues and concerns highlighted by our regulators, and our staff, relating to SECAmb's underlying organisational culture is critical in ensuring that rapid but sustainable improvements are made. This is recognised in our Five-Year Strategic Plan, under the 'Our People' theme, and within our Unified Improvement Plan. The purpose of this paper is to highlight a key element of our overarching Culture and Organisational Development programme, by providing a summary of our proposed Culture Change Plan. The Plan has been developed with the assistance of an external expert resource, namely 'Ignite' (which knows our organisation well) and aims to deliver a range of culture change initiatives over an eighteen-month period. The paper summarises the design principles, key work streams, and timeframes associated with the Plan. Phase one will ensure that the necessary foundations are in place to progress the work (under phase two) in an effective and sustainable manner. The associated governance arrangements will ensure that appropriate oversight is maintained and staff are involved at every stage.
Recommendations, decisions or actions sought	The work summarised in this paper represents a critical factor in ensuring the organisation's future success, and staff must recognise that it is being led by the Board. Therefore, the Board is asked to formally endorse and support the implementation of the proposed Culture Change Plan.

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

Five-Year Strategic Plan – 'Our People'

1. Introduction and Purpose

1.1 In August, following the publication of the Lewis report, I gave my commitment to all staff that we will, together, build a better workplace. I have since talked to many colleagues from across all our services and have been heartened by the genuine desire of everyone to confront unacceptable behaviour and performance. The Care Quality Commission (CQC) inspection letter published this month further underlines that we have much to do to improve services and regain the full confidence of our staff and community. The clear message from staff, as well as our regulators, is that the Board must tackle those underlying cultural and internal safeguarding failings which have allowed poor practices to thrive and to undermine our Service. To this end, I have commissioned external specialist expertise to support this essential work.

1.2 Within this context, the purpose of this paper is to provide the Board with a summary of a critical element of this agenda, namely the proposed Culture Change Plan. The Plan aims to underpin the delivery of the Trust's five-year Strategic Plan, and assist in addressing our organisational culture and internal safeguarding issues. In particular, this paper seeks the Board's endorsement and support for the implementation of phase one of the Plan.

2. Background and Context

Identification of Cultural Issues

2.1 Both the outcomes of the 2017 re-inspection of the Trust by the CQC, and the findings of the locally-commissioned report on perceptions of bullying and harassment (the Lewis Report), demonstrated a need to improve certain aspects of the organisation's underlying culture. Received in August 2017, the Lewis Report highlighted a range of concerns relating to poor management practices in certain areas of the organisation, and a more widespread demonstration of disrespectful and inappropriate behaviours exhibited by staff towards their colleagues: some of this behaviour clearly met the definition of bullying and harassment. The CQC outcomes report, published in October 2017, acknowledged that a number of processes had been put in place to deal with bullying, and to emphasise a 'no tolerance' approach towards such behaviour. Furthermore, staff considered that the problem was beginning to be less of an issue.

2.2 Notwithstanding this more positive observation by the CQC, the outcomes report also highlighted certain shortcomings within the 'well-led' inspection domain, which are strong indicators of organisational culture. Principal concerns were as follows:

- Trust strategy and core values were not recognised by front line staff, and staff did not feel engaged with the Trust's vision. Individuals generally felt supported by their immediate managers, but cited a 'disconnect' between front line staff and senior managers;
- the overall score associated with staff engagement arising from the 2016 NHS staff opinion survey showed no significant change and remained below the national average for ambulance services;
- the 2016 NHS staff opinion survey scores relating to staff advocacy (recommending their Trust as a place to work); staff motivation at work; and the ability of staff to contribute to improvements at work, were all worse than the national average; and
- in total, responses associated with seventeen areas of the staff opinion survey had deteriorated when compared to the previous year, including: appraisal levels; percentage of staff feeling unwell due to work related stress; satisfaction with resourcing and support; recognition and value by managers; physical violence from patients and public; and experiencing bullying and harassment from colleagues.

Immediate Responses

2.3 In making an initial response to these issues, the Executive Team determined to hear directly from staff, in order to gain further understanding. Therefore, throughout August and September, over thirty focus groups were convened at locations across the Trust's geography. The purpose of the focus groups, all of which were attended by at least one member of the Executive Team, was to invite and encourage staff to voice their views and experiences relating to those issues highlighted in the two recent Reports, and to engage in discussion to consider what type of culture they would like to see promoted by colleagues, and therefore what improvements need to be made within the organisation. Four main improvement themes emerged from these discussions, namely:

- promoting an engaged workforce, with a voice and stake in the future direction and shape of the organisation;
- developing effective management and leadership teams;
- effectively tackling bullying, harassment and workplace discrimination; and
- supporting colleagues through welfare and well-being programmes.

2.4 The Board, too, has recognised and acknowledged the need to effect changes in organisational culture and internal safeguarding, and is committed to leading those changes. Hence, the Unified Improvement Plan highlights 'Culture' as one of eight associated principal objectives, all of which are focused on service delivery and improvement. Similarly, within the Trust's revised five-year Strategic Plan, 'staff engagement and support' is included as a priority area for years one and two.

3. Proposed Culture Change Plan - Overview

3.1 Earlier in 2017 the Board commissioned external assistance to support the transfer of staff and services to the new Headquarters and Operations Centre in Crawley. This assistance was provided by 'Ignite', which has an extensive track

record in leading culture change and HR transformation in the NHS and wider public sector. To date, Ignite has demonstrated a good understanding of SECAmb, its people and the challenges faced by the organisation, and the Ignite team offers essential additional expertise and capacity to the Trust. The development of the Culture Change Plan, and the implementation of phase one, represents the second part of Ignite's work and will be undertaken within their existing contract with the Trust.

Strategic Alignment

3.2 The Culture Change Plan draws on the four strategic themes within the Trust's five-year Strategic Plan (i.e. People, Patients, Enablers, and Partners) and centres on the one to two-year strategic priority areas, which include Staff Engagement and Support. Reflecting the Trust's current organisational and operational challenges, including regulatory action, performance weaknesses and staffing difficulties, the development and implementation of the Plan represents a central plank of the overarching Culture and Organisational Development (OD) programme. Essentially, the Plan is framed around three key areas: Leadership; Behaviour; Supporting infrastructure, as summarised in Table 1, below:

Table 1: Culture Change Plan - Framework

The high-level 'Plan on a page' is provided at **Appendix 1**.

Design Principles

3.3 Drawing from the Trust's recent past, the Plan is forward looking and designed to help deliver the ambition and goals associated with the Trust's Strategic Plan - is built around specific needs, outcome focused and has a strong clinical emphasis. The Plan, when implemented, will challenge not only the leadership of

the Trust, but all staff. Hence, the key design principles underpinning the provisions of the Plan are as follows:

- there is an absolute focus on outcomes;
- interventions and actions are specific and tailored;
- implementation of interventions and actions is informed by staff engagement;
- there is a recognition that culture = behaviour, plus infrastructure;
- interventions must be recognised by staff as being coherent, 'joined-up', courageous, and having 'teeth'; and
- culture change must empower staff to make changes at a local level.

Principal Work Streams and Timeframes

3.4 A key success factor will be the effective engagement of staff at all levels of the organisation. With this in mind, the HR and OD teams will work closely with the Ignite team to ensure that as many people as possible are involved in this work. The three principal work streams associated with the proposed Plan are summarised as follows:

- Programme Leadership - the purpose of which is to:

  - provide clear and purposeful leadership to the programme;
  - continuously engage with staff and communicate what is going to happen, what has happened, what worked and what could be better;
  - ensure that activities happen on time and 'on quality';
  - provide forums in which programme deliverers can hold each other to account; and
  - build on the good work already undertaken in this area.

- Behavioural Performance - the purpose of which is to:

  - equip people with the 'tools' required to drive performance improvement through behavioural change;
  - clearly define the culture and 'signature' behaviours required from everyone across the organisation;
  - build a sense of shared ownership across all staff groups;
  - ensure the Executive Team and senior leaders are exemplars of the required behaviours; and
  - build on the good work already undertaken in this area.

- Building an Enabling Infrastructure - the purpose of which is to:

  - ensure all elements of the Trust's infrastructure (processes, systems, structures) enable people to perform in the required way;
  - give the programme 'teeth' by measuring behavioural (as well as 'task') performance and applying positive and negative consequences;
  - measure the success of the culture change programme; and
  - build on the good work already undertaken in this area.

3.5 The high-level Plan at Appendix 1 illustrates how the three principal work streams will be delivered in two phases, which span an eighteen-month timeframe, from October 2017 to March 2019. Phase one (October and November 2017) is concerned with ensuring the necessary foundations are in place from which to progress the culture change work, and key areas of focus include leadership and governance, early staff engagement and communications, and reviewing current People-related policies and practices. Phase two (December 2017 to March 2019) is concerned with implementation of the key interventions, realising and measuring benefits, and ensuring that the organisation is able to sustain its cultural improvements. A critical thread throughout phase two will be continued staff engagement and, again, communication.

4. Governance

4.1 From the outset, a key message for our staff will be that the implementation of our Culture Change Plan is being led by the Board. Accountability for the delivery of the associated interventions will be assumed by the HR Director, who will also ensure that appropriate oversight and scrutiny arrangements are established, which comply with the requirements of our established governance framework, and Project Management Office (PMO) reporting requirements. Hence, the implementation of all work streams will be overseen by the Culture and OD Steering Group, whose membership will include Executive Director representation. The specific internal safeguarding plans will additionally be monitored via the Compliance Steering Group led by our Executive Director of Quality and Nursing (the Trust safeguarding lead). It is recognised there will be a number of interdependencies between the two workstreams which will be monitored via the PMO. Any issues that cannot be readily resolved by the Steering Group will be escalated to the Executive Turnaround Group.

4.2 Reflecting the importance of continued staff engagement and effective communication, a 'Barometer Group' is to be established, which will include broad representation from across the organisation and act as a voice for all staff. The Group will provide a means by which regular 'soundings' are taken with respect to how the change initiatives are being received (i.e. what people are saying about the interventions; how well implementation is proceeding; how staff are reacting; potential adjustments required). Furthermore, the Board will receive regular update reports regarding implementation progress and impact.

5. Summary

5.1 The Board is aware of the need to effectively respond to regulatory issues and concerns relating to the Trust's underlying culture and internal safeguarding. These same issues and concerns have been highlighted by a recent independent review of bullying and harassment within the organisation, and by direct feedback received from our staff. This paper has provided information regarding the development and implementation of the proposed Culture Change Plan and its associated work streams and implementation timeframes. The Plan has been developed with the assistance of external expert resource, and this same resource is being retained (under the current contract) to maintain the necessary focus and momentum in implementing phase one by the end of November 2017 and preparing for phase two.

5.2 The Plan recognises that culture change is a major organisational development initiative that will necessitate time, effective leadership, and persistence in its delivery and sustainability. The work will underpin all aspects of SECAmb's operations and represents a critical factor in ensuring the organisation's future success. Therefore, it is imperative that it continues at pace, and with the full support and involvement of senior leaders, and members of the Board.

6. Recommendation

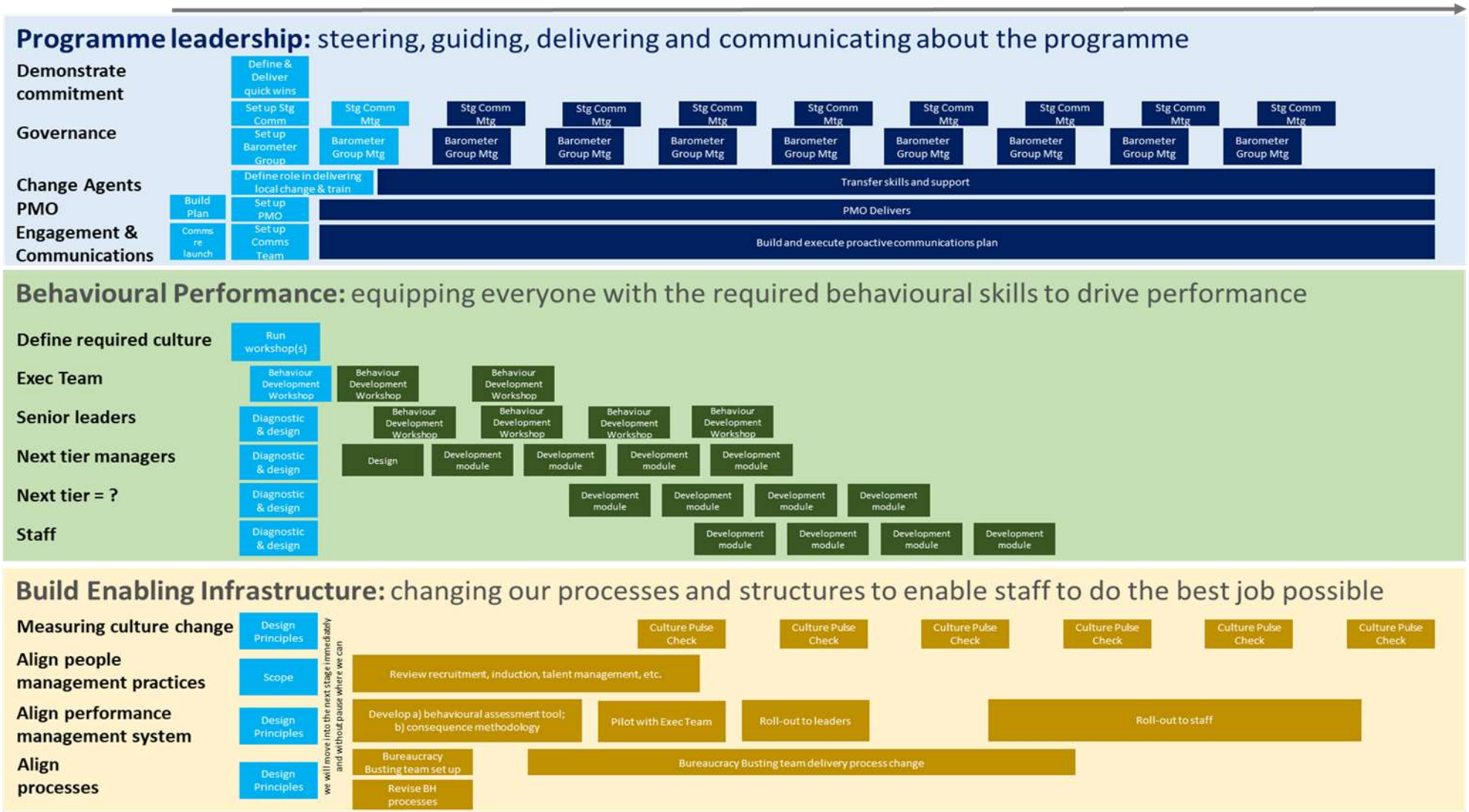
6.1 The Board is asked to endorse and support the implementation of the proposed Culture Change Plan.

Appendix:

1. High-Level Culture Change Plan

Daren Mochrie
Chief Executive

Appendix 1: High-Level Culture Change Plan



South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	109/17

Name of meeting	Board Meeting
Date	26 October 2017
Name of paper	EPRR Core Standards
Executive sponsor	Joe Garcia, Executive Director of Operations
Author name and role	Chris Stamp, Regional Operations Manager
Synopsis (up to 120 words)	NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response (EPRR) arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. As part of the national EPRR assurance process for 2017/18, the Trust has been required to assess itself against these core standards. In addition, the National Ambulance Resilience Unit (NARU) undertook a four day on-site Interoperable Capabilities Review. The Trust is also required to take a statement of compliance to a public Board meeting and to publish the statement of compliance in their annual report, therefore this paper has been written to brief the Board on the outcome of this year's assurance process.
Recommendations, decisions or actions sought	For information.

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.

Board Briefing Paper: EPRR Core Standards self-assessment and NARU Interoperable Capabilities Review 2017.

Introduction

NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer (AEO) in each organisation is responsible for making sure these standards are met.

As part of the national EPRR assurance process for 2017/18, the Trust has been required to assess itself against these core standards. The areas investigated for 2017 are:

- EPRR Core Standards
- MTFA Core Standards
- HART Core Standards

In addition to the core standards a 'deep dive' into core EPRR Governance was included in the assurance process, however the outcome of the deep dive is not included in the overall compliance ratings.

A self-assessment has been undertaken by the Head of Resilience & Specialist Operations with the support of the Contingency Planning & Resilience Team and HART Managers. The outcome of this self-assessment demonstrates that against the 104 core standards which are applicable to the Trust, the Trust is fully compliant with 98 of the core standards, partially compliant with five of the core standards and non-compliant with one core standard.

	Level of Compliance		
	Full	Partial	Non-compliant
EPRR Core Standards (1-66) (2 x not applicable)	60/66	4/66	0/66
MTFA Core Standards (1-19)	18/19	1/19	0/19
HART Core Standards (1-21)	20/21	0/21	1/21
Deep Dive – EPRR Governance (DD1-DD6)	1/6	3/6	1/6

The self-assessment was reviewed by lead commissioners and compliance agreed as detailed below.

- EPRR Core Standards against Core Standards 1-66 = **Substantial**
- Compliance against 'MTFA Core Standards' = **Substantia**l
- Compliance 'HART Core Standards = **Partial**

The definitions for compliance ratings are detailed in the following table:

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place; however, they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

Linked into the EPRR core-standards assurance process the National Ambulance Resilience Unit (NARU) undertook a four day on-site Interoperable Capabilities Review, commissioned by NHS England.

The scope of the NARU review looked at the following Interoperable capabilities

- Hazardous Area Response Teams (HART)
- Marauding Terrorist Firearms Attack (MTFA)
- Chemical, Biological, Radiological and Nuclear (CBRN)
- Mass Casualties

with each capability being evaluated through the following domains; Governance, Process, Operational Effectiveness, Personnel, Finance, Logistics and Stakeholder Engagement.

Following the on-site visit, a draft report has been provided to the Trust by the review panel, compliance levels for each of the domains are detailed in the table below.

		Level of Compliance			
KLOE	Domain	Full	Partial	Non-compliant	Overall Rating *
1-6	Governance	1/6	1/6	4/6	
7-14	Process	6/8	1/8	1/8	
15-27	Operational Effectiveness	3/13	3/13	7/13	
28-40	Personnel	7/13	2/13	4/13	
41-50	Finance	8/10	1/10	1/10	
51-61	Logistics	7/11	1/11	3/11	
62-66	Stakeholder Engagement	5/5	0/5	0/5	

*Any non-compliance within a domain renders the whole domain non-compliant

In accordance with the agreed review process the Trust had a window to review the report and challenge any aspects of its contents and we are awaiting outcome of the challenge although the compliance level is not likely to change significantly. The final report will be submitted to NHS England by the review panel, a copy will also be sent to the Trust's Accountable Emergency Officer.

As part of the process the Trust is required to take a statement of compliance to a public Board meeting and to publish the statement of compliance in their annual report.

An action plan will be put in place to address those core-standards assessed as being at non or partial compliance, it has been agreed with the Accountable Emergency Officer that a Task and Finish group is established to manage the completion of the required actions.

Recommendations

The Board are asked to note the contents of this report.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	109/17

Name of meeting	Board Meeting	
Date	26 October 2017	
Name of paper	KMSS 111 EPRR Core Standards Assurance Assessment Report	
Executive sponsor	Joe Garcia, Executive Director of Operations	
Author name and role	Andy Taylor, Information Lead, KMSS 111	
Synopsis (up to 120 words)	In common with other health providers across Urgent Care and Emergency Care, KMSS 111's Business Continuity Plans are required to be assessed regularly against a range of NHS England Core Standards in order to ensure adequate governance and coverage of the plans. KMSS 111 is required to take a statement of compliance to a public Board meeting, therefore this paper has been written to brief the Board on the outcome of this year's assurance process. In addition, NHS England require confirmation that the SECAmb Board will provide active support to the KMSS 111 service in developing and enhancing its EPRR.	
Recommendations, decisions or actions sought	For information	
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.

KMSS 111: assessment of Business Continuity plans against NHS England EPRR Assurance Core Standards (Emergency Preparedness, Resilience and Response)

Directors' summary

Introduction

In common with other health providers across Urgent Care and Emergency Care, KMSS 111's Business Continuity plans are required to be assessed regularly against a range of NHS E Core Standards, in order to ensure adequate governance and coverage of the plans.

The 2017 assessment for KMSS 111 was carried out on 30th August 2017, attended by:

- Andy Taylor (KMSS 111 Information Lead)
- Sam Proctor (SE Commissioning Support Unit, Principal Associate – Business resilience)
- Pam Bridges (111 Lead Commissioner)

Assessment Summary

KMSS 111 was assessed against 29 core standards. The initial "RAG" assessment for KMSS 111 compliance was as follows:

EPRR Core Standards:
Green: 25
Amber: 4
Red: 0

In general, the assessment concluded that "KMSS 111 have continued to work hard to achieve Substantial compliance against the EPRR Standards this year….work is required to achieve greater levels of compliance….KMSS 111 has in place a work plan."

In addition, "The commissioners of this provider can be assured that KMSS 111 has in place the required arrangements to respond to both internal disruptions and to…external major incidents."

Required Actions ("amber" standards)

Standard 6: Improved process to align Risk Assessments with LHRP and LRF bodies across the operating area, via the SECAmb Resilience group.

Standard 11: Document our "heatwave planning" protocols into BC planning, in line with Met Office guidelines.

Standard 50: KMSS 111 EPRR Officer to draw up an EPRR Programme Schedule with operational managers, to incorporate review of plans, risk assessment, external engagement and table-top exercises.

Standard 52: The EPRR training and proficiency of On-call managers to be documented (continuous personal development).

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	109/17

Name of meeting	Board Meeting
Date	26 October 2017
Name of paper	Winter Capacity Plan 2017-18
Executive sponsor	Joe Garcia, Executive Director of Operations
Author name and role	Anne Harvey, Contingency Planning & Resilience Manager
Synopsis (up to 120 words)	Historically winter brings an increased level of pressure to the health community, with pressures often peaking between December and March. In order to meet these challenges NHS England requires NHS providers to have in place winter plans covering from 1 December up to Easter. This document sets out the arrangements in place for the Trust that are to be used in order to manage the expected increase in demand during the winter period, including the key Christmas and New Year period 20 November – 6 January) which is traditionally a time of extremely high demand for the Trust and presents its own challenges. This plan has been developed with input from key stakeholders across the Trust and has been approved by the Senior Operations Leadership Team. The plan has also been ratified by the Executive Team.
Recommendations, decisions or actions sought	For information. Annex 1 – 999 Annex 2 - 111

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

South East Coast Ambulance Service NHS
NHS Foundation Trust

Winter Capacity Plan
November 2017 – April 2018

Document Number	n/a
Version:	V3
Name of originator/ author:	Anne Harvey
Winter Capacity Plan 2017 –2018	
Approved by:	Senior Operations Leadership Team
Date approved:	18th September 2017
Ratified by:	Executive Team
Date ratified:	27th September 2017

Date issued:	5th October
Date next review due:	July 2018
Target audience:	Trust Managers and External Stakeholders
Replaces:	Winter Capacity Plan December 2016 – January 2017

Contents

1 Introduction

Historically winter brings an increased level of pressure to the health community, with pressures often peaking between December and March, in order to meet these challenges NHS England requires NHS providers to have in place winter plans covering from 1st December up to Easter.

This document sets out the arrangements in place for the South East Coast Ambulance Service NHS Foundation Trust (the Trust) that are to be used for the period of this plan in order to manage the expected increase in demand over the winter period.

It is recognised that historically increased activity during the winter period has presented significant challenges to the Trust, however these demands are not always those placed directly onto the Trust but can be those affecting the wider health and social care system.

In addition, the Christmas and New Year period (20th November – 6th January) is traditionally a time of extremely high demand for the Trust and presents its own challenges, as it can see surges in demand which have the potential to at times exceed the available resources.

This plan describes the method in which the Trust seeks to manage this anticipated demand and mitigate the associated risks. In doing so this plan aims to support the delivery of the programme of work set out in the Trust's current strategic documentation.

2 Intention

2.1. It is our intention to manage this period in accordance with the visions and values of South East Coast Ambulance Service NHS Foundation Trust.

2.2. **Strategic Intention**:

- Preserve and protect lives, maintaining a timely and clinically safe service.
- Mitigate and minimise the impact of this period on the Trust and the wider NHS.
- Utilise communication mediums to inform the public and our staff where appropriate.
- Ensure demands are managed in such a way to maintain service delivery to contracted standards.

2.3. **Tactical Intention**:

- To ensure patient safety is at the centre of our actions.
- To have a predefined Command and Control Structure in place to ensure the operational demand is managed effectively.
- To maintain core services through the effective use of the escalatory frameworks employed by the Trust.

- To ensure that this period has limited impact on core fleet activity moving forward.
- To ensure the agreed escalatory framework is applied consistently across all areas of the Trust.
- To ensure a communications network is applied consistently across the Trust and wider NHS.
- To have in place a robust medical supply chain to enable effective patient treatment and care.

3 Method

3.1. This section of the Plan describes the processes to predict, monitor and mitigate the demands that are likely to be placed upon the Trust over the winter period, and looks to ensure delivery of service is maintained during surges in demand or reduced capacity. The Plan describes the arrangements for:

- Processes to monitor planned activity and resource planning
- Internal escalation triggers
- Provision of additional resources to meet surge requirements
- Support for other priority areas

3.2. **Predicted Activity**

3.3. The Trust has developed a model to predict future activity based on historic data, present performance and growing demand. This trajectory is reviewed on regular basis by the Senior Operations Leadership Team (SOLT).

3.4. The graphs at Appendix A show both the activity over the past three years and the forecast activity for the key period 21st November 2017 – 6th January 2018. The predicted activity is revised on a regular basis to take into account factors which may change predictions (i.e. Ambulance Response Programme) in order to manage resourcing and provision of unit hours. The updated graphs will be made available as required.

3.5. **Operational Resource Planning**

3.5.1. The Trust's scheduling department is responsible for delivering appropriate resources based on predicted activity and through its normal processes will develop Plan resource plans to deliver the appropriate number of operational resources to meet the forecasted demands during this period.

3.5.2. As we move towards the winter period a more accurate picture of the available resource against the predicted demands will emerge. This will be kept under constant review by the Senior Operations Leadership Team to ensure that risk periods are identified and mitigations are put in place.

3.6. Resource Variation between Forecast Demand and Actual Unit Hours

3.6.1. The Senior Operational Leadership Team have, based on historical experience have risks rated the 6-week period, prior to and including Christmas and New Year, in order to identify key periods of anticipated high demand and high abstraction rates. It is noted that in addition to the abstraction RAG, the period from 18th December to 27th December; along with New Year's Eve night shifts will see reduced overtime uptake and PAP coverage without incentives being offered to staff.

3.6.2. The measures relating to the assessment and the risk rating are set out in the table below:

Week	Date	Activity	Abstraction
1	Mon 27th November - Sun 3rd December		
2	Mon 4th - Thu 7th December		
	Fri 8th - Sun 10th December		
3	Mon 11th - Thu 14th December		
	Fri 15th - Sun 17th December		
4	Mon 18th - Thu 21st December		
	Fri 22nd - Sun 24th December		
5	Mon 25th - Sun 31st December		
6	Mon 1st - Sun 7th January		

Key		
Activity expected to be within normal planning parameters	Activity may exceed normal planning parameters – some contingency arrangements may be required	Activity likely to exceed normal planning parameters – contingency arrangements required
Abstraction: Sickness/Leave expected to be within normal planning parameters	Abstraction: Sickness/Leave may exceed normal planning parameters – some contingency arrangements may be required	Abstraction: Sickness/Leave likely to exceed normal planning parameters – contingency arrangements required

3.7. Additional Operational Capacity

3.7.1. Based on the variations and gaps in demands a number of options can be considered/ included as part of the mitigation / additional resourcing:

3.7.2. Co-responder Schemes

3.7.2.1. Working in partnership with the Fire & Rescue Services across the region, there are a number of FRS co-responding schemes in place; these can be called upon to provide an initial response to agreed categories of 999 calls. These schemes will be utilised following the agreed protocols.

3.7.3. Community First Responders

3.7.3.1. During the period of this plan Operating Units will highlight to their local CFRs and to the Voluntary Services team where community responder schemes may support resourcing gaps.

3.7.3.2. Requests for additional community responders will be based on targeted messages sent by the EOC shortly before the support is required as this has proven to achieve better results rather than blanket requests. Use will also be made of the closed twitter accounts created to foster better integration between CFRs and EOC staff.

3.7.4. Operationally Capable Managers (OCM)

3.7.4.1. The Senior Operations Leadership team will continue to work with Departmental Heads and OCMs to ensure they are targeted effectively to support operational response as required, as it is recognised that there are a number of key work areas, which if not maintained and continued may cause additional problems and issues.

3.7.4.2. OCMs may be redeployed from their normal duties to support the delivery of the operational service as required.

3.7.5. Staff Abstraction

3.7.5.1. It is proposed that there are no abstractions for the RED & AMBER periods other than pre-booked annual leave.

3.7.5.2. All short notice leave will be authorised at Operational Unit Manager level or above.

3.7.6. Private Ambulance Provision (PAP)

3.7.6.1. PAP is used throughout the year to support gaps in establishment and all are currently provided under Direct Award Contracts totalling around 25, 000 staff unit hours per month. In December last year 28,000 hours were provided and the same levels are contracted for this year.

3.7.6.2. Direct awards are being designed to cover the winter period and will include an uplift in supply but we should be realistic in our expectations and PAPs have been informed that we do not expect them to overpromise and under deliver.

3.7.7. Maintaining Key Management Priorities

3.7.7.1. It has been identified that the following management duties will continue to be prioritised in addition to maintaining an operational response to patients;

- Extra clinical support in EOC
- Focused HR Attendance Management support
- Return to work interviews

- SIRIs
- Complaints
- PALS
- Appraisals
- Monitoring hospital handovers at acute trusts via the Incident Command Hub

3.7.7.2. In order to maintain these key functions, support may be requested from other directorates and work areas within the trust, Directors and functional Heads will identify staff within support functions who will undertake identified duties under the guidance of senior/operational managers.

3.7.7.3. It is proposed that a series of workshops/exercises are held during October/November to provide Managers and staff with the training and familiarity to carry out supporting functions.

3.7.8. NHS Winter Resilience Planning

3.7.8.1. Recognising the continued increase in pressures on the wider health system over the past few winters, in July 2017 NHS England and NHS Improvement circulated guidance to all CCGs and providers regarding planning for winter 2017/18 and other operational priorities, details of which can be found on the NHS England website.

3.7.8.2. While planning for this period the Trust will continue to engage with and seek assurance from the CCGs and acute hospitals via the A&E Delivery Boards that their plans have sufficient capacity to manage surges in demand.

3.8. Hospital Handover Delays

3.8.1.1. Frequently system pressures experienced by the NHS/acute hospitals result in significant ambulance handover and turnaround delays at the majority of the acute hospitals across the Trust region, these delays subsequently impact on the trusts ability to deliver a safe service to the community.

3.8.1.2. The Trust will work closely with Acute Trusts to seek early resolution where a hospital handover delays occur following an established escalation process. However, if these actions fail to resolve the issue in a timely manner, the following Trust handover procedures may be implemented with the aim to expedite a safe method to release ambulance resources from A&E.

- Immediate Handover – Standard Operating Procedure
- Conveyance, Handover and Transfers of Care Procedure.

3.8.2. Surge and Escalation

3.8.2.1. NHS England has distinct escalation levels in the management of surge pressures as set out in Appendix B; these levels are used by the wider health community. To ensure a consistent approach the Trust's escalation plans have adopted the same system of escalation over 4 levels with related triggers and actions

3.8.2.2. Trust Escalation Plans Resource Escalatory Action Plan (REAP)

- A strategic plan that allows for escalatory measures from the 'corporate body' to support performance and disruptive events that are assessed as high risk to service delivery

3.8.2.3. Surge Management Plan

- The Surge Management Plan (due to be introduced during November 2017) will be utilised by the EOC in situations of surges in call volume, which result in the supply of ambulance service resources being insufficient to meet the clinical demand of patients. The more flexible and immediate nature of this plan will often mean that it provides a more effective and expedient response to surges in demand that are likely to be for short durations.

3.9. Adverse Weather

3.9.1.1. As part of business as normal procedures it is the responsibility of the Contingency Planning & Resilience Team to monitor any approaching adverse weather via Met Office and Local Resilience Forum (LRF).

3.9.1.2. The Trusts Tactical Advisors provide a 24 x 7 on call and act as a single point of contact for external agencies to alert for incidents or significant events.

- Tactical Advisor - SPOC - 07003 900765

3.9.1.3. Warnings of any potential adverse weather are communicated through the organisation to on-call commanders, relevant managers and functional heads.

3.9.1.4. At times of severe weather during the winter period or access via difficult terrain, the Trust needs to be able to deploy four-wheel drive (4x4) resources to provide access to patients and retrieval to road based resources.

3.9.1.5. The Trust operates a variety of vehicles with 4x4 capability across its geography as well as providing driver training for a range of operational staff. These will be deployed under the direction of Tactical Commanders in preparation for or during any adverse weather.

3.9.1.6. All of the trust's ambulances/response cars have all-weather tyres fitted in readiness for adverse weather conditions.

3.9.1.7. The Trust also has Memorandum of Understandings (MOU's) in place with Voluntary Aid Societies (VAS) who can also mobilise 4x4 vehicles and ambulances as required to support operations. In addition, a number of Memorandum of Understandings (MOU's) are in place with volunteer 4x4 groups to provide assistance at times of severe weather.

3.9.1.8. The logistics department robustly plans for the distribution of supplies of winter stock in advance of and throughout periods of adverse weather.

3.9.1.9. The Trust's MI Plan- Additional Contingencies - Adverse Weather provides further guidance and information.

3.9.2. Major Incident

3.9.2.1. In the event of a Major Incident being declared during the period, normal procedures will be followed. Please refer to the SECAmb Major Incident Plan and EOC Action Cards for further information.

3.9.3. Key Support Services - Fleet Resource Planning

3.9.3.1. Fleet services are responsible for ensuring that the Trusts vehicles are available to operations when required. However, this must be based on an effective working relationship with operational managers to ensure that vehicles are presented for scheduled maintenance and MOTs when requested and that vehicle utilisation is maximised by robust monitoring and implementation of driving standards and vehicle damage.

3.9.3.2. There are a number of measures the Fleet Department take to ensure that vehicle availability is maximised and particularly through Q3 and Q4; these include:

- All MOTs being rescheduled to avoid November and December
- Damage repairs will be 'bundled' to be undertaken in batches (unless it requires to be done for safety/ road worthiness)
- The Fleet Department has an escalatory Plan which ensure that additional maintenance capacity can be applied during periods of higher demand
- The Fleet Department will support and work alongside the Make Ready and Vehicle Preparation Programme (VPP) to ensure efficient turnaround of vehicles within the system.

3.9.3.3. There are risks associated with being able to provide sufficient vehicles to meet peak demands which have been recorded in the risk section of this Plan. This relates to the combined impacts of the new operational rotas and meeting periods of high demand during the 6 weeks of this Plan. The risks relate not only to having sufficient vehicles but also communications hardware and medical equipment.

3.10. Key Support Service – Make Ready

3.10.1. The Make Ready System is responsible for cleaning, restocking and checking equipment on ambulances and SRVs in readiness for operational shifts.

3.10.2. At times, it may be necessary for a vehicle to be “hot loaded”, in that they are not put through the full MR system to ensure that vehicles are available for operational response.

3.10.3. Key Support Services - Logistics Resource Planning

3.10.3.1. The Logistics Support Department are responsible for ensuring that all Trust locations have the availability of medical consumables, gasses, medical paperwork and sundry items to ensure that the Operational vehicles can be maintained to the required stock levels for effective patient treatment and care.

3.10.3.2. There are a number of measures taken by the Logistics Support Department to ensure that stock levels are pre-positioned and maintained to ensure maximum availability, particularly in the lead up to and through Q3 & Q4, these include:

- Medical equipment servicing is not planned during the Q3/Q4 period.
- Medical consumables stock is uplifted to account for the increase in demand.
- Medical gas supplies are uplifted and pre-positioned in certain trust areas to allow for increase in demand.
- The Logistics Support Department has an escalatory Plan which ensures that additional capacity can be applied during periods of higher demand to ensure logistic support to stations/Make Ready.
- The Logistic Support Department will support and work alongside the Make Ready and Vehicle Preparation Programme (VPP) to ensure efficient turnaround of equipment and consumable requests required to support the vehicles within the system.

3.10.3.3. There are risks associated with being able to provide sufficient equipment to meet peak demands which have been recorded in the risk section of this Plan. This relates to the combined impacts of the new operational rotas and meeting periods of high demand during the 6 weeks of this Plan. The risks relate not only to having sufficient equipment but also vehicles and communications hardware.

3.11. Key Support Service – IT

3.11.1. The Head of Information Management and Technology is responsible for ensuring 24-hour IT support which is delivered through an on-call system.

3.11.2. Dedicated support is provided to the EOCs by EOC Systems team, again through an on-call system.

3.11.3. Consideration will be given to having on-site support for key dates such as New Year's Eve.

3.12. Flu and Norovirus Outbreaks – IPC Team

3.12.1. The Infection Prevention and Control Lead is responsible for the delivery of this year's flu vaccination programme for staff. The programme commences at the end of September 2017 and the aim is to vaccinate as many staff as possible before winter pressures start to effect the Trust.

3.12.2. Any flu or norovirus outbreaks in the community are monitored by the IPC Team via the Public Health England Daily Outbreaks reporting system (these reports are also shared on a daily basis with 111). Local IPC Alerts will be sent out as and when required as well as regular updates on procedural compliance to IPC Universal Standard Precautions for staff to maintain.

3.12.3. Any flu or norovirus outbreaks within the Trust will be investigated and managed by the IPC Team with all necessary actions put in place. This will include local IPC Champions supporting the team and occupational health support from Optima.

3.12.4. The IPC Team will also liaise with EOC's, Make Ready Teams and Production Desk to provide advice on the decontamination requirements for vehicles and staff involved in any possible post treatment / transportation contamination issues.

4 Command and Control

4.1. The normal command structure will be in place throughout the Trust, details of which are found on the on-call rota accessed on the Trust's intranet @ info.secamb.nhs.uk or Operational Commander rotas.

4.2. To ensure that the Trust maintains the capability to respond to a range of issues/incidents that may arise, on-call Strategic and Tactical Commanders and Tactical Advisors should not be tasked to operational shifts, they can, however be called upon to provide support within the Incident Command Hubs(ICH)/ Strategic Suite as required.

4.3. During the period of this plan day to day responsibility of operations remains with the Director of Operations (or their nominated deputy). They are responsible for triggering a Trust wide response if the demands are outside the scope of normal procedures.

4.4. The following table outlines additional measures to be considered to support an extended command structure in the event of increased pressure on Operations.

Item	Details
Increased Managerial Oversight	The Director of Operations (or their nominated deputy) will consider establishing increased managerial oversight during key periods of this plan. This may include: additional (24/7) commander cover in the ICHs, additional support to the ICHs, additional performance teleconference and information sharing as required, to review the actions undertaken and consider additional measures.
Strategic Suite	The Director of Operations (or their nominated deputy) may consider establishing the Strategic Suite to support the Trusts normal management and command structures. This will provide additional Senior management support to assist the Trust to coordinate its response.
Clinical Oversight	Senior clinical oversight will be provided to review risks and impacts to patients and provide support and advice.

5 Risk

5.1. The following risks have been identified within the period; however, this list should not be seen as exhaustive.

Risk	Details	Mitigation
Impact on Core Services / Patient Care	It is expected that during this period there may be times when operational resources will not match demands.	Regular performance calls and weekly oversight from SOLT/Exec, to monitor activity and resourcing.
Impact on wider Health Service	There is a risk that the numbers of patients being taken to the A&E departments will cause patient flow issues and exacerbate the availability of operational resources.	Trust engaged with NHE winter resilience planning through the A&E delivery boards.
Organisational Reputation	Failure to manage the forecast demand and attend our patients in an appropriate time could lead to additional damage to the Trust's reputation.	Regular performance calls and weekly oversight from SOLT/Exec, to monitor activity and resourcing. Trust winter communications plan. Account Mangers to support communication to partner organisations
Adverse Weather	There is a potential for adverse weather during this period which could further exacerbate the challenges faced at this time, when resources are under pressure.	Adverse weather preparation and planning.
Ambulance Response Programme	Unknown impact of the Ambulance Response Programme on the Trust's service delivery.	The Trust has a plan in place to roll out the ARP, this risk is detailed on the Trust Risk register.
IT Infrastructure	During periods of significant activity there is a risk that some of the IT infrastructure may not perform to its optimum capability.(Regional telephony /new CAD not exposed to	The Head of IT has developed a work plan to address key resilience issues, progress of which will be reviewed at the IT monthly management meetings. Both the CAD

	NYE activity)	and the telephony systems have seen similar levels of demand placed upon them in comparison to last NYE. Prior to NYE, the resilience of the CAD system will be tested to ensure a failure will not impact service delivery. During the peak periods on NYE, alongside EOC management teams, IT will be on-site and monitoring the performance of the servers hosting critical systems to ensure swift action can be taken alongside suppliers in the event of any issues.
Activity flow from NHS111	Previously throughout this period A&E has seen an increased activity flow from NHS111	KMSS111 have developed their own winter capacity plan to manage activity.
East Kent 111 Provider	That the East Kent Provider does not have the appropriate arrangements in place to ensure that they can provide a robust NHS111 service for their area.	Trust to seek assurance that they have a robust plan in place to maximise operational and clinical capacity, whilst maintaining Patient Experience and mitigating pressure on the wider health economy.
PTS Provision	The Trust is not commissioned to provide PTS, if the PTS providers do not have robust resourcing over this period, this could impact on A&E when hospitals booked discharges are required to enable capacity.	This risk will need to be addressed through continued engagement with the Local Delivery Boards.
High Dependency Intermediate Care transfers	The Trust is not commissioned to provide high dependency intermediate care transfers, except when this is shown to be an escalation of care.	This risk will need to be addressed through continued engagement with 999 commissioners and the Local Delivery Boards.
Access to primary care	The Christmas and New Year bank holidays result in an extended weekend. There is limited access to primary care throughout this period adding to Ambulance/NHS111 activity.	Links to NHS Winter Resilience Planning key priorities.
EOC Fallback	Lack of West EOC fallback capacity as the business case for	The Trust has limited fallback capacity in Banstead and

capacity	Coxheath expansion not signed off.	Coxheath training room. This risk is detailed on the Trust Risk register.
Flu and Norovirus Outbreaks	The increase in winter related illnesses during this period can affect our ability to respond to demand. Both community and Trust outbreaks of flu and norovirus need to be managed appropriately and quickly to reduce the risk.	The Trusts IPC Team will lead on managing outbreaks within the Trust and providing expert advice to staff. They will also provide regular community outbreak information.

5.2. It is proposed that the Senior Operations Leadership Team will review these risks at the SOLT Risk meetings in order to manage and mitigate these risks.

6 Communication

6.1. During this period the Trust's internal and external communications led by the Trust's Communications team will include general and specific communications which support the delivery of this plan. Adopting a pro-active approach this will include internal and external messages some of which will be prepared based on foreseeable issues including the following:

- Adverse weather
- Stay Safe messages
- Extended periods of excess demands or in advance of known hot spots
- Staff communications

6.2. Regional Operations Mangers, Operating Unit Managers and Operations Managers will be responsible for liaison with operational staff within their Operational areas, as well as engaging with key stakeholders such as hospitals, CCGs and A&E delivery boards

6.3. The Trust Business Account Managers will act as commissioner liaison and provider through engagement with the Lead CCGs and the A&E delivery boards.

7 Review

7.1. The Director of Operations has overall responsibility for this plan.

7.2. This is a living plan and will be subject to a monthly review by the Senior Operations Leadership Team, who will continue to develop this plan prior to implementation, and throughout the Q3 period.

7.3. During periods of extended escalation, the Director of Operations will report to the executive, who will review the on-going impact of escalation on the Trust.

7.4. Testing of the plan will be undertaken through a tabletop-exercise process.

8 Associated Documents

8.1. This plan is underpinned by a number of Trust procedures and plans which may be invoked during periods of high demand or when system pressures in the local health economy impact on the Trust's operational response. These include

- Resourcing Escalatory Action Plan (REAP)
- Surge Management Plan
- Immediate Handover-Standard Operating Procedure

- Conveyance, Handover and Transfers of Care Procedure (Clinical Processes)
- Major Incident Plan & Additional Contingencies
- Business Continuity Management Plan
- NHS England Operational Pressures Escalation Level Framework (OPEL)
- Infection Prevention and Control Manual

9 Distribution

Internal Distribution

Senior Operations Leadership Team

Executive

Communications Team (for publication on Staff Zone)

Business Account Managers

External Distribution

NHS England South (South East)

Lead Commissioners

A&E Delivery Boards

Document Control

Manager Responsible

Name:	
Job Title:	Senior Operations Leadership Team
Directorate:	Operations

Committee to approve	Senior Operations Leadership Team	
Version No. 3	Final /~~Draft~~	Date: 18th September 2017

Approval

Person/ Committee	Comments	Version	Date
Trust Board	For information	V3	25/10/17
Anne Harvey	Section completed following input from Barry Thurston and Chris Evans	V2.3	05/10/17
Executive Team	Plan ratified subject to inclusion of completion of EOC IT systems risk mitigation.	V2.3	27/09/17
Anne Harvey	Plan updated to reflect comments received.	V2.3	22/09/17
Executive Team	Plan agreed subject to inclusion of additional comments from Strategy and Business Development Team	V2.2	20/09/17
Executive Team	For information	V2.2	20/09/17
Senior Operations Leadership Team	For approval and recommendation to executive team.	V2.2	18/09/17
Anne Harvey	In response to comments received IPC Team - addition of section 3.12 and associated risk. KMSS111 – addition of a new risk relating to EK111 provider	V2.2	15/09/17
Anne Harvey	Plan circulated to various stakeholders for review and comment.	V2.1	11/09/17
Sue Skelton, James Pavey, Andy Cashman, Anne Harvey	Review of changes made to plan and minor amendments made Table @3.6.2 updated Section 5 risks and mitigations reviewed. Appendix A – tables updated	V2.1	11/09/17
Anne Harvey	Plan updated to reflect outcomes of Plan review workshop held on 07.08.17	V2.1	August 2017
Executive Team	For ratification	V2.0	12/10/16
Senior Operations Leadership Team	Plan agreed subject to minor amendments.	V2.0	04/10/16
Senior Operations Leadership Team & Anne Harvey	Teleconference to discuss and approve the plan	V1.1	04/10/16

Senior Operations Leadership Team	Circulated for review and comment following update to plan.	V1.1	30/09/16
Anne Harvey	Document reviewed by various stakeholders and plan reworked to reflect winter planning data and arrangements for 2016 -2017.	V1.1	September 2016
Executive Team	Plan ratified	V1.0	09/09/15
Executive Team	For information and ratification	V0.02	09/09/15
OPWG	For approval and recommendation to the Executive Team	V0.02	01/09/15
Anne Harvey	Amendments made following review & comment from SOLT 3.4.6 section on incentives rewritten and table included 3.4.9 section rewritten 3.4.11 section rewritten Addition of appendices	V0.01	
Senior Operation Leadership Team	For review and comment	V0.01	17/08/15

Circulation

Records Management Database	Date:
Internal Stakeholders	Yes
External Stakeholders	Yes

Review Due

Manager	Senior Operations Leadership Team	
Period	Annually	Date: TBC

Record Information

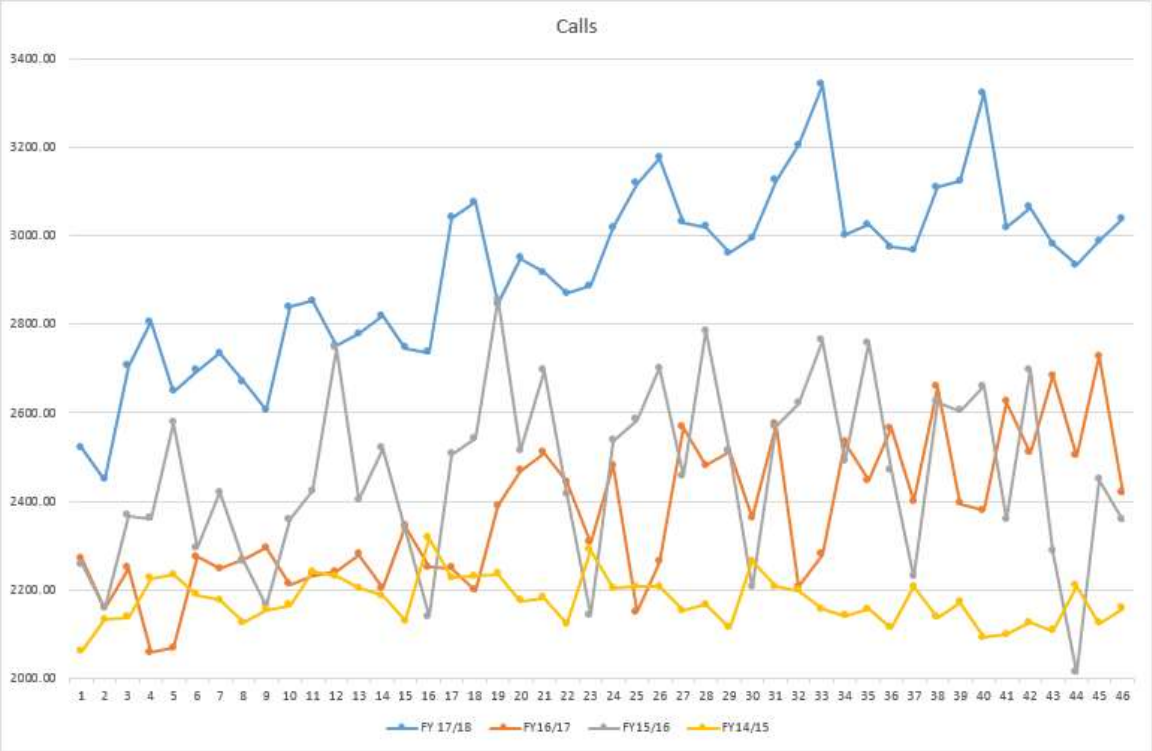
Security Access/ Sensitivity	Official
Publication Scheme	No
Where Held	Records Management database (secure area). Permission to access: on a need to know basis
Disposal Method and Date	

Supports Standard(s)/KLOE

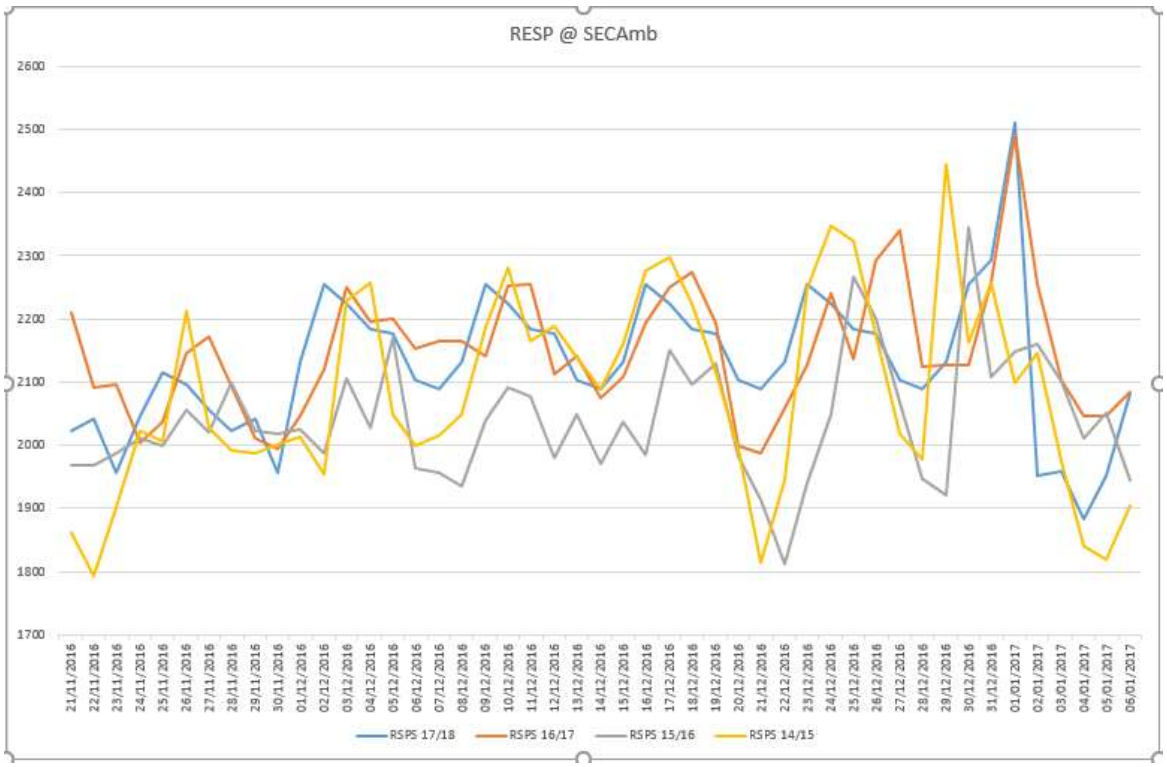
	Care Quality Commission (CQC)	**IG Toolkit**	**Other**
Criteria/KLOE:	Name core service area and CREWS elements		

Appendix A: Activity Data

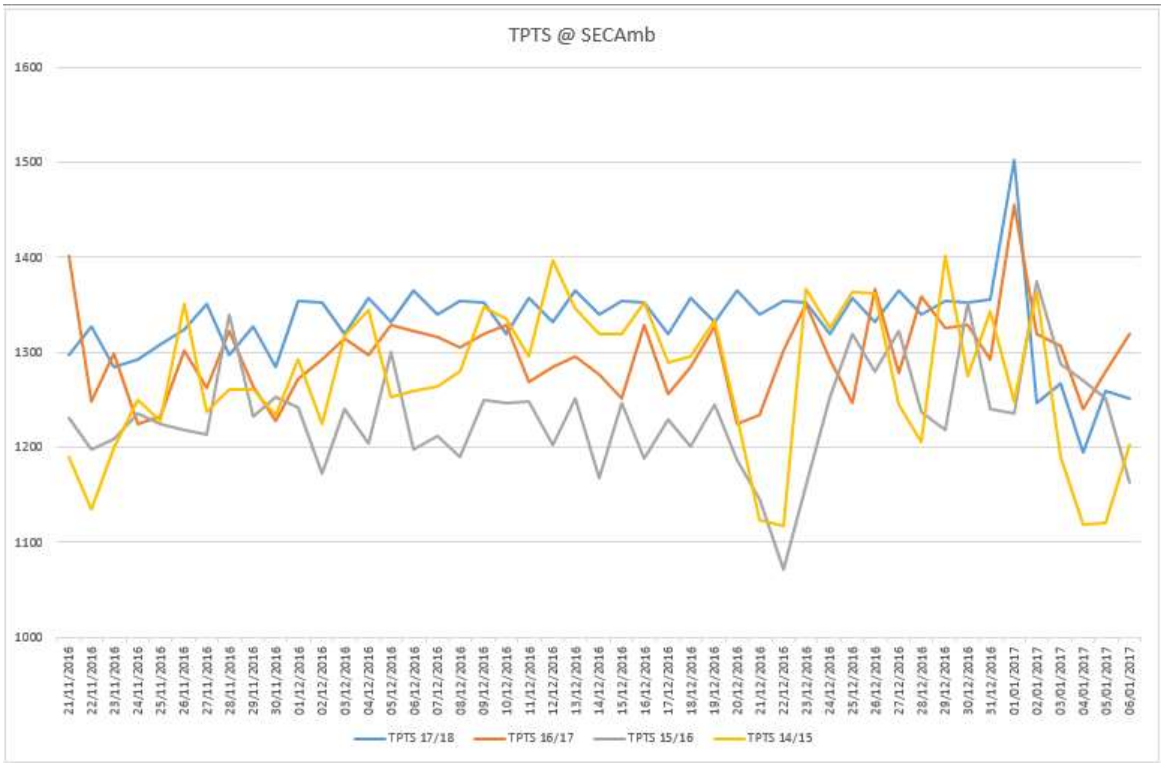
Calls 21st Nov – 6th Jan



Responses 21st Nov – 6th Jan



Transports 21st Nov – 6th Jan



Appendix B: NHS England Operational Pressures Escalation Levels

Operational Pressures Escalation Levels	
OPEL 1	The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The Local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.
OPEL 2	The local health and social care system is starting to show signs of pressure. The Local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at sub-regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.
OPEL 3	The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub-regional teams through internal reporting mechanisms
OPEL 4	Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered.

Source: NHS England Operational Pressures Escalation Framework, October 2016

Appendix C: SECAmb Resourcing Escalatory Action Plan (REAP)

REAP Definitions

The four REAP levels are as follows:

REAP Level 1 Steady State	The Trust is operating at a steady state and delivering all key performance indicators.
REAP Level 2 Moderate Pressure	The Trust is operating with a moderate pressure, where some key performance indicators are affected.
REAP Level 3 Severe Pressure	The Trust is operating with a severe pressure, where key performance indicators are not being delivered and where there is increasing staff abstractions and cross-NHS pressures are a factor.
REAP Level 4 Extreme Pressure	The Trust is operating under extreme pressure, where no key performance indicators are being achieved, significant NHS pressure is affecting all service lines and the delivery of patient care is compromised.

South East Coast Ambulance Service NHS
NHS Foundation Trust

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Winter Planning 2017/18

KMSS 111

Version: DRAFT awaiting final approval
Date: 19/10/2017
Author: Andy Taylor, Information & EPRR Lead
Approved by: John J O'Sullivan, Associate Director for Integrated Care (Head of Service - KMSS 111)

Contents

1. Document Objective

KMSS 111 has delivered a successful operational performance for the majority of the first half of the 2017-18 financial year, in addition to remaining amongst best-in-class for clinical performance across all 111 service providers nationally. The service regularly out-performs in comparison with the national 111 benchmark in the majority of key measures, whilst focusing on Quality, Patient Experience, and support of the wider health economy. It was originally intended for NHS 111 to become the gateway to urgent and emergency care and KMSS 111 is now fulfilling this role for its locality.

This document sets out the methodology in which KMSS 111 will provide a safe service during the winter period. In addition to the "Business as Usual" elements of forecasting, resource planning and consultation with other providers, the learnings from Christmas 2016 are also included.

The service is still in the process of detailed planning for the Christmas 2017 period and beyond, reviewing and modifying its call forecasts (and respective rotas) on a daily and weekly basis. Further details will be provided as we approach the critical mid-winter period and KMSS 111 will continue to supply the Lead and County lead Commissioners on a weekly basis with the detailed daily rotas (both operational and clinical) for the service, identifying predicted call volumes and associated rota fill by the hour. This enables key commissioning stakeholders the opportunity to review, challenge and understand the service's predicted position also to enable them to provide associate CCG's with the requisite assurance that they need to know that KMSS 111 remains a well organised and safe, quality-driven NHS 111 service.

2. Planning of Call Volumes

The forecast call volumes have been calculated, as last year, on the basis of daily and hourly profiles (calculated to fifteen minute intervals); projections of Average Handling Time; and an allowance for Shrinkage (Sickness and other short-term absences/non-attendance). These volumes include the Admin Line (see Section 3) currently based in Ashford, which handles patient call-backs and Repeat Prescription requests at weekends and during public holidays.

Fig A: Weekly Index of KMSS 111 Call Volume (w/c 02/10/17 = 100)

Week Commencing	Index
02/10/2017	100
09/10/2017	106
16/10/2017	107
23/10/2017	107
30/10/2017	106
06/11/2017	107
13/11/2017	113
20/11/2017	116
27/11/2017	111
04/12/2017	117
11/12/2017	113
18/12/2017	107
Christmas 25/12/2017	157
New Year 01/01/2018	119
08/01/2018	105
15/01/2018	100
22/01/2018	101
29/01/2018	104
05/02/2018	103
12/02/2018	105
19/02/2018	105
26/02/2018	107
05/03/2018	106
12/03/2018	107
19/03/2018	112
Easter 26/03/2018	163

N.B. THE WEEKLY CALL VOLUME FORECAST IS EXPRESSED AS AN INDEX. THE FORECAST VOLUMES FOR THE ENTIRE PERIOD IS COMMERCIALLY SENSITIVE HOWEVER FULL ROTA DETAILS ARE PROVIDED TO LEAD COMMISSIONERS FOR KENT, SURREY AND SUSSEX ON A WEEKLY BASIS.

Fluctuations in weekly call volumes are dependent on seasonality and public holidays. In addition, historical data and scheduled GP Surgery Protected Learning Time (PLT) closures is taken in to consideration. It is noteworthy that currently, the service activity at Easter 2018 is forecast to be higher than that of the Christmas / New Year period. This is evidenced by 2016, when an early Easter coincided with ongoing winter pressures to generate exceptionally high call volumes.

3. Staffing Requirements and Protocols (Health Advisors)

The service has evolved its management of operational Health Advisor (HA) resource during 2017, as detailed below.

The KMSS 111 Recruitment Tracker is familiar to Commissioners as the most up-to-date projection of staffing requirements for the immediate to middle-term future. It tracks recruitment and attrition, and maps the required Health Advisors and Clinical Advisors against the forecast activity volumes for each week.

Both Contact Centres are accelerating HA recruitment and training during October and November. It is envisaged that additionally circa seventy (net) HA's will reach full proficiency by Christmas 2017, with approximately thirty further going live on reduced proficiency, but fully supported, just prior to Christmas. Therefore in total it is anticipated that up to an additional one hundred Health Advisors will be recruited, trained and live-taking calls during Quarter 3 by the Christmas period.

The service has now rolled out its innovative Diamond Group process to both Contact Centres, maximising proficiency and retention through extended support for newly qualified HA's following their initial NHS Pathways training.

Recruitment and training of new staff coincides with the licence-required training of existing staff to meet compliance with the new updates of NHS Pathways versions v13 and v14, going live within KMSS 111 in late November 2017.

In terms of Christmas and New Year staff management, all rota changes and annual leave must be authorised by the respective Contact Centre managers. This is an escalation from the usual authorisation procedure.

Representatives of the KMSS 111 Senior Leadership Team will be available on-site at both Contact Centres on all days during the public holidays and at weekends during the holiday period.

The role of "Real Time Analyst" remains in place in Ashford to focus on the productivity of staff at peak periods. The analyst operates from a Daily Checklist to hold Health Advisors accountable for maintaining compliance with their planned activity (telephony and AUX time status), breaks, lunch, and warm transfers. For calls taken by CareUK Health Advisors, the Network Bridge Management team will have oversight of HA productivity and is able to liaise with the Dorking Operational management team on-site if necessary.

Several of the Joint Commissioner Provider (JCP) clinical pilots, instigated in 2017 will provide tangible benefits during the winter period:

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i. Clinical In-line Support (CIS) has been expanded in terms of its coverage and aims to achieve clinical validation of up to 90% of Green non-emergency ambulances. The service has already managed to "downgrade" 7,918 ambulances in Q1 of 2017-18 and the intention is to improve on this number in Q3, when the healthcare system and the 999 service in particular is under most pressure. The service has worked with its partners in SECAmb and Care UK IT departments to ensure alignment with the national ARP (Ambulance Response Programme) which re-categorises ambulance despatches. The implementation for phase two of ARP in SECAmb is the 22nd November 2017.

ii. The service intends to introduce "ETC 4 Validation", i.e. clinical validation of 4-hour Emergency Treatment Centre dispositions, by the start of December 2017 to maximise referrals to the early-adopter standardised Urgent Treatment Centres; in addition to Minor Injury Units and Walk in Centres, between the hours of 8am and 8pm. This will release potential pressure from Acute A&E departments, allowing their teams to focus on patients with more serious presenting symptoms. The maximum number of clinical interventions through ETC4 Validation is likely to be approximately 1,000 per month, however it is not anticipated that KMSS 111 will be able to deliver this level of effectiveness before the end of the financial year because of the increased demand on core clinician activity during the winter period and also the unpredictability of when these cases will present on the Directory of Services across the day versus clinician availability at that time.

iii. The objective of the Directory of Services (DoS) Optimisation is to move on from referring patients to "appropriate and available" services, to the "optimum" service. A process of training sessions for 111 call handlers, and DoS profiling reviews with CCG DoS Leads and

Champions (scheduled for Q3), aims to minimise any contradictory or confusing information on the DoS. Individual service providers have also been consulted to ensure that their operating models and NHS Pathways awareness are aligned to their entries in the Directory of Services.

iv. The KMSS 111 DoS Lead has been working with colleagues in SECAmb 999 to ensure that DoS usage and awareness in the South East Coast Emergency Operations Centres (EOC) is maximised for the winter.

The Ashford Service Advisor (formerly Admin) team will be in place to manage the Interactive Voice Recognition (IVR) line at weekends and during public holidays. The Service Advisors will be trained across the skillset of handling faxes, repeat prescription requests and GP OOH's call backs. A pre-planned rota to manage these Admin staff will be in place to maximise efficiency. The maximum capacity of the Service Advisor team managing the IVR line will be increased to handle up to circa 500 calls per staffed day. Patients reporting a worsening of their symptoms/condition are routed through to Health Advisors or Clinical Advisors for re-triage, as per the service's Standard Operating Procedures. This same function will be provided for corresponding calls being handled by CareUK Health Advisors for which additional training is being provided and more resource is being planned on the rotas to meet demand.

4. Operational Learnings from Christmas / New Year 2016 - 17

KMSS 111 has reinforced its operational resilience as a direct result of a significant service outage during the morning of Bank Holiday Tuesday, 27th December 2016. (Incident 2017 / 3486). The outage of the service's telephony and clinical operating platform resulted in the invoking of 50% National Contingency via NHS E for a two-hour period, until the service re-stabilised.

2017-3486 summary.docx

The KMSS 111 operational infrastructure, based on the CareUK national IT network, has subsequently been upgraded to minimise a recurrence of the failure, which was triggered by inadequate bandwidth for the intense activity experienced at that time.

The service has reviewed its Business Continuity (BC) plans and Action Cards as part of the EPRR programme, and in direct response to the December 2016 incident. The following enhancements have been made to our Business Continuity (BC) documentation:

a) A virtual control centre is set up in the event of a BC event (does not have to be an actual incident room or area).
b) The Senior on-Call Senior Manager is accountable for all performance SITREPs during the event itself.
c) The Head of Service (or assigned deputy) is responsible for all external communication i.e. Commissioners, NHS E etc. during the event.
d) The debrief and investigation process will follow the NHS E Serious Incident Framework 2015.
e) The service will re-test critical functionality on resumption of normal operations, i.e.

IMPORTANT: In the event of a system failure or telephony outage, upon resumption of the service, the FEM must be tested and re-activated if necessary, by the Senior on-Call Manager. This also applies to the Avaya Call Recording functionality.

f) The SLT has adopted the following EPRR Action Plan:

Core Standard	Description
6: Risk assessments aligned with LHRP and LRF	ART to develop county-wide relationships with other providers via the SECAmb Resilience Group and to feed into the KMSS risk assessment.
11: Severe Weather	"Heatwave" process to be documented in Action Card, as per Met Office National Heatwave Plan.
50: Ongoing exercising programme	Programme schedule (based on Integrated Emergency Management process) to be drafted and implemented.
52: Continuous Personal development for On Call managers	Evidence of individual managers' BC training and proficiency levels are to be captured.
BC Exercises	Conduct a communications exercise

The KMSS 111 EPRR Lead is playing an active role in Local Health Resilience Partnership delivery groups across Kent, Surrey and Sussex, feeding back into BC planning and also aligned with other service providers. KMSS 111 is also a member of the SECAmb Resilience Group.

KMSS 111 is incorporated into the SECAmb Trust Operational Winter Capacity Plan November 2017 – April 2018; increased activity flow from NHS 111 is logged as a risk to SECAmb but is mitigated by our own plan. The Trust plan also establishes sharing of symptomatic trend information between the 999 and 111 service. Wider operational issues across NHS 111 and the ambulance service are addressed by the SECAmb Senior Operations Leadership Team (SOLT), to which the Resilience Group is accountable.

Trust Operational
Winter Capacity Plar

The NHS E EPRR Assessment of KMSS 111 in 2017 found that our service was "Substantially Compliant" against the set of NHS E Core Standards, compared to "Partially Compliant" in 2016.

"The commissioners of this provider can be assured that the KMSS NHS 111 has in place the required arrangements to respond to both internal disruptions and to provide support to their partner organisations who are responding to external major incidents."

Other operational learnings**:**

a. **End of Life process**: Agreement was reached between KMSS 111 and its respective OOH's GP providers from Easter 2016 onwards, to ensure prioritisation of End-of-Life dispositions even if an OOH's GP service has closed to new cases

("Red" status" on the DoS) due to capacity pressures. This was implemented as a result of an incident in Christmas 2015, and has subsequently been adopted as "Business as Usual" during public holiday periods.

b. **Collaborative planning** with OOH's GP providers to ensure a joined-up approach to capacity planning. This will take the form of the sharing of anticipated 111 call profiles, regular CG meetings to discuss any concerns/issues and the live sharing of service status and incidents or events.

c. **Daily operational consultation** with other providers, OOH's GP, 999, Acutes etc. to maximise the accuracy and alignment of capacity management. We now have a representative at the daily SECAmb Tactical Commanders' Meeting, for two-way communication of the Demand Management Plan (DMP) and its escalation levels.

5. Escalation Plan

KMSS 111
Escalation Action Pl

The updated version was approved by commissioners in August 2017. KMSS 111 seeks to achieve a balance of managing demand without adversely impacting on patient safety and experience, whilst minimising the effect on other providers and the wider health system.

We have simplified the trigger points to make it easier for all stakeholders to recognise when to escalate and de-escalate the service.

The escalation actions at our disposal consist of a suite of options including:

- Suspension of non-telephony activities
- Patient Safety Callers nominated to manage low-acuity cases in the Clinical Queue
- Selection of Front End Messages
- Flexibility of usage of Clinical In-Line Support (see Section 6)

New provisions within the Escalation plan as a result of the Christmas 2016 IT incident:

a) The Senior on-Call Manager must ensure that the Operational Supervisors at each Contact Centre notify directly the Duty Managers at the downstream providers as set out in Part 2 of this document:
   i. Dorking centre: to contact Care UK (Surrey OOH)
   ii. Ashford centre: to contact MedOCC, IC24, SECAmb 999.
b) The service will re-test critical functionality on resumption of normal operations, i.e.

IMPORTANT: In the event of a system failure or telephony outage, upon resumption of the service, the FEM must be tested and re-activated if necessary, by the Senior on-Call Manager. This also applies to the Avaya Call Recording functionality.

Fig B: Suite of KMSS 111 Front End Messages, and scenarios to invoke them:

Front End Message	Reason for activation
1. Regional Contact Centre Failure	Technical difficulties within KMSS 111 service
2. National Disaster	Civil emergency, e.g. epidemic, terrorist attack, environmental
3. Exceptional Demand	Call Waiting Time above the trigger in the Escalation Plan
4. National 111 Telephony Failure	Confirmation of complete failure of 111 nationally
5. Adverse Weather Conditions	Contact centre staffing is affected by extreme weather, resulting in high Abandonment rate
6. Major H/C Service Provider issue:	Failure of other major healthcare provider, e.g. OOH or A&E.

N.B. FEM's 3, 5 and 6 should be utilised after first liaising with the North Kent DoC.

6. Clinical Focus

A number of additional actions have been taken to improve the overall clinical focus of the service, and to reinforce the robustness of our system resilience.

a) **Clinical In-line Support (CIS)**, with a real focus on providing clinician intervention and support for HA's, with regards to the decision making of HAs in determining "green", non-emergency ambulance referrals – now extended to up to 90% coverage of the weekly "heatmap" green 999 volumes.
b) Continued sharing of the **Clinical Queue Management** (navigation) between both Contact Centres. This upskilling of Clinical Supervisors in both sites increases resilience and ensures an improved oversight of the deployment of clinical resource.
c) **Homeworking kits**: the number of homeworking kits continues to be increased with the intention of creating a more flexible workforce; able to adapt more easily to the unique demands of providing a 24/7 service.
d) **Clinical Prioritisation**: after over a year of "shadow measuring" our clinical performance against allowance of 60-minute call-back times for low acuity dispositions, Clinical Prioritisation has been embedded into our operation effective from 1st October 2017. The following dispositions will be considered lower priority (i.e. no Warm Transfers):
    a. DX38 (Home Management Advice)
    b. DX39 (Symptom Management Advice)
    c. DX46 (Health Information)
    d. DX82 (Medication Enquiry)
    e. DX96 (Health Information)

63KMSS 1.0 LOP
Clinical Prioritisatior

This will enable the effective prioritisation of high and medium acuity cases, freeing up more capacity for Warm Transfers and 10-minute Call Backs where there is a greater clinical need.
e) Maintaining the use of **"call splitters"** uniformly across both Contact Centres to enable better observation and facilitate easier and quicker intervention by clinical coaches.

7. Contingencies

KMSS 111 actively considers contingencies to ensure demand levels are managed and remain clinically safe at all times.

a) In addition to the incremental **Admin support staff** referred to in Section 3, for "Business as Usual", further contingency Admin support will be recruited specifically for the holiday period. The actual additional FTEs required is yet to be finalised.
b) **Daily operational conference calls** are conducted each morning by KMSS 111 managers and supervisors to review the previous day's performance and to plan and take appropriate actions for the day ahead.
c) The SLT has **five planning meetings per week** to review staffing requirements and to address any other tactical operational and clinical issues.
d) **Collaboration with other national 111 providers** via the NHS E 111 Provider Forum in addition to collaboration with NHS E and through the Head of Service and CareUK networks.
e) **KMSS 111 attendance at A&E boards and representation on Whole System conference calls** has been planned in over the winter period.
f) **KMSS 111 SLT meetings** are conducted weekly to provide senior leadership oversight in terms of performance and all matters pertaining to the effective operations of the service.
g) **KMSS 111 SLT Representation** at main operational leadership meetings in CareUK (National IUC Network) and SECAmb (via SOLT)
h) **Service Contract meetings** conducted monthly with Director representation from both organisations and Head of Service.

8. Internal Risks + Mitigations

a) **Call volumes, and call profile flow, significantly diverging** from forecast resource requirements.
   i. Mitigated by: sharing knowledge with and input from, the Care UK National Forecasting Lead.

b) **Non-attendance of Health Advisors and Clinicians**.
   i. Mitigated by: Individual performance management and increased staff 1:1 engagement sessions; this is monitored, recorded and compliance is shared Commissioners.

c) Systemic failure (telephony or clinical system);
   i. Mitigated by: use of Business Continuity Plan (BCP), Action cards; also improved system resilience within the Care UK information infrastructure.

d) **Introduction of Call Routing** (KMSS activity divided equitably between the two Contact Centres); lack of resilience of service; clinical governance issues; technical "build" of Call Routing pilot.
   i. Mitigated by: internal escalation plan and maintained Business Continuity plans.
   ii. Mitigated by: thorough review and ratification of new CG processes to maintain a consistent quality of service and associated functions (e.g. safeguarding, complaints investigations).
   iii. Mitigated by: risk assessment of mobilisation plan by SECAmb/CareUK Directors, Go-Live approval via Service Commissioners conference call and SLT post implementation reviews scheduled to evaluate pilot impact and to determine whether

any amendments (i.e. resilience escalation trigger points) or additional work is required to maintain service performance..

e) **Ongoing work on JCP pilots**, e.g. Clinical hubs, Direct Appointment Booking
   i. Mitigated by: re-scheduling of technical work and pilot projects until a period of lower patient demand, post-Christmas.

9. External Risks + Mitigations

a) **Continuing uncertainty pertaining to the East Kent CCG's 111 / OOH's provider,** due to cease operations in January 2018. KMSS 111 performance will be adversely impacted if there is a continued degradation of the East Kent service provision prior to contract transition to a new provider. There is also uncertainty as to whether East Kent Commissioners and NHSE will request additional support from KMSS 111 at very short notice, as was requested in July 2016, September 2016 and August 2017.
   i. Mitigated by: ongoing dialogue with NHS E, EK and KMSS 111 Commissioners, also the ability to re-plan our resource if needed to scale up for East Kent call activity if requested.

b) **Overflow of calls from other major 111 providers** (e.g. recent invoking of National contingency by DHU and NWAS):
   i. Mitigated by: close collaboration with Care UK regarding potential Care UK network support.
   ii. Continued dialogue with the NHS E Telephony team and via the NHS E 111 Provider Forum.

c) **Adverse weather** impacting the availability of agents at each Contact Centre, and the wider Health infrastructure;
   i. Mitigated by: pro-active travel planning with staff (range of routes, modes of transport or sharing). As per Business Continuity Plan and Action Cards.

d) **Epidemic affecting patients and staff**, e.g. Influenza, as per the reported peak in December 2014.
   i. Mitigated by: Adoption of "Flu Line" pathway at commencement of triage). An extensive programme of flu jab vaccination has already commenced for staff, to minimise the susceptibility to an epidemic, as per the Business Continuity Plan.

e) **Inability of OOH's GP services to provide the required service**, and the consequent risk this presents.
   i. Mitigated by: range of actions including Front End Messages; bespoke scripts to manage patient expectation; DoS Capacity management plan; also collaboration with specific providers.

f) **Failure of new "standardised" Urgent Treatment Centres to be activated** before winter pressures, also inability to instigate DAB service.
   i. Mitigated by: KMSS 111 DoS Lead running buzz sessions to maximise the awareness of the service provisions of existing UCCs, WICs and MIUs; bespoke agreement with services relating to ability of 111 patients to self-present.

g) **Lack of capacity or procedural awareness at some services**, causing a crisis of confidence among 111 call handlers to make further referrals to those services

i. Mitigated by: DoS Capacity Management Protocol
ii. Mitigated by: collaboration with providers, NHS E and commissioning support units to ensure all staff understand referral procedures.

h) **The continuing rise in prescriptions requests** during the periods when GP Surgeries are closed and placing additional pressure upon OOH's GP service providers
   i. The introduction of the national NUMSAS service with close collaboration between the KMSS 111 DoS Lead and the respective CCG DoS Leads and NHS E.
   ii. Additional training sessions for 111 call handlers regarding the new NUMSAS service
   iii. The Head of Service advocating the use of NUMSAS by Community Pharmacies via appropriate external forums i.e. Local Pharmaceutical Committees, RPSGB etc.

10. Conclusion

In summary, KMSS 111 has the knowledge and experience gained from operating during winter periods since 2013, and has taken the insights and learnings from this to improve not only the quality of the service but also its resilience and operational effectiveness.

In addition, there is an ever closer working relationship between the SECAmb 999 and KMSS 111 services (as facilitated by governance meetings and the JCP 999/111 integration Clinical Pilot) and there is a genuine desire to ensure that KMSS 111 supports and protects the wider system, especially as we enter the demanding winter period. The winter and service escalation plans are also fed in to the wider Trust Resilience processes and the SECAmb Winter Plan, to ensure a collaborative and coherent approach to responding to increased demand.

The CQC's inspection of the KMSS 111 service in May 2017, found the service to be "Good" in all domains, with the exception of "Outstanding" for Leadership. We are confident that patients and providers across the KMSS area can continue to have confidence in the quality and resilience of the 111 service in their area.

11. Glossary

A&E – Accident and Emergency
AHT – Average Handling Time
AUX – Auxiliary Telephony Activities (Outbound, Admin, Lunch, Break, Training)
BCP – Business Continuity Plan
CA – Clinical Advisor
CQC – Care Quality Commission
DAB – Direct Appointment Booking
DMP – Demand Management Plan (SECAmb)
DoS – Directory of Services
ED – Emergency Department
EK – East Kent
EPRR – Emergency Preparedness, Resilience and Response
FEM – Front End Message
HA – Health Advisor
IVR – Interactive Voice Response
KMSS – Kent, Medway, Sussex, Surrey (current operating area of the service)
LHRP – Local Health Resilience Partnership
LRF – Local Resilience Forum
MIU – Minor Injuries Unit
NUMSAS – National Urgent Medication Supply Advanced Service
NHS E – NHS England
OOH – Out of Hours
PLT – Protected Learning Time
RTA – Real Time Analyst
SECAmb (South East Coast Ambulance Service)
SLT – Senior Leadership Team (KMSS 111)
SOLT – Senior Operational Leadership Team (SECAmb)
UCC – Urgent Care Centre
UTC – Urgent Treatment Centre
WIC – Walk in Centre

South East Coast Ambulance Service
NHS Foundation Trust

Integrated Performance Dashboard

October 2017 Board Meeting

SECAmb Integrated Performance Report

Contents

SECAmb Regulation Statistics

Use of Resources Metric (Financial Risk Rating)	3
CQC Compliance Status	Trust: Inadequate (Special Measures) 111 Service: Requires improvement
IG Toolkit Assessment	Level 2 - Satisfactory
REAP Level	3

Data Notes

Chart Key:

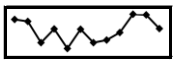
Data Point	This represents the value being measured on the chart
Run of 8 above average	These points will show on a chart when the value is above or below the average for 8 consecutive points. This is seen as statistically significant and an area that should be reviewed.
Run of 8 below average	
Above UCL	When a value point falls above or below the control limits, it is seen as a point of statistical significance and should be investigated for a root cause.
Below LCL	
AVERAGE	This line represents the average of all values within the chart.
UCL	These lines are set two standard deviations above and below the average.
LCL	
Target	The target is either and Internal or National target to be met, with the values ideally falling above or below this point.

SECAmb Clinical Safety Scorecard

Cardiac ROSC - Utstein

	Mar-17	Apr-17	May-17	12 Month's
Actual %	62.9%	62.1%	56.8%	
Previous Year %	54.8%	61.1%	61.3%	
National Average %	52.7%	54.8%	48.1%	

Cardiac ROSC - ALL

	Mar-17	Apr-17	May-17	12 Month's
Actual %	29.7%	28.0%	22.8%	
Previous Year %	28.9%	26.3%	26.4%	
National Average %	30.2%	30.2%	28.7%	

Cardiac Survival - Utstein

	Mar-17	Apr-17	May-17	12 Month's
Actual %	16.7%	33.3%	30.3%	
Previous Year %	21.4%	25.7%	33.3%	
National Average %	28.9%	31.1%	22.6%	

Cardiac Survival - All

	Mar-17	Apr-17	May-17	12 Month's
Actual %	6.7%	8.1%	6.3%	
Previous Year %	6.3%	6.2%	8.0%	
National Average %	9.0%	9.1%	8.5%	

Acute STEMI Care Bundle Outcome

	Mar-17	Apr-17	May-17	12 Month's
Actual %	65.6%	59.6%	57.5%	
Previous Year %	67.6%	69.1%	66.7%	
National Average %	78.7%	76.7%	78.4%	

Acute STEMI receiving primary angioplasty within 150 minutes

	Mar-17	Apr-17	May-17	12 Month's
Actual %	91.7%	87.9%	91.7%	
Previous Year %	98.3%	94.2%	88.2%	
National Average %	86.2%	87.6%	86.4%	

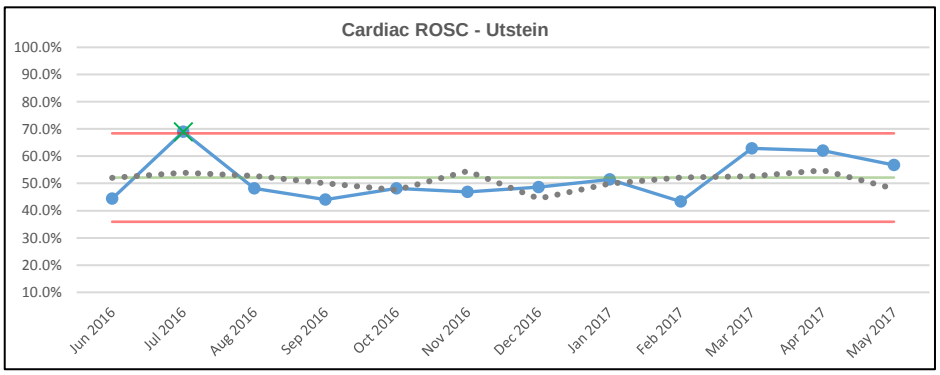
FAST Id'd Stroke - arriving at a hyperacute stroke unit within 60 minutes

	Mar-17	Apr-17	May-17	12 Month's
Actual %	59.6%	66.8%	64.9%	
Previous Year %	63.4%	76.4%	67.0%	
National Average %	55.2%	58.7%	55.2%	

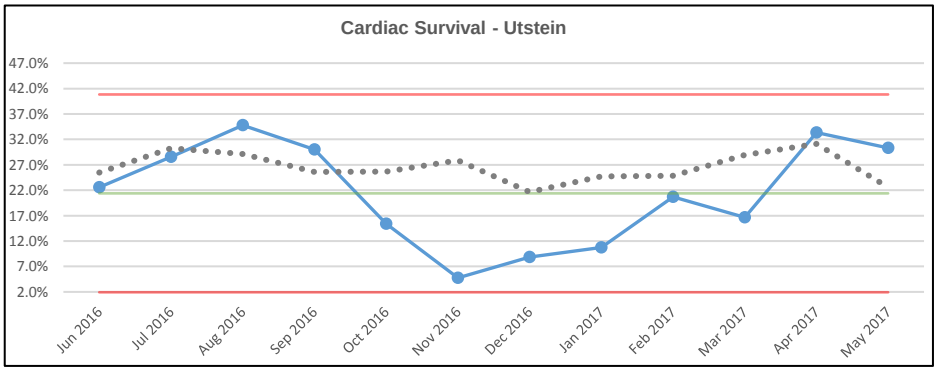
Stroke - assessed F2F receiving care bundle

	Mar-17	Apr-17	May-17	12 Month's
Actual %	94.1%	94.1%	92.3%	
Previous Year %	95.5%	95.8%	95.7%	
National Average %	98.1%	97.3%	96.6%	

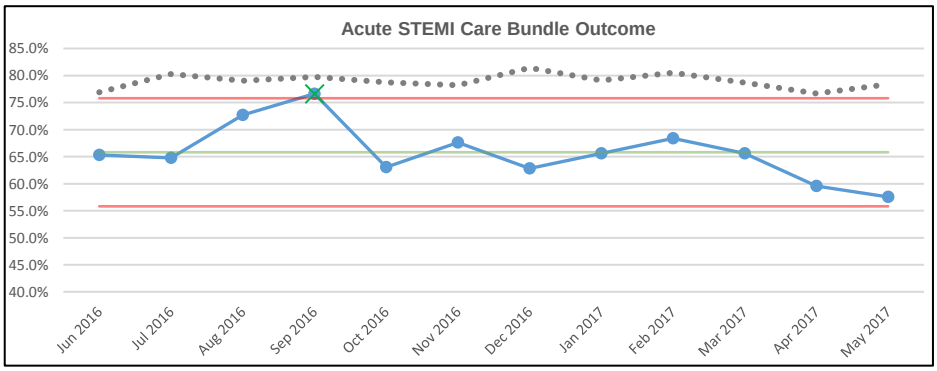
SECAmb Clinical Safety Scorecard



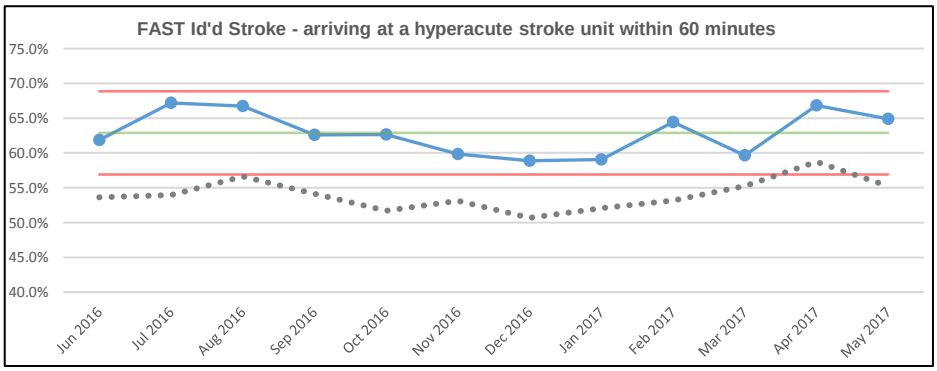
The cardiac arrest ROSC indicator for the Utstein group for May 2017 remains significantly higher than the national average. When benchmarked against the other 11 ambulance trusts, the Trust was ranked third for this indicator. in April 2017, we were ranked fourth.



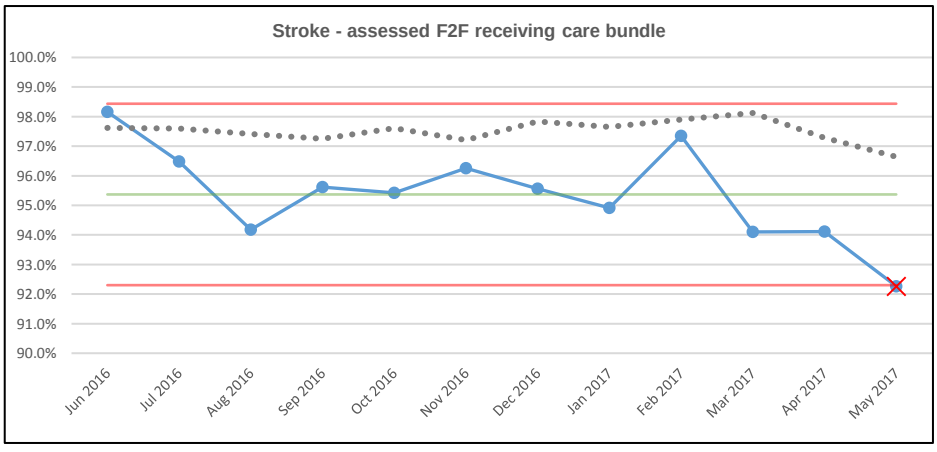
In May 2017 survival to discharge for the Utstein group was 30.3% which was a slight decrease from April 2017 when performance Monthly meetings have been introduced with representation from the clinical audit, Consultant Paramedic and the Medical Director to explore the quality of data and identify areas for improvement.



Compliance issues were due to two pain scores and analgesia not being recorded. Staff have been reminded in the weekly bulletin and Clinical Update of the need to record these interventions. We are currently reintroducing the clinical audit scorecard to share station level compliance. Work will be undertaken with Clinical Education and Operational Team Leaders to highlight the importance of compliance with these care bundles.



In May 2017performance for FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper acute stroke unit within 60 minutes remained consistent.



Compliance with the stroke care bundle continues to decrease. Non-compliance was due to a lack of recording of blood glucose. Action is required to raise staff awareness of the need to record blood The availability of IPad presents an opportunity to improve the breadth of communication with front line clinicians. Work will be undertaken with Clinical Education and Operational Team Leaders to highlight the importance of compliance with these care bundles.

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SECAmb Clinical Quality Scorecard

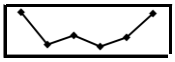
Number of Incidents Reported

	Jul-17	Aug-17	Sep-17	12 Month's
Actual	595	579	585	
Previous Year	526	493	466	

Number of Incidents Reported that were SI's

	Jul-17	Aug-17	Sep-17	12 Month's
Actual	8	10	11	
Previous Year	3	4	0	

Duty of Candour Compliance (SIs)

	Jul-17	Aug-17	Sep-17	12 Month's
Actual %	17%	30%	64%	
Target	100%	100%	100%	

Number of Complaints

	Jul-17	Aug-17	Sep-17	12 Month's
Actual	82	105	132	
Previous Year	162	144	121	
Complaints Timeliness (All Complaints)	58.2%	47.1%	42.4%	
Timeliness Target	95%	95%	95%	

Hand Hygiene

	Jul-17	Aug-17	Sep-17	12 Month's
Actual %	77%	77%	84%	

Safeguarding Training Completed (Adult) Level 2

	Jul-17	Aug-17	Sep-17	12 Month's
Actual %	26.65%	34.06%	45.22%	
Previous Year %				
Target	33%	42%	50%	

Safeguarding Training Completed (Children) Level 2

	Jul-17	Aug-17	Sep-17	12 Month's
Actual %	20.54%	35.99%	46.62%	
Previous Year %				
Target	33%	42%	50%	

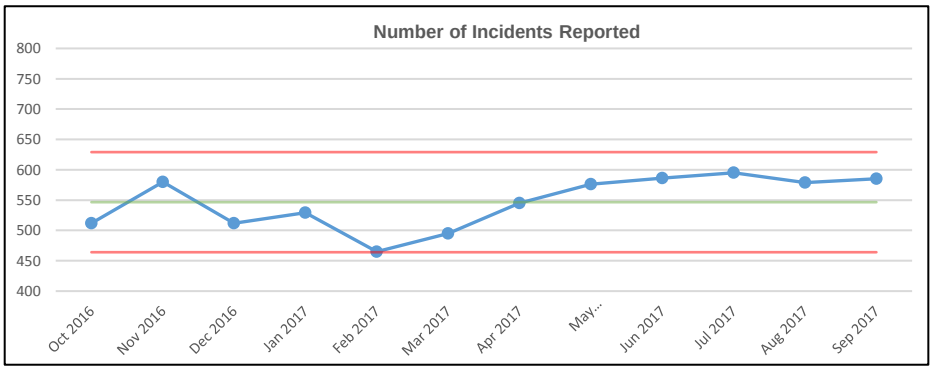
Safeguarding Training Level 3 (Adult/Child)

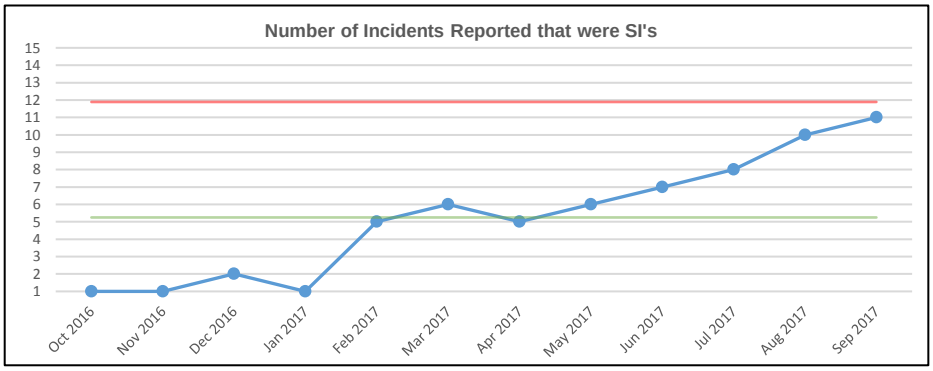
	Jul-17	Aug-17	Sep-17	12 Month's
Actual %	20.36%	23.75%	26.06%	

Medicines Management

	Jul-17	Aug-17	Sep-17	12 Month's
Actual				
Target				

SECAmb Clinical Quality Scorecard

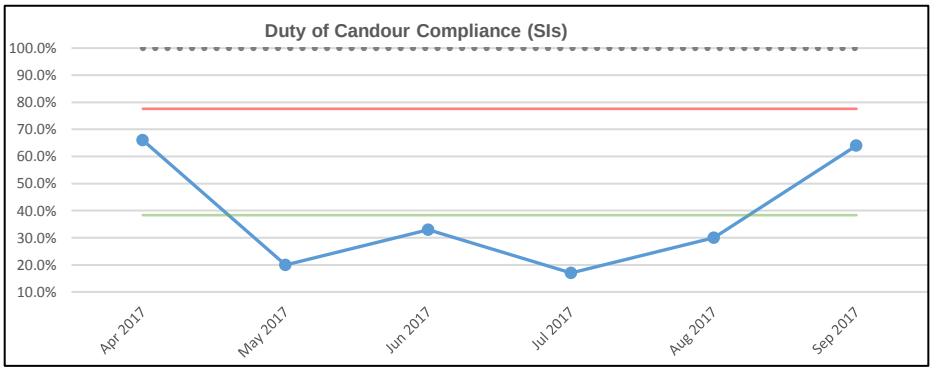




There were 13 Serious Incidents in total for the month of September.

6 were regarding delayed dispatch in EOC. 3 were regarding triage or call answering and 2 regarding a delay in call answering.

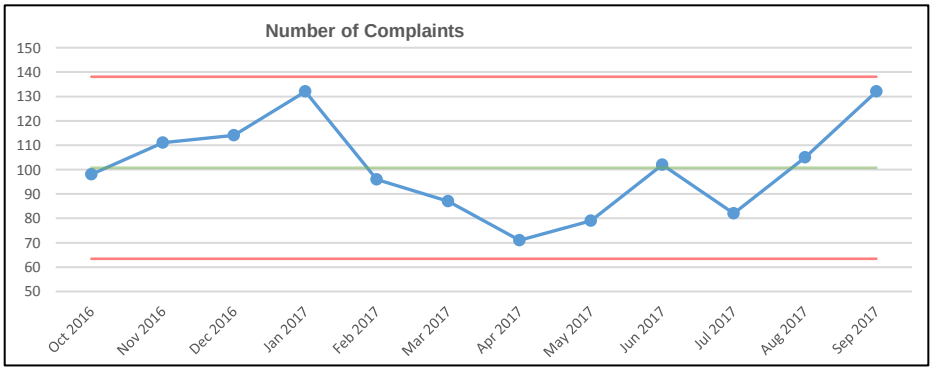
The remaining 2 incidents were within the 111 service and were regarding triage



The improved compliance for Duty of Candour is reflective of the focussed attention being paid to this aspect of care.

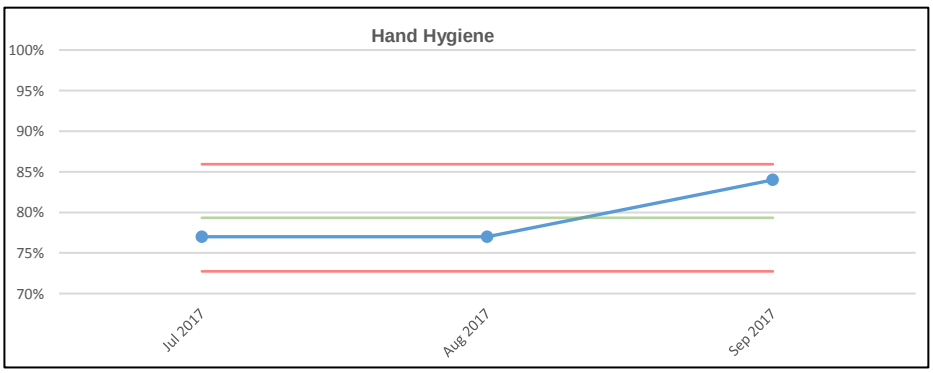
Within the month all staff involved in leading Duty of Candour attended a workshop to ensure everyone who gives advice on candour is consistent in their advice.

In addition, the Lead and the Manager for Serious incidents has been undertaking the responsibility when there has been a delay in assigning an investigating manager.



The number of complaints received has increased significantly this month as a result of two factors. Firstly, there has been an increase in complaints about NHS111 as a result of a spate of complaints from a particular out-of-hours provider (27 total complaints in September compared to 16 in August) . SECAmb's senior NHS111 management team have made contact to discuss this influx, as it was felt that some of the complaints may be spurious.

Secondly, and of more significance, is an exponential rise in complaints about ambulance delays. Thirty-seven were received in July, 52 in August and 73 in September. The average monthly figure for 16/17 was 36.



Compliance to hand hygiene is based on the 'Five Moments for Hand Hygiene' audit tool and the figures shown come from local audits carried out at each Operating Unit.

The target figure has been set at 90%, but we will raise this to 95% once we have embedded the IPC Champions into practice across the Trust. They will be responsible for raising awareness of all IPC activities and procedures at a local level which is something that the CQC didn't see consistently during their inspections.

We will also be introducing a 'Secret Shopper' style audit in the very near future. This will involve members

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SECAmb 999 Operations Performance Scorecard

Call Handling

	Jul-17	Aug-17	Sep-17	12 Month's
5 Sec EOC Performance	63.5%	58.3%	48.6%	
Previous Year	61.8%	70.9%	72.4%	
National Target	95%	95%	95%	
Average Call Pick Up Time (secs)	10.6	9.0	19.1	
Call Pick Up Time 95th Percentile (Secs)	149	170	190	

Dispatch

	Jul-17	Aug-17	Sep-17	12 Month's
Average Allocation Time - Red 2 (Secs)	118.32	116.61	148.61	
Allocation Ratio	1.63	1.61	1.60	
Response Ratio	1.15	1.13	1.10	

Red 1 8 Minute Performance

	Jul-17	Aug-17	Sep-17	12 Month's
8 Minute Response	57.5%	59.4%	50.8%	
Previous Year	62.1%	64.6%	62.6%	
95th Percentile Response Time (mins)	18.4	16.9	18.7	
Cardiac/Resp Arrest 8 Minute Performance	63.5%	63.4%	59.1%	

Red 2 8 Minute Performance

	Jul-17	Aug-17	Sep-17	12 Month's
8 Minute Response	45.8%	46.5%	39.9%	
Previous Year	49.5%	52.5%	52.8%	
95th Percentile Response Time (mins)	26.3	25.4	27.2	
Call Volume %	38.1%	39.5%	42.7%	

Green 2 30 Minute Performance

	Jul-17	Aug-17	Sep-17	12 Month's
30 Minute Response	49.4%	48.4%	37.0%	
Previous Year	71.0%	75.3%	74.0%	
95th Percentile Perf Time (hours:mins)	02:33	02:29	03:28	

Incident Outcome (Contract)

	Jul-17	Aug-17	Sep-17	12 Month's
See & Convey	53.5%	54.6%	54.6%	
See & Treat	34.1%	32.1%	31.7%	
Hear & Treat	12.4%	13.4%	13.7%	

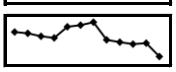
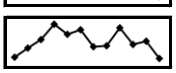
Demand/Supply

	Jul-17	Aug-17	Sep-17	12 Month's
Call Volume	101635	96596	87520	
Incidents	62276	61011	59512	
Transports	34464	33009	31639	
Staff Hours Provided Against Forecast (UHU)	101%	102%		

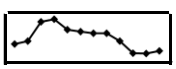
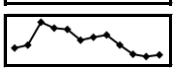
Call Cycle Time

	Jul-17	Aug-17	Sep-17	12 Month's
Clear at Scene	72.03	72.24	73.82	
Clear at Hospital	104.5	105.2	105.9	
Hours Lost at Hospital	5418	5242	5253	

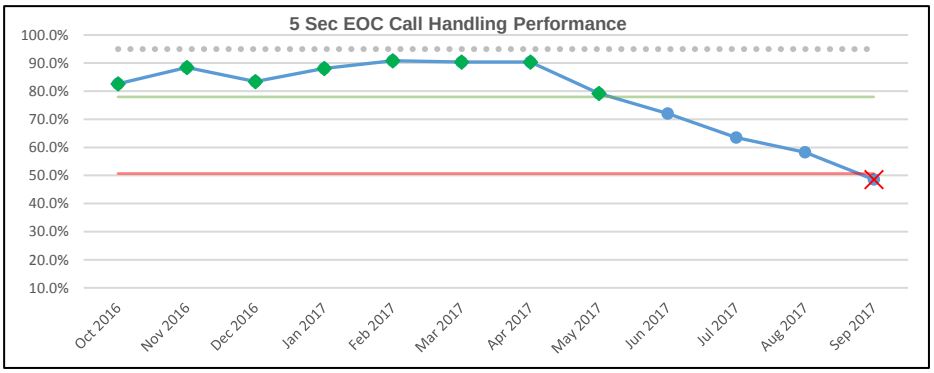
Unique Contribution to Performance

	Jul-17	Aug-17	Sep-17	12 Month's
CFR (Reds)	0.8%	0.9%	0.8%	
PAP (Reds)	1.5%	1.6%	0.9%	
Fire Responder (Red 1)	1.5%	1.6%	0.9%	

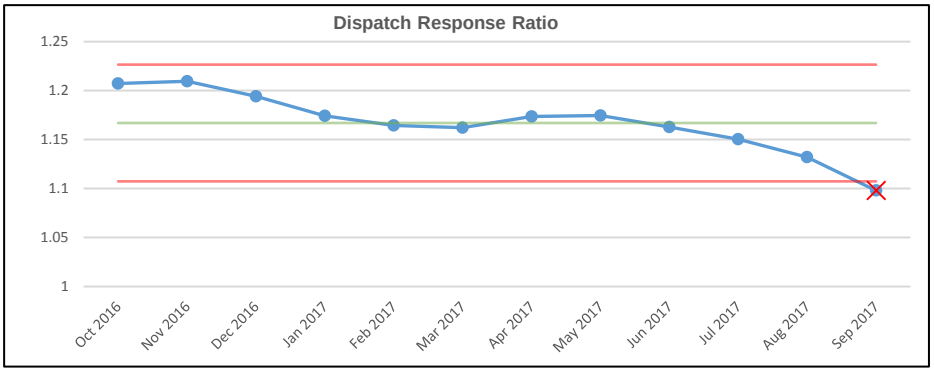
Community First Responders

	Jul-17	Aug-17	Sep-17	12 Month's
Volume of incidents Attended	1122	1110	1189	
Red 1 Attendences	121	112	118	
Hours Provided	21668	24233	20411	

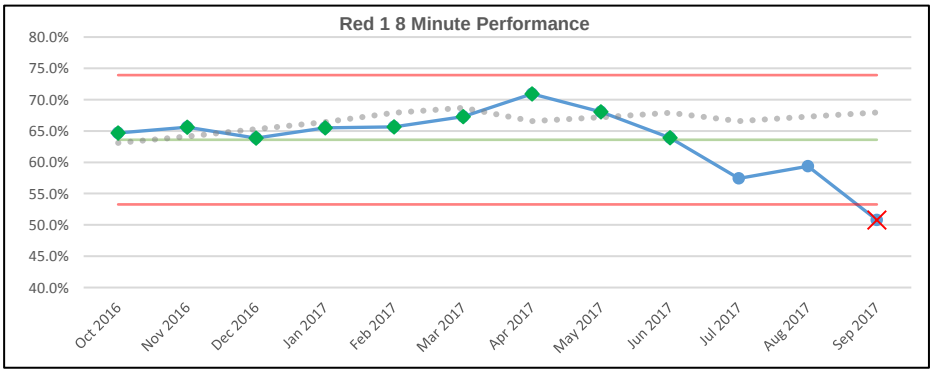
SECAmb 999 Operations Performance Scorecard



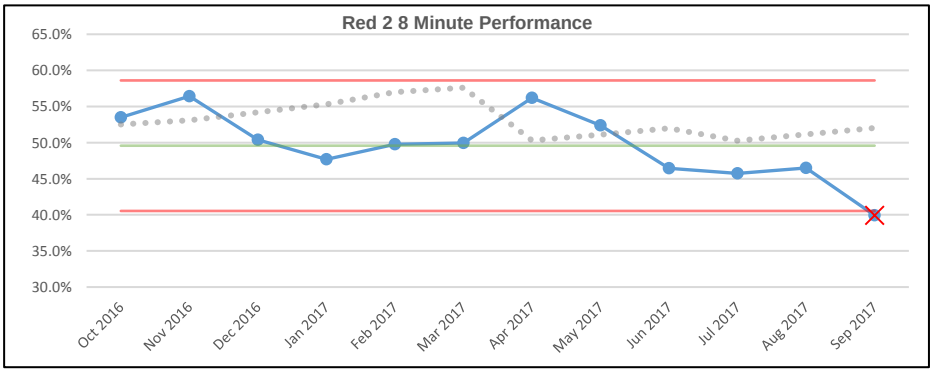
Call handling performance has continued to decline since the start of the Cleric training program. Call pick up performance has now been included within the EOC action plan to address the CQC requirement of improving AQI, with a focus on recruitment and retention of staff. Further information and analysis will be provided by the performance and information team for the next board report.



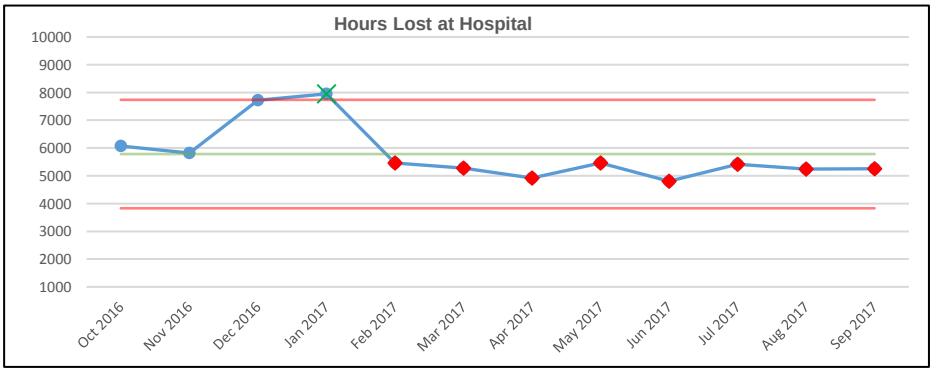
Response ratio has continued to reduce, since Jun 2017, which correlates with the reduction in Red 2 performance. This is likely due to the reduced availability of resources, resulting in less incidents that are receiving multiple responses.



Red 1 performance has declined to 51% for September 2017. A review by AACE is currently being undertaken with the aim of identifying the key areas for improvement. The report should be available shortly on this. The drop in performance is directly correlated to the reduction to the call pick up performance.



Red 2 performance also declined to 40% for September 2017. Whilst call pickup would have had a factor to play in this, it wouldn't have been as significant as the impact to Red 1. The biggest impact to this for September was the increase in abstractions required to meet the university requirements. Work is being undertaken to review all abstractions, with the aim of maximising the number of operational hours that can be deployed within the current budget.



Handover delays continue to apply a significant pressure to SECAmb, with over 5200 hours lost through handover delays. Work is being undertaken in conjunction with the CCGs by the strategy team to reduce these delays, returning hours back in to the system.

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SECAmb 111 Operations Performance Scorecard

Calls Offered

	Jul-17	Aug-17	Sep-17	12 Month's
Actual	86640	80524	80053	
Previous Year	100716	90429	86765	

Calls answered in 60 Seconds

	Jul-17	Aug-17	Sep-17	12 Month's
Actual %	91.5%	93.5%	80.2%	
Previous Year %	73.6%	91.4%	83.7%	
Target %	95%	95%	95%	

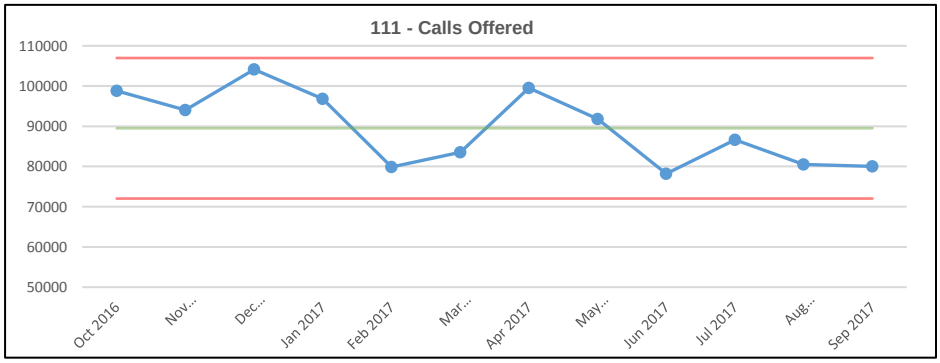
Calls abandoned - (Offered) after 30secs

	Jul-17	Aug-17	Sep-17	12 Month's
Actual %	1.1%	0.6%	2.0%	
Previous Year %	5.7%	0.9%	2.5%	
Target %	2%	2%	2%	

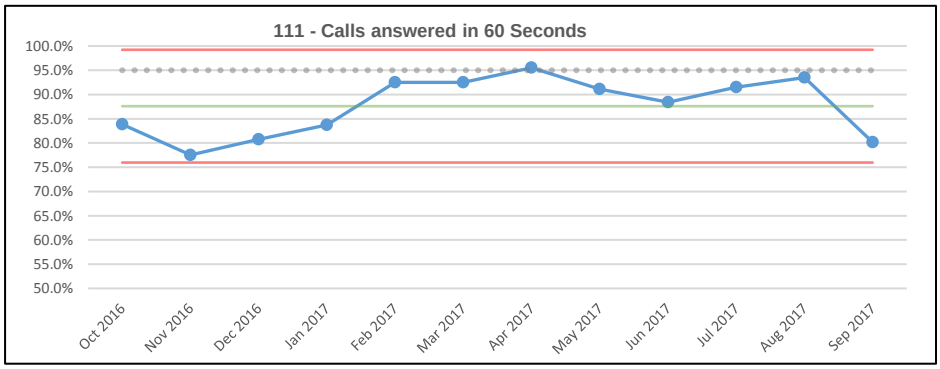
Combined Clinical KPI

	Jul-17	Aug-17	Sep-17	12 Month's
Actual %	71.8%	80.1%	69.5%	
Previous Year %	74.7%	82.2%	78.1%	
Target %	90%	90%	90%	

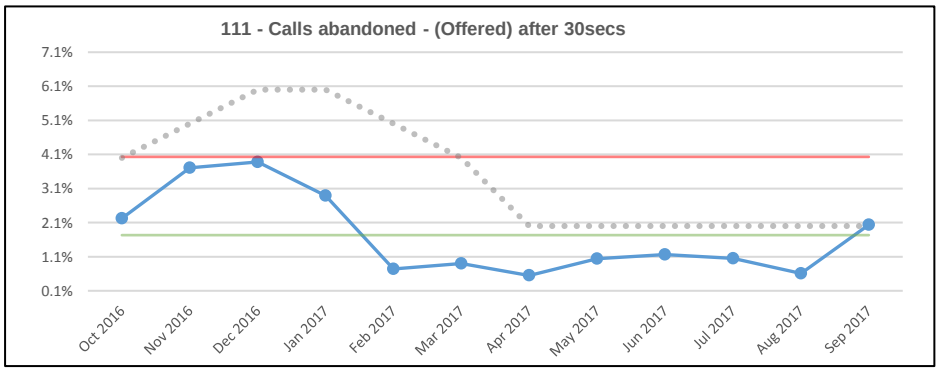
SECAmb 111 Operations Performance Scorecard



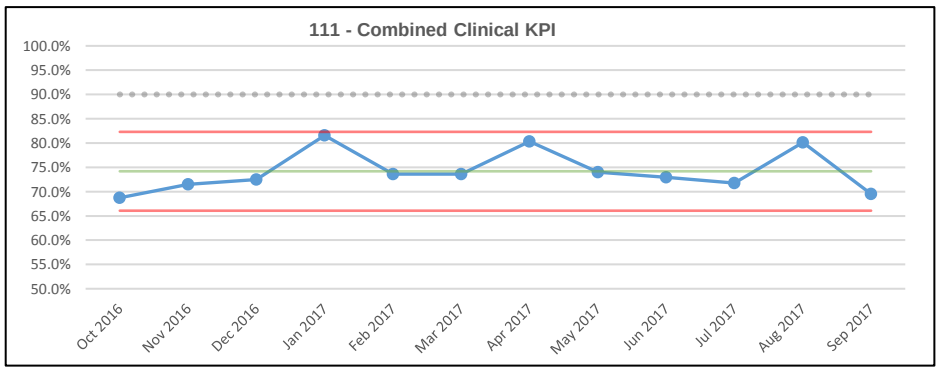
80,000 calls offered; similar to August.



The “Answered in 60” KPI dropped to 80.15%, however the “Average Speed to Answer” was 35 seconds, which confirms that we are a safe service, and are not breaching call answering to a large extent.
Operational challenges due to Annual Leave, D+V and erratic call profiling.



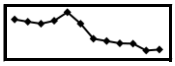
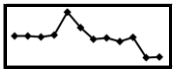
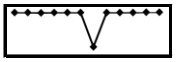
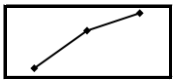
Abandonment rate up to 2.04% but still below the national average for September (2.06%).



Clinical performance declined due to lower availability of Patient Safety Callers (comfort calling) but we remain among the best-in-class for clinical performance. Referral rates to Ambulance and A+E remain significantly lower than the national average.

SECAmb Workforce Scorecard

Workforce Capacity

	Jul-17	Aug-17	Sep-17	12 Month's
Number of Staff WTE (Excl bank & agency)	3062.7	3033.42	3038.0	
Number of Staff Headcount (Excl bank and agency)	3415	3310	3313	
Finance Establishment (WTE)	3504.12	3509.12	3525.24	
Vacancy Rate	441.4	477.9	490.0	
Vacancy Rate Previous Year			346.7	
Adjusted Vacancy Rate + Pipeline recruitment %	8.25%	9.29%	9.77%	

Workforce Compliance

	Jul-17	Aug-17	Sep-17	12 Month's
Objectives & Career Conversations %	19.50%	34.06%	46.24%	
Statutory & Mandatory Training Compliance %	47.66%	59.99%	65.46%	
Previous Year %	60.00%	67.60%	73.40%	

Workforce Costs

	Jul-17	Aug-17	Sep-17	12 Month's
Annual Rolling Turnover Rate %	17.67%	17.51%	17.77%	
Previous Year %	16.90%	16.90%	16.30%	
Annual Rolling Sickness Absence %	4.83%	4.90%	4.99%	

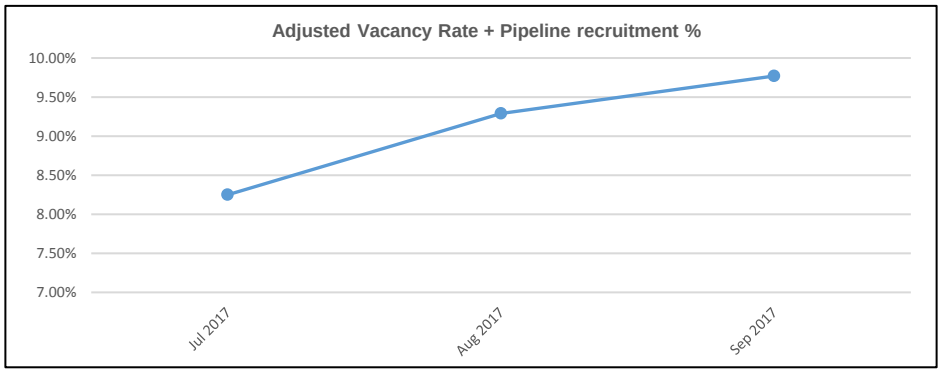
Employee Relations Cases

	Jul-17	Aug-17	Sep-17	12 Month's
Disciplinary Cases	4	9	8	
Individual Grievances	7	1	0	
Collective Grievances	1	1	1	
Bullying & Harrassment	6	0	0	
Bullying & Harrassment Previous Yr	1	0	0	
Whistleblowing	0	1	3	
Whistleblowing Previous Year	0	0	0	

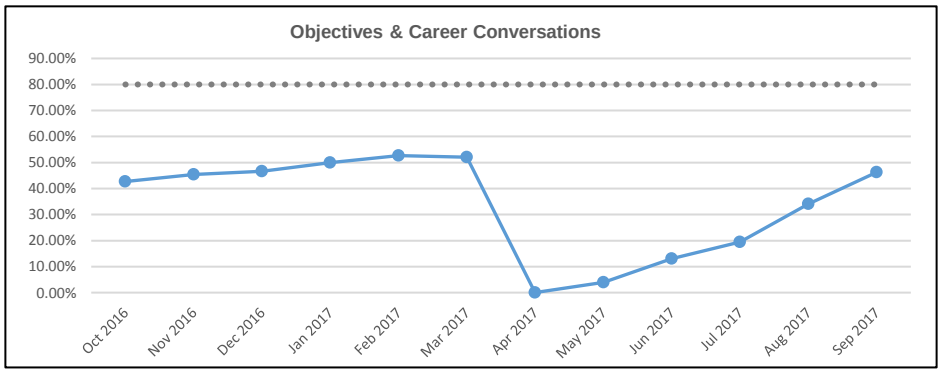
Physical Assaults (Number of victims)

	Jul-17	Aug-17	Sep-17	12 Month's
Sanctions	7	1	1	
Actual	21	17	8	
Previous Year	29	18	26	

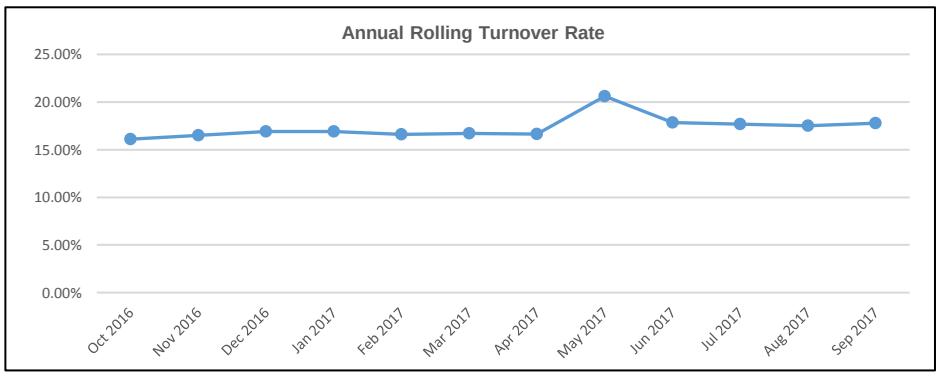
SECAmb Workforce Scorecard



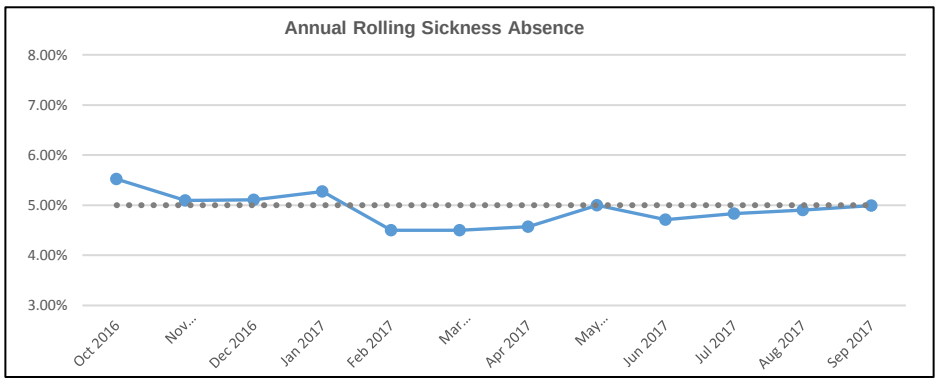
The slight increase in vacany rate is due to new roles being added to the establishment. We have increased the number of new starters per month to match the number of leavers.



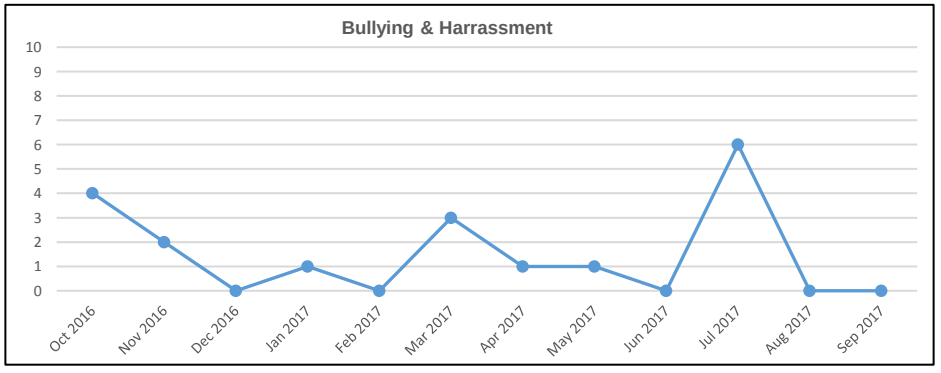
We have had a 12% month on month increase in career conversations recorded in Actus and a 27% increase in the period July - September; momentum is picking up as more staff are trained in the system – over 500 staff (mainly managers) have now been trained. Head of Learning and OD met with the Senior Operational Leadership Team to discuss improvements. SOLT to discuss with OUMs to focus on undertaking and recording conversations with staff.



The Trust turnover rate remains constant. However there is currently a high turnover rate in EOC. There is a EOC recruitment and retention action plan in place to address these issues.



This has remained stable. This is due to the close working relationship between the HR Advisors and Managers.



There have been no new bullying and harassment cases (August to September 17). There are currently 7 live cases with the longest open case being 3 months. We will be working on a B&H action plan based on the outcomes of the Focus Groups that were shared recently with the Executive.

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SECAmb Finance Performance Scorecard

Income

	Jul-17	Aug-17	Sep-17	12 Month's
Actual £	£15,778.0	£15,757.0	£14,471.8	
Previous Year £	£16,061.0	£16,354.0	£16,198.0	
Target £	£16,838.7	£16,370.0	£17,851.8	

Expenditure

	Jul-17	Aug-17	Sep-17	12 Month's
Actual £	£16,186.0	£16,463.0	£16,429.6	
Previous Year £	£16,423.8	£17,334.8	£17,095.0	
Target £	£17,241.1	£17,076.0	£18,465.1	

Capital Expenditure

	Jul-17	Aug-17	Sep-17	12 Month's
Actual £	£ 69.0	£ 225.0	£ 450.0	
Previous Year £	£ 1,826.0	£ 1,410.0	£ 1,054.0	
Target £	£ 1,140.0	£ 855.0	£ 855.0	

Cost Improvement Programme (CIP)

	Jul-17	Aug-17	Sep-17	12 Month's
Actual £	£ 1,120.0	£ 1,491.0	£ 1,330.0	
Previous Year £	£ 710.0	£ 537.0	£ 588.0	
Target £	£ 1,052.0	£ 1,293.0	£ 1,302.0	

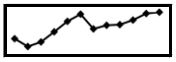
CQUIN (Quarterly)

	Q1 2017	Q2 2017	Q3 2017	12 Month's
Actual £	£ 850.0	£ 283.0		
Previous Year £	£ 952.0	£ 1,019.0	£ 716.0	
Target £	£ 849.0	£ 849.0	£ 849.0	

Surplus/(Deficit)

	Jul-17	Aug-17	Sep-17	12 Month's
Actual £	-£ 408.0	-£ 706.0	-£ 1,957.8	
Actual YTD £	-£ 2,374.6	-£ 3,080.6	-£ 5,038.5	
Target £	-£ 402.4	-£ 706.0	-£ 613.3	
Target YTD £	-£ 2,388.9	-£ 3,094.9	-£ 3,708.2	

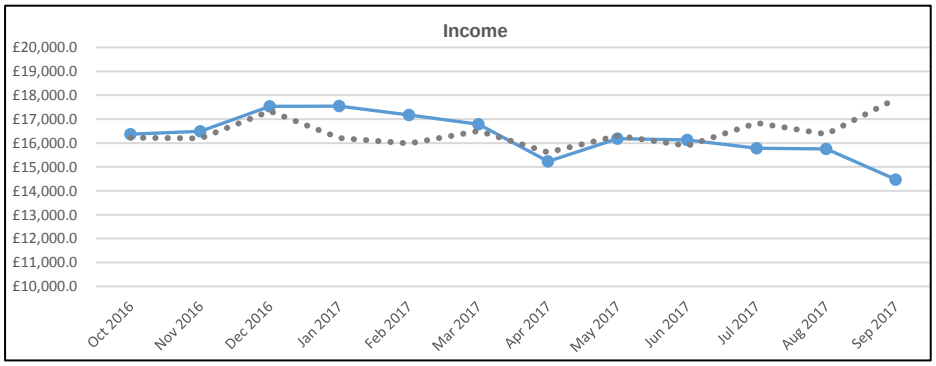
Cash Position

	Jul-17	Aug-17	Sep-17	12 Month's
Actual £	£11,605.0	£13,146.0	£13,480.0	
Previous Year £	£12,649.0	£10,951.0	£ 9,847.0	
Minimum £	£ 5,500.0	£ 5,500.0	£ 5,500.0	
Target £	£ 6,283.0	£ 5,757.0	£ 5,413.0	

Agency Spend

	Jul-17	Aug-17	Sep-17	12 Month's
Actual £	£ 201.0	£ 230.0	£ 182.0	
Previous Year £	£ 399.3	£ 670.8	£ 556.3	
Target £	£ 339.0	£ 337.0	£ 336.0	

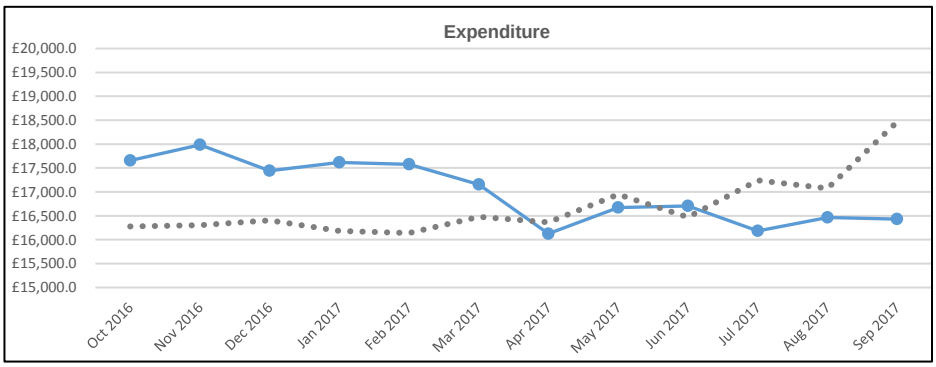
SECAmb Finance Performance Scorecard



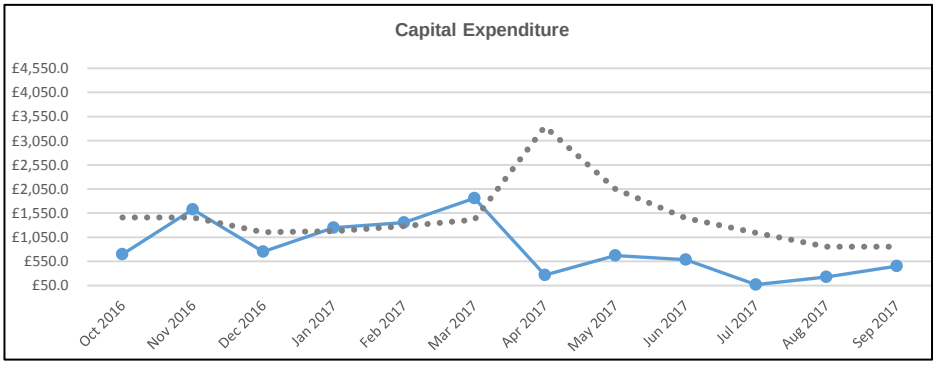
A&E income in September was down against the plan due to activity being 6.4% below plan. Following a review of activity count in the new CAD there was a catch-up from July and August. YTD was 4.4% below plan on activity and 3.5% below financially.

111 Income is above plan due to contract variation to support clinical development.

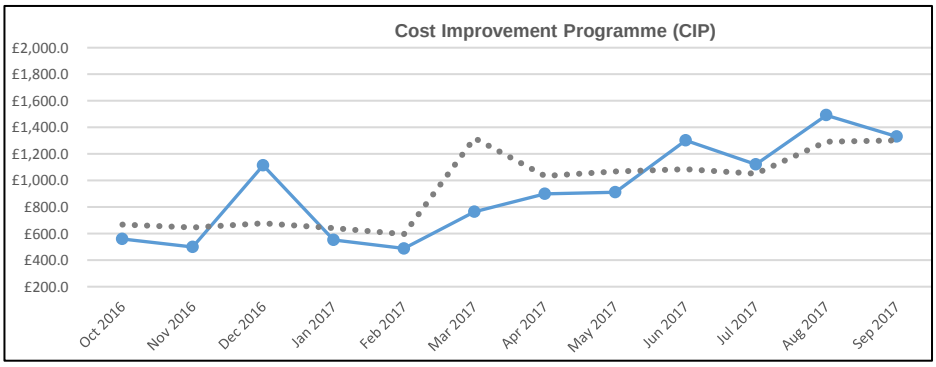
Additional Income has been earned in relation to the ambulance divert at Kent & Canterbury Hospital, in addition to NMET and Commercial



The Trust reported a £0.3m EBITDA and £0.6m deficit after financing costs. EBITDA for the year to date now stands at £1.5m and the deficit after financing costs is £3.7m.
Pay continues to underspend as a consequence of low activity, leading to reduced use of PAPs, overtime and agency. The utilisation ratios are on plan and total hours remain below plan year to date.
There has been a significant catch-up in non-pay expenditure and this is now marginally overspent in the year to date. Non-pay budgets have been profiled relatively evenly and there is a risk of an increasing overspend as Winter approaches.



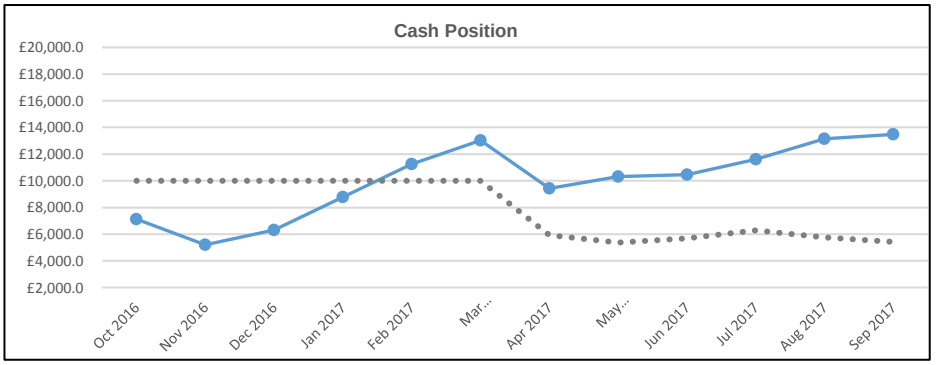
Forecast spend on the capital programme is £7.5m against a plan of £15.8m.
The projected underspend of £8.3m is entirely the result of accounting for planned vehicle replacement on operating leases, rather than finance leases.
The projected spend includes an element of re-prioritisation for the current year, due to underspending on certain planned schemes. This has enabled an acceleration of the fleet modernisation programme and other key priorities.



CIP schemes to the value of £15.1m have now been identified, matching the target.

A small element (4%) of the programme is currently at risk, principally due to slippage on the delivery of agency savings.

The PMO is seeking new schemes in order to achieve the full year target as a minimum. 55% of the projected savings relate to recurrent schemes



The cash balance at the end of September was £13.5m.

The latest cash flow forecast submitted to NHSI indicated no change in the requirement for working capital loan, which currently stands at £3.2m. This remains under regular review.

The facility is £15m.

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South East Coast Ambulance Service NHS
NHS Foundation Trust

	Item No	
Name of meeting	Trust Board	
Date	26 October 2017	
Name of paper	Complaints and Compliments Annual Report 2016/17	
Executive sponsor	Steve Lennox, Director of Nursing and Quality	
Author name and role	Louise Hutchinson, Patient Experience Lead	
Synopsis, including any notable gaps/issues in the system(s) you describe (up to 150 words)	This paper provides an overview of compliments and complaints received during the year 2016/17, including activity, subjects, themes, outcomes, performance against timescale, and learning.	
Why must **this** meeting deal with **this** item? (max 15 words)	The production of the annual complaints report is a statutory requirement, and the Trust Board wishes to be sighted on this important area of work.	
Which strategic objective does this paper link to?	It is a statutory requirement to produce a complaints annual report.	

South East Coast Ambulance Service NHS
NHS Foundation Trust

Complaints and compliments annual report, 2016/17

1 Introduction

1.1 South East Coast Ambulance Service NHS Foundation Trust (SECAmb) is committed to ensuring that patients receive an excellent standard of care whenever they use its services, and that when patients or their representatives wish to complain or feed back to us about their experience, they have every opportunity to do so. Complaints and compliments help us to identify areas where improvements to quality and services can be made and, wherever possible, steps are taken to implement changes as a result.

2 Compliments

2.1 Each year SECAmb receives an increasing number of "compliments", ie letters, calls, cards and e-mails, thanking our staff for the work they do. Compliments are recorded on SECAmb's Datix database, alongside complaints, ensuring both positive and negative feedback is captured and reported. The staff concerned receive a letter from SECAmb's Chief Executive, thanking them for their dedication and for the care they provide to our patients.

2.2 During 2016-17 SECAmb received 2,350 compliments – slightly more than the 2,327 received in 2015/16 - thanking our staff for the treatment and care they provide.

2.3 Compliments provide a welcome boost for our staff, however we also encourage and appreciate receiving feedback from those who are less satisfied with our service. We want to know how people feel about the care we provide, as this valuable feedback helps us to learn and continually improve.

2.4 A selection of positive comments from patients and relatives is provided at Appendix A.

3 Complaints

3.1 **Statistics:** During 2016/17:

- Our Emergency Operations Centre staff took 1,033,808 calls.
- Our A&E road staff made 736,936 responses to patients.
- Our PTS staff undertook 88,919 journeys.
- Our NHS 111 staff took 1,174,366 calls.
- SECAmb received 1,394 complaints.

3.2 This equates to one complaint for every 2,176 calls/journeys, meaning that 0.046% of all calls/journeys attracted a complaint. This represents a decrease of 35% against 2015/16, however during 15/16 SECAmb was providing the Patient Transport Service in Sussex, which ceased on 31 March 2016, as well as in Surrey, while in 16/17 only the smaller Surrey contract remained.

3.3 The figure below, which excludes PTS as this service is no longer provided by SECAmb, shows that in 2015/16 all complaints reduced against the previous year, and this year we have seen a 1.6% increase in complaints against last. There has been a year on year reduction in complaints about NHS111, and a disproportionate increase in EOC complaints in 16/17.

Fig 1: SECAmb complaints (excluding PTS) over the past three years

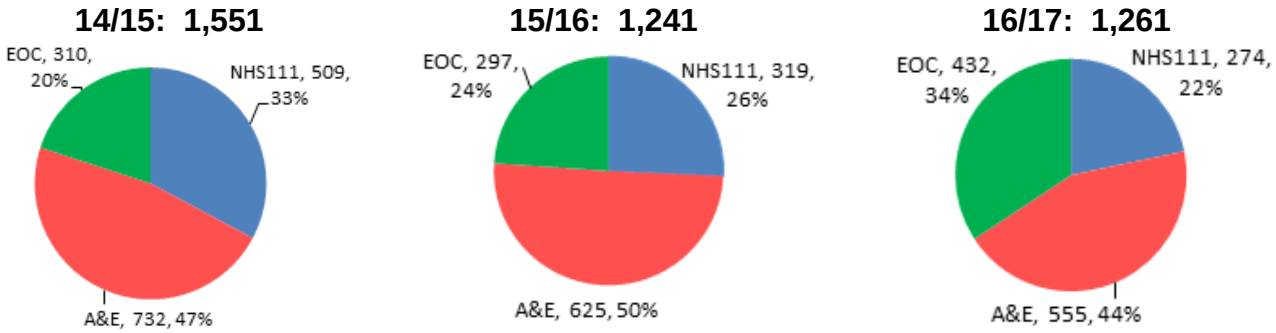


Table 1 Complaints by service/operating (OU) area and month

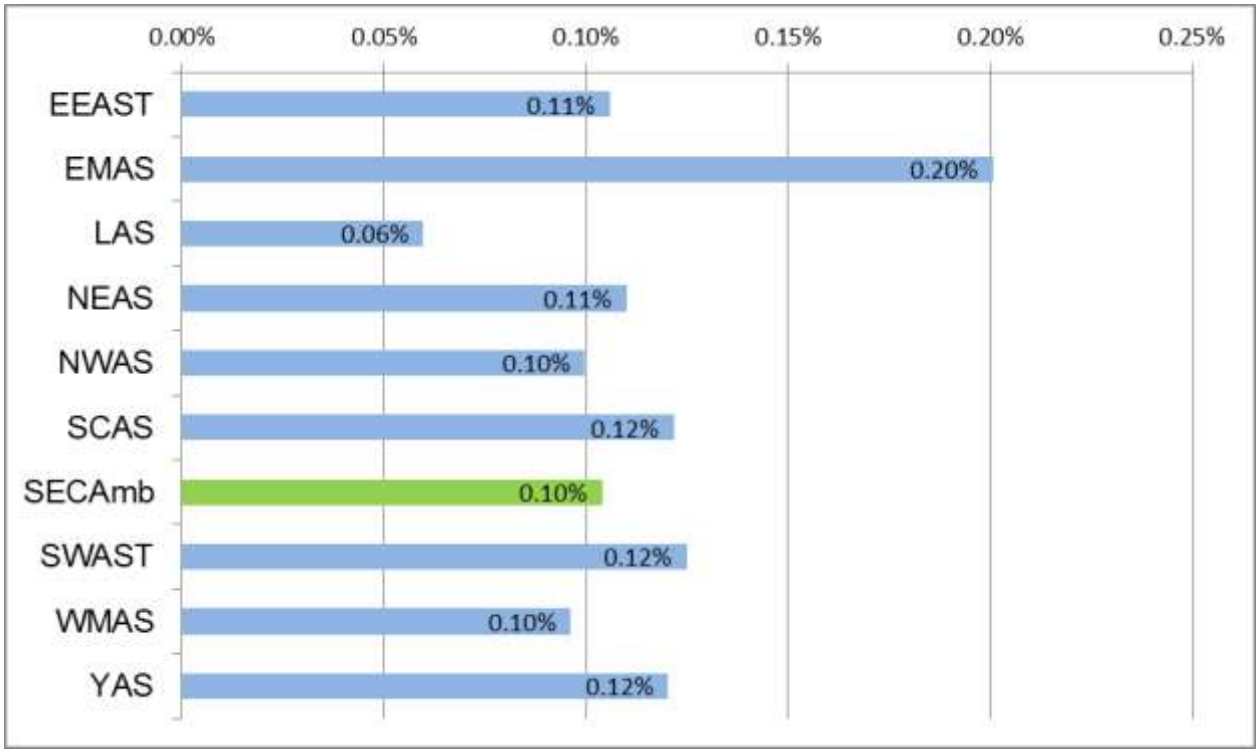
	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Total
Ashford OU	4	4	6	6	4	3	2	5	2	7	3	2	**48**
Brighton & Mid-Sussex OU	7	4	5	3	2	5	5	6	7	0	3	3	**50**
Chertsey OU	1	3	4	3	5	3	2	1	3	2	1	3	**31**
Crawley & Redhill OU	11	10	8	7	7	3	4	5	7	1	1	2	**66**
Eastbourne & Hastings OU	6	9	8	4	7	5	3	3	8	6	8	2	**69**
Guildford OU	0	4	3	6	4	3	5	5	6	2	1	2	**41**
Medway & Dartford OU	9	7	12	7	7	10	10	7	3	3	4	4	**83**
Paddock Wood OU	3	4	0	7	2	1	5	3	3	1	1	2	**32**
Thanet OU	1	3	4	6	9	5	4	3	3	4	5	3	**50**
Worthing & Chichester OU	6	11	9	7	10	9	6	5	5	8	4	4	**84**
EOC Banstead	12	8	9	17	15	9	8	13	9	9	10	6	**125**
EOC Coxheath	11	13	10	19	12	8	10	16	20	21	9	12	**161**
EOC Lewes	10	6	13	15	20	16	6	10	12	10	16	9	**143**
111 Ashford	28	14	27	28	18	27	19	11	17	20	13	10	**232**
111 Dorking	2	3	5	6	4	5	1	0	0	2	0	1	**29**
PTS Surrey	12	17	14	19	15	5	6	12	6	12	5	11	**134**
Other directorate	1	0	1	1	1	0	0	0	0	0	0	1	**5**
Unknown	1	2	1	1	0	1	0	4	0	1	0	0	**11**
Total	**125**	**122**	**139**	**162**	**142**	**118**	**96**	**109**	**111**	**109**	**84**	**77**	**1394**

3.4 **National benchmarking:** On a quarterly basis the National Ambulance Services Patient Experience Group collates the number of complaints received about their emergency services (field ops and emergency operations centres). These figures are set against emergency activity for the quarter using the 'all calls' figure, and the data for the year 2016/17 is shown below. It should be noted, however, that while some services may appear to be outliers, the numbers are so small as to be statistically insignificant.

Table 2 Data - A&E complaints against activity for English ambulance services 2016/17

Service	EEAST	EMAS	LAS	NEAS	NWAS	SCAS	SECAmb	SWAST	WMAS	YAS
A&E complaints	1164	1640	1092	599	1222	816	1076	1382	1086	1008
Activity ('all calls' figure)	1099639	816647	1826797	544267	1224757	669877	1033639	1105719	1128006	837787
Percentage of activity attracting a complaint	0.11%	0.20%	0.06%	0.11%	0.10%	0.12%	0.10%	0.12%	0.10%	0.12%

Fig 2 A&E complaints against activity for English ambulance services 2016/17

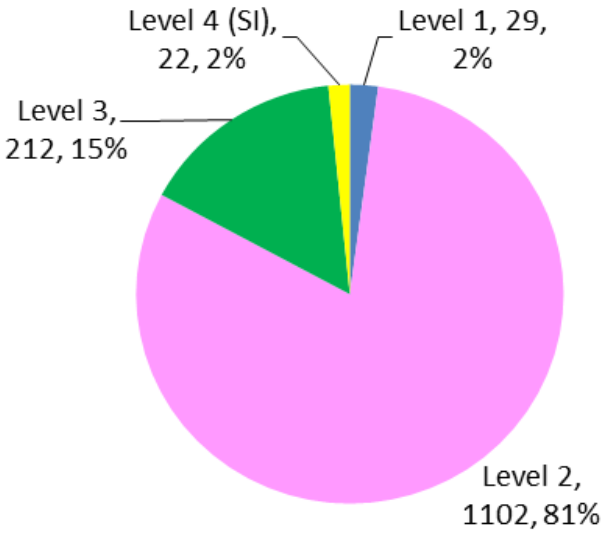


3.5 **Grading of complaints:** SECAmb's complaints are graded according to their apparent seriousness on receipt, in order to help ensure they are investigated proportionately, and the Patient Experience Team worked with operational colleagues to devise and implement the grading system.

3.6 Complaints are graded by the Patient Experience Team using a 'grading guide': Level 1 complaints are simple concerns that can be resolved by the Patient Experience Team themselves, increasing in seriousness to level 4, which is the most serious and where the complaint has also been deemed to be a Serious Incident (SI).

3.7 The majority of complaints are graded as level 2, and these are complaints that do not appear to be serious but do still require investigation by local operational managers to enable the Patient Experience Team to respond to them. Level 3 and 4 complaints, ie complaints that are of a serious or complex nature, are responded to by the Chief Executive, with less complex complaints being managed to completion by the Patient Experience Team.

Fig 3 Grading of complaints received in 2016/17



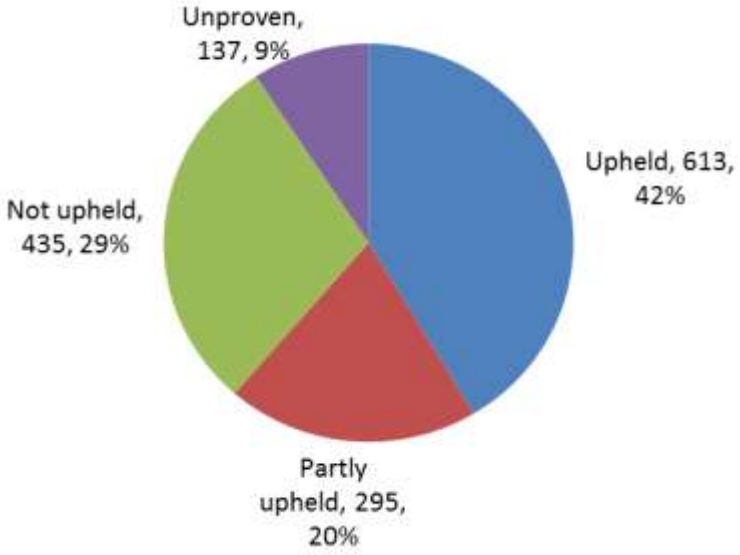
3.8 **Categorisation by subjects:** Complaints are categorised into subjects, and distinguished further by sub-subject. Complaints may concern more than one issue, hence there is a greater number of subjects than complaints.

Table 3 Complaints received during 2016-17 by subject and service area

Subject	PTS	EOC	A&E	NHS 111	Other	Total
Administration Issues	0	6	4	12	3	**25**
Communication	0	25	9	36	1	**71**
Concern about Staff	27	19	274	35	3	**358**
History Marking Issue	0	5	3	0	0	**8**
Miscellaneous	0	5	19	0	0	**24**
Patient Care	12	132	232	147	0	**523**
Timeliness	45	232	110	41	0	**428**
Transport Issues	51	3	4	0	0	**58**
	135	**427**	**655**	**271**	**7**	**1495**

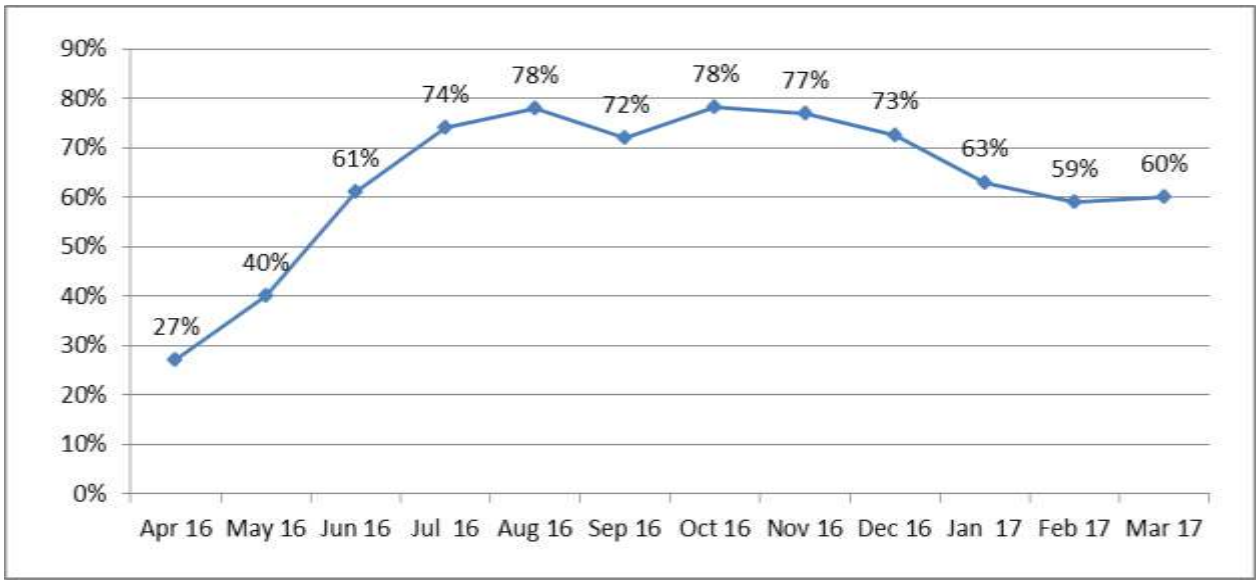
3.9 **Complaints outcomes:** When a complaint is concluded, the investigating manager, with input from the Patient Experience Team where necessary, assesses whether the complaint should be upheld, partly upheld, not upheld or in some cases, unproven, based on the findings of their investigation. During 2016/17 there were 1,480 complaints due to be responded to. Of these complaints, 62% were found to be upheld or partly upheld, as shown in figure 4.

Fig 4 Complaints by outcome, 2016/17



3.10 **Complaints response time performance:** During 2016/17 approximately 63% of complaints were responded to within the Trust's timescale, compared to 59% in 2015/16. However, it should be noted that in May 2016 the Trust's 25 working day timescale for responding to complaints was increased temporarily, such that complaints concluded during the six months from July – December 2016 had a longer timescale of 30 working days within which to be responded to. This was reverted to 25 working days in November 2016, and all complaints concluded since January 2017 have attracted the 25 working day target.

Fig 5 Complaints response time performance against the Trust timescale, 2016/17



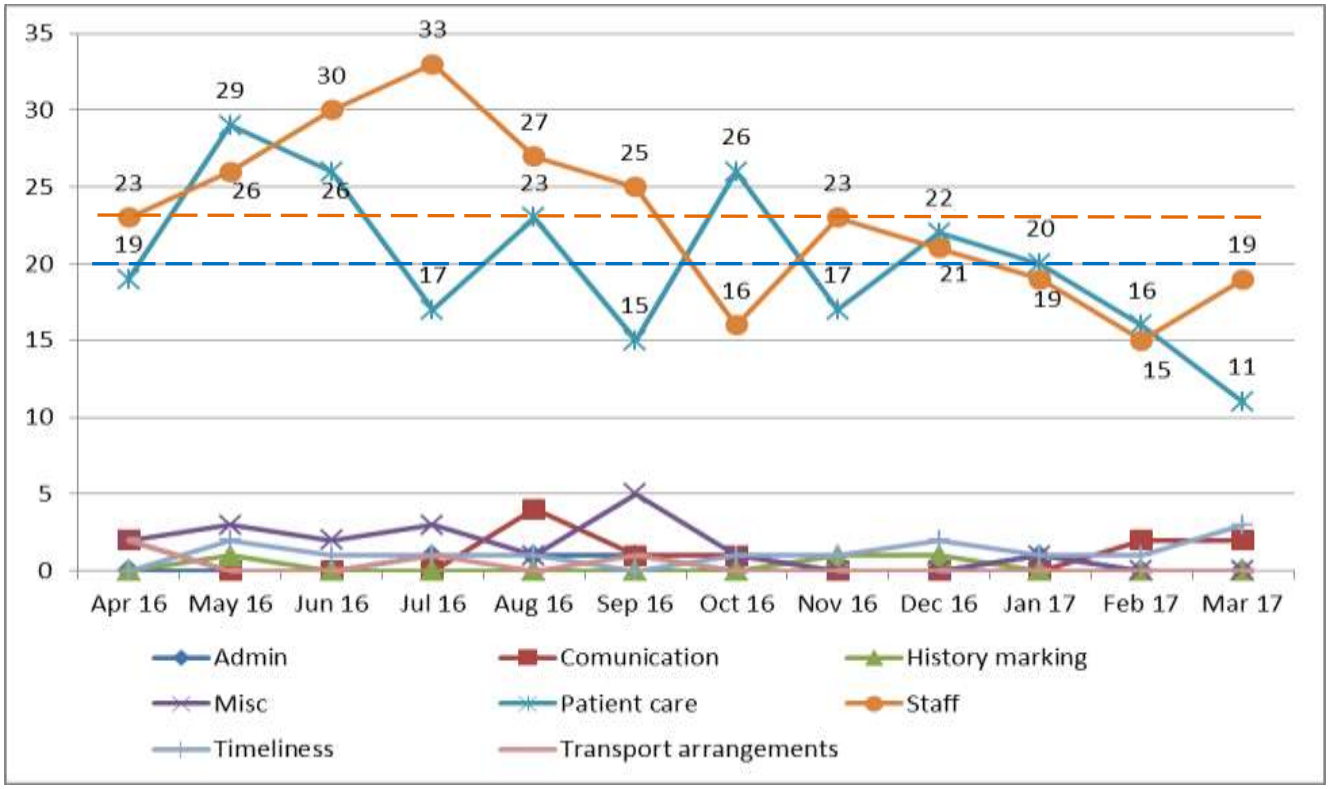
Note that some complaints were breached for reasons beyond the control of the investigating manager.

3.11 The Trust acknowledges that complaints response time performance must improve and a plan is in place to address the range of factors affecting this.

4 Complaints by service area

4.1 A&E field ops: The main themes of complaints about emergency field ops are staff conduct (this includes attitude as well as driving) and patient care.

Fig 6 A&E field ops complaints by subject



4.1.1 ***Staff conduct:*** In 2016/17 we received 277 complaints about the conduct of our A&E road staff, compared to 367 in 2015/16 and 417 in 2014/15. Of these, 45% (127) were upheld or partly upheld, compared to 51% in 2015/16. Of the 127, 83% were about conduct and attitude, and 13% were about standard of driving.

4.1.2 Action taken to mitigate against a recurrence is dependent on the nature of the complaint may include the following:

- discussion of the complaint and its impact on both the complainant and the Trust's reputation
- undertaking a reflective practice, where the member of staff reflects on the incident and produces a piece of written work to demonstrate their understanding of the impact of their actions and details how they will better handle such situations in future
- taking part in a peer review, where the staff and some of their colleagues meet with their manager and/or the Learning and Development team to discuss the scenario and how it was handled, and how what might have been done to avoid a negative outcome
- attendance at an in-house customer care session, provided by the Learning and Development team
- re-training and monitoring in the case of driving complaints.

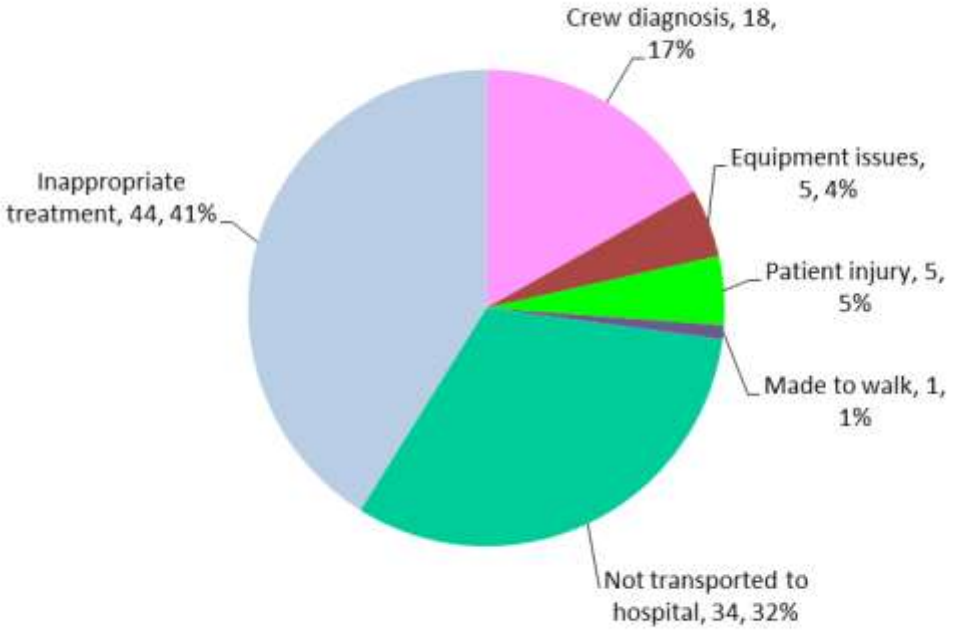
4.1.3 In 2015/16 the mandatory two-day Key Skills course for field ops staff included a Patient Experience session, which was developed by a small group of staff including a Clinical Team Leader, a Clinical Operations Manager, an Ambulance Technician, an Emergency Care Support Worker, the Head of Learning and Development, and the Patient Experience Lead. This was extremely well received and a further Patient Experience session was developed during 2016/17 for the 2017/18 training year.

4.1.4 ***Patient care:*** Complaints about patient care are divided into sub-subjects, which include:

- Crew diagnosis
- Equipment issues
- Inappropriate treatment
- Patient injury
- Patient made to walk
- Patient not conveyed to hospital
- Privacy and dignity
- Skill mix of crew

4.1.5 In 2016/17 we received 241 complaints about the care provided by our road staff, of which 46% were upheld or partly upheld, compared to 51% in 2015/16 and 35% in 2014/15.

Fig 7 Upheld or partly upheld patient care complaints received during 2016/17, by sub-subject



4.1.6 *Inappropriate treatment:* As shown in figure 7, there were 44 upheld/partly upheld complaints about inappropriate treatment, constituting the largest proportion of patient care complaints (41%). Actions were implemented and learning generated as a result of 28 of these complaints

4.1.7 There are many issues that constitute 'inappropriate treatment', most of which are infrequent occurrences. However the following common themes were identified, though numbers are not statistically significant:

- Poor manual handling x 4
- Patient taken to inappropriate destination x 4
- Lack of observations x 4
- Wrong/incorrect dosage of medication given x 3
- Patient not checked properly after RTC x 3
- Inadequate pain relief given x 3
- Wrongly conveyed patient with DNAR x 2
- No pre-alert sent to hospital x 2
- Patient not treated/observed while awaiting backup x 2
- Dismissive of/missed symptoms x 2
- Maternity action plan not followed/maternity symptoms not treated with sufficient urgency x 2

4.1.8 *Non-conveyance:* Thirty-four of the complaints received about patients not having been conveyed to hospital were at least partly upheld, and actions were implemented and learning generated as a result of 30 of these complaints. The outcomes of the 34 included the following:

- missed: fractures x 4; bacterial meningitis x 2; stroke; child bronchitis; incarcerated hernia; splenic laceration; bleed on the brain; missed sepsis
- failure to recognise severity of maternity issues x 2 (PPH and imminence of birth)
- failure to recognise severity of diabetic issues
- failure to recognise severity of asthma
- failure to recognise significance of high temperature (infection led to amputation of lower leg)
- failure to recognise lack of capacity
- lack of recognition of failed discharge x 2
- misread ECG
- SRVs instructed family to convey **a)** patient with diagnosed #femur and **b)** patient with sickle cell themselves.

4.1.9 *Crew diagnosis:* This sub-subject of 'patient care' is sometimes used interchangeably with non-conveyance, though not all misdiagnoses result in non-conveyance. Eighteen complaints of crew misdiagnosis were upheld at least in part, 15 of which saw actions implemented and learning generated as a result. These included the following:

- recurrent bowel cancer symptoms attributed to gastroenteritis
- 2 x strokes diagnosed as 1) frozen shoulder, 2) faint
- perforated gall bladder/sepsis diagnosed as trapped wind
- genuine case of sexual abuse put down to hallucinations

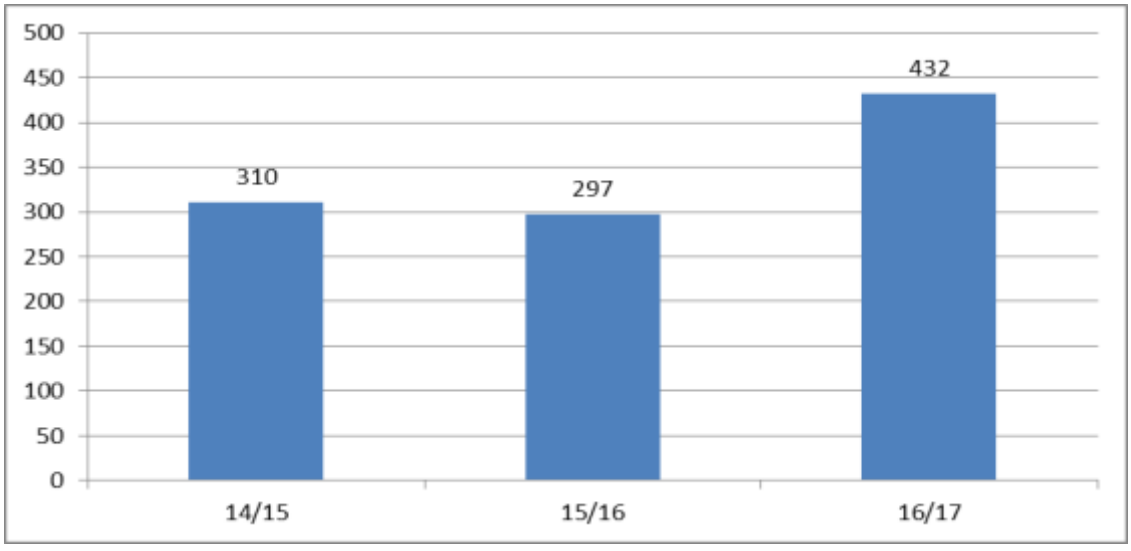
- collapsed lung diagnosed as gallstones
- severe allergic reaction diagnosed as anxiety
- missed fractured hip in learning disability patient who was thought to be panicking
- cerebral haemorrhage and fractured pelvis missed; crew believed patient was 'playing to them'

4.1.10 Actions implemented as a result of complaints about patient care included the following:

- familiarisation with the role of PPs and the Clinical Advice Desk
- undertaking of reflective practice
- peer review sessions
- arrangement of a CPD (continuing professional development) event
- articles placed in the Trust weekly bulletin
- discussion of case and outcomes with manager
- team briefing session
- review of guidance around ECG recognition; auscultation of abdomen; safe discharge of patients; blood testing; challenging others' decisions; OTTAWA knee rule; analgesia protocols; pain management; atypical cardiac presentation.
- refresher training in management of sickle cell, burns, dementia
- attendance at an obstetric management event
- spending time in a maternity unit
- working with a Clinical Team Leader one shift a week for three months.

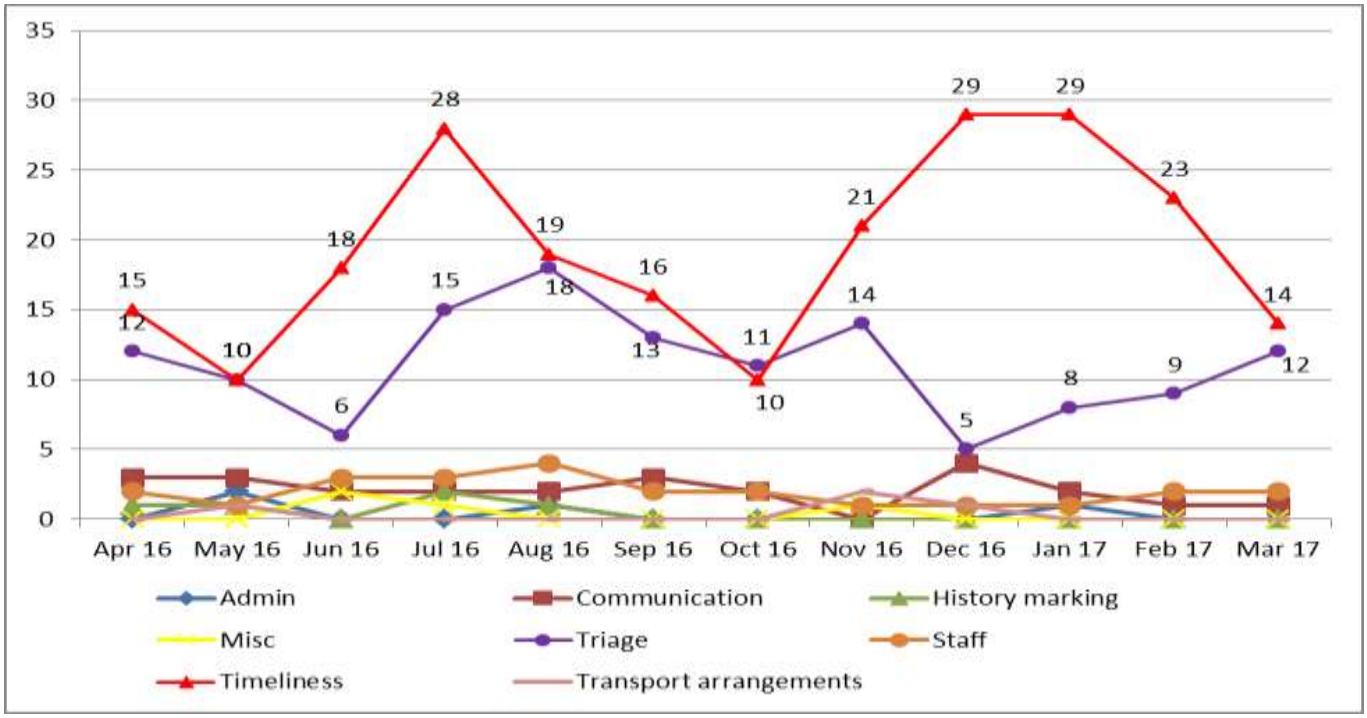
4.2 Emergency Operations Centres (EOCs): During 2016/17 432 complaints were investigated by our EOCs, compared to 297 in 2015/16.

Fig 8: EOC complaints over the past three years



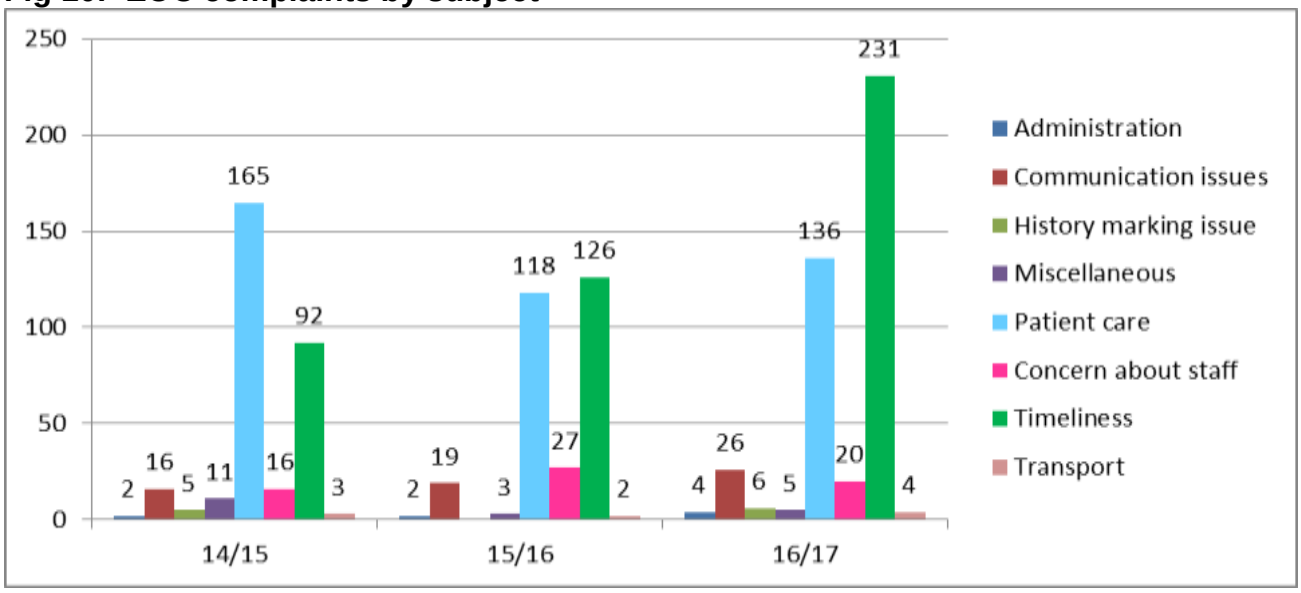
4.2.1 While EOC complaints reduced slightly in 15/16, the Trust has seen a 45.4% increase in EOC complaints this year against last year; an exponential increase when set against the overall increase in complaints of just 1.6%.

Fig 9 EOC complaints by month and subject, 2016/17



4.2.2 As can be seen from figure 9, the majority of the complaints investigated by EOC concern timeliness, followed by complaints about call triage and the disposition reached. However, it should be noted that ambulance delays are in many cases not attributable to the actions of EOC staff. Timeliness issues, which have increased exponentially this year, are assigned to EOC and investigated by EOC managers as they have the necessary expertise to interrogate the computer-aided despatch (CAD) system, and understand the systems and processes that impact on ambulance response times.

Fig 10: EOC complaints by subject

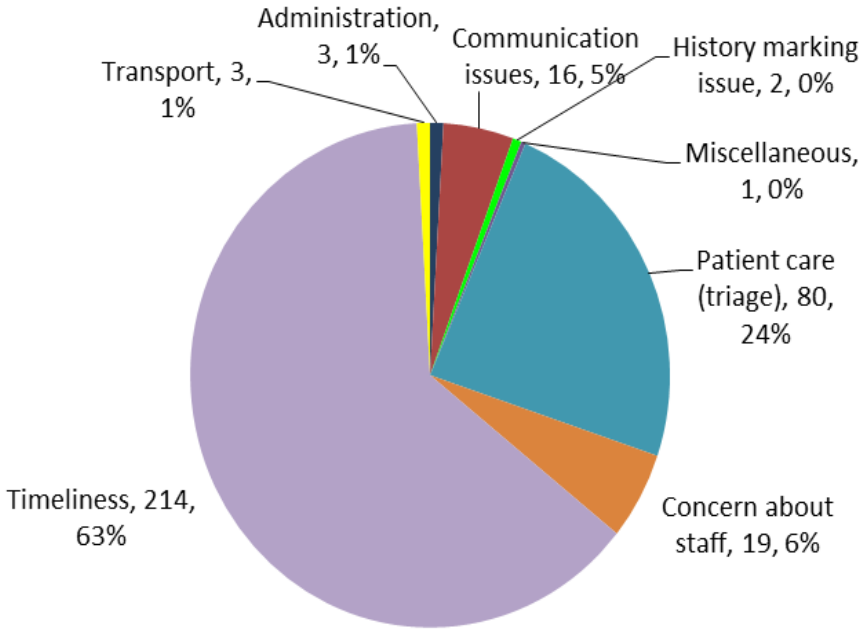


'Patient care' in the context of EOC constitutes complaints about call triage and disposition

4.2.3 As can be seen from figure 10, complaints about timeliness have continued to increase, having risen by 37% in 15/16 and by 83% this year against 2015/16.

4.2.4 Of the 432 EOC complaints received during 2016/17, 338 (78%) were upheld at least in part, compared to 297 received in 2015/16, of which 212 (71%) were upheld at least in part.

Fig 11 Upheld or partly upheld EOC complaints received during 2016/17



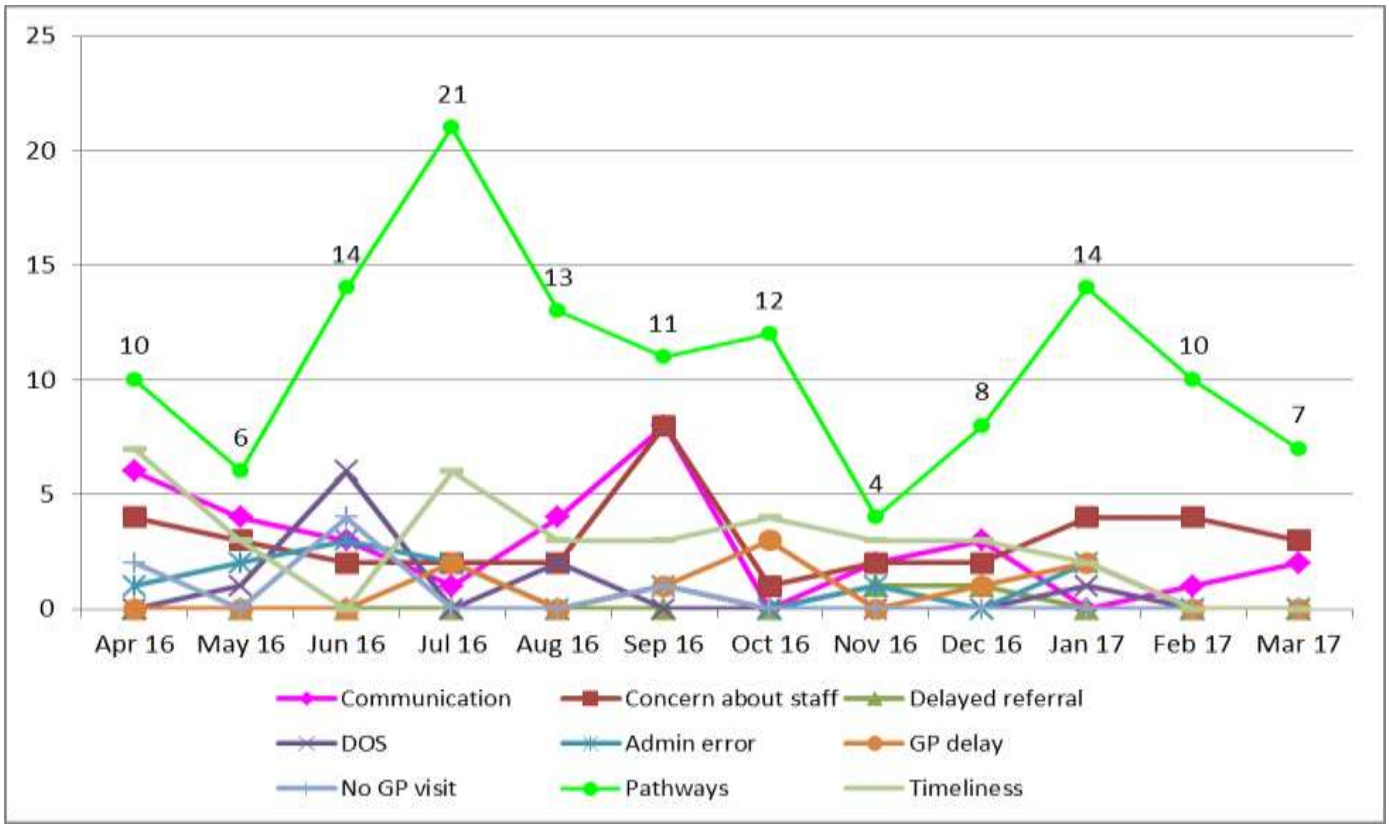
4.2.5 *Timeliness:* The majority of complaints were about timeliness, with 90% upheld at least in part.

4.2.6 *Call triage:* Of the complaints about call triage, 57% were upheld at least in part. These complaints were in the main the result of human error, with EMAs in at least 35 cases and clinicians in at least 13 cases not correctly following the triage process:

- selecting the wrong pathway
- insufficient probing
- insufficient explanation
- EMA not deferring to clinician
- clinical supervisor not using NHS Pathways to reinforce their clinical decision
- not following policy correctly
- issue with NHS Pathways itself.

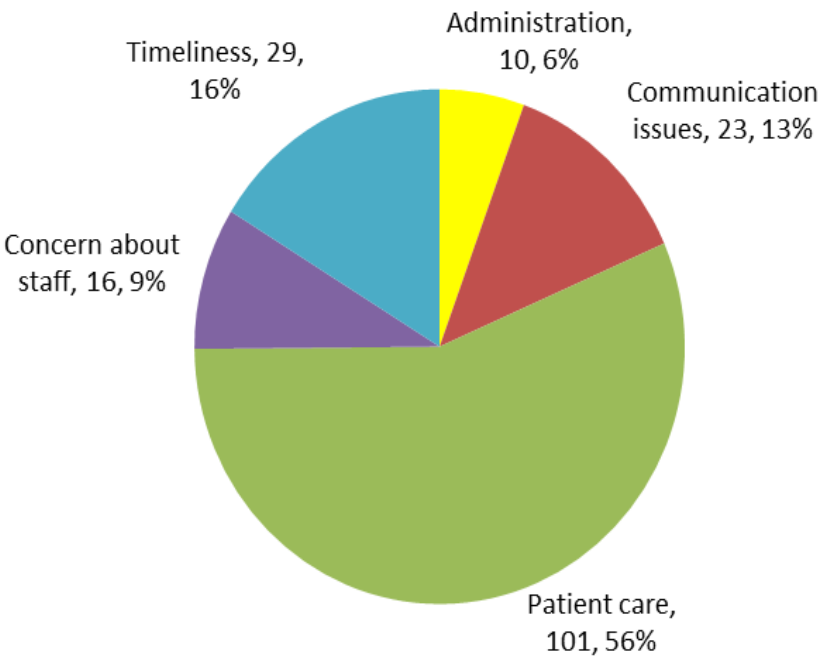
4.3 **NHS111:** During 2016/17 the Trust received 271 complaints about its NHS111 service, compared to 319 the previous year; a decrease of 15%.

Fig 12 NHS111 complaints by month and subject, 2016/17



4.3.1 As shown in Figure 12, the majority of NHS111 complaints (50%) were about triage, which saw a huge spike in July 2016. This was followed by complaints about the staff (37); timeliness (34); and communication (34).

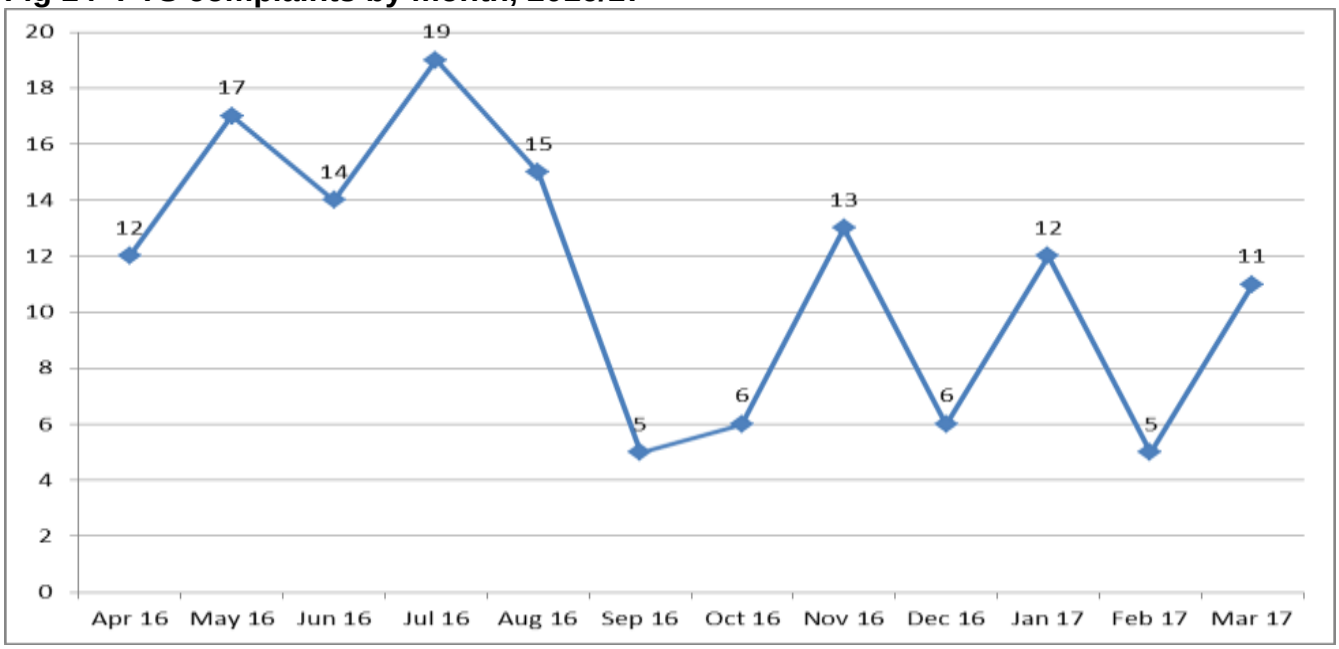
Fig 13 Upheld or partly upheld NHS111 complaints received during 2016/17



4.3.2 Of the 135 complaints received about NHS111 triage, 101 (75%) were at least partly upheld, compared to 62% in 2015/16. The same triage software, NHS Pathways, is used to triage both NHS111 and 999 calls, and as with EOC complaints, most upheld triage complaints are caused by human error, with the same root causes as for 999, for example lack of probing, wrong pathway selected, failure to recognise the severity of pain, failure to pick up on clues provided and failure to follow policy.

4.4 Patient Transport Service (PTS)

Fig 14 PTS complaints by month, 2016/17



4.4.1 There were just 135 complaints received about the Surrey Patient Transport Service (PTS) in 2016/17, compared to 398 in 2015/16. Of these complaints, most were about transport arrangements (39%) and timeliness (34%), with 19% about staff and eight per cent about patient care. Of the 135, 633 (76%) were at least partly upheld.

4.4.2 SECAmb's only remaining PTS contract, for provision of the service in most of Surrey, ceased on 31 March 2017.

5 Learning from feedback

5.1 Compliments and complaints help us to identify where things are working well and where improvements to quality and services can be made and, wherever possible, steps are taken to implement changes as a result. We also try to ensure that any learning from complaints and compliments is spread throughout the Trust and every effort is made to take all steps necessary to help prevent similar situations recurring.

5.2 The Patient Experience Team is committed to working closely with the Trust's Professional Standards Department and the Risk team to ensure that learning outcomes from investigations are shared across the whole organisation. This is done directly with staff, through clinical case reviews, the undertaking of reflective practice, and peer reviews, and is reinforced by the publication and distribution of clinical and operational instructions, and also via the Trust's weekly staff bulletin.

5.3 SECAmb provides a substantial training programme and a range of policies, procedures and guidance to help staff provide the best care and service they can to our patients. We therefore find system-wide changes to practice as a result of complaints are relatively uncommon, with the majority of learning being for the individual practitioner. However some examples of learning and changes to practice are provided at Appendix B.

6 Parliamentary and Health Service Ombudsman requests

6.1 Any complainant who is not satisfied with the outcome of a formal investigation into their complaint may take their concerns to the Parliamentary and Health Service Ombudsman (PHSO) for review. When the Ombudsman's office receive a complaint, they contact the Patient Experience Team to establish whether there is anything further the Trust feels it could do to resolve the issues. If we believe there is, the PHSO will pass the complaint back to the Trust for further work.

Table 4 PHSO investigations and outcomes

Service	**Cases investigated 2016/17**	**Number upheld 2016/17**	Cases investigated 2015/16	Number upheld 2015/16
111	1	0	5	0
A&E	5	1 (partly upheld)	4	0
EOC	2	1 (partly upheld)	3	0
PTS	1	1	0	0
Total	**9**	**3**	**12**	**0**

7 Patient Advice and Liaison Service (PALS)

7.1 PALS is a confidential service run by SECAmb's Patient Experience Team, to offer information or support and to answer questions or concerns about the services provided by SECAmb.

7.2 During 2016/17, the Patient Experience Team dealt with the following PALS enquiries:

Concern	69
Enquiry	63
Request for advice and information	62
Total	**194**

7.3 Most requests for information are Subject Access Requests, where patients or their relatives require copies of the Patient Clinical Record completed by our crews when they attended them, or recordings of 999 or NHS111 calls, for a range of reasons.

7.4 Other contacts are requests for advice and information as to what to expect from the ambulance service, people wanting to know how they can provide us with information about their specific conditions to keep on file should they need an ambulance, calls about lost property, and on occasion, families wanting to know about their late relatives' last moments.

8 Conclusion and recommendations

8.1 The number of complaints received this year has decreased overall by 35% against last year. When removing PTS from the statistics, the Trust saw a small increase of 1.6%, which is to be welcomed in a climate where complaints are rising in most sectors. However, the number of complaints about ambulance delays is increasing at exponentially and comprises a large proportion of the overall total, and the Trust has work to do to improve its ambulance response time performance, as do all ambulance trusts in the current climate of increasing demand and reducing funding.

8.2 However there is still a great deal of work to be done in order to improve how we handle, log, analyse and report on complaints, and in particular, how we triangulate and share learning across the Trust. The introduction of new Area Governance Group meetings – replicating the successful model introduced by NHS111 - will provide a platform for triangulating data and for discussing and debating how best to address complaints in order to ensure proportionality and consistency of approach and outcomes.

8.3 The recruitment of a Datix manager to the Trust will also see us better placed to customise Datix (the Trust's risk management software) to enable us to better analyse complaints and simplify reporting.

8.4 An action plan is also now in place to ensure that complaints are responded to within the Trust timescale of 25 working days; that learning is generated from all complaints that are upheld in any way; and that that learning is shared not just locally but across the whole Trust.

8.4 Compliance with our complaint response timescale of 25 working days will help to restore complainant/patient confidence in our service, and the plan will address the issues impacting on the Trust's ability to do this, with a target of 90% of complainants receiving a response to their complaint by the end of 2017/18.

8.5 Ensuring that we implement actions from all complaints that are upheld in any way will serve to mitigate a recurrence of complaints and lead to improvements in the treatment and service provided to patients and their carers. Finding new and innovative ways to share the learning from complaints will also reduce the likelihood of the problem arising again elsewhere, and will raise awareness among staff of the Trust's ethos of taking positive action as a result of complaints and of the value of complaints as a tool for improvement.

8.6 Finally, the recent introduction of training in root cause analysis, including Duty of Candour, culture, and human factors, alongside complaints investigation training for

all of those who investigate complaints, will help to improve the quality of complaints investigations, and should lead to more tailored and appropriate learning outcomes.

Louise Hutchinson, Patient Experience Lead
October 2017

Appendix A Positive comments from patients and relatives about our services

"Brilliant. Can't thank them enough. My son was seeing bugs (hallucinating). He was terrified. I was scared and crying. The lady on the phone helped and cared. Thank you."

"I phoned 111 yesterday afternoon and could not fault the marvellous service I received both from the operator and the doctor who phoned me back! I received a phone call from the doctor at 5.30pm and by 6.10pm I picked up a course of antibiotics from my nearby chemist."

"The two paramedics happened to be very close to our address anyway so arrived within a few minutes! Dave and Phil were not only extremely efficient, they were also gently entertaining which put my friend (the patient) completely at ease which made the experience as easy as it could have been. They were very thorough and also explained what they were doing. After they left our house they went straight to our GP to report. That seems to be a very good idea."

"Although I was screaming in agony and totally beside myself, your crew were able to "get through to me" and explain things with incredible care and kindness."

"Very capable, understanding, calm. They were willing to listen, well-mannered and showed concern for both my wife (the patient) and myself. They are two really nice men and a credit to the service."

"They were patient, sympathetic and clearly experienced with mental health problems in patients. Impressive."

"All the times I have had to call the ambulance service I have had nothing but caring and kindly members who have not left me until they are sure that I am able to look after myself as I live alone."

"They were so good, lovely girls, felt very safe and they helped cheer me up when I was distressed."

"The call taker was brilliant. He realised that I was in a bad way and kept me on the phone until the ambulance arrived. I was frustrated by so many questions and just wanted to get to hospital but he was really reassuring. I was on my own, which he took into account."

"I found the call taker exceptionally helpful throughout and a very calming influence at a difficult time."

Appendix B Examples of learning from complaints

Actions recommended as a result of complaints and concerns are logged in two specific fields on the Datix database; one for individual actions and one for Trust-wide action. Some examples of complaints that have generated learning or further exploration are listed below.

Learning from complaints about our Emergency Operations Centres (EOCs)

Case 1: An epilepsy nurse specialist wrote to the Trust to raise concerns about instructions that had been given to parents and carers by our 999 call takers. Several parents/carers over the preceding three months had reported to her that they had been instructed to give additional doses of midazolam (a drug used to help control seizures) to the child in their care, even though a second dose was not prescribed. She believed this was potentially dangerous advice and was seeking clarification of the Trust's policy or thinking behind this instruction.

The complaint was investigated and a number of the 999 calls audited, and it was found that our Emergency Medical Advisors (EMAs, or call-takers) had not given the correct advice. However, it was discovered that this incorrect advice had been given in part due to the poor, unclear advice provided by the triage software used by the Trust, NHS Pathways. As a result, the EMAs concerned received feedback from their manager about the error, and the issue was then raised with the NHS Pathways national governance group, and the error was corrected.

Case 2: A call was received from the father of a patient who had been awaiting a life-saving lung transplant. When an organ had become available the transplant team called 999 for an ambulance to collect the patient from his home to take him to the specialist hospital for transplantation, however it was two hours before the ambulance arrived. He reported that during that time several calls were made to chase the ambulance's arrival, and it was then established that the call had been classed as 'non urgent'. Only when the seriousness of the situation was understood was an ambulance dispatched, which then arrived within 20 minutes.

The investigation into the complaint found that the first call was triaged correctly based on the information provided, and the outcome was that a one-hour response should be provided. However, demand for ambulances at the time was higher than expected, and this had caused the delay. In addition, while information about the patient's potential transplant had been previously provided to SECAmb, this information was not listed against the patient's address.

The investigating manager liaised extensively with the transplant centre in question to determine the time parameters and procedures for transplant patients, and as a result, the Trust has improved its governance procedures around the storage and use of transplant patient details. These details are now being recorded on the Trust's Intelligence-Based Information System (IBIS), in the same way as Do Not Attempt Resuscitation instructions are stored and accessed, and this provides a more robust process for ensuring such details are readily available when a call is received for a transplant patient, and how calls for transplant patients should be handled.

Learning from complaints about our NHS111 service

Case 1: A complaint was received from the son of a 90-year-old lady who was resident in a care home. The home called NHS111 as her speech was unusual and she did not seem as mobile as usual, and NHS111 arranged for an ambulance to attend. The ambulance duly attended, however the patient was not taken to hospital as the crew felt that her condition would be better dealt with by a GP, so they contacted the out-of-hours (OOH) GP service and arranged this. The patient's condition deteriorated and the care home made several calls to NHS111 to chase the GP visit, describing the call-taker's tone as dismissive and rude. The OOH GP eventually attended and diagnosed a chest infection, however within an hour of their attendance the patient had fallen, an ambulance was called and the patient was taken to hospital and diagnosed with sepsis.

On investigation it was determined that the patient had been showing no signs of sepsis when the paramedic had attended her, and that when the first call was received chasing the GP visit, the NHS111 Health Adviser had called the OOH service to advise them. However, when the second chase call was received by NHS111, the home were mistakenly informed that no GP visit had been arranged, the Health Adviser failed to check for worsening symptoms and did not call to chase OOH as they then promised to do. The next call was passed to an NHS111 clinician, who should have taken more immediate action, but just sent through a further two-hour referral.

As a result of this complaint individual feedback was provided to the Health Adviser and clinician concerned. In addition, although the OOH GP had subsequently failed to diagnose sepsis, in order to emphasise the importance of considering sepsis, a sepsis E-learning training package was made available to all NHS111 clinicians to complete.

Case 2: A complaint was received from an out-of-hours GP service concerning NHS111's treatment of a one-year-old child who had been ill for 24 hours and was breathless and had a high temperature. The GP in question felt that the child had been incorrectly triaged as requiring a one-hour call back from the GP, believing that an emergency ambulance should have been sent.

On investigation it was found that Health Adviser had not carried out the triage correctly: they had selected the wrong pathway and should have probed further as to whether the child was fully responsive, whether there were any signs of rapid breathing, regardless of the father's negative answer to this question, and around the NHS Pathways question about whether the child was 'limp, floppy and/or unresponsive'. It was felt that had they done so, a 'Red2' (eight-minute) ambulance disposition would have been reached.

This complaint identified that callers do not recognise when a child is struggling to breath and Health Advisers may miss some of these red flags in their Pathways assessment. To ensure that the learning from this complaint was shared across the service, a presentation was developed and delivered at a series of 'buzz sessions', whereby Health Advisers and clinicians are removed from their duties in small groups to be updated about key lessons learned from complaints and incidents.

Learning from complaints about our emergency ambulance service

Case 1: A GP Practice Manager wrote to the Trust to ask why a patient of theirs was transported to hospital when he had 'PACE' documentation and a DNAR in place, both of which were shown to the ambulance crew. PACE is a system that helps meet people's health care needs in the community, rather than having to go into a nursing home or other care facility.

On receipt of the complaint the investigating manager made contact with and spoke to a significant number of staff locally, and these conversations revealed that most staff did not have a clear understanding of PACE, as this was a relatively new innovation specific to this local population.

As a result, in order to disseminate knowledge of PACE to all staff, two Continuing Professional Development (CPD) events were held, led by the Trust's End of Life Care Lead, and an article about PACE was placed in the weekly Trust bulletin.

Case 2: The wife of a man with sickle cell anaemia complained about her husband's treatment when he was experiencing an acute chest crisis. She had driven him to hospital the night before, where he was treated and discharged, however the following morning his condition escalated so she called 999. The patient's wife stated that the single responder who attended her husband was not familiar with Sickle Cell Anaemia and did not appreciate the seriousness of the situation, and that as a result she had to convey him to hospital herself to ensure he received the care he needed.

The investigation into this complaint found that the attending crew member, an ambulance technician, did not fully understand the possible consequences of a sickle cell anaemia crisis, and was also found to have lacked tact and diplomacy. As a result the technician was counselled by their manager in relation to their poor communication skills, and displayed a positive attitude in response, being receptive to the feedback. In addition, they were asked to complete a Sickle Cell and Thalassaemia Screening e-learning course in order to refresh their knowledge of these conditions, which had clearly diminished.

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SECAMB Board

QPS Escalation report to the Board

Date of meeting	20 October 2017
Overview of issues/areas covered at the meeting:	This meeting considered: ***Management Responses*** *(response to previous items scrutinised by the committee)* **MDT SI Action Plan** The committee reviewed the action plan and was **assured** with the actions. It asked to bring back an update in March 2018. **Complaints Improvement Plan** The committee has been concerned about a number of issues regarding complaints handling, including timeliness and learning. The committee is not assured with quality of complaints management but is **assured** the plan in place has the right actions. **Patient Care Records** The committee is still **not assured** with patient care records and acknowledged the amount of work still needed in this area. An update was provided specifically on the reconciliation of paper records with the CAD. The improvement plan which includes clinical records will come back to the Committee in December. ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas)* **Serious Incidents** A detailed paper was received setting out the position with incidents and SIs, following the ongoing improvement work. The committee also received the revised improvement plan and the recent outcome of a CCG assurance visit. The latter identified a need to look at an integrated process with CCGs. The committee is **not assured** with where we are with incidents, but assured there is a plan in place to ensure understanding of issues and management grip. **Quality Account Progress Update** The update was noted along with the management steps to develop measures for next year.
Reports *not* received as per the annual work plan and action required	The quarter 2 **quality report** was not completed in time for the committee. An extraordinary meeting will be scheduled for late October / early November to take this single item.
Changes to significant risk profile of the trust identified and actions required	**None**

Weaknesses in the design or effectiveness of the system of internal control identified and action required	The committee explored the current gap in a **quality improvement strategy**, which the executive is in the process of developing. It discussed the theme of learning, which runs through the compliance element of the unified improvement plan, suggesting a need to pull this out and approach it more systematically. The committee was told about a learning framework from LAS which management would consider as part of its review.
Any other matters the Committee wishes to escalate to the Board	The committee noted that we are still under 10% with the roll out of electronic paper records and was informed by management that a pilot was due to start in Thanet, to help establish the blockers. The outcome of this pilot will be considered by the committee at its meeting in December. There has been much improvement in the backlog of incidents. There is higher reporting and some evidence that there is greater awareness of how to report an incident. The committee was concerned that some of the targets within elements of the unified improvement plan appear over optimistic and asked management to consider describing some of the improvement in stages, so it is clearer for the Board to establish when improvements are likely to be more embedded. In other words, the plan should better describe the improvement journey.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Finance & Investment Committee

Date of meeting	19 October 2017
Overview of issues/areas covered at the meeting:	Management Responses: A CAD update was given; the new CAD has been up and running since 5 September and implemented under budget. The aim is to conclude the project board shortly moving in to business as usual. An EPCR update was also provided summarising the position against the business case, which is currently on budget. However, there is currently only 10% use of I-pad to-date which management confirmed it is working to improve. A trial is being started to help establish the blockages, which QPS will consider in December given link to the patient care record quality issues. Scrutiny: Financial Performance M6 is in line with plan and the committee was assured by the delivery of CIPs. The emerging risks and mitigation was discussed, including the fall in activity in the last two months and its impact on income. Business Planning The executive set out the approach this year, noting that the national guidance isn't expected until the New Year; the indication is that it will be a one-year plan and the control total will continue to apply. The committee noted the engagement plan with key stakeholders and the associated milestones. Capital Planning The committee reviewed the approach to capital planning for 2018/19 and 2019-2022. This included the Trust HQ Phase 2 Project, which predominantly relates to plans for Banstead. Performance: In terms of operational performance (how we invest in ensuring timely access to our services) the committee focussed on call answering performance given the current average call answering times and challenges with recruitment and retention. Management set out the different approaches it is exploring, including potential financial incentives. 999 voice recording was also considered and the committee was assured that regular audits continue and issues identified are being corrected, included working with the provider who is applying a new patch scheduled for 19 October. As discussed at the Board in September, a business case is being developed to explore whether there is a

	need to replace the telephony and /or voice recorder systems.
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	The committee continues to be concerned about being commissioned to levels below national standards, and by the current challenge in falling below the revised trajectories agreed with commissioners.
Weaknesses in the design or effectiveness of the system of internal control identified and action required	None
Any other matters the Committee wishes to escalate to the Board	The committee discussed the need to develop a digital enabling strategy to align with EPCR, I-pad and the new CAD. The aim is to develop this with external expertise by July 2018. In the meantime, the initial thinking will be reviewed by the committee in January 2018 and will form part of the Board strategy discussion scheduled for February 2018.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	117/17

Name of meeting	Board of Directors
Date	23 October 2017
Name of paper	Terms of Reference
Author	Peter Lee, Company Secretary
Synopsis	This is the annual review of the Board Committees' membership (Appendix 1) and the terms of reference for the Quality & Patient Safety, Workforce and Wellbeing, and Finance and Investment Committees (Appendix 2-4). The terms of reference include minor changes as reflected in the version control schedules. The assurance map purview (Annex A) has also been revised, to take account of the new Trust strategic goals, and changes to the CQC key lines of enquiry. As during the previous year, this purview will be used as a guide by the committee to ensure appropriate focus.
Recommendations, decisions or actions sought	The Board is asked to agree the Board Committee membership and revised Terms of Reference.

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**

Appendix 1
(Membership of Board Committees)

	Appointments and Remuneration	Audit	Quality & Patient Safety	Finance & Investment	Workforce & Wellbeing	Charitable Funds
Richard Foster Chair	**Chair**					
Graham Colbert Non-Executive Director	**√**	**√**		**Chair**		
Tim Howe Non-Executive Director	**√**		**√**		**√**	
Lucy Bloem Non-Executive Director	**√**		**Chair**	**√**		**√**
Terry Parkin Non-Executive Director	**√**		**√**		**Chair**	
Angela Smith Non-Executive Director	**√**	**Chair**		**√**		**Chair**
Al Rymer Non-Executive Director	**√**	**√**			**√**	**√**
Daren Mochrie Chief Executive	**√**		**A**			
Steve Lennox Executive Director of Nursing & Quality		A	**√**		**√**	
Fionna Moore Executive Medical Director			**√**		**√**	
Joe Garcia Executive Director of Operations			**√**		**√**	**√**
David Hammond Executive Director of Finance & Corp. Services		**A**		**√**		**√**
Jon Amos Executive Director of Strategy				**√**		
Steve Graham HR Director					**√**	

NB – Medical and Nurse Director will rotate membership of WWC

South East Coast Ambulance Service NHS Foundation Trust

Quality and Patient Safety Committee

Terms of Reference

1. Constitution
The Board hereby resolves to establish a committee of the Board to be known as the Quality and Patient Safety Committee ('QPS') referred to in this document as 'the committee'.

2. Purpose
The purpose of the committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to quality governance (encompassing patient safety, clinical effectiveness and patient experience) are designed appropriately and operating effectively.

3. Membership
Appointed by the Board, the membership of the committee shall constitute three independent Non-Executive Directors and three Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:
Lucy Bloem, Independent Non-Executive Director (Chair)
Tim Howe, Independent Non-Executive Director
Terry Parkin, Independent Non-Executive Director
Steve Lennox, Executive Director of Nursing & Quality (Executive Lead)
Fionna Moore, Executive Medical Director
Joe Garcia, Executive Director of Operations

4. Quorum
The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance
5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Chief Executive
- Company Secretary
- Regional Operating Manager
- Senior Manager for Clinical Governance & Quality
- Chief Pharmacist
- Patient representative

5.2. Other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are to be scrutinised.

5.3. Members are required to attend no less than two thirds of committee meetings on a rolling annual basis.

5.4. With the agreement of the chair, members of the committee or other Trust managers and officers may participate in a meeting of the committee by means of a tele/video conference. In such instances, it is a requirement that all persons participating in the meeting can hear each other. Participation in the meeting in this manner shall be deemed to constitute the presence in person at such a meeting. A member of the committee joining the meeting in this way shall count towards the quorum.

6. Frequency

The committee shall meet at least six times a year and extraordinary meetings may be called by the committee chair in addition to discuss and resolve any critical issues arising.

7. Authority

The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that the Trust's system of internal control is designed well and operating effectively. The committee will seek assurance (i.e. the elimination of reasonable doubt) from sources and systems including the front line operations, corporate services and from external independent sources such as peer review; internal audit, local counter fraud service, external audit and others, including legal or other professional advice when required.

8. Purview

The purview of the committee is set out in the accompanying purview document, which is approved by the Board along with these Terms of Reference. The committee will prioritise the acquisition and scrutiny of assurances according to the Board's requirements, using a risk based approach to prioritisation. The committee will not review all aspects of the system of internal control identified in the purview in every year.

9. Support

Under the guidance of the Company Secretary and, in conjunction with the committee chair and executive lead, the Business Support Manager to the Medical and Nurse Directors will provide secretarial support to the committee, including planning meetings twelve months in advance, setting agendas, collating and circulating papers five working days before meetings; taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting

The committee shall be directly accountable to the Trust Board. At the end of each meeting of the committee, the committee chair shall seek a consensus from committee members as to those items that shall be escalated to the Board. The chair of the committee shall provide such an escalation report to the next Board meeting, in writing where possible.

In April of each year, the committee chair will provide a concise report to the Board which will bring to the Board's attention, by exception, matters relevant to the content of the Board's annual governance statement. This report shall provide the Board with assurance as to the committee's view on:

- **a)** the design and operation of controls within its purview during the financial year ending 31 March.
- **b)** the committee's consideration of its own effectiveness.

11. Review

The committee shall reflect upon the effectiveness of its meeting at the end of each meeting. The committee shall review its Terms of Reference at least once a year to ensure that they fit with the Board's overall review of the system of internal control. Any proposed changes shall be submitted to the Board for ratification.

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0	5 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. RMCGC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16.
1.1	20 October 17		Update to membership Inclusion of additional regular attendees Administrative support provided by the Business Support Manager to Medical and Nurse Directors; from the corporate governance dept.

South East Coast Ambulance Service NHS Foundation Trust

Finance and Investment Committee ('FIC')

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Finance and Investment Committee ('FIC') referred to in this document as 'the committee'.

2. Purpose

The purpose of the committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to finance, corporate services and investments in future operational capability, are designed appropriately and operating effectively.

3. Membership

Appointed by the Board, the membership of the committee shall constitute three independent Non-Executive Directors and two Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:
Graham Colbert, Independent Non-Executive Director (Chair)
Angela Smith, Independent Non-Executive Director
Lucy Bloem, Independent Non-Executive Director
Executive Director of Finance & Corp. Services (Executive Lead)
Executive Director of Strategy & Business Development

4. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance

5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Company Secretary
- Deputy Director of Finance
- Executive Director of Operations or their deputy

5.2. At the request of a committee member, other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are to be scrutinised.

5.3. Members are required to attend no less than two thirds of committee meetings on a rolling annual basis.

5.4. With the agreement of the chair, members of the committee or other Trust managers and officers may participate in a meeting of the committee by means of a tele/video conference. In such instances, it is a requirement that all persons participating in the meeting can hear each

other. Participation in the meeting in this manner shall be deemed to constitute the presence in person at such a meeting. A member of the committee joining the meeting in this way shall count towards the quorum.

6. Frequency
The committee shall meet at least four times a year and extraordinary meetings may be called by the committee chair in addition to discuss and resolve any critical issues arising.

7. Authority
The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively. The committee will seek assurance (i.e. the elimination of reasonable doubt) from sources and systems including the front line operations, corporate services and from external independent sources such as peer review; internal audit, local counter fraud service, external audit and others, including legal or other professional advice when required.

8. Purview
The purview of the committee is set out in the accompanying purview document, which is approved by the Board along with these Terms of Reference**.** The committee will prioritise the acquisition and scrutiny of assurances according to the Board's requirements, using a risk based approach to prioritisation. The committee will not review all aspects of the system of internal control identified in the purview in every year.

9. Support
Under the guidance of the Company Secretary and, in conjunction with the committee chair and executive lead, the Finance Director Business Support Manager will provide secretarial support to the committee, including planning meetings twelve months in advance, setting agendas, collating and circulating papers five working days before meetings; taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting
The committee shall be directly accountable to the Trust Board. At the end of each meeting of the committee, the committee chair shall seek a consensus from committee members as to those items that shall be escalated to the Board. The chair of the committee shall provide such an escalation report to the next Board meeting, in writing where possible.

In April of each year, the committee chair will provide a concise report to the Board which will bring to the Board's attention, by exception, matters relevant to the content of the Board's annual governance statement. This report shall provide the Board with assurance as to the committee's view on:

- **c)** the design and operation of controls within its purview during the financial year ending 31 March.
- **d)** the committee's consideration of its own effectiveness.

11. Review
The committee shall reflect upon the effectiveness of its meeting at the end of each meeting. The committee shall review its Terms of Reference at least once a year to ensure that they fit with the Board's overall review of the system of internal control. Any proposed changes shall be submitted to the Board for ratification.

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0	21 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. FBDC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16.
1.1	20 October 17		Update to membership Inclusion of additional regular attendees Administrative support provided by the Business Support Manager; from the corporate governance dept.

South East Coast Ambulance Service NHS Foundation Trust

Workforce and Wellbeing Committee (WWC)

Terms of Reference

12. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Workforce and Wellbeing Committee (WWC) referred to in this document as 'the committee'.

13. Purpose

The purpose of the committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to the workforce (encompassing resourcing, staff wellbeing and HR processes) are designed appropriately and operating effectively.

14. Membership

Appointed by the Board, the membership of the committee shall constitute three independent Non-Executive Directors and two Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:
Terry Parkin, Independent Non-Executive Director (Chair)
Tim Howe, Independent Non-Executive Director
Al Rymer, Independent Non-Executive Director
Director of HR & OD (Executive Lead)
Executive Director of Operations
Medical or Nurse Director (rotating)

15. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Director.

16. Attendance

16.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Company Secretary
- Associate Director of HR Operations
- HR Business Support Manager

16.2. At the request of a committee member, other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are to be scrutinised.

16.3. Members are required to attend no less than two thirds of committee meetings on a rolling annual basis. *Members unable to attend should identify, with the committee chair's agreement, an appropriately informed deputy to attend the meeting.*

16.4. With the agreement of the committee chair, members of the committee or other Trust managers and officers may participate in a meeting of the committee by means of a tele/video conference. In such instances, it is a requirement that all persons participating in the meeting can hear each other. Participation in the meeting in this manner shall be deemed to constitute the presence in person at such a meeting. A member of the committee joining the meeting in this way shall count towards the quorum.

17. Frequency
The committee shall meet at least six times a year and extraordinary meetings may be called by the committee chair in addition to discuss and resolve any critical issues arising.

18. Authority
The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively. The committee will seek assurance (i.e. the elimination of reasonable doubt) from sources and systems including the front line operations, corporate services and from external independent sources such as peer review; internal audit, local counter fraud service, external audit and others, including legal or other professional advice when required.

19. Purview
The purview of the committee is set out in the accompanying purview document, which is approved by the Board along with these Terms of Reference**.** The committee will prioritise the acquisition and scrutiny of assurances according to the Board's requirements, using a risk based approach to prioritisation. The committee will not necessarily review all aspects of the system of internal control identified in the purview in every year.

20. Support
Under the guidance of the Company Secretary, and in conjunction with the committee chair and executive lead, the HR Business Support Manager will provide secretarial support to the committee, including planning meetings twelve months in advance, setting agendas, collating and circulating papers five working days before meetings; taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

21. Reporting
The committee shall be directly accountable to the Trust Board. At the end of each meeting of the committee, the committee chair shall seek a consensus from committee members as to those items that shall be escalated to the Board. The chair of the committee shall provide such an escalation report to the next Board meeting, in writing where possible.

In April of each year, the committee chair will provide a concise report to the Board which will bring to the Board's attention, by exception, matters relevant to the content of the Board's annual governance statement. This report shall provide the Board with assurance as to the committee's view on:

- **e)** the design and operation of controls within its purview during the financial year ending 31 March.
- **f)** the committee's consideration of its own effectiveness.

22. Review
The committee shall reflect upon the effectiveness of its meeting at the end of each meeting. The committee shall review its Terms of Reference at least once a year to ensure that they fit

with the Board's overall review of the system of internal control. Any proposed changes shall be submitted to the Board for ratification.

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0	12 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. WDC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16 Board.
1.1	20 Sept 16		Minor amendment proposed at para 5.3 see italicised changes.
2.0	20 October 2017		Change in Chair and Membership Additional regular attendees Administrative support provided by the HR Business Support Manager; from the corporate governance dept.

APPENDIX 1 - SECAmb Board draft assurance purview / map for 2017-18

This chart sets out the purview of each committee.
Topics are selectively picked according to the risk around each area.
Not every topic is scrutinised every year.

		Board	Q & PS	WWC	FIC	Audit	ARC	CFC
	Have we a well designed and effectively operating system of internal control to deliver the strategic goals?							
G1	Our People							
G2	Our Patients							
G3	Our Enablers							
G4	Our Partners							
1	Significant risks threatening achievement of objectives, as set out in BAF							
2	Have we enabling sub-strategies to deliver the objectives ? *Quality; clinical leadership; people (resourcing and leadership), estates, long term financial model; health, wellbeing and safety; fleet, commications; informatics.*							
	Have we established controls to deliver regulatory and legal compliance?							
3	NHSI Licence conditions compliance							
4	NHSI single oversight framework compliance							
5	NHSI regulatory ratings							
6	NHSI Code of governance compliance							
7	Annual report and accounts							
8	NICE							
9	Other regulatory disclosure statements							
10	CQC registration requirements compliance							
11	Equalities legislation							
12	Health & safety legislation							
13	Anti-fraud and anti-bribery legislation							
14	Employment legislation (bullying, harrassment, discipline, grievance, raising concerns, whistleblowing)							
	By safe, we mean that people are protected from abuse and avoidable harm.							
S1	How do systems, processes and practices keep people safe and safeguarded from abuse?							
S2	How are risks to people assessed, and their safety monitored and managed so they are supported to stay safe?							
S3	Do staff have all the information they need to deliver safe care and treatment to people?							
S4	How do we ensure the proper and safe use of medicines, where the service is responsible?							
S5	What is the track record on safety?							
S6	Are lessons learned and improvements made when things go wrong?							
	By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.							
E1	Are people's needs assessed and care and treatment delivered in line with legislation, standards (eg JRCALC, NHS Pathways licence) and evidence-based guidance to achieve effective outcomes?							
E2	How are people's care and treatment outcomes monitored and how do they compare with other similar services?							
E3	Do staff have the skills, knowledge and experience to deliver effective care and treatment? *(appraisals, mandatory training)*							
E4	How well do staff, teams and services work together to deliver effective care and treatment?							
E5	How are people supported to live healthier lives and, where the service is responsible, how does it improve the health of its population?							
E6	Is consent to care and treatment always sought in line with legislation and guidance?							
	By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.							
C1	How does the service ensure that people are treated with kindness, respect and compassion, and that they are given emotional support when needed?							
C2	How does the service support people to express their views and be actively involved in making decisions about their care, treatment and support as far as possible?							
C3	How are people's privacy and dignity respected and promoted?							
	By responsive, we mean that services are organised so that they meet people's needs.							
R1	How do people receive personalised care that is responsive to their needs?							
R2	Do services take account of the particular needs and choices of different people?							
R3	Can people access care and treatment in a timely way?							
R4	How are people's concerns and complaints listened and responded to and used to improve the quality of care?							
	By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.							
W1	**Kloe 1 Is there the leadership capacity and capability to deliver high quality, sustainable care?**							
1.2	Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?							
1.2	Do leaders understand the challenges to quality and sustainability and can they identify the actions needed to address them?							
1.3	Are leaders visible and approachable?							
1.4	Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?							
W2	**KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?**							
2.1	Is there a clear vision and a set of values, with quality and sustainability as the top priorities?							
2.2	Is there a robust realistic strategy for achieving the priorities and delivering good quality, sustainable care?							
2.4	Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?							
2.4	Do staff know and understand what the vision, values and strategy are, and their role in achieving them?							
2.5	Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?							
2.6	Is progress against delivery of the strategy and local plans monitored and reviewed and is there evidence to show this?							
W3	**KLOE 3 Is there a culture of high quality, sustainable care?**							
3.1	Do staff feel supported, respected and valued?							
3.3	Is the culture centred on the needs and experience of people who use services?							
3,3	Do staff feel positive and proud to work in the organisation?							
3.4	Is action taken to address behaviour and performance that is inconsistent with the vison and values, regardless of seniority?							
3.5	Does the culture encourage, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?							
3.6	Are there mechanisms for providing all staff at every level with the development they need, including high quality appraisal and career development conversations?							
3.7	Is there a strong emphasis on safety and well-being of staff?							
3.8	Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?							
3.9	Are there co-operative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?							
W4	**KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?**							
4.1	Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?							
4.2	Do all levels of governance and management function effectively and interact with each other appropriately?							
4.3	Are staff at all levels clear about their roles and do they understand what they are accountable for and to whom?							
4.4	Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care							
W5	**KLOE 5. Are there clear and effective processes for managing risks, issues and performance?**							
5.1	Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?							
5.2	Are there processes to manage current and future performance? Are these regularly reviewed and improved?							
5.3	Is there a systematic programme of clinical and internal audit to monitor quality, operational, and financial processes, and systems to identify where action should be taken?							
5.4	Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'?							
5.5	Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities?							
5.6	When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?							

CQC key lines of enquiry

Well-led KLOEs.

APPENDIX 1 - SECAmb Board draft assurance purview / map for 2017-18

This chart sets out the purview of each committee.
Topics are selectively picked according to the risk around each area.
Not every topic is scrutinised every year.

		Board	Q & PS	WWC	FIC	Audit	ARC	CFC
W6	**KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?**							
6.1	Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?							
6.2	Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and challenge it appropriately?							
6.3	Are there clear and robust service performance measures, which are reported and monitored?							
6.4	Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?							
6.5	Are information technology systems used effectively to monitor and improve the quality of care?							
6.6	Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required?							
6.7	Are there robust arrangements (including appropriate internal and external validation), to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?							
W7	**KLOE 7 Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?**							
7.1	Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?							
7.2	Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups?							
7.3	Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected equality characteristic?							
7.4	Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?							
7.5	Is there transparency and openness with all stakeholders about performance?							
W8	**KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?**							
8.1	In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?							
8.2	Are there standardised improvement tools and methods, and do staff have the skills to use them?							
8.3	How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?							
8.4	Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation?							
8.5	Are there systems in place to support improvement and innovation work including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?							
	Other aspects of governance							
15	Policy governance							
16	Defib strategy							
17	Long term financial model							
18	Procurement							
19	Disposals and acquisitions							
20	Standing financial instructions; standing orders; scheme of reservation & delegation							
21	Employee relations							
22	Corporate trustee responsibilities re Charity No 1059933							
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