South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

23 February 2018
10.00-13.00

Tangmere MRC

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
Introduction					
170/17	10.01	Apologies for absence	-	-	RF
171/17	10.02	Declarations of interest	-	-	RF
172/17	10.03	Minutes of the previous meeting: 11 January 2018	**Y**	Decision	RF
173/17	10.05	Matters arising (Action log)	**Y**	Decision	RF
174/17	10.10	Patient story	-	Set the tone	
175/17	10.15	Chair's Report	**Y**	Information	RF
176/17	10.20	Chief Executive's report	**Y**	Information	DM
Trust strategy					
177/17	10.30	Delivery Plan	**Y**	Assurance	DM
178/17	11.20	Culture Update	**Y**	Information	SG
Ten minute Break					
Quality & Safety					
179/17	11.50	Quality Dashboard	**Y**	Information	SL
180/17	12.05	Use of non-parental prescription only medicines	**Y**	Decision	FM
Monitoring performance					
181/17	12.15	Integrated Performance Report	**Y**	Information	SE
Governance					
182/17	12.50	Board Meeting Schedule	**Y**	Decision	PL
183/17	12.55	Any other business	-	Discussion	RF
184/17	-	Review of meeting effectiveness	-	Discussion	ALL
Close of meeting					

Date of next Board meeting: 27 March 2018
After the close of the meeting, questions will be invited from members of the public

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting,
25 January 2018

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

Present:

Richard Foster	(RF)	Chairman
Daren Mochrie	(DM)	Chief Executive
Angela Smith	(AS)	Independent Non-Executive Director
Fionna Moore	(FM)	Executive Medical Director
Graham Colbert	(GC)	Independent Non-Executive Director & Deputy Chair
Joe Garcia	(JG)	Executive Director of Operations
Lucy Bloem	(LB)	Independent Non-Executive Director
Steve Emerton	(SE)	Executive Director of Strategy & Business Development
Steve Graham	(SG)	Interim Director of Human Resources
Steve Lennox	(SL)	Executive Director of Nursing & Quality
Tim Howe	(TH)	Independent Non-Executive Director
Tricia McGregor	(TM)	Independent Non-Executive Director
Terry Parkin	(TP)	Independent Non-Executive Director

In attendance:

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

153/17 Apologies for absence

RF welcomed Board members and noted the apologies from;

Alan Rymer	(AR)	Independent Non-Executive Director
David Hammond	(DH)	Executive Director of Finance & Corporate Services

154/17 Declarations of conflicts of interest

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

155/17 Minutes of the meeting held in public on 11 January 2018

The minutes were approved as a true and accurate record.

156/17 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.

157/17 Patient story [10.07 – 10.13]
Before the video was played, SL explained that following the patient story at the previous meeting, he explored what is in place to support reflective practice. A paper was then received by the Quality & Patient Safety Committee, which identified that more needs to be done.

This story included clips from people describing a positive experience of the service. The theme was about the caring approach of staff. The Board noted the contrast with the patient experience described last time.

158/17 Chair's Report [10.13 – 10.14]
RF confirmed that this would be a regular item going forward. The report was taken as read.

159/17 Chief Executive's report [10.14 – 10.22]
DM referred to his report highlighting the following:

- Over the Christmas period, we managed relatively well, despite some of the high levels of demand. We will be reviewing our approach to the demand through the Quality and Patient Safety Committee.
- Handover delays continue to be a challenge as described in papers later on the agenda
- APR performance is relatively good. We maintain a consistent Response to Category 1 and Category 2 patients. However, much work is still needed, in particular in improving response to Categories 3 & 4. DM thanked commissioners for their support with the additional funding they provided to help support our improvement. We continue the dialogue with them to ensure this continues.
- The Wellbeing Hub is now launched.
- DM thanked all the staff who have had their flu jabs – currently 64%.

Questions:
AS asked whether it would be appropriate for a message to be sent to staff on behalf of the Trust Board, thanking them for their efforts over this very challenging winter period. The Board agreed that it would.

Action:
Message to be sent to staff on behalf of the Trust Board, thanking them for their efforts over the busy period during December and January.

RF referred to DM having now visited all our (100+) ambulance stations, noting the commitment needed to do this.

GC asked about breakdown of activity for ARP and DM estimated that it was roughly 6% Cat 1, 44% Cat 2, 49% Cat 3 and 1-2% Cat 4.

160/17 Delivery Plan [10.22 – 10.47]
DM introduced the Delivery Plan and reminded the Board that this aligns to our strategy and how we intend to deliver the first 1-2 years' objectives, which includes the CQC 'must/should dos'.

SE added that since the Board last met, work has been done to improve the supporting narrative and explain the rationale for the RAG rating. We still need to refine the process and incorporate the metrics within the integrated performance report, to give assurance to the Board on progress and highlight more clearly when progress is not being made. In addition, we need to include clearer risks, on basis that no plan is risk-free.

AS commend the openness of the paper and commentary. However, she was concern about so many red/amber projects believing this indicated non-delivery.

DM confirmed the focus given by the Executive to each area, every week. In last couple of weeks the Executive has been exploring how we review the priorities to ensure sufficient focus on the delivery plan. This has included a review of every projects across the entire Trust, with decision made to pause what is not a priority, in order to free up capacity of staff to focus on the priorities within the delivery plan.

SE gave an example of moving a project from green to amber, explaining that this is not necessarily a negative steps, but an honest appraisal of where we are at. He reminded the Board that Amber means that the plan is still on track, and the risk(s) identified can be mitigated within the resources available. AS acknowledged this but maintained that the narrative is still concerning.

TM referred to culture being Green asking whether this is a fulsome assessment of where we are at. He set this in the context of some negative feedback from some staff about culture that makes it difficult to triangulate with this RAG rating. SG responded by explaining that the Green rating reflects that the milestones in the plan have been delivered. He accepted that the dashboard does not yet fully reflect all the work being done.

TP started a discussion about how we measure the impact of what we do, over and above what we do in terms of process; the "so what" questions. The Board agreed that we must link the actions to actual impact being made. DM accepted this challenge and stated that the work being done to improve the integrated performance report will help, as it should be the metrics within this report that answer the impact question.

RF asked the Executive what now, if anything, is needed from the Board, in terms of a steer on things we need to pause/stop to ensure greater capacity, or is the Executive saying this is where we are and we have arrangements in place to ensure we deliver what is needed. In terms of priority, DM confirmed that we have been working on bring in some more programme director support to ensure increased pace. He also referenced recent discussions about establishing a sub-group, to include some NEDs, to help greater focus and visibility of the progress being made; he gave the example of complaints where we had a backlog of 200 last year, which is now almost completely reduced, despite not hitting current targets.

SL added that some areas are much improved and with safeguarding, for example, the data available today would turn this project Green, so sometimes it is a timing issue. In addition, with complaints we are re-thinking this portfolio. The team met with another provider recently and receiving support from NHSI.

LB asked if there was any feedback from last CQC deep dive. SL confirmed that we gave assurance to the CQC that we had grip on the three areas and presented the various stages of delivery.

RF summarised this item by reflecting that the Executive knows what it is doing and we are getting there. As a Board, we need to continue supporting the Executive.

161/17 **Culture** [10.47. – 11.00]
We are running with three high level objectives and this paper outlines the progress we are making.

TH referred to effective leadership only focussing on recruitment and asked whether we are doing work on training and supervision, for example. SG explained that we ensure all staff have a development programme when moving in to management. This will include 360 feedback.

DM picked up the wider point being made, and acknowledged that we are still not expressing all the work we are doing. For example, we have been for some time now running a level 5 management programme. SG agreed; this paper sets out the work we are doing differently. The course DM mentioned is business as usual.

TM referred to one of the recommendations from Prof. Lewis' review about feedback mechanisms and felt that the language in the paper seems to show we are not there yet. For example, there is reference to 'informing' staff rather than engaging them. SG explained that we do have a staff engagement forum and staff engagement champions. These have been running now for a few months as a business as usual activity.

JG added that engagement of staff is emending in to each operating unit, with each one having a strategy and a plan to ensure improved engagement. In testing this, we use a metric to demonstrate how the OUs are engaging with their people.

LB agreed with TM that the paper appears to describe what we are doing 'to' staff. SG and JG accepted that the way the paper is written gives this appearance, but reassured the Board that this is not our approach.

AS had received some anecdotal feedback from staff that engagement is improving.

RF reminded the Board about the governance review which said we are not putting enough weight on middle managers, to give them authority and then hold them to account. He asked whether in terms of key enablers do we have right people in post and are we equipping them to deliver this cultural change. JG responded by confirming that at operational unit level we have a good cohort of managers to take us forward. The assessment centre has a really high bar and as a result, we are looking to develop an aspiring director's programme to nurture talent.

RF summarised. We are starting to do the right things, but this paper does not reflect this and nor does it model the behaviour we are seeking to change. At executive level and now at operating unit level we have the right appointments. The middle-tier management is the final aspect, which needs more work.

162/17 Patient & Staff Safety Leadership Walk Rounds [11.00– 11.28]

This paper sets out some principles to help ensure greater board visibility and is before the Board, seeking its support. It will then go through the usual policy approval process. We have looked at best practice across the NHS and it supports well-led, leadership and patient safety.

AS confirmed that she finds it hard to support the principles, and explained this is on the basis that it is part of the overall control process. Therefore, it is not appropriate for NEDs to be part of what is effectively a management process. The risk is that is seen as an add-on and will confuse the overall control environment. Instead, we should ask the Executive to bring to the audit committee a 6-monthly view on the totality of the control process. The NED role is to stand back otherwise it might weaken the over control process.

TH did not disagree with the principles, as NEDs need to engage with staff. But agreed that it does seem to be an add on, and so it is difficult to see how it fits in to all the other things, such as the Chief Executive station visits, and the Quality Assurance Visits etc.

TP added that a number of NEDs have been involved in the Quality Assurance Visits and these have been very helpful. What we bring as NEDs is a non-specialist eye, which is important. The concern about the paper is how we do it and how it adds value, especially in the context of workloads and capacity of staff. We should look at the totality of visits and how it links in joined up way to quality assurance.

LB felt that what this does bring is structure and NEDs have not been out in the Trust enough in the recent past. There is overlap with others things, such as the Quality Assurance Visits.

AS reinforced from an audit perspective, the need to avoid NEDs getting too involved in management processes. Part of role is to challenge these very processes and maintain objectivity and independence.

RF summarised. First and foremost, the paper is a helpful step forward to provide structure. It needs more work before coming back to the Board.

Action:
Principles supporting the Patient & Staff Safety Leadership Walk Rounds policy to be reviewed, before coming back to the Board.

Arising from this discussion, the Board agreed that in the summer it should review the totality of the Trust's governance structure. This will help the Board when receiving proposals such as this, to more readily see how it fits, and ensure better clarity on how the Trust is working.

Action:
Board to receive a paper in the summer, setting out the totality of the Trust's governance structure. An outline plan of what is to be prepared to be agreed by the Audit Committee.

JG outlined his operational governance structure and confirmed that the quality assurance visits are integral as it helps test what is really happening, especially as they are unannounced.

Break at 11.28 – 11.44

163/17 Ambulance Hospital Handover Delays [11.44 – 12.14]

This paper highlights the work following the Quality Summit to improve hospital handover delays. It sets out progress to date. JG confirmed that, unfortunately, despite all the efforts we have not to-date seen any improvement. There are specific objectives supported by the Task and Finish Group. It has been a very challenging time during which we still managed to convey 5% less than the same period last year.

The issues during December/January have been reflected pretty much across the country so it is not specific to the South East.

There was a discussion about the negative impact on the Trust's already stretched resources. For example, the provision of our team leaders to support reduced delays at A&E is a drain on capacity and impacts on our internal governance.

TP acknowledged the dangers of drawing experience from one shift with a crew, but reflected from the shift he observed recently where there was 75% non-conveyance. This crew prevented admissions through their clinical practice and TP wondered whether CCGs are clear enough about how we deliver services.

DM added that this is a whole system issue and a national one. In terms of impact, we need to get better at monitoring impact of delays on patient safety, quality and experience. On the point about deploying team leaders in to A&E departments, all the while they are there they are not able to do supervision, appraisal, training etc. We are working with commissioners on this and looking at building in the sensitivity of handover delays to ensure sufficient resource, including the see and treat, which is the point TP has made.

The Board reflected that we are a Trust in special measures and, at the same time being innovative with working with hospitals. Yet, we are making little if any progress. Against this background, there was a discussion about the merits of continuing to provide the resources we do, given the adverse impact it is having on our internal issues.

SE stated that we appreciate the additional funding provided by commissioners currently. The demand and capacity review aims to right size the model and the finances needed to support that model. We have agreed as part of this modelling process the sensitivity of handover delays to reflect the reality. This should therefore ensure sufficient resource to provide a service.

GC asked what happens if the objectives within paper are not met. SE explained this is built in to the demand and capacity review modelling. For example, we will not be assuming a lower level of handover delays, but instead the reality of today.

RF summarised this part of the discussion. We are discussing the resource we need to deliver targets and, in particular, we cannot calculate this resource by making unrealistic assumptions re hospital handover delays. The other part is that reducing delays is whole-system issue. As we are in special measures, there is a question about how much effort we can reasonably give to this, especially in light of the marginal benefits being realised and in context of our other challenges.

JG agreed with this summary. At which point does our commitment outweigh the benefits? We know there are a number of elements not on track; appraisal/training etc. and we need to assess the extent to which this is because we focus elsewhere on things like hospital delays.

TP noted that this is discussed at every Board meeting. In terms of ARP, he explored whether Category 3 and 4 should be system targets. Our commitment is to do what we can control, but meeting Category 3 and 4 targets significantly relies on the system performing.

The Board discussed the Trust's conveyance model and whether we get the balance of risk right, and it agreed that it would prefer to continue to provide more hear and treat and more see and treat and to continue investing in specialist paramedics. Our strategy should be to continue with this model, but it must be subject to the outcome of commissioning decisions.

In summary, we are clearly gripping negotiations with CCGs. ARP is new national programme and while it is reassuring that we are close on Category 1 and Category 2, it is a new programme so it is difficult for any Trust to gauge on current levels of resourcing how achievable Category 3 and 4 targets will be. For any Trust, there is a challenge in striking the appropriate balance between immediate pressures and the longer term. We have a number of longer term strategies we are confident are the right things and will in time ensure better service for staff and patients. That said we are in special measures and the absolute focus must be on getting out of special measures.

Therefore, if the choice is between the two, the Board is saying the focus must be on immediate priorities.

164/17 **IPR** [12.14– 12.44]
SE confirmed that much of what was said under the Delivery Plan applies to the IPR. Since the last meeting, some improvements have been made to the overall narrative, but it will be developed further.

Clinical Safety (FM):
Cardiac survival has improved, but these are small numbers and so it is difficult to know if it will be sustained. Appendix A gives the breakdown.

We are starting to build a medicines dashboard and currently this includes completion of audits.

Focus on getting STEMI care bundle on track.

Questions:
GC referred to a recent meeting of the Finance Committee in which a presentation was given about the number of hours we can put out and asked what the link is between hours and clinical outcomes. FM explained that there is data, which shows a correlation between Red 1 performance and cardiac arrest survival. DM confirmed that we are looking at these measures as part of the demand and capacity review.

Quality (SL):
Incident reporting is increasing, which is positive. The number of serious incidents in January was 17. Duty of Candour for serious incidents is not yet 100%, but measures are in place to ensure this happens by end of March 2018.

Complaints are down, which is positive. ARP is helping with this in terms of managing expectations about the time some people can reasonably expect to wait for a response.

There is a new section on health and safety and new metrics will be developed for future meetings.

Questions:
LB felt that the new health and safety section is a good news story, as it is an indicator that we are heading in right direction.

TM agreed about the health and safety section and asked about the external review we have commissioned. SL confirmed that the timetable for this is to be agreed shortly, but likely to be 4-6 weeks.

Performance (JG):
The metrics set out the first full month against ARP. November's data is just based on 8 days so it is difficult to assess trends. However, we as an executive review performance on a weekly basis and the most significant concern currently is call answer times. EOC 5 second call answer in December was very challenging. There were 22% additional ring backs during some days in this period. January to-date is 72.6% so there is some small improvement; JG outlined some of the reasons for this.

The 111 team had a very difficult December due to a significant number of calls compared to the same period last year. During one day, 9000 calls were received when we were expecting 4,500. The team prepares well for fluctuations, but it can never prepare for 100% increase. Despite this, 111 did extremely well during periods of escalation to work jointly with 999, in order to minimise the number of ambulances transferred to 999. On some days there was less than 7% referrals, which is really low.

The Board discussed the impact of GP out of hours on 111, in Kent in particular, and agreed the need to discuss this with commissioners to avoid the same next winter.

Questions:
There was a question about vacancies, and our leavers figure 18%, which is double most other Trusts. This led to a discussion about, taking account of the one-off impact of the move to Crawley, whether we are going to be able to stabilise our turnover, or whether as a Board this is the figure we should expect to be the norm. The executive felt that the Trust is likely to have a higher turnover rate as we are in the South East and noted that this isn't just about the EOC as the 18% includes all staff groups.

Workforce (SG):
The vacancy rate increased due to the December-effect. We expect to see this reduce over the next period. In addition, there is some slow down in stat/man training and career conversations, linked to operational demands over Christmas, which was expected.

The leaver rates are included in the additional information section and the sickness rates are compared to other Trusts.

Finance (PA):
We are on track to deliver the control total. The in-month surplus was £800k. CIP schemes have been identified to the value of £17.3m, and we expect to achieve slightly above the target of 15.1m.

Questions:
No questions.

DM thanked staff for their efforts especially given where we were this time last year. We now have much better grip and control of our finances.

165/17 **GDPR** [12.44– 12.45]
This is for information, which the Board noted.

166/17 **QPS Report** [12.45 – 12.51]
The meeting was on Tuesday 23 January and LB took the Board through the issues highlighted in the report.

Overall, it was a positive meeting.

RF reflected that the committee seems to be saying that the areas we are looking at we are assured and where we are not assured, the committee is confident that there are measures in place to get assurance within a reasonable timeframe. Secondly, and more generally, the committee is more confident in the management grip.

LB agreed with this summary.

TH added that the difference now to before is that we know the issues, and management is open about this and clear about what corrective action is being taken.

167/17 **Finance Committee Report** [12.51 – 12.54]
GC referred to the issues highlighted in the report.

RF stated that this is a good news story on finances, on the back of huge effort of staff.

No questions.

168/17 **Any other business** [12.54 – 12.54]
None

169/17 **Review of meeting effectiveness**

Questions from observers

There being no further business, the meeting closed at 12.55

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
26.10.2017	111 17 2	The Board to agree the 2018/19 IPR in February	Board	23.02.2017	Board	IP	The IRP is in development with the latest version before the Board on 23.02.2018
29.11.2017	128 17 3	SL to explore how to obtain external verification of our safeguarding processes	SL	23.02.2017	Board	IP	
29.11.2017	130 17 4	Interim demand and capacity report to be considered by the finance and investment committee in January 2018.	DH	18.01.2018	FIC	IP	SE confirmed in January that as EOC has been added to the scope the findings will be available now in April. The findings are they are known will be reviewed by the Finance & Investment Committee on 05.03.2018.
29.11.2017	132 17 5	QPS committee to explore the link between performance and patient outcomes	PL	TBC	QPS	IP	This has been added to the QPS Committee agenda forward plan
29.11.2017	132 17 6	Finance Committee to review the finance report(s) to establish how they can include a forward view on the Trust's cash position, to help ensure more informed investment decisions.	DH	TBC	FIC	IP	
11.01.2018	144 17 7	QPS Committee to review the use and impact of the Demand Management Plan over the Christmas and New Year period	JG	08.03.2018	QPS	IP	Added to QPS Agenda for March.
11.01.2018	146 17 8	WWC to establish the extent of the issue picked up by the Audit Committee, relating to EOC staff being abused by other professionals.	JG	08.03.2018	WWC	IP	Added to WWC Agenda for March
11.01.2018	117 17 10	The Board to receive a paper in February on the high turnover rates across each directorate to understand the cause and the action taken to improve this.	SG	23.02.2018	Board	IP	Added to Feb Agenda [paper deferred to March]
25.01.2018	159 17 11	Message to be sent to staff on behalf of the Trust Board, thanking them for their efforts over the busy period during December and January.	DM	23.02.2018	Board	C	Included in the Chief Executive Weekly Message
25.01.2018	162 17 12	Principles supporting the Patient & Staff Safety Leadership Walk Rounds policy to be reviewed, before coming back to the Board.	SL	27.03.2018	Board	IP	
25.01.2018	162 17 13	Board to receive a paper in the summer, setting out the totality of the Trust's governance structure. An outline plan of what is to be prepared to be agreed by the Audit Committee.	PL	TBC	Board	IP	

Key

- Not yet due
- Due
- Overdue
- Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

	Item No	175/17
Name of meeting	Board Meeting	
Date	23 February 2018	
Name of paper	Chair's Report	
Author name and role	Richard Foster, Chair	
Synopsis	This report provides an overview of the work and engagement undertaken by the Chair since the last Board meeting.	
Recommendations, decisions or actions sought	To note.	
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**

South East Coast Ambulance Service NHS Foundation Trust

Trust Board

Chair's Report

1. Trust Board Appointments

We can now announce that Bethan Haskins has been appointed as the new Executive Director of Nursing & Quality, and will join the Trust on 1 April 2018. We are looking forwarded to welcoming Bethan to the Board of Directors. She joins at a really important time.

February will be the first Board meeting for our two recently appointed Independent Non-Executive Directors, Laurie McMahon and Adrian Twyning. Along with Tricia who joined in January, these appointments will add positively to the dynamic of the Trust Board.

2. Trust Board Development

We are in the process of establishing a Trust Board development programme. In addition to discussing with the Independent Non-Executive Directors, I have had a scoping meeting with the Chief Executive and other Executive Directors. We will be taking time in the part two Board meeting to discuss the progress to date, in particular the strategy workshop we have planned for 15 March 2018. As I mentioned last time, my March report will confirm the outputs from this workshop.

3. Engagement – internal

Since the last Board meeting I have met with my NED colleagues on two occasions where we discussed a range of issues, including the Board strategy workshop, and Board development more broadly.

I also chaired a meeting of the Nomination and Remuneration Committee where we discussed succession planning. We sought the views of this committee of the Council of Governors on who should succeed Tim Howe as Senior Independent Director. In addition, the committee reflected on what went well during the recent recruitment campaign and what we could do better next time.

I was reminded when spending time in the EOC recently just how hard our staff work to respond to the range of 999 calls we receive each day.

4. Engagement - external

We had our usual meetings with our regulators and partners on 16 February. We provided an update on the improvements we are making, as well as the current issues and risks.

Daren and I met the six upper-tier local authority leaders earlier this month to describe how we are progressing against our Delivery Plan. This was another positive opportunity to engage our external stakeholders in the work we are doing.

5. Coming Up

We are preparing for the first of two Staff Awards Ceremony, which takes place on 22 February, where the achievements of ambulance staff, volunteers and the public will be celebrated. The categories include clinical excellence, patient care and leadership. I am really looking forward to attending this and I will provide a verbal update at the meeting.

The second awards ceremony, for the West of our region, will take place in Cobham on 8 March.

Richard Foster, Chair

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

Covering January 2018

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 during January 2018.

2. Local issues

2.1 Recruitment to the Executive Team

2.1.1 Following the recent recruitment and interview process for the Director of Nursing & Quality, I am pleased to confirm that Bethan Haskins will be joining the Trust on 1st April 2018. Bethan has a broad range of experience and worked most recently as Chief Nurse across a number of Kent Clinical Commissioning Groups.

2.1.2 I would like to thank Steve Lennox for his hard work during his time as Interim Director; Steve will be remaining with the Trust for a number of months to provide additional capacity in addressing the quality issues highlighted previously by the CQC.

2.1.3 As I have previously shared, Ed Griffin has been appointed to the substantive role of Executive Director of HR and Organisation Development and will take up his post on 7th March 2018.

2.1.4 Our Interim Director of HR, Steve Graham, left the Trust on 16th February 2018 to take a short break before starting his next role. Mark Power, who is already supporting the Trust in this area, will cover this role in the interim. I would like to thank Steve for his hard work during his time with the Trust.

2.2 Fleet up-date

2.2.1 In autumn last year, I shared that we had invested £6m into improving our fleet; this included ordering 16 new Fiat van conversions as a trial, as well as 42 box-built Mercedes to replace existing ageing vehicles.

2.2.2 I am pleased that we now have firm dates for these vehicles to arrive, after their build and conversion. John Griffiths, our Head of Fleet & Logistics, has now agreed the layout for the Fiat and the first one will be fully converted in late February. We are working towards these becoming operational during April & May of this year.

2.2.3 We also have an agreed schedule with our vehicle converters, covering the delivery of the 42 Mercedes ambulances. These will be arriving from our converters in two phases – the first during May/June and the second during July/August.

2.2.4 In January, we also placed an order for a further 43 Mercedes ambulances to replace ageing vehicles. These won't be arriving in the Trust until later on this year

but I am pleased that, by the end of this year, we will be seeing almost 100 new ambulances in use across our area.

2.3 CQC 'Deep Dives'

2.3.1 As part of the CQC's approach to ensuring sufficient progress is being made to address areas of concern highlighted in the Trust's inspection report, a number of smaller short inspections known as 'deep dives' have been taking place during recent weeks. These shorter visits allow inspectors to be more responsive, targeting specific areas of interest and concern. They will also identify areas for improvement and highlight good practice from which others can learn.

2.3.2 So far, 'deep dives' have taken place looking at:

- Incident Management
- Risk Management
- Safeguarding

2.3.3 During February 2018, the CQC will be returning to review our progress in Medicines Governance. This has been a particular area of concern for the CQC but equally an area where we have made some great strides to improve.

2.3.4 The 'deep dives' are an important part of our on-going quality improvement work and of our preparation for the next CQC inspection.

2.4 Visit by the national Health & Safety Executive (HSE)

2.4.1 On 2nd February 2018, the Health & Safety Executive (HSE) visited the Trust as part of their national inspection programme of all ambulance services.

2.4.2 During their visit, the HSE team met with the Chief Executive and members of the Executive Team, as well as the Trust's Health & Safety Manager and other staff. The key focus of the visit was on musculo-skeletal disorders (MSD) caused by manual handling – an issue affecting all ambulance services.

2.5 The HSE Team discussed the Trust's approach to minimising MSD injuries amongst staff, the key causes of injury and what steps we take to prevent them. Feedback from the HSE, once received, will be invaluable in helping us to further refine our approach moving forwards.

2.5 Engagement with local stakeholders

2.5.1 During January and February 2018, I have continued to meet with a range of key internal and external stakeholders. I met with the Chief Constables and their teams of both Surrey and Sussex Police to disuss areas for further collaboration.

2.5.2 Internally, I continued my programme of station visits, with visits to Caterham, Godstone, Dartford, Thameside, Hove, Lewes, Polegate and East Grinstead. I enjoyed spending time chatting with staff during these visits and discussing the key issues that are important to them.

2.5.3 I presented an update on progress within the Trust to the Medway Health & Adult Social Care Committee.

2.5.4 We hosted a Local Authority Leaders visit whereby the Chairman and I discussed progress within the Trust and how we can continue to work together with Local Authorities. The visit concluded with a tour of HQ and the Emergency Operations Centre.

2.5.5 I met with Jeremy Quinn MP and Timothy Loughton MP and provided them with an update on improvements across the Trust.

3. Regional issues

3.1 Stroke provision in Kent & Medway

3.1.1 On 2nd February 2018, the eight Clinical Commissioning Groups (CCGs) across Kent & Medway, as well as Bexley and High Weald Lewes Haven CCGs, launched a ten-week consultation exercise into the provision of stroke services across the county.

3.1.2 The proposals being consulted on focus on establishing three, new 'hyper-acute' stroke units across Kent & Medway and the location of these units. The consultation will close on 13th April 2018.

3.1.3 SECAmb has been working closely with the CCGs during the development of the proposals, to ensure that the impact on ambulance services is properly understood and will continue to work closely with them during the consultation period. As a Trust, we will also respond formally to the consultation in due course.

4. National issues

4.1 We continue to work with the Association of Ambulance Chief Executives and NHS England on weekly winter planning conference calls.

5. Recommendation

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

Daren Mochrie QAM, Chief Executive

16th February 2018

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	177/17

Name of meeting	Trust Board
Date	23 February 2018
Name of paper	Delivery Plan Progress Update
Responsible Executive	Steve Emerton, Director of Strategy and Business Development
Author	Eileen Sanderson, Head of PMO
Synopsis	The Delivery Dashboard provides a summary of progress within this reporting period. For information the RAG status is defined as follows: ▪ RED For those projects that are at significant risk of failure due to circumstances which can only be resolved with additional support ▪ AMBER For those projects at risk of failure but mitigating actions are in place and these can be managed and delivered within current capacity ▪ GREEN For those projects which are on track and scheduled to deliver on time and with intended benefits ▪ BLUE For those projects which have completed.
Recommendations, decisions or actions sought	The Board is asked to review the dashboard in order to be sighted on the current progress of the Delivery Plan

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**

Delivery Plan Progress

Introduction

1.1 This paper provides a summary of the progress in for SECAmb's Delivery Plan. The plan includes an update on the following Steering Groups:

- Service Transformation and Delivery
- Sustainability
- Compliance
- Culture and Organisational Development
- Strategy

1.2 The Dashboard gives high level commentary and associated Key Performance Indicators (KPIs) for this reporting period where appropriate. As projects come to completion the reader should note that project closure processes will be enacted to ensure that continued and sustained delivery moves into Business as Usual (BaU). Performance will be managed / reported within existing organisational governance and within the Trust's Integrated Performance Report (IPR).

1.3 The Trust is making progress in meeting CQC 'Must Dos' and risks and issues are actively managed through the Compliance Steering Group which meets on a weekly basis. Further work is required to ensure that we have the appropriate data to assure delivery for each of the projects. As part of the Trust's reporting it is intended to move to a system that provides information, data and assurance under CQC Domains as well as project delivery per se.

1.4 Integrated Project Plans will continue to be monitored to provide assurance to Trust Executives and Board and ensure that there is pace and grip in the complete portfolio of projects. That is, they will deliver the expected outcomes and objectives as defined in Project documentation.

1.5 This report highlights exceptions with more detail on progress within the Delivery Plan Dashboard (Appendix A)

Service Transformation

1.6 **Hear and Treat** – Challenges remain with delivery of the Hear and Treat project, in particular the recruitment of sufficient clinicians. The EOC Clinical Framework which involves reviewing working shift patterns, role development, and rotations from EOC into other clinical roles is

being developed which might help to support recruitment. RAG remains Red in this reporting period due to challenges in recruitment.

1.7 **Demand and Capacity Review** – This is progressing well, with reporting scheduled for late April 2018. The scope of this work has now been extended to include EOC which has had an expected effect on the final reporting date. RAG is Green for this reporting period.

1.8 **ARP Demand and Capacity Delivery** – A workshop is due to be held on 14th February 2018 which will bring senior leaders together from across the Trust to consider and influence what is required to implement the Demand & Capacity Review.

1.9 **Hospital Handover –** This project has now been established which will look at reducing the hours lost at ambulance handover with specific focus on reducing delays over 30mins and 60 minutes. The aim of the project is to also reduce the response times in the community. The RAG status for this Project is Red for this reporting period given the 1st use of this reporting methodology and recognised system challenges.

1.10 **National Ambulance Resilience Unit** – Following the 2017 National Ambulance Resilience Unit (NARU) review, a project group has also been set up to ensure compliance with all the domains by 30th October 2018. The Mandate and QIA have been approved. This project is in start-up and RAG rated Red accordingly.

1.11 A Service Transformation and Delivery Steering Group has now been established to oversee the delivery of the projects and provide strategic direction to ensure the projects deliver to scope, time and quality.

Sustainability

1.12 **HQ Phase 2** – This project is in the process of being closed with outstanding issues concerning the Banstead site being addressed as part of the refreshed Estates Strategy. The expansion of Coxheath is on track to ensure 51 fully resilient positions by March 2018.

1.13 **ePCR** – The ePCR project is being refreshed, having delivered identified deliverables. The new project is now in start-up and under the oversight of the newly formed Digital Programme Board. As such its RAG status is Red. A revised options appraisal paper will be produced for consideration at a future Executive Board meeting.

1.14 **CIP** – Plans are on track within this reporting period, see Pipeline Dashboard and Delivery Tracker for further detail (Appendix B and C). RAG status is Green within this reporting period.

1.15 The Digital Programme Board has now been established which will provide the correct level of governance for the approval of new digital projects; therefore any emerging digital projects or any projects with a digital or ICT element will be presented to the Programme Board for consideration and approval. The Programme Board is currently reviewing projects within the programme and will start reporting in the next month.

Compliance

1.16 **Incident Management** – This project is RAG rated Amber this reporting period due to the challenge the Trust is having to complete SI investigations within 60 days. To mitigate this risk, there continues to be focus on STEIS reporting.

1.17 **Safeguarding project** – This is RAG rated Green as the Trust has now achieved the expected 85% compliance for Level 3 Safeguarding training. Challenges remain with the interdependencies with other work streams. The Task and Finish group are working to ensure that there is a greater organisational commitment to progress this work.

1.18 **Risk Management** – This remains at Amber due to the risk to evidence equipment servicing requirements but additional support is being provided by the Quality Improvement hub which will help to mitigate this risk. The project is above trajectory on 2 measures: achieving individual risks that are not on Datix and identifying the number of Risk Registers that may be held locally.

1.19 **Governance and Health Records** – The Project is RAG rated Amber due to a lack of assurance that Codestat cardiac arrest data download software will be repaired in order for the clinical audit plan to be progressed. Discussions are progressing with IT and in the next reporting period, we would hope to share the results of the investigation into the issue.

1.20 **Complaints** – The Performance for NHS 111 is consistently high, with between 88% and 100% of complaints completed within timescale across the last three months. A&E performance has also improved, increasing from 36% in October to 63% in December 2017. The project is RAG rated Green as has it exceeded targets.
The Complaints project will undergo Intensive Support shortly in preparation for the Deep Dive on 14th March 2018.

1.21 **EOC** – The project is RAG rated Red. Mitigations in place are being considered to keep the EOC environment safe. ARP performance, incidents with the longest response for all categories are reviewed daily. Resources are reviewed regularly in addition to the Demand Management Plan (DMP). Team B meetings continue to take place on a weekly basis to

monitor performance alongside monthly EOC governance and Exec Area governance reviews, which focus on areas that could impact on quality and safety.

1.22 **Performance and AQI project** – The Project RAG remains at Amber. The project is delivering against trajectory although recognised system risks may adversely affect outcomes. The Integrated Performance Report provides further information and detailed reviews take place on a weekly basis between SECAmb and Commissioners.

1.23 **Medicines Governance** – This Project RAG remains at Amber as further improvement is still needed in relation to the tagging process and drug cabinet key losses on double crew ambulances. A CQC Deep Dive will be held on 19th February 2018.

1.24 **999 Call Recording** – Call recording and auditing continues on a weekly basis with issues resolved as soon as they are found. The Project is RAG rated Green due to a clear process to replace the telephony system.

1.25 **Infection Prevention and Control** – This project is RAG rated Red. The project is being established and a new project plan is in development. This will focus on the required behaviour change to ensure that the Trust is compliant.

1.26 Risk and Issue logs are continuing to be actively managed within and across Task and Finish Groups. Where it is deemed the group cannot meet a resolution, the risk/issue is escalated to the Compliance Steering Group/Turnaround Executive and, where appropriate, intensive support will be provided. This is where additional resources will be provided from the Quality Improvement hub.

1.27 Work is taking place to identify dependencies and interdependencies within projects and the impact of these on teams within the organisation. Implementation of actions within Improvement Action Plans for all CQC projects is ongoing with provision of data to measure outcomes and to ensure a focus on quality.

Culture and Organisational Development

1.28 **Culture and OD Programme** – The RAG status of this Project is now shown against 4 distinct areas. These are:

- Staff engagement – Amber
- Culture change phase 1 – Blue
- Culture change phase 2 – Amber
- Effectiveness of Communication and Engagement – Amber

1.29 Whilst the project remains on track in the delivery of key milestones, a risk of low staff awareness of the aims and objectives of the OD Programme may impact delivery. Further communication will be disseminated and the widening of the Steering Group membership/Barometer groups will help to mitigate this issue.

Strategy

1.30 **Enabling Strategy** – Rated as Amber due to a realignment of delivery timelines for all enabling strategies.

1.31 **Annual Planning** – Rated as Amber given clear dependencies into the Demand and Capacity review. Concurrent work is being undertaken where possible.

1.32 **Quality Improvement** – This Project is in start-up and as such rated Red. This status will be updated in the coming weeks following start up meetings and the commencement of any required procurement process.

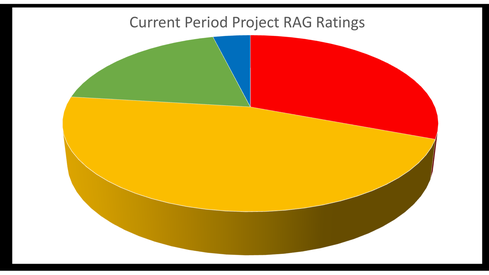
1.33 **Commissioner and Stakeholder Alignment** – This Project is rated Amber due to dependencies with external factors e.g. National Planning Guidance and Demand and Capacity Review. Concurrent work is taking place where appropriate to do so.

1.34 A Strategy Steering group will be established with key stakeholders to monitor progress on each of the key areas identified above. Appendix D outlines the Strategy timeline the Trust is working towards.

Delivery Plan Dashboard

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	Completed



South East Coast Ambulance Service NHS
NHS Foundation Trust

Reporting period from 20th January 2018 to 9th February 2018

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	CQC Deep Dive (where applicable)	Project Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
Service Transformation & Delivery Steering Group	Increased Hear and Treat	Red	Red	Scott Thowney	Joe Garcia	n/a	25.07.2018	The objective of the project is to ensure ambulance dispatch rates by appropriately and safely increasing the percentage of Hear and Treat cases from 6% to 10% from emergency call volume. The project is not on trajectory to ensure NHS Pathways compliance for recorded clinical support to call handlers as attrition continues to remain a challenge against recruited heads - current attrition year to date 28.8%. We have continued to remain 100% NHS Pathways licence compliant with an NHS Pathways Accredited clinician in EOC at 24/7 Development of the Audit infrastructure in line with the EOC Task and finish groups has led to Clinical EOC NHP Audit meeting trajectory forecast for clinical audit compliancy metrics. The integration of the Surrey Heartlands Pregnancy Advice line (ShPA) and development of the 'Labour Line' project to support call handlers and clinicians from EOC and face to face crews is on trajectory, with a high profile 'opening day' event supported by Baroness Cumberlege as the lead on the national review of maternity services scheduled for May 2018. Human Factors training was initiated within the EOC through a cascaded 'train the trainer' programme, supported by a nationally recognised lead provider supporting health care services (Terema).	45 clinical supervisors in post in EOC	32	45	45	Project RAG remains Red. This is as a result of the continued difficulty in recruiting appropriate clinicians into the role. The initial draft EOC Clinical Framework outline was discussed with project leads, identifying the primary reasons for staff leaving that will include working shift patterns, educational and role development, use of decision support software, potential rotations through EOC into the other clinical roles and the enhancement of the clinical navigator position. This is being developed into formal submission to Exec Team for review/approval to progress. The risks related to the delivery of the project are under review to ascertain whether any actions can be taken to mitigate risk. This project may move to a reduced RAG rating dependant on the outcome of the paper which is being presented to EMB.
									Hear and Treat Performance	6.0%	10%	10%	
	Demand and Capacity Review	Green	Amber	Jon Amos	Steve Emerton	n/a	13.04.2018	It should be noted that with the additional scope of the EoC the final report for this programme of work will be April 2018 with regular interim reports provided up to this deadline (including February 2018). The overall intention of this review is to evaluate and assess differing models of operational delivery taking into account current service configuration and then developing a clear cost base for such. This will then be factored into current and future contract placement with Commissioners. The outputs will include: - Review of historic demand and development of 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 compliance with the new ARP standards. - Timeline and transition plan to move from current state to the new rota profile, fleet mix etc.	Creation of fit for purpose, agreed operational model and service level options, together with evidenced costs and aligned resource, for agreement with commissioners				The completion date has moved from 1 March 2018 to 13 April 2018 and this is due to the scope of the project now including EOC. This has been signed off at the Demand and Capacity Review Oversight Group and included within the project plan. Subsequently there has been an increase in project budget. In addition to this, discussions are taking place vis-a-vis contractual arrangements beyond 31 March 2018 such that the Trust and Commissioners continue within an agreed (Contract Plan) financial envelope. With appropriate mitigations in place the status of this project moves from Amber to Green.
	ARP Demand and Capacity Delivery	Red	First reporting period so no previous RAG	Rob Mason	Joe Garcia	n/a	To be defined	Following the implementation of ARP Phase 2, which gives us more time to identify patients' needs, we have jointly commissioned a demand and capacity review with our Commissioners. This review, undertaken by Deloitte and ORH, is due to report by mid April. This project seeks to implement the findings that come out of that review and will likely define the operational, tactical and strategic plans to deliver financial and operational performance now and for future generations.	KPIs to be defined.				Project is RAG rated Red given that it is in start up. This project is dependant on the outcomes from the Demand and Capacity Review project.
	Hospital Handover	Red	First reporting period so no previous RAG	Gillian Wieck	Fionna Moore	n/a	30.04.2018	The aim of the project is to reduce the hours lost at ambulance handover with specific focus on reducing delays over 30 and 60 minutes. The aim is also to reduce the impact on response times in the community. A system wide steering group and two operational groups (East and West) have been established to deliver the improvement work needed to reduce hours lost as a result of handover delays across SECAmb area. An overall improvement for the following metrics is expected; hours lost at each hospital site, delays over 30mins and 60 minutes and improved response for category 3.	Handover delay no more than 60mins (by March 2018)	1209	N/A	0	This is the first report for this project using this methodology. The project is RAG rated Red. There are constraints within Acute trusts to meet the initial target of no delays over 60 minutes. There is a risk that granular detail around crew to clear time will not be available to support operations in delivering the 85% Crew to Clear target due to the capacity of the performance team.
									Crew to Clear time within 15mins 85% of the time	46.52%	N/A	85%	
	National Ambulance Resilience Unit	Red	First reporting period so no previous RAG	Chris Stamp	Joe Garcia	n/a	30.10.2018	The 2017 NARU Capabilities Review was undertaken last year which identified that the Trust was not compliant with 5 of the 7 domains. The aim of the project plan is to ensure full compliance with all key lines of enquiry by 30th October 2018. A project group has now been set up to deliver the objectives.	The KPIs have been identified. Data is not available for this reporting period.				Project RAG is Red due to tight timescales and cross directorate engagement required. The project is also in its early stages and it is not yet clear what support is needed. The project Mandate and QIA have been approved and the project plan is being developed.
Sustainability Steering Group	HQ PHASE 2	Amber	Amber	Paul Ranson	David Hammond	n/a	31/03/2018 previous date was 01/09/2018	Coxheath EOC Expansion (Phase 2) is on track to be completed by March 2018 (51 desks) The HQ Phase 2 Project was formally closed by the Chair of the Project Board (Director of Finance) on the 30 January 2018. The outstanding issues concerning the Banstead site and accomodation of Fleet & Logistics and Clinical Education are now to be addressed in the refreshed Estates Strategy hence the project completion date has been moved from 01/09/2018 to 31/03/2018.	51 desks to be operational by March 2018				Project RAG remains at Amber. Coxheath expansion remains on track to deliver. There is still a risk that Clinical Education and Fleet, Logistics and Production may not have vacated Banstead by 31st March 2018 however options are actively being considered and this relocation will be part of the Estates Strategy. As this project is in the process of being closed, it is anticipated that the RAG rating will be Green by the next reporting period.
	Electronic Patient Clinical Records ("EPCR").	Red	Red	Barry Thurston	David Hammond	n/a	29.03.2018	Temporary withdrawal of ePCR software to enable stability upgrades. The QIA highlighted significant risks and the pilot that was due to be undertaken at Thanet has not proceeded as planned. A revised option appraisal paper to be developed for consideration at the Executive meeting on 21 February 2018.					This project has delivered previous products and is being closed. Once the options paper has been considered and an appropriate option approved, the project will be reframed and restarted with a new Executive Lead under the oversight of newly formed Digital Steering Group.
	Financial Sustainability	Green	Green	Kevin Hervey	David Hammond	n/a	31.03.2018	On track to deliver. Some CIP schemes under-delivering but compensated for by additional schemes. Further CIP schemes under development.	£17.8 million current schemes fully validated	15.8m	£15.1m	£15.1m	Project RAG remains Green. Risk is assessed as low (specifically the likelihood of non achievement of the target) in this work area due to progress made. The Plan target is likely to be exceeded. As with all projects, risk will be continually monitored.
									£1.0 million of financial deficit forecast	£1.0m	£1.0m	£1.0m	

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	CQC Deep Dive (where applicable)	Project Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
Compliance Steering Group	Incident Management	Amber	Amber	Samantha Gradwell	Steve Lennox	08.Nov.17	01.08.2018	The Trust Incident Management process has been a reactive process used to identify harm and it was frequently perceived as a vehicle to punish staff when they were seen as causing the identified harm. The aim of this project is to ensure the Trust has an effective incident management system that clearly identifies learning and that learning is valued and shared widely across the Trust to continually drive improvements in safety.	20% increase in overall incident reporting (Monthly)	751	556	556	This project remains RAG rated Amber due to the combination of positive and negative test measures. Incident Management is progressing to plan whilst Serious Incident management is not to plan.There has been a renewed focus and changes to Duty of Candour.This should significantly improve the KPIs. The principle risk is the challenge the Trust is having to complete SI investigations within 60 days. The trust is currently at 0% for submission of SI final report to the CCG within a 60 day deadline. In order to address the backlog promptly, resource has been redirected temporarily. The system that we currently have in place addresses both the current within deadline SIs and the backlog. We anticipate that the backlog of SI reports will be removed in early March 2018. In addition we have now pooled resource to ensure that the current SIs remain within deadline.
									>75% of incidents closed within time target [SECAmb Target]	64.0%	62.0%	75.0%	
									90% of Serious Incident investigations will be completed within 60 working days.	0.0%	74.0%	90.0%	
									100% of Serious Incidents compliant with 72 hour STEIS reporting	91.0%	50.0%	100.0%	
									96% of incidents graded as near miss, no harm or low harm	94.0%	90.0%	96.0%	
									80% of incidents where feedback has been provided	8%	50%	80%	
									100% compliance with Duty of Candour for SIs	100%	90%	100%	
	Safeguarding	Green	Amber	Philip Tremewan	Steve Lennox	01.Dez.17	31.08.2018	The Trust did not fully appreciate its safeguarding obligations or understand the wider aspects of safeguarding. The development of the Safeguarding CQC Improvement Action Plan has allowed greater focus on the Trust-wide approach to Level 3 Safeguarding Children training, both face to face and e-learning. The Action Plan is divided into 6 key objectives aimed at addressing the concerns raised following the most recent CQC inspection and the Prof Duncan Lewis report into a culture of bullying and harassment at SECAmb. Weekly Task & Finish Group meetings scrutinise the Action Plan with assurances gained that positive progress is being made across each objective. The Trust has now achieved the expected 85% compliance for Level 3 Safeguarding training and further work will be undertaken to ensure that completion rates continue to increase.	The number of staff trained to level 3 Safeguarding	85.0%	85.0%	85.0%	Project is RAG rated Green. The Trust has achieved the expected 85% compliance for L3 Safeguarding Children training however the aim will be to achieve as close to 100% by the end of March 2018. There has been a drop of 2% in the actual numbers of staff feeling adequately prepared to identify safeguarding concerns compared to the previous month. Challenges remain with the interdependencies with other workstreams including Culture Change and the Bullying & Harassment issues that came out of the Duncan Lewis report. Objective 4 of the Safeguarding Improvement Plan has a strong focus on addressing inappropriate power relationships throughout the Trust and many of the actions in this objective aim to promote a more empowering and supportive staff environment. At present there is a risk that the safeguarding component of this work will stagnate unless there is greater wider organisational commitment to progress this work.
									90% 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 fed back through appraisal bulletins, local governance groups.	88.0%	n/a	90.0%	
	Risk Management	Amber	Amber	Samantha Gradwell	Steve Lennox	19.Jän.18	31.08.2018	Risk Management governance and systems were ineffective and roles and responsibilities were unclear. The Trust had an IT system that was not fit for purpose to manage the recording of the servicing data of medical devices. This caused input issues which were further aggravated by a lack of any real audit process being in place. The aim of the project is to ensure that the Trust will have effective risk management governance and systems, with clear roles and responsibilities identified. Learning is valued and shared widely across the Trust to continually drive improvements in safety. All Medical devices will be serviced, maintained and available to all operational members of staff in accordance with the Medical Devices Management Policy, and security of all Trust operational premises and ambulance vehicles will be upheld.	Individual Risks Reviewed on Datix With Principle Risk Lead (includes training & awareness)	130	126	140	Project RAG remains at Amber. The Trust has completed the work to identify the number of Risk Registers that may be held locally. Although this has been completed we have recently identified the presence of further significant work related to local Health and Safety risk assessments which need to be reviewed and possibly placed onto the corporate risk register. The necessary governance work being undertaken to address this may have an affect on project milestones. Further work is being undertaken to identfy proposed solutions.The Trust is above trajectory for revewing risks on Datix with the appropriate risk lead and this work will soon be completed. The main risk within this workstream is our ability to evidence equipment servicing requirements, but the improvement team are confident that the planned actions will deliver to plan. The data for the auditing of Medical Devices is incomplete for the period due to a lag in the recording process.
									Operational sites & Directorate Risk Registers Identified Other than Datix	29	25	29	
									Audit of Medical Devices	38%	53%	80%	
	Governance, Records & Clinical Audit	Amber	Amber	Dean Rigg	Fionna Moore	19.Jän.18	31.03.2018	The Trust did not complete Patient Clinical Records accurately, there was a lack of identified training opportunities for staff and there were delays and inefficiencies in processes involving the recovery and scrutiny of health records. The overall aim of the project is to increase the quality and efficiency of the Trust's completion, storage and audit of health records. The Patient Clinical Record form (PCR) is to be redesigned to increase ease and efficiency of completion, and therefore elicit greater compliance and quality. The current PCR audit system is a check of completeness of the form against the requirements of the Minimum Data Set. A process for scrutinising the quality of the data entered is in development.	Patient Records will be completed accurately	51.0%	75.0%	90.0%	Project RAG remains Amber due to a lack of assurance that Codestat cardiac arrest data download software will be repaired in order for clinical audit plan to be progressed. We are still awaiting assurance from IT around the scale of the repairs required and the timescales for completion. Quality Improvement methodology risk remains in place. Although the Trust has now agreed a methodology, the plan and timelines for implementation are yet to be defined. Good progress has been made in ensuring the accuracy of PCRs, with improved uptake of a new audit process which will be further developed. However, the data collected has revealed that compliance with the PCR minimum data set is lower than expected. Project timescales and trajectories will be reassessed in light of this new data. Focussed improvement work on problem areas has commenced and will continue to be developed. An external contractor has been identified to undertake scanning and indexing of forms that are not compatable with Formic, with contract arrangements being supported by procurement.
									Incidents will have Patient Clinical Record linked	85.7%	N/A	90.0%	
	Complaints	Green	Amber	Louise Hutchinson	Steve Lennox	14.Mär.18	31.03.2018	There was a lack of attention paid to complaints and the value of learning from them. Sufficient priority had not been afforded to these processes throughout the organisation. The aim of the project is to restore complainant/patient confidence in our service; to generate improvements in the treatment and service provided to patients and their carers as a result of learning from complaints; and to reduce the likelihood of problems recurring, and raise awareness among staff of the value of complaints as a tool for improvement by sharing the learning from complaints widely. Overall improvement was not as rapid as expected owing to an issue with recruiting to a dedicated post, hosted by EOC, to investigate low-level complaints about EOC and ambulance delays. Following a dip on performance as a result of the high demand, BCIs, annual leave and sickness over the Christmas and new year period, there has been a considerable improvement in compliance with the complaints response timescale.	Complaints will be concluded within the Trust's target of 25 working days.	94.7%	n/a	80.0%	The Project RAG has moved to Green as it has exceeded its target to conclude complaints within 25 working days. The team is confident that this level will be sustainable. The EOC member of staff dedicated to investigating low-level EOC complaints is now in place. Consideration is being given to the structure within EOC to ensure the investigation of low-level complaints within EOC is continued during periods of staff absence. A process mapping exercise has been scheduled for 12 March 2018 to review the complaints process to assess whether there is scope for further improvement. Data relating to shared learning of complaints will be available from March 2018.
									Evidence of learning from at least 95% of complaints that are upheld in any way.	100.0%	n/a	95.0%	
									100% of Area Governance Meetings, Clinical Evaluation & Effectiveness Sub-Group meetings will have shared learning from complaints.	Data not available	n/a	100.0%	
	EOC	Red	Red	Sue Barlow	Joe Garcia	18.Apr.18	31.08.2018	The Trust had not invested sufficiently in recruitment and retention within the EOC. Moving EOC West to Crawley has also had an impact on recruitment. Staffing and supervision levels are impacting significantly on the Trust's ability to meet the requirements for clinical supervision, call answering and call auditing set out in NHS Pathways. The aim of this project is to recruit, train, retain and appropriately deploy sufficient levels of staff in all EOC roles to achieve the target for call answering, clinical supervision and call auditing. Clinical Supervisor Recruitment and Retention is progressing which has an interdependency with the Hear and Treat Project. Call audit figures remain significantly adrift of the trajectory that would meet the requirement of approx. 1300 by April 2018. Staffing capacity is an issue. Outsourcing the function is being considered but has so far not developed into a sustainable plan/model. To help to mitigate this, the EOC Audit User Group is now established and is working with the 111 to develop the auditing and tracking tools and to establish a dedicated team who will complete future auditing. Call answer is adrift and impacts heavily by the EMA recruitment issues. EMA recruitment levels are now rising with January seeing 23 new recruits. Plans are also now in place to begin reviewing EMA rotas with interviews arranged for EMAs.	Clinical supervisors in post in EOC	33	45	45	Project RAG remains Red. Mitigations are being considered to ensure the EOC environment is safe whilst it has recruitment issues and address the increase in attrition. Daily call reviews, weekly Team B meetings and monthly quality and safety reviews continue to take place. The DMP is reviewed daily to understand the number of calls outstanding to ensure the clinical risk is being managed. Call answer trajectory was achieved for January 2018. The recent issue concerning the inability to retrieve calls for 3 weeks in December 2017 has now created a backlog. To mitigate this, resource in 111 and EOC is now refocused to carry out audits.
									The audits will take place on a monthly basis via an audit function on the info system which was created by SECAmb	36.5%	40.0%	100.0%	
									95% of calls answered within 5 seconds.	74.6%	70.0%	95.0%	
									FTE EMAs in post within EOC	154	160	171	

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	CQC Deep Dive (where applicable)	Project Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
	Performance Targets and AQIs	Amber	Amber	Chris Stamp	Joe Garcia	31.Aug.18	30.09.2018	The Trust has consistently performed poorly against some of the national performance indicators. The objective of this project is to improve compliance with national clinical and response time ambulance quality indicators. The project remains on trajectory to meet response time standards. (Category 1, Category 1T, and Category 2.) As of August 2017 50% of clinical AQI targets have been achieved with significant improvement to the remaining trajectories. Static planned targets have been included for baseline reference. However, we aim to meet or exceed national averages, which will change monthly.	Category 1 (90th centile) mm:ss	14:25	15:00	15:00	Project RAG remains Amber. Whilst the project plan is consistently on trajectory to meet performance targets, there remains a wider risk to meeting commissioned performance trajectory. Further information around this can be found on the Datix risk register (No123). Several dependency workstreams feed into this project. These remain on trajectory and are anticipated to further improve the primary KPI outcomes and remaining CQC should dos by their target dates. Internal and External/System risks and issues (for example Hand Over Delays and Staff Retention) will continue to have an impact on performance but are managed via detailed discussion at separate forums and the PT&AQI Task and Finish groups.
									Category 1T (90th centile) mm:ss	19:07	30:00	30:00	
									Category 2 (90th centile) mm:ss	28:34	40:00	40:00	
									STEMI (care bundle)	64.40%	81%	73.80%	
									Stroke (care bundle)	95.60%	98%	97.50%	
									Cardiac Arrest Survival (Combined)	25%	20.50%	19%	
									ROSC (Combined)	40.50%	41.50%	42.30%	
	Medicines Governance	Amber	Amber	Carol-Anne Davies-Jones	Fionna Moore	19.Feb.18	31.03.2018	The Trust had insufficient resource and inadequate governance and oversight of medicines. The aim of the project is to identify improvements that need to be made with regards to structures, systems and training. This will guide medicines optimisation within the Trust to ensure it is integrated into our systems, work practices and culture at all levels from individual practitioner to Board. Progress continues on the safe, secure storage of medicines and the culture change around medicines, including further strengthening governance process, pathways, legislation and on-going education/training as well as implementation of NICE good practice guidance. To measure progress we now have data on CD Breakages, Drugs Cabinet Key Losses, Compliance % per OU and Medicines Quiz Passes. A Mediciines Optimisation Strategy has been published and the medicine policy has been rewritten with staff consultation.	Medical Quiz Passes	1212	1275	2425	Project RAG remains at Amber. There are still further improvements needed in relation to our tagging process and drug cabinet key losses on double crew ambulances (DCA) and plans are in place to address this. This will continue to be monitored through the Task and Finish Group.
									Compliance per Operating Unit	97.00%	97.50%	100%	
									Drug cabinet key losses	7	0	0	
									CD Breakages	5	0	0	
	999 Call Recording	Green	Green	Barry Thurston	David Hammond	n/a	30.03.2018	The voice recording system has failed to record all 999 calls since January 2017. The aim of this project is to ensure that we have a robust voice recording system and the Trust will keep 100% of completed and accurate recordings of 999 calls. 24 calls have been audited throughout November 2017 and no issues found with call recording. 24 hour audits suspended in December 2017 due to winter pressures but auditing has started again from 05 January 2018. Daily testing of calls continue and if they are any issues found, this will be escalated to the Compliance Steering Group. A business case was approved at Trust Board (11th January 2018) to replace both the voice recording and telephone system. A project mandate and QIA will be produced shortly with a new project plan developed.	100% of all 999 calls recorded				Project RAG remains Green. There is a plan in place to replace the telephony system.
									Auditing of calls take place on a weekly basis from 05 January 2018 (circa 2500 calls)				
									Approx. 15 sample calls carried out				
	Infection Prevention and Control	Red	Red	Adrian Hogan	Steve Lennox	n/a	31.08.2018	Since November 2010 the Trust has had one person delivering the IPC programme on a day to day basis and this has led to a disconnect in the knowledge and awareness that staff delivering patient care require to ensure that no avoidable healthcare associated infections (HCAI) occur. The last two CQC inspections have highlighted the lack of resources within the IPC Team and have also evidenced poor IPC practices from staff including, hand hygiene, compliance to Bare Below the Elbows (BBE), lack of actions shown following IPC audits and cleanliness standards in vehicles and the environment. The aim of this project is to help support the engagement of staff and embedding of IPC practices across the Trust and will focus on compliance to hand hygiene procedures, compliance to BBE, cleanliness standards for the vehicles and the environment, ensure there are audit tools to provide assurances, support staff following an untoward incident and embedding IPC into practice across all structures of the Trust and most importantly to the staff. A workshop was held on 11 January 2018 to determine the scope of the project and a Project Mandate and QIA is currently being developed.	KPIs and Outcome measures unconfirmed within this reporting period - in development				Project RAG remains Red. A Project Mandate and QIA will be signed off imminently. The plan will focus on a new procedure for IPC, which will encompass all elements of practice to ensure that patients and staff come to no harm. This procedure will be known as Infection Prevention Ready and the first draft is in discussion. The risks are still around compliance to elements of IPC practice, such as hand hygiene and Bare Below the Elbows. A plan is in development to progress this project.
Culture and Organisational Development Steering Group	Culture Change	Amber	Green	Clare Irving	Steve Graham	n/a	31.03.2018	The first objective in this workstream relates to Staff Engagement. The issue of staff engagement was raised by CQC and in the Duncan Lewis report. The milestones set in this objective are designed to address those comments and relate specifically to: improving the proportion of staff participating in regular career conversations (objective setting and appraisals); the effectiveness of communications with staff; addressing bullying and harassment in the workplace and responding to, and engaging staff with, feedback received via the annual Staff Survey. All milestones in the five milestones associated with this objective are completed or on track.	Appraisal completion rate (completion by 30th April 2018)	79.0%	60.0%	80.0%	Whilst the project remains on track to deliver the key milestones with current capacity within the team, there is a risk that a lack of staff awareness of the aims and objectives of the OD Programme may impact delivery. Further communication will be disseminated and the widening of the Steering Group membership/Barometer groups will help to mitigate this issue.
									Staff Survey completion rates	39.6%	N/A	40.0%	
		Blue	Green				31.01.2018	The second objective in this workstream is to deliver Phase One of a two phase culture change programme. This phase includes the development of methodology and prinicples of change, the development of a high level plan and a review of the enabling infrastructure. All the actions in the milestones linked to this objective have been completed.	Methodology and Principles completed				
		Amber	Green				31.07.2018	The third objective is the implentation of Phase Two of the culture change programme. This objective has 3 milestones relating to review and implementation of policies to support the culture change programme; implementation of the programme of behavioural skills development and interventions; staff engagement with the local response to the National Survey. All actions are in progress in line with the action plan	Pulse surveys, QAV visits, Barometer group will be used to measure the outcomes				
		Amber	Green				31.08.2018	The final objective in the Action Plan relates to a review of the effectiveness of the communication and engagement relating to the Culture Change programme and actions.	Pulse surveys, QAV visits, Barometer group will be used to measure the outcomes				
Strategy	Enabling Strategy	Amber	Amber	Jayne Phoenix	Steve Emerton	n/a	30.09.2018	The plan was revised 06/02/18 following the executive meeting. This has refined and extended (where appropriate) timelines. Consideration is being given to ensure interdependencies between enabling strategies are taken into account and to ensure timescales fit with wider planning guidance. The extended timelines address available capacity and expertise for key areas. We have also revised which plans can be combined into one. As result there are now 20 enabling strategies listed. Of those 5 are complete and published. A further 13 will be completed by September 2018. Refer to Appendix D for the Strategy Timeline the Trust is working towards.	All strategies completed by agreed timescales.				This project remains at Amber due to the possible delays to delivery due to unforeseen interdependencies, and to limitations or changes in capacity. The baseline target to deliver moves across into the new financial year.
	Annual Planning	Amber	Amber	Jayne Phoenix Philip Astell	Steve Emerton	n/a	31.03.2018	Following the executive workshop held on 24th January 2018, it was agreed to begin to review the overarching strategy in February as part of our annual planning and as the demand and capacity work concludes. This will result in a revised strategy being published in May once we have the outcomes of the demand and capacity review agreed. During this period we will be engaging with internal and external stakeholders on both the demand and capacity plan and the overarching strategy. Business Planning is underway. The National Guidance was published on 2nd February 2018 and states we are required to have our draft operating plan in place by 8th March 2018 and the national contract CV signed by 23rd March 2018. We are in discussion with Commissioners regarding contractual arrangements for 2018/19. A series of Board development sessions are being planned at which it is intended to review the Trust's immediate priorities, discuss and agree the long term vision and aims of the Trust, and enhance the Trust Board's ways of working in the round.	Completion of budget planning, CIP planning, strategy review, workforce planning and operating plan – different components will develop during the period now until 31st May 2018 with final outcome being subject to outcome of the demand and capacity plan.				This project RAG remains at Amber due to its links to the Demand and Capacity Review.
	Quality Improvement	Red	Amber	Jon Amos	Steve Emerton	n/a	Ongoing	The Trust has agreed to use a QI methodology and a draft scope has been developed. A business case is under development following which consultancy support to implement the methodology across the organisation will be procured.	An approved quality improvement methodology is agreed and implemented.				This project is RAG rated Red. A plan for this project is yet to be developed.
	Commissioner and Stakeholder Alignment	Amber	Amber	Jayne Phoenix	Steve Emerton	n/a	Ongoing	Commissoning and Engagement strategy will include plans to focus engagement immediately on STP Leads/CEOs/Accountable Officers. The initial focus will be on the outputs of the Demand and Capacity Review. A stakeholder log has now been created which will allow the Trust to track briefings and also forecast future formal and informal engagements with stakeholders.	Alignment of commissioner and stakeholder expectations with delivery and operating plans for 2018/19				This project is RAG rated Amber due to the dependency on the Demand and Capacity review timetable. Engagement work is being undertaken concurrently with the Demand and Capaity Review project.

Red	8
Amber	12
Green	5
Blue	1

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 10 - January 2018

Programme Summary:

1. Fully validated and Pipeline schemes of £18.4m, on track to deliver the target of £19m.

2. £17.8m of fully validated savings as at 12 February 2018 reporting date- c. £16.4m cost savings and £1.4m cost avoidance moved to delivery tracker. CIP schemes are moved to the Delivery Tracker after approval by Exec Sponsor and QIA sign off.

3. Positive engagement with Execs and CIP Project Leads and effective participation in Financial Sustainability Steering Group meetings. CIP Programme governance framework and processes are fully functioning in the business.

4. Working collaboratively with Project Leads and Execs to develop further schemes 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	

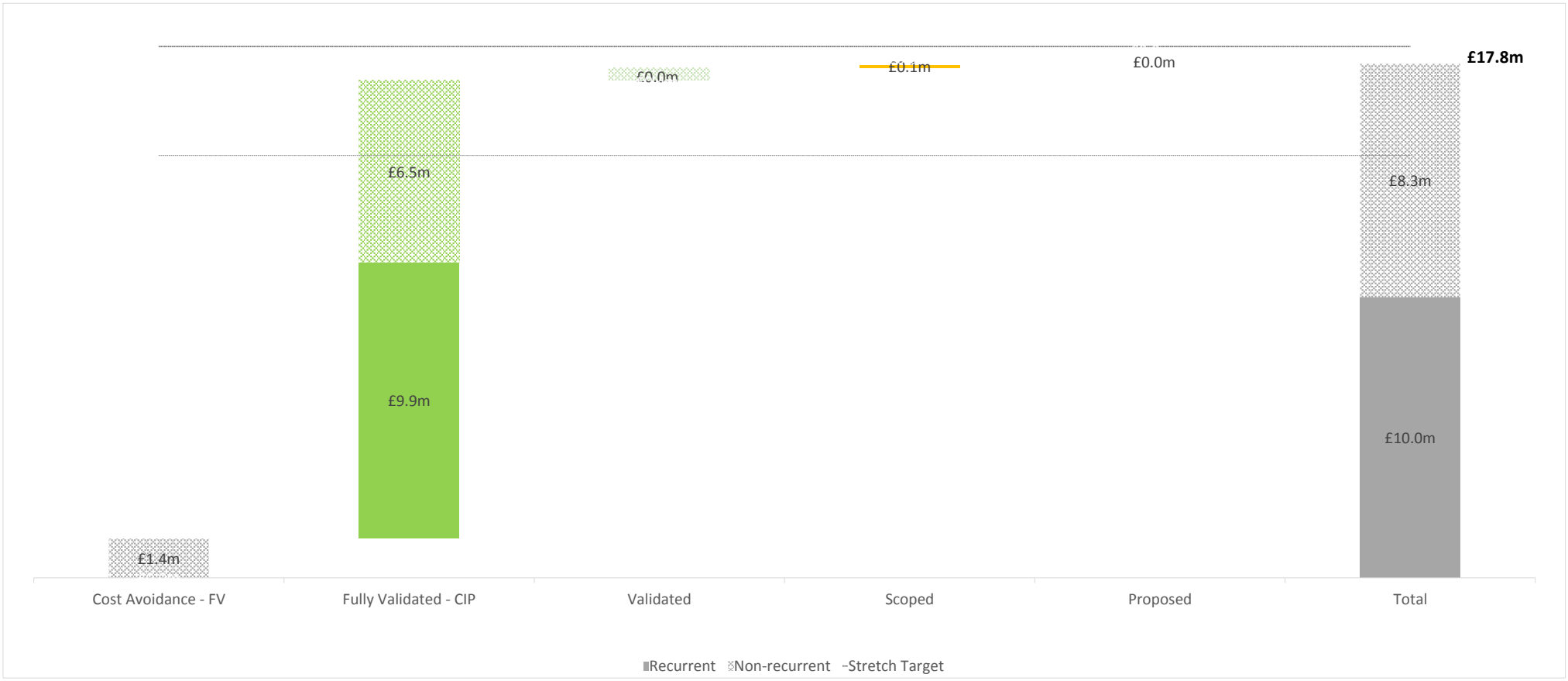
CIP Pipeline and Delivery: Risks and Issues

	Risk	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Inability to identify a reasonable proportion of recurrent schemes to build a sustainable CIPs pipeline for future years.	Robust review of existing non recurrent schemes in progress. Working collaboratively with budget leads to review approved business cases and scope and develop further recurrent schemes during the 2018/19 budget process.	Kevin Hervey	Amber	Amber	28/02/2018

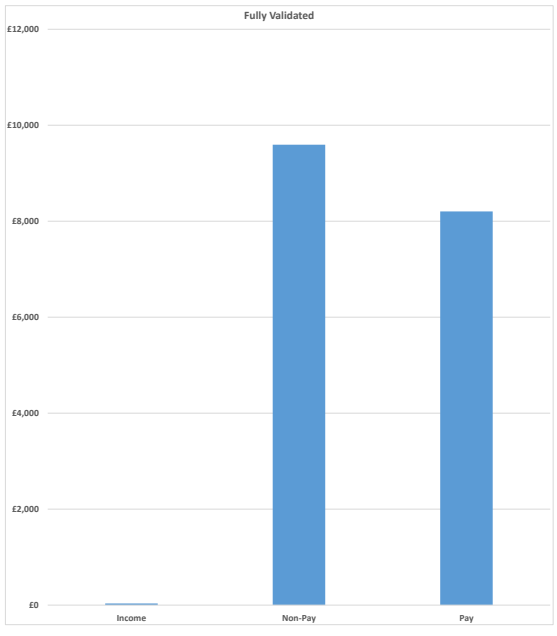
	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Delays in restructures impacting on anticipating agency savings	Liaising with relevant budget leads to monitor potential delays. Working with Budget leads and Finance Business Partners to establish and resolve issues relating to under delivering schemes. Further schemes under development to compensate.	Kevin Hervey	Amber	Amber	28/02/2018

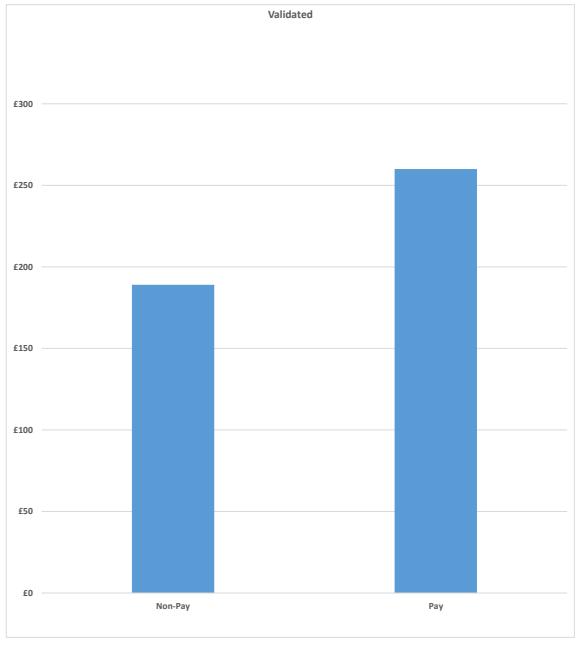
CIP Pipeline Summary

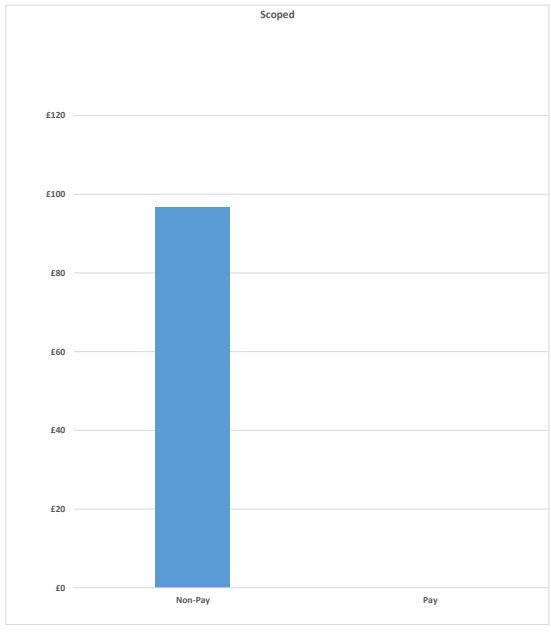
Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£1,400	£16,434	£449	£97	£0	£18,379



Pay / Non-Pay / Income Breakdown







South East Coast Ambulance Service: CIP Workstream

CIP Delivery Dashboard

Reporting Month Jan-18

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 £12.7m CIP savings year to date (YTD) 10 months to January 2017. This exceeds the NHSI plan of £12.3m by £0.4m. Recurrent schemes represent 53% of the total.

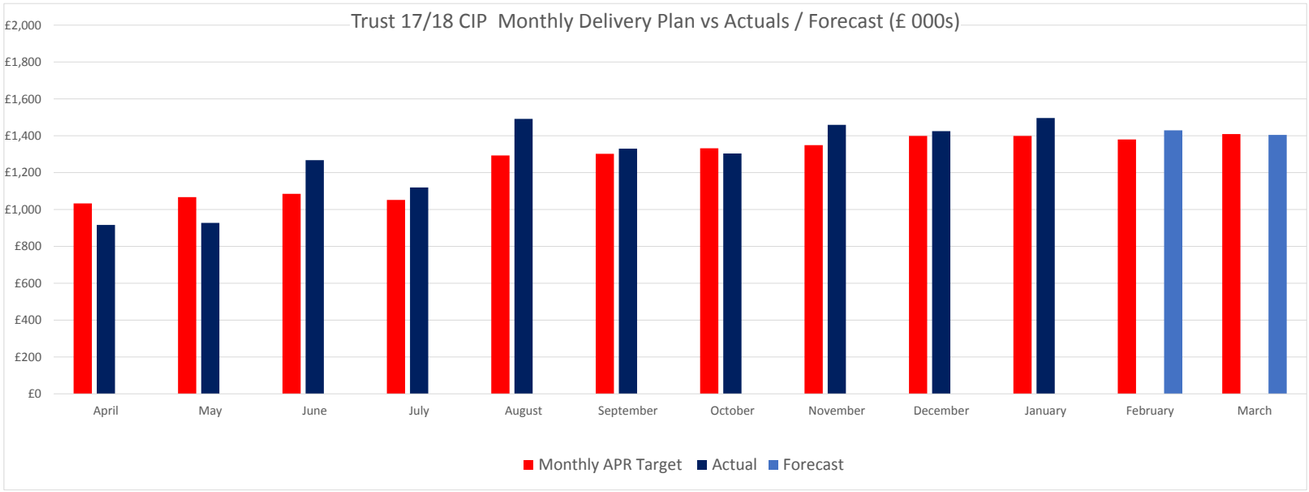
2. £17.8m of fully validated savings have been transferred to the Delivery Tracker as at 11 February 2018 reporting date.

3. The full year CIP forecast savings of £15.6m is on track to deliver beyond expectation. This is £0.5m ahead of the 2017/18 NHSI target.
This is risk adjusted to reflect the £2.3m shortfall in the fully validated schemes due predominately to underachievement in Agency premium and Task Cycle Time (TCT). Agency premium is tracking £0.9m below target as the delays in restructures across the Trust continue to require the retention of interim staff to cover key established posts. The CIP scheme for TCT of £1.2m has been withdrawn in discussion with the Operations Director due to current pressures on frontline performance targets. Recurrent schemes make up 55% of the total projected CIPs savings.

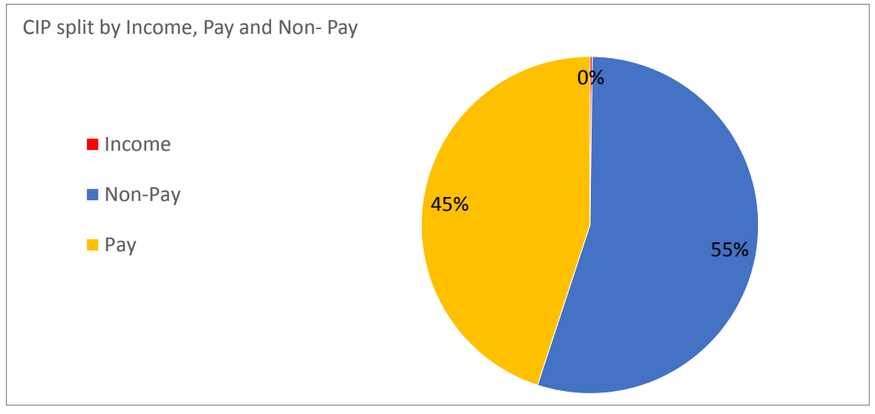
4. Regular review meetings with Budget Leads and Finance Business Partners are on going. This is currently focused on identifying new schemes to build a sustainable pipeline of recurrent schemes for future years.

1. Monthly CIP Trust Profile - as at 31 January 18

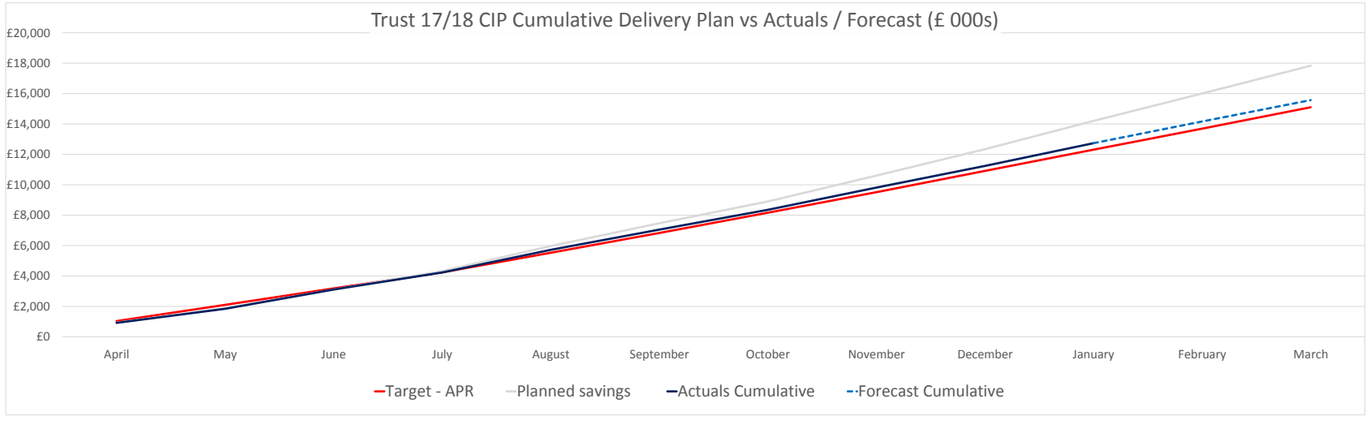
CIP Target for 17/18 £000's	Total planned savings on delivery tracker £000's - as at 31 January	Total forecast savings on delivery tracker £000's - as at 31 January	YTD Jan 18 - Target Savings £000's	YTD Jan 18 - Actual Savings £000's	YTD Jan 18 - variance £000's
15,100	17,834	15,570	12,311	12,736	425



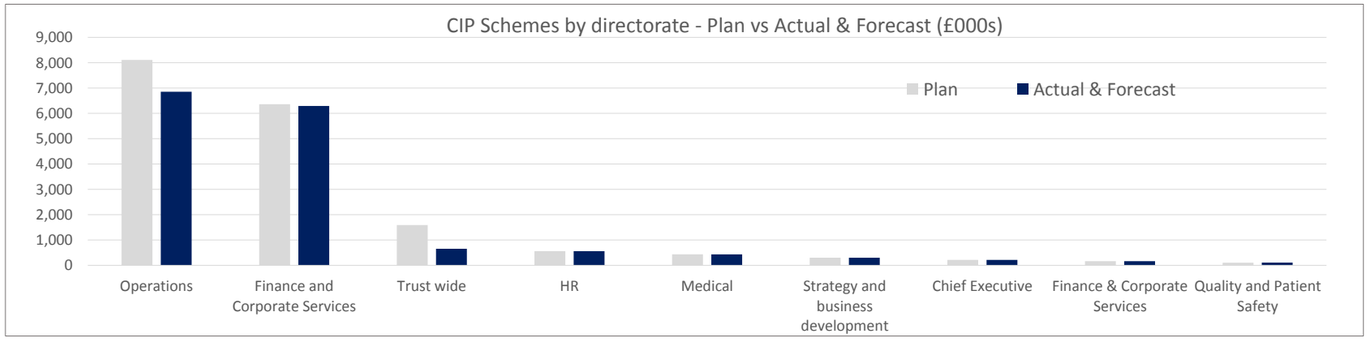
2. CIP - Planned savings split by income, pay and non-pay: as at 31 January



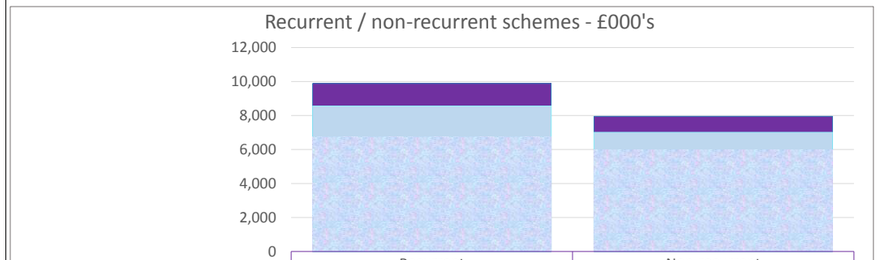
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2017/18



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

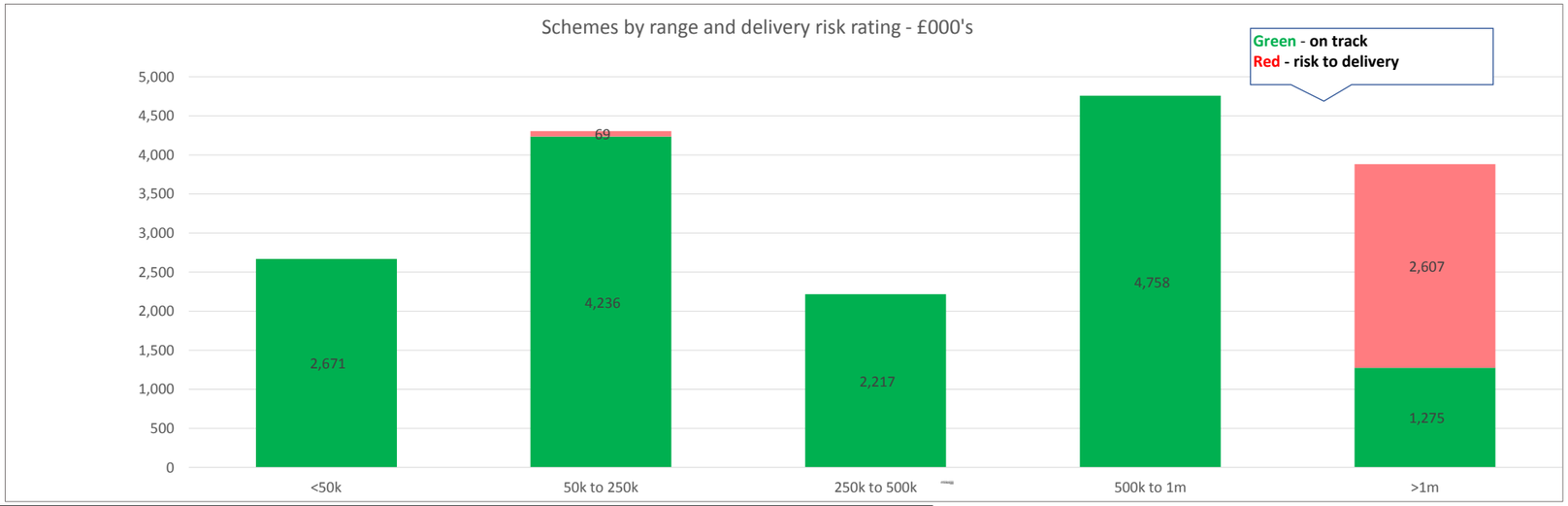


5. Value of forecast recurrent and non-recurrent savings - 31 January 2018



	Recurrent	Non-recurrent
Planned CIPs total	9,884	7,951
Sum of Actual and Forecast Cumulative	8,558	7,012
Sum of Jan - cumulative Actual	6,742	5,995

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



7. YTD Identified CIPs to Date and Savings - December Reporting Period

Scheme Category	2017/18 Value of Fully Validated Schemes - £000	2017/18 Forecast Value £000	Full Year Variance £000	YTD Planned / Fully Validated Schemes Savings (Month 10): £000	YTD Actuals (Month 10): £000	YTD Variance £000	Comments (+/- £20k variance)
Accounting efficiency	£4,705	£4,705	£0	£3,861	£3,862	£0	-
Meal break payment	£1,969	£1,969	£0	£1,709	£1,710	£1	-
Agency Premiums	£1,510	£571	(£939)	£1,259	£553	(£706)	YTD Underachievement - ongoing monitoring and corrective action in progress
Operations Efficiency	£1,435	£228	(£1,207)	£893	£177	(£715)	YTD underachievement in Task Cycle Time scheme - project has been withdrawn and is reflected in the FOT
Vacancies - clinical	£1,364	£1,364	£0	£1,190	£1,190	£0	-
Vacancies - non clinical	£1,233	£1,233	£0	£1,190	£1,193	£3	-
Fleet - Fuel: Telematics, Bunkered Fuel & Price Differential	£838	£838	£0	£747	£747	£0	-
Fleet Maintenance	£650	£650	£0	£217	£217	£0	-
External consultancy & contractors	£622	£622	£0	£516	£516	£0	-
MRC efficiency	£553	£553	£0	£433	£433	£0	-
Estates and Facilities management	£489	£489	£0	£334	£334	£0	-
EPCR efficiency	£310	£241	(£69)	£235	£201	(£34)	YTD underachievement in EPCR printing - project is not expected to deliver and is reflected in the FOT
111 Efficiency	£300	£250	(£50)	£167	£150	(£17)	YTD under delivery in AHT scheme - alternative scheme scoped to compensate
Training courses & accommodation	£271	£271	£0	£197	£197	£0	-
Staff Uniform	£253	£253	£0	£207	£207	£0	-
Discretionary Non Pay	£163	£163	£0	£115	£115	£0	-
IT productivity and Phones	£153	£153	£0	£125	£125	£0	-
Meeting room hire	£146	£146	£0	£121	£121	£0	-
Stationery	£143	£143	£0	£125	£125	£0	-
Furniture & Fittings	£133	£133	£0	£110	£110	£0	-
Travel & Subsistence	£99	£99	£0	£91	£91	£0	-
Medicines Management - Consumables	£93	£93	£0	£77	£77	£0	-
Medicines Management - Equipment	£90	£90	£0	£73	£73	£0	-
Legal cost	£78	£78	£0	£61	£61	£0	-
Books & Subscriptions	£58	£58	£0	£49	£49	£0	
Single HQ /EOC Benefits realisation	£53	£53	£0	£34	£34	£0	-
Public relations	£47	£47	£0	£39	£39	£0	-
Medicines Management - Drugs	£44	£44	£0	£4	£4	£0	-
Events Income	£35	£35	£0	£26	£26	£0	-
Variance to YTD Target	-	-	-	(1,893)	-	£1,893	Variance between YTD Identified Schemes and Control Total Target
Grand Total	£17,834	£15,570	(£2,264)	£12,311	£12,736	£425	

Enabling Strategies 6/2/18

Blue = completed

Red = overdue

Strategic Theme	Strategy	Timespan	Executive Lead	Managerial lead	Completion date (End of)	Review date	Status /Progress
People	Workforce	2017-2022	Steve Graham	Alison Walker	March 2018	Tbc	
	Clinical Education	2018-2022	Steve Graham	Sally Wentworth James	February 2018	Tbc	In progress relies on getting workforce one complete
	Apprenticeship	2018-2022	Steve Graham	Sally Wentworth James	March 2018	Tbc	
	Organisational Development	Tbc	Steve Graham	Tbc	April 2018	Tbc	
	Health and Well being	2017-2022	Steve Graham	Angela Rayner	-	2021	Published April 2017
	Volunteers	2017-2022	Joe Garcia	Tim Fellows	May 2018		
Patients	Medicines Optimisation	2017 – 2022	Fionna Moore	Carol – Anne Davies- Jones	November 2017	March 2018	Approved at EMB 3/1/18
	Clinical Strategy – to encompass Quality and Safety (including cardiac arrest)	2018 – 2022	Steve Lennox/Fionna Moore	Kathy Jones	April 2018	Tbc	
	Safeguarding	2017-2020	Steve Lennox	Philip Tremewan	November 2017	Tbc	Ratified at Board 29/11/17
	Governance this will incorporate risk strategy in future	2017 – 2022	Peter Lee	tbc	June 2018	tbc	To set up meeting in January 2018 to agree scope and who works on.
	Risk Management	2017/18	Steve Lennox	Sammy	March 2017	March	Published April 2017 will be

				Gradwell		2018	reviewed to be incorporated into above
	Research and Development	2017-2020	Fionna Moore	Julia	February 2018	Tbc	
Enablers	Fleet	2017-2022	Joe Garcia	John Griffiths	March 2018	Tbc	
	Estates	2017-2022	David Hammond	Paul Ranson	March 2018	tbc	Sent Paul template and example
	Digital and ICT	2018-2022	David Hammond	Barry Thurston	March 2018	Tbc	
	Long term Financial Plan	2017-2022	David Hammond	Philip Astell	September 2018	tbc	
Other	Communications and Engagement	2017-2022	Daren Mochrie	Janine Compton	Tbc	Tbc	Survey of Communications and Engagement activities being conducted at present and will then shape timetable for work
	Inclusion strategy (includes Equality and Diversity)	2016 – 2021	Daren Mochrie	Isobel Allen	-	Annual	Published April 2016
	Commercial /Business	2018-2022	Steve Emerton	Jayne Phoenix	May 2018	March 2019	

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	178/17

Name of meeting	Trust Board
Date	23 February 2018
Name of paper	**Update on Culture Change Activity**
Executive sponsor	Daren Mochrie, Chief Executive
Author name and role	Mark Power, Interim HR Director
Synopsis	The Trust Board has approved a comprehensive change programme that aims to address a number of underlying cultural issues highlighted, most recently, by the CQC Inspection and Duncan Lewis reports. Supported by external expert change management resource, the programme's design and delivery is informed by a well-proven behavioural change methodology. Phase 1 of the programme concluded in January, and has established a solid foundation from which the main delivery phase (Phase 2) is now being implemented. Key deliverable during this phase included programme design; the establishment of a robust project management and governance infrastructure, through which the programme is being led; awareness-raising; the revision of the Trust's core values; and the determination of agreed associated behaviours. This latter activity was undertaken with the full involvement of staff. Phase 2 focuses on the delivery of a series of mandated training modules for all members of the senior management community, and all managers down to and including OTLs, combined with the provision of professional coaching and multi-source feedback interventions. The remainder of the workforce will have an opportunity to participate in more condensed modular training. Effective communications and staff engagement continue to represent important success factors in the delivery of the programme, and this is a key work stream. The importance of measuring impact and improvement is also recognised - hence, a number of performance metrics have been identified and are being tracked.
Recommendations, decisions or actions sought	The Trust Board is asked to note the contents of this paper, and to continue to receive regular future updates.

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

Update on Culture Change Activity

1. Introduction and Context

1.1 At its meeting in December 2017, the Trust Board received a paper that provided a summary of an important organisational development (OD) initiative aimed at tackling those underlying cultural and internal safeguarding failings which, historically, allowed poor practices to prevail in some parts of SECAmb. Through direct feedback arising from staff consultation, four main improvement themes emerged as priorities for the organisation, 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.

1.2 In order to respond to these priorities, it was imperative for the Trust to embark upon an ambitious programme of work designed to fundamentally and sustainably change SECAmb's workplace culture in a way that has a measurable and positive impact in improving working environments, staff and patient experience, and service performance. The programme underpins the delivery of both the Trust's Unified Improvement Plan, and the five-year Strategic Plan, and its development and delivery are being strongly assisted by external expert resource (via Ignite Consulting).

1.3 In endorsing the programme, Trust Board members recognised that culture change is a major OD task that will necessitate the application of a well-planned and systematic Trust-wide approach, combined with effective leadership, persistence and consistency in its delivery and sustainability. Furthermore, the work will underpin all aspects of SECAmb's operations and represents a critical factor in ensuring the organisation's future success.

2. Purpose

2.1 The purpose of this paper is to provide an update on the Trust's culture change programme, by summarising the work undertaken during Phase 1 (October 2017 to January 2018). The paper also describes the activity associated with Phase 2 (February to July 2018).

3. Culture Change Programme - Phase 1 (Preparation and Infrastructure)

3.1 The relocation to the new Crawley Headquarters of a significant number of staff undertaking both operational and support function roles marked an important first step in SECAmb's culture change work and provided an excellent platform from which to apply learning and build momentum. Having provided expert change

management and project support, both prior to and during the relocation and consolidation activity, Ignite Consulting was further commissioned as the Trust's partner to assist in developing and implementing the key activity relating to the broader culture change programme. The Trust Board was informed of the main provisions of the two-phase programme, and received a copy of the associated high-level plan, which included key interventions and delivery timescales.

3.2 Phase 1 activity concluded, slightly behind schedule, in January (a delay occurred whilst agreement was sought from NHS Improvement to provide further financial support to the programme). This first phase was concerned with ensuring the necessary preparation was completed ahead of the main delivery phase, and drew heavily for direction on the Trust's Strategic Plan, and the outcomes of both the Care Quality Commission (CQC) Inspection report and the Duncan Lewis report on perceived bullying and harassment. The key strands of work undertaken are summarised as follows:

- Establishing a comprehensive Culture Change and OD Project Plan. Approved by the turnaround executive group, the Plan is consistent with the requirements of the Trust's project management office (PMO) governance framework, and reporting and monitoring infrastructure. This work addressed a significant pre-existing gap by ensuring the provisions of the culture change programme, and the various other work streams associated with the span of the HR Directorate's OD activity, were identified and brought together under one Mandate and a single overarching plan, against which measurable and timebound objectives are assigned.

- Within the overall Culture Change and OD Project Plan, developing and implementing a culture change plan, which is centred on three main areas (as summarised in the high-level plan), namely:

  - establishing and embedding programme leadership - to design, steer, guide, resource and communicate the culture change work, through a clear and purposeful leadership structure; and to ensure activities happen on time and 'on quality';
  - behavioural performance - involving staff in redefining Trust values and associated behaviours, and equipping everyone with the required behavioural skills to drive performance;
  - building an enabling infrastructure - reviewing and amending internal processes and procedures to ensure they fully support cultural and behavioural improvement and encourage effective devolved leadership.

- Implementing an appropriately constituted and representative Culture and OD Steering Group. The purpose of this body, which has convened on a fortnightly basis since last November, is to provide oversight, scrutiny and challenge to the timely delivery of all aspects of the Culture and OD Project Plan. The Steering Group is chaired by a member of the Executive team, and has PMO and staff representation. Principal risks and issues which cannot be resolved by the Group are escalated to the turnaround executive group.

- Completing a Trust-wide review and revision of SECAmb's core values and assigning associated 'signature' behaviours. The completion of this particular activity represents an essential foundation and critical reference point, without which the second phase of the culture change programme could not be successfully designed and delivered. The revised values and proposed associated behaviours (agreed in principal by the Trust Board in January) were developed in consultation with Trust staff. Multi-site focus group and 'culture conversations' activity, combined with a full census survey, provided all members of staff with the opportunity to provide their thoughts and opinions about the behavioural characteristics they would like to see demonstrated by everyone employed in SECAmb, regardless of role and seniority, and the type of culture they would wish the organisation to promote and be recognised for. The proposed values and behaviours presented to the Board last month have been further refined and are detailed at **Appendix 1**.

- Completing initial engagement activity with Executive and Non-Executive Directors to further explain and raise awareness of the culture change approach endorsed by the Trust Board. In conversation with Board members, it was also stressed that the characteristics of SECAmb's future culture will, to a significant degree, be established by the organisation's most senior leaders, whom others expect will set and maintain the 'standard'.

3.3 The work completed in Phase 1 was underpinned by a communications plan that endeavoured to ensure staff were informed of forthcoming key activities and interventions (such as focus groups, culture conversations, and the values and behaviours survey) and routinely informed of general progress. Methods of communication have, to date, included the publication of regular messages via the Chief Executive's office; the weekly staff bulletin; the monthly magazine, and the Trust intranet. Presentations have also been made at meetings of the Staff Partnership Forum, and the Staff Engagement Forum. Reflecting the importance of continued face to face engagement and effective direct communication, the Staff Engagement Forum has been established as the 'barometer group' through which regular 'soundings' are taken with respect to how particular aspects of the culture change programme are being received within the organisation (i.e. what people are saying about the interventions; how well implementation is proceeding; how staff are reacting; and potential adjustments required).

3.4 The document provided at **Appendix 2** was developed as a concise explanation of the key aspects of Trust's overall approach to culture change and OD (including the need for culture change). This 'Approach' document has been disseminated to senior managers and made available to all staff, via the Trust intranet.

4. Culture Change Programme - Phase 2 (Delivery)

4.1 The work completed during Phase 1 successfully designed the culture change programme architecture and agreed the priorities for Phase 2. Having engaged staff in the revision of SECAmb's core values, and in the determination of the associated

signature behaviours, a principal aim of this second phase is to ensure these are fully understood, effectively applied, and used to improve individual and organisational performance through behavioural change. A critical success factor is the continued clear commitment from the Trust's senior leadership community to 'champion' culture change, and to act as role models in the implementation of that change, combined with an unrelenting focus on delivery and accountability. Responsibility for the delivery of the respective programme elements is being shared between Trust staff and Ignite Consulting. Governance will continue to be provided via the established Culture and OD Steering Group.

4.2 During Phase 2, which commenced in February, Ignite Consulting is working alongside the Executive team, senior managers, managers down to and including Operational Team Leader (OTL) level, and the resident OD team to equip them with the skills to effectively promote positive behaviours and to respond appropriately when individuals or teams fail to demonstrate those behaviours. A further focus is to review and adapt the Trust's existing performance management systems, such that they are able to support the continued assessment and reinforcement of standards. A key consideration here is to ensure there is consistency, both in recognising poor standards, wherever they are, and in applying effective improvement measures.

4.3 Phase 2 modular training interventions have been designed and, with Executive team input, their content will be finalised and tested during the remainder of February and into March. The aim of these culture change modules is for participants to gain a detailed understanding of the following:

- the Trust's behavioural expectations;
- how those expectations will apply to individuals and teams, in practice;
- how individuals will be measured against those expectations and, where required, helped to improve;
- how consequences will be applied when individuals fall short of expectations; and
- how the organisation should respond when individuals exceed expectations.

The interventions will also introduce the concept of assessing behavioural performance alongside task performance to create a 'multiplier effect' with respect to driving cultural and organisational performance. This will inform the development and implementation of a revised performance management framework.

4.4 In addition to participating in this mandated modular training, each member of the Executive team and all designated senior managers will receive one to one support from a designated professional coach. The aim of these coaching sessions is to provide an opportunity for individuals to gain valuable insights into their own behaviours and how others perceive their effectiveness in providing leadership, direction and support to their respective teams. This work will be informed by prior participation in an obligatory multi-source feedback (360 degree) appraisal, the outcomes of which will be conveyed via the assigned coaches.

4.5 The majority of the Phase 2 activity will be delivered over a three-month period, commencing in April. This is designed to coincide with the formal 'launch' of the Trust's values and behaviours framework. Whilst it is not possible to provide a similar level of training and support to all Trust employees, every member of staff will

have the opportunity to participate in 'bite-sized' modules, which will provide a distillation of the modular activity described above. In order to minimise any disruption to work schedules and operational priorities, this intensive programme of work is scheduled to be delivered across multiple locations and at varying times of the day. Feedback received via various staff group discussions suggest that the planned training and development interventions are keenly awaited and will be well-received.

4.6 As part of Phase 1, a review of HR policy and practice was undertaken. The purpose of this review was to establish the extent to which current policy and practice will align with the culture change programme (i.e. are they enabling and supportive, or restrictive and disempowering?) and what action might be needed to strengthen the link between the two. Priority areas have been agreed, and additional work during Phase 2 will focus on the revision and re-implementation of a number of core documents.

4.7 All Phase 2 activity will be supported by proactive communications and engagement interventions. These will be co-led by Ignite Consulting and the Trust's communications team, with the aim of ensuring that managers and staff are kept appraised of progress and are able to provide timely feedback on any aspects of the programme. Communications will also be used to continually reinforce key messages and expectations. Whilst a variety of methods will be applied, there will be a continued emphasis on face to face communications, wherever possible. The barometer group will also provide its main 'check and balance' function, whilst acting as an important communication conduit with the wider workforce.

4.8 An important consideration in the delivery of Phase 2 is the ability to demonstrate measurable progress and improvement. Whilst it is recognised that the required cultural shift will not be achieved in the short term, nevertheless it is possible to more readily improve the organisational 'climate'. The Culture and OD Steering Group membership has identified a number of key performance indicators and trend measures that will serve to indicate the degree to which the continued culture change activity is having an impact across the organisation. These indicators and measures include, for example, data relating to the volume and nature of staff grievances and disciplinaries; complaints received from patients and service users; staff turnover levels; recruitment efficiency; and staff engagement and advocacy scores associated with regular pulse surveys.

5. Summary

5.1 This paper has provided an update on the work being undertaken in support of the Trust's two-phase culture change programme, including progress to date. Culture change is acknowledged by the Board as being a vitally important success factor in achieving the Trust's ambitions and in delivering its strategic objectives. Hence, the organisation has invested in the provision of additional expert resource to co-lead the design and implementation of the programme.

5.2 The completion of Phase 1, in January, represented the culmination of three months of activity that aimed to establish an agreed and comprehensive approach to culture change that recognises how sustainable improvement will be achieved by

applying a methodology that promotes and delivers widescale sustainable behavioural change. The application of this methodology is supported by a culture change plan, the implementation of which is managed, scrutinised and monitored within a robust governance framework. All elements associated with this first phase have been delivered.

5.3 Phase 2 is now focused on delivery and, to that end, an intense three-month period of modular training for senior managers and leaders is in its final planning stage, and will be delivered from the start of the new financial year. Throughout this period the organisation will continue to be supported by its appointed external expert resource, which will work closely with the leadership team, the internal OD team, and Trust staff. Consistent with Phase 1, key considerations for this second phase of activity are ensuring that effective communication and staff engagement is maintained, combined with the ability to demonstrate real progress and improvement.

5.4 The Trust Board will continue to receive regular updates on progress in the delivery of the culture change programme, and its impact on the organisation.

6. Recommendation

6.1 The Trust Board is asked to note the contents of this paper.

Appendices:

1. SECAmb Values and Behaviours
2. Culture and OD Approach Document

Mark Power
Interim Director of HR

18 February 2018

Appendix 2: SECAmb Values and Behaviours (finalised)

Value	Proposed descriptor
Taking **Pride**	Being advocates of our organisation and recognising the important contribution we make to its success
Striving for **Continuous Improvement**	Seeking and acting upon opportunities to do things better
Acting with **Integrity**	Being honest and motivated by the best interests of those we serve
Demonstrating **Compassion and Respect**	Supporting our colleagues, and those we serve, with kindness and understanding
Assuming **Responsibility**	Having ownership of our actions and a willingness to confront difficult situations

For each Value, a set of ‘signature’ behaviours and contra-indications have been defined by staff:

Taking Pride **Being advocates of our organisation and recognising the important contribution we make to its success**	
We will …	**We will not …**
Fulfil our roles and responsibilities to the best of our ability. Encourage our colleagues to do the best job possible. Act positively even when faced with challenges. Openly share ideas and best practice with colleagues. Proactively seeks and shares information.	Obstruct colleagues from being able to effectively do their job. Be critical of our colleagues or our organisation. Engage in negative gossip.

Striving for Continuous Improvement

Seeking and acting upon opportunities to do things better

We will …	We will not …
Encourage each other to express opinions and ideas about how we can improve patient safety and the overall quality of our services. Speak up if we can see a safer, more efficient or cost-effective way of doing things. Look for the positives, not the negatives, when others express ideas and views. Actively participate in personal and professional learning and development. Act on feedback to improve our personal performance.	Discourage someone from trying a better way of doing things. Reject opportunities to improve the way we work. Deliberately avoid or ignore problems, or difficult situations, which we can help resolve.

Acting with Integrity

Being honest and motivated by the best interests of those we serve

We will …	We will not …
Maintain high personal and professional standards. Do what we say we are going to do. Speak up when we think something is wrong. Admit to our honest mistakes. Gather information to help understanding, before making judgements.	Put self before others. Abuse our authority or influence over others by showing favouritism, or discrimination in any way. Allow our personal moods to affect others.

Demonstrating Compassion and Respect

Supporting our colleagues, and those we serve, with kindness and understanding

We will …	We will not …
Treat everyone fairly. Maintain a safe environment for our colleagues and patients. Be polite and courteous towards colleagues, patients and others with whom we have contact. Help others when they are in need of our support. Demonstrate a positive attitude towards diversity by paying attention to others' different needs.	Take advantage of others' kindness, helpfulness or support. Deliberately exclude others. Be critical or judgemental of others and their situations.

Assuming Responsibility

Having ownership of our actions and a willingness to confront difficult situations

We will …	We will not …
Consider the impact of our decisions on others before acting. Learn from our mistakes by taking appropriate action. Take care of our health, wellbeing and safety at work. Take responsibility for resolving problems. Challenge inappropriate behaviour, or poor working practices.	Allow processes to undermine or detract from meeting patient needs. Complain about situations without suggesting solutions. Expect others to work ‘above and beyond’ when we are not prepared to do so ourselves.

Appendix 1:

South East Coast Ambulance Service NHS Foundation Trust

Supporting Our Improvement Journey

SECAmb's Approach to Culture and Organisational Development: 2017-2020

SECAmb's Vision and Mission

Our Vision

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

Our Mission

To deliver our aspiration to be better today and even better tomorrow for our people and our patients

Realising our **Vision** and **Mission** will underpin the achievement of our **Five-year Strategy**

Introduction

by the Chief Executive

The Trust's Five-year Strategy and current Delivery Plan aim to respond to a number of organisational challenges facing SECAmb. Many of these challenges are historical, and effectively addressing their root causes is recognised as being a critical factor in achieving future high performance.

Earlier this year many colleagues took the opportunity to share with the Board, through focus groups, their thoughts on what it is like to work for SECAmb, what they thought of our culture and what behaviours they would like to see demonstrated by everyone who works for our Trust - regardless of their role or seniority.

These views, along with the Care Quality Commission (CQC) findings and the Lewis report into perceptions of bullying in the Trust, helped us to frame a new Vision and Mission for SECAmb. To ensure these are more than just statements of intent, we have set in motion an ambitious Culture and Organisational Development (OD) programme of work.

The purpose of this document is to summarise why this programme is important and explain the approach being taken in its delivery.

Ultimately, we aim to promote an inclusive, supportive and respectful culture based on collective achievement of shared goals, through aligned values and behaviours. Establishing and maintaining such a culture will ensure we all share in a successful future that benefits all of our staff, our patients, our service users, and our partner organisations.

Daren Mochrie QAM
Chief Executive Officer

Context

Why we are concerned with culture and OD

Culture is an important consideration for any organisation, and is largely defined by the behaviours, beliefs and attitudes of employees - how they interact with and treat each other and how they are perceived by the people they serve. An organisation's culture, whether healthy or otherwise, is largely determined by its senior leaders, who 'set the tone' for everyone else.

A formal inspection of the Trust, conducted by the Care Quality Commission (CQC) in May 2017, reported issues of concern associated with both the 'Effective' and 'Well-led' domains. These and other concerns spanning all domains served to highlight, within SECAmb, an organisational culture characterised, in general, by: low levels of staff engagement and satisfaction; decision-making and influence vested in the few; an unwillingness by some to take responsibility and accountability for their actions; and insufficient understanding of the organisation's vision and strategic objectives. This prevailing culture led, in some areas, to an acceptance of under-performance, at individual and team levels, and a reluctance to address poor practice and behaviour. The conclusions of the later Lewis Report into perceived bullying and harassment in the workplace further highlighted some shortcomings relating to staff behaviours and attitude.

The perpetuation of such a culture would almost certainly guarantee that we will fail to meet our statutory duties and obligations as a Foundation Trust, and also fail our staff, patients and service users. The present Trust Board is not tolerant of such failings and is fully committed to leading positive and sustainable change.

In promoting proactive and progressive OD interventions and culture change initiatives, the following are recognised as being key drivers:

- There is a clear link between a motivated, committed and well-informed workforce, and quality of care provided to service users.
- Successful change requires the application of empowered, supportive and intelligent leadership, at all levels, which has service quality, patient-centred care and efficiency at its heart.
- Staff must be appropriately informed of, and effectively engaged in, supporting the delivery of SECAmb's Five-year Strategy, whilst also being involved in determining, and subsequently applying, the Trust's 'signature' behaviours.
- There is widespread acknowledgement of the direct link between leadership capability and sustained high performance (the contribution and motivation of our staff are key to our collective achievements).
- There is increasing evidence that where health professionals are provided with clear information relating to the resources associated with their services, together with the authority and accountability to make improvements and efficiencies, then improved quality and better care results.
- The NHS Constitution pledges to "engage staff in decisions that affect them and the service they provide. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families" (Section 4a).
- Where staff are encouraged and supported to work to the top of their potential, it follows that all areas of the organisation will work more effectively: efficiency will improve; waste will be reduced, and overall performance will be enhanced.

Our approach

How we are responding to past failings and their root causes

The consequences of accepting poor practices and behaviour are only too evident from contemporary reports of organisational failures, both within and outside of healthcare. Where such acceptance is widespread, managers, clinical leaders and staff are disempowered and inhibited from making decisions or suggestions for improvement, and even from owning up to mistakes.

Ultimately, a culture that fails to promote engagement, inclusion and distributed responsibility, accountability and decision-making, is likely to focus on 'doing the system's business, rather than the patients'.

We recognise that the principal root causes of our recent organisational failings include:

- lack of accountability, performance management and assurance;
- inconsistent change management procedures;
- lack of support, openness and honesty;
- acceptance of poor practices and behaviours, including bullying and harassment;
- poor people management practices;
- ineffective communication between senior leadership and the wider workforce;

  and

- lack of awareness and understanding of the Trust's vision, strategic objectives, core values, and expected behaviours.

SECAmb's Board is committed to building upon current progress, strengths and opportunities to create the right environment in which to achieve a sustained and successful Service. Our approach in doing so aims to promote and maintain a 'healthy organisation' that:

- promotes trust, openness and engagement;
- engenders a 'can do' and flexible approach by all staff, encouraged by supportive working processes;
- fosters competent, confident and authentic leadership that inspires high performance, and encourages and supports personal and professional development;
- builds effective partnership working, both within SECAmb and with our partner organisations, and expects personal responsibility and accountability at all levels;

  and

- achieves high levels of staff motivation, satisfaction and wellbeing.

Through this approach we are determined to put right the failures of our past and ensure that SECAmb is recognised as an attractive organisation in which people are proud to work and contribute, and are able to fulfil their ambitions.

Our culture and OD priorities and commitments

Our priorities are focused on five key interdependent themes:

By focusing on these five themes we aim to fulfil the following principal commitments:

- **Culture Change**
  With the support and engagement of staff and volunteers, refresh the Trust values and establish a set of associated and 'measurable' behaviours; explain the relevance and importance of these behaviours, and assist staff in their adoption; explain and apply consequences when people fail to demonstrate these behaviours.

- **Effective Leadership and Management**
  Develop leadership and management competence at all levels, through our new selection and assessment processes, and development programmes.

- **Staff Engagement**
  Ensure all staff and volunteers have clear objectives, which align with SECAmb's Strategy, and a plan for their personal and professional progression, set through regular appraisal, and performance and development conversations.

- **Inclusion and Wellbeing**
  Make further improvements to the way in which we support the physical and mental health and wellbeing of our staff and volunteers.

- **Clinical Education**
  Improve our working with education and partner organisations to develop and implement career pathways and educational interventions that support effective clinician decision-making and practice.

An important consideration in achieving our objectives is to ensure that we have an effective **infrastructure** (i.e. working practices; clear lines of accountability and responsibility; policies and procedures) that enables the necessary improvements to be made and sustained.

Our focus on shared values and behaviours as a key enabler

A central plank of our Culture and OD approach is the identification of the shared values and behaviours we all expect to see demonstrated by everyone who works for SECAmb, regardless of their role. In taking full account of the views of staff, we are agreeing a set of values and behaviours that we believe will:

- help improve the way we all work together;
- enhance our environments;

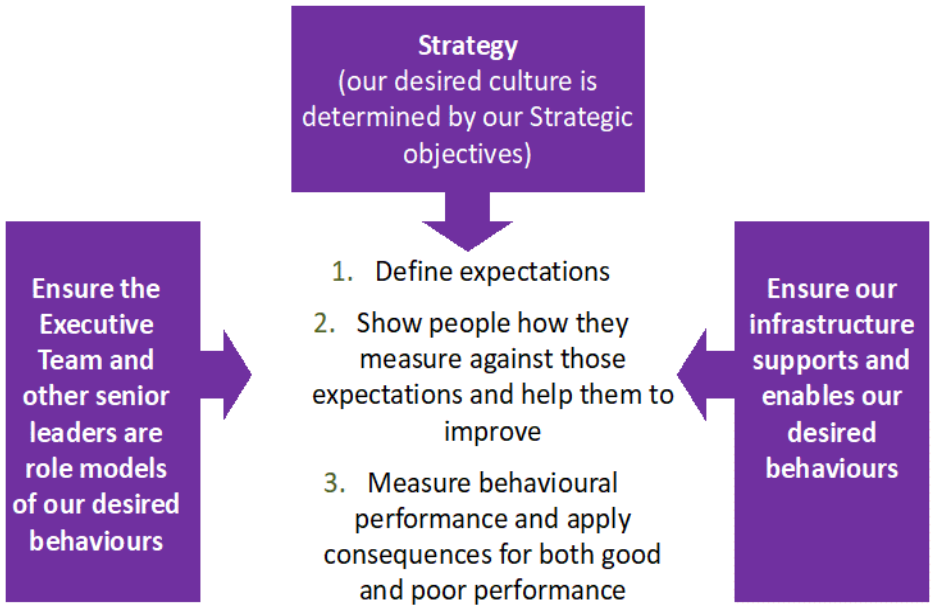
and

- have a positive impact on the care we provide to our patients and service users.

Through a rolling series of interactive development sessions, we will work with staff at all levels (including the Executive Team, and senior managers) to ensure they are equipped with the skills they need to adopt and apply our desired behaviours, and support others in doing so.

Again, we will also take appropriate measures to ensure that our organisational policies and procedures, and operating systems and processes align with our values and desired behaviours.

A summary of our culture change methodology



How we will deliver

A summary of our intentions

Commitment	Intended Outcomes	Key Enabling Actions
With the support and engagement of staff and volunteers, refresh the Trust values and behaviours.	• The consistent demonstration of our shared values and behaviours, by all staff, will positively impact all areas of our organisational performance. • Improved staff satisfaction and experience. • Improved patient satisfaction and experience. • Better clinical outcomes. • Substantial reductions in reported inappropriate behaviour.	• Reviewing, revising and agreeing our desired values and behaviours. • Equipping staff with the skills and understanding needed to adopt and demonstrate our desired behaviours, and to support others in doing so. • Being clear about the consequences of both good and poor behaviour, and being consistent in the application of those consequences.
Develop leadership and management competence at all levels, through our new selection and assessment processes, and development programmes.	• Leaders and managers have clear lines of responsibility and accountability. • Consistently high levels of leadership and management competence and confidence. • Leaders and managers are role models of SECAmb's values and behaviours. • Talent and potential, at all levels, is recognised and developed.	• Reviewing and improving the effectiveness of our leadership and management development interventions to ensure they are aligned with our Strategic objectives, and our values and behaviours. • Developing and implementing a 'staff lifecycle management' framework. • Capitalising on the opportunities provided by national leadership development programmes. • Developing and implementing a talent management and succession planning framework.

Commitment	Intended Outcomes	Key Enabling Actions
Ensure all staff and volunteers have clear objectives, which align with SECAmb's strategy, and a plan for their personal and professional progression, set through regular appraisal, and performance and development conversations.	• Improved organisational, team and individual performance. • Increased job satisfaction and better staff experience. • Reduced staff turnover. • SECAmb recognised as an attractive place to work. • Improved patient experience and clinical outcomes.	• Implementing ACTUS - an online appraisal and Personal Development Record. • Developing a tool to monitor and manage SECAmb-wide adoption and application of desired behaviours aligned to performance management processes. • Enabling staff self-service: e-staff record, e-expenses, e-procurement.
Make further improvements to the way in which we support the physical and mental health and wellbeing of our staff and volunteers.	• Improved staff health and wellbeing. • Bullying and harassment close to zero - if it is found to exist it is not tolerated. • Improved recruitment and staff retention. • SECAmb recognised as an attractive place to work.	• Incorporating a focus on improving wellbeing, and addressing bullying and harassment, into all culture change activities. • Fully implementing our agreed approach to health and wellbeing. • Fully establishing our wellbeing 'hub'. • Developing and implementing progressive supporting Policies.
Improve our working with education and partner organisations to develop and implement career pathways and educational interventions that support effective clinician decision-making and practice.	• Staff, patients and partner organisations fully involved in the design and delivery of clinical education curricula. • Improved evidence-based practice. • Education curricula are effectively governed, quality assured and evaluated, and are responsive to Ambulance Quality Indicators.	• Developing career pathways and interventions that support staff with clinical decision-making. • Developing and implementing a comprehensive and inclusive clinical education programme. • Developing and implementing personalised learning packages. • Developing and implementing comprehensive quality assurance and evaluation standards. • Ensuring that access to learning is fair and inclusive.

Leadership

Chief Executive

Responsibility: Sponsor
Tel: 01737 364401
Email: daren.mochrie@secamb.nhs.uk

Director of Human Resources (Interim)

Responsibility: Accountable Executive Lead
Tel: 07876 451159
Email: mark.power1@nhs.net

Associate Director of HR Operations

Responsibility: Delivery Lead
Tel: 07909 891435
Email: clare.irving@secamb.nhs.uk

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	180/17

Name of meeting	Trust Board
Date	23 February 2018
Name of paper	Quarterly Quality & Safety Dashboard
Executive sponsor	Steve Lennox, Director of Nursing & Quality
Author name and role	Steve Lennox, Director of Nursing & Quality
Synopsis, including any notable gaps/issues in the system(s) you describe (up to 150 words)	The quality & safety metrics (Appendix 1) is presented to Trust Board as an example of the metrics the Executive Management Board Committee and the Quality & Patient Safety Committee now receive. The strategic plan is to present the information by operational unit so that an overview can be gained on any variations in quality across the service. Where possible the try to gain the patient perspective by focussing on outcome rather than process (although there are some process measures). In addition, the Trust is developing a set of metrics for each business area (A&E, EOC and 111) so that all areas have similar oversight. They are evolutionary and as the organisation becomes more sophisticated in data collection, they may change. The following indicators are currently included; **Safety - Clinical Record** This identifies the % of clinical records that have been successfully reconciled. **Safety - PCR Audit** This enhances the above indicator to identify the main reasons from missing data why records could not be reconciled. This data set will change as clinical audit are redefining this measure. **Safety - Medicines – Lowest Compliance** This is currently completion with audit requirements and reports the lowest compliance across the OU. Next quarter it is intended that this data set becomes the % compliance with medicines standards. **Safety – Call Answering (EOC & 111)** This records contractual requirements for call Answering **Safety – Pathway Audits (EOC & 111)** This records the number of audits undertaken against the pathways requirements. **Safety – clinical Staffing Requirements (EOC & 111)** This records for EOC the minimum staffing compliance (for Pathways)

	and for 111 records attrition. **Practice – Infection Control** This records percentage compliance with Hand Hygiene **Practice – Care – Care Bundle** This reports compliance against the standards to provide good Stroke and STEMI care against the set interventions. The Trust was not collecting this by Operational Unit in July. **Practice – Training – Mental capacity, Safeguarding, Key Skills** This reports compliance with the above training requirements. **Experience – Complaints** This reports the number of complaints received **Experience – Complaint answering timeliness** This reports the number of complaints still open and out of time at the end of the month. This data set is one of the weakest data sets as the change to recording complaints about delay to the OU has meant that some investigations are incorrectly attributed to the OU when the delay is actually being undertaken by EOC. This data set will also change in the next quarter as the team have become more sophisticated in their data collection. **Experience – Number of Incidents** This reports the number of incidents per OU. **Narrative** For this dashboard, the narrative has been populated by the person undertaking the role of ROM. This is again intended to provide a slightly different perspective as the monthly reporting is sent (with varying degrees of success) to the OUMs. **Use of the Dashboard** This has been produced as a quarterly dashboard and presents data that is collected monthly, in a slightly different way to the way it is presented in the monthly Quality & Safety Report. **Analysis** There is some variation across the service with some Operational Units having stronger compliance with a number of metrics. Infection Control is the main measure that is consistently below and a new Improvement plan and a new strategic approach to Infection Control has been developed. There are no obvious indicators revealing a Trust wide issue. The monthly metrics now also have oversight and discussion at the Area Governance Meetings.
Recommendations, decisions or actions sought	For noting and comments are welcome on how this can be improved.

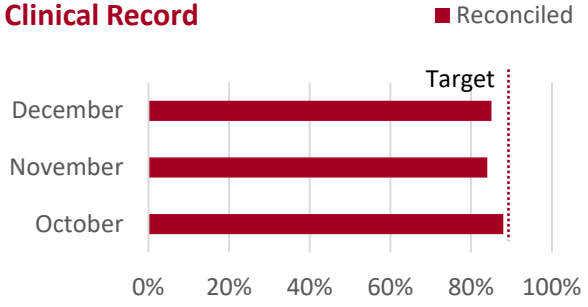
Operating Unit: **Chertsey**
Quarter: **October – December 2017**

South East Coast Ambulance Service NHS Foundation Trust

Quarterly Safety & Quality Dashboard

Safety Indicators

Clinical Record

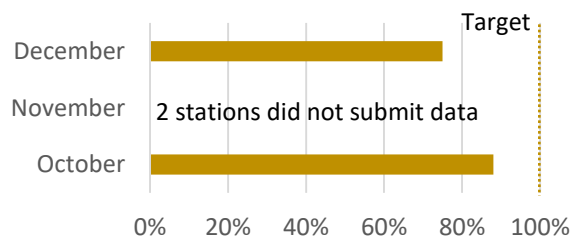


Clinical Record

PCR Audit (Snap Shot)

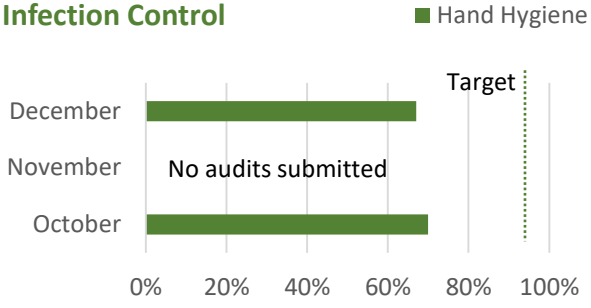
No data submitted

Medicines (Lowest Compliance)

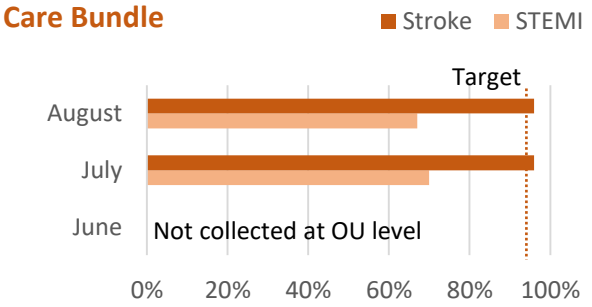


Practice Indicators

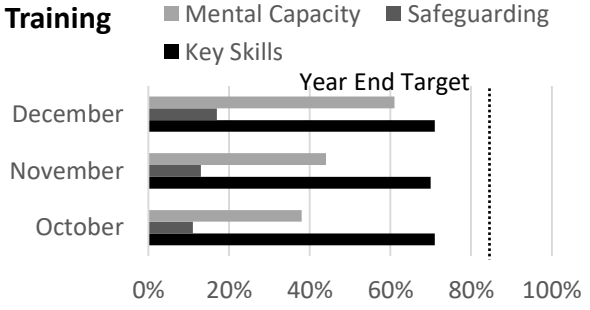
Infection Control



Care Bundle

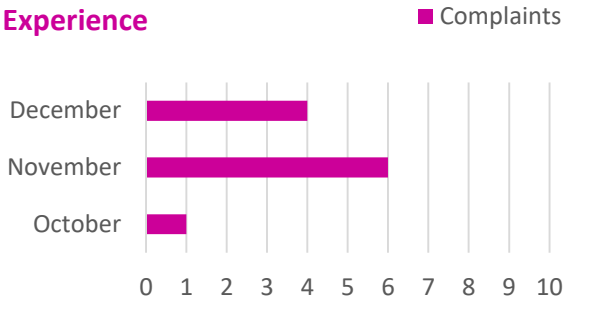


Training

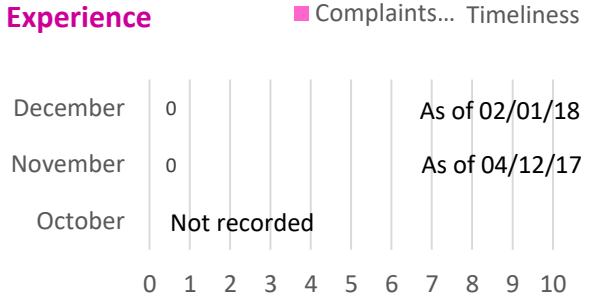


Evaluation Indicators

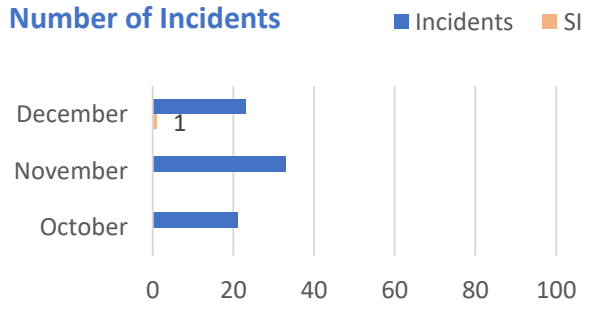
Experience



Experience



Number of Incidents



Narrative: The Chertsey Operating Unit operates from a number of sites which makes the collection of data more challenging. The unit has a vacancy rate at the Trust average and these vacancies do not appear to be making a negative impact on the above metrics. However, there have been gaps at a managerial level through sickness and vacancies which has challenged data collection and other managerial responsibilities. Compliance with medicines management appears low but standards in January (Quarter 4) are between 99-100%.

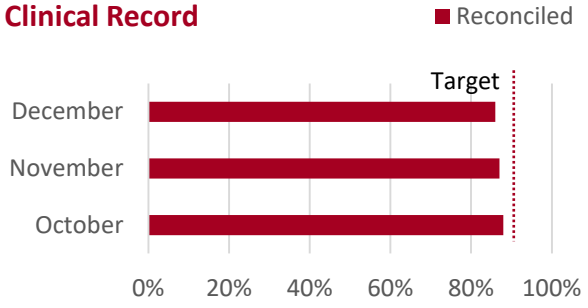
Operating Unit: **Guildford**
Quarter: **October – December 2017**

South East Coast Ambulance Service NHS Foundation Trust

Quarterly Safety & Quality Dashboard

Safety Indicators

Clinical Record

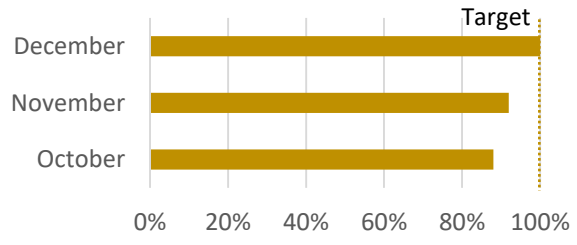


Clinical Record

PCR Audit (Snap Shot)

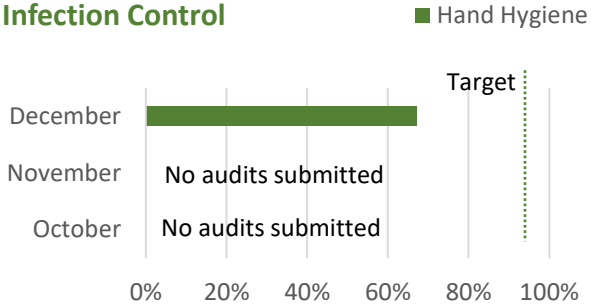
No data submitted

Medicines (Lowest Compliance)

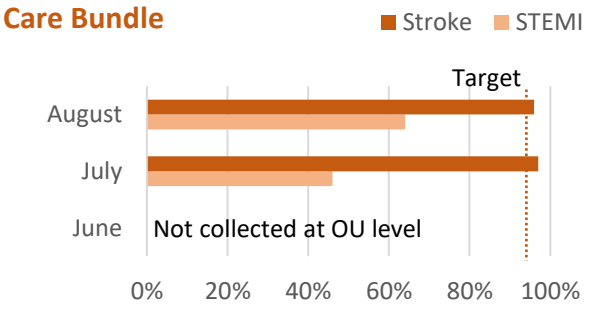


Practice Indicators

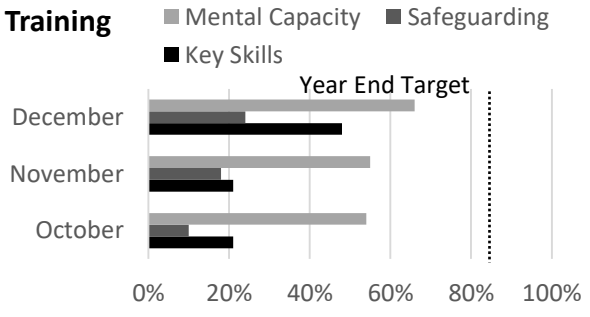
Infection Control



Care Bundle

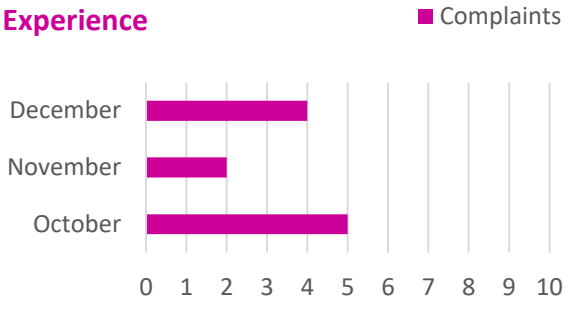


Training

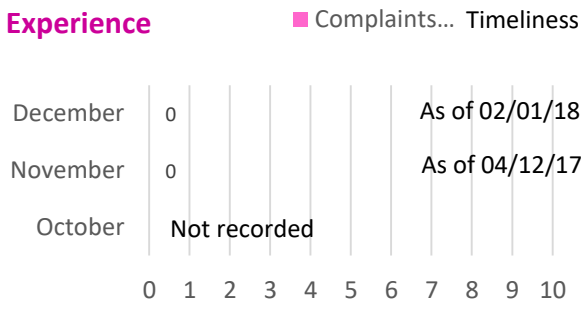


Evaluation Indicators

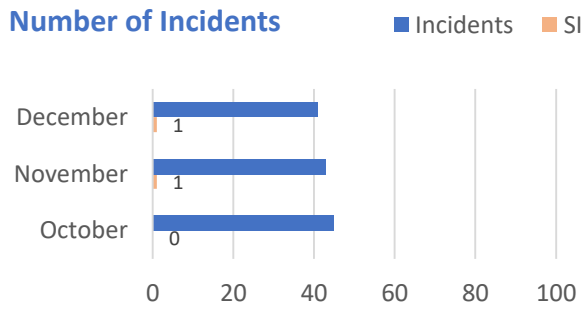
Experience



Experience



Number of Incidents



Narrative: The Operating Unit has a number of sites and a number of these have physical restrictions which makes some areas of compliance more challenging (e.g. medicines management). The management team have worked hard to ensure compliance with Infection Control standards are improved and have gone from completing 0 audits to completing the highest number across the organisation.

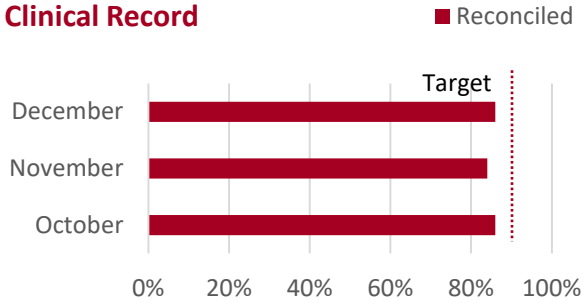
Operating Unit: **Redhill & Gatwick**
Quarter: **October – December 2017**

South East Coast Ambulance Service NHS Foundation Trust

Quarterly Safety & Quality Dashboard

Safety Indicators

Clinical Record

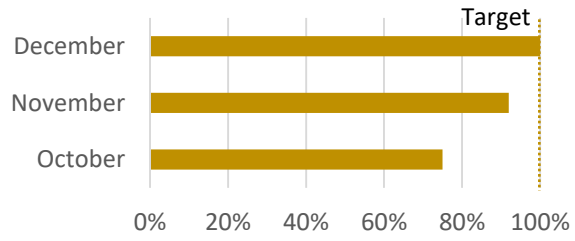


Clinical Record

PCR Audit (Snap Shot)

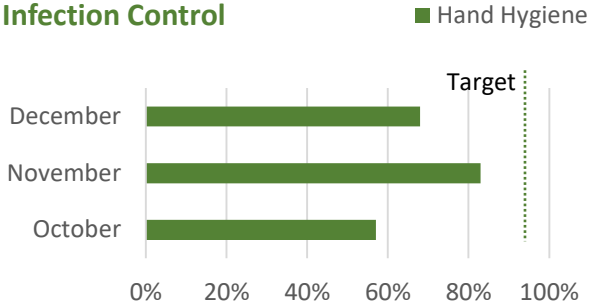
No data submitted

Medicines (Lowest Compliance)

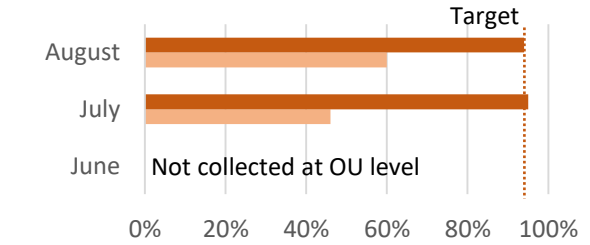


Practice Indicators

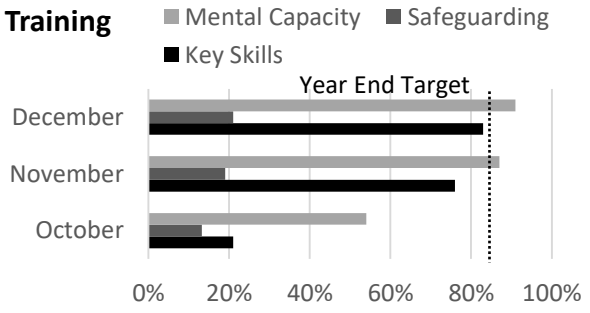
Infection Control



Care Bundle

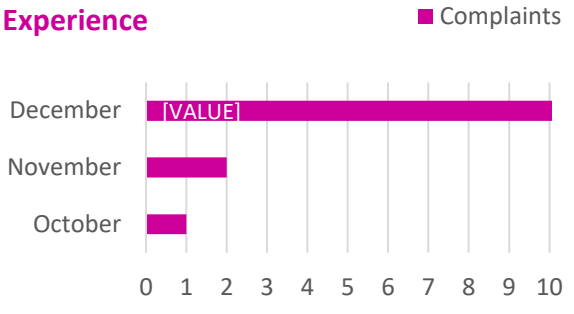


Training

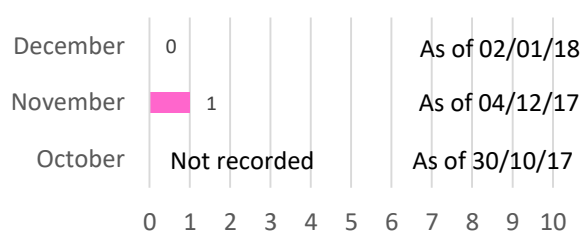


Evaluation Indicators

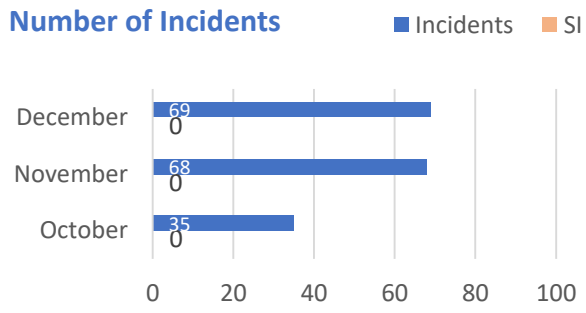
Experience



Experience



Number of Incidents



Narrative: The Operating Unit is a mix of a large Make Ready Centre and a number of traditional stations centred around a Vehicle Preparation system. There have been some gaps in managerial capacity which have now been addressed. The management team have also put in place a plan to improve infection control standards.

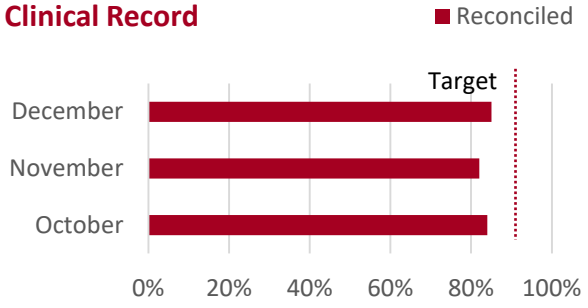
Operating Unit: **Brighton**
Quarter: **October – December 2017**

South East Coast Ambulance Service NHS Foundation Trust

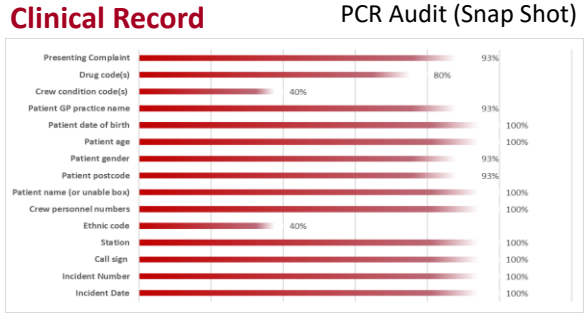
Quarterly Safety & Quality Dashboard

Safety Indicators

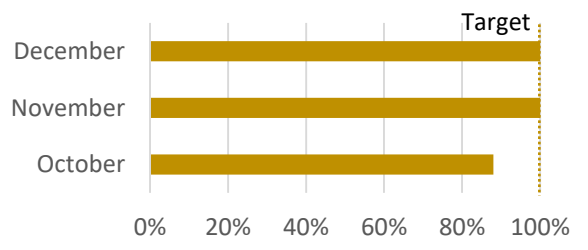
Clinical Record



Clinical Record

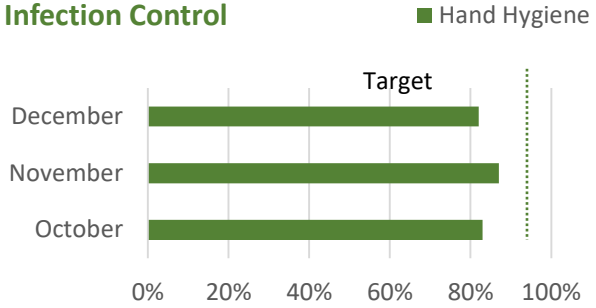


Medicines (Lowest Compliance)

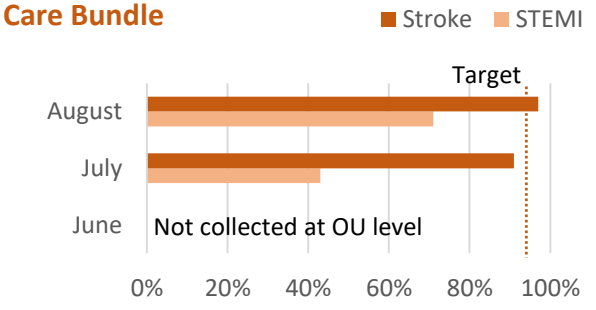


Practice Indicators

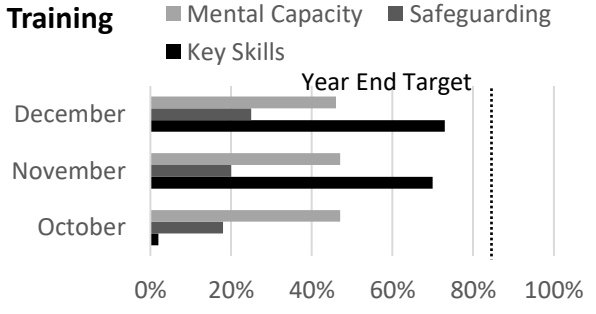
Infection Control



Care Bundle

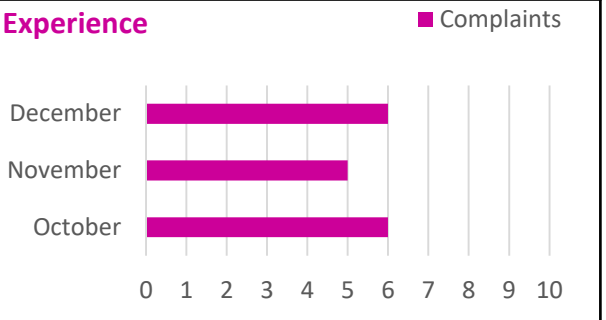


Training

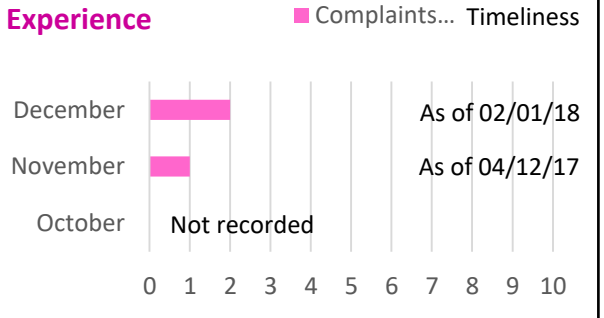


Evaluation Indicators

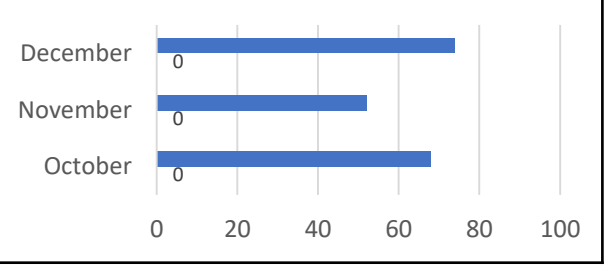
Experience



Experience



Number of Incidents



Narrative: The Brighton Operating Unit covers a large diverse geographic area and has a number of sites based on traditional ambulance stations but has managed to complete all audit returns. The Operating Unit Manager has also been supporting the Trusts Community Responder programme which has required the remaining members of the team to absorb additional responsibilities. The team have been successful in managing this change and achieving some good levels of compliance across the area.

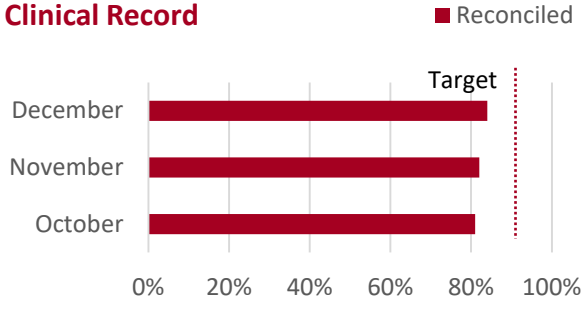
Operating Unit: **Worthing & Tangmere**
Quarter: **October – December 2017**

South East Coast Ambulance Service NHS Foundation Trust

Quarterly Safety & Quality Dashboard

Safety Indicators

Clinical Record

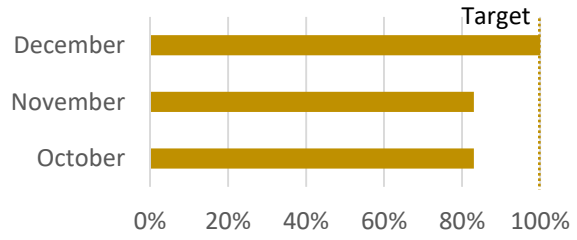


Clinical Record

PCR Audit (Snap Shot)

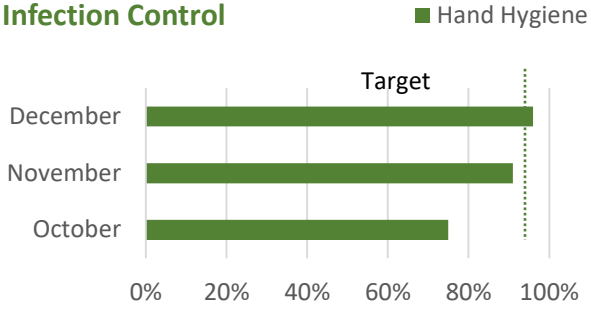
No data submitted

Medicines (Lowest Compliance)

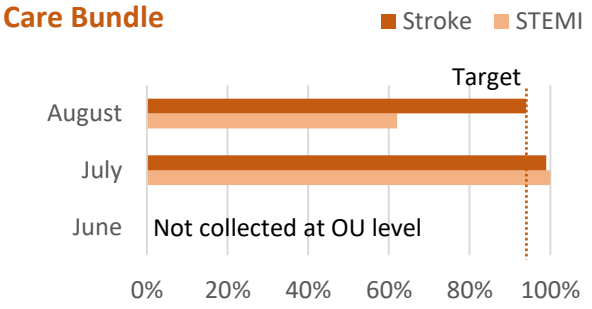


Practice Indicators

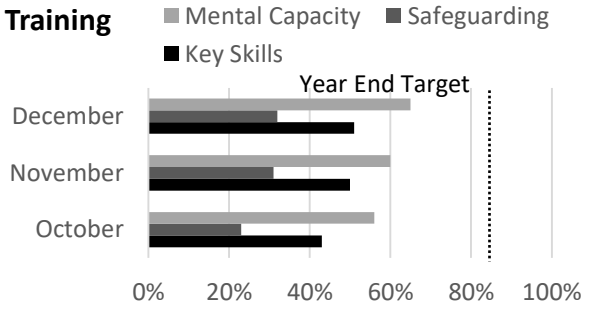
Infection Control



Care Bundle

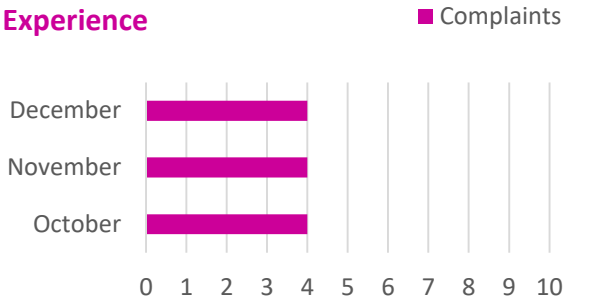


Training

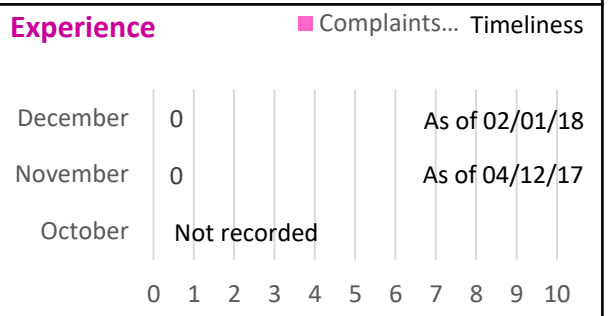


Evaluation Indicators

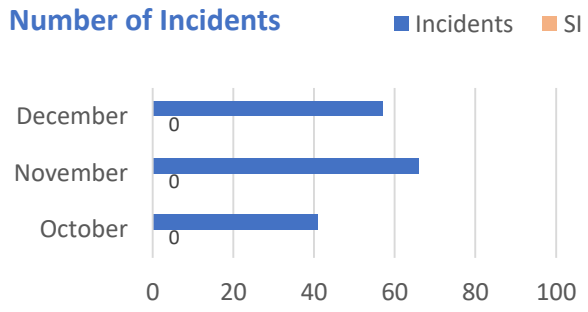
Experience



Experience



Number of Incidents



Narrative: The Chichester & Worthing Operating Unit had a number of managerial changes at the start of the year which resulted in delays in the start of Key Skills training. An action plan is now in place to address this and now we are through the Christmas/ New Year period we are on track to deliver key skills by the end of the financial year. The Operational Team Leader role became fully established at the start of November and although there are still a few vacancies the teams are fully focused on supporting the staff in meeting and maintaining our quality and safety standards.

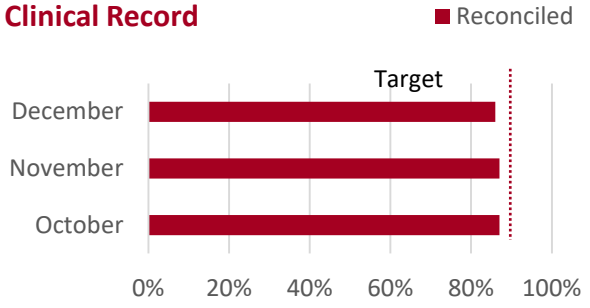
Operating Unit: **Thanet**
Quarter: **October – December 2017**

South East Coast Ambulance Service NHS Foundation Trust

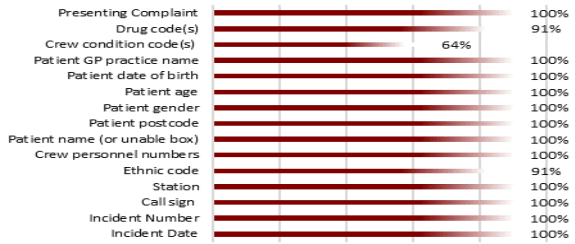
Quarterly Safety & Quality Dashboard

Safety Indicators

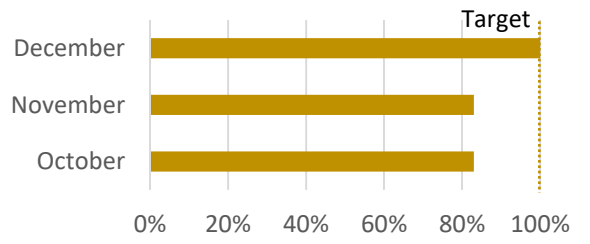
Clinical Record



Clinical Record

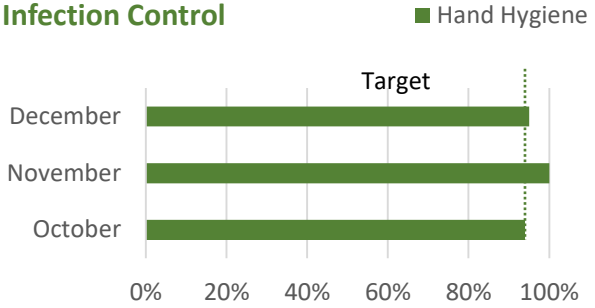


Medicines (Lowest Compliance)

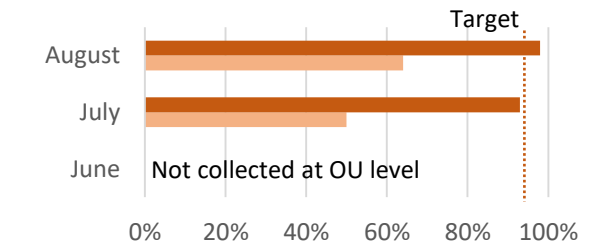


Practice Indicators

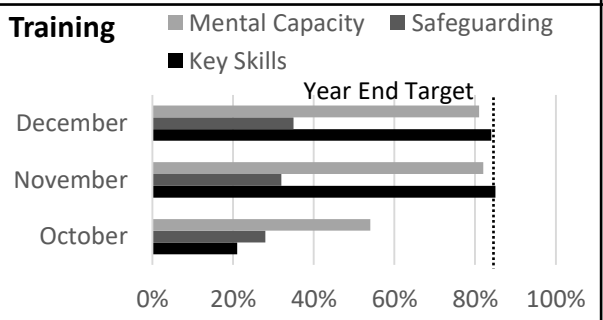
Infection Control



Care Bundle

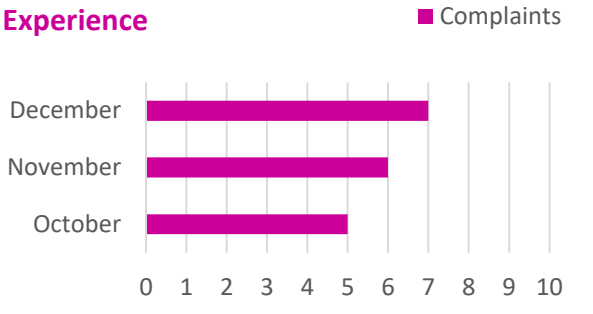


Training

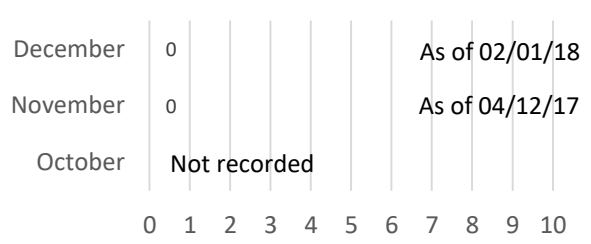


Evaluation Indicators

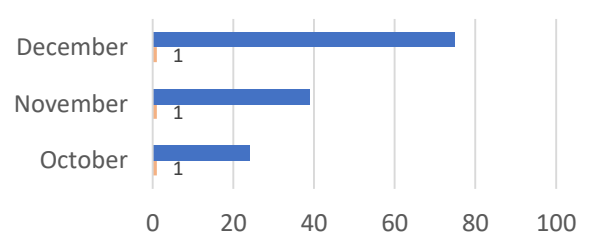
Experience



Experience



Number of Incidents



Narrative: Thanet Operating Unit has good all round compliance to quality and safety indicators for December. They have seen an increase in complaints and incidents in December over October and November commensurate with the extreme pressure throughout that period. All areas are either meeting compliance or very close to apart from safeguarding for which there is a plan in place to achieve the required level of compliance.

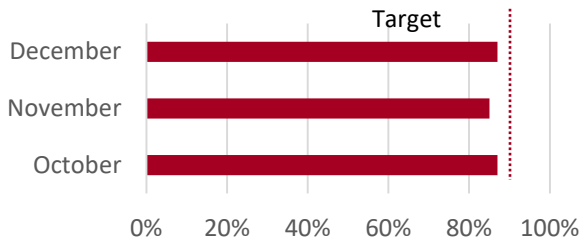
Operating Unit: **Dartford & Medway**
Quarter: **October – December 2017**

South East Coast Ambulance Service NHS Foundation Trust

Quarterly Safety & Quality Dashboard

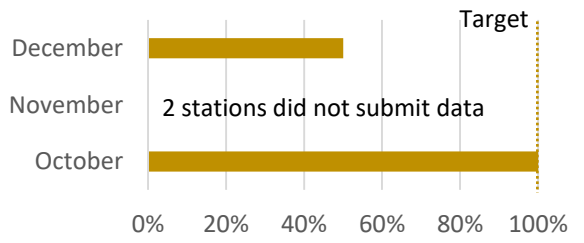
Safety Indicators

Clinical Record



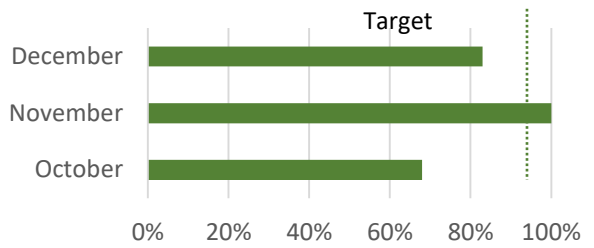
Clinical Record

Medicines (Lowest Compliance)

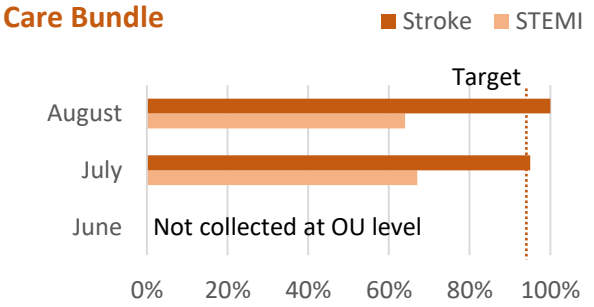


Practice Indicators

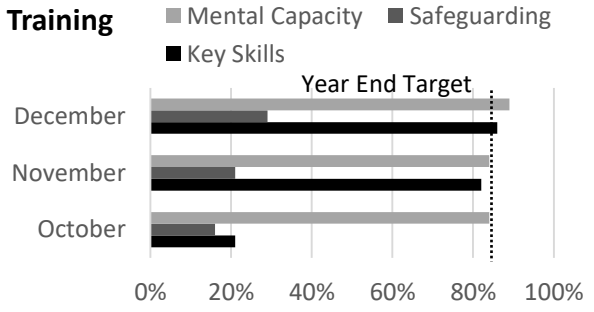
Infection Control



Care Bundle

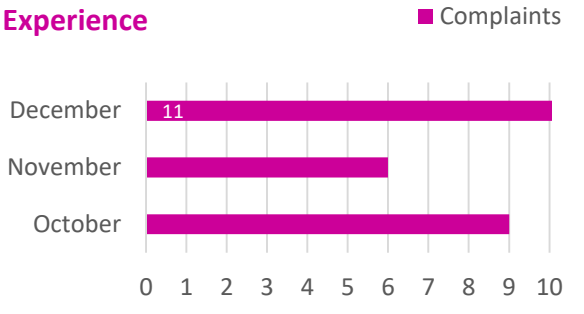


Training

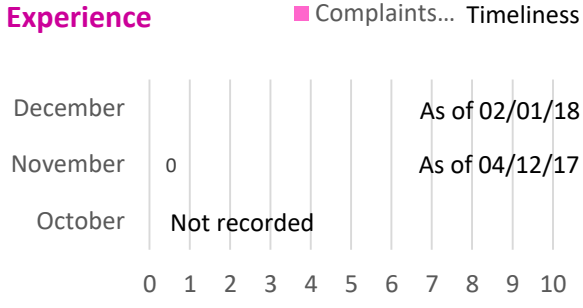


Evaluation Indicators

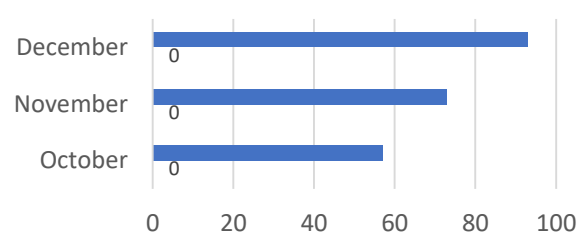
Experience



Experience



Number of Incidents



Narrative: Dartford and Medway Operating Unit have a mixed compliance to the quality and safety indicators. IPC has good compliance as does training apart from safeguarding for which a plan is in place. Dartford as a dispatch Desk has a challenge in relation to Operational Team Leaders management time in that their ratio of operational commander time to on site management time is 85% operational commander to 15% on site management this is mitigated slightly by Operational Team Leaders in Medway providing additional operational commander cover and support but this will continue to challenge this area in the coming months.

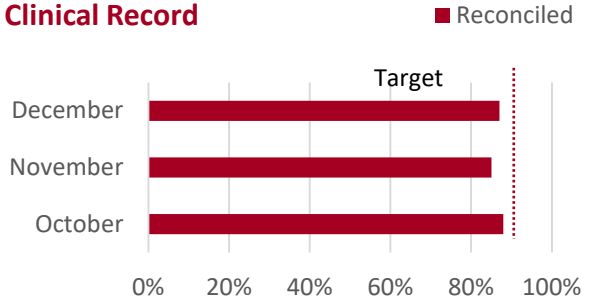
Operating Unit: **Paddock Wood**
Quarter: **October – December 2017**

South East Coast Ambulance Service NHS Foundation Trust

Quarterly Safety & Quality Dashboard

Safety Indicators

Clinical Record

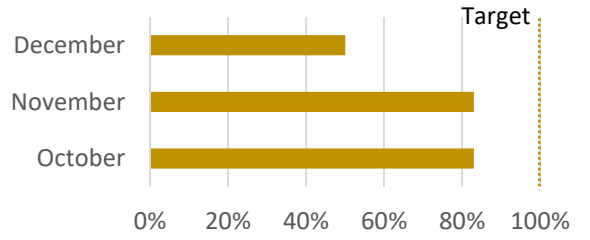


Clinical Record

PCR Audit (Snap Shot)

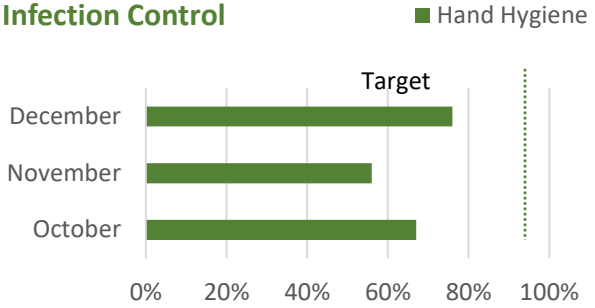
No data submitted

Medicines (Lowest Compliance)

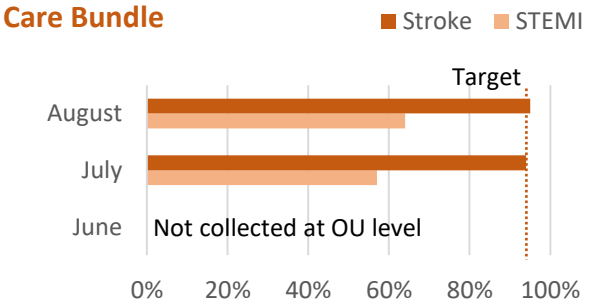


Practice Indicators

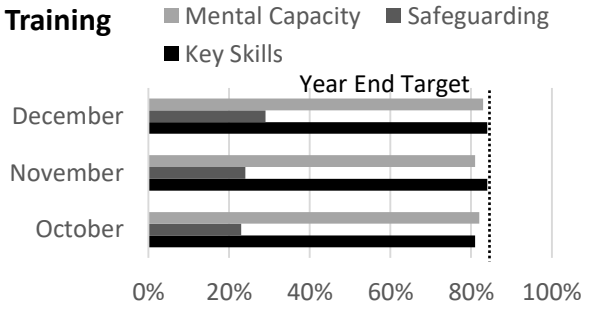
Infection Control



Care Bundle

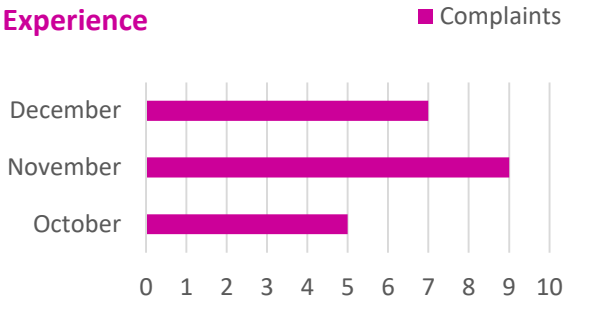


Training

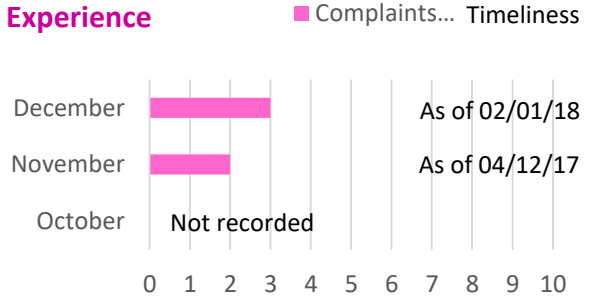


Evaluation Indicators

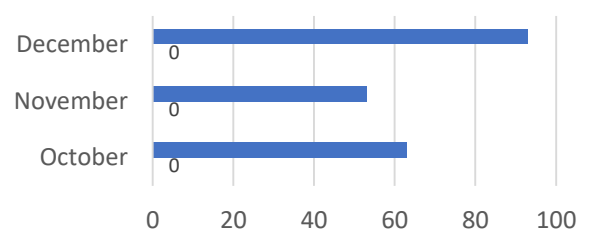
Experience



Experience



Number of Incidents



Narrative: Paddock Wood Operating Unit has good all round compliance and has seen a reduction in complaints in December over November but an increase in incident's commensurate with December pressures. This site also has a challenge with safeguarding and a plan in place to achieve the target. The unit has a high Operational Team Leader vacancy rate which is also challenging as it increases team size and therefore the OTL/team ratio. The unit utilised a local system of PCR snap shot review in real time which is why no PCR Audit data was received.

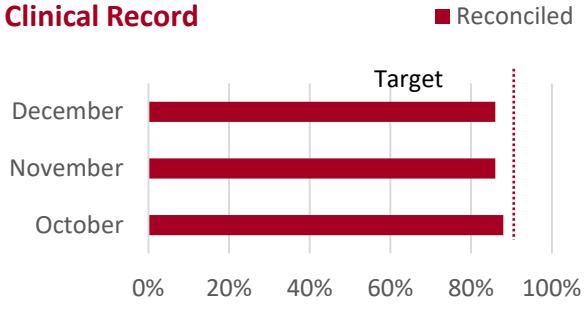
Operating Unit: **Ashford**
Quarter: **October – December 2017**

South East Coast Ambulance Service NHS Foundation Trust

Quarterly Safety & Quality Dashboard

Safety Indicators

Clinical Record

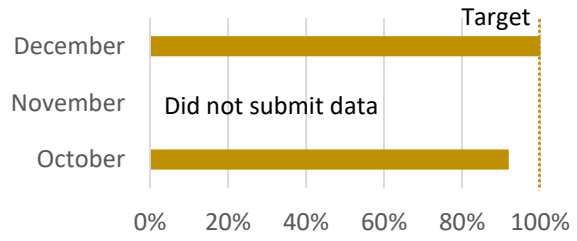


Clinical Record

PCR Audit (Snap Shot)

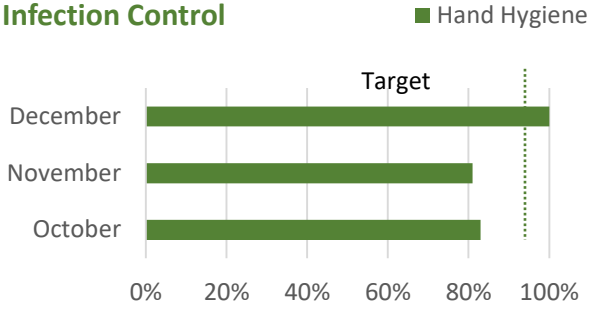
No data submitted

Medicines (Lowest Compliance)

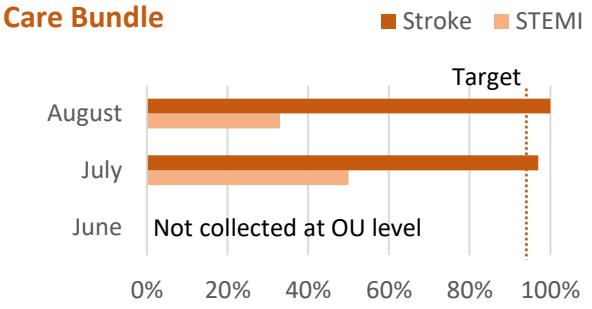


Practice Indicators

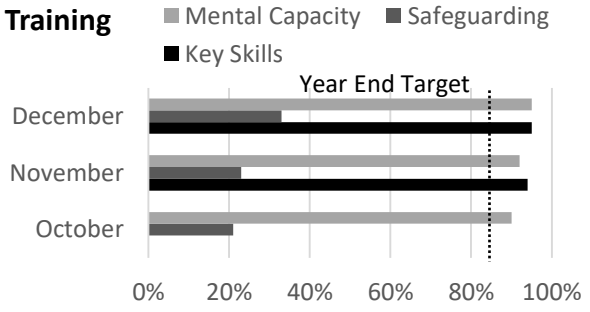
Infection Control



Care Bundle

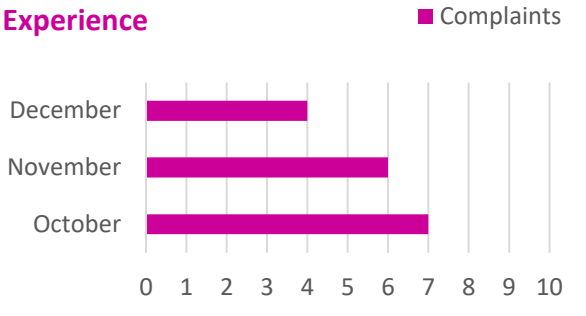


Training

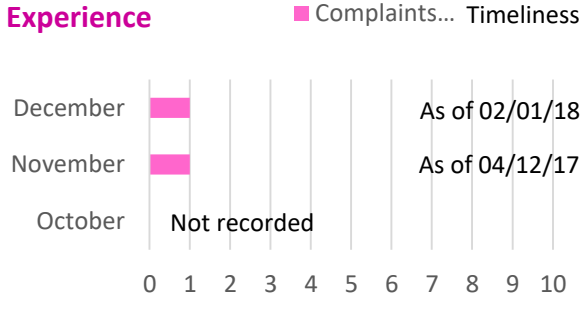


Evaluation Indicators

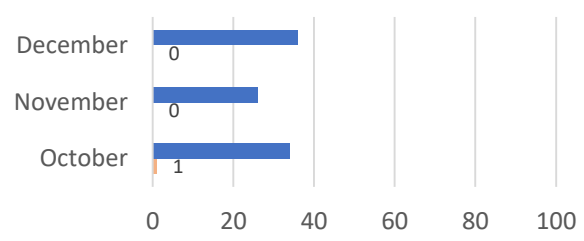
Experience



Experience



Number of Incidents



Narrative: Ashford has good compliance with all safety and quality metrics and has achieved the required annual training targets in all areas but safeguarding for which a plan is in place. In relation to no medicines data for November this was submitted on Dec 01 but too late for inclusion in the report. Ashford only has 11% vacancy factor, just below trust average and therefore large team sizes and a ratio of 60% Operational Commander to 40% on site management time which can cause challenges if operational commanders are responding to Calls. Ashford also has local clinical Quality Assurance system in place to review snapshot PCRs.

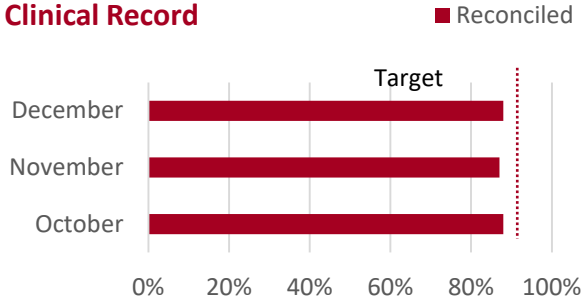
Operating Unit: **Polgate & Hastings**
Quarter: **October – December 2017**

South East Coast Ambulance Service NHS Foundation Trust

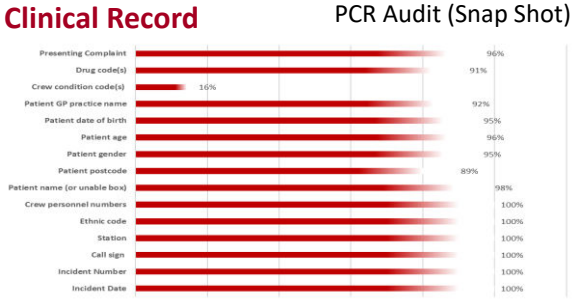
Quarterly Safety & Quality Dashboard

Safety Indicators

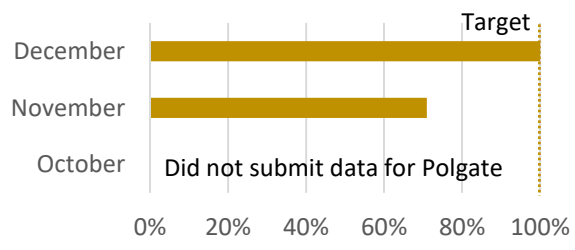
Clinical Record



Clinical Record

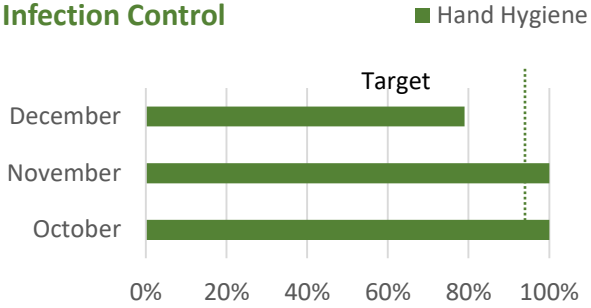


Medicines (Lowest Compliance)

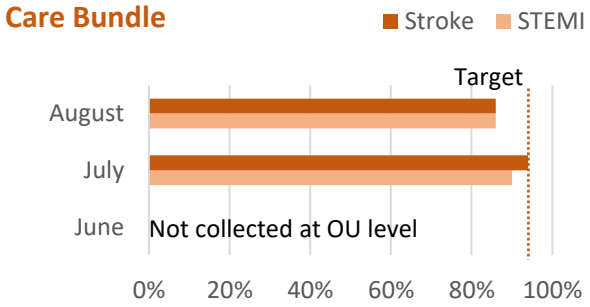


Practice Indicators

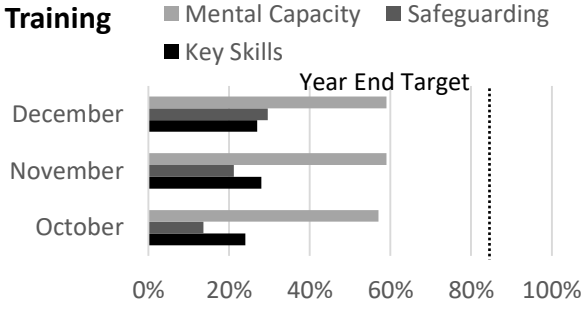
Infection Control



Care Bundle

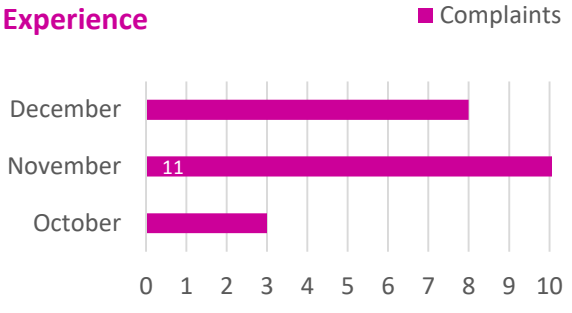


Training

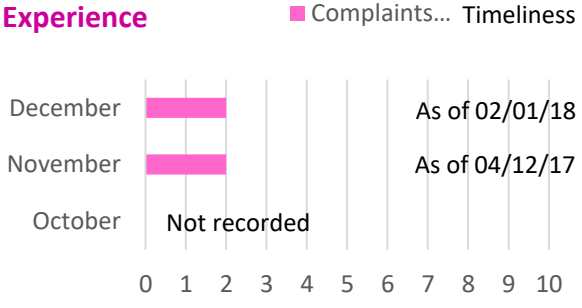


Evaluation Indicators

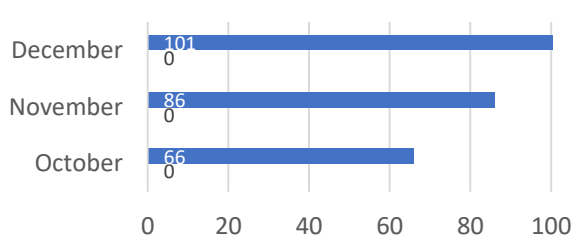
Experience



Experience



Number of Incidents



Narrative: Polgate and Hastings Operating Unit currently has good compliance to safety and quality metrics and met target indicator for medicines compliance in December. The area has the best COI care bundle compliance for stoke and STEMI in the East. The main challenge for this area is the completion of mandatory training for which there is an implemented recovery plan.

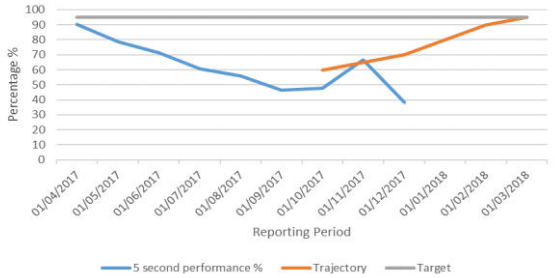
Operating Unit: **EOC Combined**
Quarter: **October – December 2017**

South East Coast Ambulance Service NHS Foundation Trust

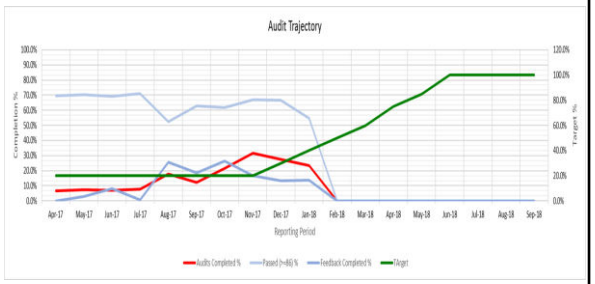
Quarterly Safety & Quality Dashboard

Safety Indicators

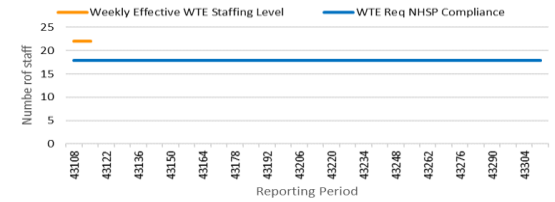
Safety — Call Answering in 5 seconds



Clinical Records — NHSP Audit Completion

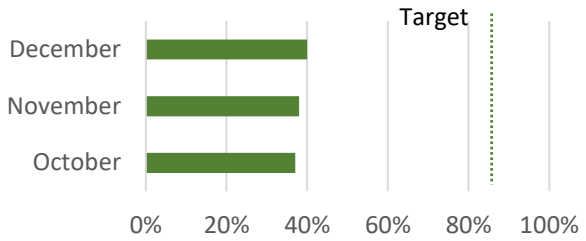


Safety — Pathways Clinical Supervisors

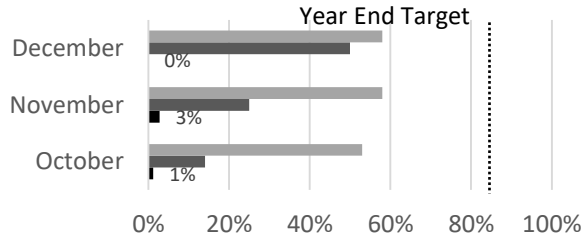


Practice Indicators

Infection Control — Training

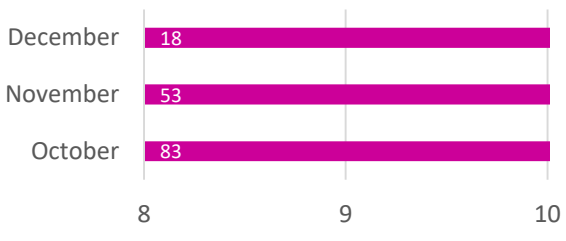


Training — Mental Capacity, Safeguarding, Key Skills

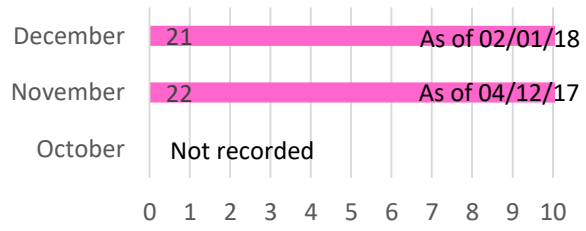


Evaluation Indicators

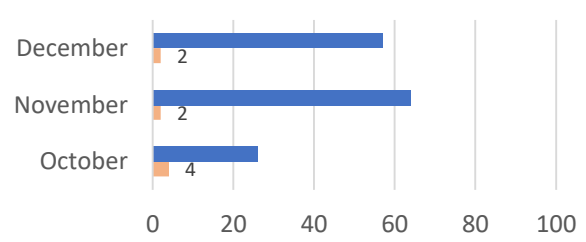
Experience — Complaints



Experience — Complaints… Timeliness



Number of Incidents — Incidents, SI



Narrative: Following a peak in call answer in November, the December turnout was more challenging, although 10,000 more calls were answered than November, 22% were relating to duplicate calls chasing ambulance Estimated Time of Arrival. Completion of audit is a challenge with capacity in the team split between training and audit. Both these areas continue to be tracked by EOC task and finish group. Numbers of complaints and incidents received primarily relates to service delays, although the impact of the ARP and management of patient expectation by EOC appears to reducing this area. Clinical management team continue to provide oversight to improve compliance with S&M training. EOC key-skills will recommence in Q4.

Operating Unit: **111**
Quarter: **October – December 2017**

South East Coast Ambulance Service NHS Foundation Trust

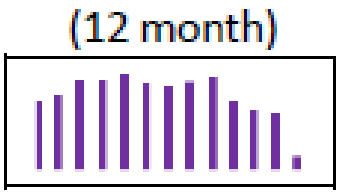
Quarterly Safety & Quality Dashboard

Safety Indicators

Safety

% Call Answering in 60 seconds

Oct 75.3%
Nov 72.9%
Dec 47.9%



Clinical Records

NHSP Audit Completion

	Ashford	Dorking	Service
HA Calls Audited % on Required (Percentage on Required)	100.0%	100.0%	100.0%
CA Calls Audited % on Required (Percentage on Required)	84.0%	100.0%	92.0%
HA Pass Rate (Passed as percentage of completed)	71.0%	81.0%	76.0%
CA Pass Rate (Passed as percentage of completed)	94.0%	99.0%	96.5%

Safety

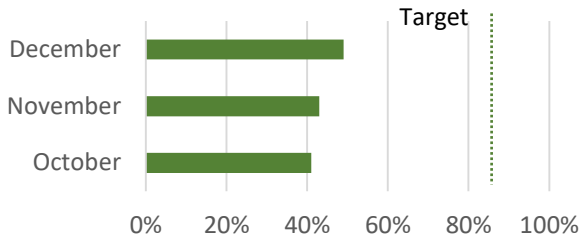
Pathways Clinical Supervisors

(Number of HAs that left each month as percentage of number of staff at start of month)

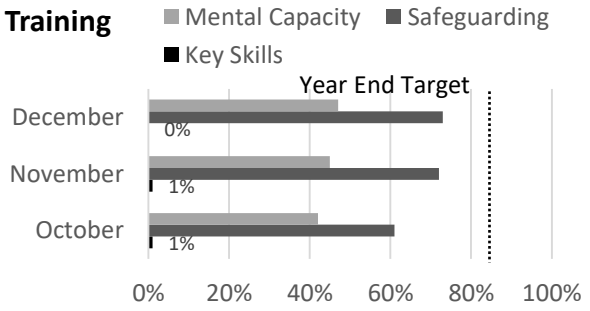
	October	November	December
Ashford	5.0%	5.5%	5.0%
Dorking	10.6%	8.1%	5.1%
KMSS	8.3%	6.8%	5.1%

Practice Indicators

Infection Control

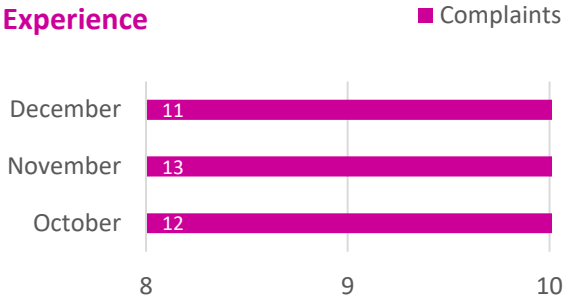


Training

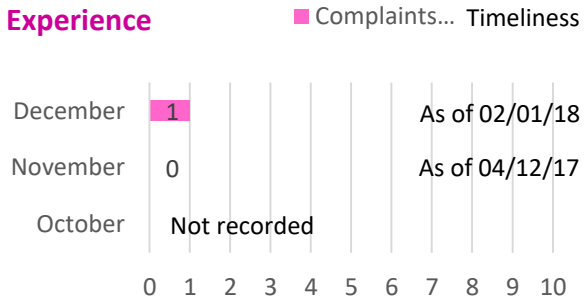


Evaluation Indicators

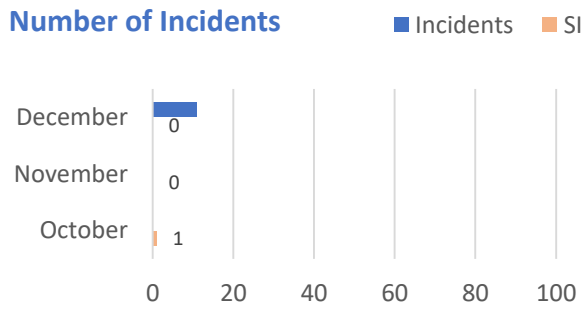
Experience



Experience



Number of Incidents



Narrative: The 111 service remains challenged operationally as a result of many factors including the significant rise in call demand, the higher than planned levels of staff attrition, Health Advisor recruitment and the adverse impact on call Average Handling Time (AHT) by call-routing, a Joint Commissioner Provider (JCP) clinical pilot implemented in Q3. However, from a clinical and patient safety perspective, the service remains strong with full NHS Pathways compliance on all elements including NHS P audits, 24/7 clinician presence, guided transfer headsets, recording functionality. In addition the year on year number of complaints is falling whilst the patient satisfaction level is rising. The key clinical outcomes of ED and 999 referral rates also remain positive compared to the NHS E benchmark.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	181/17

Name of meeting	Trust Board
Date	23. 02. 2018
Name of paper	**Use of Non-Parenteral Medicines by SECAmb clinicians (registered healthcare professionals, healthcare support workers, volunteers)**
Executive sponsor	Dr Fionna Moore
Author name and role	Carol-Anne Davies-Jones, Chief Pharmacist Andy Collen, Consultant Paramedic, Dr Fionna Moore, Medical Director
Synopsis (up to 120 words)	This paper provides a summary of the Trust's legal position regarding the use of non-parenteral prescription only medicines (POMs) by staff and volunteers. Following recommendations from the CQC report in 2017, we have worked to understand and comply with the legislation around those non-parenteral prescription only medications (POMs) drugs given by registered and non-registered clinicians. We have taken advice from the Head of Legal Services and an external expert advisor on medicines governance. This technical paper highlights our current position and the proposed changes for approval by the Board to return the Trust to a legally compliant position. The most far-reaching recommendation is the temporary suspension of the use of the drug salbutamol by the Community First Responders, pending implementation of a training package. This, and other measures proposed for existing members of staff relating to those POMs given by the non-parenteral route, should provide the Trust Board with assurance around the strict governance arrangements in place for the administration of these medicines.
Recommendations, decisions or actions sought	To approve an appropriate approach for the Trust in relation to the administration of non-parenteral medicines where specific legislation does not exist.

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 Foundation Trust

Trust Board

Use of Non-Parenteral Medicines by SECAmb clinicians and volunteers (registered healthcare professionals, healthcare support workers, co-responders, and community first responders)

1. Introduction

1.1. The treatment of patients using medicines is one of the most significant interventions our clinicians carry out. Medicines legislation is very clear regarding who can possess and administer most medicines, and specific exemptions and other mechanisms exist to facilitate the administration of medicines to patients by both our registered healthcare professional staff and non-registrants.

1.2. In the ambulance sector, it is common for non-registrants to give medicines in emergency situations, as well as paramedics.

1.3. All of the injectable medicines in the Trust formulary which can be used in this way are covered by specific legislation. Certain classifications of non-parenteral (swallowed, inhaled etc.) medicines, including those with “P” or “GSL” designations (Pharmacy Only and General Sales List respectively), can be authorised for administration using a protocol i.e. Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines.

1.4. Non-parenteral POMs (prescription only medicines) where no exemption exists present the ambulance sector with a gap in legislation specific to cover this activity, i.e. there is no specific restriction but there is no specific legal permission either. Where these medicines are limited only to registered healthcare professionals ie Paramedics, a patient group direction (PGD) may be created, but some non-parenteral POMs need to be given rapidly in order to reduce the risk of death and/or promote better outcomes.

1.5. This paper provides a briefing on the specific legal, practical, and patient safety challenges relating to administration of non-parenteral medicines, and provides recommendations.

1.6. This paper should be read in context to the procedure currently under development: *Procedure for Possession and Administration of Non-Parenteral Medicines by SECAmb Staff and Volunteers*

2. Responders who administer non-parenteral POMs

2.1. Trust staff (including bank staff) and volunteers fall into the following groups (using the NHS Career Framework designations where applicable);

2.1.1. Registered healthcare professionals (Doctors, Paramedics, Nurses etc)

2.1.2. Associate practitioners (Associate Ambulance Practitioners, Associate Practitioners, Technicians/Advanced Technicians

2.1.3. Healthcare support workers (Emergency Care Support Workers)

2.1.4. Volunteers (Community First Responders)

2.1.5. Co-responders (fire and rescue services)

3. Classifications of Medicines and legal mechanisms

3.1. Medicines are grouped into classifications, based on their legal status and/or product characteristics (including safety record, side effects etc.;

3.1.1. General Sales List (GSL)

3.1.2. Pharmacy item (P)

3.1.3. Prescription Only Medicines (POM) – A medicinal product which may only be sold or supplied against the signed prescription from an appropriate prescriber or given under an alternative legal mechanism, such as a PGD, or an exemption (for example, Schedule 19 of the Human Medicines Regulations 2012).

3.2. The legal mechanisms that cover the use of medicines are complex, and the two schedules within the Human Medicines Regulations (17 and 19) only cover parenteral medicines for administration, and do not include non-parenteral medicines.

3.3. By way of example of the impact of this peculiarity, schedule 19 allows the intramuscular injection of naloxone (a medicine used to reverse opiate overdose), but does not allow its use via intranasal administration. This is because the intranasal route is non-parenteral, and the legislation specifies parenteral injection.

3.4. Registered Healthcare professionals may also follow prescriptions, patient group directions (PGD), and patient specific directions (PSD).

4. Non-parenteral POMs in the Trust currently administered outside of clear legal framework, and recommendation for change

4.1. The current position in the Trust based on the information in this paper is that we have five medicines which are non-parenteral prescription only medicines for which there is no specific legal basis for staff to administer, which we currently authorise for use by other staff and volunteers (some of these medicines are restricted to paramedics/ healthcare professionals only).

4.2. The list also includes the recommendations for changes to these arrangements to ensure both legal compliance and patient safety;

4.2.1. **Clopidogrel**

4.2.2. Clopidogrel is an antiplatelet agent used in patients with confirmed ST elevation myocardial infarctions (STEMI). SECAmb currently stock two antiplatelet medicines.

4.2.3. **Recommendations**

4.2.4. Change to use by paramedics and other healthcare professionals only using a PGD. All other grades of responder have access to aspirin for the treatment of cardiac chest pain.

4.2.5. This would bring both antiplatelet medicines (Clopidogrel and Ticagrelor) under a PGD.

4.2.6. **Diazepam (rectal, as Stesolid)**

4.2.7. Currently only used by paramedics, but is not subject to a clear legal mechanism

4.2.8. **Recommendations**

4.2.9. Develop a PGD to align with all paramedic medicines which are not covered by exemptions

4.2.10. **Ipratropium bromide**

4.2.11. Currently used under Trust Authority for Band 4s and above

4.2.12. **Recommendations**

4.2.13. Develop a clinical protocol to support use in clinical care by staff directly employed by the Trust.

4.2.14. Implement policy and enhanced medicines governance controls.

4.2.15. **Salbutamol**

4.2.16. Trust authority for all directly employed operational staff. No PGD will be developed but this will be subject to a clinical protocol with more detail than the JRCALC guidelines.

4.2.17. Additional considerations for Salbutamol relating to the current state

- We currently authorise directly employed staff and volunteers to administer Salbutamol.

- Ongoing authority for Community First Responders and Co-responders to possess and administer Prescription Only Medicines such as Salbutamol is subject to the recommendations in Section 7.

- Currently, only one other ambulance service London Ambulance Service (LAS) allow CFRs (not co-responders) to use salbutamol, but this is under review. We are consistent with all other trusts regarding authority for directly employed staff, but very much an outlier regarding authority for volunteers to use salbutamol. However British Red Cross, Mountain Rescue teams do have access to salbutamol for administration.

- There needs to be clear understanding that allowing the possession and use of POMs by volunteers/co-responders is

contrary to medicines legislation and is not justifiable due to the factors outlined in the table below.

- In 2016/17 there were 124 administration of salbutamol by CFRs to patients, but there is no audit data to support whether these treatments were for life-threatening asthma or if the patient could have been coached to use their own prescribed/dispensed salbutamol.

- Salbutamol is a potentially life-saving medication which is generally thought to be safe, with a low incidence of complications.

Table highlighting the difference between Volunteers and Directly Employed Staff		
Type of Responder	**Volunteer**	**Emergency Care Support Worker**
Ability to report incidents	No access to DATIX currently (Ability to Incident reporting is currently under review)	Full access to report via DATIX
Training	Locally developed generic training focused on basic life support (Training is under review)	Nationally derived curriculum common to all Trusts.
Supervision	Works alone in the first responder mode, and until the crew arrives on scene	Works with at least a Band 4 clinician and often a paramedic. Does not work alone.
Audit	Limited access to accurate data against which audit of practice can take place	Fully integrated into Trust clinical governance framework.
Line management	CFR have a team leader, which is also a volunteer	Line managed by a paramedic OTL
Safe handling of medicines arrangements	Medicines signed out for long durations. Currently no access to Trust IT/emails, SOPs/policies on the intranet	Medicines signed out for each shift – usually from Omnicell system.

4.2.18. **Recommendations**

4.2.19. Develop a clinical protocol to support use in clinical care by both staff directly employed and volunteers to support medicines governance.

4.2.20. Withdraw salbutamol for CFRs and co-responders for a finite period of time, 6 months. Only reintroduce when there is sufficient evidence that the governance is in place around training, safe and secure handling of medicines, incident reporting and auditing.

4.2.21. – Implement policy and enhanced medicines governance controls.

4.2.22. **Intranasal naloxone**

4.2.23. Trust authority. Non-registered staff can give IM naloxone as a parenteral medicines under the Schedule 19 exemption in the Human Medicines Regulations (2012), but the IN route would require a PGD for paramedic use, or a clinical protocol if authority needs to be extended to other grades of staff.

4.2.24. **Recommendations**

4.2.25. Develop a clinical protocol to support use in clinical care by staff directly employed by the Trust.

4.2.26. – Implement policy and enhanced medicines governance controls.

5. Risks and Benefits (clinical and corporate)

5.1. Risks

5.2. There are a number of risks and benefits which are related to the recommendations within this paper. For the most part, the risks of continuing authorisation for prescription only medicines use by non-healthcare professionals are reputational and legal in origin.

5.2.1. The current state means that we are outside of published legislation for five medicines currently in use in the Trust

5.2.2. The governance controls relating to these medicines and the staff that used them is improving, but even with optimal governance, this still represents a legal and patient safety risk.

5.2.3. The impact of implementing the recommendations in this paper may create an operational impact where an increased number of patients require the attendance of a paramedic.

5.3. Benefits

5.4. From a practical perspective, there are residual issues which can be addressed through improvements to governance, training, audit, supervision etc, However, the legal basis for the use of POMs outside of a clear legal framework is an immovable object, and requires the Trust to take a decision to operate otherwise than in accordance with the law on the basis of patient benefit outweighing the legal issues.

5.4.1. Adopting the recommendations will return the Trust to an improved state of legal compliance.

5.4.2. From a regulatory perspective, the medicines which remain in use outside of the published legislation, such as Salbutamol, will be subject to a specific policy and enhanced medicines governance controls.

5.4.3. Restricting medicines as far as practicable will demonstrate further commitment to patient safety by aligning to the legislation wherever possible

5.4.4. These recommendations will lead to greater focus on deploying the correct clinician to the patient where a POM is indicated.

6. Summary

6.1. With regards to its directly employed staff of registered healthcare professionals and non-registered professionals (including Bank staff), SECAmb is in line with all other trusts regarding the use of non-parenteral POMs.

6.2. Where we differ is allowing access to non-parenteral POMs for volunteers (CFRs) and Co-responders (i.e. FRS). The medicines review in the wake of our warning notice in the summer of 2017 has provided us the opportunity to look in detail at the legal aspects of medicines use, and means that we are ahead of other Trusts in identifying the legal gaps, and therefore the patient safety gaps.

6.3. A policy has been drafted which covers all aspects of Trust medicines authority (attached draft).

6.4. We have listed the recommendations summarised from this paper in the next section. The Board is asked to consider these recommendations which, when followed, will bring SECAmb in line legislatively, while preserving the quality of care and promoting patient safety.

7. Recommendation

7.1. The Board is asked to note the progress made thus far in terms of addressing CQC requirements and recommendations and to note the Trusts current arrangements for the administration of non-parenteral POMs by paramedics and non-paramedics and agree the following decisions;

7.1.1. To suspend temporarily CRFs and co-responders using POMs (salbutamol) on the basis that the legislation does not support this and current medicines governance needs to be developed with volunteer workforce over the next 6 months.

7.1.2. To authorise at Board level, the use of specific non-parenteral POMs by defined grades of directly employed staff, otherwise than in accordance with the Medicines Act 1968 and the Human Medicines Regulations (2012), on the basis of immediate care for patients and in line with published best practice clinical guidelines (JRCALC).

7.1.2.1. Authority to possess and administer individual non-parenteral medicines is published, by clinical grade, in Appendix M of the Scope of Practice & Clinical Standards Policy

7.1.3. To formally agree at Board level to the recommendations set out in section 4.2 relating to the specific changes to those medicines listed as required.

7.1.4. Develop a communication strategy to support these recommendations.

Carol-Anne Davies-Jones	**Andy Collen**
Chief Pharmacist	Consultant Paramedic

NHS
South East Coast
Ambulance Service
NHS Foundation Trust

Integrated Performance Report

Performance Data for our 999 and 111 Services

Aspiring to be
Better Today and
Even Better Tomorrow
for our people and our patients

Board Meeting

February 2018

SECAmb Executive Summary

This Integrated Performance Report follows on from recent review and feedback given at Trust Board held on 11th January 2018. Reporting processes will be continually refined to:

1. Bring reporting under domains as defined by CQC. This is intended to assist SECAmb it its response to recent reviews by CQC and provide a frame work for reporting that facilitates a global and enduring view of the organisation's performance.
2. Include metrics and data from our recovery projects. This information will be transferred from the Trust's delivery Plan Dashboard as Projects deliver/close and there is an ongoing requirement to monitor performance.

Clinical Safety

There have been no significant changes in the clinical performance indicators trends (data from September 2017). As part of continuous quality improvement, there is an increased focus on sharing clinical safety data with individual Operating Units, giving Operational Team Leaders local information that they can discuss and act on with their teams. Clinical briefings have highlighted the importance of delivering all the elements of the care bundles, and the resulting benefits for patients.

Clinical Quality

Incidents - the reporting of low, no and near miss harms continue to increase towards the national average of 96% of all harms reported SECAmb currently reporting at 94%. Moderate, severe and death harms increased and overall reporting increased by 44% in the Christmas period.

Serious incident reporting increased over the December / January period with 12 being related to delays in attendance. Duty of candour compliance improved due to a change in the process where the initial contact is made by the incident team and not the investigator. On-going candour will be taken up by the investigator.

Complaints received increased overall in the month however the response performance improved in month and has been sustained into February

Hand hygiene remains below target trajectory of 95% at 84%, but shows a 1% improvement on the previous month.

Operations Performance

Continued emphasis is being place on our ability to deploy additional and targeted hours. In addition, the Trust continues to review EOC Operations including call pick up and plans have been shared for the EOC which forecast achievement of the 95th percentile for Call Pick Up by August 18. SECAmb's performance and actions to improve C1 and C4 also includes the following work:

Category 1 - Team leads are reviewing unit hours utilisation and EMA availability across 24 hour, weekly and monthly timeframes to highlight specific issues and target mitigation. The Trust also monitors EMA establishments and in particular within our Crawley EOC. Technical performance is reviewed together with the creation of an EOC score card to show call handling data on a daily basis.

An important operational concern is ETA call backs. When resourcing is adversely affected, this results in patients calling back for an ETA and increases call volume. This is being analysed to assess impact. Ongoing work within the EOC is also assessing the Nature of Call in that delivering clarity in this area will help in optimising call response time. The Trust continues to review its System Status Plan to optimise the Trust's deployment of its assets.

Category 4 - Many calls in this category come from NHS 111 where they would have had a clinical review. With this in mind, SECAmb is taking the opportunity to cross reference its operations to test if such patients are amenable to 'fit to sit' vehicles and have this information put in notes for the dispatcher when transferred.

Workforce

Compliance with appraisals and statutory and mandatory training continue to increase in line with the trajectory to deliver the target.

The vacancy rate metrics have remained constant with a projection of improvement through to the end of the financial year as we increase the number of recruitment assessment days.

Sickness absence has increased slightly but this is in line with seasonal variations in previous years.

The Board is asked to note the Report.

SECAmb CQC Rating and oversight framework

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

SECAmb Financial Performance

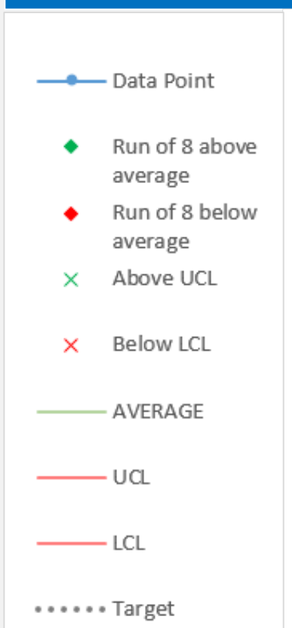
The Trust remains on track to achieve its control total of £1.0m deficit for the year after receipt of planned Sustainability and Transformation Funding (STF) of £1.3m. The Trust made a surplus of £0.8m in the month, which was in line with plan. Discussions with commissioners regarding the contract settlement for the year are being finalised. A detailed month Finance Pack is shared and is monitored through the Finance and Investment Committee (a sub committee of the Board).

SECAmb Issues and Points of Note

As we move forward we will be framing this report by CQC domains of safe, caring, effective, responsive and well led (in Workforce, Finance and Efficiency)

Contents

Chart Key



This represents the value being measured on the chart

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.
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.

This line represents the average of all values within the chart.

These lines are set two standard deviations above and below the average.

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 Return of Spontaneous Circulation (ROSC) - Utstein (a set of guidelines for uniform reporting of cardiac arrest)

	Jul-17	Aug-17	Sep-17	12 Month's
Actual %	37.9%	54.5%	50.0%	
Previous Year %	69.0%	48.1%	44.1%	
National Average %	53.4%	53.8%	51.0%	

Cardiac ROSC - ALL

	Jul-17	Aug-17	Sep-17	12 Month's
Actual %	24.4%	25.6%	25.7%	
Previous Year %	31.7%	26.0%	25.3%	
National Average %	30.9%	30.8%	32.0%	

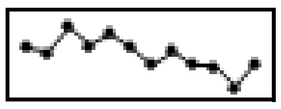
Cardiac Survival - Utstein

	Jul-17	Aug-17	Sep-17	12 Month's
Actual %	17.2%	40.6%	26.3%	
Previous Year %	28.6%	34.8%	30.0%	
National Average %	28.7%	28.8%	32.8%	

Cardiac Survival - All

	Jul-17	Aug-17	Sep-17	12 Month's
Actual %	3.6%	10.0%	5.7%	
Previous Year %	10.4%	8.9%	9.4%	
National Average %	10.0%	10.0%	10.6%	

Acute ST-Elevation Myocardial Infarction (STEMI) Care Bundle Outcome

	Jul-17	Aug-17	Sep-17	12 Month's
Actual %	62.9%	64.4%	71.9%	
Previous Year %	64.7%	72.7%	76.6%	
National Average %	76.3%	73.8%	76.9%	

Acute STEMI receiving primary angioplasty within 150 minutes

	Jul-17	Aug-17	Sep-17	12 Month's
Actual %	85.9%	86.5%	79.5%	
Previous Year %	95.2%	89.9%	86.7%	
National Average %	82.6%	86.7%	83.6%	

FAST Identified Stroke - arriving at a hyper acute stroke unit within 60 minutes

	Jul-17	Aug-17	Sep-17	12 Month's
Actual %	57.5%	57.5%	48.0%	
Previous Year %	67.2%	66.8%	62.6%	
National Average %	55.2%	54.0%	50.0%	

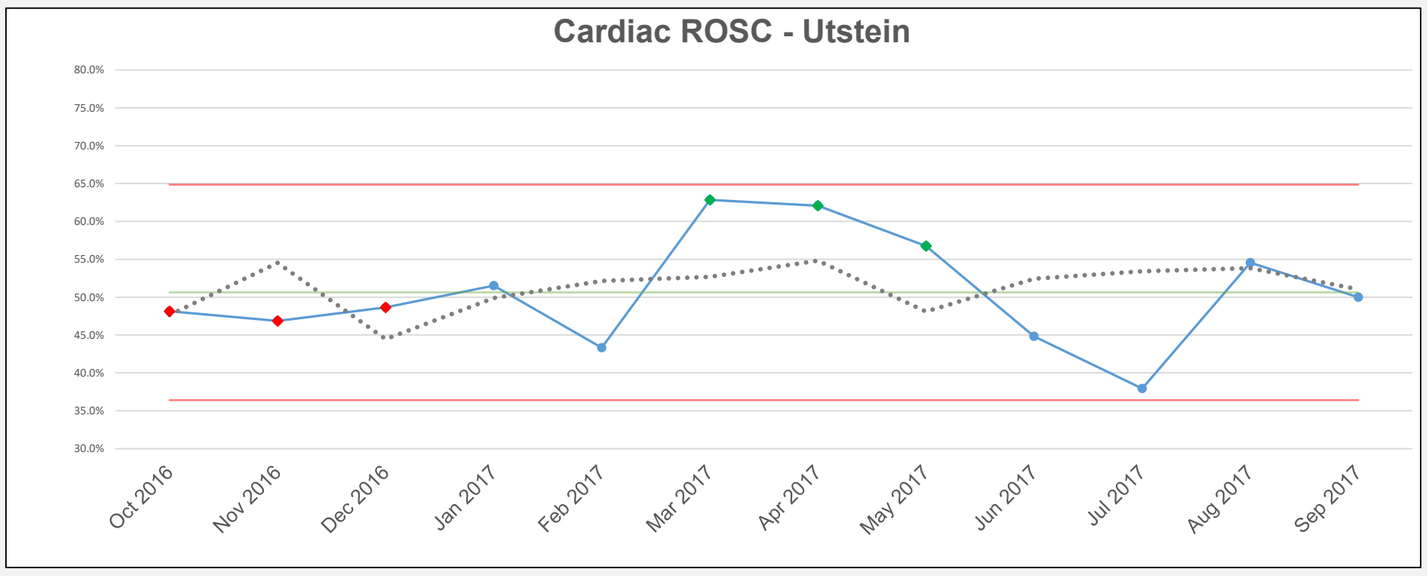
Stroke - assessed F2F receiving care bundle

	Jul-17	Aug-17	Sep-17	12 Month's
Actual %	95.2%	95.6%	93.1%	
Previous Year %	96.5%	94.2%	95.6%	
National Average %	97.2%	97.5%	96.7%	

Medicines Management

	Nov-17	Dec-17	Jan-18	12 Month's
Actual	97.10%	96.70%	97.76%	
Number of audits	136	218	201	

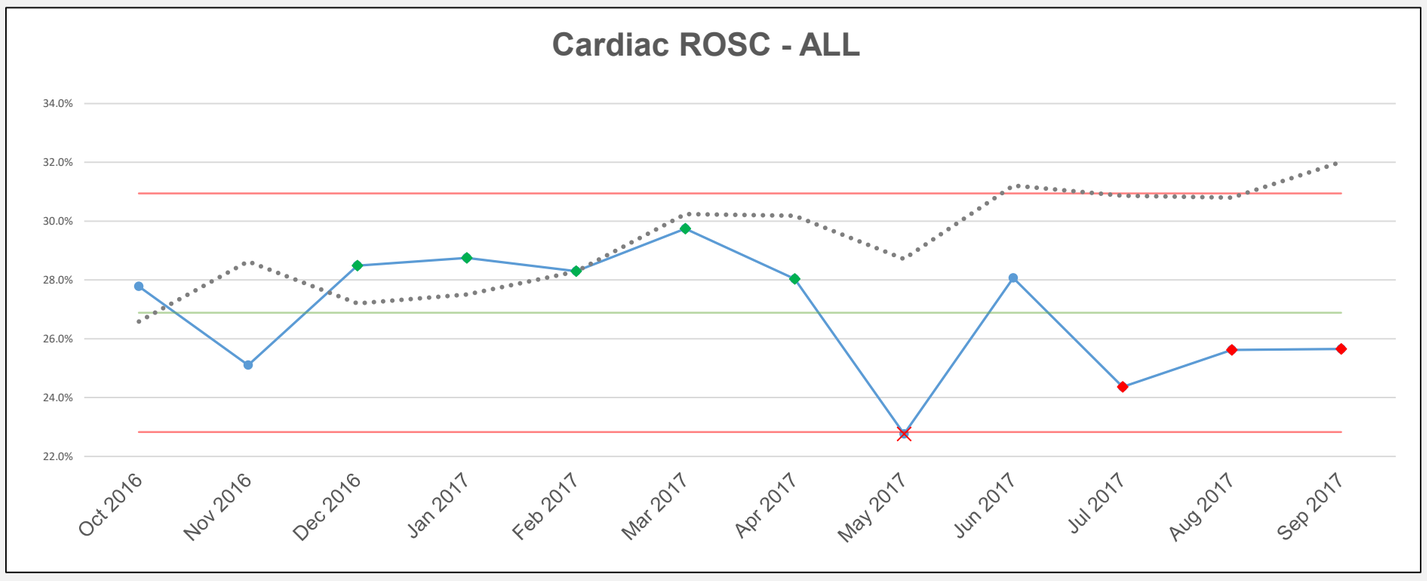
SECAmb Clinical Safety Charts



Performance for the cardiac arrest ROSC indicator for the Utstein group for September 2017 is in line with SECAmb YTD and the national average.

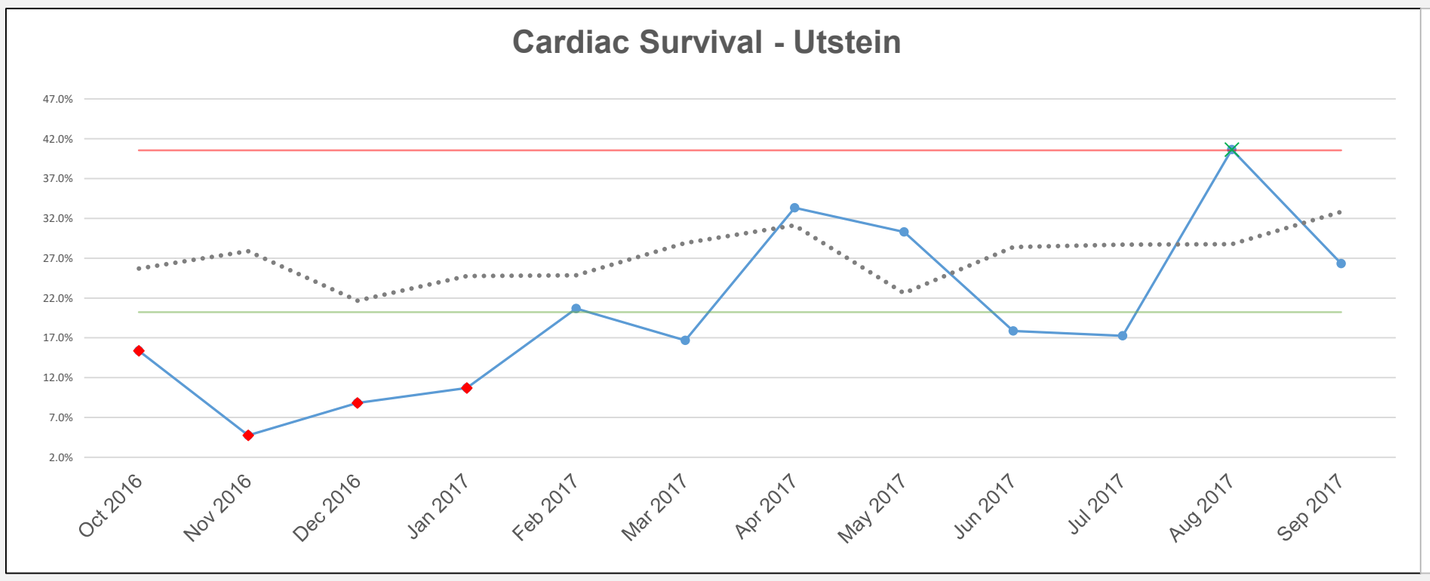
The medical directorate continue to explore potential quality improvement opportunities, including the development of a cardiac arrest registry.

A business case has been approved that will facilitate increased roll-out of mechanical Cardio Pulmonary Resuscitation (CPR) devices.

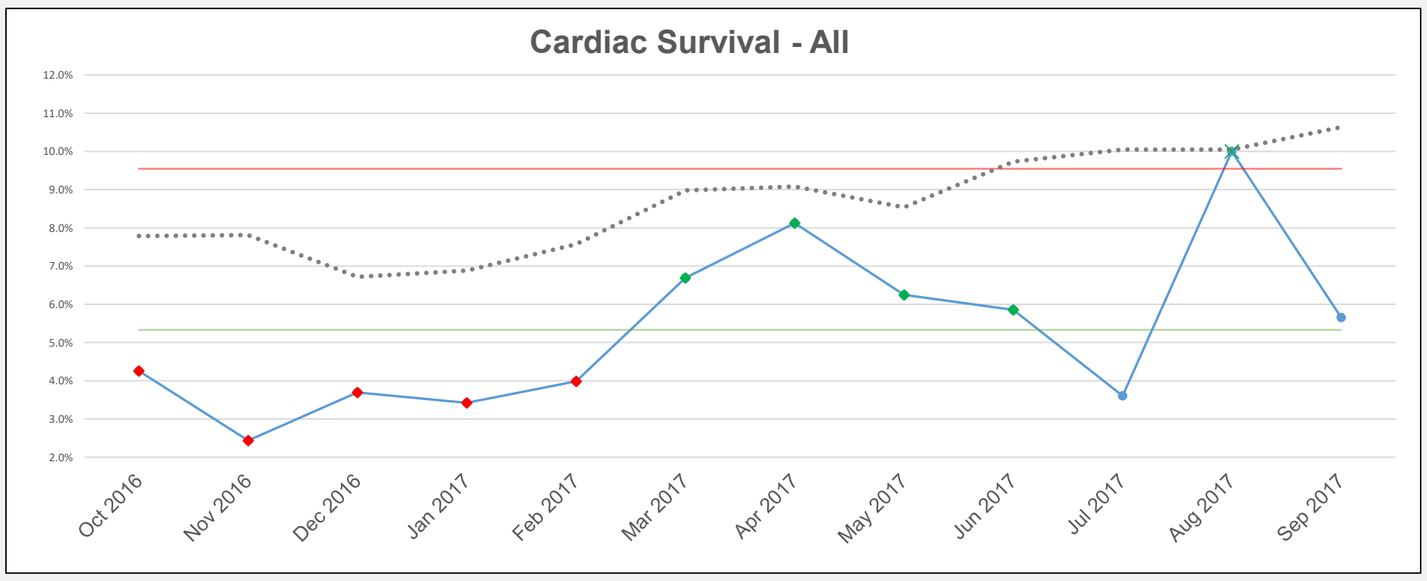


In September 2017 our performance for ROSC in all patient groups remains below the SECAmb YTD average.

Additional resuscitation training has been delivered to Operational Team Leaders who will cascade this learning to operational staff as part of the 18/19 'Key Skills' education programme.

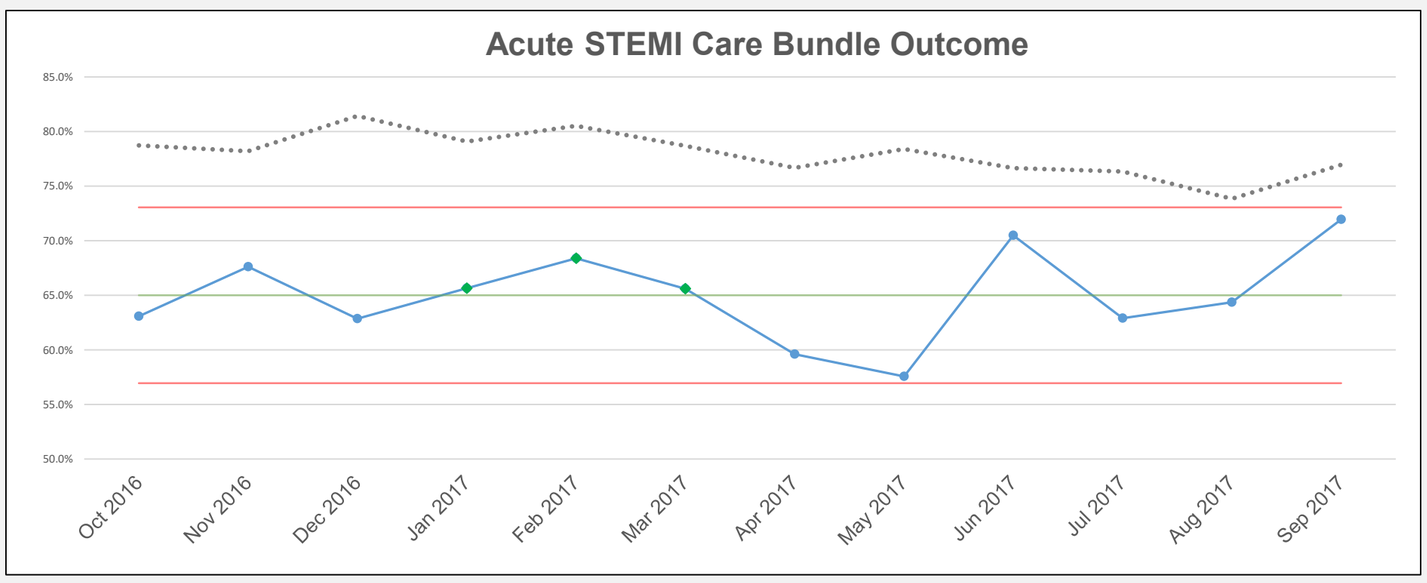


In September 2017, survival to discharge for the Utstein group was above our mean, but is below the national average. The data continues to show normal patterns of variation.



In September 2017, our cardiac survival for all cardiac arrest patients was above our average, but remains below the national average.

This appears to be in line with normal patterns of variation.



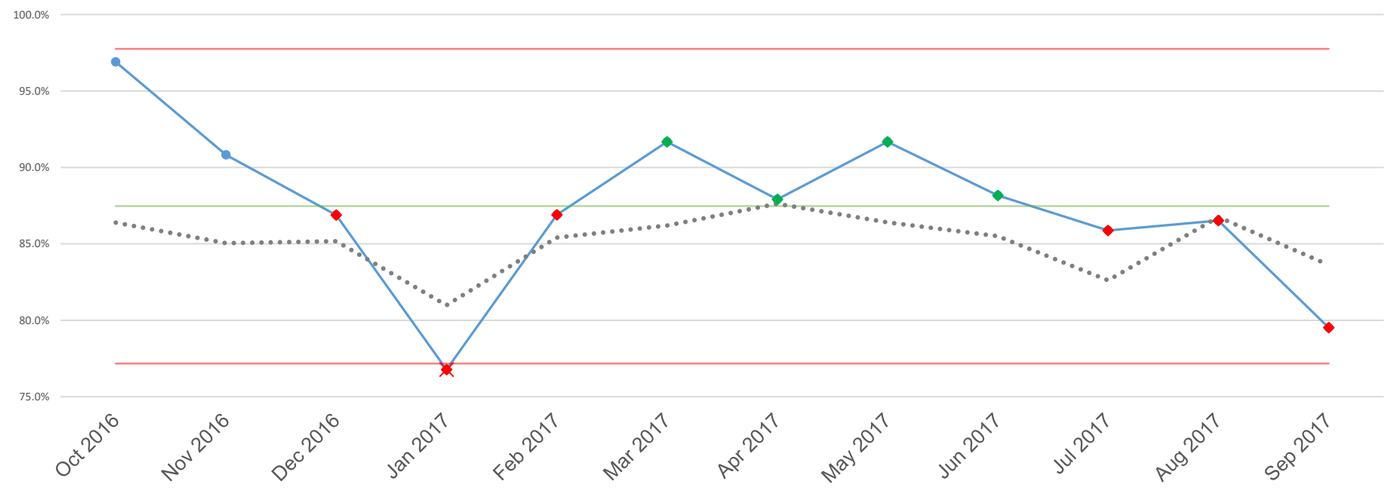
Performance for September 2017 increased to 73% and is above our YTD average.

Dashboards and quality scorecards showing local performance levels are now routinely being shared with Operating Units (OUs) to facilitate focussed quality improvement.

STEMI care is planned for inclusion in the trust's 18/19 CPD programme.

SECAmb Clinical Safety Charts

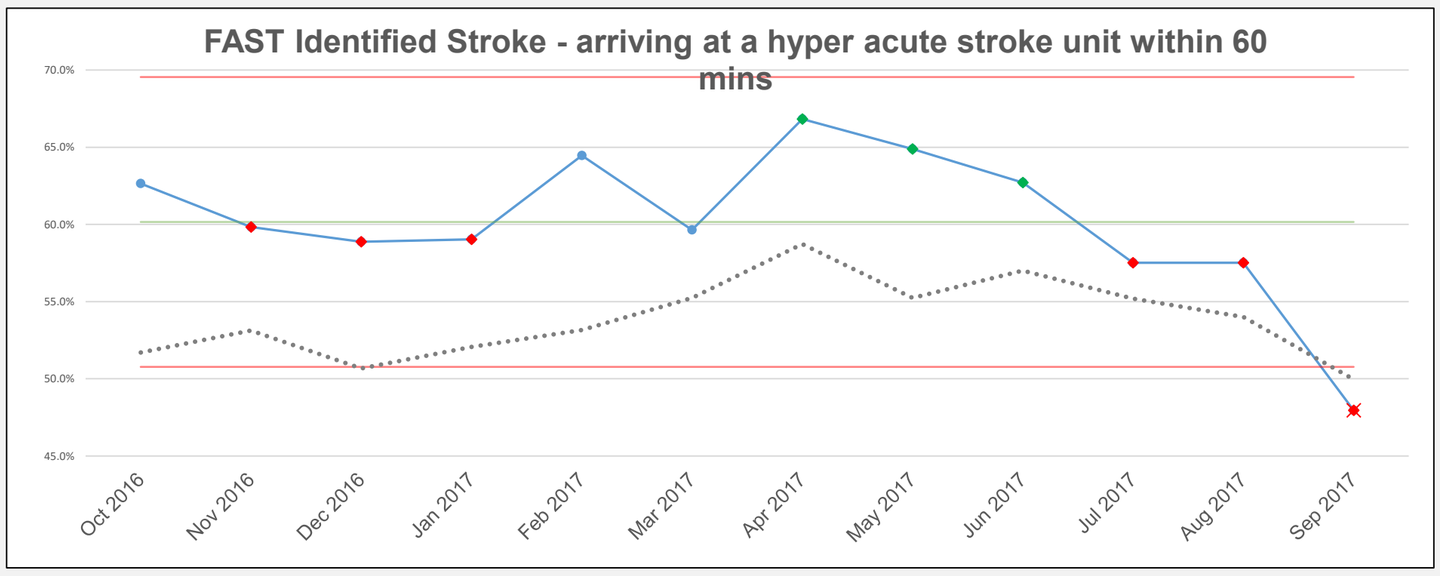
Acute STEMI receiving primary angioplasty within 150 minutes



September 2017 saw a decrease on the previous month's performance against this indicator. We are below the national average for the first time in seven months.

The reduction in performance against this indicator is in line with a reduction in our performance against the red 1 and red 2 targets for that period .

FAST Identified Stroke - arriving at a hyper acute stroke unit within 60 mins

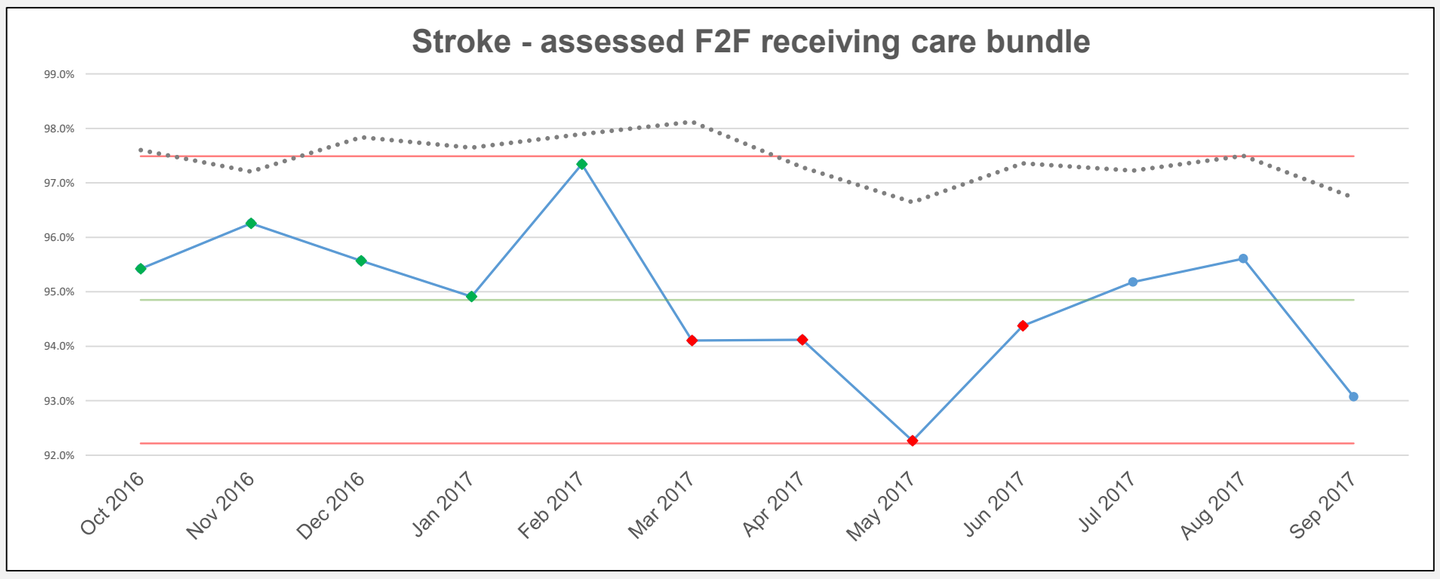


September 2017 performance for FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper acute stroke unit (HASU) within 60 minutes was below our mean and below the national average for the first time in over 11 months. Our performance for September 2017 is outside of control limits, which shows that it is outside of our expected levels of variation.

The reduction in performance against this indicator is in line with a reduction in our performance against the red 1 & 2 targets for that period.

The importance of reducing time on scene in stroke and STEMI patients is being emphasised in training delivered by our education team.

Stroke - assessed F2F receiving care bundle



Performance in completing the stroke care bundle is below national and our YTD average.

Dashboards showing local performance levels have now been shared with OUs facilitate focussed quality improvement. Regular reminders of the importance of the completion of care bundles are placed in staff communications.

Further work is planned to facilitate quality improvement in this area.

Analysis of Cardiac Arrest Data - September 2017

Number of cardiac arrests identified = 601
including DNACPR (60) / DOA (300) / No Resus by SECAmb (11)

Number of resuscitation attempts = 230

Utstein definition
Bystander witnessed
Presenting rhythm VF
Cardiac in origin

Non ROSC Definition
Patients transported to hospital in cardiac arrest with resuscitation still in progress

Utstein Data = 38 (16.5%)

Overall = 230 (100%)

ROSC sustained to hospital =
19 (50%) + 2 non ROSC

ROSC (incl. Utstein) sustained to hospital
= 59 (26%) + 4 non ROSC

Outcomes for ROSC at Hospital and Non ROSC at Hospital Patients		
Utstein	Details	Overall
10	Patient survived to discharge	13
11	Patient died in hospital	50
0	Patient still in hospital*	0
0	Patient record not found by	1
0	No reply from hospital*	0

Survival to discharge is calculated as a percentage of the Overall or Utstein figures minus any missing patient outcomes as detailed * above

Survival to Discharge = 10 (26%)

Survival to Discharge (incl. Utstein) = 13 (6%)

Additional Information - Resuscitation Attempts

Cardiac Rhythm	Overall Totals	ROSC at Hospital	Non ROSC at Hospital
Asystole	123 (53%)	14	1
PEA	54 (23%)	22	1
VF	46 (20%)	23	2
Non-shockable	1 (0%)	0	0
Not recorded	6 (3%)	0	0

CPR Bystander - 137

EMS Witnessed arrest - 21

Cardiac Arrest downloads received for September 17	
Cardiac Arrest download reports sent to crews	

Analysis of Cardiac Arrest Data by area - September 2017

Number of Resuscitation attempts = 230

Utstein Data Kent = 20 (34%)	Overall Kent = 89 (39%)
Utstein Data Surrey = 6 (3%)	Overall Surrey = 51 (22%)
Utstein Data Sussex = 12 (5%)	Overall Sussex = 90 (39%)

ROSC sustained to Hospital Kent = 8 (40%) + 2 non ROSC	ROSC (incl. Utstein sustained to Hospital Kent = 25 (28%) + 3 non ROSC
ROSC sustained to Hospital Surrey = 3 (50%) + 0 non ROSC	ROSC (incl. Utstein sustained to Hospital Surrey = 17 (33%) + 0 non ROSC
ROSC sustained to Hospital Sussex = 8 (67%) + 0 non ROSC	ROSC (incl. Utstein sustained to Hospital Sussex = 17 (19%) + 1 non ROSC

Outcomes for ROSC at Hospital and Non ROSC at Hospital Patients

Area	Utstein	Details	Overall
Kent	4	Patient survived to discharge	4
Surrey	2		3
Sussex	4		6
Kent	6	Patient died in hospital	23
Surrey	1		15
Sussex	4		12
Kent	0	Patient still in hospital*	0
Surrey	0		0
Sussex	0		0
Kent	0	Patient record not found by hospital*	0
Surrey	0		0
Sussex	0		0
Kent	0	No reply from hospital*	0
Surrey	0		0
Sussex	0		0

Survival to discharge is calculated as a percentage of the Overall and Utstein figures minus any missing patient outcomes as detailed * above

Survival to Discharge Kent = 4 (20%)	Survival to Discharge (Incl. Utstein) Kent = 4 (4%)
Survival to Discharge Surrey = 2 (33%)	Survival to Discharge (Incl. Utstein) Surrey = 3 (6%)
Survival to Discharge Sussex = 4 (33%)	Survival to Discharge (Incl. Utstein) Sussex = 6 (7%)

SECAmb Clinical Quality Scorecard

Number of Incidents Reported

	Nov-17	Dec-17	Jan-18	12 Month's
Actual	665	811	748	
Previous Year	580	512	529	

Number of Incidents Reported that were SI's

	Nov-17	Dec-17	Jan-18	12 Month's
Actual	4	7	22	
Previous Year	1	2	1	

Duty of Candour Compliance (SIs)

	Nov-17	Dec-17	Jan-18	12 Month's
Actual %	75%	80%	100%	
Target	100%	100%	100%	

Number of Complaints

	Nov-17	Dec-17	Jan-18	12 Month's
Actual	107	93	111	
Previous Year	111	114	132	
Complaints Timeliness (All	35.5%	44.0%	59.6%	
Timeliness Target	95%	95%	95%	

Compliments

	Nov-17	Dec-17	Jan-18	12 Month's
Actual	NA	121	109	

Safeguarding Training Completed (Adult) Level 2

	Nov-17	Dec-17	Jan-18	12 Month's
Actual %	55.55%	59.65%	69.33%	
Previous Year %	Dev	Dev	Dev	
Target	67%	75%	83%	

Safeguarding Training Completed (Children) Level 2

	Nov-17	Dec-17	Jan-18	12 Month's
Actual %	54.70%	59.07%	69.63%	
Previous Year %	Dev	Dev	Dev	
Target	67%	75%	83%	

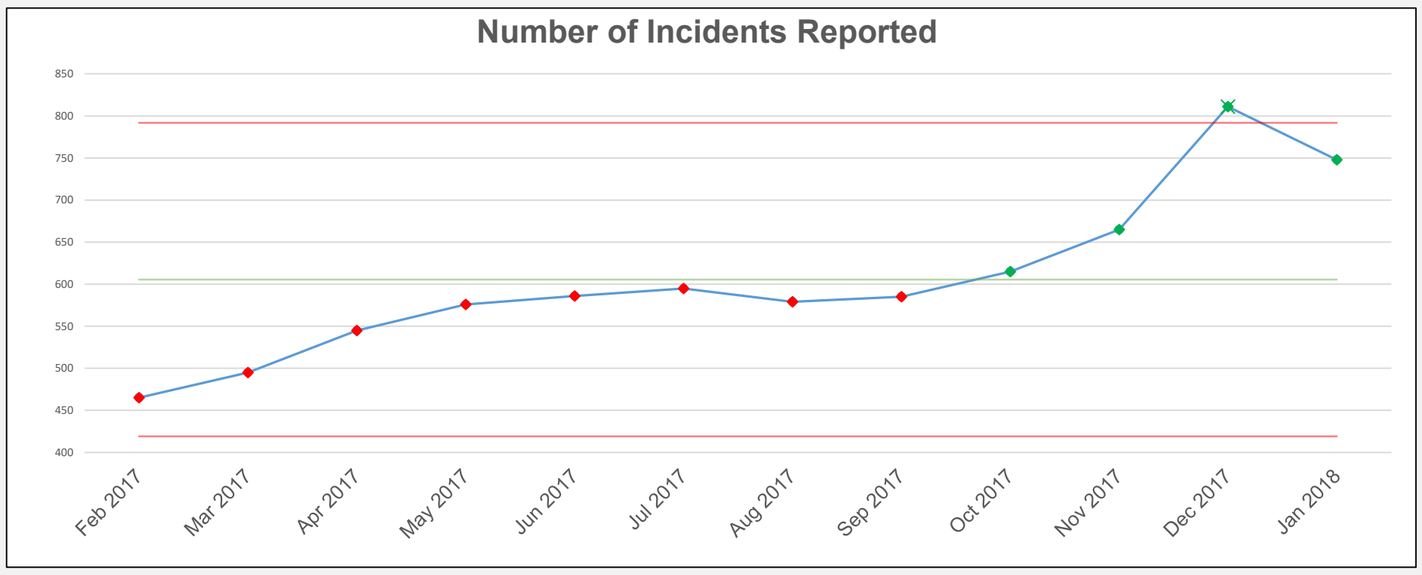
Safeguarding Training Level 3 (Adult/Child)

	Nov-17	Dec-17	Jan-18	12 Month's
Actual %	48.10%	54.41%	77.58%	

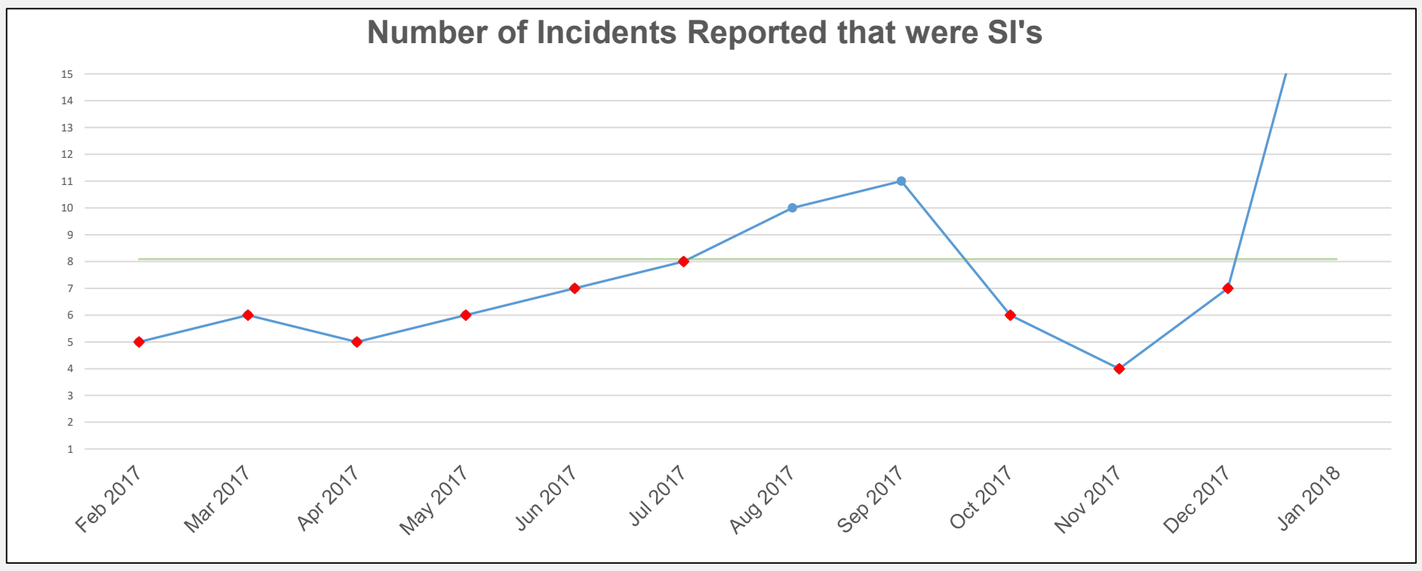
Hand Hygiene

	Nov-17	Dec-17	Jan-18	12 Month's
Actual %	89%	83%	84%	
Target	90%	90%	90%	

SECAmb Clinical Quality Charts



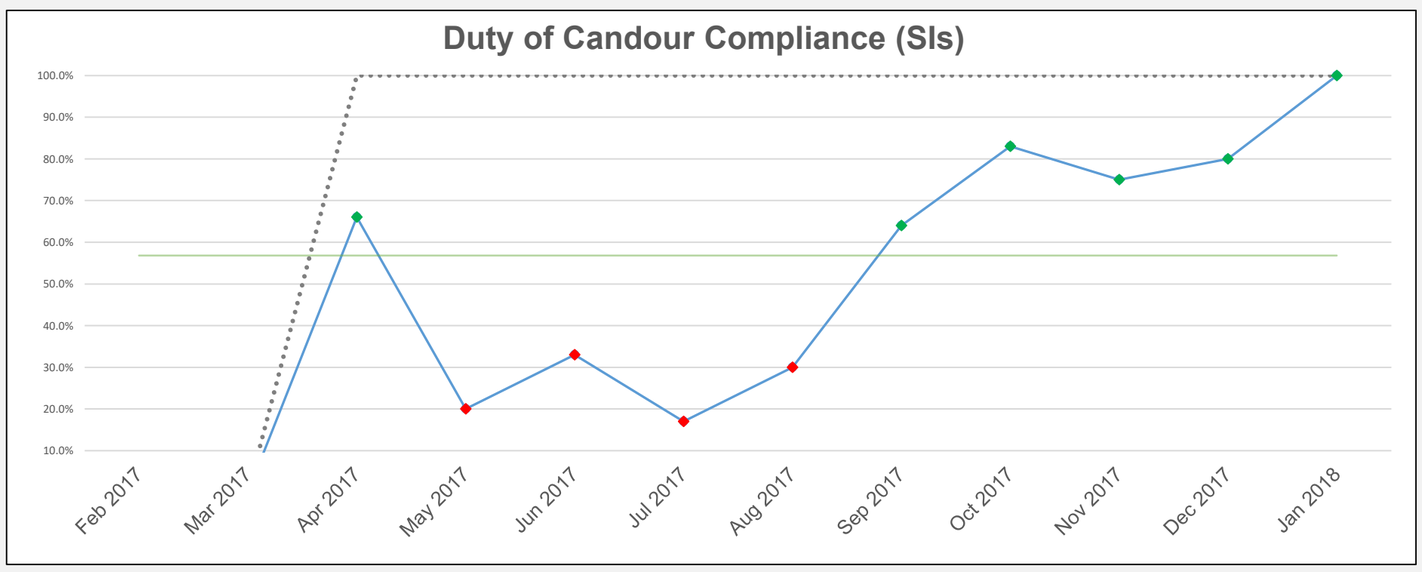
Incident reporting rates continue to be elevated across the organisation with this months figures resting at 747 for January 2018. The slight drop in number is owing to there being a increase in reporting owing to winter pressures during December. During the next quarter we aim to further increase incident reporting across the trust by including complaints that are incidents and Community First Responders being able to report directly via the Datix system. We will also be including RTC's to be reported directly onto the Datix system rather than via a road traffic accident report form which is submitted to fleet.



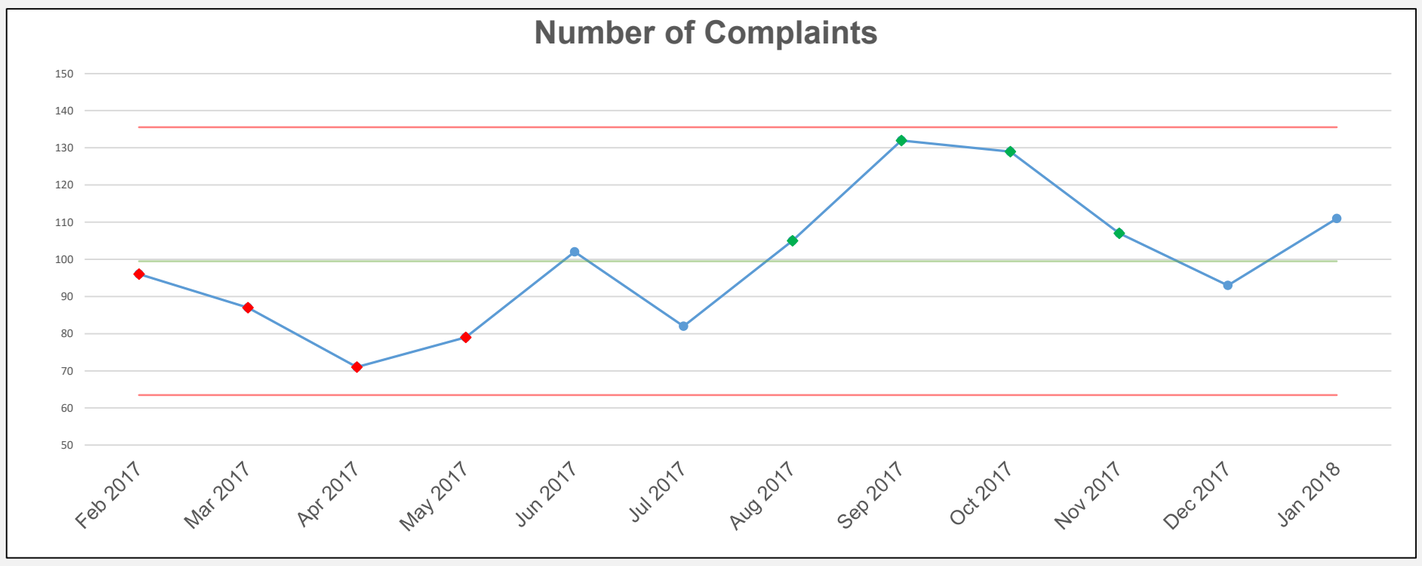
Of 22 reported incidents 12 related to delays in attendance. 2 incidents related to initial call answer delays.
2 incidents related to vehicles, 1 was a tail lift failure and 1 was a vehicle fire in the garage.

3 Patient Injuries were reported, one connected to a stretcher overturning and another to a fracture whilst transferring into a chair.

All incidents were reported on STEIS within national framework timescales.

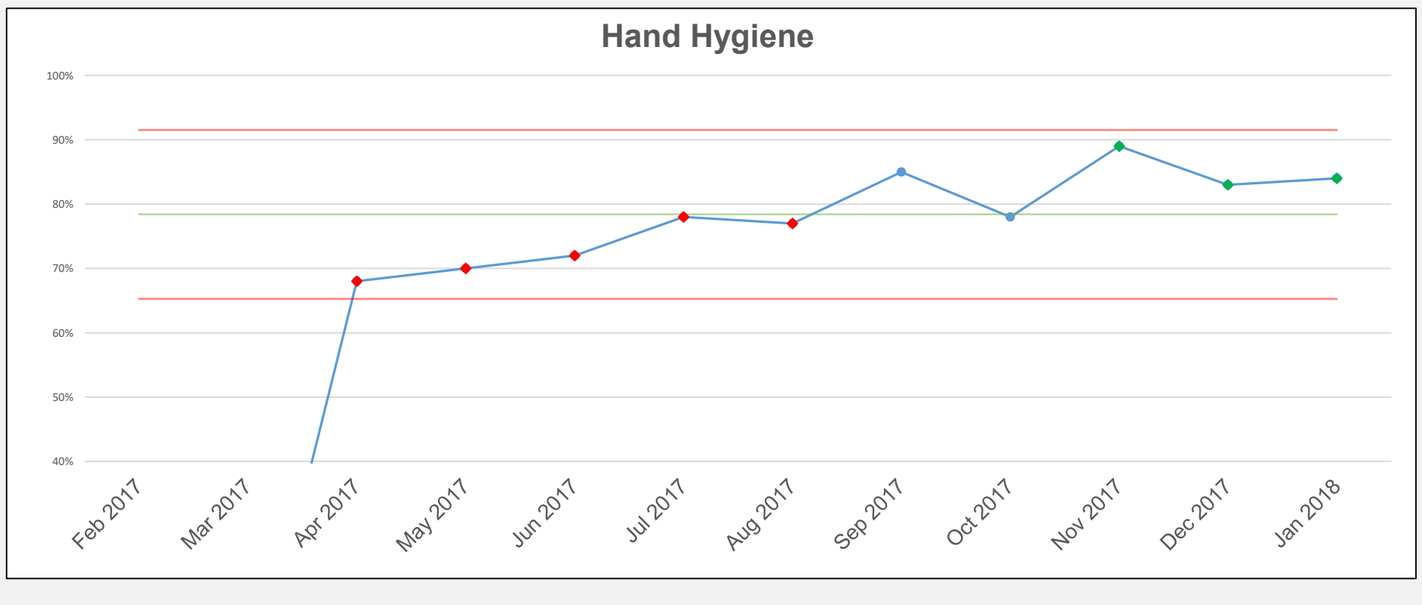


There is now a robust process for ensuring that DoC is completed following declaration of the serious incident at the weekly SIG meeting. This month there is a 100% compliance with DoC.



The number of complaints received in January increased, with 111 compared to 93 in December. Thirty-two per cent of complaints were about the timeliness of ambulance response or backup. There were 36 such complaints in January, compared to 41 in November and 32 in December. Complaints about staff are largely unchanged, with 22 compared to 21 in December, forming 20% of the total. The largest proportion of complaints were about patient care (37%), with 41 in total: 20 about crew care, ten about NHS111 triage, and 11 about EOC triage.

In January 59.4% of complaints were responded to in time, and performance has continued to improve into February, with 90%+ responded to within timescale from 1 – 16 February.



We saw a small improvement in the Trusts overall Hand Hygiene compliance for January from 83% to 84%, but some Operating Units are still not maintaining the requirement of ten audits per week. They were - Brighton, Chertsey, Paddock Wood and Redhill / Gatwick. The IPC Team have asked the IPC Champions in each area to liaise with the OTL's in the OU to rectify this for February.
We have now separated the two HART teams from the OU reports and asked that they carry out five audits per week and they are now showing on the Dashboard as a separate line.
The IPC Dashboard has been welcomed in all areas as it enables staff to keep up with both the number of audits carried out and their compliance levels.

SECAmb Health and Safety Reporting

Health and Safety (H&S)

Introduction

Having highlighted the need to strengthen our H&S team, work has begun to recruit a Head of H&S and two H&S managers, with new job descriptions written and matched. This will take a couple of months to come to fruition but it is envisaged that the new team will be in place early in the new financial year to allow greater monitoring and practical support to our Operating Units, EOCs and support services. The external review of our H&S provision has begun by Matura and meetings with key stakeholders both centrally and at a number of predetermined sites across the Trust are being planned over the next few weeks, so that an objective baseline assessment can inform a new service improvement plan.

Despite the resourcing challenges there is ongoing work being carried out to improve Health and Safety, which is overseen by the Central Health and Safety Working Group.

- The area H&S groups are planned to commence in February allowing greater local ownership of issues.
- The review of risk assessments and policies continues with a new fire safety policy presented to the joint partnership forum in February which needs a few minor amendments.
- More work is needed on the Director led staff safety walk rounds to clearly differentiate there purpose from that of the Quality Assurance Visits, and to create a schedule to allow understanding of the time commitment required.
- We have recruited a temporary bank Health and Safety manager to support the team while recruitment takes place.

We were visited by the Health and Safety Executive on the 2nd February as part of a national program of visits to ambulance trusts. The purpose of this visit was to seek board assurance into how we manage the issue of manual handling injuries but also touched on stress, and violence and aggression towards our staff. It was a positive meeting and also raised the issue of the lack of a high level national forum which Daren will take forward as a suggestion for the Association of Ambulance Chief Executives.

Violence and Aggression Incidents - See Figure 1 below

The number of reported incidents of violence and aggression toward our people continues to show a slow downward trend.

These incidents range from verbal abuse to actual physical assault. Our Security manager continues to pursue sanctions through partnership working with local police forces. The risk from lone working has been reduced by the move to ARP, we need to further strengthen our lone worker policy and procedure to ensure avoidable risks are highlighted at the earliest opportunity, ideally before dispatch.

Manual handling Incidents - See Figure 2 below

The manual handling incidents are predominantly associated with moving patients using equipment with the carry chair most commonly cited but are not always avoidable. Data from Optima Health has confirmed that lower back injuries are the most common cause of muscular skeletal disorder referral, totalling 53%. This information will begin to inform targeted risk assessment based training sessions to be included in 2018/19 operational key skills training Manual handling training is included in the Statutory and mandatory training every year with a theoretical and practical application.

Manual Handling reported incidents by Operating Unit - See Figure 5 below

There is considerable variation between Operating Units. The Operating Units do vary in head count of staff but this does not account for the size of the variation. More analysis is required to establish if the variation is due to differing operational practices or a better reporting culture in some areas with higher reporting of near misses.

H&S incidents - See Figure 3 below

An upward trend continues to be seen in the reporting of H&S incidents which is in line with the Trust's intention to increase the number of low/no harm incident reports but there has been a slight dip in January. This is an indication of greater awareness of potential risks and therefore a safer working environment. During Quality Assurance Visits, staff are now being encouraged to report low/no harm issues as well as any highlighted during the visit.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)) - See Figure 4 below

These continue to be predominantly muscular skeletal disorders associated with injuries caused or exacerbated at work. The number of reported Display Screen Equipment reports are very low and interestingly during their visit the Health and Safety Executive questioned whether they were still relevant given the improvement in equipment since the regulations were introduced.

Figure 1

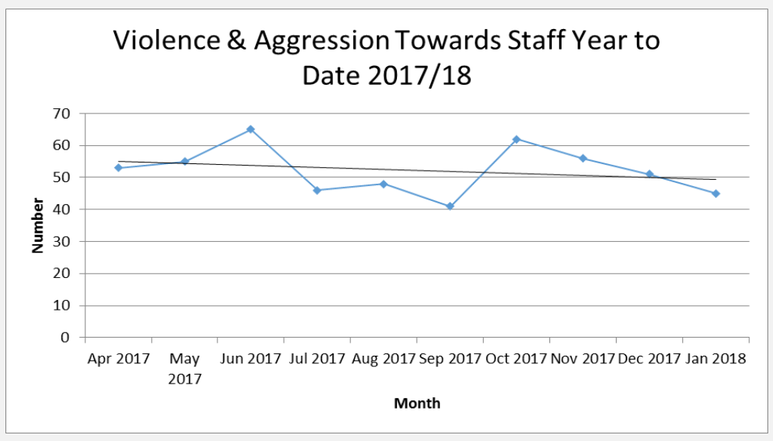


Figure 2

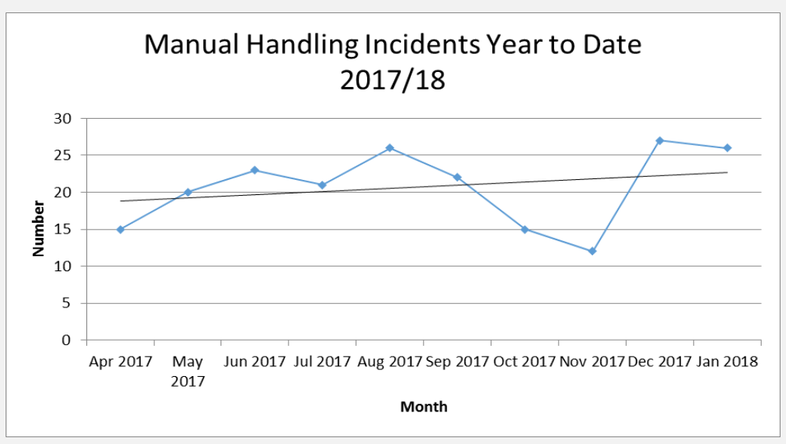


Figure 3

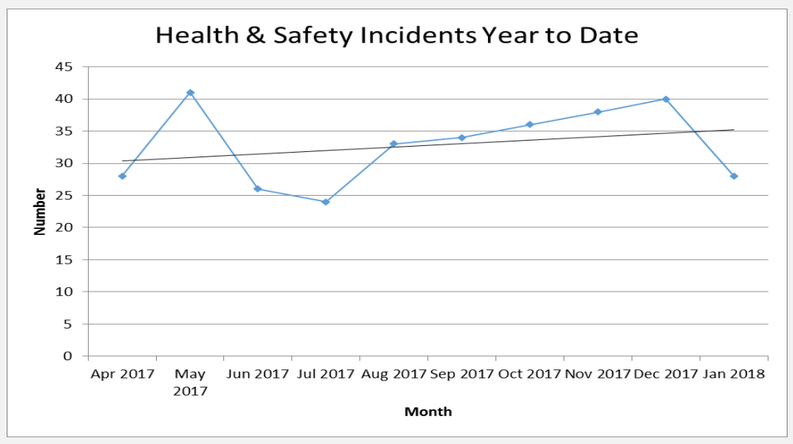


Figure 4

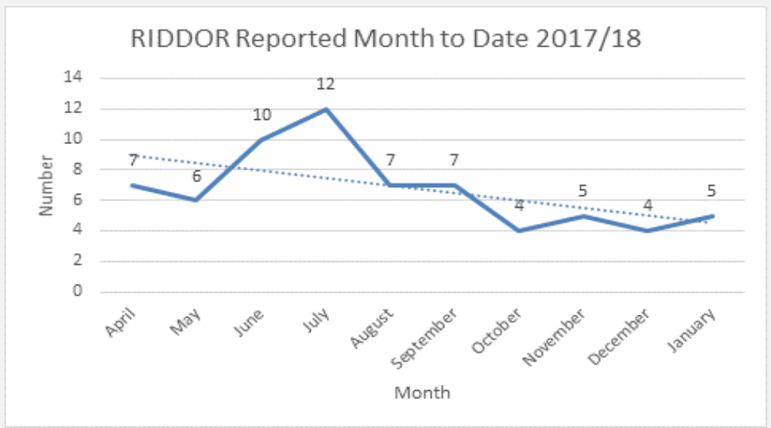
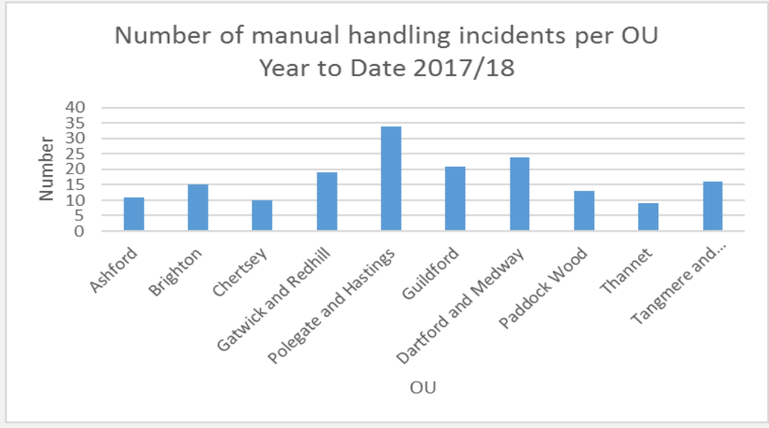


Figure 5



SECAmb 999 Operations Performance Scorecard

Call Handling

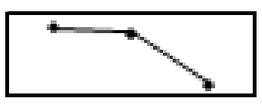
	Nov-17	Dec-17	Jan-18	12 Month's
5 Sec EOC Performance	67.4%	42.7%	74.9%	
Average Call Pick Up Time (secs)	12.7	21.5	9.8	
Call Pick Up Time 95th Percentile	124	220	132	

Dispatch

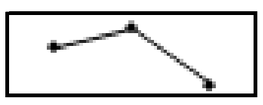
	Nov-17	Dec-17	Jan-18	12 Month's
Average Allocation Time -	NA	NA	NA	NA
Allocation Ratio	1.68	1.68	1.61	
Response Ratio	1.13	1.11	1.09	

November's performance data only refers to the 22nd - 30th (Post-ARP)

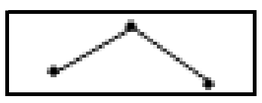
Cat 1 Performance

	Nov-17	Dec-17	Jan-18	12 Month's
Mean (00:07:00)	00:08:35	00:08:31	00:07:51	
90th Percentile (00:15:00)	00:14:59	00:15:16	00:14:05	

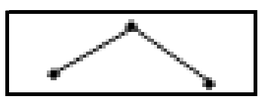
Cat 1T Performance

	Nov-17	Dec-17	Jan-18	12 Month's
Mean (00:19:00)	00:11:23	00:11:50	00:10:35	
90th Percentile (00:30:00)	00:20:34	00:21:01	00:18:59	

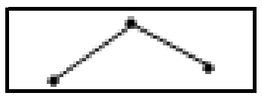
Cat 2 Performance

	Nov-17	Dec-17	Jan-18	12 Month's
Mean (00:18:00)	00:16:42	00:18:41	00:16:13	
90th Percentile (00:40:00)	00:30:43	00:34:58	00:30:11	

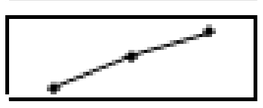
Cat 3 Performance

	Nov-17	Dec-17	Jan-18	12 Month's
Mean	01:10:05	01:39:34	01:04:04	
90th Percentile (02:00:00)	02:40:41	03:47:52	02:23:34	

Cat 4 Performance

	Nov-17	Dec-17	Jan-18	12 Month's
Mean	01:26:38	02:30:33	01:41:24	
90th Percentile (03:00:00)	03:15:10	05:54:29	04:02:33	

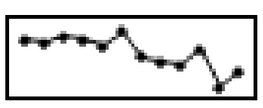
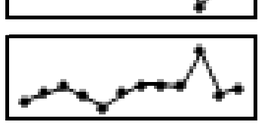
HCP

	Nov-17	Dec-17	Jan-18	12 Month's
HCP 60 (75%)	23.1%	33.5%	45.6%	
HCP 120 (75%)	18.4%	42.4%	56.7%	
HCP 240 (75%)	23.4%	51.7%	73.7%	

Demand/Supply

	Nov-17	Dec-17	Jan-18	12 Month's
Call Volume	85379	98429	86015	
Incidents	60565	63336	60560	
Transports	33858	35704	33648	

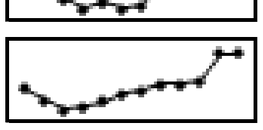
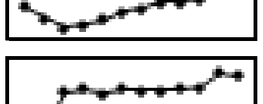
Incident Outcome (Contract)

	Nov-17	Dec-17	Jan-18	12 Month's
Hear & Treat	12.0%	18.0%	14.6%	
See & Treat	32.7%	29.7%	30.9%	
S&C HCP	6.1%	7.8%	9.3%	
S&C 999	49.2%	44.4%	45.1%	

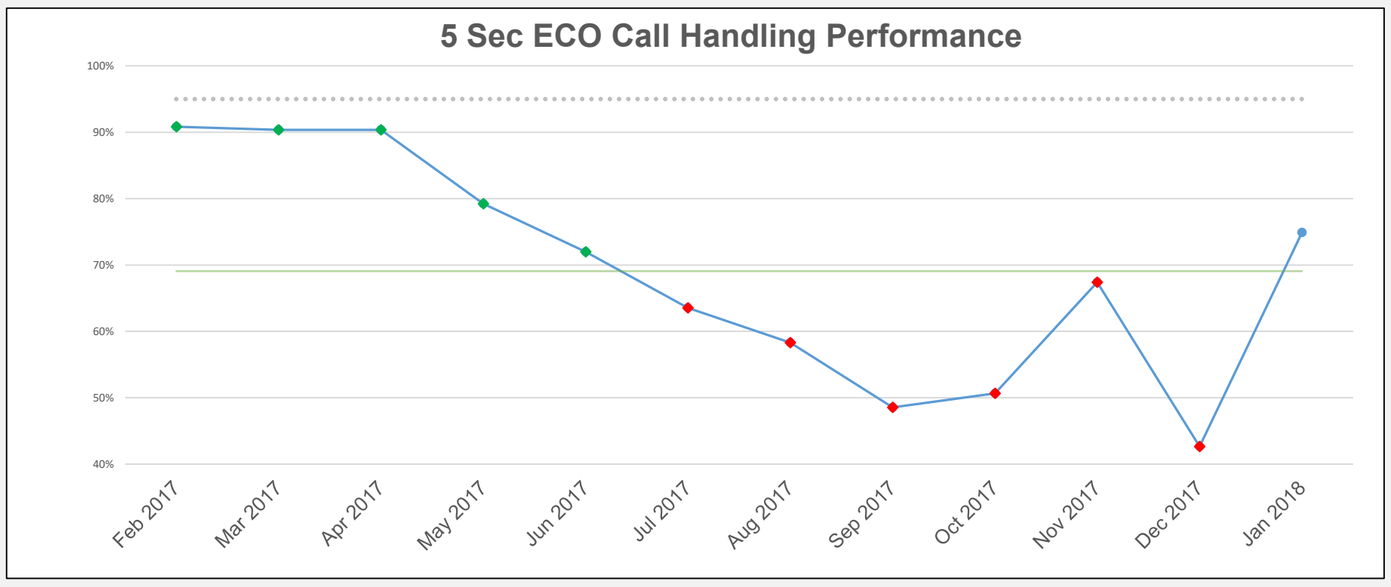
Community First Responders

	Nov-17	Dec-17	Jan-18	12 Month's
Volume of incidents Attended	1324	1518	1263	
Cat 1 Attendances	tbc	tbc	tbc	tbc
Hours Provided	14130	16216	19469	

Call Cycle Time

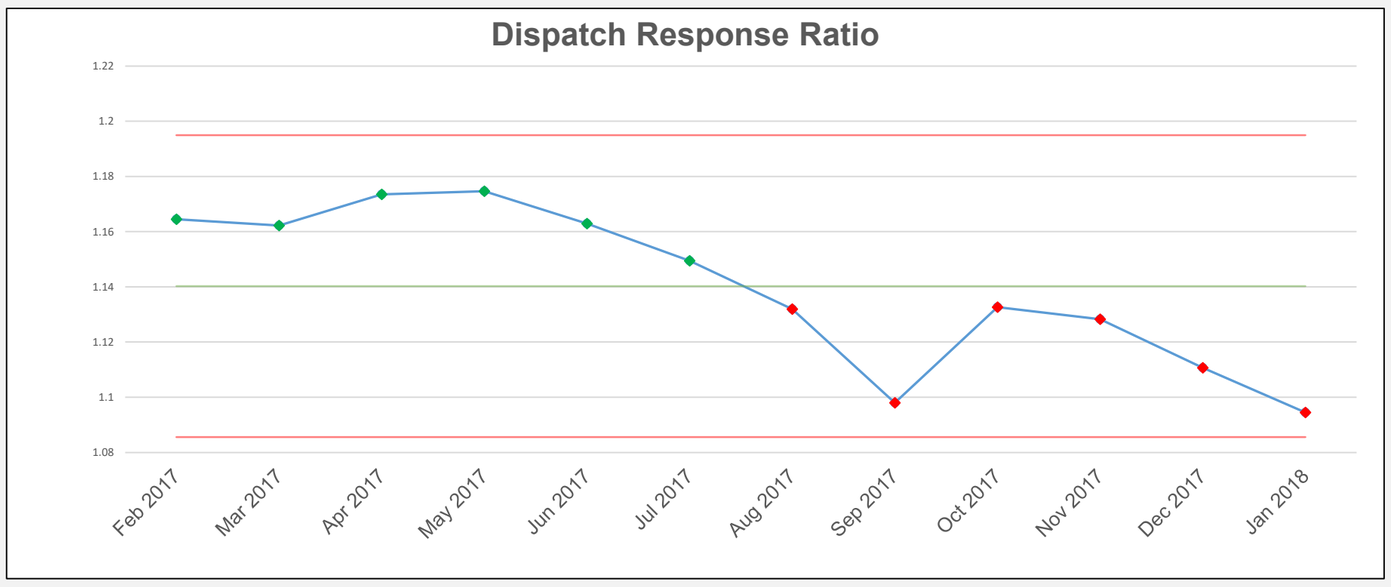
	Nov-17	Dec-17	Jan-18	12 Month's
Clear at Scene (mins)	74.59	75.84	75.74	
Clear at Hospital (mins)	106.5	110.3	110.1	
Handover Hrs Lost at Hospital (over	5522	7636	7093	
Number of Handovers	596	1433	1209	

SECAmb 999 Operations Performance Charts

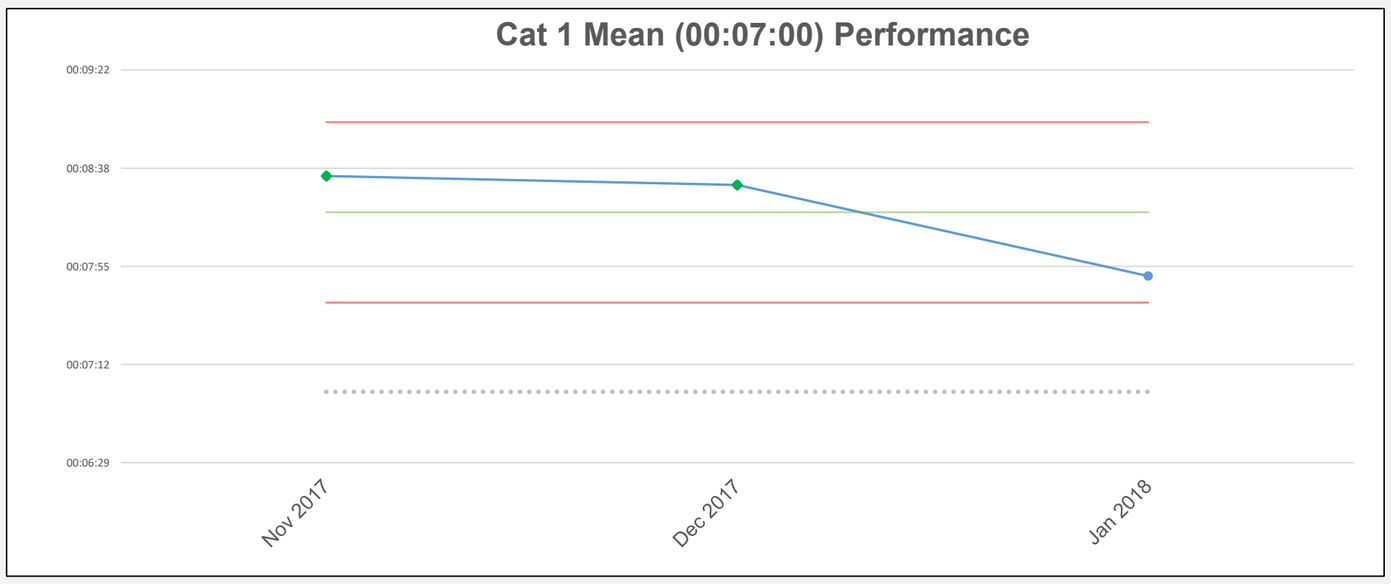


Call handling performance for January has increased with similar performance to June last year at 75%. In correlation to this there has been a significant decrease in call volume and the average call pick up time more than halved compared to last month.

Call pick up performance is now included in the EoC action plan to address the CQC requirement of improving AQI, recruitment and staff retention. Significant scrutiny is still being placed on call handling performance with all efforts being made to improve this. There has been an additional cohort of call takers recruited, that can take routine calls, to improve the efficiency of the emergency medical advisors.



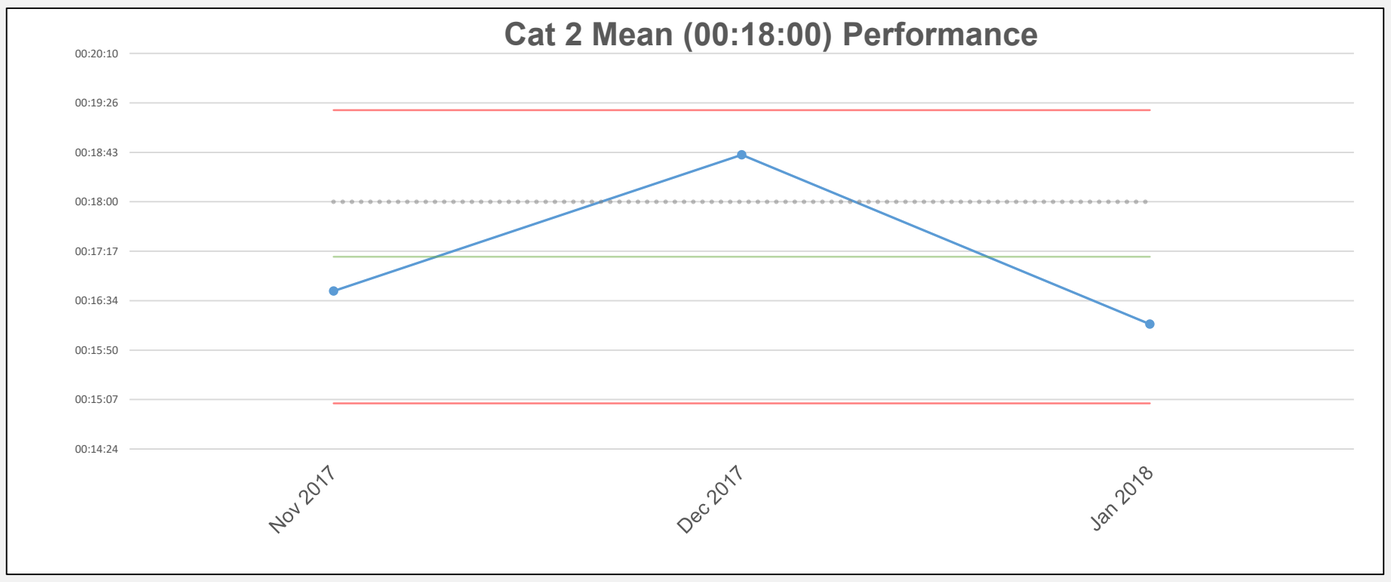
Response ratio continues to decrease. This metric will be referred to as Responses per Incident going forward as it comes under greater scrutiny with the ARP.



The Trust is currently 00:00:51 over the target mean for Cat 1 and we have achieved our 90th Centile target at 00:14:05.

Performance improved in January with the monthly mean response time dropping below 8 minutes for the first time since the introduction of ARP. Continued improvement is needed to meet the required mean of 7 minutes. The Cat 1 mean was 7 minutes or less on 6 days in the month.

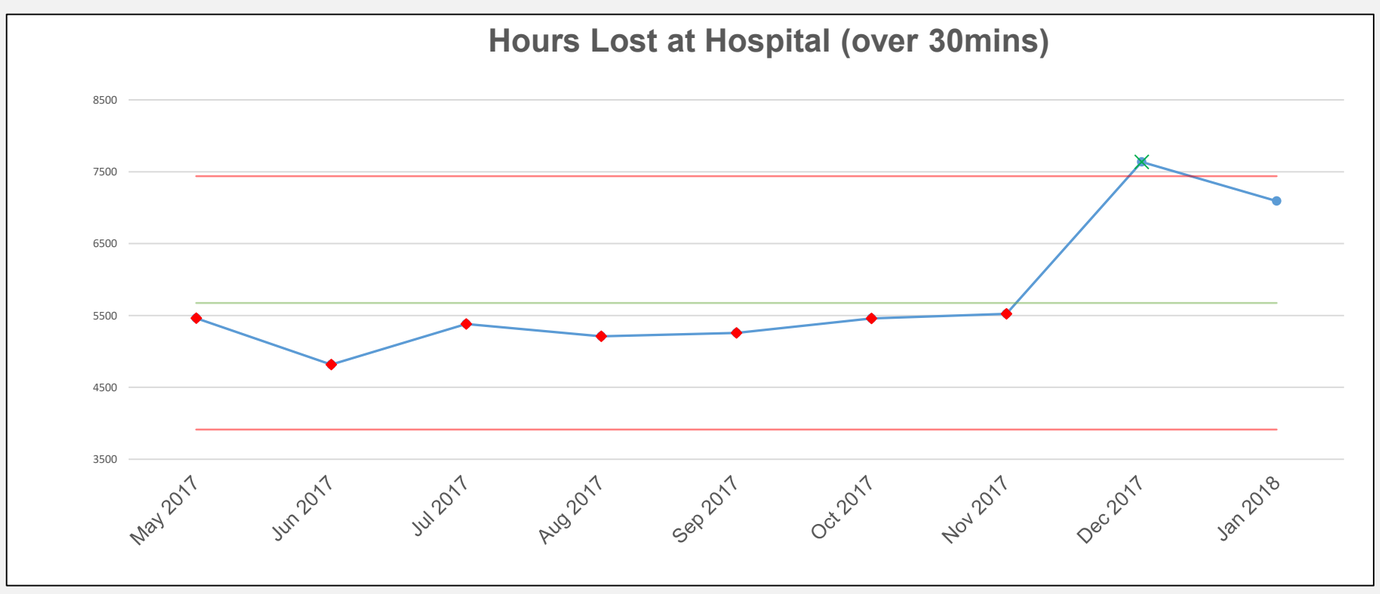
Cat 1 performance was slightly better for East EOC (00:07:40 mean) than for West EOC (00:07:59). Both met the required 90th Centile target.



Cat 2 mean performance for January was achieved at 00:16:13. For the last 3 months we have achieved our target for the 90th centile with January at 00:30:11.

In December the mean response time for Cat 2 incidents was higher than the required standard (00:18:41) so the figure for January shows a clear improvement. This correlates with a decrease in demand from December to January.

Cat 2 performance was very similar for both EOCs with West (00:16:10 mean; 00:30:22 90th Centile) very slightly outperforming East (00:16:16 mean; 00:30:02 90th Centile).



The number of patient handovers for January (1209) decreased compared to December (1433). Similarly the hours lost due to delays has decreased in January to 7093 from December which was 7636hrs.

Comparing January 2018 to January 2017 there has been a decrease of 864 hours.

The handover delays have an impact on both patient safety and experience. This also has an effect on SECAmb responses to public 999 calls.
To address this system wide issue, SECAmb and NHSI have appointed a dedicated Programme Director for 6 months to provide additional leadership and focus. A system wide Task and Finish group is in place together with two (East and West) operational groups who are responsible for delivering the changes needed to ensure improvement.

SECAmb 111 Operations Performance Scorecard

Calls Offered

	Nov-17	Dec-17	Jan-18	12 Month's
Actual	82468	124624	99868	
Previous Year	94065	104132	96799	

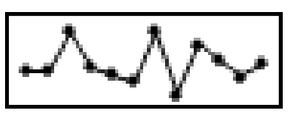
Calls answered in 60 Seconds

	Nov-17	Dec-17	Jan-18	12 Month's
Actual %	72.9%	47.9%	56.9%	
Previous Year %	77.5%	80.8%	83.7%	
Target %	95%	95%	95%	

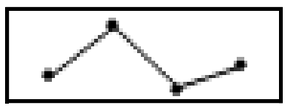
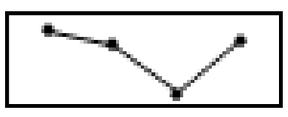
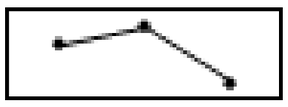
Calls abandoned - (Offered) after 30secs

	Nov-17	Dec-17	Jan-18	12 Month's
Actual %	3.6%	14.3%	8.4%	
Previous Year %	3.7%	3.9%	2.9%	
Target %	2%	2%	2%	

Combined Clinical KPI

	Nov-17	Dec-17	Jan-18	12 Month's
Actual %	75.3%	72.5%	74.7%	
Previous Year %	71.5%	72.5%	81.6%	
Target %	90%	90%	90%	

Outcomes

	Nov-17	Dec-17	Jan-18	12 Month's
999 Referrals % (Answered Calls)	12.4%	10.8%	11.4%	
999 Referrals (Actual)	9687	10954	10048	
A&E Dispositions % (Answered Calls)	7.4%	6.4%	7.5%	
A&E Dispositions (Actual)	5809	6540	6610	
Home Management %	6.4%	5.8%	TBC	

Operations Summary

The commencement of the New Year saw the continuation of significant pressure within the wider health system that had materialised through the middle of December, reaching significant peaks during the last week of December.

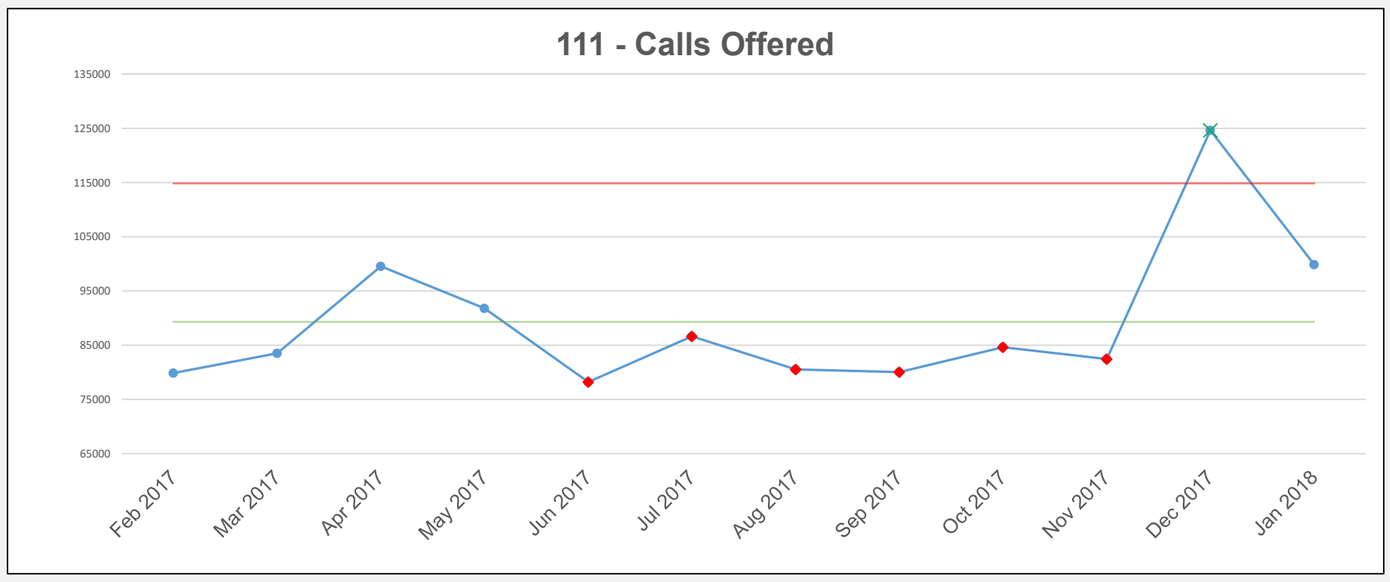
SECAmb continued the close management of its output hours to address the incident demand and this has resulted in some favourable performance against the new ARP performance standards, particularly when compared to other peer Ambulance Trust's and the England National Average position for response time performance in Categories 1, 2 and 3.

Category 4 performance continues to be a concern for the Operations Team as it is significantly beyond that of other Trust's and whilst the rationale for the long tail in performance on the lower acuity categories has been well rehearsed in previous reports to the board it is likely that significant improvements in these categories will only materialise when the factors identified in the Demand & Capacity review are materialised.

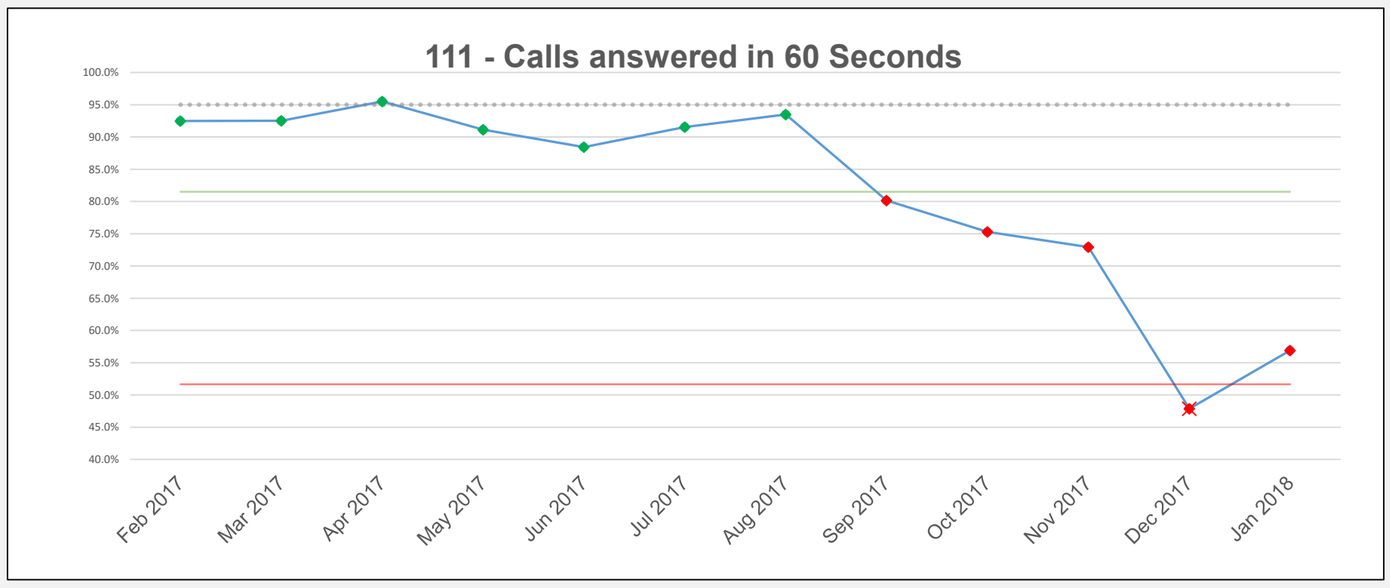
The most significant operational risk being managed by the Operations Team is the reported performance in the 999 call answering performance. The position for January is better than that of December but still far short of the 95% target figure. There is a very comprehensive suite of activities focused on a number of aspects impacting the Trust's ability to achieve the target, these focus on workforce numbers, process factors and technology aspects.

The EOC Team have a very comprehensive plan to address the workforce numbers before the end of March and a clear performance trajectory to deliver the 95% performance standard by August.

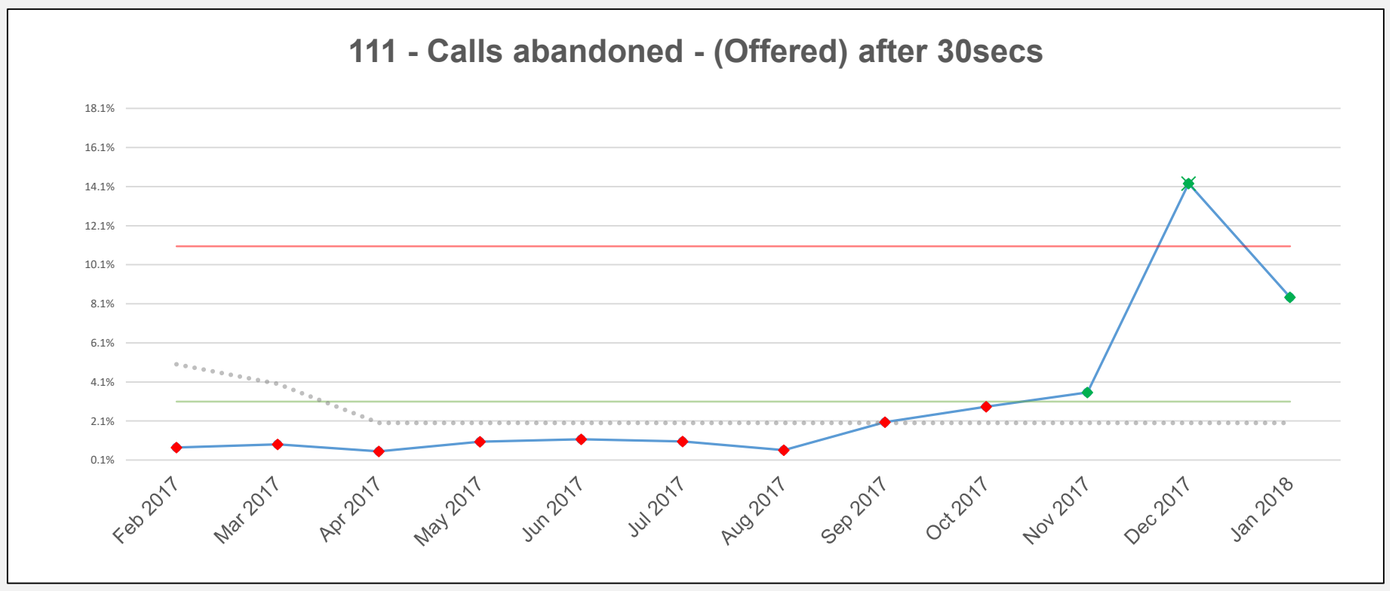
SECAmb 111 Operations Performance Charts



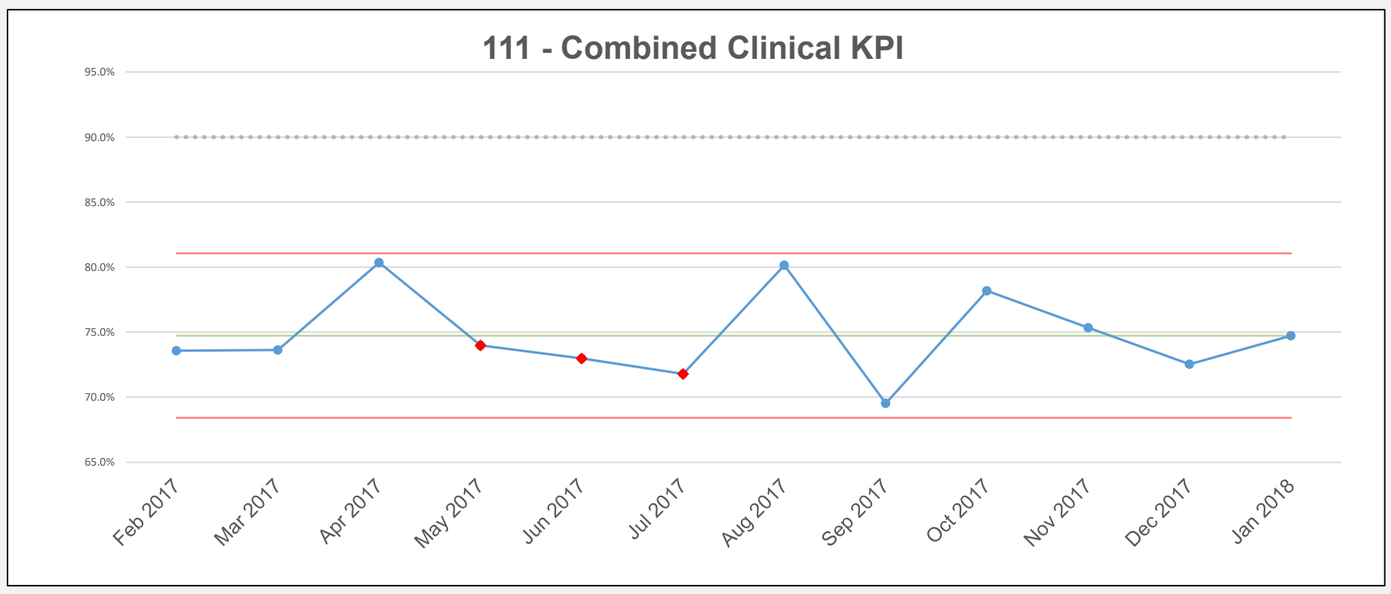
Call volumes remained high at a total of 99868 for the month, representing a 3% year-on-year increase in demand since January 2017.



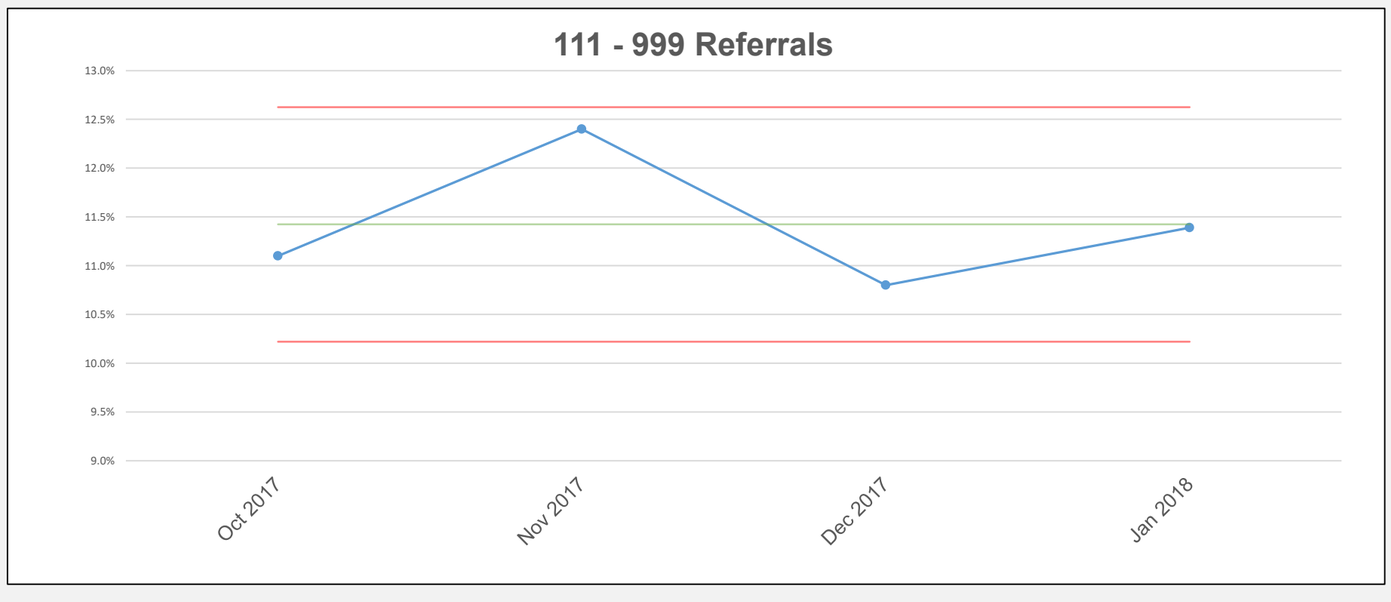
The “Answered in 60” KPI recovered to 56.88% but remains significantly lower than the national average, due to a combination of rota fill, high Average Handling Time and sickness levels.



Abandonment rate fell to 8.44% but significantly above target.



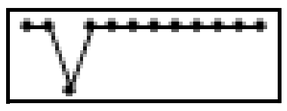
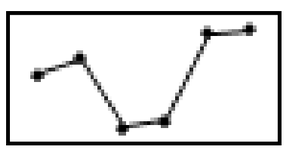
Clinical performance at 74.72%, an improvement on December. Very high demand was met with significant clinical resilience. We handled more than 1000 clinical case on three individual days during the month.



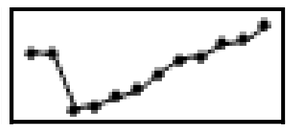
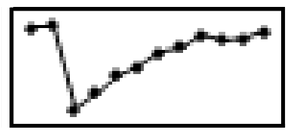
The KMSS 111 Ambulance referral rate rose to 11.39% but the service continues to mitigate AMB referrals via Clinical Inline Support.

SECAmb Workforce Scorecard

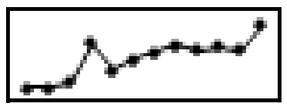
Workforce Capacity

	Nov-17	Dec-17	Jan-18	12 Month's
Number of Staff WTE (Excl bank & agency)	3061.2	3039.0	3057.6	
Number of Staff Headcount (Excl bank and agency)	3333	3308	3330	
Finance Establishment (WTE)	3524.74	3526.29	3525.29	
Vacancy Rate	13.09%	13.46%	13.40%	
Vacancy Rate Previous Year	8.22%	9.35%	9.28%	
Adjusted Vacancy Rate + Pipeline recruitment %	7.90%	10.53%	10.67%	

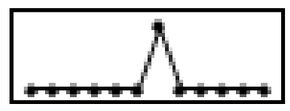
Workforce Compliance

	Nov-17	Dec-17	Jan-18	12 Month's
Objectives & Career Conversations %	62.13%	65.08%	78.81%	
Statutory & Mandatory Training Compliance %	71.06%	73.61%	79.12%	
Previous Year %	76.02%	77.30%	78.50%	

Workforce Costs

	Nov-17	Dec-17	Jan-18	12 Month's
Annual Rolling Turnover Rate %	18.05%	17.77%	17.85%	
Previous Year %	16.50%	16.90%	16.90%	
Annual Rolling Sickness Absence	4.96%	4.92%	5.22%	

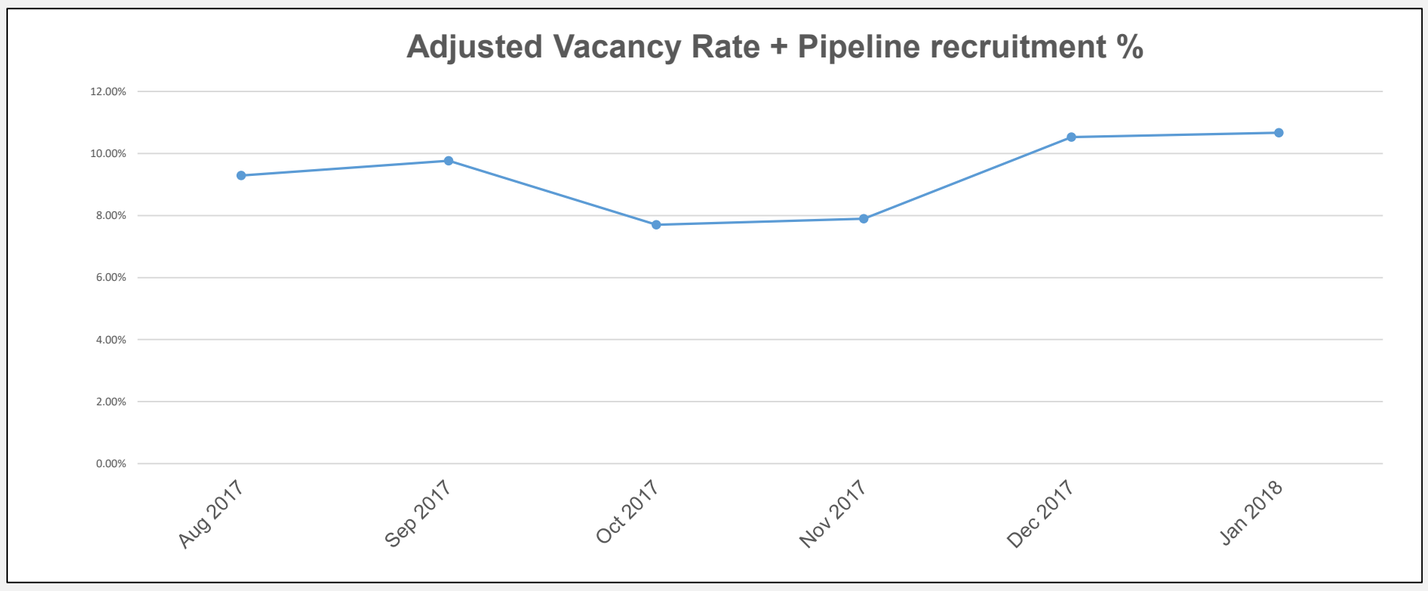
Employee Relations Cases

	Nov-17	Dec-17	Jan-18	12 Month's
Disciplinary Cases	5	2	1	
Individual Grievances	5	5	16	
Collective Grievances	1	0	1	
Bullying & Harassment	2	2	0	
Bullying & Harassment Prev	2	0	1	
Whistleblowing	0	0	0	
Whistleblowing Previous Year	0	0	1	

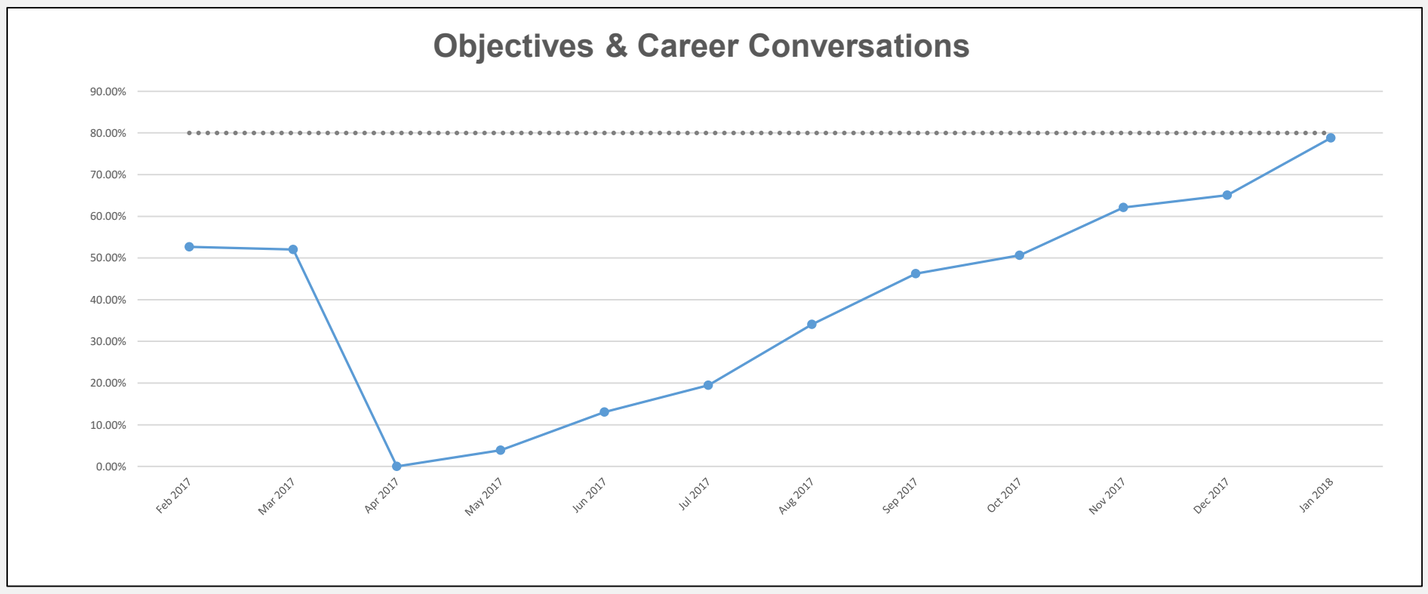
Physical Assaults (Number of victims)

	Nov-17	Dec-17	Jan-18	12 Month's
Actual	20	17	16	
Previous Year	20	19	17	
Sanctions	2	1	3	

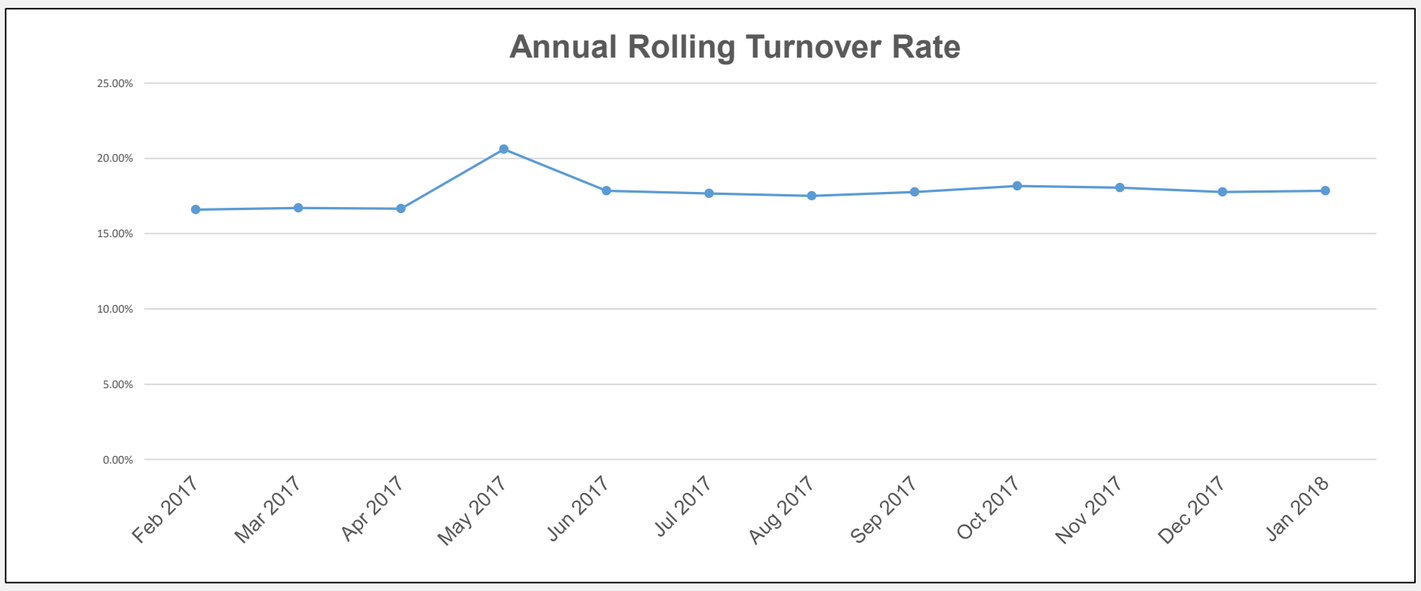
SECAmb Workforce Charts



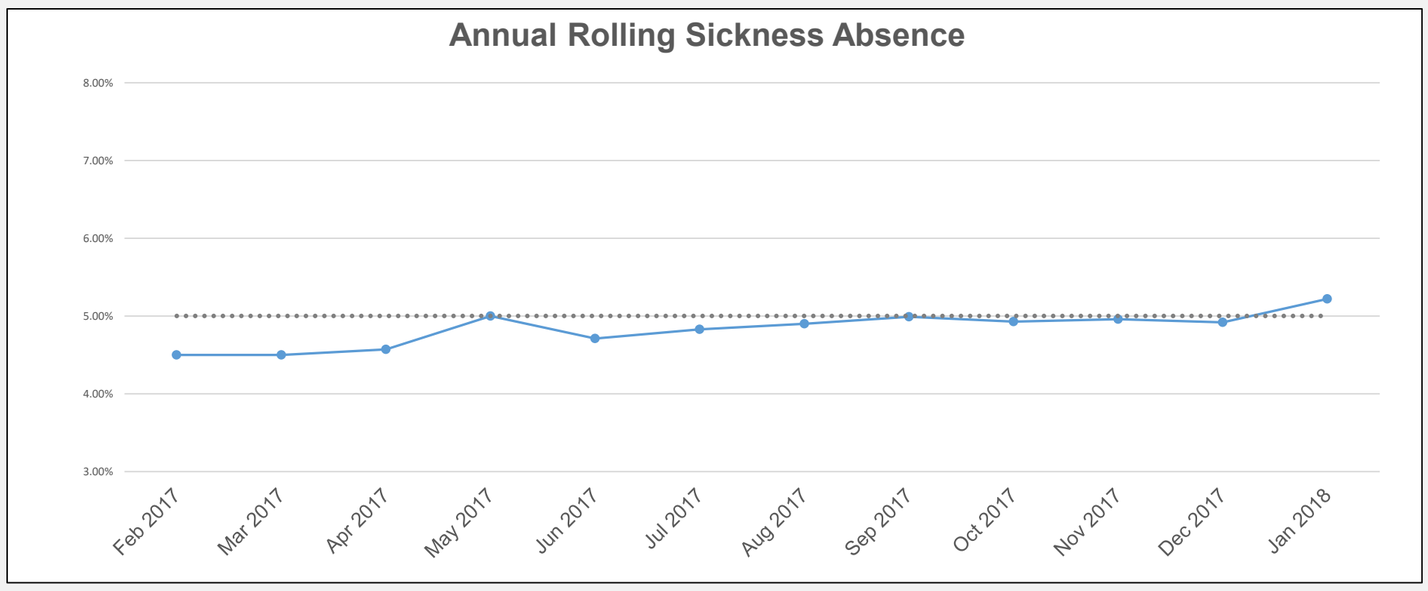
This January we have seen more new starters than leavers, with our headcount workforce rising by 22. Pipeline vacancy rates for our Operations Directorate have increased slightly but we expect net decreases as we continue to offer additional assessment days.
We have successfully aligned recruitment support with the East/West operating model and continue to work closely with HR colleagues to look at retention and resilience.
Monthly Recruitment Summit meetings are looking to address the current resourcing gaps for operational staff and bi weekly recruitment conference calls are being used to deep dive into areas wither larger ongoing recruitment needs are with an action plan put in place.



A significant increase on compliance has been seen during January and we are on target to achieve 80% compliance by 31st March 2018.
Managers continue to be supported to deliver on objectives and fully understand their accountability in this regard via area Governance.
Training on the delivery of good appraisals has been commissioned and will be delivered to managers during March.

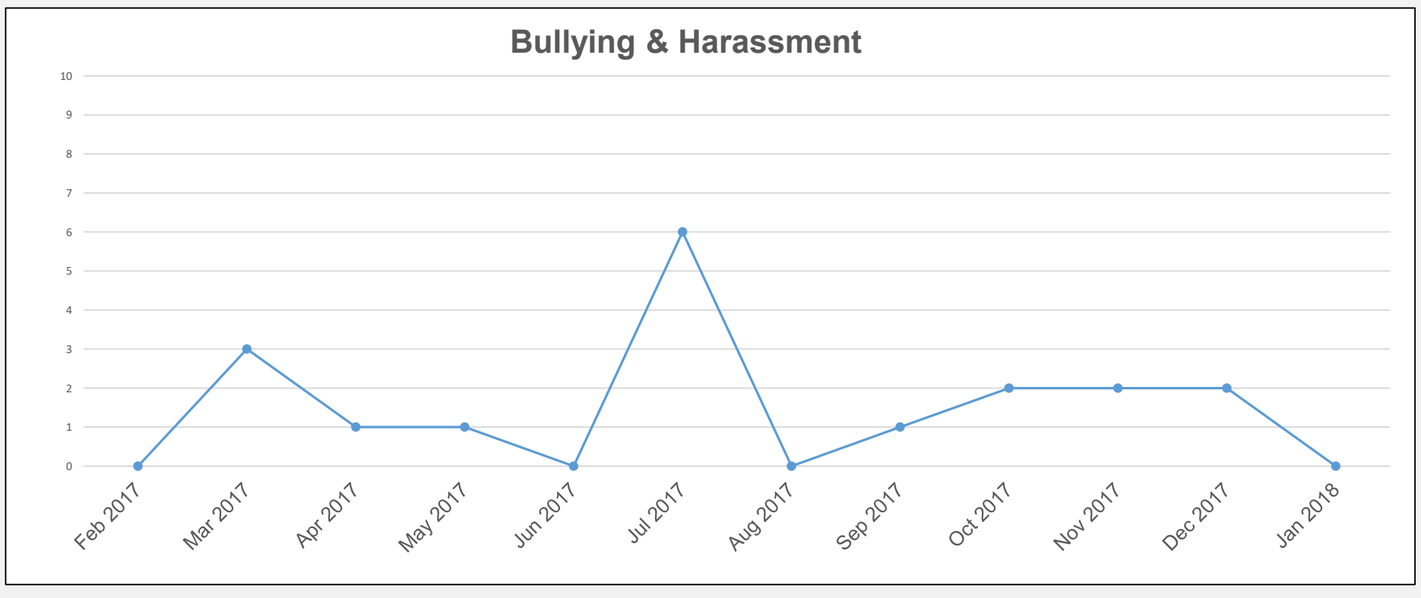


The Trusts turnover rate remains constant although a high turnover rate in EOC and 111 should be noted. This continues to be monitored by the EOC Task and Finish Group.
Further analysis has been provided i.e. Trust, Directorate and Operating Unit (OU) level and a paper for the Board is being provided for further discussion.



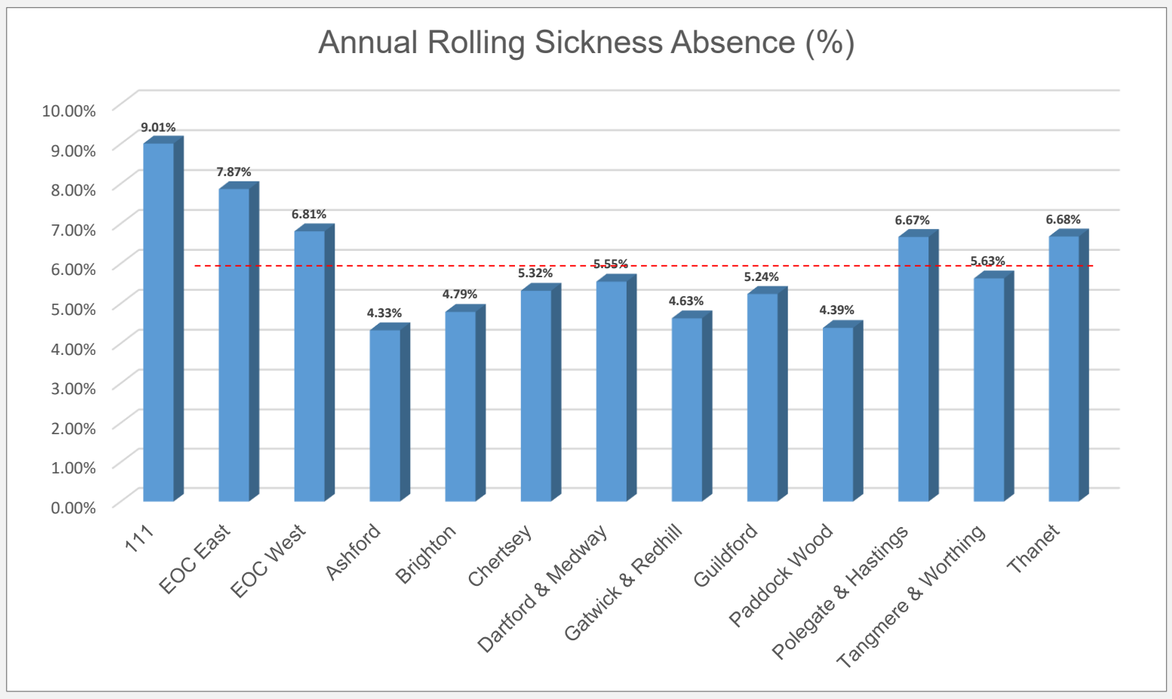
The trusts sickness rate went above 5% for the first time in 7 months. Historically this is high due to seasonal factors and it is slightly down on this time last year.
There continues to be focus on supporting staff and managers in the EOC with 1 dedicated HR Advisor in post and working hard to conclude outstanding sickness hearings. This dedicated HR Advisor supporting the EOCs has been extended to June 18. The impact of the HR Advisors in the EOC can be seen by the reduction of sickness by 50%.

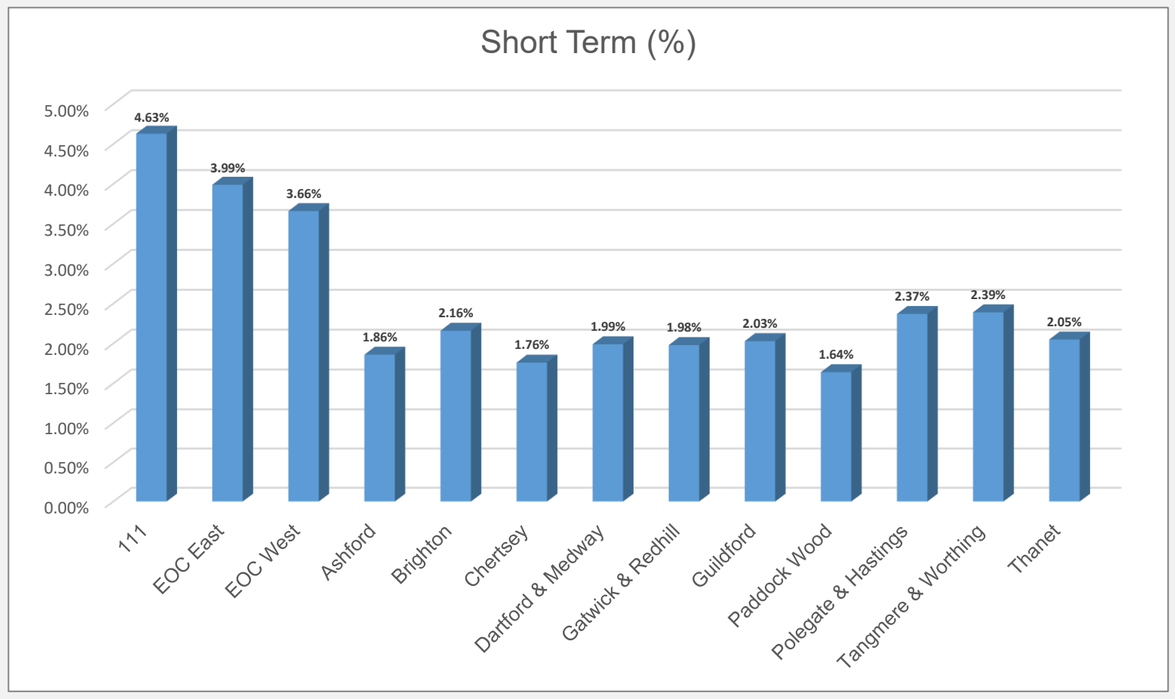
The Wellbeing hub continues to promote alternative duties. There are currently 2 pathways which are monitored and managed by a multidisciplinary team (MDT).
The benchmarking of absence against other Trusts is shown below.

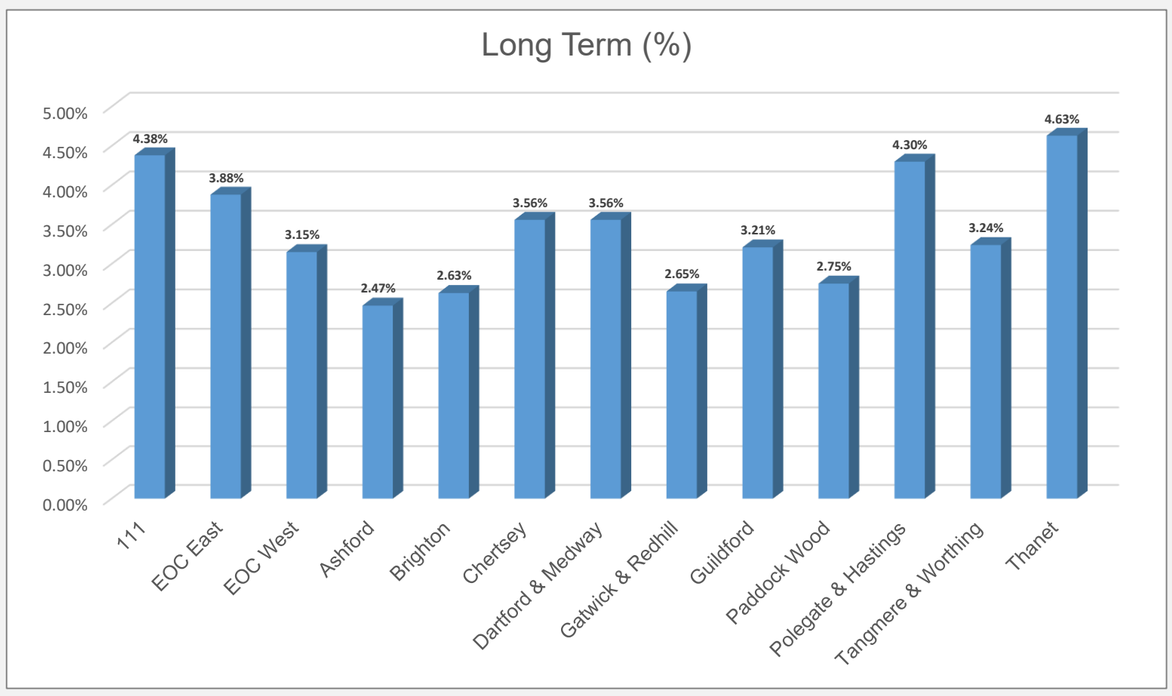


There were no new B&H cases in January.
A review of the Exit Interview Data (February 2018) shows a decline in Bullying and Harassment as a reason for leaving when compared to the December 2017 report.
External training to deliver investigation skills training to line managers, and therefore increase the number of available investigators, speeding up case management has now taken place with 22 people being trained. This is excellent news as it should have positive impacts on grievance and disciplinary timelines as well.
In January there were 16 individual grievances logged with the two main themes being recruitment process & procedures and banding & incremental issues. There were 12 of these closed, resolved or within drawn in January.

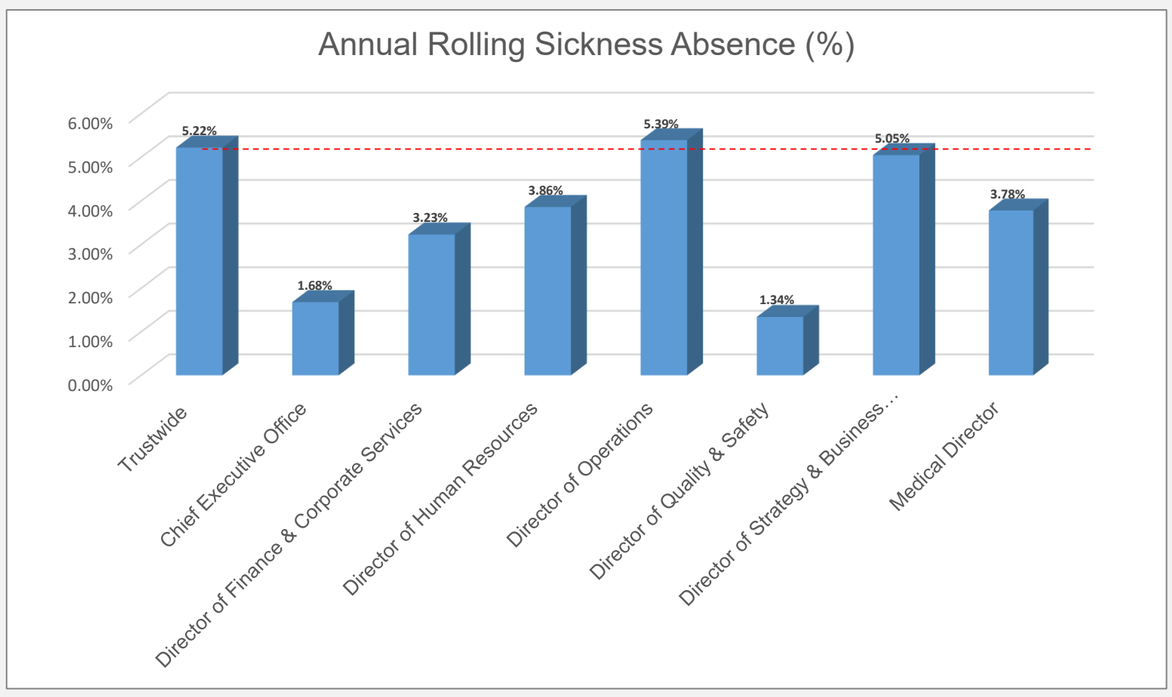
SECAmb Sickness Absence by 111/EOC/OU



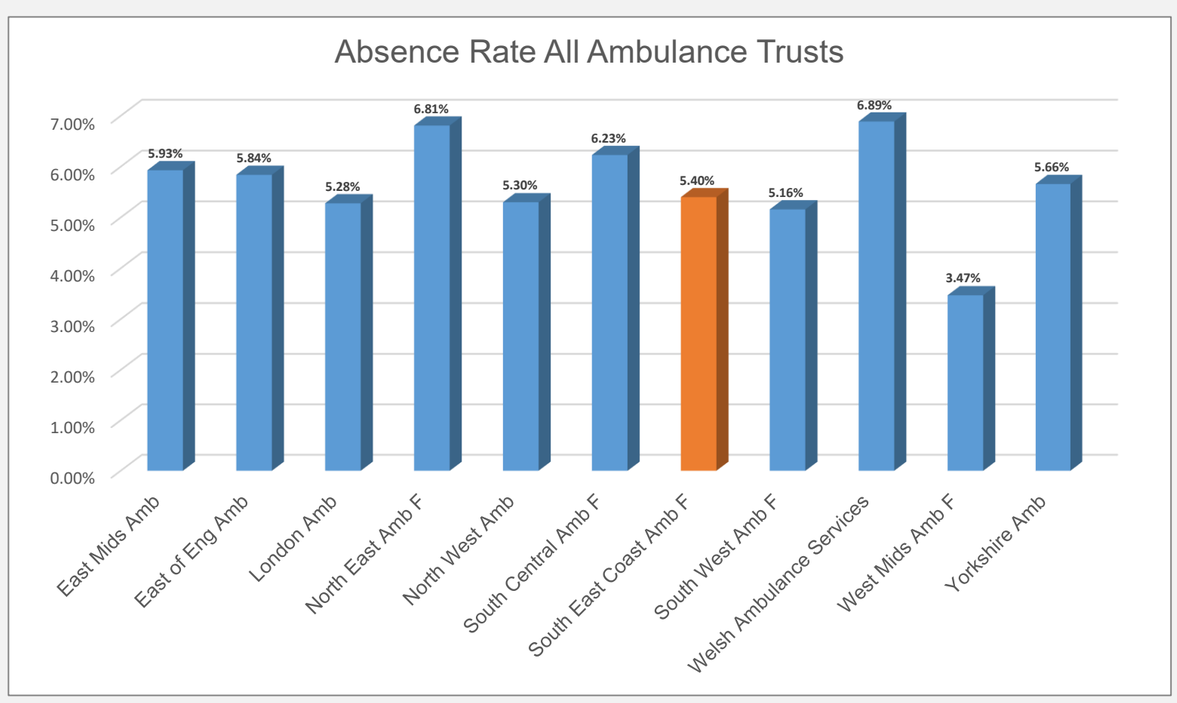




Sickness by Directorate



Benchmarking against other Ambulance Trusts



SECAmb Finance Performance Scorecard

Income

	Nov-17	Dec-17	Jan-18	12 Month's
Actual £	£ 16,493	£ 18,202	£ 17,171	
Previous Year £	£ 16,489	£ 17,536	£ 17,542	
Plan £	£ 16,817	£ 18,376	£ 17,585	

Expenditure

	Nov-17	Dec-17	Jan-18	12 Month's
Actual £	£ 16,501	£ 17,399	£ 16,404	
Previous Year £	£ 17,985	£ 17,446	£ 17,614	
Plan £	£ 16,842	£ 17,589	£ 16,827	

Capital Expenditure

	Nov-17	Dec-17	Jan-18	12 Month's
Actual £	£ 554	£ 400	£ 554	
Previous Year £	£ 1,629	£ 752	£ 1,250	
Plan £	£ 856	£ 856	£ 856	
Actual Cumulative £	£ 3,194	£ 3,594	£ 4,148	
Plan Cumulative £	£ 12,412	£ 13,268	£ 14,124	

Cost Improvement Programme (CIP)

	Nov-17	Dec-17	Jan-18	12 Month's
Actual £	£ 1,459	£ 1,425	£ 1,496	
Previous Year £	£ 500	£ 1,114	£ 552	
Plan £	£ 1,349	£ 1,399	£ 1,399	
Actual Cumulative £	£ 9,815	£ 11,240	£ 12,736	
Plan Cumulative £	£ 9,513	£ 10,912	£ 12,311	

CQUIN (Quarterly)

	Q2 17/18	Q3 17/18	Q4 17/18
Actual £	£ 846	£ 847	£ 283
Previous Year £	£ 952	£ 1,019	£ 716
Plan £	£ 848	£ 848	£ 283

*The Trust anticipates that it will achieve the planned level of CQUIN

Surplus/(Deficit)

	Nov-17	Dec-17	Jan-18	12 Month's
Actual £	-£ 8	£ 803	£ 767	
Actual YTD £	-£ 3,987	-£ 3,184	-£ 2,417	
Plan £	-£ 25	£ 787	£ 758	
Plan YTD £	-£ 4,048	-£ 3,261	-£ 2,503	

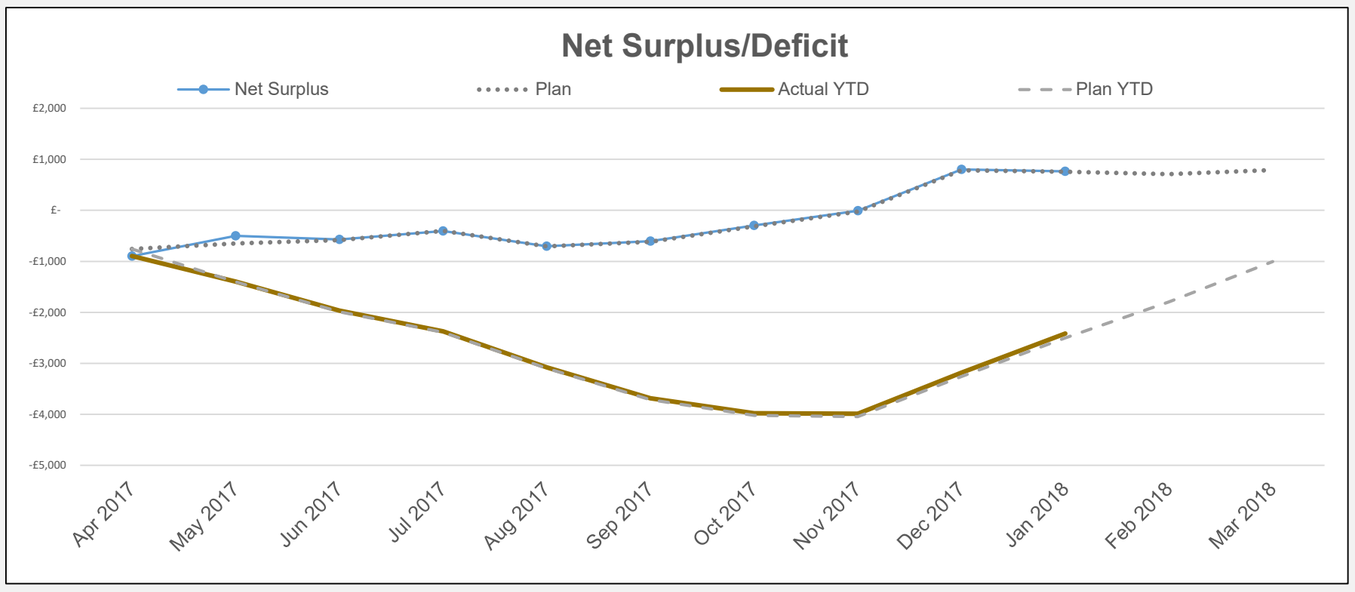
Cash Position

	Nov-17	Dec-17	Jan-18	12 Month's
Actual £	£ 16,344	£ 17,024	£ 19,564	
Minimum £	£ 10,000	£ 10,000	£ 10,000	
Plan £	£ 7,317	£ 6,088	£ 5,857	

Agency Spend

	Nov-17	Dec-17	Jan-18	12 Month's
Actual £	£ 240	£ 212	£ 316	
Plan £	£ 333	£ 331	£ 329	

SECAmb Finance Performance Charts

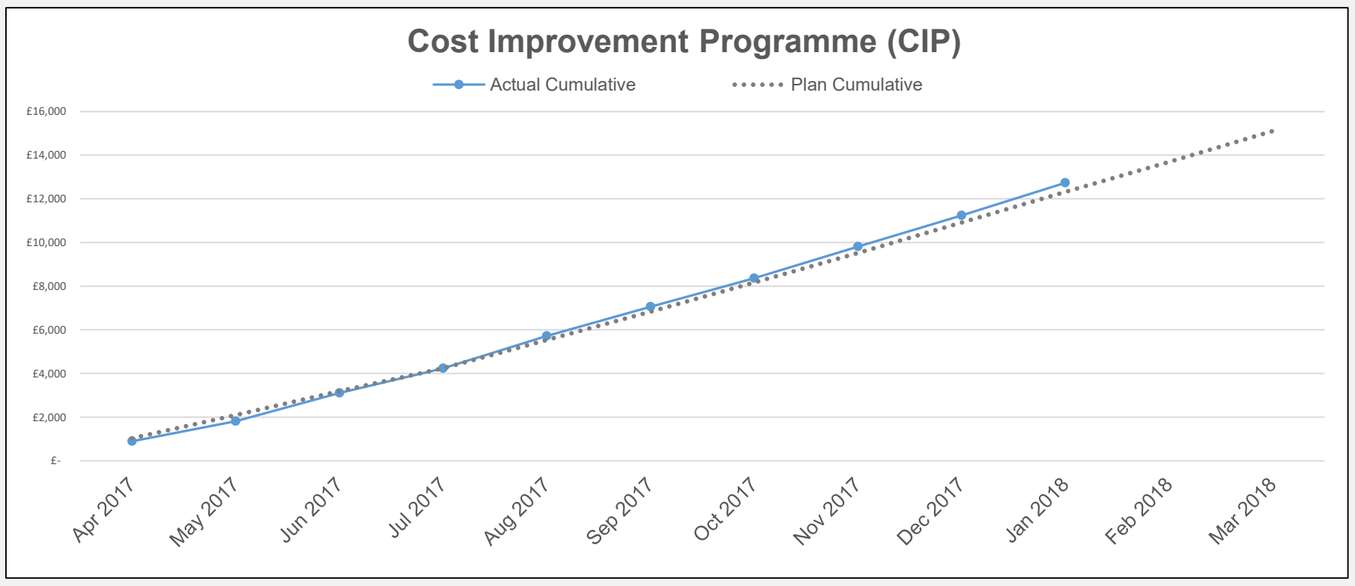


At month 10 the Trust is on track to achieve its control total of £1.0m deficit with the help of £1.3m of STF funding.

The Trust made a surplus of £0.8m in the month, in line with plan. This improved the cumulative deficit to £2.4m, which is £0.1m better than plan.

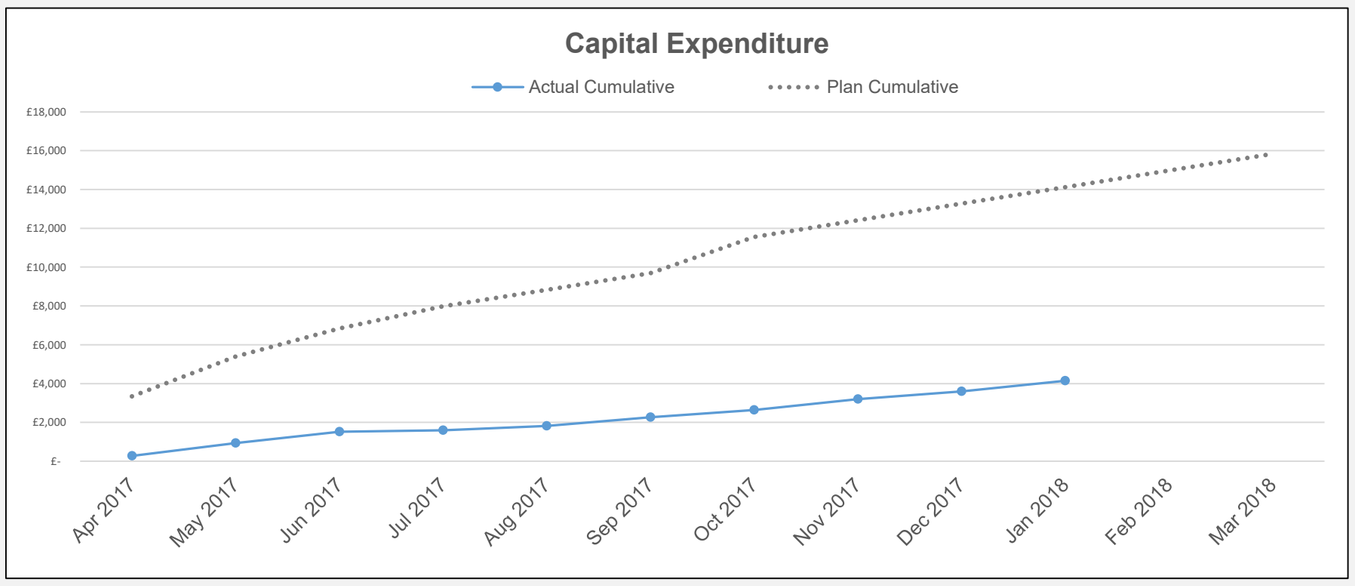
The following is a summary bridge between the original and normalised plans (£m): -

Original planned deficit (NHSI plan)	(1.0)
Structural deficit income excluded	(24.8)
Frontline hours excluded	18.9
Reserves and other budgeted costs to support delivery	5.9
'Normalised'/Commissioned plan	(1.0)



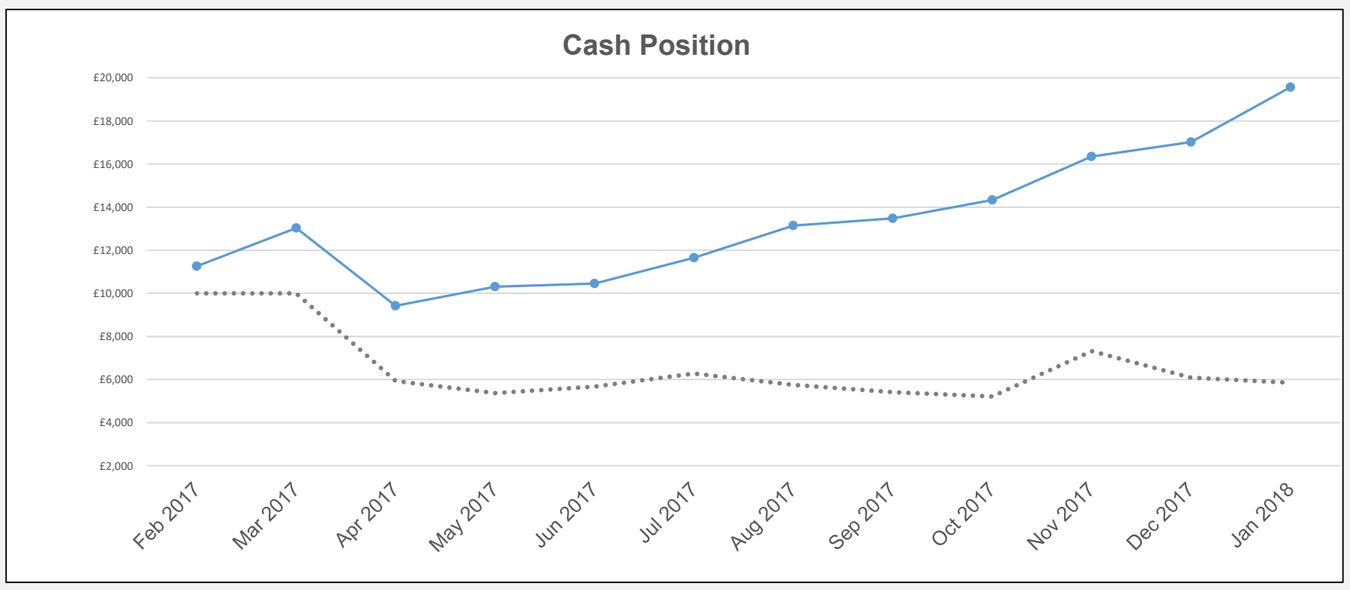
CIP schemes to the value of £17.8m have now been fully validated. The projected achievement is currently at £15.6m, exceeding the £15.1m target. 55 per cent of the projected savings relate to recurrent schemes.

The focus for cost improvement has now switched to developing plans for 2018/19.



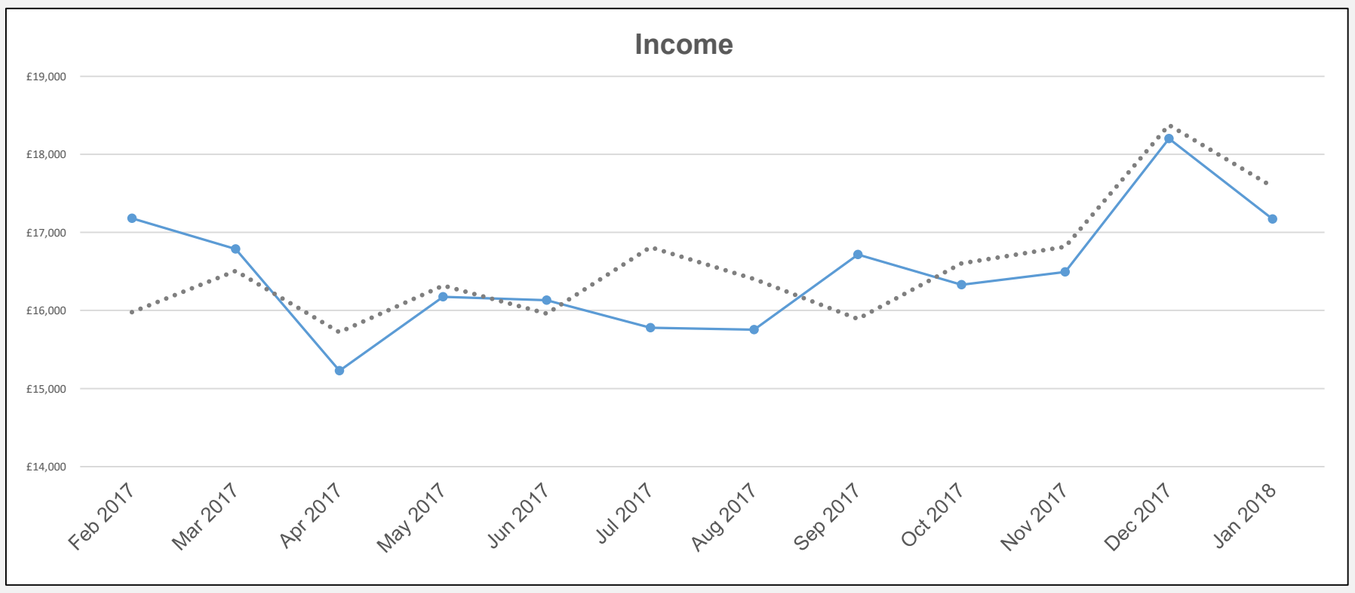
Spend on capital for the year to date is £3.9m against a plan of £14.1m. The full year forecast has increased to £8.3m against a plan of £15.8m. The reason for the increase is the new Cyber Security scheme at £0.7m, for which new central funding is available. The projected underspend on the programme is now £7.5m. £8.2m of vehicle procurement is on an operating lease and has been transferred to revenue.

The projected spend for the year includes schemes that were not in the original programme, i.e. Cyber Security £0.7m, 16 new ambulances £2.3m, Telephony and Voice Recorder £0.9m and a new Informatics System £0.2m. With the exception of Cyber Security, these are substitute schemes.



The cash position on 31 January increased to nearly £20.0m. The increase in cash holding is mainly attributed to the delayed spend on the capital programme and there will be some reversal in this trend as the remaining capital projects are completed. In spite of this, the cash flow forecast indicates that liquidity remains strong in the foreseeable future and that there are no material risks to repaying the working capital loan balance of £3.2m in March.

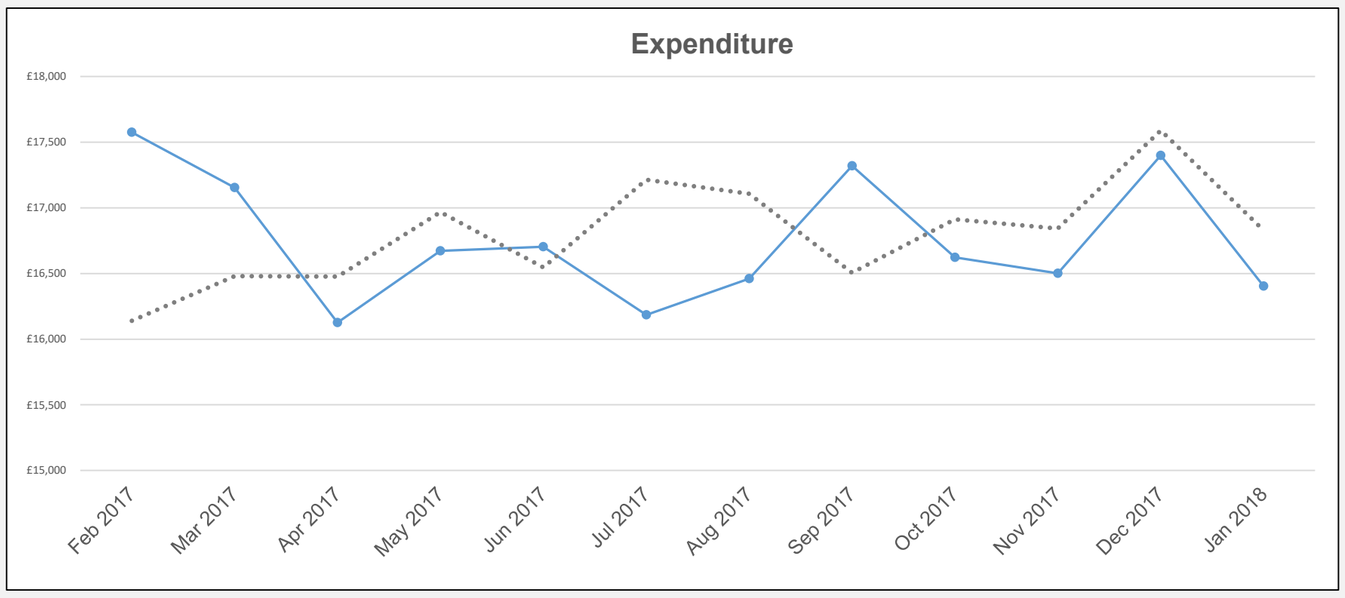
A working capital facility of £15.0m is available until January 2022, but there are no plans to make further use of this facility.



A&E contract income is £6.0m below plan for the year to date due to lower than planned activity. After taking account of other, favourable income variances, the overall adverse income variance falls to £2.4m.

The estimate of activity growth in the current year to date is zero per cent, compared to the planned 4.7%. The way the new Computer Aided Dispatch System (CAD) counts multiple responses to a single incident has exacerbated activity shortfall, although it has been assumed in the full year forecast that commissioners will fund the estimated income risk.

SECAmb Finance Performance Charts



Favourable expenditure variances, on both pay and non-pay, largely offset the adverse position on income.

Operational hours are aligned to commissioned levels of activity.

SECAmb Risk Narrative

Following the update given to the Trust Board in January further work is being undertaken in Risk identification and Management. A separate paper is now being prepared to provide the Trust Board with greater detail as to how risks are identified by Programme of Work, individual projects and how these are tracked / monitored as part of Business as Usual.

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Item No	182/17
Name of meeting	Board Meeting		
Date	23 February 2018		
Name of paper	Board Meeting Schedule		
Author name and role	Peter Lee, Company Secretary		
Synopsis	The Trust Board meets each month. The schedule (Appendix A) confirms the meeting dates for 2018/19. It includes meetings in August and December.		
Recommendations, decisions or actions sought	The Trust Board is asked to approve the meeting schedule.		
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**	

Appendix A

Date of Meeting	Time	Venue
Thursday 26 April 2018	10.00-15.00	Crawley HQ McIndoe 1, 2, 3
Friday 25 May 2018	10.00-15.00	Crawley HQ McIndoe 1, 2, 3
Thursday 28 June 2018	10.00-15.00	Polegate MRC
Thursday 26 July 2018	10.00-15.00	Crawley HQ McIndoe 1, 2, 3
Thursday 30 August 2018	10.00-15.00	Crawley HQ McIndoe 1, 2, 3
Friday 28 September 2018	10.00-15.00	Crawley HQ McIndoe 1, 2, 3
Thursday 25 October 2018	10.00-15.00	Tangmere MRC 1, 2, 3, Multipurpose Room
Thursday 29 November 2018	10.00-15.00	Crawley HQ McIndoe 1, 2, 3
Thursday 20 December 2018	10.00-15.00	Crawley HQ McIndoe 1, 2, 3
Thursday 24 January 2019	10.00-15.00	Ashford MRC
Thursday 28 February 2019	10.00-15.00	Crawley HQ McIndoe 1, 2, 3
Thursday 28 March 2019	10.00-13.00	Crawley HQ McIndoe 1, 2, 3