KPMG

Governance review

South East Coast Ambulance Service NHS Foundation Trust

February 2018

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Background

Background

The Care Quality Commission published the report from their inspection of the Trust in September 2016. An overall rating of inadequate was provided, with inadequate ratings provided in the domains of safety and well led. Issues were identified relating to incident reporting, safeguarding arrangements and medicine management which primariliy drove the inadequate rating for patient safety.

The well led element of the inspection identified gaps relating to accountabilities within the Executive team and there being a number of interim postholders on the Board. Risk management processes were found to not enable active identification and escalation of risks to the Board and a bullying and harassment culture had been reported by staff.

Following the finalisation of the report the Trust has developed an action plan to respond to the findings of the CQC. Progress against the action plan is reported to the Board at each meeting against 11 workstreams. Each workstream has been assigned a project lead and an Executive lead. Workstreams have been assigned to the domains of the CQC inspection, with six relating to the safety domain and three to the well led domain.

Monitoring of progress is incorporated into the Trust's wider Unified Recovery Plan (URP). The URP was developed after Monitor (now NHS Improvement) published in November 2015 that the Trust was in breach of its license conditions. The Trust was asked to undertake actions to address Monitor's concerns relating to decision making, governance and patient safety.

In June 2016 changes to governance and risk management processes were approved by the Board. The sub-committee structure was redesigned to enable the Board to operate as a unitary Board. The risk management strategy was also updated to clarify the reporting arrangements for risks depending on their severity and likelihood.

At the June 2017 Board meeting the Trust reported that one of the 11 CQC workstreams had been completed (security improvement plan), five were on target to be delivered on time and realise the anticipated benefits, four were at risk and one had been incorporated into another action plan. The at risk workstreams were as follows:

- Clinical audit – identified as being at risk due to capacity constraints;
- Incident and serious incident reporting – a three month delay in implementation to August 2017 to clear the full backlog of incidents requiring investigation;
- Medicine management – a three month delay in implementation to November 2017; and
- Patient records – a three month delay in implementation to August 2017 to enable further review of the accuracy of recording incident numbers.

The Trust has agreed with NHS Improvement to undertake an independent review of its governance arrangements. The scope has been agreed to provide assurance over the revisions to the governance and risk management structures and the operation of the assurance framework in areas where concerns were identified by the CQC.

The CQC completed a follow up inspection in May 2017. The results from the inspection were published during the course of our fieldwork, with the Trust continuing to be rated as inadequate in the domains of safe and well-led and inadequate overall. A follow up visit specifically to review medicines management processes has recently been undertaken with informal feedback received demonstrating improvements were being made, however formal results from this visit have not yet been published.

Background

Objectives

Objective	Description of work to undertake
Objective One Benchmarking of governance structure	We compared your governance structure to other ambulance service providers and a wider peer group of NHS providers. We considered the sub-committees and groups responsible for monitoring performance and providing assurance to the Board and Council of Governors, including those responsible for managing risk.
Objective Two Document review	We assessed the design and content of papers presented to the Council of Governors, Board, sub-committees and other key groups to consider whether information is sufficient to enable informed decision making. We assessed the compliance of the new Board sub-committees formed in 2016 with their terms of reference to consider whether they have discharged their responsibilities in line with their terms of reference.
Objective Three Risk management strategy	We assessed the risk management strategy to review the process for escalating risks from the front line to the Board promptly. We reviewed the effectiveness and speed of the escalation of risks identified by front line staff up to the Board and assess how they are scrutinised by the appropriate committee according to their severity. We followed risks through from their first identification and recording within directorates to the first time they received scrutiny by the Senior Management Team and Executive Management Team.
Objective Four Assurance Framework deep dive	We completed deep dives into a sample of your strategic risks to consider the effectiveness of the assurance process. We reviewed the appropriateness of the mitigations that have been established and undertook testing to verify that controls developed to mitigate the risk have been implemented effectively. We considered: ▪ Incident reporting and review; ▪ Safeguarding; ▪ Medicine management; and ▪ Bullying and harassment.
Objective Five Stakeholder interviews	We met with your Executive Directors, Non-Executive Directors and senior managers involved in governance and the areas of focus you requested to obtain more detailed feedback on the effectiveness of the Board's operation. We also held a workshop with a selection of your governors and met with stakeholders from NHS Improvement, the Care Quality Commission and your commissioners.
Objective Six Board and committee observation	We observed meetings of your Board and its primary sub-committees to assess the effectiveness of their operation. We will consider whether information provided to the meetings was sufficient and appropriate to enable decision making and consider how time is spent between different agenda items to assess if the committees spend their time making decisions or receiving information for noting.

Executive summary

Conclusion

The Trust has progressed with the development of improved governance processes and the implementation of the improvement actions required as a result of the Care Quality Commission (CQC) inspection and, more recently, the report issued by Professor Duncan Lewis. There has been improved scrutiny of key clinical matters at the Board and there has been progress made in establishing a more stable Board, with key Executive positions appointed permanently. This has supported improved sharing of information across the Board and its sub-committees.

Good progress has been made in the implementation of medicines management improvements, with a number of improvements noted through our visits to stations and observations of crews. A medicines management optimisation plan was used to drive the implementation of the changes required, with senior leadership through the Medical Director and Chief Pharmacist and representation by Operating Team Leaders on the action group overseeing its implementation. This has been followed up by daily audits undertaken across stations and frequent feedback provided on their outcomes through calls between the Medicines Administrator and the OTLs.

Overall we found an Executive and senior management team that was open and honest about the challenges the organisation continues to face. There is clear ownership by the Executive of the issues that must be addressed and this is evidenced in the way in which they contribute to, engage in and drive much of the Task and Finish work that is delivered through the Programme Management Office (PMO). There is clear accountability felt at the top of the organisation. However, we do consider there to be a risk that too much Executive time is taken up in the implementation of changes needed. Whilst they must champion the improvement plans it is also important for the senior management and senior operational team members to take an increasing role in driving implementation. Otherwise there is a risk that accountability will not be spread across the Trust and the Executive will continue to spend more of their time on operational change than on driving the new strategic direction that is also required. There has been a real need for the Executive to grip the issues and we understand why, given the scale of the issues and the need to demonstrate improvement both internally and externally, they have taken such an involved role in seeing through the plans. However, we believe that there needs to be a shift towards greater accountability at the next level of management down from the Executive. To do this effectively it is also important that the Trust establishes the right operational and governance structures to facilitate the exchange of timely information from the Board down to each operating unit and operating team and from those teams up to the Board. We acknowledge that the Executive now recognise this and see the development of greater ownership and accountability by intervening management tiers as a key next step in the Trust's improvement plan.

There are not routine divisional governance and accountability mechanisms in place for the oversight of performance at an Operating Unit or Regional level. Performance against key access standards is regularly reviewed at a Trust-wide level through the Senior Operational Leadership Team and Operating Units have established management teams to review performance. However, disaggregated management information is not consistently available to provide a balanced and holistic view of performance within each Operating Unit or the regions that considers elements such as finance, workforce, quality and safety. Performance is not currently reviewed by the Executive at a Regional or Operating Unit level, which would support identification of any areas with problems and accountability for performance, for example if there were particularly high levels of sickness or incidents at specific stations this may be suggestive of issues arising that would impact on the quality of delivery or the working environment for staff.

The performance information available to the Board has been improved through the development of a performance scorecard, with dashboards for operational performance indicators, finance, workforce and quality and safety. Risk ratings are used across the scorecards and trend information is provided within the reports, however the reports exceed 40 pages, restricting the ability to promptly identify where there may be concerns. Workforce indicators do not have targets established to determine where performance is behind plan and information is not always available in time for the Board and so not presented.

Executive summary

Conclusion (continued)

The Executive has led on the implementation of changes required in a number of areas following the CQC report and changes to the Board. While this has supported the development of stability and focus on priority areas for change in patient safety and quality it is important that an appropriate balance is found for responsibility for the delivery of change amongst the senior management team, which would allow the Executive to focus on key strategic matters. Based upon our observations of the Executive and Senior Management Team (SMT) meetings there is scope for further responsibility to be delegated to the SMT, which has to date been assigned specific tasks, such as the refresh of policies.

As further projects are implemented to support the delivery of required actions from the CQC's most recent inspection it is important that there are effective communication channels and feedback mechanisms. Discussions with crews fed back that often when incidents or safeguarding concerns are raised feedback is not received as to what has happened as a result. Our benchmarking of incidents reported to the National Reporting and Learning Systems shows that the Trust has the lowest number of incidents reported of all English ambulance trusts. Communication will need to be carefully managed to ensure important messages are able to be cascaded to staff and that feedback is provided, either where checks are undertaken on compliance or where matters are reported.

As the Trust seeks to exit special measures it will be important that structures are in place to support the transition from a project approach to business as usual. The Trust will need to have effective information and monitoring mechanisms in place to enable it to receive assurance as to whether revised processes have been embedded across its sites and allow prompt action to be taken where issues are emerging.

Executive summary

Areas of good practice

- ✓ The medicines management optimisation plan was delivered with the involvement of Operating Team Leaders (OTL) on its oversight group to provide a link to the operational teams responsible for day to day delivery. Following the introduction of daily checks a call is held between the Medicines Administrator and the OTLs to provide feedback on the outcomes.
- ✓ Meetings of the Board and its sub-committees that we observed were well chaired and had a good balance of forward and backward looking information as well as the majority of the agendas being used for scrutiny and agreeing actions rather than information being made available for noting.
- ✓ There is an appropriate governance structure in place to allow review of the key elements of performance at a Trust wide level. The governance structures are closely aligned with those used by the NHS providers we have benchmarked the Trust against.
- ✓ There is a well defined structure in place for the identification and escalation of risks. There are defined forums for the review of risks at different levels with dedicated meetings of the SMT and Executive on a monthly basis that are used for the review of risks.

Areas for development

- — A formal structure for monitoring and scrutinising local performance has not been established to enable the Executive to obtain assurance that any issues arising in specific areas are being identified and appropriate actions being taken to resolve them. While governance structures have been established for Operating Units we were unable to identify how these escalated to the Regions or how they were held to account by the Executive for the delivery of performance. **See recommendation one.**
- — Holistic performance information is not consistently available to enable analysis at a locality level, including consideration of quality, safety, financial and workforce performance. This may prevent management from identifying where there are concerns with specific Operating Units or stations. The performance information reported to the Board is not sufficiently concise to support prompt identification of issues requiring further scrutiny. Workforce information is not always available for the performance scorecard and does not have targets set for some key measures. **See recommendation two.**
- — A Senior Management Team has been established and delegated responsibility for specific tasks, such as oversight of the review of policies. However, it does not yet have a clearly defined role to support the Executive in the management of the Trust and oversight of performance matters. **See recommendation three.**
- — Feedback from ambulance crews set out that often when incidents or safeguarding alerts are raised feedback is not received to explain how they have been dealt with. This may reduce the incentive to ensure incidents are raised and reported. We benchmarked the Trust's incident reporting against other ambulance trusts and identified it has the fewest reported incidents of the 10 ambulance trusts in England. To support the effective implementation of changes required to deliver the response plan to the CQC inspection it is important that effective mechanisms are in place to cascade key messages and provide feedback. **See recommendation four.**
- — New risks are presented to the SMT and Executive Risk and Assurance Meeting on a monthly basis for review. The SMT also reviews all risks scored over 12 and the Executive all risks over 15. Insufficient information is included in the risk registers to enable detailed scrutiny of whether mitigations are appropriate. **See recommendation five.**

Executive summary

Recommendations

The table below sets out the recommendations raised as a result of our review:

	Red	Amber	Green	Total
Made	2	3	4	**9**
Accepted	2	3	4	**9**

Acknowledgment

We thank your staff for their assistance during the review.

Recommendations

We set out below the recommendations raised as a result of our review. These have been prioritised in line with the ratings shown in the table below:

Priority rating for recommendations					
●	**Red**: material issues to the design of governance processes that present a significant risk to achievement of the Trust's objectives. We believe that these issues might mean that you do not meet a system objective or reduce (mitigate) a risk.	●	**Amber**: issues that have an important effect on internal controls and Well Led arrangements but do not need immediate action. You may still meet a system objective in full or in part or reduce (mitigate) a risk adequately but the weakness remains in the system.	●	**Green**: issues that would, if corrected, improve the system of internal control and Well Led arrangements in general but are not vital to the overall system. These are generally issues of best practice that we feel would benefit you if you introduced them.

To help Management with the prioritisation of our recommendations, acknowledging current resource constraints and existing pressures as well as the recommendation priority ratings, we have outlined below an indicative timeline for implementation.

Immediate actions (one to three months):

- Senior Management Team (recommendation three)
- Risk reporting (recommendation five)
- Meeting management (recommendation six)
- Review of action plans (recommendation nine)

Short term actions (three to six months):

- Divisional governance structures (recommendation one)
- Management information (recommendation two)
- Communication (recommendation four)
- Alignment of committees to risk register (recommendation seven)
- Board Assurance Framework risks (recommendation eight)

Medium term actions (six to 12 months):

Recommendations

#	Risk	Issue, Impact and Recommendation	Management Response/Officer/Due Date
1	1	**Divisional governance structures** Although management meetings are held at an Operating Unit level a formal divisional governance structure to escalate to the Regions has not been established. Performance is not currently reviewed and scrutinised by the Executive for individual Regions or Operating Units. This would provide the Executive with visibility of any performance issues emerging in specific locations and allow them to obtain assurance that appropriate mitigations were being put in place. Regional Boards should be established as part of the restructuring of operations, with a Board for each of the East and West regions, consisting of the Regional Operations Manager, Operating Unit Managers, Finance Business Partner, HR Business Partner and senior clinicians from the Region. These should meet on a monthly basis with a terms of reference considering operational performance, finance, HR, risk management, quality and safety and other governance matters, such as incidents and complaints. A quarterly review should be held for each of the Regions, 111 and the EOC between the division and the Executive. Reports should be provided to the meeting to set out the performance of the service against the above domains and actions being taken to resolve any performance issues reviewed by the Executive to obtain assurance they are appropriate. We have set out in Appendix E an example of the matters we would expect to see considered.	**Agreed** During the period of this review steps were being taken to revise the divisional governance structure. Since then, an Area Governance Review meeting structure has been established. There are five area governance review meetings held monthly; EOC, 999 East, 999 West, Resilience and Specialist Operations, and 111. They are chaired by the Executive Director of Operations and membership includes regional operational managers, relevant business partners and managers from other directorates. The Executive Director of Nursing & Quality and Executive Medical Director also attend. There are is a standard agenda covering operational performance, quality, workforce, finance and risk. Scorecards have been introduced to ensure that quality and performance can be managed from OTL level upwards. *Responsible officer:* Executive Director of Operations

Recommendations

#	Risk	Issue, Impact and Recommendation	Management Response/Officer/Due Date
2	1	**Management information** Consistent management information is not available at a divisional or locality level to enable identification of trends or concerns at specific locations that may require action to be taken. Although performance against access targets can be monitored locally other key management information sources, including workforce, quality and safety are not consistently made available to Regions or Operating Units to support their management. Consistent hierarchies should be established for the Trust's reporting systems to enable reporting by Operating Unit and by Region. Balanced scorecards should be developed for the Regions to enable Regional Operating Managers to obtain an overview of the performance within each region and distributed for the Regional Boards recommended (see recommendation one). Performance reports presented to the Board and sub-committees should be reviewed to reduce the length of reports and support users in more easily identifying where performance issues are arising that require scrutiny. Current reports include a number of pages of trend diagrams, whilst these may support scrutiny of areas where performance is not being achieved a more concise method for reporting these would support reviewing performance. A number of workforce targets do not have targets formally established, such as vacancy and turnover rates. We also noted that at the last two Board meetings workforce indicators had not all been able to be reported due to performance information not being available. A review of the reporting timetable for workforce information should be undertaken to identify how information can be developed in time for reporting to the Board. When assurance committees and the Board are determining whether they are assured over a specific matter they must ensure that a supporting evidence base has been provided as part of the assurance report to confirm the basis on which they are giving their assurance.	**Agreed** The October Trust board approved funding for the implementation of a new data warehouse and Business Intelligence system to bring together reporting in a coherent way to meet the needs of the organisation. The Business Intelligence team has also recently been increased in size with two additional analysts joining the team in October 2017. A range of dashboards incorporating performance, workforce and quality data are in development to meet the needs of the various management groups and the new operational structure. Further work is required to improve consistency of reporting structures across all data systems to align data to the division/operating unit/team structure. A new more concise board report was presented in October and is being further developed with the Audit Committee to provide consistency. This process will further prioritise metrics for board reporting and determine targets through benchmarking with other ambulance and wider NHS sector providers. *Responsible officer:* Executive Director of Strategy and Business Development

Recommendations

#	Risk	Issue, Impact and Recommendation	Management Response/Officer/Due Date
3	2	**Senior Management Team** Executive Management Team (EMT) meetings are held on a weekly basis. Our observations of two EMT meetings identified that meetings spent a significant amount of time considering detailed operational matters, such as reviewing processes for keeping user accounts up to date on the risk management system. There is a risk of management stretch amongst Executive members as the Trust seeks to implement its Task and Finish Groups in response to the CQC inspection. The Senior Management Team currently has a limited role in supporting the overall management of the Trust, with meetings overseeing the refresh of policies and reviewing risks scored over 12. A review of the matters considered by the EMT should be undertaken to assess where further responsibility could be delegated to the SMT. A formal escalation mechanism should be established from the SMT to the EMT so that any issues arising can be escalated for consideration by the Executive.	**Agreed** A review is being undertaken of the current executive meeting structure and SMT, with the aim to ensure better clarity of purpose and division of responsibilities. The aim is to conclude this review and have the new structure in place by February 2018. There is already in place a formal mechanism for escalating issues from SMT to the executive whereby at the end of each meeting the Chair establishes what issues should be escalated. The executive management board has a standing item at the start of each meeting to receive such escalation. This mechanism has been reinforced. *Responsible officer:* Chief Executive
4	2	**Communication** Feedback from staff consistently set out that when matters were reported, such as incidents and safeguarding concerns, that feedback was not received to inform them of how they were dealt with and any matters arising as a result. This was fed back as a significant contributing factor to the low levels of incidents that have been reported. The medicines management optimisation plan has effectively communicated the importance of changes being made to medicines management, with Executive led communication to Operating Team Leaders for further cascade. However, as further workstreams are implemented there will be limited capacity for this to be replicated for all of the projects undertaken. Appropriate operational representation should be factored into all the Task and Finish Groups to support the cascade of information to operational teams. This should include Regional Operating Managers and Operating Managers responsible for feeding information back. As part of the risk, incident and safeguarding action plans consideration should be given to how feedback to users can be improved.	**Agreed** The Trust's improvement plan includes a measure relating to feedback to staff. This plan is overseen by the related task and finish group and the Compliance Steering Group. The aim is to ensure feedback is provided, electronically, via the central incident team, as part of the incident closure process. Quality Improvement (driver diagrams) will be displayed at stations, highlighting the learning / action taken as a result of incident reporting. In addition, as each task and finish group undergoes the 'intensive support' phase of the improvement plan the Trust is sharing progress with operational staff to help engagement and sustained improvement. *Responsible officer:* Executive Director of Nursing and Quality

Recommendations

#	Risk	Issue, Impact and Recommendation	Management Response/Officer/Due Date
5	2	**Risk reporting** The EMT and SMT receive reports of new risks raised and all risks above 15 and 12 respectively for review on a monthly basis. On a quarterly basis the Executive report shows the full details of the risk register, while at other meetings this sets out those that are overdue for review to enable monitoring of whether risk review is taking place appropriately. Review at the meetings should be focused on considering whether the target risk score is appropriate, mitigating actions identified are sufficient to manage the risk to its target level and whether timescales are appropriately prompt. Mitigating actions against risks should have responsible officers and due dates assigned. Where the full risk register is not presented to the Executive exception reporting against the completion of actions would support increased effectiveness of monitoring of risk management. A formal risk appetite has not been defined to support the consideration of the level of risk willing to be accepted depending on the nature of the risk. 16% of risks on the risk register have a target risk that remains extreme or high. The Board should consider its risk appetite for different natures of risk (such as financial, quality and safety) and update the risk management strategy to incorporate this. When new risks are reviewed the alignment of the target risk score to the risk appetite should be considered.	**Agreed** The risk management improvement plan continues to progress, as part of the delivery plan, and is now supported by a risk management project lead. Particular focus has been given to ensuring principal risk leads are identified against all risks, and that risks are assigned to specific 'forums' – to ensure the forums regularly review those risks within its remit. Although a formal education programme is being scoped, developed and implemented; education opportunities have already been identified. For example, during risk reviews with individuals and teams, training and awareness of the new processes is taking place. The Executive is scheduled to have a risk management workshop on 13 December 2017 to help clarify its role, so that it consistently seeks the assurance of the overall risk strategy, picking up the issues identified by this review. This will include developing a formal risk appetite. *Responsible officer:* Executive Director of Nursing and Quality
6	3	**Meeting management** Though meetings are generally well managed we identified some opportunities to improve the efficiency of the Board and its sub-committees. Although agendas for the Board set out anticipated timings for agenda items this has not been replicated for Board sub-committees. The Board agenda format should be adopted for each of the sub-committees to support management of meetings so that all agenda items receive sufficient attention. Action logs were often not sufficiently specific to be able to clearly identify what the expected action had been when following up matters arising at subsequent meetings and updates were not provided in advance of the meeting. This increases the length of time required to consider matters arising and may mean they are not implemented as promptly as expected. The secretary for meetings should circulate the agreed actions following the writing of the meeting minutes and circulate these to responsible officers. Updates should be requested from management in advance of circulating papers for the meeting.	**Agreed** There was already a standard agenda format in place for board committees and this has now been updated to ensure timings of agenda items. Each committee reviews the action log ahead of meetings, so that it is sufficiently updated. Work has been done to ensure the minutes are clear, including the actions. A review has been undertaken of the current action logs to ensure they accurately describe the action required. *Responsible officer:* Company Secretary

Recommendations

#	Risk	Issue, Impact and Recommendation	Management Response/Officer/Due Date
7	3	**Alignment of Committees to risk register** A purview map is used to set out the alignment of the Board sub-committees' responsibilities to the Trust's objectives and the five CQC domains under their revised inspection framework. The QPS and Workforce and Wellbeing Committee have undertaken regular assurance deep dives into a number of specific areas, determining from these whether they are assured or not. We were unable to establish a formal feedback mechanism for the assurance considered by the Committee to inform the risk register, either by updating assurances against existing risks or identifying new risks. A standing agenda item should be included at the end of committee meetings to consider whether new risks have been identified that require escalation to the risk register.	**Agreed** Although it has been practice for board committees to reflect whether a risk discussed is on the risk register, supported by the board escalation report having a section on any changes to the risk profile of the Trust, a standing agenda item has been included so that the committee specifically establishes whether any new risks have been identified. *Responsible officer:* Company Secretary
8	3	**Board Assurance Framework risks** Only two of the risks recorded on the Board Assurance Framework are scored as extreme. However, there are 22 extreme risks recorded on the risk register, many of which relate to the findings raised by the Care Quality Commission. While the BAF has been designed to consider specific risks to the achievement of the strategy, this may mean the Board's attention is not sufficiently focused on the greatest risks the Trust is facing. A review of the extreme risks should be undertaken to assess whether there are risks that require recording on the BAF due to their importance in achieving the core objectives of the Trust, especially its our patients objectives.	**Agreed** A review of the Board Assurance Framework in being undertaken to ensure the right objectives are captured and, therefore, the most relevant risks. The aim is to conclude this during January 2018, acknowledging the BAF is dynamic and therefore continuously being reviewed. In addition, as part of the risk management improvement plan, the reporting is being improved so that the Board also receives risks not on the BAF that are rated as 'extreme'. This will be each quarter starting in January 2018. Responsible officer: Company Secretary

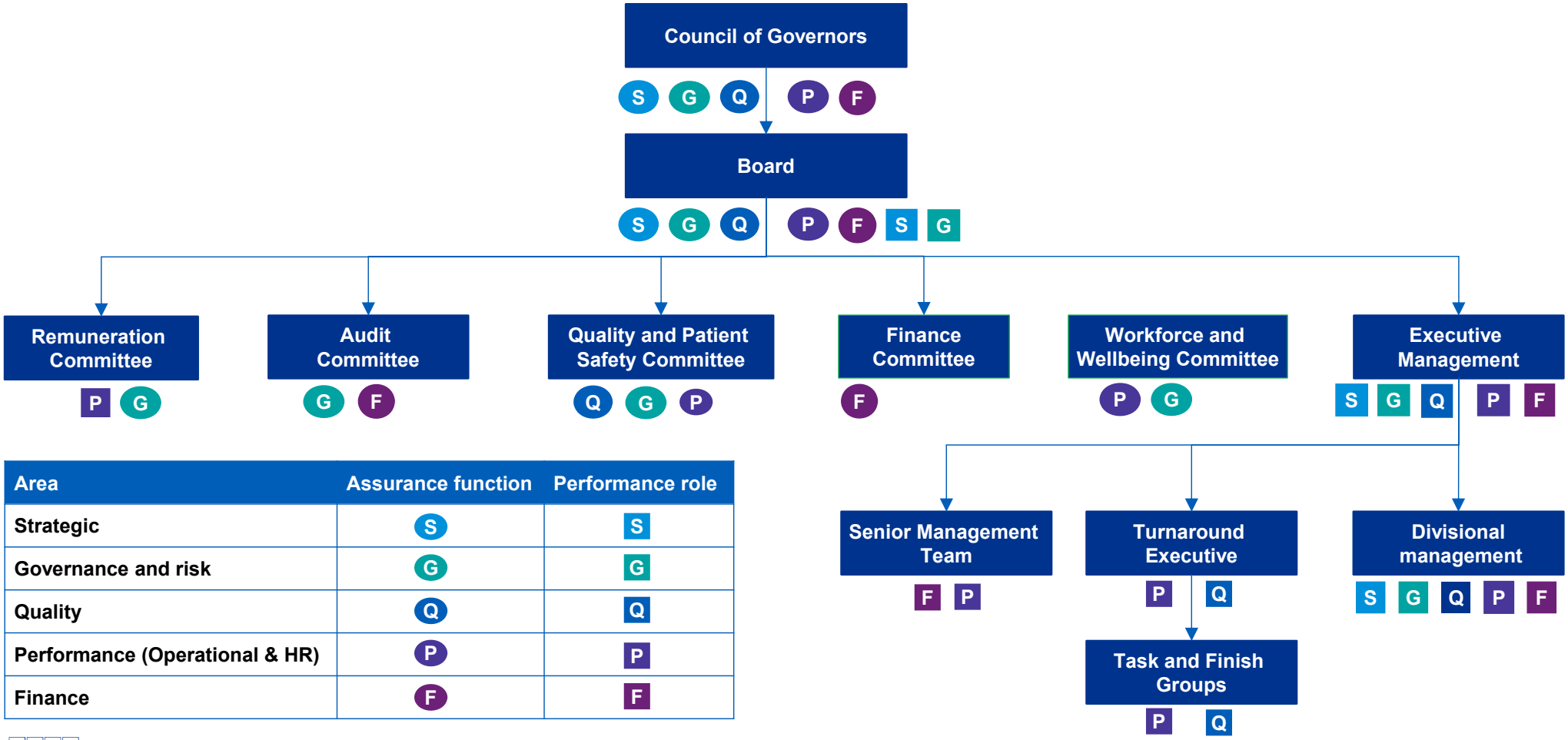
Recommendations

#	Risk	Issue, Impact and Recommendation	Management Response/Officer/Due Date
9	3	**Review of action plans** Following the completion of our clinical deep dives we have identified eight specific findings where actions to comply with the must-do's set out by the CQC had not been fully implemented. We have provided full details in Appendix B. While most of these are addressed through action plans being implemented a review of the action plans should be undertaken to verify all findings have been accounted for, including as part of updating Standard Operating Procedures where necessary.	**Agreed** ▪ Medicines - a review of medicines governance improvement plans has been undertaken to ensure the findings and recommendations from this review have been considered. ▪ Vehicle checks - the check sheet has been produced and the Incident Resourcing, Deployment & Management Standard Operating Procedure includes a section that refers to the 10-minute vehicle check time. ▪ Record keeping – there are no plans to include record keeping as a specific part of key skills for 2018/19, but compliance with completion of PCRs, including (where it is required) the recording of consent and mental capacity, is reviewed regularly by OTLs. A PCR for every member of staff is audited every month and the minimum data set is being reinforced to ensure clarity of what is expected. *Responsible officer:* Executive Medical Director

Appendix A

Governance structure

We have benchmarked the Board governance structure against other ambulance providers and against a peer group of Foundation Trusts in other sectors to consider the alignment of the committees and their roles to industry practice. We set out below a summary of the Board governance structure and the role of each committee. On the following page we provide commentary on the comparisons against the industry.



Area	Assurance function	Performance role
Strategic	S	S
Governance and risk	G	G
Quality	Q	Q
Performance (Operational & HR)	P	P
Finance	F	F

Appendix A

Governance structure

Comparison of Trust structure to benchmark

The table below summarises the key differences identified between the governance structure at the Trust and the benchmarked peers we reviewed.

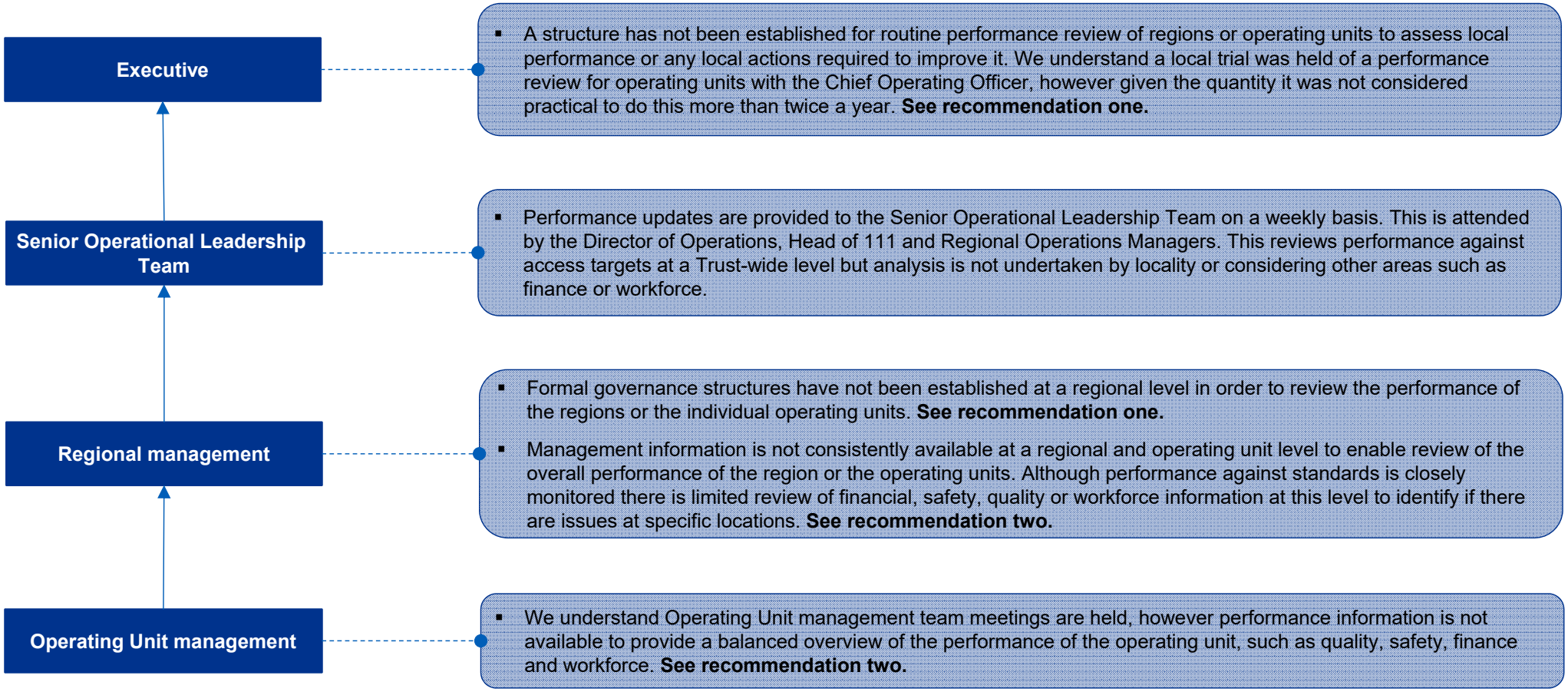
Domain	Benchmarked expectation	KPMG commentary
Divisional governance	Divisions have governance meetings established to enable management to review local performance, risks and quality matters. Scrutiny is completed by the Executive of this performance on at least a quarterly basis to enable identification and escalation of issues.	— Oversight of performance at a local level is completed by Operating Units for operations. — Within the Trust's management structure the Operating Units report to regions, however we were unable to identify that there was a formal governance structure to enable escalation and review of performance at a regional level. **See recommendation one.** — Although Trust-wide performance is considered by the Senior Operational Leadership Team on a regular basis there is not a formal escalation and scrutiny mechanism established for the Executive to review the performance of the regions or operating units. Local performance is not routinely reviewed to enable identification of any risks or issues arising in specific areas. **See recommendation one.**
Senior Management Team	The Senior Management Team (SMT) undertakes review of performance in order to identify the reasons for any adverse performance and actions required to achieve targets. A delegated limit is in place for the SMT to be able to take decisions on behalf of the Executive where financial commitments are lower.	— The SMT has been assigned some specific tasks, such as oversight of the review of policies, to support the Executive in delivery of the range of work required to be completed. However, we were unable to establish that a clear role for the SMT had been defined to support it in the management of the Trust's operations or decision making and support the workload of the Executive. **See recommendation three.**

Appendix A

Governance structure

Divisional governance structure

We assessed the structures in place for managing operational performance at a regional and operating unit level. We set out below our understanding of the design and commentary on the assurance available.

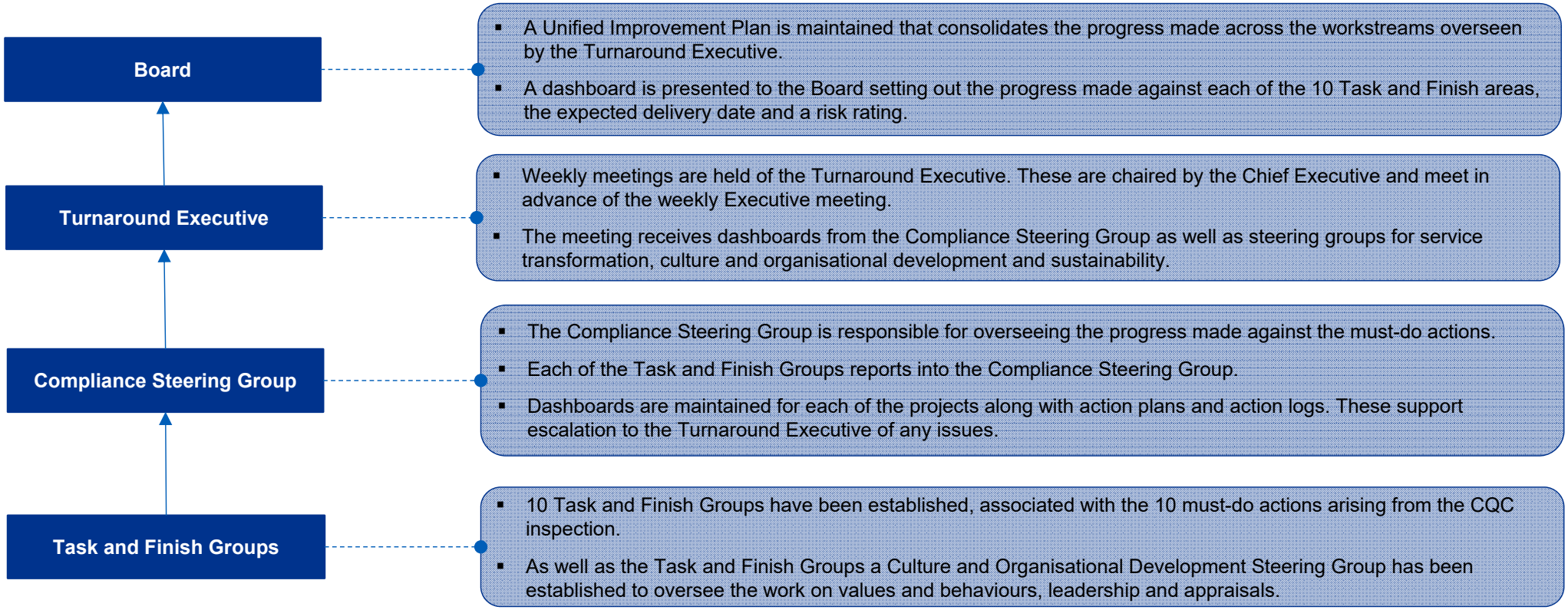


Appendix A

Governance structure

Oversight of CQC actions

We reviewed the project management and governance structure in place for overseeing the implementation of the must-do actions identified by the CQC following their inspections of the Trust. We set out below our understanding of the structure and commentary on its design.



Standardised project documents have been setting up, including plans setting out the actions required and responsible officers and monitoring documents. However, we have been unable to identify plans in place to enable the full range of Task and Finish Groups to transition changes into business as usual and monitor the effectiveness of their implementation as part of recurring activities. Given the range of activities to be implemented between now and March 2018 it is important that this is carefully considered to manage communications to operational services and ensure there is the capacity and reporting available to identify risks of non-compliance. **See recommendation one.**

Appendix A

Governance structure

Paper review

We reviewed three key sets of documents that underpin the governance arrangements. For each of these we have provided commentary on strengths and areas for development to support operation of the committees.

Domain	Strengths	Areas for development
Terms of reference	— A purview map is used to set out the key controls that the committees are responsible for. This is agreed on an annual basis to enable prevalent issues to be added to the requirements for review.	— No development areas noted.
Agendas	— Board agendas set out planned timings for each item to help guide the meeting to give sufficient time to each item on the agenda. — Agendas are generally structured with those items for assurance and decision earliest on the agenda, which is where the majority of committees' time should be focused. — The purpose and owner of papers on the agenda are set out clearly on the agenda.	— Agendas for sub-committees do not set out the timings for expected agenda items. **See recommendation six.**
Minutes	— Minutes clearly identify where actions were agreed.	— No development areas noted.
Action logs	— Responsible officers and due dates are identified for each action.	— Across the committees we reviewed actions from previous meetings had not consistently been updated ahead of the meeting. **See recommendation six.** — Actions are not always sufficiently specific to enable clear follow up in future meetings, such as requesting that the style of papers are amended. **See recommendation six.**

Appendix A

Governance structure

We reviewed papers provided to the key committees of the Trust and the Board in the last 12 months to assess whether the design of information presented was sufficient to enable effective scrutiny and decision making.

Domain	Strengths	Areas for development
Board	— A standing agenda item is provided to set out an update on the implementation of the Unified Improvement Plan. — Clinical effectiveness measures reported to the Board as part of the balanced scorecard make effective use of national benchmarks to consider the Trust's performance. — Performance against indicators is RAG rated to provide a visual indication of how the Trust is performing against its target.	— An integrated performance dashboard is presented to each meeting of the Board. Whilst it provides a holistic view of a range of performance areas, including workforce, finance, safety and performance it is often over 40 pages in length, reducing the ability for the Board to focus on the most significant issues requiring attention. **See recommendation two.** — Workforce performance does not have targets set in a number of areas, such as vacancies or sickness where this would enable better identification of whether there are concerns. In a number of instances data was not available for measures on the workforce scorecard, for example in June 2017 data was not available on appraisals or mandatory training and in May 2017 data was not available on vacancies. **See recommendation two.**
Quality and Patient Safety Committee (QPS)	— The QPS receives a quarterly quality and safety report. This sets out performance metrics at a Trust-wide level across a range of quality and safety dimensions, including complaints, incidents, infection control and safeguarding. — An overall RAG rating is provided for each of the areas considered in the performance report to set out the overall level of assurance. An explanation is provided as to how each rating has been derived. — We observed effective follow up of assurance items at following meetings to present evidence to show that risks had been mitigated, with evidence provided to support this.	— No development areas identified.

Appendix A

Governance structure

Domain	Strengths	Areas for development
Workforce and Wellbeing Committee (WWC)	— A workforce information report is presented to each meeting of the WWC. The report includes a one page summary of the Trust-wide workforce metrics, showing monthly performance for the last three months and the trend in performance. — We were able to see evidence of well developed papers being produced in response to specific queries and concerns relating to workforce matters.	— The workforce information report contains a number of pages of very detailed appendices, such as the headcount in each individual team from Electronic Staff Records and the number of leavers by individual team. The volume of data provided restricts the ability to determine the key areas of focus required from the Committee. **See recommendation three.**
Audit Committee	— Progress reports are provided by each of the internal and external auditors to each meeting of the Committee. — Standing items are brought to the committee to review the risk register and the Board Assurance Framework. We have provided further review of these as part of our risk management review in section two.	— There are opportunities to consolidate the length of some papers presented to the Committee in order to more clearly focus on key messages requiring Non-Executive scrutiny, for example losses and special payments reports are regularly at least 10 pages with very detailed breakdowns included. **See recommendation two.**

Appendix A

Governance structure

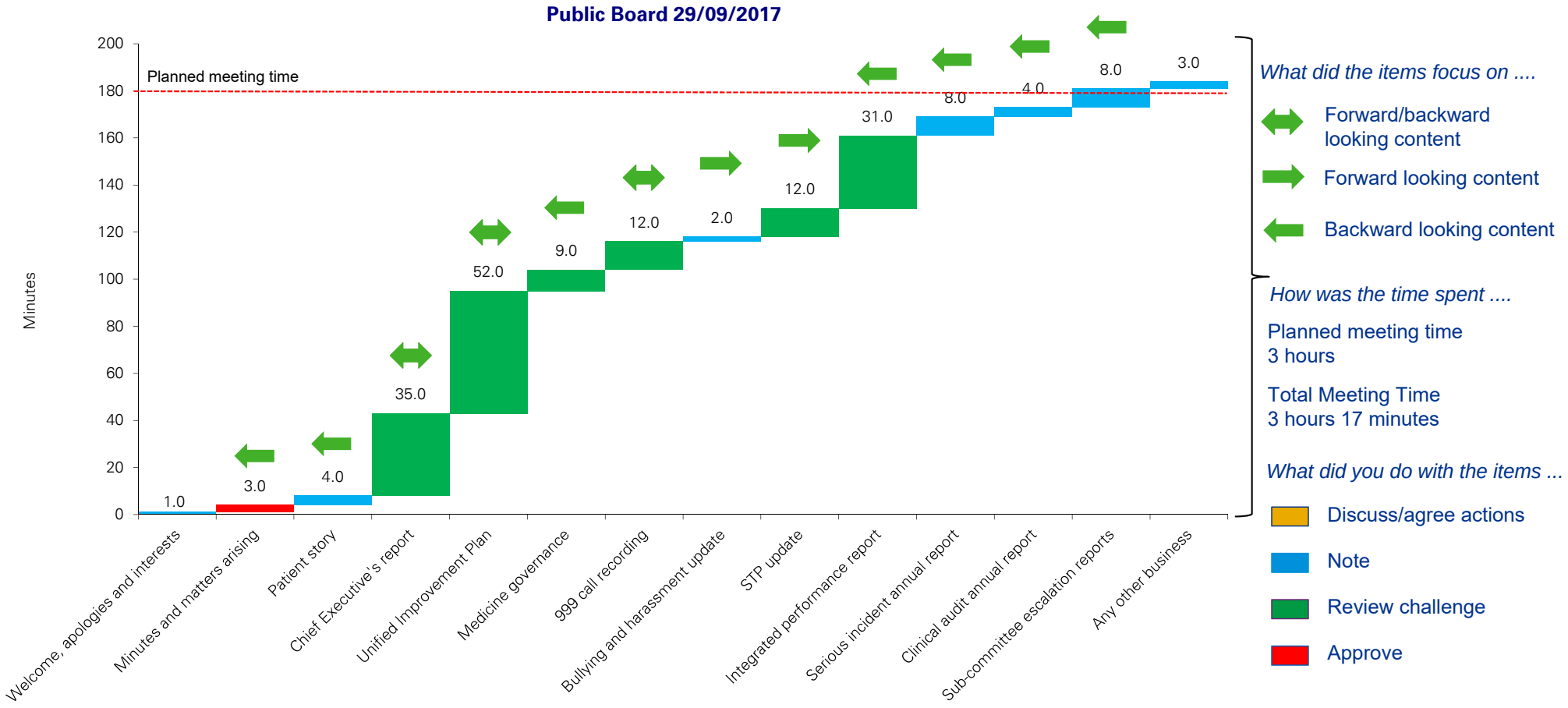
Domain	Strengths	Areas for development
Council of Governors	— The Chief Executive's report is a standing item on the agendas for every meeting. This includes coverage of regional and local issues as well as operational performance. — Key reports requiring Council involvement are presented as a standing item on the agenda. These reports are discussed where necessary and not just merely noted. — The action log is discussed at the start of meetings so that any issues with delivery can be raised. The action log is sufficiently detailed with owners, completion dates and updates. — The Council meetings have a strong steer on clinical issues arising for SECAMB including filling senior posts and clinical performance.	— An integrated performance dashboard is presented to each meeting of the Council. Whilst it provides a holistic view of a range of performance areas, including workforce, finance, safety and performance it is often over 40 pages in length which may reduce the ability for the Council to focus on the most significant issues requiring attention. **See recommendation two.**

Appendix A

Governance structure

Effectiveness of Board and sub-committees

We attended meetings of the Board, Quality and Patient Safety Committee, Audit Committee and Executive Management Team to assess the effectiveness of meetings. We summarise our observations below.



Appendix A

Governance structure

Following our attendance at the September 2017 Board meeting we made the following observations on the effectiveness of its operation.

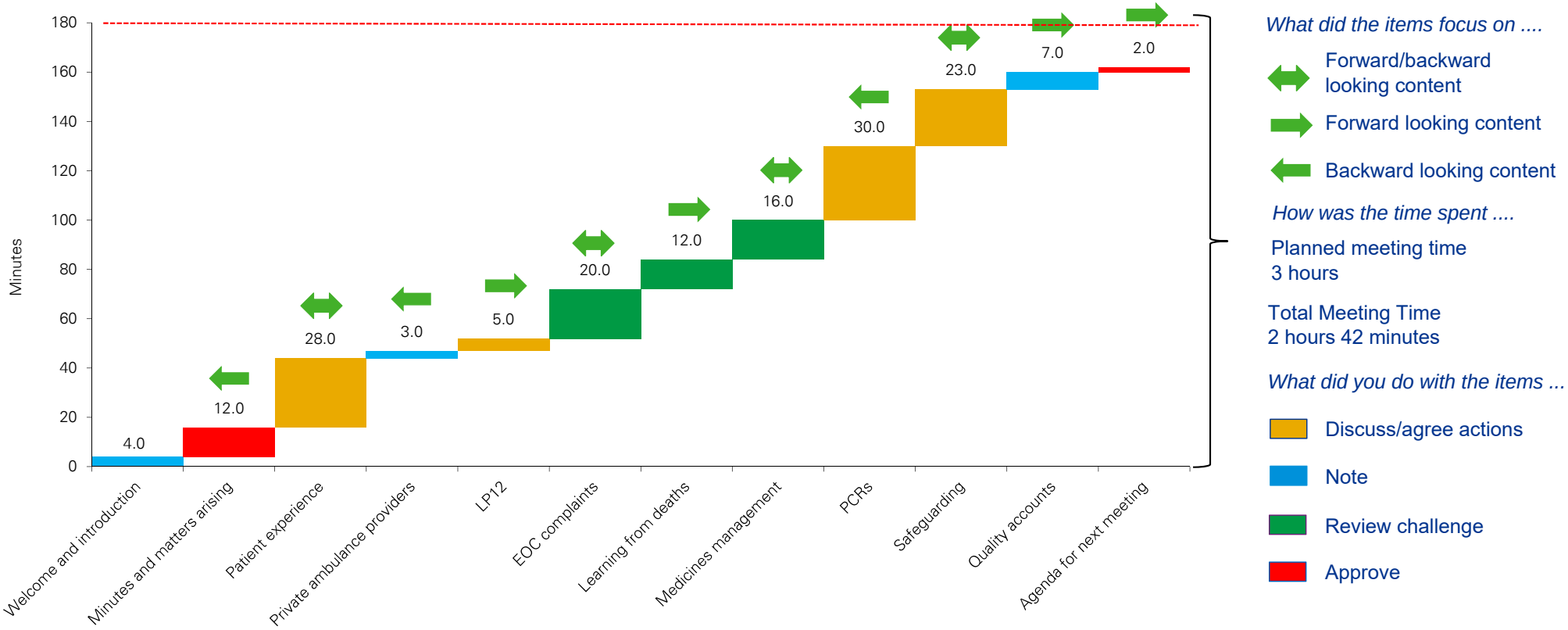
Areas of good practice	Areas for development
— There was an effective balance of forward and backward looking information included within the agenda.	— One item on the agenda relating to medicines management was presented for assurance, however data to support the explanation was not provided to the meeting, therefore while the Board determined it was assured there was no supporting evidence made available to the meeting to support this. We do, however, note that we are aware evidence had been provided in other meetings prior to the Board to enable this assurance to be reached. Despite this the Board must only record that it is assured when stated performance is supported by an evidence base at the Board meeting.
— 77% of the public Board's time was spent reviewing items for assurance and agreeing further actions that were required in order to improve the level of assurance available. This is an effective balance over the level of information that was presented for noting.	
— There was strong engagement from across each of the Non-Executives with the agenda items. We observed evidence of triangulation of items discussed at sub-committees with information presented to the Board.	

Appendix A

Governance structure

Quality and Patient Safety Committee (QPS)

We observed the September 2017 QPS. The chart below sets out the use of time of the meeting. We have then set out our commentary on the effectiveness of the meeting.



Throughout the meeting we observed strong engagement across its membership in the items presented. There was an effective balance between forward and backward looking information. The majority of items presented to the Committee were for scrutiny and reviewing. Where items were brought to the Committee for assurance there were clear summaries to determine why it was assured and we observed evidence of items being requested to come back to a future meeting as there was not yet assurance available.

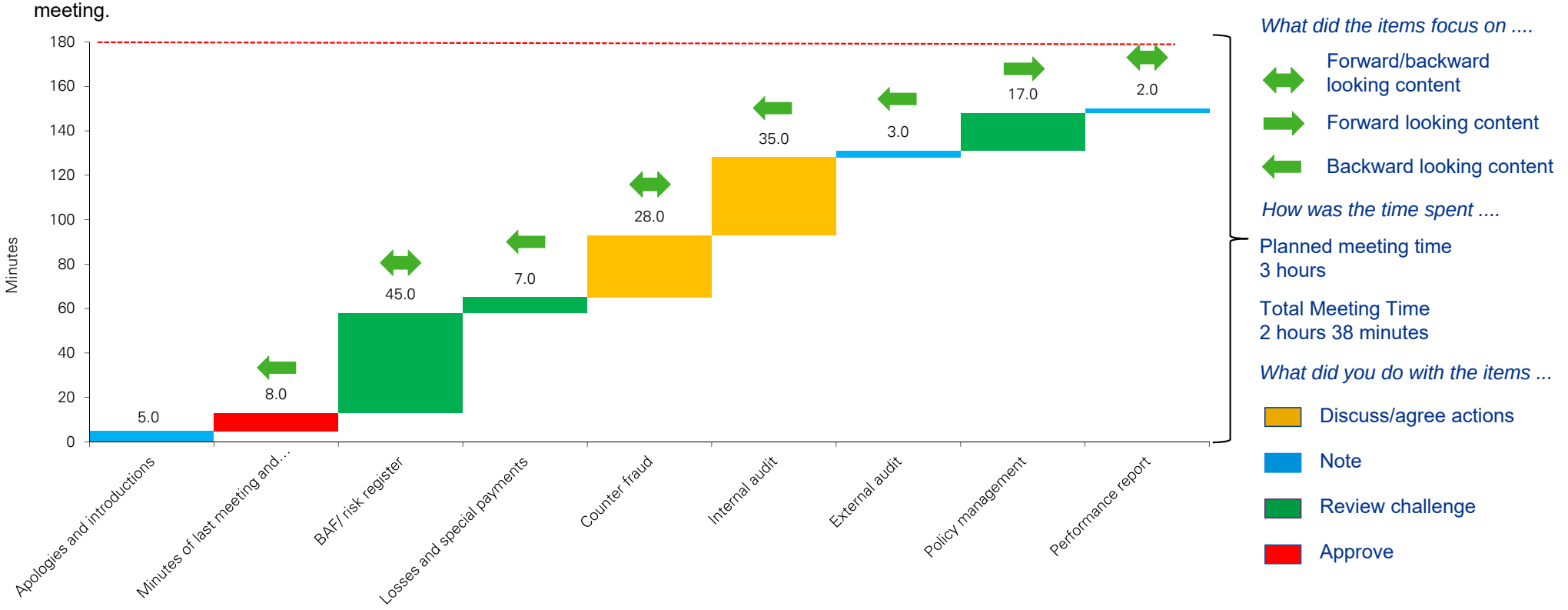
Although there was effective discussion of assurance in key risk areas we were unable to identify how the outcomes of these discussions were used to update the risk register to confirm where assurance was in place or gaps in assurance had been identified. **See recommendation seven.**

Appendix A

Governance structure

Audit Committee

We observed the September 2017 Audit Committee. The chart below sets out the use of time of the meeting. We have then set out our commentary on the effectiveness of the meeting.



We observed strong engagement from all of the Non-Executive Director members in the agenda items, including detailed consideration of the Board Assurance Framework and potential risks arising from the counter fraud investigation undertaken. Actions were clearly agreed, with responsible officers assigned to enable follow up at future meetings.

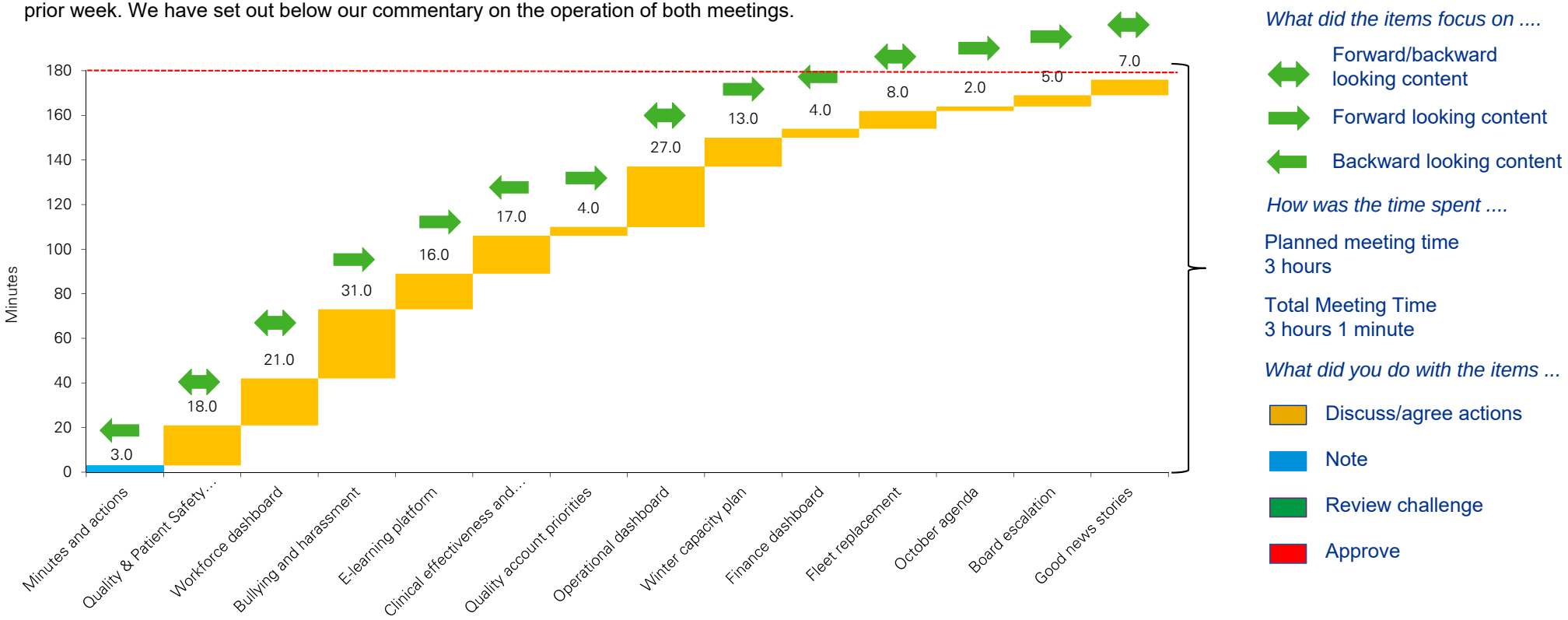
There was an effective balance between forward and backward looking information on the agenda and an appropriate level of papers presented being for scrutiny and agreement of actions.

Appendix A

Governance structure

Executive Board

We observed the September 29 2017 Executive Board. The chart below sets out the use of time of the meeting. We also observed the Executive Risk and Assurance Group the prior week. We have set out below our commentary on the operation of both meetings.



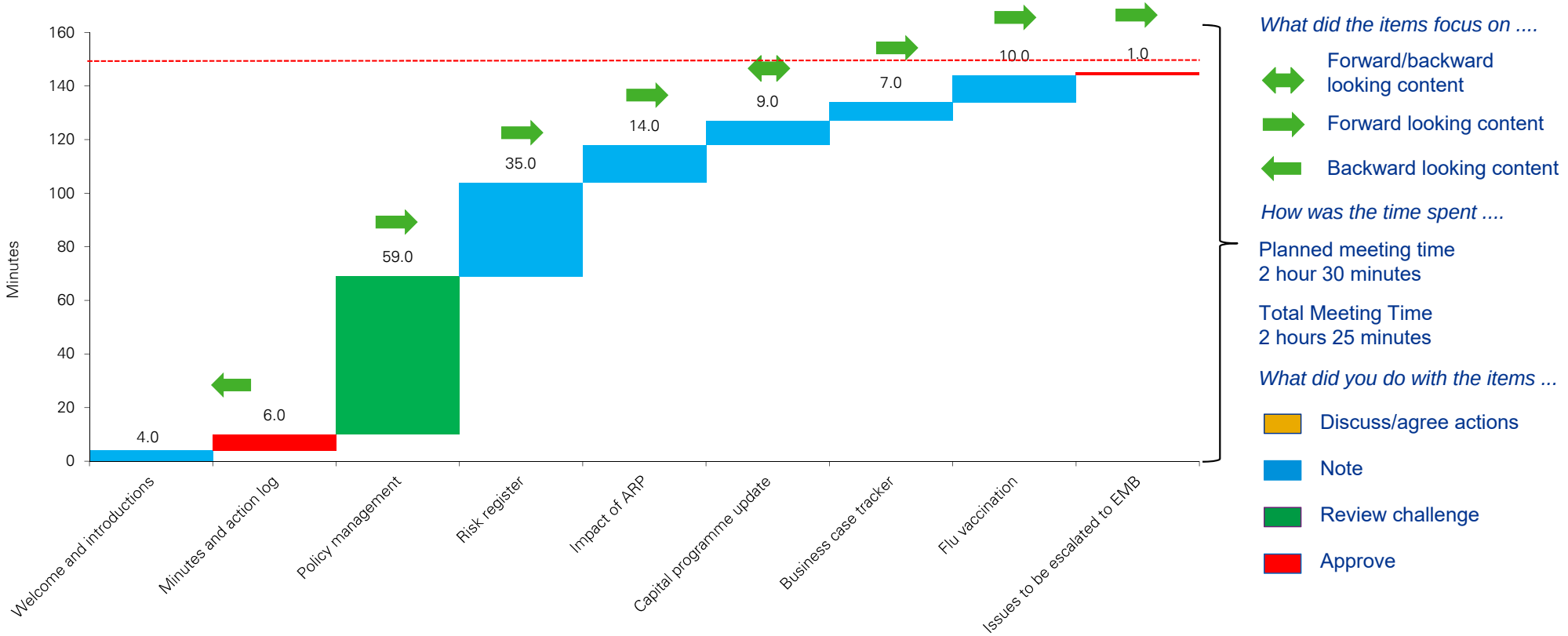
Across the two Executive meetings observed we were able to see evidence that there was very strong engagement across the Executive with the issues being considered. Meetings were well chaired with actions clearly agreed. The majority of items on the agenda related to areas of significant risk and findings from the CQC, demonstrating there is engagement in key issues. However, in a number of instances discussions related to detailed operational matters, such as the management of access to the risk management system. There is an opportunity for the Executive to delegate responsibility for some of these matters in order to enable it to make more focused use of its time to focus on setting the strategic direction to deal with key matters. **See recommendation two.**

Appendix A

Governance structure

Senior Management Team (SMT)

We observed the 1 September 2017 SMT. The chart below sets out the use of time of the meeting. We have set out below our commentary on the operation of both meetings.



We observed strong engagement throughout the meeting, with each of the attendees contributing to agenda items, especially those relating to the review of policies. We were not always able to clearly determine the decisions that had been made in the meeting to assess whether the policies had been approved to be adopted subject to suggested revisions or needed to be brought back to the meeting.

The role of agenda items was not always clear. All items other than policies were presented for information, including the risk register, which was tabled at the meeting. The same risk deep dive was completed at the Executive Risk and Assurance meeting, however the SMT could have been used to consider the actions that were agreed at the Executive. **See recommendation two.**

Appendix A

Governance structure

Oversight of reports

The Trust has recently received a number of reports requiring and recommending that it take action, including its inspection by the CQC, the review of culture by Professor Duncan Lewis and a safeguarding investigation commissioned in response to allegations at the Knaphill station.

Each of the must-do actions from the CQC inspection has had a Task and Finish Group established with a specific action plan developed to consider each of the development areas identified relating to the subject by the CQC. These have responsible owners and Executives assigned responsible for delivery and are overseen by the Compliance Steering Group.

At the time of our report a formal action plan in response to the Duncan Lewis report had not yet been developed, however the Trust has undertaken a series of bullying and harassment workshops to support it in identifying the most appropriate actions to be taken We attended two of these workshops and observed strong engagement with the staff members attending to consider actions that could be taken to support improvement to the culture within the organisation, we have provided further analysis in Appendix B. We attended the September 2017 Governor Development Committee and confirmed that consideration was being given to the best way for recommendations for the governors to be implemented.

Although the Board was not satisfied with the quality of the report into Knaphill we confirmed that an investigation had been undertaken into the specific allegations made and that the station has been closed and management is therefore able to demonstrate that action has been taken in response to the issues identified. The majority of the recommendations raised by the report were accepted and incorporated into the Trust's action plans. A Safeguarding Group has been established to oversee the levels of safeguarding referrals, a dashboard has been developed that includes referrals made relating to staff to support the Trust in overseeing the safeguarding activity and concerns. There is HR attendance at the Safeguarding Group to support the management of any cases and learning from referrals. A Task and Finish Group has been established to deliver the safeguarding improvements required by the CQC, a short term action plan has been developed and is overseen by the Safeguarding Group. A longer term action plan to support strategic improvements is being developed.

However, locality based reporting systems are not currently in place to enable review of performance at individual stations or operating units, which is important in supporting management to oversee operations and identify where there may be specific areas of concern that require further investigation of action to be taken. **See recommendation one.**

Conclusion

The Board sub-committee structure is in line with those for comparable Trusts that we have benchmarked you against, both within the ambulance sector and other NHS Foundation Trusts. The Executive Board meets weekly, with each meeting of the month having a different focus, including one meeting reviewing performance and one reviewing risk.

A Senior Operational Leadership Team has been established, chaired by the Director of Operations, which reviews Trust-wide operational performance and meets on a weekly basis. However, there is not a formal divisional governance structure in place for the review of local performance at regional level and for scrutiny of local performance by the Executive. Performance information is not consistently available at an Operating Unit or Region level to enable scrutiny across a range of indicators to support the Executive in monitoring whether there are issues in specific locations. **See recommendation one.**

Appendix A

Governance structure

A Senior Management Team has been established to provide support to the Executive in managing key Trust issues. This has been delegated specific responsibilities, including oversight of the policy review project, and receives risks scored 12 and above on a standing basis for review. However, there is an opportunity for the SMT to take on an increased role in supporting the Executive. The majority of the items presented to the SMT were provided for information and did not relate to the performance of the Trust. Weekly Executive meetings currently last three hours and considered operational matters in significant detail, matters that could be addressed elsewhere to free time for the Executive to focus on strategic matters. **See recommendation two.**

A performance dashboard has been developed for the Board that includes sections relating to achievement of targets, quality and safety, workforce and finance. The reports make effective use of risk ratings to set out where performance targets are not being achieved and provide trajectory information showing performance on a monthly basis since the start of 2016-17. However, the reports are very lengthy, which restricts the ability to identify the key issues requiring scrutiny by the Board. A number of workforce indicators have not had targets set and did not always have data available for reporting. **See recommendation three.**

A Task and Finish structure has been established to oversee the 10 key workstreams required to implement changes required as a result of the CQC inspections. It is planned to utilise the model adopted for changes to be made to medicines management practices that has been successful in the last six months as a basis for the development of the Task and Finish Groups. Whilst this will provide a strong framework for management to identify and drive the changes required it is important that consideration is given as to how this becomes embedded as usual within the Regions, both to enable effective communication of expectations from the Executive to operational teams and monitoring to assess whether they have been appropriately implemented.

Appendix B

Assurance deep dive

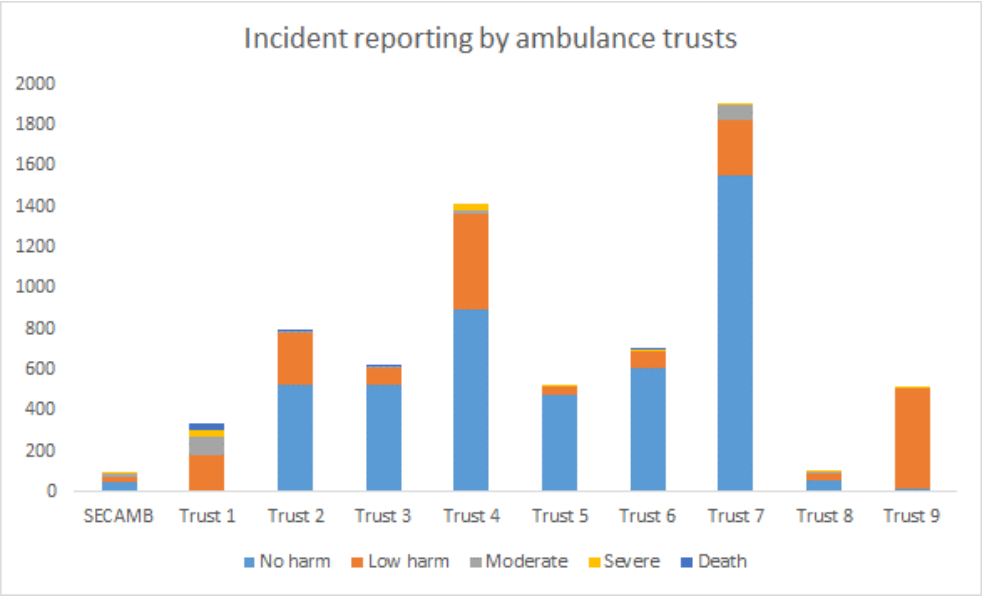
We have undertaken deep dives into four assurance framework risks as agreed with management to assess the management of the risks. We reviewed documentation and during August 2017 we observed crews from a variety of ambulance stations to assess the extent to which mitigations had been implemented.

Incident reporting

The CQC identified findings relating to low levels of incident reporting and evidence not being effectively shared when incidents occurred to support learning lessons.

An incident management improvement action plan has been agreed following the CQC inspection. The Nursing Director is the Executive lead for its implementation and the Head of Risk is the management lead. The plan is due for completion by the end of December 2017. The plan includes actions to understand the barriers to incident reporting by staff by the end of November 2017. The action plan also sets out the need to develop and embed mechanisms for disseminating lessons from incidents, however these mechanisms had not yet been determined at the time of our review.

A Serious Incidents Group has been established to oversee the reporting and review of serious incidents. This is responsible for reviewing root causes analyses following the investigation of serious incidents and considering the lessons to be learned. The Group is attended by the Medical Director and Nursing Director, as well as managers from the risk, compliance, safeguarding and claims teams, though operational attendance at the Group could support the Trust in cascading lessons learned arising from incidents and overseeing the implementation of changes recommended following root cause analyses. **See recommendation four.**



Staff we met as part of our observations were all aware of the incident reporting process. We received feedback from staff that completion of Datix reports was often completed at the end of a shift due to time constraints during the shift. We also obtained feedback from crews that there was limited feedback when incidents were reported. Although automated notifications were sent to confirm that the incident had been received there was sometimes no further follow up of the outcomes from review the incident. **See recommendation four.**

We benchmarked the levels of incident reporting for the 10 ambulance trusts in England based on data submissions to the National Reporting and Learning System. This covers the period from September 2016 to March 2017. The chart to the right shows that the Trust had significantly lower levels of incidents reported to NRLS than its peers during the period under review. We note the overall level of incidents reported on the quarterly Quality and Patient Safety report shows higher levels of incident reporting and we understand the Trust has experienced difficulties in completion of NRLS reporting.

Risk deep dives were undertaken by the SMT and the Executive during September 2017 to consider the risk recorded on the risk register relating to the backlog of incident reporting. The action plan developed by management has addressed each of the findings set out by the CQC. Risks have been recorded on the risk register relating to the backlog of incidents, delays in serious incident investigations and failure to record incidents.

Appendix B

Assurance deep dive

Safeguarding

The CQC inspection identified that level 3 training had not always been provided to staff that could come into contact with patients and operational staff were not aware of how the Safeguarding Lead could be contacted. An operational action plan has been developed for safeguarding to be used as the workplan for making safeguarding improvements in the next 12 months. A strategic safeguarding plan is currently being developed to determine the actions required in the medium and long term.

A Safeguarding Group has been established. This is chaired by the Chief Nurse and also attended by representatives from safeguarding adults and children teams, the education team, a Frequent Call Lead and a Regional Operations Manager. The Group has been established to support the monitoring of safeguarding activity, sharing of lessons learned from safeguarding cases and case reviews and monitor the implementation of safeguarding actions.

A performance dashboard has been developed for monitoring of safeguarding performance. This includes training compliance rates and the number of cases that have been raised to help identify whether there are reductions in the levels of referrals being made. Informal evidence of understanding of safeguarding processes is incorporated based on feedback received as a result of Nursing Director assurance visits to stations.

We observed the September 2017 meeting of the Safeguarding Group. The agenda included updates on the development of action plans and the safeguarding dashboard. We noted that the items on the agenda were all noted with limited scrutiny provided, however are aware that this is a new group that has been established and is still determining the information to be presented and scrutinised.

Scrutiny of performance in addressing the gaps in safeguarding assurance has been provided through the Quality and Patient Safety Committee, which has undertaken assurance deep dives into the actions being taken to improve safeguarding compliance. The most recent deep dive was completed in September 2017.

A level 3 training course has been introduced for staff that lasts for a full day to provide intensive training to those that most need it. Following difficulties in freeing capacity for staff to attend the full day training course the Trust has procured an electronic module and is now targeting provision of the face to face training to those that are considered to most require it based on their roles. Other staff are to be required to complete the electronic learning module. We observed discussion at the Executive and Quality and Safety Committee as to whether level 3 training should be provided to all clinical staff, however having now determined how the training will be rolled out it is important that the positive aspects of the training to reinforce understanding and accountability are reinforced. As of September 2017 training rates for safeguarding were as follows:

Level 2 adults	Level 2 children	Level 3	Mental Capacity Act
27%	20%	20%	77%

Discussions with crews fed back that they had difficulty coordinating the availability of training dates with rostered shifts and some staff set out that they expected they would have to complete the training on a rostered day off. Difficulties in releasing time for training are likely to intensify as the Trust enters the winter season and so it is important that planning is undertaken to release sufficient time for training completion in advance of winter.

As part of our observations with crews we verified that there was a good understanding of safeguarding reporting mechanisms. There was strong awareness of matters that should be reported by those staff we met. We observed an example of a crew dealing with a young adult with learning difficulties living in a supported care environment and observed that appropriate advice was sought from the Clinical and Operating Team Leaders and appropriate documentation was maintained. We received feedback from staff that where safeguarding concerns were raised there was often limited feedback as to how issues raised had been addressed and any outcomes from the referral. **See recommendation four.**

Appendix B

Assurance deep dive

Medicine management

A warning notice was issued by the CQC following their first inspection relating to the governance and systems in place to ensure medicines are ordered, stored, used and disposed in line with legal and professional standards.

A medicines management optimisation plan was implemented in response to the findings of the inspection. This was due to be implemented by 22 September as a result of the deadline set by the CQC for the Trust to demonstrate its compliance with the standards. The optimisation plan had 12 workstreams relating to the requirements set out by the CQC, including secure storage, scope of practice for staff, management of controlled drugs and out of date medicines.

A Task and Finish Group was established to oversee the implementation of the plan. This included the Medical Director, Chief Pharmacist and attendance by Operating Team Leaders (OTL) to enable messages to be cascaded to operational departments. Briefings were given by members of the Executive, including the Chief Executive and Director of Operations to groups of OTLs to set out the expectations of teams and the importance of compliance.

Checklists have been developed by the Chief Pharmacist and provided to the OTLs to support monitoring of whether processes have been appropriately implemented. This allows compliance with secure storage of drugs and medicines to be monitored. Checks were originally introduced on a quarterly basis, however these are now undertaken daily by OTLs and submitted to the Medicines Administrator. A daily conference call is held between the Medicines Administrator and the OTLs in order to provide feedback on the results to the operating teams.

Updates were provided to the Quality and Patient Safety Committee setting out progress being made in the implementation of the medicines management optimisation plan on a regular basis. Medicines management metrics have also been incorporated into the quarterly scorecard presented to the QPS to support monitoring of the extent to which changes have become embedded, including the number of medicines management incidents raised and compliance rates with medicines management audits.

We observed examples of good medicine management and improvements in a number of the areas where deficiencies had originally been found by the CQC at each of the ambulance stations we visited during August 2017 and we observed that medicines were generally well recorded on the patient record documentation reviewed. However, we identified some areas where changes introduced as a result of the optimisation plan had yet to be fully embedded. We have set out the details of the exceptions noted as part of this appendix on pages 34 and 35 to support management in reviewing the optimisation plan and continuing to obtain assurance that necessary changes are becoming embedded within teams.

During our visits to stations we observed inconsistent practice for the secure storage of drugs. At Brighton and Guildford stations medication rooms were locked with Digi-locks that are regularly changed. However, at Medway the miscellaneous drug cupboard and secure cupboard where staff return used drug pouches are in the vehicle garage due to space constraints within the medication room. At Brighton an Omnicell unit has been purchased and provides greater controls to the access of medications. One member of staff highlighted a work around that had been implemented to return ampoules of unused morphine to stock, as usually Omnicell units are programmed to distribute drugs and not to accept them back into stock. However other staff we spoke to stated there was no problem with the system to return drugs to stock.

Appendix B

Assurance deep dive

Bullying and harassment

The Trust commissioned an independent report by Professor Duncan Lewis in order to further understand the issues relating to bullying and harassment identified within the CQC report. The report was received by the Trust in August 2017 and an action plan was being developed at the date of our review.

As part of the response to the Duncan Lewis report the Trust has arranged bullying and harassment workshops in order to explore the issues further with staff and consider solutions in order to improve the culture. Workshops have been held across the Trust's sites to provide opportunities for members of staff across the full geography of its services to be included and workshop timings were phased to enable as many staff as possible to attend.

We observed two of the workshops held during September 2017 to assess the effectiveness of the sessions. Workshops were chaired by a member of the Organisational Development team or an Executive and all were attended by a member of the Executive. There were varying levels of attendance across the sessions observed, with 22 members of staff at one and three at the other. Workshops were structured around four consistent questions to consider:

- Whether the findings from the Duncan Lewis report were recognised;
- What good management looks like;
- What poor management looks like; and
- What actions the Trust should take.

In both instances sessions overran significantly compared to the one hour allocated and we understand that this was consistent across the workshops. Attendance at the workshops was not monitored, therefore we were unable to establish who had attended workshops and whether there were any significant gaps in attendance, such as by specific staff groups or areas.

At the workshops we observed comprehensive notes of feedback were taken and meetings were open, with all contributions treated with respect and recorded. As the formal action plan had not been drafted at the date of our review we have not assessed the appropriateness of the action plan.

We observed the senior members of the Trust, including the Chair and Chief Executive, regularly reinforcing that bullying and harassment was not acceptable and would not be tolerated within the Trust. During our visits and discussions with crews we received feedback that there had been a noticeable improvement in the culture of the Trust and staff were encouraged to speak up.

At the May 2017 Workforce and Wellbeing Committee it was reported that the number of collective and individual grievances had increased compared to 2016, with 34 grievances raised between January and April 2017 compared to 35 cases in 2016. However, the number of whistleblowing cases has reduced in 2017, with only one raised in the year to date compared to four during 2016. This may reflect increased confidence in the grievance processes in place and staff not feeling the need to utilise whistleblowing mechansism, however it reiterates the importance of management continuing to emphasise the ability for staff to raise concerns in confidence and demonstrate that they will be appropriately investigated.

Appendix B

Assurance deep dive

Summary of findings

We have set out below a summary of the findings from our observations of ambulance stations and operations completed in August 2017. We have not raised specific recommendations for these findings, but we recommend that the action plans being implemented are reviewed to verify that all necessary actions are incorporated. **See recommendation nine.**

Finding	Recommendation
Medicine storage We observed several instances of ambulance crews leaving ambulance doors open. On two occasions the medication bag was not securely stored in the ambulance, potentially allowing unauthorised access to gases and drug packs.	Staff should be reminded to ensure ambulance doors are locked if no crew members will remain with the ambulance and bags containing medication be securely stored or remain with a crew member. Spot checks should continue to be undertaken of ambulance security at hospitals.
Medicine management policy The medicine management policy available at the stations visited and on the intranet was due for review in June 2017.	We are aware that a programme of policy review is being undertaken across the Trust. The medicines management policy should be reviewed, ratified and made available on the intranet. Following this checks should be undertaken of printed versions at stations to verify they have been updated.
Patient Group Directives (PGD) Although paramedic practitioners have received updated PGDs those for other staff grades were due for review in May 2017. Staff fed back that they are required to confirm they have understood the PGDs but no training is available to support this.	PGDs should be reviewed and updated for remaining staff groups. A database should be introduced to monitor completion of PGD training.
Medical gases At one station visited we identified that the medical gas storage had been left unlocked. Staff we spoke to were not aware that medical gases had expiry dates that required checking. We identified one instance of a medical gas cylinder that had expired in June 2017 being held at a station. It was not clear whether make ready teams were checking cylinders for expiry dates and this information is not recorded on the vehicle preparation form.	Regular checks of gases held on ambulances and at stations should be undertaken by staff to verify that they have not expired. Checks of specific ambulances should be recorded on the vehicle preparation form.

Appendix B

Assurance deep dive

Finding	Recommendation
Monitoring assignment of drug pouches to crews Ambulance crews are not required to 'sign out' or 'sign in' drugs packs at the start or end of each shift. The introduction of this would enhance the audit trail of packs and allow identification of which crew handled specified drugs should there be any issues with patient medication during the course of, or following the shift.	The Trust should introduce a process that allows the identification and matching of drug pouches to ambulance crews.
Controlled drug disposal The patient care record (PCR) does not prompt staff to document of a measure of a controlled drug was disposed rather than being administered to the patient. We found limited evidence of partial doses being recorded on the PCR. We were informed by some staff that controlled drugs were disposed of down a sink, out of line with Trust policy.	The Trust should amend the PCR to include an area specifically for the use of CDs and include a box where staff can document how much of the dose has been administered, and how much has been disposed of. The Trust should remind staff of the correct method for the disposal of unused CD medication, and ensure documentation is completed to demonstrate that disposals are signed and witnessed.
Recording of Mental Capacity Act assessments The new PCR forms require staff to tick if there are concerns with the patient's mental capacity, and staff said they assess all patients mental capacity, however there was limited documentary evidence that staff record this assessment. Staff were observed to be very good at seeking consent for all the interventions they had with patients, although consent to treatment was not consistently documented on the PCRs we reviewed.	The Trust should consider the inclusion of good record keeping skills as part of the annual Key Skills update. Compliance with the recording of consent and mental capacity should be monitored by the OTLs when records are reviewed each month.
Vehicle checks Vehicle checks completed at Make Ready sites have a check sheet completed, however at other sites crews are required to undertake checks but these are not documented. Some staff provided feedback that insufficient time was made available at the start of shifts to complete vehicle checks.	The Trust should develop a revised check sheet that all staff are required complete. The Trust should ensure the provision of 10 minutes at the start of each shift for the completion of vehicle checks is protected.

Conclusion

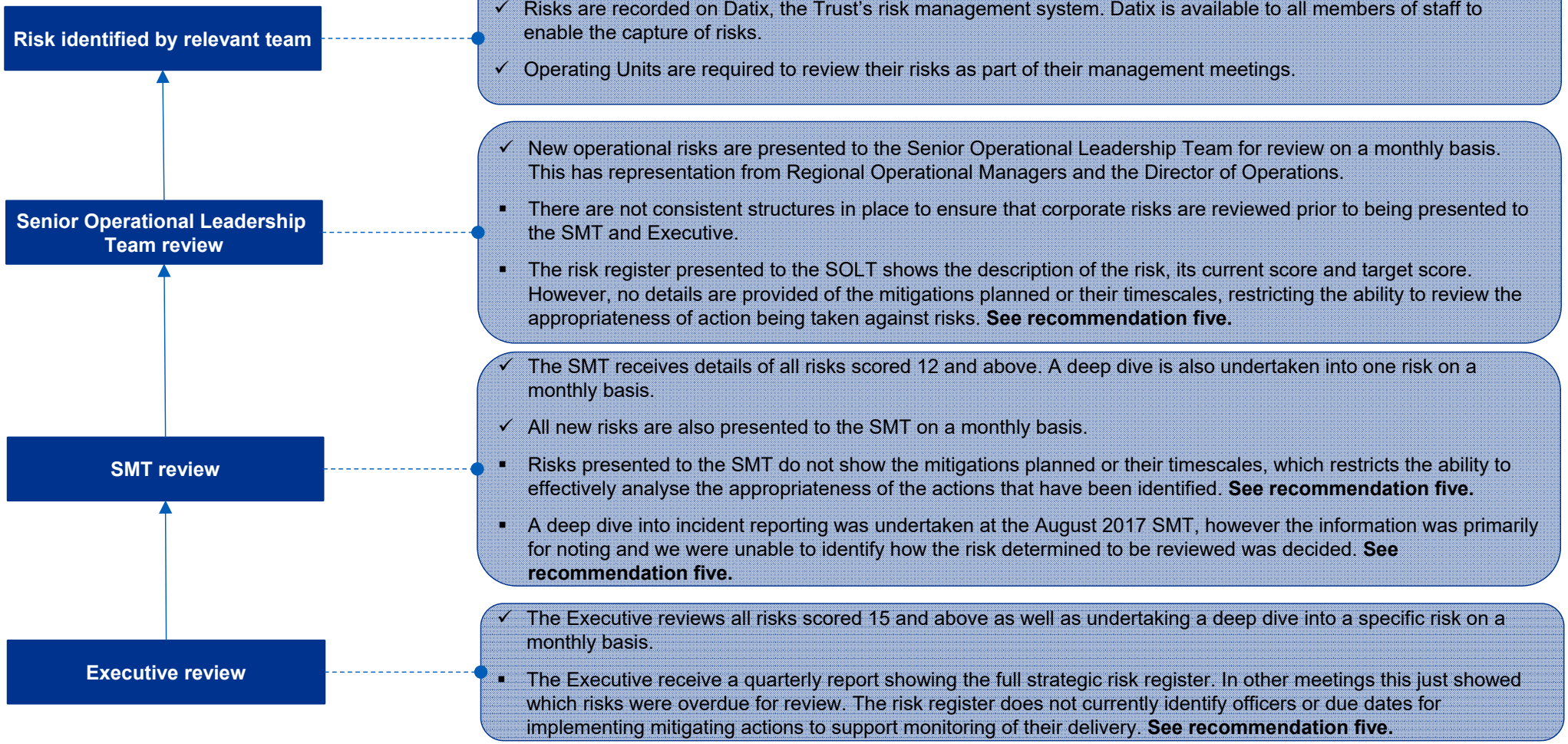
Positive progress has been made in a number of areas in response to the findings from the CQC inspection. Significant work has been undertaken as part of the medicines management optimisation plan, with senior led briefings provided to OTLs and daily checks undertaken of compliance. These have also involved regular feedback to OTLs on the results from the checks, an element that we received feedback has not consistently been in place for areas such as incidents.

Appendix C

Risk management

Risk identification and review

The structure below sets out the expected processes for the identification and review of new risks and our commentary on its design.



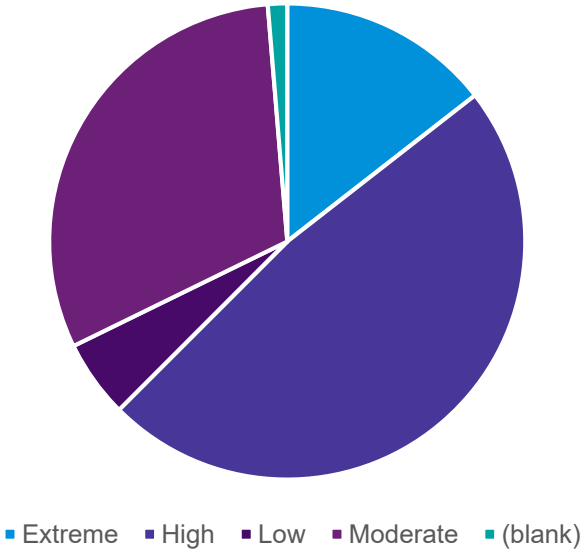
Appendix C

Risk management

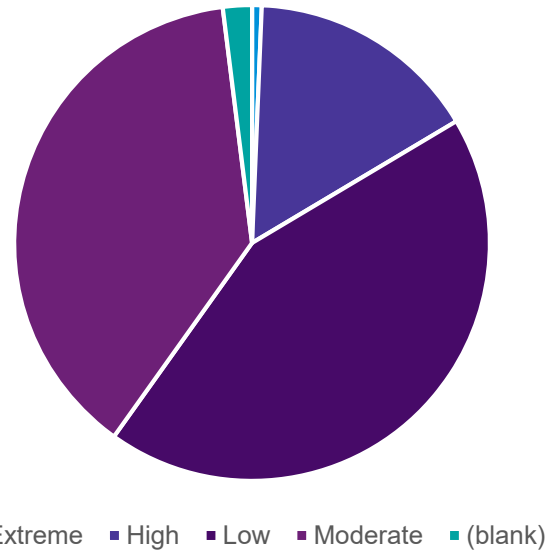
Risk appetite

We analysed risks recorded on the risk register to assess trends in the recorded risks. We have set out below a summary of the findings from this review:

Analysis of current risk grading



Analysis of target risk rating



The charts above show the current and target risk scores for all of the 152 risks recorded on the Trust's risk register. One risk has a target risk to remain as an extreme risk, suggesting the Trust is willing to accept an extreme level of risk. This relates to connectivity issues for testing of the CAD system for recording activity delays the handover of systems to the EOC. The residual risk score for this risk is moderate, suggesting the target risk has not been scored in line with the actual risk appetite. **See recommendation five.**

A further 24 risks have a high risk appetite, of which two have a residual risk score of moderate and 14 have already been reduced to a high risk but remain open, suggesting the true risk appetite is seeking to further reduce the risk.

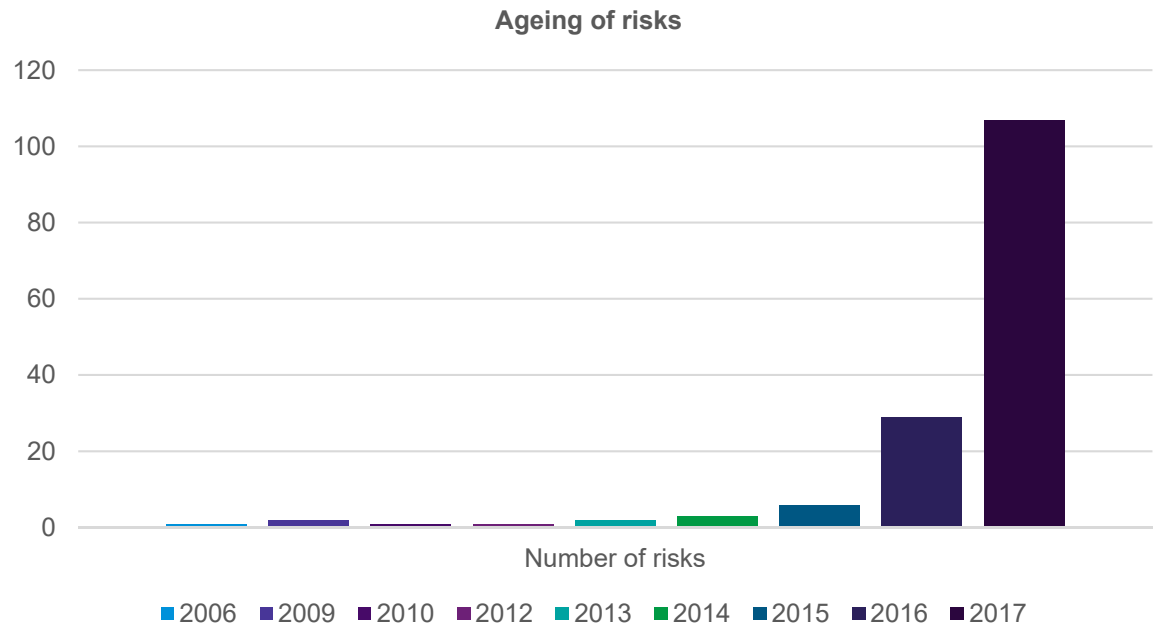
Although a risk management strategy is in place limited work has been performed to define the Trust's risk appetite and review whether target risks are being set in line with the Trust's appetite for risk, which could either mean insufficient mitigation is implemented or that resources are utilised to reduce risks below the level necessary.

Appendix C

Risk management

Ageing of risks

We analysed the ageing of risks held on the Trust's risk register to assess the effectiveness of mitigations implemented:



107 of the 152 risks recorded on the risk register were raised during 2017. This shows there has been a greater focus placed on the identification of risks during the year to support management in having oversight of the risks occurring across services.

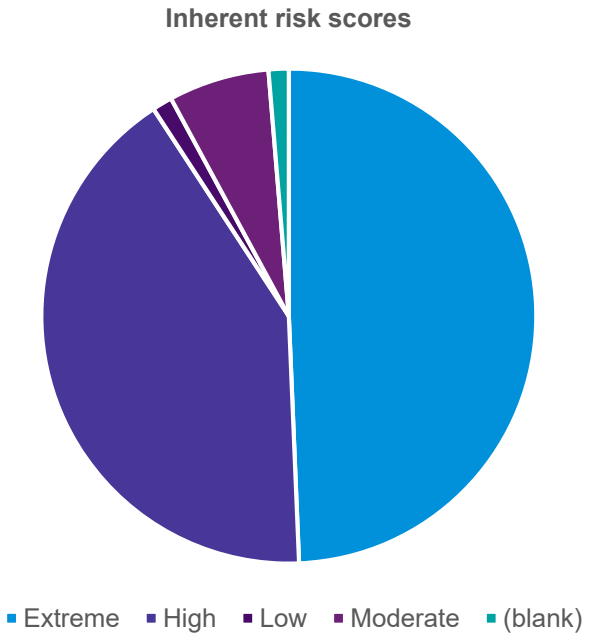
Of the 16 risks recorded in 2015 and earlier eight have a moderate risk score, six high and one is scored as an extreme risk (relating to handover delays). Three of the risks have not reduced in score since being added to the risk register, relating to non-compliance with the Data Protection Act, failure to identify defibrillators within 200 metres of Category A patients and business continuity.

Appendix C

Risk management

Risk scoring

We analysed the inherent risk scores of the risks on the risk register, as set out below:



Only two of the risks recorded had a low inherent risk score. This suggests that there remains further work to be done to identify lower rated risks facing the Trust. While it is understandable to be focused on ensuring that the highest risks have been recorded at first prompt identification of lower risks can help the Trust to gain assurance they are effectively managed prior to them becoming more significant risks. **See recommendation five.**

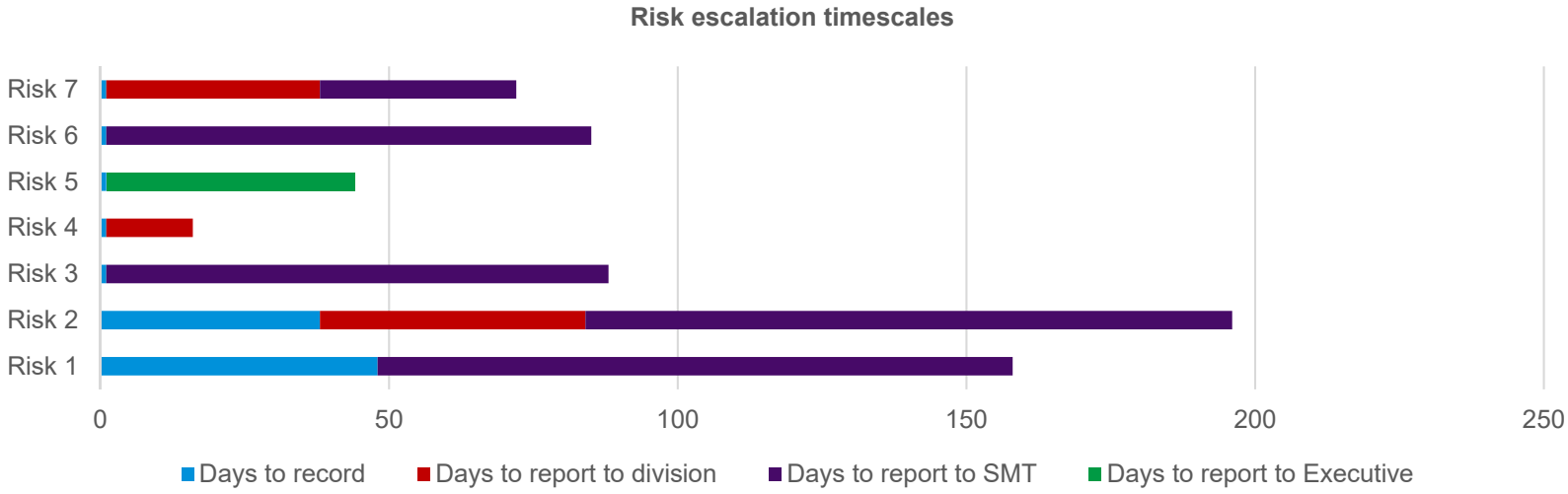
Two risks have been recorded on the risk register without a score. These both related to health and safety and were raised at the end of September and so are waiting to be fully validated.

Appendix C

Risk management

Risk escalation

It is important that new risks can be promptly escalated as they emerge to provide assurance that appropriate actions have been identified and will be implemented on a sufficiently timely basis to help mitigate and manage the risk. We have set out on page 38 the processes for review and escalation of risks depending on the grading applied. We selected a sample of 10 risks identified during the year to assess the length of time taken for the risk to be escalated from its identification to it being reported at the relevant forums.



For three of the risks we were unable to identify the timescales for reporting of the risks. These were risks that did not require reporting above a divisional level and we were unable to identify the divisional meeting that they were reported to. For a further five of the risks we were unable to identify the timescale within which they were reported to a divisional meeting. **See recommendation one.**

There was a significant variance in the time taken for risks to be escalated. We noted that risks with a longer timescale had predominantly been raised earlier in the year (risks 1 and 2 above) and we were able to see an improvement in the timeliness of reporting during the year following the revision of the SMT agenda and making the risk register a standing agenda item. Risks 1 to 3 were raised between January and March 2017 and in each case they were first reported to the SMT in June 2017 following the implementation of revised monitoring arrangements. **See recommendation five.**

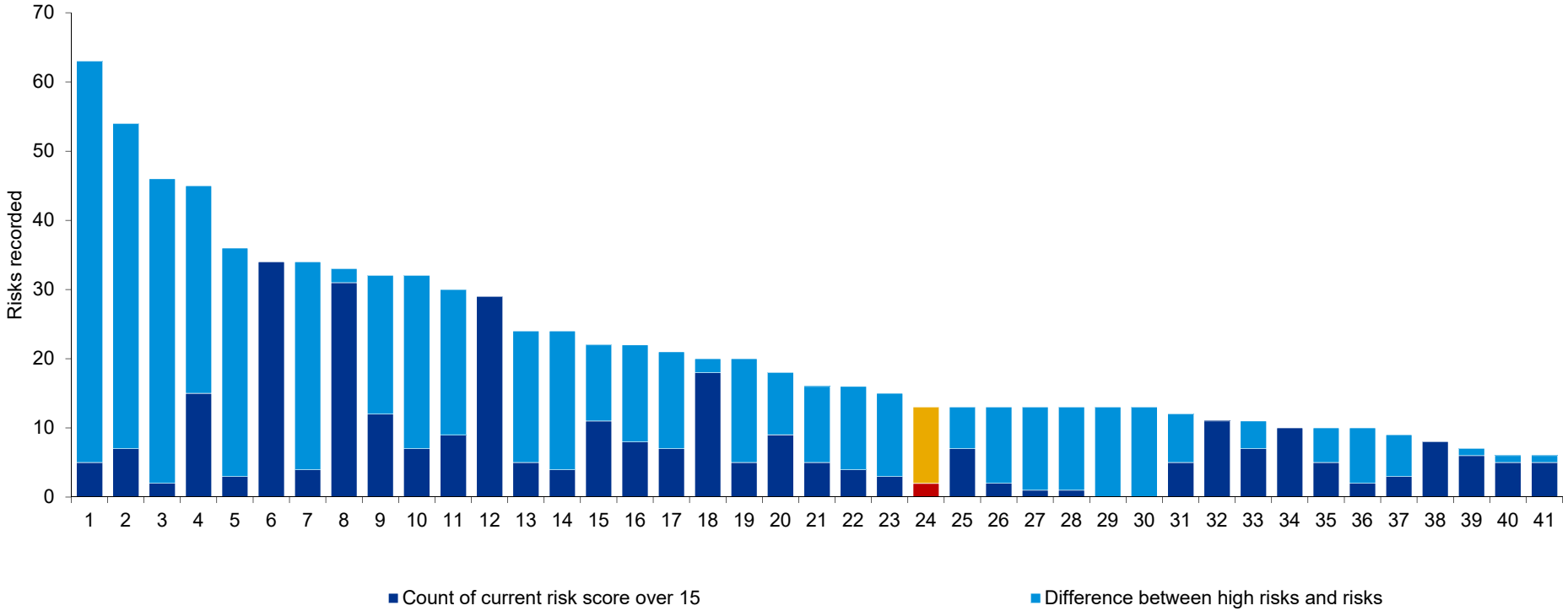
Two risks in our sample took over one month to be recorded on Datix following their identification. These related to the move to the new headquarters and the new CAD project. We noted that both were project risks with separate oversight mechanisms and that they were the earliest risks in our sample, identified at the end of 2016. This is consistent with reflections from the original CQC report relating to completeness of risk recording, however we note that there was a significantly improved timeliness in the recording of risks as the year progressed.

Appendix C

Risk management

Board Assurance Framework

We have benchmarked the contents of the Board Assurance Framework (BAF) against 40 other NHS Trusts and Foundation Trusts to identify how the Trust's compares against industry practice. The chart below shows the number of risks recorded on BAFs across the sector to enable the Trust to identify how it compares.



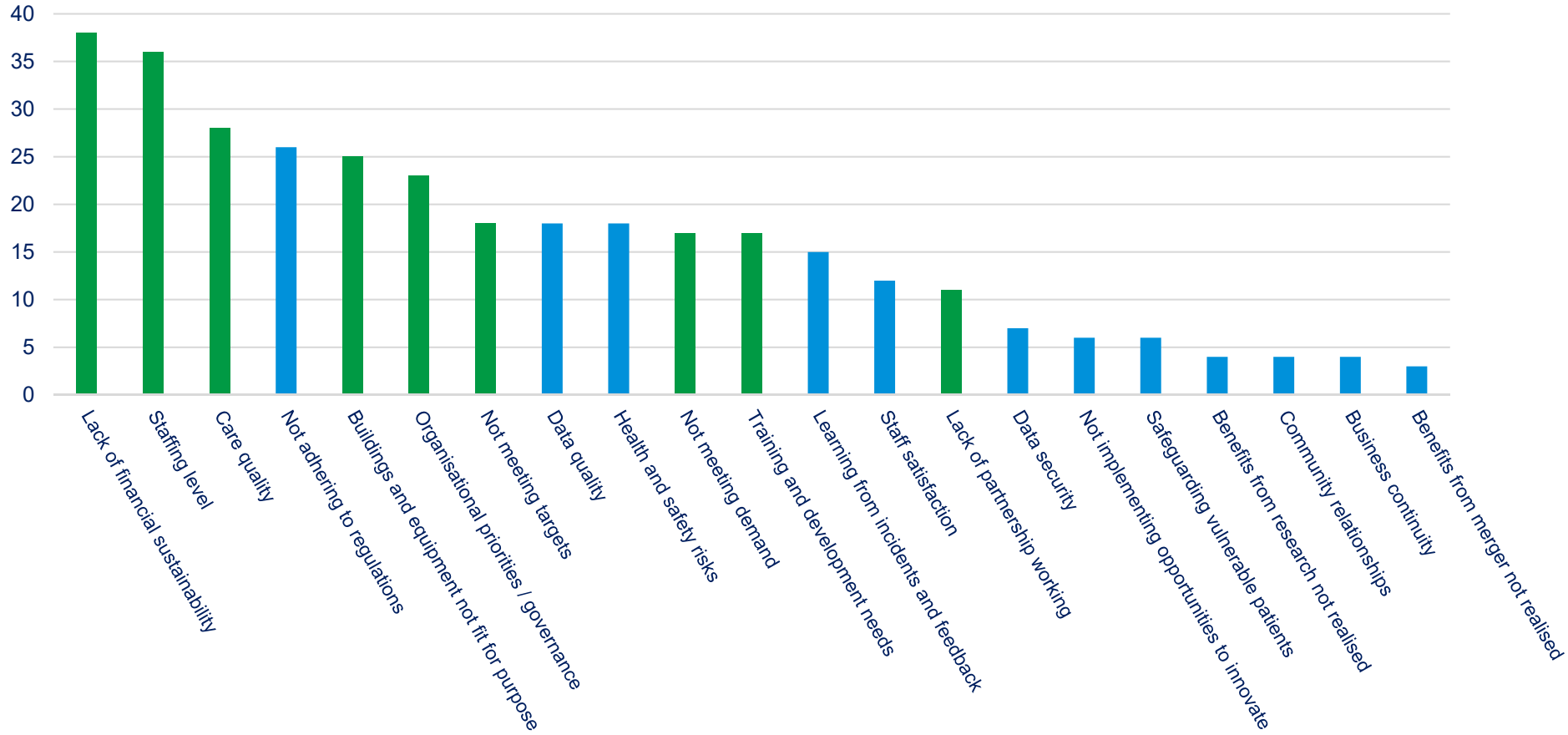
The chart shows that the Trust has a consistent quantity of risks recorded on its BAF compared to the majority of its industry peers, however it has a smaller number of high rated risks on its BAF, with only two of the objectives rated as being at extreme risk of not being achieved. The Trust's BAF has assessed risk based on its 16 objectives underpinning its strategic goals. Three of the objectives do not have any risks identified against their non-achievement, relating to volunteers, the appropriateness of the fleet and working with partners.

There is limited alignment between the risks to strategic objectives recorded on the BAF and the extreme risks identified on the risk register. While the two documents should not duplicate each other this may suggest there are risks to achievement of the strategic objectives not identified on the BAF.

Appendix C

Risk management

We have identified the most common risks recorded on BAFs across the peer group of NHS providers reviewed and considered which of these are recorded on the SECAMB BAF. The chart shows how many of the benchmarked NHS providers had included the selected risk on their BAF. Those risks shown in green are included on the SECAMB BAF.



The Trust has identified the most common risks on its BAF. A number of risks have been identified relating to its ability to deliver services to its patients, though these are primarily related to the capacity of teams and do not explicitly consider compliance with key regulatory expectations. **See recommendation eight.**

Appendix D

Example divisional performance review agenda

The table below sets out an example of the matters we would expect to see considered at a divisional performance review to enable the Executive to obtain assurance over how the division is being operated.

Domain	Matters to be considered
Operational performance	▪ Scorecard of performance against key performance indicators for the service in the region. ▪ Actions being taken to resolve missed performance indicators.
Finance	▪ Financial performance against budget. ▪ Forecast financial performance for the full year. ▪ Identification and implementation of devolved cost improvement plans.
Workforce	▪ Completion of appraisal and mandatory training. ▪ Sickness rates. ▪ Vacancies and turnover rates.
Risk	▪ Overview of significant risks and actions being taken to manage them.
Quality and safety	▪ Incidents occurring during the period and trends identified from review of incidents. ▪ Complaints, including learning from red rated complaints and trends identified. ▪ Performance in audits of Trust priority areas, such as medicines management or PCRs.
Strategy	▪ Performance against operating plan for the region. ▪ Key activities to be undertaken in the next quarter to progress the objectives of the division. ▪ Celebration of successes achieved during the quarter.

Appendix E

Stakeholder involvement and documents reviewed

We held interviews with the following stakeholders during August and September 2017 to inform our review:

Name	Job title	Name	Job title
Richard Foster	Chairman	Daren Mochrie	Chief Executive
Lucy Bloem	Non-Executive Director	Angela Smith	Non-Executive Director
Al Rymer	Non-Executive Director	Tim Howe	Non-Executive Director
Terry Parkin	Non-Executive Director	Peter Lee	Company Secretary
Dr Fionna Moore	Interim Medical Director	Joe Garcia	Director of Operations
Steve Graham	Interim Director of HR	Steve Lennox	Director of Nursing
David Hammond	Director of Finance	Jon Amos	Director of Strategy
Carol-Ann Davis	Chief Pharmacist	Ellie Wilkes	Head of PMO
Eileen Sanderson	Head of PMO	Sue Skelton	Regional Operations Manager
Samantha Gradwell	Head of Risk	Elizabeth Kershaw	Inspection Manager, Care Quality Commission
Paul Bennett	Delivery and Improvement Director, NHS Improvement	Suzanne Cliffe	Head of Delivery and Improvement, NHS Improvement

We observed the following committees as part of our review:

- Senior Management Team – 1 September 2017;
- Audit Committee – 4 September 2017;
- Governor Development Committee – 5 September 2017;
- Quality and Safety Committee – 7 September 2017;

Appendix E

Stakeholder involvement and documents reviewed

- Bullying and harassment workshops at Nexus House and the Brighton station in September 2017;
- Executive Risk and Assurance Group – 20 September 2017;
- Safeguarding Group – 25 September 2017;
- Executive Board – 27 September 2017; and
- Public and private Board – 29 September 2017.

We reviewed the following documents to inform our review:

- Papers and minutes of the public Board for the last 12 months;
- Papers and minutes of the private Board for the last 12 months;
- Papers and minutes of the Quality and Patient Safety Committee for the last 12 months;
- Papers and minutes of the Audit Committee for the last 12 months;
- Papers and minutes of the Workforce and Wellbeing Committee for the last 12 months;
- Papers and minutes of SMT meetings;
- Papers and minutes of SOLT meetings in August and September 2017;
- Board Assurance Framework;
- Download of risks recorded on Datix;
- Risk management strategy;
- Risk improvement plan;
- Incidents improvement plan; and
- Governance structure for Unified Improvement Plan.

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