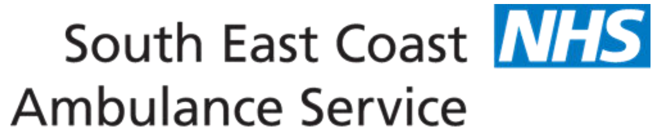
Care Quality Commission 'Should & Must do' Oversight and Assurance Report
March 2018



Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Safe	The Trust **must** take action to ensure they keep a complete and accurate recording of all 999 calls.	Number of 999 calls audited vs the number of issues found		**KPI Now**	KPIs currently being met
				KPI Future	Plan is in place to replace the electronic system. Due to commence April 2018.
				Pace & Grip	Call recording audited weekly and reports into compliance by exception. Trust has strong oversight. Plan to move to IPR for Board oversight.
Safe	The Trust **must** protect patients from the risks associated with the unsafe use and management of medicines in line with best practice and relevant medicines licences. This should include the appropriate administration, supply, security and storage of all medicines, appropriate use of patient group directions and the management of medical gas cylinders.	Monthly OU Compliance Audit - January **(FEB DATA AVAILABLE MID-MARCH 18)** Percentage: 100%, 90%, 80%, 70%, 60%, 50%, 40%, 30%, 20%, 10%, 0% OU: Ashford, Brighton, Chertsey, Chichester & Worthing, Gatwick & Redhill, Guildford, HART, Medway & Dartford, Paddock wood, Polgate & Hastings, Thanet, Stores Sussex Surrey & Kent	Compliance % with DoH Guidance for Medical Gases Per Station Percentage: 100, 90, 80, 70, 60, 50, 40, 30, 20, 10, 0 Station: Ashford, Brighton, Burgess Hill, Chertsey, Dartford, Epsom, Farnborough, Gatwick MRC, Godalming, Guildford, Hastings, Haywards Heath, Hove, Lewes, Littlehampton, Medway, Paddock Wood, Polegate MRC, Redhill, Sheppey, Shoreham, Sittingbourne, Tangmere, Thameside, Thanet MRC, Tongham, Worthing	**KPI Now**	KPIs currently within compliance standards however an emerging issue with lost drug keys. Plan being put into place.
				KPI Future	Oversight of medicines management in place with weekly and monthly audit returns. Next step is to improve the business as usual oversight of medicines management by creating medicines dashboard that has monitoring at Trust's Medicines Governance Group.
				Pace & Grip	Medicines governance dashboard will demonstrate grip and pace is demonstrated through Improvement Plan.

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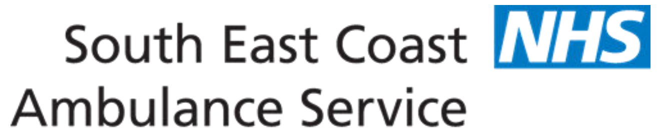

Domain	CQC Findings (‘Must or Should Do’)	Metric 1	Metric 2	Confidence	
Safe	The Trust **must** take action to ensure there are a sufficient number of clinicians in each EOC at all times in line with evidence-based guidelines.	Clinical Supervisor Establishment to meet minimum required Staffing for NHS Pathways Compliancy Weekly NHSP Compliance Staffing Level; WTE Req NHSP Compliance		KPI Now	In terms of the specific request to have sufficient clinicians we currently meet the minimum requirement for Pathways. However, the Trust recognises the need to do more in order to improve safety in EOC.
				KPI Future	No identified risk to this KPI changing.
				Pace & Grip	Whilst confident that the actual KPI will be complaint there are wider gaps in clinical oversight which is acknowledged in the risk register. Minimum staffing to be placed on IPR.
Well Led	The Trust **must** take action to ensure all staff receive an annual appraisal in a timely way so that they can be supported with training, professional development and supervision.	% of all staff having completed objective setting/conversation/appraisal recorded on Actus Actual; Trajectory; Target		KPI Now	Above trajectory for delivery of appraisal. However, there is work in 2018/19 to ensure the appraisals are of a higher quality.
				KPI Future	No identified risk to this KPI changing.
				Pace & Grip	Grip demonstrated through IPR measure. Recognition of importance demonstrated through action to improve the quality of appriaslas through 2018/19.

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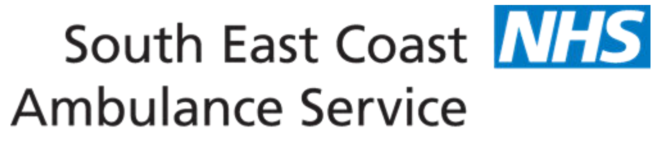
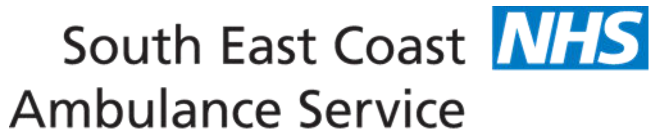
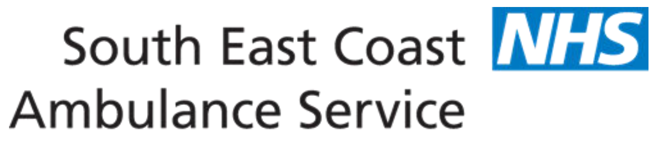


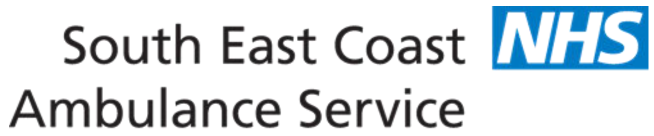
Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Safe	The Trust **must** take action to ensure all staff understand their responsibilities to report incidents.	Incident Numbers (all) Actual / Trajectory 850, 800, 750, 700, 650, 600, 550, 500, 450, 400, 350 May 2016 – May 2018 590 571		**KPI Now**	KPI above target.
				KPI Future	No identified risk to this KPI changing.
				Pace & Grip	Grip demonstrated through IPR measure. Recognition of importance demonstrated through action to improve reporting in the Improvement Plan.
Safe	The Trust **must** ensure improvements are made on reporting of low harm and near miss incidents.	% of incidents as near miss, no harm or low harm % of Incidents / Trajectory 100%, 90%, 80%, 70%, 60%, 50%, 40%, 30%, 20%, 10%, 0% Jul 2015 – May 2018 96% 92%		**KPI Now**	KPI has slightly slipped in January but overall has been within target levels.
				KPI Future	No identified risk to this KPI changing.
				Pace & Grip	Grip to be demonstrated through inclusion in IPR and Pace to be demonstrated through Improvement Plan actions.



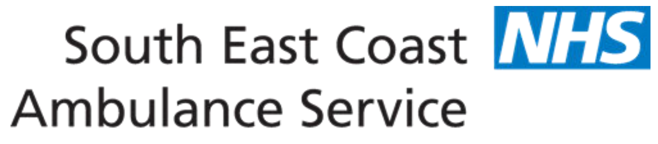
Domain	CQC Findings (‘Must or Should Do’)	Metric 1	Metric 2	Confidence	
Safe	The Trust **must** investigate incidents in a timely way and share learning with all relevant staff.	% of Incidents Closed Within Time Target % Closed on Time; Trajectory 84%; 66%	Feedback to Reporting Staff & Receiving Feedback; Trajectory 70%; 8%	KPI Now	Trust is now monitoring the rate of feedback given following an incident but the fields on Datix are often blank making it difficult to feedback to the reporting individual.
				KPI Future	A plan is in place and training is occurring to increase the identification of learning.
				Pace & Grip	Grip to be demonstrated through inclusion in IPR and Pace to be demonstrated through Improvement Plan actions.
Safe	The Trust **must** ensure all staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns receive an appropriate level of safeguarding training.	Safeguarding Adult & Child L2 training L2 child (elearning) **; L2 adult (elearning) **; Trust Target - 85%	L3 safeguarding training completion trajectory April 2017-March 2018 actual completion %; planned completion %; Trust target (85%)	KPI Now	KPI reached for L3 KPI almost reached for L2
				KPI Future	No identified risk to this KPI not reaching compliance threshold.
				Pace & Grip	Grip to be demonstrated through inclusion in IPR and Pace to be demonstrated through Improvement Plan actions.



Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Effective	The Trust **must** take action to meet national performance targets.	**Category 1 for SECAmb** C1 Mean, C1 90th Centile, Mean Standard, 90th Centile Standard	**Category 2 for SECAmb** C2 Mean, C2 90th Centile, Mean Standard, 90th Centile Standard	KPI Now	KPIs have improved since 2017 CQC visit and there are occasions where the Trust performs well against peer Trusts. However, this is not consistent and this has facilitated an Amber RAG status.
		Category 3 for SECAmb C3 Mean, C3 90th Centile, 90th Centile Standard	**Category 4 for SECAmb** C4 Mean, C4 90th Centile, 90th Centile Standard	KPI Future	No risks identified to impact on the KPIs
				Pace & Grip	A comprehensive improvement plan is in place and performance has improved. However, ultimately the plan is focussed on abstractions and vacancy factor which are factors challenging to mitigate.



Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Safe	The Trust **must** ensure patient records are completed, accurate and fit for purpose, kept confidential and stored securely.	**Percentage of PCRs Containing Full Minimum Data Set (Trust Wide/Monthly Reporting)** Percentage: Jul.17 ≈ 28; Aug.17 ≈ 40; Sep.17 ≈ 51; Target 90 Legend: % PCRs with Full MDS; Target	**Percentage Incidents on Info.SECAmb with PCR Attached (Reconciled Records)** Jul.17 – Dez.17 (Jul.17, Aug.17, Sep.17, Okt.17, Nov.17, Dez.17); Target 90 Legend: % Incidents with PCR; Target	**KPI Now**	Metrics are now in place for unreconciled cases (the measure for stored securely) and metrics are now in place for completion. This has revealed the main reason the Trust is unable to reconcile is through data inaccuracies rather than lost records.
				KPI Future	An improvement plan is in place but this may not be fully recovered prior to CQC inspection.
				Pace & Grip	The Trust will be able to demonstrate that it is not through "lost" records but through documentation that records are unable to be reconciled. The Trust can demonstrate that this is now audited and discussed.
Safe	The Trust **must** ensure the CAD system is effectively maintained.	The CAD system is maintained by the Trust ICT Department, Supplier Organisations and Third Party Companies bought in to carry out specific areas of maintenance. The critical system infrastructure supplying the control room are made up of a number of systems – CAD, telephony, voice recording, triage, mobile data and the radio system. The systems are duplicated at Crawley and Coxheath and significant work recently undertaken by the Trust has been to move the systems from Banstead to Crawley to reduce the risk of network failure having an impact on the system. Every month, a Third Party checks and tests the underpinning infrastructure whilst live in failover mode – this means that whilst it's being used, the live system is switched off and failed over to Coxheath and then back again. The data/information is held in a number of different places as copies are on both the Crawley and Coxheath sites. Live data is regularly archived to keep the system lean in terms of volumes of records which ensures that the system runs quickly and efficiently.		**KPI Now**	CAD failure on risk register and being monitored through Business as Usual and has been replaced since the 2017 CQC visit
				KPI Future	No risks identified to impact on the KPIs
				Pace & Grip	CAD maintenance to be placed on IPR.



Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Effective	The Trust **must** improve outcomes for patients who receive care and treatment.	AQI Clinical Outcomes - ROSC and ROSC Utstein Group 80.0%, 70.0%, 60.0%, 50.0%, 40.0%, 30.0%, 20.0%, 10.0%, 0.0% Nov-16, Dec-16, Jan-17, Feb-17, Mar-17, Apr-17, May-17, Jun-17, Jul-17, Aug-17, Sep-17, Oct-17, Nov-17, Dec-17 ROSC-Average, ROSC-SECAmb, ROSC(U)-Average, ROSC(U)-SECAmb, Linear (ROSC-Average), Linear (ROSC-SECAmb), Linear (ROSC(U)-Average), Linear (ROSC(U)-SECAmb)	AQI Out of Hospital Cardiac Arrest | Survival to Discharge (& Utstein Group) 50.0%, 40.0%, 30.0%, 20.0%, 10.0%, 0.0% Nov-16, Dec-16, Jan-17, Feb-17, Mar-17, Apr-17, May-17, Jun-17, Jul-17, Aug-17, Sep-17, Oct-17, Nov-17, Dec-17 OOHCA-Average, OOHCA-SECAmb, OOHCA(U)-Average, OOHCA(U)-SECAmb, Linear (OOHCA-Average), Linear (OOHCA-SECAmb), Linear (OOHCA(U)-Average), Linear (OOHCA(U)-SECAmb)	KPI Now	Current metrics involve very small numbers of patients so standard would be better monitored annually, which the Trust is currently unable to do. In addition, the data is 3 months older than the reporting period.
				KPI Future	Low confidence that this can be significantly improved prior to CQC inspection.
				Pace & Grip	Grip can be demonstrated through inclusion in quality dashboard and discussion every month with OUMs at Area Governance and also reported in the monthly Quality & Safety Report as a narrative by Clinical Audit.
Safe	The Trust **must** ensure the risk of infection prevention and control are adequately managed. This includes ensuring consistent standards of cleanliness in ambulance stations, vehicles and hand hygiene practices, and uniform procedure followed.	**1a. % compliance against target of hand hygiene audits carried out (Monthly data)** Hand Hygiene 100, 90, 80, 70, 60, 50, 40 Apr 2017, May 2017, Jun 2017, Jul 2017, Aug 2017, Sep 2017, Oct 2017, Nov 2017, Dec 2017, Jan 2018, Feb 2018, Mar 2018 Staff Compliance, Target, Linear (Staff Compliance)	**1b. % compliance against target of BBE audits carried out (Monthly data)** Bare Below the Elbow 100, 90, 80, 70, 60, 50, 40 Apr 2017, May 2017, Jun 2017, Jul 2017, Aug 2017, Sep 2017, Oct 2017, Nov 2017, Dec 2017, Jan 2018, Feb 2018, Mar 2018 Staff Compliance, Target	KPI Now	KPIs not within compliance level.
				KPI Future	New strategic plan and supporting improvement plan developed. High confidence of delivery.
				Pace & Grip	Grip and Pace can be demonstrated through IPC dashboard and escalated meeting (now monthly).

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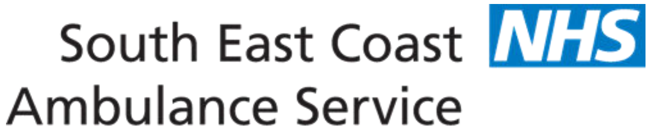
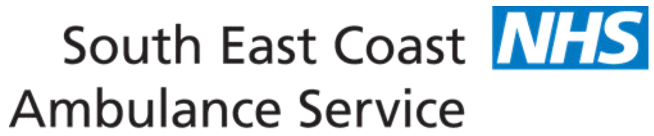
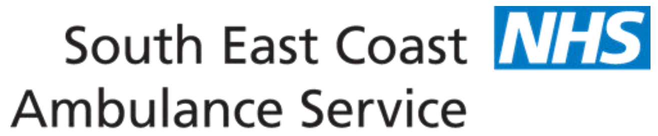


Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Well Led	The Trust **must** ensure that governance systems are effective and fit for purpose. This includes systems to assess, monitor and improve the quality and safety of services.	Number of open, closed, proposed for closure and new risks on Datix. (Open 151; Closed 77; Proposed for Closure 9; New 3 – Week Commencing 08/11/2017 – 21/02/2018; No. of Risks)	1. Governance structure to be reviewed 2. IPR to be reviewed	KPI Now	Risk management progressing but other governance mechanisms under review.
				KPI Future	Risk management progressing will and improvement plan in place. However, other governance processes still awaiting review or too juvenile to measure success. Review meeting planned in March 18.
				Pace & Grip	At present not yet assured that all governance processes will be in place but new corporate governance strategy due for publication prior to the CQC 2018 visit.
Safe	The Trust **must** ensure all medical equipment is adequately serviced and maintained.	% of Medical Devices Serviced in/out of Programme in 2017/18 (Total; % Serviced in Programme; % Serviced out of Programme; Target (95%) – LP 12 2.4%; LP 15 1.8%; LUCAS 0.0%; NO2 1.6%; P-PAC 2.8%; LSU 2.7%; Mangar 0.8%; Target 95%)	Number of Medical Devices Audited this Quarter (Actual; Trajectory – Dez.17 0; Jän.18 30 / 80; Feb.18 159; Mär.18 239; [VALUE] as at 02/03/2018)	KPI Now	KPI showing as compliant but recent assurance checks reveals that elements may have been omitted. Currently being re-assessed.
				KPI Future	Predict that KPI will be reliable but at present not confident of the level of compliance.
				Pace & Grip	Grip will be demonstrated by adding this to the IPR and the associated improvement plan will illustrate improvements.



Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Effective	The Trust **must** continue to ensure there are adequate resources available to undertake regular audits and robust monitoring of the services provided.	4a Percentage Clinical Audit Programme Complete (Cumulative) [MONTHLY UPDATE]		**KPI Now**	Already reach end of year KPI target
				KPI Future	Already reach end of year KPI target
				Pace & Grip	To be added to IPR
Responsive	The Trust **must** ensure the systems and processes in place to manage, investigate and respond to complaints, and learn from complaints are robust.	% of complaints concluded within timescale	% Area Governance Meetings and Clinical Effectiveness Subgroups which have received complaints paper demonstrating learning Data to be provided quarterly Include: 111 EOC East West Central	**KPI Now**	Initial performance targets now reached however, plans to address learning just launched but confident they will deliver.
				KPI Future	Initial performance targets now reached however, plans to address learning just launched but confident they will deliver.
				Pace & Grip	Enhanced complaints monitoring on IPR and patient experience group to have metrics.

Domain	CQC Findings (‘Must or Should Do’)	Metric 1	Metric 2	Confidence	
Safe	The Trust should take action to audit 999 calls at a frequency that meets evidence-based guidelines	Clinical Audit Completion Trajectory (chart: Audits Completed %, Feedback Completed %, Target; 01/04/2017 – 01/08/2018)		KPI Now	KPI not yet on track but within sight.
				KPI Future	Currently below trajectory but current improvement plan is now delivering the required improvements.
				Pace & Grip	Confident that auditing will stay on track but on risk register as dependent on staff retention.
Responsive	The Trust should ensure 100% of frequent callers have an Intelligence Based Information System (IBIS) or other personalised record to allow staff taking calls to meet their individual needs	N.B. Stage 1 letters denote the start of the journey through the frequent caller management process and subsequently have an IBIS record created at the time of the letter being sent	(chart: Number of Stage 1 Letters Sent by Month, Oct-16 – Mar-18; Kent, Surrey, Sussex)	KPI Now	Not subject to an improvement plan but part of business as usual with management team making improvements.
				KPI Future	No risks identified to suggest KPIs will not be met.
				Pace & Grip	Yet to be defined



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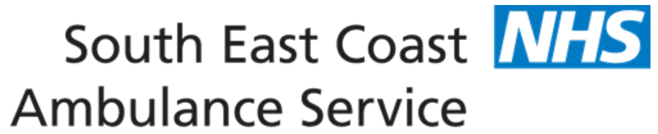
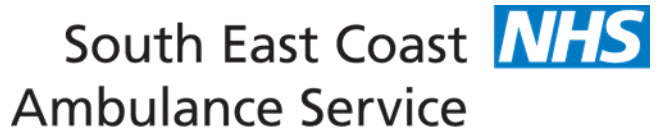
Responsive	The Trust should take action to ensure all patients with an IBIS record are immediately flagged to staff taking calls 24 hours a day, seven days a week.	Data not available to produce a graph.	The number of vacancies on the IBIS desk have been minimal over the past 6 months, meaning there have been minimal instances of the desk having to close, which would result in crews not being notified of care plans. The commissioner funding provided for IBIS only allows us to employ six IBIS Data Assistants – equating to one per shift in EOC. This gives little resilience in cases of last-minute sickness, so we will always continue to have the odd vacancy every so often. This is mitigated by important patient records (e.g. DNACPRs and Patient Specific Instructions) having an associated CAD marker to automatically 'flag' to the attending crew, should the desk be closed.	KPI Now	Currently no performance graph in order to provide assurance. To be developed as part of governance review.
				KPI Future	
				Pace & Grip	
Responsive	The Trust should consider reviewing the arrangements for escalation under the demand management plan (DMP) so that patients across The Trust receive equal access to services at times of DMP.	Approval of the Surge Plan		KPI Now	Surge plan not yet implemented
				KPI Future	Currently being replaced by surge plan and delayed by need for each CCG to sign off surge plan
				Pace & Grip	Surge plan will be in place. Potential KPI to be placed on IPR regarding use of surge.



Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Well Led	The Trust should consider improving communications about any changes are effective and timely, including the methods used	Review of communications in place		KPI Now	No specific KPI but delivery of review outcome and associated plan to be developed.
				KPI Future	Plan to be in place.
				Pace & Grip	Plan to be in place.
Safe	The Trust should review all out of date policies.	**Policies reviewed as part of the Policies Management Project** Pie chart: 34; 8 Policies reviewed and up to date; Policies out of date (review in progress)		KPI Now	Majority of policies currently within date.
				KPI Future	Considerable work has been undertaken to ensure suite of policies are in date. Assurance requested regarding policies that go out of date in 2018. To be considered as part of governance review.
				Pace & Grip	To be part of IPR.



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Safe	The Trust should ensure all first aid bags have a consistent contents list and they are stored securely within the bags.	South East Coast Ambulance Service NHS NHS Foundation Trust First Aid Kits ➢ Standardised contents list ➢ Monthly check of contents ➢ HSE check. ➢ Replacements to be ordered through Procurement		KPI Now	Action completed
				KPI Future	
				Pace & Grip	
Well Led	The Trust should engage staff in the organisation's strategy, vision and core values. This includes increasing the visibility and day to day involvement of The Trust executive team and board, and the senior management level across all departments.	To be inserted QAV graph with Director representation	To be inserted Safety visits	KPI Now	Engagement plan in place. Visibility metrics not yet in place.
				KPI Future	Plans are in place to increase the profile of the Board across the Trust and aspects of communication are being reviewed.
				Pace & Grip	Slight risk in length of time it is taking to launch. However confident this will be in place soon.

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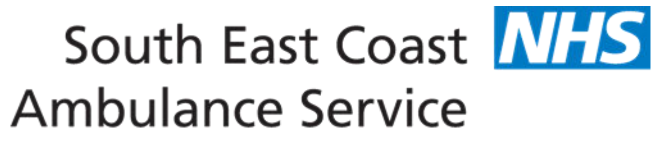
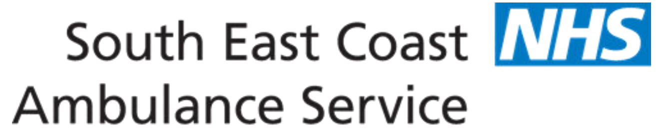
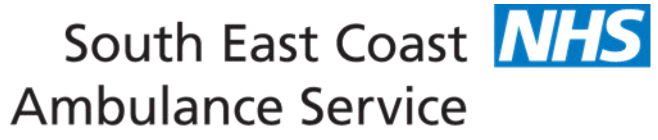


Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Well Led	The Trust should continue to sustain the action plan from the findings of staff surveys, including addressing the perceived culture of bullying and harassment	Experience of bullying and harassment at SECAmb Nov 2017 0, 0.1, 0.2, 0.3, 0.4, 0.5, 0.6, 0.7, 0.8, 0.9, 1 no, yes	Reported incidents of B&H Number: 0, 1, 2, 3, 4, 5, 6, 7 Date: Dec 2016, Jan 2017, Feb 2017, Mar 2017, Apr 2017, May 2017, Jun 2017, Jul 2017, Aug 2017, Sep 2017, Oct 2017, Nov 2017, Dec 2017, Jan 2018	KPI Now	KPI measure in place but still trying to understand acceptable compliance.
				KPI Future	Culture improvement plan now in place and has started to deliver. Metrics will turn green. Awaiting to see if rapid improvements are made.
				Pace & Grip	Ultimately the CQC assessment will include dialogue with staff. Current information suggests staff may not feel the degree of change the Trust anticipates.
Responsive	The Trust should continue to address the handover delays at acute hospitals	Average Cycle Time (Clear At Hospital): Scheduled Resource (Last 13 Weeks) *Data Updated: 2018-02-26 03:31:10* Minutes: 106, 107, 108, 109, 110, 111, 112, 113 Week(Mon): 27-11-2017, 04-12-2017, 11-12-2017, 18-12-2017, 25-12-2017, 01-01-2018, 08-01-2018, 15-01-2018, 22-01-2018, 29-01-2018, 05-02-2018, 12-02-2018, 19-02-2018		KPI Now	Metric currently showing compliance but not fully confident of sustainability.
				KPI Future	Project is in place that includes sector wide engagement. Plan will be to demonstrate we have managed our 15 minutes "go green"
				Pace & Grip	Weekly oversight of metrics at exec Board. To be included in new IPR



Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Effective	The Trust **should** ensure there are systems and resources available to monitor and assess the competency of staff.	Currently unsighted on outcomes from this requirement. Will discuss as part of the next phase of recovery work.		KPI Now	
				KPI Future	
				Pace & Grip	
Caring	The Trust **should** ensure that patients are always involved in their care and treatment.	Only recently commenced observation of consent as part of Quality Assurance Visits. Anticipate there will be a graph in the next few weeks.	Insert Mental Capacity Act graph from Quality Assurance Visits once populated.	KPI Now	Not being progressed as a specific project but consent and MCA measured as part of QAV and this demonstrates compliance.
				KPI Future	No identified risks to suggest compliance will not be sustained.
				Pace & Grip	Assessed during QAV where substantial report is produced for the area and a summary included in Monthly patient quality & safety report and quarterly QAV report.



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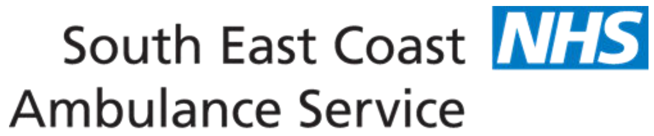
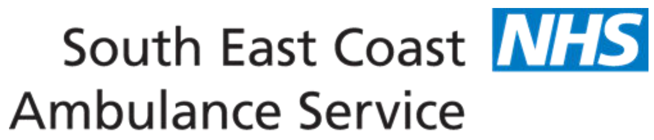
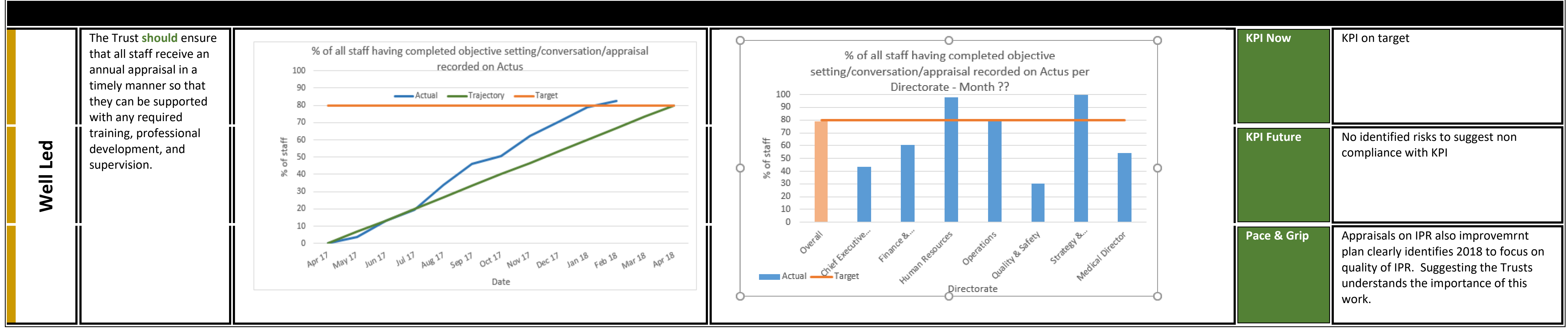
<tr><th>Domain</th><th>CQC Findings ('Must or Should Do')</th><th>Metric 1</th><th>Metric 2</th><th colspan="2">Confidence</th></tr>
<tr><td rowspan="3">Caring</td><td rowspan="3">The Trust should ensure that patients are always treated with dignity and respect</td><td rowspan="3">To develop a graph indicating dignity issues within complaints.</td><td rowspan="3"></td><td>KPI Now</td><td>Intentionally not progressed as a specific project. Diginity monitored through complaints process and assurance visits and addressed on a case by case basis.</td></tr>
<tr><td>KPI Future</td><td>No anticipated issues</td></tr>
<tr><td>Pace & Grip</td><td>Will be captured within complaints reporting and Quality Assurance Visits.</td></tr>
<tr><td rowspan="3">Safe</td><td rowspan="3">The Trust should ensure all ambulance stations and vehicles are kept secured.</td><td rowspan="3">% of checked vehicles locked whilst unattended
% Compliance: 100%, 90%, 80%, 70%, 60%, 50%
Period: 30/10/17 - 05/11/17, 06/11/17 - 12/11/17, 13/11/17 - 19/11/17, 20/11/17 - 26/11/17, 27/11/17 - 03/12/17, 04/12/17 - 10/12/17, 11/12/17 - 17/12/17, 18/12/17 - 24/11/17, 08/01/18 - 14/01/18, 15/01/18 - 21/01/18, 22/01/18 - 28/01/18, 05/02/18 - 11/02/18, 12/02/18 - 18/02/18</td><td rowspan="3">Number of MRCs, Stations and Trust HQ which have completed a Quarterly Site Security Assessment (MRCs, Stations, Trust HQ)
Target, Actual
No. of Premises: 60, 50, 40, 30, 20, 10, 0
Q3 2016/17, Q4 2016/17, Q1 2017/18, Q2 2017/18, Q3 2017/18, Q4 2017/18
[VALUE] as at 28/02/2018</td><td>KPI Now</td><td>KPI for vehicles in place and demonstrates compliance.

KPI for stations not yet in place.</td></tr>
<tr><td>KPI Future</td><td>No risks identified to suggest KPIs will not be met.</td></tr>
<tr><td>Pace & Grip</td><td>Security to be on IPR.</td></tr>
</table>

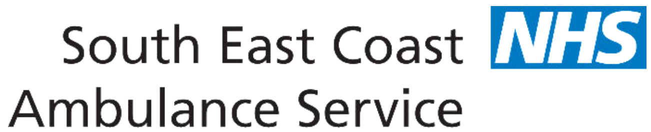


Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Safe	The Trust should ensure all vehicle crews have sufficient time to undertake daily vehicle checks within their allocated shifts.	Currently have new "tick list" developed but not yet capturing compliance. To be discussed as part of next phase of recovery work.		KPI Now	
				KPI Future	
				Pace & Grip	
Responsive	The Trust should ensure individual needs of patients and service users are met. This includes bariatric and service translation provisions for those who need access.	The updated bariatric SOP was brought to JPF in early February, however it was not signed off due to minor documentation errors (reference to R1/R2 instead of C1/C2 etc.) The SOP has now been revised and will be presented at the next meeting of the JPF for approval. After this time communication will be cascaded to all staff. The SOP will define further monitoring and audit process and going forward the performance and information team will be able to report on bariatric performance. There remains an issue with identifying bariatric trained personnel on the CAD. East of England Ambulance Service have had the same issue and are working with Cleric for a solution. This is expected to be completed at some point this month. EOC systems may be able to copy this solution to our CAD (as it will already have been developed). Service Translation: Please see attached for evidence and further information. (Email held by PMO) https://secamb.sharepoint.com/sites/intranet/news/Pages/interpretationservice.aspx Communications have now been cascaded to operational staff to ensure that there is consistency in accessing interpretation/translation services. Further reminders will be sent out in the weekly bulletin		KPI Now	
				KPI Future	
				Pace & Grip	





Well Led	The Trust **should** ensure that all staff receive an annual appraisal in a timely manner so that they can be supported with any required training, professional development, and supervision.	KPI Now	KPI on target
		KPI Future	No identified risks to suggest non compliance with KPI
		Pace & Grip	Appraisals on IPR also improvemrnt plan clearly identifies 2018 to focus on quality of IPR. Suggesting the Trusts understands the importance of this work.



		Item No	193

Name of meeting	Trust Board
Date	27 March 2018
Name of paper	Should and Must Do Assurance
Executive sponsor	Steve Lennox, Director of Nursing & Quality
Author name and role	Steve Lennox, Director of Nursing & Quality
Synopsis, including any notable gaps/issues in the system(s) you describe (up to 150 words)	The following paper provides assurance on the progress of the CQC Must and Should do's. There are three RAG rated indicators with each improvement area. RAG 1 is an indication as to current progress against the KPI. RAG 2 is the anticipated progress against the KPI towards project closure and RAG 3 is an indication of grip. Some projects may miss their KPI but still be able to demonstrate strong oversight. There are 9 Green Must do improvement areas There are 6 Amber Must do improvement areas There are 2 Red Must do improvement areas There are 5 Green Should do improvement areas There are 7 Amber Should do areas There are 5 Red Should do areas The projects are monitored through the compliance steering group. However, the focus of this group will now change to look at the five domains within their entirety and consider what other areas may need to be addressed. The current assurance paper suggests significant progress across the majority of areas. The identified gaps will be addressed through the continuing work of the Steering Group.
Recommendations, decisions or actions sought	For information.

South East Coast Ambulance Service **NHS**
NHS Foundation Trust

		Item No	
Name of meeting	Trust Board		
Date	27th March 2018		
Name of paper	2017 National NHS Staff Survey		
Executive sponsor	Daren Mochrie, Chief Executive		
Author name and role	Mark Power, Independent HR Consultant		
Synopsis (up to 120 words)	The most recent National NHS Staff Survey was conducted between September and December 2017 and local outcomes were reported to the Trust in late February 2018. The Survey questions are assigned to a range of 'Key Findings' which are grouped under nine main themes relating to aspects of the working environment and staff experience. Overall, across all Key Findings, SECAmb's 2017 outcomes are similar to those of the previous year. When compared with the ambulance sector average scores, the Trust's outcomes are unfavourable. The paper provides an outcomes summary and informs the Trust Board how a response plan will be agreed and implemented, which addresses key aspects of the Survey feedback. This response plan will fully align with the work associated with the Trust's culture change activity and aim to evidence demonstrable progress ahead of the 2018 Survey period.		
Recommendations, decisions or actions sought	The Trust Board is asked to note the contents of this paper.		
Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).		**No** If yes and approval or ratification is required, a completed EA Record must be attached.	

South East Coast Ambulance Service NHS Foundation Trust

Trust Board

2017 National NHS Staff Survey

1. Purpose

1.1 The purpose of this paper is to facilitate the formal receipt, by the Trust Board, of a summary of the local outcomes associated with the 2017 National NHS Staff Survey. The paper also summarises the activity that will be undertaken in the short term to determine priority actions in response to local staff feedback.

2. Background

2.1 All NHS trusts, NHS foundation trusts, clinical commissioning groups, and commissioning support units in England are mandated to participate in the annual NHS Staff Survey (the Survey). Within SECAmb, the Survey is administered by Quality Health, which is one of two independent providers who have NHS England approved contractor status. Rather than limit participation to the minimum required sample set for a trust of its size, SECAmb elected to commission Quality Health to conduct a full census Survey on its behalf. Accordingly, all staff who were substantively employed by the Trust on 1 September 2017 were eligible to receive a Survey questionnaire.

2.2 Survey questions are nationally determined and are structured thematically, thereby enabling 'Key Findings' to be appropriately grouped. A total of 32 Key Findings (KFs) are grouped under the following nine work-related themes:

- Appraisals and Support for Development
- Equality and Diversity
- Errors and Incidents
- Health and Wellbeing
- Working Patterns
- Job Satisfaction
- Managers
- Patient Care and Experience
- Violence, Harassment and Bullying

Within the Survey outcomes report, KFs are presented as either percentage scores, or scale summary scores (with '5' representing the maximum score).

2.3 The Survey was administered over a twelve-week period during September to December 2017, and the full results were received in late February 2018. Results for all NHS organisations were nationally published on 6 March 2018 and are accessible via the National Survey website: www.nhsstaffsurveys.com.

3. Outcomes Summary

3.1 A report providing a summary of outcomes for the 2017 National NHS Staff Survey conducted in SECAmb is provided as **Appendix 1**. The headlines associated with the summary report are provided below.

Response Rate

3.2 The overall response rate was 44% (i.e. 1,460 staff), which represents a 4% increase compared with the previous year. Within this total, 40% of responses were received from Paramedics; 15% from Ambulance Control staff; 11% from Ambulance Technicians; and 9% from Emergency Care Assistances. The lowest number of responses were received from Administrative and Clerical staff; and staff occupying Central Functions and Corporate Services roles.

Main Advocacy Questions

3.3 The responses associated with four particular 'advocacy' questions inform KF1 - 'Staff recommendation of the organisation as a place to work or receive treatment'. For 2017, compared with the 2016 outcomes, staff responses to three of these advocacy questions improved, and there was no change in the fourth. Therefore, the overall score for KF1 increased from 3.03 to 3.08. The average score for all ambulance trusts was 3.44.

Overall Staff Engagement

3.4 The questions comprising KFs 1, 4 and 7 are used to calculate an overall staff engagement score. These questions relate to individuals' ability to contribute to improvements at work; their willingness to recommend the Trust as a place to work or receive treatment; and the extent to which they feel motivated and engaged with their work. Possible staff engagement scores range from 1 (where staff are poorly engaged) and 5 (where staff are highly engaged). The Trust's score of 3.22 was consistent with the previous year (3.21), but worse than the average score for all ambulance trusts (3.45).

Most Significant Changes

3.5 Compared with the 2016 outcomes, the most significant improvements reflected in the 2017 results related to five KFs, namely: the quality of non-mandatory training, learning or development; the quality of appraisals; the percentage of staff experiencing physical violence from staff; the percentage of staff experiencing harassment, bullying or abuse from patients and public; and staff confidence and security in reporting unsafe clinical practice.

3.6 Conversely, in the same period, staff experiences deteriorated in two areas, namely: the percentage of staff agreeing that their role makes a difference to patients/service users; and the percentage of staff appraised in the previous twelve months.

Changes and Comparisons Across all Key Findings

3.7 When all 32 KFs are considered, between 2016 and 2017 there was no change in 20 areas, a statistically relevant positive change in ten areas, and a statistically negative

change in two areas. When compared with all ambulance trusts, SECAmb was worse than average in 27 areas; better than average in two areas; and average in three areas.

4. Next Steps

4.1 Whilst there have been improvements in some areas, overall the Survey results are disappointing and highlights that SECAmb is performing less well than its immediate comparator organisations. Staff feedback also confirms the importance and relevance of the work being undertaken to improve the Trust' underlying culture. This includes the launch, in April, of SECAmb's revised organisational values and behaviours, which have been informed by staff consultation activity conducted since October 2017. The work associated with SECAmb's culture improvement will continue at pace, with the full support, involvement and commitment of the senior leadership team.

4.2 The Trust will be required to administer the 2018 national NHS Staff Survey from early September, which provides for a period of only five months in which to further communicate the 2017 results to staff, agree key actions in response, and demonstrate progress against those actions. This activity is being led by the HR Directorate and includes the involvement of the Staff Engagement Forum (SEF), Joint Partnership Forum (JPF) and Workforce and Wellbeing Committee (WWC). The Executive Team will endorse the emergent proposed response plan on 25 April, and subsequent implementation will be overseen by the WWC. The Trust Board will receive a progress update report at its July meeting.

5. Summary

5.1 Receipt of the 2017 National NHS Staff Survey local outcomes demonstrated that, whilst the response rate had improved, across all associated Key Findings there was little change in staff feedback since the previous year. When measured against the ambulance sector average scores, SECAmb's results do not compare well. There is a relatively small window of opportunity, before the implementation of the 2018 Survey, in which to respond to staff feedback. Therefore, a realistic and achievable response plan is being developed with the involvement of the Trust's established engagement fora, and the appropriate Board sub-committee will ensure agreed actions are effectively implemented. Response actions will, wherever possible, be aligned with the Trust's culture change activity which, in itself, aims to directly address many of the issues highlighted by the Survey outcomes.

6. Recommendation

6.1 The Trust Board is asked to note the contents of this paper and to receive a progress update report at its meeting in July 2018.

Appendix:

1. 2017 National Staff Survey - SECAmb Results Summary

Appendix 1:

2017 National Staff Survey

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) Results Summary

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4: Full description of 2017 Key Findings for South East Coast Ambulance Service NHS Foundation Trust (including comparisons with the trust's 2016 survey and with other ambulance trusts) 16

1. Introduction to this report

This report presents the findings of the 2017 national NHS staff survey conducted in South East Coast Ambulance Service NHS Foundation Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

These sections of the report have been structured thematically so that Key Findings are grouped appropriately. There are nine themes within this report:

- Appraisals & support for development
- Equality & diversity
- Errors & incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment & bullying

Please note, two Key Findings have had their calculation changed and there have been minor changes to the benchmarking groups for social enterprises since last year. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2017 survey results for South East Coast Ambulance Service NHS Foundation Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who "Agree" and "Strongly Agree" compared to the total number of staff that responded to the question.

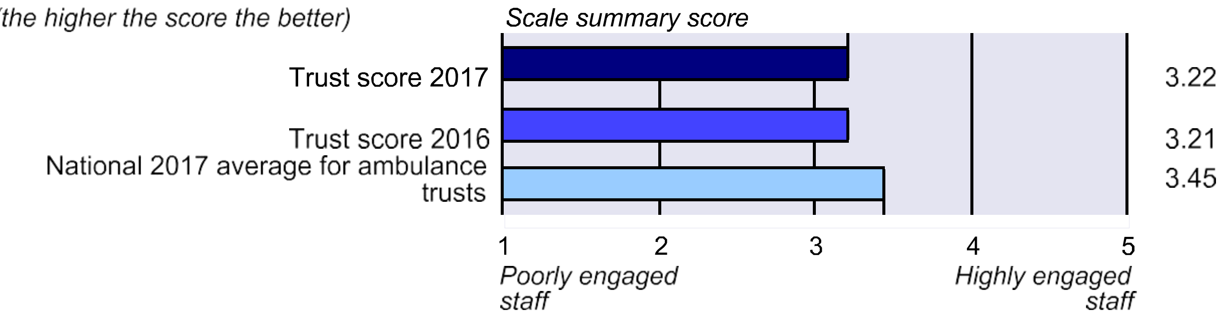
Q21a, Q21c and Q21d feed into Key Finding 1 "Staff recommendation of the organisation as a place to work or receive treatment".

		Your Trust in 2017	**Average (median) for ambulance trusts**	**Your Trust in 2016**
Q21a	"Care of patients / service users is my organisation's top priority"	46%	59%	41%
Q21b	"My organisation acts on concerns raised by patients / service users"	50%	62%	49%
Q21c	"I would recommend my organisation as a place to work"	27%	47%	26%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	61%	70%	61%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.08	3.44	3.03

2. Overall indicator of staff engagement for South East Coast Ambulance Service NHS Foundation Trust

The figure below shows how South East Coast Ambulance Service NHS Foundation Trust compares with other ambulance trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.22 was below (worse than) average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how South East Coast Ambulance Service NHS Foundation Trust compares with other ambulance trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2016 survey.

	Change since 2016 survey	Ranking, compared with all ambulance trusts
OVERALL STAFF ENGAGEMENT	• No change	! Below (worse than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	• No change	! Below (worse than) average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	! Below (worse than) average
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	! Below (worse than) average

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

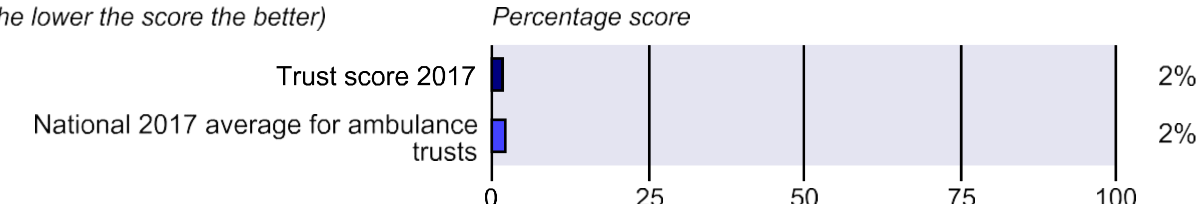
3. Summary of 2017 Key Findings for South East Coast Ambulance Service NHS Foundation Trust

3.1 Top and Bottom Ranking Scores

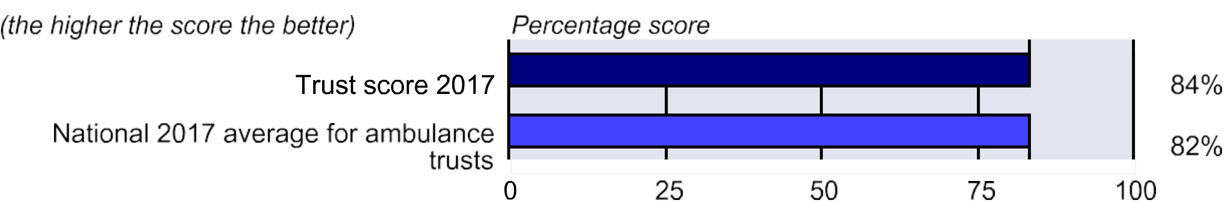
This page highlights the five Key Findings for which South East Coast Ambulance Service NHS Foundation Trust compares most favourably with other ambulance trusts in England.

TOP FIVE RANKING SCORES

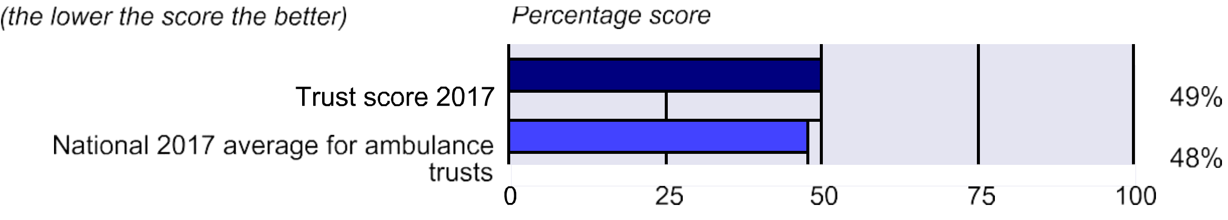
✓KF23. Percentage of staff experiencing physical violence from staff in last 12 months



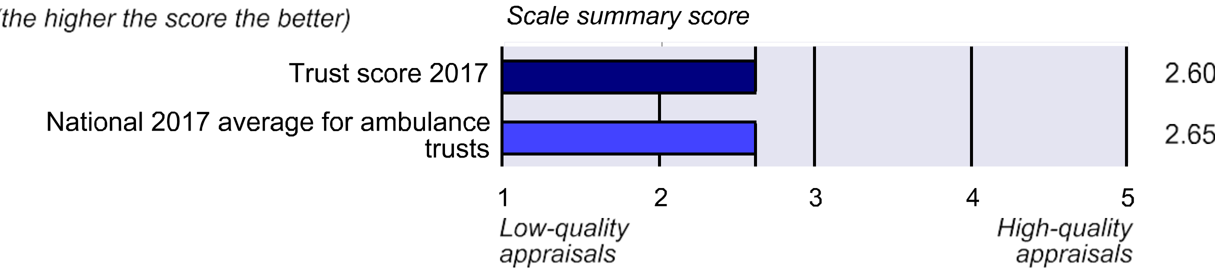
✓KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month



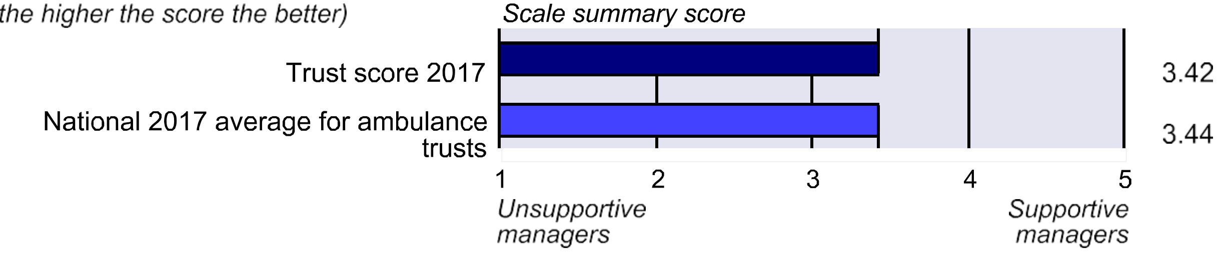
✓KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



✓KF12. Quality of appraisals



✓KF10. Support from immediate managers

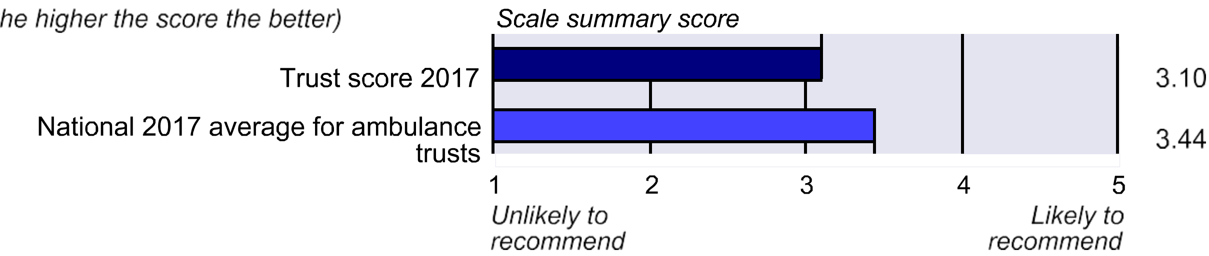


For each of the 32 Key Findings, the ambulance trusts in England were placed in order from 1 (the top ranking score) to 11 (the bottom ranking score). South East Coast Ambulance Service NHS Foundation Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

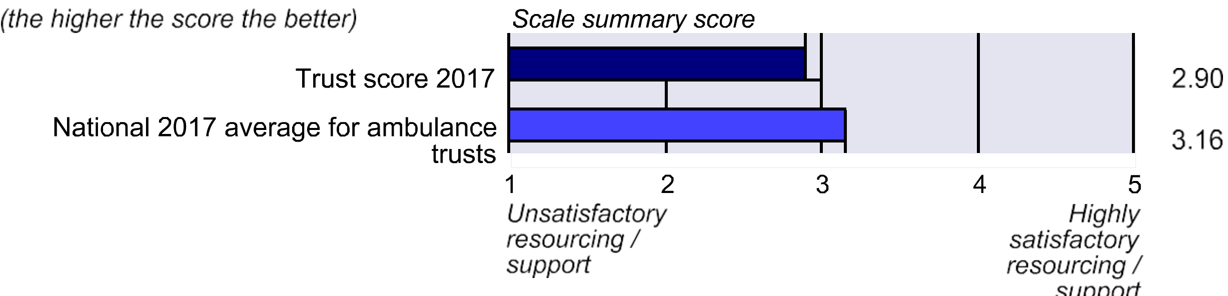
This page highlights the five Key Findings for which South East Coast Ambulance Service NHS Foundation Trust compares least favourably with other ambulance trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

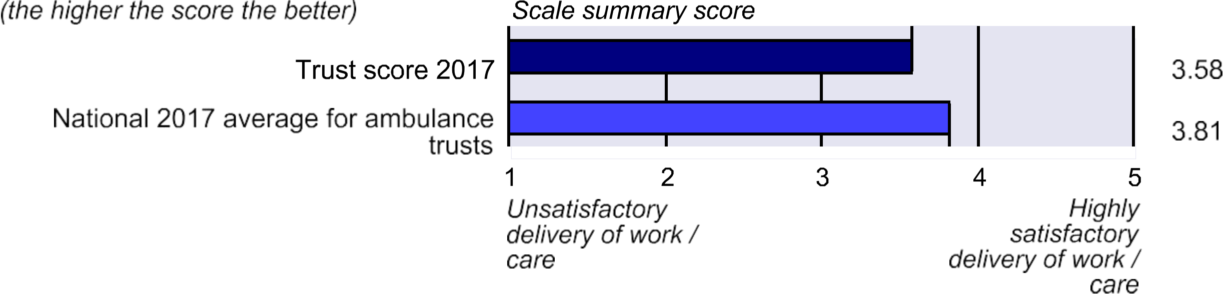
! KF1. Staff recommendation of the organisation as a place to work or receive treatment



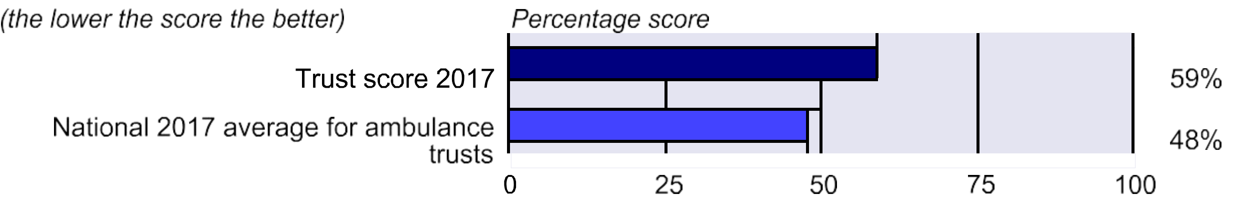
! KF14. Staff satisfaction with resourcing and support



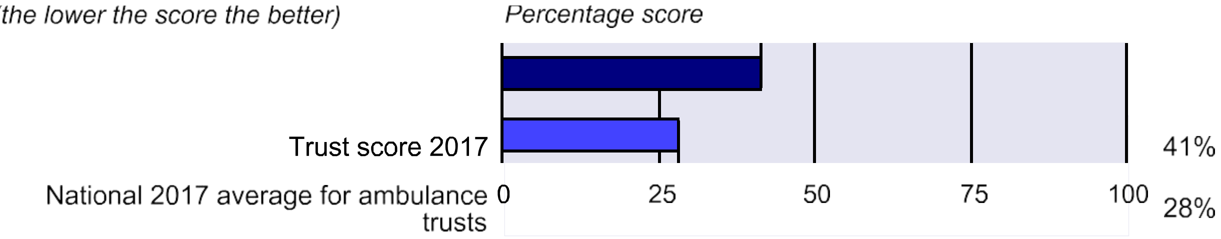
! KF2. Staff satisfaction with the quality of work and care they are able to deliver



! KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months



! KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



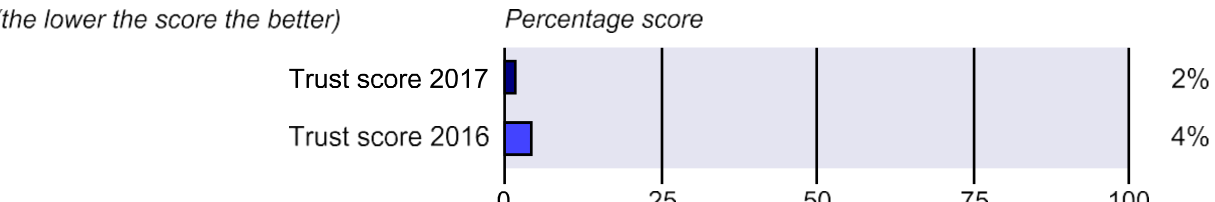
3.2 Largest Local Changes since the 2016 Survey

This page highlights the five Key Findings where staff experiences have improved at South East Coast Ambulance Service NHS Foundation Trust since the 2016 survey. (This is a positive local result. However, please note that, as shown in section 3.3, when compared with other ambulance trusts in England, the score for Key finding KF13 is worse than average).

WHERE STAFF EXPERIENCE HAS IMPROVED

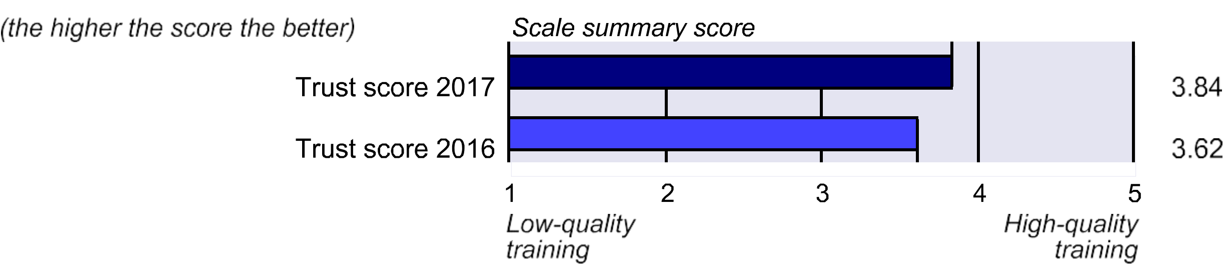
✓KF23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



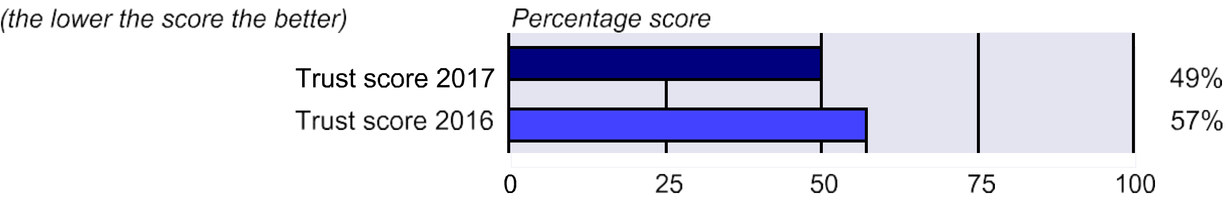
✓KF13. Quality of non-mandatory training, learning or development

(the higher the score the better)



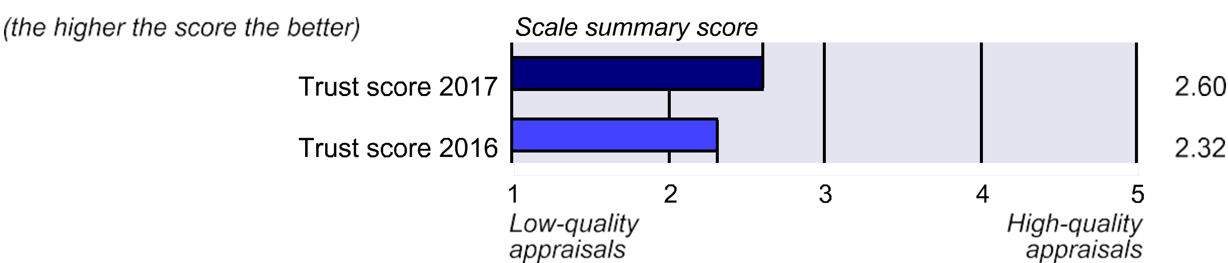
✓KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



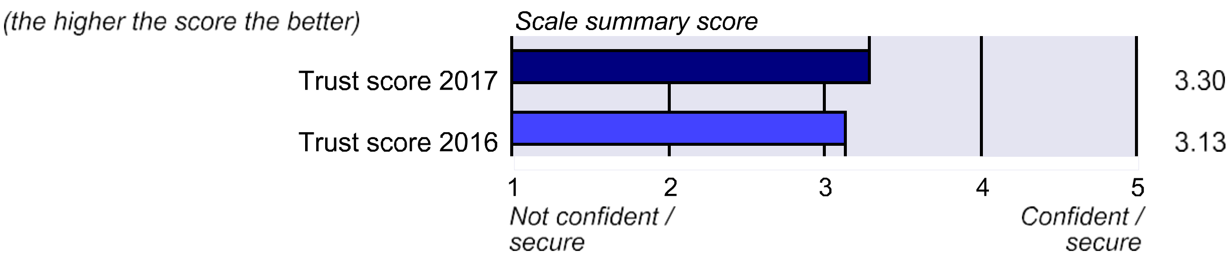
✓KF12. Quality of appraisals

(the higher the score the better)



✓KF31. Staff confidence and security in reporting unsafe clinical practice

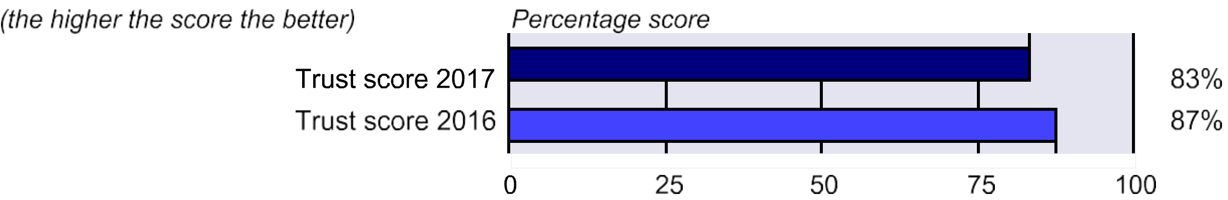
(the higher the score the better)



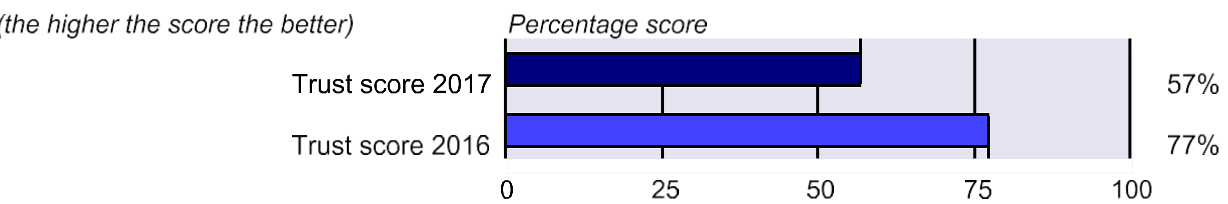
This page highlights the two Key Findings where staff experiences have deteriorated since the 2016 survey. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

WHERE STAFF EXPERIENCE HAS DETERIORATED

! KF3. Percentage of staff agreeing that their role makes a difference to patients / service users



! KF11. Percentage of staff appraised in last 12 months



Because the Key Findings vary considerably in terms of subject matter and format (e.g. some are percentage scores, others are scale scores), a straightforward comparison of score changes is not the appropriate way to establish which Key Findings have deteriorated the most. Rather, the extent of 2016-2017 change for each Key Finding has been measured in relation to the national variation for that Key Finding. Further details about this can be found in the document ***Making sense of your staff survey data***.

3.3. Summary of all Key Findings for South East Coast Ambulance Service NHS Foundation Trust

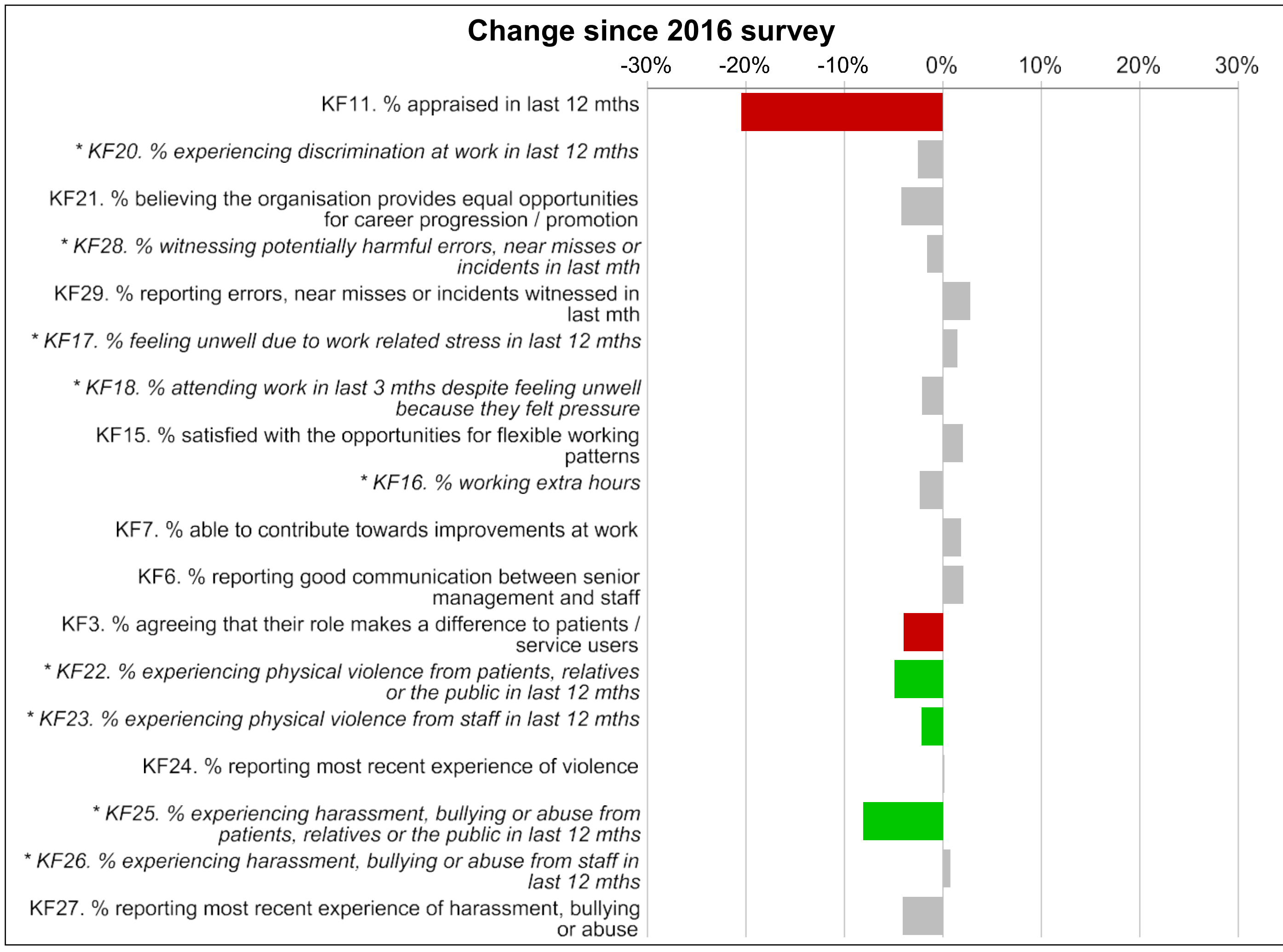
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2016 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2016 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for South East Coast Ambulance Service NHS Foundation Trust

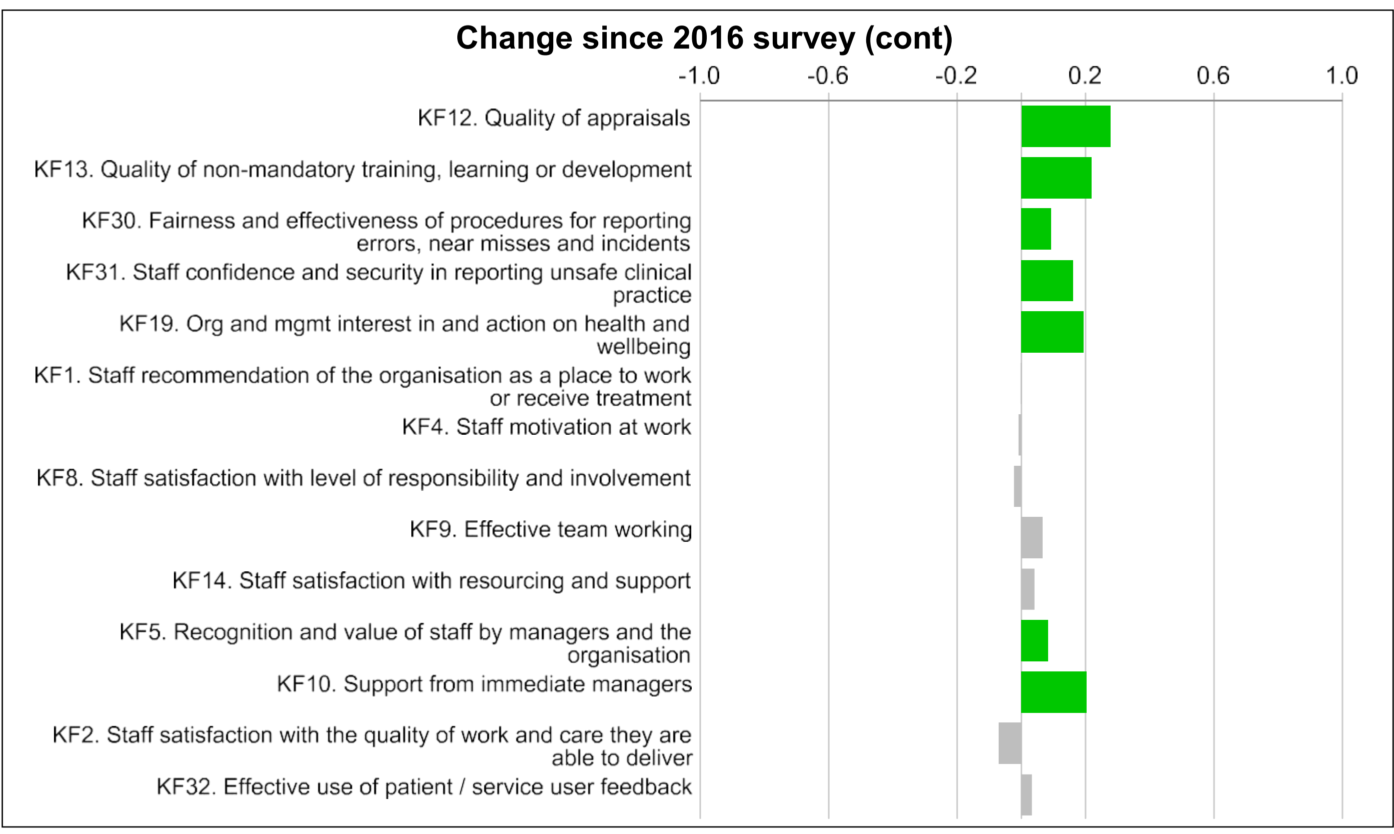
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2016 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2016 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for South East Coast Ambulance Service NHS Foundation Trust

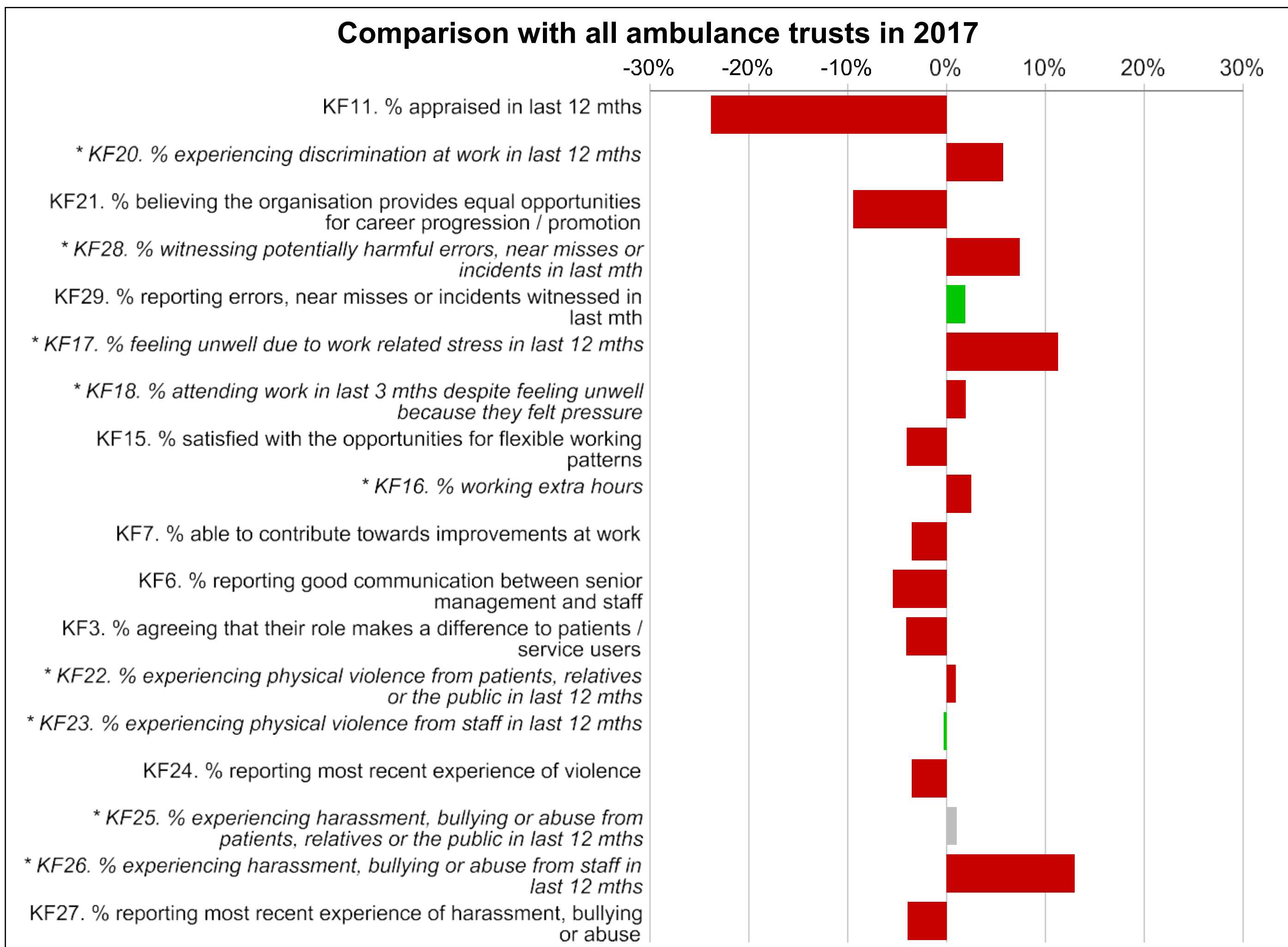
KEY

Green = Positive finding, e.g. better than average.

Red = Negative finding, i.e. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for South East Coast Ambulance Service NHS Foundation Trust

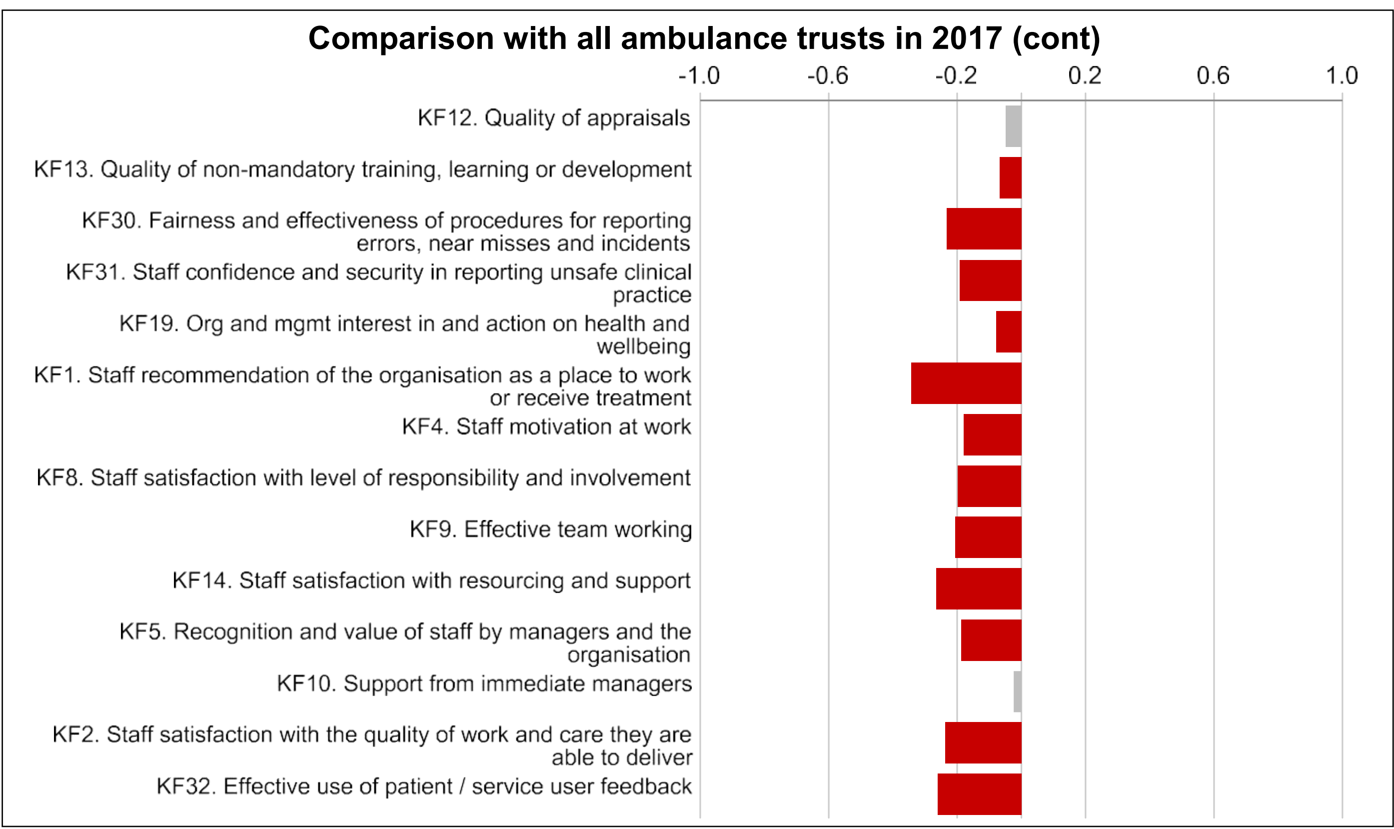
KEY

Green = Positive finding, e.g. better than average.

Red = Negative finding, i.e. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.4. Summary of all Key Findings for South East Coast Ambulance Service NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2016.

! Red = Negative finding, e.g. worse than average, worse than 2016.

'Change since 2016 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2016 survey.

-- No comparison to the 2016 data is possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2016 survey	Ranking, compared with all ambulance trusts in 2017
Appraisals & support for development		
KF11. % appraised in last 12 mths	! Decrease (worse than 16)	! Below (worse than) average
KF12. Quality of appraisals	✓Increase (better than 16)	Average
KF13. Quality of non-mandatory training, learning or development	✓Increase (better than 16)	! Below (worse than) average
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	! Above (worse than) average
KF21. % believing the organisation provides equal opportunities for career progression / promotion	• No change	! Below (worse than) average
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	! Above (worse than) average
KF29. % reporting errors, near misses or incidents witnessed in last mth	• No change	✓Above (better than) average
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	✓Increase (better than 16)	! Below (worse than) average
KF31. Staff confidence and security in reporting unsafe clinical practice	✓Increase (better than 16)	! Below (worse than) average
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	• No change	! Above (worse than) average
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	• No change	! Above (worse than) average
KF19. Org and mgmt interest in and action on health and wellbeing	✓Increase (better than 16)	! Below (worse than) average
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	• No change	! Below (worse than) average
* *KF16. % working extra hours*	• No change	! Above (worse than) average

3.4. Summary of all Key Findings for South East Coast Ambulance Service NHS Foundation Trust (cont)

	Change since 2016 survey	Ranking, compared with all ambulance trusts in 2017
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	• No change	! Below (worse than) average
KF4. Staff motivation at work	• No change	! Below (worse than) average
KF7. % able to contribute towards improvements at work	• No change	! Below (worse than) average
KF8. Staff satisfaction with level of responsibility and involvement	• No change	! Below (worse than) average
KF9. Effective team working	• No change	! Below (worse than) average
KF14. Staff satisfaction with resourcing and support	• No change	! Below (worse than) average
Managers		
KF5. Recognition and value of staff by managers and the organisation	✓ Increase (better than 16)	! Below (worse than) average
KF6. % reporting good communication between senior management and staff	• No change	! Below (worse than) average
KF10. Support from immediate managers	✓ Increase (better than 16)	• Average
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	• No change	! Below (worse than) average
KF3. % agreeing that their role makes a difference to patients / service users	! Decrease (worse than 16)	! Below (worse than) average
KF32. Effective use of patient / service user feedback	• No change	! Below (worse than) average
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	✓ Decrease (better than 16)	! Above (worse than) average
* *KF23. % experiencing physical violence from staff in last 12 mths*	✓ Decrease (better than 16)	✓ Below (better than) average
KF24. % reporting most recent experience of violence	• No change	! Below (worse than) average
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	✓ Decrease (better than 16)	• Average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	! Above (worse than) average
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	! Below (worse than) average

4. Key Findings for South East Coast Ambulance Service NHS Foundation Trust

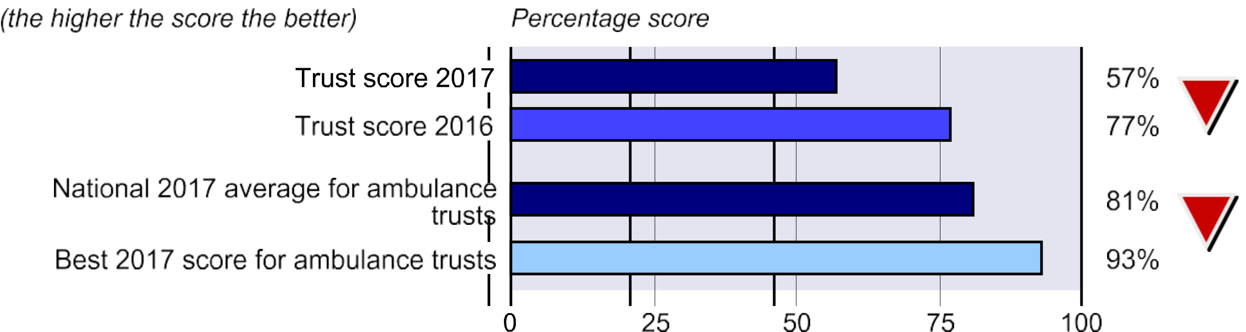
South East Coast Ambulance Service NHS Foundation Trust had 1405 staff take part in this survey. This is a response rate of 44%[1] which is average for ambulance trusts in England (42%), and compares with a response rate of 40% in this trust in the 2016 survey.

This section presents each of the 32 Key Findings, using data from the trust's 2017 survey, and compares these to other ambulance trusts in England and to the trust's performance in the 2016 survey. The findings are arranged under nine themes: appraisals and support for development, equality and diversity, errors and incidents, health and wellbeing, working patterns, job satisfaction, managers, patient care and experience , and violence, harassment and bullying.

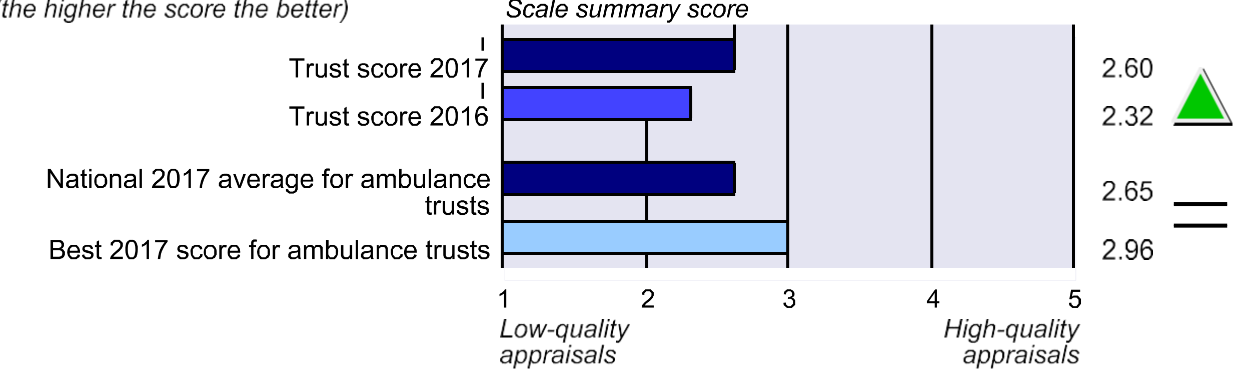
Positive findings are indicated with a green arrow (e.g. where the trust is better than average, or where the score has improved since 2016). Negative findings are highlighted with a red arrow (e.g. where the trust's score is worse than average, or where the score is not as good as 2016). An equals sign indicates that there has been no change.

Appraisals & support for development

KEY FINDING 11. Percentage of staff appraised in last 12 months

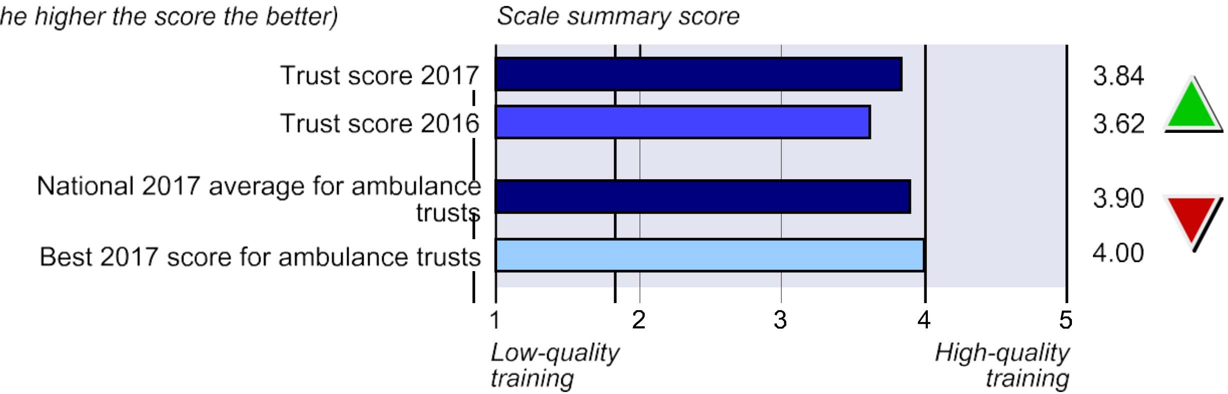


KEY FINDING 12. Quality of appraisals



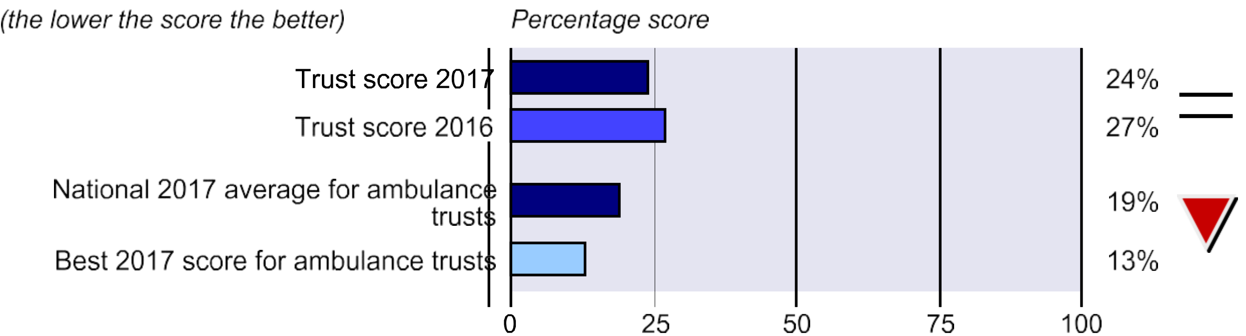
[1]Questionnaires were sent to all 3192 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

KEY FINDING 13. Quality of non-mandatory training, learning or development

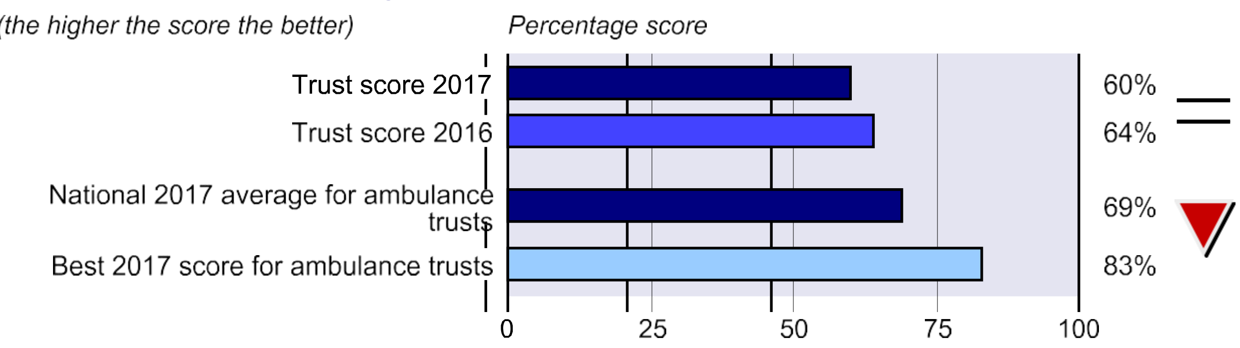


Equality & diversity

KEY FINDING 20. Percentage of staff experiencing discrimination at work in the last 12 months

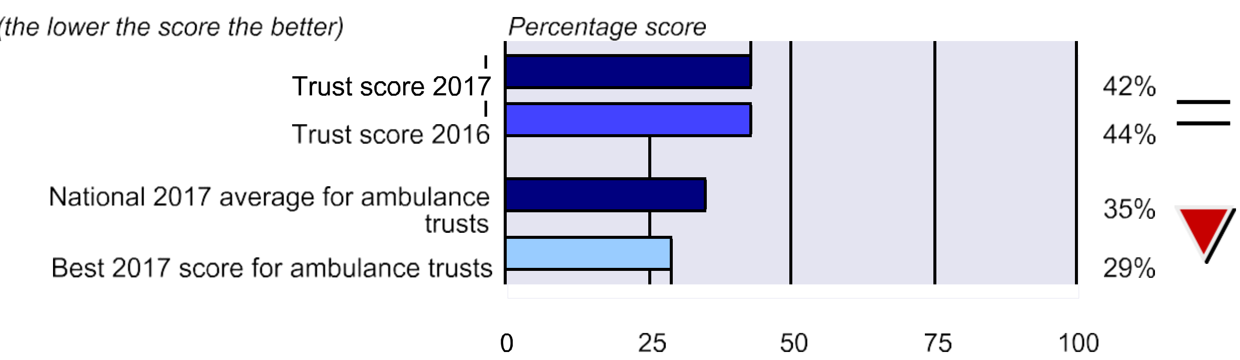


KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

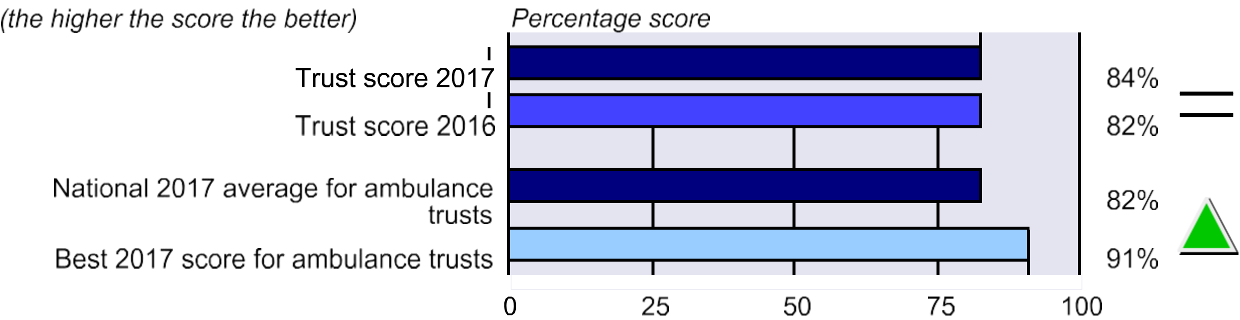


Errors & incidents

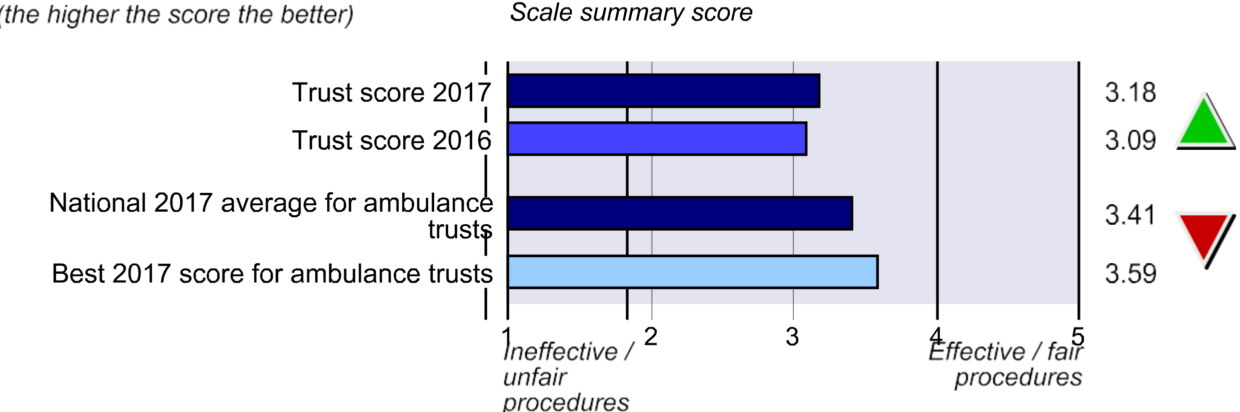
KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month



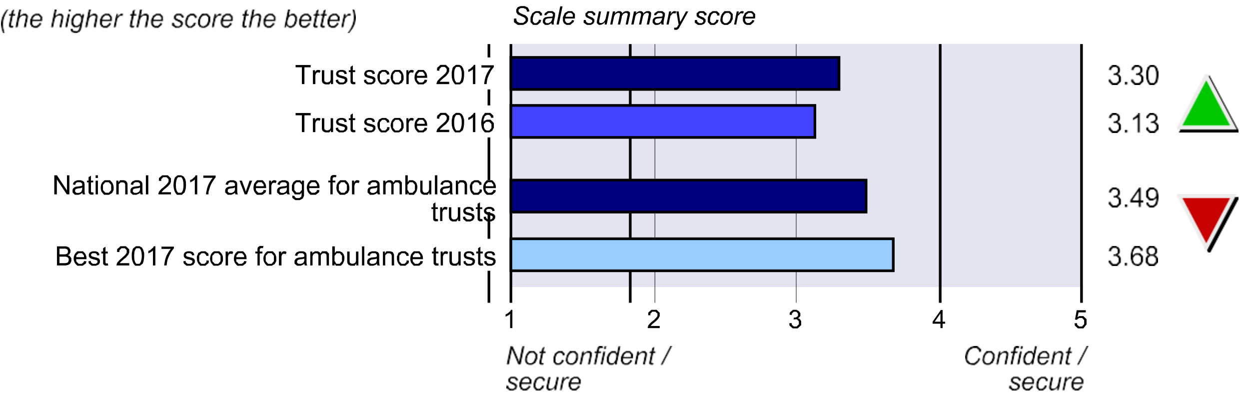
KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month



KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

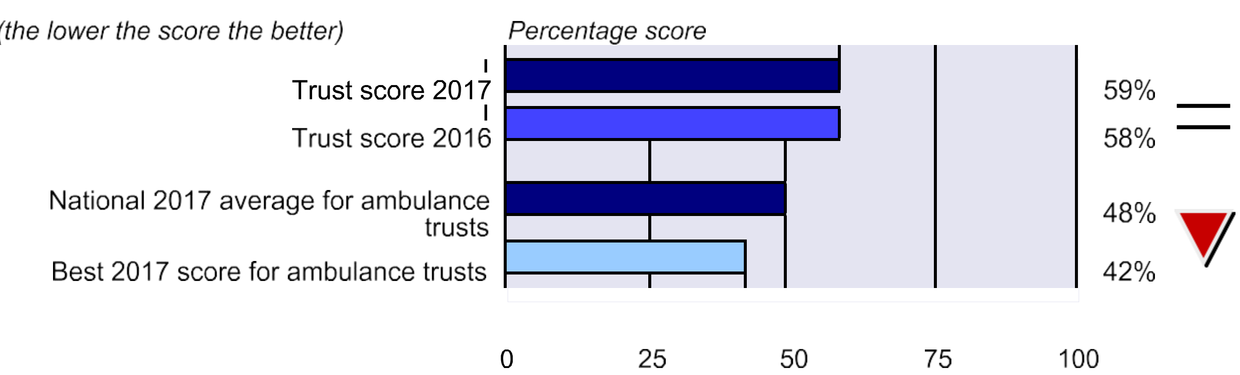


KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice

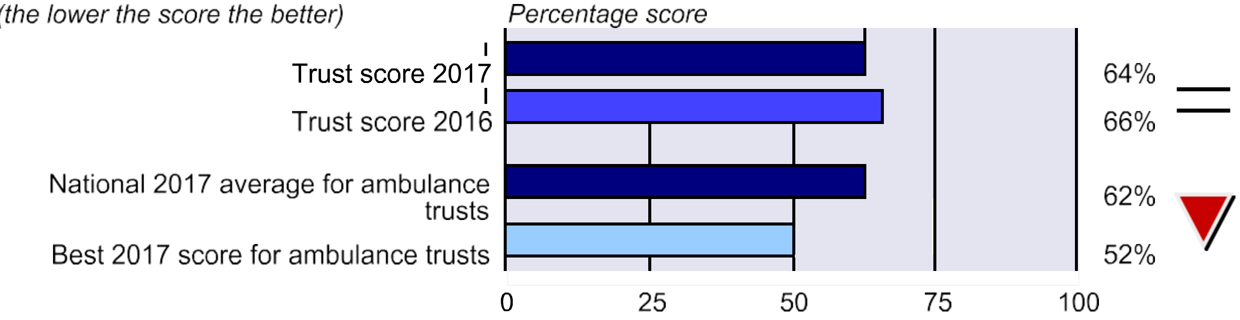


Health and wellbeing

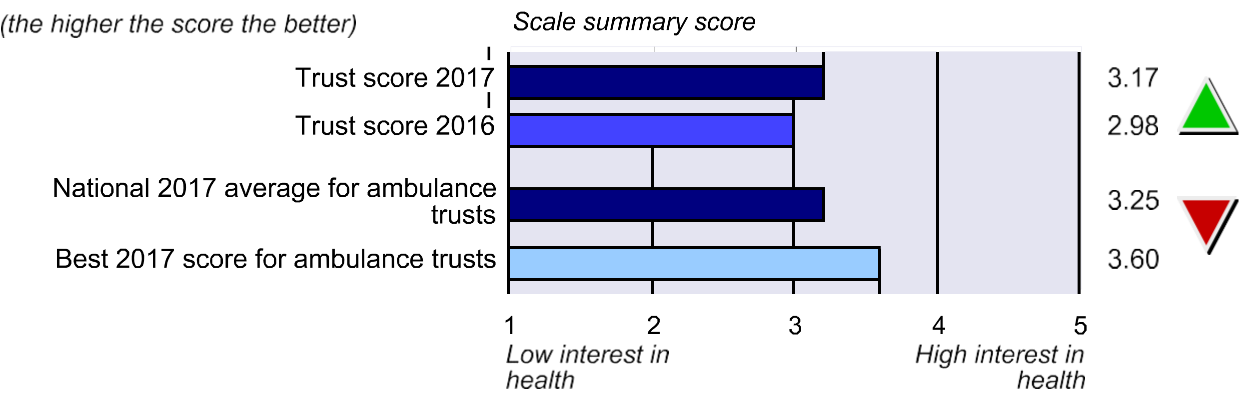
KEY FINDING 17. Percentage of staff feeling unwell due to work related stress in the last 12 months



KEY FINDING 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

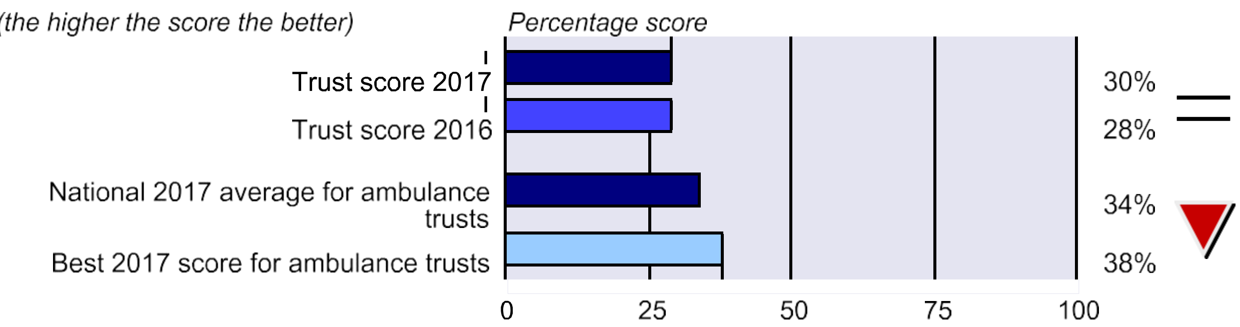


KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

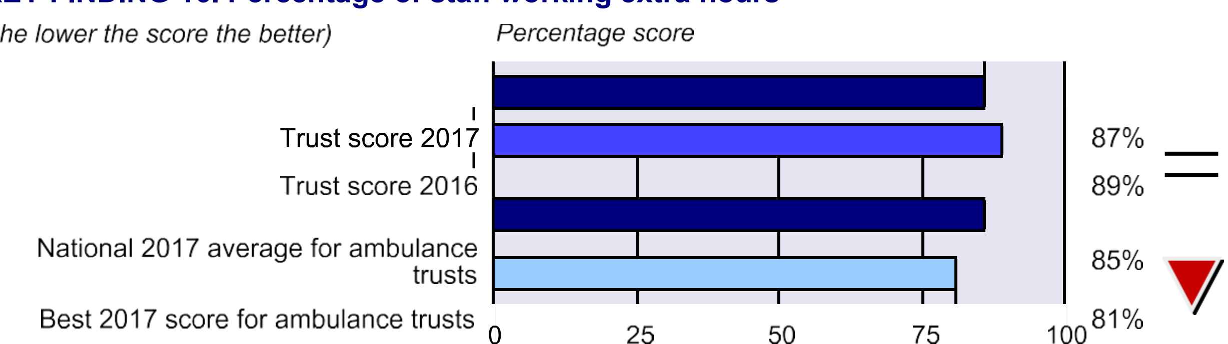


Working patterns

KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns

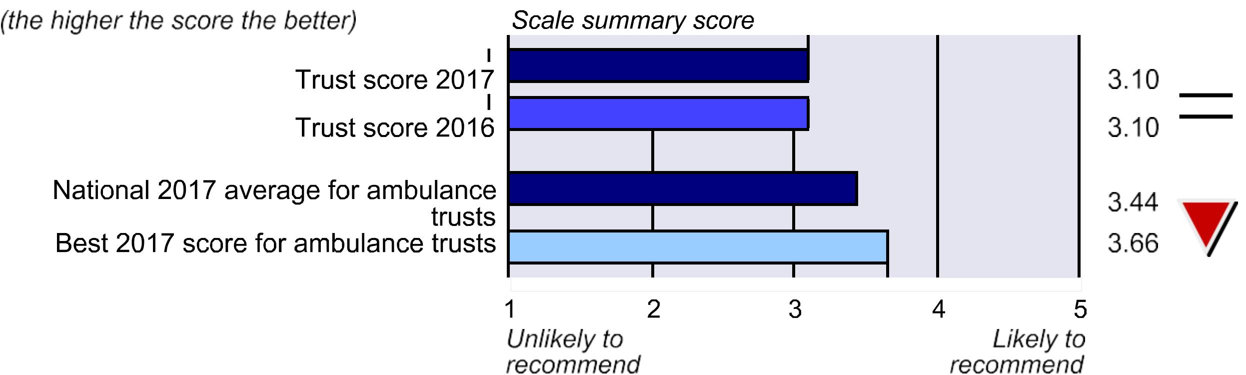


KEY FINDING 16. Percentage of staff working extra hours

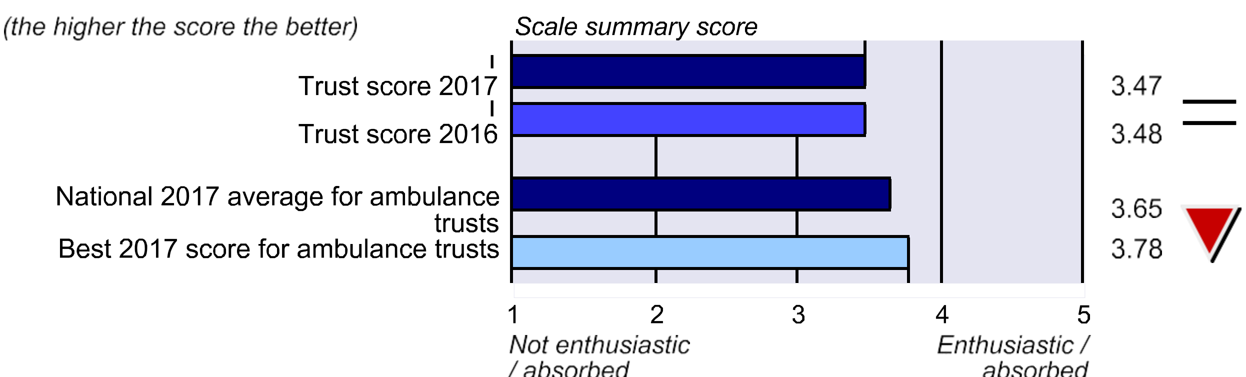


Job satisfaction

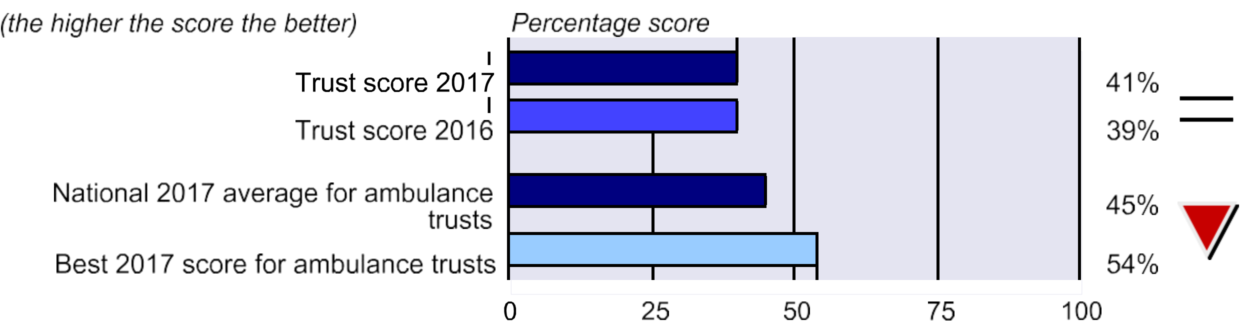
KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment



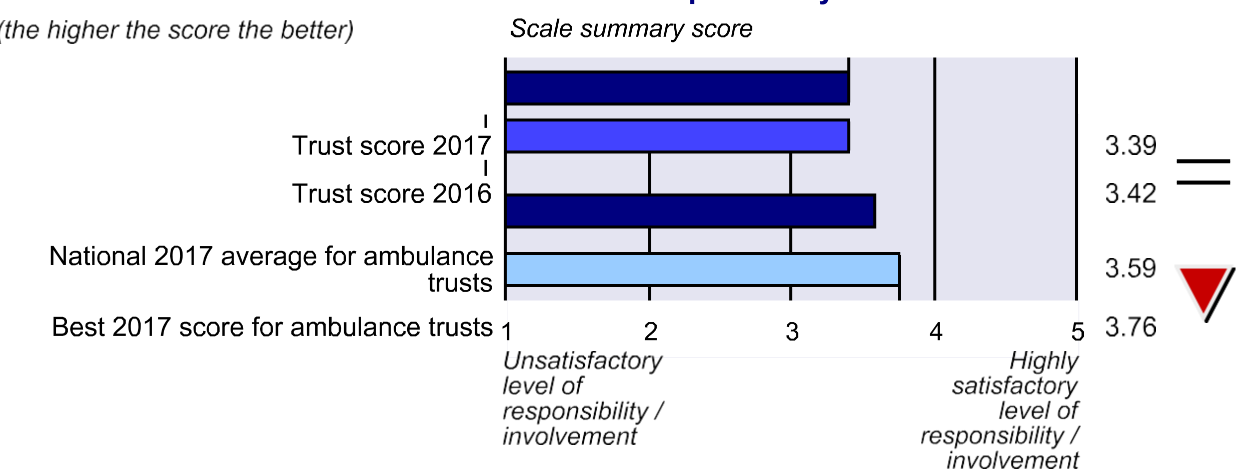
KEY FINDING 4. Staff motivation at work



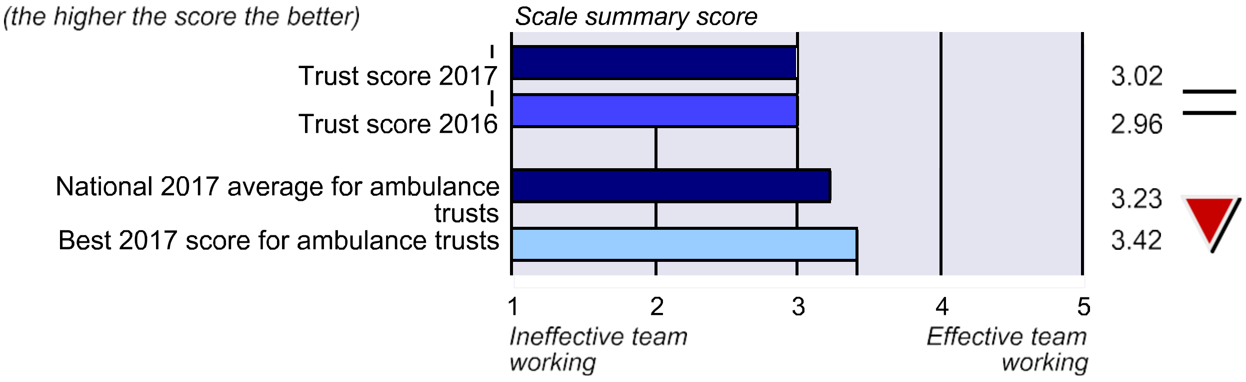
KEY FINDING 7. Percentage of staff able to contribute towards improvements at work



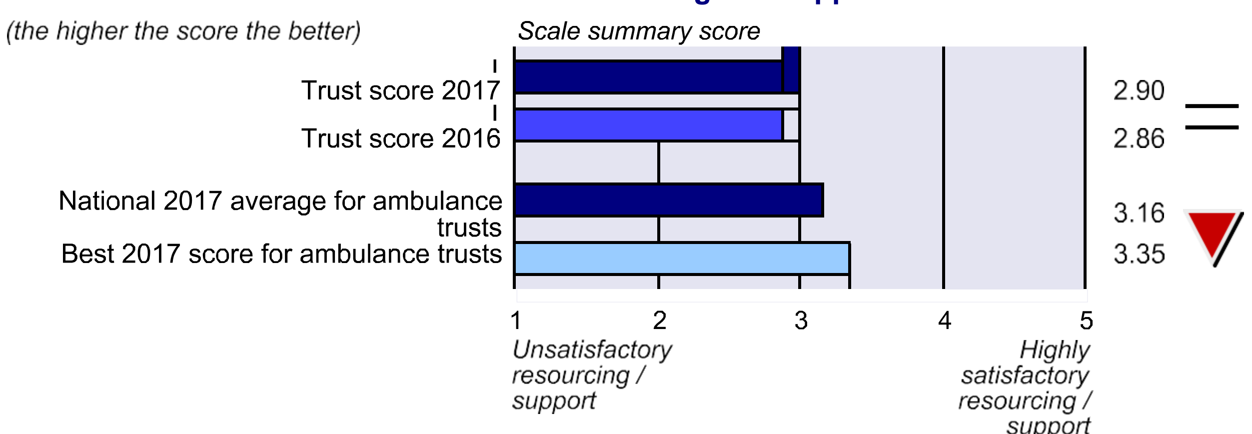
KEY FINDING 8. Staff satisfaction with level of responsibility and involvement



KEY FINDING 9. Effective team working

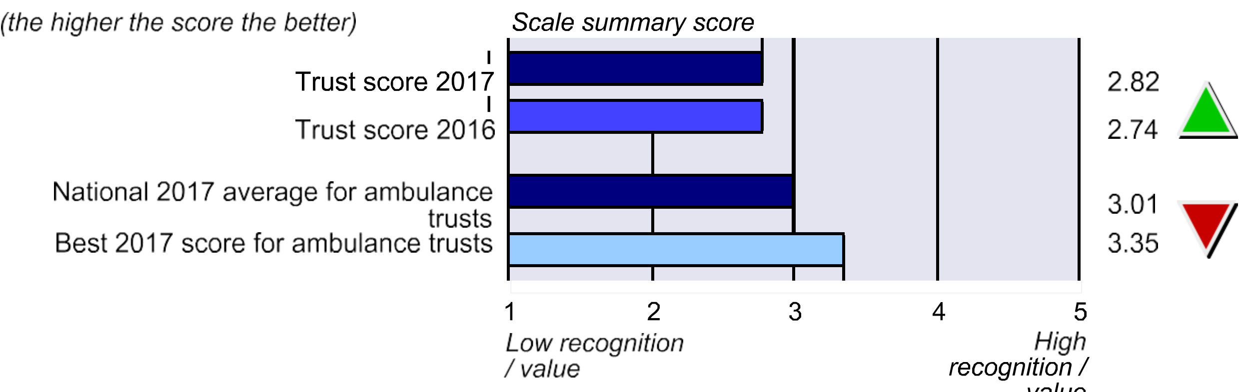


KEY FINDING 14. Staff satisfaction with resourcing and support

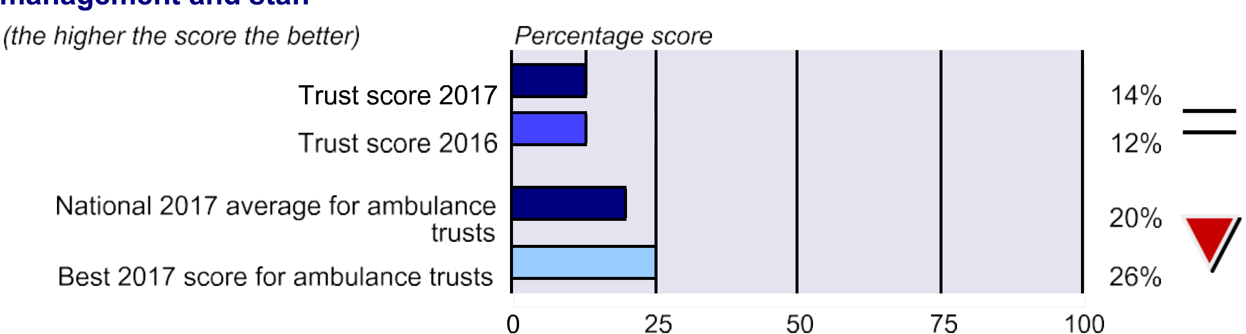


Managers

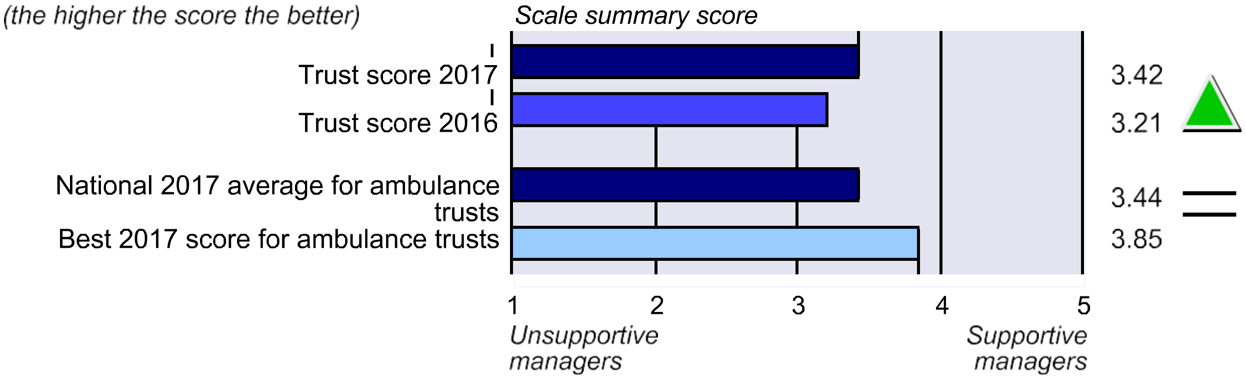
KEY FINDING 5. Recognition and value of staff by managers and the organisation



KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff

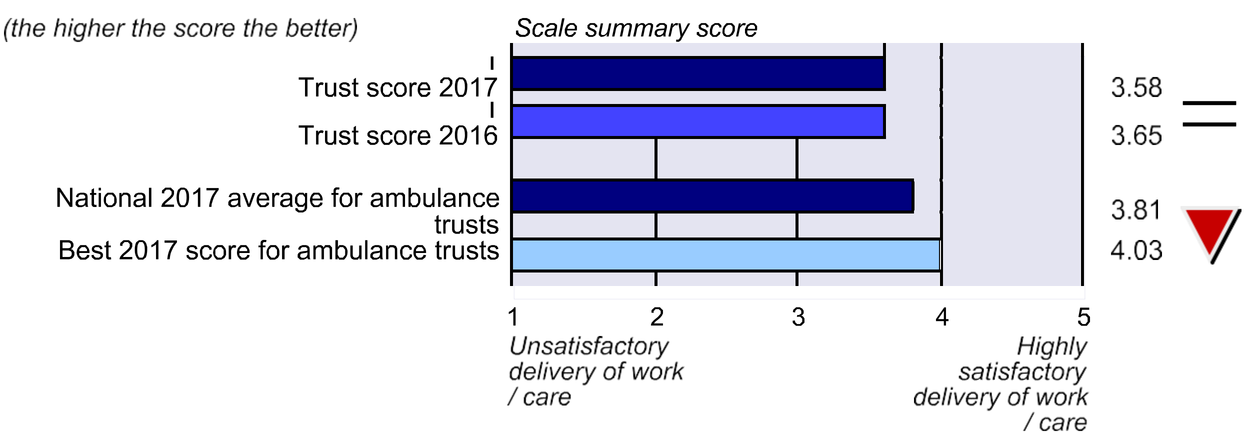


KEY FINDING 10. Support from immediate managers

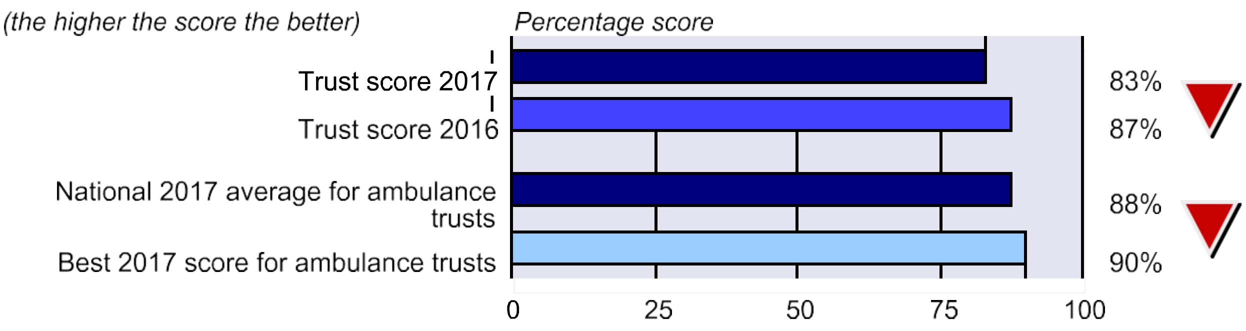


Patient care & experience

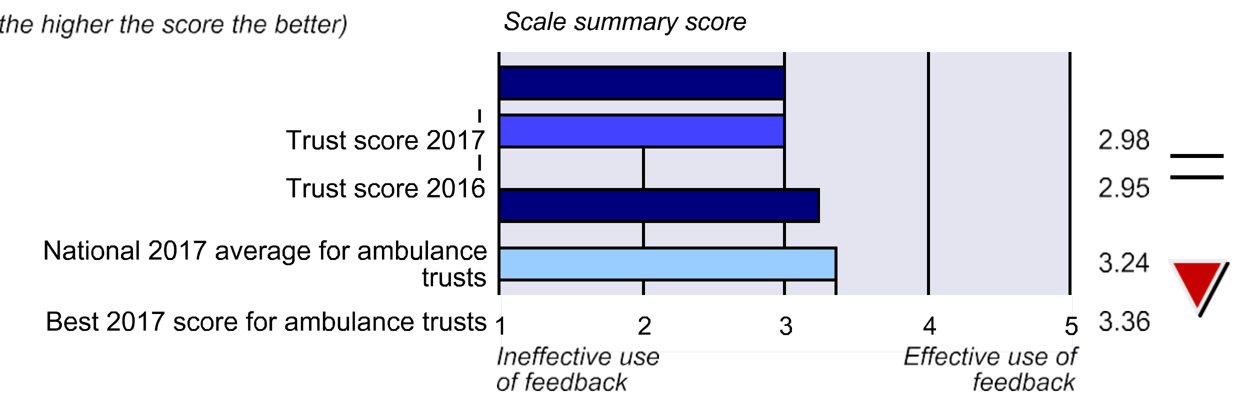
KEY FINDING 2. Staff satisfaction with the quality of work and care they are able to deliver



KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users

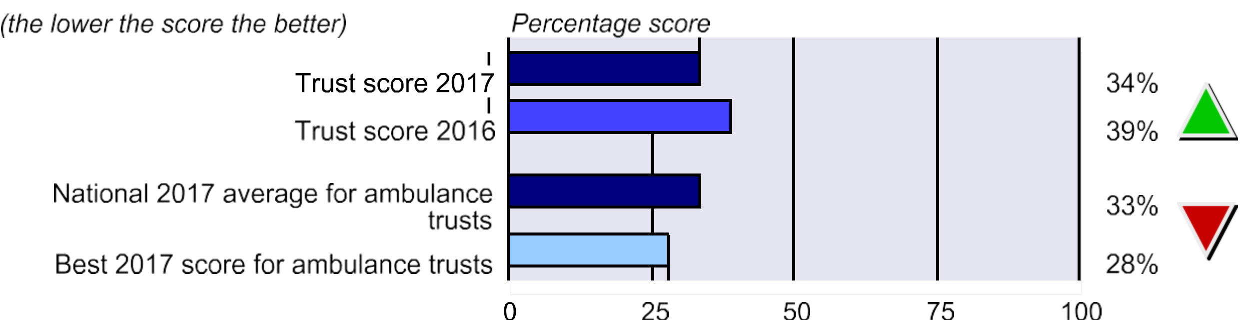


KEY FINDING 32. Effective use of patient / service user feedback

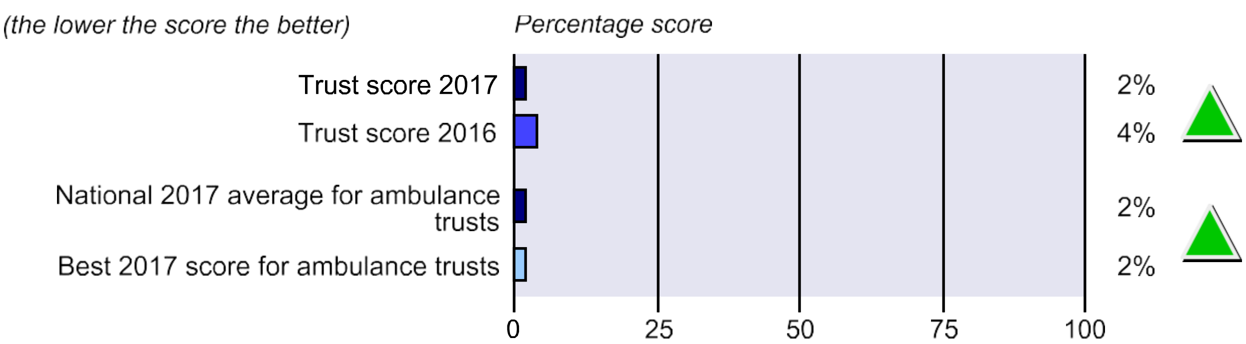


Violence, harassment & bullying

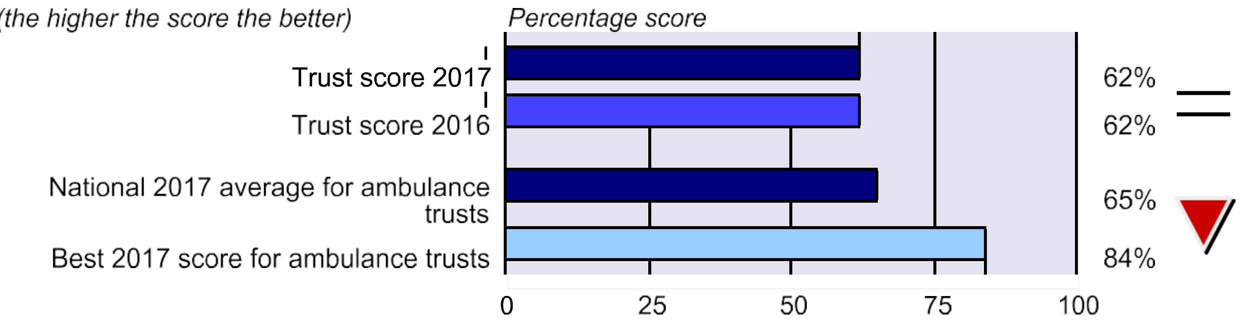
KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months



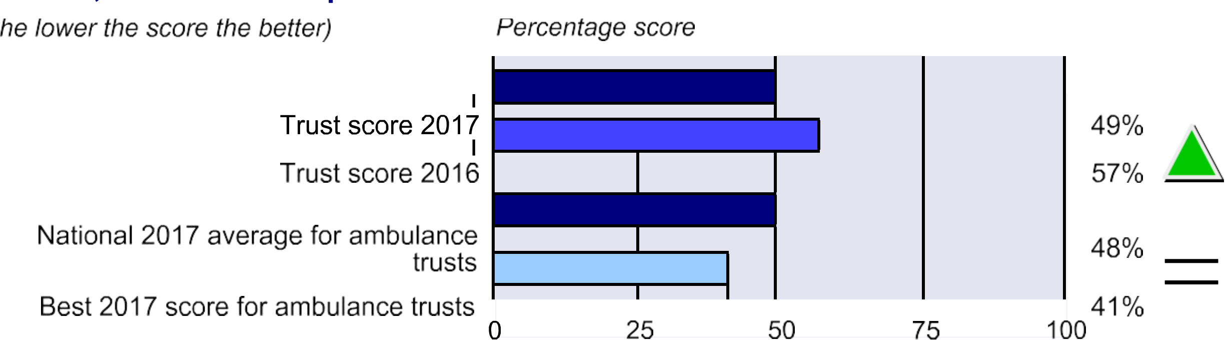
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months



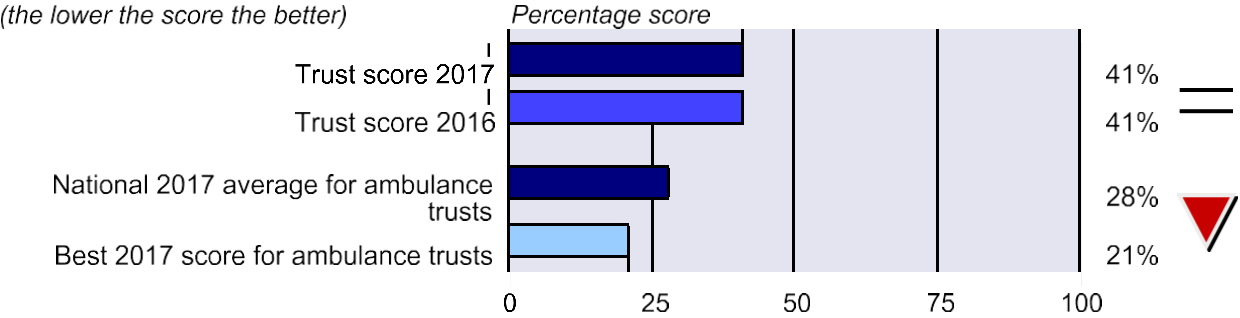
KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence



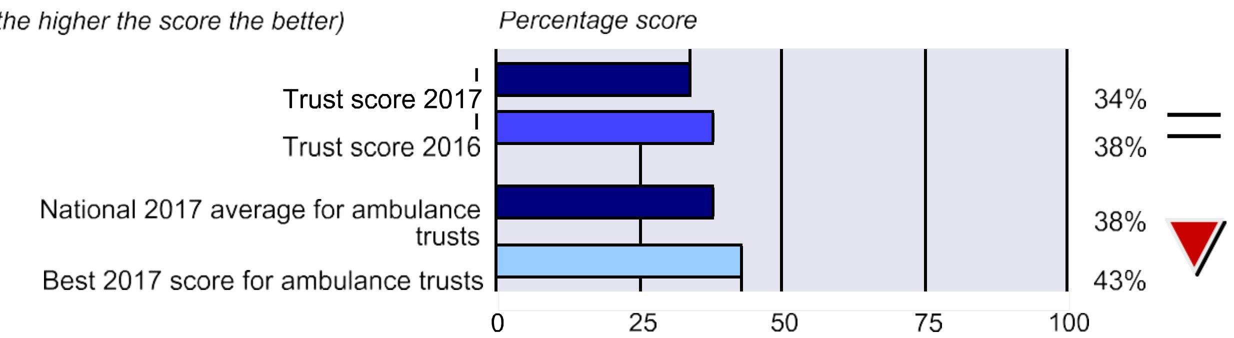
KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse



Integrated Performance Report

Performance Data for our 999 and 111 Services

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

Board Meeting

March 2018

SECAmb Executive Summary

This Integrated Performance Report continues to respond to the feedback given at Trust Boards held in January 2018. It is intended to develop this report such that updates on data and supporting narrative in all areas are included under the headings of CQC domains. This will ensure that the reader and the Trust Board have a clear line of sight on recovery and sustained delivery by domain.

A new template report is now available and is being reviewed. The Director for Strategy and Business Development for SECAmb will work with SECAmb Non-Executive Directors, Commissioners, NHS Improvement and NHS England to ensure that reporting and information sharing on a monthly cycle will deliver the required assurance for the Trust Board our Regulators and stakeholders.

It is clear that SECAmb and our NHS Provider colleagues across our geography continue to operate in a highly volatile environment and in different settings of patient care. As such, SECAmb and Lead Commissioners are strengthening the joint review of performance via weekly calls to examine performance data, the triangulation of SECAmb's response times with the day to day targeted allocation of additional hours, the assessment of competing operational pressures and clinical / quality indicators to mitigate clinical risk.

A key component of ensuring delivery is the jointly commissioned Demand and Capacity review which is intended to demonstrate how the Trust (with the support of Commissioners) will sustainably deliver all operational and clinical performance targets.

Clinical Safety
The clinical safety data continues to show normal patterns of variation. Completion of care bundles remains below the national average; these care elements will be given increased focus now they have been added as an objective on the governance, health records and clinical audit improvement action plan. Our time quality indicators continue to be affected by any reduction in performance Red / Category 1 and 2 response times.

Clinical Quality
The Quality metrics illustrate improved compliance. Duty of Candour remains at 100% for the most serious incidents. The next phase of the improvement work is to consider the less serious incidents and the team are reviewing the process for undertaking this. Safeguarding Level 2 and Level 3 training has reached the 85% target associated with mandatory training. Whilst this is a significant contribution to our safeguarding improvements there remains work to be done. The team are currently developing the bespoke training for the coming year.

Serious Incident investigations still remain below plan for their completion time but the reported numbers have returned to more normal levels in February. The new Infection prevention ready plan has been completed and is being implemented. Improvements in hand hygiene have been made but there are other IPC work streams such as uniform policy and vehicle cleaning that the team are strengthening their oversight for. The complaint portfolio has reached the target set within the Improvement Plan of 80% of complaints being responded to within 25 working days. This is a considerable achievement and the attention will now focus on being able to evidence the Trust is learning and implementing actions from the complaints process.

Operational Performance
Continued emphasis is being place on our ability to deploy additional and targeted hours. As reported to the Board in February, the Trust continually monitors and seeks to mitigate risk in EOC operations. A number of areas are highlighted together with the Trust's response on page 22 of this report.

Workforce
A set of priorities has been established for the HR Directorate. These are:
- **Fit for Purpose HR** - Including the review and update of process and policies. We will prioritise the areas of work including the Trust's end-to-end ability to attract, select, offer, on-board and educate frontline staff to meet current demands
- **Workforce Plan** - We will have a workforce plan for how we resource up to achieve the new performance targets by September. In line with the Demand and Capacity Review, we will have a strategic workforce plan quarter by quarter through to 2021. This will also drive the resource requirements for us in HR
- **Culture and OD** - Our Culture and OD programme is being re-positioned to ensure it is well lead with pace and grip. This will draw in a number of already running areas of work including the Lewis Report recommendations, Staff Survey follow-up and well-being.
- **Workforce Strategy** – The Trust will finalise its Workforce Strategy. This will then influence a clear plan for the work of HR.

The above will be under-pinned by the work of Protecting the Organisation on People-related risk.

The Trust Board is asked to note this report.

SECAmb CQC Rating and oversight framework

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

SECAmb Financial Performance

With one month of the financial year to go, the Trust continues to forecast achievement of its control total of £1.0m deficit for the year. This is after receipt of planned Sustainability and Transformation Funding (STF) of £1.3m. The forecast before STF is £2.3m.

Following the conclusion of contract settlement discussions with commissioners, the Trust is projecting that the full contracted income value will be achieved. The Trust is also forecasting full delivery of its £15.1m cost improvement target.

Further details of financial performance are included in this report. A more detailed reporting pack is provided to directors, senior managers and regulators and this is closely monitored through the Finance & Investment Committee, a subcommittee of the Board.

Risks associated with delivery of the control total are now considered to be low.

SECAmb Issues and Points of Note

As stated above, reporting content, format and detail will be discussed and finalised through a working group. It remains the intention to report under the domains of safe, caring, effective, responsive and well led (in Workforce, Finance and Efficiency)

Contents

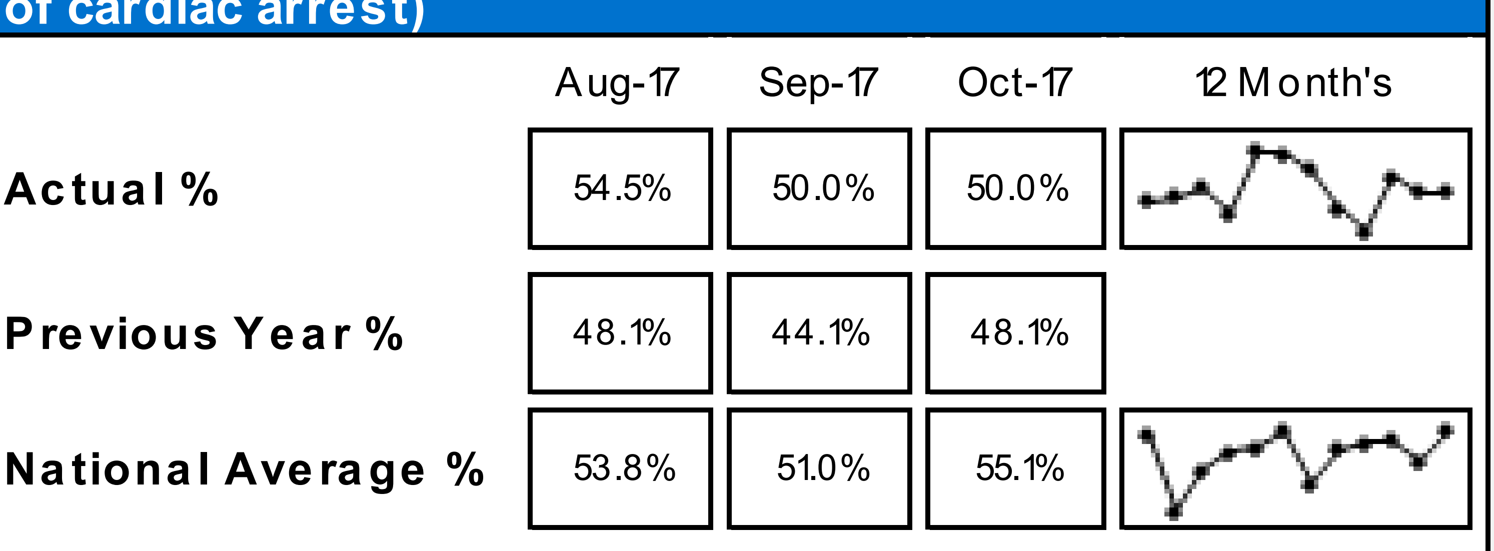
Clinical Safety	4
Clinical Quality	9
Operations Performance	12
Workforce	16
Finance	19

Chart Key

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

SECAmb Clinical Safety Scorecard

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



	Aug-17	Sep-17	Oct-17	12 Month's
Actual %	54.5%	50.0%	50.0%	
Previous Year %	48.1%	44.1%	48.1%	
National Average %	53.8%	51.0%	55.1%	

Cardiac ROSC - ALL

	Aug-17	Sep-17	Oct-17	12 Month's
Actual %	25.6%	25.7%	25.2%	
Previous Year %	26.0%	25.3%	27.8%	
National Average %	30.8%	32.0%	30.2%	

Cardiac Survival - Utstein

	Aug-17	Sep-17	Oct-17	12 Month's
Actual %	40.6%	26.3%	30.8%	
Previous Year %	34.8%	30.0%	15.4%	
National Average %	28.8%	32.8%	28.3%	

Cardiac Survival - All

	Aug-17	Sep-17	Oct-17	12 Month's
Actual %	10.0%	5.7%	10.9%	
Previous Year %	8.9%	9.4%	4.3%	
National Average %	10.0%	10.6%	10.2%	

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

	Aug-17	Sep-17	Oct-17	12 Month's
Actual %	64.4%	71.9%	57.4%	
Previous Year %	72.7%	76.6%	63.1%	
National Average %	73.8%	76.9%	76.4%	

Acute STEMI receiving primary angioplasty within 150 minutes

	Aug-17	Sep-17	Oct-17	12 Month's
Actual %	86.5%	79.5%	87.4%	
Previous Year %	89.9%	86.7%	96.9%	
National Average %	86.7%	83.6%	84.3%	

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

	Aug-17	Sep-17	Oct-17	12 Month's
Actual %	57.5%	48.0%	53.6%	
Previous Year %	66.8%	62.6%	62.6%	
National Average %	54.0%	50.0%	49.3%	

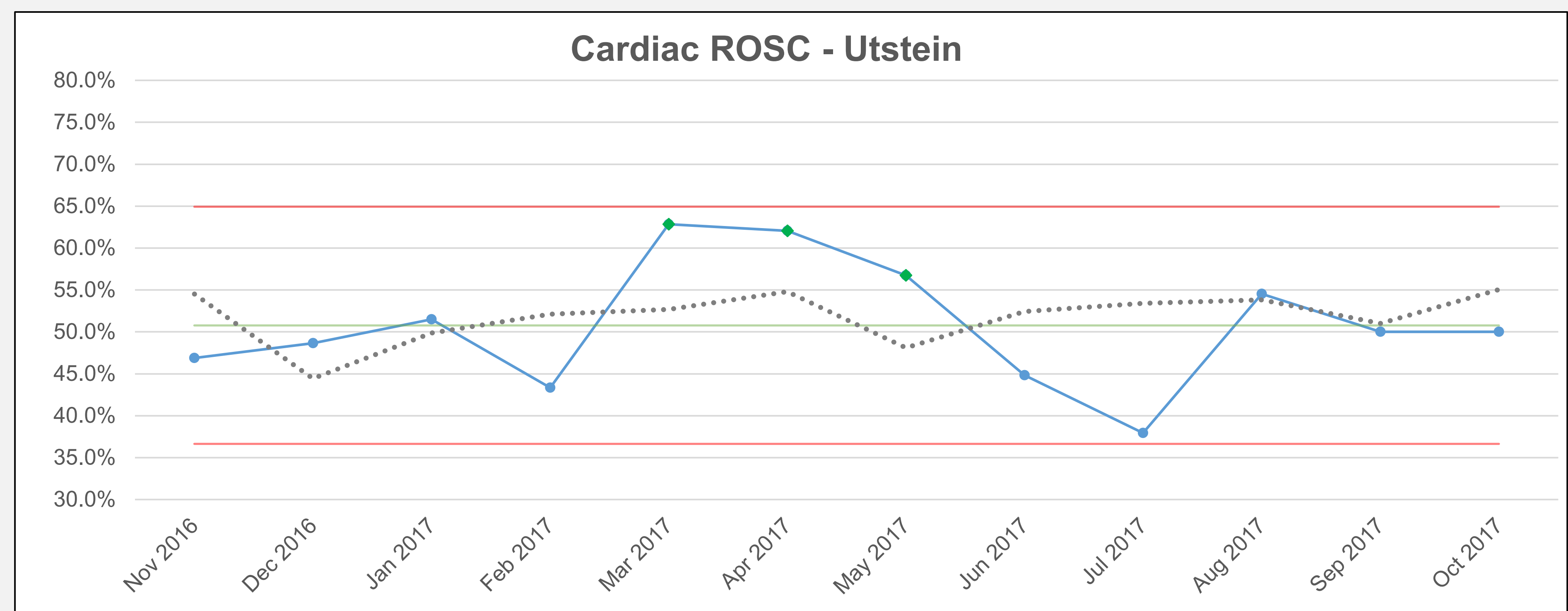
Stroke - assessed F2F receiving care bundle

	Aug-17	Sep-17	Oct-17	12 Month's
Actual %	95.6%	93.1%	93.5%	
Previous Year %	94.2%	95.6%	95.4%	
National Average %	97.5%	96.7%	97.1%	

Medicines Management

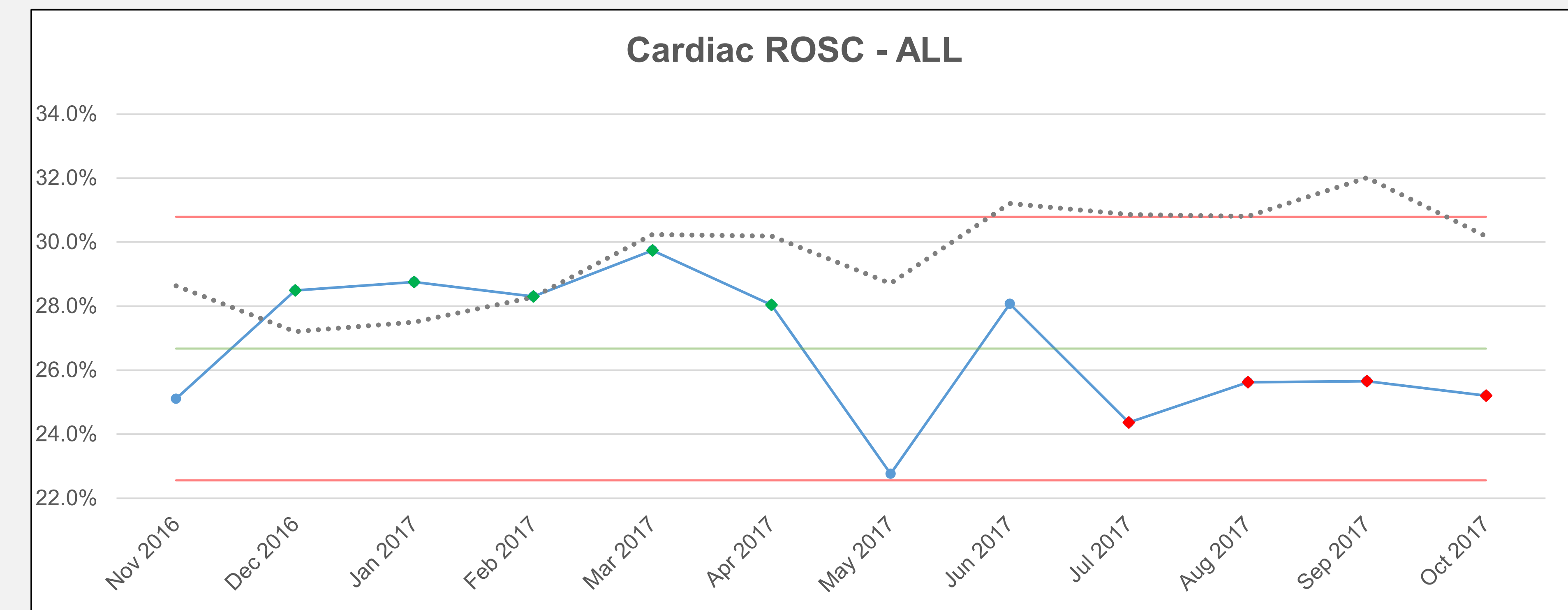
	Dec-17	Jan-18	Feb-18	12 Month's
Actual	96.70%	97.76%	97.57%	
Number of audits	218	201	190	

SECAmb Clinical Safety Charts



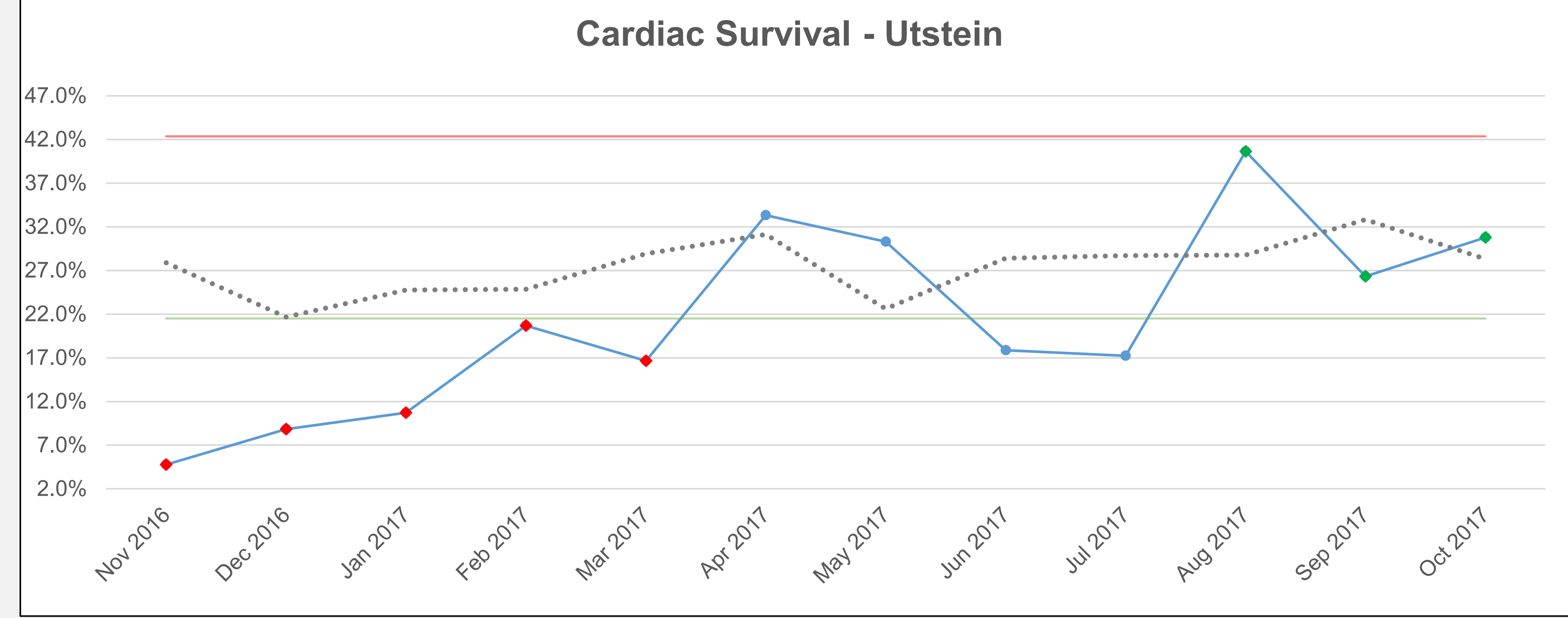
Performance for the cardiac arrest ROSC indicator for the Utstein group for October 2017 is in line with SECAmb YTD and below the national average.

The medical directorate continue to explore potential quality improvement opportunities. Opportunities for improved data collection and analysis for continuous improvement will be explored when the 2018/2019 clinical audit plan is developed.



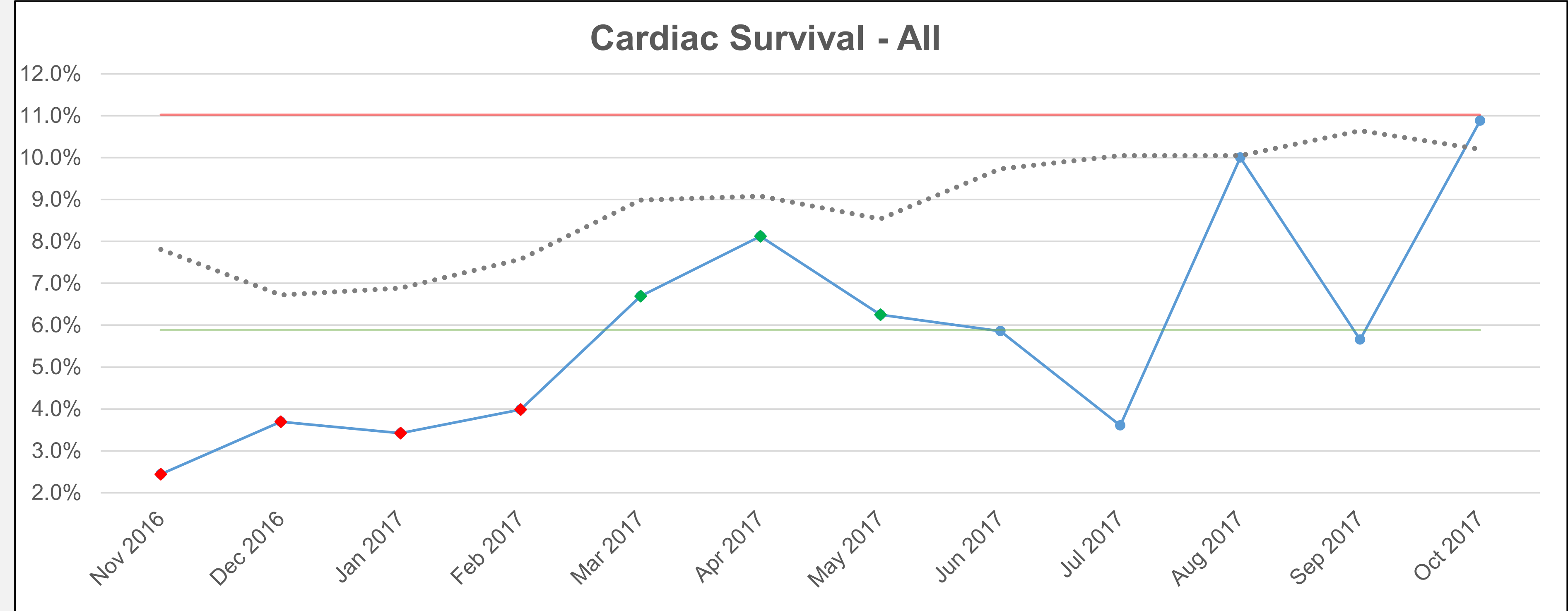
In October 2017 our performance for ROSC in all patient groups remains below the SECAmb YTD average.

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



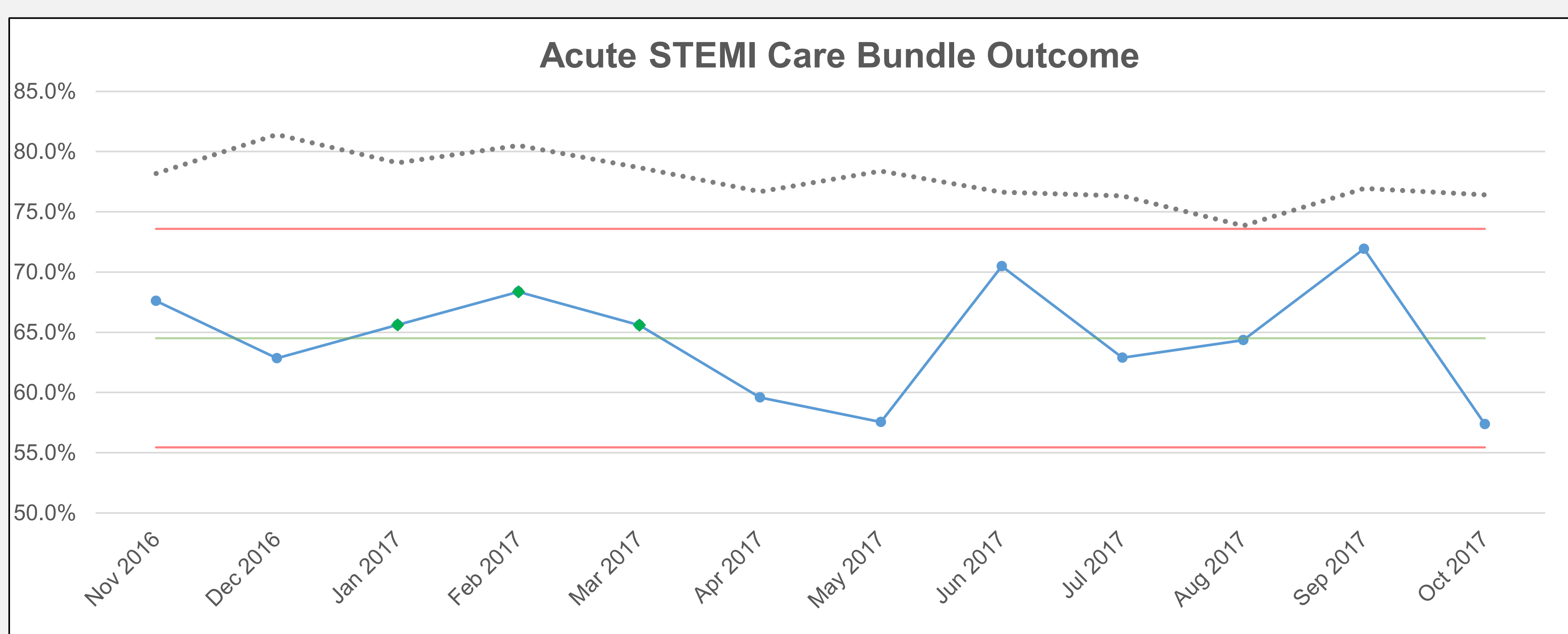
In October 2017, survival to discharge for the Utstein group was above our mean and above the national average. The data continues to show normal patterns of variation.

Our relatively strong performance in this patient group suggests that there are greater opportunities for improvement in patients with an initial rhythm that is non-shockable.



In October 2017, our cardiac survival for all cardiac arrest patients was above our average and above the national average.

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

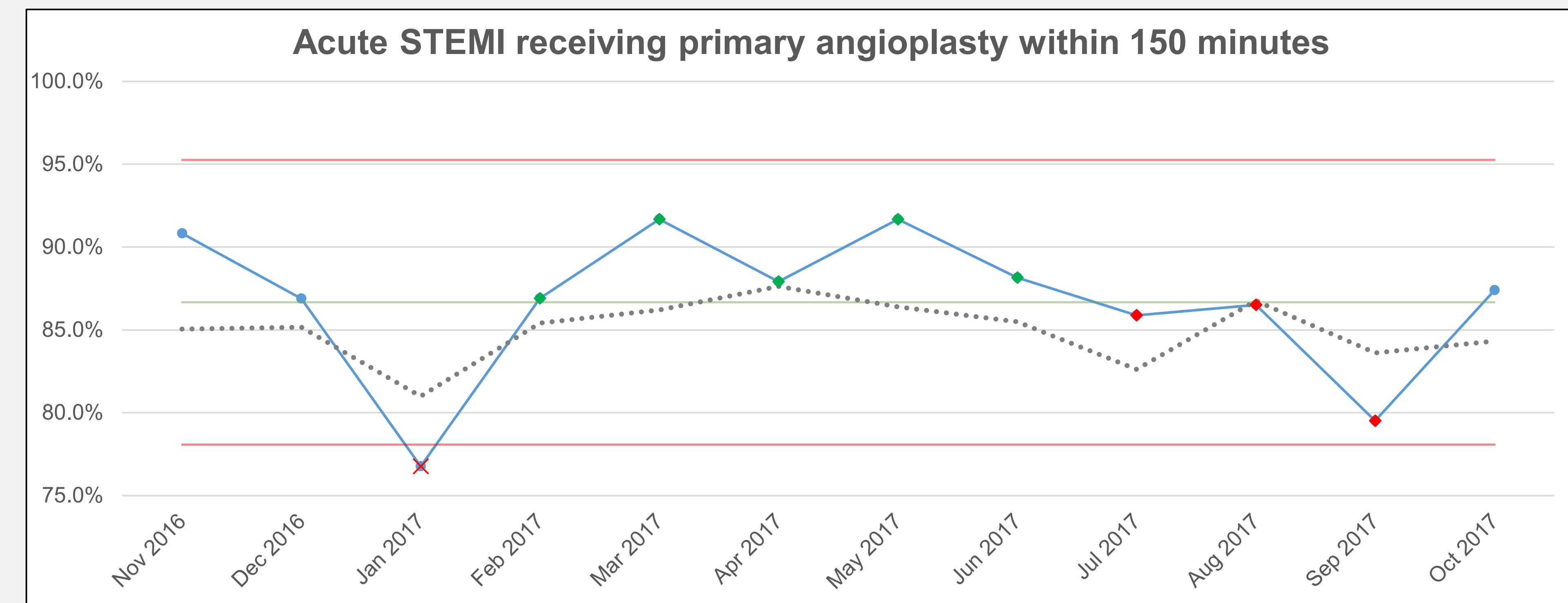


Performance for October 2017 was below our YTD and the national average.

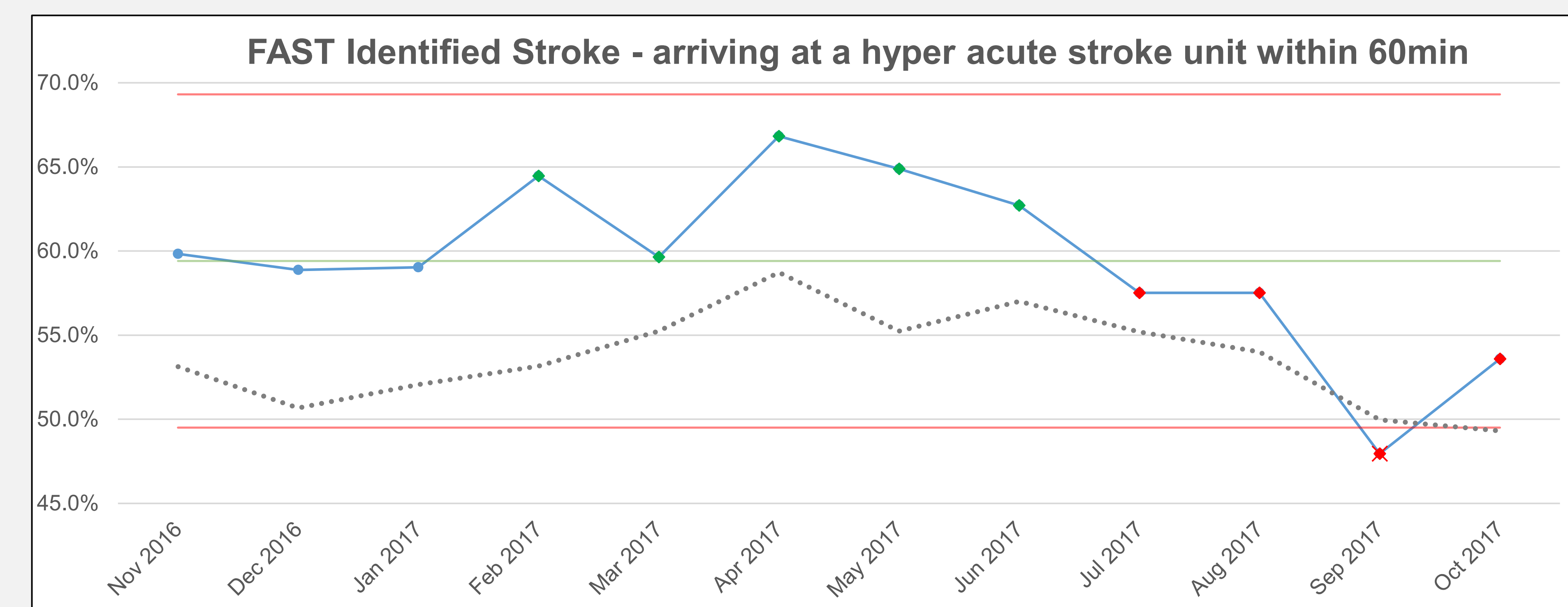
Dashboards and quality scorecards showing local performance levels are now routinely being shared with Operating Units (OUs) to facilitate focussed quality improvement.

It has been identified that morphine and GTN are being withheld by some clinicians when managing inferior STEMI. Clinical Education will arrange for the Head of Clinical Education to meet our higher education partners to discuss possible inconsistencies in messaging.

SECAmb Clinical Safety Charts



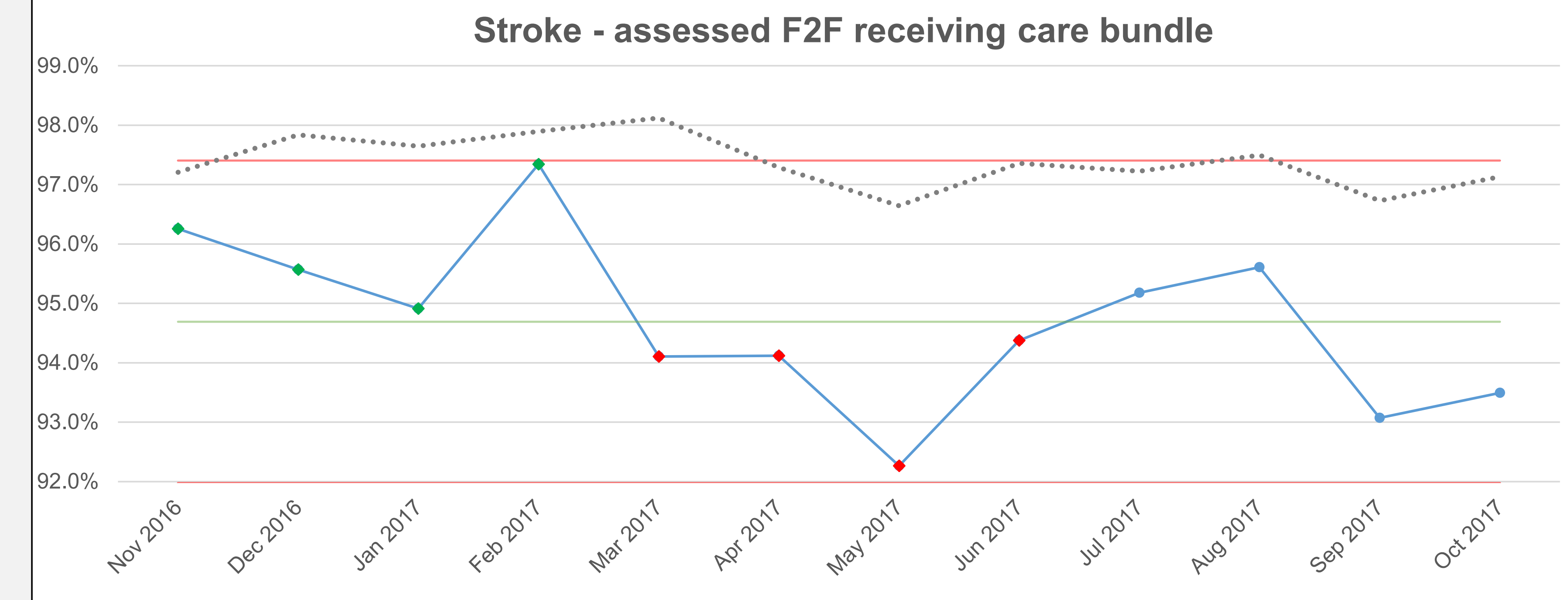
October 2017 saw an increase on the previous month's performance against this indicator. We are once again above the national average and our own average.



October 2017 performance for FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper acute stroke unit (HASU) within 60 minutes was below our mean, but above the national average.

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

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



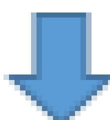
Performance in completing the stroke care bundle is below national and our YTD average.

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

An objective to improve the completion of Stroke and STEMI care bundles has now been added to the Governance, Health Records and Clinical Audit Improvement Action Plan, which will result in an increased focus on these elements of care.

Analysis of Cardiac Arrest Data - October 2017

Number of cardiac arrests identified = 667
including DNACPR 28 / DOA 378 / No Resus by SECAmb 13 / Post Arrest 4 / In hospital arrest 2



Number of resuscitation attempts = 247 (37%)

Utstein definition
Bystander witnessed
Presenting rhythm VF
Cardiac in origin

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

Utstein Data = 40 (16%)

Overall = 242 (98%)

ROSC sustained to hospital = 20 (50%) + 2 Non ROSC

ROSC (incl. Utstein) sustained to hospital 61 = (25%) + 10 Non ROSC

Outcomes for ROSC at Hospital and Non ROSC at Hospital Patients

Utstein	Details	Overall
12	Patient survived to discharge	26
9	Patient died in hospital	42
0	Patient still in hospital*	1
1	Patient record not found by	2
0	No reply from hospital*	0

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

Survival to Discharge = 12 (31%)

Survival to Discharge (incl. Utstein)= 26 (11%)

Additional Information - Resuscitation Attempts

Cardiac Rhythm	Overall Totals	ROSC at Hospital	Non ROSC at Hospital
Asystole	114 (47%)	10	6
PEA	51 (21%)	11	1
VF	64 (26%)	34	2
Non-shockable	3 (1%)	1	0
Not recorded	10 (4%)	5	1

CPR Bystander - 134 (55%)

EMS Witnessed arrest - 39 (16%)

Cardiac Arrest downloads received for Oct-17	0
Cardiac Arrest download reports sent to crews	0

Analysis of Cardiac Arrest Data by area - October 2017

Number of Resuscitation attempts = 241 (1 inc was PAS crew)

Utstein Data East = 16 (7%)	Overall East = 121 (50%)
Utstein Data West = 24 (10%)	Overall West = 120 (50%)

ROSC sustained to Hospital East = 10 (62.5%) + 0 non ROSC	ROSC (incl. Utstein sustained to Hospital East = 33 (27%) + 5 non ROSC
ROSC sustained to Hospital West = 10 (42%) + 2 non ROSC	ROSC (incl. Utstein sustained to Hospital West = 28 (24%) + 5 non ROSC

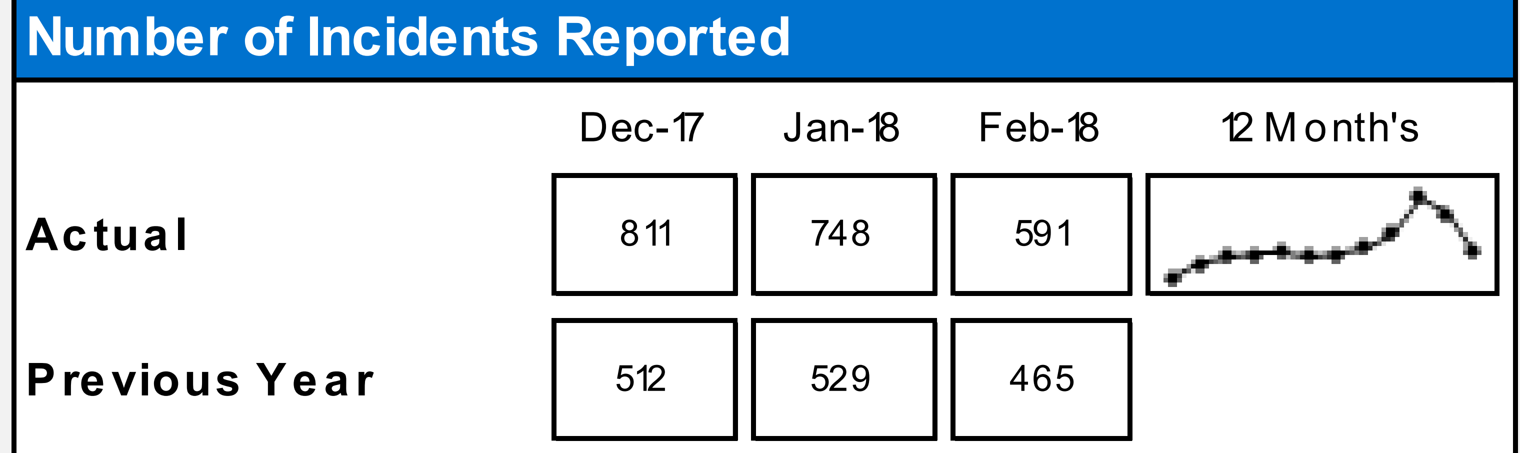
Outcomes for ROSC at Hospital and Non ROSC at Hospital Patients

Area	Utstein	Details	Overall
East	5	Patient survived to discharge	12
West	7		14
East	5	Patient died in hospital	25
West	5		19
East	0	Patient still in hospital*	1
West	0		0
East	1	Patient record not found by hospital*	2
West	0		0
East	0	No reply from hospital*	0
West	0		0

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

Survival to Discharge East = 5 (31%)	Survival to Discharge (Incl. Utstein) East = 12 (10%)
Survival to Discharge West = 7 (29%)	Survival to Discharge (Incl. Utstein) West = 14 (12%)

SECAmb Clinical Quality Scorecard



Number of Incidents Reported

	Dec-17	Jan-18	Feb-18	12 Month's
Actual	811	748	591	
Previous Year	512	529	465	

Number of Incidents Reported that were SI's

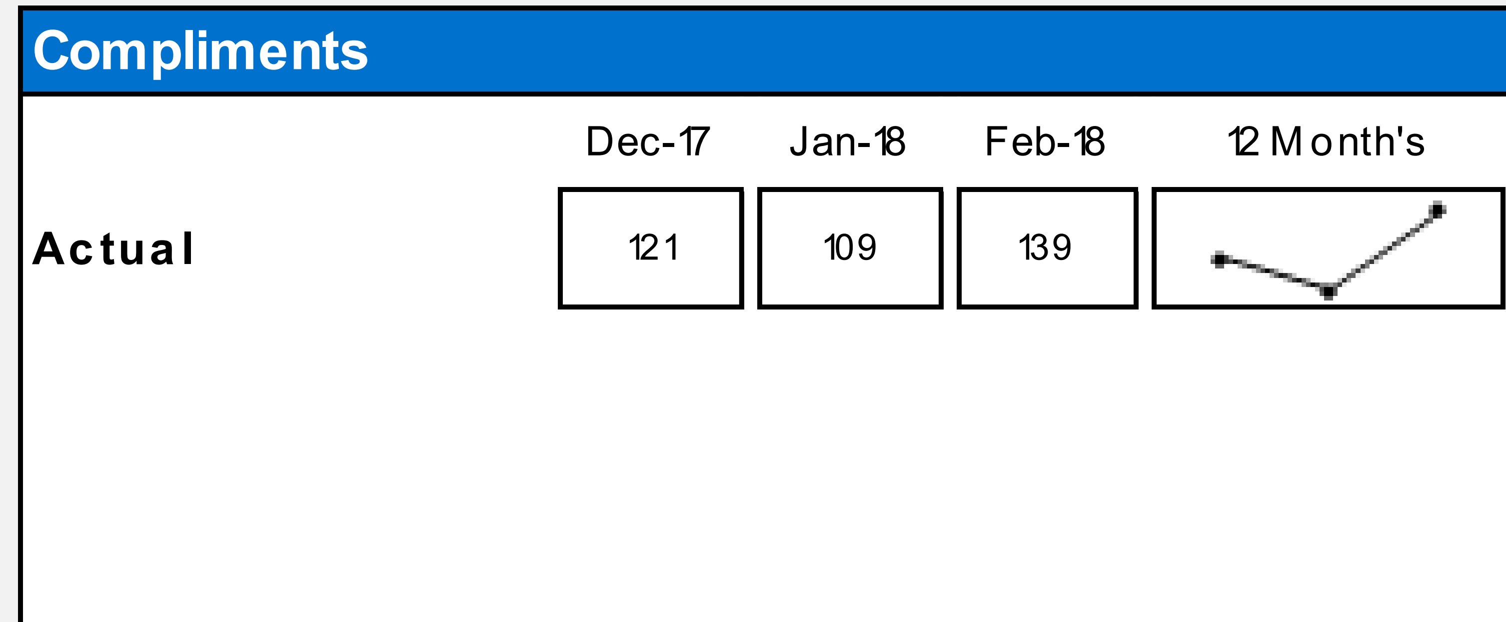
	Dec-17	Jan-18	Feb-18	12 Month's
Actual	7	22	6	
Previous Year	2	1	5	

Duty of Candour Compliance (SIs)

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

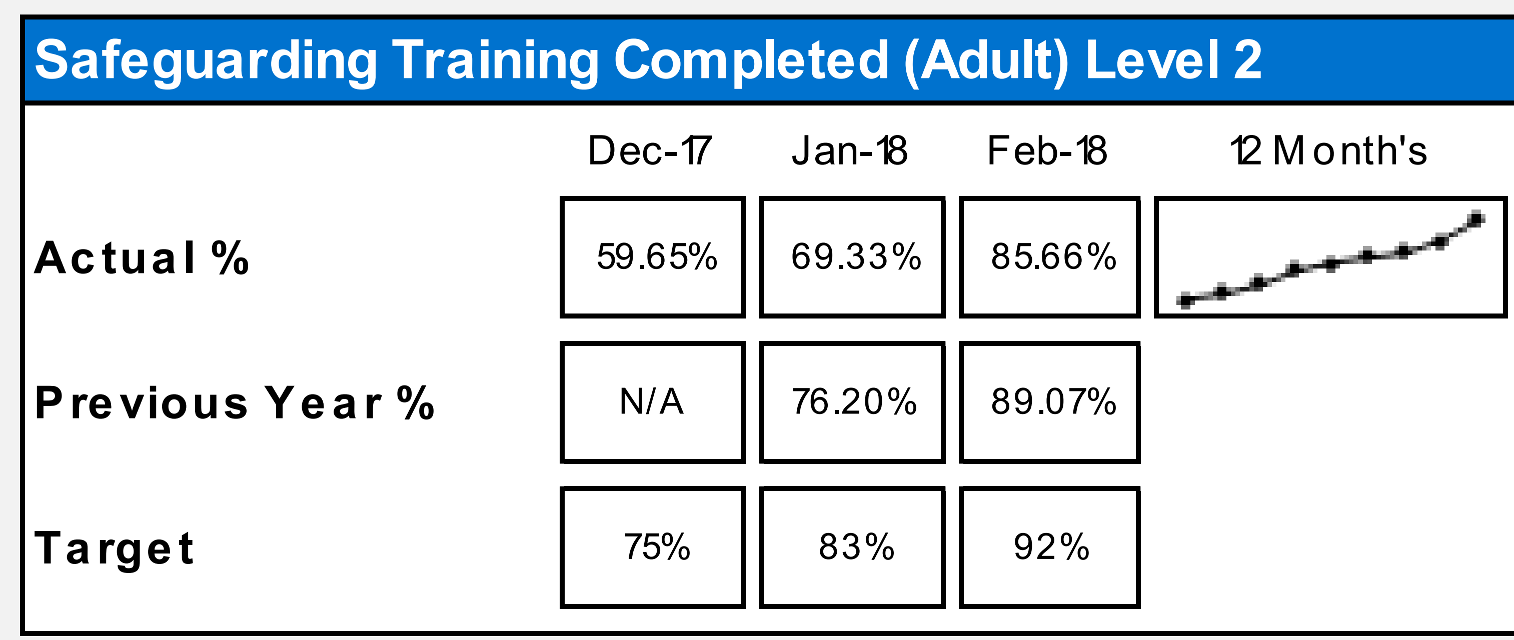
Number of Complaints

	Dec-17	Jan-18	Feb-18	12 Month's
Actual	93	111	127	
Previous Year	114	132	96	
Complaints Timeliness (All	44.0%	59.6%	98.2%	
Timeliness Target	95%	95%	95%	



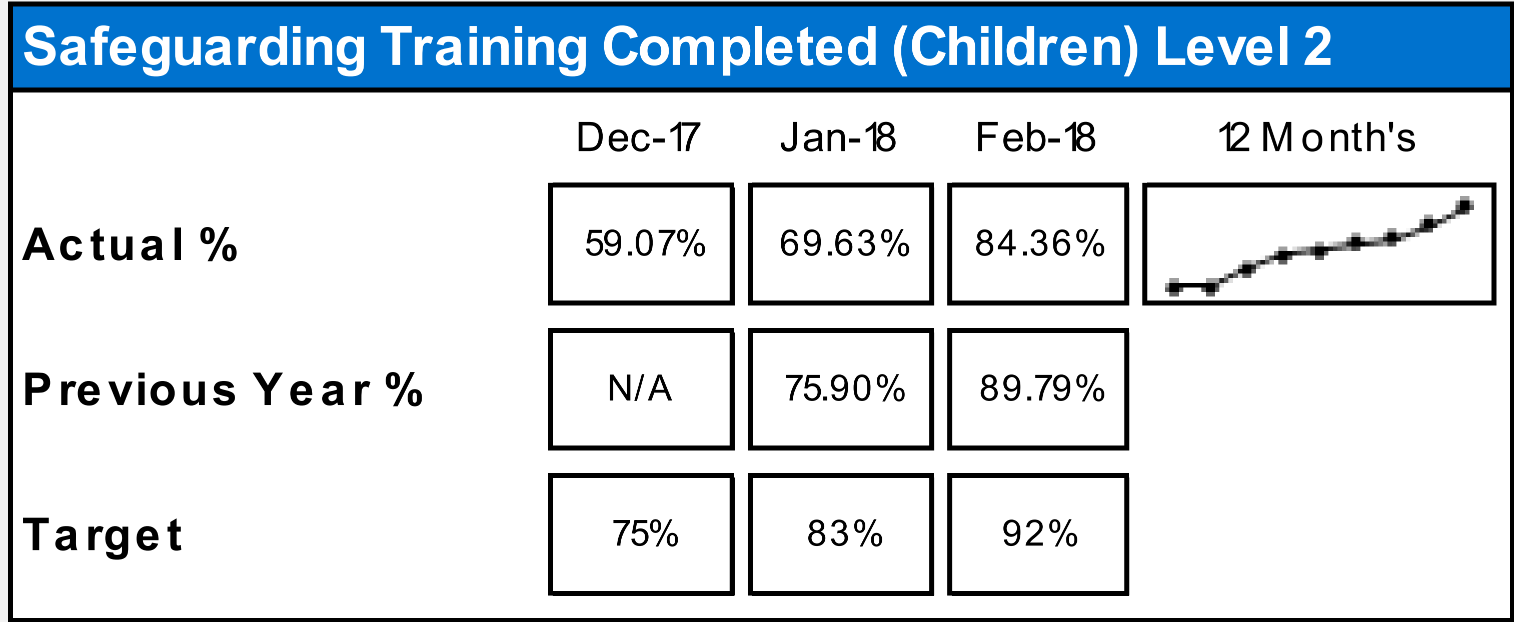
Compliments

	Dec-17	Jan-18	Feb-18	12 Month's
Actual	121	109	139	



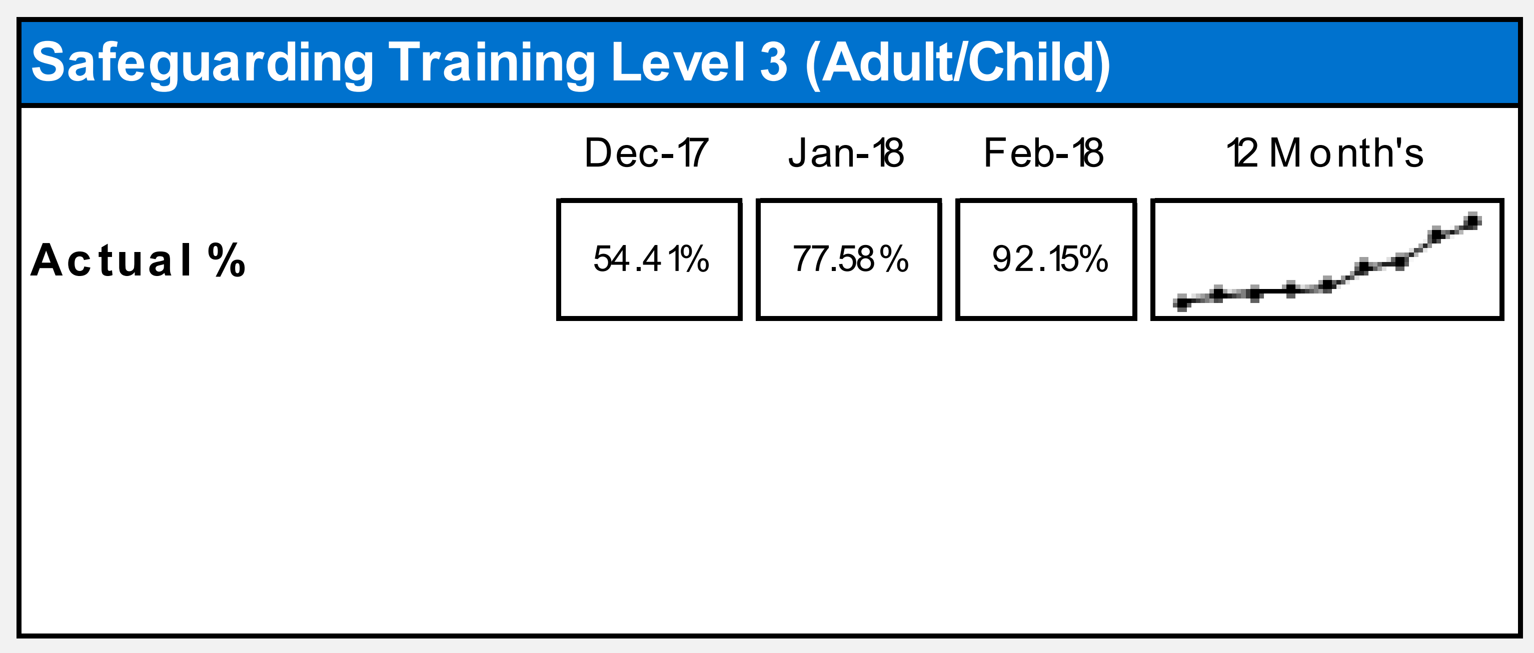
Safeguarding Training Completed (Adult) Level 2

	Dec-17	Jan-18	Feb-18	12 Month's
Actual %	59.65%	69.33%	85.66%	
Previous Year %	N/A	76.20%	89.07%	
Target	75%	83%	92%	



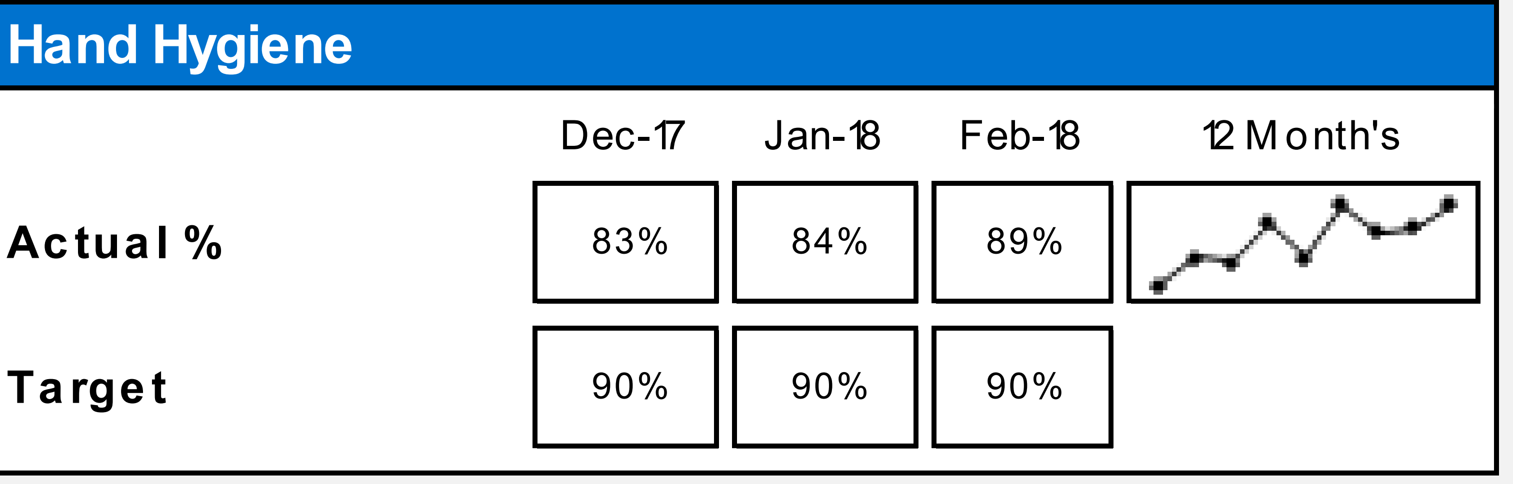
Safeguarding Training Completed (Children) Level 2

	Dec-17	Jan-18	Feb-18	12 Month's
Actual %	59.07%	69.63%	84.36%	
Previous Year %	N/A	75.90%	89.79%	
Target	75%	83%	92%	



Safeguarding Training Level 3 (Adult/Child)

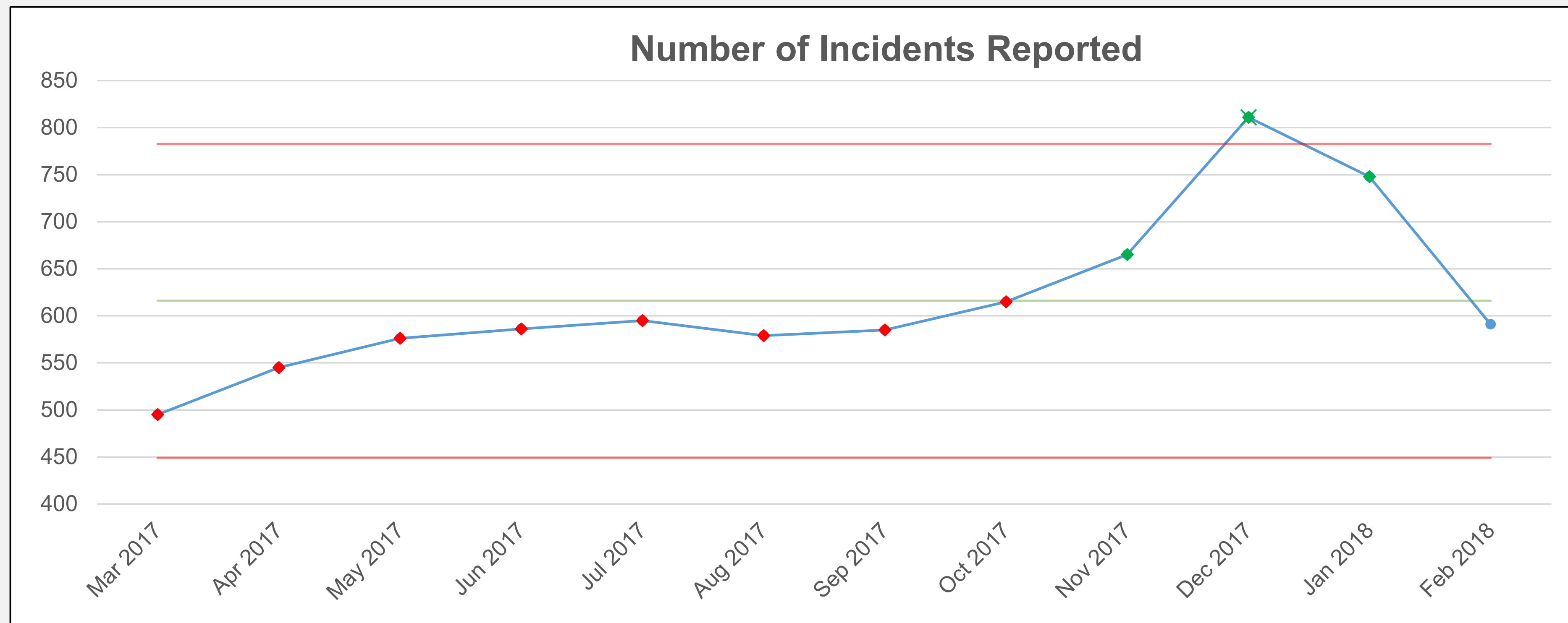
	Dec-17	Jan-18	Feb-18	12 Month's
Actual %	54.41%	77.58%	92.15%	



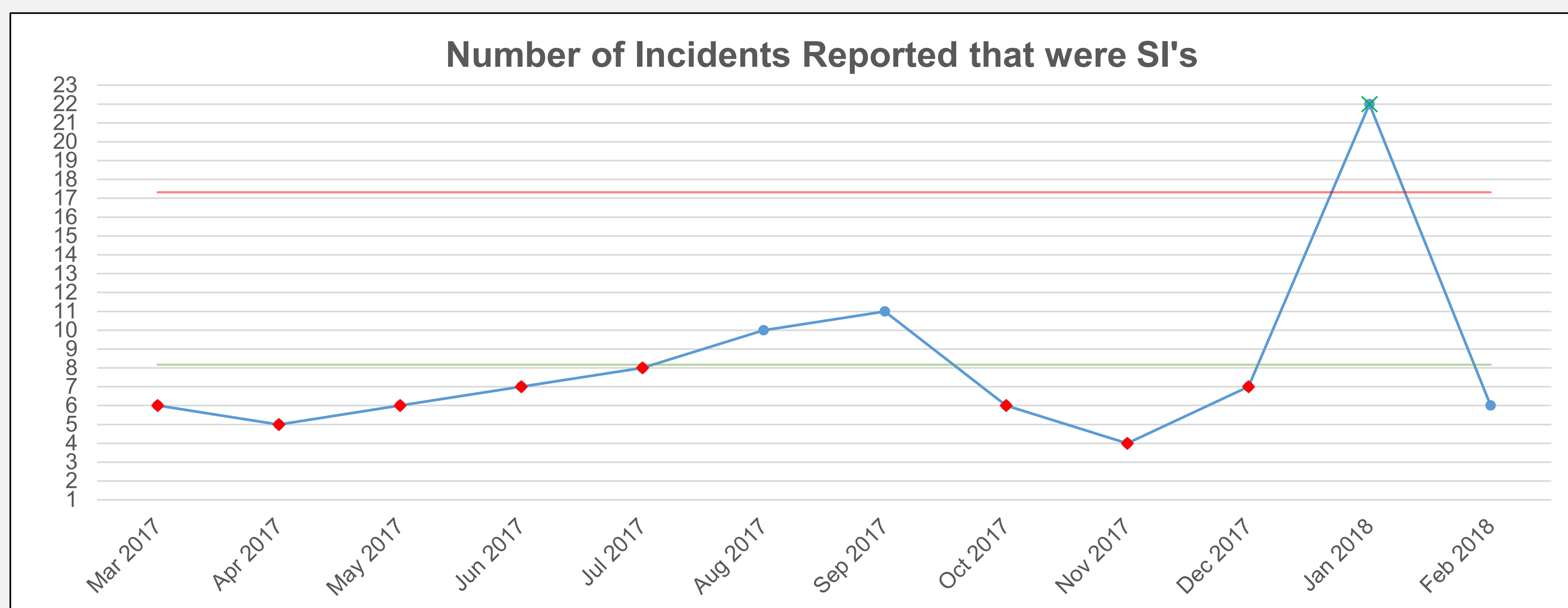
Hand Hygiene

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

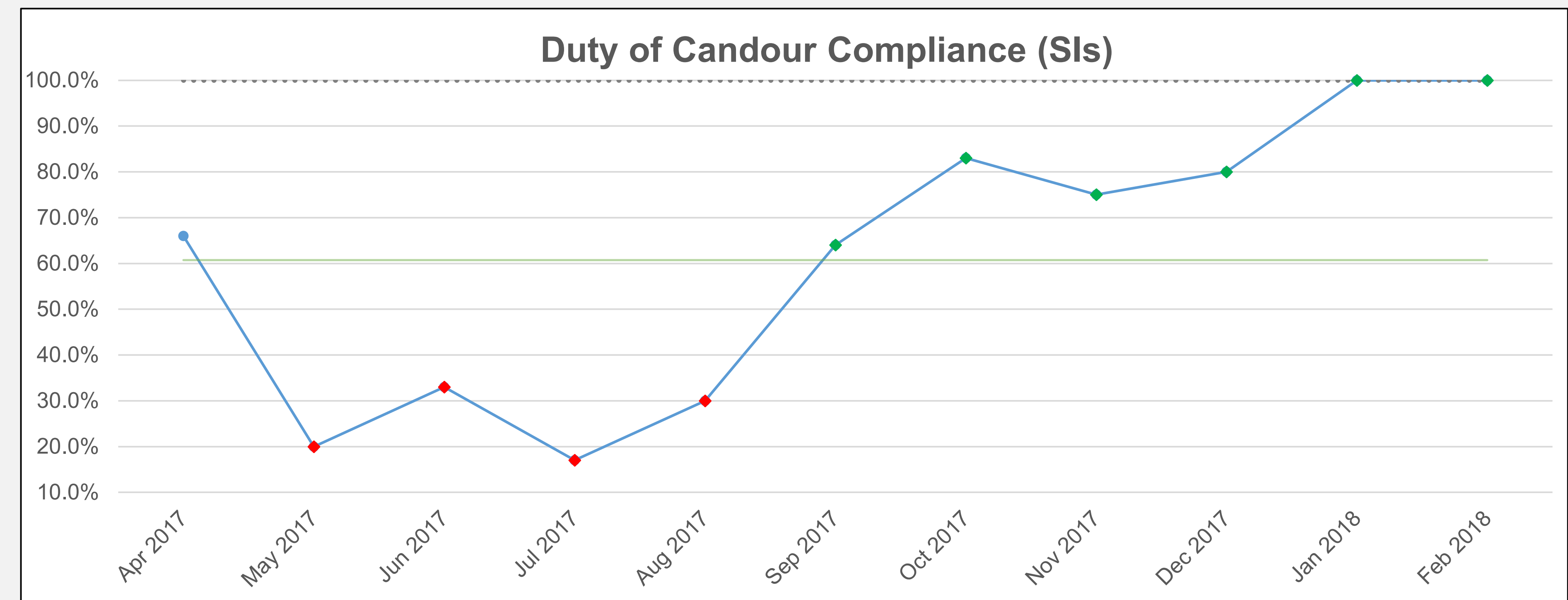
SECAmb Clinical Quality Charts



Incident reporting rates have dropped this month. February is a shorter month and there was a peak in reporting for incidents over the Christmas and New Year period. During the next quarter we aim to further increase incident reporting across the trust by including complaints that are incidents and Community First Responders being able to report directly via the Datix system. We will also be including RTC's to be reported directly onto the Datix system rather than via a road traffic accident report form which is submitted to fleet. We anticipate a steady rise over the next few months again.

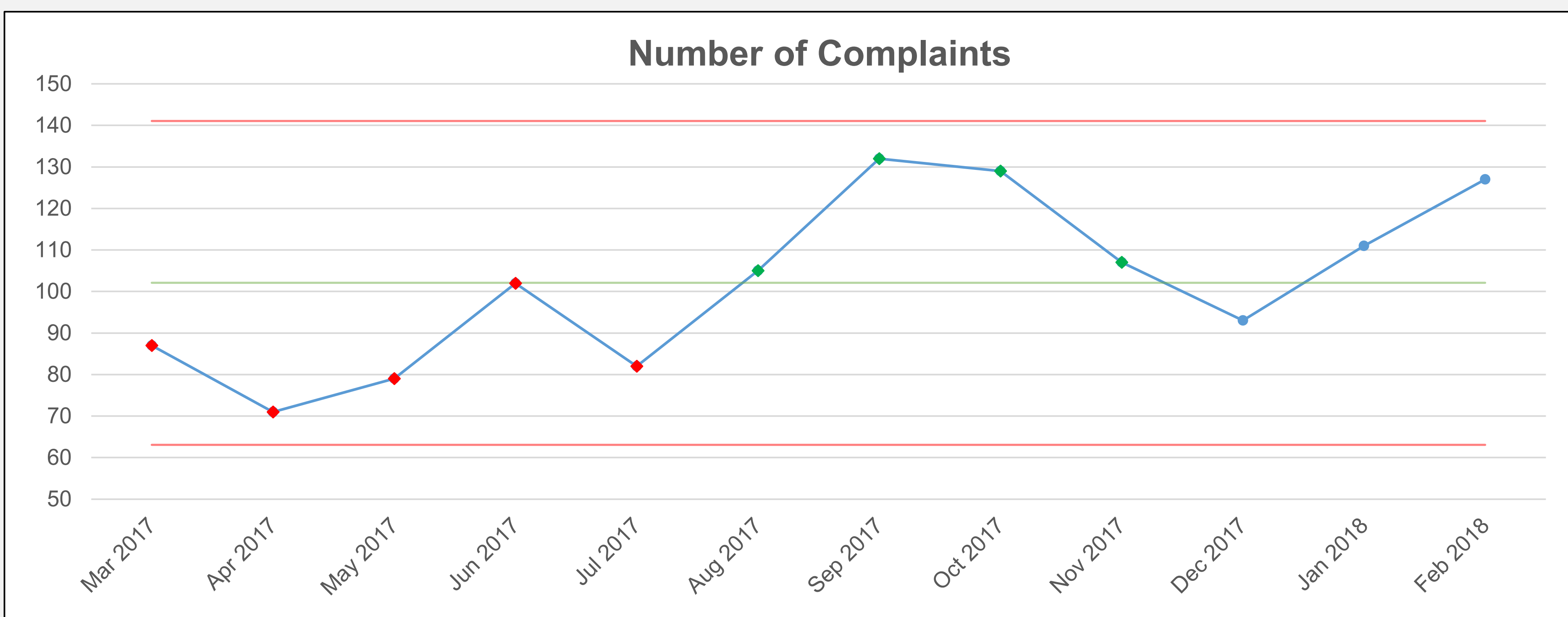


A significant decrease in the numbers reported this month following a large increase in January.
6 SIs were reported for the following reasons:
Call Answer delay – 1
Patient Care – 1
RTC – 1
Patient Injury – 1
Triage – 1
Safeguarding – 1
Service Areas reporting were:
A&E Ops – 3
EOC – 1
Trustwide – 1
KMSS111 -1



Reporting on this indicator has changed to reflect the due date during the month to meet DoC (previously reported on the SIs reported during the month).

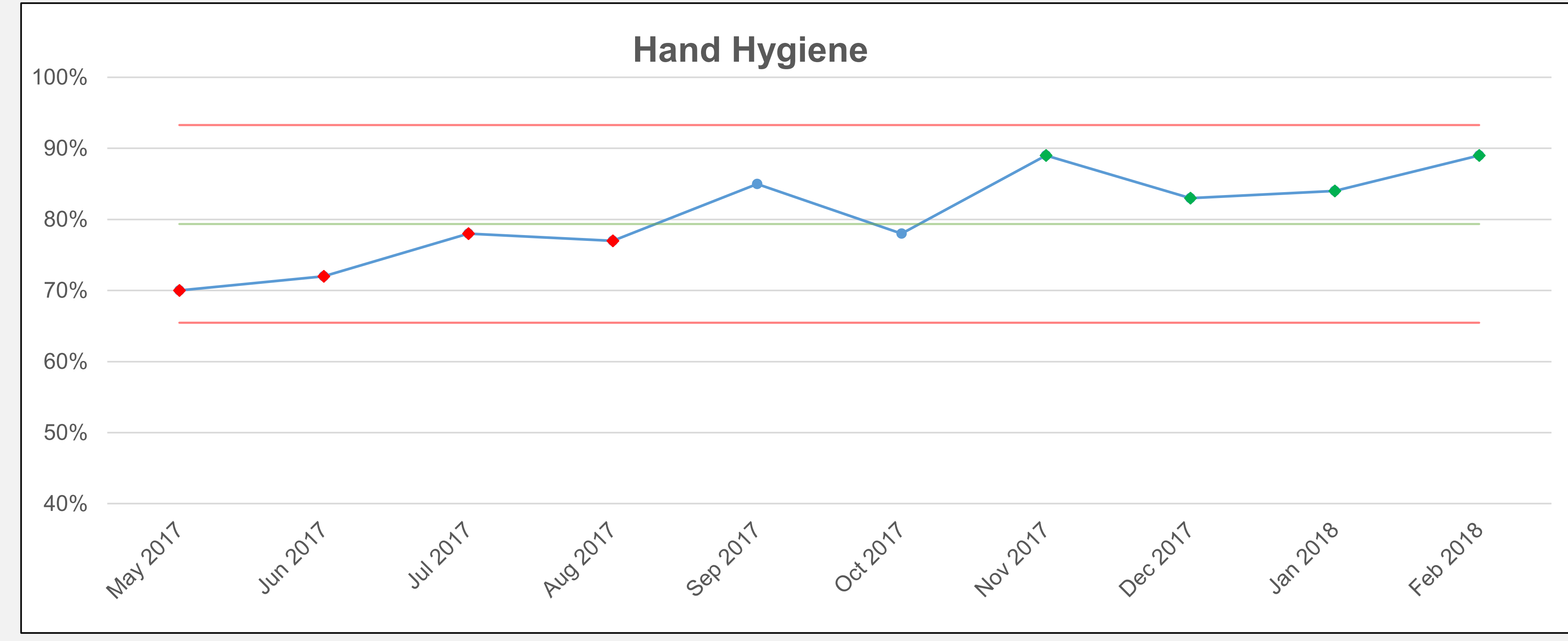
100% of timeframes for those SIs requiring Duty of Candour were met this month.



The number of complaints received in February was 127; a significant increase on the 111 received in January, and the highest number since September and October, when 127 were recorded in both months. Thirty-one percent of complaints received (n=42) were about timeliness of response, compared to 32% (n=36) in January, and the highest number received since September 2017.

Twenty-one per cent of complaints were about call triage (n=28; 11 NHS111 and 17 EOC); 19% about staff behaviours; and 15% about patient care.

In February, 98.16% of complaints were responded to within timescale (107/109), compared to 59.4% in January.



We have seen a 5% improvement in the Trusts overall Hand Hygiene compliance for February and we are just 1% away from the 90% compliance target. However, some Operating Units are still not maintaining the requirement of ten audits per week. They were – Ashford, Brighton, Chertsey, Guildford, Paddock Wood and North Kent. The IPC Team have asked the IPC Champions in each area to liaise with the OTL's in the OU to rectify this for March.
We have now separated the two HART teams from the OU reports and asked that they carry out five audits per week, which they both achieved in February. HART Ashford were 71% compliant and HART Gatwick achieved 96% compliance.

SECAmb Health and Safety Reporting

Health and Safety (H&S)

Introduction

The Head of H&S advert has closed and interviews are scheduled for March 2018. The external review of our H&S provision continues with a number of location based visits and interviews having taken place.
As the area H&S meetings begin in March the central H&S working group will focus on the issues that are on the corporate risk register.
The review of risk assessments and policies continues with a new fire safety policy now agreed and the moving and handling and bariatric policies due to be presented to the JPF this month.
A revised Leadership patient and staff safety walk round proposal with further clarity and a proposed schedule will return to the Board this month.
The first IOSH for leading safely for directors course took place in February with six Non Executive Directors and two Executive directors in attendance.
As a result of the increased interest generated by the IOSH course the first quarterly H&S report will go to the Board this month.
Following the visit from the health and safety executive (HSE) a formal response was sent by Daren Mochrie highlighting the areas that we will be working on as a result.

Violence and Aggression Incidents - See Figure 1 below

The number of reported incidents of violence and aggression toward our people continues to show a slow downward trend.
These incidents range from verbal abuse to actual physical assault. The lone worker policy is in draft written by the operations team with input from the quality improvement hub. A report has been produced by our security lead to understand how we benchmark against other ambulance trusts and to explain actions in place and to be developed to further mitigate the risk and reduce occurrences. The Health and Safety executive suggested that we should look to our local mental health colleagues for advice on managing this risk as experts in the field.

Manual handling Incidents - See Figure 2 below

Manual handling incidents remain high especially given that February is a short month. The visit from the HSE in February focused on this area as it is a national problem for ambulance services which given the nature of the work is not surprising. There are other Trusts that have made improvements in certain areas such as care homes with no-lift policies which we can learn from. We also need to look at how we safeguard our community first responders. Access to Datix is the first step and is being facilitated by the CFR leads. 9 clinical education staff have level 3 training in manual handling and will be used to ensure that OTLs delivering key skills are suitably informed of best practice.

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

There has not been capacity due to sickness in the H&S team to further interrogate this data and begin to understand the reasons for the variation.

H&S incidents - See Figure 3 below

An upward trend continues to be seen in the reporting of H&S incidents which is in line with the Trust's intention to increase the number of low/no harm incident reports. The area H&S meetings and the plan to carry out H&S training for all OTLs will increase awareness of the need to record all issues on Datix and should further drive up reporting rates. IOSH training for Board members this month has increased awareness and it is hoped that a program of patient and staff leadership walk rounds will be agreed to further emphasise the importance of safety in the workplace at all levels of the Trust

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

While RIDDOR reports continue to fall, they are small numbers. We still do not regularly meet our target to report these within 15 days. It is believed that the training for OTLs, the changes to the moving and handling policy once published and communicated and a letter from the director of operations to all the leadership teams will improve this.

Figure 1

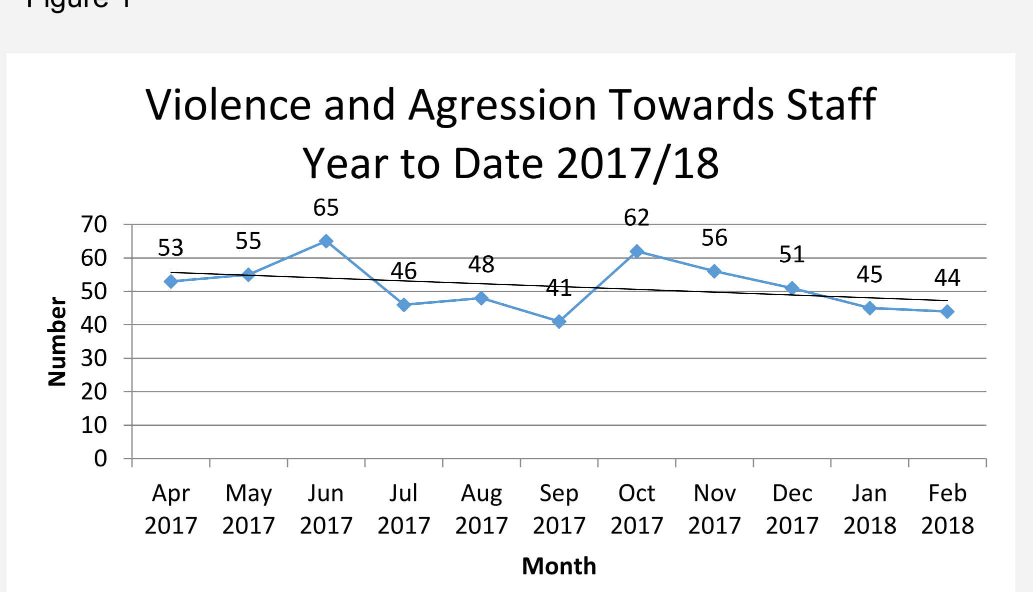


Figure 2

Manual Handling Incidents Year to Date 2107/18

Month	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Number	15	20	23	21	26	22	15	12	27	26	25

Figure 3

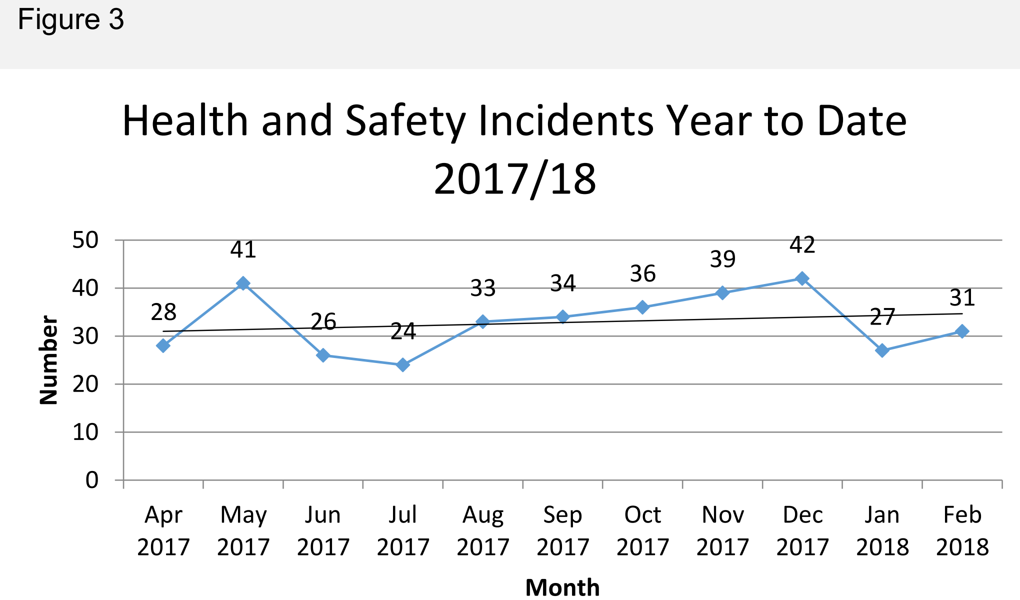


Figure 4

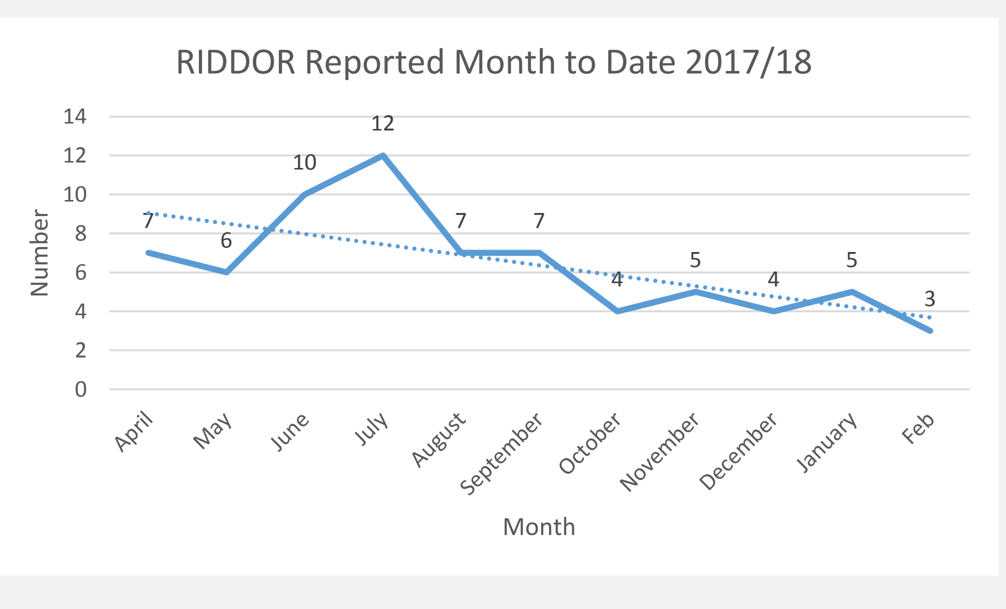
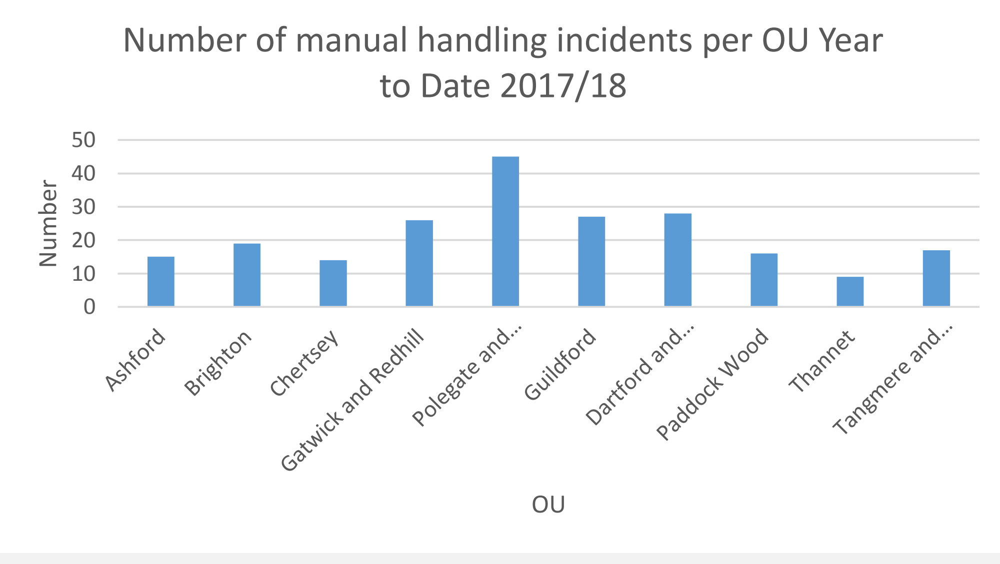
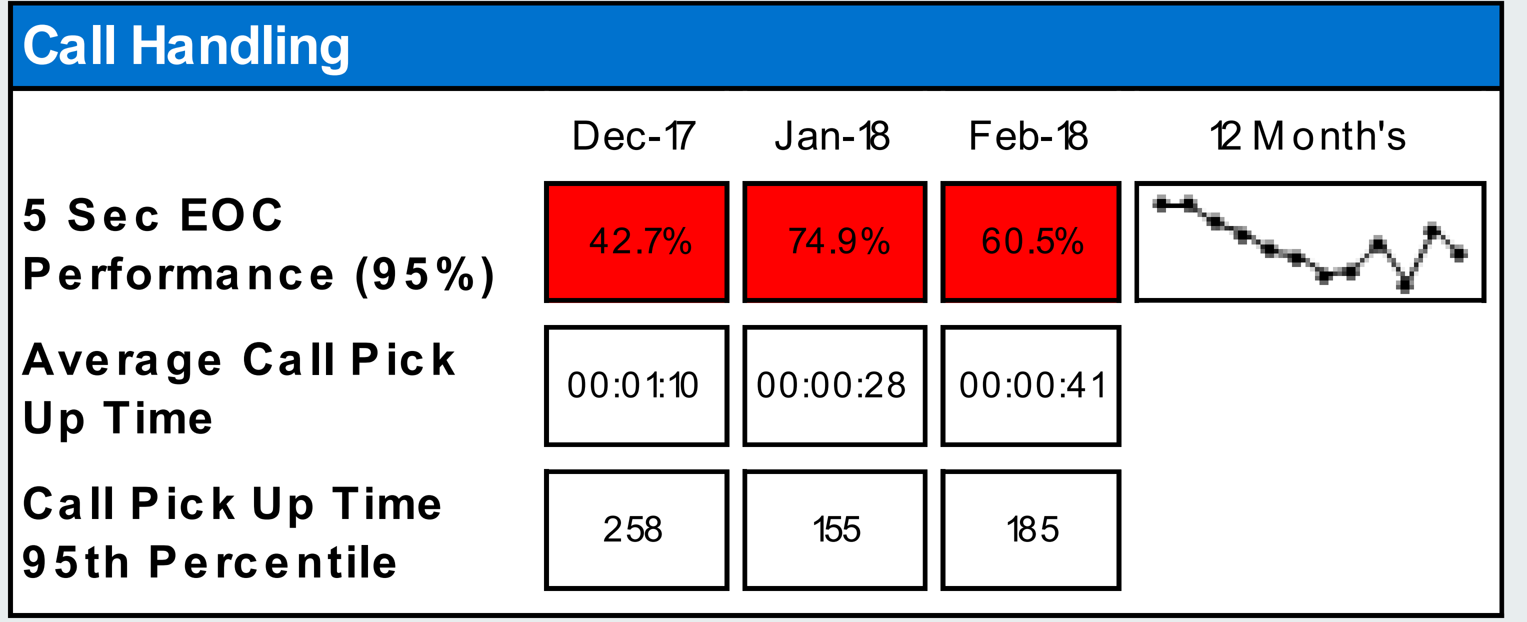


Figure 5

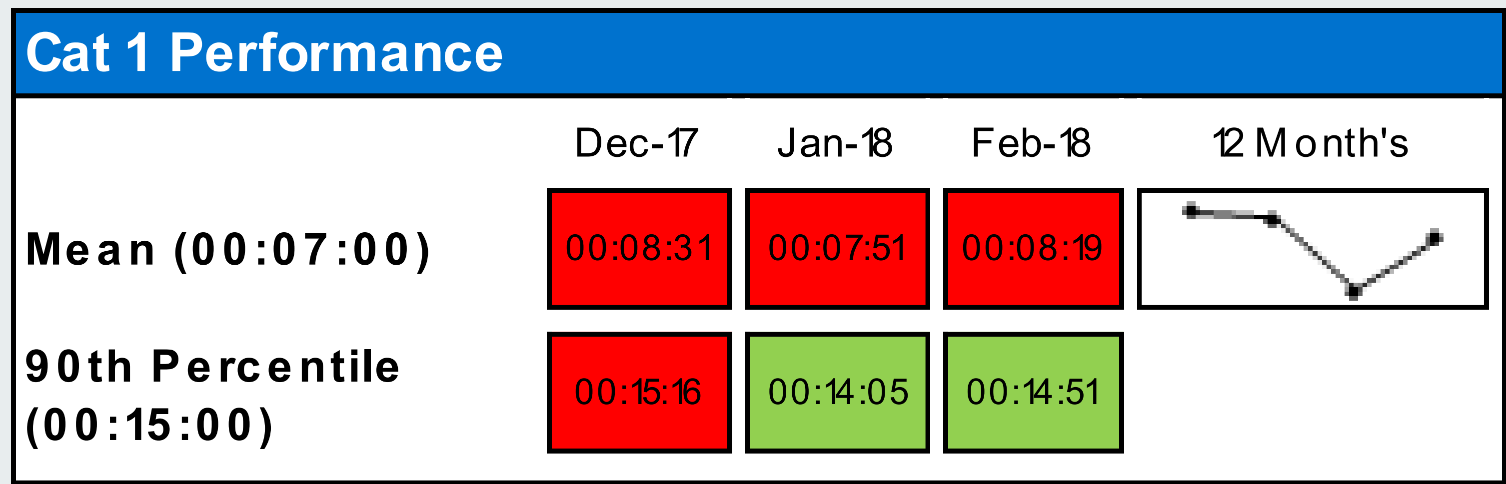


SECAmb 999 Operations Performance Scorecard



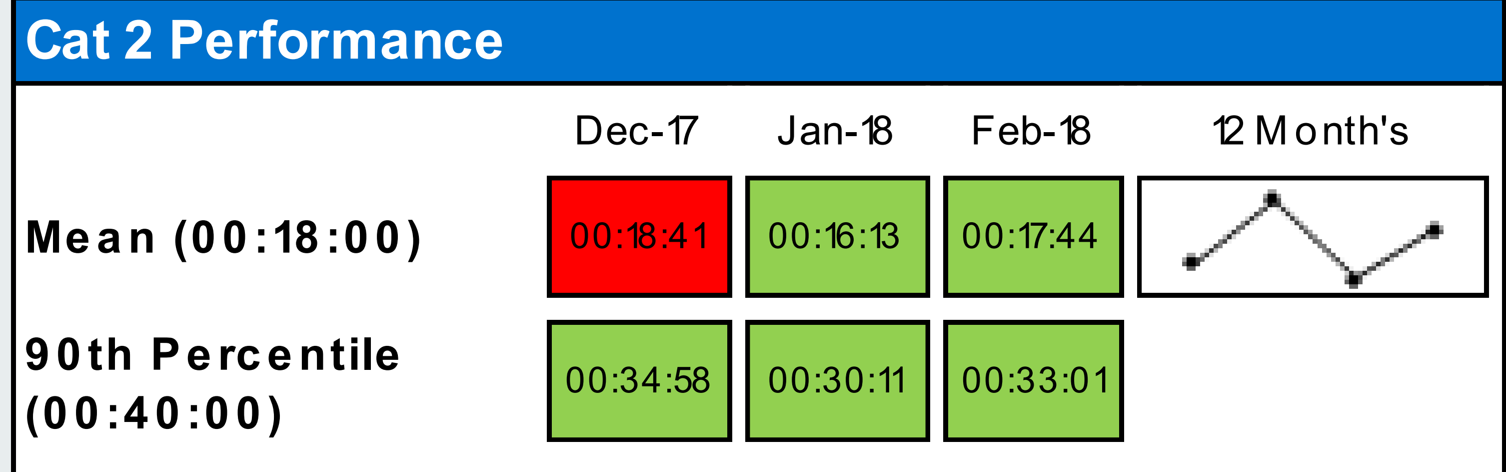
Call Handling

	Dec-17	Jan-18	Feb-18	12 Month's
5 Sec EOC Performance (95%)	42.7%	74.9%	60.5%	
Average Call Pick Up Time	00:01:10	00:00:28	00:00:41	
Call Pick Up Time 95th Percentile	258	155	185	



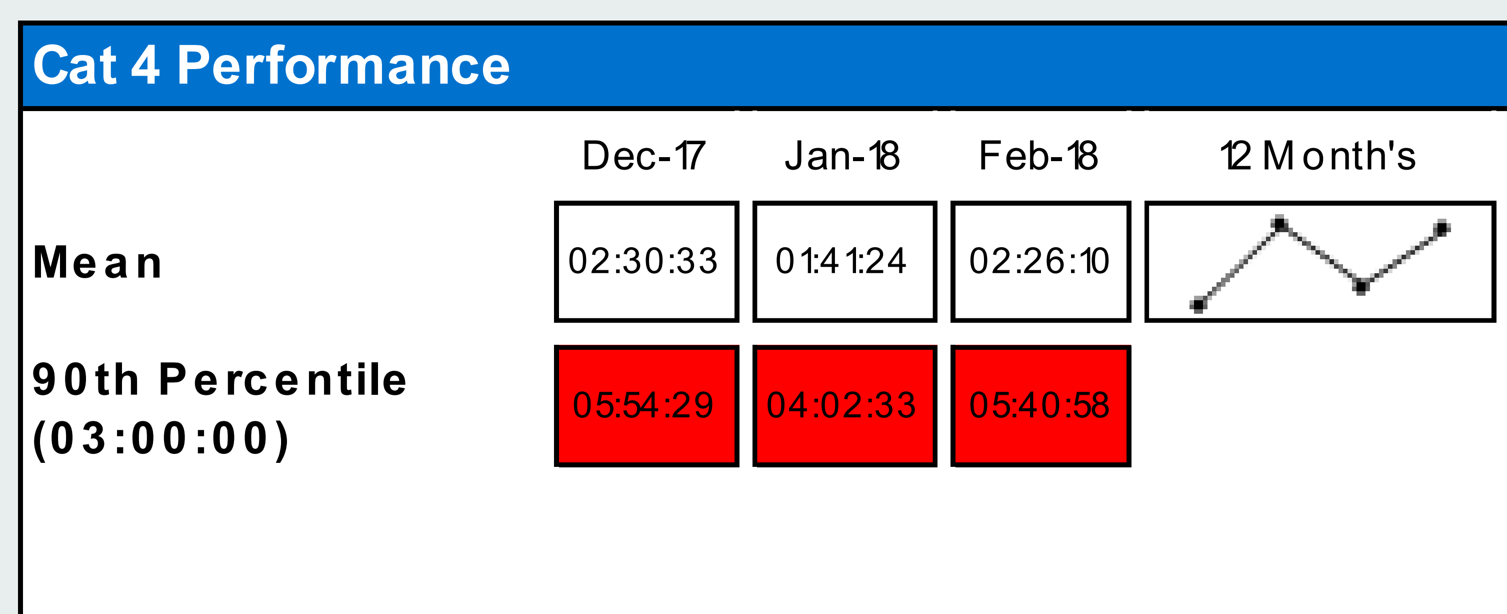
Cat 1 Performance

	Dec-17	Jan-18	Feb-18	12 Month's
Mean (00:07:00)	00:08:31	00:07:51	00:08:19	
90th Percentile (00:15:00)	00:15:16	00:14:05	00:14:51	



Cat 2 Performance

	Dec-17	Jan-18	Feb-18	12 Month's
Mean (00:18:00)	00:18:41	00:16:13	00:17:44	
90th Percentile (00:40:00)	00:34:58	00:30:11	00:33:01	



Cat 4 Performance

	Dec-17	Jan-18	Feb-18	12 Month's
Mean	02:30:33	01:41:24	02:26:10	
90th Percentile (03:00:00)	05:54:29	04:02:33	05:40:58	

Demand/Supply

	Dec-17	Jan-18	Feb-18	12 Month's
Call Volume	98436	86023	80740	
Incidents	63341	59870	52890	
Transports	40027	38351	34069	

Community First Responders

	Dec-17	Jan-18	Feb-18	12 Month's
Volume of incidents Attended	1518	1263	1121	
Cat 1 Attendances	tbc	tbc	tbc	tbc
Hours Provided	16216	19469	15150	

Dispatch

	Dec-17	Jan-18	Feb-18	12 Month's
Average Allocation Time - Cat 1 (Secs)	tbc	tbc	tbc	tbc
Allocation Ratio	tbc	tbc	tbc	tbc
Response Ratio	1.84	1.85	1.83	

Cat 1T Performance

	Dec-17	Jan-18	Feb-18	12 Month's
Mean (00:19:00)	00:11:50	00:10:35	00:11:20	
90th Percentile (00:30:00)	00:21:01	00:18:59	00:20:26	

Cat 3 Performance

	Dec-17	Jan-18	Feb-18	12 Month's
Mean	01:39:34	01:04:04	01:27:53	
90th Percentile (02:00:00)	03:47:52	02:23:34	03:19:44	

HCP

	Dec-17	Jan-18	Feb-18	12 Month's
HCP 60 (75%)	33.5%	45.6%	43.1%	
HCP 120 (75%)	42.4%	56.7%	48.2%	
HCP 240 (75%)	51.7%	73.7%	65.9%	

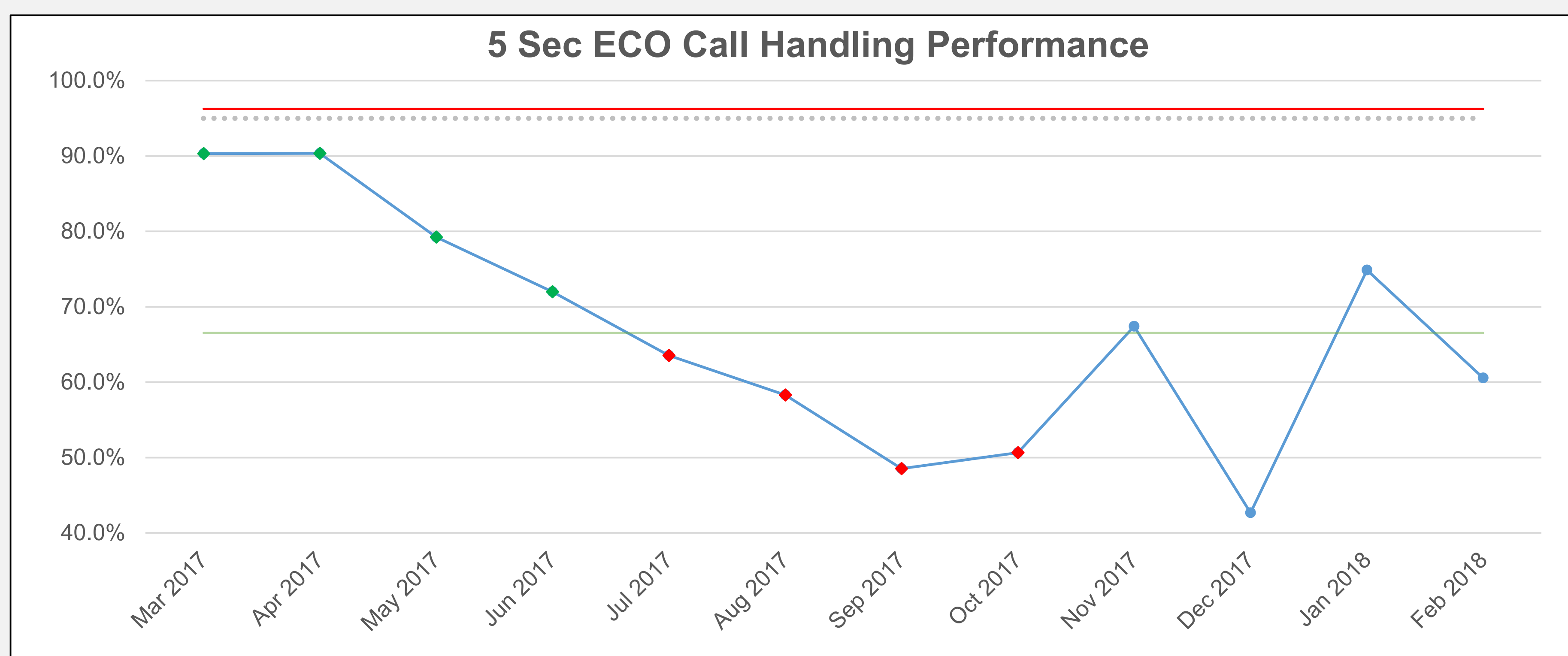
Incident Outcome AQI

	Dec-17	Jan-18	Feb-18	12 Month's
Hear & Treat	4.9%	4.7%	5.2%	
See & Treat	34.3%	34.4%	33.9%	
S&C	60.8%	60.9%	60.9%	

Call Cycle Time

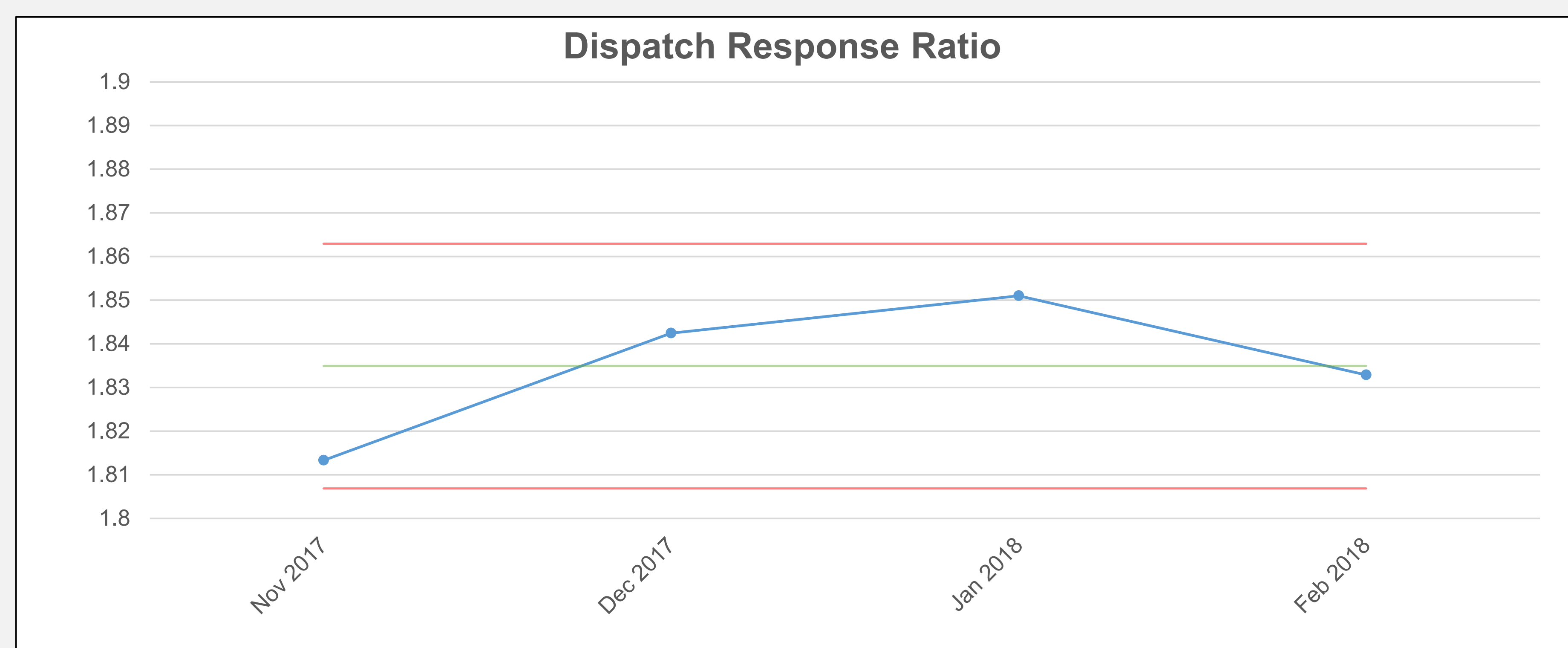
	Dec-17	Jan-18	Feb-18	12 Month's
Clear at Scene (mins)	75.84	75.74	75.30	
Clear at Hospital (mins)	110.3	110.1	109.2	
Handover Hrs Lost at Hospital (over	7636	7093	5697	
Number of Handovers >60mins	1433	1209	875	

SECAmb 999 Operations Performance Charts

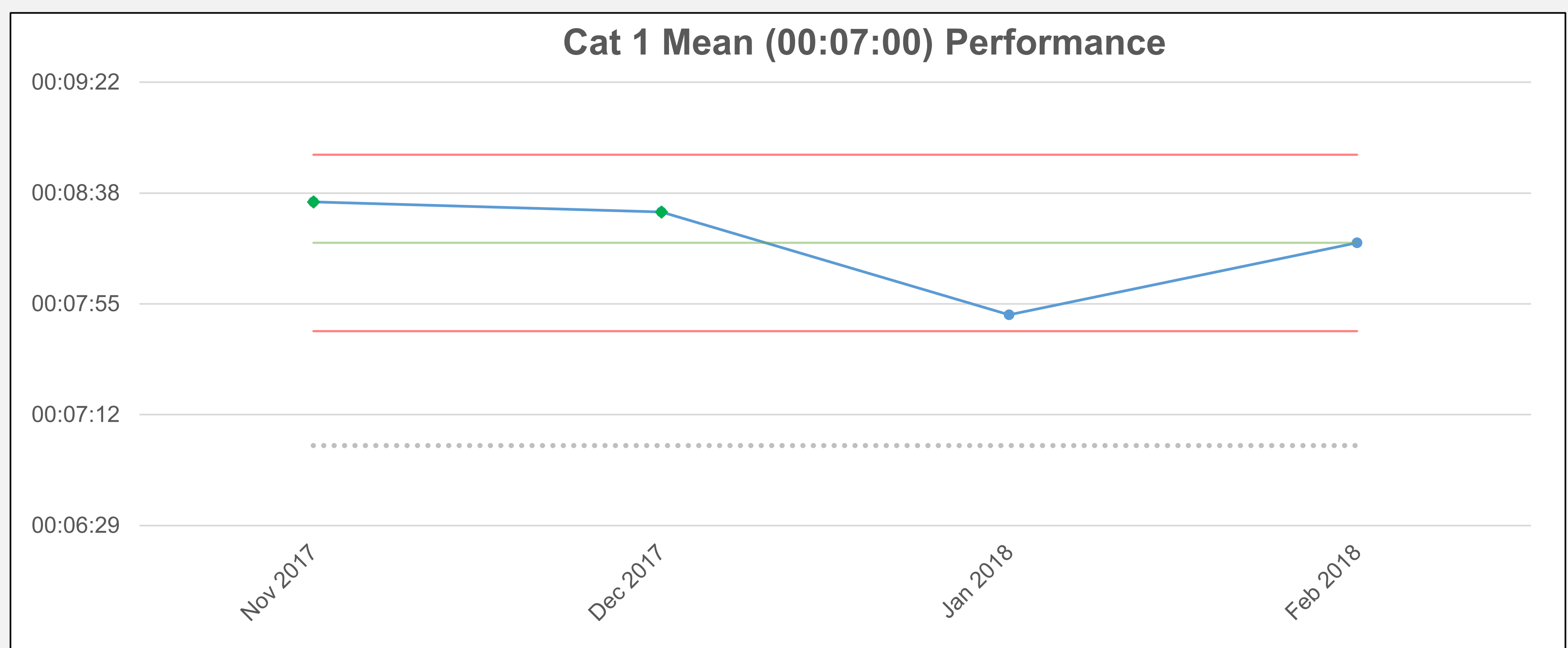


After the improvement in call handling performance recorded in January, performance for February decreased significantly to 60.5%. This is similar to the level in July and August 2017. This drop in call answer performance came despite a decrease in call volume. The average call pick up time has increased compared to last month.

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



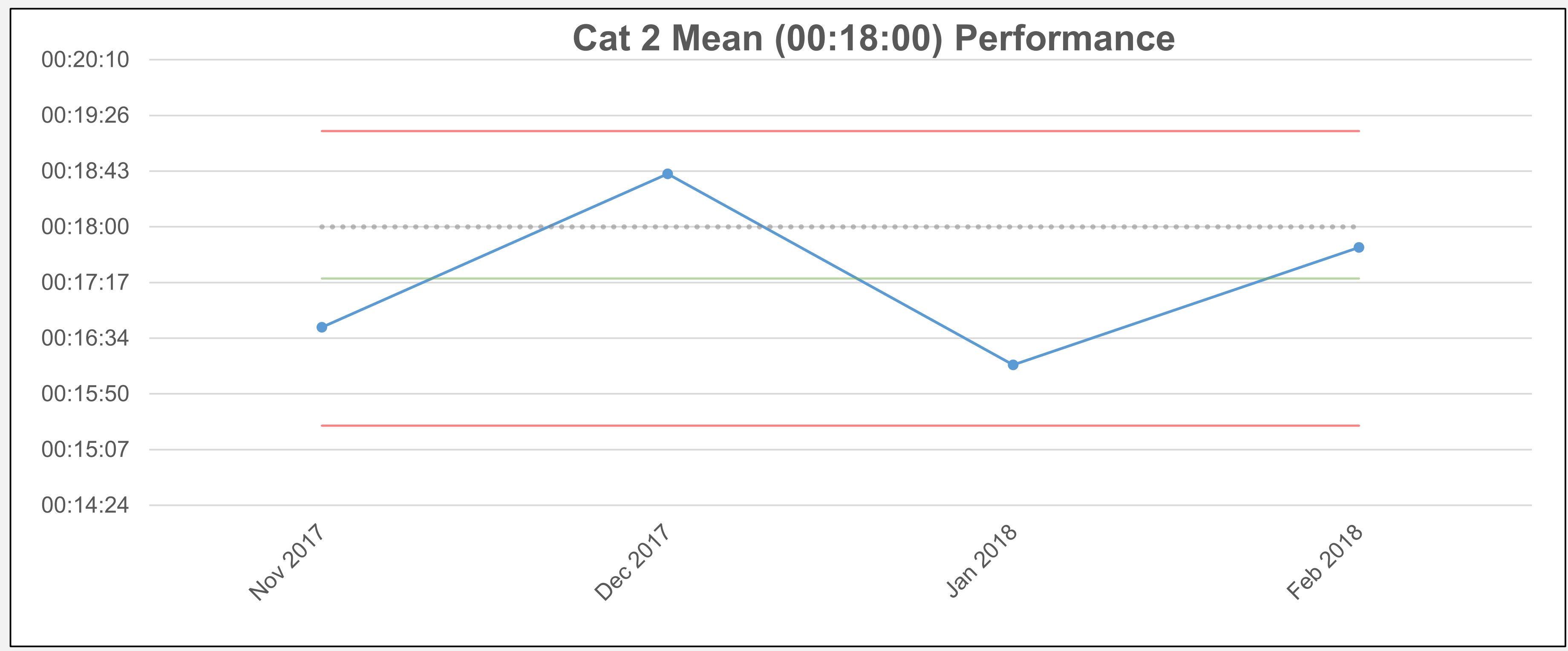
Response ratio continues to decrease. This metric will be referred to as Responses per Incident going forward as it comes under greater scrutiny with the ARP.



The Trust is currently 00:01:19 over the target mean for Cat 1 and we have achieved our 90th Centile target at 00:14:51.

Response time increased in February, bearing in mind we had snowfall for just over a week towards the end of the month. The monthly mean response time is still lower than what was reported in November and December. Continued improvement is needed to meet the required mean of 7 minutes. The Cat 1 mean did not go below 7 minutes in February, the lowest mean time reached was 00:07:02 and highest 00:10:32.

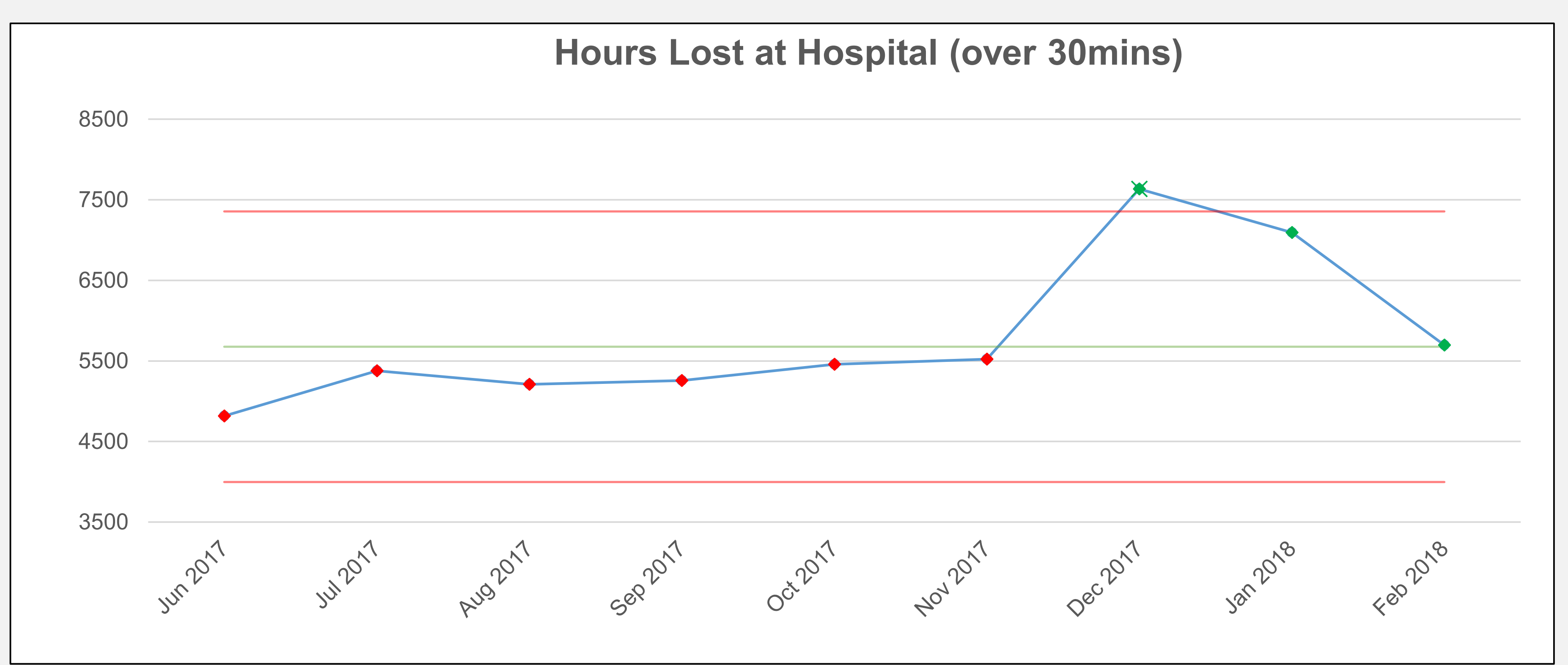
The average Cat 1 performance was slightly better for West EOC (00:08:16 mean) than for East EOC (00:08:23). East did not meet the required 90th Centile target (00:15:11).



Cat 2 mean performance for January was achieved at 00:17:44. We are still continuing to achieve our target for the 90th centile with February at 00:33:01.

In December the mean response time for Cat 2 incidents was higher than the required standard (00:18:41) we have increased slightly for February compared to January but we still remain within target which shows a clear improvement. This correlates with a decrease in demand from December to February.

Cat 2 performance was similar for both EOCs with East (00:17:12 mean; 00:31:21 90th Centile) outperforming West (00:17:59 mean; 00:34:05 90th Centile).



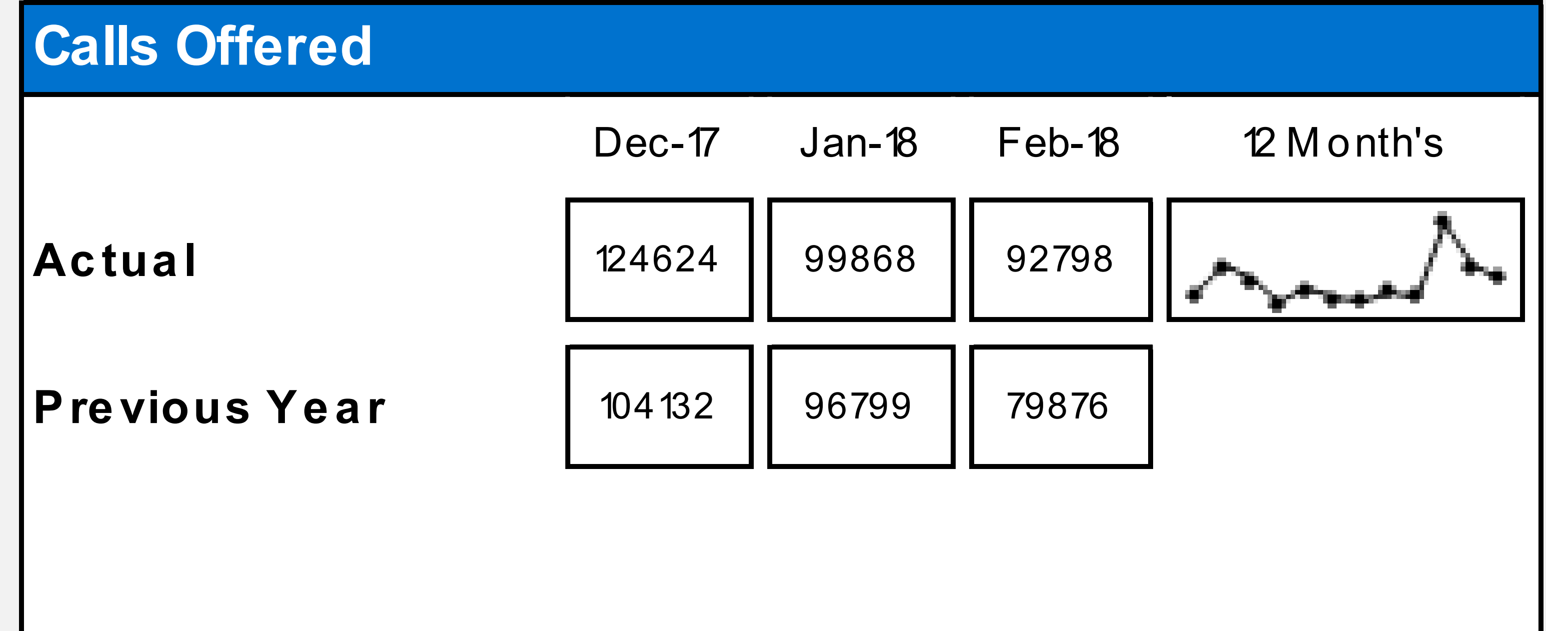
There were 875 patient handovers over 60mins for February (daily average 31) this is a decrease compared to January 1209 (daily average 39). Similarly the hours lost over 30 mins due to delays has decreased in February to 5697hrs (average 203.5) from January which was 7093hrs (average 228.8).

Comparing February 2018 to February 2017 there has been a increase of 228 hours.

The handover delays have an impact on both patient safety and experience. This also has an effect on SECAmb responses to public 999 calls.

To address this system wide issue, SECAmb and NHSI have appointed a dedicated Programme Director for 6 months to provide additional leadership and focus. A system wide Task and Finish group is in place together with two (East and West) operational groups who are responsible for delivering the changes needed to ensure improvement.

SECAmb 111 Operations Performance Scorecard

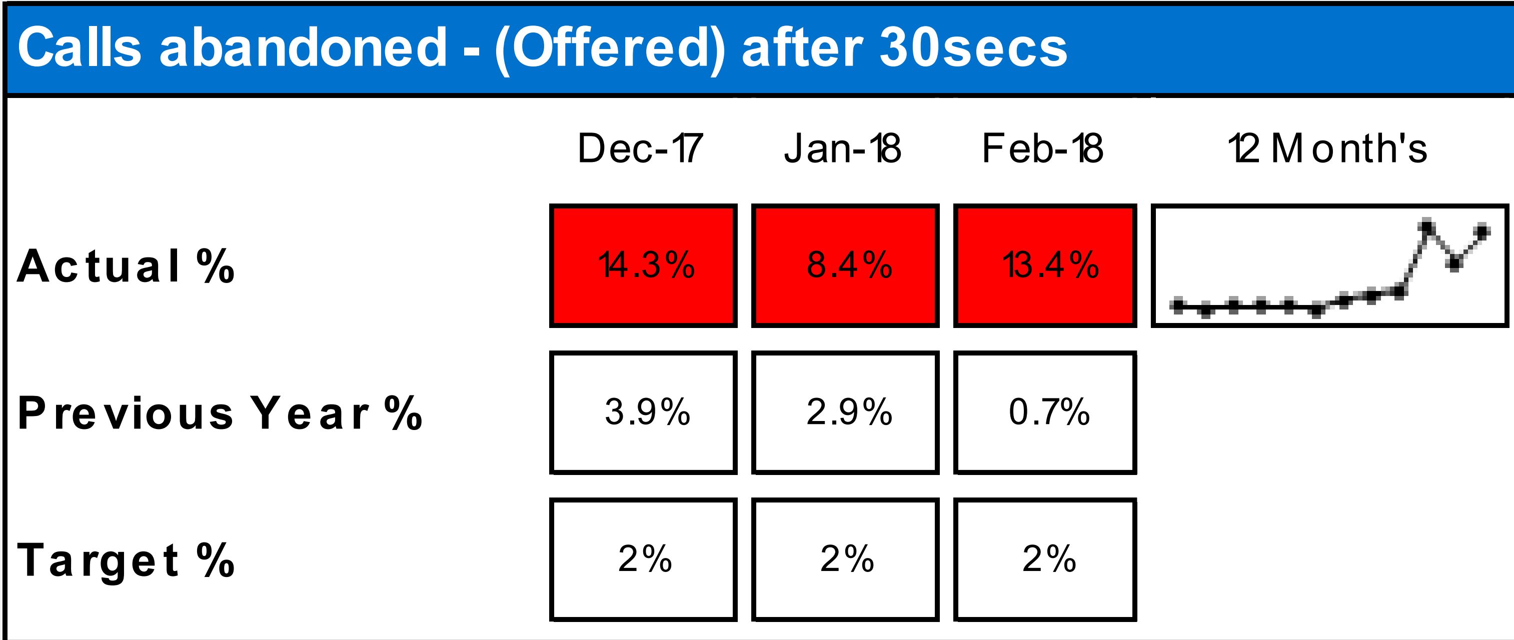


Calls Offered

	Dec-17	Jan-18	Feb-18	12 Month's
Actual	124624	99868	92798	
Previous Year	104132	96799	79876	

Calls answered in 60 Seconds

	Dec-17	Jan-18	Feb-18	12 Month's
Actual %	47.9%	56.9%	49.2%	
Previous Year %	80.8%	83.7%	92.5%	
Target %	95%	95%	95%	



Calls abandoned - (Offered) after 30secs

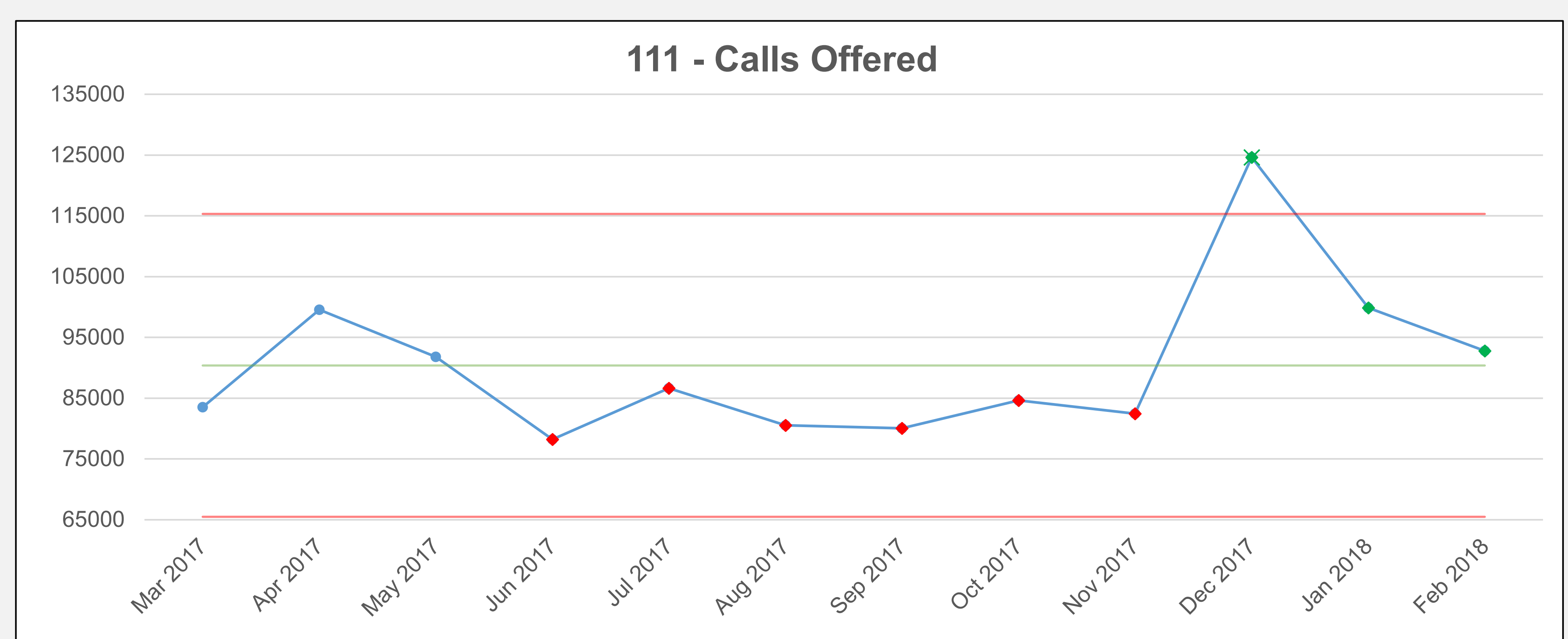
	Dec-17	Jan-18	Feb-18	12 Month's
Actual %	14.3%	8.4%	13.4%	
Previous Year %	3.9%	2.9%	0.7%	
Target %	2%	2%	2%	

Combined Clinical KPI

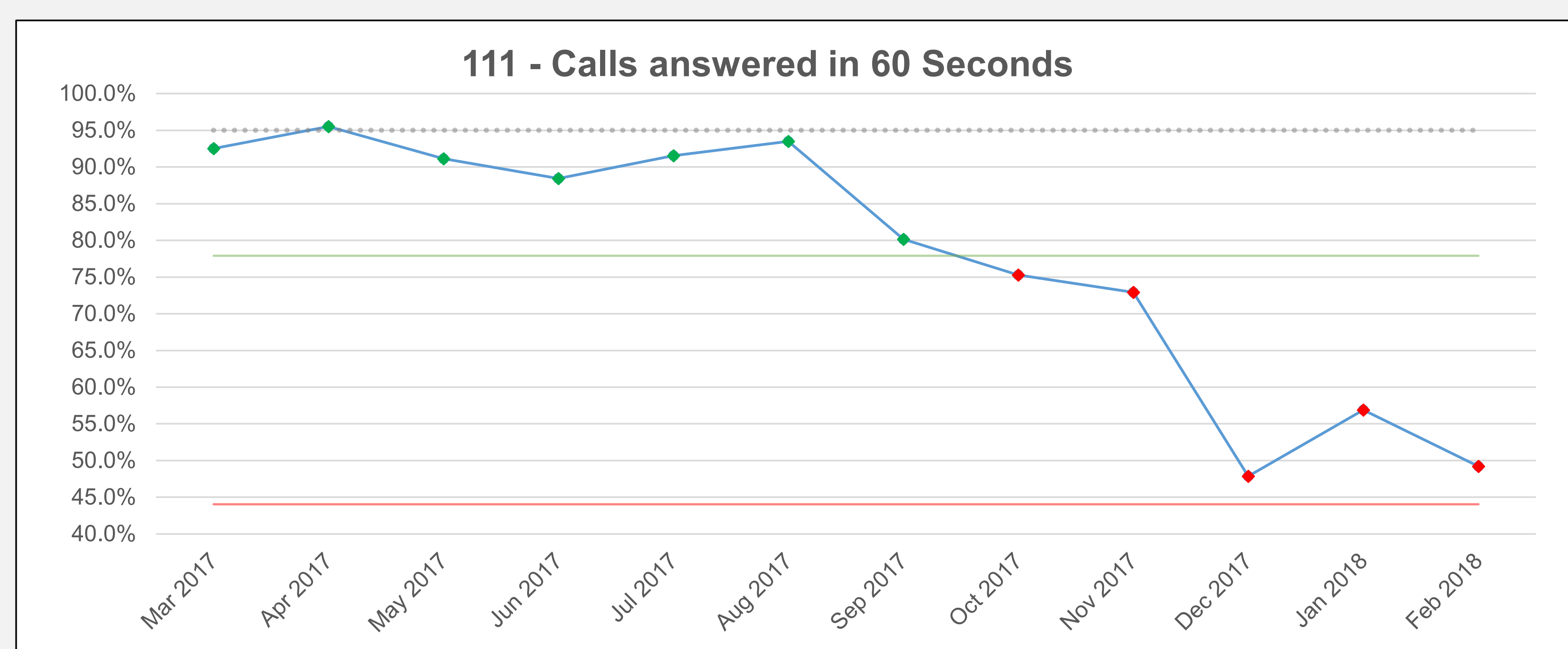
	Dec-17	Jan-18	Feb-18	12 Month's
Actual %	72.5%	74.7%	71.4%	
Previous Year %	72.5%	81.6%	73.6%	
Target %	90%	90%	90%	

Outcomes

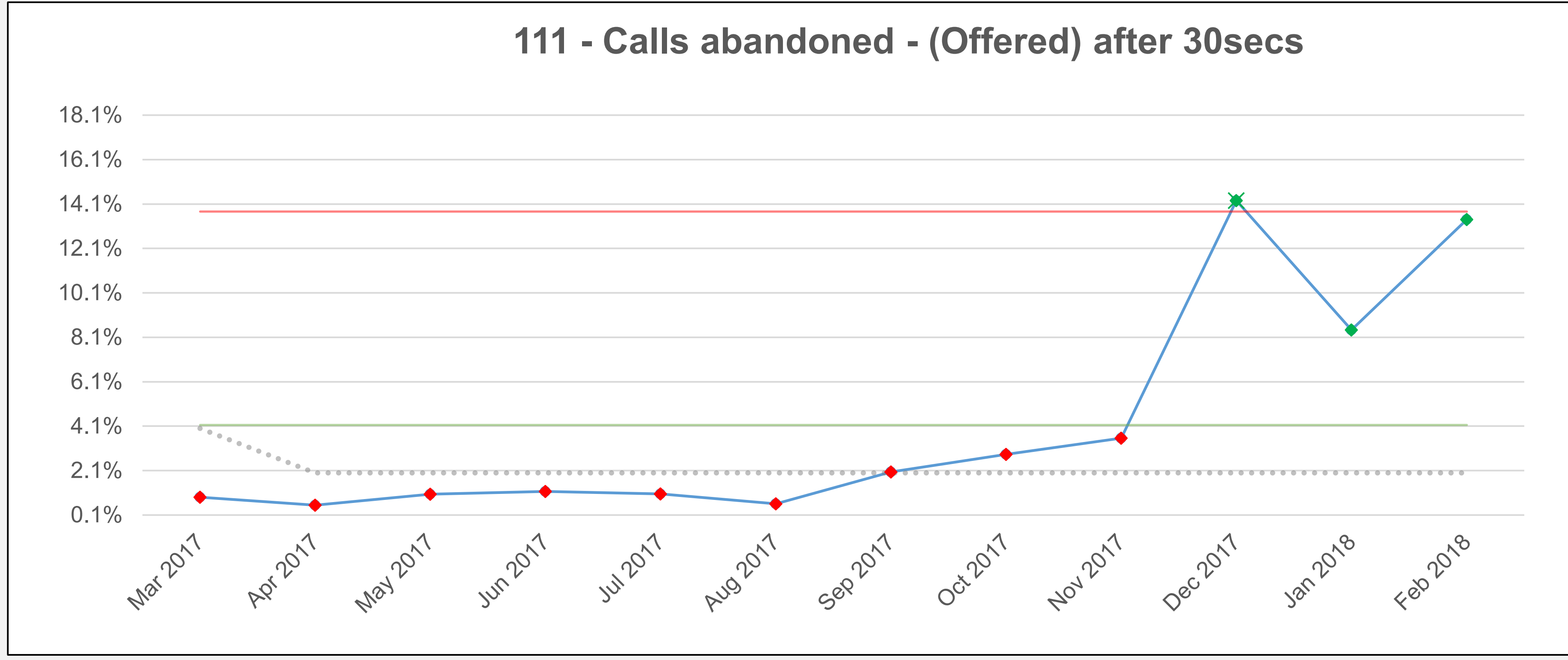
	Dec-17	Jan-18	Feb-18	12 Month's
999 Referrals % (Answered Calls)	10.8%	11.4%	11.7%	
999 Referrals (Actual)	10954	10048	9129	
A&E Dispositions % (Answered Calls)	6.4%	7.5%	7.2%	
A&E Dispositions (Actual)	6540	6610	5604	
Home Management %	5.8%	TBC	TBC	

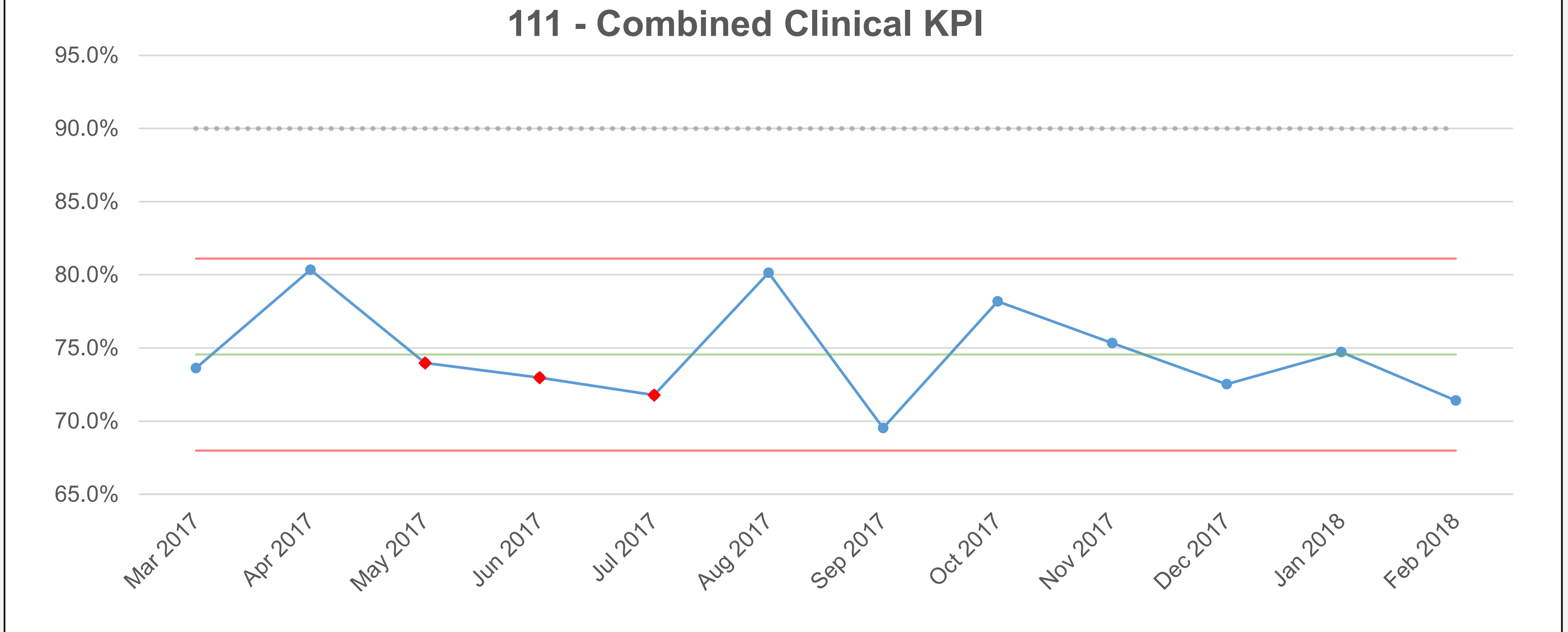


Call volumes climbed to 92798 for the month, representing a 16% year-on-year increase in demand since February 2017.

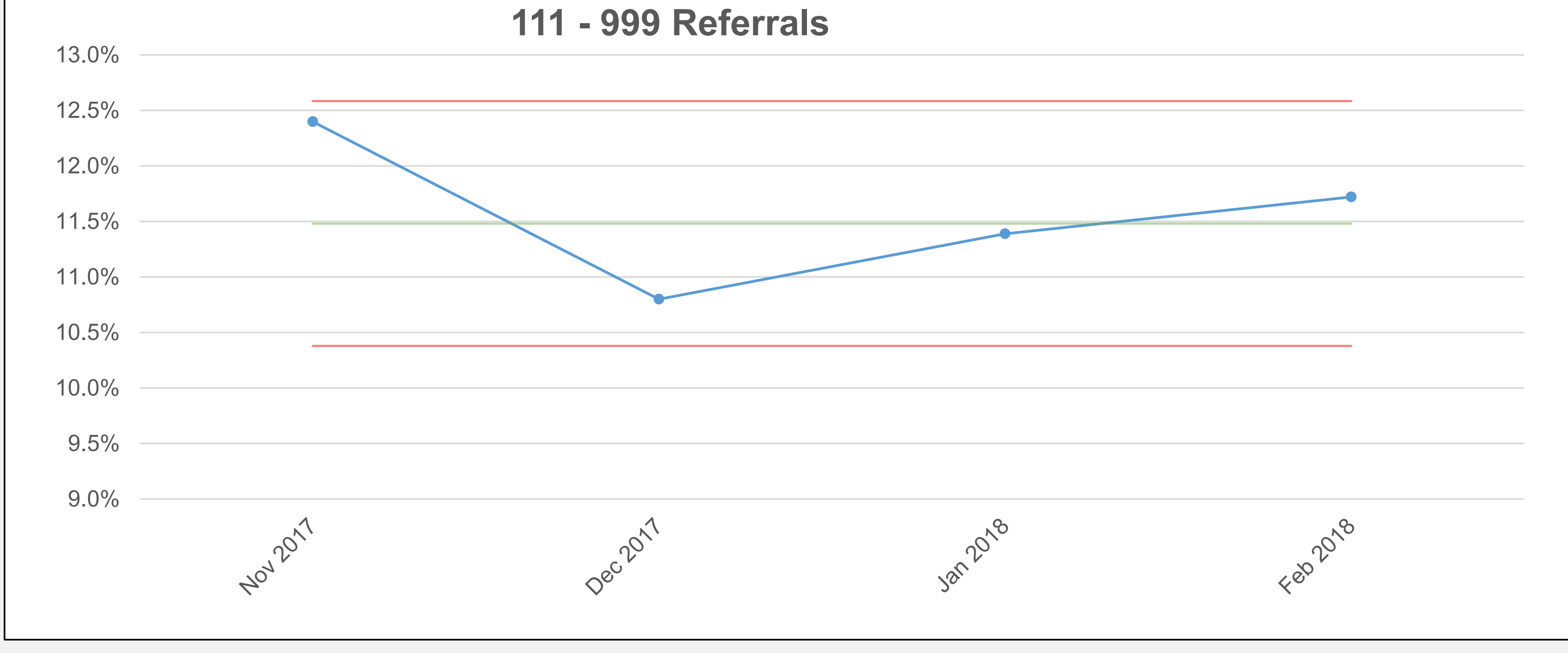


The “Answered in 60” KPI consequently declined to 49.2%, due to issues arising from rota fill, productivity, and sickness levels.





Clinical performance at 71.4% again outperformed the national average by a significant margin, emphasising our status as a clinically-driven service.



The KMSS 111 Ambulance referral rate rose to 11.7% but the service continues to mitigate AMB referrals via Clinical Inline Support.

SECAmb Workforce Scorecard

Workforce Capacity

	Dec-17	Jan-18	Feb-18	12 Month's
Number of Staff WTE (Excl bank & agency)	3039.0	3057.6	3079.8	
Number of Staff Headcount (Excl bank and agency)	3308	3330	3350	
Finance Establishment (WTE)	3526.29	3525.29	3527.29	
Vacancy Rate	13.46%	13.40%	12.65%	
Vacancy Rate Previous Year	9.35%	9.28%	8.23%	
Adjusted Vacancy Rate + Pipeline recruitment %	10.53%	10.67%	9.20%	

Workforce Compliance

	Dec-17	Jan-18	Feb-18	12 Month's
Objectives & Career Conversations %	65.08%	78.81%	83.95%	
Statutory & Mandatory Training Compliance %	73.61%	79.12%	86.32%	
Previous Year %	77.30%	78.50%	81.90%	

Workforce Costs

	Dec-17	Jan-18	Feb-18	12 Month's
Annual Rolling Turnover Rate %	17.77%	17.85%	17.74%	
Previous Year %	16.90%	16.90%	16.60%	
Annual Rolling Sickness Absence	4.92%	5.22%	5.26%	

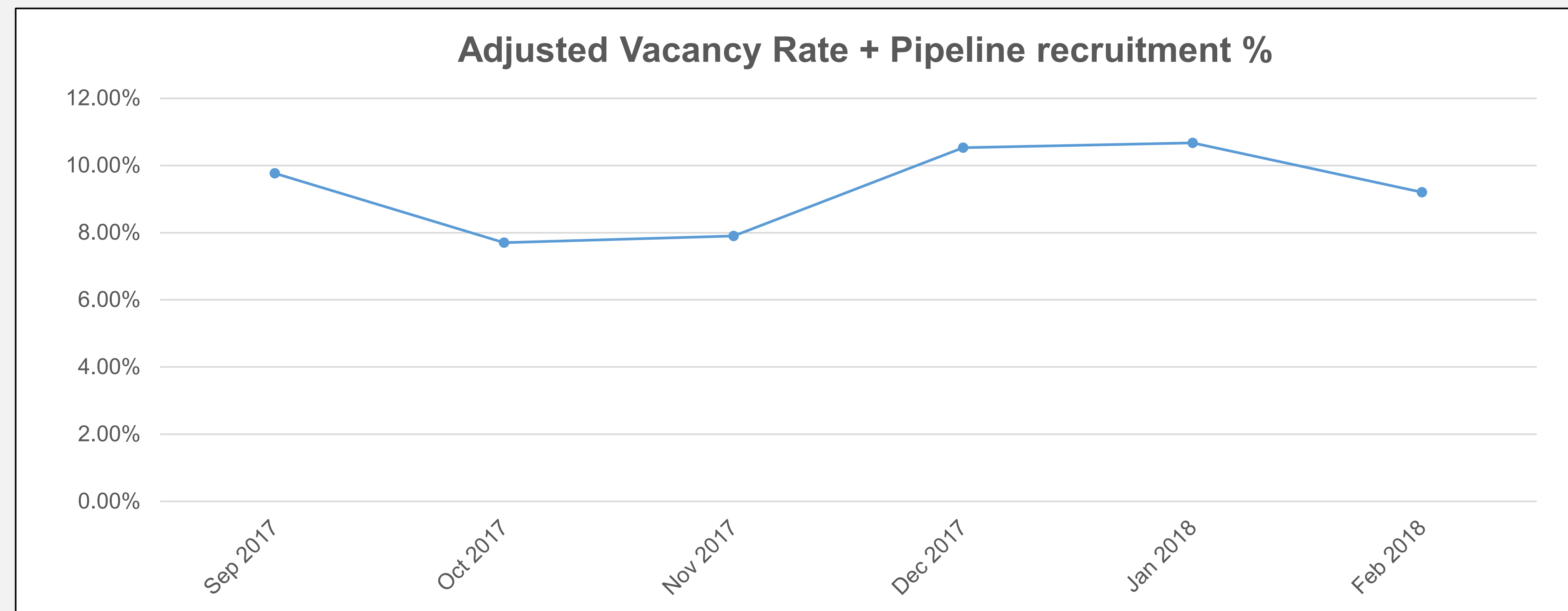
Employee Relations Cases

	Dec-17	Jan-18	Feb-18	12 Month's
Disciplinary Cases	2	1	6	
Individual Grievances	5	16	6	
Collective Grievances	0	1	1	
Bullying & Harassment	2	0	2	
Bullying & Harassment Prev Yr	0	1	0	
Whistleblowing	0	0	1	
Whistleblowing Previous Year	0	1	0	

Physical Assaults (Number of victims)

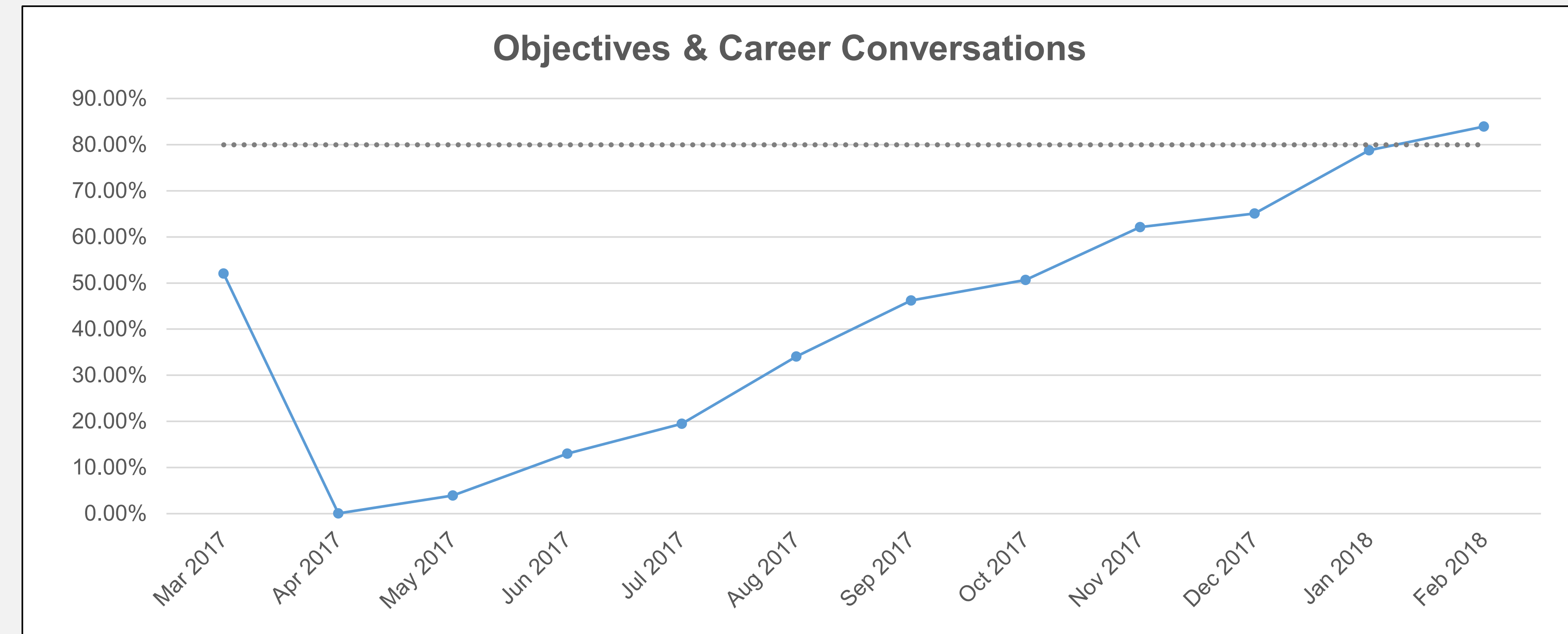
	Dec-17	Jan-18	Feb-18	12 Month's
Actual	17	16	15	
Previous Year	19	17	16	
Sanctions	1	3	3	

SECAmb Workforce Charts



The increase in assessment centres and other recruitment activities has resulted in an increase in pipeline (offers of employment) for March/April.

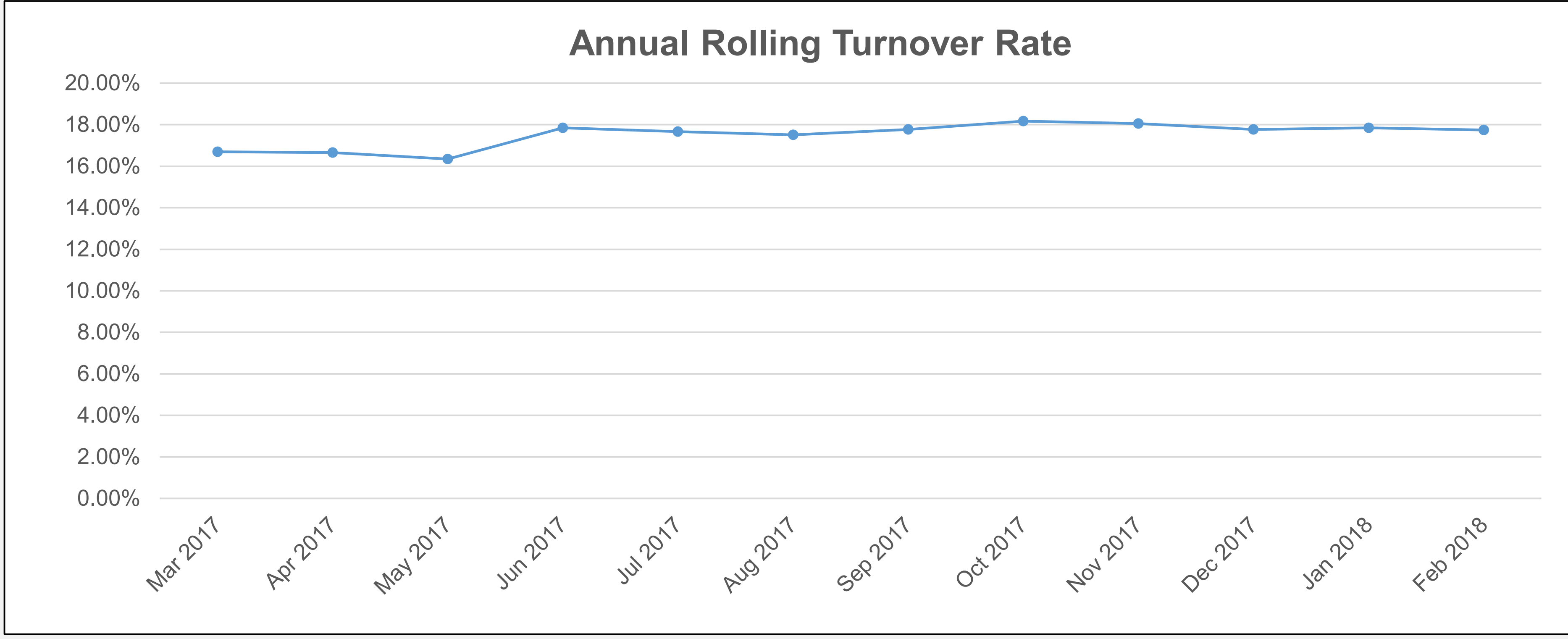
Monthly Recruitment Summit meetings look to address the short term resourcing gaps for operational staff. Action plan(s) are being put in place, closely monitored to and bi weekly recruitment conference calls are being used to deep dive into areas with larger ongoing recruitment needs.



A significant increase in compliance was seen during January and this continued in February resulting in the Trust reaching its 80% compliance one month early.

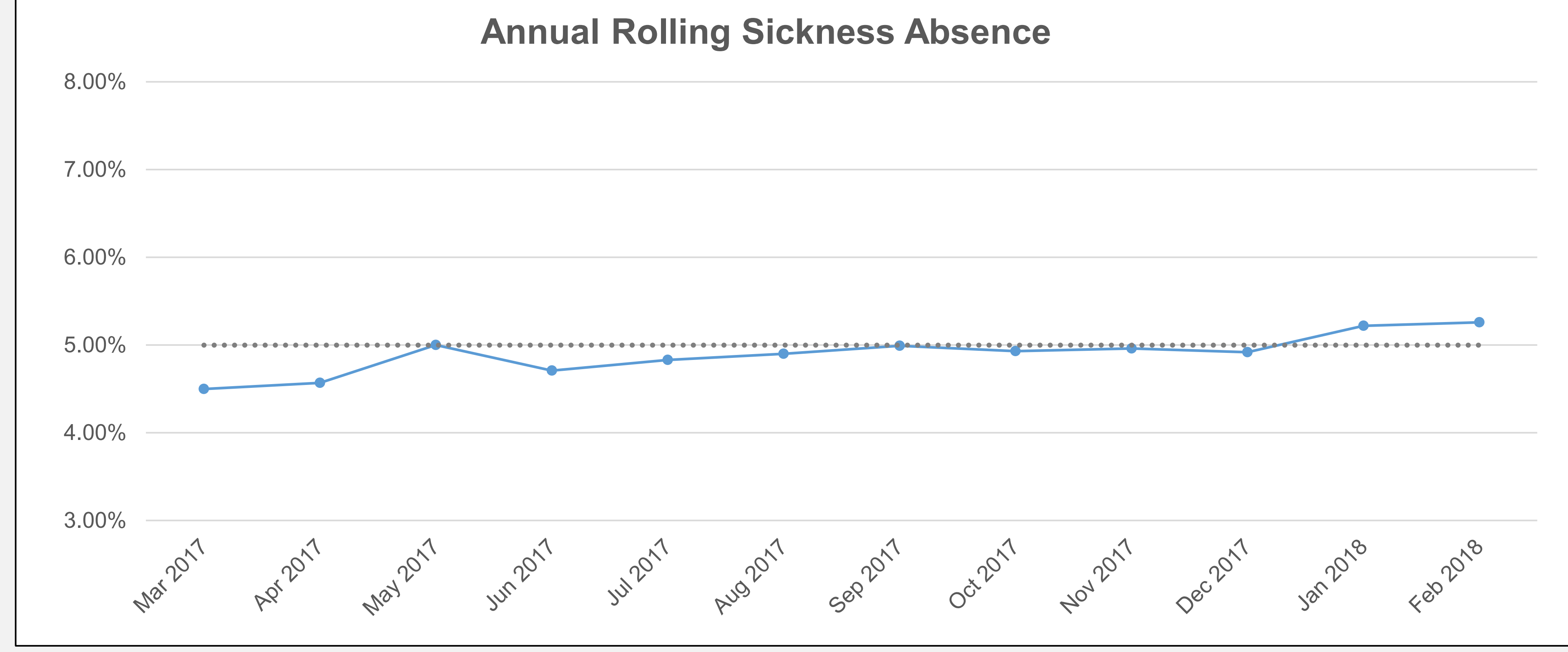
Managers continue to be supported to deliver on objectives and fully understand their accountability in this regard via area Governance.

Training on the delivery of good appraisals has been commissioned and is currently being delivered to managers during March/April.



The Trust turnover rate remains constant although a high turnover rate is still seen in EOC and 111 should be noted. This continues to be monitored by the EOC Task and Finish Group.

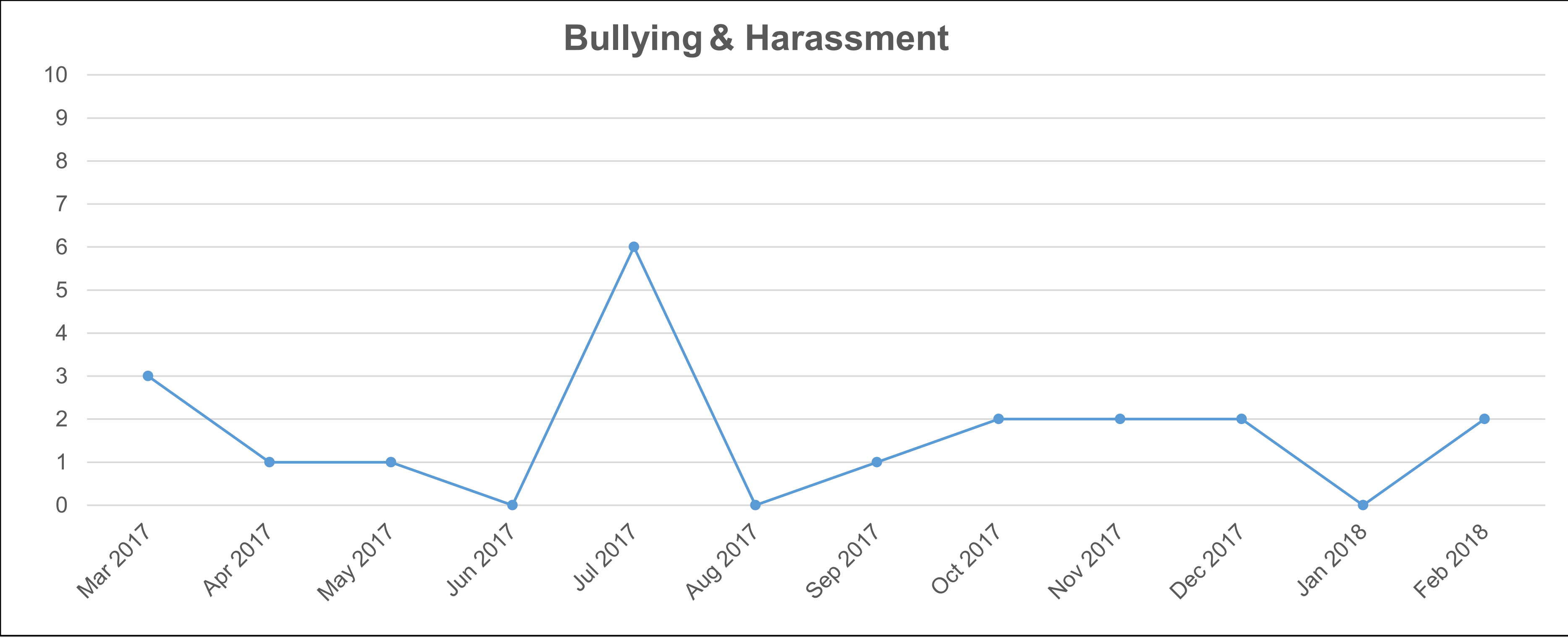
Further analysis has been provided i.e. Trust, Directorate and Operating Unit (OU) level and a paper for the Board is being provided for further discussion.



The trusts sickness rate stayed above 5% this month. During winter months we usually see peaks in seasonal reasons i.e. colds and flu however Gastrointestinal problems account for the majority of absence occurrences.

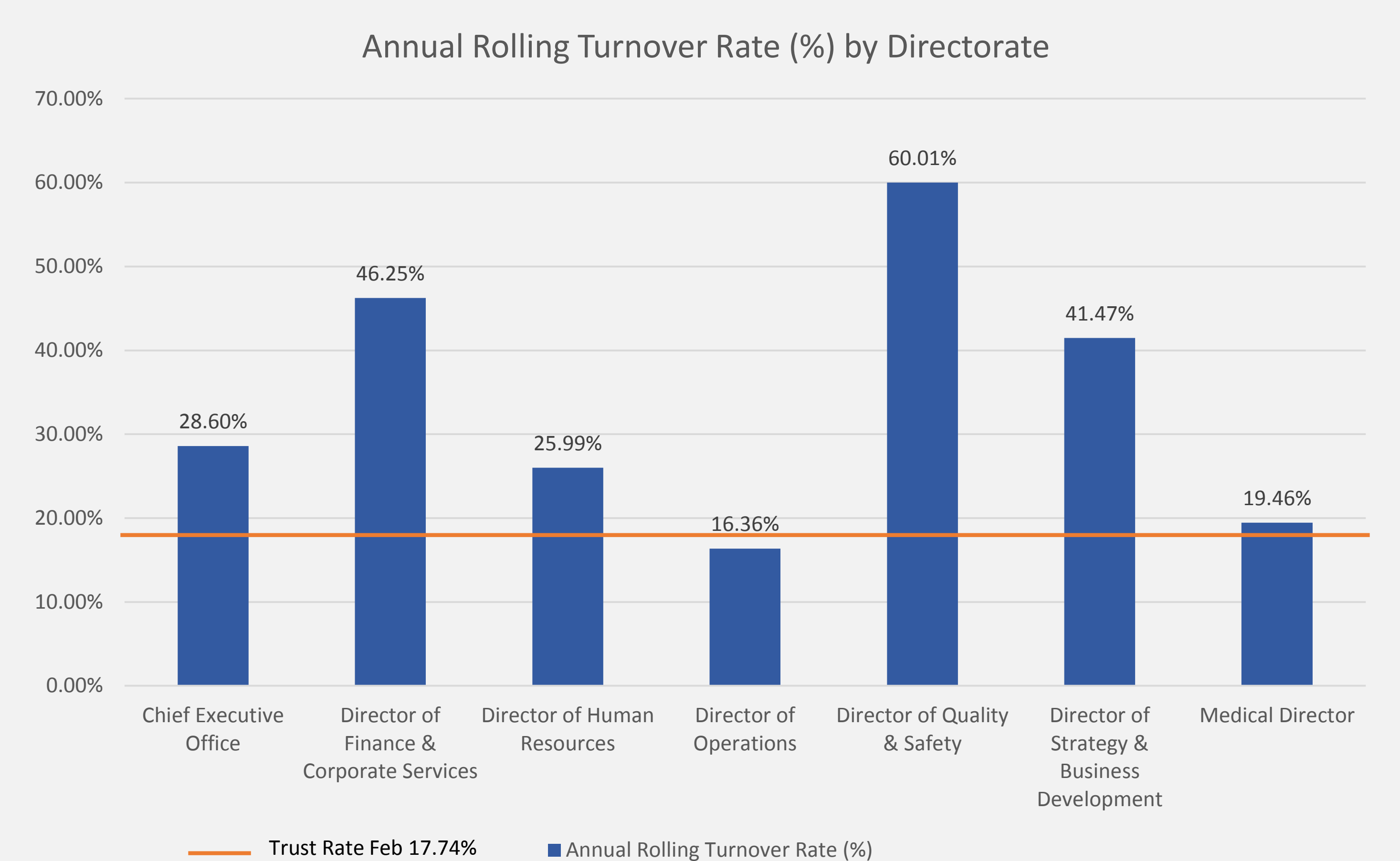
There continues to be focus on supporting staff and managers in the EOC with a dedicated HR Advisor working hard to conclude outstanding sickness hearings. The impact of the HR Advisor in the EOC has seen a significant reduction in sickness absence, so it is recommended that this be introduced in 111.

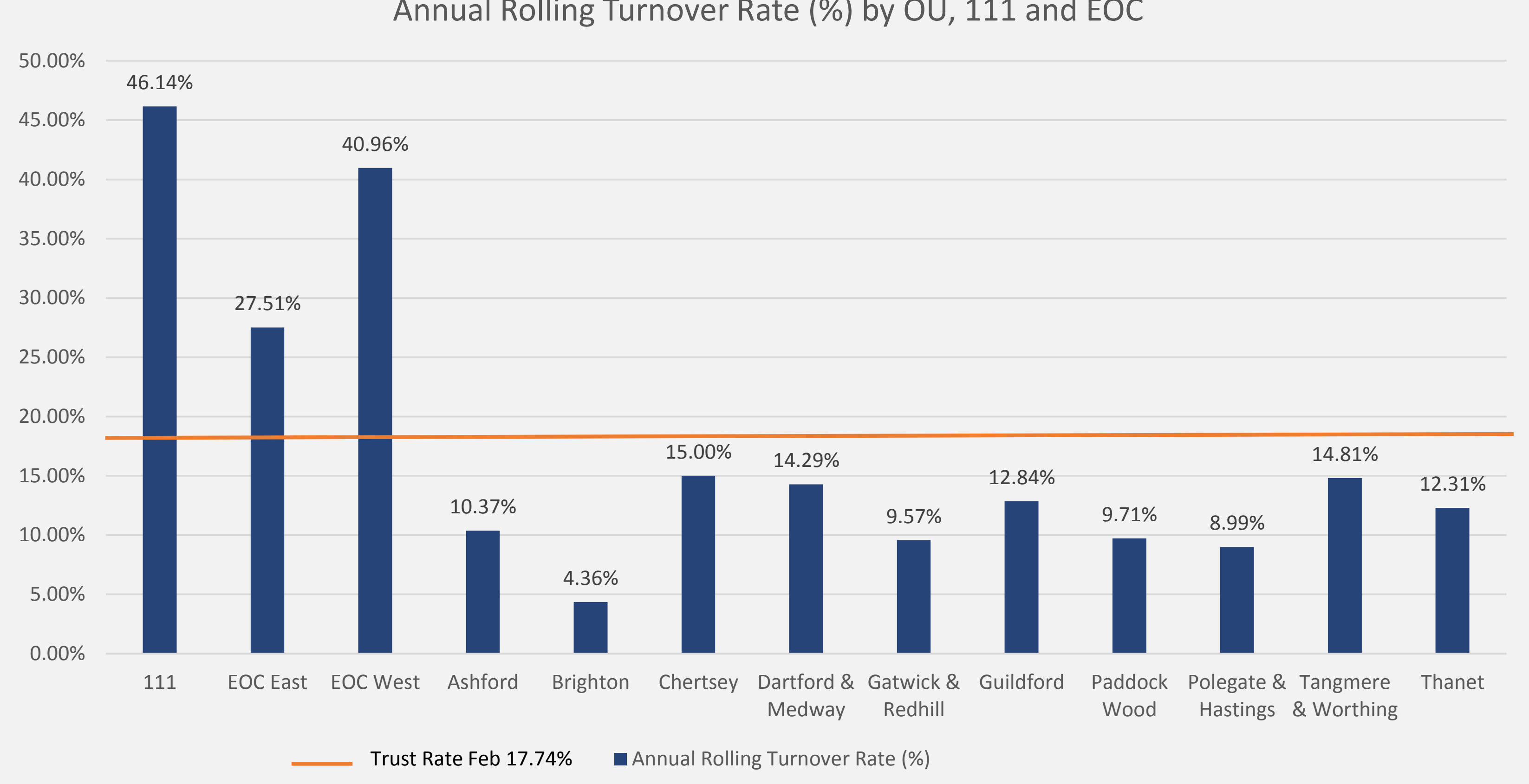
The Wellbeing hub continues to promote alternative duties. There are currently 2 pathways which are monitored and managed by a multidisciplinary team (MDT).



There were two new B&H cases in February..
A review of the Exit Interview Data (February 2018) shows a decline in Bullying and Harassment as a reason for leaving when compared to the December 2017 report which is positive. However, the 2017 Staff Survey results show that 430 respondents have experienced bullying/harassment/abuse from managers over the last 12 months but according to our data only 20 cases were reported. We will look at this as part of the Staff Survey Action Planning.

SECAmb Turnover Rate – Deep Dive





The table below shows the Annual Rolling Turnover Rate WTE by Directorate (Number of staff WTE)

Chief Executive Office	Finance & Corporate Services	HR	Operations	Quality & Safety	Strategy & Business Development	Medical
11.5 (40.35)	**18.2** (39.36)	**19.8** (76.16)	**464.3** (2837.93)	**16.8** (28)	**5.5** (13.33)	**8.7** (44.63)

The table below shows the Annual Rolling Turnover Rate WTE by OU, 111 & EOC (Number of Staff WTE)

111	EOC East	EOC West	Ashford	Brighton	Chertsey	Dartford & Medway	Gatwick & Redhill	Guildford	Paddock Wood	Polegate & Hastings	Tangmere & Worthing	Thanet
69.6 (150.9)	**39** (141.65)	**89.7** (219.1)	**13.3** (128.2)	**7.3** (167.85)	**21.4** (142.73)	**31.4** (219.4)	**24.4** (255.40)	**19.8** (154.52)	**13.2** (135.52)	**20** (223.12)	**31** (209.89)	**21** (169.92)

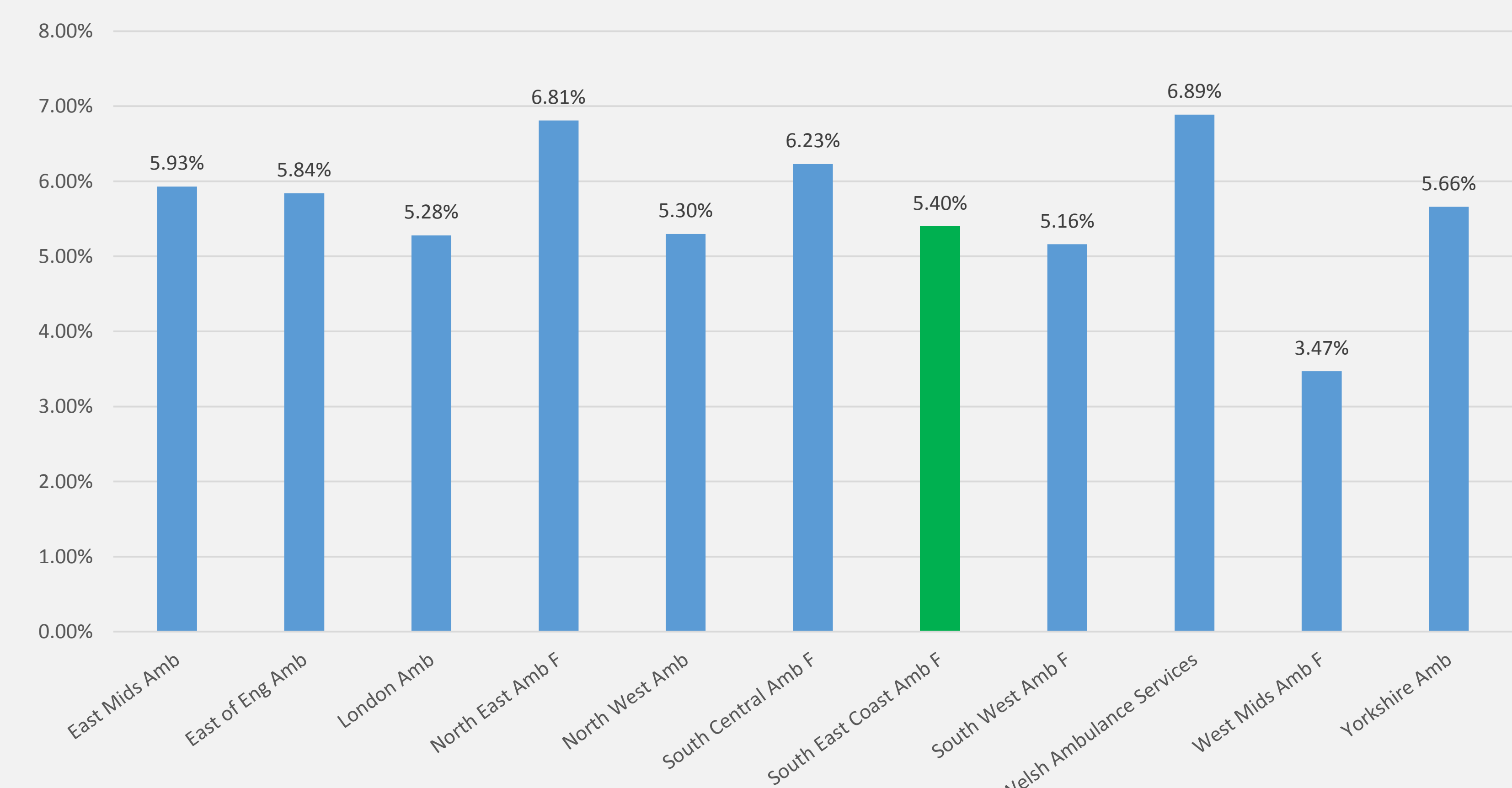
Key Area's:

EOC East and West – To support the EOC's we have a dedicated HR Advisor who is located in EOC West but travels to EOC East. She is focused on working with the EOC Managers on identifying what the sickness triggers are, linking in with the Wellbeing Hub and supporting the existing staff off sick to bring them back into the work place. The EOC have developed and launched an EOC career framework with a target of reducing the EMA turnover by 30% of it's current budgeted position. This career framework focuses on pay progression whilst keeping the EMA's within the call handling team.

111 – Based on the positive impact the EOC HR Advisor has had we would recommend we implement the same dedicated resource in 111. Early indications show that the retention issues relate to HA's being a band 2 and our competitor opposite paying more money.

The table below provides a snap shot of the roles/teams that fall under each Directorate. This is not a comprehensive list.

Chief Executive Office	Finance and Corporate Services	Human Resources	Operations	Quality and Safety	Strategy and Business Development	Medical
Executive Assistants, Legal, Business Support Managers, NED's, Corporate Governance etc.	Finance, Estates & Procurement(Facilities, Buyers, Contract Managers), IT etc.	Wellbeing Hub, Resourcing, Service Centre, Workforce Information, Clinical Education, HR BP's etc.	EOC, 111, Paramedics, Contingency Planning & Resilience, HART, MRC's, Scheduling OU Managers etc.	Patient Experience, Safeguarding, Health & Safety, Incidents, Risk, Information Governance etc.	Strategy and Partnership, PMO, Performance Improvement, Analysts etc.	Clinical Audit, Records Management, Frequent Caller, Medicines Support Workers, Research etc.



The graph to the left shows how SECAmb compares to other Ambulance Trusts absence rate. We currently rank 5th lowest which places us in the middle. This is being monitored on a monthly basis and we are working in conjunction with other Ambulance trusts to share best practice.

SECAmb Finance Performance Scorecard

Income

	Dec-17	Jan-18	Feb-18	12 Month's
Actual £	£ 18,202	£ 17,171	£ 16,810	
Previous Year £	£ 17,536	£ 17,542	£ 17,179	
Plan £	£ 18,376	£ 17,585	£ 16,109	

Expenditure

	Dec-17	Jan-18	Feb-18	12 Month's
Actual £	£ 17,399	£ 16,404	£ 16,032	
Previous Year £	£ 17,446	£ 17,614	£ 17,576	
Plan £	£ 17,589	£ 16,827	£ 15,400	

Capital Expenditure

	Dec-17	Jan-18	Feb-18	12 Month's
Actual £	£ 400	£ 285	£ 554	
Previous Year £	£ 752	£ 1,250	£ 1,356	
Plan £	£ 856	£ 856	£ 856	
Actual Cumulative £	£ 3,594	£ 3,878	£ 4,432	
Plan Cumulative £	£ 13,268	£ 14,124	£ 14,980	

Cost Improvement Programme (CIP)

	Dec-17	Jan-18	Feb-18	12 Month's
Actual £	£ 1,425	£ 1,496	£ 1,380	
Previous Year £	£ 1,114	£ 552	£ 488	
Plan £	£ 1,399	£ 1,399	£ 1,380	
Actual Cumulative £	£ 11,240	£ 12,736	£ 14,116	
Plan Cumulative £	£ 10,912	£ 12,311	£ 13,691	

CQUIN (Quarterly)

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

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

Surplus/(Deficit)

	Dec-17	Jan-18	Feb-18	12 Month's
Actual £	£ 803	£ 767	£ 778	
Actual YTD £	-£ 3,184	-£ 2,417	-£ 1,639	
Plan £	£ 787	£ 758	£ 709	
Plan YTD £	-£ 3,261	-£ 2,503	-£ 1,794	

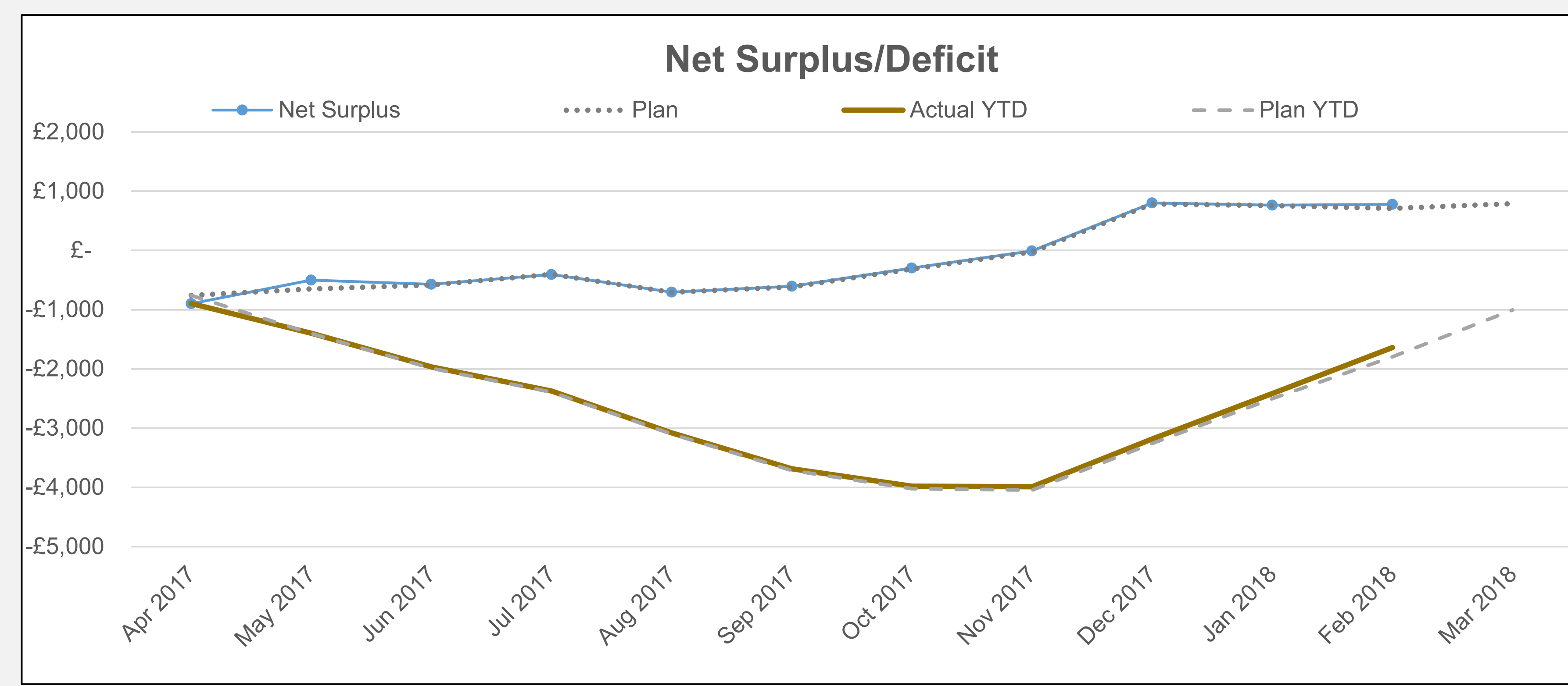
Cash Position

	Dec-17	Jan-18	Feb-18	12 Month's
Actual £	£ 17,024	£ 19,564	£ 23,953	
Minimum £	£ 10,000	£ 10,000	£ 10,000	
Plan £	£ 6,088	£ 5,857	£ 5,728	

Agency Spend

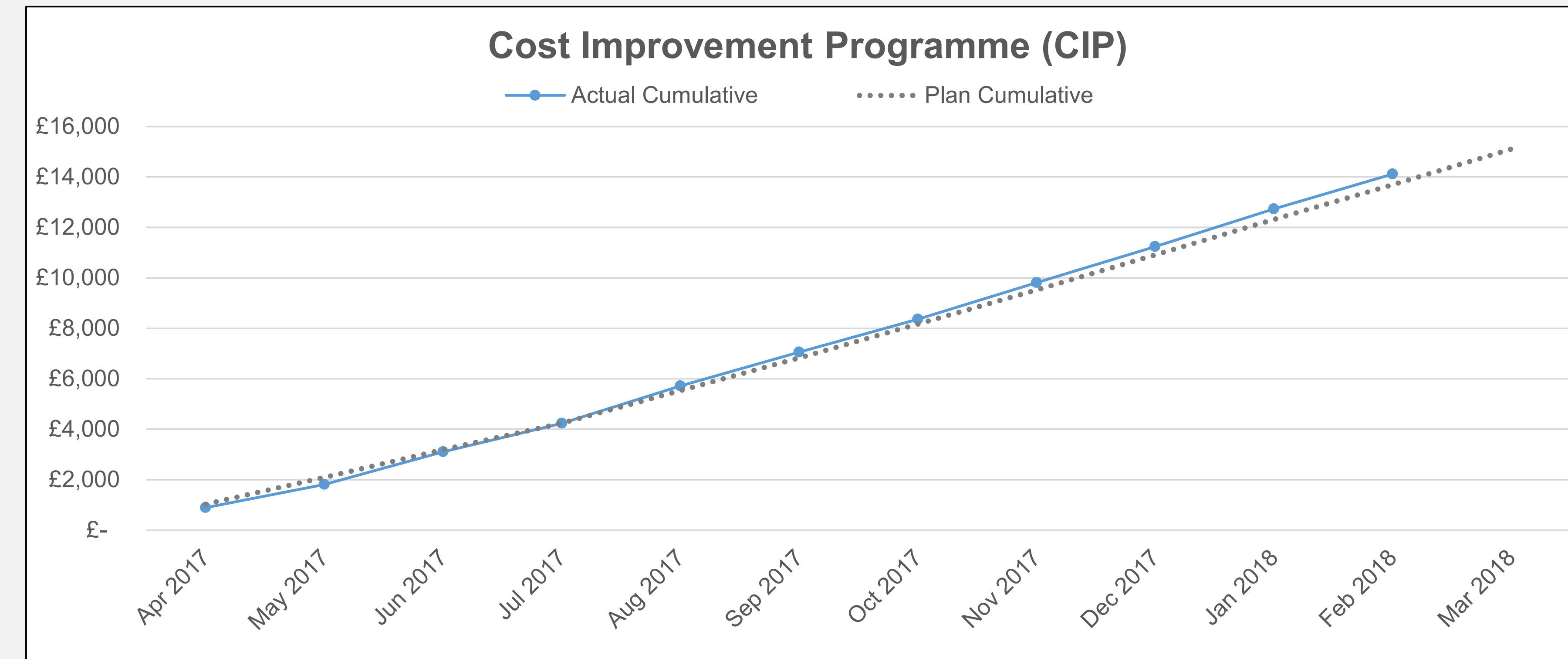
	Dec-17	Jan-18	Feb-18	12 Month's
Actual £	£ 212	£ 316	£ 223	
Plan £	£ 331	£ 329	£ 328	

SECAmb Finance Performance Charts



With one month of the financial year to go, the Trust continues to forecast achievement of its control total of £1.0m deficit for the year. This is after receipt of Sustainability and Transformation funding (STF) of £1.3m.
In the month the Trust made a surplus of £0.8m for the third month in a row, as planned. The cumulative deficit is now £1.6m, which is £0.2m better than plan.
The following is a summary bridge between the original and normalised plans (£m): -

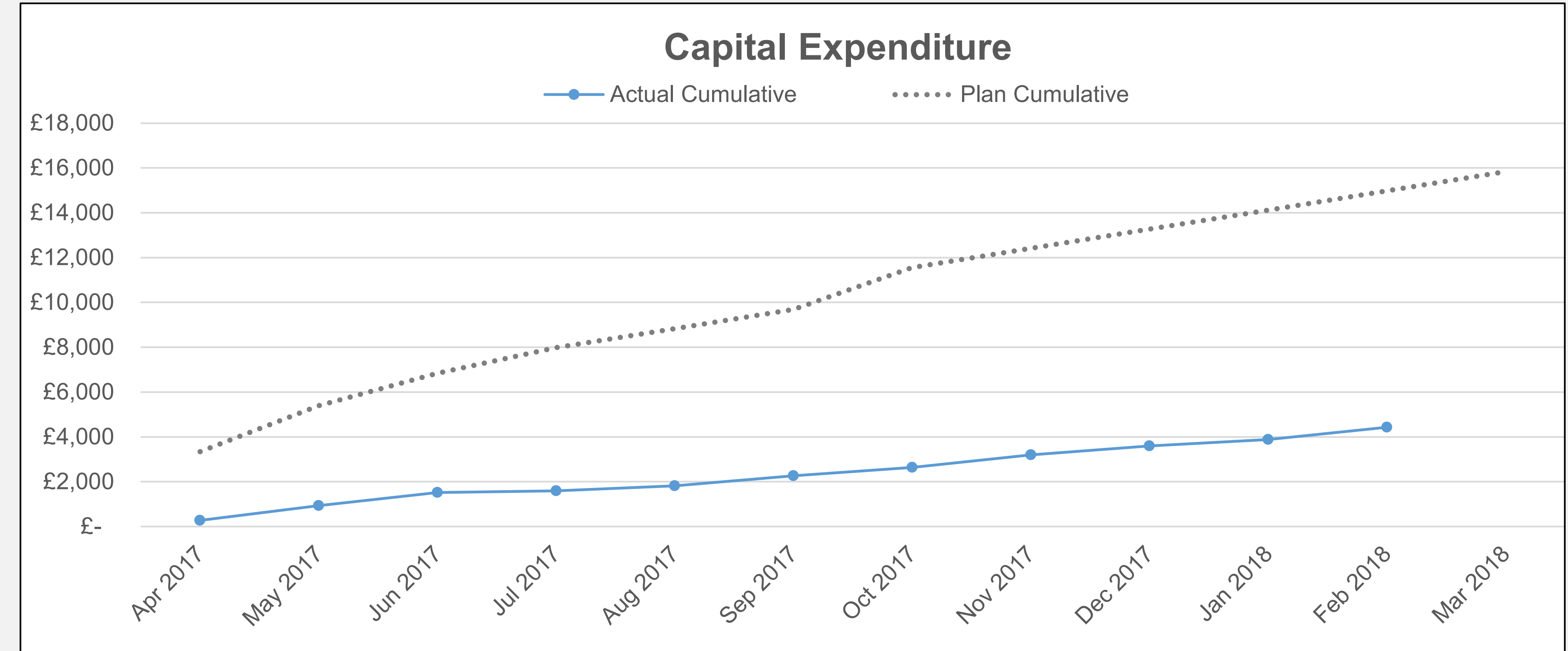
Original planned deficit (NHSI plan)	(1.0)
Structural deficit income excluded	(24.8)
Frontline hours excluded	18.9
Reserves and other budgeted costs to support delivery	5.9
'Normalised'/Commissioned plan	(1.0)



CIP schemes to the value of £17.8m have now been fully validated. The projected achievement in the current year is £15.5m, which compares favourably with the £15.1m target.

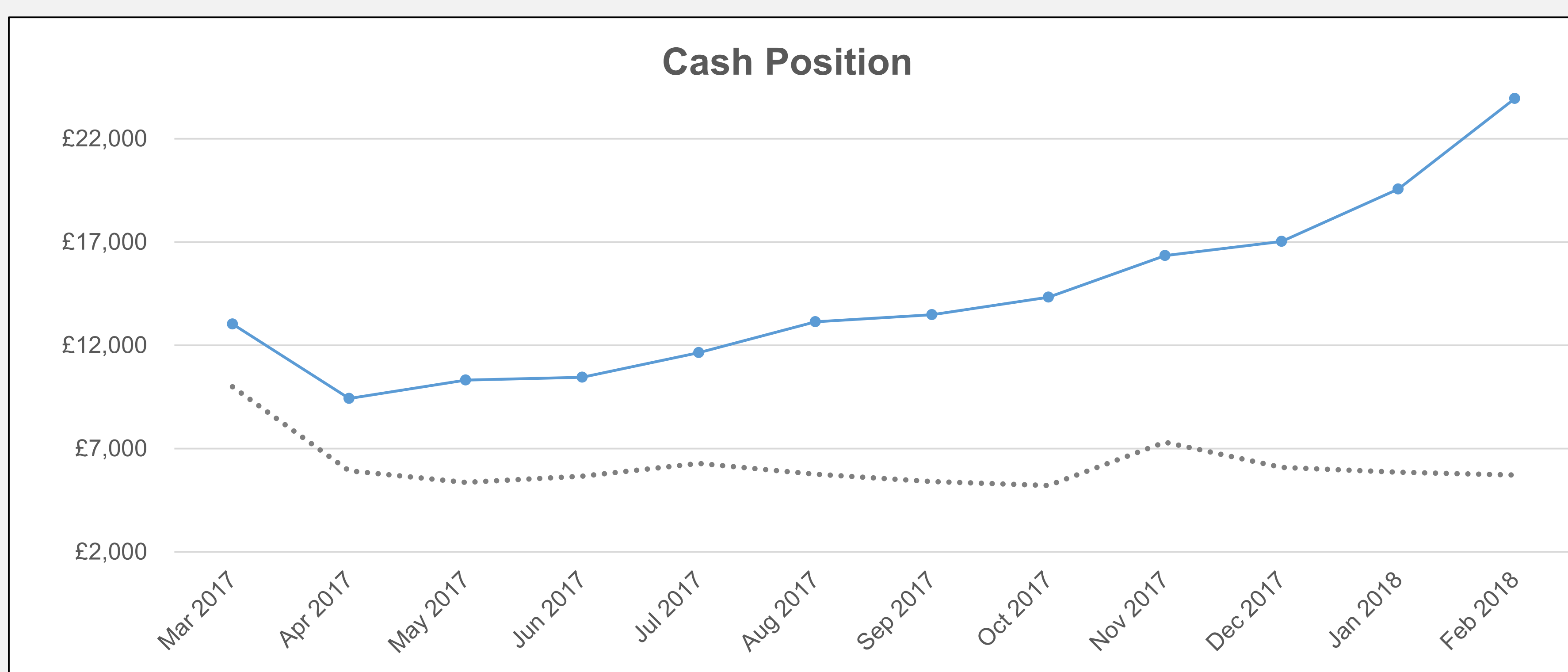
Plans are £0.4m ahead of plan for the year to date.

Good progress is being made in developing new schemes for 2018/19, with a delivery target of £11.4m.

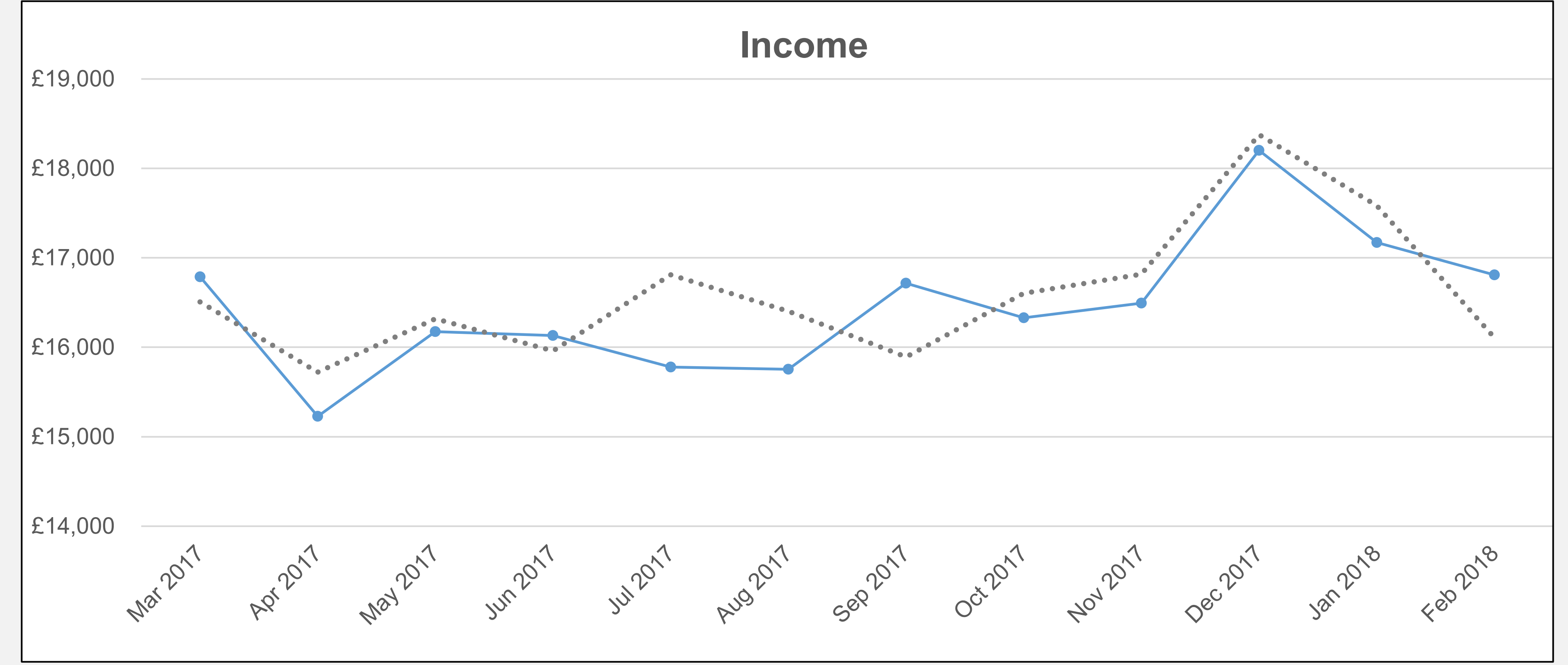


Spend on capital for the year to date is £4.7m against a plan of £15.0m. The full year forecast has fallen from £8.3m to £7.9m due to scheme slippage. The plan for the year is £15.8m. The projected underspend on the programme of £7.9m is mainly due to £8.2m of planned vehicle replacement, which has been moved from capital to revenue as procurement is via an operating lease.

The projected spend for the year includes schemes that were not in the original programme, i.e. Cyber Security £0.7m, 16 new ambulances £1.8m, Telephony and Voice Recorder £0.04m and a new Informatics System £0.12m. With the exception of Cyber Security, these are substitute schemes.

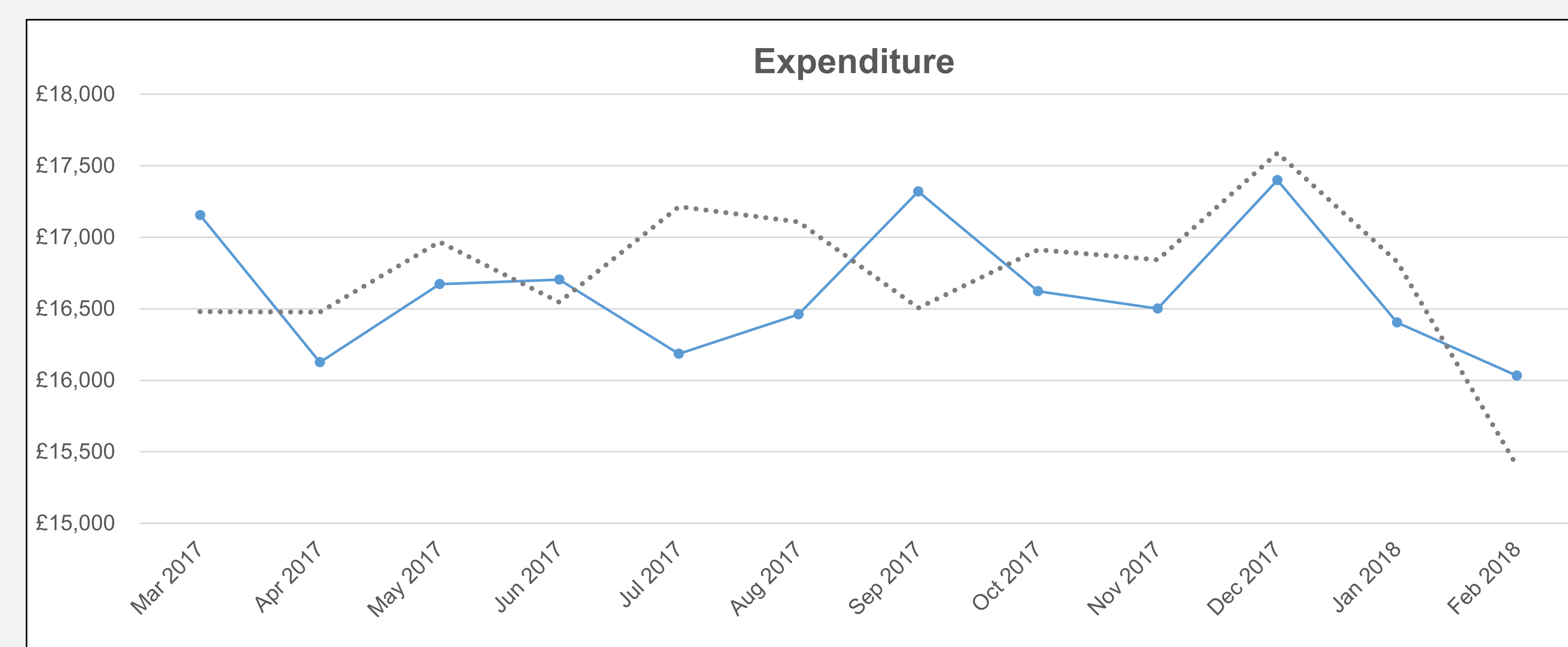


The cash position at 28 February increased again to nearly £24.0m. The increase in cash holding is mainly attributed to the delayed spend on the capital programme. After allowing for the catch up on capital spend, the cash flow forecast indicates that liquidity remains strong for the foreseeable future. The working capital loan balance of £3.2m was repaid in March.



A&E contract income is £6.9m below plan for the year to date due to lower than planned activity. Activity growth in the current year to date has been close to zero, compared to the planned 4.7%. However, the overall adverse income variance is just £1.7m adverse due mainly to additional income from East Kent Hospitals (£1.8m) to support the increased cost of diverts, CQUIN (£0.7m), NMET (£0.6m), Special Measures funding (£0.5m) and 111 Pilot funding (£0.4m).

SECAmb Finance Performance Charts



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

Operational hours are aligned to commissioned levels of activity.

SECAmb Risk Narrative

Following the update given to the Trust Board in January, further work is being undertaken in Risk Identification & Management. The Audit Committee has agreed to provide an update at the Trust Board in April 2018 on risk. Notwithstanding the planned update in April this report sets out some of the key issues / risks that have been highlighted within our EOC and what the Trust has done to manage risk and issues in Call Handling. These are set out below by area and the Trust's management response:

1. The service has been challenged with call answer times for over a year, but became particularly challenged during the implementation of a new computer aided dispatch system (CAD) in May 2017. A number of actions have been taken to resolve the Trust's performance challenges and a general improvement is becoming evident. To be able to provide an adequate call answer time to our 999 lines, the Trust requires the right level of staffing for each shift. SECAmb has faced challenges with correct staff provision for several years, but has been significantly challenged since May 2017, with the new CAD implementation. This segregated telephony systems affected the Trust's ability to determine accurate staffing requirements at our EOCs.

2. Factors affecting staffing include; recruitment and retention issues, short term and long term sickness, dismissal, or through poor planning of staff rosters. The Trust found that errors were being made in the scheduling of staff within the EOC. **Response**: the Trust has since introduced a temporary team with focus specifically on EOC scheduling.

3. The Trust found weaknesses in the advertising, selection, recruitment and on-boarding process - leading to missed opportunities to fill vacancies appropriately. **Response**: A temporary 'Training Lead' role was created to manage the CAD training during its initial deployment. This has since been extended to oversee the recruitment process from initial advert through to delivery of a new member of staff into the EOC.

4. The Trust found EOC teams were failing to manage some areas of sickness correctly. **Response**: A new temporary HR Advisor role was subsequently introduced in January to help the EOC teams have a better focus on staff sickness and be supported in managing all HR issues more effectively.

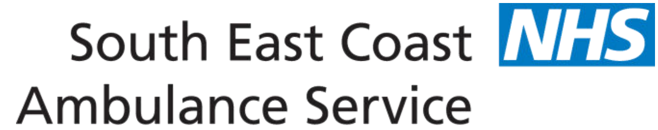
5. The retention of staff remains an issue, particularly so for the West EOC where the cost of living is higher and nearby businesses are offering better pay and benefits packages for similar roles. **Response:** To help resolve this, a business case has been created to support paying EMAs recruitment and retention premia and to provide progression routes for EMAs.

6. The Trust identified that there was a need to process map the current role of the EMA. Over time it has become complex and subsequently it can be difficult to understand where areas of weakness are and how this can be improved. **Response:** This trust will accurately identify process times, and compare/benchmark with other trusts to help understand and resolve issues.

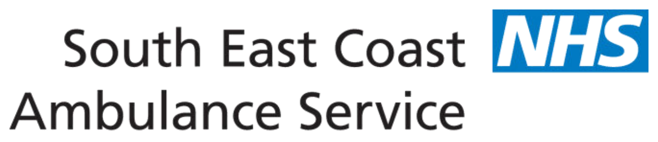
7. The Trust has a number of issues with technology and continue to find the existing phone system a challenge to work with. **Response:** The trust has gone out to tender for a new telephony and voice recorder solution to help resolve the challenges. In the short term the Trust has introduced a thorough three step process for the collation, reporting and issuance of data reports.

8. The EOC task and finish group meets weekly and reports into the Turnaround Executive committee where the plan, objectives and risks are reviewed. The 95% 5 second call answer performance target trajectory is due to be achieved by August 2018 and as reported the Trust continues to proactively manage the risk of sustained recruitment and retention.

		Item No	197
Name of meeting	Trust Board		
Date	27 March 2018		
Name of paper	Integrated Performance Report (March 2018)		
Executive sponsor	Steve Emerton Executive Director for Strategy & Business Development		
Author name and role	Steve Emerton Executive Director for Strategy & Business Development		
Synopsis (up to 120 words)	This Integrated Performance Report continues to respond to the feedback given at the Trust Board held in January 2018. It is intended to develop this report such that updates on data and supporting narrative in all areas are included under the headings of CQC domains. This will ensure that the reader and the Trust Board have a clear line of sight on recovery and sustained delivery by domain. The report includes clinical safety, clinical quality, operational performance, workforce and finance. The Director for Strategy and Business Development for SECAmb will work with relevant stakeholders to ensure that reporting and information sharing on a monthly cycle will deliver the required assurance for the Trust Board our Regulators and stakeholders.		
Recommendations, decisions or actions sought	What is the board/committee being asked to consider and/or decide? • To note current position and activities to mitigate risk		
Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).		**No**	



		Item No	199/17
Name of meeting	Trust Board		
Date	27 March 2018		
Name of paper	Health & Safety Update		
Executive sponsor	Daren Mochrie, Chief Executive		
Author name and role	Steve Lennox, Director of Nursing & Quality Giles Adams, Head of Compliance Julia Brown, Health & Safety Manager		
Synopsis, including any notable gaps/issues in the system(s) you describe (up to 150 words)	This paper updates the Trust Board on work being undertaken within the Health & Safety portfolio. There has been some fluctuation in the personnel within this portfolio and this has revealed the need to invest further in the oversight of Health & Safety. A plan for investment has been approved and this is highlighted within the paper. An independent audit is also being undertaken to establish the Trust's current compliance with best practice and once delivered in April a comprehensive action plan will be developed. In the meantime, priorities have been identified and the paper provides a commentary on progress. A copy of the Health & Safety dashboard is also attached for information.		
Recommendations, decisions or actions sought	For information and assurance		



Quarterly Report, Q3 2017/18
Updated for March Trust Board

Health & Safety

1. Introduction

1.1. This quarterly report is an updated report for Trust Board. The paper originated as the new quarterly Health & Safety but has been updated to answer some of the themes emerging from the recent IOSH training for Board members.

1.2. The Head of Compliance and Health and Safety Manager produced the initial report. The Head of Compliance reports directly to the Executive Director for Nursing and Quality who is responsible for the strategic direction and compliance of health and safety practice throughout the Trust. Responsibility for ensuring staff are safe rests with all Directors and managers. A Health and safety team supports the Head of Compliance.

1.3. Health and Safety should be an organisational priority and have visibility not only because of the potential risks posed to our people, visitors and patients' health and safety but also because of the sentencing guidelines for health and safety offences which came in to force on 1st February 2016. These provide for the first time clear guidance on how all health and safety cases should be sentenced.

1.4. The main effect of the change to the guidelines has been a rise in the number and size of fines for health and safety offences. Large fines are no longer limited to cases involving a fatality and are being imposed even where an actual incident has been avoided. This is because the guidelines place a greater focus on exposing workers to risk. Individuals responsible are coming under greater scrutiny and aggravating factors, such as cost-cutting at the expense of safety, will push the penalty up the scale from the starting point.

1.5. In the Health and Safety Executive (HSE) strategy document published in 2016 they set six strategic themes

- Acting together: Promoting broader ownership of health and safety in Great Britain
- Tackling ill health: Highlighting and tackling the costs of work-related ill health
- Managing risk well: Simplifying risk management and helping business to grow
- Supporting small employers: Giving SMEs simple advice so they know what they have to do
- Keeping pace with change: Anticipating and tackling new health and safety challenges
- Sharing our success: Promoting the benefits of Great Britain's world-class health and safety system

1.6. The HSE have set three priority area for NHS Trusts, manual handling, stress, and violence and aggression. All three areas are of concern for SECAmb as they are for all ambulance Trusts due to the nature of our work and the wide and varied environments in which we operate.

1.7. This paper is the first quarterly report on H&S for the Trust and aims to identify the current position, risks and work streams underway and planned to make our Trust a safer place to work for our people, contractors and visitors.

2. Health & Safety Team

2.1. The Trust has recently recognised that additional specialist resources are required for this important aspect of our work. An uplift in the team has been approved and is in various stages of implementation (see table below).

Post	Previous	Approved	Status Update
Head of Compliance Band 8C	X1 Secondment	X1 Substantive	Advert planned for 09/03/18
Head of Health & Safety Band 8B	None	X1 new post	Advert closed. Shortlisting in place
Health & Safety Manager Band 7	X2 (one vacant post)	X3 (one in post)	Advert planned for 17/03/18 for the additional two posts
Back Care Advisor Band 6	X1 (Covered by bank)	X1	Advert planned for 24/03/18

2.2. This is a significant enhancement to the team. It should allow the Trust to make significant improvements to the Health & Safety portfolio. The structure will allow a Health & Safety Manager in each of the three Operational areas (East, West, Others) and they will build relationships with the respective management teams.

3. Current Actions

3.1. A number of actions are currently in place to help raise the profile of Health & Safety across the Trust. The most significant actions are;

- Increase in establishment of the H&S Team
- Establishment of a H&S dashboard for H&S working group (see appendix 1) Introduce a range of H&S metrics into the Integrated Performance Report
- Undertake a HSE inspection visit in February 2018 focussing on Muscular Skeletal Disorders
- Launch an audit by an independent H&S expert to undertake a gap analysis which is due for presentation to Trust Board in April 2018.
- Invite all members of the Trust Board to undertake IOSH training. At the time of completing this report, 5 members had been trained in the first session.
- The Health & Safety Working Group has been escalated to a monthly meeting.

4. Governance

4.1. The governance of Health & Safety is as follows;

4.2. The Director of Nursing & Quality is responsible for monitoring compliance with H&S and for the processes where the Trust maintains oversight of compliance to the legislative and good practice requirements.

4.3. The Director of Human Resources is responsible for the welfare of the workforce.

4.4. The Director of Operations is responsible for the management of the workforce.

4.5. The Finance Director is responsible for the built environment.

4.6. The Health & Safety Working Group is currently chaired by the Head of Compliance and reports into the Executive Management Board. Health & Safety comes under the purview of the Trust Board's Workforce and Wellbeing Committee.

4.7. Once the current audit has been complete a comprehensive Action Plan will be developed that will drive the work of the Health & Safety Working Group (this is detailed later in this report).

5. Current Health & Safety Risks

5.1. All Health and Safety risks rated over 12 are visible for the Board to monitor through the corporate risk register on Datix as summarised below with actions to mitigate;

- **Contractor controls assurance** – Revised policy and procedure and audit schedule to be developed

- **Fleet ergonomic assessments** – currently no capacity or expertise within the team to carry this out. Either through recruitment into the trainer/back care specialist role or externally sourced, a new policy and procedure can be produced with task specific ergonomic risk assessments and subsequent promotion.

- **Incidents of violence and aggression against staff** - History marking, dynamic risk assessment of scene, pre deployment risk assessments by EOC, security folder for alerts/updates at each site, man down facility on airwave radios, articles and individual guidance, program of OU talks and guidance by security manager, CFR deployment protocol, development of single responder task and finish group and policy, future development of violence and aggression procedure and updated conflict resolution training.

- **Musculo-skeletal disorders and manual handling injuries** – key skills programme, dynamic risk assessment, DSE policy including self-assessment and trained assessors, occupational health fast track referral, revised manual handling training for induction and key skills, new effective moving and handling policy and procedure and bariatric procedure to JPF 20/03/18, employ competent person i.e., back care specialist.

- **Non-compliance with The Regulatory Reform (Fire Safety) Order (RRFSO)** - fire risk assessments for all sites have been completed by Facilities Management Contractor (Oakleaf), facilities management contractor (Rydon) is contracted to

provide fire safety checks for all sites, central health and safety working group (forum) has oversight of the outcomes from the fire risk assessments, fire policy agreed, fire marshal training program for all sites well under way, fire risk assessments and actions to be shared by estates with accountable person for each site , site fire evacuation procedures to be audited by H&S, central health & safety working group to receive assurance the facilities management contractor is reacting to identified fire safety concerns.

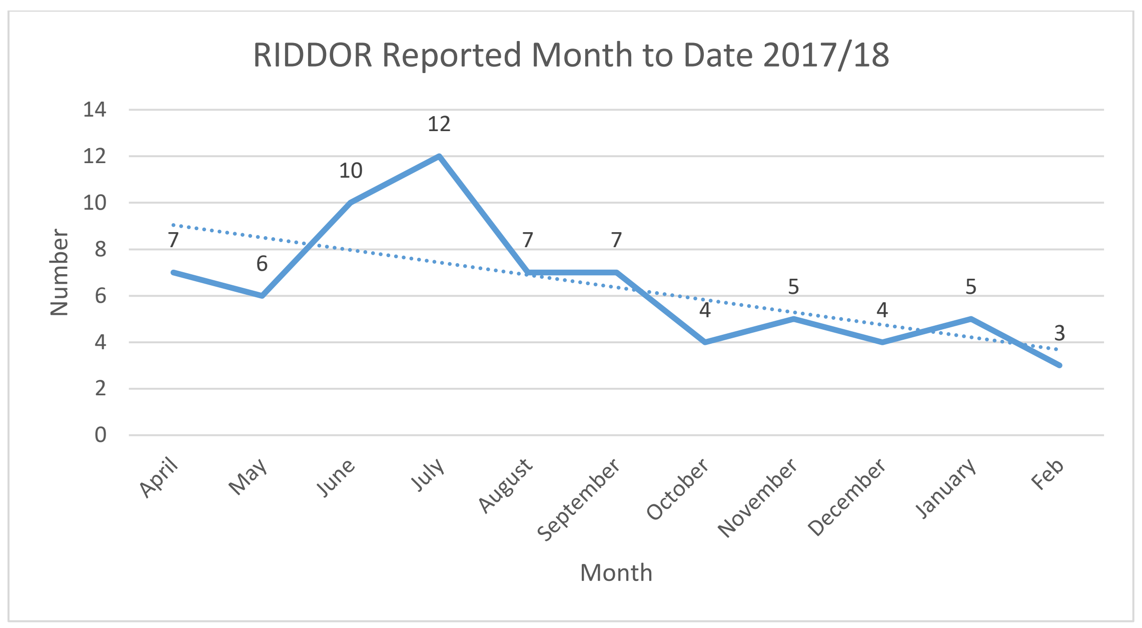
- **Fleet working at height** - written safe system of work in place for all fleet workers, all work on vehicle roofs currently contracted out.

6. Statistics

6.1. All organisations are required to follow the legislation on RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) 1995. This requires the reporting of any absence from work of over seven days as a result of a work related injury or illness.

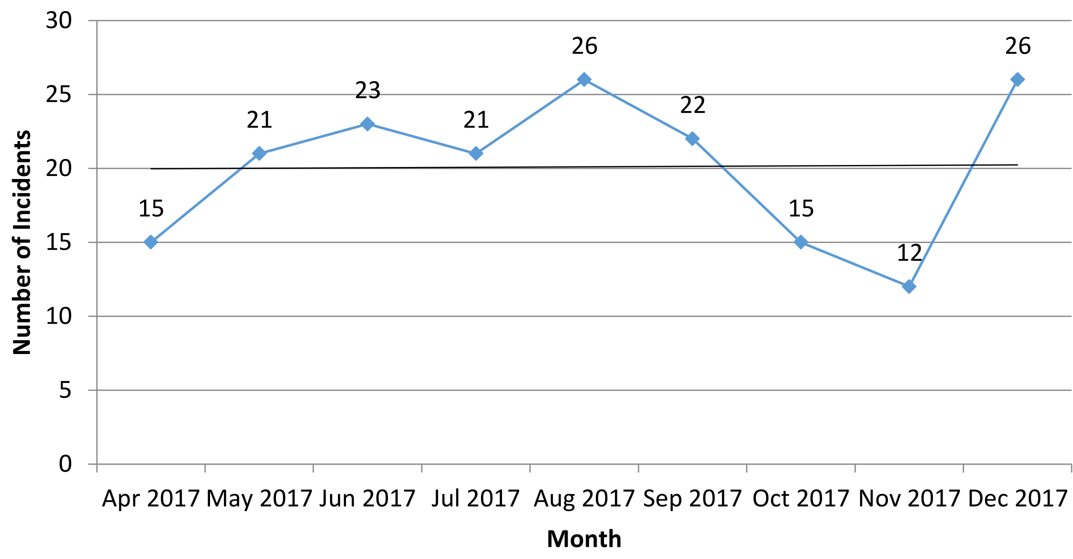
6.2. This should be recorded in the “accident book” and SECAmb uses the Datix system for this. These are required to be reported to the HSE within 15 days of occurrence.

Chart 1: RIDDOR reporting



6.3. All manual handling incidents including no or low harm are recorded on Datix and are predominantly associated with moving patients using equipment and are not always avoidable

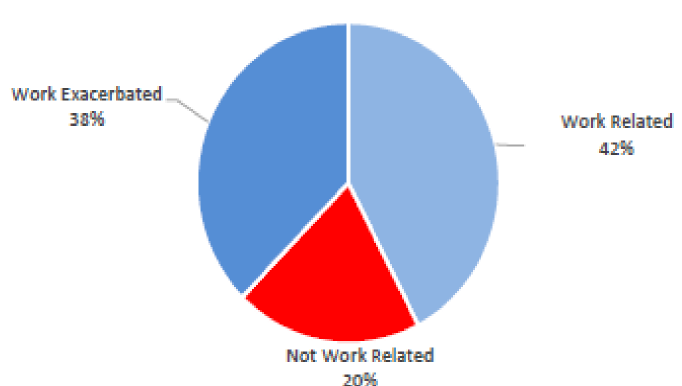
Chart 2. Manual Handling Incidents



6.4. All muscular skeletal disorders are referred to the Trust's occupational health provider Optima Health who collect aggregated data showing that the top three injury areas are; lower back 53%, shoulder 16% and knee 7%. They also record whether it was a new caused at work or not or if it is an existing injury exacerbated at work.

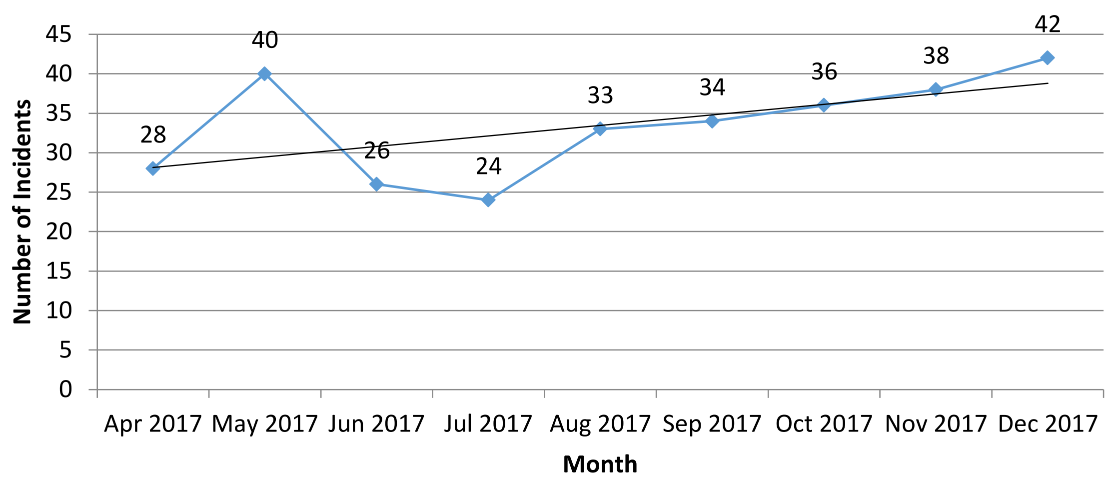
Chart 3. Referral (Injury cause)

Referral Root Analysis: Injury Cause (December 2017)



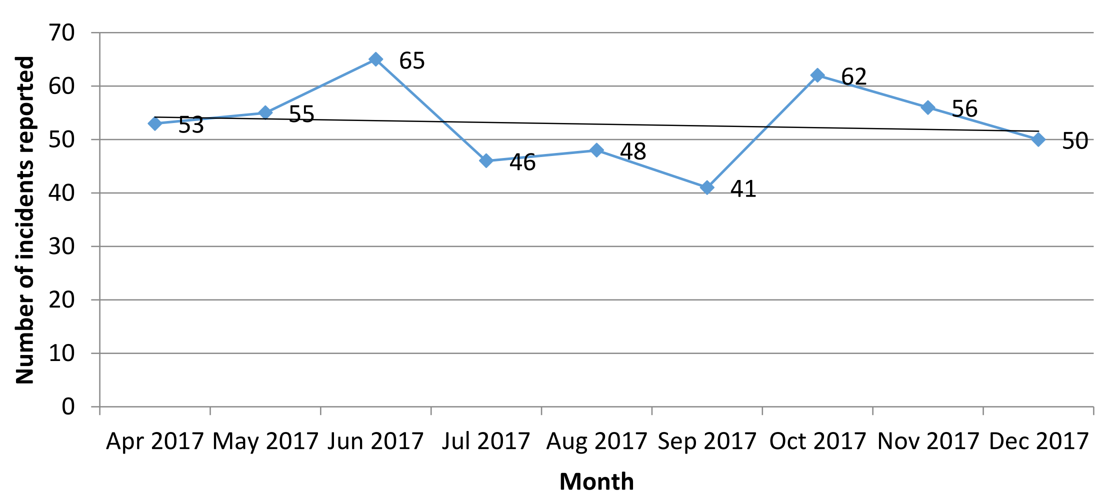
6.5. H&S incidents reported that do not result in a manual handling issue or RIDDOR report therefore likely to be a near miss.

Chart 4. Q3 Incidents



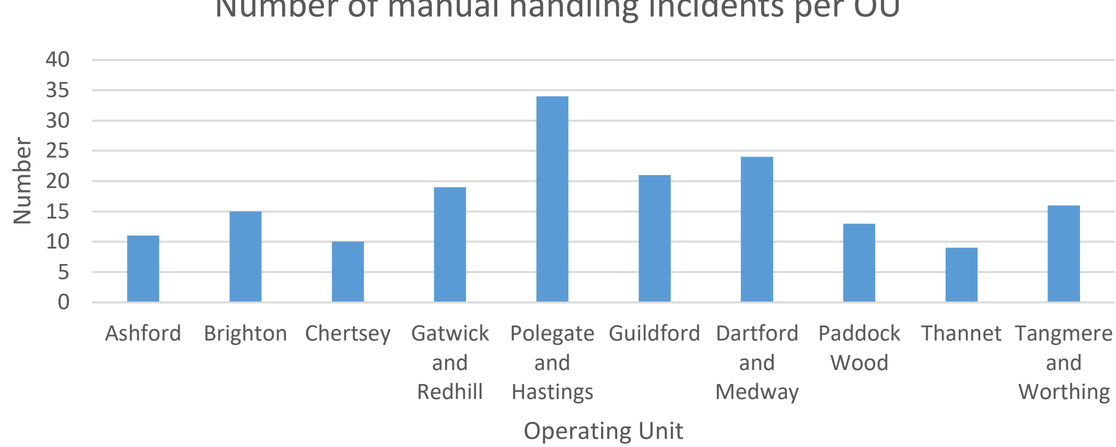
6.6. The number of reported incidents of violence and aggression toward our people. These incidents range from verbal abuse to actual physical assault.

Chart 5. Violence & Aggression



6.7. The Trust operates from 10 operating units (OU) and to establish shared awareness and learning opportunities the graph below shows the number of reported manual handling incidents by OU.

Chart 6. Manual handling incidents by Operating Unit



7. Themes and Trends

7.1. The RIDDOR data in 6.2. are comprised of the confirmed reports to the HSE recorded in the month that they are reported, with the majority of absences >7 days caused by lifting and handling injuries. Use of the carry chair is reported by staff on Datix as the most common cause.

7.2. Overall, it shows a downward trend this financial year which is positive as it points towards a lower number of absences as a result of injuries at work. However the numbers are low are subject to slight change as there a small number of needle stick and contamination incidents where blood test results have not yet been confirmed and therefore may become RIDDOR reportable.

7.3. The Trust currently does not always meet the timescales for RIDDOR reporting. One suggested reason for this is that the current policy on incident reporting states that if a member of staff cannot complete a report at the time then they should complete it on their return. Clearly if this is longer than 15 days this will result in non-compliance with the statutory timeframe.

7.4. In 6.4. An upward trend is seen in the reporting of H&S incidents which is in line with the Trust's intention to increase the number of low/no harm incident reports. This is an indication of greater awareness of potential risks and therefore a safer working environment.

7.5. Manual handling incidents show a steady trend in 6.5. but there is considerable variation between OUs. The OUs do vary in head count of staff but this does not account for the size of the variation. More analysis is required to establish if the variation is due to differing operational practices or a better reporting culture in some areas with higher reporting of near misses.

7.6. While the number of reported incidents of violence and aggression directed at our people continues to show a slow downward trend with 476 reported to 31/12/17 compared to 554 at the same time last year, it is still unacceptably high.

8. Lessons Learned

8.1. The quarterly Central Health and Safety Working Group has been escalated to a monthly meeting to reflect the workload of the group (CHSWG). The terms of reference were also reviewed and revised to ensure the right attendance list.

8.2. CHSWG decided that the area H&S meetings also needed to be resumed after nearly 12 months hiatus. The group felt strongly that this would allow greater local ownership and resolution of lower level problems so that the central group could focus on the more overarching issues. These will begin again in February. In addition, Health & Safety is being added to the agenda at the Area Governance meetings but will not be able to flourish until the new band 7 H&S managers have taken up post.

8.3. With the reinstatement of local/area H&S meetings, East West and EOC/HART, will come the revitalisation of the site health and safety site inspection process. This will allow monitoring of OU compliance with H&S inspections and will highlight any issues where learning can be shared and support offered.

8.4. A robust action plan is now attached to all H&S risks on the risk register along with a principle risk lead as this will help to drive change and will be reviewed at the CHSWG. (Appx 1)

8.5. The vast majority of the actions are RAG rated as High or Extreme due to the potential consequences. However, the aspiration is to reduce them to moderate or low.

8.6. To enable an objective baseline assessment of where we are on H&S, the Trust is commissioning an independent external review to inform a new service improvement plan.

8.7. Analysis of DATIX and RIDDOR reports has highlighted emergency patient moves and the carry chair as the cause of many of our MSDs often with the added factor of heavy patients of difficult environments. This has led to a full review of Trust risk assessments along with new high risk activity risk assessments.

8.8. The Bariatric policy is being reviewed to ensure that it is still fit for purpose.

8.9. The manual handling policy was out of date and there is a draft new moving and handling policy in progress.

8.10. Completion of DSE self-assessments is relatively low.

8.11. Fire safety compliance continues to be a challenge, highlighted by a false activation of a fire alarm in Banstead and a lack of knowledge/ownership to resolve appropriately. This was as a direct result of the move to Crawley and the limited staff left on site not being fully considered, although this has now been resolved. A visit to Coxheath highlighted that the majority of emergency lighting was not working and that the fire escapes were poorly maintained but there is a schedule of works that will remedy this.

8.12. Quality assurance visits and reports from local managers found that fire extinguishers on several sites had not had their annual checks and were therefore out of date.

9. Lessons Shared

9.1. A new Health and Safety policy has been written laying out the Trust's intention, which will help to shape its strategy. This will be shared with all staff and will be available on the Trust's intranet site, the Zone.

9.2. The reporting of RIDDOR in a timely fashion was linked to poor compliance with DATIX investigations by managers. A letter was drafted for the Director of Operations and sent to all OUMs, to cascade to their teams ensuring that managers are aware of the importance of reporting at the earliest opportunity.

10. Improvement Plan

10.1. An improvement plan is in development for the Central health & Safety Working Group to monitor and deliver. This will be developed further once the audit has been completed. But the key areas are as follows;

- Enhance the H&S team with a Head of Health and Safety and a further H&S manager.

- Commission an external review of the Trust's H&S provision to establish an independent appraisal of where we are and to highlight some further improvement actions.

- Creation of Area H&S groups to deal with local issues and share solutions, escalating problems that cannot be resolved to the CHSWG.

- Review of all risk assessments for equipment and vehicles and the creation of a suite of risk assessments to address the more regular but challenging scenarios faced by our people.

- Review of the Bariatric procedure to ensure that it is fit for purpose and meets the needs in this growing area of health provision.

- Creation of a new system for the inspection of Trust sites and the recording of this information that it open and available to allow shared learning.

- Consider the use of a digital solution such as SHE software to manage the Trust's H&S requirements and to aid with data collection and statutory reporting requirements.

- Commence a program of training for all managers that aims to improve knowledge of H&S law, the Trust's policies and procedures, risk assessments and safe systems of working, accident investigations and the new workplace site inspections. This will be a long half day, in house session.

- Improve Board awareness by providing an IOSH Safety for Directors and Executives course, instigating a program of Board safety walk rounds at all sites and including H&S metrics in future board reports.

- Explore the instigation of an individual welfare assessment within the ACTUS appraisal process to allow greater first line management awareness of specific issues and personal responsibility for welfare and limitations.

- H&S team to work closely with clinical education to ensure that lesson plans for 2018/19 mandatory training cover risk assessments and safe systems of work.

- Highlight more opportunities for shared learning,

11. Conclusion

11.1. The H&S team has had a period of instability and which has resulted in a predominantly reactive service. The new structure of the team will allow a far more proactive approach and a greater ability to share learning.

11.2. Shared learning is the key for a safer working environment for our people and this report highlights that there is potential for improvement in this area that will begin to be addressed by the area H&S meetings.

11.3. The Trust is committed to making the working conditions as safe is as practicably possible to allow our people to “Go Home Healthy”.

11.4. H&S has not always had a high profile within the Trust but there is a desire from road to board to ensure that it is visible and incorporated in all that we do.

11.5. We have highlighted many areas for improvement and the strengthened H&S team will allow greater focus, grip and pace to drive change.

11.6. We need to reduce our Muscular Skeletal Disorders, which includes the lifting and handling injuries, but also disorders associated with workstation set up, repetitive strain etc.

11.7. We have a good working relationship with all of the recognised unions who are all attendees at the CHSWG and who are all committed to working together to improve safety.

11.8. The openness exhibited by the Trust in commissioning an external review into H&S should add weight to the improvement plan and will undoubtedly highlight further areas which require improvement.

11.9. When appointed the Head of H&S will need to develop a full improvement plan following the model used for the CQC improvement plans, which considers realistic and achievable targets and develops subsequent actions that will demonstrate a positive trajectory.

Appendix 1

Health and Safety Summary February 2018

05

Incident Reporting DATIX (4th December – 4th February 2018)
Number of incidents: 1546
Near misses: 142 Non-clinical related: not reported
Violence and aggression: of which Knife related
Manual handling: see next slide

Number New PL claims: Costs of claims paid out -
Number New EL claims: Costs of claims paid out -

RIDDOR	Dec 4th – Dec 31st	2017*	2018
Total	12	79	9
Over 7 day absences (injury)	12	72	8
Dangerous Occurrence	0	1	0
Occupational disease	0	6	0

Health and Safety update

- Policies to JPF February include MH, Bariatric, Fire Safety
- Re-writes for e-learning
- Site Safety inspections to be carried out or reviewed by the Station managers with the support of health and safety – on hold
- Training by Safety Managers on hold for all site managers and champions having health and safety responsibility to cover managing safely, risk assessment, accident investigation, DATIX reporting, Riddor compliance, and site safety inspections.

HSE contact

- HSE visit to SECAmb took place Friday 2nd February 2018
- HSE emailed re Manual Handling injury ref DCA doors
- HSE/NARSAF joint National MH working group 1st March

Risk Assessments	Percentage completed Trust wide
High risk activity risk assessments	1
Manual handling equipment/activities	unknown
DSEAR COSHH PUWER	unknown
Building site risk assessments	unknown
Fire Risk Assessments	100%
First Aid risk assessments	0%
Vehicle risk assessments	unknown

Current Challenges in Safety

- Lack of resource, e.g. Admin
- Slow reactivity of the organisation to address health and safety issues
- Violence and aggression against frontline staff
- Compliance with Fire Safety order 2005
- Compliance with Management Regulations 1999 – lack of Risk Assessments
- Poor levels of incident investigation
- Injuries resulting from manual handling
- Contractor Control

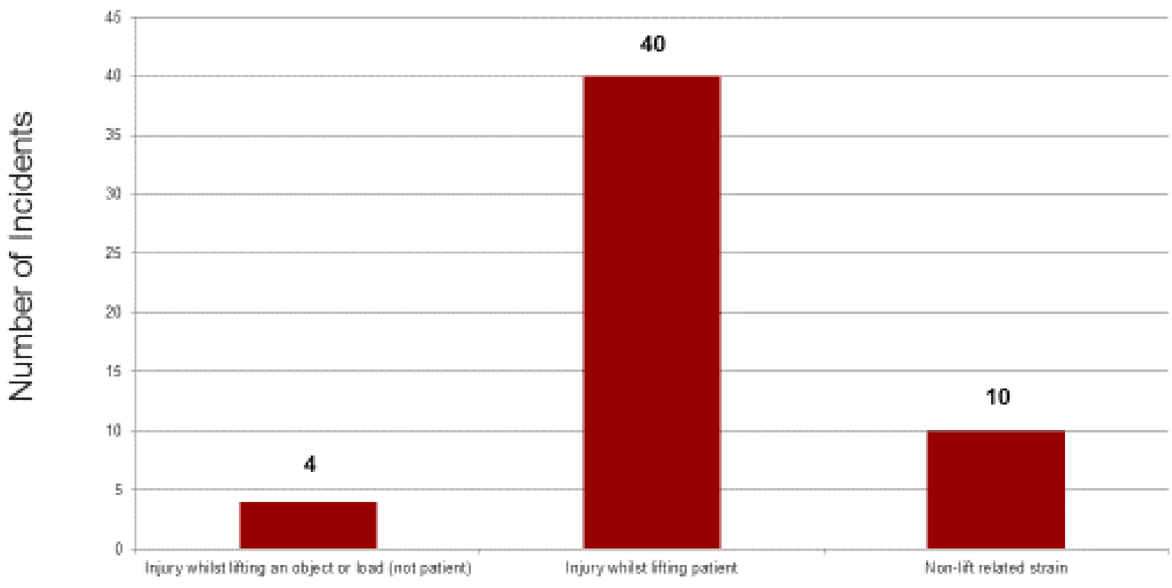
Health and Safety Training	Completed in this reporting period
DSE Assessor	0
Fire Marshal/Fire Induction	0
First Aid	0

Workplace site inspections: completion by area
West:
East:
Fire Evacuation tests :
West: no figures
East: no figures

Appendix 2

Health and safety: Manual Handling incidents 05

Incidents by Sub-Category for Health and Safety Manual Handling
December 4th – February 4th = incidents



SECAMB Board

QPS Escalation report to the Board

<table>
<tr><td>Date of meeting</td><td>08 March 2018</td></tr>
<tr><td>Overview of issues/areas covered at the meeting:</td><td>This meeting considered a number of Management Responses (response to previous items scrutinised by the committee), including:

Mental Health Complaints(Assured)
In January, the committee received a position paper on the Trust's mental health care provision. It noted a potential disparity in how complaints were handled involving people with mental health difficulties, in light of the numbers not upheld. However, the evidence provided in the management response assured it that there is no such disparity.

Management also confirmed that data is being captured to allow the service to know the numbers of children conveyed under s.136 of the Mental Health Act, and the committee was assured by evidence provided showing the good response times for all patients conveyed under 136. The aim is to include this data in the Trust Board's integrated performance report, as part of its revision.

In addition, the committee discussed some disparity in the S136 conveyance data that has been identified. It was agreed that a paper would be bought to the committee in May to clarify the position.

Patient Care Records (Partially Assured)
The committee sought evidence from the legal and patient experience teams in relation to the numbers of times they could not provide a PCR on request, and whilst there remains an issue with unreconciled PCR's the data provided provides assurance that the Trust is able to locate records when needed. . Management will ensure an incident is formally reported via Datix when a PCR cannot be provided, so that this can be monitored.

Medical Equipment (Not Assured)
Management deferred this response due a finding during a recent Quality Assurance Visit that has given rise to concern about the reliability of the equipment servicing data. This is being explored and the committee will consider the findings in April.

Infection Prevention & Control (Partially Assured)
In January, the committee was assured that this is an area being given much focus by management. However, it asked for an interim update on the specific measures being put in place to ensure sustained improvement, to include the number of audits completed and the related compliance. The evidence provided demonstrated to the committee that we are heading in the right direction.

The committee thanked management for the responses in the specific areas, which were clear and addressed the questions.

The meeting also considered a number of Scrutiny Items (where the</td></tr>
</table>

	committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas), including; **The 'tail' (Not Assured & Escalation to Board** The committee received a presentation providing an overview of call answer performance from November 2017 to January 2018, which included a breakdown of fractile times to demonstrate the longest calls. The committee was extremely concerned by the performance and continued issues. This was most starkly highlighted by our performance in relation to other Ambulance Trusts. . Management confirmed the actions being taken to manage call answer as part of the improvement plan, which is being monitored via the EOC Task and Finish Group. The committee challenged the plan, testing the extent to which it is too optimistic given the reality of the size and complexity of the issues. In particular, recruitment and retention in the EOC. The committee has asked the workforce and wellbeing committee to scrutinise the actions being taken to improve EOC recruitment and retention; it plans to do this in May. The committee asked the Executive to consider what else we could do to improve performance in this area and agreed this issue should be escalated to the Board. **111 (Partially Assured)** The committee scrutinised 111 performance, its clinical indicators, audit compliance, patient outcomes, and risks. Whilst the service has been compliant with quality aspects such as complaints responses and pathways audit it is clear that the performance of 111 has dropped since the end of Q3. The committee explored the call routing project that led to some of the issues from November 2017 and identified concern about internal governance, which it has asked the CEO to further explore and revert upon. It also considered the 111 Operational Recovery Plan that has been put in place to rectify the issues, which is demonstrating some improvement. **Use and impact of the Demand Management Plan over Christmas / New Year (Assured)** The paper set out the actions taken following the business continuity incident during this period, and use of the demand management plan. The committee noted the high number of hours lost through hospital handover delays, acknowledging some things are not within our control. Overall, the committee felt that this period was well planned and despite the challenges well managed. Management confirmed that it is reviewing the serious incidents during this period to consider any themes, and will bring back the findings to the committee. It is also undertaking a similar review during the week of adverse weather, late February / early March. **NARU Interoperable Capability Project (Partially Assured)** Management set out the current position with regard to the NARU Interoperable Capability Project. It noted the actions and will receive an update in May. In addition, it was agreed a paper was required that will provide an overview on all aspects of HART (governance, operations etc.) will be brought in September 2018 prior to the next HART review.

	Consent to Treatment (Assured) The committee explored the extent to which consent to treatment is being sought in line with legislation and guidance. It was assured that consent is taught to all grades of staff, and is well understood, particularly where patients lack capacity. However, it noted a gap in the recording of consent in patients with capacity, and the current PCR not including a specific space on the form to document this. In turn, audit of consent is not currently possible for patients where consent is implied. Management is taking steps to amend the PCR, and will ensure ePCR meets the required standard for recording consent. Despite this, the committee was assured with the systems and practice currently in place and have agreed a paper will be brought in Q2 to provide assurance that appropriate amendments have been made. The committee also received the **Q3 Quality & Safety Report.** This report from the functional areas provided an update on quality and patient safety across the corporate functions and the operational unit areas. The committee felt this was an improved report, and asked management to pull out the learning more specifically in future reports. Some key points included • From the Mortality and Morbidity paper that consideration needs to be given to how to record handover delays more effectively • The committee committed that all members will participate in a QAV visit by end of Q1
Reports *not* received as per the annual work plan and action required	None
Changes to significant risk profile of the trust identified and actions required	**None**
Weaknesses in the design or effectiveness of the system of internal control identified and action required	Management identified that the current **telephone platform** has an anomaly not yet understood which adds 2 seconds to some calls. This supports the case to procure a new 999-telephone system.
Any other matters the	Following the scrutiny of the ‘tail’ the committee did not think the Board is well-enough sighted on all the challenges with **call answer performance**. It asked

Committee wishes to escalate to the Board	for more detail to be included in the IPR from March. The executive management board approved a business case recently to invest in developing the **EMA career framework** in order to improve recruitment and retention. This creates a career structure, accelerates EMAs through Band 3, and formalises the EMA coach role at Band 4. In addition, EMA team leaders will now move to Band 5 from Band 4. The committee questioned whether this is sufficient or further investment is needed.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Finance & Investment Committee

Date of meeting	5th March 2018
Overview of issues/areas covered at the meeting:	This meeting also considered a number of Scrutiny Items which affect the strategic direction of the Trust **Demand and Capacity Review (interim readout)** The Committee noted the ongoing work, the addition to scope to include EOC and the change in timing for the final report to late April / May. The two different models being considered by Commissioners were discussed and the implications for the organisation reviewed. This included the likely impacts on the wider health care system. The team was asked to provide clear descriptions of the two options and to set out how resources would need to be scaled up in each case. **Integrated Urgent Care (111)** The Committee noted the different Commissioner intentions for Surrey, Sussex and Kent and that attempts to influence the system had been unsuccessful. This would mean that separate bids would be required and that the Commissioners were not interested in synergies with 999 nor maintaining the current call- centre scale benefits. The rational for SECAamb continuing to be involved in the bidding process was discussed. **Business Planning** The Committee noted the 18/19 Financial Plan, which was required to be submitted by NHSI, including the main underpinning assumptions. At present, the plan does not include the output from the Demand and Capacity Review and the resulting operational improvement that this would deliver if additional resources were made available. The Committee noted the "advice" given by NHSI as to how this should be handled. The Committee expect to review a plan as to how resources will be ramped up asap. **EPCR** Although the use of iPads within the Trust was viewed as a major success, the EPCR software has not delivered the Business Case originally approved by the Board. The Executive Team were reviewing options and will make recommendations asap.
Reports *not* received as per the annual work plan and action required	• None
Changes to significant risk profile of the trust identified and actions	• Slippage in the timetable for delivering the capacity review output which may affect the ability to produce a robust Business Plan. • Plans for EPCR.

required	• Fleet and IT Enabling Strategies remain outstanding.
Weaknesses in the design or effectiveness of the system of internal control identified and action required	• none
Any other matters the Committee wishes to escalate to the Board	1. Way forward for EPCR and iPads. 2. Demand and Capacity Review outputs and expected outcomes 3. 2018/19 Business plan implications.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	08 March 2018
Overview of issues/areas covered at the meeting:	This was moved from February due to a national winter pressures meeting. The meeting considered a number of ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas),* including; **Appraisals (Assured)** The committee noted the good progress with appraisals / career conversations. The Trust was at 86% as of 19 February 2018. The next step is to improve the quality of appraisals. **Gender Pay Gap (Partially Assured)** There is still analysis to complete in order to get the full picture. The paper confirmed there is a good staff gender balance. There is a WRES workshop for the Trust Board on 27 March and the committee will continue to keep this area under review until all the analysis is complete. **Personnel files (Not Assured)** The committee was not assured that there is robust systems to manage staff files. It has asked management for more information in order to fully understand the issue and will consider this at the next meeting. **EOC Staff (Assured)** The committee explored an issue raised by the audit committee, which the Trust Board also discussed recently, about anecdotal evidence that staff in the EOC sometimes deal with inappropriate behaviour from other professionals. The director of operations looked in to this and could not find any direct evidence, by talking to staff and listening to recordings. EOC staff have been encouraged to report any such behaviour. The committee also reviewed the usual **workforce dashboard**. In consideration of this it has asked management to provide better clarity on vacancy levels to establish the extent to which we should expect a level of vacancy to provide for flexible working. The committee was also concerned about turnover rates, in particular in the EOC, which is not sustainable. It asked that EOC recruitment and retention be specifically included on the dashboard going forward. **Workforce planning assumptions** was considered and the committee requested for the next meeting the plan for developing the workforce plan. The staff survey results were discussed. The committee shared the disappointment of management with the overall results. Despite this, some green shoots were noted, especially about section 7 "your manager".

Reports *not* received as per the annual work plan and action required	None
Changes to significant risk profile of the trust identified and actions required	None – the committee reviewed the workforce risks on the risk register and was confident that they reflected the current issues.
Weaknesses in the design or effectiveness of the system of internal control identified and action required	The Board should note the significant issue of recruitment and retention. Specifically within the EOC. The committee acknowledged this is a difficult issue to resolve and that management is working hard to find solutions, but felt that we need to think even more creatively.
Any other matters the Committee wishes to escalate to the Board	The workforce plan is on progress and the committee will scrutinise the plan to develop the plan at its next meeting. The committee will also prioritise the scrutiny of health and safety during Q1 of 2018/19.

SECAMB Board

Summary Report on the Audit Committee Meeting of 5th March 2018

<table>
<tr><td>Date of meeting</td><td>5 March 2018</td></tr>
<tr><td>Overview of issues/areas covered at the meeting:</td><td>The key areas covered in this meeting related to Internal Audit, Policy Oversight & Risk Management

The Committee was concerned at the number of outstanding Audit Actions; however many relate to HR. The Committee was confident that these would be addressed swiftly by the new HR Director
The preliminary Internal Audit Opinion for 2017/18 is disappointing but not surprising. A final opinion will be presented to the Committee in May together with the balance of Internal Audit Reports in relation to the 2017/18 audit program
The committee found it easy to commend recent developments in Risk Management, but was disappointed that neither the Risk Register nor a report based upon it could yet be recommended to the Board.
The Executive was keen to present the Risk Register to the March 2018 Board; however, the recommendation of the committee was that an Exceptional Audit Committee should be planned for April to scrutinise Risk Management matters with the aim of recommending a Board Assurance Framework, an overall Risk Register and an overall Risk Report to the April Board. Peter Lee will organise after consultation with executive colleagues / consideration of other priorities and invite all Directors (attendance of ED and NED that do not normally take part in AuC to be optional)
Peter Lee will agree with Board subcommittee chairs the policies to be overseen by each Committee with Audit Committee picking up the balance

Concerns over the quality of Health & Safety at SECAmb had recently been raised with the Audit Chair. In the discussion that followed, it was noted that:

The Executive were intending to present a Health & Safety paper to the March 2018 Board
Health & Safety was within the purview of the Workforce Committee. The Audit Committee asked for confirmation from the Workforce Committee as to its state of confidence/assurance in this area
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<tr><td>Board Assurance Framework (BAF)</td><td>Due to time pressures and other emerging priorities, the executive had not been able to prepare a new Board Assurance Framework proposal. The will be considered now at the April Exceptional Audit Committee.

The Committee has previously stated its expectations in this area, with the Audit Chair running a workshop for the Executive in December 2017. The Committee expects an effective BAF to cover ALL of the following questions:

Are policies appropriate, up to date and working effectively?
Are Key controls identified and working effectively?
Progress against Strategy/plans and other agreed target standards, identifying any regulatory standards and/or stakeholder expectations that we do not intend to
</td></tr>
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	achieve? • Have key risks been considered, reported and managed appropriately?
Risk Register and Risk Report	The committee reviewed the design of a new Risk Management process and the latest draft of an overall SECAmb Risk Register. No Risk Report was presented. Progress over the last year must be seen as disappointing; however the Committee was able to commend recent developments and an obvious new emphasis in this area. The Committee was unable to recommend the Risk Register to the Board at this stage and recommended that an Exceptional Audit Committee be established in April with an aim of recommending a Risk Register and a Risk Report to the April Board
Policy Suite Review	It was agreed that Peter Lee would work with each Board subcommittee to agree a list of policies to be subject to oversight by that committee. The Audit Committee will oversee all policies not being overseen by any other Board subcommittee
Internal Audit and Fraud Management	The Committee was concerned with the number of overdue Audit Actions, but recognised that most of these related to the HR area. The executive assured the committee that the new HR director would move forward the actions quickly unless more pressing priorities were to arise. The committee accepted the 2018/2019 Counter Fraud plan as presented but asked RSM and David Hammond to review the relative resources being expended between Internal Audit and Counter Fraud Activities against a hypothesis that SECAmb would benefit from a re-allocation towards Internal Audit activity over the next year. The Draft Internal Audit Opinion remains preliminary. The Committee was disappointed but not surprised by the opinion offered. Few formal 2017/18 audits have been concluded as yet, but the findings from management reviews and those audits that have been completed are disappointing.