South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

26 April 2018
10.00-13.00

Crawley HQ

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
Introduction					
01/18	10.01	Apologies for absence	-	-	GC
02/18	10.02	Declarations of interest	-	-	GC
03/18	10.03	Minutes of the previous meeting: March 2018	Y	Decision	GC
04/18	10.05	Matters arising (Action log)	Y	Decision	GC
05/18	10.10	Patient story	-	Set the tone	
06/18	10.15	Chief Executive's report	Y	Information	DM
Trust strategy					
07/18	10.25	Delivery Plan Including Deep Dives: • Culture Programme Update • 999 Call Handling • CQC Inspection Preparation	Y Y N Y	Assurance Assurance Assurance Assurance	DM EG JG BH
Risk Management					
08/18	11.15	Risk Report / Board Assurance Framework	Y	Information	PL / BH
Ten Minute Break					
Monitoring performance					
09/18	11.40	Integrated Performance Report	Y	Information	SE
10/18	12.00	Safeguarding Annual Report	Y	Decision	BH
11/18	12.10	Patient Experience Annual Report	Y	Decision	BH
Governance					
12/18	12.20	Paramedic Re-Banding	Y	Information	EG
13/18	12.25	Information Governance Annual Report	Y	Decision	BH
14/18	12.35	GDPR Update	Y	Information	BH
Holding to account					
15/18	12.45	Escalation report; Quality & Patient Safety Committee	Y	Information	LB
16/18	12.50	Escalation report; Audit Committee	Y	Information	AS
17/18	12.55	Any other business	-	Discussion	GC

19/18	-	Review of meeting effectiveness	-	Discussion	ALL
Close of meeting					

Date of next Board meeting: 25 May 2018
After the close of the meeting, questions will be invited from members of the public

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting,
27 March 2018

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

Present:

Richard Foster	(RF)	Chairman
Daren Mochrie	(DM)	Chief Executive
Adrian Twyning	(AT)	Independent Non-Executive Director
Alan Rymer	(AR)	Independent Non-Executive Director
David Hammond	(DH)	Executive Director of Finance & Corporate Services
Ed Griffin	(EG)	Executive Director of HR & OD
Fionna Moore	(FM)	Executive Medical Director
Graham Colbert	(GC)	Independent Non-Executive Director & Deputy Chair
Joe Garcia	(JG)	Executive Director of Operations
Laurie McMahon	(LM)	Independent Non-Executive Director
Lucy Bloem	(LB)	Independent Non-Executive Director
Steve Emerton	(SE)	Executive Director of Strategy & Business Development
Tim Howe	(TH)	Independent Non-Executive Director
Tricia McGregor	(TM)	Independent Non-Executive Director
Terry Parkin	(TP)	Independent Non-Executive Director

In attendance:

Peter Lee	(PL)	Trust Secretary
Janine Compton	(JC)	Head of Communications
Sara Songhurst	(SS)	Deputy Clinical Director

RF welcomed Board members, in particular EG as this was his first Board meeting. RF also thanked SL in his absence, for this support in the past year. Bethan Haskins will be joining in April as Executive Director of Nursing & Quality.

185/17 Apologies for absence

Angela Smith	(AS)	Independent Non-Executive Director
Steve Lennox	(SL)	Executive Director of Nursing & Quality

186/17 Declarations of conflicts of interest

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

187/17 Minutes of the meeting held in public on February 2018

The minutes were approved as a true and accurate record.

DRAFT

188/17 Matters arising (action log)

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

189/17 Patient story [11.04- 11.12]

JC explained that this was a staff story about a member of staff who had experienced violence and aggression at work.

After the film was played RF reflected that he would expect Trust policies in instances like this to be as robust as any other Trust. He confirmed that it is common policy to be clear when staff are assaulted to expect prosecution to take place.

TH noted that the reference in the film to Human Resources has been raised before; in the past, they have been quite rigid and need to show more compassion. EG agreed.

DM referred to a recent presentation by Simon Stevens where he supported ambulance trusts reporting all incidents of assaults on staff.

190/17 Chair's Report [11.12 – 11.14]

RF corrected some errors in his report. The reference to ARC was actually the Nominations Committee and he clarified that appraisals are due to start.

There were no questions in the Chair's report.

191/17 Chief Executive's report [11.14-11.22]

DM highlighted the areas set out in his report.

RF referred to the Trust recently implementing its business continuity arrangements and asked whether the Board should be assured that they are in place and working, or concerned that we needed to implement them as frequently. DM confirmed that both is true. We should not be going in to business continuity as much as we should be, but we know some other Trusts that did trigger business continuity struggled more than we did. DM has asked JG to review this.

JG added that the triggers recently have been as a consequence of system-wide pressures. For example, increased hospital handover delays at a time we take less patients to hospital.

GC noted that during February Cat 3 & Cat 4 performance was significantly worse than January. JG explained that this was because January was relatively settled, and demand then increased following the snow/cold weather in February. Again, this pressure was system-wide.

192/17 Delivery Plan [11.22 – 12.30]

RF confirmed that that the Trust strategy has a 2-year focus on immediate issues and the Board has agreed to review years 3-5 over the next few months. In the meantime, we have asked the Executive to establish an 'elevator view' of the current strategy. The enabling strategies support the overall strategy and the two enabling strategies on the agenda are before the Board for first view. They will then come back the Board in April / May for decision.

DRAFT

ICT Strategy

DH explained that this first draft puts us in a place to build from. At a recent 'flight deck' meeting of 150 operational leaders, we explored what actions would make the biggest difference and most of the feedback related to Wifi and connectivity.

DH confirmed that the work on Wifi is ongoing and will be completed by June 2018. This is why it is not in the strategy itself. We have rolled out I-pads and have a forward-view for EPCR which will be picked up by the relevant project(s).

To make it more meaningful LB felt the strategy should set out the intended impact, rather than just what we are going to do.

LM asked how robust this is in relating to partner information systems. DH explained that we are working with STPs on a number of things. The whole integration needs to be led by the system, but for now there is not a clear view on what the system wants or needs. Therefore, in the meantime, we are engaging them with what we are doing and ensuring what we have in place is interoperable.

RF reminded the Board that he is working with NEDs to designate each to work within specific areas. AT will be working with DH on IT.

Fleet Strategy

JG explained this is a will continue to be a dynamic strategy, reacting to the outcome of the demand and capacity review. DH added that the detailed financial modelling is a work in progress.

RF mentioned that CCTV and body warn cameras are becoming increasingly more important in the criminal justice system. Therefore, when we refresh our fleet, we ought to think about how we use CCTV proactively to help safeguard staff and patients. DM added that body warn cameras are also helpful for training purposes, acknowledging that the healthcare setting has slightly different implications.

Delivery Plan Update:

SE explained this report has further evolved since the last meeting, with greater focus on the narrative report. He handed over to colleagues to update on each of the areas.

Service Transformation

JG confirmed the position with each project as set out in the paper.

GC asked about the system support with hospital handover delays. JG confirmed this is starting to have some impact, and includes looking at the processes within A&E departments. The project has been extended a further 12 months due to the improvements being demonstrated.

Action:
Hospital handover delay presentation to the Single Oversight Group to be provided to FIC to show the positive impact.

TP asked JG which hospitals have shown the most significant improvement and what have they done to achieve this. JG confirmed that William Harvey is one, even during adverse weather and felt this was due to internal leadership at the hospital.

LB asked if we could have sight of performance by hospital.

DRAFT

Action:
The Board to receive data on hospital handover delays by hospital.

Sustainability
DH confirmed the position with each project, as set out in the paper.

GC asked how we ensure that we maintain the quality of Nexus House. DH confirmed we have an internal HQ user group to ensure we do our bit. With regards the communal areas, we are engaged with the landlords.

TH asked about the timeframe for telephony. DH confirmed that the plan is end of May.

Compliance
The progress with each project was highlighted as set out in the paper.

On medical devices, JG added that we were not assured, as we wanted to be and so split this out from the original combined project with risk management. This will help get better grip of the issues, mostly relating to record keeping and maintenance of the asset list. QPS Committee is exploring this.

The Board noted the good progress with improved management of complaints.

In reference to the EOC project RF asked about recruitment and whether it is the view of JG and EG that the things in place will solve the problems. JG explained that the measures we are now taking, e.g. EMA recruitment and retention will help. We can do things to improve the working environment and there is more we can do regarding remuneration; this would come to the Board for decision. JG added that we are recruiting more locally now. From a HR perspective, EG explained we can improve the end-to-end process which will aid retention. The current process is being refreshed, including how we better understand why people leave.

The Board explored the NHS pay deal and the impact of this.

The discussion then turned to medicines governance. SS confirmed that the project is amber on the basis that we need to embed the improvements made over the past year, including the management of controlled drugs. SS explained that some staff are still sometime taking these home rather than signing them back in; broken ampules (due to clumsiness); and drug keys where we still have a significant number of losses.

The Board noted that a number of projects are coming to an end and the need to ensure business as usual process has equally robust checks was acknowledged.

LB asked about infection prevention and control (IPC) and specifically vehicle cleanliness. JG updated that the recent MRC scorecard does show some areas of weakness, mainly with VPP. One of the projects within IPC is to do our own swabbing rather than by a third party. One operating unit has a deep clean performance of 66%, which is concerning. DH explained this also relates to demand and capacity, e.g. churn of vehicles due to being short. The local swabbing is aimed at helping more local ownership. QPS Committee will continue to closely monitor progress with IPC.

Culture and OD
EG updated the Board on Phase 2 of the culture change programme. Work is ongoing to review all projects that has an element of culture change, e.g. hand hygiene. Also, we need to more overtly connect things like leadership walk rounds.

DRAFT

Strategy
SE confirmed that we will be reviewing our strategy (years 3-5) as part of the steering group. He highlighted progress against the four areas as set out in the paper.

193/17 CQC Must Do Update [12.30 – 12.35]
SS explained that this paper draws from the Delivery Plan (compliance) and sets out in more detail the position with progress against the CQC must dos / should dos. DM added that this was developed after feedback from the Board to bring out what the executive live and breathe each day.

The Board felt this was an excellent paper. It helps to better understand the pace and grip in each area.

194/17 Staff Survey Results [12.35-12.38]
EG highlighted the following;

- We need to identify specific areas from the survey to track progress against the culture change programme.
- Pulse Surveys – we need more frequent and more focussed questions.
- We need to look at leaders and managers to think about their impact in the areas of greatest concern.

In summary, this is important intelligence and the next step is to get more granular on the specific metrics.

195/17 Bullying & Harassment Recommendations [12.38-12.45]
This paper updates the Board on how the recommendations are being taken forward. Some areas are complete and others are underway. EG felt some areas need to be more clearly defined, e.g. role of NEDs, and the ongoing voice of staff. We also need to check their understanding of this. In addition, some communication is needed to confirm the work done to-date in response.

Action:
The Board will receive a further update on the actions taken in response to the Bullying & Harassment Report.

196/17 Paramedic Re-Banding [12.45 – 12.46]
EG confirmed that a paper will come to the Board in April.

[Lunch at 12.46]

197/17 IPR [13.20 – 13.51]
SE confirmed this month's report continues to evolve and in due course, the CQC report received earlier will be incorporated in to the IPR.

Directors highlighted the key areas as set out in the report and received questions from the Board.

Clinical Safety:
No questions

DRAFT

Clinical Quality:
LB asked that we now include duty of candour compliance with moderate harm having now got 100% compliance for serious harm.

TH asked about the number of stations not compliant with hand hygiene audits. JG explained the different approach (safe to care) is aimed at encouraging all areas to improve; balancing the approach and performance management. DM explained this detail is addressed through the area governance review meetings.

Operational Performance:
JG specifically highlighted the measures to improve call handling.

GC asked about Cat 3 (45% of what we do) and the current variance. JG explained this relates directly to our inability to resource adequately to ensure timely response to this category of patients. GC also asked about the tail and JG explained that we have looked in detail at tail activity via the demand and capacity review. The modelling will set out the resource needed to meet ARP standards.

SE referred to how crews are allocated to the tail and then re-allocated to higher acuity patients, due to lack of resource. The demand and capacity modelling is such that if we are right sized then in meeting Cat 1 and 2 we will automatically deliver Cat 3 & 4. In turn, this will help call answering, as there will be less callbacks.

In summary, RF reflected that despite doing our best to meet demand, we currently don't have the sufficient resources; this is what the demand and capacity review is aiming to address.

There was then a discussion about 111 and the Board noted the adverse impact on performance by the exponential increase in demand.

Workforce:
EG set out the deep dive in the paper relating to staff turnover challenges and explained the other sources of data we will include going forward, including the feedback from staff who have concerns, and the wellbeing hub.

The Board discussed the potential risk of staff not recognising the career conversation being part of the ongoing appraisal process.

In terms of employee relations cases, RF felt it would help in the future to have a view on what is in the system and time taken to resolve and benchmark against others.

Action:
Data on employee relations cases – numbers outstanding; time taken to resolve; benchmark against others Trusts – to be included in the IPR as part of its review.

Finance:
DH confirmed we have now paid the working capital facility.

No questions.

DRAFT

198/17 Leadership Walk Rounds [13.51 – 13.54]
This is an updated paper from the version received in January. It is something we should do as a Board and fits with well-led and the Francis recommendations relating to the link between "ward and board". We have 100 locations and so it will be 3 or 4 visits each year, per director.

LB agreed the need for this and noted that we must ensure we take account of the quality assurance visits.

199/17 Health & Safety (H&S) [13.54 – 14.00]
This is the first Quarterly H&S report for the Board. It sets out the key priorities, including recruiting to the health and safety team. The health and safety deep dive is underway to get a better assessment of where we are and what we need to do in the immediate and longer term.

AR asked about fire safety inspections and DH confirmed this is pretty much complete from an infrastructure perspective.

Action:
WWC to consider the outcome of the health and safety review/deep dive.

200/17 Quality Account Metrics [14.00 – 14.02]
We now have guidance for the mandated indicators as set out in the paper and what is listed are the topics chosen. It is for the Board to approve the indicators.

Decision:
The Board approved the quality account metrics.

201/17 QPS Committee [14.02- 14.12]
LB took the Board through the headings listed in the escalation report.

LB highlighted in particular the concern explored by the committee relating to call answer, as discussed by the Board earlier.

With regards 111. LB confirmed that from Q3 there has been a drop in performance and the committee explored one particular project and its impact on performance, which it will consider at its next meeting.

There was a discussion about governance in the context of two areas of escalation (111 and HART) being parts of the Trust that are more autonomous. The Board agreed that there is no substitute for a regular programme of looking at everything.

202/17 FIC [14.13- 14.14]
GC added that there was an exceptional meeting held last week to review the approach to the 111 bid in Sussex. We had a good view of this, as discussed in part 2.

There were no questions.

DRAFT

203/17 WWC [14.14- 14.16]

TP explained that the really good news is that we have exceeded the target for appraisals/career conversations. The next step is to demonstrate the impact of these conversations.

TP drew to the Board's attention the issue with management of paperwork. This is a significant risk to the Trust, in particular staff files. Work is needed to mitigate the risks in this area, challenged by the number of moves in the past year or so.

DH added that this was discussed at the last audit committee and the internal audit review will help focus on the solution.

204/17 AUC [14.16-14.17]

This report was taken as read.

205/17 Any other business

LB noted the recent press coverage relating to candidate checks / qualifications and felt that the Board needs assurance this will not happen again. EG confirmed that he has instructed an audit on the pre-qualification checks.

206/17 Review of meeting effectiveness

Questions from observers

There being no further business, the meeting closed at 14.19

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

Date ___________________________

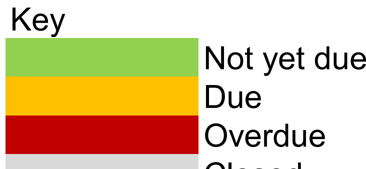
DRAFT

DRAFT

South East Coast Ambulance Service NHS FT action log

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
29.11.2017	132 17 1	Finance Committee to review the finance report(s) to establish how they can include a forward view on the Trust's cash position, to help ensure more informed investment decisions.	DH	TBC	FIC	C	GC confirmed the report includes the cash position - this action can therefore be closed.
25.01.2018	162 17 2	Board to receive a paper in the summer, setting out the totality of the Trust's governance structure. An outline plan of what is to be prepared to be agreed by the Audit Committee.	PL	June	Board	IP	Included on the agenda forward plan for June
27.03.2018	192 3	Hospital handover delay presentation to the Single Oversight Group to be provided to FIC to show the positive impact.	SE	TBC	FIC	IP	
27.03.2018	192 4	The Board to receive data on hospital handover delays by hospital.	JG	April	Board	c	NEDs added to the weekly updated report sent by email.
27.03.2018	195 5	The Board will receive a further update on the actions taken in response to the Bullying & Harassment Report.	EG	TBC	Board	IP	
27.03.2018	197 6	Data on employee relations cases – numbers outstanding; time taken to resolve; benchmark against others Trusts – to be included in the IPR as part of its review.	SE	TBC	Board	IP	
27.03.2018	199 7	WWC to consider the outcome of the health and safety review/deep dive.	BH	TBC	WWC	IP	

Key



Not yet due
Due
Overdue
Closed

South East Coast Ambulance Service NHS

NHS Foundation Trust

		Item No	
Name of meeting	Trust Board		
Date			
Name of paper	Chief Executive's Report		
Executive sponsor	Chief Executive		
Author name and role	Daren Mochrie		
Synopsis (up to 120 words)	The Chief Executive's Report provides an overview of the key local, regional and national issues involving and impacting on the Trust and the wider ambulance sector.		
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.		
Why must **this** meeting deal with **this** item? (max 15 words)	To receive a briefing on key issues, as noted above.		
Which strategic objective does this paper link to?	2. Culture		
Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).		Yes / **No**	

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S REPORT TO THE TRUST BOARD

1. Introduction

1.1 This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional and national issues of note in relation to the Trust during March and April 2018.

2. Local issues

2.1 Recruitment to the Executive Team

2.1.1 As reported previously, Bethan Haskins joined the Trust on 1st April 2018 as the Executive Director of Nursing & Quality. Bethan has a broad range of previous experience and worked most recently as Chief Nurse across a number of Kent Clinical Commissioning Groups. I am sure that we will benefit from her skills and insight over coming months.

2.1.2 We have also now begun the selection and recruitment process for the substantive Executive Medical Director post. The advert closed on 9th April 2018 and interviews with short-listed candidates will take place in May.

2.2 Resignation of Chairman

2.2.1 On 18th April 2018, the Trust announced that Chairman Richard Foster had decided to stand down from the role, with immediate effect, for health reasons.

2.2.2 I would like to thank Richard for his contribution to the Trust during the past 12 months and wish him well for the future.

2.2.3 Deputy Chairman, Graham Colbert, will take on the duties of the Chairman until future arrangements are decided by the Council of Governors, who have the constitutional responsibility for appointing Foundation Trust Chairs.

2.3 Engagement with local stakeholders

2.3.1 During recent weeks, I have continued to meet with a range of key internal and external stakeholders. On 19th March 2018, I attended a meeting involving members of various Scrutiny Committees from across our region, to update members on how SECAmb is performing and our plans for the future.

2.3.2 On 23rd March 2018, I had one of my regular meetings with Michael Wilson, the Chief Executive of Surrey & Sussex Healthcare NHS Trust (SASH). SASH are our 'buddy Trust', which allows us to provide practical support and advice to each other as needed.

2.3.3 On 18th April 2018, I, and the whole Exec Team, attended an engagement session at the House of Commons to which all of our regional MPs were invited. I was pleased that, during a busy time politically, 13 of our MPs attended the session, during which we provided an up-date on how the Trust is performing and our progress during recent months.

2.3.4 The session, which was hosted by Peter Kyle MP for Hove on our behalf, also included a Q&A session – issues raised by MPs included our response to Category 3 and 4 patients, the level of resources available to us and the impact on us of changes in other parts of the healthcare system.

2.3.5 I found it an extremely useful session and we are hoping to repeat this moving forward on a regular basis.

2.4 Performance over Easter

2.4.1 During the recent long Easter weekend, including two Bank Holidays, I was pleased that, overall, the Trust was able to provide a good level of service to our patients. This reflected a great deal of hard work put in by many staff across the Trust.

2.4.2 Whilst our performance to Category 1 and 2 patients, the most seriously ill and injured patients, compared well to our colleagues nationally, we have lots of work to do to improve our response to Category 3 and 4 patients, where our performance is less good. I know that Joe Garcia and his team are working hard to ensure that we respond to all of our patients as promptly and efficiently as possible, with the resources available to us.

2.5 WRES Workshop

2.5.1 On 27th March 2018, I was delighted to welcome Yvonne Coghill, the national Director for the WRES (the NHS Workforce Race Equality Standard) to SECAmb when she visited our HQ.

2.5.2 The WRES was created so NHS Trusts could demonstrate how they are addressing race equality issues in a range of staffing areas. Each year, the performance of each Trust is measured against nine indicators looking at the experience of BME staff in the workplace.

2.5.3 During her visit, Yvonne joined a workshop involving Board members, members of our BME network and other staff to look at how SECAmb performed against the indicators last year, as well as discussions on how we could make improvements for the future.

2.5.4 It was a great opportunity to discuss these issues together and I was very pleased that in seven of the nine indicators we had seen improvements compared to the previous year; we had also performed well against our colleagues nationally. Thank you to everyone who took part.

2.6 Improving the culture of the Trust

2.6.1 I am very pleased that during the past few weeks, we have started to see the individual coaching sessions and leadership development programmes begin that are a key part of changing our culture and making the organisation a better place to work for everyone.

2.6.2 Sessions have been held for the Exec Team and for other Senior Managers utilising 360 degree feedback provided by peers and by direct reports. I know that lots of positive feedback was given, which recognised the improvements being made, however there was also some less positive feedback; some of it was challenging to read but nevertheless constructive. Feedback such as this is key to making improvements and I know will have a real impact as we move forward.

2.6.3 Similar training will be rolled out across the organisation over the next six months. It may take different formats at different times to accommodate the different ways in which our staff work but all staff will have access to it.

3. Regional issues

3.1 3.1 Stroke provision in Kent & Medway

3.1.1 The ten-week consultation exercise into the provision of stroke services across Kent & Medway ended on 20th April 2018.The proposals consulted on focused on establishing three, new 'hyper-acute' stroke units across Kent & Medway and the location of these units.

3.1.2 We will continue to work closely with the CCGs to ensure that the impact on ambulance services is properly understood.

4. National issues

4.1 Ambulance Leadership Forum (ALF)

4.1.1 On 20th & 21st March 2018 I attended the national Ambulance Leadership Forum, the main conference for the ambulance sector, with representatives from all UK ambulance services, as well as some international colleagues, attending.

4.1.2 The Conference included presentations by a number of key national and international speakers, including the Chief Executive of the NHS, Simon Stevens, who spoke on a number of issues including system pressures and hand-over delays.

4.1.3 The main topic of Simon Stevens' speech was violence and aggression against ambulance staff and his desire to see the authorities take the toughest possible action against members of the public who subject frontline ambulance crews and control room staff to violent acts or abuse while on duty.

4.1.4 Within SECAmb, whilst deploring the level of violence and aggression our staff face, I am pleased that the number of sanctions against individuals who commit these assaults are up significantly for 2016/17 at 104, compared to 49 in the previous year. These include a range of criminal and civil prosecutions ranging from fines to custodial sentences. I am currently awaiting figures for 2017/18 and hope to see that the increase in sanctions has continued.

4.1.5 The huge majority of patients and members of the public know that this kind of behaviour is deplorable but sadly, there are a very small number of individuals who seem to think this is acceptable. We will always work to take action against anyone who attacks or abuses our staff.

4.1.6 During the ALF Awards Event I was also delighted to see IBIS Manager, Tom Pullen, awarded the specialist paramedic award. This award is given to someone who has consistently shown great passion and commitment to saving lives and advancing patient care. Tom has certainly shown this in the work he has been doing to develop IBIS and ensuring patients receive the right care, in the right place at the right time. Well done Tom!

5. Recommendation

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

Daren Mochrie QAM, Chief Executive

19th April 2018

Agenda No	

Name of meeting	Trust Board
Date	16th April 2018
Name of paper	PMO Delivery Progress Update
Responsible Executive	Steve Emerton, Director of Strategy and Business Development
Author	Eileen Sanderson, Head of PMO
Synopsis	This paper provides a brief update on the progress made to the Delivery Plan
Recommendations, decisions or actions sought	What is the board / committee being asked to consider and/or decide? • To note the continued progress made in relation to the PMO improvements • To note the developments of the CQC Task and Finish Groups • To review the dashboard to be fully sighted on the current progress of the Delivery Plan

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**

Introduction

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

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

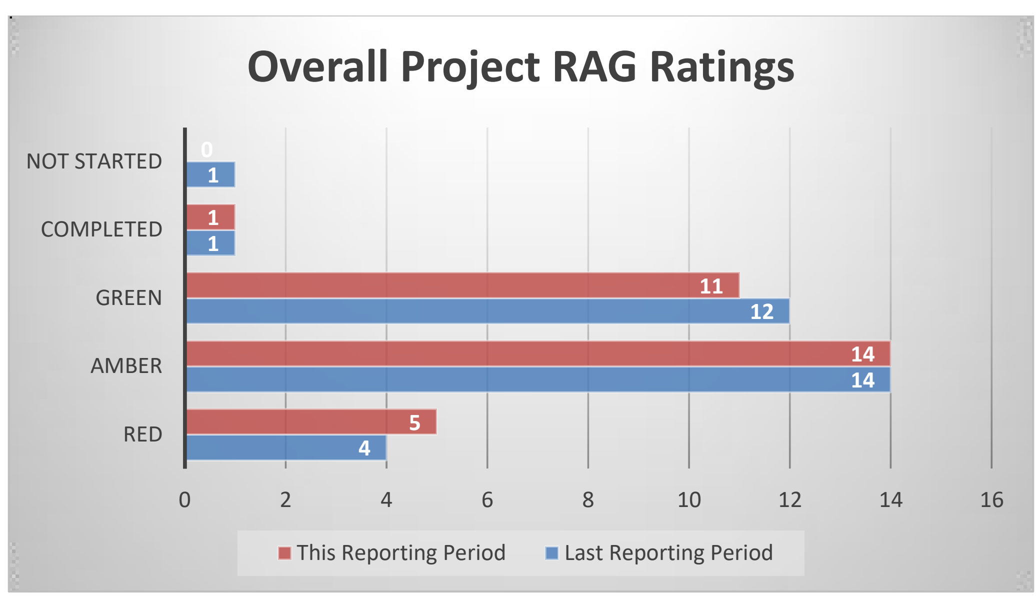
1.1 The Dashboard gives high level commentary and associated Key Performance Indicators (KPIs) for this reporting period where appropriate. As projects come to completion the reader should note that project closure processes will be enacted to ensure that continued and sustained delivery moves into Business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

1.2 A summary of overall progress and whether the projects are on track to deliver within the expected completion dates and/or risks of failing can be found in the detail of this report.

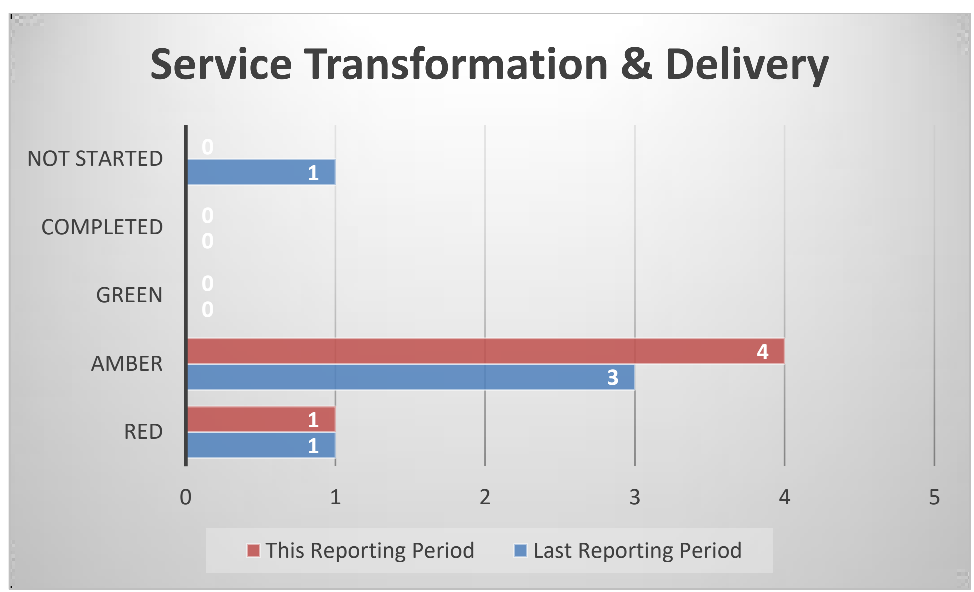
1.3 The Delivery Plan Dashboard (Appendix A) provides a summary of progress within this reporting period. For information the RAG status is defined as follows:

- Red – For those projects that are at significant risk of failure due to circumstances which can only be resolved with additional support
- Amber – For those projects at risk of failure but mitigating actions are in place and these can be managed and delivered within current capacity
- Green – For those projects which are on track and scheduled to deliver on time and with intended benefits
- Blue – For those projects which have completed.
- White – For those projects not started

1.4 The graph below provides an overview of status of the projects within the Delivery Plan.



Service Transformation & Delivery



2.0 **Hear and Treat** – The Project RAG for this period is rated Red as we have not increased Clinical EOC capacity and the clinical EOC establishment remains below required targeted staffing levels. Early stages to implement the approved Clinical Framework have begun with new job descriptions in development and evaluation, as well as the implementation of the Manchester Triage Solution work stream which will facilitate clinical rotation and improve the scope of clinicians that may be used within Hear and Treat. Completion of these will allow improvements to the recruitment process to achieve the primary objective of improving Hear and Treat performance from 6% to 10% by the end of July 2018

2.1 **Demand and Capacity Review** – The project remains RAG rated Amber. The aim of this review is to evaluate and assess differing models of operational delivery. The completion of this study will be by the end of April 2018, with the aim of delivering the report by mid May 2018.

The timeline for developing the workforce trajectory is challenging and the Trust and partner organisation are looking to optimise the schedule to mitigate any delay.

2.2 **ARP Demand and Capacity Delivery** – The project is RAG rated Amber. The Demand & Capacity review indicates the need to recruit approximately 400 Paramedics. This represents a doubling of recent years' recruitment results for Paramedics. Work has begun to provide a recruitment pipeline for each OU by grade. This will then inform what actions can be taken to meet the shortfall. The first ARP Delivery project group has met and will continue to meet fortnightly and dependencies with other projects is being considered and conflicts resolved.

2.3 **Hospital Handover –** The project is RAG rated Amber. The project has been extended to March 2019 as an acknowledgement that more time is needed to successfully undertake this programme. The RAG rating has since been reviewed as a consequence and it is now RAG rated Amber. There are constraints within Acute Trusts to meet the initial target of no delays over 60 minutes. There is good engagement from the majority

of Acute Trusts but not all. These issues have had an impact on meeting the no delays >60 minutes for March 2018.

Reports with granular detail around Crew to Clear times have been provided and are being piloted in two areas prior to rollout to all areas. The prompt at 10 minutes to airwaves handset is now in place. Both delays have had an impact on meeting the Crew to Clear target by March.

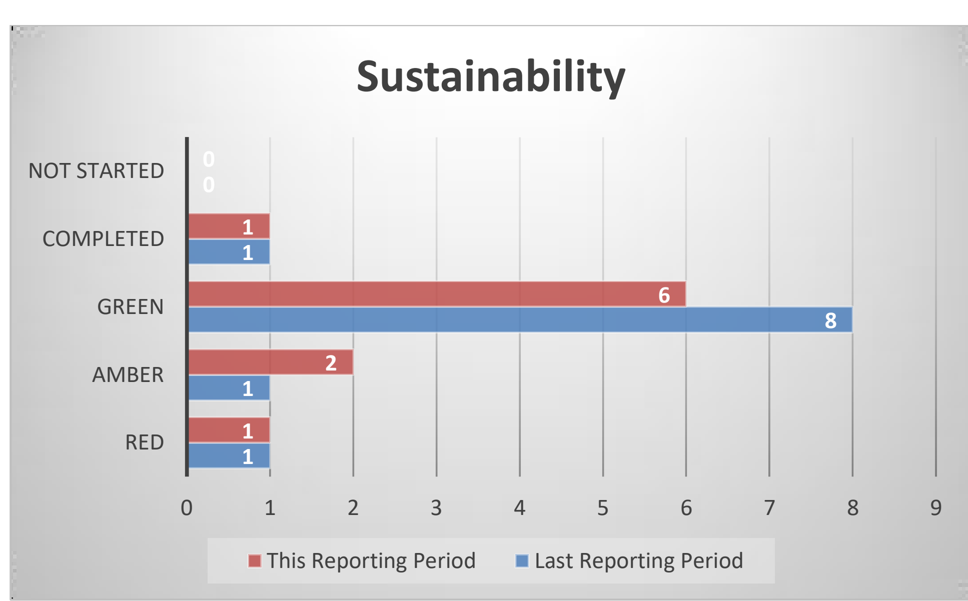
2.4 **National Ambulance Resilience Unit** – This project continues to remain at Amber as although progress is being made, there continues to be risks in relation to completion by the 30th October 2018.

The project plan has been updated to bring it in line with more tangible and meaningful objectives, which match the 2017 NARU capability review. The mandate is also being updated to align to measureable KPIs.

The Business Case for the procurement of the Scavenger system has been developed and is currently awaiting finance approval.

There are currently risks regarding our ability to provide additional operational capacity, as there is a lead-time for the training of new HART/MTFA operatives, this will affect our ability to meet certain objectives in the short-term. This issue is progressing, however, we will not see an impact on operational cover until completion of their course by the end of August 2018.

Sustainability



3.0 **CIP** – The project remains RAG rated Green. The plans are on track within this reporting period – refer to the Pipeline Dashboard and the Delivery Tracker for further details (Appendix B and C). The Trust has constructed £17.8m of fully validated schemes but operational issues post validation have prevented full realisation of some of the CIP schemes, which has led to their withdrawal or downsizing. The Trust is forecasting a CIP achievement of £15.5m against the plan target of £15.1m and it has been agreed with Executives that we will not actively pursue any further schemes for 2017/18. A CIP plan

for 2018/19 has now been developed and will require further refinement before final submission to NHSI on 30 April 2018.

3.1 The Digital Programme Board has now been established and any projects with an IT element will be presented to the Board for consideration. The Programme Board is currently overseeing 8 projects:

- Banstead Point of Presence (POP)
- Business Intelligence Improvement
- Cyber Security
- Spine Connect
- Provider Connect
- GP Connect
- Replacement of Telephony and Voice Recording
- Fleet Management system

A number of projects above complete in this reporting period and will be removed from the list following confirmation of completion through the Digital Programme Board. New key projects moving onto the list will be:

- Banstead Point of Presence (Phase 2 Implementation)
- Cyber Security (Phase 2 implementation)
- ePCR
- Trust Back up strategy
- GRS App
- WAN/LAN/WiFi upgrade

3.2 **Banstead POP** – The project remains RAG rated Green. The project is to relocate the Airwave Point of Presence servers from Banstead to Crawley. The POP servers contain the hardware and associated software to allow the dispatching of emergency vehicles. Installation of all the servers has now been moved to Crawley and the next phase will be to commission and decommission the sites. Phase 1 is complete with hardware delivered and on site at Crawley. Phase 2, go live implementation, will begin in April 2018. A new plan will be developed to support this. No risks or issues highlighted in this reporting period.

3.3 **Business Intelligence Improvement** – The project RAG has moved from Red to Amber. The project is to deliver a consistent approach of reporting by developing a new data warehouse structure that improves consistency of reporting. The project consists of a number of elements including a new data warehouse, new BI tools, new control room dashboards, upgrade to Lightfoot ARP dashboards and new interfaces into CAD. With the exception of the control room dashboards the project remains green. The Dashboard work is being undertaken by a current supplier, Call Vision, who have recently been taken over by Capita and are struggling to allocate resource. A decision to be made on alternative options, given the anticipated timescale, by end April 2018.

3.4 **Cyber Security** – The project RAG has moved from Green to Blue as this element of the project is now complete. Phase 2 of this project will involve the implementation of new hardware, software and monitoring. A new project plan will be developed and will be reported in the next period.

3.5 **Spine Connect** – The project remains RAG rated Green. Funding was recently secured from NHS Transformation to provide integration with Cleric and access to the NHS Spine Services to enable staff, initially EOC and then front line, to look up patients NHS number

on the Spine, view Summary Care Records and view Child Protection flags. Software has been completed and is under test in EOCs and is intended to go live as planned. There is a slight change to the call taking process to capture the NHS number which is being handled by the EOC team. Following implementation, the Trust will be gathering the NHS number and access to SCR is still planned for June 2018 and Child Protection in July 2018.

3.6 **Provider Connect** – The project remains RAG rated Green. Funding was recently secured to deliver an interface to enable IBIS access to Mental Health care plans by the end of April 2018. The quality assurance process will commence at the beginning of April in preparation for the deployment of the Mental Health Care Plans into IBIS at the end of April 2018. No risks or issues highlighted in this reporting period.

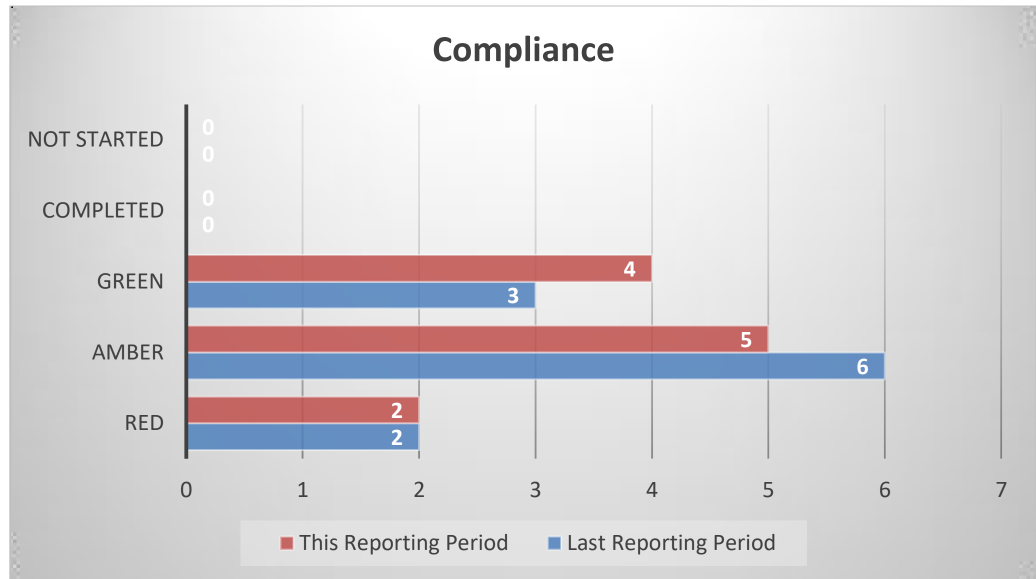
3.7 **GP Connect** – The project remains RAG rated Green. Funding was recently secured to deliver a GP message interface from IBIS to inform GPs of patient interventions across the Trust's regional footprint. The procurement of the Docman Connect solution has been completed. The next stage of the project is to develop and test the system to ensure IBIS integration by early April 2018. No risks or issues highlighted in this reporting period.

3.8 **Replacement Fleet Management System** – The project remains RAG rated Green. This project is to replace the existing 'Fleet Man' system supplied by Cleric, to improve reporting by 1 October 2018. The system will provide an asset tracking methodology for all patient conveying equipment. The Business Case, Project Mandate and QIA have recently been approved. A project plan is currently being developed which will outline clear deliverables and defined timescales. No risks or issues highlighted in this reporting period.

3.9 **Replacement of Telephony and Voice Recording system** – The project RAG is moved from Green to Amber due to the delivery dates remaining unknown until contract awarded, which is expected by 16th April 2018.

3.10 **ePCR** – The project is RAG rated Red. The current project as it stands will be going through a project closure and new projects will be initiated; iPads and ePCR solution. An RFI (Request for Information) has been developed and issued to a number of current ambulance providers with an expectation of a return by 13th April 2018. From these responses a specification will be created along with a business case for resubmission to the Trust Board.

Compliance



4.0 **Incident Management** *(CQC Must Do)* – This project is RAG rated Amber this reporting period due to the continued challenge the Trust is having to complete and clear the backlog of SI investigations within 60 days. Extra capacity has been provided to support the team to mitigate this issue. The majority of the backlog has been cleared in March however there is a high demand in April as the 22 SIs reported in January 2018 are due for submission to the CCG. Much work has been undertaken to ensure that these are being managed to prevent a new backlog from developing. The team are on track to clear all backlog SIs in April and to ensure that the SIs due in April are submitted by the deadline. This will put the project back on track for successful delivery by 1st August 2018.

4.1 **Safeguarding project** *(CQC Must Do)* – The project is RAG rated Green as the Trust has now achieved the expected 85% compliance for Level 3 Safeguarding training and the final completion rate within the 2017/18 reporting period is 98.04%.

The Trust Quality Assurance Visits will continue to focus on safeguarding oversight which will provide evidence on how prepared staff feel in escalating safeguarding concerns and identify any gaps.

The project lead is currently working through the project closure documentation. As part of this process, the work streams that have not completed within the project timeframe will be captured in the project closure document and transferred to business as usual.

4.2 **Risk Management** *(CQC Must Do)* – The project remains RAG rated Amber. The Trust has completed the work to identify the number of Risk Registers that may be held locally. However, further gaps relating to Health & Safety and Project Management risk management have recently been identified and subsequently recorded onto the risk management improvement plan:-

- Local Health and Safety risk assessments (outcome from routine site inspections) must be placed onto the Trusts risk register (Datix). A baseline assessment is being undertaken to identify the gaps and risk 348 has been recorded (Principle Risk Lead: Giles Adams).
- All project risks need to be placed onto the Trusts risk register (Datix). Further meetings with Project leads need to be scheduled to further discuss the gaps and proposed solutions.

- Addressing the above gaps may have an affect on current project milestones.

4.3 **Medical Devices** *(CQC Must Do)* – This project continues to be RAG rated Red. The Project Mandate and QIA are complete and Exec approved, as are the Task and Finish Group ToRs. A RACI has been completed to ensure key roles and responsibilities within the project are assigned to appropriate persons demonstrating those who are responsible and accountable and those to be consulted and informed.

A revised Improvement Action Plan has been developed to align with the refreshed Mandate. The project risk register has been revised with a small number of new risks to delivery identified which largely pertain to potential capacity and resource impacts.

In terms of project evolution, it is anticipated to move to a RAG rating of Amber by the end of April 2018 in accordance with the progression of Objective 4; and moving to Green is anticipated by end May 2018. The CQC Deep Dive for this project has been brought forward to 6th June 2018 (from 4th July 2018).

4.4 **Governance and Health Records** *(CQC Must Do)* – The project remains RAG rated Amber due to poor performance in accuracy of completion of the minimum data set in patient care records, linking of patient care records to Info.SECAmb and delivery of care bundles.

This month we achieved our target for the number of PCR audits to be completed for the first time and an electronic system is now ready for testing that will send automatic feedback to individuals. A procedure for PCR completion is due to go out to consultation, which will offer staff additional guidance on how to complete PCRs accurately.

In April, we will reduce the length of the CAD incident number to reduce transposition errors and improve linking of records to Info.SECAmb.

A project risk around the agreement of a quality improvement methodology is still in place; however, a timeline has now been developed which aligns the agreement and development of this methodology to the Culture Change programme within the organisation.

We are developing a process that will make it easier for OU leadership to provide staff with developmental feedback on care bundle compliance.

4.5 **Complaints** *(CQC Must Do)* – This project remains RAG rated Green. The introduction of the new role of Operational Team Leader (OTL), and the complaints investigation training provided to operational managers and OTLs from October 2017 to March 2018, has increased the number of people capable of investigating complaints, and has also improved the quality of investigation reports such that fewer reports now have to be returned for further work. In February 2018 and March 2018 respectively, 98.2% and 97.7% of complaints were concluded within the Trust's 25 working day timescale.

A Shared Learning Discussion Group has been created, whose purpose is to triangulate information gleaned from serious incidents, complaints, safeguarding, etc, to consolidate learning across all areas, and to discuss the development of new mechanisms for sharing learning across the Trust.

The project lead is currently working through the project closure documentation. As part of this process, the work streams that have not completed within the project timeframe will be captured in the project closure document and transferred as part of business as usual.

4.6 **EOC** *(CQC Must Do)* – The project remains at Red due to the pressure on clinicians, continued challenges with recruiting necessary EMA staff, audit levels not meeting the national requirements and failure to meet call answer trajectory.

The expectation is that this project will move to Amber by end of June 2018 following the realisation of the Clinical Retention Plan, the introduction of the EOC Clinical Framework and CDSS, with a continued push towards meeting audit requirements.

It is anticipated that the project will move to Green by end of August 2018 following the development of the Clinical Framework Proposal, HR recruitment and progression strategies for clinical recruitment and the EMA Retention framework (including EMATL evaluation) as part of a career progression scheme.

Risks to meeting audit compliance, meeting call answer time national standards, and EOC reporting and system functionality remain extremely high although the introduction of the above Framework and strategies are expected to mitigate these risks.

Issues include the live performance metric, challenges to recruiting enough EMA staff, high staff turnover and increased call volume. The reintroduction of a dedicated HR resource for recruitment and the management of staff sickness is having a positive impact.

Intensive Support has allowed for the isolation and resolution of project blockers.

4.7 **Performance and AQI project** *(CQC Must Do)* – The project remains RAG rated Amber. Whilst the Trust broadly remains on trajectory to meet C1/2 performance targets, there remains a wider risk to meeting commissioned performance before the project can be considered Green.

Through reducing lost operational hours, better meeting the needs of service users, and enhanced fleet and recruitment strategy, performance has continued to improve.

Suboptimal provision of operational hours and increased hospital turnaround contributed to poor performance through winter however, we continue to see a positive trend towards meeting or exceeding C1 and C2 targets.

The majority of "should do" actions are now complete with the notable exception of bariatric provision. A resolution for this is expected by the end of June to ensure that this objective remains on trajectory.

Internal/External system risks and issues (for example Hand Over Delays and Staff Retention) will continue to have an impact on performance but are managed via detailed discussion at separate forums and the Performance and AQI Task and Finish group.

4.8 **Medicines Governance** *(CQC Must Do)* – This project has moved from Amber to Green in this reporting period. The CQC found that the Trust had insufficient resource, inadequate governance and oversight of the safety and security of medicines. The aim of the project is to identify improvements that need to be made to structures, systems and training. This will guide medicines optimisation within the Trust, ensuring it is integrated into our systems, work practices and culture at all levels from individual practitioner to Board.

The Chief Pharmacist is currently working through the project closure documentation. As part of this process, the work streams that have not completed within the project

timeframe will be captured in the project closure document and transferred to the Medicines Optimisation Annual Plan as part of business as usual.

DCA key losses have reduced this month. This is due to a change in the number of keys carried. Guidance on how to investigate and risk assess medicines key loss is currently being developed by the Chief Pharmacist. DCA key loss will be monitored by the Medicines Governance Group chaired by the Executive Medical Director.

4.9 **999 Call Recording** *(CQC Must Do)* – The Project is RAG rated Green due to a clear process to replace the telephony system. Weekly audits remain ongoing, and further changes to the system have remained frozen unless it is related to a known error. The new telephony system is out to tender and a decision is expected to be made around 16 April 2018.

4.10 **Infection Prevention and Control** *(CQC Must Do)* – This project remains RAG rated Amber, but good progress is being made. The project mandate and QIA have now been formally signed off with clear objectives and timelines defined.

A new audit process and schedule is now in place and there has been further improvement in Trust compliance with Hand Hygiene and Bare Below the Elbows.

There has also been improvement in compliance to the schedule for Deep Cleans following discussions with the contractor, Estates and IPC Teams. The Infection Prevention Ready Procedure will be in place by August 2018 which will address all elements of practice to ensure that patients and staff come to no harm.

A second IPC Practitioner has now joined the team for a six-month secondment, which will help with developing the local IPC Champions and the introduction of the IP Ready Procedure.

Risk and Issue logs are continuing to be actively managed at both the IPC Task and Finish Group and IPC Sub Group. Where it is deemed the group cannot meet a resolution, the risk/issue is escalated to the Compliance Steering Group/Turnaround Executive and, where appropriate, intensive support will be provided from the Quality Improvement hub.

Culture and Organisational Development

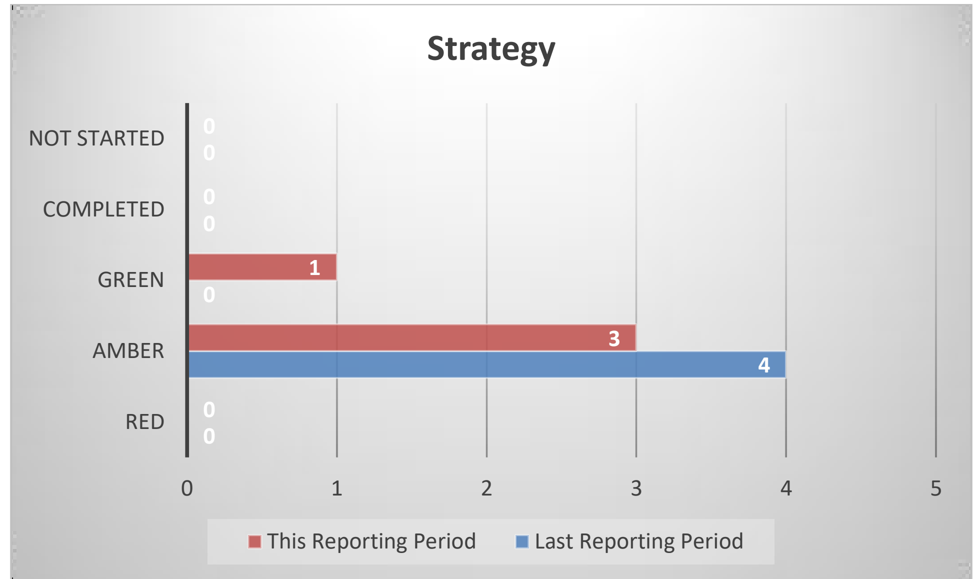
5.0 **Culture and Organisational Development** – This project is RAG rated Red. The leadership development component is now fully underway. EMB and SMT members are going through a 360-degree feedback process followed by individual coaching sessions.

The EMB went through a team feedback process and had the first team coaching day on the 4th April 2018

EMB and SMT members will attend 4 leadership development modules that are currently being scheduled. We are undertaking a review of the work of the Learning & OD team to ensure that all of their work is aligned with the programme.

The Associate Director of HR will work full time on the programme for the next 6 – 9 months to ensure pace and traction. Later this month the programme will be redefined to ensure it includes key elements currently not aligned.

Strategy



6.0 The Trust is currently reviewing and updating its overarching Five Year Strategic Plan 2017-2022. This will build on the work of our teams to create our existing plan and take into account the Trust's significant achievements in the first year of the plan and recognise continued challenges. The update which is planned annually or as a response to internal or external triggers, will take into account the implications and opportunities arising from our Joint Demand and Capacity Review.

6.1 **Enabling Strategies** – These are the suite of enablers of our Five year plan and include a range of items listed in Appendix D. This project is RAG rated Amber. This list has been reviewed and consolidated by combining workforce into two documents rather than four but with the same content coverage. The Trust is taking appropriate steps to ensure that board members are able to contribute and comment earlier in the process.

6.2 **Annual Planning** – This is the annual enactment of our strategy. This project remains RAG rated Amber given clear dependencies with the Demand and Capacity review. A draft submission and operating plan was submitted and a further iteration will be produced based on feedback received. An agreement has been made to continue year two of the 2017/19 contract until the completion of the Demand and Capacity Review. We are reviewing all the contract schedules to reflect changes in the last year and in national policy.

6.3 **Quality Improvement** – This project is RAG rated Amber. The potential adoption of the national Lean programme was not taken forward. The Trust is now reviewing alternatives.

6.4 **Commissioner and Stakeholder Alignment** – This project remains RAG rated Green. The planned Commissioner and Engagement event took place on 19th March 2018 and further engagement sessions are being planned. The Trust has now drafted a clinical case for change and assessment of risk of harm in support of the Demand and Capacity Review (see 2.1)

Delivery Plan Dashboard

Reporting period from 9th March 2018 to 9th April 2018

RAG Key:

Key	Meaning
Red	At significant risk of failure due to circumstances which can only be resolved with additional support
Amber	A risk of failure but mitigating actions are in place and these can be managed and delivered within current capacity
Green	On track and scheduled to deliver on time and with intended benefits
Blue	Completed
White	Not yet started

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	CQC Deep Dive (where applicable)	Project Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
Service Transformation & Delivery Steering Group	Increased Hear and Treat	Red	Amber	Scott Thowney	Joe Garcia	n/a	25.07.2018	The aim of the project is to ensure ambulance dispatch rates by appropriately and safely increasing the percentage of Hear and Treat cases from 6% to 10% from emergency call volume. Early stages to implement the approved Clinical Framework have begun with new job descriptions in development and evaluation, as well as the implementation of the Manchester Triage Solution work stream which will facilitate clinical rotation and improve the scope of clinicians that may be used within Hear and Treat. Completion of these will allow improvements to the recruitment process to achieve the primary objective of improving Hear and Treat performance from 6% to 10% by the end of July 2018 Communications through direct one to one staff engagements have been scheduled to outline highlights of the clinical framework, and detailing the NHS Pathways 100% compliance, to the EOC clinical teams within EOC. Clinical and Operational EOC In line Support – This is live and in use within both EOCs from 04/04/2018 and ensures NHS Pathways license compliance. The Clinical Framework CSN Role Job Description and Evaluation has been completed and approved, and recruitment to role planned by 27/04/2018 in liaison with finance team. The ShPA (Labour Line) awareness communications have been shared with EOC teams, and will be shared across the Trust by the Comms team through a newsletter. EOC IT Preparation for the ShPA line has been completed and all Midwives have been trained in role in preparation for go-live on 9th April 2018.	45 clinical supervisors in post in EOC	31	45	45	The Project RAG for this period is rated Red as we have not increased Clinical EOC capacity and the clinical EOC establishment remains below required targeted staffing levels. The principle risk to the project remains that, if the Trust does not recruit to the required number of clinical supervisors for EOCs, SECAmb will not be able to optimise hear and treat performance. This is recorded and monitored within the trust risk register (Rated 12).
									Hear and Treat Performance	6.5%	10%	10%	
	Demand and Capacity Review	Amber	Amber	Jon Amos	Steve Emerton	n/a	04/05/2018 (previous date was 13/04/2018)	The aim of this review is to evaluate and assess differing models of operational delivery. The completion of this study will be by the end of April 2018, with the aim of delivering the report by mid May 2018. A great deal of work is being undertaken now with respect to triangulating the work with workforce, and fleet to ultimately deliver performance compliance within an agreed timescale.	Creation of fit for purpose, agreed operational model and service level options, together with evidenced costs and aligned resource, for agreement with commissioners				The project remains RAG rated Amber. No risks and issues highlighted in this reporting period.
	ARP Demand and Capacity Delivery	Amber	Not started	Rob Mason	Joe Garcia	n/a	01.04.2021	The Demand & Capacity review indicates the need to recruit approximately 400 Paramedics. This represents a doubling of recent years' recruitment results for Paramedics. Work has begun to provide a recruitment pipeline for each OU, by grade. This will then inform what actions can be taken to meet the shortfall. The first ARP Delivery project group has met and dependencies with other projects is being considered and conflicts resolved.	KPIs to be defined.				Project is RAG rated Amber. Project Mandate and QIA are in development. The risk to the delivery of this project is the ability to recruit Paramedics, doubling historical effort. Work will be underway shortly to identify what needs to be done to ensure this target is achieved.
	Hospital Handover	Amber	Red	Gillian Wieck	Joe Garcia	n/a	30.04.2018	The aim of the project is to reduce the hours lost at ambulance handover with specific focus on reducing delays over 30 and 60 minutes. The aim is also to reduce the impact on response times in the community. A system wide steering group and two operational groups (East and West) have been established to deliver the improvement work needed to reduce hours lost as a result of handover delays across the SECAmb area. An overall improvement for the following metrics is expected; hours lost at each hospital site, delays over 30mins and 60 mins, and improved response for category 3.	Handover delay no more than 60mins (by March 2018)	1032	N/A	0	The project is RAG rated Amber. The project has been extended to March 2019 as an acknowledgement that more time is needed to successfully complete this programme. There are constraints within Acute Trusts to meet the initial target of no delays over 60 minutes. There is good engagement from the majority of Acute Trusts but not all. These issues have had an impact on meeting the no delays >60 minutes for March 2018.
									Crew to Clear time within 15mins 85% of the time	46.30%	85%	85%	
	National Ambulance Resilience Unit	Amber	Amber	Chris Stamp	Joe Garcia	n/a	30.10.2018	The 2017 NARU Capabilities Review was undertaken last year which identified that the Trust was not compliant with 5 of the 7 domains. The aim of the project plan is to ensure full compliance with all key lines of enquiry by 30th October 2018. A project group has now been set up to deliver the objectives. The Business Case for the procurement of the Scavenger system has been developed and is currently awaiting finance approval.	The KPIs have been identified although data is not available for this reporting period. Work is progressing to ensure that clear objectives are developed and monitored against delivery through the NARU Working Group which meets fortnightly.				Project RAG remains Amber due to tight timescales and limited progress on some of the milestones. Additional resources are now in place to help bring this on target following the recruitment of new managers. There are currently risks regarding the Trust's ability to provide additional operational capacity, as there is a lead time for the training of new HART/MTFA operatives. This issue is progressing, however, we will not see an impact on operational cover until completion of their course by the end of August 2018
	Electronic Patient Clinical Records ("EPCR")	Red	Red	Barry Thurston	David Hammond	n/a	29.03.2018	The current project as it stands will be going through a project closure and new projects (iPads and EPCR solution) will be initiated. An RFI (Request for Information) has been developed and issued to a number of current ambulance providers with an expectation of a return by 13th April 2018. From these responses a specification will be created along with a business case for resubmission to the Trust Board.					This project remains RAG rated Red.
	Financial Sustainability	Green	Green	Kevin Hervey	David Hammond	n/a	31.03.2018	The plans are on track within this reporting period – refer to the Pipeline Dashboard and the Delivery Tracker for further details (Appendix B and C). The Trust has constructed £17.8m of fully validated schemes but operational issues post validation have prevented full realisation of some of the CIP schemes, which has led to their withdrawal or downsizing. The Trust is forecasting a CIP achievement of £15.5m against the plan target of £15.1m and it has been agreed with Executives that we will not actively pursue any further schemes for 2017/18. A CIP plan for 2018/19 has now been developed and will require further refinement before final submission to NHSI on 30 April 2018.	Current CIP schemes fully validated	15.5m	£15.1m	£15.1m	Project RAG remains Green. There are no risks or issues on Project Delivery – the PMO Finance Team has ceased the search for further CIPs in agreement with Turnaround Executive following attainment of the target.
									£1.0 million of financial deficit forecast	£1.0m	£1.0m	£1.0m	

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	CQC Deep Dive (where applicable)	Project Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
Sustainability Steering Group	Banstead Point of Presence (POP)	Green	Green	Stewart Edwards	David Hammond	N/A	31.10.2018	The project is to relocate the Airwave Point of Presence servers from Banstead to Crawley. The POP servers contain the hardware and associated software to allow the dispatching of emergency vehicles. The servers have now been moved to Crawley and installed and the next phase will be to commission and decommission the sites. Phase 1 is complete with hardware delivered and on site at Crawley. Phase 2, go live implementation, will begin in April 2018. A new plan will be developed to support this.	Airwave Point of Presence servers relocated from Banstead to Crawley	All hardware delivered and onsite at Crawley	No data available	Relocation of servers to Crawley	The project remains RAG rated Green. No risks or issues highlighted in this reporting period.
Sustainability Steering Group	Business Intelligence Improvement	Amber	Green	Alex Croft	David Hammond	N/A	01.06.2018	The project is to deliver a consistent approach of reporting by developing a new data warehouse structure that improves consistency of reporting. The project consists of a number of elements including a new data warehouse, new BI tools, new control room dashboards, upgrade to Lightfoot ARP dashboards and new interfaces into CAD.	A consistent approach of reporting by developing a new data warehouse structure that improves consistency of reporting	No data available	No data available	No data available	The project moves from Green to Amber as Call Vision, who have recently been taken over by Capita are struggling to allocate resource. Alternative options are being reviewed to ensure this is still completed by April 2018.
Sustainability Steering Group	Cyber Security	Blue	Green	James Fox	David Hammond	N/A	31.03.2018	As a result of the Wannacry ransom outbreak in May 2017, NHS England released funding to support Trauma Centres and Ambulance Trusts in mitigating gaps in their IT security model. Project completed on time as expected and Phase 2, implementation of new hardware, software and monitoring will commence in April 2018 and will be supported by a new plan.	All software and hardware is procured	No data available	No data available	No data available	This project is completed.
Sustainability Steering Group	Spine Connect	Green	Green	Phil Smith	David Hammond	N/A	30.07.2018	Funding was recently secured from NHS Transformation to provide integration with Cleric and access to the NHS Spine Services to enable staff, initially EOC and then front line, to look up patients NHS number on the Spine, view Summary Care Records and view Child Protection flags. Software has been completed and is under test in EOCs and is intended to go live imminently. The EOC project completion date is 30/07/2018. There is a slight change to the call taking process to capture the NHS number which is being handled by the EOC team (within the scope of the project). Access to SCR is planned for June 2018 and CP-IS (Child Protection Information System) by July 2018. Whilst the technical elements are well under way, there are several Information Governance issues that need to be addressed by the Trust prior to NHS Digital full approval to access SPINE Services.	PDS - NHS Number Capture: percentage of C3/C4 calls are matched to an NHS Number.	60%	No data available	60%	This project remains RAG rated Green..
									SCR - Summary Care Record: percentage of SCR accessed records where available and appropriate for the type of call.	No data available	No data available	50%	
									CPIS - Child Protection Information Sharing: percentage of calls where CPIS flag queried	No data available	No data available	80%	
Sustainability Steering Group	Provider Connect	Green	Green	Phil Smith	David Hammond	N/A	30.04.2018	Funding was recently secured to deliver an interface to enable IBIS access to Mental Health care plans by the end of April 2018. Provider engagement is now complete, system developments to select and share care plans is ongoing and on track to complete by end of March 2018. The quality assurance process will commence at the beginning of April 2018 in preparation for the deployment of the Mental Health Care Plans into IBIS at the end of April 2018.	Number of mental health crisis care plans available on IBIS	No historical data available. Future KPI/Outcome data will be available once the service is implemented		80%	The project remains RAG rated Green. No risks and issues highlighted in this reporting period.
									Percentage of mental health plans that successfully match a 999 call			15%	
									Percentage reduction in conveyances where a mental health care plan is present			5%	
Sustainability Steering Group	GP Connect	Green	Green	Phil Smith	David Hammond	N/A	30.04.2018	Funding was recently secured to deliver a GP message interface from IBIS to inform GPs of patient interventions across the Trust's regional footprint. The procurement of the Docman Connect solution has been completed. The next stage of the project is to develop and test the system to ensure IBIS integration by early April 2018.	Percentage of selected referrals successfully delivered to the GP system	No historical data available. Future KPI/Outcome data will be available once the service is implemented		95%	The project remains RAG rated Green. No risks and issues highlighted in this reporting period.
									Percentage of selected referrals received via Docman inbox in primary care			60%	
									Percentage of selected referrals successfully filed within the GP system			80%	
Sustainability Steering Group	Replacement Fleet Management System	Green	Green	John Griffiths	David Hammond	N/A	01.10.2018	This project is to replace the existing 'Fleet Man' system supplied by Cleric, to improve reporting by 1 October 2018. The system will provide an asset tracking methodology for all patient conveying equipment. The Business Case, Project Mandate and QIA have recently been approved. A project plan is currently being developed which will outline clear deliverables and defined timescales.	The Fleet Management system will be replaced and implemented.				This project remains RAG rated green. No risks and issues highlighted in this reporting period.
Sustainability Steering Group	Replacement of Telephony and Voice Recording System	Amber	Green	Phil Smith	David Hammond	N/A	01.05.2018	This project is to replace the existing telephony and voice recording system. Bidders have now completed their submissions and SECAmb are now marking their responses. On track to award contract in mid April 2018.	Telephony and Voice Recording system replaced and implemented				This project is RAG rated Amber due to the delivery dates remaining unknown until contract awarded in mid April 2018.

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	CQC Deep Dive (where applicable)	Project Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
Compliance Steering Group	Incident Management	Amber	Amber	Samantha Gradwell	Steve Lennox	08.Nov.17	01.08.2018	The Trust Incident Management process has been a reactive process used to identify harm and it was frequently perceived as a vehicle to punish staff when they were seen as causing the identified harm. The aim of this project is to ensure the Trust has an effective incident management system that clearly identifies learning, and that learning is valued and shared widely across the Trust to continually drive improvements in safety. The majority of the backlog has been cleared in March, however, there is a high demand in April 18 as the 22 SIs reported in January are due for submission to the CCG. Much work has been undertaken to ensure that these are being managed to prevent a new backlog from developing. The team are on track to clear all backlog SIs in April 2018 and to ensure that the SIs due in April 2018 are submitted by the deadline. This will put the project back on track for successful delivery by 1st August 2018.	20% increase in overall incident reporting (Monthly) >75% of incidents closed within time target [SECAmb Target] 90% of Serious Incident investigations will be completed within 60 working days. 100% of Serious Incidents compliant with 72 hour STEIS reporting 96% of incidents graded as near miss, no harm or low harm 80% of incidents where feedback has been provided 100% compliance with Duty of Candour for SIs	625 73.0% 33.0% 100.0% 91.0% 8% 100%	575 69.0% 87.0% 90.0% 96.0% 70% 100%	556 75.0% 90.0% 100.0% 96.0% 80% 100%	This project is RAG rated Amber for this reporting period due to the continued challenge the Trust is having to complete and clear the backlog of SI investigations within 60 days. Extra capacity has been provided to support the team to mitigate this issue.
	Safeguarding	Green	Green	Philip Tremewan	Steve Lennox	01.Dez.17	31.08.2018	The Trust has now achieved the expected 85% compliance for Level 3 Safeguarding training and the final completion rate within the 2017/18 reporting period is 98.04%. Highlighted at the Safeguarding T&F group on 29/03/18 was the identified lack of confidence by large proportion of staff in one OU area in the current reporting mechanisms following QAV. Anecdotally this is reflective of experiences in other areas. This feedback suggests that a considerable number of staff who disclosed concerns during a QAV have little confidence that bullying and harassment allegations against the OU leadership will be taken seriously or handled in a discreet way. Although it's recognised that this is not necessarily a safeguarding issue, the T&F Group have agreed to maintain oversight until it can be formally attributed to other workstreams currently underway.	The number of staff trained to level 3 Safeguarding 90% of staff, when asked on audit, feel adequately prepared to identify safeguarding concerns and know how to obtain assistance. This will be measured through quality assurance visits and fed back through appraisal bulletins, local governance groups.	96.9% 95.0%	85.0% n/a	85.0% 90.0%	Project is RAG rated Green. Highlighted in the last report was the risk that the project may not deliver the project objectives by 31 August 2018 due to the interdependencies with the Culture Change to ensure that there is safeguarding oversight of disciplinary cases that have safeguarding themes. A comprehensive review of these cases took place during March and April 2018 and recommendations have been made in the March Quality & Patient Safety report aimed at promoting partnership working between HR and the Safeguarding Team that will improve safeguarding assurance across the Trust. As an additional measure to mitigate the risks associated with the culture change work there has been agreement that Safeguarding will contribute at the Culture & OD Task & Finish Group. The Trust Quality Assurance Visits will continue to focus on safeguarding oversight which will provide evidence on how prepared staff feel in escalating safeguarding concerns and identify any gaps.
	Risk Management	Amber	Amber	Samantha Gradwell	Steve Lennox	19.Jän.18	31.08.2018	The Trust has completed the work to identify the number of Risk Registers that may be held locally. However, further gaps relating to Health & Safety and project risk have recently been identified and subsequently recorded onto the risk management improvement plan:- * Local Health and Safety risk assessments (outcome from routine site inspections) must be placed onto the Trusts risk register (Datix). A baseline assessment is being undertaken to identify the gaps and risk 348 has been recorded (Principle Risk Lead: Giles Adams). * All project risks need to be placed onto the Trusts risk register (Datix). Further meetings with Project Leads need to be scheduled to further discuss the gaps and proposed solutions.	Individual Risks Reviewed on Datix With Principle Risk Lead (includes training & awareness) Number of Directorates and Operating Units reviewed for existence of local Risk Registers (only Datix authorised)	140 29	140 29	140 29	Project RAG remains at Amber. Addressing the gaps relating to Health and Safety and project risks may have an affect on current project milestones.
	Medical Devices	Red	Red	Nicola Brooks	Steve Lennox	N/A	30.09.2018	The Trust had an IT system that was not fit for purpose to manage the recording of the servicing data of medical devices. This caused input issues which were further aggravated by a lack of any real audit process being in place. All Medical devices will be serviced, maintained and available to all operational members of staff in accordance with the Medical Devices Management Policy, in the delivery of patient safety and care. The Trust will ensure that the security of all Trust operational premises and ambulance vehicles will be upheld. The Project Mandate and QIA are complete and Exec approved, as are the Task and Finish Group ToRs. A RACI has been completed to ensure key roles and responsibilities within the project are assigned to appropriate persons demonstrating those who are responsible and accountable and those to be consulted and informed. A revised Improvement Action Plan has been developed to align with the refreshed Mandate. In terms of project evolution, it is anticipated to move to a RAG rating of Amber by the end of April 2018 in accordance with the progression of Objective 4; and moving to Green is anticipated by end May 2018. The CQC Deep Dive for this project has been brought forward to 6th June 2018 (from 4th July 2018).	Double Crewed Ambulances (DCAs) and Single Response Vehicles (SRVs) Audited per Quarter. Submission of QUARTERLY ite Security Assesements in 2017/18 (MRCs, Stations, Crawley HQ, Fleet VMC) % of checked vehicles locked whilst unattended	287 62% 93%	239 100% 100%	239 100% 100%	This project continues to be RAG rated Red whilst work concludes to define the KPIs and establish core actions regarding Objective 4 *'Servicing, maintenance and storage of Medical Devices and serial numbered patient handling equipment used by external providers on behalf of the Trust'.* The project risk register has been revised with a small number of risks to delivery identified which largely pertain to potential capacity and resource impacts. Clear workstreams and timelines are now in place for existing staff and additional admin has been appointed.
	Governance, Records & Clinical Audit	Amber	Amber	Dean Rigg	Fionna Moore	19.Jän.18	31/07/2018 (note that the original date was 31/03/2018)	The Trust did not complete Patient Clinical Records accurately, there was a lack of identified training opportunities for staff and there were delays and inefficiencies in processes involving the recovery and scrutiny of health records. The overall aim of the project is to increase the quality and efficiency of the Trust's completion, storage and audit of health records. The Patient Clinical Record form (PCR) is to be redesigned to increase ease and efficiency of completion, and therefore elicit greater compliance and quality. The current PCR audit system is a check of completeness of the form against the requirements of the Minimum Data Set. A process for scrutinising the quality of the data entered is in development. This month we achieved our target for the number of PCR audits to be completed for the first time and an electronic system is now ready for testing that will send automatic feedback to individuals. A procedure for PCR completion is due to go out to consultation, which will offer staff additional guidance on how to complete PCRs accurately. In April 2018, we will reduce the length of the CAD incident number to reduce transposition errors and improve linking of records to Info.SECAmb.	Patient Records will be completed accurately Incidents will have Patient Clinical Record linked STEMI (care bundle) Stroke (care bundle) Cardiac Arrest Survival (Combined) ROSC (Combined)	50.0% 86.7% 71.80% 95.20% 11% 20.70%	0.0% N/A 81% 98% n/a n/a	90.0% 90.0% 73.80% 97.50% n/a n/a	Project RAG remains Amber due to poor performance in accuracy of completion of the minimum data set in patient care records, linking of patient care records to Info.SECAmb and delivery of care bundles. A project risk around the agreement of a quality improvement methodology is still in place, however, a timeline has now been developed which aligns the agreement and development of this methodology to the Culture Change programme within the organisation. We are developing a process that will make it easier for OU leadership to provide staff with developmental feedback on care bundle compliance.
	Complaints	Green	Green	Louise Hutchinson	Steve Lennox	14.Mär.18	31.03.2018	There was a lack of attention paid to complaints and the value of learning from them. Sufficient priority had not been afforded to these processes throughout the organisation. The aim of the project is to restore complainant/patient confidence in our service; to generate improvements in the treatment and service provided to patients and their carers as a result of learning from complaints; and to reduce the likelihood of problems recurring, and raise awareness among staff of the value of complaints as a tool for improvement by sharing the learning from complaints widely. The introduction of the new role of Operational Team Leader (OTL), and the complaints investigation training provided to operational managers and OTLs from October 2017 to March 2018, has increased the number of people capable of investigating complaints, and has also improved the quality of investigation reports such that fewer reports now have to be returned for further work. In February 2018 and March 2018 respectively, 98.2% and 97.7% of complaints were concluded within the Trust's 25 working day timescale. A Shared Learning Discussion Group has been created, whose purpose is to triangulate information gleaned from serious incidents, complaints, safeguarding, etc, to consolidate learning across all areas, and to discuss the development of new mechanisms for sharing learning across the Trust.	Complaints will be concluded within the Trust's target of 25 working days. Evidence of learning from at least 95% of complaints that are upheld in any way. 100% of Area Governance Meetings, Clinical Evaluation & Effectiveness Sub-Group meetings will have shared learning from complaints.	94.0% 100.0% 82.3%	80.0% 95.0% 100.0%	80.0% 95.0% 100.0%	This project remains RAG rated Green.

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	CQC Deep Dive (where applicable)	Project Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
	EOC	Red	Red	Sue Barlow	Joe Garcia	18.Apr.18	31.08.2018	The Trust had not invested sufficiently in recruitment and retention within the EOC. Moving EOC West to Crawley has also had an impact on recruitment. Staffing and supervision levels are impacting significantly on the Trust's ability to meet the requirements for clinical supervision, call answering and call auditing set out in NHS Pathways. The aim of this project is to recruit, train, retain and appropriately deploy sufficient levels of staff in all EOC roles to achieve the target for call answering, clinical supervision and call auditing. Clinical staff activity, prioritisation of roles and mapping of profile data has allowed clinical support to remain focussed, and has ensured that we meet Pathways licence requirements. This will have a positive impact in keeping establishment attrition down. A collaborative approach with NHS Pathways and CCGs and an Audit Improvement Plan have allowed us to create a realistic target trajectory toward audit compliance and meeting NHS Pathways audit compliance requirements. Process mapping of the current role of EMA and implementing process changes, have allowed us to realise efficiencies in call handling and improve performance with current EMA staffing. Dedicated HR Support to manage sickness levels and the implementation of an agreed overtime incentive 01/03/2018 – 12/04/2018 before implementation of new UHU planning model, has had some impact on achieving call answering times.The focus on recruitment and the introduction of a Training Lead role has also had some impact on supporting this achievement with further improvements expected in the future.	Clinical supervisors in post in EOC	31	45	45	The project remains RAG rated Red due to the pressure on clinicians, continued challenges with recruiting necessary EMA staff, audit levels not meeting the national requirements and failure to meet call answer trajectory. The expectation is that this project will move to Amber by end of June 2018 following the realisation of the Clinical Retention Plan, the introduction of the EOC Clinical Framework and CDSS, with a continued push towards meeting audit requirements. It is anticipated that the project will move to Green by end of August 2018 following the development of the Clinical Framework Proposal, HR recruitment and progression strategies for clinical recruitment and the EMA Retention framework (including EMATL evaluation) as part of a career progression scheme. Risks to meeting audit compliance, meeting call answer time national standards, and EOC reporting and system functionality remain extremely high although the introduction of the above Framework and strategies are expected to mitigate these risks. Issues include the live performance metric, challenges to recruiting enough EMA staff, high staff turnover and increased call volume. The reintroduction of a dedicated HR resource for recruitment and the management of staff sickness is having a positive impact. Intensive Support has allowed for the isolation and resolution of project blockers.
									Number of audits per month	51.8%	60.0%	100.0%	
									95% of calls answered within 5 seconds.	59.0%	75.0%	95.0%	
									FTE EMAs in post within EOC	161	171	171	
	Performance Targets and AQIs	Amber	Amber	Chris Stamp	Joe Garcia	31.Aug.18	30.09.2018	Through reducing lost operational hours, better meeting the needs of service users, and enhanced fleet and recruitment strategy, performance has continued to improve. Suboptimal provision of operational hours and increased hospital turnaround contributed to poor performance through winter however, we continue to see a positive trend towards meeting or exceeding C1 and C2 targets. The majority of "should do" actions are now complete with the notable exception of bariatric provision. A resolution for this is expected by the end of June to ensure that this objective remains on trajectory.	Category 1 Mean	48:00	07:00	07:00	Project RAG remains Amber. Whilst the Trust broadly remains on trajectory to meet C1/2 performance targets, there remains a wider risk to meeting commissioned performance (Datix risk 123) before the project can be considered Green. Internal/External system risks and issues (for example Hand Over Delays and Staff Retention) will continue to have an impact on performance but are managed via detailed discussion at separate forums and the PT&ASI Task and Finish group.
									Category 1 90th Centile	15:00	15:00	15:00	
									Category 2 Mean	33:00	18:00	18:00	
									Category 2 90th Centile	26:00	40:00	40:00	
	Medicines Governance	Green	Amber	Carol-Anne Davies-Jones	Fionna Moore	19.Feb.18	31.03.2018	The CQC found that the Trust had insufficient resource, inadequate governance and oversight of the safety and security of medicines. The aim of the project is to identify improvements that need to be made to structures, systems and training. This will guide medicines optimisation within the Trust, ensuring it is integrated into our systems, work practices and culture at all levels from individual practitioner to Board. The Chief Pharmacist is currently working through the project closure documentation. Over 85% of the project has been delivered on time. Where the work streams have not been met there will be documentation of why. The work streams that have not made the deadline will all be captured in the project closure document from PMO and transferred to the Medicines Optimisation Annual Plan. The new medicines policy and SOP on PGD development have been approved. There are two more SOPs going through the approval process. DCA key losses have reduced this month. This is due to a change in the number of keys carried. Guidance on how to investigate and risk assess medicines key loss is currently being written by the Chief Pharmacist. DCA key loss will be monitored by the MGG chaired by the Executive Medical Director. The Trust has seen over 60% reduction in CD breakages of diazemuls comparing Q4 of 2016/17 and Q4 of 2017/18, and over 30% reduction in the breakages of morphine. This result is largely due to the introduction of the CD pouch in September 2017. However, we still need to continue to monitor and reduce this breakage rate. These figures will be presented to the MGG as a standing agenda item.	Medical Quiz Passes	2090	2425	2425	This project has moved from Amber to Green in this reporting period. The Medicines Quiz Passes KPI can be reduced to 2257, following a dicussion around removing the OTLS (168) from this overall total, as their training is not undertaken through the online quiz. This decision requires approval from CADJ before the new targets are reflected on this dashboard. The risk associated with DCA drug cabinet key losses will be picked up as BaU with monitoring continuing and reporting into Medicines Governance Group.
									Compliance per Operating Unit	94.00%	97.50%	97.50%	
									DCA Drug cabinet key losses (Cumulative Total Nov 17 to Present)	155	n/a	n/a	
									CD Breakages (March Total)	22	0	0	
	999 Call Recording	Green	Green	Barry Thurston	David Hammond	n/a	30/03/2018 (date changed from 30/06/18)	Weekly audits remain ongoing, and further changes to the system have remained frozen unless it is related to a known error. The new telephony system is out to tender and a decision is expected to be made around 16 April 2018. The Project is RAG rated Green due to a clear process to replace the telephony system.	100% of all 999 calls recorded				Project RAG remains Green. The main risks are: 1) all faults are not eradicated, and further errors could well appear. Mitigation for this is weekly testing. 2) new telephony procurement route has opened an opportunity for other providers which might extend timescales. Mitigations have been considered.
									Auditing of calls take place on a weekly basis from 05 January 2018 (circa 2500 calls)				
									Approx. 15 sample calls carried out				
	Infection Prevention and Control	Amber	Red	Adrian Hogan	Steve Lennox	n/a	31.08.2018	Since November 2010 the Trust has had one person delivering the IPC programme on a day to day basis and this has led to a disconnect in the knowledge and awareness that staff delivering patient care require to ensure that no avoidable healthcare associated infections (HCAI) occur. The last two CQC inspections have highlighted the lack of resources within the IPC Team and have also evidenced poor IPC practices from staff including hand hygiene, compliance to Bare Below the Elbows (BBE), lack of actions shown following IPC audits and cleanliness standards in vehicles and the environment. The aim of this project is to help support the engagement of staff and embedding of IPC practices across the Trust and will focus on compliance to hand hygiene procedures, compliance to BBE, cleanliness standards for the vehicles and the environment, ensure there are audit tools to provide assurances, support staff following an untoward incident and embedding IPC into practice across all structures of the Trust and most importantly to the staff. A new audit process and schedule is now in place and there has been further improvement in Trust compliance with Hand Hygiene and BBE. There has also been improvement in compliance to the schedule for Deep Cleans following discussions with the contractor, Estates and IPC Teams. The Infection Prevention Ready Procedure will be in place by August 2018 which will address all elements of practice to ensure that patients and staff come to no harm. A second IPC Practitioner has now joined the team for a six-month secondment which will help with developing the local IPC Champions and the introduction of the IP Ready Procedure.	Hand Hygiene Staff Compliance	92%	No data available	90%	This project remains RAG rated Amber, but the progress being made is good. Risk and Issue logs are continuing to be actively managed at both the IPC Task and Finish Group and IPC Sub Group. Where it is deemed the group cannot meet a resolution, the risk/issue is escalated to the Compliance Steering Group/Turnaround Executive and, where appropriate, intensive support will be provided from the Quality Improvement hub.
									Bare Below the Elbow	96%	No data available	90%	
									Vehicle Cleanliness Compliance	67%	No data available	75%	
									Station Cleanliness - Buildings Compliant	68%	No data available	100%	
									Station Cleanliness - Buildings Completed	100%	No data available	100%	

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	CQC Deep Dive (where applicable)	Project Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
Culture & Organisational Development Steering Group	Culture & OD	Red	Green Blue Green Green	Clare Irving	Ed Griffin	n/a	TBC	The leadership development component is now fully underway. EMB and SMT members are going through a 360-degree feedback process followed by individual coaching sessions. The EMB went through a team feedback process and had the first team coaching day on the 4th April 2018 EMB and SMT members will attend 4 leadership development modules that are currently being scheduled. We are undertaking a review of the work of the Learning & OD team to ensure that all of their work is aligned with the programme. The Associate Director of HR will work full time on the programme for the next 6 – 9 months to ensure pace and traction. Later this month the programme will be redefined to ensure it includes key elements currently not aligned.	KPIs to be defined.				This project is RAG rated Red.
Strategy	Enabling Strategy	Amber	Amber	Jayne Phoenix	Steve Emerton	n/a	30.09.2018	This list has been reviewed and consolidated by combining workforce into two documents rather than four but with the same content coverage. The Trust is taking appropriate steps to ensure that board members are able to contribute and comment earlier in the process. Please see Appendix D for further information on timelines.	All strategies completed by agreed timescales.				This project remains RAG rated Amber due to the interdependencies and links to the Delivery and Capacity Review.
	Annual Planning	Amber	Amber	Jayne Phoenix Philip Astell	Steve Emerton	n/a	30/04/2018 (date changed due to national contract timelines and commissioners)	A draft submission and operating plan was submitted and a further iteration will be produced based on feedback received. An agreement has been made to continue year two of the 2017/19 contract until the completion of the Demand and Capacity Review. We are reviewing all the contract schedules to reflect changes in the last year and in national policy. The completion date is dependent upon NHS Improvement timescales.	Completion of budget planning, CIP planning, strategy review, workforce planning and operating plan – different components will develop during the period now until 31st May 2018 with final outcome being subject to outcome of the demand and capacity plan.				This remains RAG rated Amber given clear dependencies into the Demand and Capacity review.
	Quality Improvement	Amber	Red	Jon Amos	Steve Emerton	n/a	30.11.2018	The potential adoption of the national Lean programme was not taken forward. The Trust is now reviewing alternatives.	The Trust has approved to adopt a QI methodology and an implmentation plan is in place for roll-out across the Trust supported by a QI team.				This project is RAG rated Amber.
	Commissioner and Stakeholder Alignment	Green	Green	Jayne Phoenix	Steve Emerton	n/a	Ongoing	The planned Commissioner and Engagement event took place on 19th March 2018 and further engagement sessions are being planned. The Trust has now drafted a clinical case for change and assessment of risk of harm in support of the Demand and Capacity Review (see 2.1)	Alignment of commissioner and stakeholder expectations with delivery and operating plans for 2018/19				This project remains RAG rated Green.

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Programme for 2017/18 to deliver a minimum of £15.1m savings to achieve the planned £1m control total | Financial Reporting Period: Month 12 - March 2018

Programme Summary:

1. Developed Fully Validated and Pipeline schemes of £18.5m against a target of £19m. See the Delivery Tracker for details of actual achievement.

2. £17.8m of fully validated savings as at 30 March 2018 - c. £16.4m cost savings and £1.4m cost avoidance moved to delivery tracker. CIP schemes are moved to the Delivery Tracker after approval by Exec Sponsor and QIA sign off.

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

4. Continuing to in work collaboration with Project Leads and Execs to develop schemes to meet the 2018/19 CIPs target of £11.4m.

CIP Opportunity Classification - KEY

Opportunity Status	Description	Key
Fully Validated	Scheme with confirmed savings calculation prior to delivery tracking	
Validated	Scheme with identified benefits under development	
Scoped	Scheme to be scoped for further development	
Proposed	Proposed CIP idea in analysis	

CIP Pipeline and Delivery: Risks and Issues

	Risk	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Inability to identify a reasonable proportion of recurrent schemes to build a sustainable CIPs pipeline for future years.	Continue to work in collaboration with budget leads to review pipeline ideas and develop further recurrent schemes during the 2018/19 budget process.	Kevin Hervey	Amber	Amber	30/06/2018

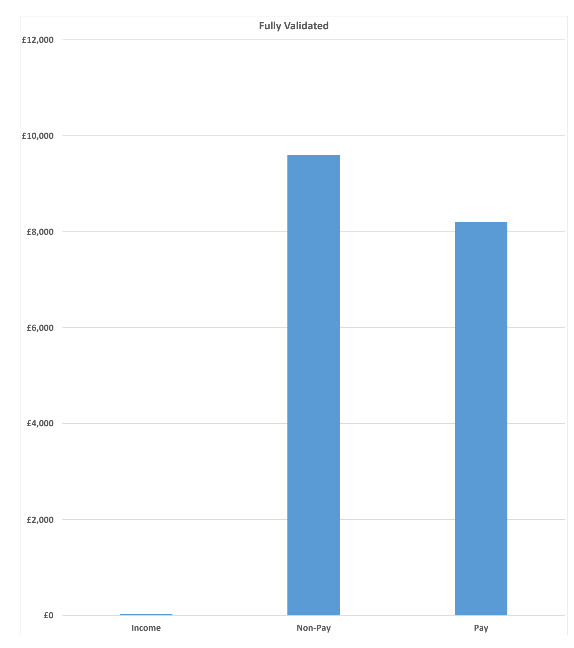
	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by

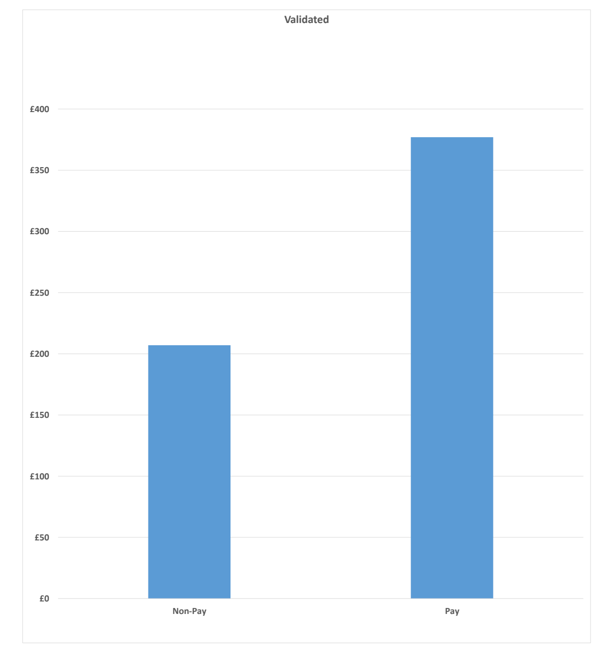
CIP Pipeline Summary

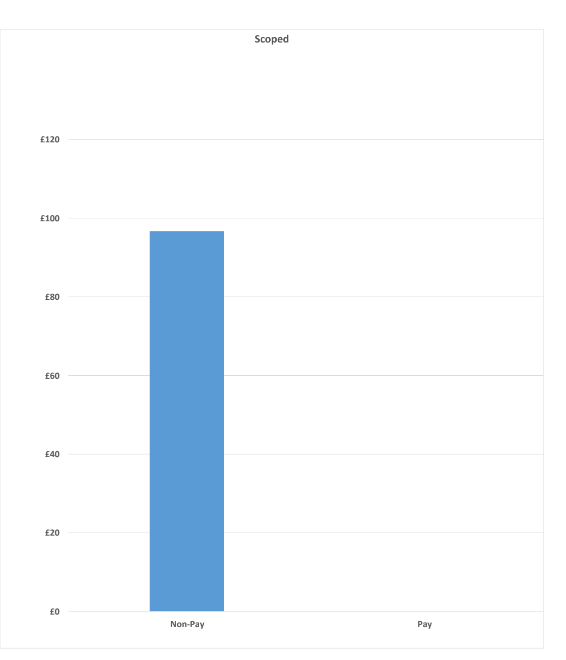
Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£1,400	£16,436	£584	£97	£0	£18,516

£18.5m
£0.0m
£0.1m
£0.0m
£6.5m
£8.5m
£9.9m
£10.0m
£1.4m
Cost Avoidance - FV
Fully Validated - CIP
Validated
Scoped
Proposed
Total
Recurrent
Non-recurrent
Stretch Target

Pay / Non-Pay / Income Breakdown







South East Coast Ambulance Service: CIP Workstream

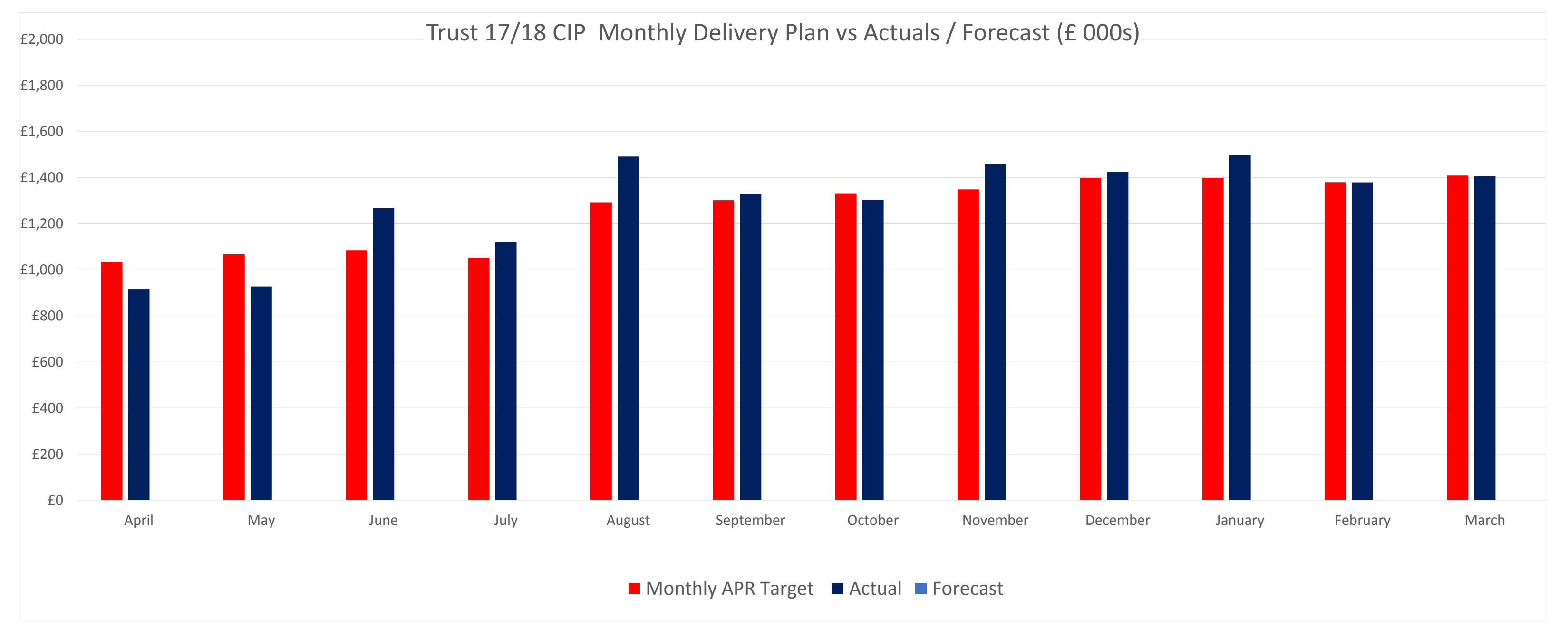
CIP Delivery Dashboard

Reporting Month Mar-18

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

1. Monthly CIP Trust Profile - as at 30 March 18

CIP Target for 17/18 £000's	Total planned savings on delivery tracker £000's - as at 30 March	Total forecast savings on delivery tracker £000's - as at 30 March	YTD Mar 18 - Target Savings £000's	YTD Mar 18 - Actual Savings £000's	YTD Mar 18 - variance £000's
15,100	17,836	15,522	15,100	15,522	422



Programme Summary: (See Pipeline Tracker for Risks and Issues)

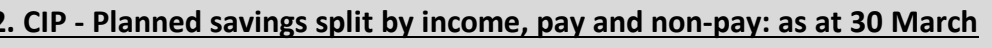
1. Achieved £15.5m CIP savings in 2017/18 financial year. This in line with projections and £0.4m ahead of the NHSI plan. The recurrent schemes represent 55% of the total.

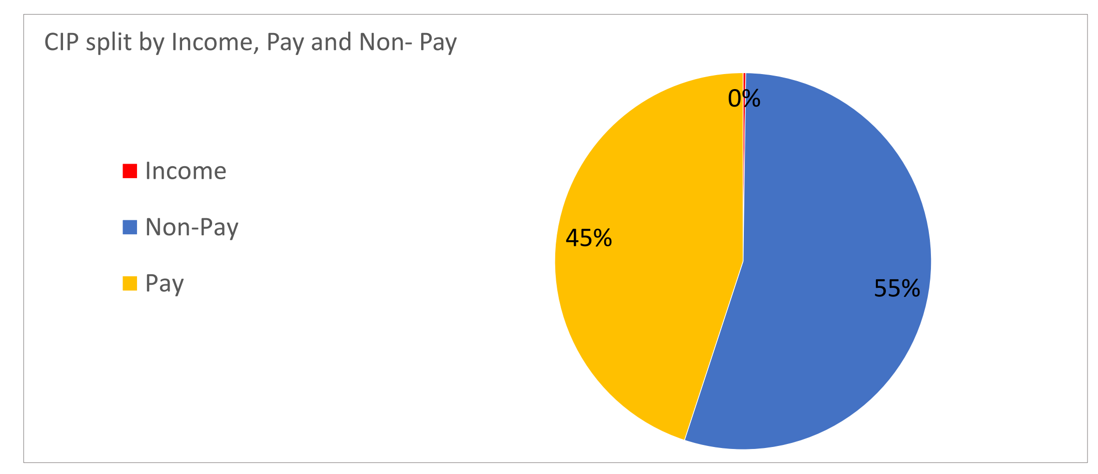
2. £17.8m of fully validated savings have been transferred to the Delivery Tracker as at 30 March 2018 reporting date.

3. The forecast outturn of £15.5m was risk adjusted to reflect the £2.3m shortfall anticipated in some fully validated schemes, notably, underachievement in Agency premium and Task Cycle Time (TCT). Agency premium tracked £0.9m below target as the delays in restructures across the Trust continued to require the retention of interim staff to cover key established posts. The CIP scheme for TCT of £1.2m was withdrawn in discussion with the Operations Director due to unprecedented pressure on frontline performance targets. The PMO CIPs Team ceased the development of additional 2017/18 schemes in agreement with Turnaround Executive Committee following the achievement of the £15.1m target in February 2018 and shifted the focus to 2018/19 schemes.

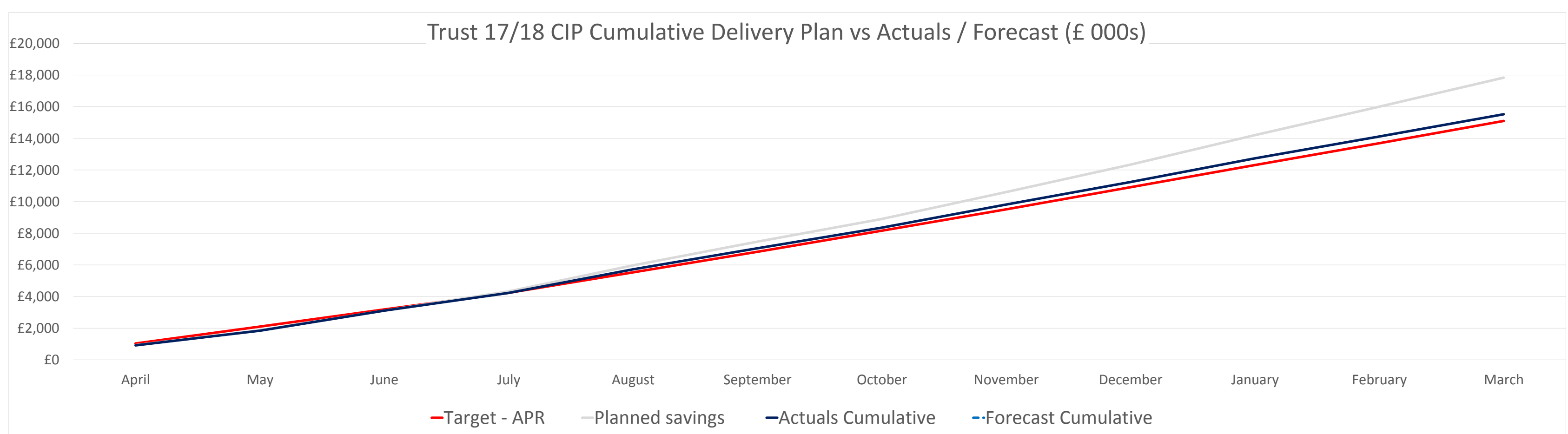
4. Regular review meetings with Budget Leads and Finance Business Partners continue to take place. These are currently focused on identifying new schemes to build a sustainable pipeline of recurrent schemes for 2018/19.

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

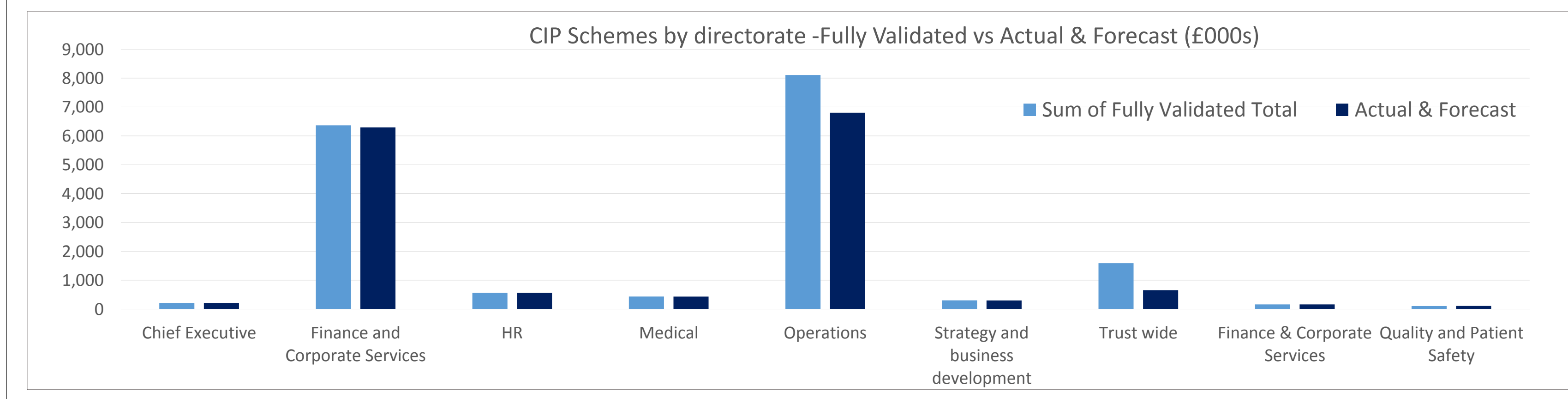




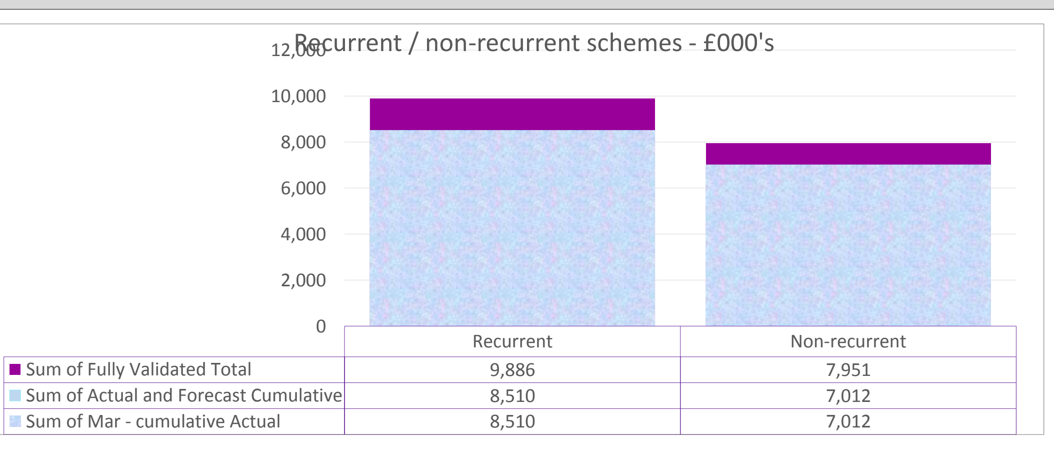
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2017/18



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

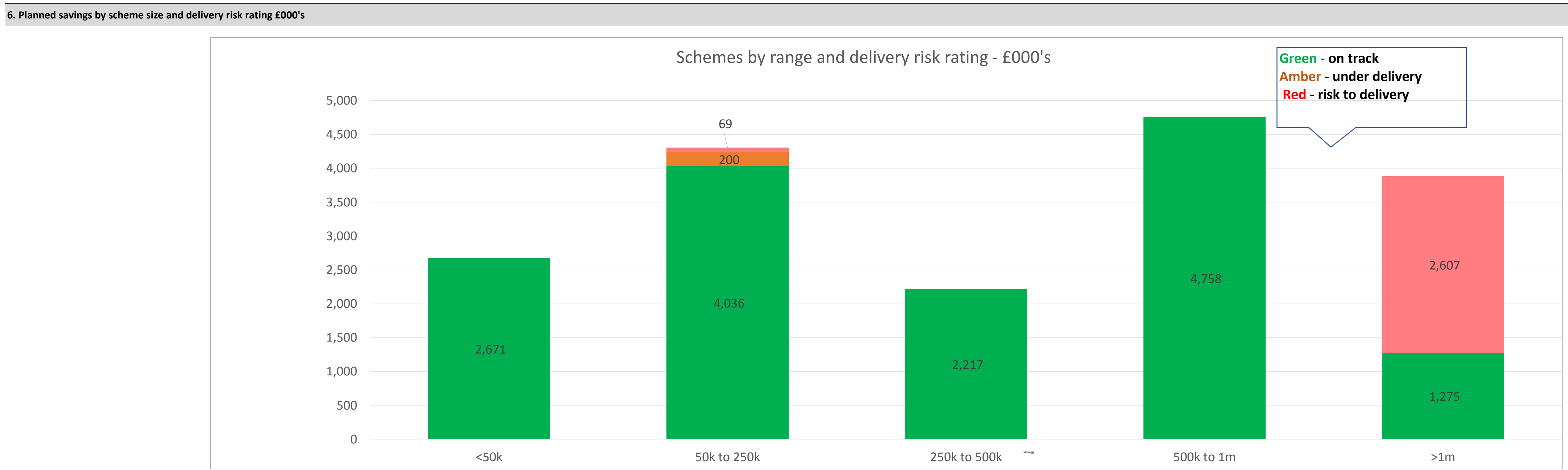


5. Value of forecast recurrent and non-recurrent savings - 30 March 2018



	Recurrent	Non-recurrent
Sum of Fully Validated Total	9,886	7,951
Sum of Actual and Forecast Cumulative	8,510	7,012
Sum of Mar - cumulative Actual	8,510	7,012

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



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

Scheme Category	2017/18 Value of Fully Validated Schemes - £000	2017/18 Forecast Value £000	Full Year Variance £000	YTD Planned / Fully Validated Schemes Savings (Month 12): £000	YTD Actuals (Month 12): £000	YTD Variance £000	Comments (+/- £20k variance)
Agency Premiums	£1,510	£571	(£939)	£1,510	£571	(£940)	YTD Underachievement - scheme under delivered due to delays in restructures across several departments
Events Income	£35	£35	£0	£35	£35	£0	-
External consultancy & contractors	£622	£622	£0	£622	£622	£0	-
Furniture & Fittings	£133	£133	£1	£133	£133	£0	-
Legal cost	£78	£78	£0	£78	£78	£0	-
Meal break payment	£1,969	£1,969	£0	£1,969	£1,969	£0	-
Meeting room hire	£146	£146	£0	£146	£146	£0	-
MRC efficiency	£553	£553	£0	£553	£553	£0	-
Public relations	£47	£47	£0	£47	£47	£0	-
Staff Uniform	£253	£253	£1	£253	£253	£0	-
Stationery	£143	£143	£0	£143	£143	£0	-
Travel & Subsistence	£101	£101	(£0)	£101	£101	£0	-
Vacancies - clinical	£1,364	£1,364	£0	£1,364	£1,364	£0	-
Vacancies - non clinical	£1,233	£1,233	(£0)	£1,233	£1,233	£0	-
(blank)	£0	£0	(£1)	£0	£0	£0	-
EPCR efficiency	£310	£241	(£69)	£310	£241	(£69)	YTD underachievement in EPCR printing - project was not expected to deliver and was reflected in the FOT
Accounting efficiency	£4,705	£4,705	£0	£4,705	£4,705	£1	-
Medicines Management - Equipment	£90	£90	£0	£90	£90	£0	-
Medicines Management - Consumables	£93	£93	£0	£93	£93	£0	-
Books & Subscriptions	£58	£58	(£0)	£58	£58	£1	-
111 Efficiency	£300	£200	(£100)	£300	£200	(£100)	YTD under delivery in Average Handling Time scheme - compensated by alternative schemes
Operations Efficiency	£1,435	£228	(£1,207)	£1,435	£228	(£1,207)	YTD underachievement in Task Cycle Time scheme - project has been withdrawn as reflected in the FOT
Fleet - Fuel: Telematics, Bunkered Fuel & Price Differential	£838	£838	£0	£838	£838	£0	-
Estates and Facilities management	£489	£489	£0	£489	£489	£0	-
IT productivity and Phones	£153	£153	£0	£153	£153	(£0)	
Discretionary Non Pay	£163	£163	£0	£163	£163	(£0)	-
Training courses & accommodation	£271	£271	£0	£271	£271	£0	-
Single HQ /EOC Benefits realisation	£53	£53	£0	£53	£53	£0	-
Medicines Management - Drugs	£44	£44	£0	£44	£44	£0	-
Fleet Maintenance	£650	£650	£0	£650	£650	£0	-
Variance to YTD Target	-	-	-	(2,736)	-	£2,736	Variance between Fully Validated Schemes and Control Total Target
Grand Total	£17,836	£15,522	(£2,314)	£15,100	£15,522	£422	

Appendix D

Enabling Strategies 4/4/18

Blue = completed

Strategic Theme	Strategy	Timespan	Executive Lead	Managerial lead	Completion date (End of)	Review date	Status /Progress	RAG
People	Workforce , Apprenticeship and Organisational Development	2017-2022	Ed Griffin	?	March 2018	Tbc	Deferred to go to April board as former post holder not completed new Director needs to review and finalise Agreed with EG HR Director to combine these 3 into one People Strategy	
	Clinical Education	2018-2022	Ed Griffin	Sally Wentworth James	February 2018	Tbc	In progress relies on getting workforce one complete above	
	Health and Well being	2017-2022	Steve Graham	Angela Rayner	-	2021	Published April 2017	
	Volunteers	2017-2022	Joe Garcia	Tim Fellows	May 2018		To check status as now referred to Strategy team and scope is not clear	
Patients	Medicines Optimisation	2017 – 2022	Fionna Moore	Carol – Anne Davies- Jones	November 2017	March 2018	Approved at EMB 3/1/18	
	Clinical Strategy – to encompass Quality and Safety (including cardiac arrest)	2018 – 2022	Steve Lennox/Fionna Moore	Kathy Jones	April 2018	Tbc	Likely to require more time	
	Safeguarding	2017-2020	Steve Lennox	Philip Tremewan	November 2017	Tbc	Ratified at Board 29/11/17	
	Governance this will incorporate risk strategy in future	2017 – 2022	Daren Mochrie	Peter Lee	June 2018	tbc	Is being scoped at present	

Appendix D

	Risk Management	2017/18	Steve Lennox	Sammy Gradwell	March 2017	June 2018	Published April 2017 will be reviewed to be incorporated into above so is June 2018	
	Research and Development	2017-2020	Fionna Moore	Julia Williams	February 2018	Tbc	With lead to finalise and can then go to EMB Chased 20/3/18 will now be ready to go to the April Board	
Enablers	Fleet	2017-2022	Joe Garcia	John Griffiths	March 2018	Tbc	Presented at March Board awaiting comments and will need revision in line with review of overall strategy	
	Estates	2017-2022	David Hammond	Paul Ranson	March 2018	tbc	Presented at March Board awaiting comments and will need revision in line with review of overall strategy	
	Digital and ICT	2018-2022	David Hammond	Barry Thurston	March 2018	Tbc	Presented at March Board awaiting comments and will need revision in line with review of overall strategy	
	Long term Financial Plan	2017-2022	David Hammond	Philip Astell	September 2018	tbc		
Other	Communications and Engagement	2017-2022	Daren Mochrie	Janine Compton	Tbc	Tbc	Survey of Communications and Engagement activities being conducted at present and will then shape timetable for work	
	Inclusion strategy (includes Equality and Diversity)	2016 – 2021	Daren Mochrie	Isobel Allen	-	Annual	Published April 2016	
	Commercial /Business	2018-2022	Steve Emerton	Jayne Phoenix	May 2018	March 2019		

South East Coast Ambulance Service NHS
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SOG Workforce Deep Dive

April 2018

Content

- HR & workforce priorities
- Focus on our culture change
  - Values & behaviours
  - Leadership development
  - Lewis Report follow-up

Your service, your call

HR Priorities

- Fit for Purpose HR
- Workforce Plan
- Culture & OD
- People Strategy

An under-pinning theme of:

- Protecting the Organisation on People related risks

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Fit for Purpose HR

- We have up to date, clear and easy to use policies
- Our processes are efficient and effective, with clear ownership and tracking
- Immediate priorities -
  - our end-to-end ability to attract, select, offer, onboard and educate frontline staff to meet our current demands
  - Pre-appointment screening
  - Staff records
- Ensuring we have the right structure, capability, confidence and capacity across the HR team

Your service, your call

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Workforce Plan

- Have a workforce plan for how we resource up to required levels over the next 6 months
- In line with the Demand and Capacity Review, a strategic workforce plan quarter by quarter through to 2021.
- A design for HR based on the future organisational requirements

Your service, your call

Culture and OD

- Our Culture and OD programme is being well lead with pace and grip
- We have aligned workstreams across HR to deliver our culture change
- Established metrics for how we track and evaluate progress

- Targeted on being an organisation that is ***inclusive***, ***attractive***, ***effective*** and ***safe***.

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Establishing SECAmb's Core Values and Signature Behaviours

SECAmb's Five Values:

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

For each Value, a set of 'signature' Behaviours ('we will') and contra-indications ('we will not') have been defined by staff:

Taking Pride

Being advocates of our organisation and recognising the important contribution we make to its success

We will …	We will not …
Fulfil our roles and responsibilities to the best of our ability.	Obstruct colleagues from being able to effectively do their job.
Encourage our colleagues to do the best job possible.	Complain, without recommending a solution.
Act positively even when faced with challenges.	Engage in negative gossip.
Openly share ideas and best practice with colleagues.	
Proactively seeks and shares information.	

Striving for Continuous Improvement

Seeking and acting upon opportunities to do things better

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

Acting with Integrity

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

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

Demonstrating Compassion and Respect

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

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

Assuming Responsibility

Having ownership of our actions and a willingness to confront difficult situations; and acting in the best interests of safety and quality

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

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Progress to date on Culture

- Establishment of new set of values with staff
- 360 degree feedback for all Exec and senior managers
- Coaching for all participants
- 4 x leadership development modules
- Executive and Board development

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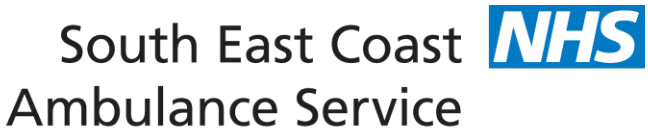
Progress to date on Culture - 2

- Action plan in response to the Lewis Report recommendations
- Now undertaking a review of all existing Learning and OD activities to fully align with the Culture Programme
- Baselining the programme to ensure that there is full alignment of all other key activities, e.g. well being, EDI, metrics for engagement and culture change
- Introduction of a full time programme lead
- Formally integrating cultural impact of any re-organisation

Your service, your call

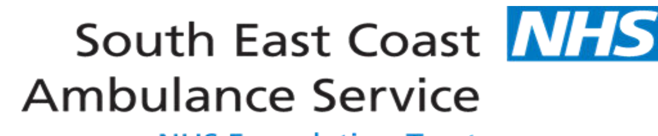
People Strategy

- Finalise and agree our People Strategy
- This will then enable us to set a clear plan for the work of HR



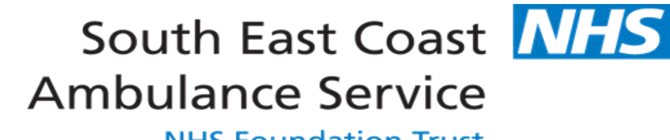
		Item No	07/18
Name of meeting	Trust Board		
Date	26 April 2018		
Name of paper	Should and Must Do Assurance		
Executive sponsor	Bethan Haskins, Executive Director of Nursing & Quality		
Author name and role	Steve Lennox, Associate Director of Nursing & Quality		
Synopsis, including any notable gaps/issues in the system(s) you describe (up to 150 words)	The following paper provides an update to the Board on the previous report in March 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. This was the position in the last report for the "KPI now" 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 Total = 34 This is the position in this report for the "KPI now" There are 10 Green Must do improvement areas There are 6 Amber Must do improvement areas There are 1 Red Must do improvement areas There are 5 Green Should do improvement areas There are 9 Amber Should do areas There are 2 Red Should do areas Total = 33 One indicator has been removed this month (appraisals) as it was accidently duplicated in the previous report. The projects are monitored through the compliance steering group. However, the focus of this group is now evolving 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 and this is being sustained 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.

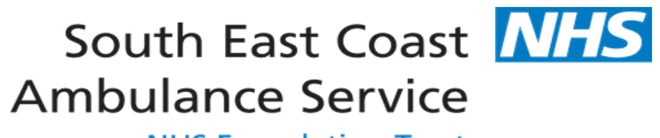


Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Safe	The Trust **must** take action to ensure they keep a complete and accurate recording of all 999 calls. Source of data (IT)	Number of 999 calls audited vs the number of issues found Total Issues (missing calls and quality issues) / No. Call Audited	Not applicable	**KPI Now** **No Change on Previous**	KPIs currently being met
				KPI Future **No Change on Previous**	Plan is in place to replace the telephony and voice recording system
				Pace & Grip **No Change on Previous**	Call recording audited weekly (now undertaken locally and not through IT) and reports into compliance by exception. Trust has strong oversight. Plan remains 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. Source of data (Medicines Governance IAP)	Monthly OU Compliance Audit Compliance Percentage / OU Ashford, Brighton, Cherstsey, Worthing & Tangmere, Gatwick & Redhill, Guildford, HART, Medway & Dartford, Paddock wood, Polgate & Hastings, Thanet January / Feb / March	Compliance % with DoH Guidance for Medical Gases Per Station Percentage / 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** **Change from Amber on Previous**	KPIs currently within compliance standards and previous months issue of lost drug keys has improved.
				KPI Future **No Change on Previous**	Oversight of medicines management in place with weekly and monthly audit returns. Next step is still 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 **No Change on Previous**	Medicines governance dashboard will demonstrate grip and pace through Improvement Plan.

Care Quality Commission 'Must and Should Do' Oversight and Assurance Report
April 2018



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. Source of data (EOC IAP)	Clinical Supervisor Establishment to meet minimum required Staffing for NHS Pathways Compliancy Weekly NHSP Compliance Staffing Level; WTE Req NHSP Compliance 110%, 105%, 100%, 95%, 90%, 85%, 80%, 75%, 70%, 65%, 60% 30/10/2017, 06/11/2017, 13/11/2017, 20/11/2017, 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, 26/02/2018, 05/03/2018, 12/03/2018, 19/03/2018, 26/03/2018, 02/04/2018, 09/04/2018, 16/04/2018, 23/04/2018, 30/04/2018, 07/05/2018, 14/05/2018, 21/05/2018, 28/05/2018, 04/06/2018, 11/06/2018	Not applicable	**KPI Now No Change on Previous**	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 Change on Previous	No identified risk to this KPI changing.
				Pace & Grip No Change on Previous	Whilst confident that the actual KPI will be complaint there are wider gaps in clinical oversight which is acknowledged in the risk register. Plan to put minimum staffing on the 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. Source of data (Culture & OD IAP)	% of all staff having completed objective setting/conversation/appraisal recorded on Actus Actual; Trajectory; Target % of staff: 0, 10, 20, 30, 40, 50, 60, 70, 80, 90, 100 Date: Apr 17, May 17, Jun 17, Jul 17, Aug 17, Sep 17, Oct 17, Nov 17, Dec 17, Jan 18, Feb 18, Mar 18, Apr 18		**KPI Now No Change on Previous**	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 Change on Previous	No identified risk to this KPI changing.
				Pace & Grip No Change on Previous	Grip demonstrated through IPR measure. Recognition of importance demonstrated through action to improve the quality of appraisals through 2018/19.



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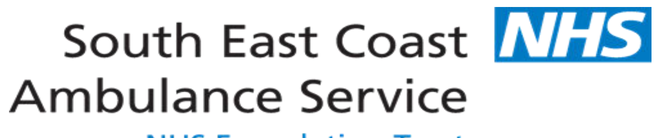
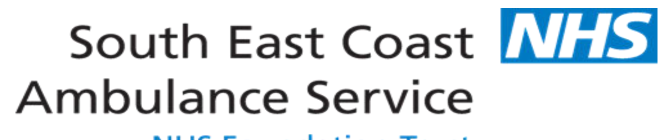
Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Safe	The Trust **must** take action to ensure all staff understand their responsibilities to report incidents. Source of data (Incident Management IAP)	Incident Numbers (all) Actual / Trajectory 625 / 575		**KPI Now** **No Change on Previous**	KPI above target. A drop in February has been recovered and above daily trajectory for the days in April.
				KPI Future **No Change on Previous**	No identified risk to this KPI changing.
				Pace & Grip **No Change on Previous**	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. Source of data (Incident Management IAP)	% of incidents as near miss, no harm or low harm % of Incidents / Trajectory 96% / 91%		**KPI Now** **Change on Previous from Green to Amber**	KPI has been below the heightened trajectory for 2 months. Some departments still to come on line with reporting low level and this is being addressed through the improvement plan.
				KPI Future **No Change on Previous**	No identified risk to this KPI changing. Once all departments are reporting low harm the trajectory will be met.
				Pace & Grip **No Change on Previous**	Grip to be demonstrated through inclusion in IPR and Pace to be demonstrated through Improvement Plan actions.

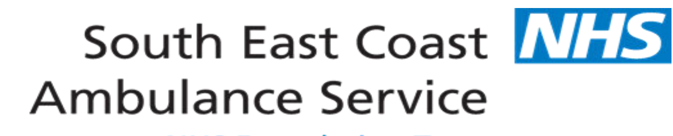
Care Quality Commission 'Must and Should Do' Oversight and Assurance Report
April 2018



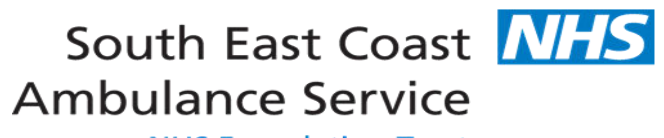
Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Safe	The Trust must investigate incidents in a timely way and share learning with all relevant staff. Source of data (Incident Management IAP)	% of Incidents Closed Within Time Target (% Closed on Time; Trajectory; 73%; 69%)	Feedback to Reporting Staff (% Receiving Feedback; Trajectory; 70%; 8%) Technical issue with Datix for the March reporting. Now resolved for April but unable to recover data for March.	KPI Now No Change on Previous	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 No Change on Previous	A plan is in place and training is occurring to increase the identification of learning.
				Pace & Grip No Change on Previous	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. Source of data (Safeguarding IAP & Safeguarding Lead)	2017/18 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 No Change on Previous	KPI reached for L3 KPI reached for L2
				KPI Future No Change on Previous	No identified risk to this KPI not reaching compliance threshold.
				Pace & Grip No Change on Previous	Grip to be demonstrated through inclusion in IPR and pace to be demonstrated through Improvement Plan actions. Project moving out of Compliance Steering Group and into business as usual with the internal safeguarding group leading assurance of continued delivery to the clinical group.



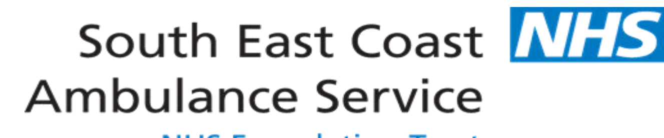
Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Effective	The Trust **must** take action to meet national performance targets. Source of data (CAT and CAT 2 – Performance Targets & ASIs IAP)	Category 1 for SECAmb	Category 2 for SECAmb	**KPI Now** **No Change on Previous**	KPIs 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	Category 4 for SECAmb	**KPI Future** **No Change on Previous**	No risks identified to impact on the KPIs
				Pace & Grip **No Change on Previous**	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. Source of data (Governance, Health Records & Clinical Audit IAP)	1a Percentage of PCRs Containing Full Minimum Data Set (Trust Wide / Monthly Reporting) Percentage Jul-17, Aug-17, Sep-17, Oct-17, Nov-17, Dec-17 % PCRs with Full MDS — Target	2a. Percentage Incidents on Info.SECAmb with PCR Attached (Reconciled Records) [MONTHLY UPDATE] Jul-17, Aug-17, Sep-17, Oct-17, Nov-17, Dec-17, Jan-18 % Incidents with PCR — Target	KPI Now No Change on Previous	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 No Change on Previous	An improvement plan is in place but this may not be fully recovered prior to CQC inspection.
				Pace & Grip No Change on Previous	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. Source of narrative (IT)	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.	**Same narrative as previous report. Project essentially closed.**	KPI Now No Change on Previous	CAD failure on risk register and being monitored through Business as Usual and has been replaced since the 2017 CQC visit
				KPI Future No Change on Previous	No risks identified to impact on the KPIs
				Pace & Grip No Change on Previous	CAD maintenance to be placed on IPR.

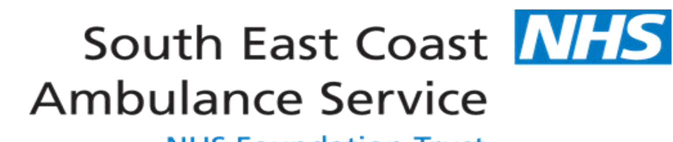


Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Effective	The Trust **must** improve outcomes for patients who receive care and treatment. Source of data (Governance Health Records Project Lead)	AQI Clinical Outcomes - ROSC and ROSC Utstein Group ROSC-Average; ROSC-SECAmb; ROSC(U)-Average; 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) 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** **No Change on Previous**	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 **No Change on Previous**	Low confidence that this can be significantly improved prior to CQC inspection.
				Pace & Grip **No Change on Previous**	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. Source of data (Infection Prevention & Control IAP)	**5a. % of staff who are compliant with hand hygiene audits carried out (monthly data)** Hand Hygiene Target; Staff Compliance; Linear (Staff Compliance)	**5b. % staff compliance against target of BBE audits carried out (monthly data)** Bare Below the Elbow Target; Staff Compliance	**KPI Now** **Change from red on Previous**	KPIs within compliance level for 2 consecutive months (HH) and have returned to compliance level for BBE.
				KPI Future **No Change on Previous**	New strategic plan and supporting improvement plan developed. High confidence of delivery. Not yet green as not yet fully live.
				Pace & Grip **No Change on Previous**	Grip and Pace can be demonstrated through IPC dashboard and escalated meeting (now monthly).

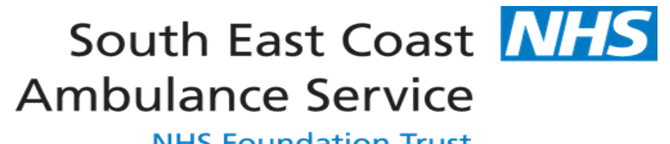


Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Well Led	The Trust **must** ensure that governance systems are effective and fit for purpose. This includes systems to assess, monitor and improve the quality and safety of services. Source of data (Risk Management IAP)	Number of open, closed, proposed for closure and new risks on Datix. Series1 Series2 Series3 Series4 No. of Risks: 0, 20, 40, 60, 80, 100, 120, 140, 160, 180 Week Commencing: 04/01/2018, 11/01/2018, 18/01/2018, 25/01/2018, 01/02/2018, 08/02/2018, 15/02/2018, 22/02/2018, 01/03/2018, 08/03/2018, 15/03/2018, 22/03/2018, 29/03/2018 163, 78, 12, 2	Not applicable	**KPI Now No Change on Previous**	Risk management progressing but other governance mechanisms under review and identified as a gap in pre-assessment self assessment.
				KPI Future No Change on Previous	Risk management progressing well and improvement plan in place. However, other governance processes still awaiting review or too juvenile to measure success.
				Pace & Grip No Change on Previous	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. Source of data (Risk Management IAP)	% of Medical Devices Serviced (2016 - 2018) 2016 2017 2018 Target (95%) 95% % of Medical Devices: 0%, 20%, 40%, 60%, 80%, 100% Medical Device: LP 12, LP 15, LUCAS, Entonox DMU, P-PAC, LSU, Mangar	Number of DCAs and SRVs Audited per Quarter Actual Target No. of DCAs and SRVs Audited: 0, 50, 100, 150, 200, 250, 300, 350 Q1 - Jan - Mar, Q2 - Apr Jun, Q3 - Jul - Sep, Q4 - Oct - Dec 287, 239	**KPI Now No Change on Previous**	KPI showing as compliant but too ealy in project re-launch to gain assurance of sustainability.
				KPI Future No Change on Previous	Predict that KPI will be reliable but at present not confident of the level of compliance.
				Pace & Grip No Change on Previous	Grip will be demonstrated by adding this to the IPR and the associated improvement plan will illustrate improvements.

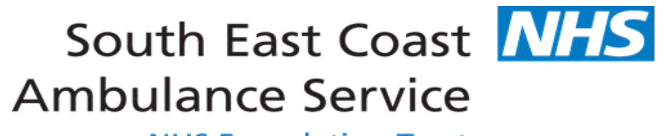
Care Quality Commission 'Must and Should Do' Oversight and Assurance Report
April 2018



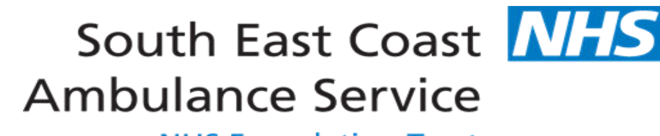
Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Effective	The Trust **must** continue to ensure there are adequate resources available to undertake regular audits and robust monitoring of the services provided. Source of data (Governance, Health Records & Clinical Audit IAP)	4a Percentage Clinical Audit Programme Complete (Cumulative) [MONTHLY UPDATE] % Programme Completed (Cumulative); Target Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18		**KPI Now No Change on Previous**	Already reach end of year KPI target.
				KPI Future No Change on Previous	Already reached end of year KPI target.
				Pace & Grip No Change on Previous	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. Source of data (Complaints IAP)	% of complaints concluded within timescale 111; A&E; EOC; Overall; Target	% Area Governance Meetings (AGM) received Quality report Feb-18 Mar-18 Apr-18 NHS 111 AGM; EOC AGM; East AGM; West AGM; Central AGM	**KPI Now No Change on Previous**	Initial performance targets now reached and sustained for 8 weeks.
				KPI Future No Change on Previous	Initial performance targets now reached however, plans to address learning just launched but confident they will deliver.
				Pace & Grip No Change on Previous	Enhanced complaints monitoring on IPR and patient experience group to have metrics.



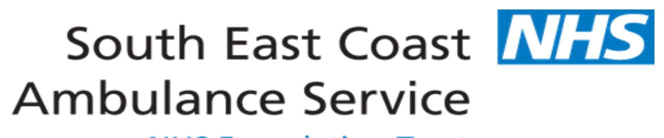
Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Safe	The Trust **should** take action to audit 999 calls at a frequency that meets evidence-based guidelines Source of data (EOC IAP)	Total Audit Completion Rate 100% 80% 60% 40% 20% 0% Apr.17 Mai.17 Jun.17 Jul.17 Aug.17 Sep.17 Okt.17 Nov.17 Dez.17 Jän.18 Feb.18 Mär.18 Apr.18 Mai.18 Jun.18 Jul.18 Aug.18 Sep.18 Audits Completed % Target		**KPI Now No Change on Previous**	Curently meeting revised trajectory but left amber as not exceeding trajectory.
				KPI Future No Change on Previous	Currently on trajectory but current improvement plan is now delivering the required improvements.
				Pace & Grip No Change on Previous	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 Source of data (Frequent Caller Lead, Clinical Development Team)	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	Number of Stage 1 Letters Sent 45.00 40.00 35.00 30.00 25.00 20.00 15.00 10.00 5.00 0.00 Month Kent Surrey Sussex	**KPI Now No Change on Previous**	Not subject to an improvement plan but part of business as usual with management team making improvements.
				KPI Future No Change on Previous	No risks identified to suggest KPIs will not be met.
				Pace & Grip No Change on Previous	Yet to be defined



Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
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 No Change on Previous**	Currently no performance graph in order to provide assurance. To be developed as part of governance review.
				KPI Future No Change on Previous	
				Pace & Grip No Change on Previous	
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.	Plan approved		**KPI Now Change from Red on Previous**	Surge plan is now live
				KPI Future No Change on Previous	New Surge Management Plan is implemented when the Trust is unable to meet operational demand or is likely to experience operational challenges.
				Pace & Grip No Change on Previous	The Trust will manage its demand effectively across the Trust. Potential KPI to be placed on Integrated Performance Report (IPR) regaarding use of Surge

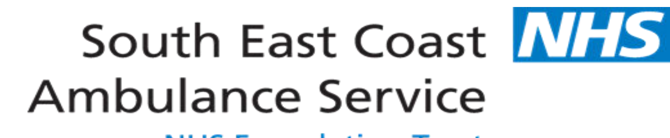


Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Well Led	The Trust **should** consider improving communications about any changes are effective and timely, including the methods used	Review of communications in place and new procedure to be launched week of 22 April 2018		**KPI Now Change from Amber on Previous**	No specific KPI but a revised procedure has been developed and agreed and is for launch week 22 April 2018.
				KPI Future No Change on Previous	Procedure agreed and will be in place.
				Pace & Grip No Change on Previous	Procedure agreed and will be in place.
Safe	The Trust **should** review all out of date policies. Source of data (Corporate Services)	Policies Reviewed as part of the Policies Management Project 4 38 Policies reviewed and up to date; Policies out of date		**KPI Now No Change on Previous**	Majority of policies currently within date.
				KPI Future No Change on Previous	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 No Change on Previous	Being considered as part of IPR when refreshed.

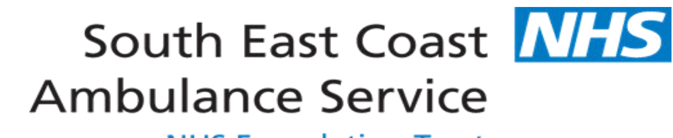


<table>
<tr><th>Domain</th><th>CQC Findings
('Must or Should Do')</th><th>Metric 1</th><th>Metric 2</th><th colspan="2">Confidence</th></tr>
<tr><td rowspan="3">Safe</td><td rowspan="3">The Trust should ensure all first aid bags have a consistent contents list and they are stored securely within the bags.</td><td rowspan="3">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</td><td rowspan="3">Not applicable</td><td>KPI Now
No Change on Previous</td><td>Action completed</td></tr>
<tr><td>KPI Future
No Change on Previous</td><td></td></tr>
<tr><td>Pace & Grip
No Change on Previous</td><td></td></tr>
<tr><td rowspan="3">Well Led</td><td rowspan="3">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.

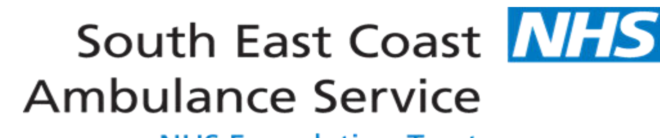
Source of data
PIR return</td><td rowspan="3"><table><tr><th colspan="6">Director Visits Total for 2017/18</th></tr><tr><td>Daren</td><td>49</td><td>Fionna</td><td>19</td><td>Lucy</td><td>31</td></tr><tr><td>Joe</td><td>52</td><td>Jon A</td><td>16</td><td>Angela</td><td>9</td></tr><tr><td>David</td><td>28</td><td>Richard</td><td>10</td><td>Graham</td><td>10</td></tr><tr><td>Steve G</td><td>12</td><td>Tim</td><td>21</td><td>Laurie</td><td>2</td></tr><tr><td>Steve L</td><td>19</td><td>Terry</td><td>22</td><td>Tricia</td><td>2</td></tr><tr><td>Ed</td><td>1</td><td>Al</td><td>12</td><td>Adrian</td><td>0</td></tr><tr><td>Steve E</td><td>?</td><td></td><td></td><td></td><td></td></tr></table>
Please note the Non Executive Directors do not have a specific Trust base therefore Crawley has been included in their collection of data, unlike the Executive Directors and the Chairman who are based at Crawley and therefore this has not been included as visited Trust location.</td><td rowspan="3"></td><td>KPI Now
No Change on Previous</td><td>Recording in place but standard yet to be agreed.</td></tr>
<tr><td>KPI Future
No Change on Previous</td><td>Plans are in place to increase the profile of the Board across the Trust and aspects of communication are being reviewed.</td></tr>
<tr><td>Pace & Grip
Change from Amber on Previous</td><td></td></tr>
</table>



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 Source of data (Culture & OD IAP for Metric 2)	Experience of bullying and harassment at SECAmb Nov 2017 (no / yes)	Reported incidents of B&H (Number by Date, Dec 2016 – Feb 2018)	**KPI Now No Change on Previous**	KPI measure in place but still trying to understand acceptable compliance.
				KPI Future No Change on Previous	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 No Change on Previous	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 Source of data (Hospital Turnaround Lead)	Total Hours Lost >30 minutes (Turn-around), April – March: 2013-14 Year, 2014-15 Year, 2015-16 Year, 2016-17 Year, 2017-18 Year		**KPI Now No Change on Previous**	Meaurement changed to align with external reporting. Clear oversight of impact. Remains amber.
				KPI Future No Change on Previous	Project is in place that includes sector wide engagement.
				Pace & Grip No Change on Previous	Weekly oversight of some metrics at Exec Board.



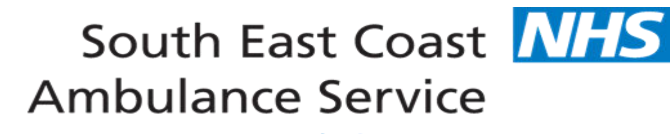
Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Effective	The Trust **should** ensure there are systems and resources available to monitor and assess the competency of staff.	Not currently sighted on this issue.	Not currently sighted on this issue.	KPI Now No Change on Previous	
				KPI Future No Change on Previous	
				Pace & Grip No Change on Previous	
Caring	The Trust **should** ensure that patients are always involved in their care and treatment.	No graph available yet.	No graph available yet.	KPI Now No Change on Previous	Not being progressed as a specific project but consent and MCA measured as part of QAV and this demonstrates compliance. Not yet sufficient data to populate a graph.
				KPI Future No Change on Previous	No identified risks to suggest compliance will not be sustained.
				Pace & Grip No Change on Previous	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.



Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Caring	The Trust **should** ensure that patients are always treated with dignity and respect Source of data Quality Accounts/Complaints Lead	Pie chart for whole year. Complaint Themes Overall Privacy and dignity, 2 Skill mix of crews, 3 Patient injury, 10 Crew diagnosis, 73 DOS issues, 4 Equipment issues, 8 GP callback delay, 1 HCP failed to visit, 1 Inappropriate treatment, 78 Made to walk, 7 Not transported to hospital, 27 Pathways (triage), 272		**KPI Now** **No Change on Previous**	Intentionally not progressed as a specific project. Diginity monitored through complaints process and assurance visits and addressed on a case by case basis.
				KPI Future **No Change on Previous**	
				Pace & Grip **No Change on Previous**	Currently considering how this can be specifically monitored.
Safe	The Trust **should** ensure all ambulance stations and vehicles are kept secured. Source of data (Medical Devices Management IAP)	% of checked vehicles locked whilst unattended % Compliance (50%–100%) 53 passed, 1 failed 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; 07/02/18 - 18/02/18	**% Compliance for Trust sites who have completed a Quarterly Site Security Assessment** (see table below)	**KPI Now** **No Change on Previous**	KPI for vehicles in place and demonstrates compliance. KPI for stations in place but audit returns are currently poor. Being addressed through operations with OUMs.
				KPI Future **No Change on Previous**	No risks identified to suggest KPIs will not be met.
				Pace & Grip **No Change on Previous**	Security to be on IPR when refreshed.

% Compliance for Trust sites who have completed a Quarterly Site Security Assessment

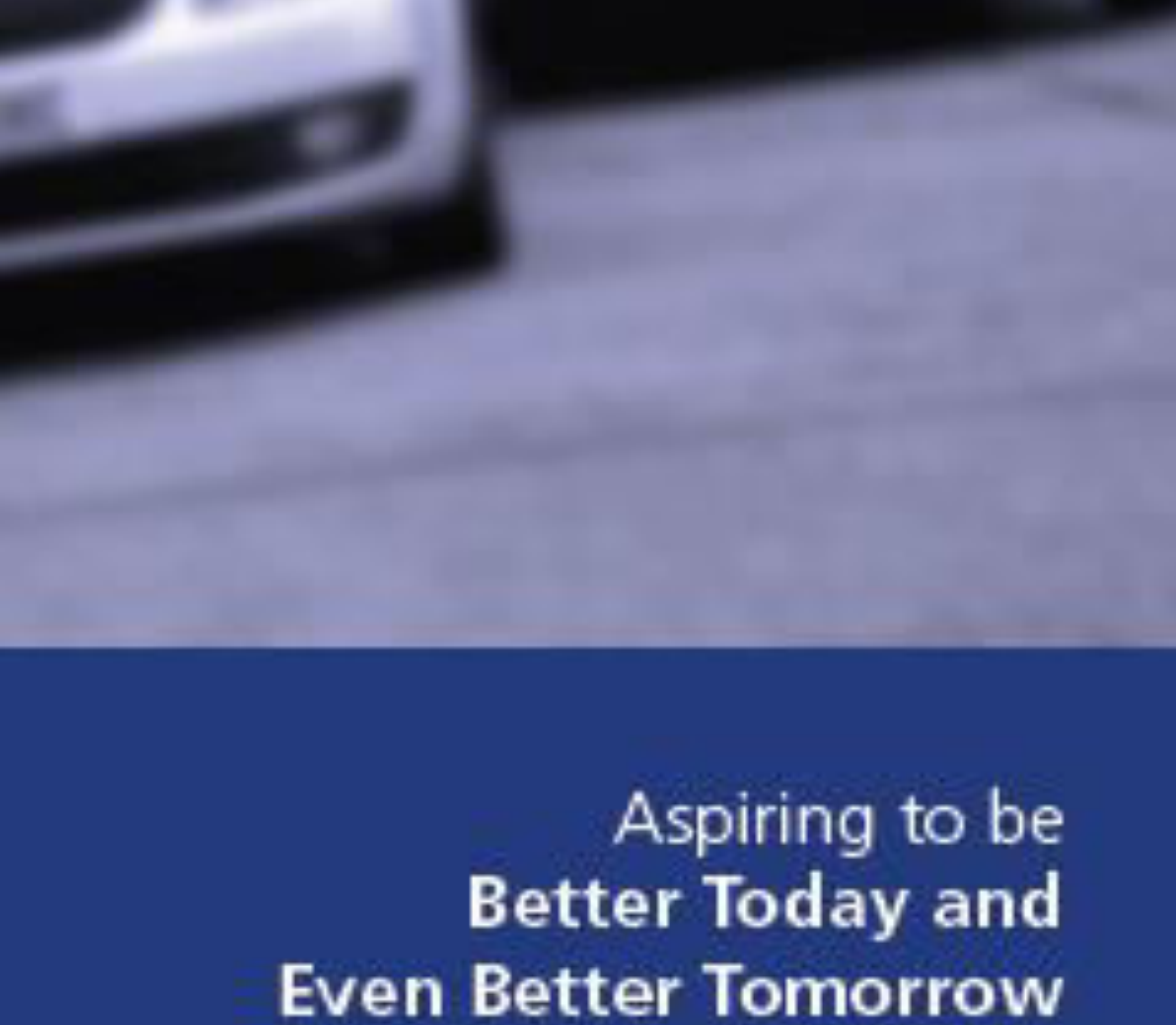
2017/18	Kent	Surrey	Sussex
Q1	93%	64%	77%
Q2	91%	71%	84%
Q3	96%	86%	84%
Q4	91%	57%	100%



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.	The software to enable vehicle checks will be in the Trust and available for the MDTs from the 16th April. Plan would be to roll out to a pilot site in the first instance		**KPI Now Change from Amber on Previous**	Software to enable vehicle checks will soon be available for the Mobile Data Terminals (MDT). This will be piloted in the first instance.
				KPI Future Change from Red on Previous	Software implemented in all MDTs so all vehicle checks are undertaken. This will be made available from April 2018.
				Pace & Grip Change from Red on Previous	KPI to be defined
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. Source of narrative (Operational Team Leader)	The proposition is to embed this into the Trust's current Patient Specific Instruction (PSI) process. Applications for a 'bariatric PSI' will be made by community professionals (e.g. GP) and sent to our Clinical Data Assistants to draft a PSI. The document will be reviewed by a Band 7 Clinical Lead (on behalf of our Consultant Paramedic) prior to being uploaded to IBIS. An associated 'at risk' CAD marker will instruct EMAs in EOC to triage through Module 0 (to rule out Cat 1 or Cat 2 disposition) and then transfer to a Clinical Supervisor for further assessment. The Clinical Supervisor will utilise the PSI on IBIS to support decision making and advise Resource Dispatchers as to an appropriate resource/vehicle, clinical grade and response timeframe etc. Attending front-line clinicians will be able to access the PSI document through IBIS on their iPads whilst en-route to the patient. The team has started contacting GPs where we have previously attended an incident for one of their patients that required use of the bariatric vehicle. We are using this approach as a 'soft launch' to support a few professionals and patients through the process, allowing us to embed it into the Trust prior to more formal communications across the region.		**Pace & Grip Change from unclassified on Previous**	
				KPI Future Change from unclassified on Previous	
				Pace & Grip Change from unclassified on Previous	

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

April 2018

Important Notice

To facilitate the continued improvement of this report it has been agreed to allow for more time for preparation. This will mean that the data reported is for two months prior to the Board report. For example, The April Trust Board meeting will review Februarys data. This will enable adequate validation of the data, and support the provision of additional and more detailed commentary within the board reports going forward. The Board will note that meetings are held with Commissioners to review contemporary (un validated) date on a weekly basis. This will provide the Executive with increased assurance as to the reliability / accuracy of reports.

SECAmb Executive Summary

The format of this IPR is now intended to remain the same and a planned review conducted in 6 months. The Trust will be able to continually refine content, be clear on actions taken in response to data and adapt the content (through drop down menus) to enable consistent reporting format and content at OU Level (this work is ongoing).

The Board is asked to note that in the last reporting period extensive work has been undertaken in the collation, preparation and submittal of our Performance Information Request from CQC. By way of background, the Trust received a request from CQC on the 29th March 2018. The Provider Information Request contained a mixture of quantitative and qualitative questions that CQC requested answers to as well and providing a comprehensive list documents that the Trust was required to Submit. The submittal was due by 5pm on the 25th April 2018.

The Board should note the extensive work conducted by Directorates and led by Directorate Business Support Managers to create, on time, a comprehensive response to the questions posed and supporting evidence and collateral. As part of the submission, SECAmb was required to conduct a self-assessment of the documentation prepared. This covers:

1. Emergency and Urgent Care
2. Emergency Operation Centre
3. Patient Transport Services
4. 111
5. Resilience

These areas are then subject to a self evaluation across the CQC Domains with supporting narrative:

1. Safe
2. Caring
3. Effective
4. Responsive
5. Well led (in Workforce, Finance and Efficiency)

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

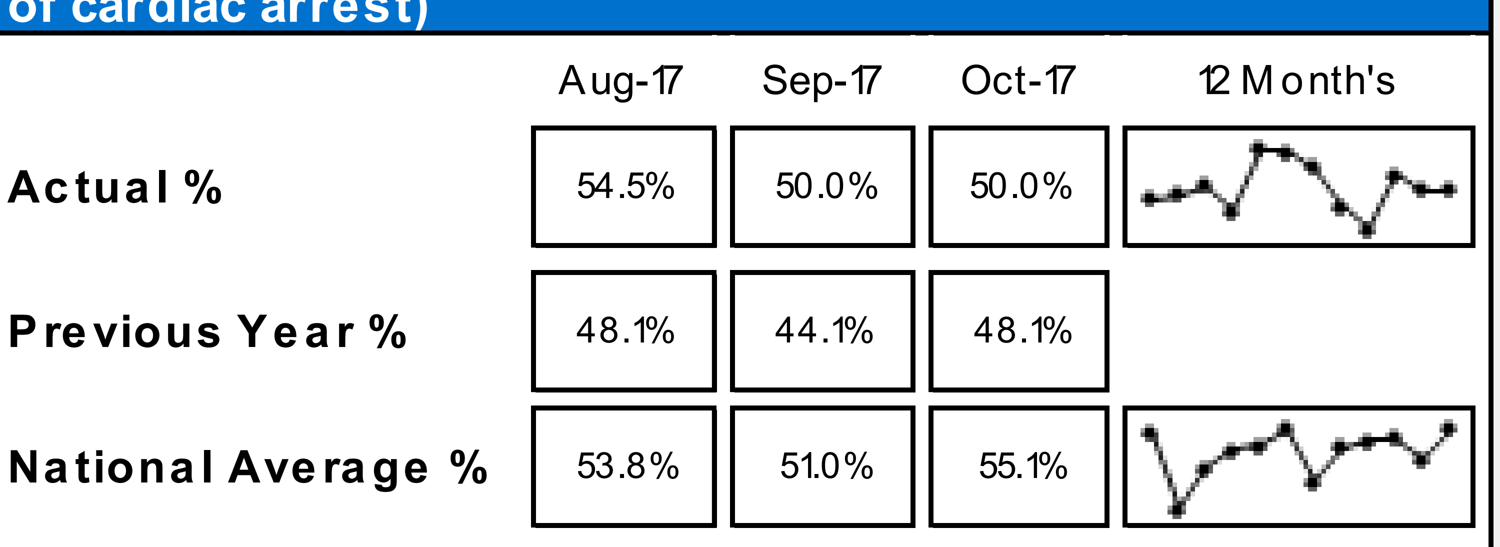
Section	Page
Clinical Safety	4
Clinical Quality	9
Operations Performance	12
Workforce	16
Finance	19

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%	

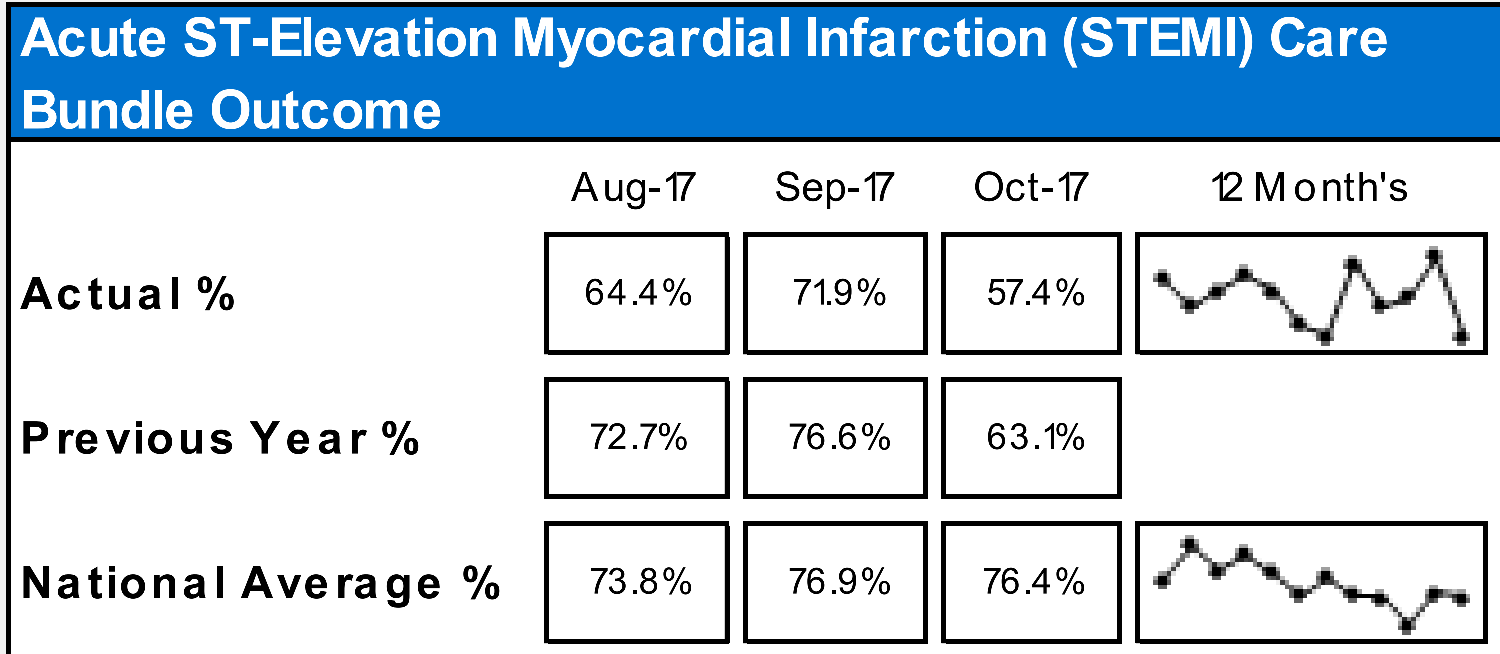
Cardiac Survival - Utstein

	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%	

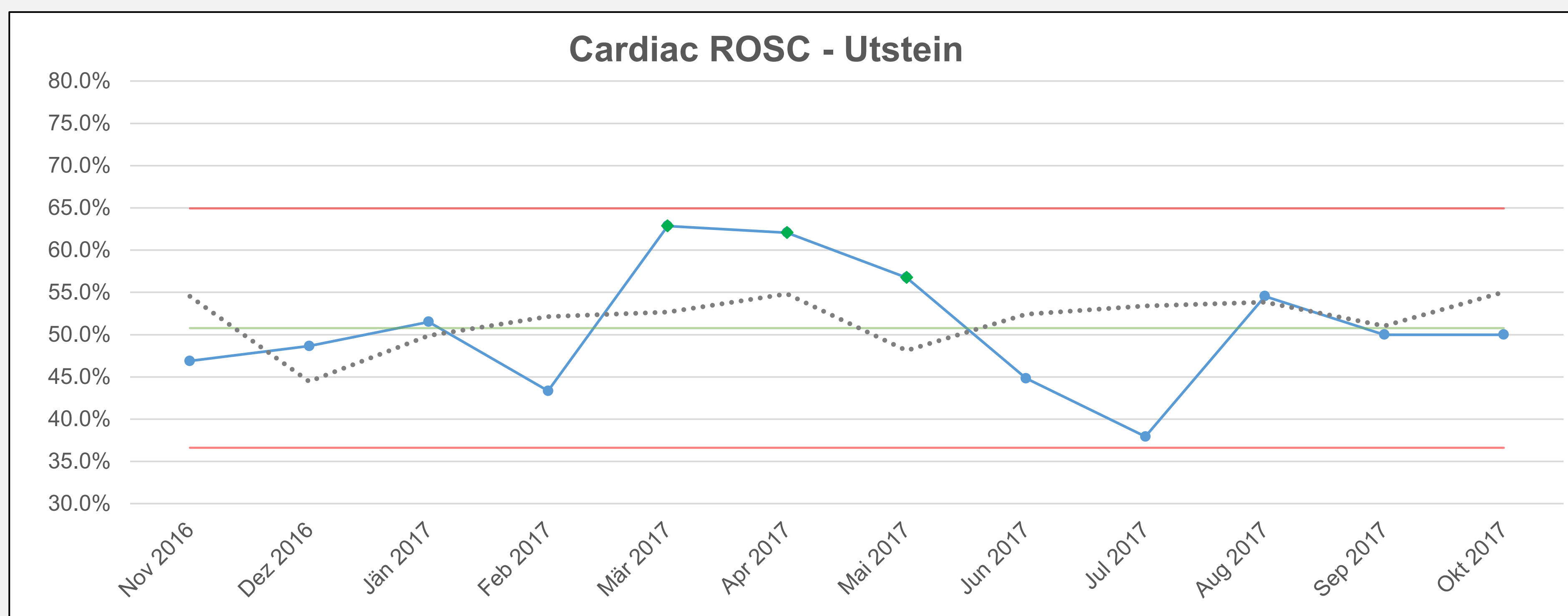
Stroke - assessed F2F receiving care bundle

	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

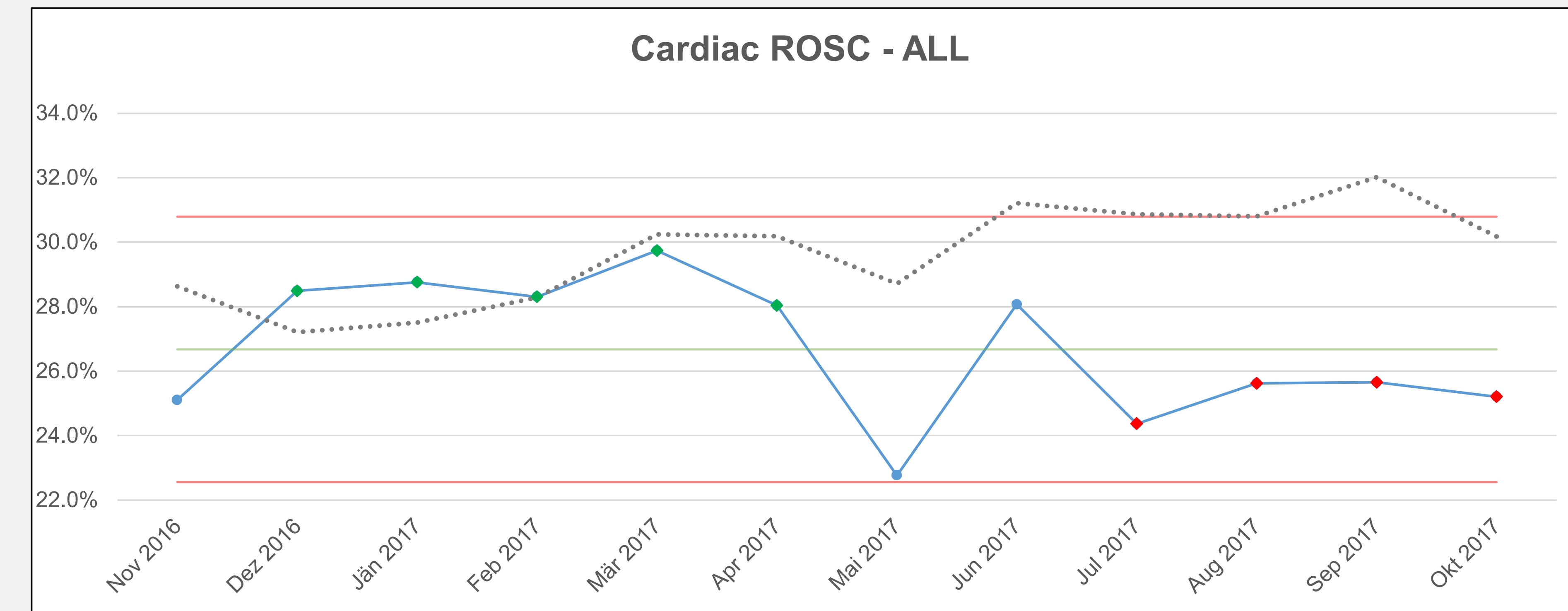
	Dec-17	Jan-18	Feb-18	12 Month's
Actual	96.70%	97.76%	97.57%	
Number of audits	218	201	190	

SECAmb Clinical Safety Charts



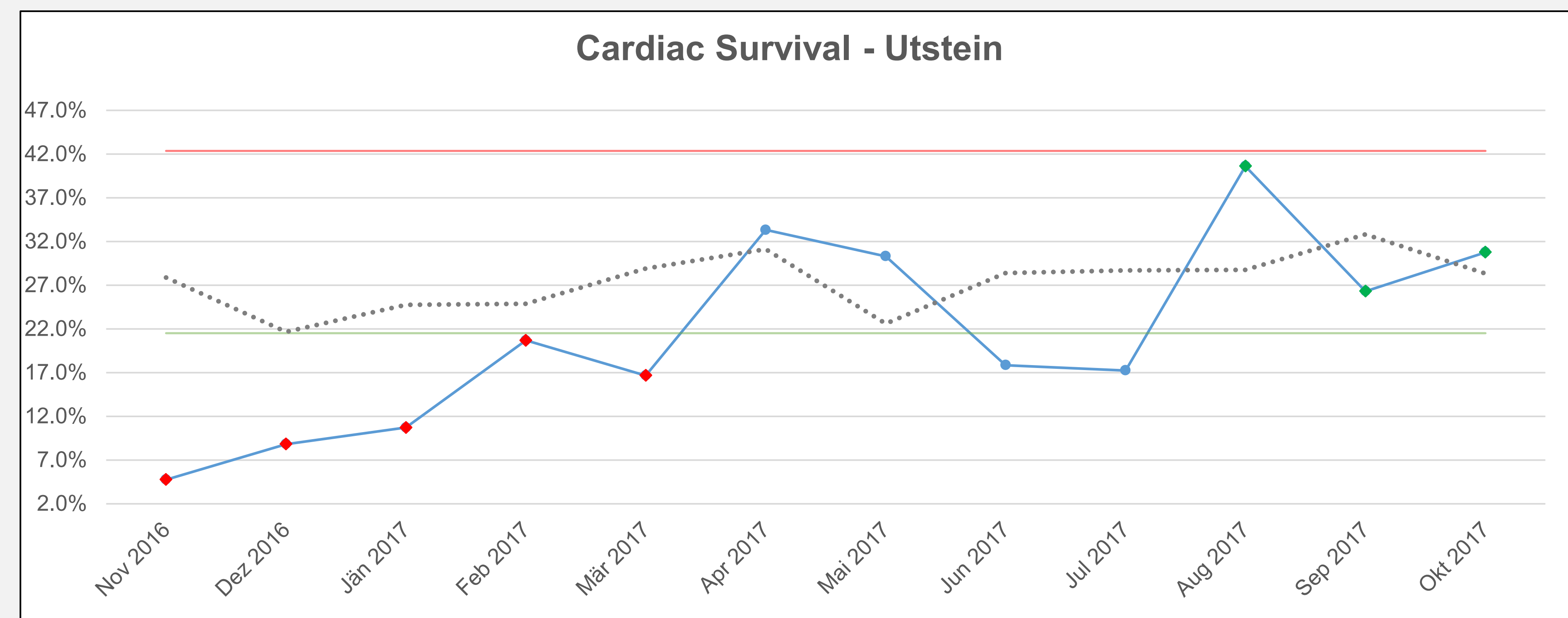
Performance for the cardiac arrest ROSC indicator for the Utstein group for October 2017 is in line with SECAmb YTD and below the national average.

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.



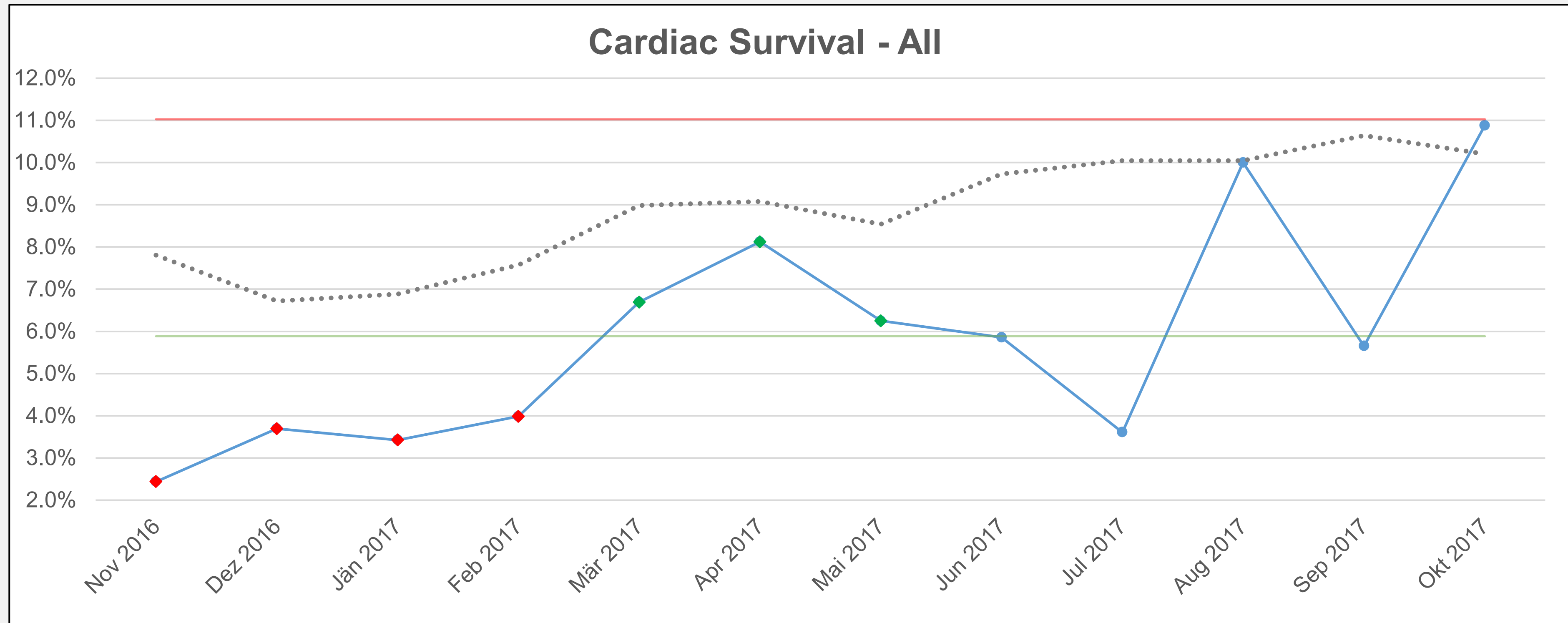
In October 2017 our performance for ROSC in all patient groups remains below the SECAmb YTD average.

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.



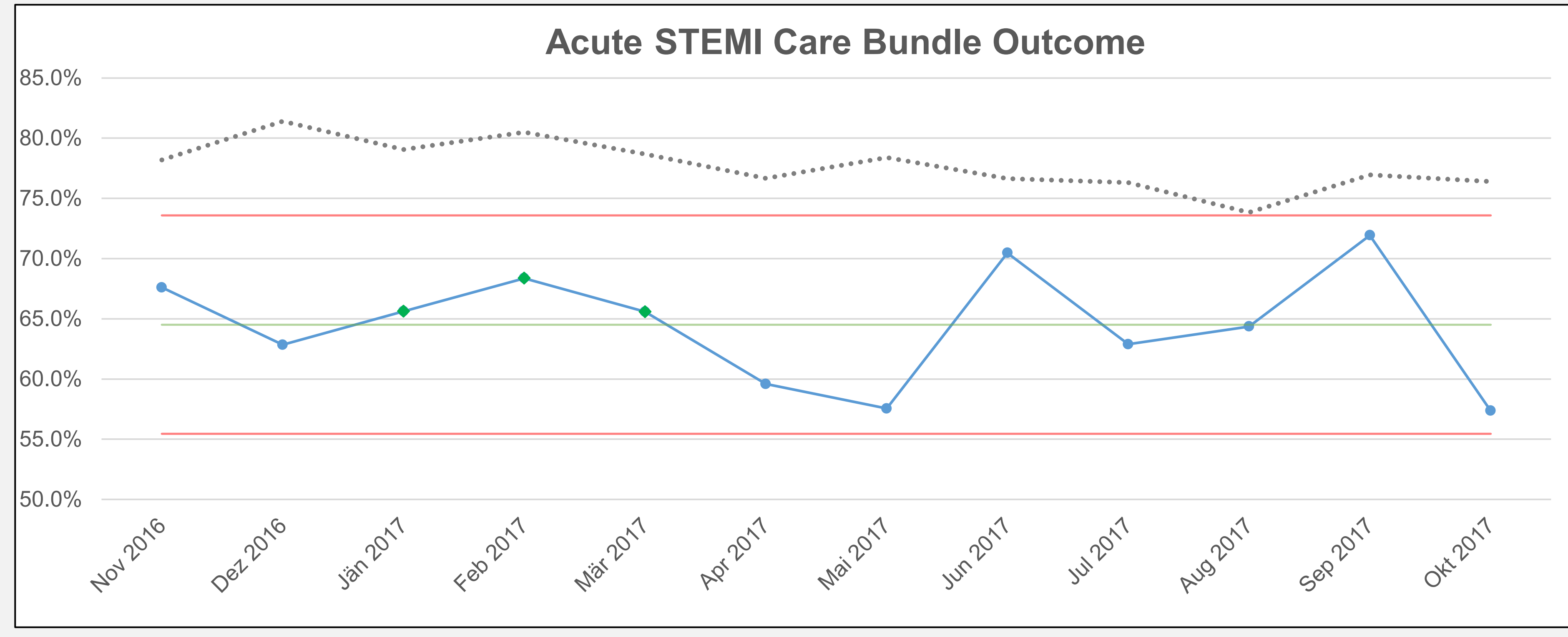
In October 2017, survival to discharge for the Utstein group was above our mean and above the national average. The data continues to show normal patterns of variation.

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.

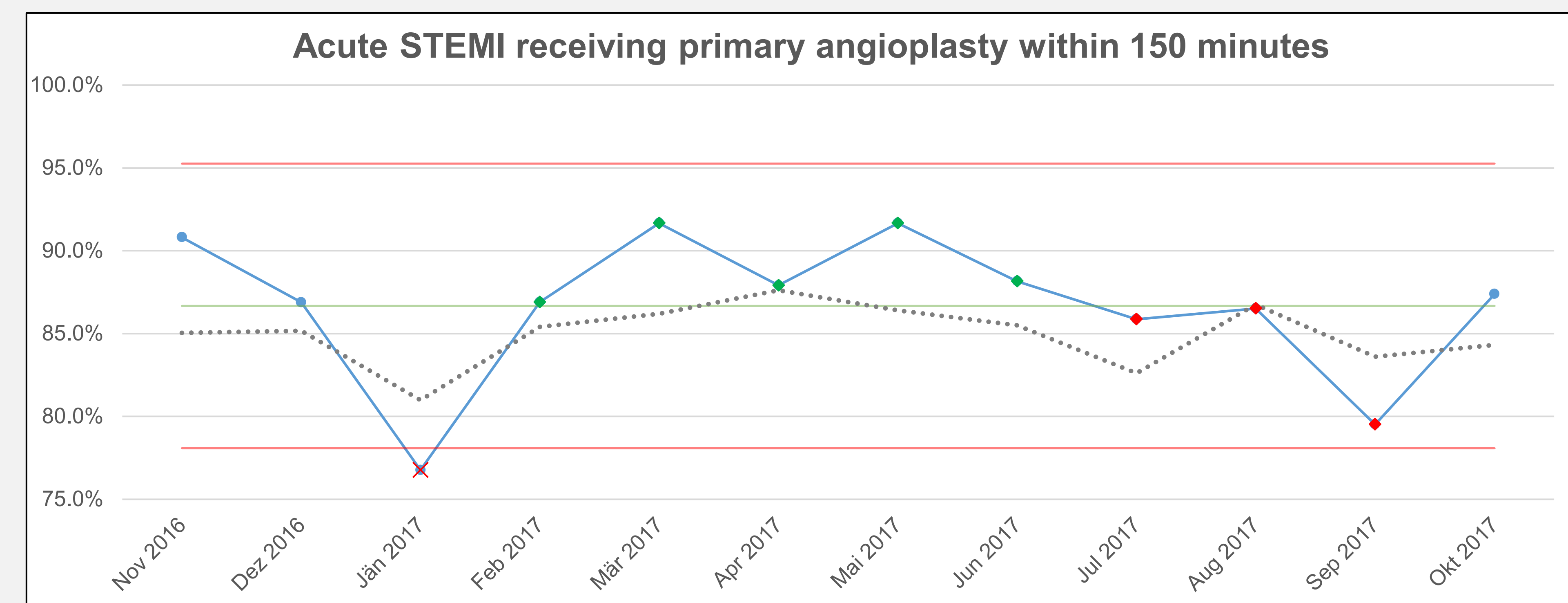


Performance for October 2017 was below our YTD and the national average.

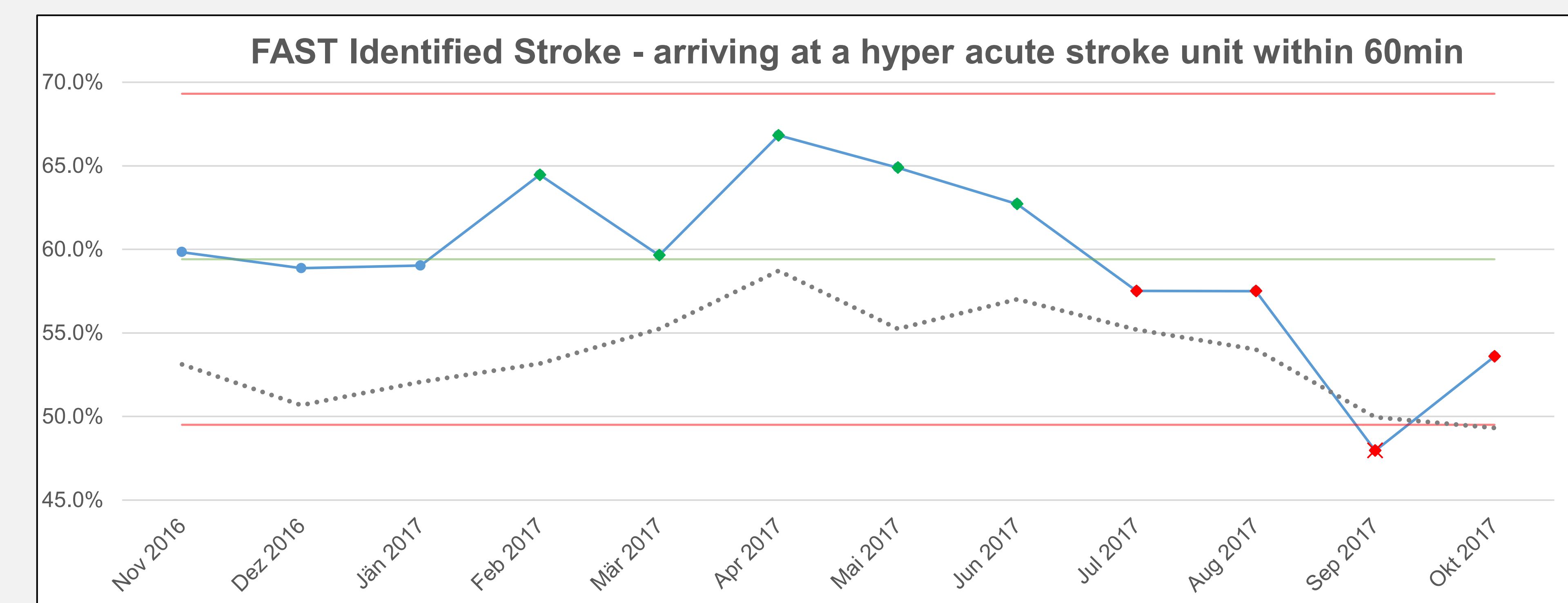
Dashboards and quality scorecards showing local performance levels are now routinely being shared with Operating Units (OUs) to facilitate focussed quality improvement.

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



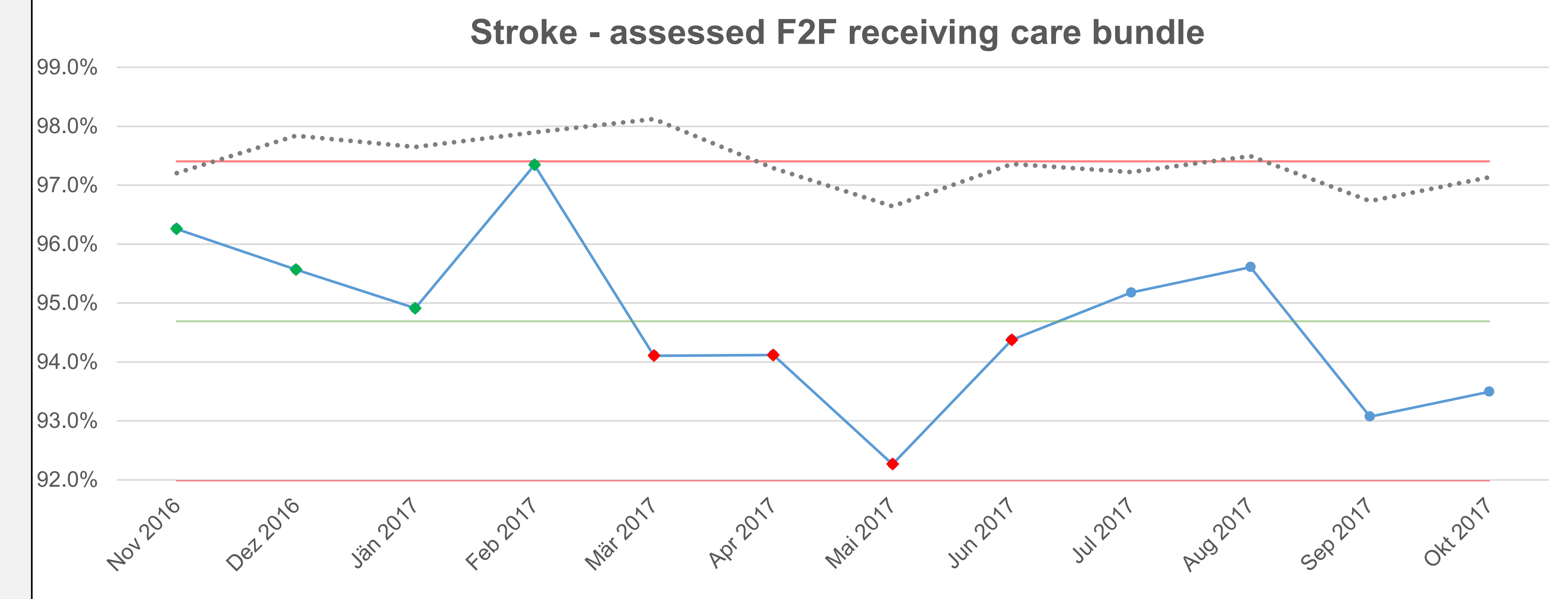
October 2017 saw an increase on the previous month's performance against this indicator. We are once again above the national average and our own average.



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.



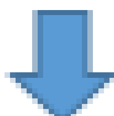
Performance in completing the stroke care bundle is below national and our YTD average.

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

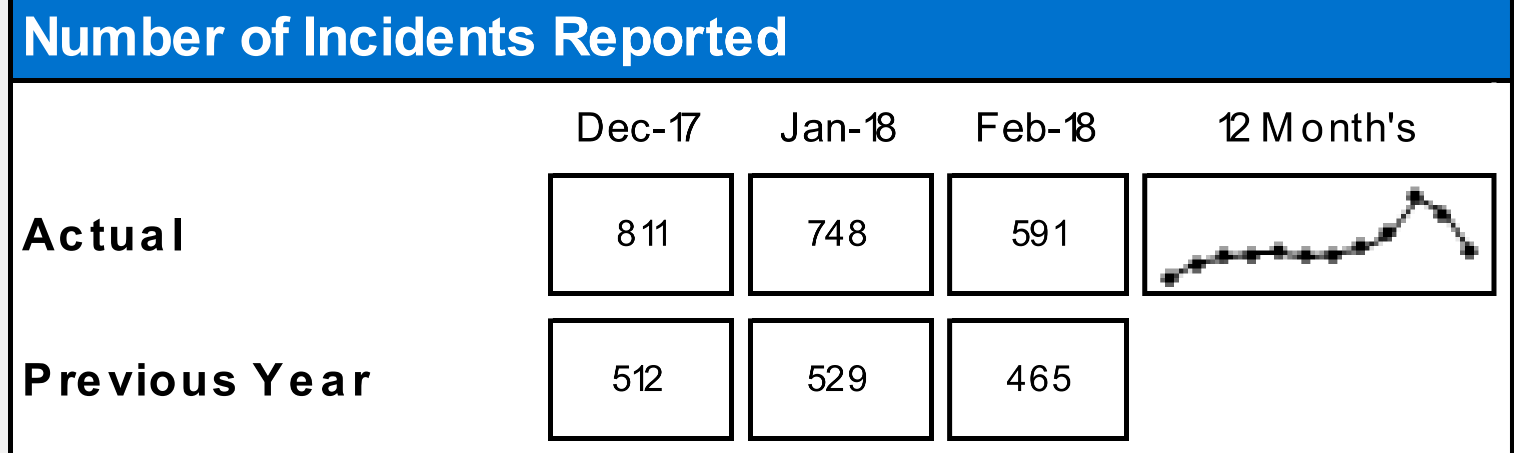
Area	Utstein	Details	Overall
East	5	Patient survived to discharge	12
West	7		14
East	5	Patient died in hospital	25
West	5		19
East	0	Patient still in hospital*	1
West	0		0
East	1	Patient record not found by hospital*	2
West	0		0
East	0	No reply from hospital*	0
West	0		0

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

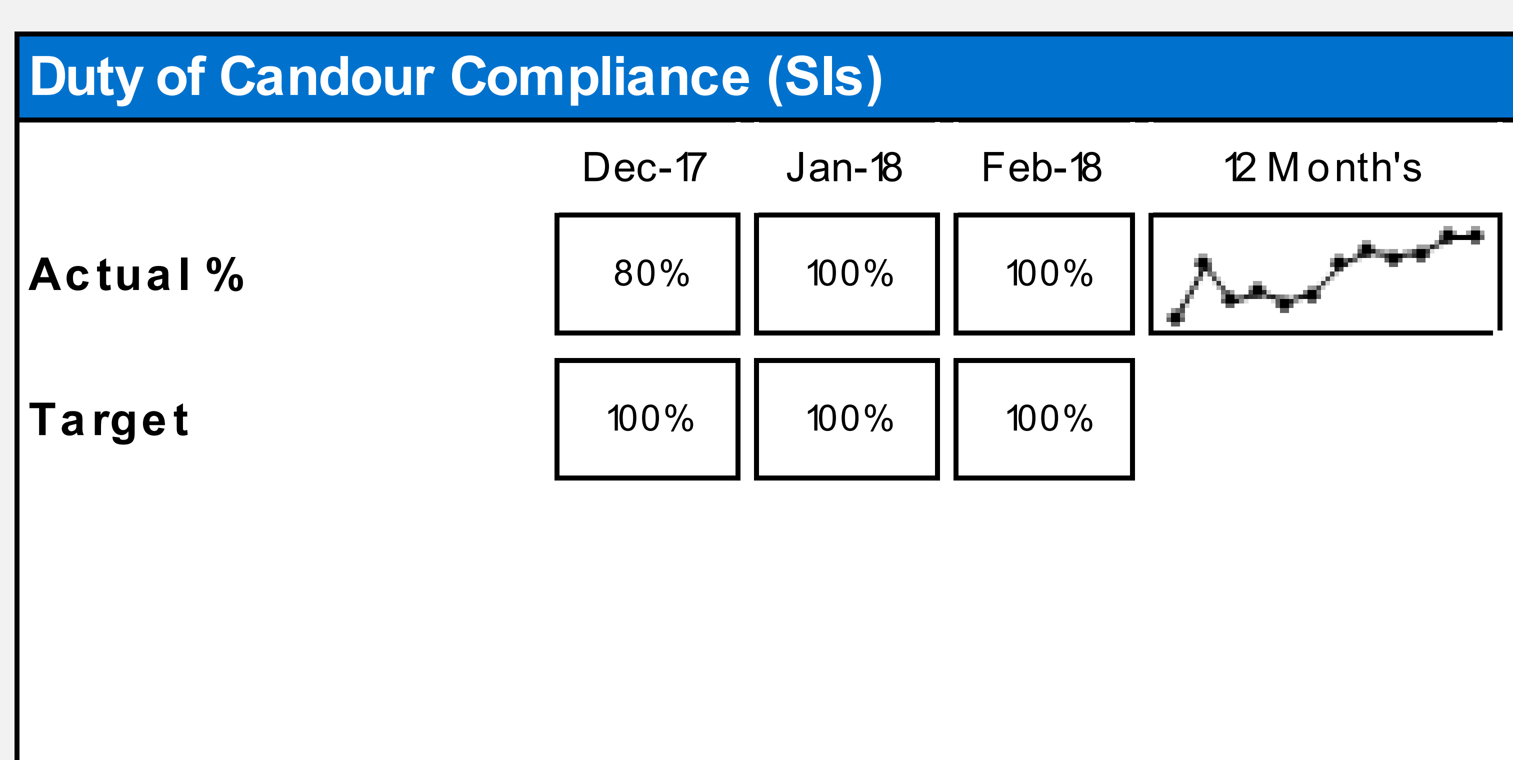


	Dec-17	Jan-18	Feb-18	12 Month's
Actual	811	748	591	
Previous Year	512	529	465	

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)

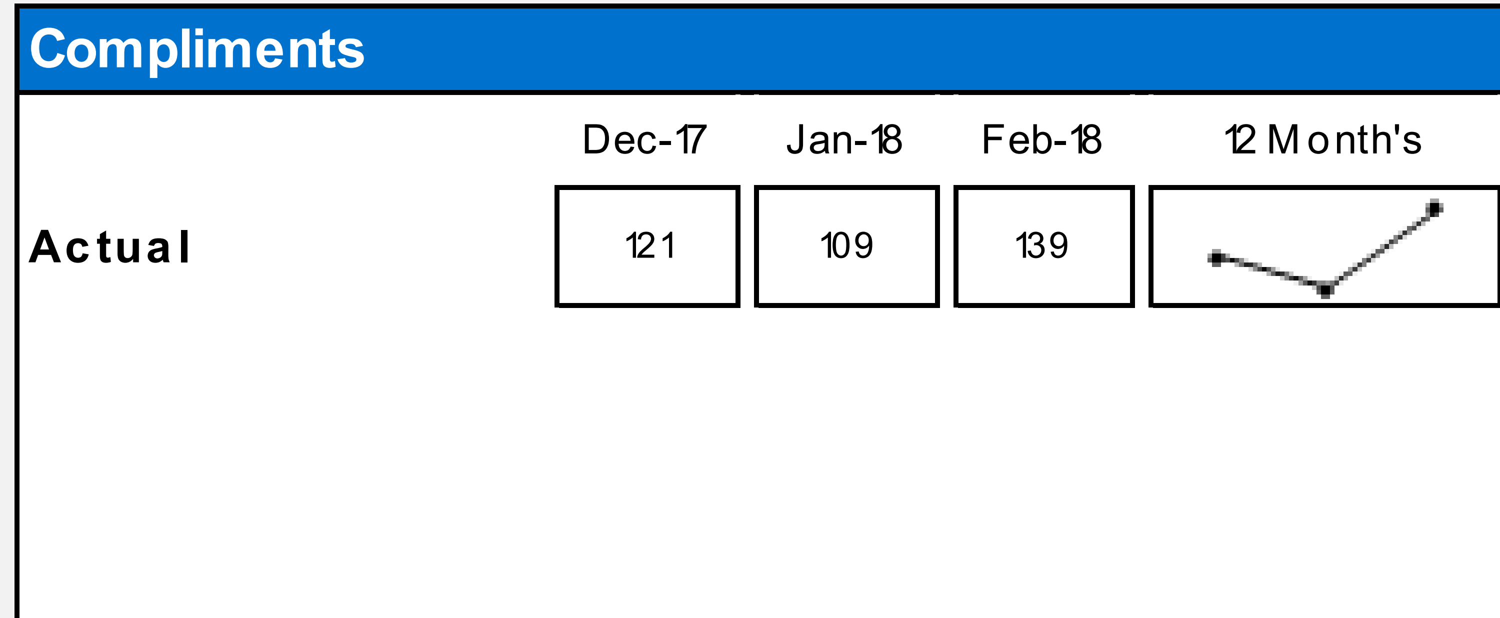


	Dec-17	Jan-18	Feb-18	12 Month's
Actual %	80%	100%	100%	
Target	100%	100%	100%	

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

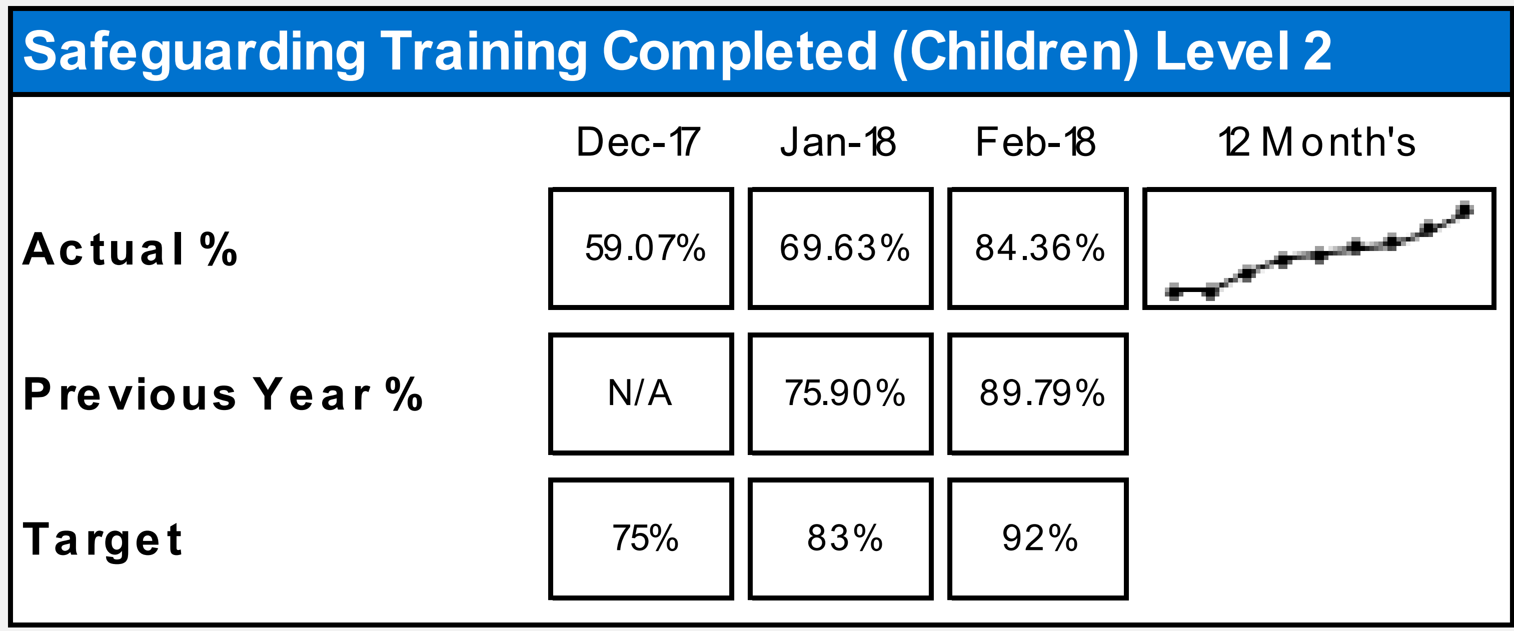


	Dec-17	Jan-18	Feb-18	12 Month's
Actual	121	109	139	

Safeguarding Training Completed (Adult) Level 2

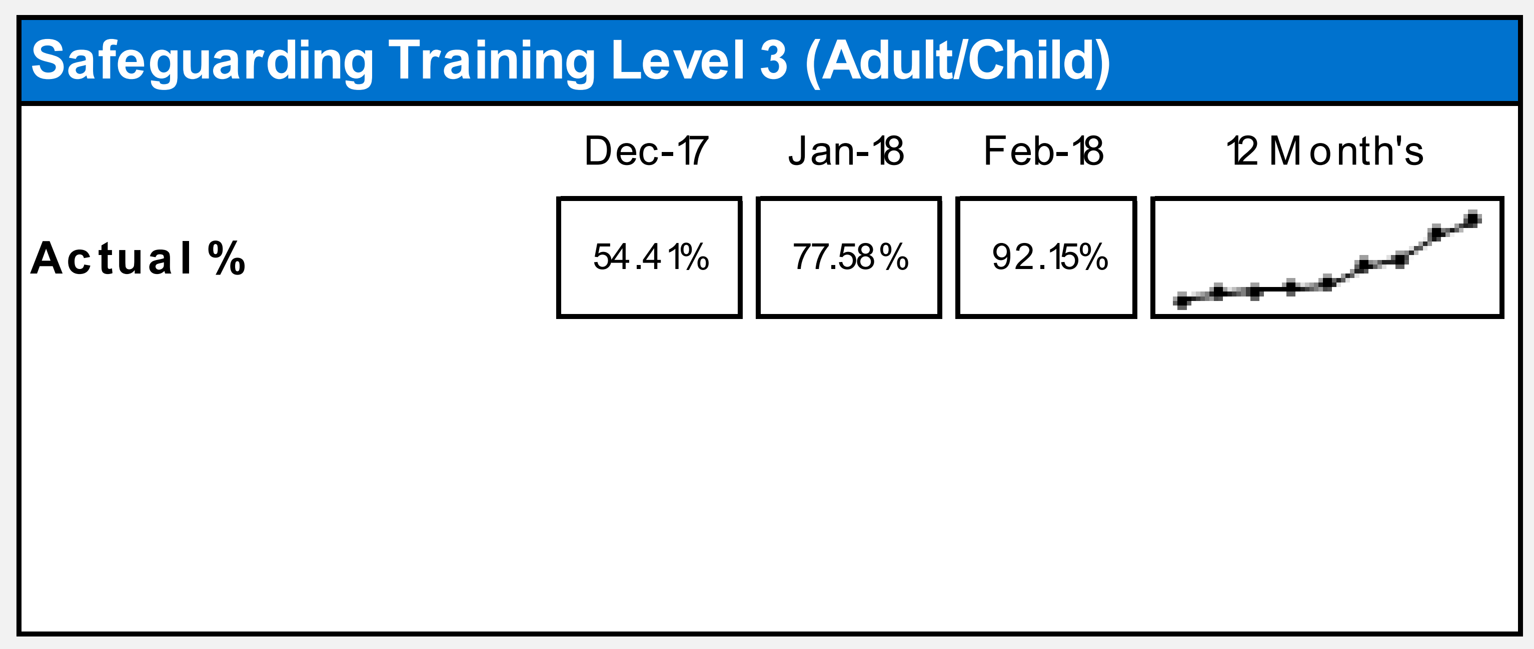
	Dec-17	Jan-18	Feb-18	12 Month's
Actual %	59.65%	69.33%	85.66%	
Previous Year %	N/A	76.20%	89.07%	
Target	75%	83%	92%	

Safeguarding Training Completed (Children) Level 2



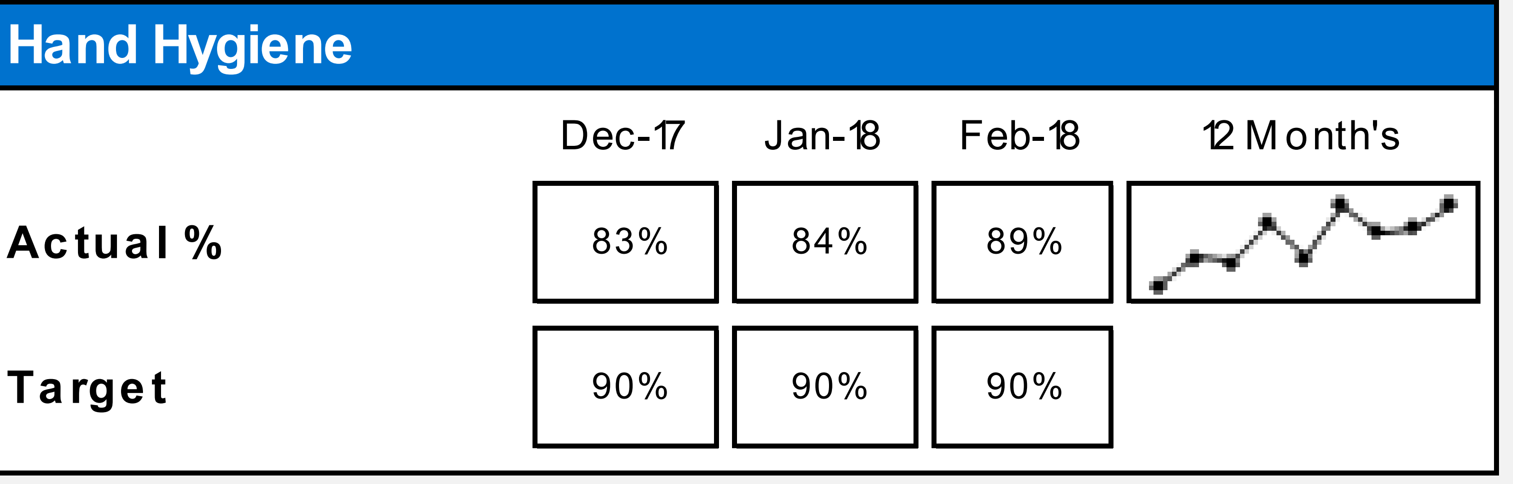
	Dec-17	Jan-18	Feb-18	12 Month's
Actual %	59.07%	69.63%	84.36%	
Previous Year %	N/A	75.90%	89.79%	
Target	75%	83%	92%	

Safeguarding Training Level 3 (Adult/Child)



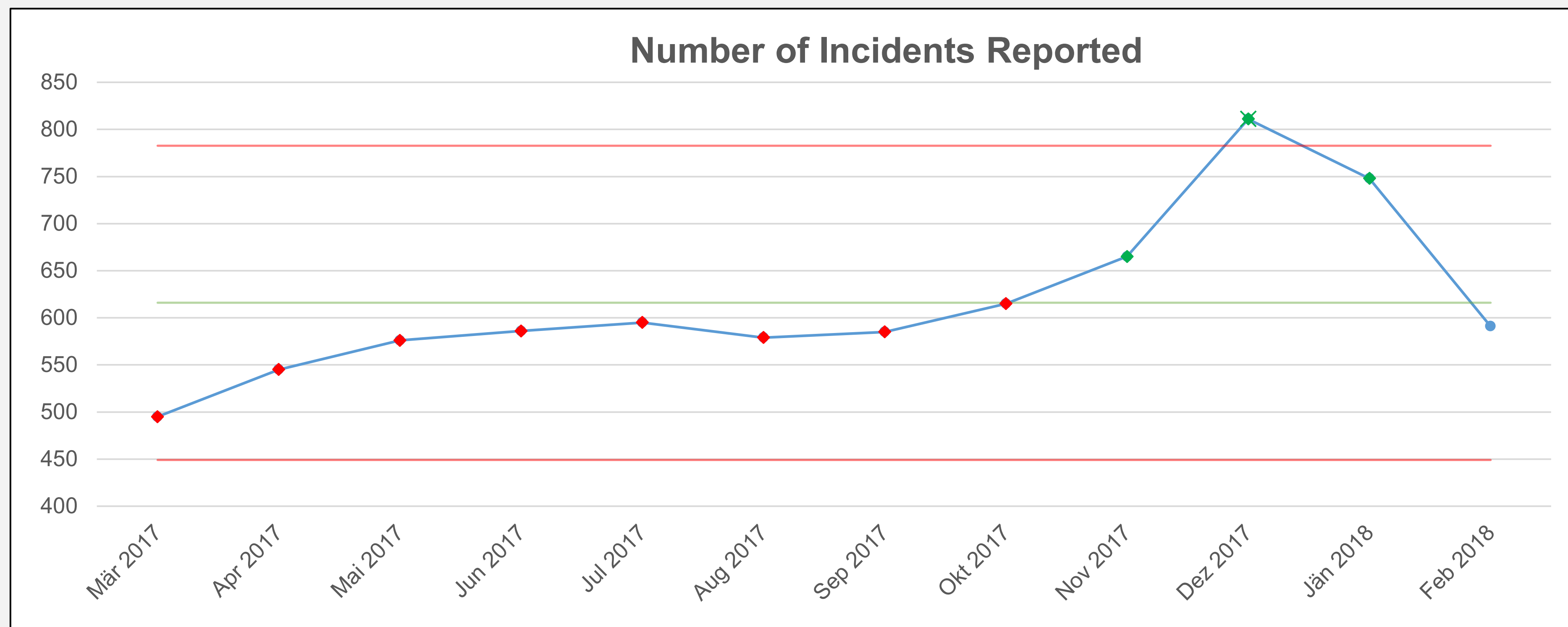
	Dec-17	Jan-18	Feb-18	12 Month's
Actual %	54.41%	77.58%	92.15%	

Hand Hygiene

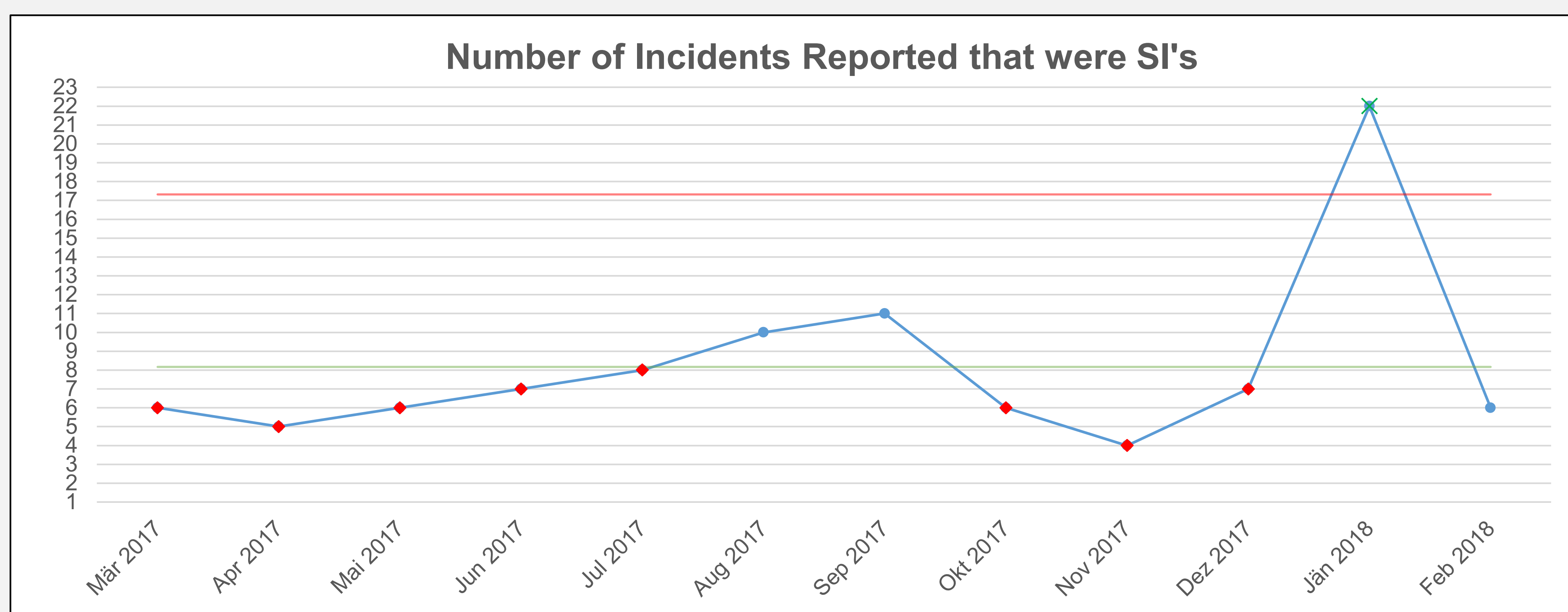


	Dec-17	Jan-18	Feb-18	12 Month's
Actual %	83%	84%	89%	
Target	90%	90%	90%	

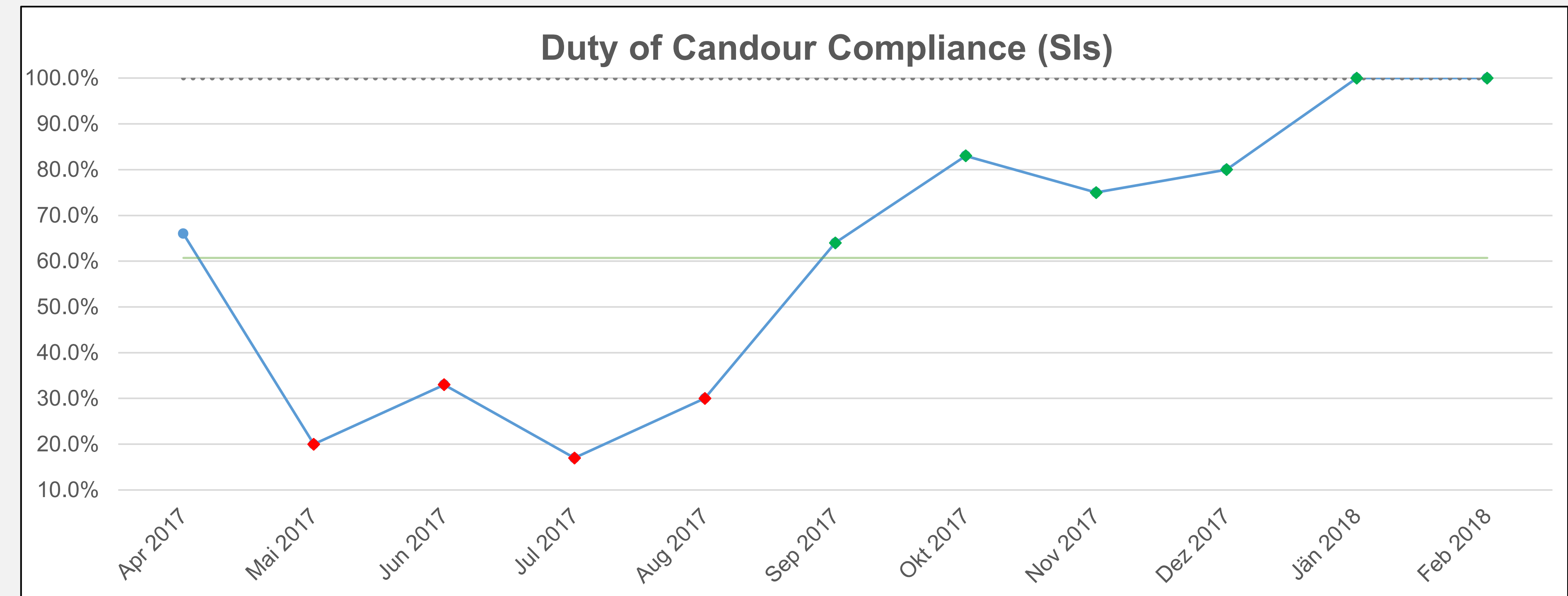
SECAmb Clinical Quality Charts



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.

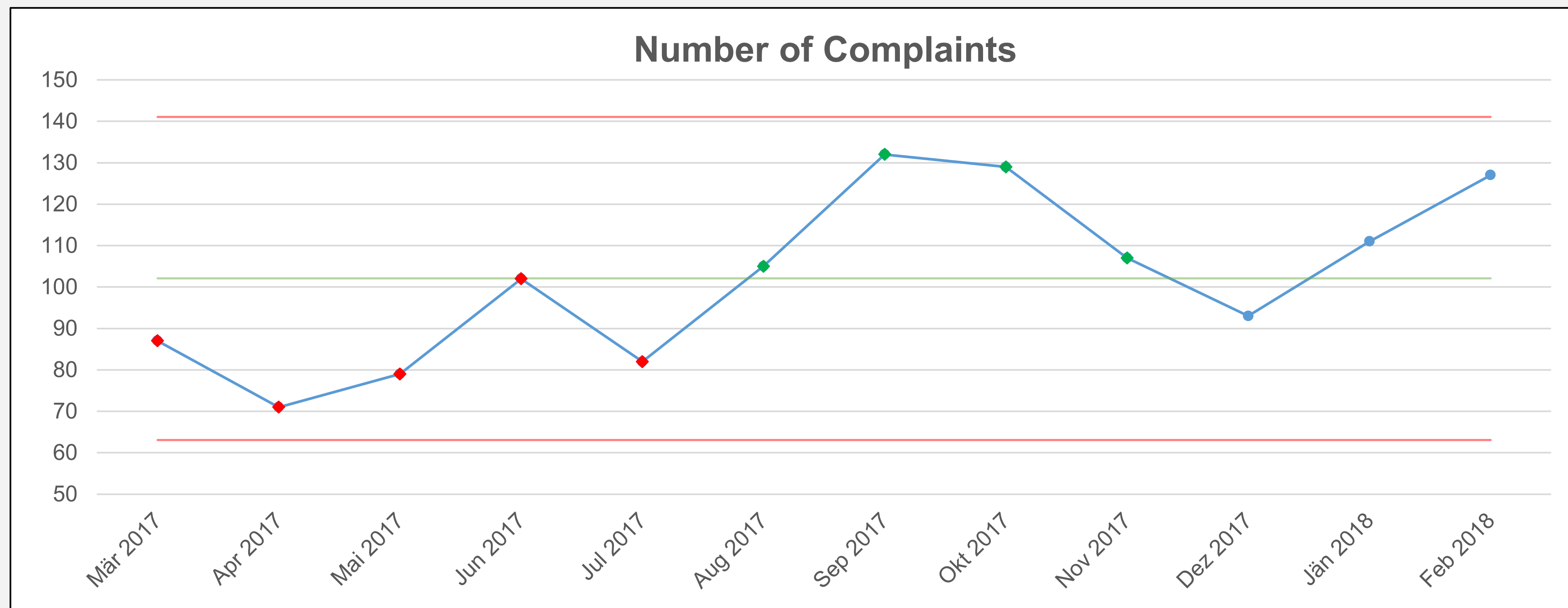


A significant decrease in the numbers reported this month following a large increase in January.
6 SIs were reported for the following reasons:
Call Answer delay – 1
Patient Care – 1
RTC – 1
Patient Injury – 1
Triage – 1
Safeguarding – 1
Service Areas reporting were:
A&E Ops – 3
EOC – 1
Trustwide – 1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

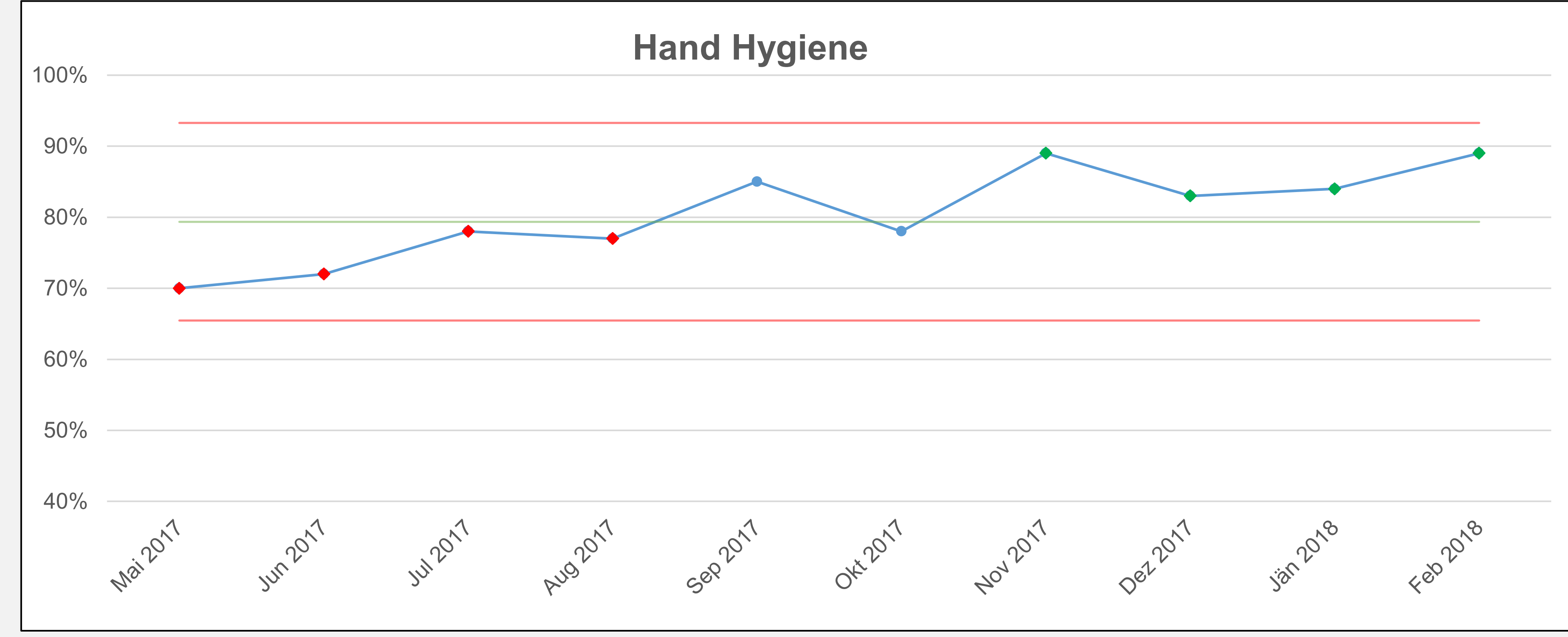
100% of timeframes for those SIs requiring Duty of Candour were met this month.



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 February.
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.

Health and Safety (H&S)

Introduction

The Head of H&S advert has closed with two candidates shortlisted from eight applicants and interviews are pencilled in for the 19th March. 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

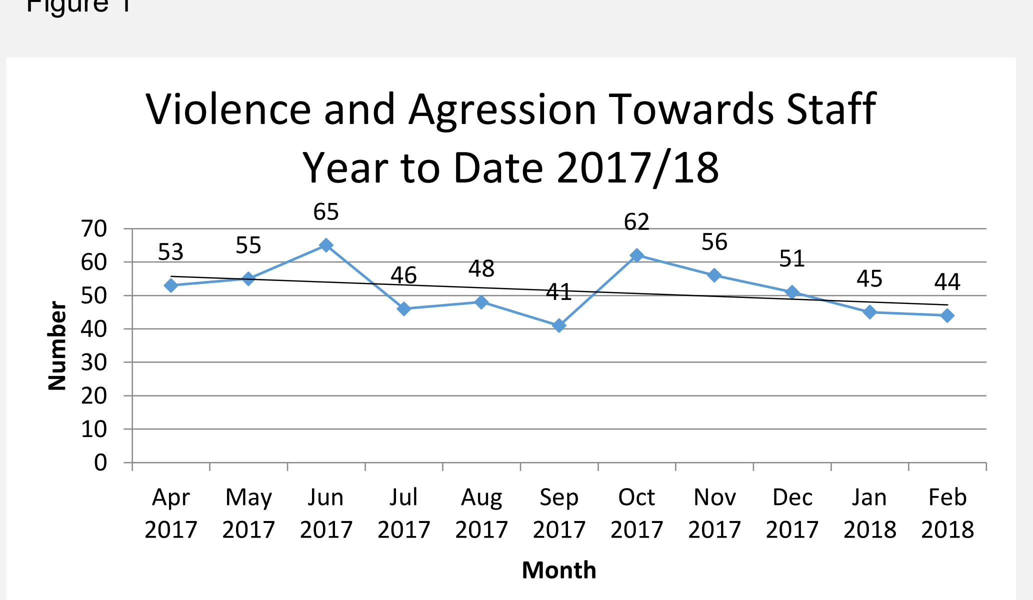


Figure 2

Manual Handling Incidents Year to Date 2107/18

Number

Month

Apr 2017 May 2017 Jun 2017 Jul 2017 Aug 2017 Sep 2017 Oct 2017 Nov 2017 Dec 2017 Jan 2018 Feb 2018

15 20 23 21 26 22 15 12 27 26 25

Figure 3

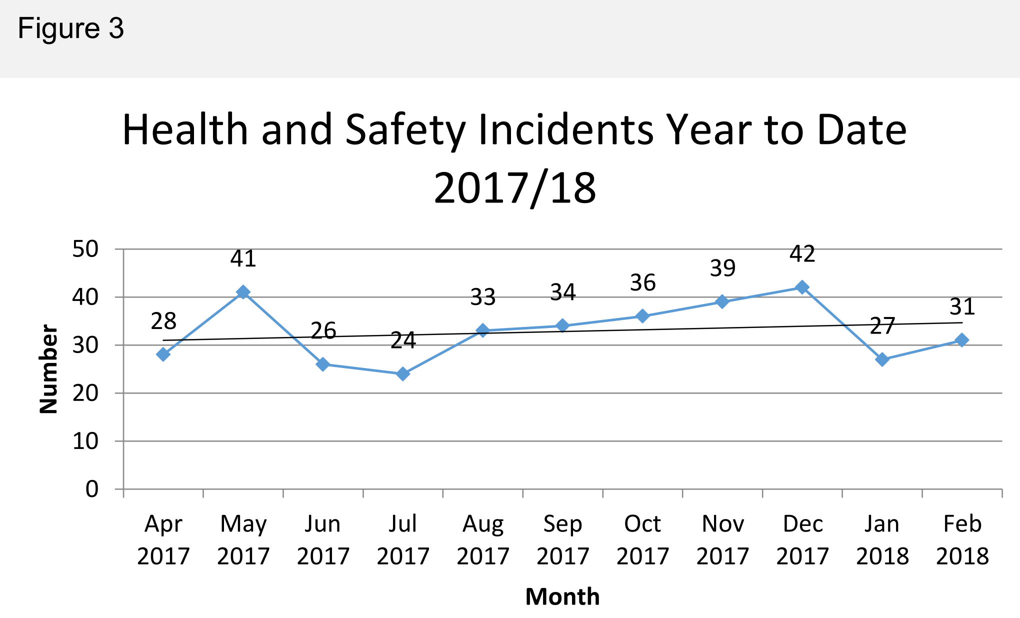


Figure 4

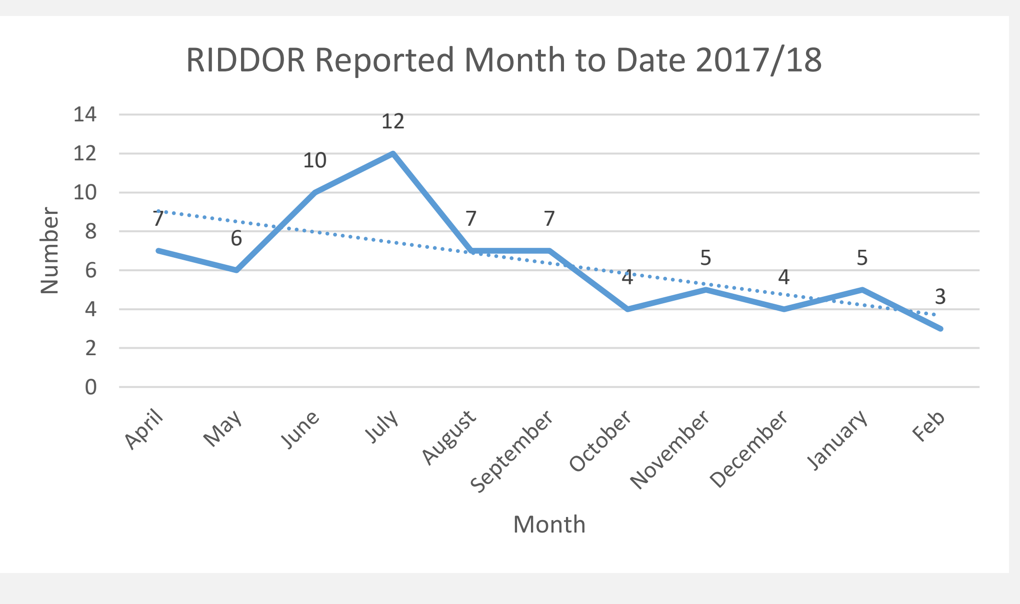
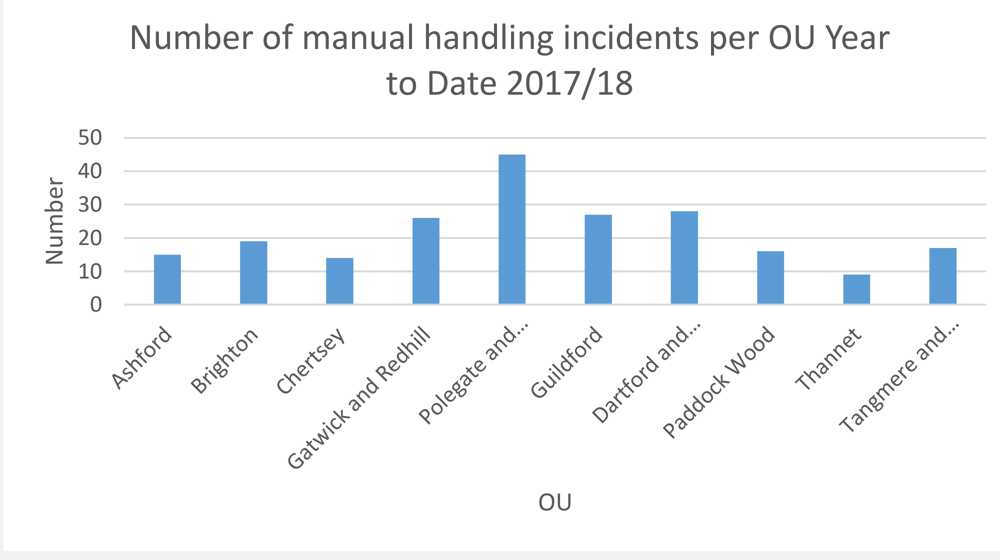
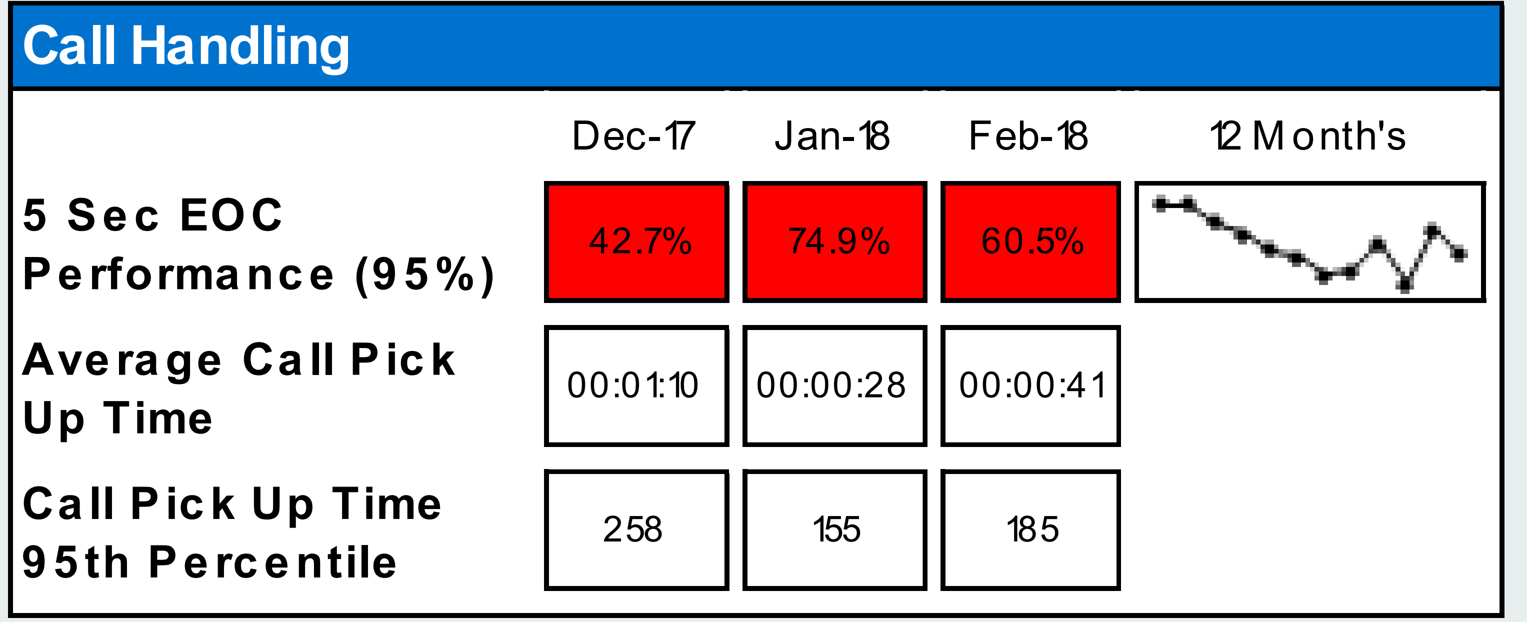


Figure 5



SECAmb 999 Operations Performance Scorecard

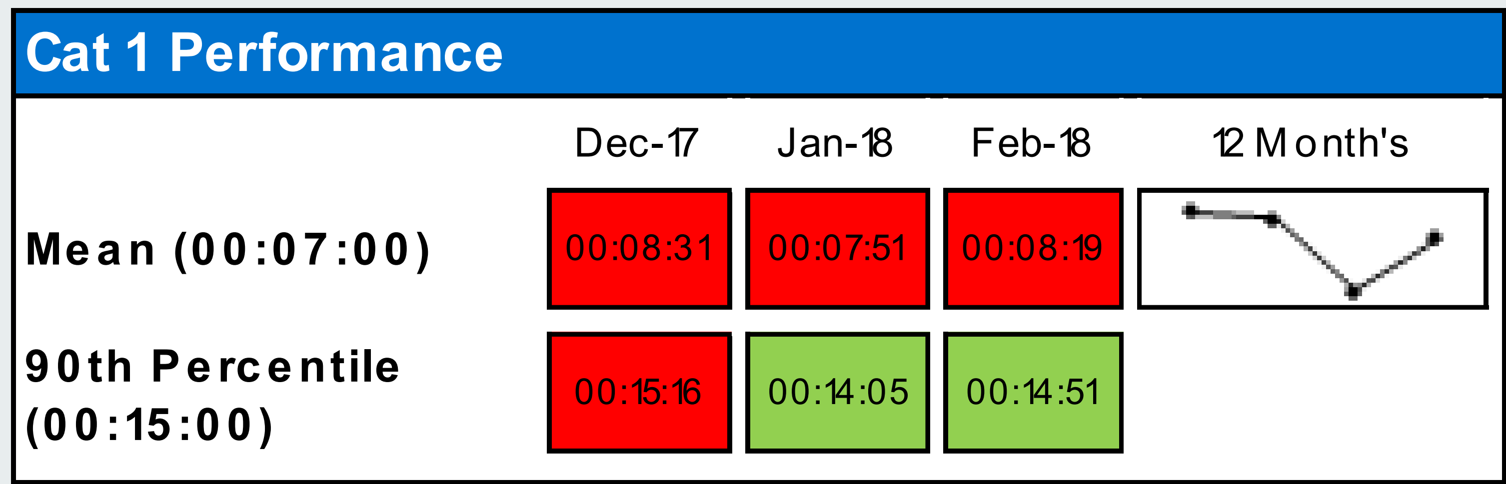


Call Handling

	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	

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	

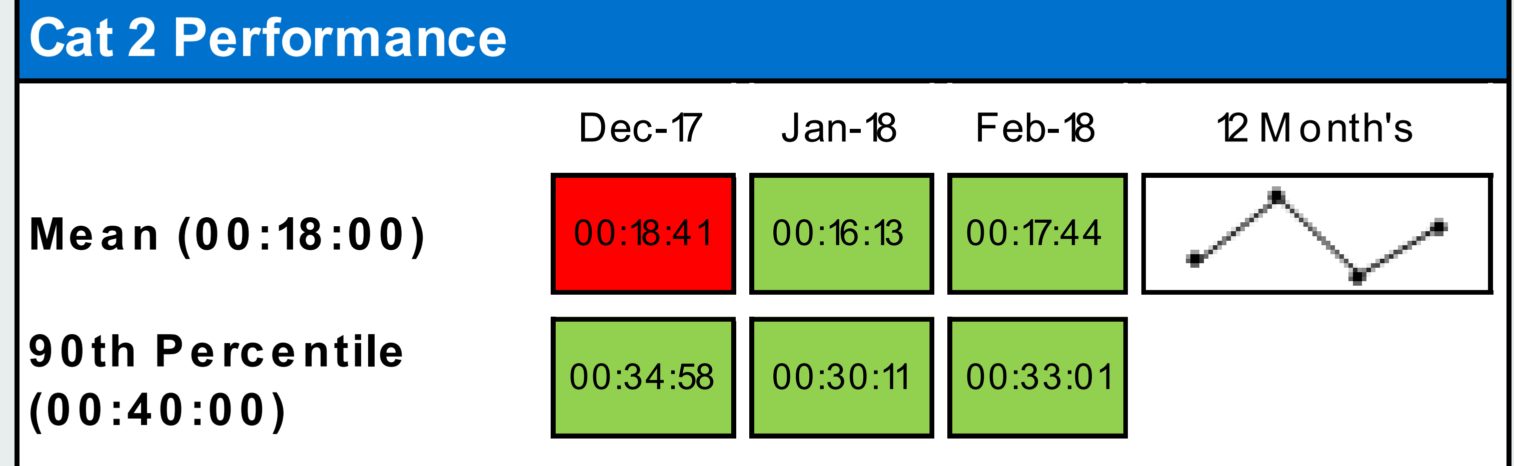


Cat 1 Performance

	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 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	

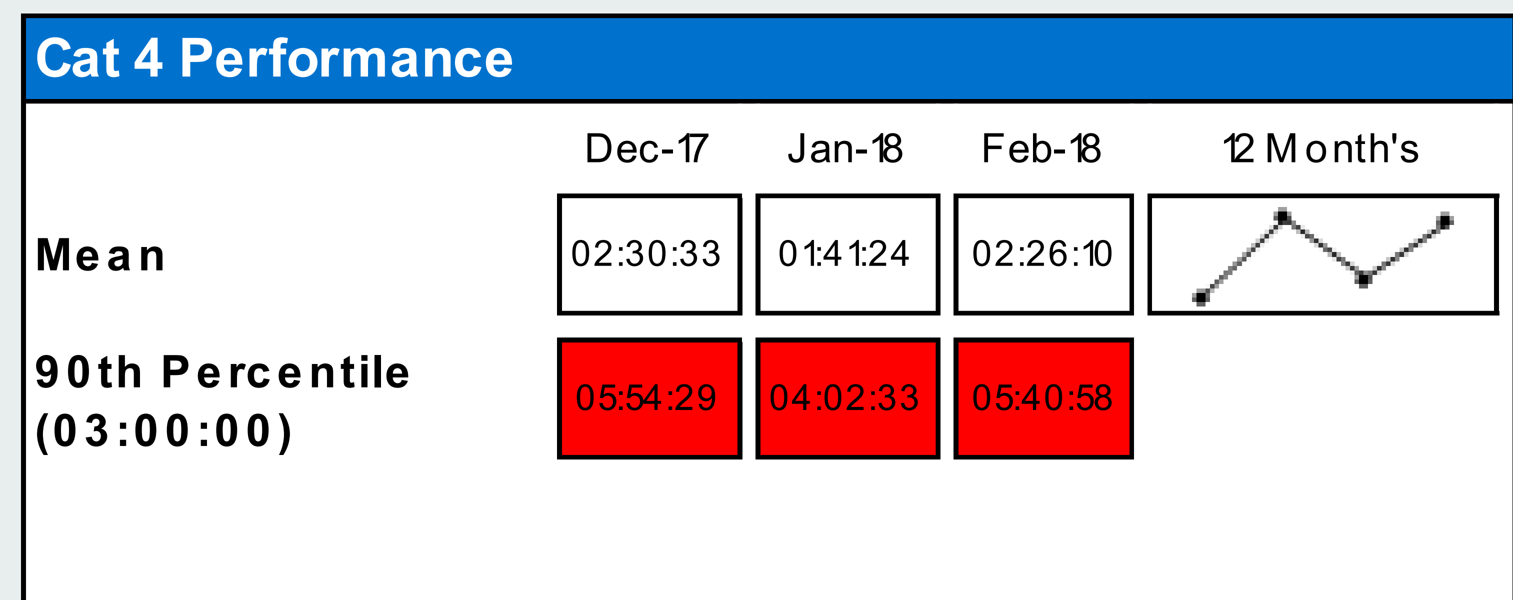


Cat 2 Performance

	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 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	



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	

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%	

Demand/Supply

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

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%	

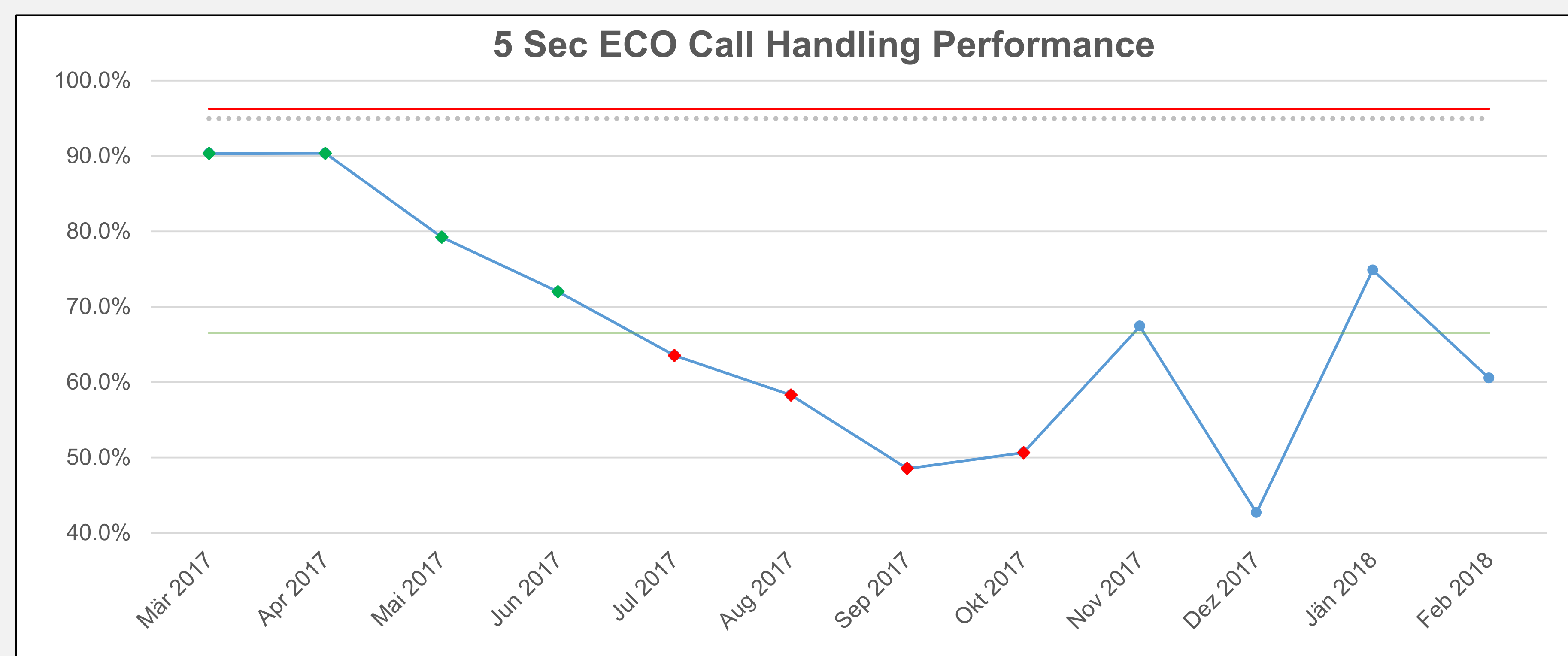
Community First Responders

	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	

Call Cycle Time

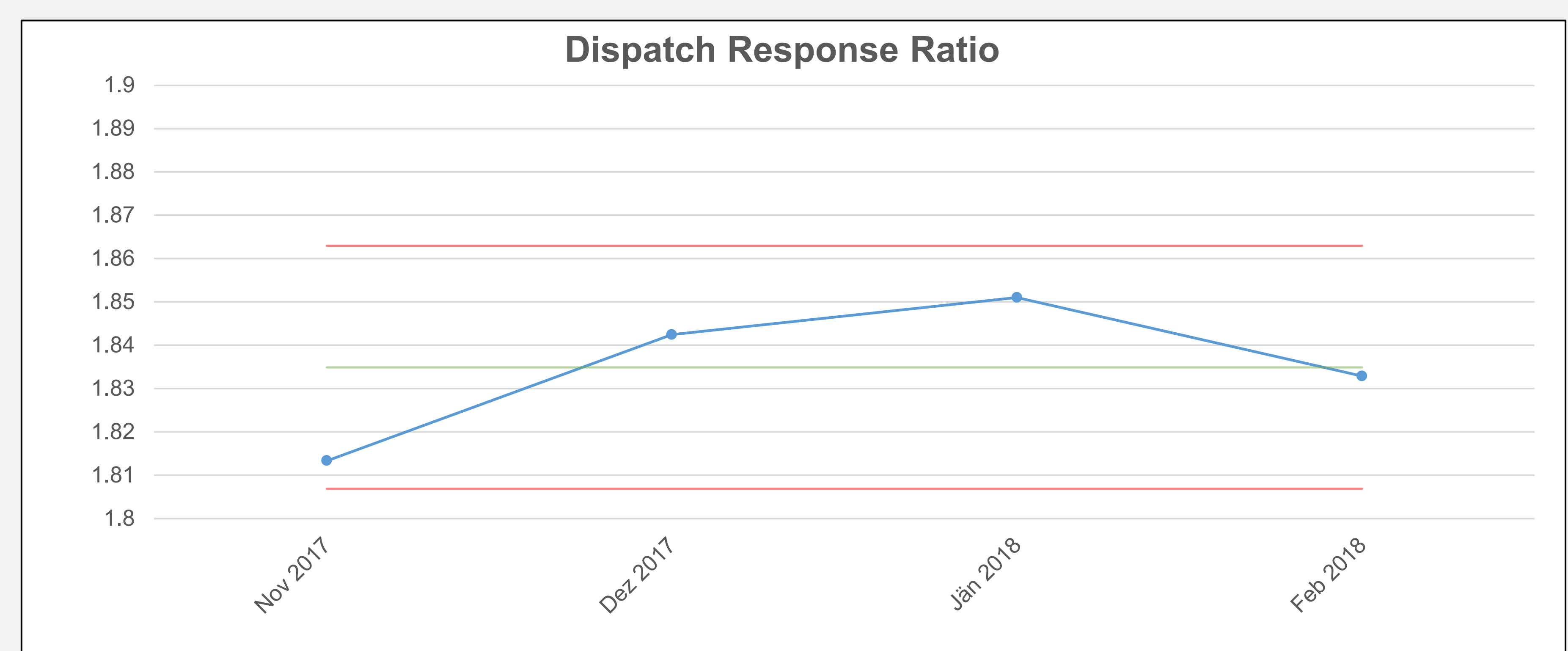
	Dec-17	Jan-18	Feb-18	12 Month's
Clear at Scene (mins)	75.84	75.74	75.30	
Clear at Hospital (mins)	110.3	110.1	109.2	
Handover Hrs Lost at Hospital (over	7636	7093	5697	
Number of Handovers >60mins	1433	1209	875	

SECAmb 999 Operations Performance Charts

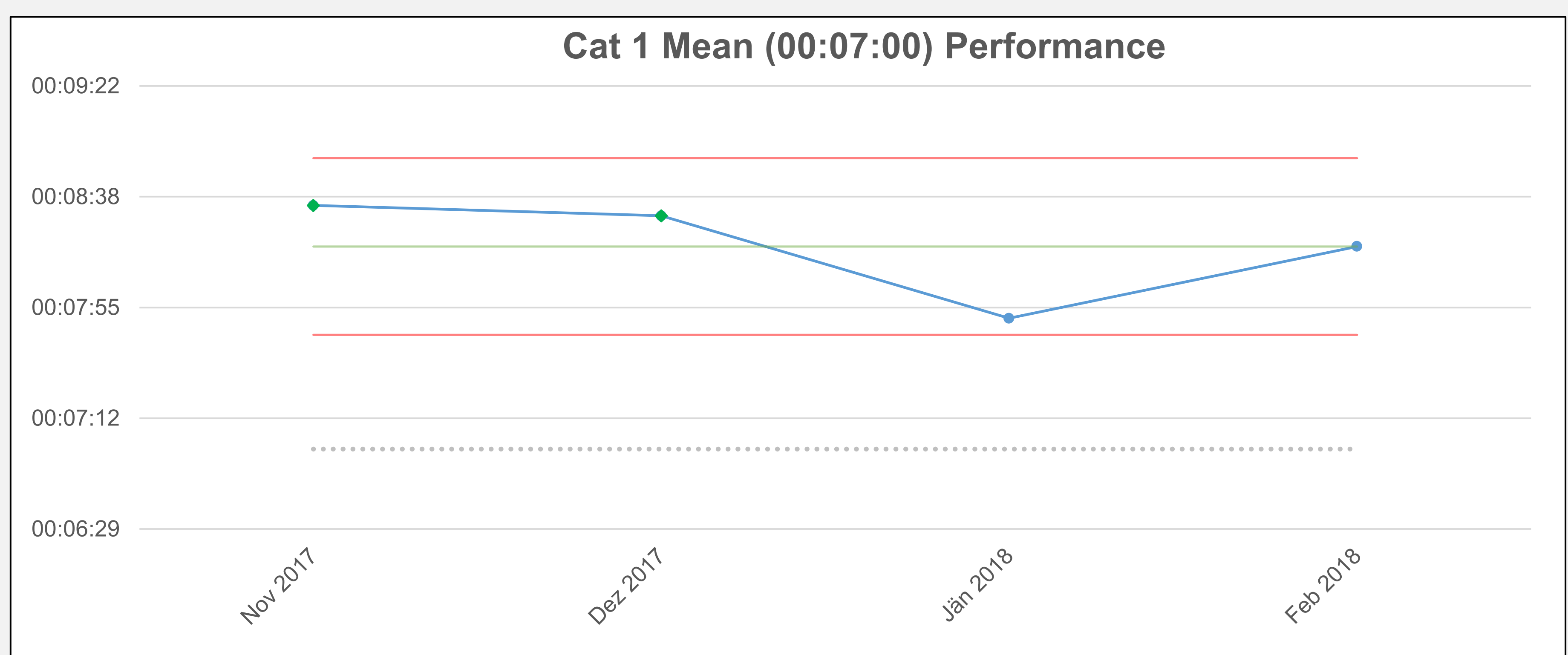


After the improvement in call handling performance recorded in January, performance for February decreased significantly to 60.5%. This is similar to the level in July and August 2017. This drop in call answer performance came despite a decrease in call volume. The average call pick up time has increased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



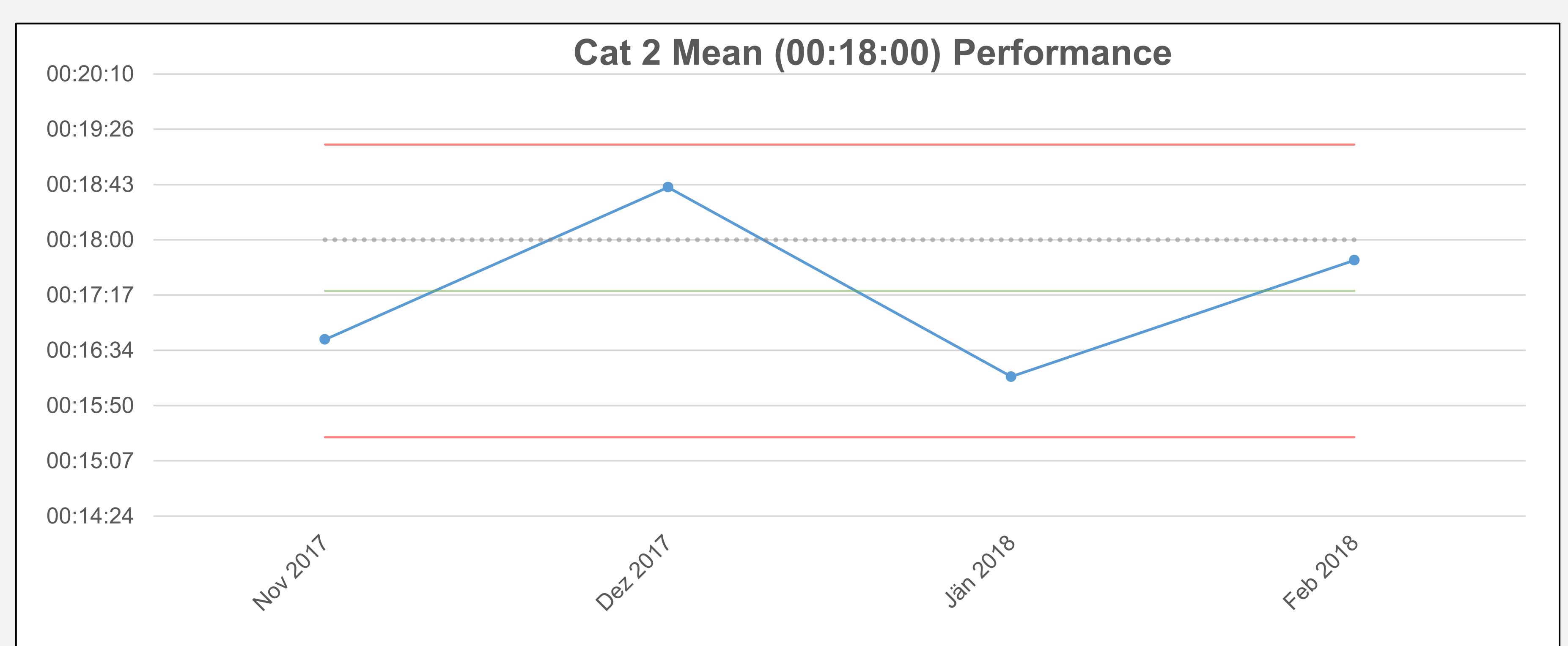
Response ratio continues to decrease. This metric will be referred to as Responses per Incident going forward as it comes under greater scrutiny with the ARP.



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.

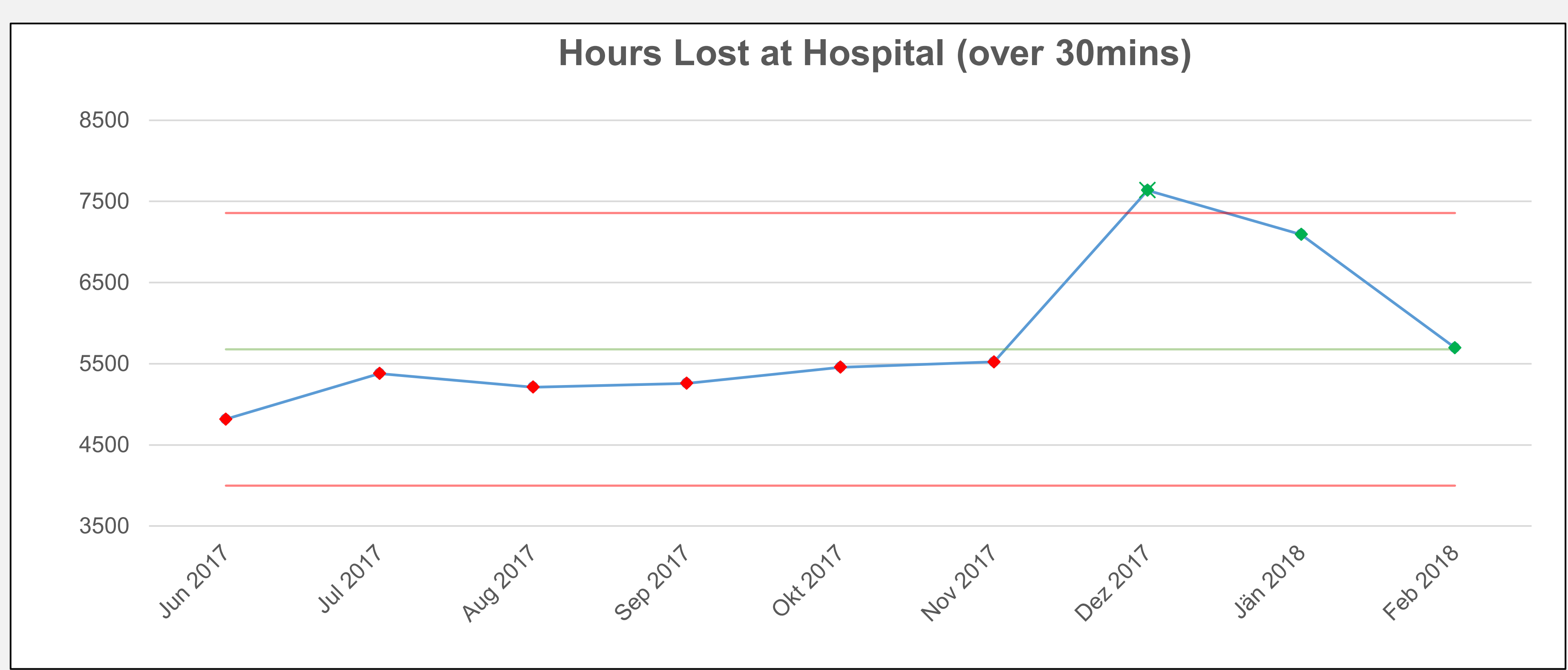
The average Cat 1 performance was slightly better for West EOC (00:08:16 mean) than for East EOC (00:08:23). East did not meet the required 90th Centile target (00:15:11).



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).



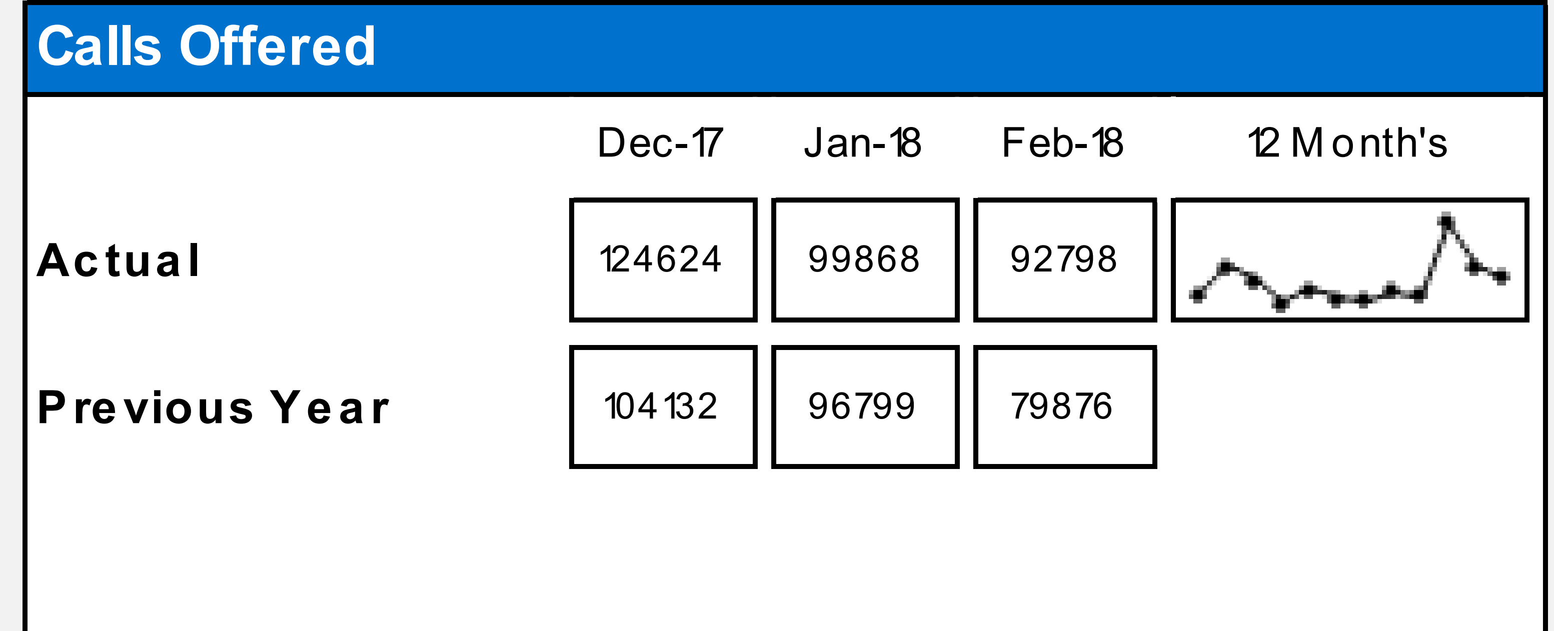
There were 875 patient handovers over 60mins for February (daily average 31) this is a decrease compared to January 1209 (daily average 39). Similarly the hours lost over 30 mins due to delays has decreased in February to 5697hrs (average 203.5) from January which was 7093hrs (average 228.8).

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

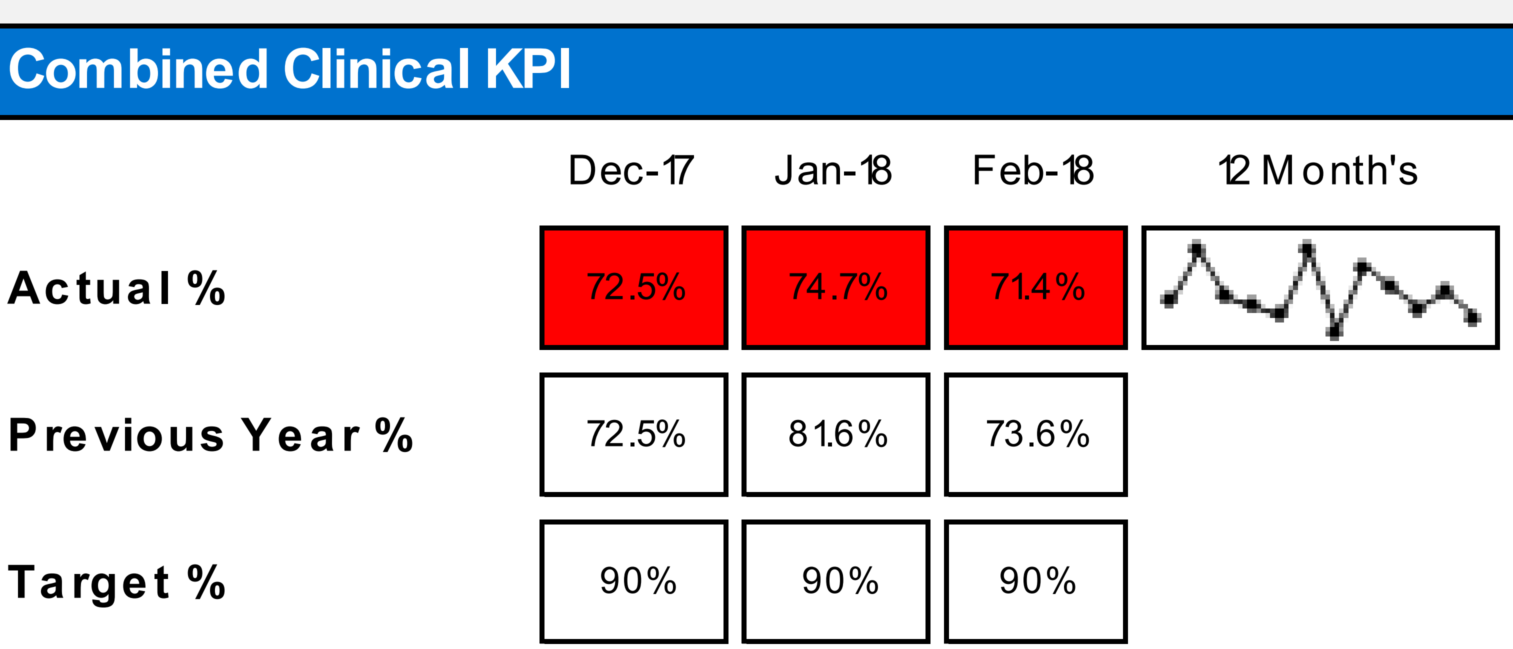
	Dec-17	Jan-18	Feb-18	12 Month's
Actual	124624	99868	92798	
Previous Year	104132	96799	79876	

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%	

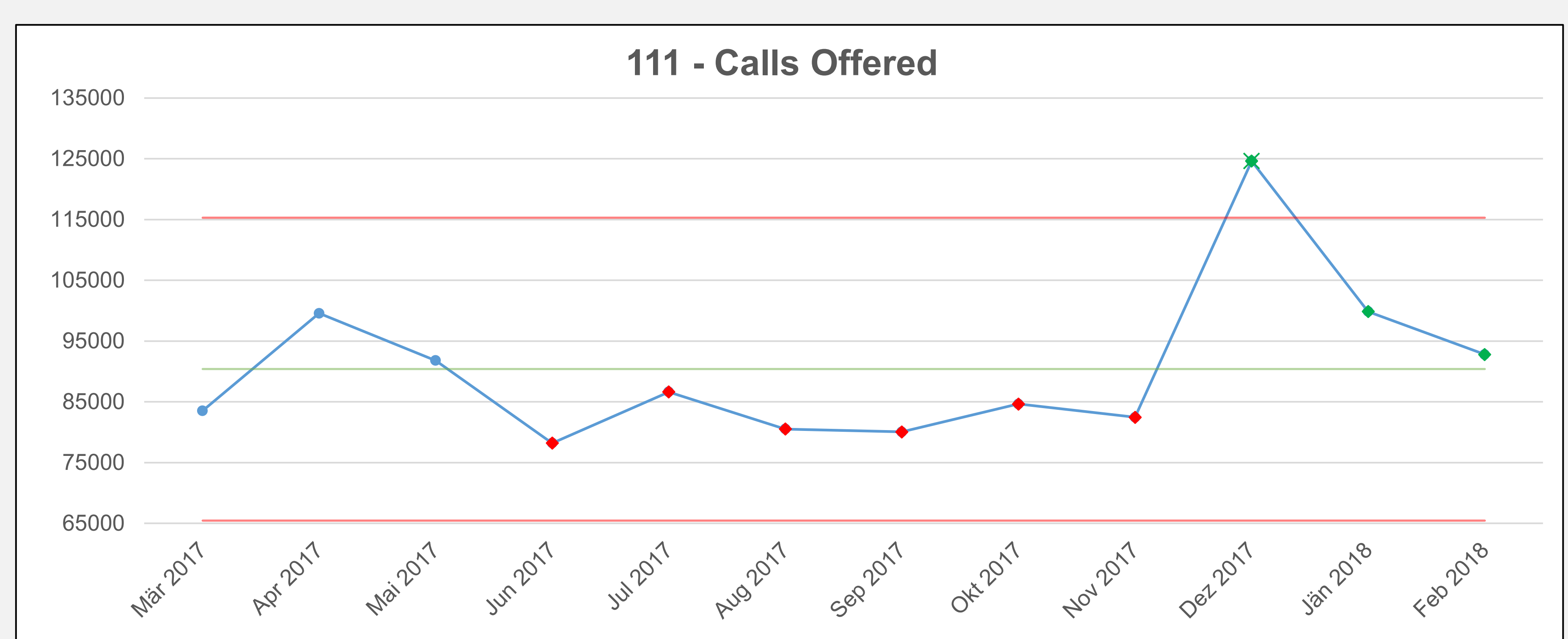


Combined Clinical KPI

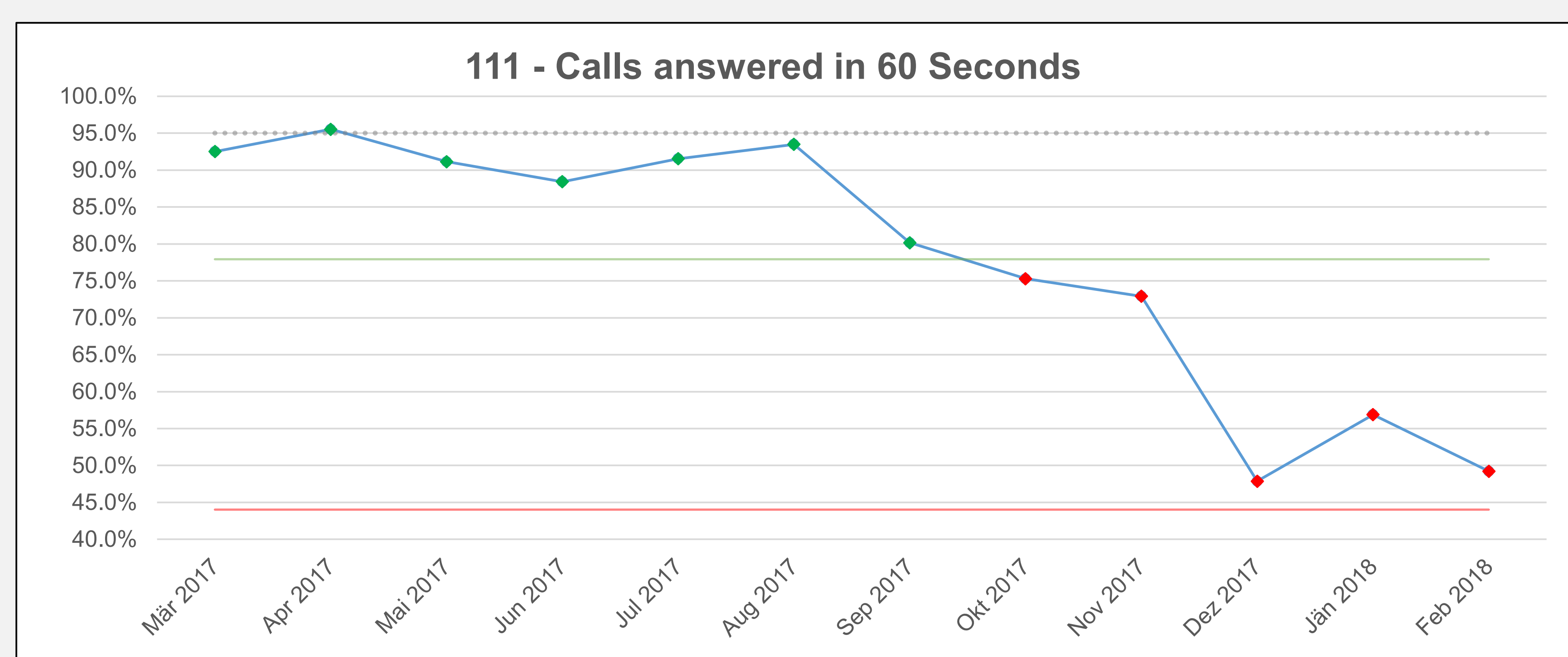
	Dec-17	Jan-18	Feb-18	12 Month's
Actual %	72.5%	74.7%	71.4%	
Previous Year %	72.5%	81.6%	73.6%	
Target %	90%	90%	90%	

Outcomes

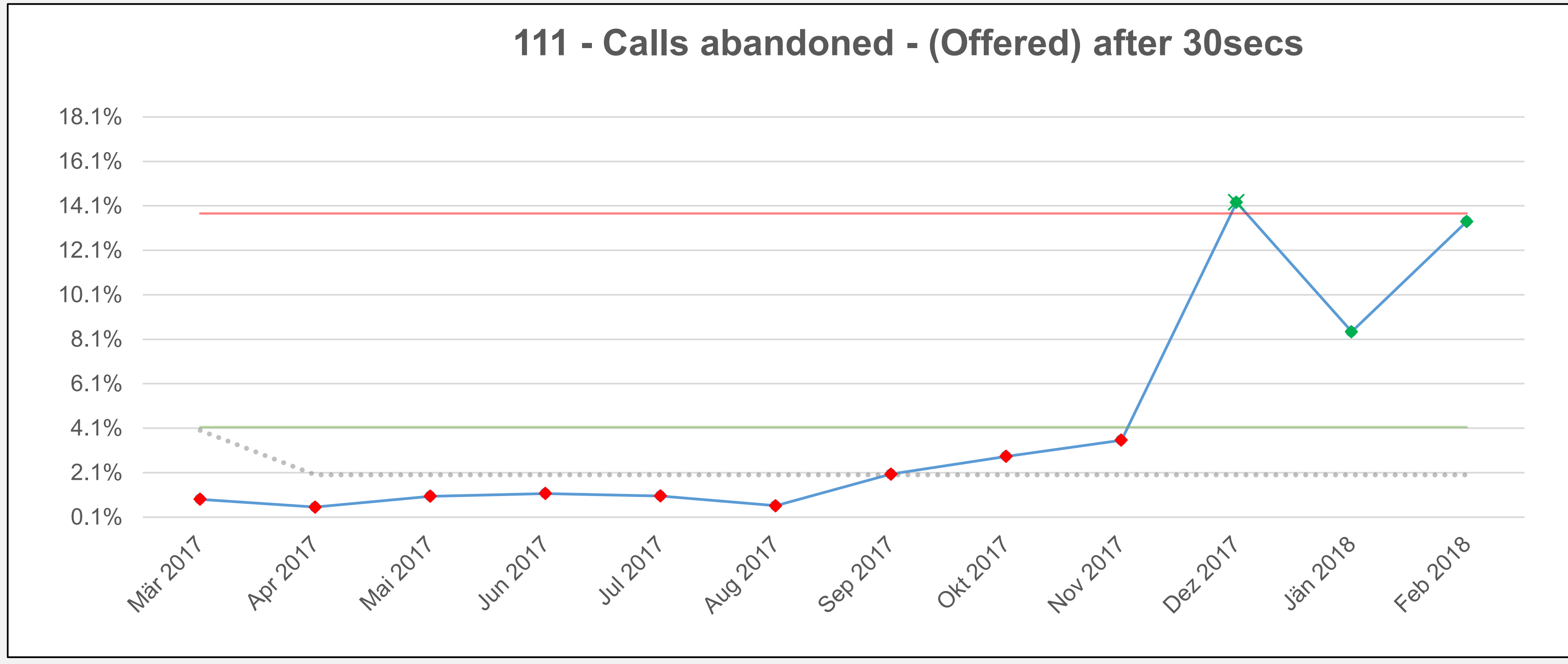
	Dec-17	Jan-18	Feb-18	12 Month's
999 Referrals % (Answered Calls)	10.8%	11.4%	11.7%	
999 Referrals (Actual)	10954	10048	9129	
A&E Dispositions % (Answered Calls)	6.4%	7.5%	7.2%	
A&E Dispositions (Actual)	6540	6610	5604	
Home Management %	5.8%	TBC	TBC	

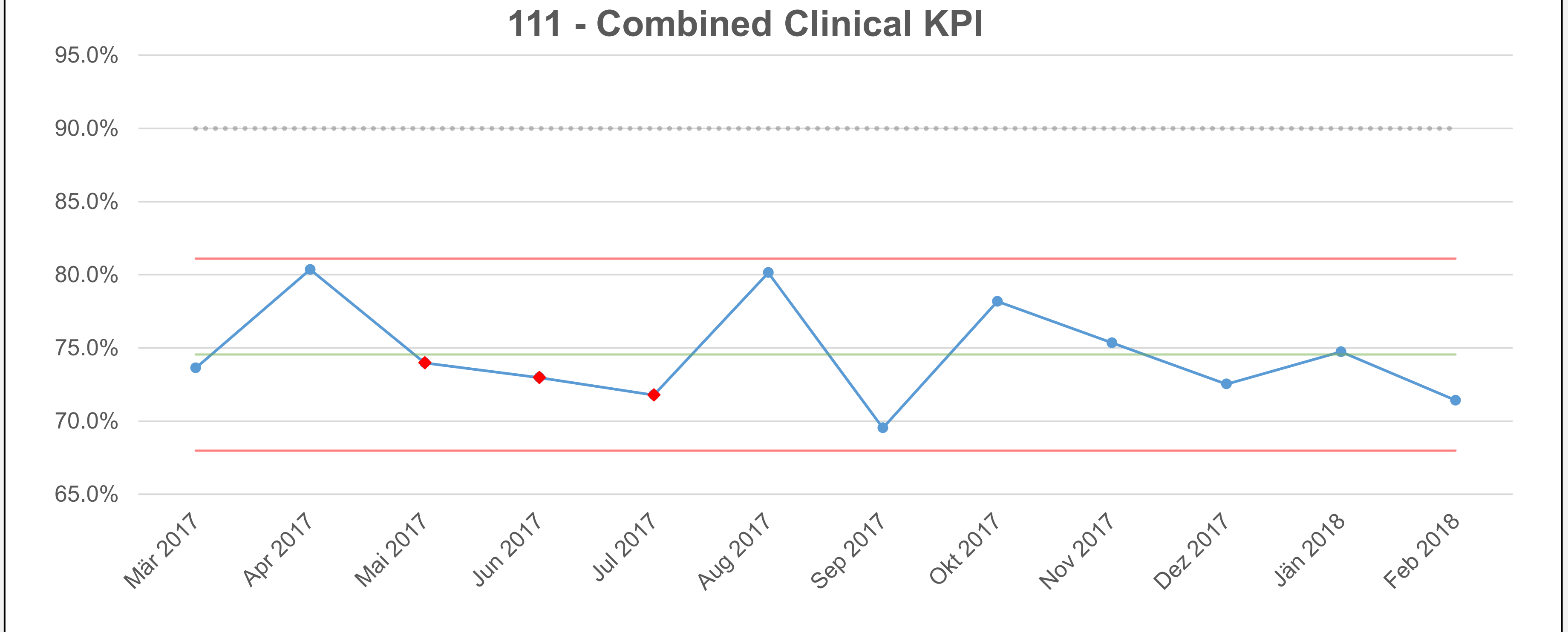


Call volumes climbed to 92798 for the month, representing a 16% year-on-year increase in demand since February 2017.

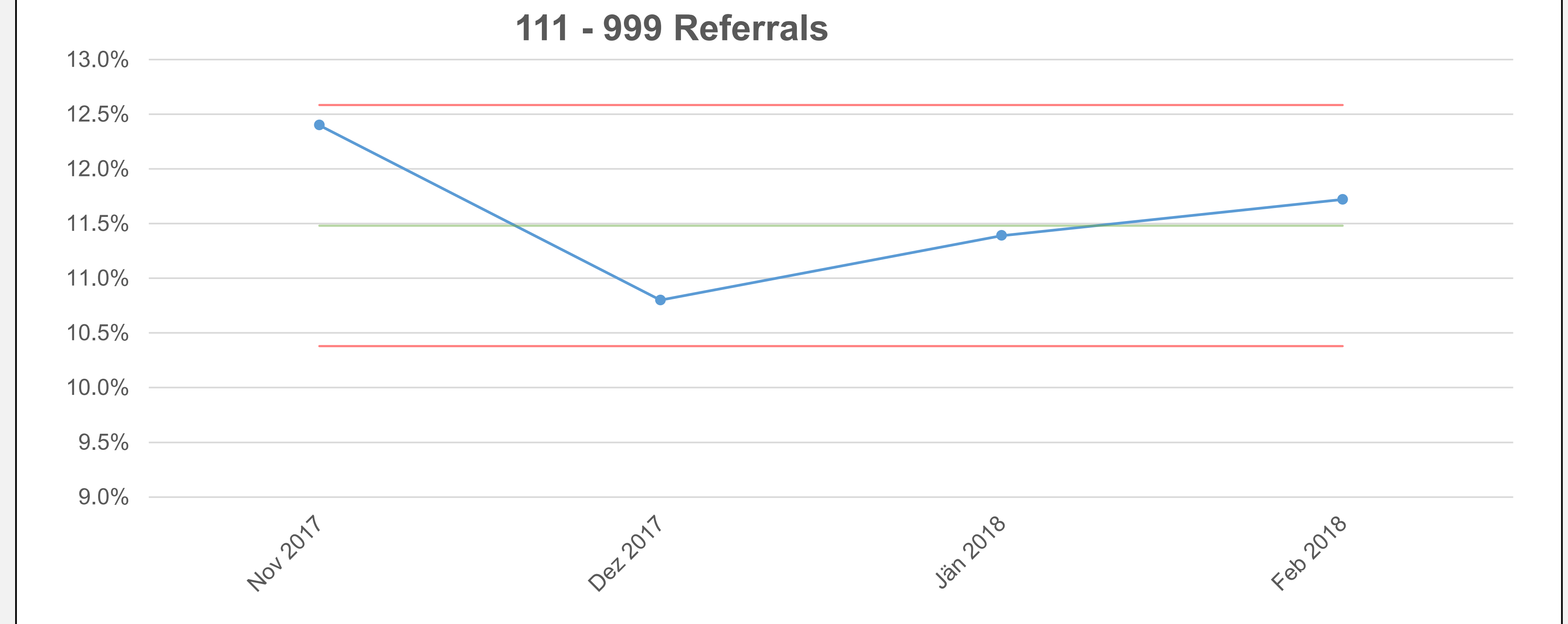


The “Answered in 60” KPI consequently declined to 49.2%, due to issues arising from rota fill, productivity, and sickness levels.





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%	

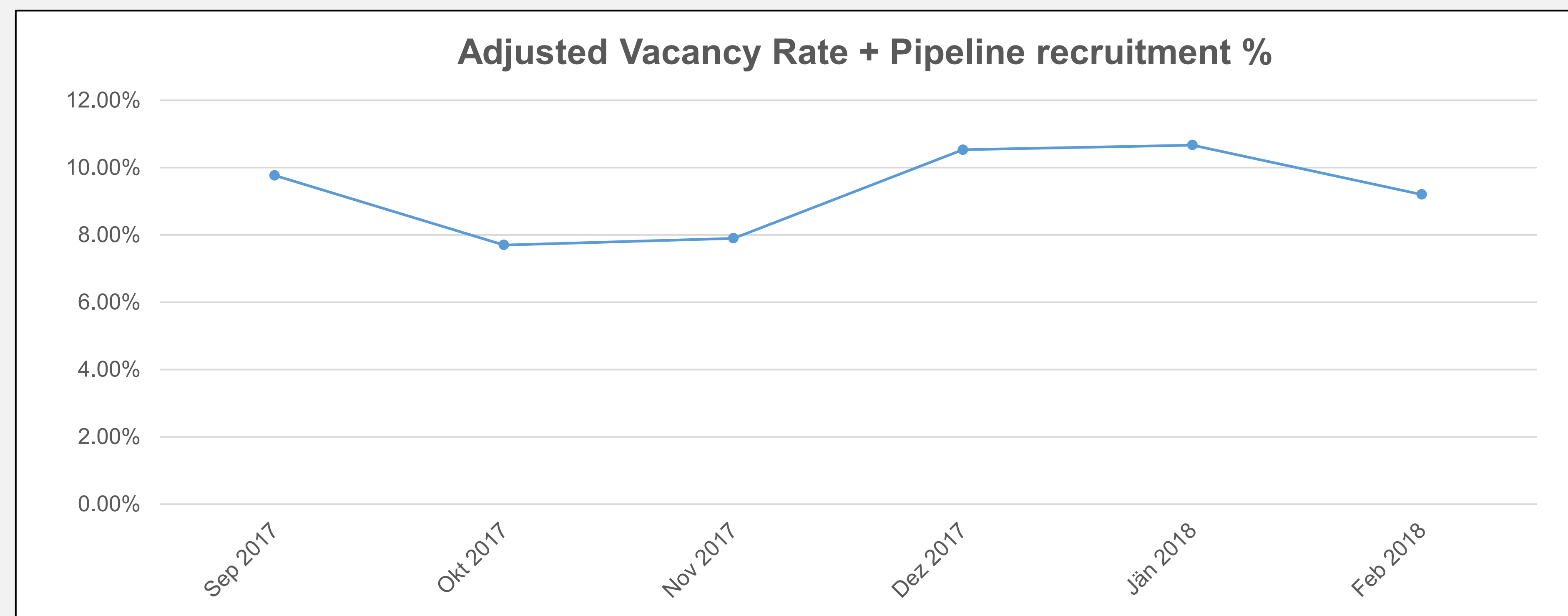
Employee Relations Cases

	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)

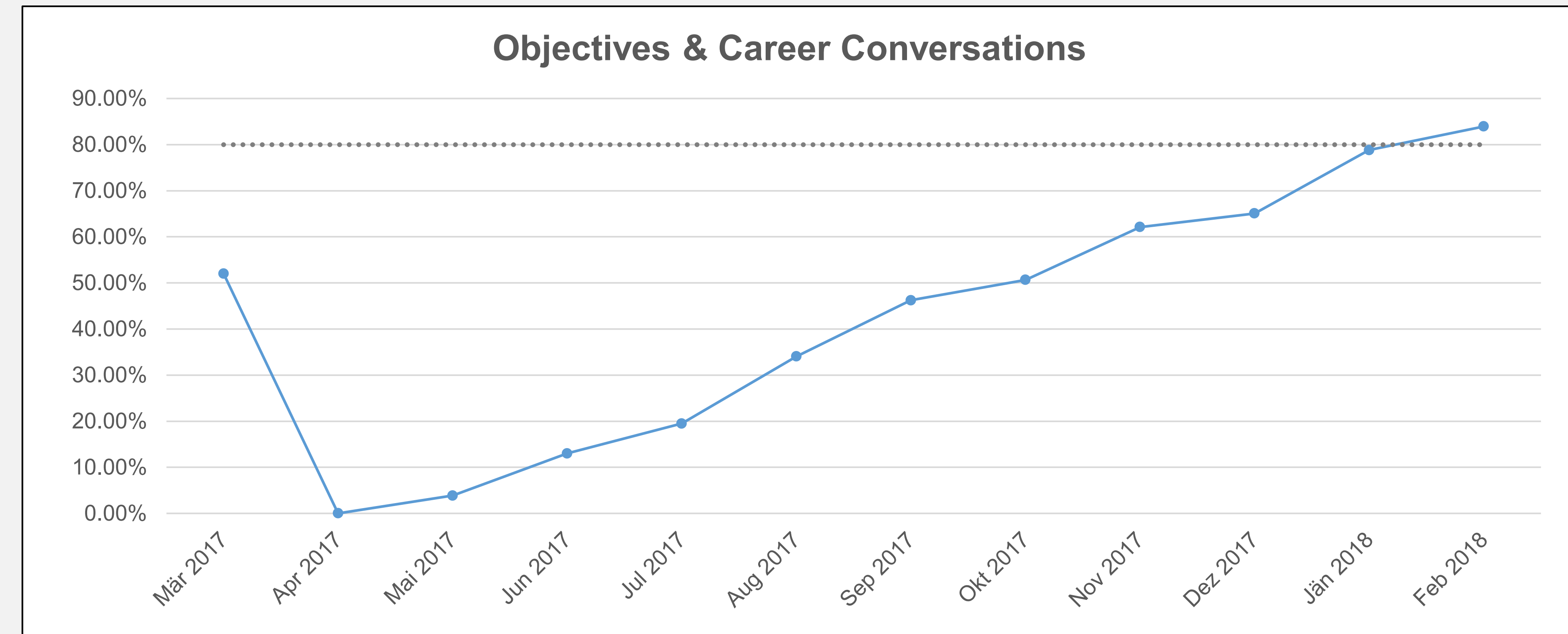
	Dec-17	Jan-18	Feb-18	12 Month's
Actual	17	16	15	
Previous Year	19	17	16	
Sanctions	1	3	3	

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.

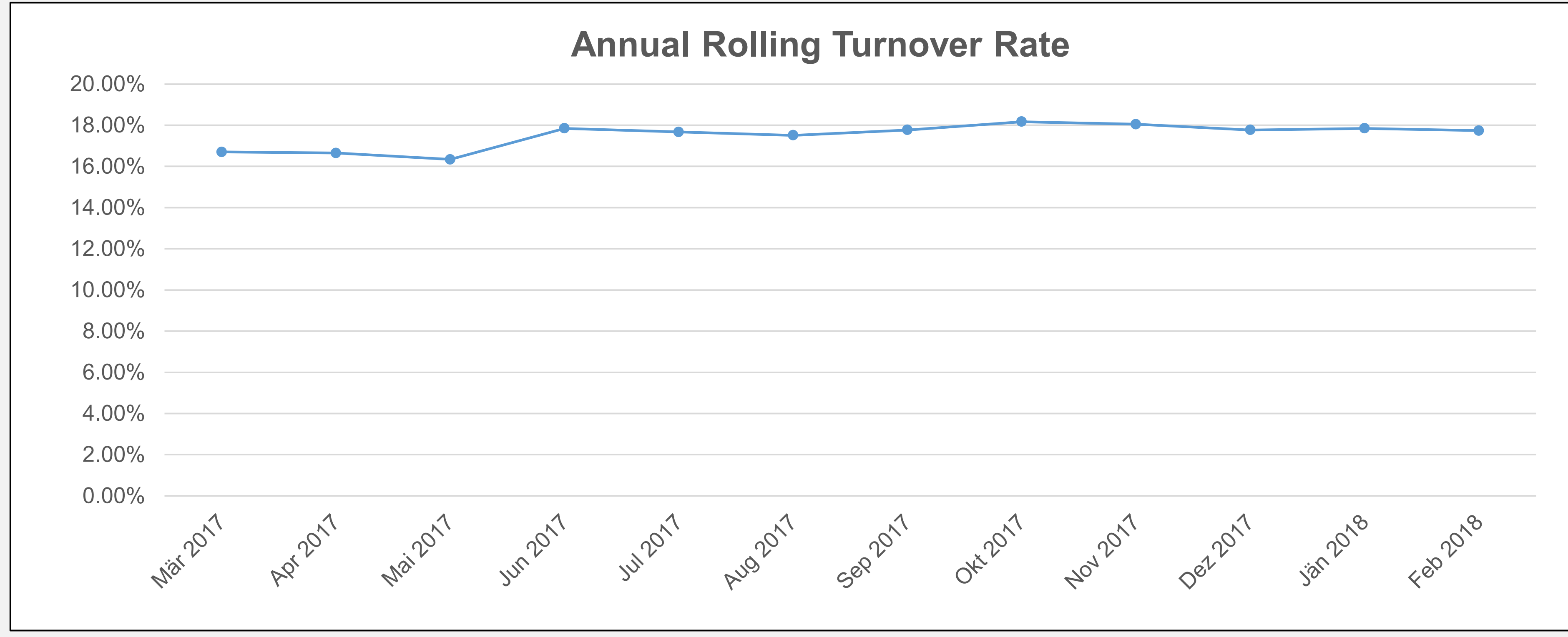
Monthly Recruitment Summit meetings look to address the short term resourcing gaps for operational staff. Action plan(s) are being put in place, closely monitored to and bi weekly recruitment conference calls are being used to deep dive into areas with larger ongoing recruitment needs.



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.

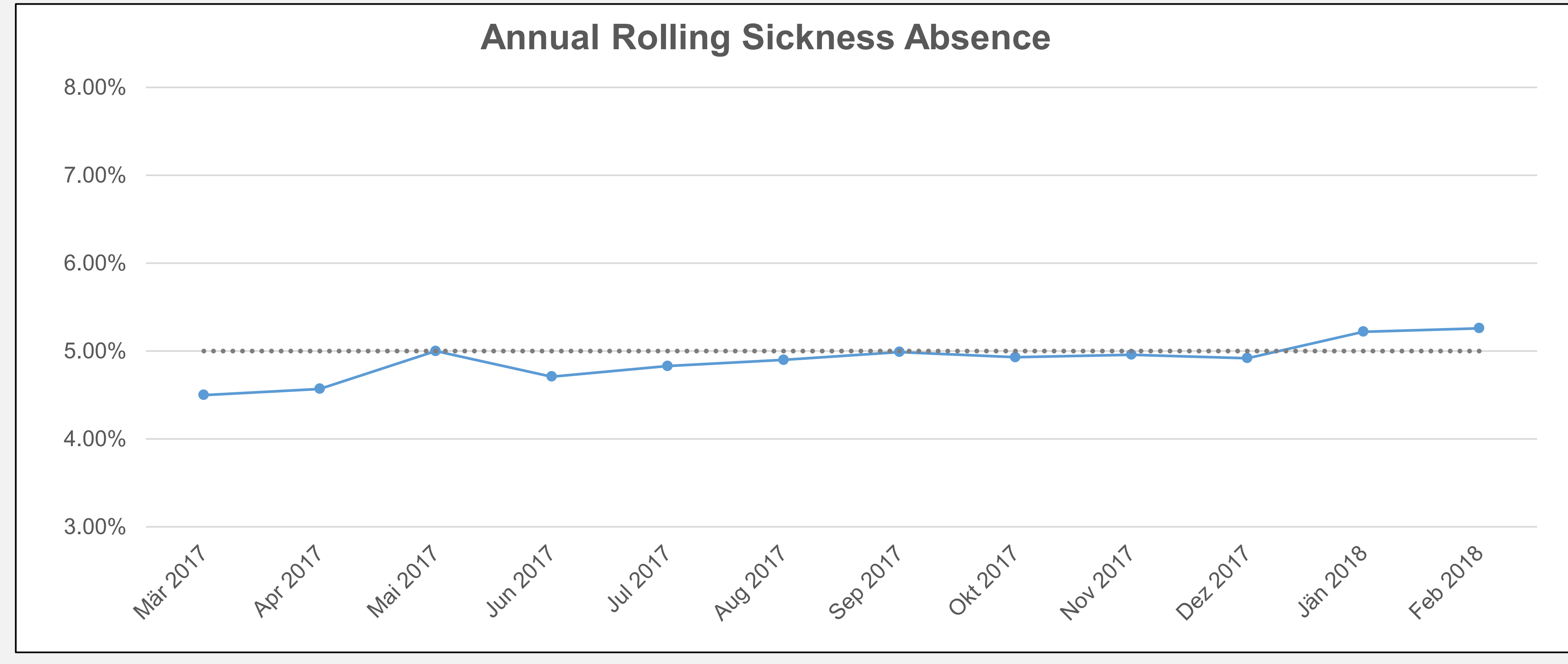
Managers continue to be supported to deliver on objectives and fully understand their accountability in this regard via area Governance.

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.

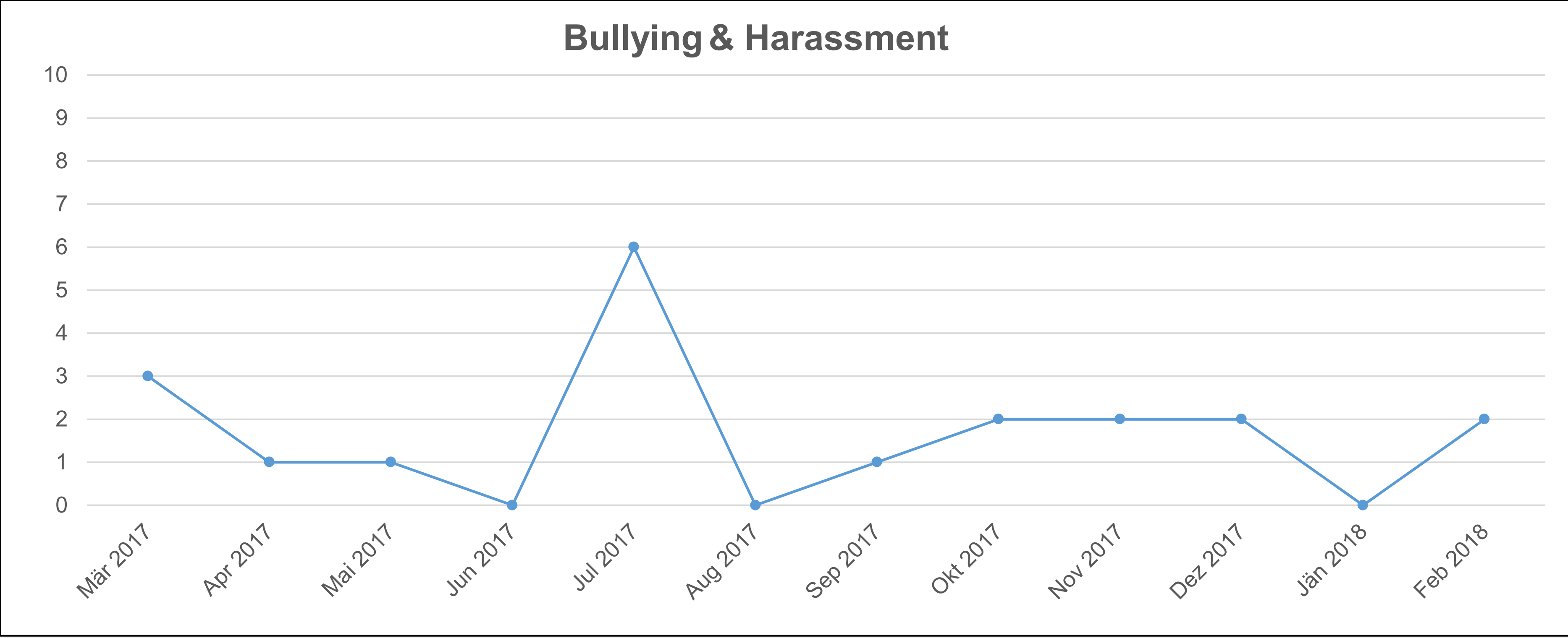
Further analysis has been provided i.e. Trust, Directorate and Operating Unit (OU) level and a paper for the Board is being provided for further discussion.



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.

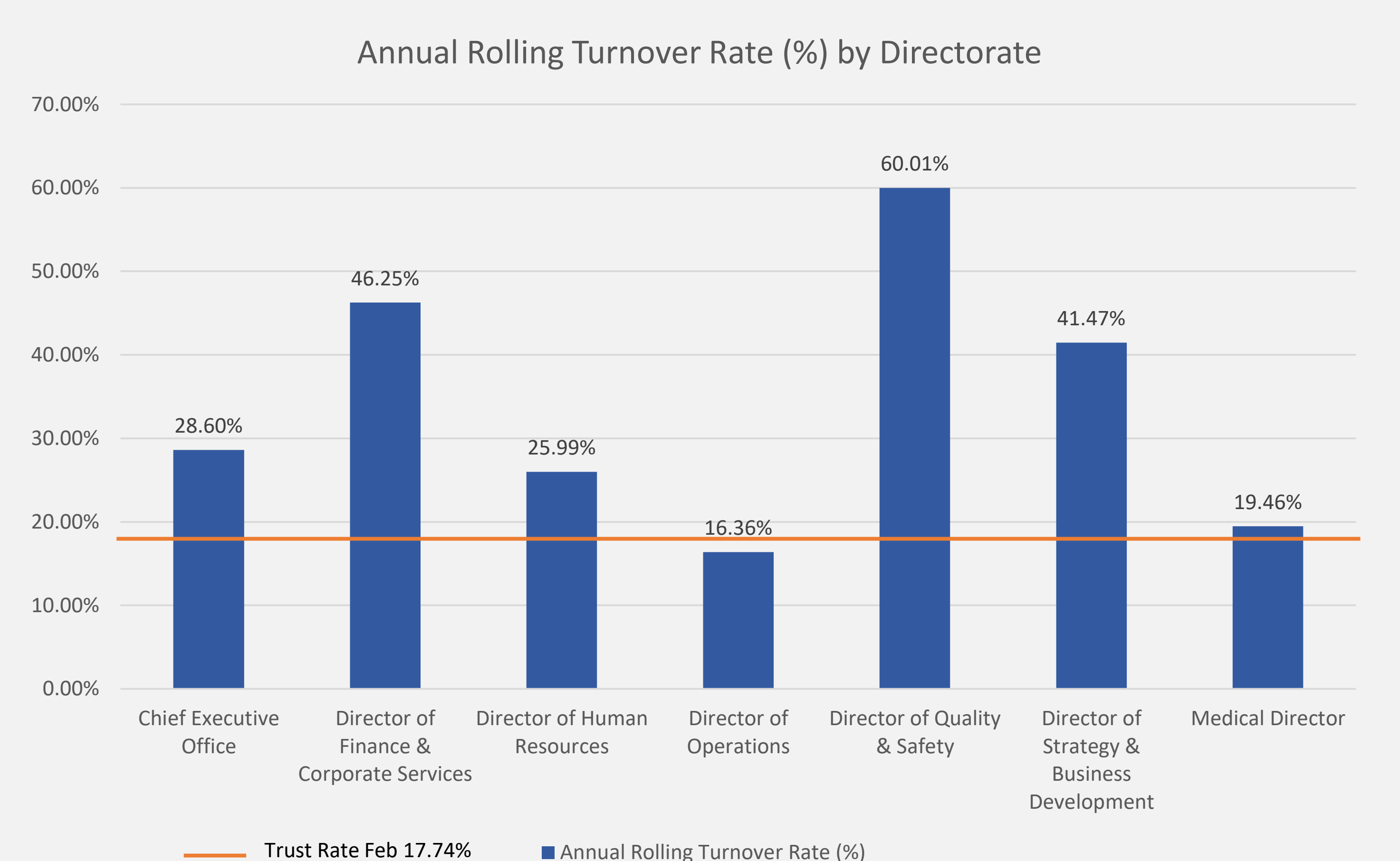
There continues to be focus on supporting staff and managers in the EOC with a dedicated HR Advisor working hard to conclude outstanding sickness hearings. The impact of the HR Advisor in the EOC has seen a significant reduction in sickness absence, so it is recommended that this be introduced in 111.

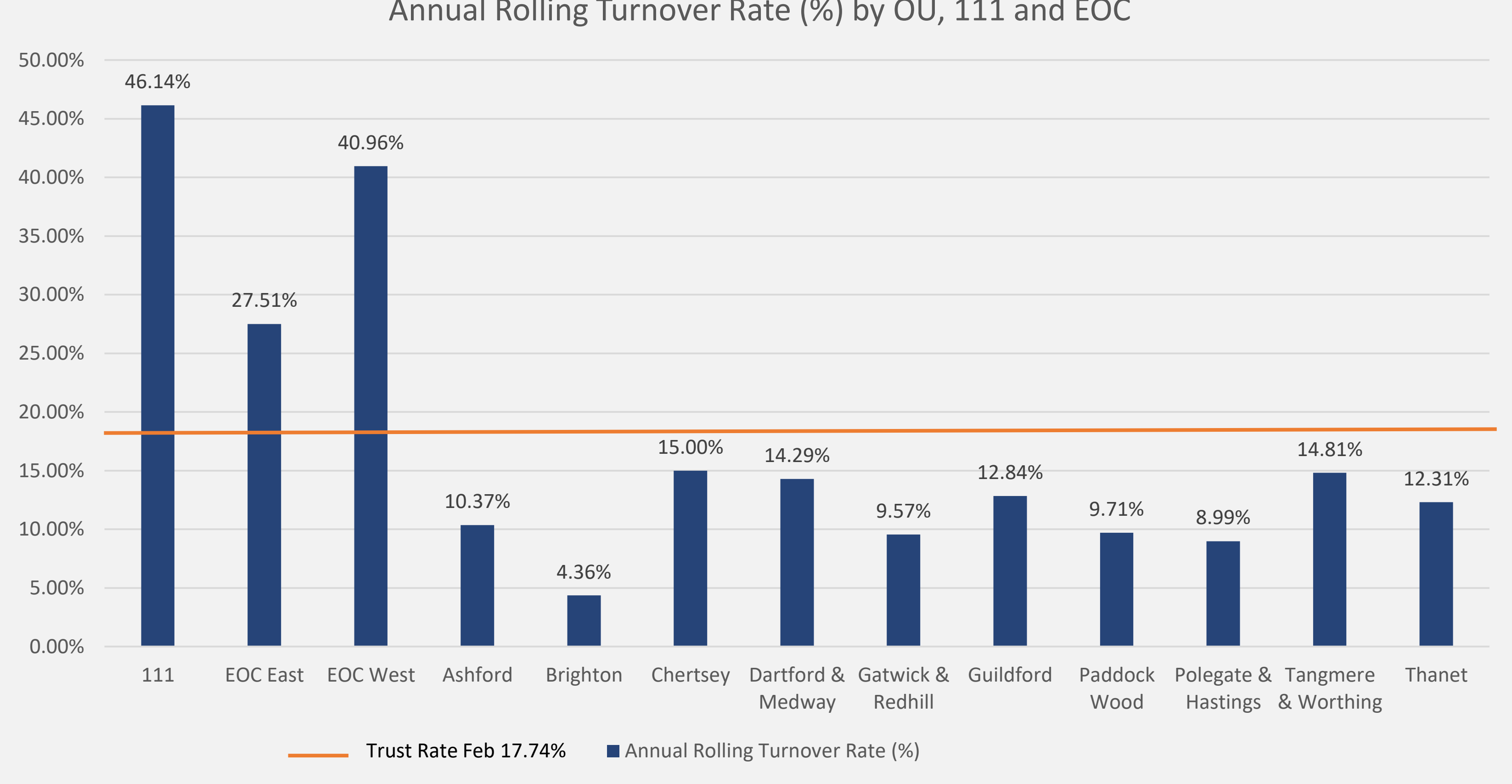
The Wellbeing hub continues to promote alternative duties. There are currently 2 pathways which are monitored and managed by a multidisciplinary team (MDT).



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)

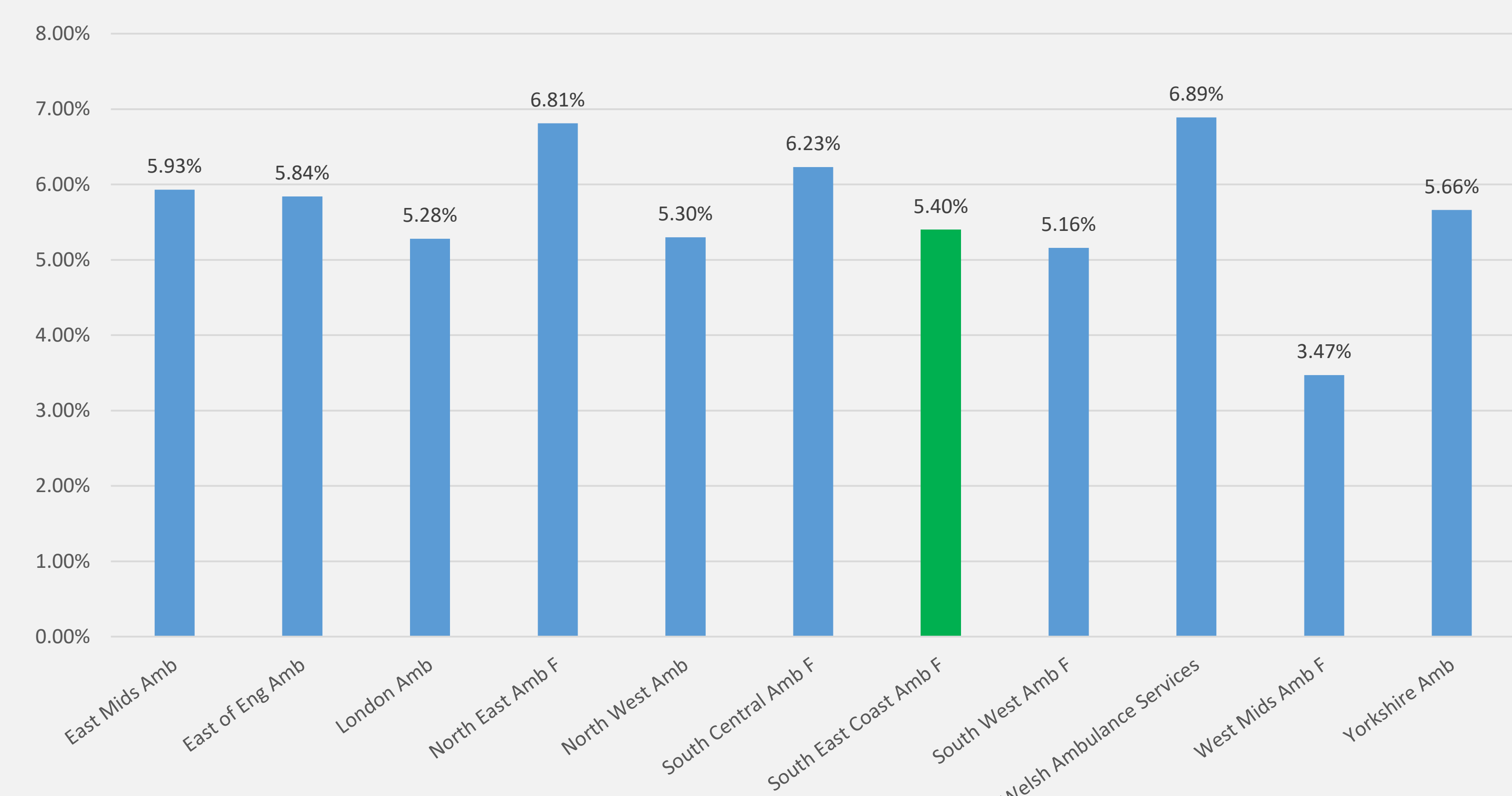
Key Area's:

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	

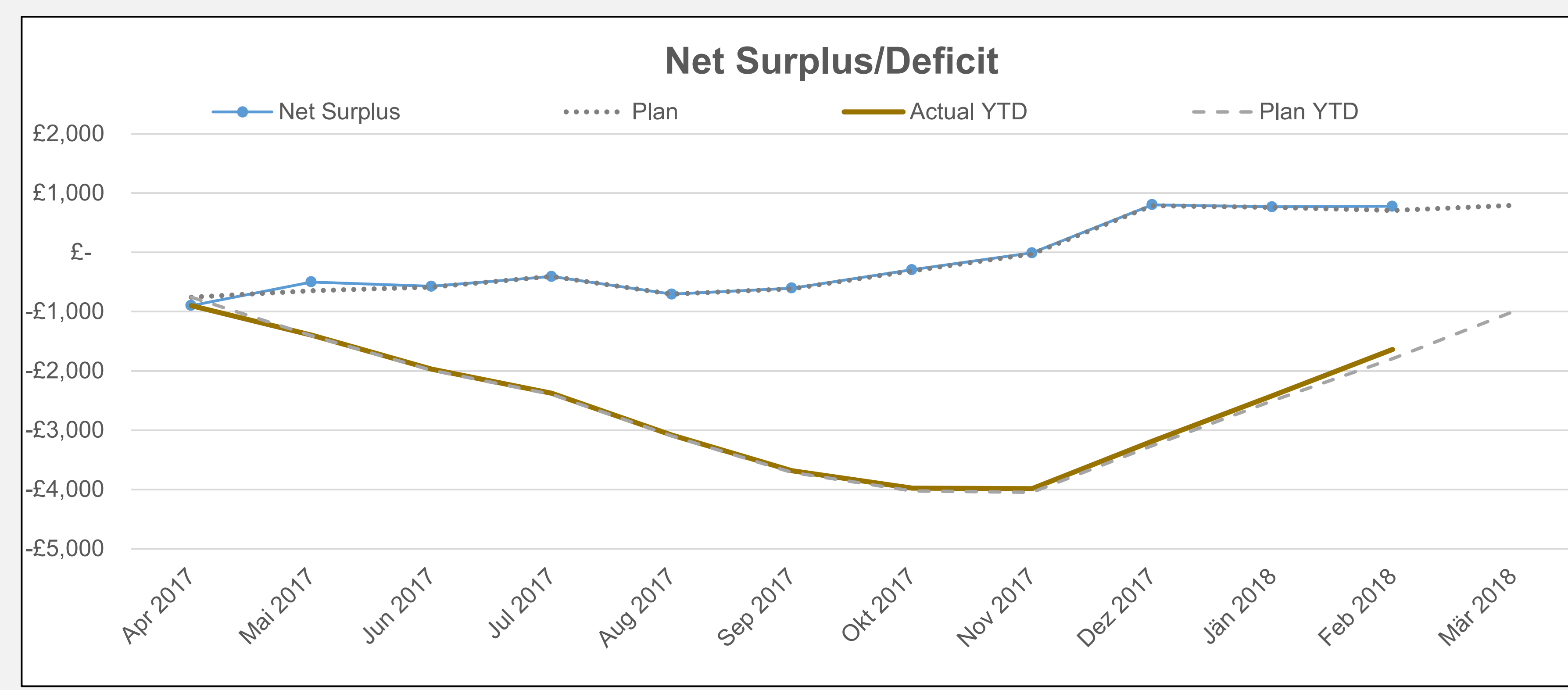
Cash Position

	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

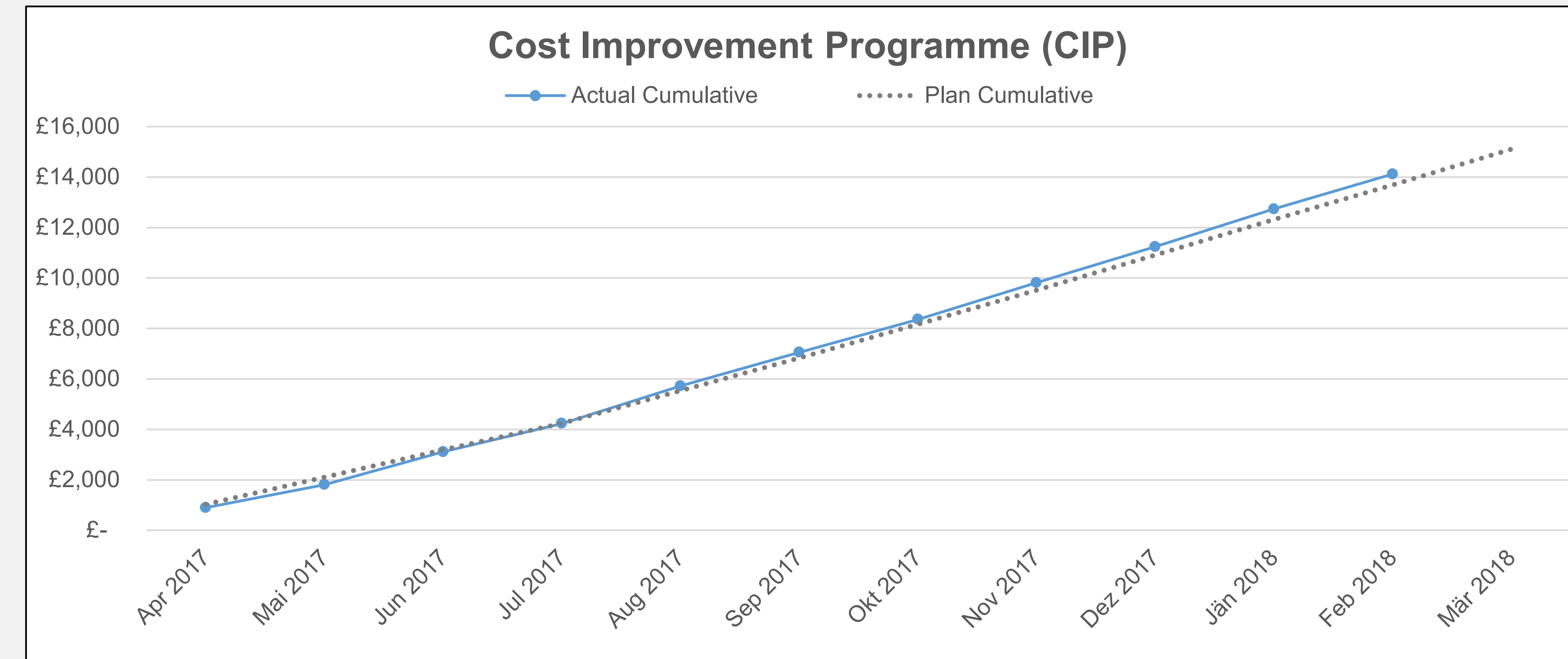
	Dec-17	Jan-18	Feb-18	12 Month's
Actual £	£ 212	£ 316	£ 223	
Plan £	£ 331	£ 329	£ 328	

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): -

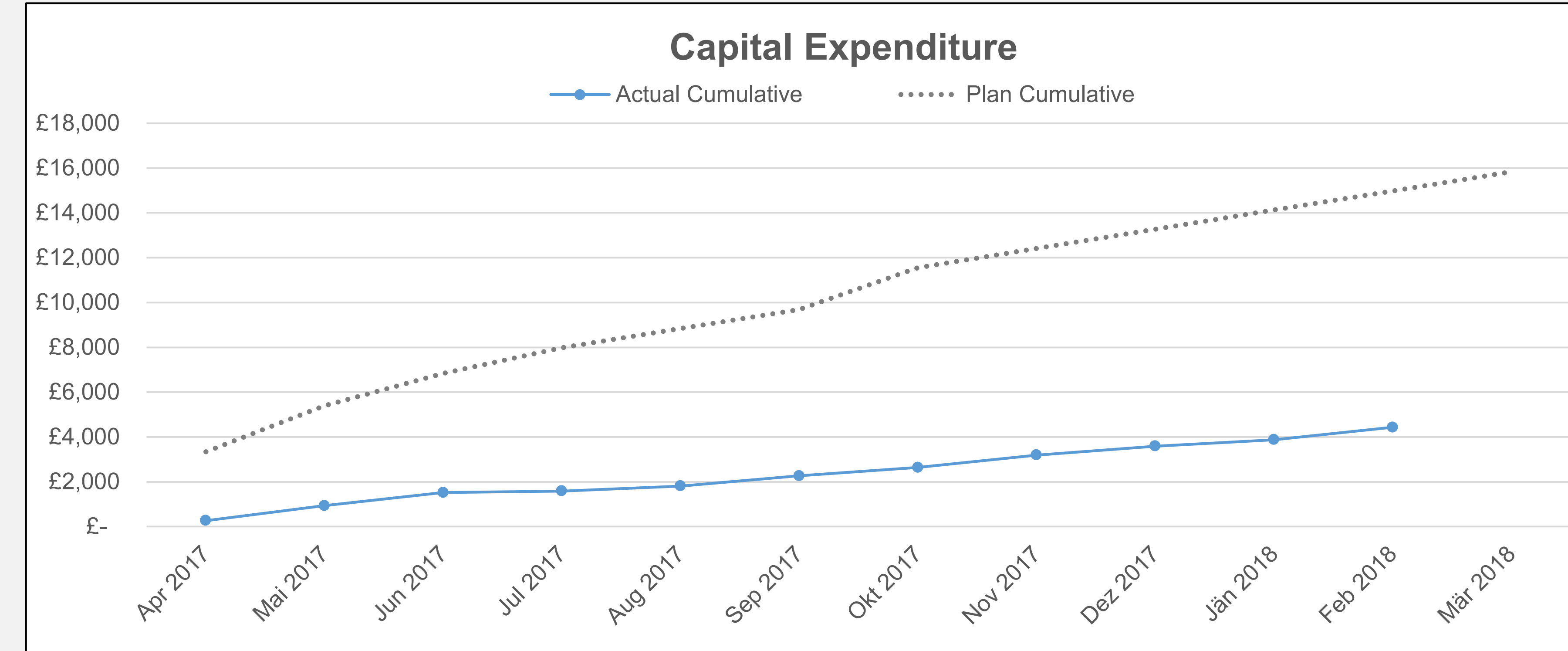
Original planned deficit (NHSI plan)	(1.0)
Structural deficit income excluded	(24.8)
Frontline hours excluded	18.9
Reserves and other budgeted costs to support delivery	5.9
'Normalised'/Commissioned plan	(1.0)



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.

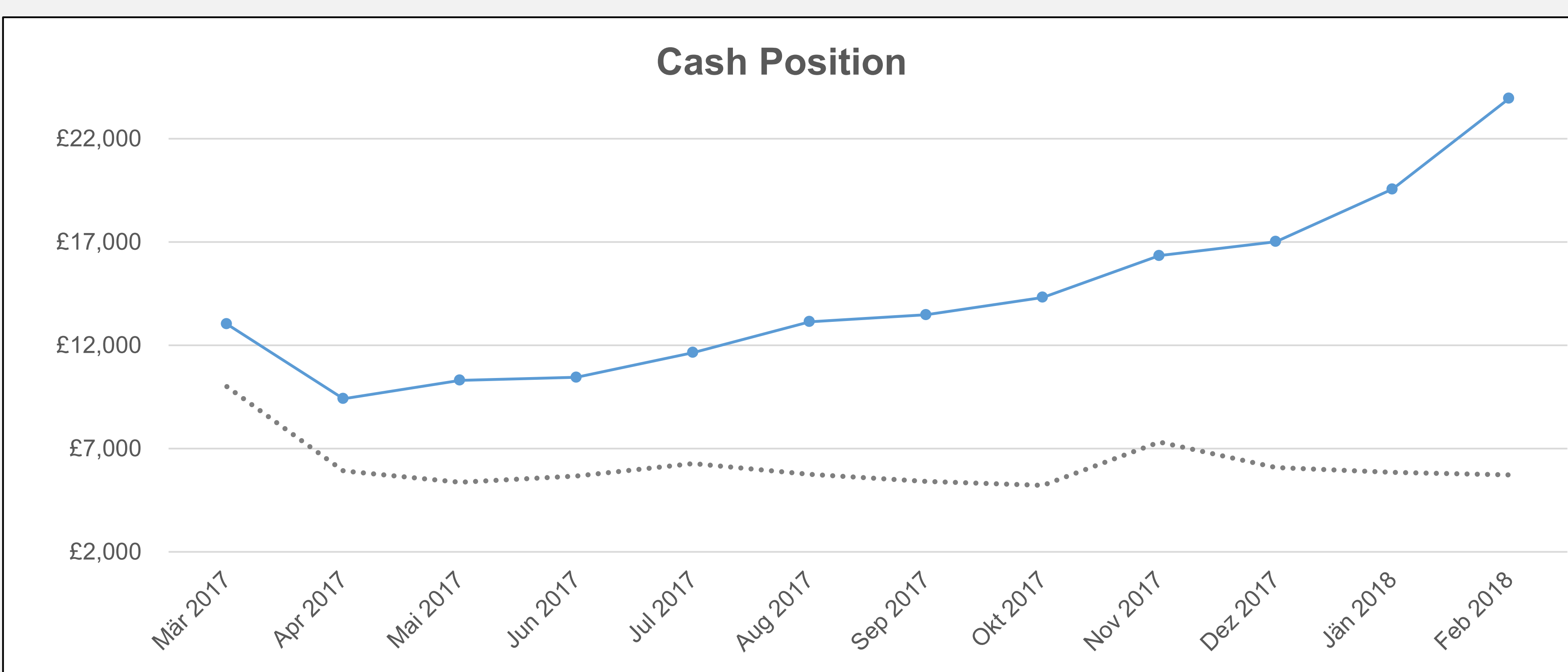
Plans are £0.4m ahead of plan for the year to date.

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

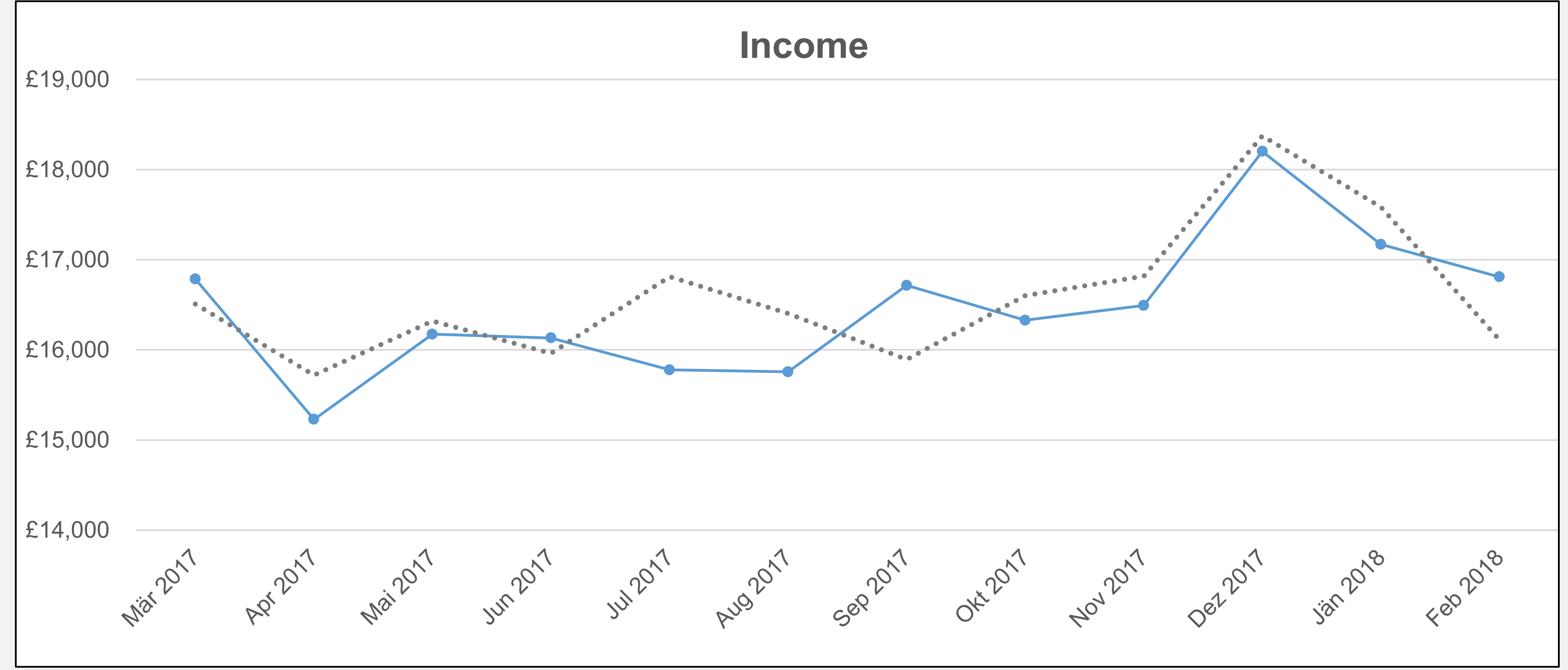


Spend on capital for the year to date is £4.7m against a plan of £15.0m. The full year forecast has fallen from £8.3m to £7.9m due to scheme slippage. The plan for the year is £15.8m. The projected underspend on the programme of £7.9m is mainly due to £8.2m of planned vehicle replacement, which has been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

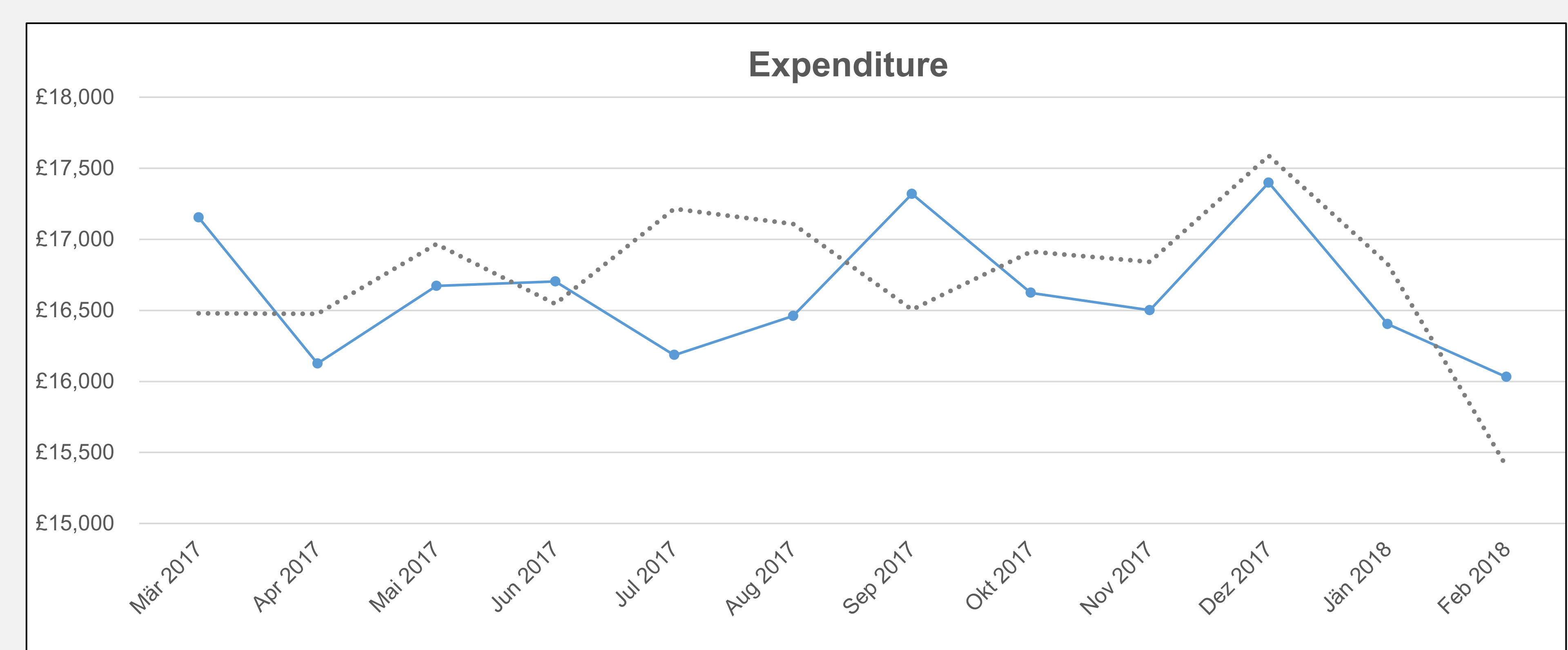
The projected spend for the year includes schemes that were not in the original programme, i.e. Cyber Security £0.7m, 16 new ambulances £1.8m, Telephony and Voice Recorder £0.04m and a new Informatics System £0.12m. With the exception of Cyber Security, these are substitute schemes.



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).



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.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	10/18

Name of meeting	Trust Board
Date	26.04.2018
Name of paper	Safeguarding Annual Report
Responsible Executive	Bethan Haskins, Executive Director of Nursing & Quality
Author	Jane Mitchell Safeguarding Lead & Philip Tremewan, Safeguarding Nurse Consultant
Synopsis	This paper provides data and narrative around the work which has been undertaken by the safeguarding team during 2017/18. This includes the CQC must-do action around delivery of training; it also includes information regarding the Integrated Action Plan (IAP) and work pertaining to the cultural and organisational aspects of safeguarding.
Recommendations, decisions or actions sought	The Board is asked to confirm its assurance that the report accurately reflects compliance in delivery against the safeguarding requirements.

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**

Draft

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1. Introduction

South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to delivering excellent clinical care that contributes to improvements in patient outcomes. As a Trust, we aspire to deliver world class outcomes for patients.

Everybody has the right to be safe no matter who they are or what their circumstances. Safeguarding is about protecting children, young people and adults at risk of harm. While there are a number of contributory factors which are known to increase the level of risk to children, young people and adults, it is extremely challenging for practitioners in any one organisation to identify and act upon concerns when those vulnerabilities give way to maltreatment. The Trust is a geographically large organisation covering a range of both rural and urban environments and though overall, the area covered by the Trust is relatively affluent, there are some notable pockets of high deprivation which may also impact on the level of risk affecting the patients living in these areas.

As part of a wider commitment by all health organisations to safeguard and promote the welfare of patients, the Trust encourages and supports staff to identify adults and children at risk in the community who may be suffering harm from abuse or have unmet care needs. The Trust is not able, nor is it appropriate, to manage the needs of these patients therefore it is essential that partnership working and an understanding of different roles and responsibilities is vital. Any person identified as being at risk should have a referral made to the Trust's central safeguarding team to enable partner agencies, predominately social services, to assess the situation and offer onward support and care provision as appropriate.

The purpose of this report is to provide assurance to the Trust Board that the organisation is meeting its statutory safeguarding requirements and to provide information on the safeguarding activity and work of the safeguarding team during 2017/18.

Jane Mitchell
Safeguarding Lead

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2. Background and Overall Activity

The safeguarding department forms part of the Nursing and Quality Directorate. The Director with responsibility for safeguarding is the Director of Nursing, with a change in post holder seen at the start of the reporting period. Governance arrangements across the whole Trust have been reviewed and updated during the reporting period, with the safeguarding agenda being no exception.

The safeguarding department's internal systems are underpinned by the Trusts approved Safeguarding Policy, Safeguarding Referral Procedure and local safeguarding administration procedures. The work of the department is monitored by and reported through a series of multi-disciplinary groups in accordance with the Trusts corporate governance arrangements. The Safeguarding Sub-Group (SSG), which was re-started during 2016/17 has continued to be well supported by both internal and external stakeholders and has altered its arrangements from bi-monthly meetings to monthly in the past 3 months.

As one of the focus areas of work following the most recent CQC inspection, safeguarding has also been subject to intensive support from the Programme Management Office (PMO) with weekly scrutiny at the Clinical Scrutiny Group (CSG) and weekly task and finish group meetings. The move to monthly SSG meetings is anticipating this intensive scrutiny stepping down to 'business as usual' whilst maintaining the momentum in activity. This group is chaired by the Director of Nursing and Quality, and reports into the Quality & Safety group.

At the start of the reporting period the department substantively comprised a team of a WTE Safeguarding Lead (SGL), a WTE Safeguarding Support Officer (SSO) and 3 WTE Safeguarding Coordinators (SGCO). The team was not fully staffed with SGCO vacancies equating to a shortfall of 60% due to maternity leave and resignations. Further pressure was seen with the end of a secondment, increasing the shortfall to 82%. The SSO also left their position during this time leaving a significant reduction in the ability of the team to function. Approval to recruit to the vacant SGCO positions, although in establishment, was not given immediately and vacancies were tot filled until the end of September. The SSO post was filled on a secondment basis at the end of October. An additional resource in the form of a Consultant Nurse for Safeguarding commenced in post at the end of August with a focus on delivering the Trust's action plan for improving safeguarding cultures from a staff experience perspective. Delivery of the CQC must-do around training remained within the SGL remit.

Further work has been undertaken regarding structure and capacity across the whole directorate during the reporting period and a new structure for the safeguarding department, including increasing capacity, has now been agreed.

The safeguarding work during 2017/18 has been extremely focussed and subject to intense scrutiny by both internal and external stakeholders over the past year. The CQC inspection identified training paramedic staff to level three (children) in line with the

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Intercollegiate guidelines as a must-do for the Trust; this has been given support at Executive level across the whole organisation. Additional work has focussed on staff safeguarding following an external review regarding bullying and harassment within the organisation.

3. Referrals

The department has seen an increase in referral activity of 8% over the 2017/18 reporting period which has been managed within the current staffing levels as previously described. This is good news against the small drop in referrals seen in the previous reporting period which may indicate it was not the start of a downward reporting trend. The total number of referrals for 2017/18 to 11,272 for both adults and children. Every referral into the department is scrutinised by the SGCO team and forwarded to the relevant social care team for either adults or children where it is appropriate to do so. Given the extremely challenging time during the summer of 2017 where staffing levels were extremely low, referrals continued to be managed in a timely way, which should be commended.

The safeguarding team has also seen an increase in other areas of activity, including, acting as appoint of contact for internal and external stakeholders and coordinating meeting requests. The team also collates information pertaining to child deaths, including offering signposting to support services available to staff following these tragic and traumatic incidents and coordinating meeting requests (rapid response etc.) for example. Child death overview panels meet regularly and are now supported by Operational Managers who attend meetings in their local areas whilst still supported by the central safeguarding team.

There has been a sharp rise in enquiries under s42 of the Care Act (2014) which can range in simple enquiries such as call time confirmation, to complex investigations. Complex cases are investigated by local operational managers with input from the safeguarding department, and will be flagged as potential Serious Incidents (SIs) as appropriate. Escalation into this process can occur at any point should information be identified. During the reporting period all of the complex cases have been in regard to significant time delays in responding to 999 calls.

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Referral data for the year can be seen below:

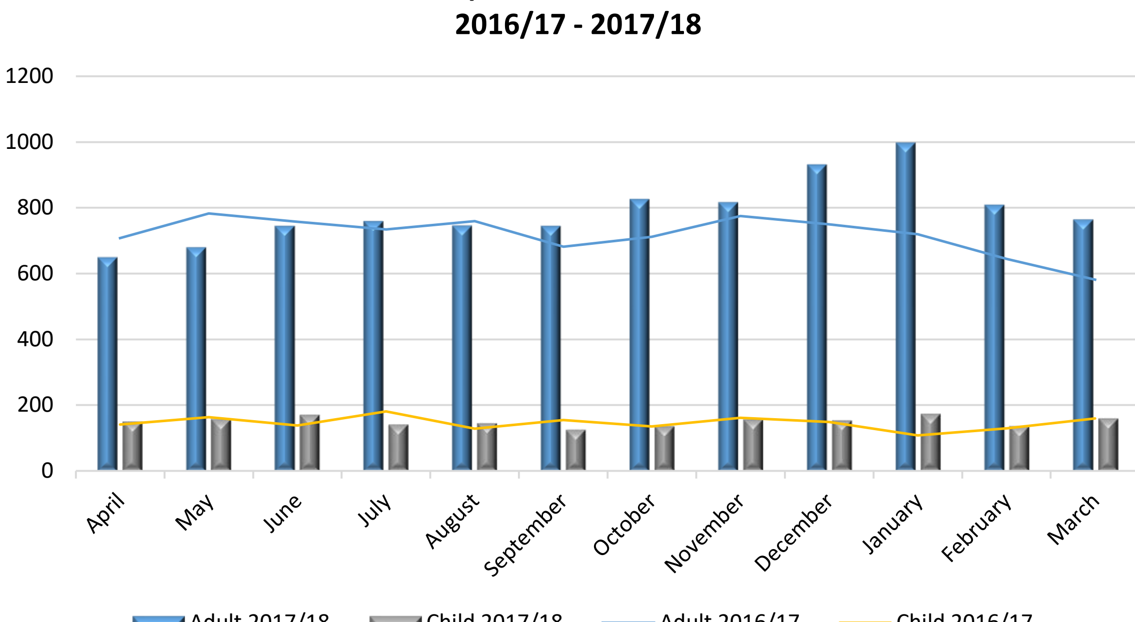

Figure 1: comparative referral data 2016/17- 2017/18

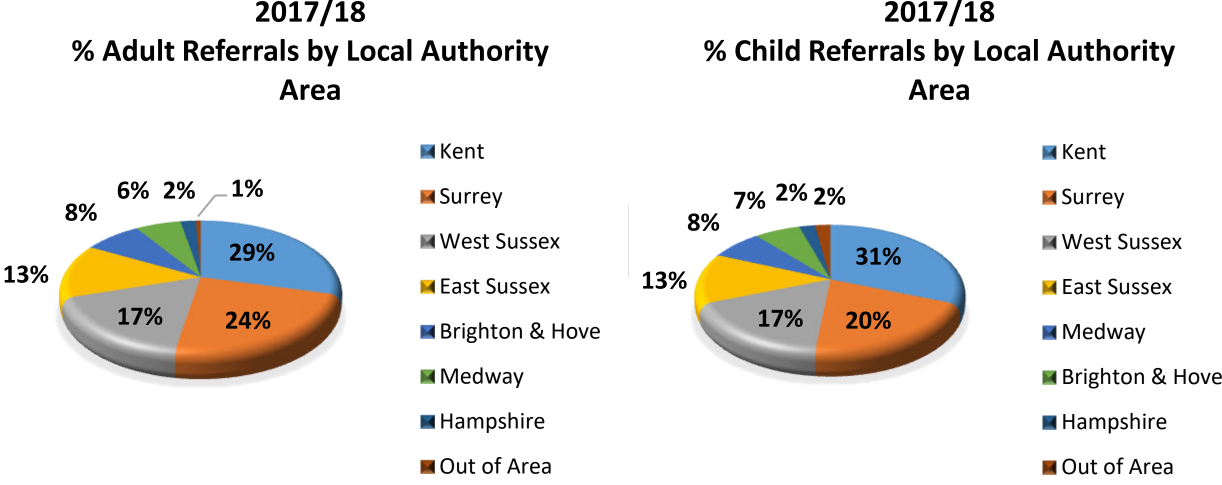

Figure 2: % Adult and child referrals by LA 2017/18

The breakdown of referrals by local authority area shows that the reporting rates are broadly what could have been predicted given the size of each local authority area, with the highest number of referrals being received for Kent (the largest county) and the fewest referrals being received for Hampshire (excluding the very low numbers of referrals for patients normally resident outside of the SECAmb area). This reflects the same distribution proportions seen in 2016/17.

The rates for adult referrals have been consistently much higher than those received for children year on year and this remains the case for 2017/18. Although the distribution of referrals for children and adults is almost identical, the ratio of child to adult referrals is approximately 1:5. This does reflect the service user demographic of the ambulance

service, with the majority of the users of our services being adults. Many of the child referrals are for children of the primary ambulance service user, where children are identified as living in possibly abusive environments or where additional care and support needs have been identified.

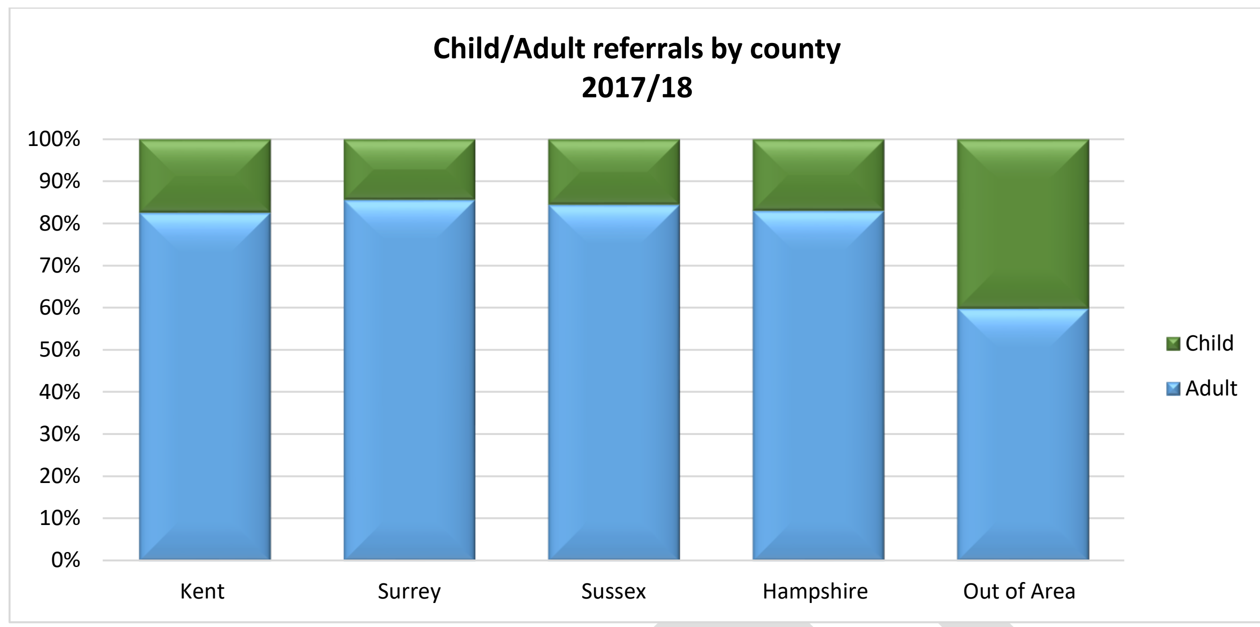

Figure 3: Child/Adult referrals by whole County

The primary concern highlighted by staff may include more than one category of abuse and the top six types of abuse for both adults and children are outlined below.

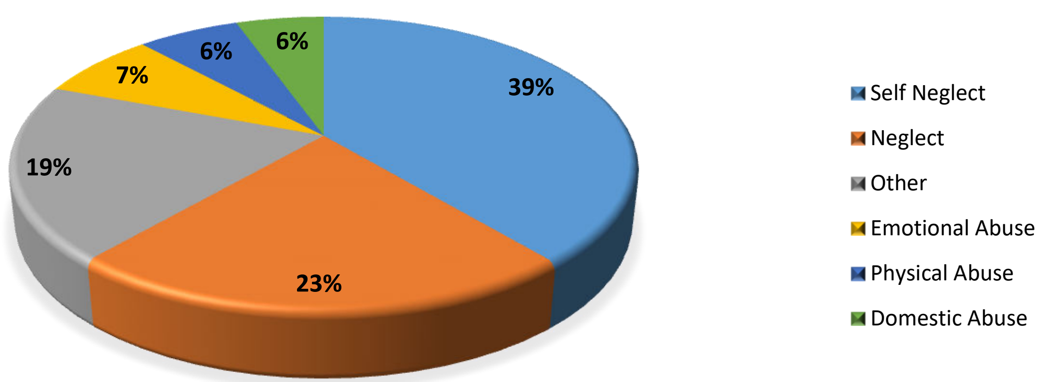

Figure 4: Types of concerns - Adults

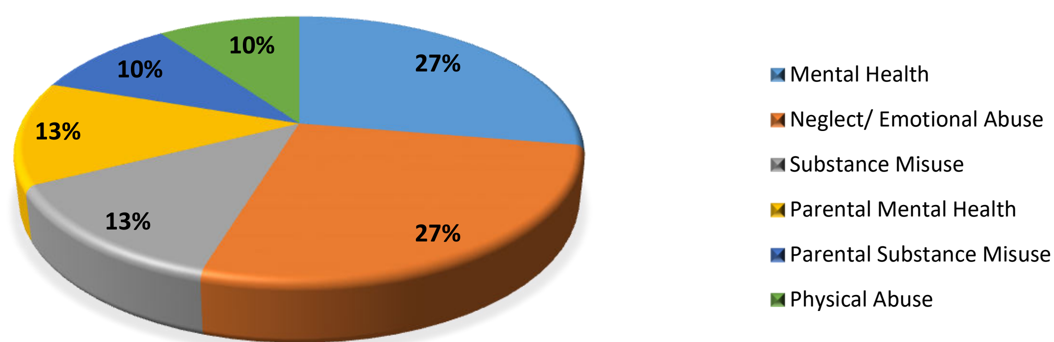

Figure 5: Types of concerns - children

The approval status of referrals relates to whether feedback has been received from the local authority and the case has been 'closed' on the safeguarding database, with feedback given to the referring member(s) of staff. Overall feedback rates are low, at 6% of the total number of referrals sent to local authorities This is in line with previous years, but a marked reduction seen during 2016/17 where the year-end feedback rate was 13%; feedback forms continue to be sent with every referral. It was not possible to process 2% of referrals received, resulting in the report being rejected, this is a reduction on the previous year (previously 8%), however a change from August. in arrangements regarding rejecting referrals must be noted. Referrals were previously rejected if there was insufficient information received and it had not been possible to obtain any further information after repeated attempts, this is no longer the case and referrals are now only rejected if there is a lack of consent without a clear public health or wider safeguarding concern identified.

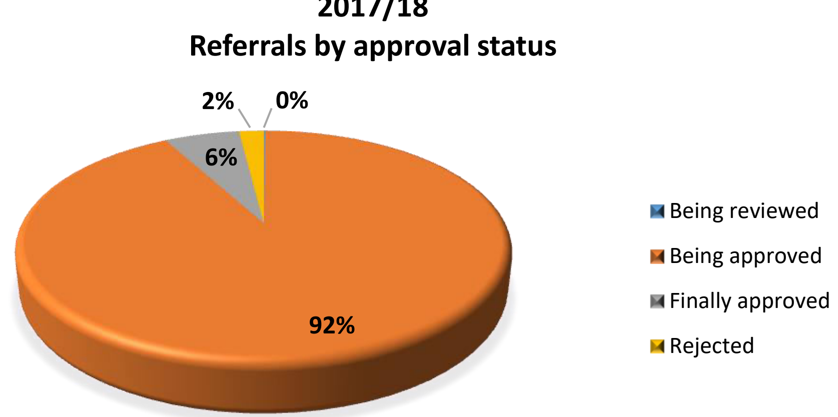

Figure 6: overall year end approval status

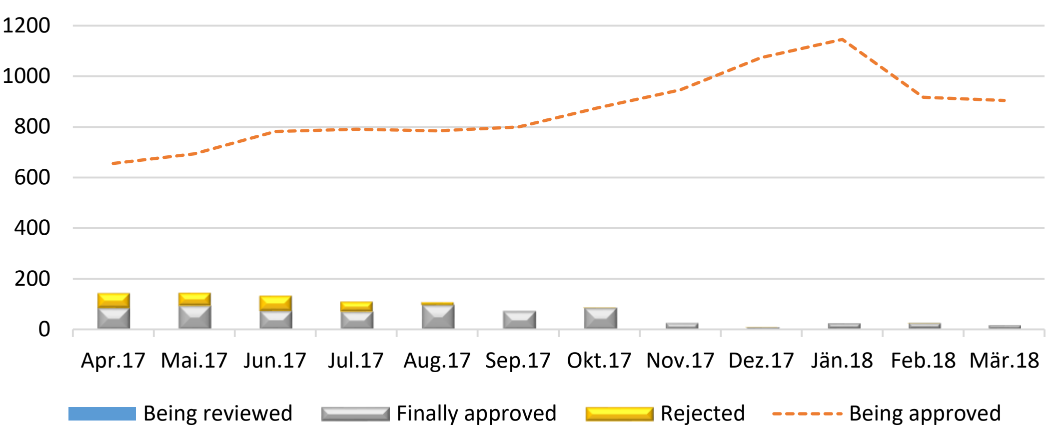

Figure 7: approval status shown by month

As a response to concerns raised during CQC's 2017 inspection and themes highlighted within the external bullying & harassment review, several safeguarding strategies were developed aimed at addressing tightening the Trust's response to safeguarding allegations made against its staff. This includes a thorough process where all learning from internal and external safeguarding work is captured and appropriately shared across the organisation. This ensures that risk of harm and abuse to patients, carers and Trust staff can be mitigated.

Examples of this work include:

- a process that ensures safeguarding expertise has oversight of complaints and allegations that have a potential safeguarding theme. This provides assurance of a robust process has that evidences a proportionate safeguarding response

- a clear process that ensures mandatory notifications to CQC (under Regulation 18 requirements) regarding allegations of abuse by SECAmb staff

- a review of the Safeguarding Scorecard that reflects the Trust's internal safeguarding activity. Implementation of a safeguarding scorecard that identifies training figures, allegations of safeguarding concerns raised against staff, progress in investigations into staff concerns and feedback following QA visits

- a review of all disciplinary cases over the past two years that provided an expert safeguarding opinion on each case and to assure the Trust's senior leadership that action has been taken where safeguarding issues were missed or where an individual's welfare may have been compromised

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4. Training

Trust staff undertook a number of safeguarding related training programmes during 2017/18. Support staff completed Level 2 child and adult e-learning, patient facing frontline staff completed an e-learning course for the Mental Capacity Act and all paramedic staff were required to complete Level 3 safeguarding child training in line with the Intercollegiate document guidelines in response to the CQC report must-do action; this was completed primarily via e-learning. The Trust also delivered face to Level 3 child and adult training to Operational managers (team-leaders and above), and clinically registered staff working in the Emergency Operations Centres and 111 in Ashford (with Dorking staff completing their Level 3 training through their employer Care UK). Face to face sessions were also delivered to all newly employed paramedics through the transition to practice programme. Level one safeguarding was not delivered as a stand-alone session, however all new staff did receive an introduction to safeguarding within SECAmb as part of their corporate induction programme. It was agreed with the CCG that the Trust target for completion of safeguarding related training would be 85% in line with other provider organisation targets.

Figures for each training level can be viewed below:

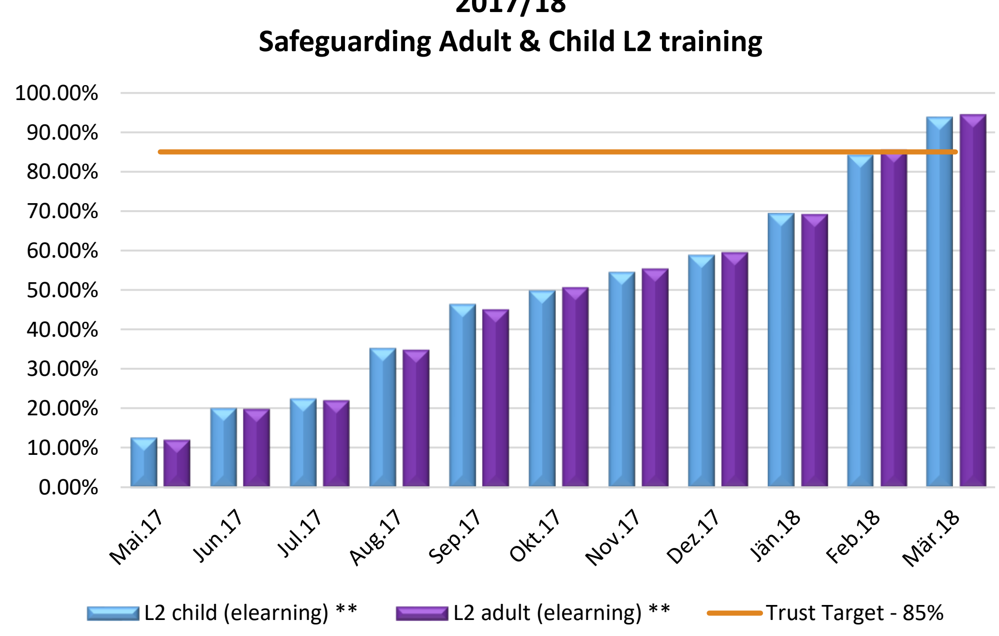

Figure 8: Level 2 training figures (year end)

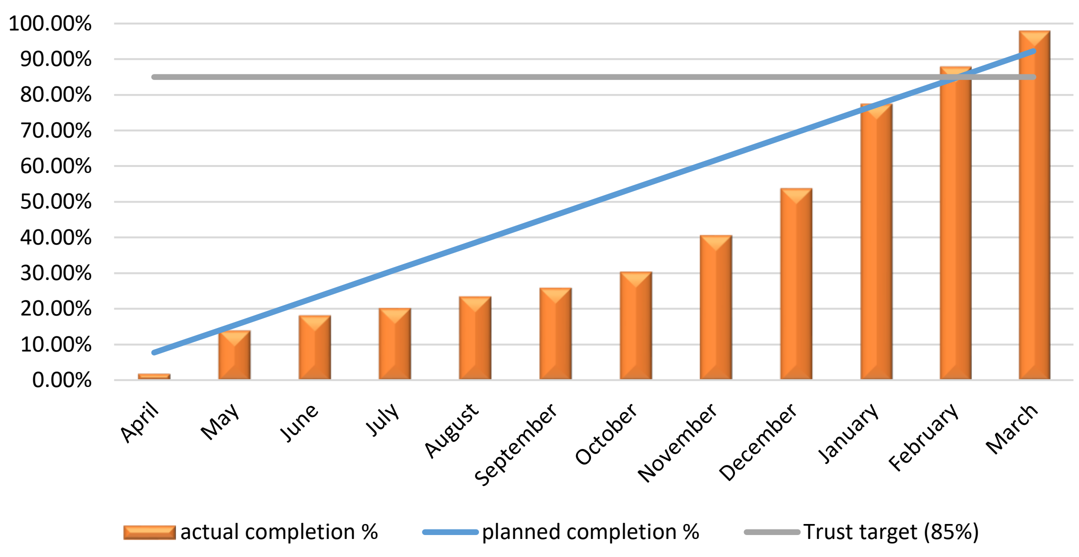

Figure 9: Level 3 training figures (Trust total - year end)

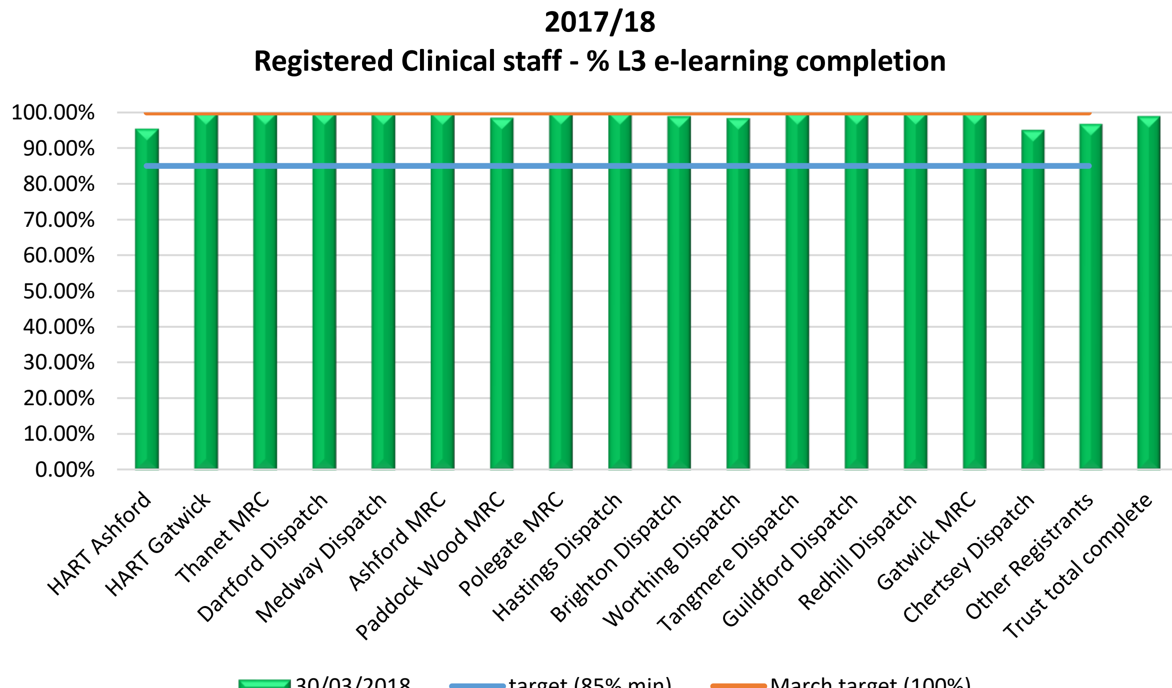

Figure 10: L3 training figures - e-learning for all registered clinical staff

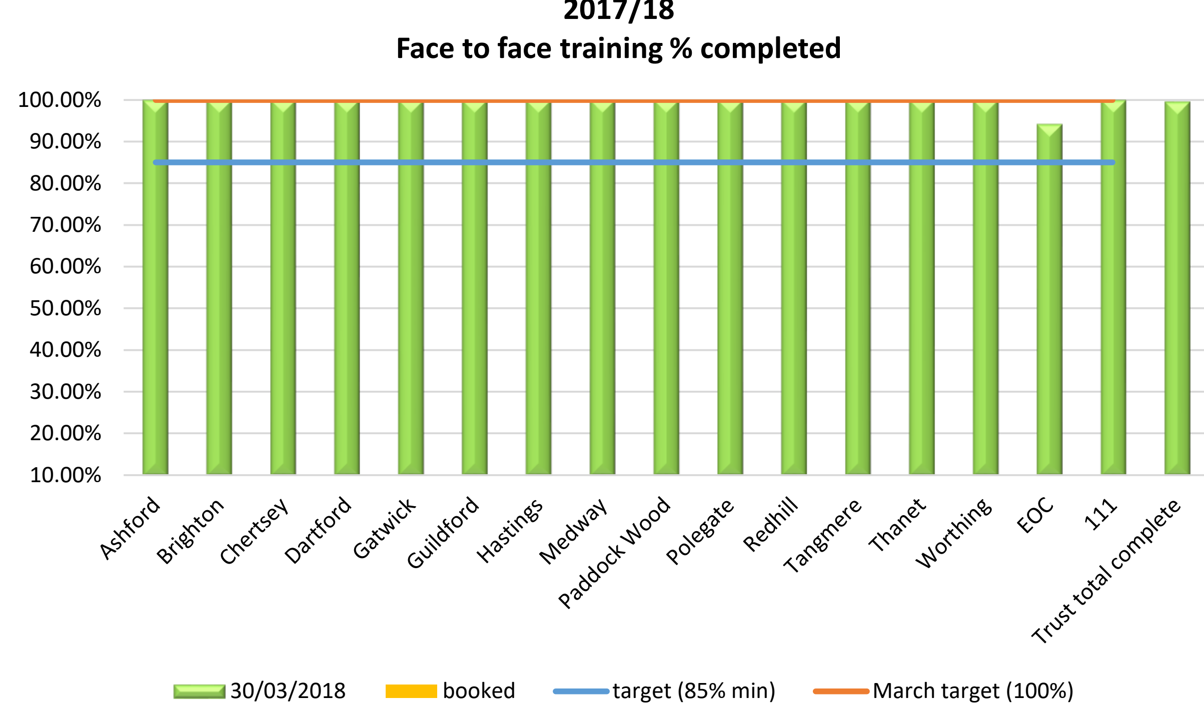

Figure 11: face to face training delivery

Training at all levels has exceeded the 85% target. The totals for each level can be seen in the table below

Course	Year end completion
L2 child (elearning)	93.99%
L2 adult (elearning)	94.62%
MCA (elearning)	92.36%
L3 (child adult)	98.04%

Table 1: overall training data

5. Assurance and accountability

Local Safeguarding Children Boards (LSCBs) seek assurance about organisational compliance under Section 11 of the Children Act 2004. The introduction of the Care Act 2015 placed Safeguarding Adult Boards (SABs) onto a statutory footing and each Board has been developing benchmarking assurance tools to identify good practice for safeguarding adults which broadly replicates the Section 11 requirements.

Section 11 requests are received every two years so there was no requirement to complete any during the reporting period, however two requests have been received for completion during Q1 of 2018/19.

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The commissioning arrangements for safeguarding were changed in April 2017, with the West Sussex CCGs taking over responsibility for assurance requirements. The West Sussex CCG assurance tool was completed and quarterly focussed updates have been submitted throughout the year for assurance purposes. This information has been shared with other CCGs in line with their information sharing arrangements.

The Trust also completed the pan-Sussex Safeguarding Adult Board assurance toolkit and took part in the associated 'challenge' event where responses were discussed and further actions identified.

As safeguarding was one of the key areas of focus for the Trust following the CQC inspection, it has undergone some additional scrutiny as outlined above. Alongside the Integrated Action Plan (IAP) and weekly scrutiny of progress against that, the day to day business of the safeguarding department has been mapped against a 'business as usual' workplan. This includes areas contained within the CCG assurance framework to ensure evidence is mapped against progress. The workplan is reviewed at the SSG meetings.

Following an internal review of safeguarding arrangements, it was agreed that safeguarding commissioning responsibility would be transferred from Swale to West Sussex CCG from April 2017. The Trust has already undertaken a review of service using the new CCG assurance and accountability framework as a benchmark for quarterly updates from April 2017 which will be overseen as a standing agenda item at the SSG. The benchmark document has been included in this report as appendix A.

The Trust submitted an assurance paper to NHS England and the Trust board in line with NHS expectations following the publication of the Lampard enquiry, which is currently being reviewed for 2018. There have been some gaps identified which will be included in the workplan for safeguarding for 2018/19, these include improved links with HR colleagues, in particular with regard to managing allegations and the final ratification of the Trust's visitors policy which will include safeguarding oversight. The departmental workplan can be seen as appendix B.

6. Learning

In line with the Local Safeguarding Children Boards (LSCB) Regulations (2006) which describes the responsibility of LSCBs in relation to undertaking Serious Case Reviews (SCRs) under Section 14 of the Children Act 2004, and for Safeguarding Adult Boards (SABs) the Care Act 2015 introduced the requirement to undertake Safeguarding Adult Reviews (SARs). During 2017/18, the Trust was required to provide information for four SCRs and thirteen SARs. The rate of SARs being commissioned by SABs has remained relatively static (fourteen received during 2016/17) and a significant reduction seen in SCRs (eleven received during 2016/17); obviously these vary year on year and fall outside of the control of SECAmb. Basic chronology or summary of involvement information has been shared for all seventeen reviews. Three cases have had summary information shared within the past few weeks so it is not yet known whether IMRs may

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still be requested; one case has been investigated as a Serious Incident (SI) so it is likely that an IMR will be required if the SAB decide to commission a full SAR. Details can be seen in table 2 below.

There have been two SIs as a direct result of safeguarding escalation, one where a summary of involvement identified a significant delay in response time, but also identified a missed opportunity to re-triage the call when new clinical information was disclosed. The second also pertains to a delay/non-attendance following which the patient died.

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004), during 2017/18 the Trust was required to provide information for one DHR (a reduction from the previous year). A full IMR was completed, however Trust specific learning was not identified due to the limited nature of the contact with the subject of the review.

	DHR		SCR		SAR	
	Info only	IMR	Info only	IMR	Info only	IMR
East Sussex Q1						
Q2						
Q3						
Q4						
West Sussex Q1					3	
Q2						
Q3					1	
Q4					3	
Brighton & Hove Q1						
Q2			1			
Q3						
Q4					1	
Surrey Q1						
Q2						
Q3					1	
Q4						
Kent Q1			1		2	
Q2						
Q3		1			2	
Q4			1			
Medway Q1						
Q2						
Q3						
Q4			1			
Totals		1	4		13	

Table 2: safeguarding reviews by Safeguarding Board area

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The safeguarding team has also undertaken a deep dive review into internal safeguarding practice. This has been commenced as part of the response to the external review into bullying and harassment undertaken by Duncan Lewis which identified pockets of poor safeguarding practice, including grooming, in one particular area of the Trust. The recommendations from this report will be monitored by the SSG and learning shared across the Trust.

There have also been improvements made across specialities within the organisation, with safeguarding now being represented on the SI group, included as a consideration within medicines misuse and counter fraud. Work has commenced to improve links with HR.

The Safeguarding Lead represents the Trust at the National Ambulance Safeguarding Group (NASG) which reports directly to the national ambulance Quality, Governance and Risk Directors Group (QGARD). The NASG has good representation from all English and Welsh Ambulance safeguarding leads. The group provides peer support and informal supervision as well as sharing good practice and any broader ambulance service learning points from reviews undertaken in individual areas which may translate to other services. During 2017/18 this has included allegations against staff, supervision models and supporting

7. Inspections

The Trust was inspected by the Care Quality Commission (CQC) in May 2017 which identified areas of improvement for the Trust with regards to safeguarding. Specific areas requiring improvement were around delivery of training to Level 3 (children) in line with the Intercollegiate guidelines as outlined above.

A programme of work to address the areas identified by the CQC, which had been commenced following the inspection in 2016, was expanded to incorporate areas identified as part of the external review into bullying and harassment. The Trust has supported this work across all directorates and significantly invested in staff to deliver against the training requirements. A safeguarding consultant commenced working with the Trust in August 2017 to deliver against the safeguarding cultural aspects (bullying and harassment) of the improvement plan.

The full safeguarding IAP can be seen as appendix C.

8. Key achievements during 2017/18

Staff had reported that feedback from referrals was not received on a regular basis; whilst this is requested from the appropriate local authority, as outlined above, responses to these requests remain low. If feedback is received from the local authority, this is shared with the referring member of staff; however, to provide increased assurance to staff that their referral has been managed, a process acknowledging that

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the referral has been actioned and sent to the local authority has been implemented. This has been well received by staff.

Joint working with HR around allegations is being embedded with increased links and oversight of all cases by safeguarding now being undertaken. A deep-dive review has been undertaken into historical cases where staff have been subject to disciplinary cases, regardless of whether they remained employed to the end of the process (i.e. resigned); this is supporting the wider Trust work being undertaken around bullying and harassment.

Safeguarding has been embedded within the Quality Assurance Visit (QAV) process with all staff asked about both their knowledge and skills in regard to keeping patients safe, and their own experiences of possible bullying and harassment. This data is included in the monthly scorecard which forms part of the safeguarding monthly report. Locker-room contents, including images, are also reviewed as part of this assurance process.

Partnerships across directorates within the Trust has been strengthened over the past year, this has been driven by increased support at Executive Director level which has cascaded through all levels of staff. A move towards greater local accountability across all areas of work within the Trust has seen Operational support for the child death overview and one area is piloting a safeguarding liaison role to support staff in their locality.

Delivery of the safeguarding Level 3 training over the year has exceeded the target of 85%. The Trust commitment was to attempt to reach 100% compliance, although this was not possible during the year, staff who should have completed the training, but who were unable, will continue to be supported in completing this as soon as possible. The impact of training is difficult to measure, however there has been an increase in referrals seen during the year which implies a greater understanding and underpinning knowledge has been achieved

9. Priorities for 2018/19

Over the coming year the Safeguarding Team will continue to work with other areas of the Trust to ensure that safeguarding practice for all staff continues to remain an area of priority to improve patient safety and ensure that children and adults at risk of harm or abuse are identified and reported using Trust procedures. The safeguarding team have been invited to attend the HR business partner meetings to improve safeguarding assurance and scrutiny across all HR functions within the Trust. The Trust is working to improve confidence in reporting mechanisms for staff who may be experiencing bullying and harassment and safeguarding considerations (regarding possible controlling, coercive or grooming behaviours) are being included within the proposed support model. Specialist training for staff who may be providing this support and HR colleagues who may be notified of these cases is under development.

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The Trust will continue its focus on safeguarding training throughout the coming year in line with the safeguarding training needs analysis. The Level 3 face to face training was well received and this will continue to be delivered to newly qualified paramedics, EOC and 111 clinicians during the year. Front-line clinical staff (including EOC and 111) will be expected to complete e-learning and an hour of face to face key-skills training is focussing on harmful behaviours and grooming of vulnerable groups; this includes staff groups who may be at increased risk of being targeted, such as foreign nationals or students on placement for example. Staff targeted to attend the Level 3 training day during 2017/18 will also be completing an additional training session regarding managing grooming and its impact on families and staff.

Additional resourcing for the safeguarding team has been agreed and the process of recruitment is underway. The Director of Nursing post has been recruited to with a substantive post holder now in place, this will bring increased stability across the safeguarding agenda and wider quality workstreams.

10. Conclusion

Safeguarding has continued to encounter significant challenges over the past year. The shortfall in staffing has had a serious impact, particularly on external relationships with social care teams and the responsiveness of the department to requests for information. This, coupled with the additional pressure to deliver a comprehensive programme of face to face training created a number of risks to the Trust; these were reflected on the Trust Risk Register.

Despite the challenges, the team has managed to deliver core business, managing the safeguarding referrals in a timely way. Training has been well received overall and compliance has far exceeded CCG requirements of 85%, reaching an overall compliance level of 98.04% at Level 3. This has only been possible to achieve with support across directorates and at all levels from the Chief Executive to local team managers.

The focussed support around safeguarding and the delivery of the IAP has highlighted the interdependencies of a number of areas including HR, culture and organisational development and frontline operations and raised the profile of safeguarding in these areas. This will have a positive impact on the ability of the Trust to deliver safe and effective patient care, embed the concept of safeguarding as everybody’s business and improve the safeguarding of staff within the organisation.

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11. Appendices

Appendix A CCG benchmarking document	Sussex CCG's Safeguarding Standar
Appendix B Safeguarding departmental workplan	Safeguarding Workplan 2017 - 201ε
Appendix C IAP (year end position)	Copy of IAP V28 Safeguarding.xlsx

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	Item No	11/18

Name of meeting	Trust Board
Date	26 April 2018
Name of paper	Annual Complaints Report
Executive sponsor	Bethan Haskins, Executive Director of Nursing and Quality
Author name and role	Louise Hutchinson, Head of Patient Experience & Steve Lennox, Associate Director of Nursing and Quality
Synopsis, including any notable gaps/issues in the system(s) you describe (up to 150 words)	The attached report is the Annual Complaints and Compliments Report. It is a statutory requirement to produce this report annually. The report reflects the change in emphasis. The Trust is moving towards a focus on learning and has placed this at the head of the report. This is evolving and developing and there is more to do in this area during 2018/19. However, this change is a positive development. The report has also been written to be more patient facing than previous reports. This is evidenced through the presentation style of the document, the inclusion of examples such as a number of the patient stories presented to Trust Board, and providing information on how we manage complaints. This is a reflection of our attempt to hold ourselves to account to our patients. The report highlights a number of lessons learned through individual complaints and through themes. The report also identifies that the response rate of 80% responded to within 25 days has been realised and maintained. This is a significant change for the Trust and is a reflection of how the whole organisations is now prioritising complaints.
Recommendations, decisions or actions sought	It is recommended that the Board approve the Annual Complaints Report for publication.

South East Coast Ambulance Service
NHS Foundation Trust
NHS
2017/18
Annual
Complaints and
Compliments Report
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Introduction

I am delighted to introduce the Trust's 2017/18 Annual Complaints Report. The report describes the considerable focus we have placed on complaints during the year and our intention to place complaints at the heart of our ambition to become an organisation that values feedback and views complaints as an opportunity to learn and make improvements.

As Chief Executive I am personally involved in the complaints process. I actively read complaints and personally respond to the most serious and I receive weekly reports on progress. During the year I have met with complainants and whilst we do not resolve all of the issues all of the time I hope complainants feel that we have listened and that we value the time and effort they have taken to tell us how we are doing.

We still have a great deal to do. However, we can now demonstrate that we identify learning from the majority of our complaints. We can also demonstrate that we are making progress in sharing and implementing the learning across the organisation and we now produce monthly posters that summarises the main themes. In order to reflect the changing emphasis on learning we have placed learning at the head of this report.

We have also developed our patient stories at Trust Board. This allows Board members to hear the complainant's perspective directly. We regularly video record the complainant telling their story and present this, in full, to the Trust Board. They are now also made available on the Trust's website and we are very grateful to the patients that contribute to this initiative. A number of these stories have been repeated through this annual report.

We have also dramatically improved our response time. Our ambition was to respond to 80% of our complainants within 25 working days. This is an ambitious target for a service that delivers care across a wide geography as information can take a while to become available. Nevertheless, we have now achieved this ambition and I would like to thank everyone involved for prioritising the reading, allocation, investigation and completion of responses within this time frame. We have managed to do this without reducing the quality of our response. We monitor satisfaction with responses by reporting the numbers that we have failed to resolve and are reported to the Ombudsman.

I hope these successes and this Annual Report demonstrate the value that we now place on patient experience and our ambition to become a more responsive organisation. If you have any questions or concerns that you wish to raise please do contact us via any of the methods outlined at the end of this report.

Daren Mochrie QAM

Patient Story to Trust Board 23 February 2018

From an initial 999 call at 1.29pm, an ambulance crew arrived at 04.23pm.

An edited extract from the recording of the patient and her relative was as follows:

"I hit the ground pretty hard and pretty fast and it was a quiet day. I shouted *help* for about 30 seconds maybe longer. A car did come up behind me and I could see her and she stopped luckily. As she got out the first thing she said was am I all right? I said no, I explained and she phoned the ambulance. The other lady went to find something to put on me so that I didn't get cold. As time progressed the lady from the yard came down and a guy overtook and pulled over on the left and he was an off-duty metropolitan policeman. He tried to phone for an ambulance hoping that he might have some sort of sway (it was about 1:45 at this time) and he didn't get any joy. I had a few rugs added to me to keep me warm. As long as I didn't move and as long as I kept still I was fine. So I didn't move I stayed still.

The ambulance arrived about 4:30. I'm not the type of person to worry or panic I'm quite laid back and I was literally laid back so I thought an ambulance was going to come eventually I wasn't particularly worried but obviously a little bit later on I was starting to get cold.

They were good, they took a long time to assess the situation. I thought they were not faffing but they just took a really long time to decide what they were going to do, when surely it was pretty obvious what they need to do, and get off the road. It just seemed to take a really, really, long time to do anything.

So, I went to x-ray and I had broken my femur, damaged my hip and I was operated on the next day. I'm alright. I still know that they all want to get there and do the best they can to get the patients where they have to go".

Following an investigation, the call handling, call categorisation and dispatch response were found to be correct but the service was receiving very high call volumes at this time. In this case welfare calls, which may have prompted the priority of response to have been upgraded, were not conducted.

Despite a very cold day on the ice the Board were informed that the patient was making good progress and recovering with good humour.

The dispatch and clinical team involved have been given feedback on this case for reflective practice as part of their continual professional development.

What have we learned?

Overall, we have learnt that our patients are happy with the service that we provide.

The ratio of complaints against the Trust's activity levels is very low. During 2017/18 our Emergency Operations Centre staff took 1,079,650 calls, our A&E road staff made 704,578 responses to patients and our NHS 111 staff took 1,113,938 calls. In all of this activity the Trust received 1,238 complaints. This equates to one complaint for every 2,341 patient interactions. This means that 0.043% of all calls/journeys have attracted a complaint.

A full table is supplied in the appendix that compares the Trust with other ambulance services but 0.043% compares favourably across the Ambulance sector where rates range from 0.05%-0.16%.

However, for some patients it is clear that they receive care that is unsatisfactory and it is important that we learn and improve services based on this feedback.

We provide substantial training programs and a range of policies, procedures and guidance to help staff provide the best care and service they can to our patients. We find that system-wide changes to practice as a result of complaints have been relatively uncommon, with the majority of learning being for the individual practitioner. However, we are now better at asking if this experience could re-occur. We are improving our Trust wide learning.

Theme 1. Patient Care

The aspect of our service that received the most complaints was the actual patient care received with 508 complaints.

These can vary in severity but one example (presented here as the First Complaint Example in this report) is an example of the wound care that was received.

First Complaint Example for *Patient Care*

E&U/A&E Care (Operations)

A complaint was received on behalf of an elderly patient with dementia who had slipped on her driveway and had cut and bruised her face and knee. A paramedic arrived and covered the right eye with a saturated saline pad secured with a head bandage, and arranged for a paramedic practitioner to attend to glue or stitch the wound. The paramedic left and owing to a high level of demand the practitioner did not arrive until several hours later, by which time the patient was agitated and distressed. The crew found the patient's wounds still had grit in them and that the ripped skin below the patient's eye had not been unfurled and preserved. The crew were unable to repair the wound as it was too close to her eye and the patient had to be taken to hospital. This was 12 hours after the patient had fallen, causing the patient and her daughter unnecessary anxiety and stress.

Outcome and learning

It is clear the response time reliability of the practitioner greatly affected the outcome, and in this instance resulted in moderate harm. However, the crew could have referred to the urgent care handbook available on the Trust-issued iPad, and could also have used the iPad Face Time function to discuss the case with another clinician.

The investigator discussed this case with the paramedic concerned, reminding them about using the iPad to help with their decision making process. They also noted some issues with the clinical record completion, which had no mental capacity assessment, and reiterated the importance of thorough PCR completion. As a result of this complaint the investigating manager has put together a wound assessment training package to be delivered on the Trust's clinical training programme in 2018/19.

What have we learned?

Theme 2. Timeliness

The second highest theme that received complaints was timeliness.

This area received 463 complaints. Occasionally the complaint can be a perceived delay, rather than an actual delay, because we have failed to manage expectations properly. Other complaints about delay can manifest as a delay but be about another aspect of our service. The Second Complaint example is regarding a perceived delay but in reality the issue was very different.

Second Complaint Example for *Delay*

111 Service

The complainant's son was suffering with pins and needles from his ear to his feet. The complainant called 111 in the morning who advised her to call her son's GP. The complainant and her son had to wait until the GP was free at lunchtime, who then advised the complainant to call 999. An ambulance was arranged to attend, but the complainant received a call back 15-20 minutes later to advise the patient that he was 3rd in line. The complainant took her son to hospital due to the delay and he was later diagnosed as having had a stroke.

The investigating manager confirms that a call was received, reporting pins and needles in the right arm and legs, and the health adviser spoke to the patient. The pathway used was 'numbness or unusual feelings in the skin' and the disposition reached was for the patient to "Speak to the Primary Care Service within 1 hour". As the call was during the patient's GP hours, they were advised to contact their own GP.

Outcome and learning

The investigating manager has concluded that the health adviser used an incorrect pathway and should have probed further, which would have picked up stroke symptoms and taken them down the stroke pathway. The incorrect disposition did cause a delay in patient care, as the stroke pathway would have increased the urgency with which the case was dealt. The health adviser has since left the organisation. However, the investigating manager developed an information sheet for all staff regarding the recognition of stroke symptoms and explains how our electronic triage system manages these symptoms.

What have we learned?

Theme 3. Attitude and Behaviour

The number of complaints about A&E staff behaviours has continued to reduce. In 2017/18 240 complaints were received about A&E road staff behaviour, compared to 277 in 16/17 and 367 in 2015/16. Of these, 51% were upheld or partly upheld, compared to 45% in 2016/17. Of the 240, 87% were about conduct and attitude and 13% were about standard of driving, exactly as last year.

Third Complaint Example for *Staff Concerns*

E&U/A&E Care (Operations)

The parents of a severely disabled patient raised concerns that a crew member who attended their son refused to recognise the parental wishes that they had drawn up for any care provider who treats him, which are included in his 'hospital passport'. Instead, the crew member advised the nurse at the care home that the document, drawn up by the patient's parents as a result of a 'best interest' meeting in February 2017, had expired. The parents were concerned that the crew member appeared not to understand the document, and that it had been removed from their son's hospital passport. They are concerned if they had not attended the hospital and inserted a new copy of this document, then two valuable conversations with the doctors regarding their son's deterioration and management plan would not have taken place, and this could have had a detrimental effect on his outcome.

Outcome and learning

On investigation it was deemed that the clinician did not provide an adequate level of service/care at a number of stages, and that as the DNACPR was not marked 'indefinite' as would be the norm in such cases, this should have prompted the crew to look at the other parts of the Care Summary, given the hand-over from the care staff, which would have guided the crew as to the Best Interests meeting outcome. The investigation manager requested that the crew become proficient in the Advance Care Planning process by reading relevant guidelines; that they should become proficient in the Code Yellow Sepsis pathway through JRCALC guidelines; and that both should have a clinical skills update regarding when to call for paramedic back up. The Patient Experience Team has undertaken to liaise with Learning and Development to check as to staff's understanding of 'hospital passports', and will request that information about them is shared across the organisation.

What have we learned?

Theme 4. Triage

The Trust has received 161 complaints regarding the triage process.

These are often difficult to resolve as the electronic system used is a national process. However, any learning is shared as part of a national process and themes that occur across the country do lead to changes within the software. Local changes are more difficult as NHS Pathways is reluctant to support this as it can introduce regional variation.

Nevertheless, lessons can be learnt through triage complaints.

Fourth Complaint Example for *Triage*

Emergency Operations Centre

The daughter of a patient raised concerns that her mother was not sent an ambulance when she called 999 on the advice of her hospital consultant, who had diagnosed gallstones and said that if she experienced pain she should call 999. The patient called when she was experiencing severe abdominal pain, however the disposition reached was to contact a primary care service within six hours. The daughter feels this is unacceptable and an ambulance should have been sent to help her mother.

Outcome and learning

An audit of the call found that the triage was non-compliant, as the Emergency Medical Adviser (EMA) should have taken on board the patient's comments about her pre-existing condition and should have checked to see if she had a pre-determined management plan. Instead they over-probed with regard to pain, which may have pressured the patient into a response which caused contradictory answers. The EMA placed the caller on hold during the assessment, but did not explain why and did not document any clinical input into this call, although it could be heard in the background that the EMA was being coached. The investigating manager confirms that had the pre-determined management plan route been followed, the patient would have likely have received an ambulance response. The EMA's manager met with them to discuss the case, in particular the pathway they followed, about listening to the caller and picking up on potential pre-determined pathways, and also about explaining to callers in advance that they are going to be put on hold and why.

Patient Story to Trust Board 11 January 2018

A patient's family talked about the lack of care given to their mother and grandmother at the end of her life.

An edited extract from the recording of the daughter and granddaughter is as follows;

"She was a very independent lady. She went to the shops every day with her walker.

At about 15:30 she was asleep on the sofa and I said "nana are you ok?" She looked slumped and just not with it. Her breathing was very shallow and had a sort of rattle. So I called an ambulance.

I rang my mum and she came straight over. The ambulance people arrived. One of them got out first. I was saying she's in here but he was just rolling in very casually, chewing gum. He came in and says what's this? He didn't sound very confident. He said "is this breathing normal?" and I said "no she's normally more active". He just sort of sat there and started taking notes. We were thinking could you not give her any oxygen you could see she was struggling and she was in a lot of pain.

He just seemed more interested in writing down the date of birth but I thought we could do this afterwards. After about half an hour to 40 minutes they eventually decided they were going to put her on a chair. He got under her arm and pulled her to the edge of the sofa where she just collapsed like a rag doll. He didn't bend down.

My daughter looked at her, went down underneath, and screamed and said "she's not breathing". The other one came over and just grabbed her and almost threw her on the trolley. They didn't even do it together which I thought was wrong. They hadn't done anything to help her. They didn't speak to her, they didn't hold her hand, they didn't say to her don't worry we'll get you sorted they just didn't speak to us they didn't say a word.

It was probably one of the most traumatic things I've seen. I know it certainly was for my daughter. Sshe was my mum and her nan and to see her treated like that. All I can say is I feel sorry for anybody that ever gets those two treating their family.

An investigation found the patient was gravely unwell. The care and compassion given was not of the standard expected. Both attending members of staff underwent additional training. The Trust Board were distressed to hear this account and have asked the Consultant Paramedic to relook at the way our clinicians undertake reflective practice to ensure it is effective and meaningful.

How do we share the feedback?

The Patient Experience Team work closely with the risk team, safeguarding team, professional standards team and others to ensure that learning from all areas is triangulated and that outcomes from investigations are shared across the whole organisation. A concerted effort is currently being made to find new ways of sharing learning more widely, with the following recent achievements:

- Patient stories (video or audio) are shown at every Trust board meeting, and more importantly, a link to all patient stories is provided on the front page of the Trust's intranet, encouraging staff to view them.
- Quality posters have been developed, showing monthly complaints numbers and subjects and sharing a recent example of learning from a complaint, as well as a recently received compliment to provide balance. Posters are also produced providing similar information for safeguarding and incidents.
- Complaints statistics, narrative and examples of learning are shared at all Area Governance Group meetings through the monthly Quality and Patient Safety Report.
- A cross-departmental shared learning discussion group has been established to consider means and mechanisms for sharing learning from complaints, incidents, safeguarding and SIs.
- Work is also underway to develop a 'learning repository' on the Trust's intranet.

How do we encourage and gather feedback?

We still have work to do regarding widening the opportunities for patients to give feedback.

The Trust's website contains information for patients how to raise a complaint directly with the Patient Experience Team. The contact details for the Patient Advice and Liaison Service are also available on the NHS Choices and Care Opinion website. NHS Choices can also be used by patients to leave feedback and this is monitored by the Patient Experience Team. At the end of 2017/18 there were 23 comments on NHS Choices giving the Trust a satisfaction rating of 4.5 Stars. All postings had been responded to.

We also use the compliments process to evaluate our service. Each year the Trust receives an increasing number of "compliments", ie letters, calls, cards and e-mails, thanking the staff for the work they do.

Compliments are recorded on SECAmb's Datix database, alongside complaints, ensuring both positive and negative feedback is captured and reported. The staff concerned receive a letter from the Chief Executive, thanking them for their dedication and for the care they provide to our patients.

During 2017/18 the Trust received 1,688 compliments thanking our staff for the treatment and care they provide. This is a reduction against the 2,350 received in 2016/17. Overall the compliments we receive do provide a welcome boost for the staff.

How do we manage complaints?

The Trust's complaints are graded according to their apparent seriousness on receipt. The Patient Experience Team worked with operational colleagues to devise and implement the grading system. This is in order to help ensure that all complaints are investigated proportionately.

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

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

Figure 1 illustrates the split by levels of complaints.

When a complaint is concluded, the investigating manager, with input from the Patient Experience Team where necessary, assesses whether the complaint should be upheld, partly upheld, not upheld or in some cases, unproven, based on the findings of their investigation. This is not communicated with the complainant but helps the team to decide on the severity of what may or may not have gone wrong for the patient and the action required to prevent it happening again.

During 2017/18 there were 1,222 complaints due to be responded to. Of those complaints concluded at the time of writing, 70% were found to be upheld or partly upheld, as shown in Figure 2.

Figure 1. Grading of complaints received in 2017/18

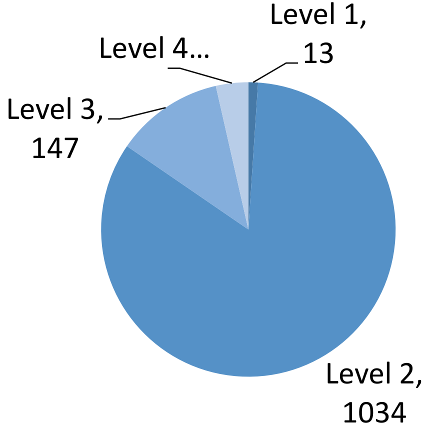
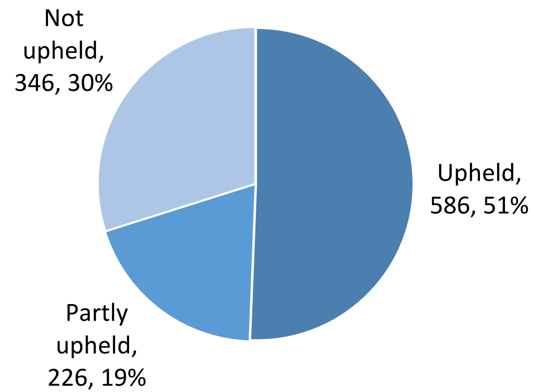


Figure 2. Complaints by outcome, 2017/18



Improvements to overall services

Care has been highlighted as the most common theme arising out of complaints. Whilst the Trust has a strong record of addressing the concerns with individual clinicians the wider learning has been weak. However, each year a mandatory clinical training programme is undertaken for all clinicians and this year the 2018/19 programme has been directly linked to learning. Complaint themes, Serious Incident themes, and national guidance have all been explicitly identified for each course included within the programme.

Complaints about delay are more difficult to address as they are often dependent upon available resources. The introduction of the new model of delivery in November (known as the Ambulance Response Programme) has released some benefits in that it allows the Trust to target resources more appropriately and helps the Trust to get the right resource to those patients who are most seriously ill. The Trust is also working with the commissioners to undertake a review of the Trust's demand and capacity and it is anticipated that this will release some resourcing benefits.

As previously outlined, "Attitude and Behaviour", whilst improving, is highlighted in complaint themes as a significant area. We do share stories about attitude and behaviour and a number of the patient stories at Trust Board have an element of behaviour within them. However, the Trust is undertaking a number of actions to make improvements in this area. For example, all senior managers and leaders are undertaking a programme of leadership development. This is also supported by the ambition to improve the number of staff who have completed an appraisal and the Trust has invested in an electronic system to support this work. Additionally, a Trust behaviours guide has been developed which when launched will clearly identify the expected behaviours of all staff working within the organisation.

The Trust has significantly strengthened the governance around complaints during the year. A weekly summary report is now produced and is distributed widely across the Trust.

In addition, a complaints dashboard has been developed as part of the associated improvement plan and this is presented weekly to one of the Executive led committees.

Complaints now also feature on the monthly Quality & Safety dashboard and this is supported by a monthly report summarising the activity, themes and lessons learned. This report is circulated to commissioners, the Executive Board and to senior managers.

There are a number of areas that are monitored as part of our governance processes. These are reported in the following pages.

Governance Area 1
Number of Complaints

The number of complaints received in 17/18 reduced slightly against 2016/17.

There has been a year on year reduction in complaints about NHS111, and a significant decrease this year in the number of complaints about our A&E service.

However, there has been a disproportionate increase in EOC complaints, the majority of which are about delayed ambulance response and backup.

The three-year breakdown is presented in the following three pie charts. The 2017/18 breakdown by service area is presented in the following table (Table 1).

SECAmb complaints (excluding Patient Transport Services and corporate complaints) over the past three years

Figure 3. Year 2015/16: 1,241

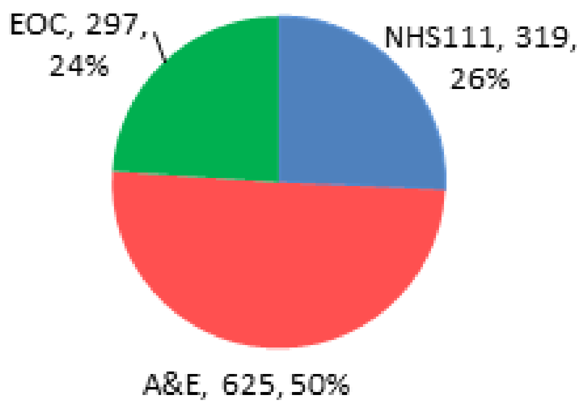


Figure 4. Year 2016/17: 1,261

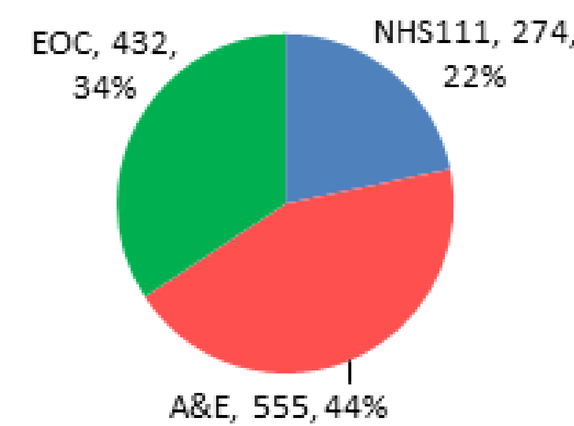


Figure 5. Year 2017/18: 1,228

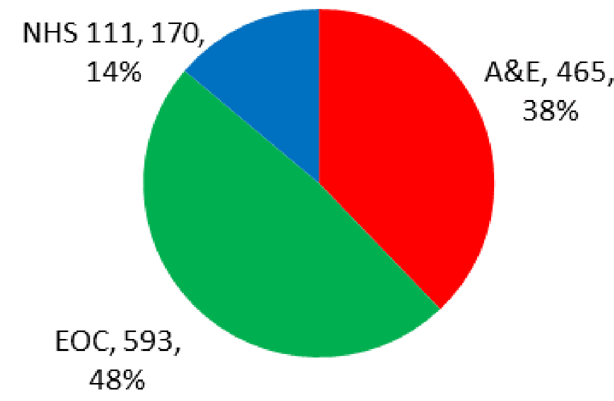


Table 1. Complaints by service/operating unit area and month

	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	**Total**
Ashford 111 Centre	15	7	9	6	16	25	11	12	8	15	16	7	**147**
Dorking 111 Centre	1	0	2	0	0	2	2	1	3	2	3	6	**22**
Banstead EOC	6	8	9	9	16	5	1	6	0	0	0	0	**60**
East EOC	17	8	15	14	17	24	19	14	3	6	7	3	**147**
West EOC	5	10	22	20	23	46	55	34	13	11	11	18	**268**
Ashford	4	5	5	3	0	1	6	3	3	2	10	6	**48**
Brighton and Mid Sussex	1	3	4	3	4	0	4	5	6	7	9	5	**51**
Chertsey	2	3	3	4	3	3	1	4	3	5	5	6	**42**
Gatwick and Redhill	1	3	3	3	1	5	1	2	12	7	12	6	**56**
Guildford	1	5	4	2	1	0	6	2	4	5	7	3	**40**
HART	0	0	0	0	0	0	0	0	0	0	0	1	**1**
Medway and Dartford	5	8	6	0	7	4	9	6	9	15	12	14	**95**
Paddock Wood	5	1	0	5	2	3	5	4	7	11	7	6	**56**
Polegate and Hastings	1	3	4	1	2	3	2	6	8	9	12	10	**61**
Thanet	3	7	1	7	3	3	4	4	8	2	10	10	**62**
Worthing and Tangmere	2	5	8	4	6	3	3	4	2	12	4	12	**65**
Other directorate	0	2	6	1	2	2	0	0	2	1	1	0	**17**
Total	**69**	**78**	**101**	**82**	**103**	**129**	**129**	**107**	**91**	**110**	**126**	**113**	**1238**

Governance Area 2
Themes within Complaints

This section reports on the main themes arising from complaints by each of the service areas.

Urgent and Emergency Care

The main themes of complaints about the Trust's main field operations service are staff conduct (this includes conduct as well as driving) and patient care.

Broad actions that are taken to mitigate against a recurrence of a complaint is dependent on the nature of the complaint. However, they may include the following interventions:

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

In 2017/18, as in 2015/16, the mandatory two-day Key Skills course for field operations staff included a Patient Experience session, which was developed by Learning and Development and the Head of Patient Experience. This was very well received and a further Patient Experience session will be planned for 2019/20.

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

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

Crew diagnosis*:* This sub-subject of 'crew diagnosis' is sometimes used interchangeably with non-conveyance, though not all misdiagnoses result in non-conveyance. Twenty-six complaints of crew misdiagnosis were upheld at least in part. These included the following:

- Seven cases where the patient was diagnosed as having a stroke
- Six missed fractures, including three spinal, one neck of femur and one wrist
- Two cases of MI, one case of heart failure, one case of endocarditis
- Three cases of sepsis
- Three cases of serious infection
- Blood clot
- Renal failure

Measures are put in place to prevent a recurrence. Training in stroke recognition forms part of the annual training and will be addressed there to improve Trustwide practice. Cases of missed fractures is a theme that has emerged recently from complaints, safeguarding and SIs, in particular a lack of recognition of potential spinal fractures and insufficient immobilisation. Early work has included an analysis of the manual handling training provided to all grades of staff, and full outcomes and learning will be disseminated following the conclusion of an ongoing SI complaint.

***Inappropriate treatment**:* There were 23 upheld/partly upheld complaints about inappropriate treatment (compared to 44 in 2016/17), constituting the second largest proportion of upheld patient care complaints.

The following common themes were identified, though numbers are not statistically significant:

- Poor manual handling x 6
- Patient taken to inappropriate destination x 3
- No pre-alert sent to hospital x 4
- Lack of observations/ECG x 3
- Inadequate pain relief given x 3
- Dismissive of/missed symptoms x 2
- Lack of urgency in three cases, including a patient bleeding post-tonsillectomy
- Poor End of Life care

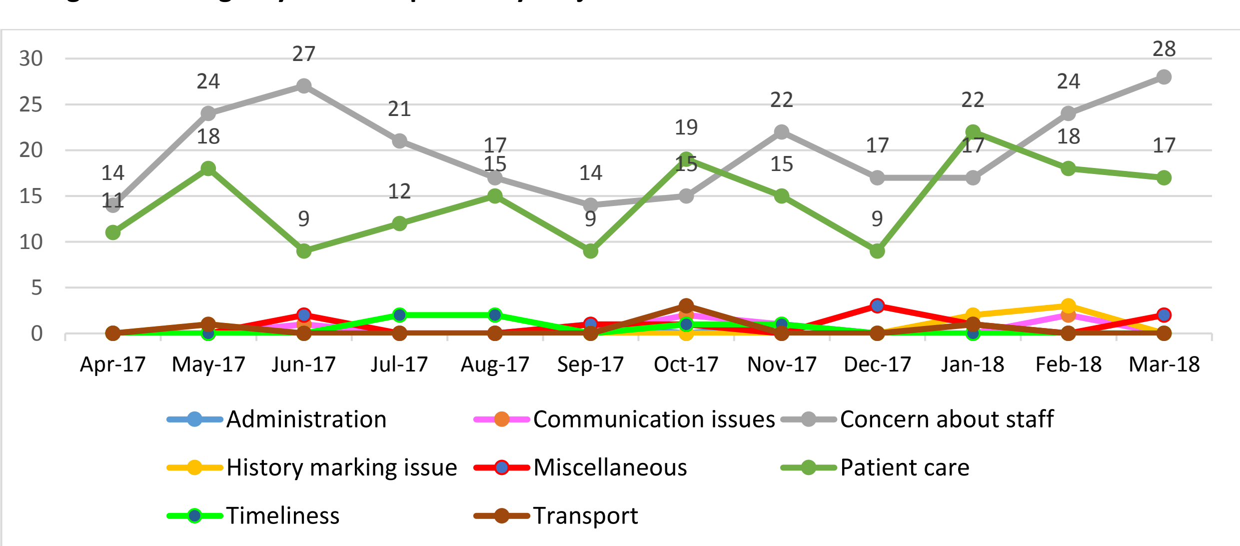
Non-conveyance: Only 11 of the complaints received about patients not having been conveyed to hospital were at least partly upheld, compared to 34 in 2016/17. The findings from these complaints investigations identified the following:

- missed fractures x 2; sepsis x 2; perforated appendix
- severe pain diagnosed as sciatica when it was metastatic lung cancer affecting the spinal membrane
- no onward referral of care and DVT later diagnosed
- failure to recognise a fall was caused by AF
- failure to listen to relevant patient history

Actions implemented/to be implemented as a result of complaints about patient care include the following:

- redistribution of the local acquired pneumonia pathway throughout OU area
- reflective practice exercises
- peer review sessions
- articles placed in the Trust weekly bulletin
- review of the potential gap in education, the requirement for training and the benefit of a direct pathway for ENT emergencies
- discussion of case and outcomes with manager
- development of a wound care package to be delivered at Key Skills training
- staff review of guidance around OTTAWA ankle rules; safe discharge of patients; blood testing; analgesia protocols; pain management; sepsis, via the sepsis e-learning module on SECAmb Live
- the sharing of information about 'hospital passports' across the Trust.

Figure 6. Urgent & Emergency Care complaints by subject



Emergency Operations Centres (EOCs)

During 2017/18 a total of 593 complaints were investigated by our managers, compared to 432 in 2016/17.

There has been a significant increase in the number of complaints investigated by our EOCs across the past three years, and the 593 received in 17/18 represent a 37% increase against last year. The biggest contributor to this is the increase in complaints about ambulance response times, with 415 received in 2017/18 compared to 204 in 2016/17.

Timeliness: The majority of the complaints investigated by EOC concern timeliness/delay. However, it should be noted that these delays are in generally not attributable to the actions of EOC staff. Timeliness issues are assigned and investigated by EOC managers as they have the necessary expertise to interrogate the computer-aided despatch (CAD) system, and understand the systems and processes that impact on ambulance response times.

The national Ambulance Response Programme was implemented by SECAmb on 22 November 2017, and it was hoped this new system might enable us to better manage callers' expectations and lead to fewer complaints.

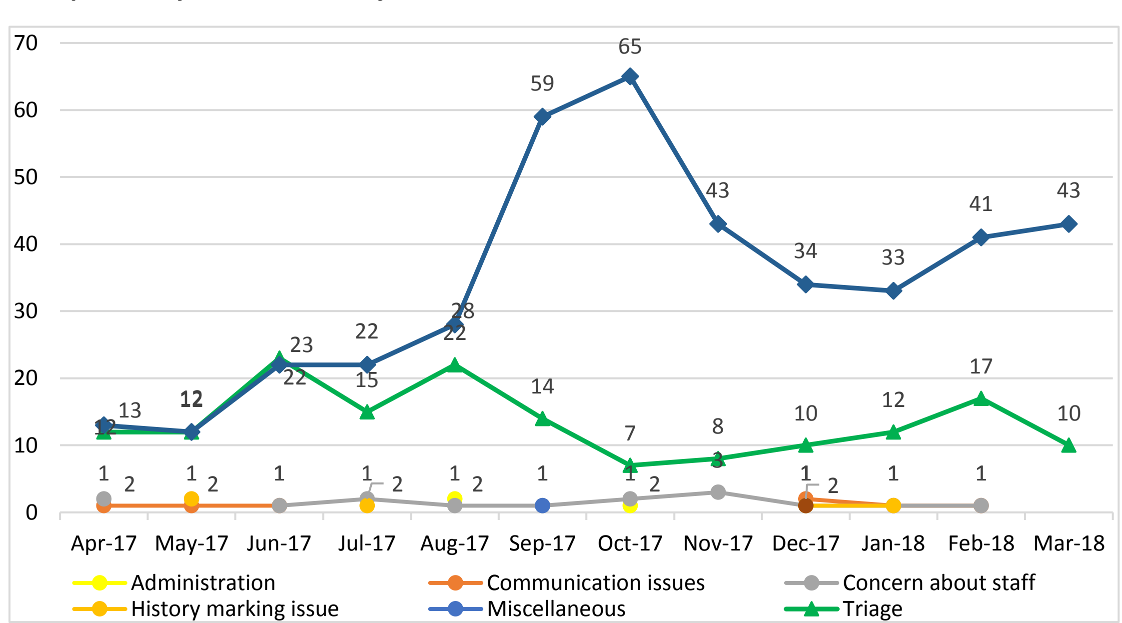
The number of complaints about ambulance response times did decrease in November, December and January, however it began to increase in February and again in March.

***Call triage**:* Of the complaints about call triage, 70% were upheld at least in part. These complaints were in the main the result of human error, with EMAs and some clinicians not correctly following the triage process:

- selecting the wrong pathway
- insufficient probing
- EMA not deferring to clinician
- clinical supervisor not using NHS Pathways to reinforce their clinical decision
- not following policy correctly
- particular condition policy not followed
- call not correctly passed to other ambulance service
- issue with NHS Pathways itself.

Of the EOC complaints received during 2017/18, 83% were upheld at least in part. Outcomes are shown by subject in fig 11.

Figure 7 EOC complaints by month and subject, 2017/18



NHS111 Service

During 2017/18 the Trust received 170 complaints about its NHS111 service, compared to 271 in 2016/17 and 319 in 2015/16. This represents a 37% reduction in complaints against last year.

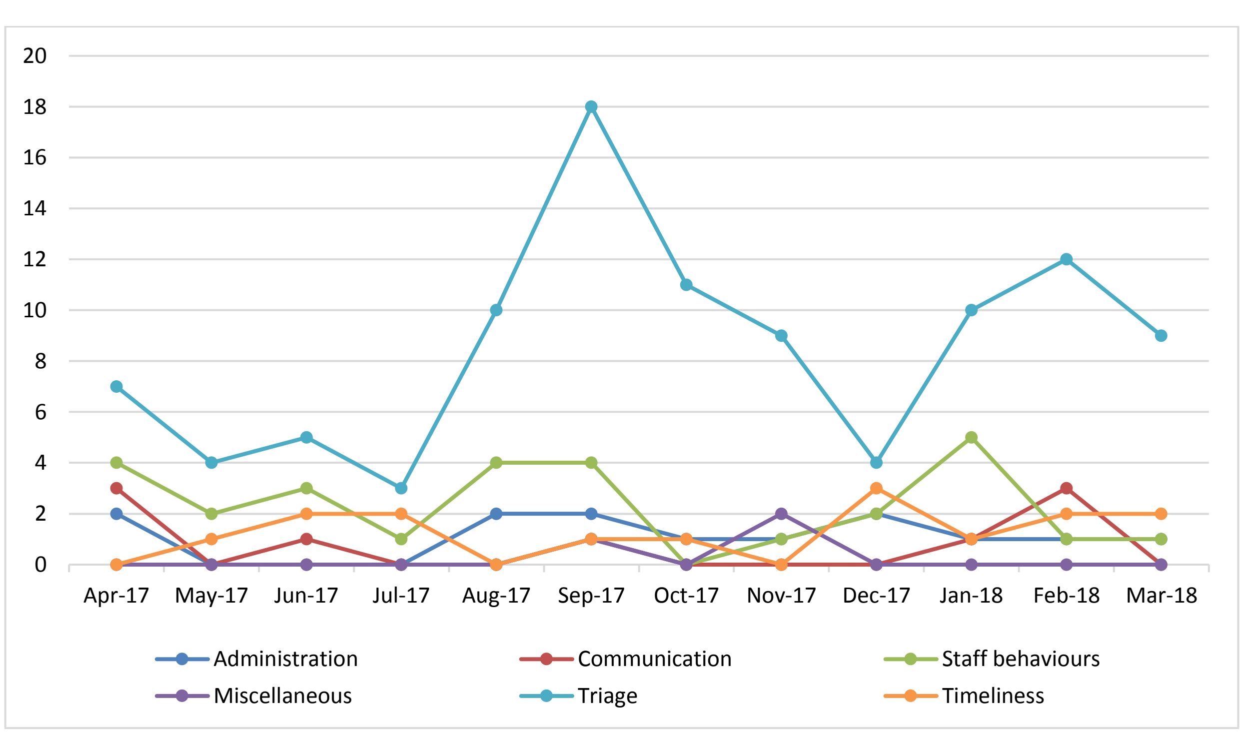
60% (n=102) of NHS111 complaints (60%) were about call triage, which saw a spike in September. This was followed by complaints about staff (16%); timeliness (9%); and administration (8%).

Call triage: Of the complaints about call triage 69% were at least partly upheld, compared to 75% in 2016/17. The same triage software, NHS Pathways, is used to triage both NHS111 and 999 calls, and as with EOC complaints, most upheld triage complaints are caused by human error. Some of the issues with these complaints include lack of probing, long, uncomfortable pauses during questioning, selection of the wrong pathway, failure to recognise the severity of pain, failure to pick up on clues provided and failure to follow policy, failure to refer to a clinician.

NHS111 have good systems in place for sharing learning, including a learning monthly patient experience bulletin and regular 'buzz sessions', where staff who are on duty are invited to listen to updates re topical issues affecting the service, and it is hoped that some of this work will be replicated for other of the Trust's service areas.

Of the NHS111 complaints received in 2017/18, 65% were upheld at least in part, with outcomes shown by subject in fig 8.

Figure 8 NHS111 complaints by month and subject, 2017/18



Governance Area 3

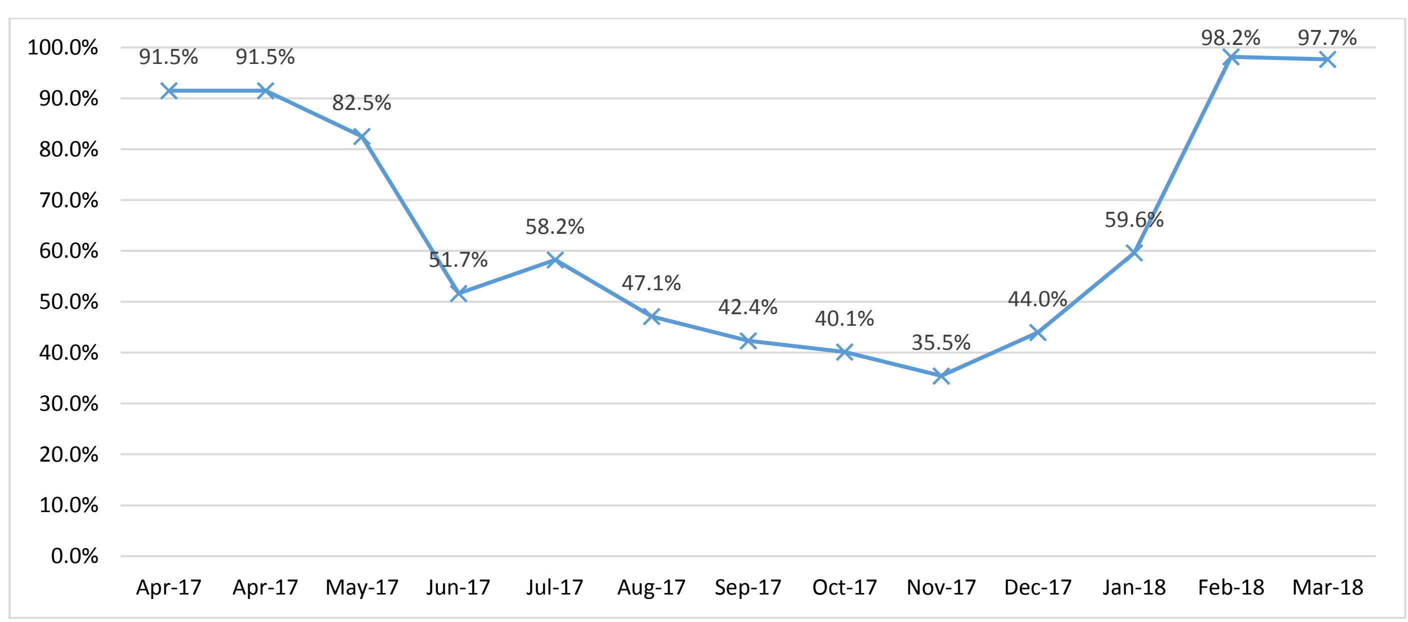
Timeliness of Response

The Trust's complaints response target is 25 working days. In late summer 2017 a new role of Operational Team Leader (OTL) was introduced to help realise this ambition. This role includes responsibility for investigating low-level complaints and assisting managers with more serious complaints. This role was supported by bespoke training. Also, fourteen complaints investigation courses were provided from October 2017 to March 2018. More than 168 Operational Team Leaders were trained and 32 Operational Managers and Operating Unit Managers. This has helped increase the number of staff able to undertake investigations from an original 32 to almost 200.

In addition, a new role of Emergency Operations Centre Complaints Investigator was established towards the end of 2017. This has helped to ensure that low-level investigations are completed within timescale.

During 2016/17 approximately 61% of all complaints were responded to within the Trust's timescale, compared to 63% in 2016/17. However, every week since the beginning of February in excess of 91% of complaints have been concluded within timescale, with 98.2% and 97.7% concluded within timescale in February and March respectively.

Figure 9 Complaints response time performance against the Trust timescale, 2017/18



Governance Area 4
Status of the Complaint

The Trust operates a system of designating a complaint as upheld, or not, once the investigation has completed. This is undertaken by the investigating manager and serves as an indicator as to the degree and severity of the negative experience.

In 2017/18 169 complaints were received about the care provided by our road staff, compared to 241 in

complaints, 50% were deemed to be upheld or partly upheld.

Figure 10 Patient care complaints upheld or partly upheld, by sub-subject

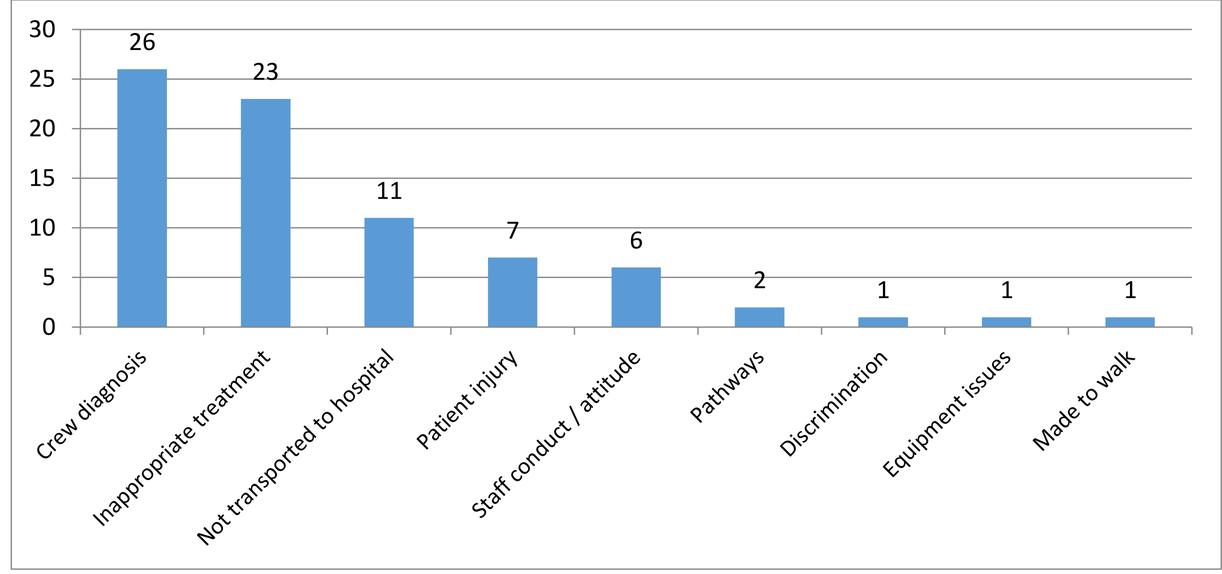


Figure 11 EOC complaints 2017/18 by subject and outcome

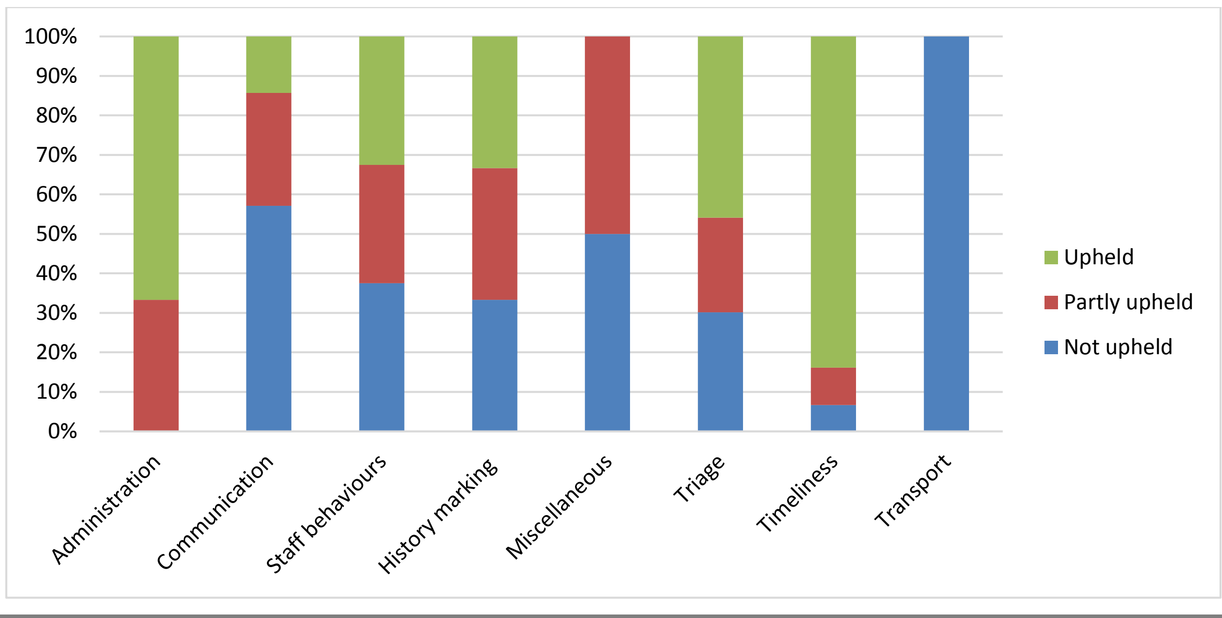
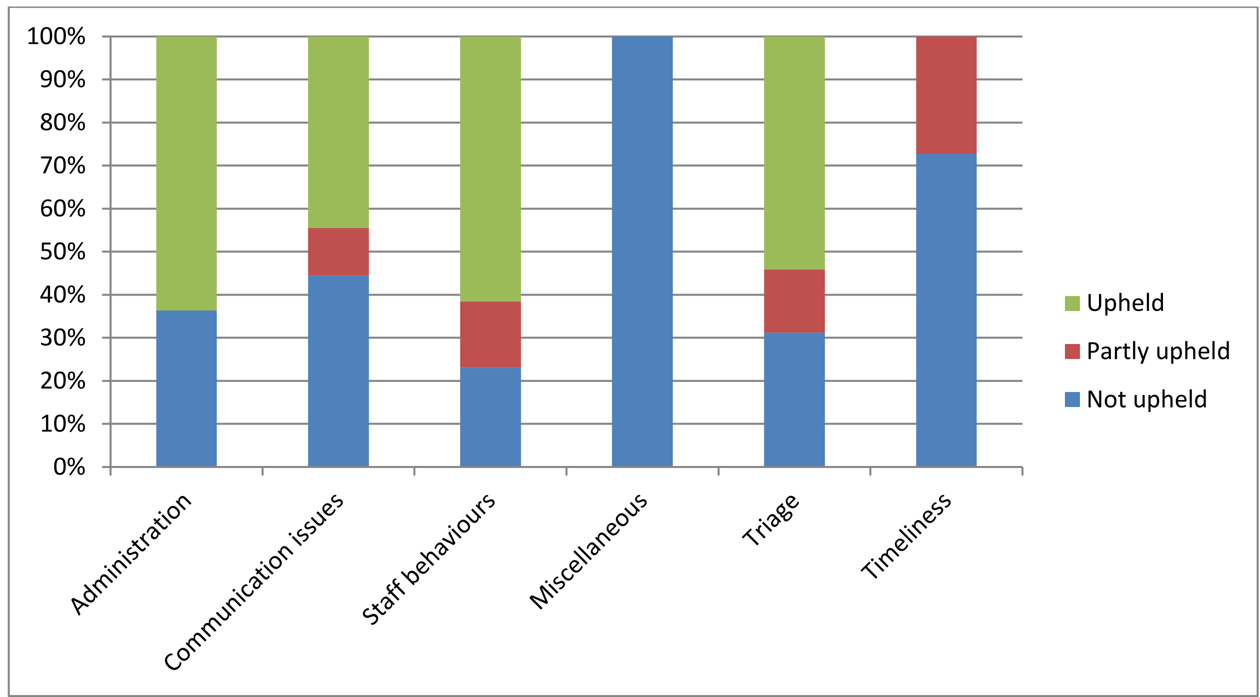


Figure 12 NHS111 complaints 2017/18 by subject and outcome



Quality of complaint responses (Ombudsman)

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

In 2017/18 we were notified by the Ombudsman of 13 cases they wished to have more information about and/or investigate. Of these, two were partially upheld, two were not upheld, and the remainder are still open.

One complaint partially upheld this year (this was also an SI) concerned poor patient assessment, insufficient pain relief and poor attitude, and while the PHSO acknowledged that the Trust had taken action to mitigate a recurrence of the issue, they felt that a more robust apology was required. The other is detailed as the Fifth Complaint Example.

Fifth Complaint Example

One of the complaints partially upheld by the ombudsman in the last year concerned a member of staff who did not treat a pre-obstetric emergency with sufficient urgency. The PHSO acknowledged that further training had been provided for the member of staff concerned, but would like us to provide this for all staff.

Outcome and learning

Although our annual key skills programme has been finalised for this year, in the meantime the Trust has purchased a licence for the Pre-Hospital Obstetric Emergency Training Course (POETs), which is an eight-hour online course and all of our paramedics will be encouraged to complete this. In addition, the Maternity Card developed by the London Ambulance Service for their front line staff will be incorporated into the Trust Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Plus guidance, so that it is available as an aide memoire for our staff. Arrangements have also been made for the Consultant Midwife with the London Ambulance Service to train some of our Critical Care Paramedics in obstetric emergencies so that they can cascade this training to our front line staff.

Patient Advice and Liaison Service (PALS)

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

During 2017/18, the Patient Experience Team dealt with the following PALS enquiries:

Table 4 PALS enquiries 2017/18 compared to 2016/17

	2017/18	2016/17
Concern	61	69
Enquiry	49	63
Request for advice and information	234	62
Total	**344**	194

Subject Access Requests, where patients or their relatives require copies of the Patient Clinical Record completed by our crews when they attended them, or recordings of 999 or NHS111 calls, make up the majority of our information requests. The number of these requests has grown exponentially this year, with a 275% increase against last year. There is a concern that the Trust will receive more requests following the introduction of the new General Data Protection Regulations (GDPR) in May 2018, as currently organisations charge for providing SAR information, but will no longer be able to under GDPR.

Other types of advice and information might include what to expect from the ambulance service, people wishing to know how they can provide us with information about their specific conditions to keep on file should they need an ambulance, calls about lost property, how to highlight patients' difficult to find addresses, and more.

Patient Story to Trust Board 25 January 2018

A number of telephone compliments were presented to Trust Board;

Case 1 "I had three men along last Sunday I think it was when it was very very hot and I couldn't breathe at all. I felt very worried. All I wanted was advice but they came up and were very kind indeed. I don't know their names but I would like you to try and find out and thank them for making the effort to come and see me. I am housebound and I live alone thank you very much anyway for the three men."

Case 2. "Could you tell them how much I appreciate it and the service I got from your people was fantastic. It didn't take them long to get to me and they spent all of the time needed in trying to work out what my problem was. I highly recommend them. Very very good people thank you very much."

Case 3. "I was very impressed with the ambulance service I received when I hurt my foot. They were very kind and very jolly and I couldn't have had better treatment. Thank you very much".

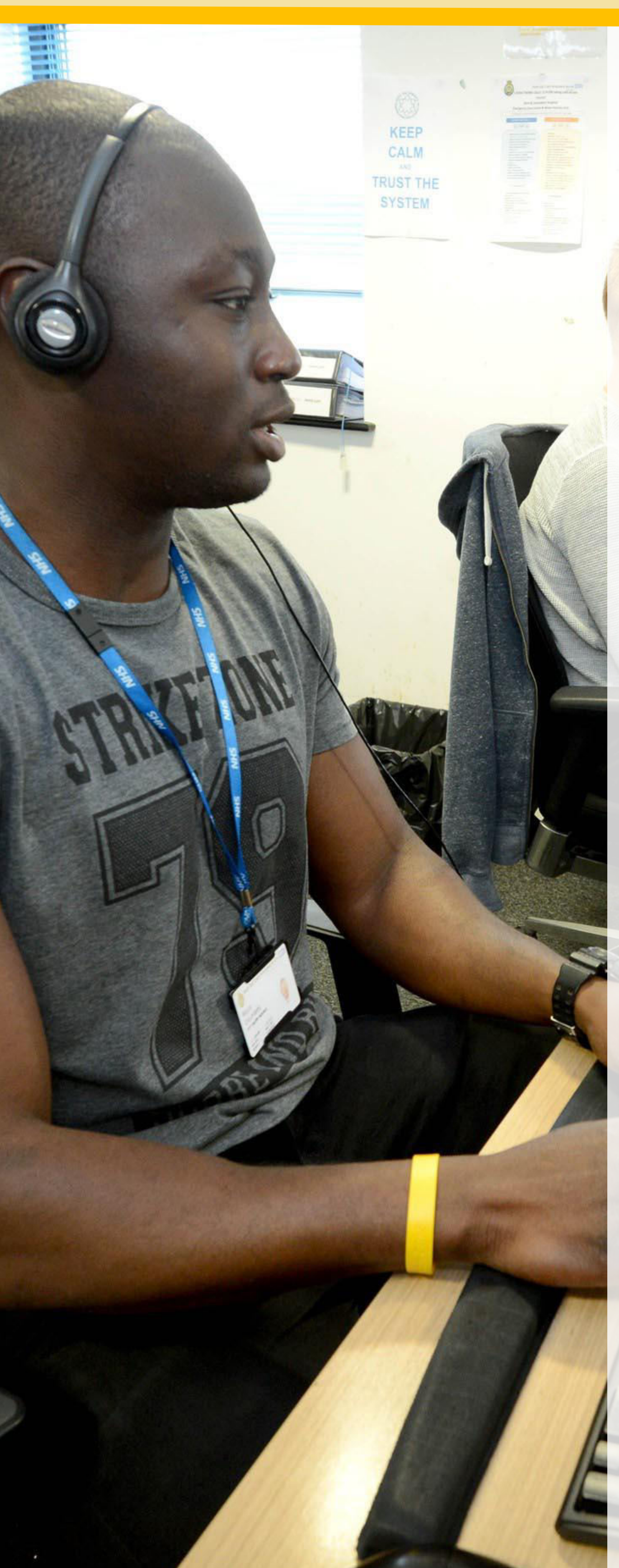
Case 4. "I'd like to say how satisfied I am with the visit. How very kind she was and she did everything to help me and I was really pleased to see her and meet her and to say that I would recommend her to go anywhere anytime".

Case 5. "I called an emergency in the night because I had an enormous nose bleed, because I was on warfarin, and the hospital team came and man and a lady. They were absolutely marvellous they were very friendly very reassuring. They fitted in with me completely and I became great friends with them in the time that they were with me and they took me to the East Surrey and they stayed with me until someone else came to fetch me. I can't speak highly enough for them and I'm most grateful to them for what they did for me."

Case 6 "The paramedic came here today this morning called Henry, extremely polite extremely helpful, and we would recommend him to anybody. I can't say anymore about him at all apart from the fact he was extremely extremely helpful thank you."

Case 7. "They were very pleasant and polite and were very helpful, thank you, bye."

Conclusion



The number of complaints received this year has decreased despite an increase in activity and the issues all trusts are experiencing with response time performance. However, the number of complaints about ambulance delays is too high and comprises a large proportion of the overall total, and the Trust has work to do, in liaison with its commissioners, to improve its ambulance response time performance, as do all ambulance trusts in the current climate of increasing demand and reducing funding.

The Trust's performance in terms of responding to patients within its 25 working day timescale has improved dramatically, with in excess of 91% of complaints responded to within timescale every week since the beginning of February. This improvement is a result of the introduction of the new investigator role of field ops managers at all levels. They have undertaken in-house complaints investigation training over the last six months, and the training has had a positive impact on the quality of complaints investigations and reports as well as the timeliness of their completion.

Progress has been made in terms of ensuring the Trust learns from complaints, and all complaints that are upheld, even in part, must now propose actions to mitigate a recurrence, leading to an improvement in care and services for patients. Finding new and innovative ways to share the learning from complaints will also reduce the likelihood of the problem arising again elsewhere, and will raise awareness among staff of the Trust's ethos of taking positive action as a result of complaints and of the value of complaints as a tool for improvement.

Some new mechanisms for sharing learning have been introduced, however there is still more work to do to consider how best to do this, acknowledging that everyone learns differently, and the recently-established shared learning discussion group is progressing this work.

Finally, the recent introduction of training in root cause analysis, including Duty of Candour, culture, and human factors, alongside complaints investigation training for all of those who investigate complaints, will help to improve the quality of complaints investigations, and should lead to more tailored and appropriate learning outcomes.

Contact us

If you make a complaint, an acknowledgement will be sent to you within three working days of receipt. The Trust aims to respond to you within 25 working days and if this is not possible, we will keep you informed about the reasons why and when you can expect to receive the response.

A complaint may be made by post, by email, by telephone, or by SMS/text, and all contact details are shown below.

Patient Experience Team
South East Coast Ambulance Service NHS Foundation Trust
Nexus House
4 Gatwick Road
Crawley
RH10 9BG

Tel: 0300 1239242

Email: complaints@secamb.nhs.uk   If you have an nhs.net address, please forward concerns to pet.secamb@nhs.net

Text/SMS only - 07824 625370

If you would like help in making your complaint, you can contact a local advocacy service who will be able to assist you. Their service is free, independent and confidential. The name of the provider of advocacy services in Kent, Surrey, West Sussex, East Sussex and Brighton and Hove and their contact details, are listed below.

Brighton and Hove – Impetus provide the Independent Complaints Advocacy Service (ICAS), Tel: 01273 229002, website: http://www.bh-impetus.org/projects/independent-complaints-advocacy-service-icas/

East Sussex – SEAP provide the Independent Complaints Advocacy Service, Tel: 0330 440 9000, website: http://www.seap.org.uk/services/nhs-complaints-advocacy/

Kent – SEAP provide the Independent Complaints Advocacy Service, Tel: 0330 440 9000, website: http://www.seap.org.uk/services/nhs-complaints-advocacy/

Surrey – Healthwatch Surrey provide the Independent Complaints Advocacy Service, Tel: 0300 030 7333, email; advocacy@sdpp.org.uk website; http://www.healthwatchsurrey.co.uk/

West Sussex – The contact details for the IHCAS service are, Tel - 0300 012 0122, email - ihcas@healthwatchwestsussex.co.uk,
Website - http://www.healthwatchwestsussex.co.uk/

Office - Healthwatch West Sussex, Billingshurst Community Centre, Roman Way, Billingshurst. RH14 9QW

Appendix I – Additional Data

National benchmarking: On a quarterly basis the National Ambulance Services Patient Experience Group collates the number of complaints received about their emergency services (field ops and emergency operations centres). These figures are set against emergency activity for the quarter using the 'all calls' figure, and the data for the first three quarters of the year 2017/18 (Q4 was not available at the time of writing) is shown below. It should be notedt hat while some services may appear to be outliers, the numbers are so small as to be statistically insignificant.

A&E complaints against activity for English ambulance services
Q1 – Q3, 2017/18

Service	EEAST	EMAS	LAS	NEAS	NWAS	SCAS	SECAmb	SWAST	WMAS	YAS
A&E complaints	875	1150	686	410	956	418	716	869	817	457
Activity ('all calls' figure)	867185	701373	1234042	371295	1014103	83770	821876	812914	872236	581493
Percentage of activity attracting a complaint	0.10%	0.16%	0.06%	0.11%	0.09%	0.05%	0.09%	0.11%	0.09%	0.08%

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

Complaints received during 2017-18 by subject and service area

	A&E	EOC	NHS111	Other	Total
Administration	2	4	13	2	**21**
Communication issues	7	9	9	2	**27**
Concern about staff	262	33	31	2	**328**
History marking issue	6	5	0	1	**12**
Miscellaneous	10	2	3	3	**18**
Patient care	200	200	107	1	**508**
Timeliness	31	415	17	0	**463**
Transport arrangements	7	1	0	0	**8**
Total	**525**	**669**	**180**	**11**	**1385**

Appendix II – Positive Feedback Examples

I would like to thank the crew who attended and for all they did for my dad. They worked hard and well as a team to resuscitate him and I believe had him breathing on his own when they got him in the ambulance. He was however very poorly and sadly died in hospital. I would particularly like to thank Alex, the paramedic who was first on scene and whose calm professionalism made a stressful time the more bearable. Alex took me to the hospital I will always remember his kindness and care. My dad has had many ambulance calls this year and has always been treated with such kindness and respect. In difficult times and conditions of working where criticism seems to be all you read, I feel that I must express my gratitude for all you do.

Last night I was in severe pain and in desperation, my wife called for an ambulance. Whilst I was in pain my mind was not conducive to kind thoughts, bearing in mind media reports on the failures of the NHS. I felt dread at the anticipated wait. The ambulance arrived within an hour and my fears were unfounded. The crew arrived and immediately brought calm by their quiet and efficient manner. They listened carefully and politely to my explanation of the circumstances. Once I was more comfortable they explained at great length what had probably caused my predicament and how to prevent it from happening again. They conveyed the feeling I was their only patient and it was so reassuring. Their attitude, knowledge and tranquillity were amazing. You have two excellent employees, who, in my opinion are superb ambassadors for the NHS. Please convey mine and my wife's grateful thanks.

I am writing to express my thanks to the paramedics who attended my mother and took her to hospital. They were extremely kind to a very difficult patient and to myself and my sisters, who I am sure will agree with everything in this letter. At one point they could have legitimately said they had done all they could and have left us to cope, but they persisted and decided my mother had insufficient capacity. This meant that we at least had the comfort that she was going to be taken to hospital and looked after properly. They were caring towards the family and I cannot praise them enough. Please make them aware of the content of this letter, we did thank them at the time but I would like them to know about this letter.

I am writing to you to once again praise your kind, dedicated staff who came to my family's aid yesterday morning. Just before 9am my aunt, Elizabeth, called an ambulance as she had tragically found my uncle (her husband) had died during the night. She was with her daughter and her daughter's partner at the time and it was a horrible shock to them, as this was unexpected and sudden. As I was staying across the road at another relative's house I came to find them all with an ambulance crew breaking the tragic news. Both my aunt and I were very impressed with how well the crew were able to switch focus immediately to consoling the family, which they did so perfectly, finding the right balance of rapport and sympathy combined with professionalism. My aunt Elizabeth has been singing their praises all day yesterday and I have no doubt that the way they looked after her has helped her with her grieving process.

I want to say a big thank you for the truly excellent service I received from an ambulance crew on Christmas day. I have a condition that means when I get a vomiting attack it can last for days and it is very important that I receive hydration from the nearest hospital. My father called an ambulance and spoke to a very helpful man on the phone. The ambulance arrived promptly. The crew were absolutely fantastic. They were kind, efficient, patient and extremely knowledgeable. They took me to hospital and treated me with so much respect and care on the way. I would be so grateful if you could trace them and praise them, they are absolutely fantastic at their job. I am much better now thanks to the help of your efficient ambulance service.

I am emailing to thank you for your attendance. I discovered my elderly father unresponsive and fitting. The call handler was really calm and Helpful. Within minutes two crews had arrived to help, everyone introduced themselves. They were all calm and effective and made sure I understood what was going on. My father was very aggressive when he came round and the paramedics handled him with skill and care, making sure I understood why they needed to consider sedation and police involvement. They all made an effort with my 4-year-old daughter to make sure she wasn't frightened; in fact my daughter now wants to be a paramedic. Thank you all for being there when we needed you.

The kindness and consideration shown to my wife after her heart attack was beyond words. If it was ever possible to give those three young ladies a huge hug and kiss for giving me the best Christmas present a man could ever have, I would do so; because of their expertise my wife is with me today. The media and newspapers give you bad press and jump on the bandwagon of poor time keeping and responses but you never hear of the amazing work they do.

Last night I spoke to a gentleman, 111 health advisor, who also called me back at 19:16. I was also passed to a paramedic. May I just say how thankful I am to both the healthcare advisor and paramedic. They got me the help I so desperately needed, stayed with me on the line to make sure I was okay. They kept me talking, and most of all waited until the ambulance arrived. They are a real asset to the 111 service and the NHS as a whole. The bad press that 111 has received certainly doesn’t resemble anything to how last night was handled. I overdosed on two medications, I was freezing cold, and lonely and they got me to safety. I was frightened. Also the ambulance crew who came to my aid are also a real asset. I was worried how I would be judged for taking an overdose, and definitely felt I was a burden. Please can they be thanked, as well. I hope all four people involved last night will be personally identified and thanked on behalf of me and given a good pat on the back.

Firstly, I want to say a global thank you. You are all superstars!! You may not feel like it but you are. Secondly may I thank you personally for the attention you gave my mother at her flat. Your attention is a great comfort to us. You cleaned my mother and made her safe. You looked after her until she was in the hospital. For that, all I can say is thank you. What you do is more than a job, much more. You mean the world to the vast majority of us out here and I know we don't always show our appreciation, just, please, be assured that we do want and need your bravery and dedication.

SECAMB Board

QPS Committee Escalation report to the Board

Date of meeting	06 April 2018
Overview of issues/areas covered at the meeting:	This meeting considered a number of ***Management Responses*** (*response to previous items scrutinised by the committee)*, including: **Mobile Data Terminal (MDT) Action Plan (Partially Assured)** The committee received an update on the actions taken in response to the independent review carried out in 2016/17. The committee felt that the progress in some areas was not adequate, required more thorough documentation or clarity, including whether we have fully discharged our duty of candour. A management response has been requested for May. **NRLS Data (Assured)** The committee received assurance in December that the Trust is submitting its incident data to the National Reporting and Learning System (NRLS), in line with requirements. It asked for a report in April to check this was sustained. The committee is assured by the evidence it received and will seek assurance again in 6 months' time. **OU Management Capacity (Partially Assured)** The committee explored the extent to which there are management capacity issues by OU, following a theme identified in the Q3 quality and safety report. While there are some gaps, these are being managed through acting up roles and it is clear the executive have clear sight on this issue and are taking steps to resolve this. The management structure that has been put in place has had a positive impact in a number of areas, for example key skills, hand hygiene, supervision and appraisal. The committee explored the difficulty in doing everything and, therefore, how managers are supported to ensure focus on the priorities. **Quality Impact Assessments (Assured)** The committee received details of the 3-monthly reviews of each QIA. It challenged management to ensure the all views are taken in to account when assessing the quality impacts. While noting the current process works well, it also explored the resilience of the current structure and the Director of Nursing & Quality will report to the committee in May how this will be reviewed. In summary, the committee is assured that the process is working and that steps are being taken to evolve it further. **Data Availability (Partially Assured)** In February, the committee received the Q3 quality and safety report and asked management to confirm whether the improved data now available is being used at station level to inform practice. The committee noted that new mechanisms have been put in place (Teams A,B,C,D,E)

	to ensure good cascade of data / information to front line staff, and agrees with management that this needs embedding through the divisional governance structure that has been established. This needs to be supported by appropriate technology, balanced with face-to-face time and also work on how the impact of data and communication can be measured. **Medical Equipment (Not Assured)** The response set out how management ensures all equipment is recorded and scheduled for servicing and maintenance. Although the committee is not assured, it is confident that there is an improved understanding of the issues with a clear plan in place to address them, both in terms of short-term fixes and a long-term solution. An update will come to the May meeting with a scrutiny item at the June meeting. The meeting also 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; **Infection Prevention and Control renewed approach (Assured)** The committee considered the new approach to infection prevention and control (IPC) which focusses on being 'infection prevention ready'. A new improvement plan has been developed to support this, which the committee received. A significant shift was noted in hand hygiene and bare below the elbow, which was evidenced by some of the data, e.g. hand hygiene is now above trajectory. The committee is assured with the plan in place and it will look specifically at vehicle IPC at its May meeting. **Community First Responder Governance (Partially Assured)** This paper was well received and helped to set out the work being done to improve the governance to support CFRs. There has been increased focus with an OUM lead and investment to improve the training, provision of equipment, and the management of CFRs, although the committee felt the priorities could be clearer and better communicated to the CFR community. The committee was encouraged by all the work being undertaken. However, it did not have evidence to be fully assured that CFRs are practicing safely and that they are being kept safe. It has therefore asked for a management response in May, to provide this evidence. **Complaints Management (Assured)** The committee considered the presentation given to the CQC as part of the deep dive in to complaints management, and is assured by the good progress being made. In particular, with the sustained improvement in the timeliness of responses to complaints. It noted the next step to further improve how we learn from complaints and ensure complainant satisfaction. With regards the latter, it explored the number of cases referred to the Parliamentary and Health Service Ombudsman. The committee also received the excellent **2018/19 Clinical Audit Plan.** It noted the ambition within the plan and challenged management on whether there is sufficient capacity. Management will confirm at the May meeting whether there are any

	potential resource issues.
Reports *not* received as per the annual work plan and action required	The committee did not receive the following items,; 1. 111 Governance (management response) 2. EOC call answer performance (scrutiny) 3. Committee annual self-assessment These have been deferred to May
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	**Medical Equipment** continues to be a concern, but the committee is now assured that there is focus on the area with a clear rectification plan in place. The challenge is both short term but also assuring a longer-term change cross directorates.
Any other matters the Committee wishes to escalate to the Board	As a matter of routine, the committee now undertakes a review of any risks that have emerged during the meeting. It then asks management to confirm at the next meeting that they are properly reflected on the risk register. The risks identified at this meeting included: 1. CFR governance, e.g. recruitment and standards of practice. 2. CFR engagement 3. Not closing fully all the actions agreed following the MDT review. 4. Non delivery of the clinical audit plan - linked to capacity 5. Impact of not receiving quality and timely papers on governance.