South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

25 May 2018
10.00-12.15

Crawley HQ

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
Introduction					
20/18	10.01	Apologies for absence	-	-	GC
21/18	10.02	Declarations of interest	-	-	GC
22/18	10.03	Minutes of the previous meeting: 26 April 2018	**Y**	Decision	GC
23/18	10.05	Matters arising (Action log)	**Y**	Decision	GC
24/18	10.10	Patient story	-	Set the tone	
25/18	10.20	Chief Executive's report	**Y**	Information	DM
Risk Management					
26/18	10.25	Board Assurance Framework Risk Report	**Y**	Decision	PL
Trust strategy					
27/18	10.35	Delivery Plan Including Deep Dives: • H&T • Medical Devices • Culture	**Y**	Assurance	DM JG FM EG
Quality & Performance					
28/18	11.00	Quality & Patient Safety Committee Escalation Report	**Y**	Assurance	LB
29/18	11.05	Workforce & Wellbeing Committee Escalation Report	**Y**	Assurance	TP
30/18	11.10	Integrated Performance Report	**Y**	Information	SE
Governance					
31/18	11.30	Audit Committee Escalation Report	**Y**	Assurance	AS
32/18	11.35	Learning from External Reviews	**Y**	Decision	BH
33/18	11.45	Paramedic Re-Banding	**Y**	Assurance	EG
34/18	11.50	External Governance Review – Management Action Update	**Y**	Assurance	PL
35/18	12.00	Board Committee Annual Review	**Y**	Information	PL
36/18	12.05	Register of Interests / Fit & Proper Persons Test	**Y**	To Note	PL
Closing					
37/18	12.10	Any other business	-	Discussion	GC
38/18	-	Review of meeting effectiveness	-	Discussion	ALL

Close of meeting

Date of next Board meeting: 28 June 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,
26 April 2018

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

Present:

Graham Colbert	(GC)	Interim Chair
Daren Mochrie	(DM)	Chief Executive
Adrian Twyning	(AT)	Independent Non-Executive Director
Alan Rymer	(AR)	Independent Non-Executive Director
Angela Smith	(AS)	Independent Non-Executive Director
Bethan Haskins	(BH)	Executive Director of Nursing & Quality
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

01/18 Apologies for absence

GC thanked Richard Foster for the work he did over the past year as Trust Chair, and thanked the Council fo Governors for appointing him as Interim Chair.

GC welcomed members and observers and, in particular, BH to her first board meeting.

There were no apologies.

02/18 Declarations of conflicts of interest

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

03/18 Minutes of the meeting held in public in March 2018

The minutes were approved as a true and accurate record.

04/18 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.

05/18 Patient story [10.01 – 10.10]
This a story from a patient who had a positive outcome following a cardiac arrest. The EOC were supportive in providing instructions on CPR until the crew arrived.

AR commented on the term mentioned in the video; chain of survival and also reference to HEMS. FM confirmed that HEMS are used when there is some distance from the incident to hospital. She then explained that as described in the cardiac arrest strategy, the chain of survival is a series of links from the call for help to treatment. The first couple of links are most critical, i.e. recognising the need for help and early CPR. It is therefore really important we answer calls quickly. It takes a system to save a life and the video helped to illustrate this.

06/18 Chief Executive's report [10.10 – 10.17]
DM highlighted the issues set out in the paper. He thanked Richard Foster for his support over the past year and also Surrey and Sussex Heatlhcare NHS Trust, for the buddy support it is providing.

LM asked about the meeting with MPs and DM explained they were interested in how we were engaging with the wider system. SE added that it was a good session and we took the opportunity to highlight the chain of survival and the need for the system to respond to the challenges and how this could ease some of the pressures. TH and GC confirmed that overall the MPs were very supportive of the service.

07/18 Delivery Plan [10.17 – 11.18]
SE signposted members to the changes made to the narrative part of the report. Some areas are red and management continues to work with commissioners on the demand and capacity review and delivery of ARP. This is drawing to conclusion and it is showing there is a resource requirement to enable the Trust to deliver ARP. Once signed off, the workforce plan will inform the demand and capacity modelling in order to confirm the trajectory.

The Board asked about the areas in Red:

- ECPR – DH explained that we continue the market testing exercise and will bring a full evaluation and next steps to FIC and then to Board in May.

- Medical Devices – FM confirmed it is early in the project and expects it to move to Amber during May and Green in early June. It is the CQC deep dive in June.

The Board then received details of the delivery plan deep dives:

Culture
EG talked to the slides in the paper. In terms of a fit for purpose HR, the first priority is looking at the end-to-end resourcing process. Two consultants are being brought in to help design the HR function to deliver the workforce plan and help ensure all processes are designed in a way that are efficient and effective. We will also look at the OD design and resource needed.

The second priority is about pre-appointment screening and ensuring good staff record keeping.

In terms of the workforce plan, there are two elements. The first is to meet the needs as part of demand and capacity review and the second is to plan for the interim circa 6 months.

It is critical we ensure the culture change is led with grip and pace. The associate director of HR is working full time for the next 9 months on this. The priority is to develop a new mandate to ensure the right level of plans and alignment of all the workstreams, including wellbeing and inclusion. Important too to ensure we clalrify the culture we are moving towards, i.e. inclusive, attractive, effective and safe. This will inform the people strategy, which is under development.

In addition, there has been much work over the past four months to redefine the values and behaviours. The launch of the values will be done in an integrated way.

Progress to date includes:

- Executive and SMT 360 degree feedback.
- Coaching sessions for Executive and SMT.
- Started the leadership development modules.
- Executive coaching day and Board development sessions.

The Board was invited to ask questions.

AS asked whether we could be more explicit, i.e. compliance with policy / standards. EG responded that linking policies to standards is the effective part of the organisational culture, and we need to make it easier for staff to comply, which includes having clear and easy to use policies and procedures.

AR was encouraged by the clarity of thinking and the progress being made, but noted the delivery plan is showing as Red, suggesting areas we need to work on. EG agreed; we need to reframe the culture programme to give us clearer things to track. Some infrastructure needs review, e.g. to attract and retain staff. Some of this will be through line manager support.

AT referred to the vacancy rate of 13% and turnover of 18%, and asked when the executive will feel the initiatives will make a practical difference to the KPIs and how the Board support this. He acknowledged some things are tactical and wondered whether we need more strategic thinking. EG confirmed that there will be a mix of tactical and strategic. The three components which the Board will have oversight of will include:

1. Revised people strategy – to come via WWC to Board
2. HR delivery plan will have operational and strategic components
3. Workforce Plan coming to WWC in May.

TP added that WWC had a pre meeting recently and the committee has more confidence now in the executive in terms of its understanding of the issues and the plan to address them. The level of scrutiny referenced will be delivered through WWC.

DM added that we have been playing catch up and we are now much clearer about what we need. Priorities are the workforce, and we are getting on with filling critical posts, and EOC, where we are clear on the workforce trajectory, especially with EMAs. On the road we have carried a number of vacancies and there is much work ongoing to ensure we fill the baseline. Whatever is then needed post the demand and capacity review will be brought to Board through WWC.

999 Call Handling

In terms of progress against objectives JG explained that we have delivered 100% of the number of NHS pathway trained clinicians to remain NHS pathway compliant. However, the project remains red as we have

not yet recruited the clinicians to support the increase in hear and treat. JG outlined the steps being taken to recruit and train clinicians, including the introduction of the Manchester triage tool; a decision support tool. This enables us to be more dynamic in how we can resource the EOC with clinicians. Some feedback to-date is that clinicians are willing to work in the EOC periodically, but not all the time.

We are pushing recruitment of EMAs. We have had a high attrition and between February and March we lost 40 WTE (some moved to different roles, e.g. dispatch or ECSWs), and so have mobilised accordingly; we are now up to the 171 establishment and aiming to give more headroom. This has helped us deliver the April trajectory for call answering – over 80%.

Project also includes compliance of NHSP audits. These trajectories are being met with the aim of 100% by June 2018.

DM added that the EOC leadership team has done a huge amount of work to make the improvements JG has outlined. DM chairs the intensive support group and is confident in the pace and grip of this improvement plan. We need to sustain it and learn from how we got to this position.

The Board was invited to ask questions.

AT reflected his recent experience of the EOC and surprise by the intensity of the EMA role; one of the most important yet least paid. JG confirmed the work being done to improve the EOC career structure, including the acceleration through the pay bands.

The Board explored the apparent mismatch between the role and how it is remunerated and acknowledged the other factors too, such as working environment. JG outlined some of the steps to improve the latter, to help lessen the intensity.

LB confirmed that QPS has been tracking call answer performance closely. Meeting the trajectory is really positive. A paper is due at the next meeting about EOC performance and its link to patient safety.

On the Manchester triage tool FM confirmed that this supplements NHS Pathways. NHSP is for EMAs and is very scripted. The Manchester triage tool is used in ambulance services for registered health care professionals as a framework for asking questions. They then use their clinical expertise to decide on the course of action for the patient.

CQC Inspection Preparation
The paper was taken as read and the Board was invited to ask questions

TM felt that it was really helpful to see the progression. IBIS is still red and could we next time have more assurance on the timeline / progress.

TH asked about culture, which is flagged as red, yet in terms of progress we are moving along and so does the rag-rating underplay this. DM confirmed that once some of the steps are taken it will move to Amber.

There was also come challenge about whether the progress in some areas is over-stated.

In terms of CQC preparation, BH explained the PIR has been completed and submitted. A huge amount of work went in to this and she thanked the business support managers for their support and coordination. The return was quality assured internally and via NHSI Improvement Directors. The next steps include working on the gaps identified through this work, which EMB will consider at its next meeting.

In addition, we are working on a detailed plan to prepare for the inspection to ensure people are well prepared. We are awaiting the date of the inspection and our best guess is that it will be in July.

08/18 Risk Report / BAF [11.18 – 11.43]

BH took the Board through the risk report, noting the vastly improving picture. There is lots more to do, but we are much better placed than before. The recent exceptional audit committee received details of how each extreme risk has reviewed by the head of risk and company secretary to help moderate some of the scoring. In addition, 44 review meetings with management groups has taken place to ensure risk is on agendas and being managed. All risks are now aligned to an operational group, and board committee (for oversight). The Policy has undergone substantial change and is now out to consultation.

AS confirmed that risk management is always a journey and we have made considerable progress since the start of the year. The risk register is bottom up, which raises challenges in terms of how risks are described and rated. AS felt that we should not take too seriously how risks are scored as this is work in progress. Instead, the important thing is that the risk management process has been designed, and starting to embed. Therefore, the risk profile is expected to change.

AS reflected that when you start to get to grips with risk you focus on the red-rated risks. However, when you mature you look at those rated green; the risks you think you have managed, and those not on the register at all. Currently, there is inconsistent risk scoring, and to enable better comparison against other NHS trusts we use the same risk scoring matrix.

TM thanked the team for their work, in building solid foundation to ensure the right systems and process to manage risk well.

The Board then discussed the BAF risks, and PL set out the approach. The Board agreed the key thing is that the BAF should convey the key risks and in light of some directors feeling there might be some gaps, the Board agreed to hold a workshop before the June meeting to ensure the Board is behind the risks included in the BAF.

Action:
Board workshop to be scheduled in June to agree the BAF risks

Break 11.43 – 11.55

09/18 IPR [11.55 – 12.15]

SE explained the change to the reporting schedule to allow more time for the executive to consider the data and provide better narrative. The report therefore includes the same data as last month. The aim is to use this report to have a more forward view.

JG explained the improvement in operational performance. In the previous week we missed mean Cat 1 by 14 seconds. We delivered the 90th centile and for both Cat 1 and Cat 2. Cat 3 and Cat 4 is showing some improvement although there is work to do, linked to the demand and capacity review. Call answer time has significantly improved; in the previous week we achieved 88.4% and April to-date is 83% (within 5 seconds). This improvement within the EOC is due to additional scrutiny in people, process and technology.

In summary, we are prioritising acutely unwell patients, and this group of patients are getting a timely response. The challenge is in Cat 3 and Cat 4, due to available capacity.

The Board discussed the hours we put out each day, which pushes the limit of affordability and links to what we are commissioned. The work with commissioners is helping to establish the resource needed to meet demand. Currently we put out circa 63,000 hours per week and the demand and capacity review is showing a need for 70,000. Our discussions are therefore based on how this is achieved.

The Board noted that 111 indicators are still red and JG confirmed that the 111 team is working through its recovery plan. It had a better Easter and there is an improving position. The expectation is that it will meet is targets by Q2.

In terms of finance, DH confirmed that the year-end was submitted in time. The Trust achieved its control total of 0.9m deficit, which is positive although means we are still a deficit trust. Some funds came through from the centre, which puts us in surplus. We repaid our overdraft and so are in a better cash position and the revised capital projection was achieved as was the CIP and agency cap.

10/18 Safeguarding Annual Report [12.15 – 12.19]
BH confirmed that this annual report is for Board to endorse. It will then be published. BH explained that much has been achieved in the past year and highlighted from the report two areas; resource capacity and training. On training BH felt this was a great achievement and probably the best across all ambulance services.

The Board endorsed the report.

11/18 Patient Experience Annual Report [12.20 – 12.34]
BH highlighted the huge amount of work to improve timeliness for complaints. The Board endorsed the format of the report, with the theme of learning running through it. It asked management to consider how we might use this as a template for other annual reports, to ensure consistency.

There was a discussion about the need for commentary on some of the peaks highlighted in the report and some of the differences, e.g. 111 between Ashford and Dorking.

Action:
QPS to undertake a trend analysis for complaints.

The Board then explored how we encourage staff to undertake training outside of key skills, when issues arise from complaints.

The Board endorsed the report.

12/18 Paramedic Re-Banding [12.34 – 12.34]
EG confirmed that we are in process of a self-assessment process to identify training needs. A paper will come to Board in May.

13/18 IG Annual Report [12.34 – 12.40]
BH highlighted the themes from the report, including the achievements and actions to be taken.

There was a request from the Board to have some clarity on timelines, in particular on page 11 relating to records management; do we have adequate resource? TP confirmed this is on the WWC agenda for its next meeting.

Overall, the Board felt it was a good report but noted the areas needing to be improved.

Action:
The Audit Committee to provide deeper scrutiny of the internal controls relating to information governance.

GC asked DH for an update on cyber security. DH confirmed that we received £700k NHS Digital funding to enhance our cyber security and work will complete in May. Most of this includes patching and replacing older hardware. We are on track with work.

The Board endorsed the IG annual report.

14/18 **GDPR Update** [12.40 – 12.42]
BH assured the Board on the work ongoing. She explained that we have an action plan in place, including a privacy notice. Some final tweaks are needed to the policy, awaiting Royal Assent. We are on track to be compliant and are working with other ambulance trusts.

Action:
The Audit Committee to receive an update of the GDPR action plan at its meeting in July.

Action:
SE to confirm who the General Data Protection Officer is.

15/18 **QPS** [12.43 – 12.50]
LB outlined the work of the committee at its last meeting, confirming the areas of assurance received, as set out in the report.

No questions

16/18 **AUC** [12.50 – 12.51]
AS confirmed the committee met in workshop-mode looking at the progress with risk management. Feedback was provided as discussed earlier.

No questions

17/18 **Any other business**
DM confirmed that the independent health and safety review is due to conclude in the next few days and a summary will be provided to the WWC.

TP reflected that we have seen a number of annual reports, which highlight good progress in training (an area the Board asked to be prioritised), and wondered if there is a demonstrable link with this to some of the improvements.

18/18 **Review of meeting effectiveness**

There being no further business, the meeting closed at 12.55

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

Date _____

South East Coast Ambulance Service NHS FT action log

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
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	195 5	The Board will receive a further update on the actions taken in response to the Bullying & Harassment Report.	EG	June	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	Ongoing
27.03.2018	199 7	WWC to consider the outcome of the health and safety review/deep dive.	BH	July	WWC	IP	To be scheduled for the meeting in July
26.04.2018	08/18 8	Board workshop to be scheduled in June to agree the BAF risks	PL	June	Board	C	Held on 19.05.2018
26.04.2018	11/18 9	QPS to undertake a trend analysis for complaints	PL	TBC	QPS	IP	
26.04.2018	13/18 10	The Audit Committee to provide deeper scrutiny of the internal controls relating to information governance.	PL	TBC	AUC	IP	
26.04.2018	14/18 11	The Audit Committee to receive an update of the GDPR action plan at its meeting in July.	PL	July	AUC	IP	
26.04.2018	15/18 12	To confirm who the General Data Protection Officer is.	SE	May	Board	C	

Key

- Not yet due
- Due
- Overdue
- Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	25/18

Name of meeting	Trust Board	
Date	25.05.2018	
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.	
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 April and May 2018.

2. Local issues

2.1 Recruitment to the Executive Team

2.1.1 We are holding interviews shortly for the substantive Executive Medical Director post. I hope to be able to provide an up-date regarding an appointment shortly.

2.2 Interim Chairman

2.2.1 Following Richard Foster's decision to step down as Chairman on health grounds, I am pleased to confirm that the Council of Governors appointed Graham Colbert as Interim Chairman on 25 April 2018.

2.2.2 Graham, who will serve as Interim Chair until a substantive appointment is made by the Council of Governors, has been a Non-Executive Director with SECAmb since 2012. He was previously Deputy Chair and I know has the skills and experience to support the Trust as we continue our period of improvement.

2.2.3 I would like to thank him for agreeing to serve as our Interim Chair and look forward to working with him over coming months.

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 23rd April 2018, I was delighted to meet with members of the four Retirement Associations who cover our region, when they held their first joint meeting at Crawley HQ.

2.3.2 During their visit, members of the Association enjoyed a tour of the new EOC, as well as discussing how they can continue to support their many members and feel well connected to SECAmb today. I look forward to attending their future meetings whenever I can.

2.3.3 On 11th May 2018, the Interim Chairman and I held one of our regular meetings in Surrey with the Right Honourable Jeremy Hunt MP, the Secretary of State for Health & Social Care. Our meetings are a good opportunity to discuss issues relating to his constituency (South West Surrey), as well as broader regional and national issues.

2.3.4 During our meeting, we discussed the improvements being made across the Trust including our response to the new Ambulance Response Programme, Winter and Stroke. Mr Hunt acknowledged the efforts of our staff in continuing to provide a

good service overall to our patients, despite high levels of demand and asked me to pass on his thanks to them.

2.4 Royal Visit

2.4.1 On 8th May 2018, I was extremely proud to welcome HRH The Countess of Wessex to Crawley when she officially opened our Emergency Operations Centre and Trust HQ.

2.4.2 The Countess was accompanied by the Lord Lieutenant of West Sussex, Mrs Susan Pyper and we also welcomed The Mayor of Crawley, Councillor Brian Quinn, Chief Executive of Crawley Borough Council, Natalie Brahma-Pearl and Crawley MP, Henry Smith to our HQ.

2.4.3 During her visit, The Countess was given a tour of the EOC where she met and spoke with emergency medical advisors, dispatchers and clinicians. She then unveiled a plaque and made a short speech in front of dozens of our staff.

2.4.4 I understand that The Countess thoroughly enjoyed her visit and appreciated the opportunity to spend time with our staff, learning more about the services we provide.

2.4.5 The visit was a real celebration and gave us an opportunity to pay tribute to all of our staff, right across the Trust, who are committed to providing the very best care to our patients. It also received significant positive local and regional media coverage.

2.5 Executive Management Board (EMB)

2.5.1 The Trust's Executive Management Board (EMB), which meets weekly, is a key part of the Trust's decision-making and governance processes. I thought it may be useful to include a regular, brief update on the work undertaken through the EMB moving forward.

2.5.2 As part of its weekly meeting, the EMB regularly considers quality, operational (999 and 111) and financial performance. During recent weeks, the EMB has also:

- Spent time focussing on the potential forthcoming CQC Inspection, reviewing the on-going work underway to address issues identified previously by the CQC, ensuring that preparations are in hand and ensuring that Executive Directors support this preparation in the most effective way
- Reviewed a number of projects underway within the Trust, to ensure staff are focussed on the right areas, given the capacity needed to deliver our strategic goals
- Considered the progress and benefits being realised by the Trust's Wellbeing Hub, which was initially introduced as a trial in December 2017. Given the positive feedback by staff, the EMB have agreed in principle that the Wellbeing Hub should be made permanent.

2.6 Improving the culture of the Trust

2.6.1 During recent weeks, we have continued to see much work underway as part of the broader programme to improve the culture of the Trust and make the

organisation a better place to work for everyone. This includes individual coaching sessions for Directors and other senior leaders utilising 360-degree feedback provided by peers and by direct reports. Feedback such as this is key to making improvements and I know will have a real impact as we move forward.

2.6.2 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.

2.6.3 I have also been very pleased to see lots of work underway to develop a new set of values and behaviours for us all to work to, which will be officially launched in June 2018. This has included a competition for staff to design a new set of logos to represent the values visually and I was delighted to see more than 350 staff help to choose the eventual winner.

3. Regional issues

3.1 Launch of Maternity Advice Line

3.1.1 9th May 2018 saw the multi-agency Maternity Advice Line formally launched at Crawley by Baroness Cumberlege, former Health Minister and author of the 2015 NHS England Better Births review.

3.1.2 The 24/7 advice line has been providing support to pregnant women within the Surrey Heartlands area (under the care of Royal Surrey County Hospital, Ashford and St Peter's Hospitals and Epsom and St Helier Hospitals) since 9th April 2018. It enables women to access advice and support from a midwife during pregnancy, labour and following the birth of their baby. The midwives providing the service are based in the West EOC, working closely with our own EOC staff.

3.1.3 The feedback from the launch event was extremely positive and was filmed by ITV – thank you to everyone involved in developing and launching this initiative.

3.1.4 This is a fantastic initiative and a good example of partnership working across the healthcare system. I am delighted that we are able to host it here and look forward to seeing how it will work over coming months to benefit our patients.

4. National issues

4.1 Nothing to note

5. Recommendation

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

Daren Mochrie QAM, Chief Executive

20th May 2018

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	26/18

Name of meeting	Trust Board
Date	25 May 2018
Name of paper	Board Assurance Framework Risk Report
Responsible Executive	Executive Team
Author	Peter Lee, Company Secretary
Synopsis	On 18 May 2018, the Board held a workshop to identify and confirm the risks that should be included within the BAF Risk Report. The risks agreed during the workshop are set out in this paper. Over the next couple of weeks, the executive leads will ensure the risk register is updated, accordingly, and each risk will then be set out in the template (Appendix A). The completed risk report will then come to the Board in June 2018.
Recommendations, decisions or actions sought	The Board is asked to agree the risks to be included in BAF risk report.

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**

Board Assurance Framework- Risk Report

1. Background

In April 2018, the Trust Board received a revised BAF risk report, which drew risks from the risk register in order that the report reflected both the bottom up and top down view of risk.

The Board felt that more work was needed to ensure all the relevant risk were captured and so agreed to hold a workshop. This took place on 18 May and included the Chair, plus six NEDs, two executive directors, and the company secretary. The Trust's NHSI Improvement Director also attended.

Prior to the workshop, each director was asked to confirm their view of the top risks. Unsurprisingly, a number of themes emerged. The Executive Management Board considered the themes and suggested provided its collective view of the risk to be included.

2. BAF Risks

The risks proposed to the Board for inclusion in the BAF risk report are listed in the table below. This includes the risk escalated by QPS on 21 May. Between now and the board meeting in June, the executive leads will update the risk register and summarise each risk using the agreed template (Appendix A).

Theme	BAF Risk	Goal	Lead	Board Oversight
Staffing	Risk that we will not delivery the planned workforce as a result of; • Inability to recruit to the current gaps • retain current staff • Inability to recruit to the future needs Due to; • not having optimal HR support functions • not having optimal education and training Which may lead to poor patient (and staff) outcomes and experience, and not meeting national performance targets.	Our People	Director of HR	WWC
Culture	Risk of not improving the culture and behaviours within the Trust, as a result of; • Not embedding the Trust's values and behaviours • Poorly developed leadership and management styles Which may lead to low staff morale, issues with retention, adverse impact on patient care and reputational damage.	Our People	Director of HR	WWC
H&S	Risk that we do not comply with H&S legislation as a result of sub optimal infrastructure and governance, which may lead to harm to staff and related sanctions on the Trust and / or individual directors.	Our People	Director of Nursing & Quality	WWC
Safe Recruitment	Risk that the Trust is not able to always provide evidence of the relevant pre-employment checks, as a result of inadequate internal controls / record keeping, which may lead to sanctions and reputational damage.	Our People	Director of HR	WWC
EOC	Risk that we do not answer at least 95% of 999 calls within 5 seconds as a result of; • non-delivery of the planned workforce [see separate risk on staffing] • design of the processes and technology within EOC Which may lead to patient harm due to delay in providing care and treatment	Our Patients	Director of Operations	QPS
Care & Treatment	Risk that the Trust does not meet the fundamental standards of care (as set out in section 2 of the Heath & Social Care Act 2008 (Regulated Activities) Regulations 2014), as a result of in effective leadership, policies and internal controls, which may lead to patient harm and being in	Our Patients	Director of Nursing & Quality	QPS

	breach of CQC registration / Provider License.			
111 (current)	Risk that the Trust does not achieve operational standards for 111 as a result of increased pressure on the service, which may lead to patient harm.	Our Patients	Director of Operations	QPS
ARP	Risk that the Trust does not achieve ARP standards as a result of insufficient resources (to be broken down in the controls / actions, i.e. lost hours, fleet, money, 111 / OOH etc.), which may lead to patient harm.	Our Enablers	Director of Operations	FIC
IT	Risk that IT does not enable delivery of services as a result of; • System development maturity and integration not achieved a right pace • Ability to respond to a major cyber crime Which may lead to inability of delay to provision of care	Our Enablers	Director of Finance & Corp Services	FIC
Governance	Risk that the Trust does not adhere to Information Governance requirements and standards as a result of inadequate systems, resourcing and controls, which may lead to sanctions from the ICO and reputational damage.	Our Enablers	Director of Strategy (SIRO)	AuC
Resilience	Risk that the Trust does not have appropriate business continuity plans, which may result in non-delivery of service(s)	Our Enablers	Director of Operations	AuC
111 (future)	Risk of not being able to mobilise for / exit from the 111 contract as a result of delay and differential timelines of procurement, which may lead to clinical harm, financial loss, adverse pressure on 999 and the Trust not meeting its strategic aim of integration.	Our Partners	Director of Strategy	FIC
Change	Risk that the Trust is unable to influence system change as a result of; • Capacity to engage with STPs and system partners • Complexity of the environment, e.g. STPs at different stages Which may lead to non-delivery of the Trust strategy.	Our Partners	Director of Strategy	Board

Appendix A
(Template)

Goal	Risk ID	Date risk opened:

Underlying Cause / Source of Risk:	Accountable Director	
	Scrutinising Forum	
	Inherent Risk Score	
	Residual Risk Score	
	Risk Treatment (tolerate, treat, transfer, terminate)	
	Target Risk Score	

Controls in place (what are we doing currently to manage the risk)

Gaps in Control

Assurance: Positive (+) or Negative (-)	Gaps in assurance

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.

Last update		Last considered by the Board	

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	27/18

Name of meeting	Trust Board
Date	25 May 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	The Board is asked 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

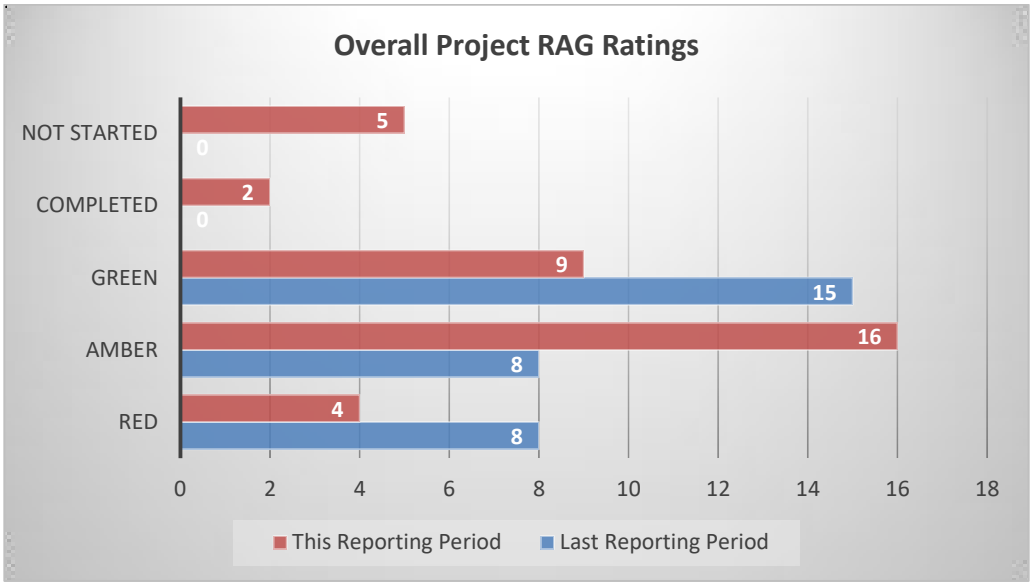
1.1 The Dashboard gives high level commentary and associated Key Performance Indicators (KPIs) for this reporting period where appropriate. As projects come to completion the reader should note that project closure processes will be enacted to ensure that continued and sustained delivery moves into Business 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.

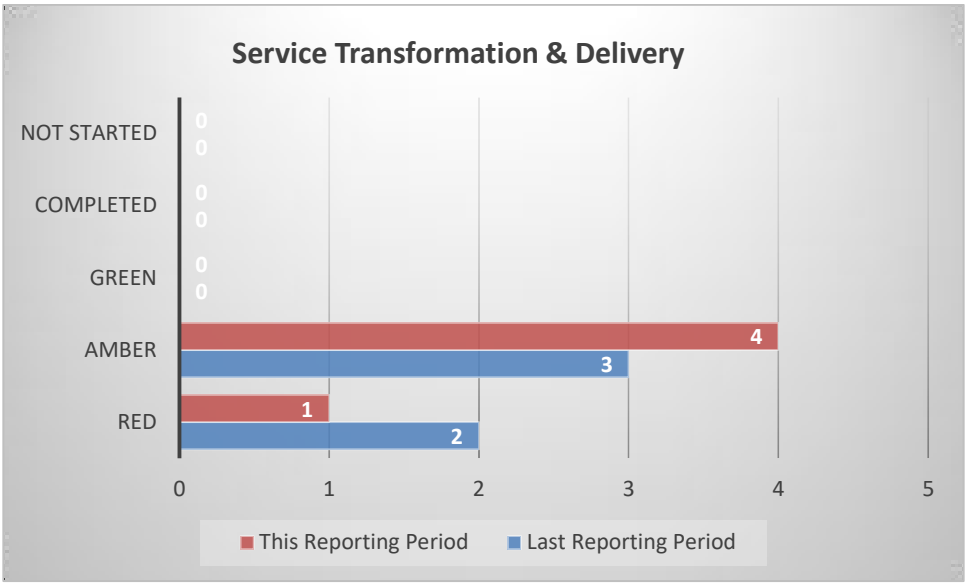
1.3 The Delivery Plan Dashboard (Appendix A) provides a summary of progress within this reporting period. For information the RAG status is defined as follows:

- 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. (Please note additional projects have been added since the last Report)



Service Transformation & Delivery



2.0 **Hear and Treat** – The project RAG for this remains at Red due to the numbers of clinical supervisors in post in EOC remaining static. Recruitment of Clinical Navigators and Clinical Managers is now underway. Discussions with HR has also recently commenced to recruit specifically to use the Manchester Triage System model.

The expectation is that this project will move to **Amber** towards the end of September 2018 following the realisation of benefits from the Clinical Framework and we can demonstrate an increased capacity of the clinical supervisors in post in EOC.

NHS Pathways compliance for recorded clinical support to call handlers continues to remain 100% NHS Pathways licence compliant with an NHS Pathways Accredited clinician in EOC at 24/7.

Development of the Audit infrastructure in line with the EOC Task and finish continues to show Clinical EOC NHS Pathways Audit meeting trajectory forecast for clinical audit compliancy metrics.

The official launch of the Surrey Heartlands Pregnancy Advice line (ShPA) in partnership with Surrey Heartlands and Better Births on the 9th May 2018 was completed and received by NHSE and CCG providers positively - It was identified within first 4 weeks of activity 2500 calls were taken to the line, with 86 interactions in Ambulance dispatch from the midwife team to both EOC and front line road staff across the trust region. These resulted in 34 ambulance downgrades with 30 resulting in an alternative resource allocation and ambulance stood down.

2.1 **Demand and Capacity Review** – The project remains RAG rated Amber. The Demand and Capacity review is nearing completion with Deloitte and ORH working to create a delivery trajectory to compliance with ARP standards at the time of writing. The review will also be considering modelling of the EOC as well as ARP compliance. As such, modelling will be subject to sensitivity analyses across a number of areas in order to set out short, medium and longer term delivery profiles to full ARP compliance. In tandem with this modelling (on the selected targeted dispatch option), work continues to develop

potential contracting approaches (our discussions have shown a commitment by all parties to support the selected delivery profile for its full duration) and plans to engage wider stakeholders in the results of the review. The review is on track to deliver its draft report by the end of May and subsequently generate a final report in June this year

2.2 **ARP Demand and Capacity Delivery** – The project remains RAG rated Amber. Workforce for each grade have now been modelled by quarter by Operating Unit (OU) to Q1 2021/22. This information is being used by Deloittes as part of the Demand & Capacity Review.

Meetings are currently taking place with each OU Manager during May to establish a recruitment pipeline to meet the requirements of the workforce assumptions provided by Deloittes. The principle risk of not recruiting sufficient staff is being mitigated by developing local OU recruitment plans. The output of these meetings will be the publication of a strategy (early June) which will describe the activities to ensure the workforce numbers meet the Demand and Capacity review requirements.

During June 2018, it is anticipated that a similar process will be followed for vehicles with a Fleet strategy published in July.

2.3 **Hospital Handover –** The project RAG remains at Amber. The project has been extended to March 2019 as an acknowledgement that more time is needed to successfully undertake this programme. A national objective has recently been set to have no hospital handover delays >30 minutes by September. Six hospital trusts within SECAmbs area have been offered additional support by NHSI to achieve the objective. There is good engagement from the majority of Acute Trusts but there are considerable system wide pressures that are impacting on patient flow and trusts ability to reduce handover delays to meet this target.

Reports with granular detail around Crew to Clear times have been provided will be sent out to managers with communication to support their use. The prompt at 10 minutes to airwaves handset is now in place. Delays with the introduction of both of the report and the prompt have had an impact on meeting the Crew to Clear target by March.

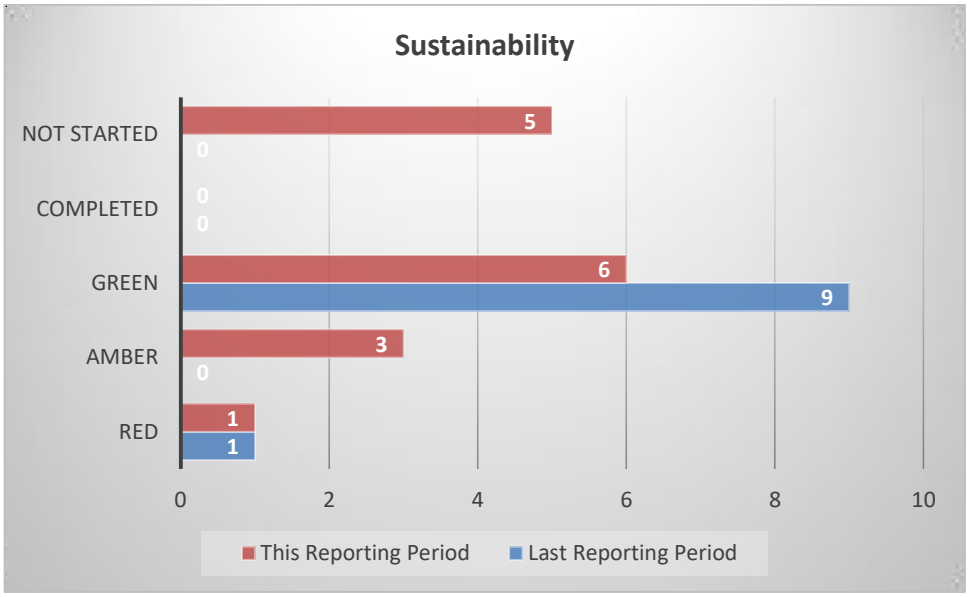
2.4 **National Ambulance Resilience Unit** – The project continues to remain at Amber as although progress is now being made, there continues to be some risks in relation to completion by the 30th October 2018.

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 has also been updated to align to measureable KPIs.

The Business Case for the procurement of the Scavenger has been approved by the EMB and we are now looking at the installation of this equipment.

We are now able to report on some of the metrics relating to the project. Namely, the Commander Competency and HART capacity and rota performance. These metrics will be added to in the next few weeks to include IOR compliance through delivery within the Key Skills programme and HART response time performance standards via CAD reporting.

Sustainability



3.0 **CIP** – The Cost Improvement Programme (CIP) target has been set at £11.4m (5.5% of operating expenses) for 2018/19 and features a broad range of schemes, including some requiring further development. The schemes take no account of any changes that might arise from the actions of the four Sustainability Transformation Programmes (STP) with which the Trust is engaged. The recently introduced Ambulance Response Programme (ARP) has not yet been fully assessed in terms of impact on the Trust; this will need to be kept under review in terms of potential CIPs effect. The Demand and Capacity Review is ongoing and the outcome in terms of CIPs cannot yet be determined. An end-to-end review of operational cycle times, including handover delays at A&E Departments, is also ongoing. A CIP allocation of £2.9m has been included for operations efficiencies but no detailed workings are available for the reasons stated above.

As in previous years, the CIP schemes differentiate between those which are recurrent and those which are non-recurrent in nature. Savings identified via recurrent CIP schemes in 2017/18 have been factored directly into budget setting for 2018/19. Savings identified via non-recurrent CIP schemes in 2017/18 have been reassessed for 2018/19 with Budget Holders to determine if they have an ongoing savings impact; to the extent that the savings are confirmed as ongoing, new 2018/19 CIPs have been developed.

A strict governance process continues to be operated by the Programme Management Office (PMO). Schemes are developed via a Project Mandate, signed by the Budget Holder and Executive Director, and via Quality Impact Assessments, which consider the impact on clinical effectiveness, patient safety and patient/staff experience, and require approval from the Deputy Director of Quality and Safety. Financial Sustainability Steering Group meetings are held weekly to develop plans and support performance management. A recent Internal Audit review of the Trust's CIPs process concluded that the Board can take substantial assurance that the controls upon which the organisation relies to manage the identified risk(s) are suitably designed, consistently applied and operating effectively. The Trust intends to develop CIP schemes for 2018/19 beyond the value of the £11.4m

target to provide a buffer against any schemes which do not deliver. At this early stage of the financial year, the project is rated Amber.

3.1 The Digital Programme Board is currently in the process of enacting the closure process for a number of projects and detailed information on those projects is contained within the narrative of this report. The Programme Board is currently overseeing 14 projects:

- Banstead PoP
- Business Intelligence Improvement
- Spine Connect
- Provider Connect
- GP Connect
- Replacement of Telephony and Voice Recording
- Fleet Management system
- Cyber Security
- ePCR
- Trust Back up strategy
- GRS App
- Station Upgrades
- Automated Temperature Monitoring
- Incident Management Software

A full 12 month pipeline of upcoming digital projects is in development and will be shared with the Board in due course.

3.2  **Banstead POP** – The project remains RAG rated Green. Phase 1, the installation of hardware and software into the Trusts data centre infrastructure is complete. The remaining item is the network connectivity, ordered through the Ambulance Radio Programme (ARP) and to be delivered by BT in June 2018. The project will move to implementation phase through summer where a cutover from Banstead to Crawley will take place allowing Banstead equipment to be decommissioned by Airwave.

3.3  **Business Intelligence Improvement** – The project RAG remains at 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 project will now move to an internal deployment.

3.4  **Cyber Security** – The project RAG remains at Green. Under the NHS Digital programme a 21 million pound fund was made available, primarily for ambulance and trauma centres to improve infrastructure in which the Trust were awarded 720k. A range of products were purchased, including a fundamental shift from the current Cisco based network to a Fortinet system. Planning is underway to complete implementation in the first quarter of the new financial year.

3.5  **Spine Connect** – The project remains at Green and is currently on track. PDS development is now complete and currently being tested with EOC**.** SCR developments (Cleric) are due early June and will then go into test with EOC**.** CP-IS development is complete but there is a national hold on any Ambulance Services going live (but the Trust can still test)

EOC have a requirement to have a new development completed before the end of May (Manchester Triage, MTS). This functionality will go live early June and then PDS will be switched on (live) sometime afterwards (EOC to determine).

There is an element of user awareness/training for each of the three components.

3.6 **Provider Connect** – The project remains RAG rated Green. System has been tested and connectivity is yet to be proven (pending Mental Health Trust engagement). It is anticipated that this will be tested shortly and the project will be moving into closure phase.

3.7 **GP Connect** – The project remains RAG rated Green. The Trust have demonstrated end to end connectivity and are able to transfer patient information between Trust systems and GP systems via Docman. The project is now in its closure phase and is likely to be complete in the next reporting period.

3.8 **Replacement Fleet Management System** – The project remains RAG rated Green. A project plan is currently being developed which will outline clear deliverables and defined timescales. Hardware is under review to establish full requirements for the proposed system. No risks or issues highlighted in this reporting period.

3.9 **Replacement of Telephony and Voice Recording system** – The project remains at Amber until we have an agreed project plan. Order has now been placed with the Trusts preferred supplier. Supplier has submitted a plan for deployment and implementation which will see a full system deployment by October 2018. A review is currently underway to establish the impact of hosting the hardware in a tier 3 data centre.

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. In closing the existing project the iPads and associated sim cards will be moved to business as usual and the remaining elements closed. A Request For Information (RFI) was sent to various suppliers and a number of responses were received that gave assurances that the Trust were not limited to their current supplier for an IoS version of the software. Project is expected to restart this quarter.

3.11 **Trust Backup Strategy** – The project hasn't commenced and is expected to commence within the coming weeks. The aim of the project is to align Trust business continuity plans, the project is intended to ensure that the Trust have wider system availability and also that data recovery is far more effective than the current plan. Project resource is currently being sought to move this project into implementation phase.

3.12 **GRS App** – The project hasn't commenced and is expected to commence within the coming weeks. The project is intended to upgrade the existing version of the GRS system to include accessibility for smart phone access. The upgrade will allow staff to access their shifts from their mobile phones, including offers for overtime. Project resource is currently being sought to move this project into implementation phase.

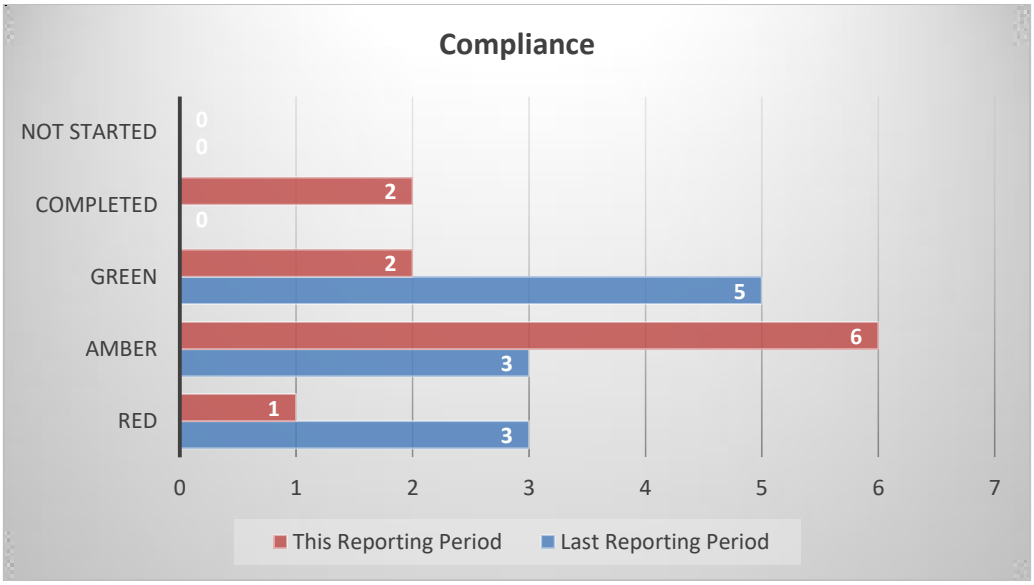
3.13 **Station Upgrades** – The project hasn't commenced and is expected to commence within the coming weeks. The station upgrade project is complex and includes a number of associated projects including WAN access, WiFi access and station equipment. A project mandate and project plan will be developed shortly.

3.14 **Automated Temperature Monitoring** – The project hasn't commenced. The project is to implement automated temperature monitoring devices at each of the sites which will ensure continuous temperature measurements, alerting and electronic recording and

storage of historical data. A business case will be going to the Executive Management Board at the end of this month for a decision.

3.15 **Incident Management Software –** The project is RAG rated Green. The project is to implement an Incident Management Software that will allow the Trust to manage information in real time in large or protracted incidents ranging from Events, Major Incidents, Business Continuity and Critical incidents. The Business Case has been approved, Project Mandate and QIA has been signed off and a project plan is currently in development.

Compliance



4.0 Following the self-assessment on the Provider Information Return for CQC, there are number of areas which the Trust still needs to maintain grip and focus and as a result, the Compliance Steering Group will be refocused to include the following three main projects which are all considered significant. These are:

- Recruitment (including the recruitment plan and safer recruitment)
- Governance and Risk
- Care of patients with complex needs

Other gaps from the self-assessment are smaller projects and would retain a route into compliance. These are:

- Patient Engagement
- QI Method
- National Early Warning Score (NEWS) Audit

It is anticipated updates on progress will be in the next reporting period.

4.1 **Incident Management** *(CQC Must Do)* – This project is RAG rated Amber this reporting period due to the continued challenge of clearing the backlog of Serious incidents and the level of compliance with the 60 day deadlines. Although extra capacity has been provided to the team there continues to be a significant level of work required in supporting those investigators undertaking a serious incident investigation. The new tools and templates will further support staff with the new methodology and it is hoped it will assist staff in

presenting a robust report. Of the sixteen investigations that were due seven were received and submitted to the CCG. Work continues to ensure that these figures improve.

This project will be transitioning into Business as Usual so will be moving into the closure phase shortly.

4.2 **Safeguarding project** *(CQC Must Do)* – The project is RAG rated Blue (completed). Project Closure has now been signed off by Compliance Steering Group on Tuesday 15th May 2018. The remaining longer term actions will embed safeguarding into the wider Culture and OD work streams.

Processes are in development for the safeguarding of our staff and will be overseen by the Safeguarding Sub-group. The Clinical Board will provide additional scrutiny and the remaining actions will be incorporated into the Culture Plan once the Steering Group has been established and can demonstrate pace and traction.

4.3 **Risk Management** *(CQC Must Do)* – The project remains RAG rated Amber. Implementation and audit of effective governance pertaining to risk management remains on-going, for example; operational groups terms of reference are being revised that reflect risk management responsibilities.

Support is being provided by the Improvement Hub to implement Multi-disciplinary training (MDT) and a risk management awareness programme. Revised Risk Management procedural documents is currently out to consultation with the Joint Partnership Forum.

This project will be closed in its current form and will be incorporated into the wider project plan for Governance and Risk project.

4.4 **Medical Devices** *(CQC Must Do)* – The project is now RAG rated as Amber from Red as projected last month and is on target to be Green by the end of May. Work continues with many of the actions now marked complete. Of those still open, clear plans are in place to ensure their development as required. Evidence validation for current evidence has been completed. Current challenges are:

a) The update to the Trusts fleet man system (medical devices asset register) – work continues by the Head of Logistics to complete this by COP 18th May 2018.
b) The CFR team continue to progress their asset register and chase all CFRs to provide their defib asset register details to the Voluntary Services Team. Those CFRs that have not replied were formally written to last week to chase their returns, with any gaps being followed up by the CFR Team Leaders in person.
c) Personal issue equipment – work on the business case continues by Consultant Paramedic Lead and is now being expanded to include additional options for consideration; further details around the costings; and an expansion of the benefits realisations. Once concluded the case will be submitted to the Executive Management Board (EMB).

The project is now in Intensive Support in readiness for the CQC Deep Dive scheduled for 6th June 2018.

4.5 **Governance and Health Records** *(CQC Must Do)* – The project is RAG rated Green from Amber. Operating units are now consistently returning PCR audits and delivering feedback to their teams based on this feedback. Quality assurance via Operating units are now consistently returning PCR audits and delivering feedback to their teams based

on this feedback. Quality assurance visits are finding that PCRs are stored securely on station and a procedure to govern this is in the final stages of approval.

In April, we reduced the length of the CAD incident number to reduce transposition errors and improve linking of records to Info.SECAmb. Data will soon be available to evidence the improvements this has produced. Operating Unit leadership are taking ownership of their unreconciled records and driving local improvements. The most successful changes will be spread across the Trust.

The 2018/19 Clinical Audit Plan is in progress and involves wider staff engagement through the Staff Engagement Forum and Clinical Education in order to drive the improvements that are needed in Ambulance Quality Indicators and related clinical measures.

This project has been proposed for closure by Compliance Steering Group and the project lead will work through project closure documents.

4.6 **Complaints** *(CQC Must Do)* – This project is RAG rated Blue as complete as it has delivered its objectives. There does remain a risk that SECAmb is unable to meet target response for complaints at periods of exceptionally high demand owing to a lack of contingency in the current operational model. This risk will continue to be monitored via Datix. Appropriate learning will continue to be shared at relevant forums, and training will be ongoing as part of business as usual.

4.7 **EOC** *(CQC Must Do)* – This project remains RAG rated Red due to EOC clinical establishment remaining below target levels and without recent improvement. Audit compliance and answer 5 second performance are exhibiting progress towards aligning with the trajectory required to meet the project's objectives within the deadline.

The expectation is that this project will move to **Amber** by end of June 2018 following implementation of the EOC Clinical Framework and implementation of the Manchester Triage System, with a continued push towards meeting audit requirements and EOC recruitment target.

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

The risk to meeting call answer time national standards have slightly reduced but remain high. The risk to meeting audit compliance requirements is now moderate thanks to consistently meeting improvement trajectory. Telephony, system and data challenges linked to EOC reporting and functionality remains a high risk – this particular risk is owned by Associate Director of IT and managed through the Digital Programme Board.

Issues include the live performance metric, challenges to recruiting enough EMA staff, high staff turnover and increased call volume, including the high numbers of calls where callers are following up on the ambulance response. The reintroduction and bolstering of dedicated HR resources for recruitment and the management of staff sickness is having a positive impact.

Intensive Support allowed for the isolation and resolution of project issues and the Deep Dive was received positively by the CQC, who commended the candid approach to recognising where improvements in EOC performance were required.

4.8 **Performance and AQI project** *(CQC Must Do)* – Performance and ASI project (CQC Must Do) – The project remains RAG rated Amber. Whilst the Trust remains on trajectory to meet C1/2 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.

The majority of 'should do' actions are now complete and we continue to see a positive trend towards meeting or exceeding C1/2 targets. The Bariatric 'should do' is almost complete as the SOP has now been signed off, pending full communication to staff.

Recruitment and retention remains a significant and increasing risk to delivery of C3/4, however these performance targets are out of scope for the project. Recruitment continues to be managed via detailed discussion at the recruitment summit.

Incomplete milestones on this workstream are likely to be duplicated by new projects (Demand and capacity, GP Connect, GRS app, Complex Patient groups etc.) and once duplication is confirmed these actions can be transferred and the performance project proposed for closure.

4.9 **Medicines Governance** *(CQC Must Do)* – The project is RAG remains Green. The project is now going through the project closure phase.

Fifty-five work streams in the improvement plan were completed within the timeframe of fifty-nine. Where the work streams have not been met they will be pulled through for completion to the Medicines Optimisation Annual Plan 2018/19.

DCA key losses have reduced significantly within this reporting period through the amendment and approval process. Guidance has also been developed on how to investigate and risk assess medicines key loss. DCA key loss will be continued to be monitored by the MGG chaired by the Executive Medical Director.

The Trust has seen 69% reduction in CD breakages in April 2018 compared to April 2017. 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. Ampoule snappers are been trialled in the Paddock Wood area. These figures will be presented to the MGG as a standing agenda item.

4.10 **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 until the replacement system has been implemented.

4.11 **Infection Prevention and Control** *(CQC Must Do)* – This project remains RAG rated Amber, but progress being made is good. Once we have introduced the new IP Ready Procedure (June) it is hoped to move to a RAG rating of Green.

The 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, which are now both showing compliance to the target of 90%.

We are also seeing improvements in the environmental audit completions and a review of the content of the audit will take place at the end of May. The IPC Team have been asked to add a section on fridge cleanliness and food storage to the monthly audit and share

some guidance with staff on the need for compliance. The IPC Lead has also been asked to provide further guidance to staff on uniform cleaning and consider national guidance with the possibility of introducing washing machines on stations for staff to wash their uniform.

The Infection Prevention Ready Procedure will now be in place following full consultation by June 2018 which will address all elements of practice to ensure that patients and staff come to no harm.

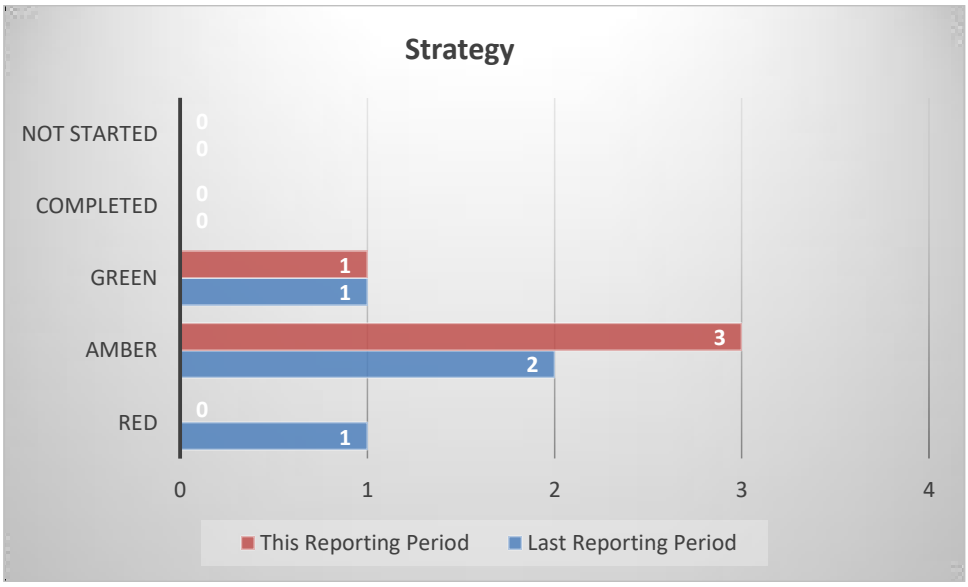
Culture and Organisational Development

5.0 **Culture and Organisational Development** – This programme remains RAG rated Red due to the plan currently being refreshed and objectives re-aligned. The Senior Leadership Development Training is now fully underway. EMB and Senior Leadership Team (SLT) members have gone through a 360-degree feedback and have had a least one coaching session. Both EMB and all of SLT have completed module 1 leadership training session with module 2 commencing this week. EMB have their 2nd Executive Team Session next week.

Later this month, all invitations are being sent out to Band 7 and 8 Managers to commence Module 1 training from 4th June 2018. The roll out of 360-degree feedback to Band 7 and 8 Managers will commence over the next 6-12 months once Coaches are fully trained to provide feedback.

A new refreshed plan will be published at the end of May 2018 with The Values Launch scheduled for 12th June 2018.

Strategy



6.0 The Trust is currently reviewing and updating its overarching Five Year Strategic Plan 2017-2022, by utilising the NHSI strategy development toolkit as we did to develop the original plan. 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. During this month we are working on the framing and diagnostic phase including planning meeting with stakeholders. The update 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 B below. This project is RAG rated Amber. The Trust is ensuring that Board members are able to contribute and comment earlier in the process. To that end Workforce, Fleet, Estates, ICT and Research and Development are under way.

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. The second submission and operating plan was submitted in April 2018 and a final iteration will be published including any 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. This will be enacted through a contract variation including changes to the national NHS contract. We are reviewing and finalising 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 Trust is developing a specification to tender for external support to embedding of a QI programme from Q3 onwards, to align with the culture change programme already underway. The specification is expected to be completed by the end of Q1.

6.4 **Commissioner and Stakeholder Alignment** – This project remains RAG rated Green. Engagement sessions are taking place and 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)

Appendix B

Enabling Strategies 8/5/18
Blue = completed
Red = changes since last month

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	Ed Griffin	March 2018 revised date June 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 Draft went to board for consultation with aim to go to board thereafter	
	Clinical Education	2018-2022	Ed Griffin	Sally Wentworth James	February 2018 revised date May 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 revised date July 2018		To check status as now referred to Strategy team and scope is to be clarified	
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	Bethan Haskins /Fionna Moore	Kathy Jones	April 2018 revised date June 2018	Tbc		
	Safeguarding	2017-	Steve Lennox	Philip	November	Tbc	Ratified at Board 29/11/17	

		2020		Tremewan	2017			
	Governance this will incorporate risk strategy in future	2017 – 2022	Daren Mochrie	Peter Lee	June 2018	tbc	Is being scoped at present	
	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 revised date May 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 Chased again as not had as yet	
Enablers	Fleet	2017-2022	Joe Garcia	John Griffiths	March 2018 revised date September 2018	Tbc	Presented at March Board and April FIC awaiting comments and will need revision before returning to board in 2-3 months	
	Estates	2017-2022	David Hammond	Paul Ranson	March 2018 revised date June 2018	tbc	Presented at March Board and April FIC awaiting comments and will need revision before returning to board in 2-3 months	
	Digital and ICT	2018-2022	David Hammond	Barry Thurston	March 2018 revised date July 2018	Tbc	Presented at March Board and April FIC awaiting comments and will need revision before returning to board in 2-3 months	
	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	Jon Amos	June 2018	March 2019		

Delivery Plan Dashboard

Reporting period from 1st April 2018 to 30th April 2018

RAG Key:

Red	At significant risk of failure due to circumstances which can only be resolved with additional support
Amber	A risk of failure but mitigating actions are in place and these can be managed and delivered within current capacity
Green	On track and scheduled to deliver on time and with intended benefits
Blue	Completed
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	Red	Scott Thowney	Joe Garcia	n/a	25.07.2018	The objective of the project is to ensure ambulance dispatch rates by appropriately and safely increasing the percentage of Hear and Treat cases from 6% to 10% from emergency call volume. The clinical framework approved off by the Executive Team is in progress with Interviews scheduled to appoint 14x Clinical Safety Navigators to be in post for June 2018. These staff will ensure 24/7 cover at East and West EOC's by NHS Pathways clinicians as integral aspects of the Trust Surge Management plans and coordination of EOC clinical activity in driving optimisation of hear and treat with current staffing levels. Clinical Code matching of the Manchester Triage solution has been completed, with Training material and courses booked. This will enable us to utilise existing workforce in support of hear and treat, alongside our current clinical decision support of NHS Pathways. EOC Systems are supporting this work stream development with our CAD supplier (CAD) NHS Pathways compliance for recorded clinical support to call handlers continues to remain 100% NHS Pathways licence compliant with an NHS Pathways Accredited clinician in EOC at 24/7 Development of the Audit infrastructure in line with the EOC Task and finish continues to show Clinical EOC NHS Pathways Audit meeting trajectory forecast for clinical audit compliancy metrics (Achieving 70% for April and targeting 85% for May 2018). The official launch of the Surrey Heartlands Pregnancy Advice line (ShPA) in partnership with Surrey Heartlands and Better Births on the 9th May 2018 was completed and received by NHSE and CCG providers positively - It was identified within first 4 weeks of activity 2500 calls were taken to the line, with 86 interactions in Ambulance dispatch from the midwife team to both EOC and front line road staff across the trust region. These resulted in 34 ambulance downgrades with 30 resulting in an alternative resource allocation and ambulance stood down.	45 clinical supervisors in post in EOC	31	45	45	The project RAG remains at Red. Until the project is able to demonstrate an increased capacity of the clinical supervisors in post in EOC and benefits are realised from the Clinical Framework, the project will remain at Red. There is an increasing challenge to meet the Hear and Treat Performance target within the project completion date however the recruitment of the Clinical Safety Navigators, Rota Review and other process improvements will help to support the mitigation of this risk.
									Hear and Treat Performance	6,5%	10%	10%	
	Demand and Capacity Review	Amber	Amber	Jayne Phoenix	Steve Emerton	n/a	04/05/2018 (previous date was 13/04/2018)	The Demand and Capacity review is nearing completion with Deloitte and ORH modelling of a delivery trajectory to compliance with ARP standards ongoing at the time of writing. This will be subject to sensitivity analyses across a number of areas in order to set out short, medium and longer terms delivery profiles to full ARP compliance. In tandem with this modelling (on the selected targeted dispatch option) work will continue to develop potential contracting models (our discussions have shown a commitment by all parties to support the selected delivery profile for its full duration) and plans to engage wider stakeholders in the results of the review. The review is on track to deliver its draft report by the end of May and subsequently generate a final report in early June this year.	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.
	ARP Demand and Capacity Delivery	Amber	Amber	Rob Mason	Joe Garcia	n/a	01.04.2021	The project remains RAG rated Amber. Workforce for each grade have now been modelled by quarter by Operating Unit (OU) to Q1 2021/22. This information is being used by Deloittes as part of the Demand & Capacity Review. Meetings are currently taking place with each OU Manager during May to establish a recruitment pipeline to meet the requirements of the workforce assumptions provided by Deloittes. The principle risk of not recruiting sufficient staff is being mitigated by developing local OU recruitment plans. The output of these meetings will be the publication of a strategy (early June) which will describe the activities to ensure the workforce numbers meet the Demand and Capacity review requirements. During June 2018, it is anticipated that a similar process will be followed for vehicles with a Fleet strategy published in July.	KPIs to be defined.				No risks or issues highlighted in this reporting period
	Hospital Handover	Amber	Red	Gillian Wieck	Joe Garcia	n/a	31/03/2019 (was previously 30/04/2018)	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 and as a consequence it is now RAG rated Amber. A national objective has recently been set to have no hospital handover delays >30 minutes by September 2018. Six hospital trusts within SECAmb's area have been offered additional support by NHSI to achieve the objective. There is good engagement from the majority of Acute Trusts. Reports with granular detail around Crew to Clear times have been provided will be sent out to managers with communication to support their use. The prompt at 10 minutes to airwaves handset is now in place. Delays with the introduction of both of the report and the prompt have had an impact on meeting the Crew to Clear target by March.	Handover delay no more than 60mins (by March 2018)	516	N/A	0	The project is RAG rated Amber. System wide pressures are impacting on patient flow and the Trust's ability to reduce handover delays to meet target.
									Crew to Clear time within 15mins 85% of the time	47,30%	85%	85%	
	National Ambulance Resilience Unit	Amber	Amber	Chris Stamp	Joe Garcia	n/a	30.10.2018	The project continues to remain at Amber as although progress is now being made, there continues to be some 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 has also been updated to align to measureable KPIs. The Business Case for the procurement of the Scavenger has been approved by the EMB and we are now looking at the installation of this equipment. We are now able to report on some of the metrics relating to the project. Namely, the Commander Competency and HART capacity and rota performance. These metrics will be added to in the next few weeks to include IOR compliance through delivery within the Key Skills programme and HART response time performance standards via CAD reporting.	The KPIs have been identified although data is not available for this reporting period.				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	TBC	A Request For Information (RFI) was sent to various suppliers and a number of responses were received that gave assurances that the Trust were not limited to their current supplier for an IOS version of the software.					This project remains RAG rated Red. The project is expected to restart this quarter which will see the RAG entry moved from Red once a plan is in place.
	Financial Sustainability	Amber	Green	Kevin Hervey	David Hammond	n/a	31.03.2019	The Trust has reported a CIP target of £11.4m to NHSI as part of the 2018/19 Budget and Plan. The Delivery Plan update for the month provides more detail on the construction of the CIP Programme. Project mandates are in the course of completion prior to being signed off by the Executive Sponsor and then sent to the Deputy Clinical Director for Quality Impact Assessment. A Delivery Plan Tracker and Pipeline Tracker will then be constructed, and will be available to the June meeting of the Board. The Board will be aware that the Trust successfully delivered £15.5m of CIPs schemes in 2017/18 against a target of £15.1m.	Current CIP schemes fully validated	TBC	TBC	£11.4m	No risks or issues highlighted in this reporting period.
	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. The remaining item is the network connectivity, ordered through the Ambulance Radio Programme (ARP) and to be delivered by BT in June 2018. The project will move to implementation phase through summer where a cutover from Banstead to Crawley will take place allowing Banstead equipment to be decommissioned by Airwave.	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.
	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 remains at Amber due to the control room dashboards which will now move to an internal deployment.
	Cyber Security	Green	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. Planning is underway to complete implementation in the first quarter of the new financial year.	All software and hardware is procured	No data available	No data available	No data available	No risks and issues reported within this reporting period

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	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. PDS development is now complete and currently being tested with EOC SCR developments (Cleric) are due early June and will then go into test with EOC CP-IS development is complete but there is a national HOLD on any Ambulance Services going live (but we can still test) EOC have a requirement to have a new development completed before the end of May (Manchester Triage, MTS). This functionality will go live early June and then PDS will be switched on (live) sometime afterwards (EOC to determine). There is an element of user awareness/training for each of the three components.	PDS - NHS Number Capture: percentage of C3/C4 calls are matched to an NHS Number.	60%	No data available	60%	No risks and issues highlighted in this reporting period.
									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%	
	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. The system has been tested and connectivity is yet to be proven (pending Mental Health Trust engagement). It is anticipated that this will be tested shortly and the project will be moving into closure phase.	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%	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%	
	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 Trust have demonstrated end to end connectivity and are able to transfer patient information between Trust systems and GP systems via Docman. The project is now in project closure phase.	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%	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%	
	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. A project plan is currently being developed which will outline clear deliverables and defined timescales. Hardware is under review to establish full requirements for the proposed system.	The Fleet Management system will be replaced and implemented.				No risks and issues highlighted in this reporting period.
	Replacement of Telephony and Voice Recording System	Amber	Green	Phil Smith	David Hammond	N/A	Mid Oct 2018 (TBC) (Previous date 01/05/2018)	This project is to replace the existing telephony and voice recording system. Order has now been placed with the Trusts preferred supplier. Supplier has submitted a plan for deployment and implementation which will see a full system deployment by October 2018.	Telephony and Voice Recording system replaced and implemented				This project is RAG rated Amber until an agreed plan is in place.
	Trust Backup Strategy	White	First reporting period	Jason Tree	David Hammond	N/A	TBC	This project is to identify business continuity requirements with system owners and procure/implement infrastructure and processes to maintain compliance. A Business case to be developed to scope out the requirements of the project.	To be defined	N/A	N/A	N/A	No risks and issues highlighted in this reporting period.
	GRS App	White	First reporting period	Jason Tree	David Hammond	N/A	TBC	This project is to develop an App to supplement the current GRSWeb subscription that the Trust has, providing the same information to mobile devices (personal details and contact information, shift and absence information as well as being able to manage shift swaps, time off and timesheets etc.) A Business Case is currently being developed to scope out the requirements of the project.	To be defined	N/A	N/A	N/A	No risks and issues highlighted in this reporting period.
	Station Upgrades	White	First reporting period	Jason Tree	David Hammond	N/A	31.03.2019	The aim of the project is currently being scoped and it will focus on improving WAN and Wi-Fi access and station equipment.	To be defined	N/A	N/A	N/A	No risks and issues highlighted in this reporting period.
	Incident Management Software	Green	First reporting period	David Wells	David Hammond	N/A	30.09.2018	Introduction of an incident management software to allow the Trust to manage major and critical incidents more effectively, with the ability to share information in real time via an internet connection. The Business case has been approved, project mandate and QIA signed off. Project Plan is currently in development.	New software programme implemented that can be used to manage large or protracted incidents.				No risks and issues highlighted in this reporting period.
	Automated Temperature Monitoring	White	First reporting period	Timothy Poole/ Jason Tree	David Hammond	N/A	TBC	Procurement, installation and implementation of an electronic platform to allow medicines environment to be monitored automatically Business case currently being developed	All stations to have automated temperature monitoring	N/A	100%	100%	No risks and issues highlighted in this reporting period.
	Incident Management	Amber	Amber	Samantha Gradwell	Bethan Haskins	08.Nov.17	01.08.2018	The Trust Incident Management process has been a reactive process used to identify harm and it was frequently perceived as a vehicle to punish staff when they were seen as causing the identified harm. The aim of this project is to ensure the Trust has an effective incident management system that clearly identifies learning, and that learning is valued and shared widely across the Trust to continually drive improvements in safety.	20% increase in overall incident reporting (Monthly)	721	579	583	
									>75% of incidents closed within time target [SECAmb Target]	74,0%	72,0%	75,0%	
									90% of Serious Incident investigations will be completed within 60 working days.	14,0%	88,0%	90,0%	
									100% of Serious Incidents compliant with 72 hour STEIS reporting	100,0%	100,0%	100,0%	
									96% of incidents graded as near miss, no harm or low harm	93,0%	96,0%	96,0%	
									80% of incidents where feedback has been provided	100%	80%	80%	
									100% compliance with Duty of Candour for SIs	100%	100%	100%	
	Safeguarding	Blue	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. This feedback will be incorporated into the Culture Plan. The project continues to be rated as green. Following a Project Closure Request made on the 17th April 2018 by the CSG the remaining longer-term actions will embed safeguarding into the wider Culture and OD workstreams. Processes are in development for the safeguarding of our staff and as this project moves to BAU, the outstanding areas are to be overseen by the Safeguarding Sub-group. The Clinical Board will provide additional scrutiny and the remaining actions will be incorporated into the Culture Plan when the Steering Group has been established and can demonstrate pace and traction. Approval of the Project Closure request was granted at the Turnaround Executive Meeting chaired by the CEO on the 2nd May 2018.	The number of staff trained to level 3 Safeguarding	96,9%	85,0%	85,0%	Project is RAG rated Blue. Concerns remain that despite project closure, progress remains slow with the actions that have interdependencies with the Culture Plan. These risks are mitigated by the provision of on-going scrutiny at the Safeguarding Sub-group and Clinical Board. 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.
									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.	95,0%	n/a	90,0%	

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	Risk Management	Amber	Amber	Samantha Gradwell	Bethan Haskins	19.Jän.18	31.08.2018	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, for example; outcome from routine site inspections, must be placed onto the Trusts risk register (Datix). A baseline assessment has now been undertaken and has identified inconsistencies and gaps with process and frameworks. Risk 348 has been recorded (Principle Risk Lead: Giles Adams; Accountable Executive: Bethan Haskins) and the Central Health & Safety Group monitors actions and controls assurance. • All project risks need to be placed onto the Trusts risk register (Datix). To address the identified gaps, meetings with PMO leads have taken place and the changes are being jointly implemented. • Addressing the above gaps will have an effect on project milestones. Implementation and audit of effective governance pertaining to risk management remains on-going, for example; operational groups terms of reference are being revised that reflect risk management responsibilities. Revised procedural documents are progressing along SECAmb's consultation and approval pathway. Multi-disciplinary training (MDT) and a risk management awareness programme to be implemented and support is being provided by the improvement hub.	Individual Risks Reviewed on Datix With Principle Risk Lead (includes training & awareness)	140	140	140	The number of forums who has ratified their ToRs to include risk management is below the planned figure due to poor responses from these forums Chairs'. Chief Executive has communicated to senior management asking for the ToRs to be ratified and to confirm this with Andy Lyons (Risk Delivery Lead) by 15th May 2018.
									Number of Directorates and Operating Units reviewed for existence of local Risk Registers (only Datix authorised)	29	29	29	
									Number of Forums Terms of Reference Ratified to Include Risk Management	2	14	22	
	Medical Devices	Amber	Red	Nicola Brooks	Steve Lennox	N/A	30.09.2018	Current challenges are: a) The update to the Trusts fleet man system (medical devices asset register) – work continues by the Head of Logistics to complete this by COP 18th May 2018. b) The CFR team continue to progress their asset register and chase all CFRs to provide their defib asset register details to the Voluntary Services Team. Those CFRs that have not replied were formally written to last week to chase their returns, with any gaps being followed up by the CFR Team Leaders in person. c) Personal issue equipment – work on the business case continues by Andy Collen and is now being expanded to include additional options for consideration; further details around the costings; and an expansion of the benefits realisations. Once concluded the case will be submitted to the EMB. The project is now in Intensive Support in readiness for the CQC Deep Dive scheduled for 6th June 2018. CQC preparation has been completed in draft (diver diagrams) and Joe Garcia (Director of Operations) has confirmed he will chair the meeting.	Double Crewed Ambulances (DCAs) and Single Response Vehicles (SRVs) Audited per Quarter.	113	80	240	No risks and issues highlighted in this reporting period.
									Submission of QUARTERLY Site Security Assessments in 2017/18 (MRCs, Stations, Crawley HQ, Fleet VMC)	69%	100%	100%	
									% of checked vehicles locked whilst unattended	96%	100%	100%	
									Number of CFRs who have provided their defib asset register details to the Voluntary Services Team	167	162	500	
	Governance, Records & Clinical Audit	Green	Green	Dean Rigg	Fionna Moore	19.Jän.18	31/07/2018 (note that the original date was 31/03/2018)	Operating units are now consistently returning PCR audits and delivering feedback to their teams based on this feedback. Quality assurance visits are finding that PCRs are stored securely on station and a procedure to govern this is in the final stages of approval. In April, we reduced the length of the CAD incident number to reduce transposition errors and improve linking of records to Info. SECAmb. Data will soon be available to evidence the improvements this has produced. Operating unit leadership are taking ownership of their unreconciled records and driving local improvements. The most successful changes will be spread across the Trust. The 2018/19 Clinical Audit Plan is in progress and involves wider staff engagement through the Staff Engagement Forum and Clinical Education in order to drive the improvements that are needed in Ambulance Quality Indicators and related clinical measures. This project has been proposed for closure by CSG and the project lead will work through project closure documents.	Patient Records will be completed accurately	54,0%	0,0%	90,0%	No risks and issues highlighted in this reporting period.
									Incidents will have Patient Clinical Record linked	86,5%	N/A	90,0%	
									STEMI (care bundle)	72,00%	81%	73,80%	
									Stroke (care bundle)	95,00%	98%	97,50%	
									Cardiac Arrest Survival (Combined)	6%	n/a	n/a	
									ROSC (Combined)	21,00%	n/a	n/a	
	Complaints	Blue	Green	Louise Hutchinson	Steve Lennox	14.Mär.18	31.03.2018	The Complaints project is now complete as it has delivered its objectives. There does remain a risk that SECAmb is unable to meet target response for complaints at periods of exceptionally high demand owing to a lack of contingency in the current operational model. This risk will continue to be monitored via Datix. Appropriate learning will continue to be shared at relevant forums, and training will be ongoing as part of business as usual.	Complaints will be concluded within the Trust's target of 25 working days.	97,9%	80,0%	80,0%	This project is now closed having achieved its objectives.
									Evidence of learning from at least 95% of complaints that are upheld in any way.	100,0%	95,0%	95,0%	
									100% of Area Governance Meetings, Clinical Evaluation & Effectiveness Sub-Group meetings will have shared learning from complaints.	82,3%	100,0%	100,0%	
	EOC	Red	Red	Sue Barlow	Joe Garcia	02.Mai.18	31.08.2018	EOC clinical establishment remains below target levels and without recent improvement. Audit compliance and answer 5 second performance are exhibiting progress towards aligning with the trajectory required to meet the project's objectives within the deadline. The expectation is that this project will move to Amber by end of June 2018 following implementation of the EOC Clinical Framework and implementation of the Manchester Triage System, with a continued push towards meeting audit requirements and EOC recruitment target. It is anticipated that the project will move to Green by end of August 2018 following the realisation of improvements in clinical recruitment from the Clinical Framework Proposal, HR recruitment and progression strategies for EMA recruitment and the EMA Retention framework (including EMATL evaluation) as part of a career progression scheme. The risk to meeting call answer time national standards have slightly reduced but remain high. The risk to meeting audit compliance requirements is now moderate thanks to consistently meeting improvement trajectory. Telephony, system and data challenges linked to EOC reporting and functionality remains a high risk – this particular risk is owned by Barry Thurston and managed through the Digital Programme Board. Issues include the live performance metric, challenges to recruiting enough EMA staff, high staff turnover and increased call volume, including the high numbers of calls where callers are following up on an ambulance response. The reintroduction and bolstering of dedicated HR resources for recruitment and the management of staff sickness is having a positive impact. Intensive Support allowed for the isolation and resolution of project issues and the Deep Dive was received positively by the CQC, who commended the candid approach to recognising where improvements in EOC performance were required.	Clinical supervisors in post in EOC	30	45	45	The project RAG is Red. The risk to meeting call answer time national standards has slightly reduced but remains extremely high. The risk to meeting audit compliance requirements is now moderate thanks to consistently meeting improvement trajectory. Telephony, system and data challenges linked to EOC reporting and functionality remains a high risk – this particular risk is owned by Barry Thurston and managed through the Digital Programme Board. Issues include the live performance metric, challenges to recruiting enough EMA staff, high staff turnover and increased call volume, including the high numbers of calls where callers are chasing an ambulance response. The reintroduction and bolstering of dedicated HR resources for recruitment and the management of staff sickness is having a positive impact. Intensive Support allowed for the isolation and resolution of project blockers and the Deep Dive was received positively by the CQC, who commended the candid approach to recognising where improvements in EOC performance were required.
									Number of audits per month	80,0%	85,0%	100,0%	
									95% of calls answered within 5 seconds.	84,0%	80,0%	95,0%	
									FTE EMAs in post within EOC	172	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. The majority of 'should do' actions are now complete and we continue to see a positive trend towards meeting or exceeding C1/2 targets. The Bariatric 'should do' is almost complete as the SOP has now been signed off, pending full communication to staff. Incomplete milestones on this workstream are likely to be duplicated by new projects (Demand and capacity, GP Connect, GRS app, Complex Patient groups etc.) and once duplication is confirmed these actions can be transferred and the performance project proposed for closure.	Category 1 Mean	07:26	07:00	07:00	The project remains RAG rated Amber. Whilst the Trust remains on trajectory to meet C1/2 targets, there remains a wider risk to meeting commissioned performance before the project can be considered Green. Recruitment and retention remains a significant and increasing risk to delivery of C3/4, however these performance targets are out of scope for the project. Recruitment continues to be managed via detailed discussion at the recruitment summit.
									Category 1 90th Centile	13:40	15:00	15:00	
									Category 2 Mean	16:53	18:00	18:00	
									Category 2 90th Centile	32:03	40:00	40:00	

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
	Medicines Governance	Green	Green	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. Fifty-five work streams in the improvement plan were completed on time out of fifty-nine. Where the work streams have not been met they will be pulled through for completion to the Medicines Optimisation Annual Plan 2018/19. DCA key losses have reduced significantly this month to three losses. This is due to a change in the number of keys carried. The SOP is going through the amendment and approval process and also includes guidance on how to investigate and risk assess medicines key loss. DCA key loss will be monitored by the MGG chaired by the Executive Medical Director. The Trust has seen 69% reduction in CD breakages in April 2018 compared to April 2017. 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. Ampoule snappers are been trialled in the Paddock Wood area. These figures will be presented to the MGG as a standing agenda item. The medicines quiz passes are targeted at 97% completion. Current completion figure is 89.4%. DCA drug cabinet key losses significantly reduced in April due to intervention made in March 2018. Monitoring will be picked up as BAU with reporting into Medicines Governance Group.	Medical Quiz Passes	2208	2425	2425	This project is Green in this reporting period. The Medicines Governance improvement action plan is going through closure documentation and moving to BAU.
									Compliance per Operating Unit	93,31%	97,50%	97,50%	
									DCA Drug cabinet key losses (Cumulative Total Nov 17 to Present) Three keys lost in month of April significant reduction.	158	n/a	n/a	
									CD Breakages (April Total)	14	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. Order has now been placed with the Trusts preferred supplier with an expected timescales of October 2018 for full system deployment.	100% of all 999 calls recorded				No risks and issues reported within this reporting period
									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	This project is still RAG rated Amber, but the progress being made is good. Once we have introduced the new IP Ready Procedure (June) it is hoped to move to a RAG rating of Green. The IPC Practitioners are now being freed up to support the local Operating Units and EOC's and face-to-face sessions with OTL's have been arranged to help support the audit schedule and compliance requirements. Implementation of actions within Improvement Action Plans for all CQC projects is ongoing with provision of data to measure outcomes and to ensure a focus on quality.	Hand Hygiene Staff Compliance	92%	No data available	90%	The project RAG is Amber. There is a risk that the Trust has no central record of staff vaccination history. Initial work has commenced to address this risk with joint working from the IPC Team and HR.
									Bare Below the Elbow	92%	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%	
Culture & Organisational Development Steering Group	Culture & OD	Red	Red	Clare Irving	Ed Griffin	n/a	TBC	The Plan is currently being refreshed by the Culture Programme Team who have been released to focus on the project full time for the next 9-12 months. The Senior Leadership Development Training is now fully underway. EMB and SLT members have gone through a 360-degree feedback and have had a least one coaching session. Both EMB and all of SLT have completed module 1 leadership training session with module 2 commencing this week. EMB have their 2nd Executive Team Session next week. To date:- 63% of all 360 reports are complete 83% have attended module 1 89% have had their 1st coaching session This week all invites are being sent out to Band 7&8 Managers to commence Module 1 training from 4th June 2018. Phased 360s for Band 7&8 Manager will commence over the next 6-12 months once Coaches able to provide feedback have been training in-house.	KPIs to be defined.				This project is RAG rated Red due to the plan currently being refreshed and objectives re-aligned.
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 B 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 Trust is developing a specification to tender for external support to embedding of a QI programme from Q3 onwards, to align with the culture change programme already underway. The specification is expected to be completed by the end of Q1.	The Trust has approved to adopt a QI methodology and an implementation 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.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Delivery Plan Deep Dive

Hear and Treat

1. Introduction

1.1. This report is to outline the current status of the Hear and Treat Programme, where the programme is with respect to delivery timelines versus goals and what the next steps are for programme delivery.

2. Hear and Treat Status / Progress

2.1. The objective of the programme is to ensure ambulance dispatch rates by appropriately and safely increasing the percentage of Hear and Treat cases from 6% to 10% from emergency call volume. The delivery of this is noted to be dependent across a range of work streams relating predominantly to clinical staffing levels and has been hindered by challenges to retain and recruit clinical staff, the mismatch of demand capacity/profiling leading to rota variances and the amount of additional clinical activity within the EOC.

2.2. NHS Pathways compliance for recorded clinical support to call handlers continues to remain 100% NHS Pathways licence compliant, with an NHS Pathways Accredited clinician always present and operating in EOC 24/7.

2.3. The current clinical establishment for EOC remains 31 WTEs, with the new clinical staffing requirement being 38 WTEs with 14 WTE Clinical Safety Navigators (a new role being introduced as part of the new clinical framework).

2.3.1. Several work streams have been initiated to meet each of these variable factors, each of which will contribute towards delivering the final desired outcome. The clinical framework approved by the Executive Management Board is still being implemented, with interviews scheduled for week commencing 21 May 2018 to appoint 14 x Clinical Safety Navigators (CSNs) to be in post prior to July 2018. These staff will ensure 24/7 cover at both East and West EOCs by deploying NHS Pathways clinicians, and the role is integral to the effective delivery of the Trust's revised Surge Management Plan (SMP) and the co-ordination of EOC clinical activity, in driving optimisation of Hear and Treat with the current levels of clinician staffing.

2.3.2. By introducing an additional Clinical Decision Support Software (CDSS) assessment solution, we are able to increase our ability to recruit wider clinical skill sets and increase the utilisation of existing Trust clinicians. This work stream required a business case and governance assurance process, which are in progress. Clinical Code matching of the Manchester Triage System (MTS) has been completed, with training material and courses booked for the first cohorts in the EOC. The MTS go-live is scheduled for June 2018 although this will gain momentum as more clinicians are trained and can be mobilised.

2.3.3. The official launch of the Surrey Heartlands Pregnancy Advice line (ShPA) in partnership with Surrey Heartlands STP and Better Births on 9 May 2018 was completed and received by NHS England, CCG commissioners and other provider stakeholders positively – as part of the initial review process, it has been identified within the first four weeks of activity that 2,500 calls were taken through this line, with 86 interactions in Ambulance dispatch from the midwife team to both EOC and front line road staff across the region serviced by the Trust. This resulted in 34 x 999 downgrades, with 30 ambulances becoming available as an alternative resource allocation, enabling SECAmb to redirect patients to alternative and more appropriate services.

2.3.4. The current Clinical Supervisor (CS) rota does not meet the demand profiles or volumes based on 26 weeks of historical activity. Previous modelling for CS rotas was based against EMA requirements, rather than CS activity. A rota review has been initiated – this work stream was significantly delayed pending agreement of rota parameters. Conclusion for this review is expected by July 2018.

3. Next Steps

3.1. Completion of rota review to align capacity to demand.

3.2. Introduction of MTS to EOC facilitating recruitment of additional skill sets to EOC to include mental health clinicians and pharmacists.

3.3. Appointment of the 24/7 Clinical Safety Navigator roles at East and West EOC.

3.4. Appointment of the clinical framework EOC Operational Managers (Clinical) to support CSN roles and facilitate the delivery of increased Hear and Treat performance.

4. Summary

4.1. Until the project is able to demonstrate a tangible increase in the capacity of the Clinical Supervisors in post at the EOC and the subsequent benefits are realised from the Clinical Framework, the project will remain Red.

4.2. There is an increasing challenge to meet the Hear and Treat Performance target within the project completion date, however, the recruitment of the Clinical Safety Navigators, Rota Review and other process improvements will help to support the mitigation of this risk.

SECAMB Board

QPS Committee Escalation report to the Board

Date of meeting	21 May 2018
Overview of issues/areas covered at the meeting:	This meeting immediately followed the Audit Committee, which the Chair of QPS attended, and considered the **Quality Account** as the first item. The committee noted the feedback already provided by the Audit Committee and had nothing in addition to add, in terms of amendment. It agreed that this is the best report for many years and thanked Steve Lennox and everyone else that had supported its development. Subject to the amendments being made the committee agreed to recommend this to the board. The committee then moved in to standard business and considered a number of ***Management Responses*** (*response to previous items scrutinised by the committee)*, including: **111 Call Routing QIA RCA** At its meeting in March, the committee reviewed the 111 call routing pilot, and asked for a root cause analysis to establish whether the governance process was followed, specifically relating to a quality impact assessment (QIA). This confirmed that a QIA was completed and submitted to the PMO, however the approval process was not followed beyond this. The learning is to remove a single contact point and put in place a 'QIA review Group' to consider all QIA's, whether they be related to a project, CIP scheme, policy, or any other change. **Section 136 Data** At the committee meeting in March an issue was identified relating to a potential disparity between the s136 (of the Mental Health Act) data of the Trust and the local mental health trust. Management confirmed that a significant disparity does exist and have set out a number of actions to be taken over the next 3 months to ensure a referral process our partners have confidence in and resolution of the data issues. **NARU Update** This management response set out the progress to date with the NARU interoperable capability improvement plan. The committee is assured that the plan in place is robust with sufficient governance and oversight. It is also assured with the progress being made against the plan. A HART scrutiny item scheduled for September. 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; **EOC call answer performance; impact on patient safety.** This report provided a summary of EOC call performance and the impact on patient safety between 22 November 2017 (when ARP was introduced) and 31 March 2018. It also considered the impact on staff in both the EOC and in Operations and the resourcing issues within both areas. In addition, there was a thematic overview of

	incidents, serious incidents and complaints and any recorded harm experienced by patients. The committee is assured by the clarity in the holistic understanding of the issues. The plan in place to improve call answer performance is robust and there is management focus. The committee was particularly assured by focus on the clinical navigator role, the procedure for auditing the tail; if felt this was a really positive step, the over-establishment to add resilience, and by the emphasis on staff wellbeing and engagement. It noted that 23% of EOC leavers actually went on to front line workforce. Concerns were explored on the ability to recruit to the number needed. The thematic review demonstrated the impact of long waits and the committee explored the role of BT in escalating calls but concluded the only way of assuring patient safety is for the Trust to meet the call performance times. There was also concern about the long waits, compounded by ETA calls being almost 20% of the total volume of calls. The committee asked management to confirm that we discharged our duty of candour responsibilities for the incidents listed, and that the learning described has been shared. **Surge and clinical harm review** Between 26 February and 5 March 2018 the Trust declared a Business Continuity Incident due to the demand placed upon the service. During this period, three incidents were identified where there was potential for patient harm due to the delays experienced. This was the review of those incidents, and reviews like this are now standard practice for the Trust. The committee noted the review of each incident and the theme relating to the challenges of being able to ensure timely call backs, to identify any deterioration in patients' condition. The committee felt this was a thorough and honest review. The medical director will be raising at the national medical director forum concern about the very high number of care line calls, to see how other trusts manage this issue. **Bariatric Care** This was a review detailing the measures taken to meet the objectives in relation to bariatric provision, to include vehicles, equipment and response capability. The committee is partially assured that the Trust has the procedures, resources and equipment in place to support Bariatric care. It asked for the item to come back in November when the training programme is complete. In addition the committee asked to medical director to undertake a review of manual handling and report incidents back to the committee. **Internal Safeguarding** The committee considered the reviewed that management has undertaken of safeguarding cases over the past two years, to assure itself nothing has been missed, including any disciplinary cases with a potential safeguarding component. The committee also received the review of the 'Lampard' recommendations, again to

	ensure nothing has been missed. This review identified some significant gaps, including with recruitment checks, e.g. potential DBS / reference gaps. This links to the staff records risk the Board considered in April. The committee was reassured by the executive that this is a high priority, with measures in place to address the issues by the end of June 2018 – see section below on risk profile. Overall, therefore, the committee is not assured on internal safeguarding. **Medicines Governance** In 2017, Ann Jacklin, independent pharmacist advisor, was instructed by the Trust and NHSI to review and oversee the Trust's medicines governance optimisation plan. This was in two phases, discovery and implementation. Phase 2 (implementation) has now concluded and Ann Jacklin is due to provide her final report in June 2018. In the meantime, she was invite to the committee to summarise her findings. The committee was assured by the feedback, which confirmed that the Trust is now in a position where it can be assured it has the right systems and processes in place with the right leadership to both safely manage its medicines and to also address any variations/ discrepancies in medicines use in a timely and proportionate manner. The meeting also considered performance, including; **Clinical Audit Report 2017/18** The committee felt this was a good report at confirming what has been done, in particular the work to improve out of hospital cardiac arrest. However, it felt that it lacked clarity on how the recommendations have been implemented and impact of them; closing the audit cycle. The committee will review in November the actions and recommendations from clinical audit to test what has changed. This will include monitoring the timely completion of actions. **Medicines Governance QAVs** This was an overview of the quarterly QAVs since October 2017. The committee was concerned to learn that some of the actions recommended by the Chief Pharmacist were slow to be actioned. These had been escalated to the medical director to ensure more timely action. The committee suggested that the executive should consider an escalation process for legally required changes to ensure that these are actioned as a priority.
Reports *not* received as per the annual work plan and action required	The committee did not receive the following items, which have been deferred to June; 1. CFR Governance Management Response 2. Accountable Officer for Controlled Drugs Annual Report
Changes to significant risk profile of the trust identified	Following on from the internal safeguarding scrutiny item noted above, the committee asked management to undertake a risk assessment to be considered by the Trust Board, detailing the risk relating to staff recruitment checks / staff record keeping. This is to be included a risk in the BAF risk report.

and actions required	
Weaknesses in the design or effectiveness of the system of internal control identified and action required	Recruitment checks / Staff records (as above) As evidenced by the feedback from the medicines QAVs, there timely escalation and implantation of actions that are mandated through regulation need to be strengthened.
Any other matters the Committee wishes to escalate to the Board	**CIP QIAs** The committee had expected to receive a summary of the QIAs relating to the CIP schemes for the year ahead. Management confirmed that the schemes are in the processes of being approved and so the QIAs will follow in June. **Risk Register** The committee will set up a small sub-group in June to review the 87 risks from the risk register, aligned to QPS. Overall, the committee was pleased with the quality and timeliness of papers. The next step for management is to ensure more evidence is provided confirming the action taken / to be taken.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	11th May 2018
Overview of issues/areas covered at the meeting:	This was moved from April due to the previous meeting being in March. The meeting considered a number of ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas),* including; **Workforce Planning (Partially Assured)** The committee noted the good progress with pulling a workforce plan together. They need a plan of how the Trust will be shaped and blend of the teams i.e. paramedic numbers, technician numbers etc. This needs to include the recruitment plan. **Culture Programme (Assured)** The committee is really pleased with the work happening on this. The values will be launched on the 12th June and work is already well underway with Executive and Senior Management 360 feedback, coaching sessions and training modules. Concern around HR resource to support this. **Recruitment and Retention in the EOC – Plan to improve (Not Assured)** The committee was not assured that there is a clear plan with timeline to resolve all the issues highlighted. The key areas of pressure are: - Recruitment process - Career paths that pull people out of the EOC - Physical environment in the EOC - Higher paid roles close to EOC i.e. Virgin Atlantic Call Centre - Quality of line management There has been good work carried out to understand what the problems are but committee requires a plan to understand the action to resolve them, quick wins and resource required. **Personnel Files (Partial Assured)** The committee were assured that work was underway to clearly define the size of the issue and create a clear project plan to resolved. This also includes the pre-appointment screening including DBS checks. However, this is a high risk and the committee recommend to the Executive team that this is adequately resource. The committee also reviewed the usual **workforce dashboard**. In consideration of this it has asked management to provide themes for each meeting along with analysis for the committee to discuss. The committee reviewed committee **risks.** The committees view is the risks register requires further development to accurately reflect the granularity of risks. The **HR Transformation Programme** was discussed to ensure the committee had an understanding of the changes happening within HR.

Reports *not* received as per the annual work plan and action required	None
Changes to significant risk profile of the trust identified and actions required	None – the committee reviewed the workforce risks on the risk register and was confident that they reflected the current issues.
Weaknesses in the design or effectiveness of the system of internal control identified and action required	The risk register needs to be further developed for the next committee meeting to give clear risks with mitigating actions.
Any other matters the Committee wishes to escalate to the Board	The committee will also prioritise the scrutiny of health and safety during Q2 of 2018/19.

NHS
South East Coast
Ambulance Service
NHS Foundation Trust

Integrated Performance Report

Performance Data for our 999 and 111 Services

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

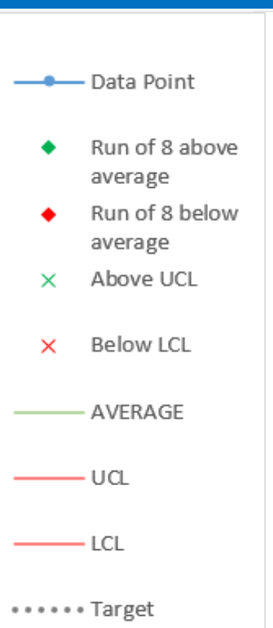
Board Meeting

May 2018

Contents

SECAmb CQC Rating and Oversight Framework

Chart Key



This represents the value being measured on the chart

These points will show on a chart when the value is above or below the average for 8 consecutive points. This is seen as statistically significant and an area that should be reviewed.
When a value point falls above or below the control limits, it is seen as a point of statistical significance and should be investigated for a root cause.

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

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

The target is either and Internal or National target to be met, with the values ideally falling above or below this point.

SECAmb Executive Summary

This report now contains reference to the Care Quality Commission domains and sets out the must and should do requirements as set out in the Trust's inspection report. The Board will be aware that projects intended to respond to the findings of the Care Quality Commission and reports on progress can be found in the overarching Delivery Plan.

As a number of projects are nearing completion, the projects will be subject to a closure process and handover to Business as Usual. This will mean that data previously reported within the Delivery Plan will transfer to this Integrated Performance Report (IPR). This will ensure that the Trust Board is assured of sustained recovery and continuous quality improvement. This will result in a more detailed report over time as projects are completed together with the provision of specific and targeted detail in the Trust's day to day operations and Strategic planning.

In addition to the above, each area of the report is prefaced with the opportunity to reflect on where areas of work support and provide evidence for compliance with the Care Quality Commission Domains. The Trust Board is asked to note that the Finance Directorate is compiling information intended to respond to the Care Quality Commission's enquiries in financial – well led. This remains work in progress although a financial performance summary is included below.

Further development of the report will be undertaken with Executive and Non Executive Directors to ensure that there is a clear flow between organisational objectives, organisational risk and the content of the IPR. As stated above, compliance with many requirements is reported on through the Trust's Delivery Plan whilst projects remain live. The Trust is also undertaking a process of reviewing and developing its 5 year Strategic Plan (required annually) and this will comprise a stock take and reappraisal of organisation objectives.

In summary, as this report continues to evolve and expand it will transfer the assurance function from our Delivery Plan to Business as Usual reporting. This will provide the Trust Board with a clear line of site as to compliance with Care Quality Commission standards and how the Trust responds to organisational risk and issues.

SECAmb Our People

The HR Directorate are currently undergoing a HR Transformation Programme to allow us to support our staff. For us to be a successful Ambulance Trust we need people inside and outside the organisation to see our culture defined as an inclusive, attractive, effective and safe place to work. The HR Transformation Programme consists of the following work streams:

Re-engineering key People Processes
Re-design of the HR function
Culture Change programme for SECAmb
Identification and management of HR-related risk
Development of the People Strategy and the HR Delivery Plan

SECAmb Financial Performance

The Trust has achieved its control total of £1.0m deficit for the year, this includes the agreed Sustainability and Transformation Funding (STF) of £1.3m. In addition, the Trust has received further STF (incentive plus bonus) of £1.4m and CQUIN risk reserve previously held by commissioners of £0.8m, resulting in a reported surplus of £1.3m for 2017/18.

The Trust achieved a Cost Improvements of £15.5m this was greater than the target of £15.1m.

The Trust's Use of Resources Risk Rating (UoRR) is a 1, a significant improvement on the planned level of 3 due to the favourable late adjustments as described above.

The Trust has submitted its 2018/19 plan to NHSI on the 30 April 2018, which meets its control total of £0.8m deficit.

Risks to this plan include the delivery of its CIP targets, outcome of the Demand and Capacity review, delivery of performance targets, being able to come out of CQC special measures, recruitment difficulties and any unfunded local pay pressures. Engagement with its partners is ongoing in order to mitigate as many of these as possible.

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.

Safe

CQC Findings ('Must or Should Do')

- The Trust must take action to ensure they keep a complete and accurate recording of all 999 calls.
- 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.
- 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.
- The Trust must take action to ensure all staff understand their responsibilities to report incidents.
- The Trust must ensure improvements are made on reporting of low harm and near miss incidents.
- The Trust must investigate incidents in a timely way and share learning with all relevant staff.
- 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.
- The Trust must ensure patient records are completed, accurate and fit for purpose, kept confidential and stored securely.
- The Trust must ensure the CAD system is effectively maintained.
- 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.
- The Trust must ensure all medical equipment is adequately serviced and maintained.
- The Trust should take action to audit 999 calls at a frequency that meets evidence based guidelines.
- The Trust should review all out of date policies.
- The Trust should ensure all first aid bags have a consistent contents list and they are stored securely within the bags.
- The Trust should ensure all ambulance stations and vehicles are kept secured.
- The Trust should ensure all vehicle crews have sufficient time to undertake daily vehicle checks within their allocated shifts.

Caring

- The Trust should ensure that patients are always involved in their care and treatment.
- The Trust should ensure that patients are always treated with dignity and respect.

Effective

- The Trust must take action to meet national performance targets.
- The Trust must improve outcomes for patients who receive care and treatment.
- The Trust must continue to ensure there are adequate resources available to undertake regular audits and robust monitoring of the services provided.
- The Trust should ensure there are systems and resources available to monitor and assess the competency of staff.

Responsive

- The Trust must ensure the systems and processes in place to manage, investigate and respond to complaints, and learn from complaints are robust.
- 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.
- 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.
- 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.
- The Trust should continue to address the handover delays at acute hospitals.
- 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.

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.
- 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.
- The Trust should consider improving communications about any changes are effective and timely, including the methods used.
- 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.
- The Trust should continue to sustain the action plan from the findings of staff surveys, including addressing the perceived culture of bullying and harassment.

SECAmb Clinical Safety - Safe

Patient records: The backlog in scanning Patient Clinical Records (PCRs) has now been cleared, allowing forms to be validated on arrival. The Trust moved to a 4 digit CAD number on 18th April. It is too early to know whether this change has had the desired effect of further reducing the number of PCRs which are not linked with CAD numbers.

Medicines Management: Regular auditing of medicines management at OU level is undertaken by Operational Team Leaders, with high levels of compliance (>95%). Quality Assurance Visits (announced and unannounced) provide further evidence of compliance. Temperature monitoring is undertaken daily on all sites, with central monitoring through the OTL checks. This has proved effective, but very time consuming, so a business case is being prepared to source reliable electronic monitoring.

SECAmb Clinical Safety - Caring

SECAmb Clinical Safety - Effective

National performance targets: The clinical indicator data summarises November performance, with 3 months available to collect outcome data (survival to discharge) from hospitals, and a further month to validate the national return to DH.

The number of patients in each group is small, leading to month on month variation. However, the Trust generally tracks below the national average. The care bundles for stroke and STEMI tell a similar story.

The initiatives undertaken thus far have included analysing the care bundles to identify those areas where we fail to score well and to publicise to staff where practice, and in particular documentation could be improved. This has been done through regular articles in the weekly bulletin encouraging staff to complete all the elements of the FAST, to record blood glucose measurements (both for stroke) and to record two pain scores and administer pain relief to any patient with a score over zero. This approach does not appear to have been effective. We will now undertake a different approach, looking to see which ambulance services regularly perform well against these indicators and analysing how we might learn from this.

SECAmb Clinical Safety - Responsive

Demand management: The Trust introduced the Surge Management Plan on 19th February 2018, superseding the Demand Management Plan. This allows the Trust to prioritise responses to the most seriously ill and injured patients at times when demand exceeds the available resource.

On occasions when the higher escalation levels of Purple and Black permit alternative scripts to be used, clinical review is undertaken to ensure the safety of these decisions. The Head of Compliance also undertakes a retrospective review of any case where a response has not been dispatched to review the safety of the decision, the adherence to protocol and to flag any area for learning.

SECAmb Clinical Safety - Well Led

SECAmb Clinical Safety Scorecard

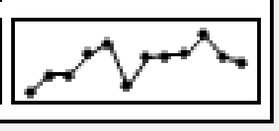
Cardiac Return of Spontaneous Circulation (ROSC) - Utstein (a set of guidelines for uniform reporting of cardiac arrest)

	Sep-17	Oct-17	Nov-17	12 Month's
Actual %	50.0%	50.0%	51.2%	
Previous Year %	44.1%	48.1%	46.9%	
National Average %	51.0%	55.1%	47.4%	

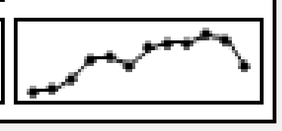
Cardiac ROSC - ALL

	Sep-17	Oct-17	Nov-17	12 Month's
Actual %	25.7%	25.2%	24.1%	
Previous Year %	25.3%	27.8%	25.1%	
National Average %	32.0%	30.2%	28.5%	

Cardiac Survival - Utstein

	Sep-17	Oct-17	Nov-17	12 Month's
Actual %	26.3%	30.8%	32.5%	
Previous Year %	30.0%	15.4%	4.8%	
National Average %	32.8%	28.3%	27.3%	

Cardiac Survival - All

	Sep-17	Oct-17	Nov-17	12 Month's
Actual %	5.7%	10.9%	9.9%	
Previous Year %	9.4%	4.3%	2.4%	
National Average %	10.6%	10.2%	8.3%	

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

	Sep-17	Oct-17	Nov-17	12 Month's
Actual %	71.9%	57.4%	70.6%	
Previous Year %	76.6%	63.1%	67.6%	
National Average %	76.9%	76.4%	76.0%	

Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography

	Sep-17	Oct-17	Nov-17	12 Month's
Mean (hh:mm)			02:11	
National Average			02:12	
90th Centile (hh:mm)			02:45	
National Average			02:58	

Stroke - call to hospital arrival

	Sep-17	Oct-17	Nov-17	12 Month's
Mean (hh:mm)			01:08	
National Average			01:13	
50th Centile (hh:mm)			01:01	
National Average			01:06	
90th Centile (hh:mm)			01:38	
National Average			01:49	

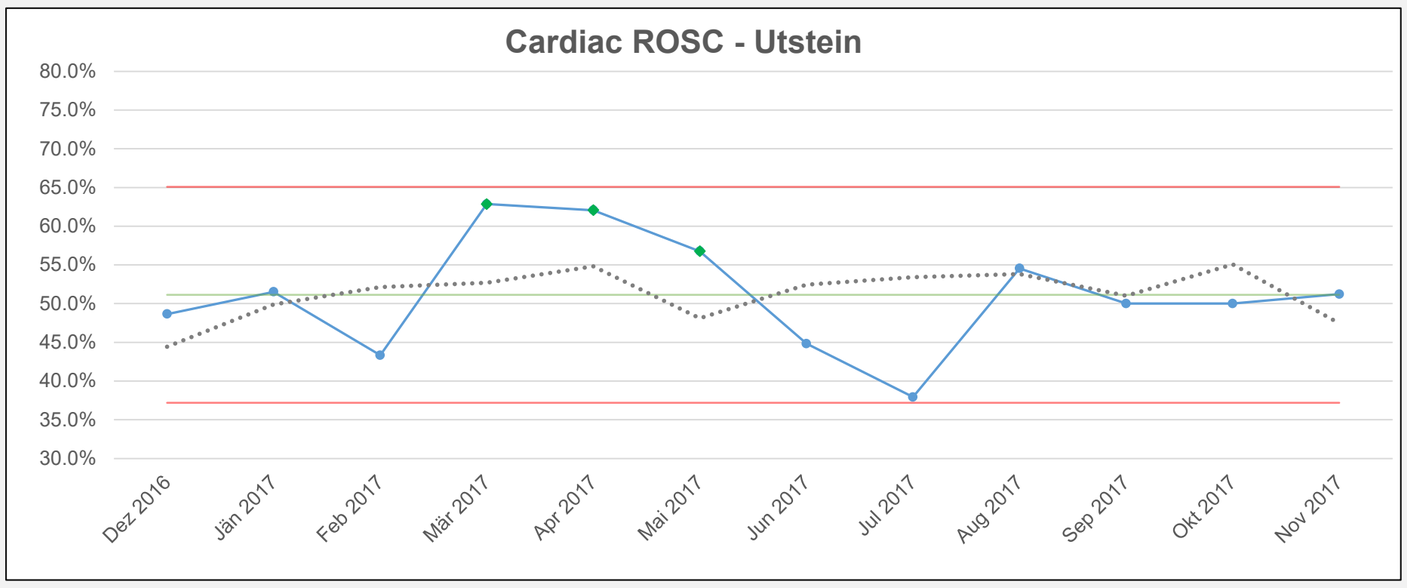
Stroke - assessed F2F diagnostic bundle

	Sep-17	Oct-17	Nov-17	12 Month's
Actual %	93.1%	93.5%	96.2%	
Previous Year %	95.6%	95.4%	96.3%	
National Average %	96.7%	97.1%	97.0%	

Medicines Management

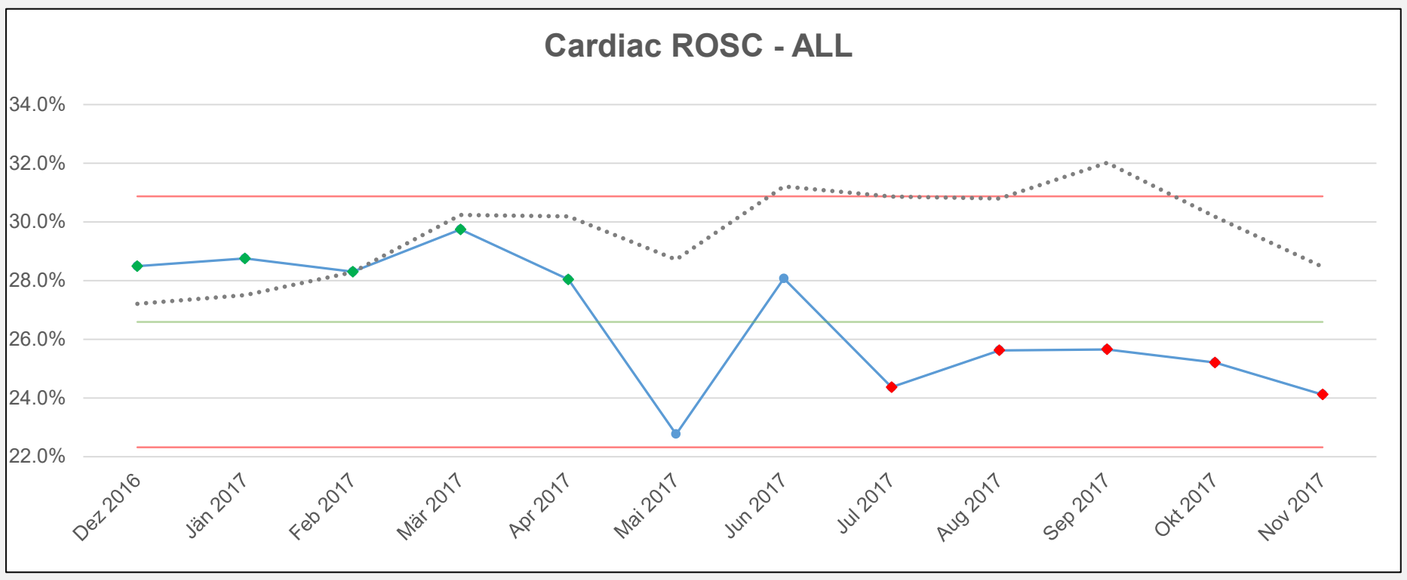
	Jan-18	Feb-18	Mar-18	12 Month's
Actual	97.76%	97.57%	97.50%	
Number of audits	201	190	201	

SECAmb Clinical Safety Charts



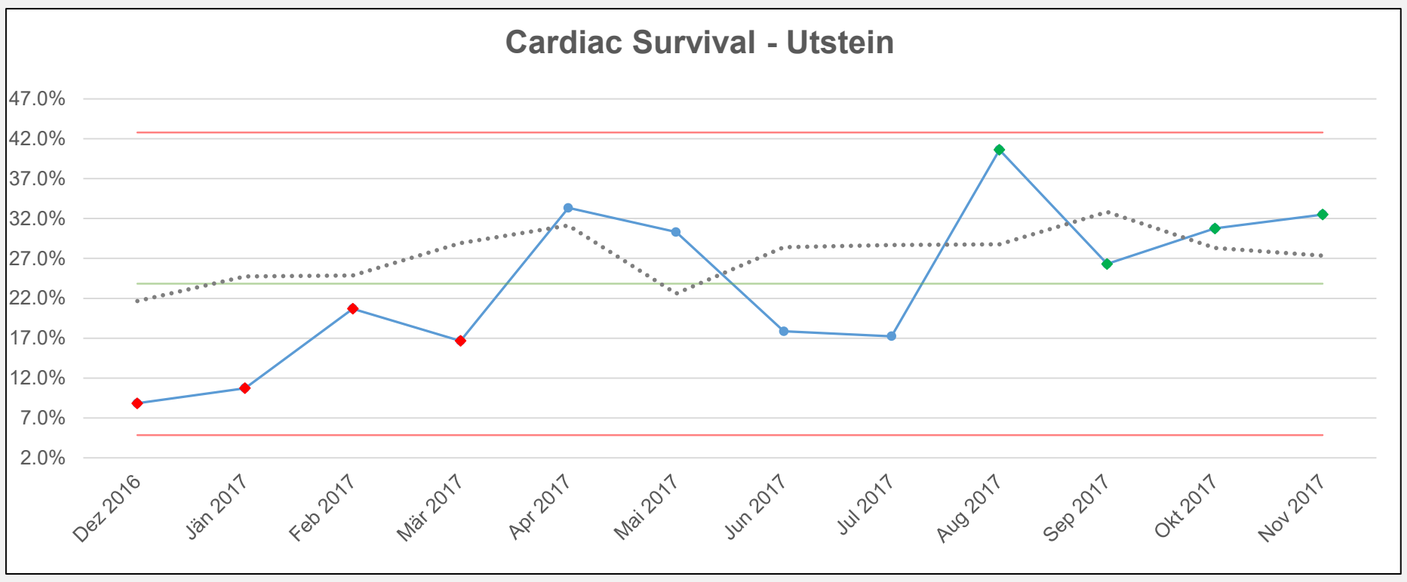
Performance for the cardiac arrest ROSC indicator for the Utstein group for November 2017 is in line with SECAmb YTD and above the national average.

The medical directorate has allocated a senior clinician to lead on the Trust's cardiac arrest survival improvement programme from May to July initially.



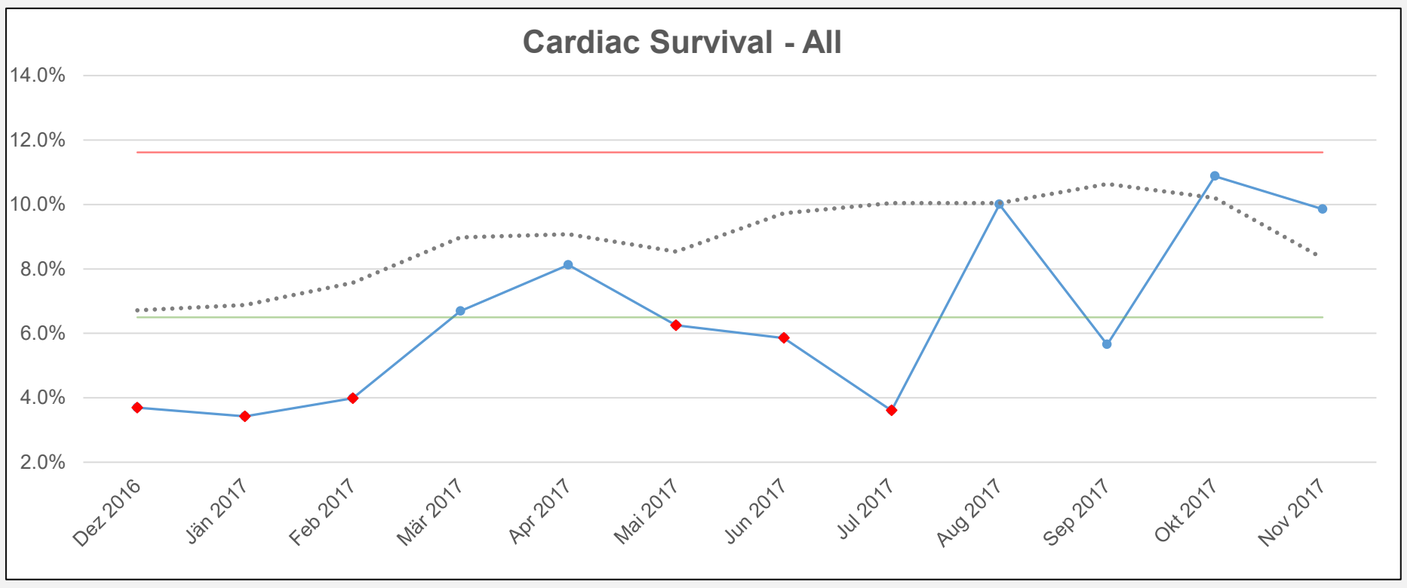
In November 2017 our performance for ROSC in all patient groups remains below the SECAmb YTD average.

A low proportion of patients gaining a ROSC is in line with delays in call answering and response times in November 2017



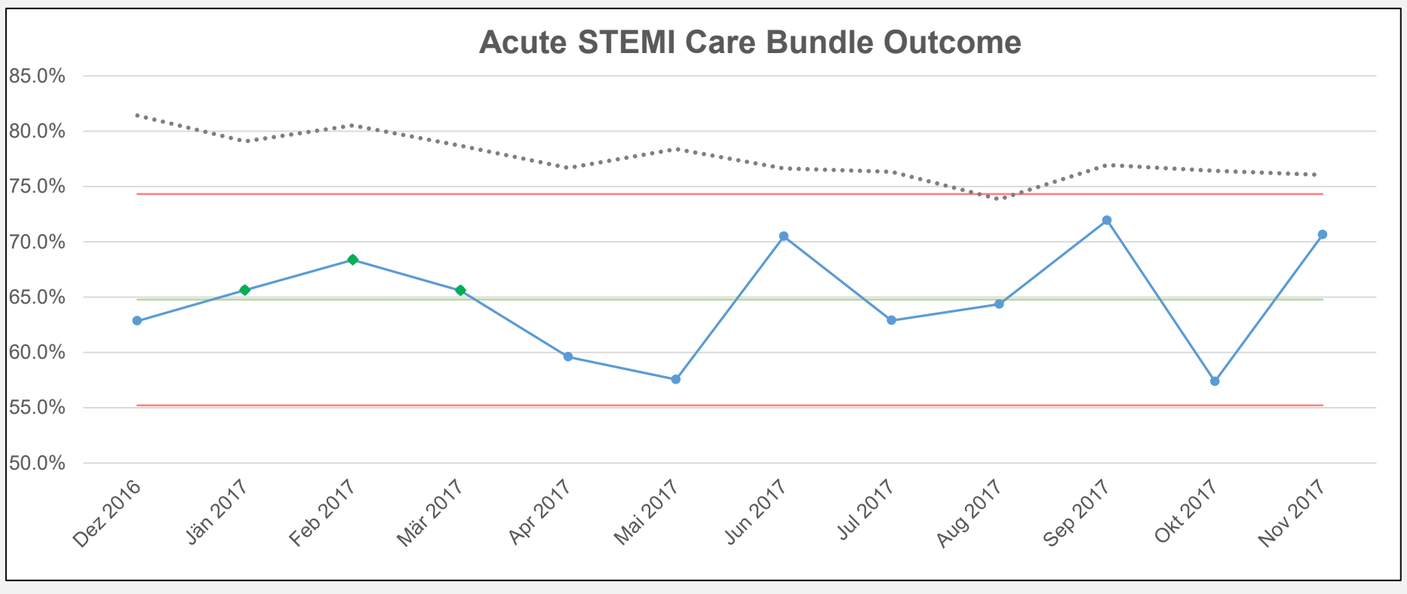
In November 2017, survival to discharge for the Utstein group was above our mean and above the national average. The data continues to show normal patterns of variation.

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

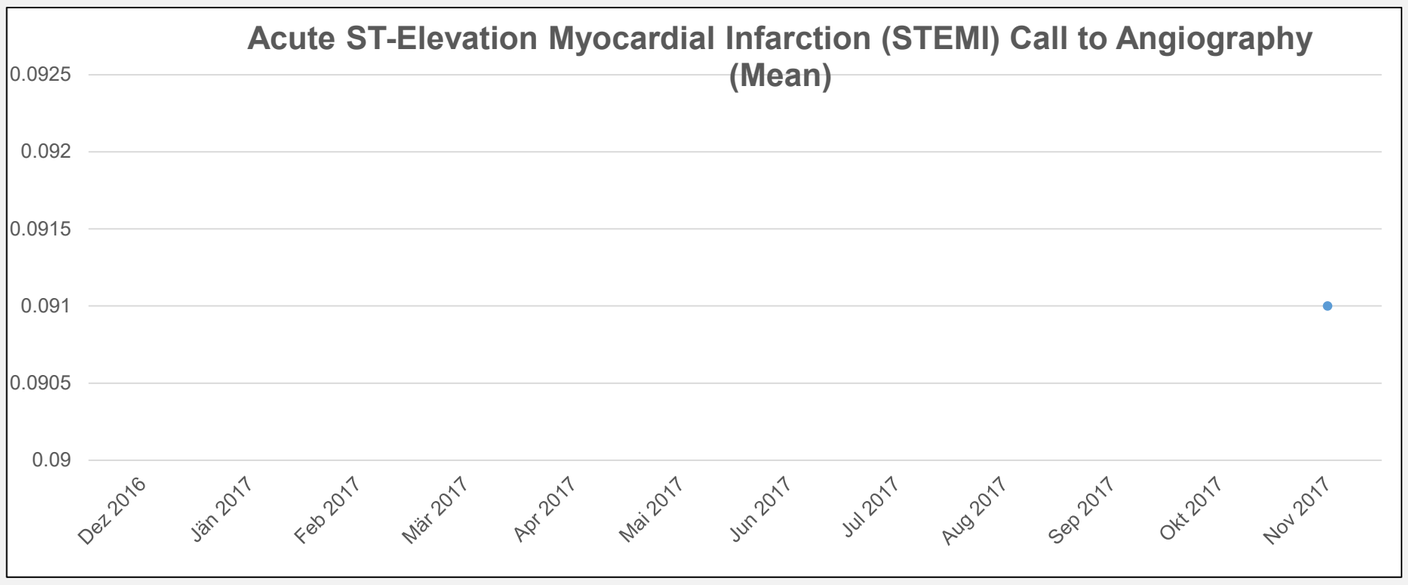
This appears to be in line with normal patterns of variation.



Performance for November 2017 was below the national average.

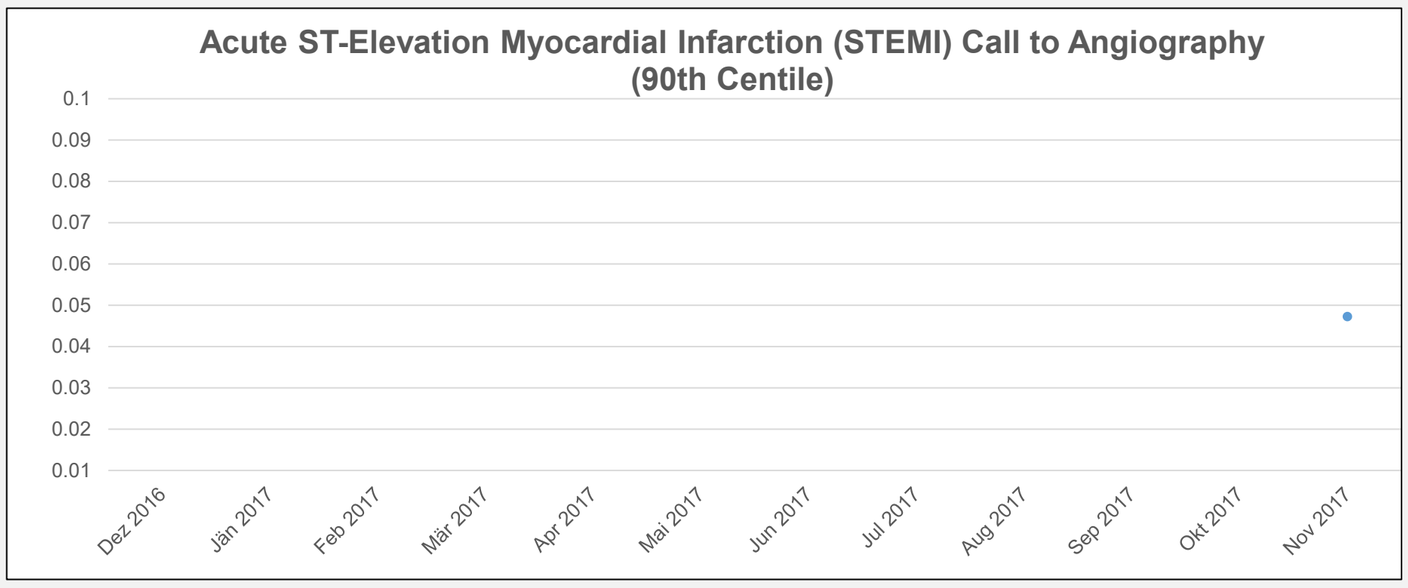
Dashboards and quality scorecards showing local performance levels are now routinely being shared with Operating Units (OUs) to facilitate focussed quality improvement. A suite of feedback tools and information sheets has also been developed.

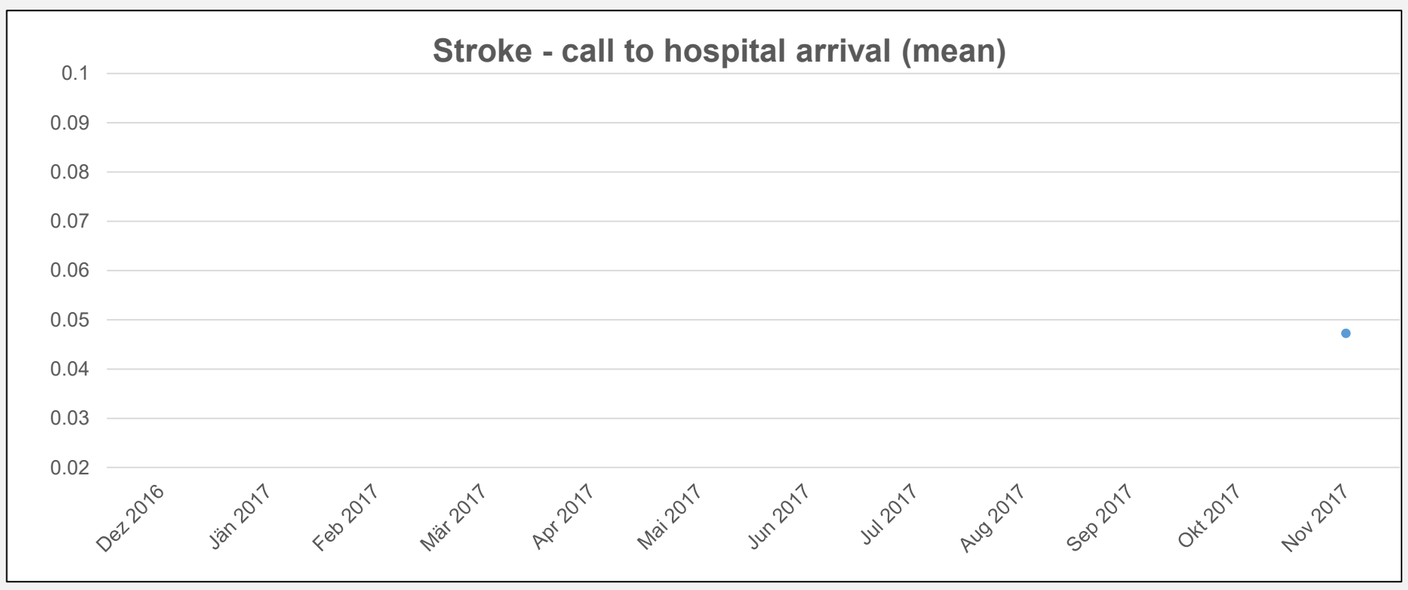
SECAmb Clinical Safety Charts



In November 2017 the method for measuring the timeliness of care delivered to STEMI patients changed to a measure of mean and 90th centile call to angiography (the procedure used to visualise the blood vessels that supply the heart).

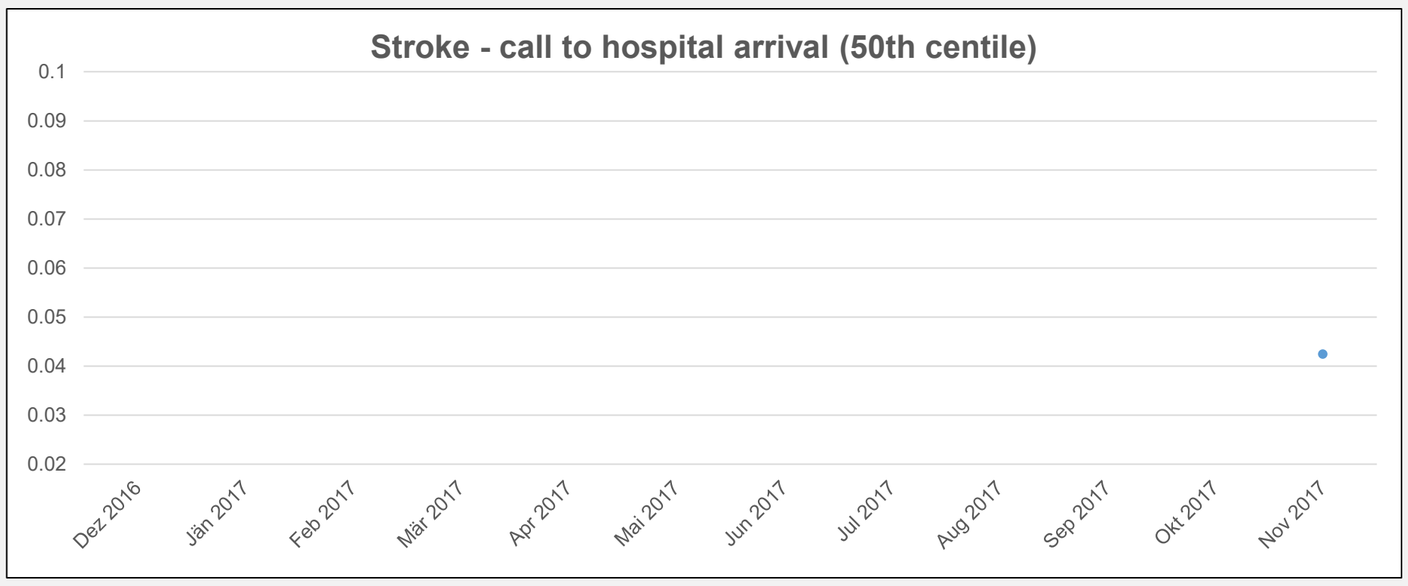
This data is reported by acute Trusts into the Myocardial Ischemia National Audit Project (MINAP) database. This database only contains confirmed STEMIs, rather than suspected STEMIs that this measure was previously based upon.

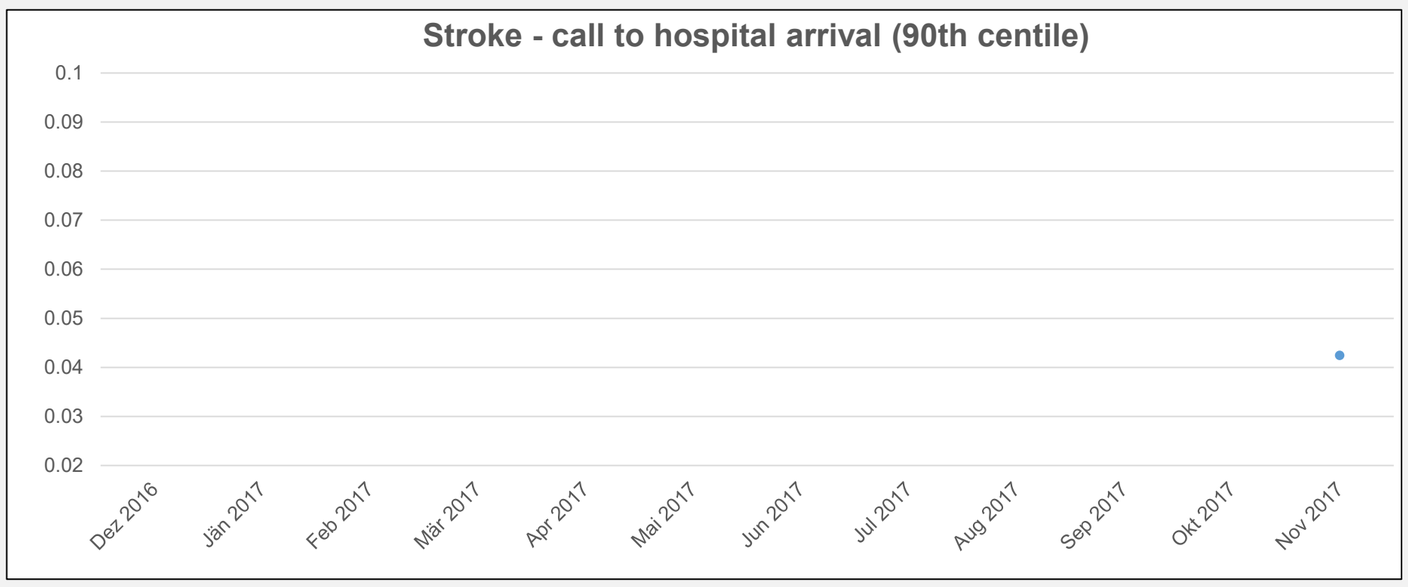




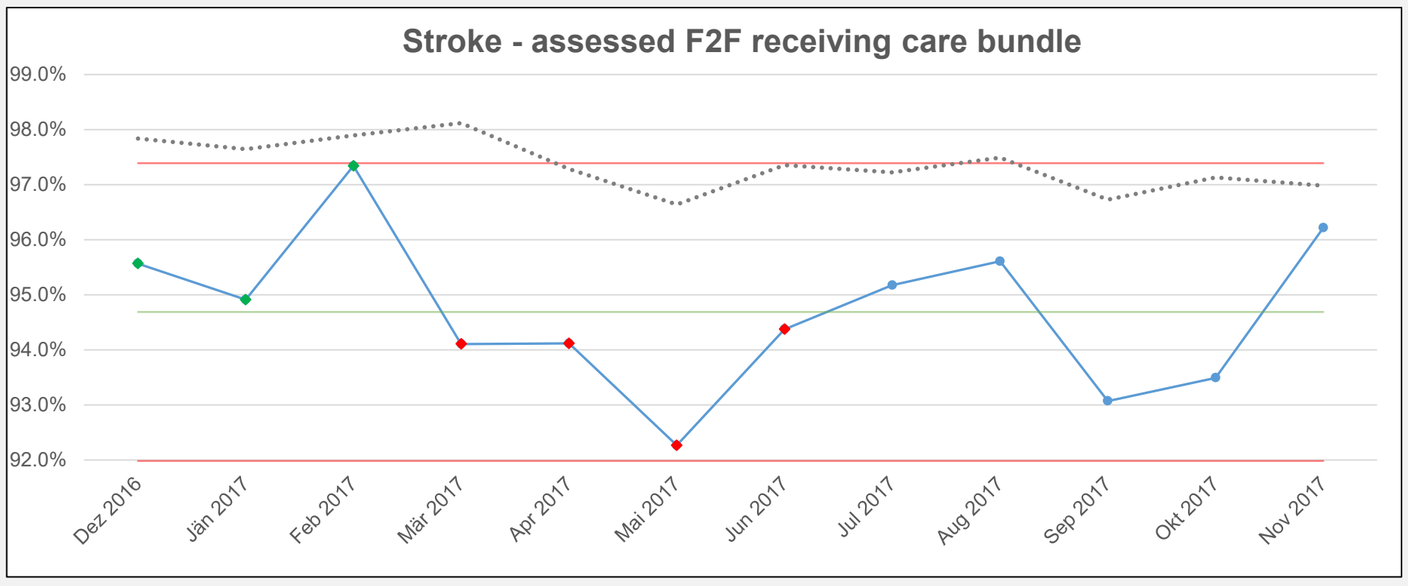
In November 2017 the method for measuring the timeliness of care delivered to stroke patients changed to a measure of mean and 90th centile call to arrival at a hyper-acute stroke centre.

This data is reported by acute Trusts into the Sentinel Stroke National Audit Programme (SSNAP) database. This database only contains confirmed strokes, rather than suspected strokes that this measure was previously based upon.





SECAmb Clinical Safety Charts



Performance in completing the stroke care bundle is below national 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. A suite of feedback tools and information sheets has also been developed.

For internal circulation only

Analysis of Cardiac Arrest Data – Nov 2017

Number of cardiac arrests identified = 708
includes DNACPR 53 (7%) / DOA 364 (51%) / No Resus by SECAmb 6 (1%) /
In Hospital Arrest 2 (0%) / Post Arrest 1 (0%)

Number of Resuscitation Attempts = 289 (41%)
including DNACPR 5 (2%) / Hospital Arrests 2 (1%)

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 = 41 (14%)

Overall = 282 (98%)

ROSC sustained to hospital
= 21 (51%) + 0 non ROSC

ROSC (incl. Utstein) sustained to hospital
68 = (24%) + 8 non ROSC

Outcomes for ROSC at Hospital and Non ROSC at Hospital Patients		
Utstein	Details	Overall
13	Patient survived to discharge	27
7	Patient died in hospital	41
1	Patient still in hospital*	3
0	Not found – no patient identifiable data*	5
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 (Utstein) = 13 (33%)

Survival to Discharge (inc Utstein) = 27 (10%)

Additional Information – Resuscitation Attempts

Cardiac Rhythm	Overall Totals	ROSC at Hospital	Non ROSC at Hospital
Asystole	154 (55%)	12	2
PEA	55 (20%)	15	3
VF	63 (22%)	35	3
Non-shockable	6 (2%)	5	0
Not recorded	4 (1%)	1	0

CPR Bystander – 149 (53%)

EMS Witnessed arrest – 36 (13%)

Cardiac Arrest downloads received for Nov 17	0
Cardiac Arrest download reports sent to crews N	0

SECAmb Clinical Quality - Safe

Incident reporting has reduced in the quarter – however this is comparable for the same quarter last year. The overall incident reporting is on average a 20% increase from last year.

All incident reporting is now transferred into DATIX system (quality assurance visits, complaints that are identified as incidents, road traffic collision).

Hand hygiene compliance has improved to above the 90% compliance target.

All safeguarding training compliance achieved.

SECAmb Clinical Quality - Caring

90% compliance with the internal 10 day target (nationally the target is “when reasonably possible”) continues to be tracked and monitored through DATIX.

123 compliments received, which is less than last month of 139.

SECAmb Clinical Quality - Effective

Incident reporting closure “backlog” remains within local KPIs equivalent to 2 weeks of reporting.

SECAmb Clinical Quality - Responsive

Incident reporting access approved for private providers and community first responders.

97% complaint response within time scale.

Serious incident reporting weekly increased to 12 for the month – 5 x delayed attendance.

SECAmb Clinical Quality - Well Led

Proposal for improvement plan closure to BAU for complaints and safeguarding

SECAmb Clinical Quality Scorecard

Number of Incidents Reported

	Jan-18	Feb-18	Mar-18	12 Month's
Actual	748	591	627	
Previous Year	529	465	495	

Number of Incidents Reported that were SI's

	Jan-18	Feb-18	Mar-18	12 Month's
Actual	22	6	12	
Previous Year	1	5	6	

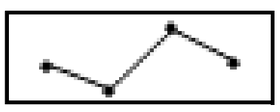
Duty of Candour Compliance (SIs)

	Jan-18	Feb-18	Mar-18	12 Month's
Actual %	100%	100%	90%	
Target	100%	100%	100%	

Number of Complaints

	Jan-18	Feb-18	Mar-18	12 Month's
Actual	111	127	112	
Previous Year	132	96	87	
Complaints Timeliness (All	59.6%	98.2%	97.7%	
Timeliness Target	95%	95%	95%	

Compliments

	Jan-18	Feb-18	Mar-18	12 Month's
Actual	109	139	123	

Safeguarding Training Completed (Adult) Level 2

	Jan-18	Feb-18	Mar-18	12 Month's
Actual %	69.33%	85.66%	94.62%	
Previous Year %	76.20%	89.07%	90.90%	
Target	85%	85%	85%	

Safeguarding Training Completed (Children) Level 2

	Jan-18	Feb-18	Mar-18	12 Month's
Actual %	69.63%	84.36%	93.99%	
Previous Year %	75.90%	89.79%	91.70%	
Target	85%	85%	85%	

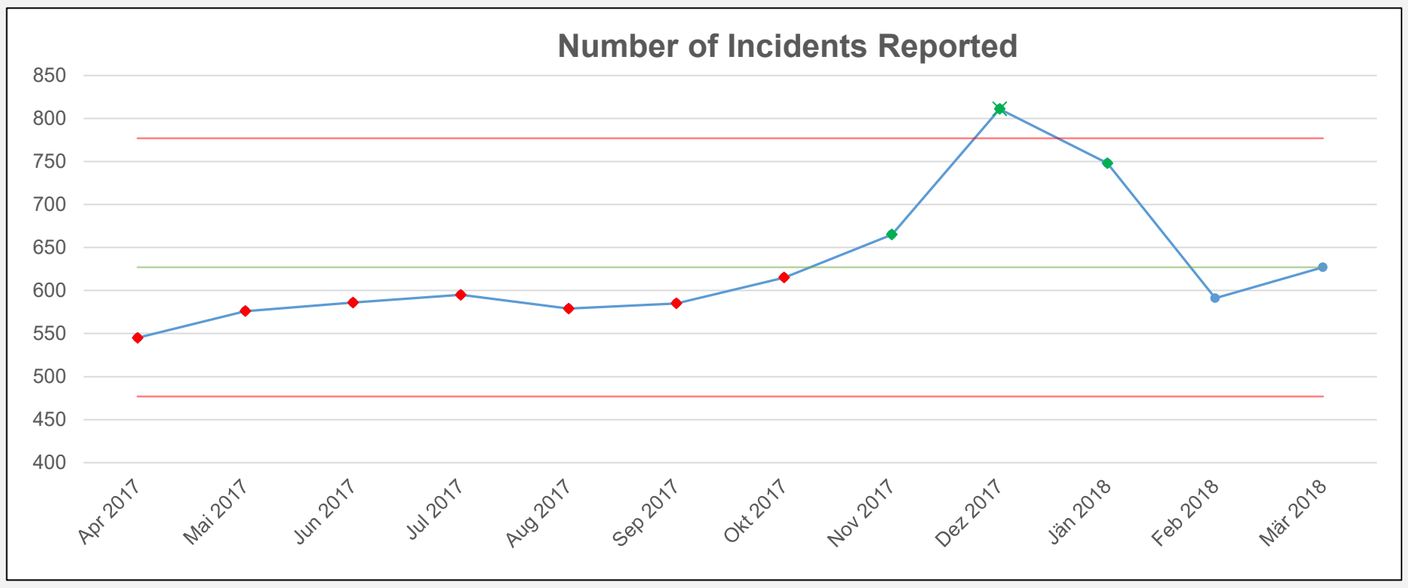
Safeguarding Training Level 3 (Adult/Child)

	Jan-18	Feb-18	Mar-18	12 Month's
Actual %	77.58%	92.15%	98.04%	

Hand Hygiene

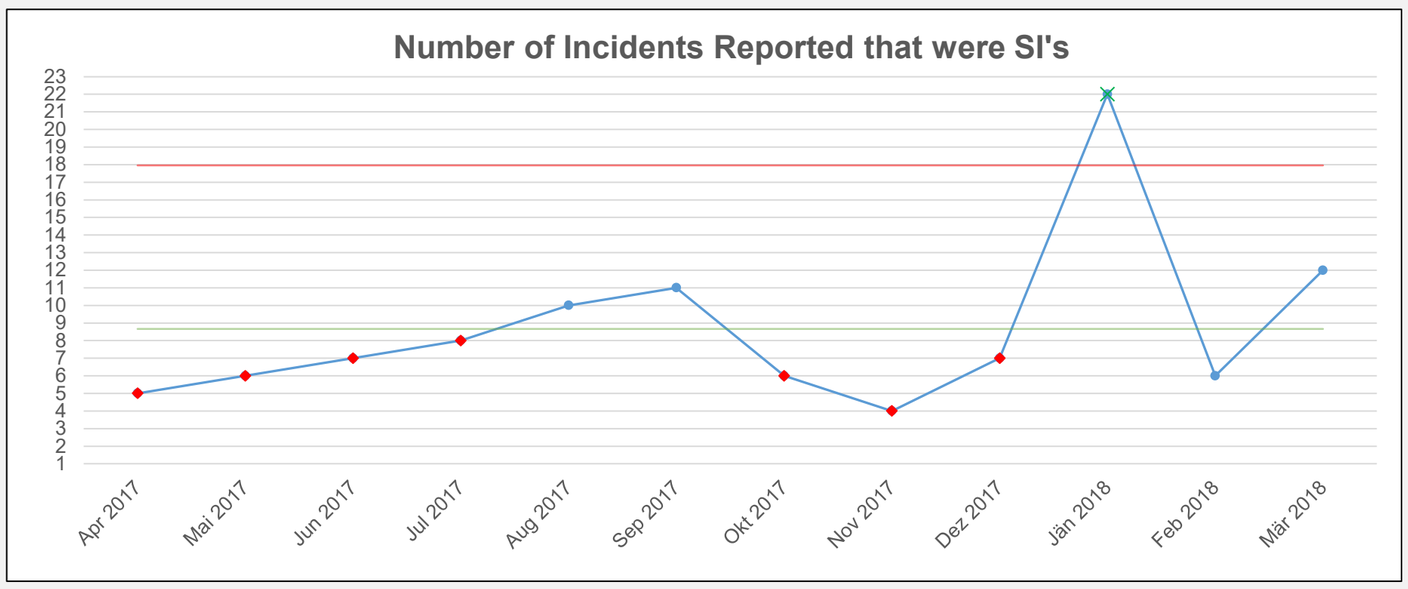
	Jan-18	Feb-18	Mar-18	12 Month's
Actual %	84%	89%	92%	
Target	90%	90%	90%	

SECAmb Clinical Quality Charts



Incident reporting rates have increased slightly in March 2018. Reporting rates are currently expected to rise over the next few months as a number of other reporting processes will be transferring to the Datix system. These include; the incident identified by the Quality Assurance Visits, Complaints that are also incidents being reported, RTC incidents and CFR's and PAP's are currently negotiating a process for incidents to be up loaded onto Datix.

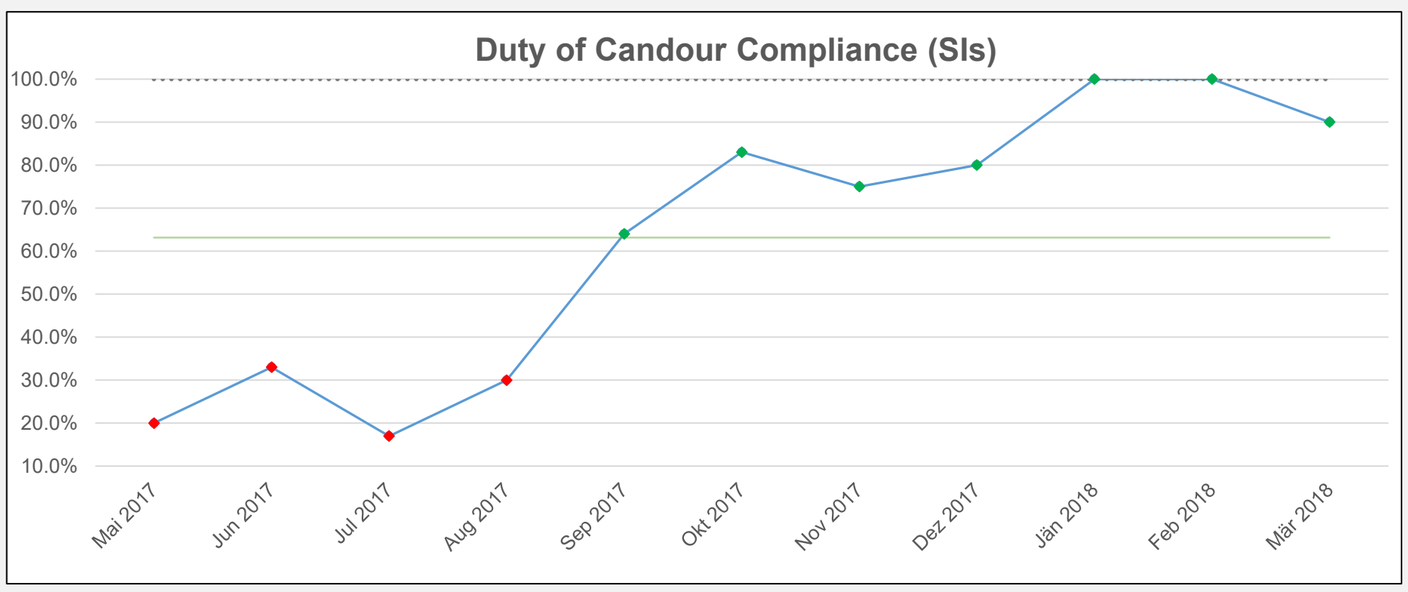
The Trust board should be aware that there are currently no significant backlogs held within the Datix system.



12 SIs were reported for the following reasons:

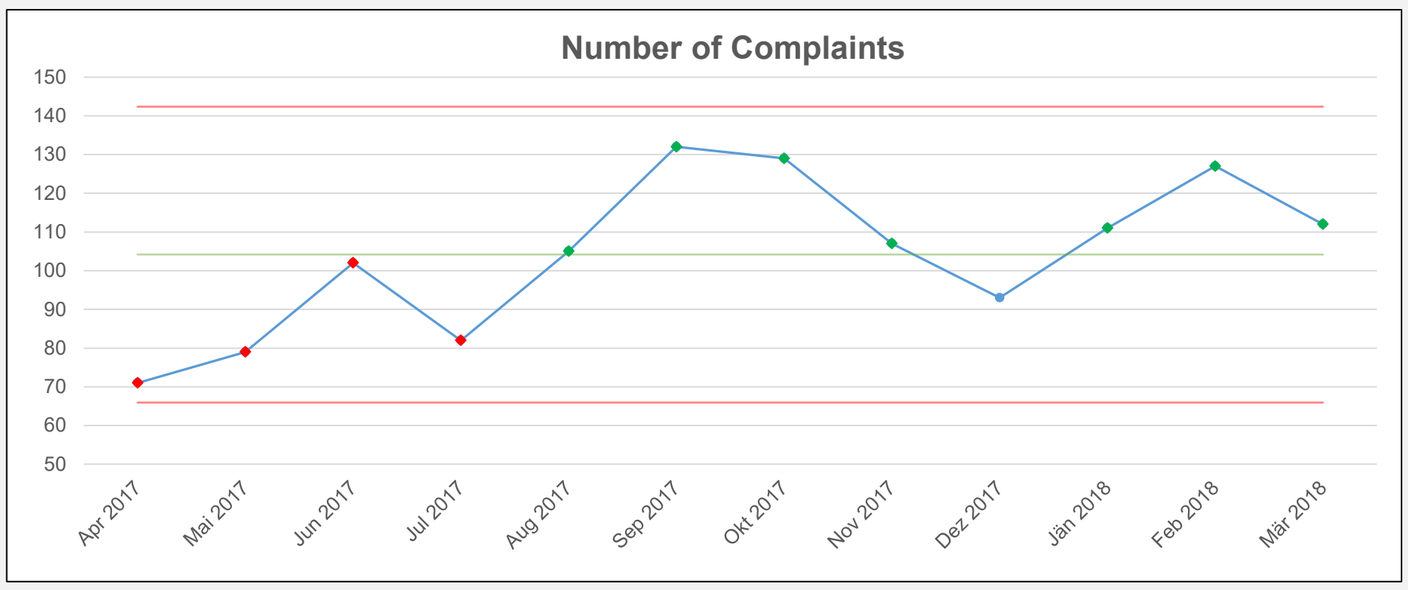
Delayed attendance - 5
Call Answer delay – 2
Patient Care – 1
Triage – 4

Service Areas reporting were:
A&E Ops – 1
EOC – 10
KMSS111 -1

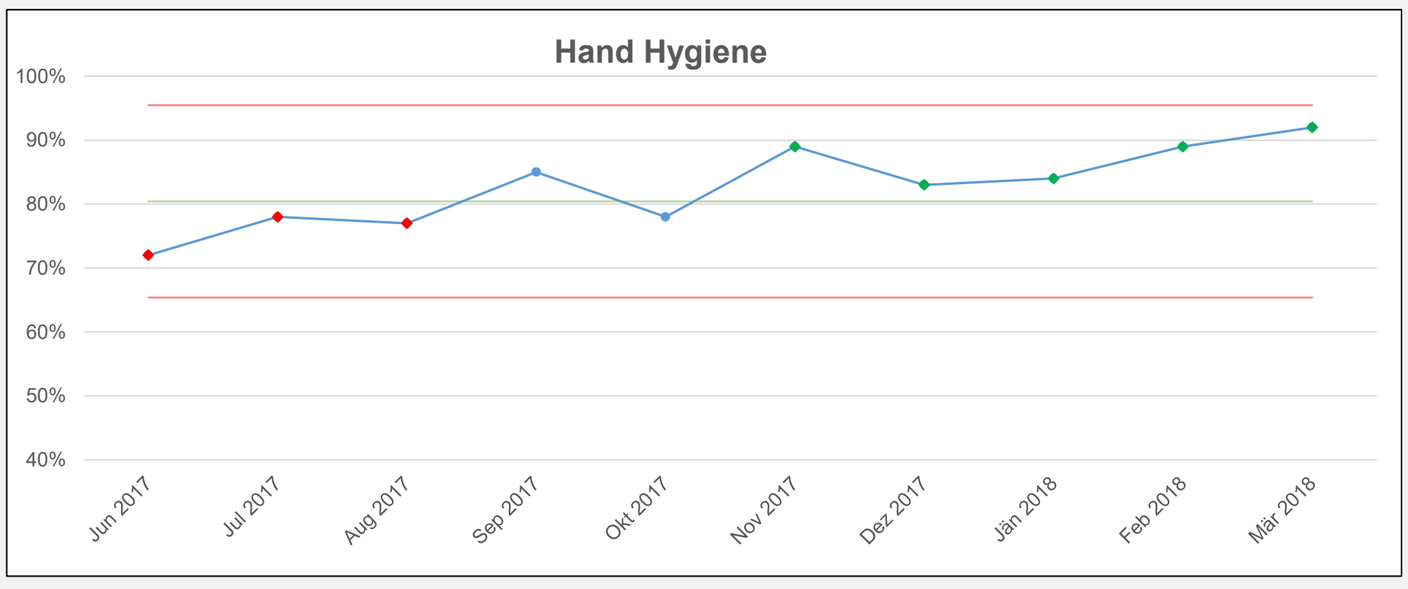


Reporting on this indicator reflects the due date during the month to meet DoC.

100% for those SIs requiring Duty of Candour were completed this month. 90% were within the 10 day internal deadline.



The Trust received and opened 112 complaints in March 2018, which is slightly more than the monthly average for the year of 104.
The top three subjects of complaints for all English ambulance services are invariably patient care; timeliness; and staff behaviours, and the order of these varies from month to month and service to service. The subject with the highest number of complaints for SECAmb in March was timeliness, with 45 complaints compared to 41 in February, 35 in January and 32 in December. Of these, 42 were about ambulance response time. There were 36 complaints about 'patient care' (which includes EOC and 111 triage), compared to 46 in February; and 28 about staff behaviours compared to 27 in February. Every week since the beginning of February the Trust has concluded in excess of 90% of complaints within timescale, with 97.7% (125/128) concluded within timescale in March.



This is the first month that we have achieved the target for hand hygiene compliance, which is showing as 92% for a 90% target. We are still seeing some Operating Units (OU's) not maintaining the requirement of ten audits per week. They were – Brighton, Tangmere / Worthing, Paddock Wood and Gatwick / Redhill. Gatwick HART were also four short of their monthly total required.

A new IPC Audit Schedule has been sent out to all OU's which we hope will make it easier for teams to manage the process and maintain the required number of audits undertaken and we will report on the outcome of this new schedule next month.

Health and Safety (H&S)

Introduction

The Head of H&S vacancy remains unfilled as one of the shortlisted candidates withdrew and the other failed to attend. We are seeking financial approval for an agency solution in the short term while we advertise again with a suitable candidate available already interviewed and available in two weeks.
The external review of our H&S provision continues with a number of location based visits and interviews having taken place.
The terms of reference for the central H&S working group have been amended to reflect the need to review the risk register as a standing agenda item.
The Leadership patient and staff safety walk round procedure has been agreed at the Board and will now need to be ratified via JPF and SMT.
The first quarterly H&S report went to the Board this month.
Due to continued staff shortages within the H&S team we have been unable to progress the regional H&S groups or site H&S inspection procedure although we have carried out a survey to understand the different methods currently in operation across the trust.

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 with a reduction in physical assaults from last year. We currently have a sanction rate of 40% but with a reduction in criminal sanctions and a rise in civil sanctions.

Manual handling Incidents - See Figure 2 below

Manual handling incidents remain high but are predominantly low harm with a slight upward trend over the year. Community First Responders have now been given access to DATIX which will allow them to report incidents first hand rather than relying on SECAMB staff to complete on their behalf. We will need to monitor this to see if it has removed a barrier to reporting and if we have been historically been under reporting in this area.

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. We will look first at the outlier, Polegate and Hastings, to begin to understand the reasons.

H&S incidents - See Figure 3 below

The upward trend seen through Q3 has dropped off in Q4 possibly due to the lack of H&S resourcing to drive reporting of H&S incidents. 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 but will not be instigated until the H&S team is strengthened. A further Board level IOSH training session is required to inform more of the executive team of their H&S responsibilities. The planned program of patient and staff leadership walk rounds will 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 and have messaged managers several times. This includes messages from the Director of Operations and the Deputy Clinical Director, to emphasise the statutory imperative to capture this at the earliest opportunity. We are also exploring a notification directly from GRS when a member of staff books sick as a result of an injury or assault sustained at work.

Figure 1

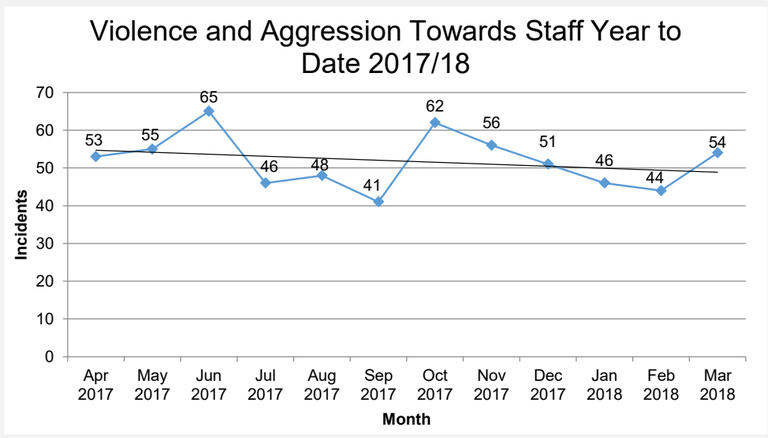


Figure 2

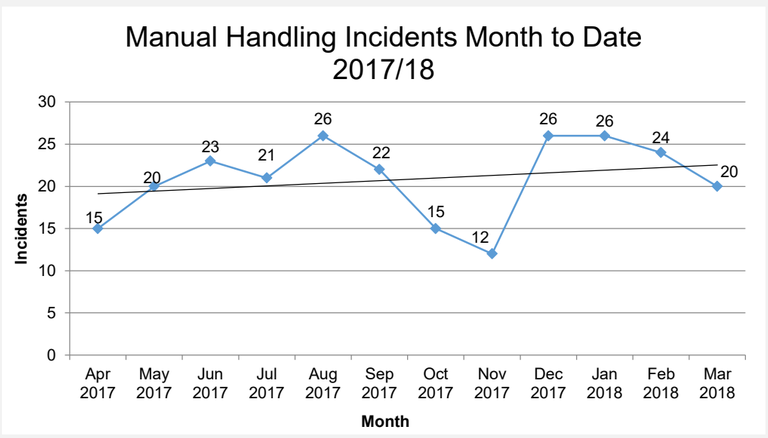


Figure 3

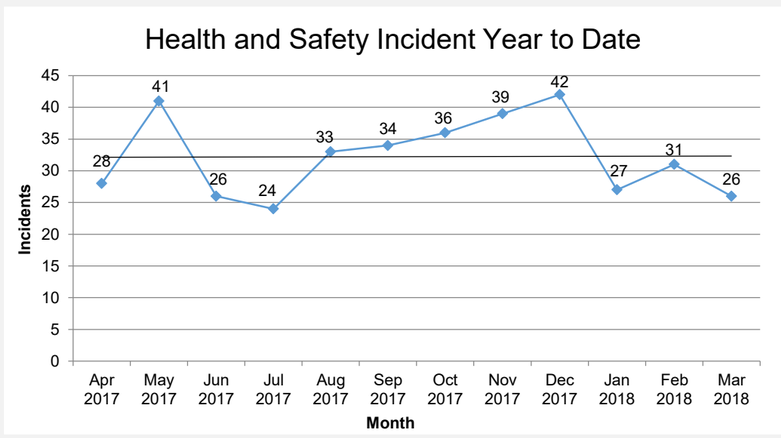


Figure 4

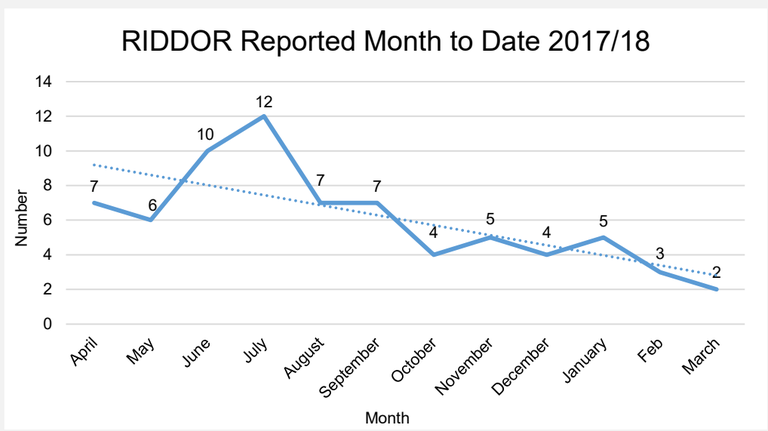
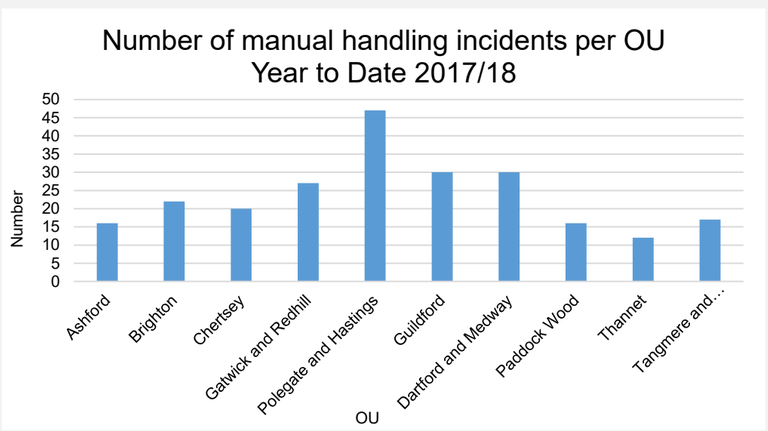


Figure 5



SECAmb Operations 999 - Safe

Call Answer Performance: Call answer 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. It is intended that the Trust will meet the 95% performance trajectory by August 2018. In this respect, there has been an additional cohort of call takers recruited, that can take routine calls, to improve the efficiency of the Emergency Medical Advisors.

Duplicate Calls: The surge in duplicate ETA calls has caused a significant strain on call answering. The percentage of duplicate calls increased sharply over August and September 2017 and has remained at between 16-18%. In this regard, data is being collated to understand the reasons for this increase (i.e. time of day etc). The Trust is also looking at provision of a hard deck of 100 DCAs at night, together with the recruitment of 300 Operational staff by November 2018.

SECAmb Operations 999 - Caring

Surrey Heartlands Pregnancy Advice Line: Recently went live within EOC. This is a collaborative venture between SECAmb, Royal Surrey County Hospital, Epsom & St Helier University Trust and Ashford & St Peter's Hospital, which has been established as part of the Better Births early adopter's maternity transformation programme and seeks to provide a single point of advice and support for women across Surrey Heartlands who have booked and are under the care of these hospitals. A team of midwives employed by the three Trusts form a bespoke hub, providing a 24-hour telephone service fielding all calls from pregnant women booked for care at the three Trusts offering telephone triage, advice and sign-posting to the most appropriate place of care.

This project provides far greater support to our EMAs in the event that maternity related calls are received within the EOC, as well as assistance to crews as appropriate.

SECAmb Operations 999 - Effective

Response Time Performance Targets: C1 performance is improving, together with a consistent C2 performance. However, the Trust is not meeting C3 and C4 response time targets due to resourcing levels. A Demand and Capacity Review is being undertaken to ensure SECAmb understand the structural gaps in funding and resourcing in this respect. Additional vehicles are also being brought into the Trust to ensure the correct mix to meet patient needs, which will consist of 16 new Fiat van conversions, 85 new Mercedes box bodies and 30 second-hand Fiat conversions from West Midlands Ambulance Service.

Daily Quality Reviews: In order to attempt to mitigate risk, the longest call answer times and longest call duration are reviewed on a daily basis. In addition, reviews are undertaken when responses have breached the 90th centile x 3. These reviews highlight lessons learned surrounding patient safety/whether the Trust could have done something differently and provided a better response for future reference.

SECAmb Operations 999 - Responsive

Surge Management Plan: The SMP went live on 19 February, with one-hour, one-day, one-week and one-month reviews undertaken by Operations. By undertaking this review process, the Trust were able to identify that the triggers set out initially did not enable a pro-active support mechanism and, therefore, these were revised to lower levels and the one-day, one-week and one-month reviews re-set and undertaken again, with no significant issues identified. The SMP is now being revised in line with comments received following these reviews, with an updated version to be circulated by the end of May once this document has been through the governance process.

Handover Improvement Project: This project is being undertaken in collaboration with Acute Trusts, with the target of having no patients waiting longer than 60-minutes for handover. This will result in improved patient experience and reinstate much needed resource hours back into the system to provide a better level of service to patients.

SECAmb Operations 999 - Well Led

Key Skills Training: This has commenced throughout the Trust for Operational staff. In addition, objectives are currently being set for the Operations Team.

Teams A-F Operational Meeting Structure: New structure in place, which standardises Operational meetings across all levels, ensuring that there is a consistent approach to escalation of risks and issues, together with information flow.

SECAmb 999 Operations Performance Scorecard

Call Handling

	Jan-18	Feb-18	Mar-18	12 Month's
5 Sec EOC Performance (95%)	74.9%	60.5%	61.8%	
Average Call Pick Up Time	00:00:28	00:00:41	00:00:44	
Call Pick Up Time 95th Percentile	155	185	207	

Dispatch

	Jan-18	Feb-18	Mar-18	12 Month's
Average Allocation Time - Cat 1 (Secs)	tbc	tbc	tbc	tbc
Allocation Ratio	tbc	tbc	tbc	tbc
Response Ratio Cat 1	1.85	1.83	1.75	

Cat 1 Performance

	Jan-18	Feb-18	Mar-18	12 Month's
Mean (00:07:00)	00:07:51	00:08:19	00:08:14	
90th Percentile (00:15:00)	00:14:05	00:14:51	00:15:09	

Cat 1T Performance

	Jan-18	Feb-18	Mar-18	12 Month's
Mean (00:19:00)	00:10:35	00:11:20	00:11:30	
90th Percentile (00:30:00)	00:18:59	00:20:26	00:21:37	

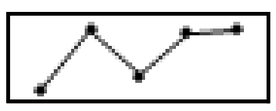
Cat 2 Performance

	Jan-18	Feb-18	Mar-18	12 Month's
Mean (00:18:00)	00:16:13	00:17:44	00:19:37	
90th Percentile (00:40:00)	00:30:11	00:33:01	00:37:17	

Cat 3 Performance

	Jan-18	Feb-18	Mar-18	12 Month's
Mean	01:04:04	01:27:53	01:41:02	
90th Percentile (02:00:00)	02:23:34	03:19:44	03:52:06	

Cat 4 Performance

	Jan-18	Feb-18	Mar-18	12 Month's
Mean	01:41:24	02:26:10	02:29:08	
90th Percentile (03:00:00)	04:02:33	05:40:58	05:54:23	

HCP

	Jan-18	Feb-18	Mar-18	12 Month's
HCP 60 (75%)	45.6%	43.1%	38.4%	
HCP 120 (75%)	56.7%	48.2%	54.6%	
HCP 240 (75%)	73.7%	65.9%	66.6%	

Demand/Supply

	Jan-18	Feb-18	Mar-18	12 Month's
Call Volume	86023	80740	91009	
Incidents	59870	52890	57818	
Transports	38351	34069	37575	

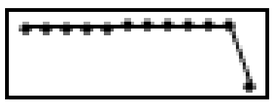
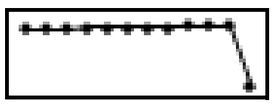
Incident Outcome AQI

	Jan-18	Feb-18	Mar-18	12 Month's
Hear & Treat	4.7%	5.2%	5.9%	
See & Treat	34.4%	33.9%	32.8%	
See & Convey	60.9%	60.9%	61.3%	

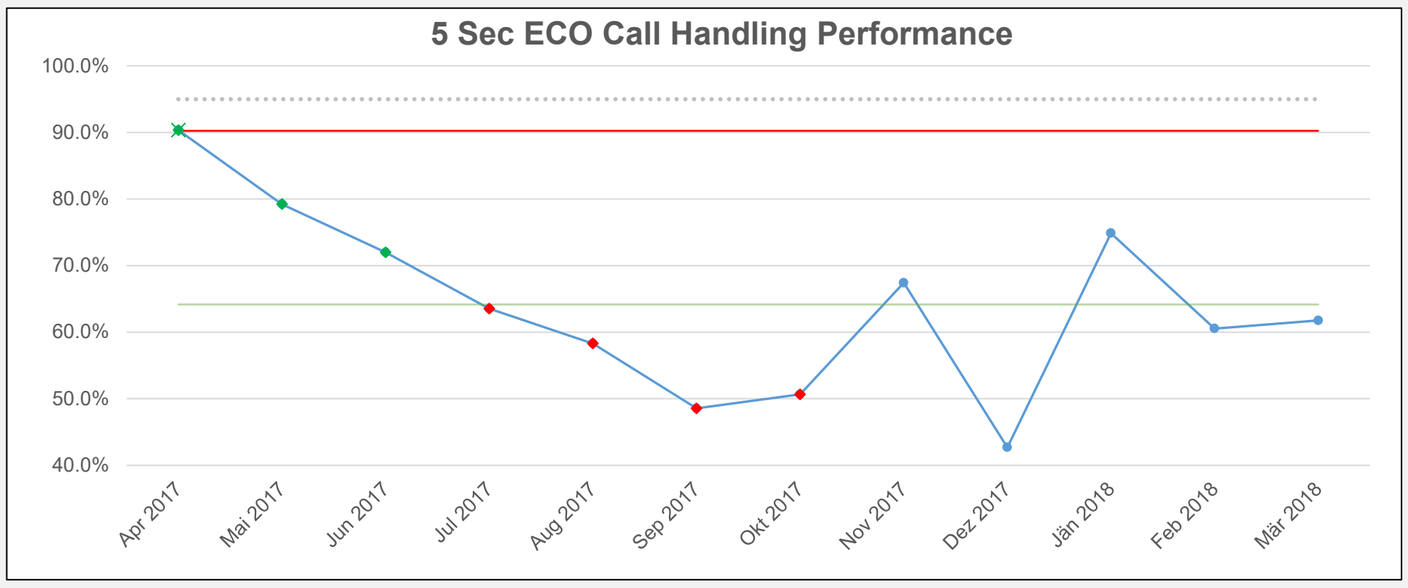
Community First Responders

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

Call Cycle Time

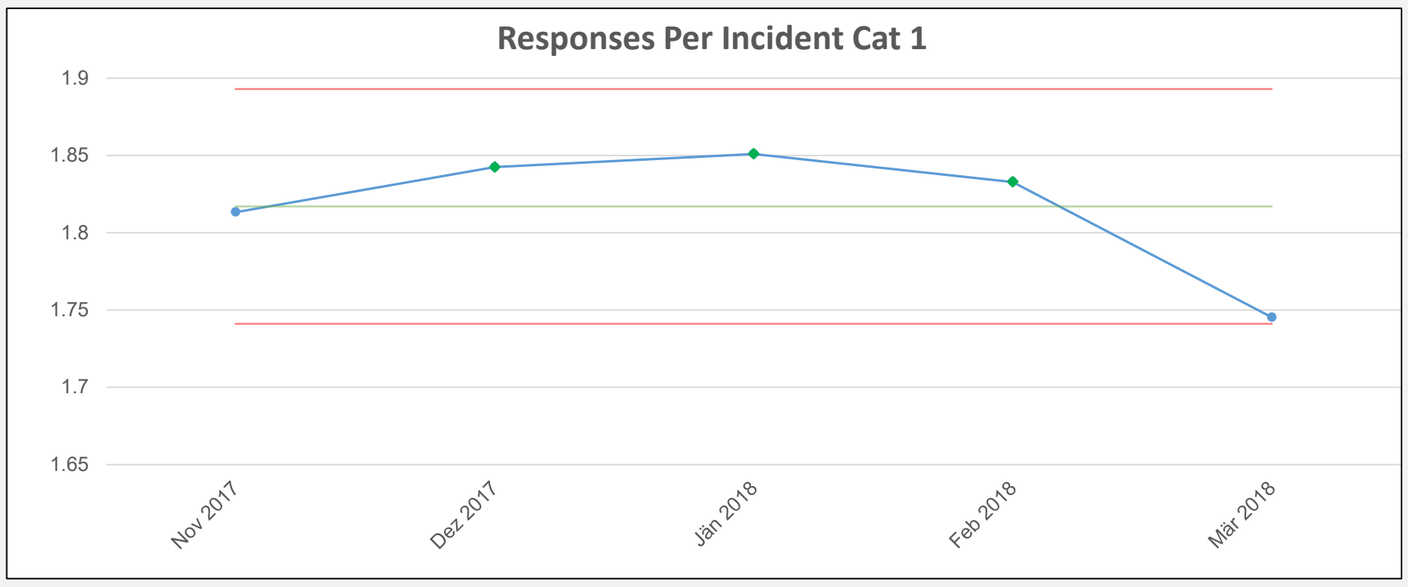
	Jan-18	Feb-18	Mar-18	12 Month's
Clear at Scene (mins)	75.74	75.30	tbc	
Clear at Hospital (mins)	110.1	109.2	tbc	
Handover Hrs Lost at Hospital (over	7093	5697	6338	
Number of Handovers >60mins	1209	875	1032	

SECAmb 999 Operations Performance Charts

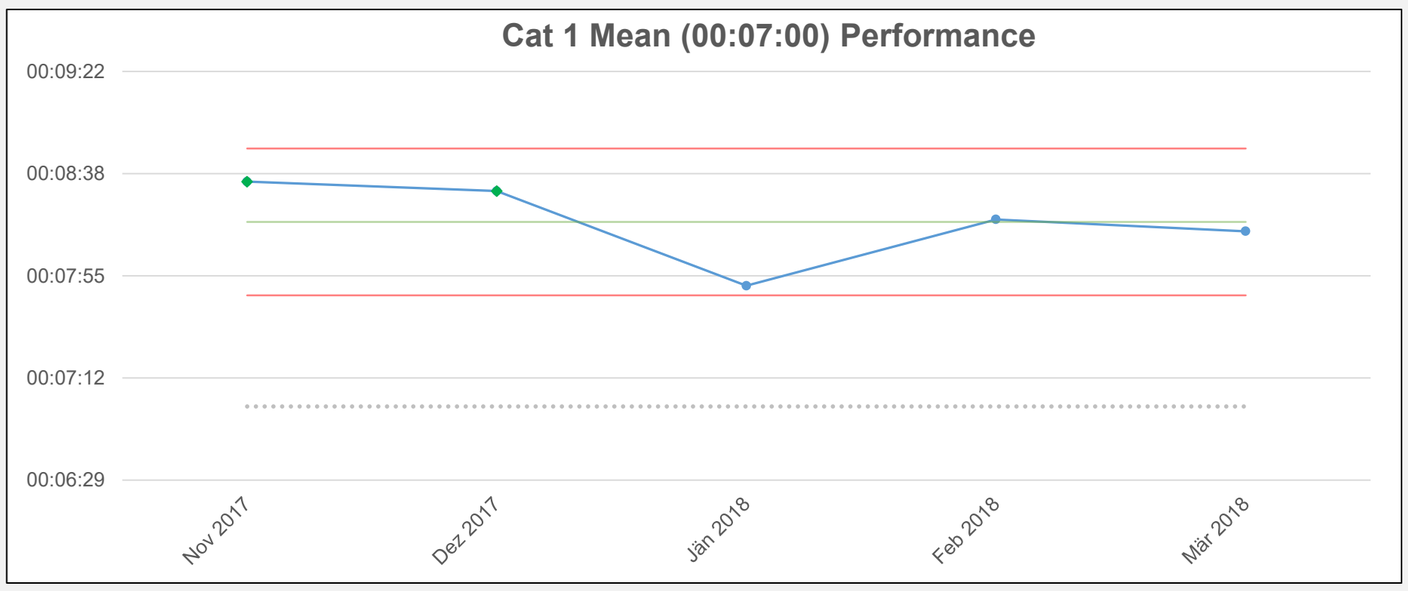


Call answer performance for March has increased slightly to 61.8%. There was also an increase in call volume of 11%. The average call pick up time of 44 seconds has increased compared to last month.

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 reaching the lowest point to date.

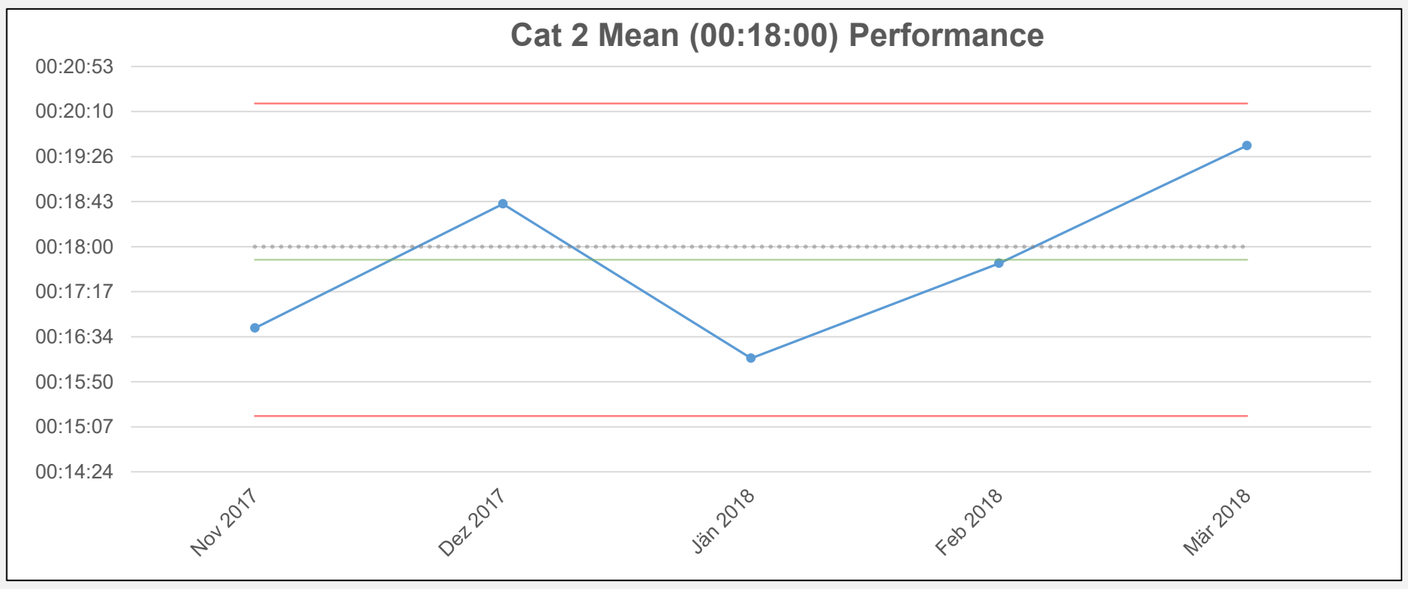


The Trust is currently 00:01:16 over the target mean for Cat 1 and 10 seconds over our 90th centile target.

Response time has stayed relatively the same in February and March, bearing in mind we had snowfall for just over a week towards the end of the February.

There were 2 days in March where we achieved Cat 1 mean, the lowest mean time reached was 00:06:11 and highest 00:09:42.

The Cat 1 response time target was slightly better for West EOC (00:08:13 mean) than for East EOC (00:08:22). Neither East or West reached the required 90th Centile target (East missed by 5 seconds and West 12 seconds).

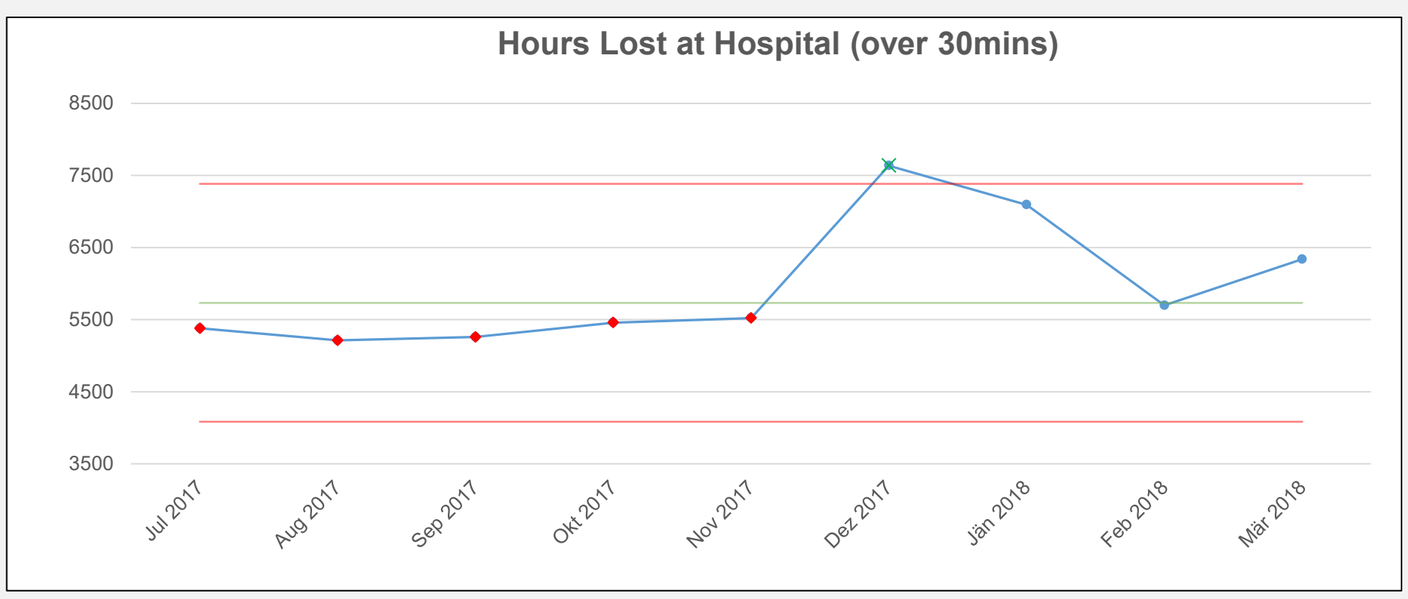


We did not achieve our Cat 2 mean response time target for March. There has been a continuous increase in response time since January and we have reached the highest mean time to date in March. This correlates to a 12.7% increase in demand compared to February.

We are still continuing to achieve our 90th percentile target since the introduction of ARP in November 2017, with March having a response time of 00:37:29.

There were 7 individual days where we achieved our Cat 2 mean target, the best response time being 00:14:27 and worst response time of 00:24:34.

East and West did not achieve the mean response time target, both had a response time of 00:19:50. The 90th percentile target was reached for both, East achieving 00:37:25 and West 00:37:34.



There were 1032 patient handovers over 60mins for March (daily average of 33 patients) this is an increase of 15% compared to February. Similarly the hours lost over 30 mins due to delays has increased to 6338 hours (daily average of 204.5 hours).

Year on year March 2018 has an increase of 1063.02 hours lost over 30mins and the total number of patient handovers over 60mins has increased by 37%.

The hospital with the highest total hours lost over 30 mins was Medway Hospital (701.5hrs) and 2nd is Royal Sussex County (647.3hrs) both hospitals have the highest average daily patient handovers (Medway 104 and Royal Sussex County 99 patients).

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

SECAmb Operations 111 - Safe

Safety remains a key priority for 111 with performance continually monitored and reviewed. This is best demonstrated by the Operational Recovery Plan (ORP) created by the service to combat a deteriorating level of performance in quarter four. Risk management is embedded across the whole service with good levels of reporting for incidents on Datix and a consistently high rate of successful completion of incident investigations. The levels of complaints remained static in quarter four, despite the far greater level of service activity experienced year on year. There was also no breaching of any complaint reports in terms of investigation responses back to the Trust's Patient Experience Team.

The service continues to refine its staff workforce planning tool to deploy resource and prioritise when call handlers (especially clinicians) are most needed to meet demand, even with erratic call profiles and fluctuating demand.

SECAmb Operations 111 - Caring

The service's mission statement is "caring for patients and each other" and this remains central to the service's ethos. A huge effort has been made with regards to staff engagement in quarter four and this has resulted in the creation of a "Culture Club" in the service's Ashford 111 Contact Centre. This forum is aimed at facilitating colleague feedback and enabling a more collaborative approach to dealing with issues, concerns and opportunities that arise in the service. A number of initiatives are on-going in terms of engagement with external stakeholders to improve the patient experience and also with respect to making the 111 Contact Centre a more enjoyable place to work.

SECAmb Operations 111 - Effective

Daily, weekly and monthly monitoring and analysis is undertaken to benchmark the service against its contractual KPI's and against national performance. The service continues to work coherently with its Commissioners to address any issues and the current Operational Recovery Plan (ORP) was written inn conjunction with Commissioners and progress against this is reviewed on a weekly conference call. The survive also embarked on a series of Joint Commissioner Provider (JCP) clinical pilots in 2017/18 and this has resulted in an increased focus on clinical intervention and system integration.

SECAmb Operations 111 - Responsive

The service continues to reach out and engage with all stakeholders including patients, Commissioners and NHS E. An example of this was the collaboration with another local provider to develop a specific script to manage patient expectations for that service when it is in escalation. This was particularly pertinent over the Easter period when the service was able to protect multiple providers when there were periods of incredibly high demand within the urgent and emergency care system.

The service has detailed recruitment and retention plans and uses a workforce planning tool to endeavour to match resources to demand. Complaints and incidents in relation to the service are managed effectively and the learns and improvements subsequently identified are shared and embedded within the service to promote best practice.

SECAmb Operations 111 - Well Led

The service has a clearly defined management structure in place with daily and weekly meetings taking place to ensure that the service's Senior Leadership Team (SLT) has a clear understanding of performance, risks and what actions are required to ensure that the service stays on track with its plans. The SLT has developed an Operational Recovery Plan (ORP) in collaboration with Commissioners which has provided a clear focus on what actions are required to deliver the level of performance and milestones that patients and all stakeholders (internal and external) have a right to expect.

The governance meetings, both internal and external continue to take place with risks and opportunities explored to ensure that patient safety and quality is maintained. KMSS 111 remains clinically-led and the service continues to be fully compliant with its NHS Pathways license requirements (including audit requirements), this is despite the challenges of incredibly high service activity and call volumes in quarter four.

SECAmb 111 Operations Performance Scorecard

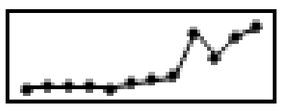
Calls Offered

	Jan-18	Feb-18	Mar-18	12 Month's
Actual	99868	92798	112748	
Previous Year	96799	79876	83545	

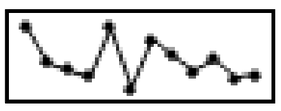
Calls answered in 60 Seconds

	Jan-18	Feb-18	Mar-18	12 Month's
Actual %	56.9%	49.2%	45.1%	
Previous Year %	83.7%	92.5%	92.5%	
Target %	95%	95%	95%	

Calls abandoned - (Offered) after 30secs

	Jan-18	Feb-18	Mar-18	12 Month's
Actual %	8.4%	13.4%	15.7%	
Previous Year %	2.9%	0.7%	0.9%	
Target %	2%	2%	2%	

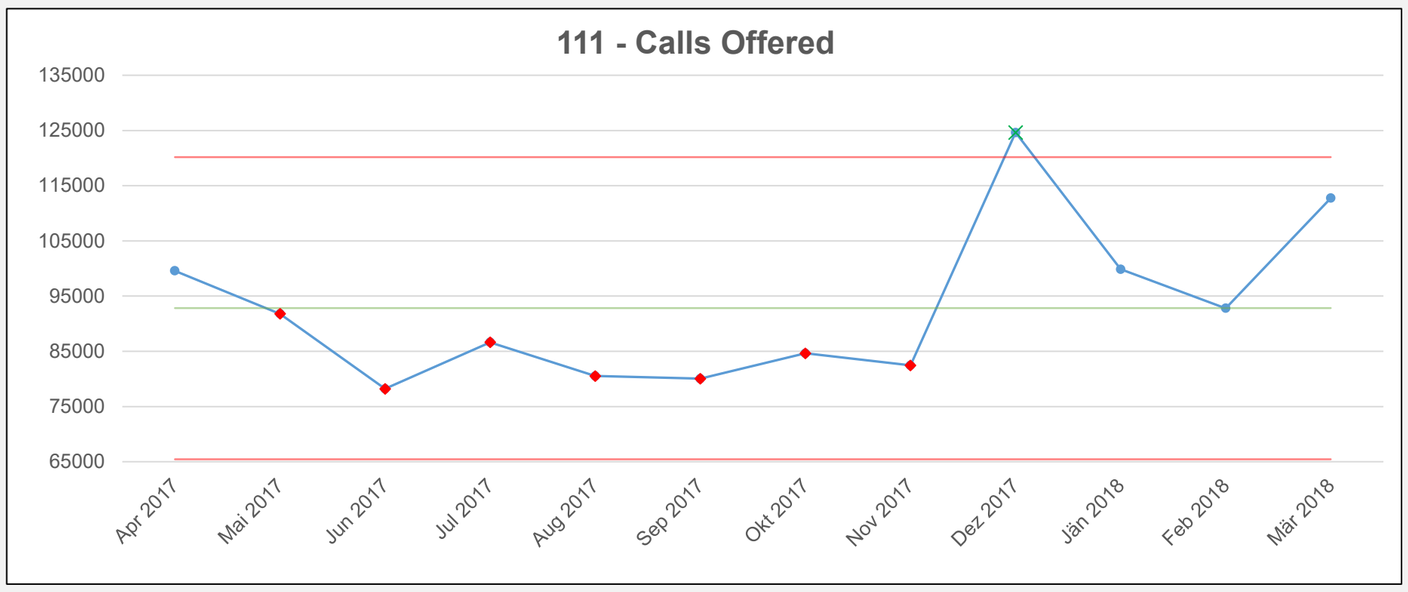
Combined Clinical KPI

	Jan-18	Feb-18	Mar-18	12 Month's
Actual %	74.7%	71.4%	71.9%	
Previous Year %	81.6%	73.6%	73.6%	
Target %	90%	90%	90%	

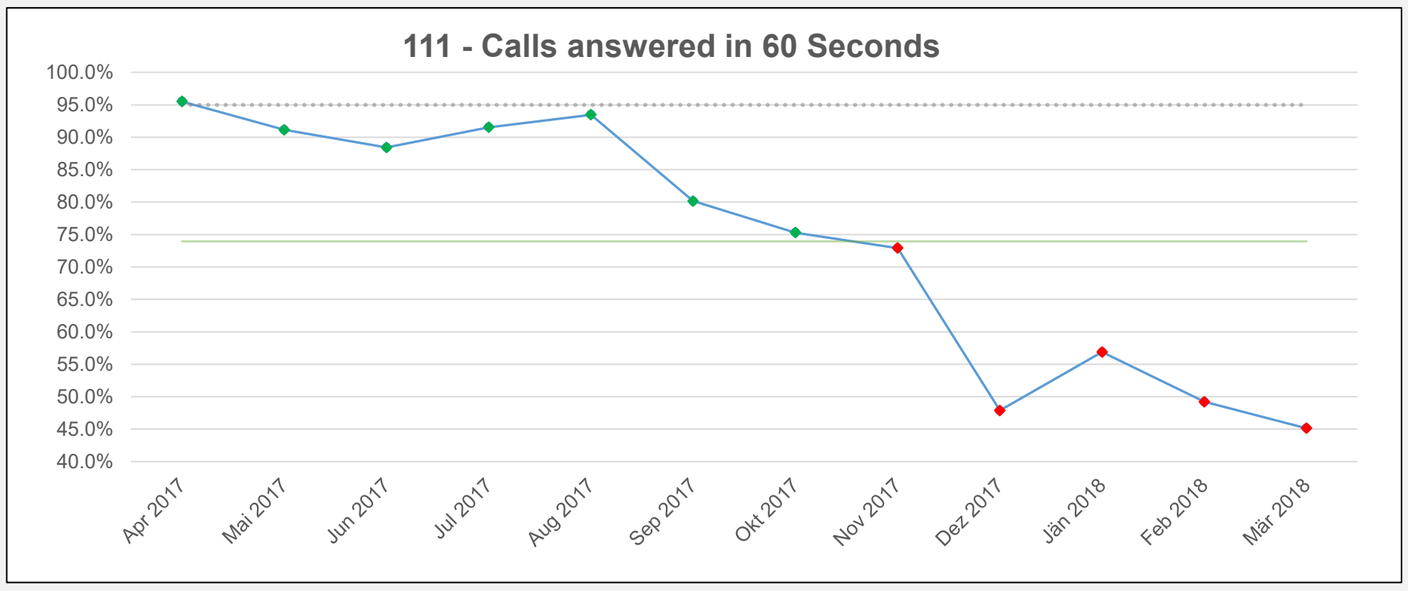
Outcomes

	Jan-18	Feb-18	Mar-18	12 Month's
999 Referrals % (Answered Calls)	11.4%	11.7%	10.5%	
999 Referrals (Actual)	10048	9129	9627	
A&E Dispositions % (Answered Calls)	7.5%	7.2%	7.3%	
A&E Dispositions (Actual)	6610	5604	6756	
Home Management %	tbc	tbc	tbc	

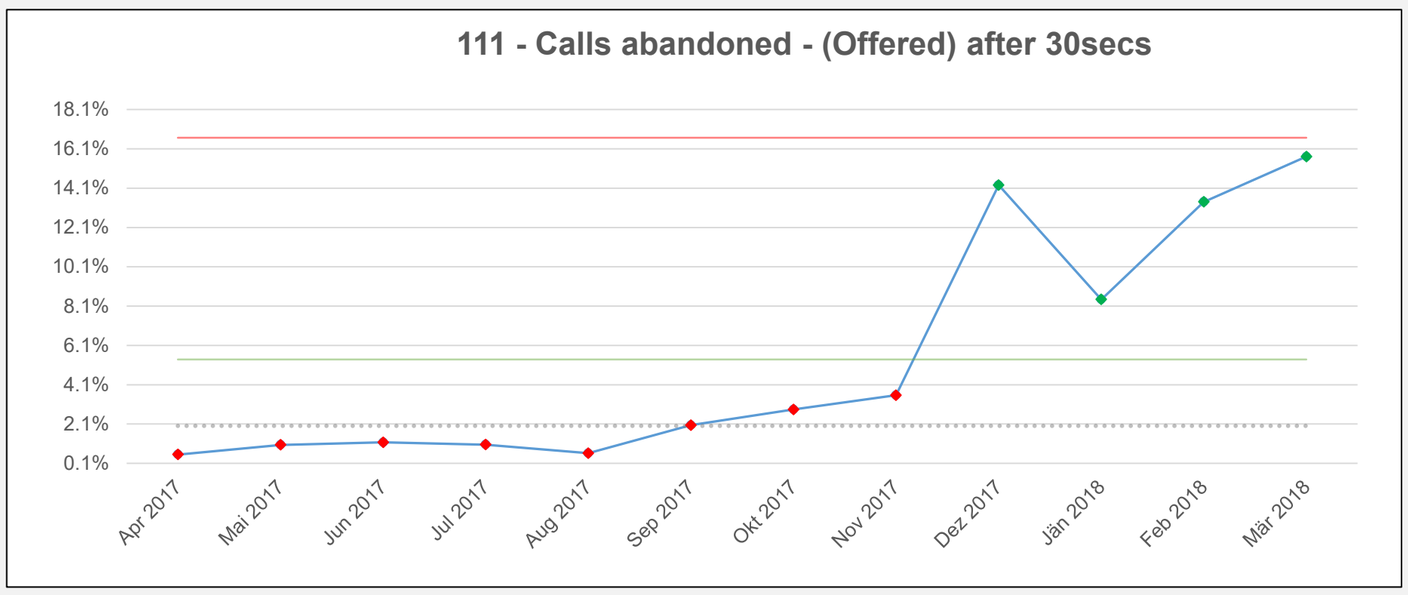
SECAmb 111 Operations Performance Charts

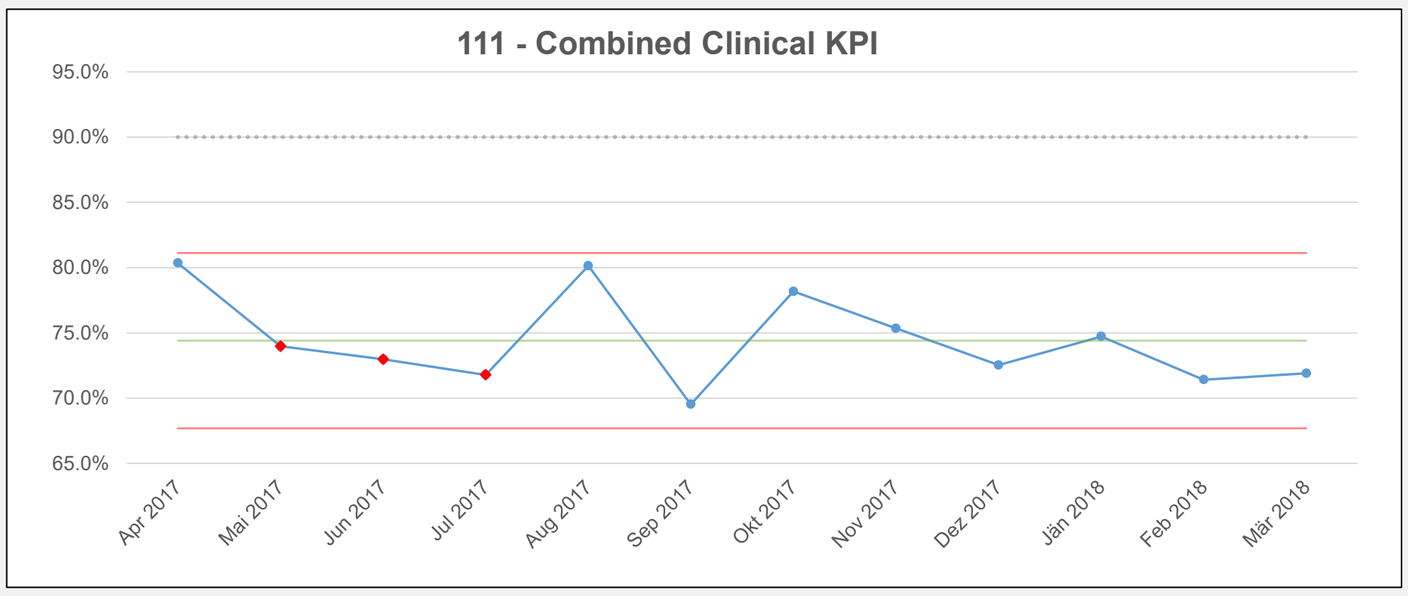


Call volumes climbed to 112748 for the month, a month of extreme pressures caused by adverse weather, winter pressures and the Easter weekend.
There was a steep rise in calls made to 111 in quarter four in comparison to the previous six months and also year on year. This increase in demand was as a direct result of the conflation of winter pressures and the episodes of adverse weather experienced in the New Year.
The higher level of activity culminated in March 2018 being the busiest month experienced by KMSS 111 outside of December.
The increased activity in 111 is attributable to a number of factors including increased patient awareness of the 111 service and incredibly high demand experienced within Primary Care overflowing in to 111. Inevitably this led to more patients entering the urgent and emergency care system after receiving an NHS Pathways triage assessment with the majority of healthcare providers under pressure.

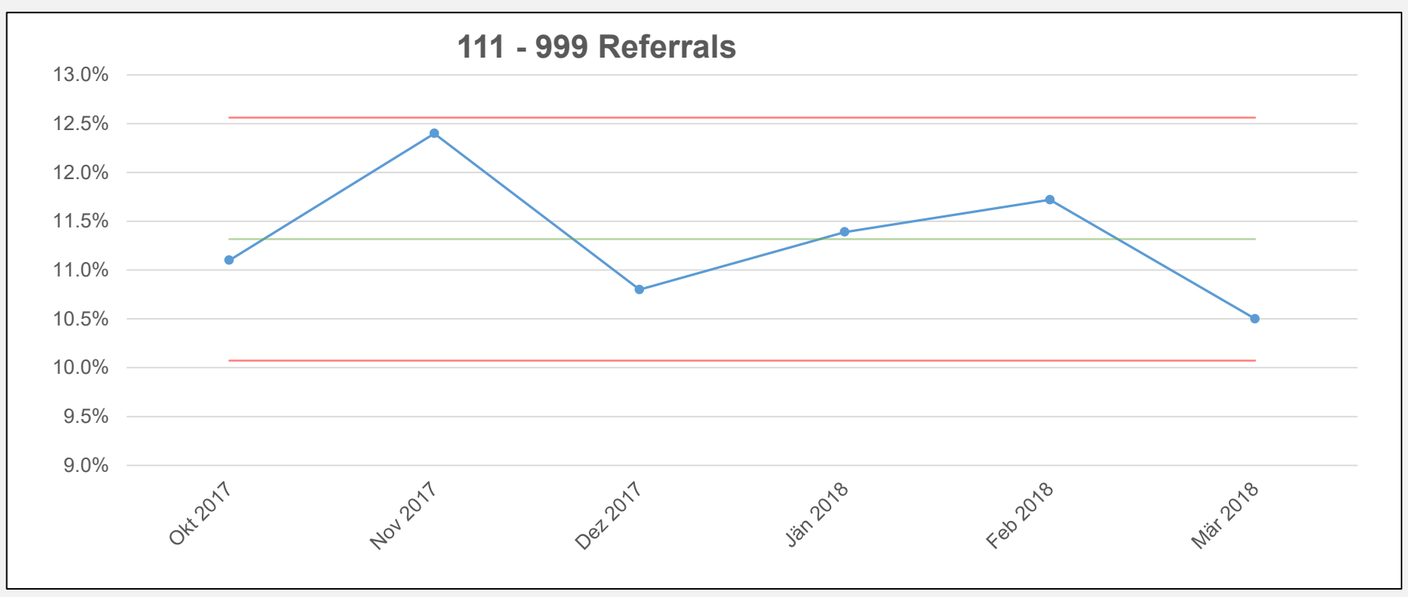


The “Answered in 60” KPI consequently declined slightly to 45.1%, as a result of the high demand experienced in quarter four and a higher than planned rate of shrinkage (sickness/non-attendance) and staff turnover.
However, there were tangible signs of recovery towards the latter half of March as large cohorts of newly-trained Health Advisors started actively taking calls during the month, as per the 111 recruitment plan.
The incredibly high level of call activity and the inability of 111 to deliver the operational Answer in 60 seconds KPI, resulted in an elevated level of churn and a high level of call abandonment, especially at weekends with sharp spikes of call activity. The higher levels of sickness and erratic call profiles (when calls present to 111) also contributed to the higher rate of abandoned calls.





Clinical performance at 71.9% again outperformed the national average by a significant margin, emphasising our status as a clinically-driven service.
The service’s clinical performance, as articulated by its Combined Clinical KPI (patients receiving an immediate transfer to a clinician or a call-back from a clinician within 10 minutes) was consistently above 70% across the quarter.
In essence this means that over two thirds of patients triaged by KMSS 111 had a rapid clinical intervention within ten minutes of being assessed. This level of performance is consistently 10% better than the NHS E national average and demonstrates 111’s commitment to patient care and being a clinically-led and quality-driven service.



The KMSS 111 Ambulance referral rate fell significantly to 10.5% due to the continued effects of Clinical Inline Support.
The 111 service has invested a tremendous amount of time, planning and resource to operating its Clinical In-line Support (CIS) on a 24/7 basis during 2017/18. This has meant that there is always at least one “floor-walking” clinician tasked with validating non-emergency Cat 3 and 4 ambulances. As a result, the KMSS 111 Ambulance referral rate fell significantly to 10.5% in March and remains consistently better than the NHS E national average as the service endeavours to protect the ambulance service, especially at periods of high demand and when the 999 service is under pressure.

SECAmb 111 Operations further information

Quarter 4 Performance

KMSS 111 has experienced a very challenging quarter four of 2017/18 and in particular March, which saw demand associated with winter pressures conflate with the anticipated increase of service activity in the approach to the Easter period. Call activity and the ability of the service to answer calls in 60 seconds exceeded the capability of the service and available resource to meet this demand. As a result, the operational KPI's of "Answer in 60" and "Call abandonment rate" were disappointing. However, the service continues to deliver a strong clinical performance with its combined clinical KPI almost 10% better than the NHS E national 111 average for March and the rate of 999 referrals continuing to be below the national average, demonstrating the service's commitment to utilising its clinical resource to protect the wider urgent and emergency care system.

The service has created a detailed Operational Recovery Plan (ORP) in conjunction with Commissioners and this was a key factor in the service's performance improving in the second half of March and especially across the intensely busy Easter period.

SECAmb Workforce - Safe

SECAmb continually works to promote safe working practice and through the Trust's delivery plan is taking substantive action by way of cultural development and ongoing recruitment drives to ensure that recruitment pipelines are in place to address staff shortfalls. The HR Directorate is working closely with the Demand and Capacity to create a work force plan / trajectory that will enable the Trust to meet ARP Targets over time. Similarly the cross directorate work to mitigate risk through the allocation of overtime, targeted increases in staff rotas at key points as well as the use of PAPS continues to support compliance with this domain.

SECAmb Workforce - Caring

As mentioned above SECAmb places a great deal of importance in the caring nature of its service and in the support of colleagues within the Trust. Our culture programme is making steady progress and the Trust continues to build upon the work of the Wellbeing Hub.

SECAmb Workforce - Effective

Workforce is central to successful delivery and the plans and delivery within the HR Directorate is a key enabler for operations to optimise the hours available on the road and within the EOC environment.

SECAmb Workforce - Responsive

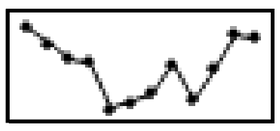
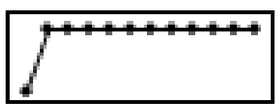
SECAmb continues to engage with its workforce via a number of methods. Our pulse surveys continue and plans are in train to meet with and support Operational Units in their geography by way of recruitment and staff engagement. This will also be coordinated with the work of the Strategy and Business Development Directorate to take on the views of our teams in the further development of the Trust's Strategic Plan and supporting objectives. In addition to this work the HR department is increasingly responsive to the potential challenges faced by all personnel when seeking to engage in HR Process. This work will continue to optimise process and signpost more effectively.

SECAmb Workforce - Well Led

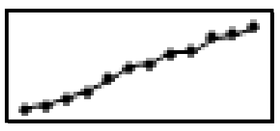
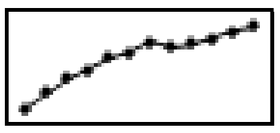
As the Cultural development programme continues within SECAmb this will highlight and disseminate those behaviours and values selected by the Trust's personnel that support successful delivery and in many ways are key to being well led. Key roles within the programme are ring fenced and much of the activity undertaken is about enabling, supporting and empowering our teams to lead and get the best out of each other.

SECAmb Workforce Scorecard

Workforce Capacity

	Jan-18	Feb-18	Mar-18	12 Month's
Number of Staff WTE (Excl bank & agency)	3057.6	3079.8	3077.0	
Number of Staff Headcount (Excl bank and agency)	3330	3350	3349	
Finance Establishment (WTE)	3525.29	3527.29	3532.29	
Vacancy Rate	13.40%	12.65%	12.82%	
Vacancy Rate Previous Year	9.28%	8.23%	9.64%	
Adjusted Vacancy Rate + Pipeline recruitment %	10.67%	9.20%	9.83%	

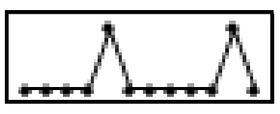
Workforce Compliance

	Jan-18	Feb-18	Mar-18	12 Month's
Objectives & Career Conversations %	78.81%	83.95%	91.95%	
Statutory & Mandatory Training Compliance %	79.12%	86.32%	93.24%	
Previous Year %	78.50%	81.90%	85.00%	

Workforce Costs

	Jan-18	Feb-18	Mar-18	12 Month's
Annual Rolling Turnover Rate %	17.85%	17.74%	17.19%	
Previous Year %	16.90%	16.60%	16.70%	
Annual Rolling Sickness Absence	5.22%	5.26%	5.12%	

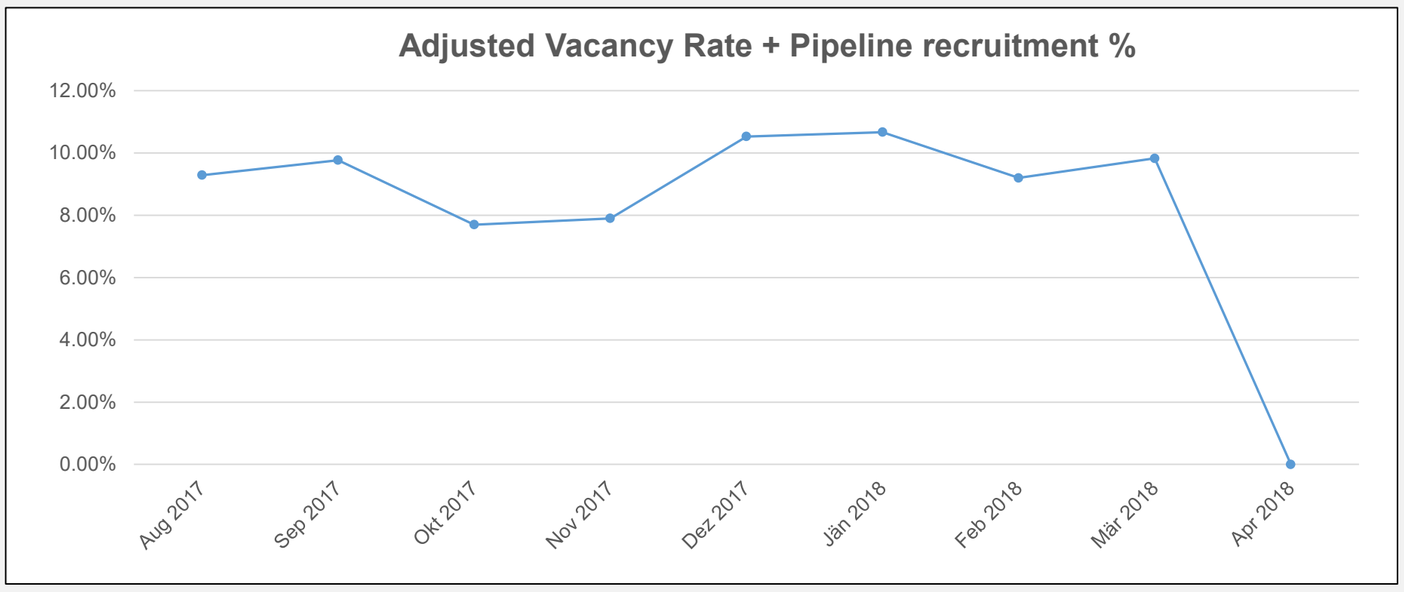
Employee Relations Cases

	Jan-18	Feb-18	Mar-18	12 Month's
Disciplinary Cases	1	6	4	
Individual Grievances	16	6	5	
Collective Grievances	1	1	3	
Bullying & Harassment	0	2	1	
Bullying & Harassment Prev Yr	1	0	3	
Whistleblowing	0	1	0	
Whistleblowing Previous Year	1	0	0	

Physical Assaults (Number of victims)

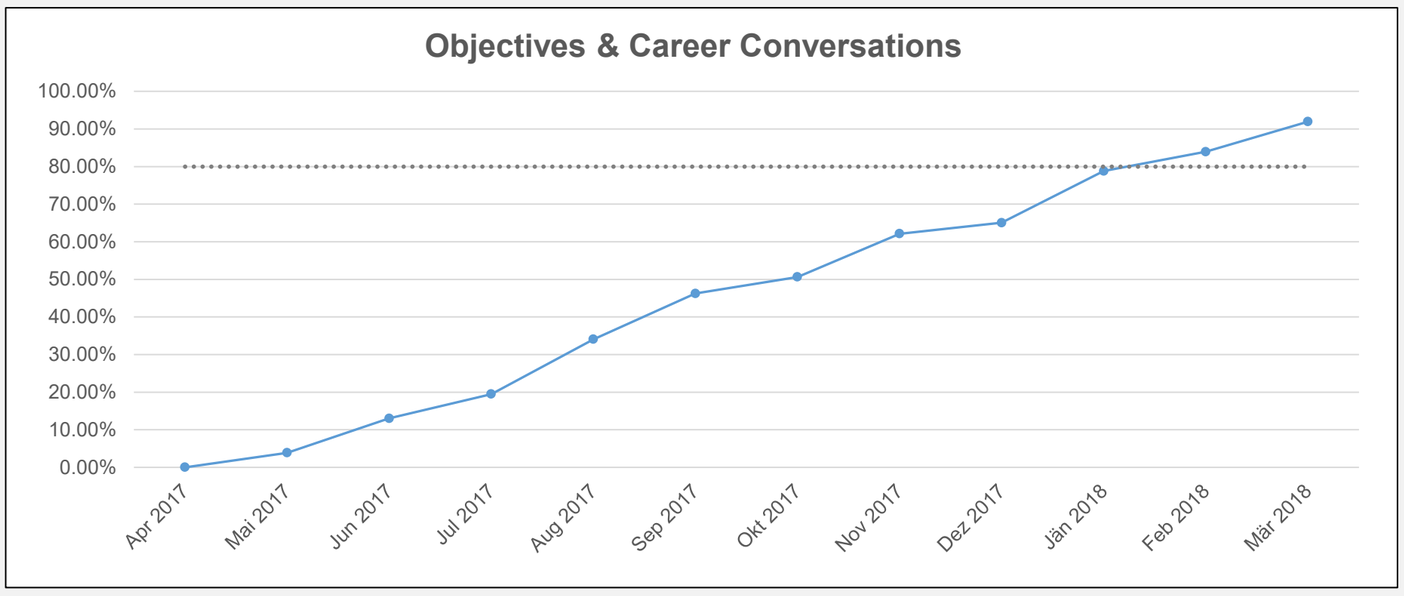
	Jan-18	Feb-18	Mar-18	12 Month's
Actual	16	15	17	
Previous Year	17	16	18	
Sanctions	3	3	9	

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.

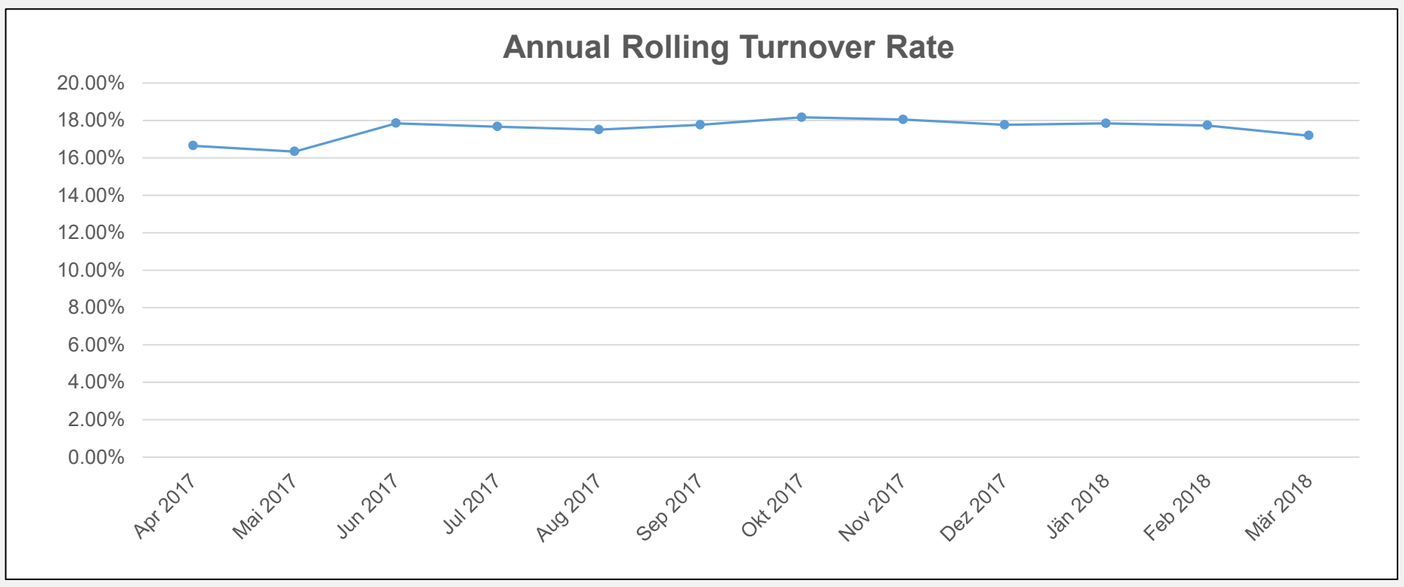
Monthly Recruitment Summit meetings and intensive support meeting to address the short term resourcing gaps for operational staff. Recruitment have brought in additional staff, 2 Recruitment Advisors and 1 Compliance Admin, to address the increasing work load.



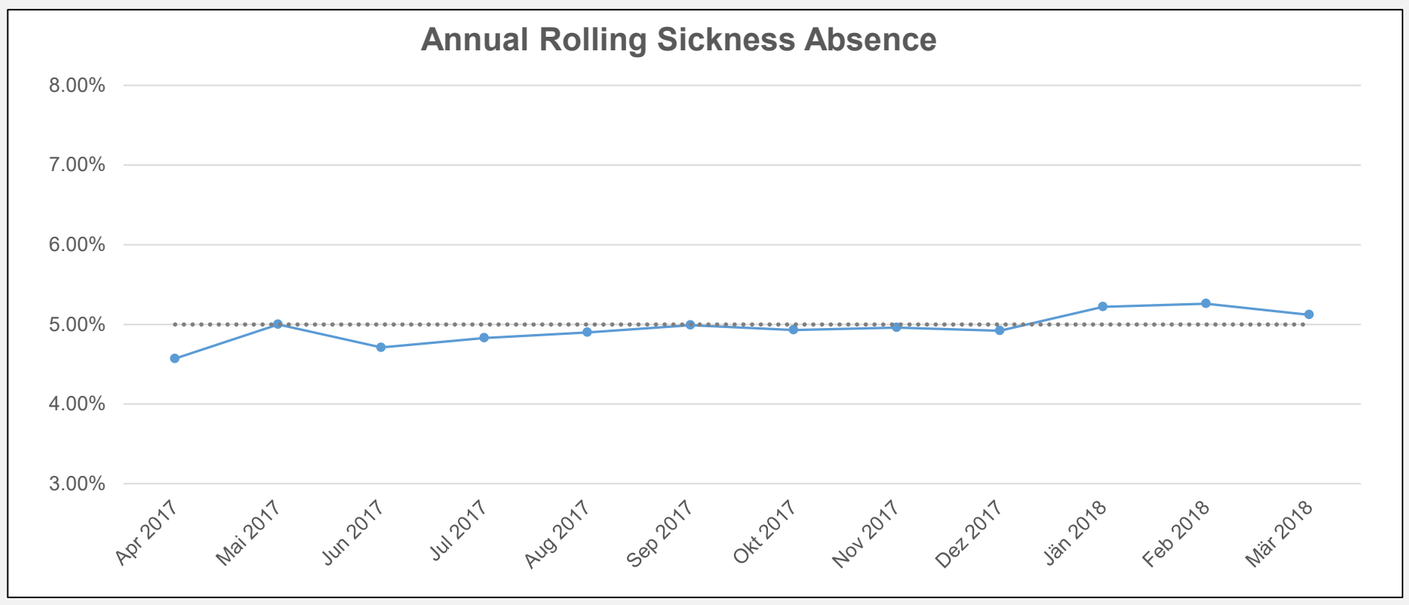
In March we exceeded the end of year target of 80%, we achieved 91.95%.

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 May and June.

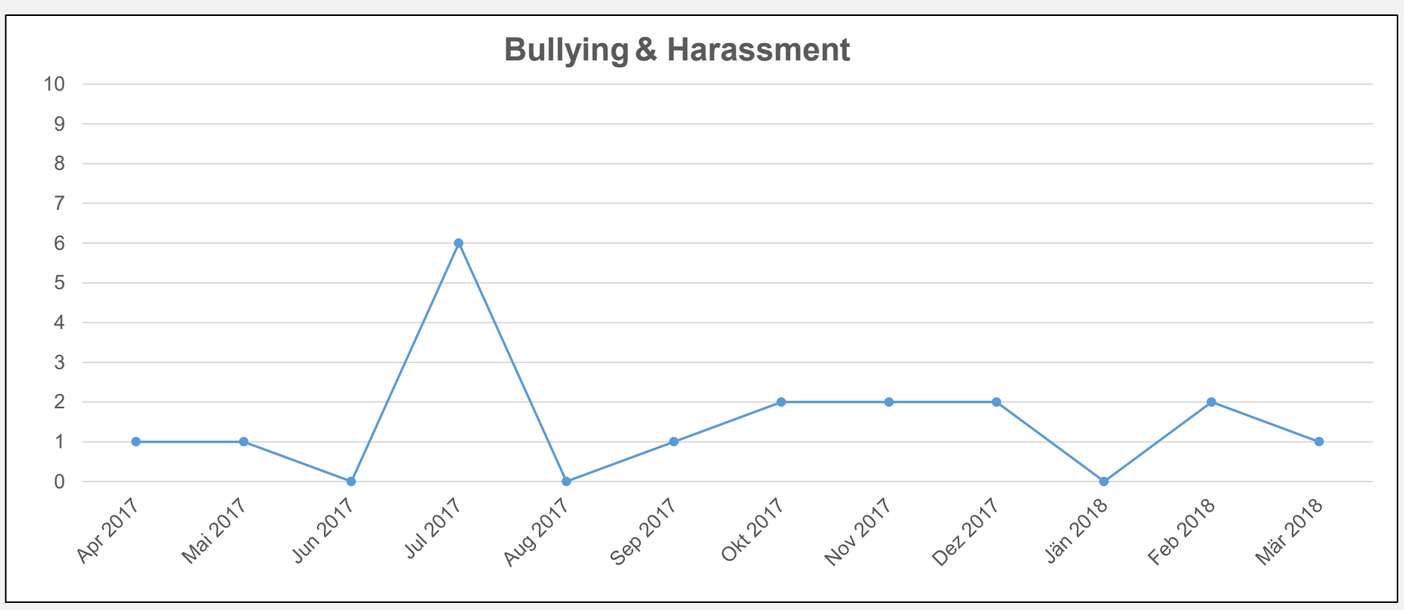


The Trust turnover rate remains constant although a high turnover rate is still seen in EOC and 111 should be noted. This continues to be monitored by the EOC Task and Finish Group.



The trusts sickness rate stayed above 5% this month. 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 was 1 new B&H cases in March.

A review of the Exit Interview Data (March 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 Finance Performance Scorecard

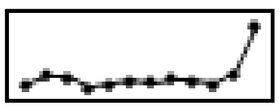
Income

	Jan-18	Feb-18	Mar-18	12 Month's
Actual £	£ 17,171	£ 16,810	£ 25,743	
Previous Year £	£ 17,542	£ 17,179	£ 16,787	
Plan £	£ 17,585	£ 16,109	£ 17,367	

Expenditure

	Jan-18	Feb-18	Mar-18	12 Month's
Actual £	£ 16,404	£ 16,032	£ 22,806	
Previous Year £	£ 17,614	£ 17,576	£ 17,154	
Plan £	£ 16,827	£ 15,400	£ 16,576	

Capital Expenditure

	Jan-18	Feb-18	Mar-18	12 Month's
Actual £	£ 285	£ 780	£ 3,190	
Previous Year £	£ 1,250	£ 1,356	£ 1,859	
Plan £	£ 856	£ 856	£ 856	
Actual Cumulative £	£ 3,878	£ 4,658	£ 7,848	
Plan Cumulative £	£ 14,124	£ 14,980	£ 15,836	

Cost Improvement Programme (CIP)

	Jan-18	Feb-18	Mar-18	12 Month's
Actual £	£ 1,496	£ 1,380	£ 1,406	
Previous Year £	£ 552	£ 488	£ 764	
Plan £	£ 1,399	£ 1,380	£ 1,409	
Actual Cumulative £	£ 12,736	£ 14,116	£ 15,522	
Plan Cumulative £	£ 12,311	£ 13,691	£ 15,100	

CQUIN (Quarterly)

	Q3 17/18	Q4 17/18	Q1 18/19
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)

	Jan-18	Feb-18	Mar-18	12 Month's
Actual £	£ 767	£ 778	£ 2,937	
Actual YTD £	-£ 2,417	-£ 1,639	£ 1,298	
Plan £	£ 758	£ 709	£ 791	
Plan YTD £	-£ 2,503	-£ 1,794	-£ 1,003	

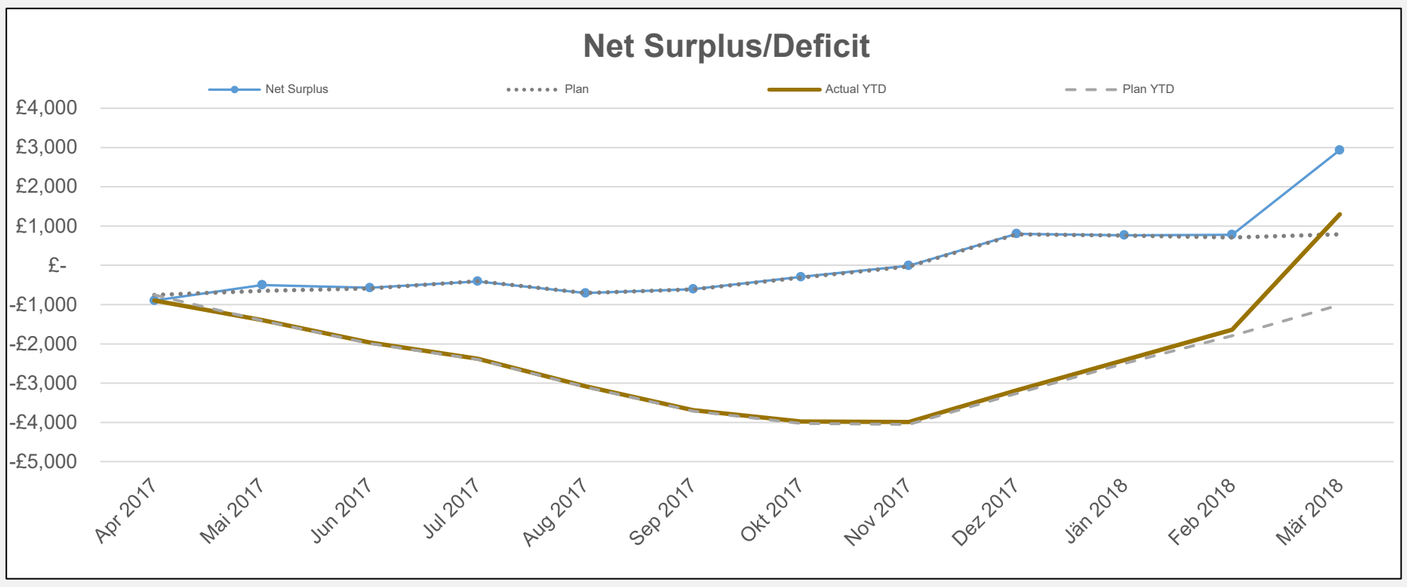
Cash Position

	Jan-18	Feb-18	Mar-18	12 Month's
Actual £	£ 19,564	£ 23,953	£ 22,892	
Minimum £	£ 10,000	£ 10,000	£ 10,000	
Plan £	£ 5,857	£ 5,728	£ 5,459	

Agency Spend

	Jan-18	Feb-18	Mar-18	12 Month's
Actual £	£ 316	£ 223	£ 413	
Plan £	£ 329	£ 328	£ 325	

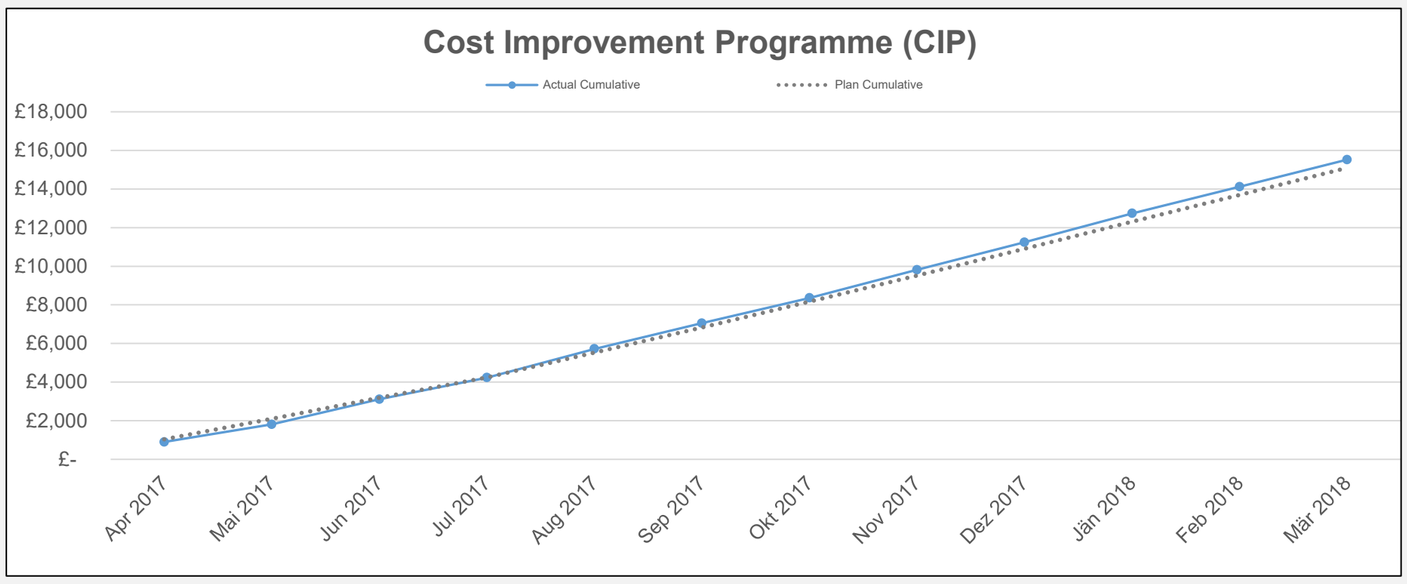
SECAmb Finance Performance Charts



The Trust has met its control total for the year (£1.0m deficit). Following late adjustments to funding announced by NHSI, the final Trust position for the year is a surplus of £1.3m, which is £2.3m better than plan. The position before these adjustments was a deficit of £0.9m.

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

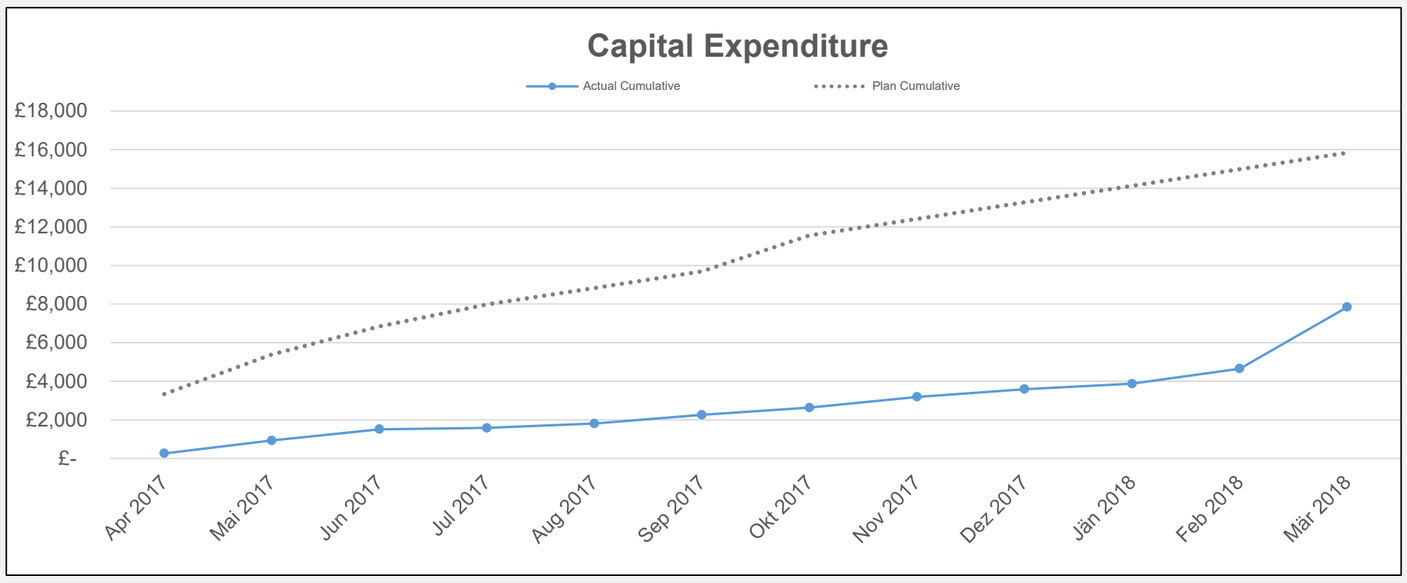
Original planned deficit (NHSI plan)	(1.0)
Structural deficit income excluded	(24.8)
Frontline hours excluded	18.9
Reserves and other budgeted costs to support delivery	5.9
'Normalised'/Commissioned plan	(1.0)



CIP schemes achieved £15.5m for the year, as projected at month 11.

Actual achievement was £0.4m ahead of plan for the year.

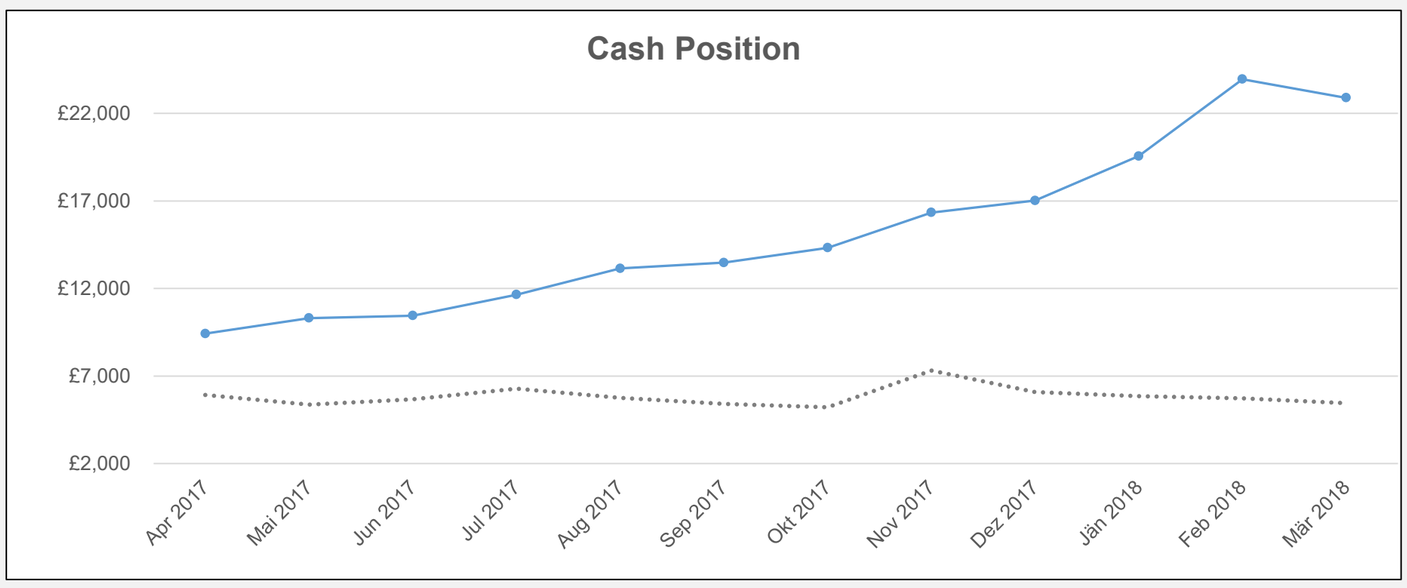
Good progress is being made in developing new schemes for 2018/19, with a delivery target of £11.4m.



Spend on capital for the year was £7.8m against a plan of £15.8m.

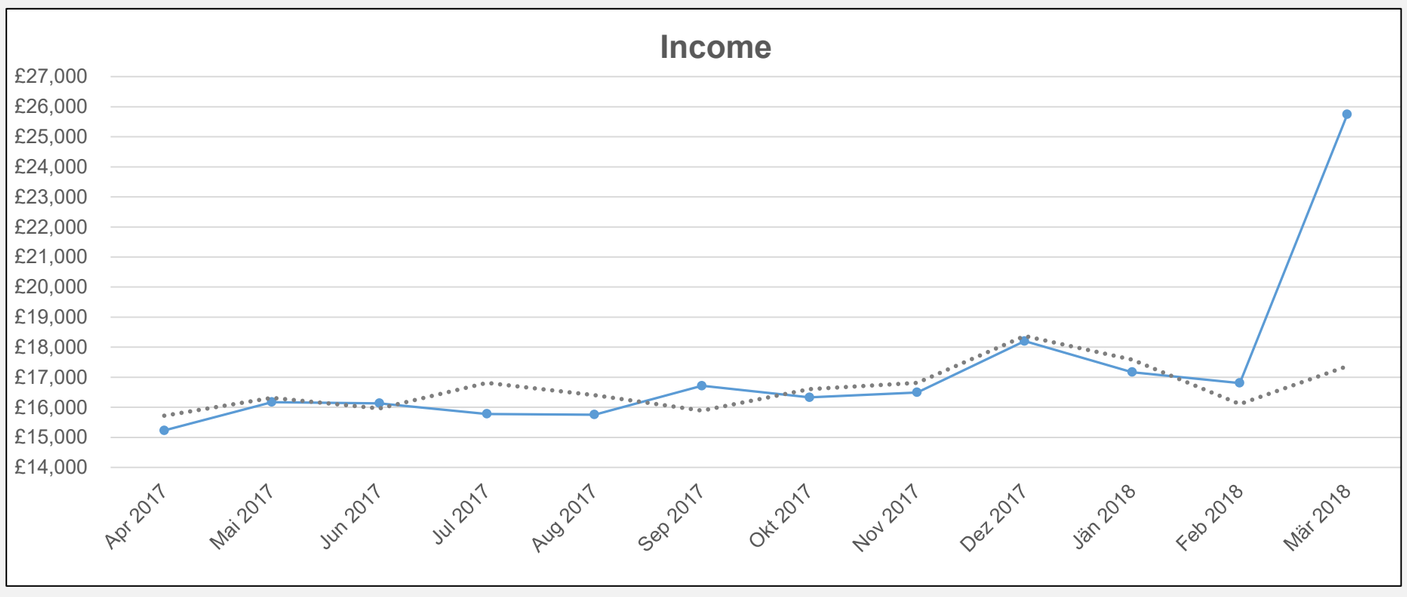
The underspend on the programme of £8.0m is mainly due to £8.2m of planned vehicle replacement, which has been moved from capital to revenue as procurement is via an operating lease.

The 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 and a new Informatics System £0.1m. With the exception of Cyber Security, these are substitute schemes.



The cash position ended the year at £22.9m, a reduction on the £24.0m balance at the end of February.

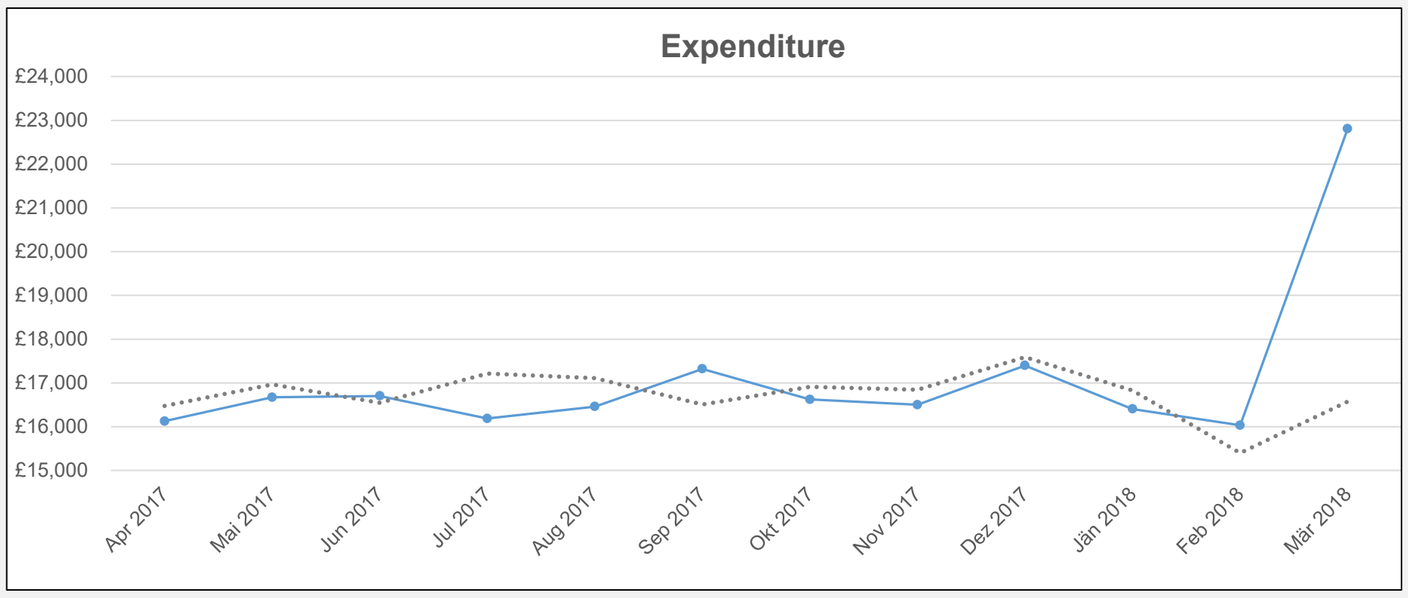
The cash balance has increased by nearly £10.0m over the year, partly attributable to a £9m reduction in cash spend on the capital programme compared to 2016/17. There is a £2.8m capital creditor outstanding at year end. The cash flow forecast continues to show strong liquidity for the foreseeable future. The working capital loan balance of £3.2m was repaid in March.



A&E contract income was £1.6m below plan for the year due to lower than planned activity. Activity growth in the current year to date has been close to zero (+0.2%), compared to the planned 4.7%.

Despite the above, the overall income variance was £6.7m favourable, due mainly to additional income from East Kent Hospitals (£2.0m) to support the increased cost of diverts, CQUIN (£1.9m, including risk reserve released in March), NMET (£0.7m), Special Measures funding (£0.8m) and additional STF Incentive released (£1.4m).

SECAmb Finance Performance Charts



Overall costs are broadly in line with income and for the year are £4.4m greater than planned.

This partly comes from supporting East Kent Hospitals (£2.0m), Special Measures (£0.8m) and additional supporting costs across the Trust across both pay and non pay.

Operational hours are aligned to commissioned levels of activity.

The significant increase in costs in the month reflected a year-end review of provisions and an adjustment to the profile of depreciation charges on assets that are planned to be replaced in 2018/19.

SECAMB Board

Summary Report on the Audit Committee Meeting of 21st May 2018

Date of meeting	**21 May 2018**
Overview of issues/areas covered at the meeting:	The key areas covered in this meeting related to the March 2018 Year End Subject to amendments discussed at the meeting, The Committee concluded that it: • Accepted the "Limited Assurance" Internal Audit Opinion for the last year • Accepted executive commitment to resolve new and outstanding HR management actions rapidly • Recommended that the Board adopt the proposed Annual Governance Statement • Recommended that the Board adopt the Annual Self Assessment Certificates • Recommended that the Financial Accounts be prepared on a going concern basis • Recommended that the Board adopt the proposed Financial Accounts • Recommended that the Board adopt the proposed Annual Report • Was able to support the proposed Quality Report (Subject to a detailed review by the Quality Committee) • Accepted the proposed Internal Audit plan for 2018/19 (subject to a proposed review at (and/or before) the next meeting) The Committee thanked the Executive, Internal and External Audit teams for their work and complemented the evident improvement in year end papers in comparison to last year
Internal Audit and related matters	The committee discussed recent Internal Audit work, outstanding actions and the overall opinion for the year. The committee was concerned at the outcome of the Staff Records Audit and the number of outstanding HR related management actions, but was encouraged by executive commitment to resolve issues quickly. Whilst the committee noted that the executive were already working on these matters with the Quality and Workforce Committees, the committee asked that the HR Director and/or the Chief Executive attend part of the next Audit Committee meeting to demonstrate overall plans / funding / resources sufficient to resolve issues on a timely and prioritised basis. The Internal Audit Opinion for the year was disappointing (Limited Assurance) but reflected findings throughout the year and the number of outstanding management actions. Internal Audit noted a favourable development trajectory in the last quarter. If policies, controls, governance and risk management continue to develop at this pace, it was suggested that the Internal Audit opinion would likely be better at the next year end. In the context of the overall Internal Audit Opinion, the committee accepted (subject to amendments discussed) the Annual Corporate Governance Statement and various Annual Self Certification Certificates.

	The committee discussed the proposed Internal Audit plan for 2018/19. The committee felt able to support it as a good start; however, the committee asked that the plan be reviewed at (and/or before) the next meeting to consider such matters as: - coverage against the Key Risks agreed in principle at a Board Workshop last week - alignment against a forthcoming executive paper that will set out an overall governance and assurance framework across the trust - the right size of the Internal Audit program in relation to other sources of assurance
External Audit, VfM and Quality Report	The committee received a report from KPMG covering their financial audit, review of the Quality report and Value for Money opinion. The committee discussed going concern matters and concluded that it is appropriate to prepare the March 2018 Financial Accounts on a going concern basis. The committee noted that all significant External Audit work for the year-end had been completed. The Committee discussed the proposed Financial Accounts and Annual Report in detail. Subject to amendments discussed at the meeting, and with the support of KPMG, the committee recommends to the Board that these be adopted. The committee took an overall look at the proposed Quality Report, noting that it was subject to a detailed review by the Quality Committee. Subject to that review, the Committee supported the proposed report.
Thanks	The committee thanked the Executive, Finance, External Audit and Internal Audit teams for their work over the year and complemented the evident improvement in year end papers

South East Coast Ambulance Service NHS Foundation Trust

Item No	32/18

Name of meeting	Trust Board
Date	25.05.2018
Name of paper	Learning from External Reviews
Executive sponsor	Bethan Haskins, Executive Associate 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)	Each year high profile reports on NHS provision are published and this short paper reviews the four main papers that have been published during 2017/18 and identifies how the Trust will consider the learning. The papers are; 1. Wirral University Teaching Hospital Foundation Trust.(March 2018) 2. Report of Liverpool Community Health Independent Review. (January 2018) 3. The Kerslake Report: An independent review into the preparedness for, and emergency response to, the Manchester Arena attack on 22nd May 2017. (March 2018) 4. Cardiothoracic Surgery: Get It Right First Time Programme National Specialty Report. (March 2018)
Recommendations, decisions or actions sought	The Board is asked to note the recommendations.

South East Coast Ambulance Service NHS Foundation Trust

Learning from External Reviews
Trust Board Report

1. Introduction

1.1. In previous years there have been major external reviews that have led to NHS wide changes. These have included the Mazars Report (Southern Health) in 2015 and the Lampard Review (Jimmy Savile) also in 2015.

1.2. There have been no significant NHS wide reviews published in 2017/18. However, there have been a few Independent Reviews of NHS services and other publications where provider Trusts are expected to review the published documents and identify appropriate lessons for local consideration.

1.3. This paper reviews the main reports published over the 2017/18 and the implications for SECAmb.

2. NHSi Commissioned Reviews

Wirral University Teaching Hospital Foundation Trust (March 2018)

2.1. This review is regarding the health of the Trust Board in terms of culture, style and relationships. It is not about patient care.

Summary

2.2. The review commissioned by NHS Improvement, examines issues raised about the Trust during 2017 and NHS Improvement's handling of these concerns when they were raised with NHS Improvement's regional team. It also looks at the Trust's handling of a serious disciplinary case.

2.3. The concerns reviewed by the investigator were identified as follows;

- alleged failure to follow due process in connection with some senior appointments, with aligned allegations of misrepresentation of senior staff views;
- alleged poor functioning of the WUTH board, Executive Management Team (EMT) relationships, and aligned poor internal handling by the board of the related concerns raised by senior staff; and
- an unhealthy working environment and culture which inhibits staff raising concerns.

2.4. The report outlines how a number of governance failings at the trust during 2017 led to the breakdown of relations between the executive directors, non-executive

directors, the former Chair and former Chief Executive, and how staff at all levels felt unable to speak freely about concerns they held.

Implications for SECAmb

2.5. There are no immediate lessons for SECAmb although a more strategic reflection for Board members would be beneficial. The following recommendations are recommended.

- Recommendation. Trust Board members to read the full paper. **Action All.**
- Recommendation. Simple review of policy and guidance on the recruitment of Executive Directors **Action Director of HR.**
- Recommendation. Themes of the paper to be considered as part of the Boards Development. **Action Company Secretary.**

Report of Liverpool Community Health Independent Review (January 2018)

2.6. This review is an in-depth review and primarily focusses on inexperienced leadership then led to inadequate quality/clinical governance resulting in patient harm.

Summary

2.7. An independent review into the widespread failings by a community health Trust was published in January 2018. The review conducted by Dr Bill Kirkup CBE, commissioned by NHS Improvement, reviewed the issues at Liverpool Community Health NHS Trust from November 2010 to December 2014.

2.8. The report outlines how cost improvement programmes imposed by the Trust in a bid to gain foundation Trust status put the safety of patients at risk, and that a culture of bullying meant that staff were scared to speak up or that incidents were ignored or not escalated. The review found that the external overview of the Trust failed to identify the services problems for at least four years, and concluded that earlier intervention would have reduced the avoidable harm that occurred to patients and staff across the trust.

2.9. The report identifies a clear view that clinical capability to deliver the patient care required was compromised by inadequate staffing levels, training, supervision and skills mix. They found that staff worked in a reactive environment, and prevention work was not introduced in a timely manner. Clinical competence and training were lacking in some staff; evidence-based standards were not uniformly applied; learning from incidents and serious incidents was not shared for wider learning; and staff had little time to undertake clinical and management supervision, preventing reflective practice and learning.

2.10. The organisational culture of the Trust was poor, reflecting the Trust leadership. Bullying of staff was prevalent, and staff worked in a climate of fear that discouraged them from speaking out about the problems they experienced and that was detrimental to their wellbeing. Incident reporting was discouraged and incidents

downgraded. Staff were wrongly blamed for errors instead of incidents being learned from to the detriment of staff and patient care.

Implications for SECAmb

2.11. There are opportunities for learning within this report for SECAmb. The recommendations are presented in Appendix I but Board members are encouraged to read the full report.

2.12. In particular, the references to culture may be worthy of consideration. There are a number of other functions such as, Quality Impact Assessments and Serious Incident Reviews where lessons may be transferrable.

2.13. The learning is high level but key themes can be applied and the areas with the highest impact lie within the Trust's Workforce Committee and the Quality & Patient Safety Committee;

- Recommendation. For both the Workforce Committee and the Quality and Patient Safety Committee to consider the report and use the report to assist in identifying the additional scrutiny items through the year. **Action relevant Non Executive Chairs and Executive Director.**

3. National Reports

The Kerslake Report: An independent review into the preparedness for, and emergency response to, the Manchester Arena attack on 22nd May 2017. (March 2018)

3.1. The above review focussed on the response to the attack from zero to nine days after the incident. The author and the review panel are of the view that the response was overwhelmingly positive but as the likelihood of repeat incidents is high it is important to identify all the opportunities to learn.

Summary

3.2. It is not in the scope of this paper to report on the detail of the report as there are inevitably lessons for the ambulance service. The intention of this paper is to acknowledge and capture the report and propose how the Trust will review the detail.

3.3. The report is extremely comprehensive and reviews all contributing agencies and how their roles overlap in such events. Highlights to give an indication of what the report contains include the following;

- Poor communication and poor procedures.
- Inadequate telecommunications for the National Mutual Aid Telephony system (national issue and the Home Office leading the improvements).
- Behaviour of some media agencies/individuals.
- Multiple duties that fell to the Police Gold Commander.
- Confusion and late launch of PLATO.
- Support for the families.
- Lack of canvas stretchers.

- Public health guidance on vaccination following blood borne virus risks.

Implications for SECAmb

3.4. The report needs a full review. However, the review also needs to take into consideration the lessons from similar events in London. There is no independent report but there will be reflections by London Ambulance and the Kirslake report needs to be reviewed alongside the review of London. There are lessons for people who undertake the various levels of command in these situations, lessons for EOC and for HART

- Recommendation. For the Medical Director to undertake the led role in reviewing the report and identifying the key issues for sharing across the organisation and undertake a presentation at a future Quality & Safety Committee. **Action Medical Director.**

Cardiothoracic Surgery: Get It Right First Time Programme National Specialty Report. (March 2018)

3.5. Get It Right First Time (GIRFT) published their review of surgical cardio-thoracic services in March 2018. GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.

Summary

3.6. The cardiothoracic review found significant degrees of unwarranted variation in a number of key areas, including patient pathways and associated bed management, management of clinical risk and adverse clinical outcomes, lung cancer services, aorto-vascular surgery, mitral valve repair, and clinical coding.

Implications for SECAmb

3.7. The review is mainly for those Trust's that provide Trauma services. However *Recommendation 14:* Ensure that acute aortic syndrome patients are only operated on by rotas of acute aortic syndrome specialist teams which has the action "Establish formal agreements between referring hospitals, receiving specialist units and ambulance services for transfer of AAD patients to the relevant specialist centre" does have an impact on ambulance Trusts.

- Recommendation. For the Director of Strategy to discuss with commissioners. **Action Director of Startegy.**

4. Other Reports/Publications

R v Southern Health NHS Foundation Trust Sentencing Remarks (March 2018)

4.1. Not a report but included here due to the significance of the above decision. Southern healthcare were successfully prosecuted for failing to deliver the Health & Safety at Work Act 1974 by failing to protect patients from the risk of serious harm. The Trust received an aggregate fine of £2,000,000.

Summary

4.2. The findings are regarding the highly publicised cases of patient death at Southern Health NHS Foundation Trust. The identified failings were;

- Failing to ensure the patients were provided with appropriate care
- Insufficient risk analysis
- Failures in risk analysis
- Ineffective policies and procedures
- Ineffective and poor leadership
- Failure to respond to warnings and events in a timely and appropriate manner.
- There were failures be healthcare staff to safely and appropriately supervise patients.
- There was poor governance, poor documentation and a poor and worrying reporting practice when things went wrong or were flagged up.
- There were failures of supervision.
- Failure (which the Trust recognised) to learn lessons and improve practice.

5. Conclusion

5.1. This paper has summarised the four main reports that have been published in 2017/18 that are a review of service or in the case of Southern Healthcare a legal consequence following a review.

5.2. The following table summarises the four papers. There is no proposed follow-up beyond the recommendations within the table.

Summary Table

Paper/Report	Main Theme	SECAmb Action	Link
Wirral University Teaching Hospital Foundation Trust. ***(March 2018)***	This review is regarding the health of the Trust Board in terms of culture, style and relationships. It is not about patient care.	Recommendation. Trust Board members to read the full paper. **Action All**. Recommendation. Simple review of policy and guidance on the recruitment of Executive. **Action Director of HR**. Recommendation. Themes of the paper to be considered as part of the Boards Development. **Action Company Secretary**.	https://improvement.nhs.uk/documents/2492/NHSI_WUTH_Final_Report.pdf
Report of Liverpool Community Health Independent Review. ***(January 2018)***	This review is an in-depth review and primarily focusses on inexperienced leadership then led to inadequate quality/clinical governance resulting in patient harm.	Recommendation. For both the Workforce Committee and the Quality and Patient Safety Committee to consider the report and use the report to assist in identifying the additional scrutiny items through the year. **Action relevant Non Executive Chairs and Executive Director.**	https://improvement.nhs.uk/documents/2403/LiverpoolCommunityHealth_IndependentReviewReport_V2.pdf
The Kerslake Report: An independent review into the preparedness for, and emergency response to, the Manchester Arena attack on 22nd May 2017. ***(March 2018)***	The review focussed on the response to the attack from zero to nine days after the incident.	Recommendation. For the Medical Director to undertake the led role in reviewing the report and identifying the key issues for sharing across the organisation and undertake a presentation at a future Quality & Safety Committee. **Action Medical Director.**	https://www.kerslakearenareview.co.uk/media/1022/kerslake_arena_review_printed_final.pdf

Cardiothoracic Surgery: Get It Right First Time Programme National Specialty Report. ***(March 2018)***	The cardiothoracic review makes recommendations to reduce unwarranted variation within cardiothoracic surgery	Recommendation. For the Director of Strategy to discuss with commissioners. **Action Director of Strategy**	http://gettingitrightfirsttime.co.uk/wp-content/uploads/2018/04/GIRFT-Cardiothoracic-Report-1.pdf

Appendix I

Liverpool Community Trust: REVIEW FINDINGS

1. Liverpool Community Health NHS Trust (LCH) was a dysfunctional organisation from the outset. The Trust acted inappropriately in pursuit of Foundation Trust (FT) status, setting infeasible financial targets that damaged patient services. The Trust managed services that it was ill-equipped to deal with, particularly prison healthcare in HMP Liverpool. Senior leadership and the Board failed to realise that the Trust was out of its depth, and did not take heed of the effects. Staff were overstretched, demoralised and, in some instances, bullied. Significant unnecessary harm occurred to patients. External NHS bodies failed to pick up the problems for four years.

2. The Trust was created as a new organisation in 2010 with a new and inexperienced management team. Their leadership was inadequate from the outset. The Chair and non-Executive Directors were also relatively inexperienced and offered insufficient challenge to the management team.

3. The Trust Board's principal objective was to become a FT, though frontline staff did not share this view. This objective dominated the time and attention of the management team, and they and the Board became blind to the real concerns that began to arise throughout the organisation.

4. The Trust had sufficient contract income at least to continue with its previous level of services when established. It was asked by its commissioners to achieve a very significant cost saving over the next four years, and appears to have offered little or no challenge to the feasibility of achieving this while sustaining existing service levels. Services were commissioned by two Clinical Commissioning Groups (CCGs) and NHS England (NHSE), and it is not clear that any had an overall view on the cumulative impact. This naivety on the part of the Trust tipped it into a position of major cost pressures.

5. In addition to their acceptance of an unsustainable revenue position, the Trust undertook to generate a significant cash surplus over the same period. This appears to have been generated by a desire to demonstrate a robust financial position in pursuit of their application to become a FT, but the cumulative impact of this with the revenue reduction was not adequately considered.

6. In order to address the external and self-imposed cost pressures, the management team embarked on a series of drastic cost-improvement measures. Unless there are exceptional circumstances, an annual cost improvement programme of 4% is generally regarded as the upper end of achievability; the Trust undertook to achieve 15% in a year. There is no evidence that the management team or the Trust Board recognised the substantial risk that this posed.

7. Proposed cost improvements mainly involved reducing staff numbers, as they were bound to, given the nature of community services. Proposals were subject to quality impact assessment (QIA), a process that should have identified the adverse effects on

services so that they could be mitigated and, if necessary, the proposal abandoned. However, these assessments were grossly deficient in the Trust, and failed to identify the obvious adverse consequences of most of the proposals that were implemented. On the occasions that QIAs were undertaken, they were not actively managed nor robustly reviewed.

8. The Trust should have had clear and effective systems to manage risk, including the clinical risk arising from over-ambitious and ill-considered cost improvement measures, as well as clinical governance systems to monitor the quality of clinical services. Both should have informed the QIAs but, in practice, systems were unclear and ineffective. At one point, the Executive Director responsible for clinical quality was the Finance Director, who had set the cost improvement targets, and the Medical Director had no clear responsibility for clinical quality.

9. This placed significant responsibility for clinical quality on the Nurse Director, but she was, for at least part of the period, the Trust's Chief Operating Officer, and therefore also responsible for achieving the cost improvement programme.

10. The result of this confused and conflicted arrangement was that Trust management neither identified properly the serious risks inherent in the cost improvement programme nor picked up the significant adverse consequences for services as they began to emerge. They remained focused predominantly on becoming a FT.

11. The adverse consequences were significant. First, many staff soon became demoralised. They had not felt involved in planning for the impact of staff reductions, and when they reported difficulty in maintaining safe and effective services, they did not feel listened to; certainly there was no evident change in the approach taken. Sickness absence levels rose, worsening staffing levels further.

12. Second, although it is clear that most staff tried hard to compensate for staff reductions, it is equally clear that services began to suffer despite their efforts. The incidence of patient harm incidents subject to mandatory reporting nationally rose, including pressure ulcers and falls. Other incidents, some serious, should also have been reported and investigated, but we heard repeated accounts that reporting was discouraged, investigation was poor, incidents were regularly downgraded in importance, and action planning for improvement was absent or invisible.

13. Third, it is clear to us that the reaction of the Trust Board to this gathering crisis in services was based on denial. The management team was still focused predominantly on becoming a FT, and reports of service problems were not only a distraction, they would adversely affect the assessment of the Trust's capability of achieving their goal.

14. The initial impact fell predominantly on the middle managers, positioned between the Trust Board's insistence on pushing through the cost reductions regardless and the staff's difficulty in maintaining safe and effective care and their consequent unhappiness. Unfortunately, faced with this undoubtedly challenging position, it is clear that their response was inadequate and inappropriate and, in too many cases, included extreme action against more junior staff, amounting to bullying. Whatever its origin in the pressure they were under themselves, this behaviour was inexcusable.

15. When some staff attempted to raise concerns, or in some cases grievances as a result of being bullied, the response was seriously deficient. We heard repeated accounts that staff would be suspended without being told why, or what the next steps would be. In some cases, these suspensions lasted for many months without any apparent process for resolution. We heard specific examples of very poor practice in nursing management and human resources (HR). There were serious shortcomings in the leadership of both departments.

16. We heard that this caused significant distress to those so treated, and affected their long-term wellbeing. We have no doubt that the reports of these occurrences spread to other staff, and contributed significantly to a climate of fear and insecurity among Trust staff generally that made them understandably very reluctant to speak out about both service failures and working conditions.

17. There were additional problems. The Trust adopted an approach of expanding its provision. It took on responsibility for an additional geographical area – Sefton – while still struggling to manage an entirely different type of service – prison healthcare in HMP Liverpool. The acquisition of community services for Sefton caused immediate difficulties in integrating staff with a different organisational culture. Attempts to redeploy staff between localities caused friction, further worsening staff morale.

18. The management of prison health services proved even more problematic, with serious concerns about service delivery and some stark incidents that were not reported and investigated properly. The Trust should have recognised that it had neither the experience nor the capability to manage this service area. Their failure to realise that they were out of their depth caused significant harm to patients.

19. It is clear in light of all of these failings that the Trust was seriously dysfunctional. There was a lack of leadership at senior and middle levels. The Trust Board lacked the capability to see beyond its goal of becoming a FT, and failed to recognise the significant harm that its programme of cost reduction was inflicting. Demoralised staff were badly treated and sometimes bullied, and there was a failure of nursing management and HR procedures. Serious incidents causing patient harm were not reported, not investigated and lessons not learned. The result was unnecessary harm to patients.

20. Service commissioners did not take adequate steps to identify problems with the services delivered by the Trust. Initially, Primary Care Trust (PCT) commissioners assessed the Trust as low risk, based on their view of initial contract income. When commissioning transferred to CCGs, a reduction in contract income was proposed that was infeasible at the same level of service. When this was accepted, no concern was raised over the potential effects. The challenge of a very different service, healthcare in HMP Liverpool, also failed to generate concern among commissioners. When NHSE assumed responsibility, their monitoring was no more effective, and was marred by an undeclared potential personal conflict of interest.

21. External overview also failed to identify the service problems for at least four years. The Strategic Health Authority (SHA) regarded the Trust as low risk, despite its newness and the inexperience of its senior staff, and provided inadequate briefing when it was

abolished and the responsibility transferred to the NHS Trust Development Authority (TDA). The NHS TDA did identify concerns but subsequently reversed its assessment for reasons we were unable to determine. The Care Quality Commission (CQC) failed to identify the extent and nature of the problems until they were alerted by Rosie Cooper MP. In part, these failures were because reconfigured organisations were coming to terms with new roles and did not communicate effectively, but this is insufficient alone to account for the missed opportunity.

22. Any of these external organisations could have identified the problems afflicting the Trust earlier had they looked critically at the information available to them. The primary responsibility, however, lay with the organisation statutorily accountable for the service, Liverpool Community Health NHS Trust. The Trust not only failed in its duty to provide safe and effective services, it concealed this from external bodies. Both patients and staff suffered harm for too long as a result.

		Agenda No	34/18

Name of meeting	Trust Board
Date	25 May 2018
Name of paper	External Governance Review – Management Action Update
Responsible Executive	Daren Mochrie, Chief Executive
Author	Peter Lee, Company Secretary
Synopsis	In the summer of 2017, KPMG were commissioned jointly with the Trust and NHSI, to undertake a governance review. The final report, which included the management response, was received in February 2018 and published on the Trust's website. The table in Appendix A updates the Board with the progress made against each recommendation.
Recommendations, decisions or actions sought	For information.

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

.

Appendix A - Governance Review Recommendations / Management Response

#	Issue, Impact and Recommendation	Management Response
1	**Divisional Governance Structures** Although management meetings are held at an Operating Unit level a formal divisional governance structure to escalate to the Regions has not been established. Performance is not currently reviewed and scrutinised by the Executive for individual Regions or Operating Units. This would provide the Executive with visibility of any performance issues emerging in specific locations and allow them to obtain assurance that appropriate mitigations were being put in place. Regional Boards should be established as part of the restructuring of operations, with a Board for each of the East and West regions, consisting of the Regional Operations Manager, Operating Unit Managers, Finance Business Partner, HR Business Partner and senior clinicians from the Region. These should meet on a monthly basis with a terms of reference considering operational performance, finance, HR, risk management, quality and safety and other governance matters, such as incidents and complaints. A quarterly review should be held for each of the Regions, 111 and the EOC between the division and the Executive. Reports should be provided to the meeting to set out the performance of the service against the above domains and actions being taken to resolve any performance issues reviewed by the Executive to obtain assurance they are appropriate. We have set out in Appendix D an example of the matters we would expect to see considered.	Executive Director of Operations During the period of this review, steps were being taken to revise the divisional governance structure. Since then, a new meeting structure has been established. There are five area governance review meetings held monthly; EOC, 999 East, 999 West, Resilience and Specialist Operations, and 111. They are chaired by the Executive Director of Operations and membership includes regional operational managers, relevant business partners and managers from other directorates. The Executive Director of Nursing & Quality and Executive Medical Director also attend. There are is a standard agenda covering operational performance, quality, workforce, finance and risk. Scorecards have been introduced to ensure that quality and performance can be managed from OTL level upwards. From June 2018, these area governance reviews will be chaired by the Chief Executive and will include every executive director.
2	**Management Information** Consistent management information is not available at a divisional or locality level to enable identification of trends or concerns at specific locations that may require action to be taken. Although performance against access targets can be monitored locally other key management information sources, including workforce, quality and safety are not consistently made available to Regions or Operating Units to support their	Executive Director of Strategy & Business Development In October 2017, the Trust Board approved funding for the implementation of a new data warehouse and Business Intelligence system to bring together reporting in a coherent way to meet the needs of the organisation. The Business Intelligence team has been increased in size with two additional analysts joining the team since this review. A range of dashboards incorporating performance, workforce and quality data have been

	management. Consistent hierarchies should be established for the Trust's reporting systems to enable reporting by Operating Unit and by Region. Balanced scorecards should be developed for the Regions to enable Regional Operating Managers to obtain an overview of the performance within each region and distributed for the Regional Boards recommended (see recommendation one). Performance reports presented to the Board and sub-committees should be reviewed to reduce the length of reports and support users in more easily identifying where performance issues are arising that require scrutiny. Current reports include a number of pages of trend diagrams, whilst these may support scrutiny of areas where performance is not being achieved a more concise method for reporting these would support reviewing performance. A number of workforce targets do not have targets formally established, such as vacancy and turnover rates. We also noted that at the last two Board meetings workforce indicators had not all been able to be reported due to performance information not being available. A review of the reporting timetable for workforce information should be undertaken to identify how information can be developed in time for reporting to the Board. When assurance committees and the Board are determining whether they are assured over a specific matter they must ensure that a supporting evidence base has been provided as part of the assurance report to confirm the basis on which they are giving their assurance.	improved to meet the needs of the various management groups and the new operational structure. Further work is required to improve consistency of reporting structures across all data systems to align data to the division/operating unit/team structure. A new more concise Trust Board integrated performance report has been established to provide consistency, using best practice from other provider trusts.
3	**Senior Management Team** Executive Management Team (EMT) meetings are held on a weekly basis. Our observations of two EMT meetings identified that meetings spent a significant amount of time considering detailed operational matters, such as reviewing processes for keeping user accounts up to date on the risk management system. There is a risk of management stretch amongst Executive members as the Trust seeks to implement its Task and Finish Groups in response to the CQC inspection. The Senior Management Team currently has a limited role in supporting the	Chief Executive A review has been undertaken and SMT has been replaced with a new Senior Leadership Team (SLT), consisting the executive team and senior managers. The aim of the SLT is to ensure better links between senior managers and the executive in the management and leadership of the Trust. The SLT reports directly to the Executive Management Board. A set-up meeting is scheduled for June with formal monthly meetings starting in July.

	overall management of the Trust, with meetings overseeing the refresh of policies and reviewing risks scored over 12. A review of the matters considered by the EMT should be undertaken to assess where further responsibility could be delegated to the SMT. A formal escalation mechanism should be established from the SMT to the EMT so that any issues arising can be escalated for consideration by the Executive.	
4	**Communication** Feedback from staff consistently set out that when matters were reported, such as incidents and safeguarding concerns, that feedback was not received to inform them of how they were dealt with and any matters arising as a result. This was fed back as a significant contributing factor to the low levels of incidents that have been reported. The medicines management optimisation plan has effectively communicated the importance of changes being made to medicines management, with Executive led communication to Operating Team Leaders for further cascade. However, as further work streams are implemented there will be limited capacity for this to be replicated for all of the projects undertaken. Appropriate operational representation should be factored into all the Task and Finish Groups to support the cascade of information to operational teams. This should include Regional Operating Managers and Operating Managers responsible for feeding information back. As part of the risk, incident and safeguarding action plans consideration should be given to how feedback to users can be improved.	Executive Director of Nursing and Quality The incident management improvement plan includes a measure relating to feedback to staff. This plan is overseen by the related task and finish group and the Compliance Steering Group. The aim is to ensure feedback is provided, electronically, via the central incident team, as part of the incident closure process. Quality Improvement notices are displayed at stations, highlighting the learning / action taken as a result of incident reporting. In addition, as each task and finish group undergoes the 'intensive support' phase of the improvement plan the Trust is sharing progress with operational staff to help engagement and sustained improvement.
5	**Risk reporting** The EMT and SMT receive reports of new risks raised and all risks above 15 and 12 respectively for review on a monthly basis. On a quarterly basis the Executive report shows the full details of the risk register, while at other meetings this sets out those that are overdue for review to enable monitoring of whether risk review is taking place appropriately. Review at the meetings should be focused on considering whether the target risk score is appropriate, mitigating actions identified are sufficient to manage the risk to its target level and whether timescales are appropriately	Executive Director of Nursing and Quality The risk management improvement plan continues to progress, as part of the delivery plan, supported by a risk management project lead. Particular focus has been given to ensuring principal risk leads are identified against all risks, and that risks are assigned to specific groups and committees – to ensure groups regularly review those risks within its remit. A formal structure has been established for every group meeting, to guide the Chairs in how to consider risk. Although a formal education programme has not yet been implemented, education opportunities have been identified. For example, during risk reviews with individuals and

	prompt. Mitigating actions against risks should have responsible officers and due dates assigned. Where the full risk register is not presented to the Executive exception reporting against the completion of actions would support increased effectiveness of monitoring of risk management. A formal risk appetite has not been defined to support the consideration of the level of risk willing to be accepted depending on the nature of the risk. 16% of risks on the risk register have a target risk that remains extreme or high. The Board should consider its risk appetite for different natures of risk (such as financial, quality and safety) and update the risk management strategy to incorporate this. When new risks are reviewed the alignment of the target risk score to the risk appetite should be considered.	teams, training and awareness of the new processes is taking place. In addition, the executive had a risk management workshop in December 2017 to help clarify its role, and ensure it consistently seeks the assurance of the overall risk strategy, picking up the issues identified by this review. The Audit Committee held single-item meeting on risk management in April 2018, to review the improvement plan, strategy, policy and risk register.
6	**Meeting management** Though meetings are generally well managed we identified some opportunities to improve the efficiency of the Board and its sub-committees. Although agendas for the Board set out anticipated timings for agenda items this has not been replicated for Board sub-committees. The Board agenda format should be adopted for each of the sub-committees to support management of meetings so that all agenda items receive sufficient attention. Action logs were often not sufficiently specific to be able to clearly identify what the expected action had been when following up matters arising at subsequent meetings and updates were not provided in advance of the meeting. This increases the length of time required to consider matters arising and may mean they are not implemented as promptly as expected. The secretary for meetings should circulate the agreed actions following the writing of the meeting minutes and circulate these to responsible officers. Updates should be requested from management in advance of circulating papers for the meeting.	Company Secretary There was already a standard agenda format in place for board committees and this has now been updated to ensure timings of agenda items. Each committee reviews the action log ahead of meetings, so that it is sufficiently updated. Work has been done to ensure the minutes are clear, including the actions. A review was undertaken of the action logs to ensure they accurately describe the action required.
7	**Alignment of Committees to risk register** A purview map is used to set out the alignment of the Board sub-committees' responsibilities to the Trust's objectives and the five CQC domains under their revised inspection framework. The QPS and Workforce and Wellbeing Committee have undertaken regular assurance deep dives into a number of specific areas, determining from these whether they are assured or not.	Company Secretary Although it has been practice for board committees to reflect whether a risk discussed is on the risk register, supported by the board escalation report having a section on any changes to the risk profile of the Trust, a standing agenda item has been included so that the committee specifically establishes whether any new risks have been identified.

	We were unable to establish a formal feedback mechanism for the assurance considered by the Committee to inform the risk register, either by updating assurances against existing risks or identifying new risks. A standing agenda item should be included at the end of committee meetings to consider whether new risks have been identified that require escalation to the risk register.	
8	**Board Assurance Framework risks** Only two of the risks recorded on the Board Assurance Framework are scored as extreme. However, there are 22 extreme risks recorded on the risk register, many of which relate to the findings raised by the Care Quality Commission. While the BAF has been designed to consider specific risks to the achievement of the strategy, this may mean the Board's attention is not sufficiently focused on the greatest risks the Trust is facing. A review of the extreme risks should be undertaken to assess whether there are risks that require recording on the BAF due to their importance in achieving the core objectives of the Trust, especially it's 'our patients' objectives.	Company Secretary A review of the Board Assurance Framework has been undertaken to help ensure the most relevant risks to the achievement of objectives are captured. This was received by the Trust Board in April and on 18 May the Board held a workshop to review and agree the BAF risks. An exercise to review all extreme-rated risks was undertaken in March. All extreme risks are now included in the BAF risk report.
9	**Review of action plans** Following the completion of our clinical deep dives we have identified eight specific findings where actions to comply with the must-do's set out by the CQC had not been fully implemented. We have provided full details in Appendix B (below). While most of these are addressed through action plans being implemented a review of the action plans should be undertaken to verify all findings have been accounted for, including as part of updating Standard Operating Procedures where necessary.	Executive Medical Director • Medicines - a review of medicines governance improvement plan was undertaken to ensure the findings and recommendations from this review have been considered. • Vehicle checks - the check sheet has been produced and the Incident Resourcing, Deployment & Management Standard Operating Procedure includes a section that refers to the 10-minute vehicle check time. • Record keeping – there are no plans to include record keeping as a specific part of key skills for 2018/19, but compliance with completion of PCRs, including (where it is required) the recording of consent and mental capacity, is reviewed regularly by OTLs. A PCR for every member of staff is audited every month and the minimum data set is being reinforced to ensure clarity of what is expected.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	35/18

Name of meeting	Board of Directors
Date	25 May 2018
Name of paper	Board Committee Annual Review
Author	Peter Lee, Company Secretary
Synopsis	This is the annual review of Board Committees' membership (Appendix 1) and the terms of reference for the Audit, Quality & Patient Safety, Workforce and Wellbeing, and Finance and Investment committees (Appendix 2-5). The amendments to the terms of reference are indicated in the version control schedules at the end of each document. The assurance purview map (Annex A) is included for information. This has not changed since it was approved by the Board in October 2017.It will continue to guide each committee ensure appropriate focus.
Recommendations, decisions or actions sought	The Board is asked to agree the Board Committee membership and revised Terms of Reference.

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

Appendix 1
(Membership of Board Committees)

Membership of Board Committees

	Appointments and Remuneration	Audit	Quality & Patient Safety	Finance & Investment	Workforce & Wellbeing	Charitable Funds
Graham Colbert Interim Chair	√					
Tim Howe Non-Executive Director	√		√		√	
Lucy Bloem Non-Executive Director	√		Chair	√		
Terry Parkin Non-Executive Director	√		√		Chair	
Angela Smith Non-Executive Director	√	Chair		Chair		Chair
Al Rymer Non-Executive Director	Chair	√			√	√
Tricia McGregor Non-Executive Director	√	√	√			√
Laurie McMahon Non-Executive Director	√		√		√	
Adrian Twyning Non-Executive Director	√			√	√	
Chief Executive	√	A	A			
Executive Director of Nursing & Quality		A	√*			
Executive Medical Director			√	√		
Executive Director of Operations			√		√	√
Executive Director of Finance & Corp. Services		A*		√*		√*
Executive Director of Strategy				√	√	
Executive Director of HR			√		√*	

*denotes committee Executive-Lead

A – Attends

Appendix 2
(Audit Committee)

South East Coast Ambulance Service NHS Foundation Trust

Audit & Risk Committee (AuC)

Terms of Reference

1. Constitution

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Audit & Risk Committee (AuC), referred to in this document as 'The Committee'.

2. Purpose

2.1. The purpose of the Committee is to provide the Trust with a means of independent and objective review of internal control over the following key areas:

- Financial systems
- The information used by the Trust
- Assurance Framework systems
- Performance and Risk Management systems
- Compliance with law, guidance and codes of conduct

2.2. In undertaking such review, the Committee provides assurance to the Chief Executive and to the Board about fulfilment of the responsibility of the Trust's Accounting Officer, who under the terms of the National Health Service Act 2006 is held responsible to Parliament by the Public Accounts Committee for the overall stewardship of the organisation and the use of its resources.

3. Membership

3.1. The Committee shall have not less than three members, appointed by the Board from amongst the independent Non-Executive Directors of the Trust. The Chairman of the Trust shall not be a member. One of the members having recent and relevant financial experience shall be appointed Chair of the Committee by the Board.

3.2. **Current members:**

- Angela Smith, Independent Non-Executive Director (Chair)
- Al Rymer, Independent Non-Executive Director
- Tricia McGregor, Independent Non-Executive Director

In addition, each Independent Non-Executive Director will be an ex-officio member of the committee.

4. Quorum

4.1. The quorum necessary for formal transaction of business by the Committee shall be two Independent Non-Executive Directors.

5. Attendance

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

- Chief Executive
- Executive Director of Finance & Corporate Services
- Executive Director of Nursing & Quality
- Company Secretary
- Internal Auditor
- External Auditor
- Counter Fraud

5.2. The Chairman and organisational managers and officers may be invited to attend meetings for specific agenda items or when issues relevant to their area of responsibility are to be discussed.

5.3. Officers unable to attend a meeting are required to send a fully briefed deputy or provide a written update to the Committee members at least two working days beforehand. Members and officers are required to attend 75% of these Committee meetings.

5.4. The Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should non-attendance jeopardise the functioning of the Committee the Chair will discuss the matter with the members and if necessary seek a substitute or replacement.

5.5. Attendance at Committee meetings will be disclosed in the Trust's Annual Report and Accounts.

6. Frequency

6.1. The Committee shall meet at least four times a year and extraordinary meetings may be called by the Chair between regular meetings to discuss and resolve any critical issues arising.

6.2. At least once a year the Committee shall meet privately with the External and Internal Auditors. The External Auditor or the Internal Auditor may request a private meeting if they consider this to be necessary.

6.3. Meeting dates will be diarised on a yearly basis.

7. Telephone Conference

7.1. With leave of the Chair of the Committee, any member or attendee of the Committee may participate in a meeting of the Committee by means of a teleconference/videoconference where circumstances require it or similar communications equipment whereby all persons participating in the meeting can hear each other and participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.

8. Authority

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

8.2. The Committee is authorised by the Board to investigate any action within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

8.3. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers necessary. It may challenge the reports and duties of other Committees to ensure due and robust business processes are in place.

9. Duties

9.1. The subject matter for meetings will be wide-ranging and varied but in particular it will cover the following:

9.2. Governance, Risk Management and Internal Control

9.2.1. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives.

9.2.2. In carrying out this work, the Committee shall primarily utilise the work of Internal Audit, External Audit and other assurance functions, but shall not be limited to these audit functions. It may seek reports and assurances from directors and managers as appropriate. The Committee may also take assurances from work undertaken by other established committees of the Trust Board.

9.2.3. Reviews by the Committee shall concentrate on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This shall be evidenced through the Committee's use of an effective Assurance Framework to guide its work and the work of the audit and assurance functions that report to it. In particular, the Committee shall review the adequacy of:

i. All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, External Auditor's opinion or other appropriate independent assurances, prior to endorsement by the Board;

ii. The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks (including through review of the Risk Register and Board Assurance Framework) and the appropriateness of the above disclosure statements;

iii. The processes for ensuring compliance with relevant regulatory, legal and code of conduct requirements;

iv. The policies and procedures for all work related to fraud, corruption and security management as set out in the NHS Standard Contract which requires providers to put in place appropriate arrangements for counter fraud and as required by NHS Protect;

v. The Trust's whistleblowing policy(s) so test that arrangements are in place for proportionate and appropriate investigation;

vi. The Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

9.3. Internal Audit

9.3.1. The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit standards and provides appropriate independent assurance to the Committee, Chief Executive and Board. This shall be achieved by:

vii. Consideration of the provision of the Internal Audit service, the cost of the service and any questions of resignation and dismissal;

viii. Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework;

ix. Consideration of the major findings of Internal Audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources;

x. Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

xi. Annual review of the effectiveness of Internal Audit.

9.4. External Audit

9.4.1. The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This shall be achieved by:

xii. Consideration of the appointment and performance of the External Auditor in so far as compliance with governance codes permits;

xiii. Making a recommendation to the Council of Governors on the appointment, reappointment or removal of the External Auditor; and if the Council of Governors does not accept the Committee's recommendation, ensuring that the Board includes in the annual report a statement from the Committee explaining its recommendation and setting out reasons why the position of the Council of Governors was different;

xiv. Discussion and agreement with the External Auditor, before audits commence, about the nature and scope of the audit ensuring coordination, as appropriate, with other External Auditors in the local health economy;

xv. Discussion with the External Auditor concerning assessment of the Trust with regard to locally evaluated risks, and the associated impact on the audit fee;

xvi. Reviewing all External Audit reports, including agreement of the ISA 260 before submission to the Trust Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

9.5. Financial Reporting

9.5.1. The Committee shall ensure that systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

9.5.2. The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

xvii. The wording of the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

xviii. Changes in, and compliance with, accounting policies and practices;

xix. Unadjusted mis-statements in the Financial Statements;

xx. Major judgemental areas;

xxi. Significant adjustments resulting from audit.

9.6. Other Assurance Functions

9.6.1. The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider any implications for the governance of the organisation.

9.6.2. These shall include, but shall not be limited to, consideration of any reviews by Department of Health arms length bodies, regulators or inspectors (e.g. NHSI, Care Quality Commission, NHS Resolution etc.), or professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

9.6.3. In addition, the Committee shall review the output of other committees established by the Board, whose work can provide relevant assurance to the Committee's own scope of work.

10. Reporting

10.1. The Committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

10.2. The Committee shall report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework in identifying key risks to the achievement of the Trust's strategic objectives the completeness and embeddedness of risk management in the Trust, and the integration of governance arrangements.

11. Support

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

12. Review

12.1. The Committee will undertake a self-assessment at the end of each meeting to review its effectiveness in discharging its responsibilities as set out in these Terms of Reference.

12.2. The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. Any proposed changes shall be submitted to the Board for approval.

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

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0		March 2016	
1.1			1. Amend to Audit and Risk 2. Included members 3. Amended attendees 4. Quorum from 3 to 2 NEDs to reflect other committees. 5. Authority section to be consistent with other committees 6. Amended the admin support arrangements 7. Included review from every 2 years to annually to be consistent with other committees

Appendix 3
(Quality Committee)

South East Coast Ambulance Service NHS Foundation Trust

Quality and Patient Safety Committee

Terms of Reference

13. Constitution

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

14. Purpose

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

15. Membership

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

The members of the committee shall be:
Lucy Bloem, Independent Non-Executive Director (Chair)
Tim Howe, Independent Non-Executive Director
Terry Parkin, Independent Non-Executive Director
Tricia McGregor, Independent Non-Executive Director
Laurie McMahon, Independent Non-Executive Director
Executive Director of Nursing & Quality (Executive Lead)
Executive Medical Director
Executive Director of Operations
Executive Director of HR & OD

16. Quorum

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

17. Attendance

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

- Chief Executive
- Company Secretary
- Deputy Clinical Director
- Chief Pharmacist
- Consultant Nurse / Paramedic
- Regional Operating Manager
- Head of IT

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

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

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

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

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

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

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

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

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

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

23. Review

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

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0	5 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. RMCGC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16.
1.1		23 October 2017	Update to membership Inclusion of additional regular attendees Administrative support provided by the HR Business Support Manager; from the corporate governance dept.
1.2			Updated membership

Appendix 4
(Finance Committee)

South East Coast Ambulance Service NHS Foundation Trust

Finance and Investment Committee ('FIC')

Terms of Reference

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

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

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

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

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

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

- Company Secretary
- Deputy Director of Finance
- A senior manager from operations

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

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

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

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

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

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

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

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

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

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

34. Review

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

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0	21 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. FBDC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16.
1.1	19 October 17	23 October 17	Update to membership Inclusion of additional regular attendees Administrative support provided by the HR Business Support Manager; from the corporate governance dept.
1.2			Update to membership

Appendix 5
(Workforce Committee)

South East Coast Ambulance Service NHS Foundation Trust

Workforce and Wellbeing Committee (WWC)

Terms of Reference

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

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

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

The members of the committee shall be:
Terry Parkin, Independent Non-Executive Director (Chair)
Tim Howe, Independent Non-Executive Director
Al Rymer, Independent Non-Executive Director
Laurie McMahon, Independent Non-Executive Director
Adrian Twyning, Independent Non-Executive Director
Executive Director of HR & OD (Executive Lead)
Executive Director of Operations
Executive Director of Strategy

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

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

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

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

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

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

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

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

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

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

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

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

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

45. Review

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

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0	12 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. WDC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16 Board.
1.1	20 Sept 16		Minor amendment proposed at para 5.3 see italicised changes.
2.0	04 October 2017		Change in Chair and Membership Additional regular attendees Administrative support provided by the HR Business Support Manager; from the corporate governance dept.
2.1			Updated membership Reduced frequency to minimum 4 times a year (from 6)

APPENDIX 1 - SECAmb Board draft assurance purview / map for 2017-18

This chart sets out the purview of each committee.
Topics are selectively picked according to the risk around each area.
Not every topic is scrutinised every year.

		Board	Q & PS	WWC	FIC	Audit	ARC	CFC
	Have we a well designed and effectively operating system of internal control to deliver the strategic goals?							
G1	Our People							
G2	Our Patients							
G3	Our Enablers							
G4	Our Partners							
1	Significant risks threatening achievement of objectives, as set out in BAF							
2	Have we enabling sub-strategies to deliver the objectives ? *Quality; clinical leadership; people (resourcing and leadership), estates, long term financial model; health, wellbeing and safety; fleet, commications; informatics.*							
	Have we established controls to deliver regulatory and legal compliance?							
3	NHSI Licence conditions compliance							
4	NHSI single oversight framework compliance							
5	NHSI regulatory ratings							
6	NHSI Code of governance compliance							
7	Annual report and accounts							
8	NICE							
9	Other regulatory disclosure statements							
10	CQC registration requirements compliance							
11	Equalities legislation							
12	Health & safety legislation							
13	Anti-fraud and anti-bribery legislation							
14	Employment legislation (bullying, harrassment, discipline, grievance, raising concerns, whistleblowing)							
	By safe, we mean that people are protected from abuse and avoidable harm.							
S1	How do systems, processes and practices keep people safe and safeguarded from abuse?							
S2	How are risks to people assessed, and their safety monitored and managed so they are supported to stay safe?							
S3	Do staff have all the information they need to deliver safe care and treatment to people?							
S4	How do we ensure the proper and safe use of medicines, where the service is responsible?							
S5	What is the track record on safety?							
S6	Are lessons learned and improvements made when things go wrong?							
	By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.							
E1	Are people's needs assessed and care and treatment delivered in line with legislation, standards (eg JRCALC, NHS Pathways licence) and evidence-based guidance to achieve effective outcomes?							
E2	How are people's care and treatment outcomes monitored and how do they compare with other similar services?							
E3	Do staff have the skills, knowledge and experience to deliver effective care and treatment? *(appraisals, mandatory training)*							
E4	How well do staff, teams and services work together to deliver effective care and treatment?							
E5	How are people supported to live healthier lives and, where the service is responsible, how does it improve the health of its population?							
E6	Is consent to care and treatment always sought in line with legislation and guidance?							
	By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.							
C1	How does the service ensure that people are treated with kindness, respect and compassion, and that they are given emotional support when needed?							
C2	How does the service support people to express their views and be actively involved in making decisions about their care, treatment and support as far as possible?							
C3	How are people's privacy and dignity respected and promoted?							
	By responsive, we mean that services are organised so that they meet people's needs.							
R1	How do people receive personalised care that is responsive to their needs?							
R2	Do services take account of the particular needs and choices of different people?							
R3	Can people access care and treatment in a timely way?							
R4	How are people's concerns and complaints listened and responded to and used to improve the quality of care?							
	By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.							
W1	**Kloe 1 Is there the leadership capacity and capability to deliver high quality, sustainable care?**							
1,2	Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?							
1,2	Do leaders understand the challenges to quality and sustainability and can they identify the actions needed to address them?							
1,3	Are leaders visible and approachable?							
1,4	Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?							
W2	**KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?**							
2,1	Is there a clear vision and a set of values, with quality and sustainability as the top priorities?							
2,2	Is there a robust realistic strategy for achieving the priorities and delivering good quality, sustainable care?							
2,4	Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?							
2,4	Do staff know and understand what the vision, values and strategy are, and their role in achieving them?							
2,5	Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?							
2,6	Is progress against delivery of the strategy and local plans monitored and reviewed and is there evidence to show this?							
W3	**KLOE 3 Is there a culture of high quality, sustainable care?**							
3,1	Do staff feel supported, respected and valued?							
3,3	Is the culture centred on the needs and experience of people who use services?							
3,3	Do staff feel positive and proud to work in the organisation?							
3,4	Is action taken to address behaviour and performance that is inconsistent with the vison and values, regardless of seniority?							
3,5	Does the culture encourage, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?							
3,6	Are there mechanisms for providing all staff at every level with the development they need, including high quality appraisal and career development conversations?							
3,7	Is there a strong emphasis on safety and well-being of staff?							
3,8	Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?							
3,9	Are there co-operative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?							
W4	**KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?**							
4,1	Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?							
4,2	Do all levels of governance and management function effectively and interact with each other appropriately?							
4,3	Are staff at all levels clear about their roles and do they understand what they are accountable for and to whom?							
4,4	Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care							
W5	**KLOE 5. Are there clear and effective processes for managing risks, issues and performance?**							
5,1	Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?							
5,2	Are there processes to manage current and future performance? Are these regularly reviewed and improved?							
5,3	Is there a systematic programme of clinical and internal audit to monitor quality, operational, and financial processes, and systems to identify where action should be taken?							
5,4	Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'?							

CQC key lines of enquiry

Well-led KLOEs.

APPENDIX 1 - SECAmb Board draft assurance purview / map for 2017-18

This chart sets out the purview of each committee.
Topics are selectively picked according to the risk around each area.
Not every topic is scrutinised every year.

		Board	Q & PS	WWC	FIC	Audit	ARC	CFC
5,5	Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities?							
5,6	When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?							
W6	**KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?**							
6,1	Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?							
6,2	Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and challenge it appropriately?							
6,3	Are there clear and robust service performance measures, which are reported and monitored?							
6,4	Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?							
6,5	Are information technology systems used effectively to monitor and improve the quality of care?							
6,6	Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required?							
6,7	Are there robust arrangements (including appropriate internal and external validation), to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?							
W7	**KLOE 7 Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?**							
7,1	Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?							
7,2	Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups?							
7,3	Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected equality characteristic?							
7,4	Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?							
7,5	Is there transparency and openness with all stakeholders about performance?							
W8	**KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?**							
8,1	In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?							
8,2	Are there standardised improvement tools and methods, and do staff have the skills to use them?							
8,3	How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?							
8,4	Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation?							
8,5	Are there systems in place to support improvement and innovation work including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?							
	Other aspects of governance							
15	Policy governance							
16	Defib strategy							
17	Long term financial model							
18	Procurement							
19	Disposals and acquisitions							
20	Standing financial instructions; standing orders; scheme of reservation & delegation							
21	Employee relations							
22	Corporate trustee responsibilities re Charity No 1059933							
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34								
35								
36								
141								

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Agenda No	36/18

Name of meeting	Trust Board
Date	25 May 2018
Name of paper	Register of Interests / FPPT
Responsible Executive	Peter Lee, Company Secretary
Author	Peter Lee, Company Secretary
Synopsis	It is good corporate governance practice for Directors to declare any professional or personal interests which are relevant to their roles at the Trust. This ensures that any relevant interests are identified proactively and are managed to ensure that there is no actual or perceived improper influence over decisions taken by the Board. The Trust's policy on declaration of interests requires that Directors declare at meetings any interests, which are directly relevant to matters being discussed at those meetings. Directors are also required to record their interests in the Register of Interests, which is made accessible to the public online and in the Annual Report. It is good practice for this to be received by the Board annually. The Board has agreed an enhanced Fit and Proper person annual declaration (Appendix B) to support the requirements of the Fit and Proper Person test. These have been signed by all directors.
Recommendations, decisions or actions sought	To note

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

.

Appendix A Register of Director's Interests and Fit and Proper Person Declaration: 25 May 2018

Name	Title	Interests Declared	FPPT Declaration Completed
Graham Colbert	Interim Chair	Employed by Genomics England Ltd; Trustee of the British Lung Foundation	Yes
Adrian Twyning	Independent Non-Executive Director	Employment with Dixons	Yes
Al Rymer	Independent Non-Executive Director	Director of Lune Consulting Ltd; Chair of Trustees of Church of England Soldiers, Sailors and Airmens Clubs – Charity welfare facilities for Armed Forces; Chairman and Director of Church of England Soldiers, Sailors and Airmens Housing Association – Charitable Sheltered Housing provision; President of Selsey RNLI Lifeboat Station – Lifesaving	Yes
Angela Smith	Independent Non-Executive Director	Independent Council Member at the University of Sussex and Chair and owner of GlobeRisk Ltd, a management consultancy business.	Yes
Laurie McMahon	Independent Non-Executive Director	Director of the Realisation Collaborative, specialising in organisational development; Board member of The Horsebridge Arts and Community Centre, Whitstable and Trustee of The Collaborative Foundation, a charitable organisation aimed at improving public management.	Yes
Lucy Bloem	Independent Non-Executive Director	Deloitte Partner (medically retired)	Yes
Terry Parkin	Independent Non-Executive Director	Managing Director of Monkmead Consulting Ltd; Chief Executive Officer of King's Academy Group; Member of Children's and Young Persons Disability Steering Group	Yes
Tim Howe	Independent Non-Executive Director	Director of Komoka Ltd HR Consultancy; Trustee Age UK (Sutton)	Yes

Tricia McGregor	Independent Non-Executive Director	Non-Executive Director of KSS AHSN, supports and works with all health providers in KSS; Visiting Professor of Univercity of Surrey, Trains Paramedics in SECAmb; Provision of Interim and Consultancy work of Tricia McGregor Ltd; and Interim Chief Executive Registrar at the General Chiropractic Council (the government regulator of chiropractors)	Yes
Daren Mochrie	Chief Executive	Member of the College of Paramedics; Member of the Royal College of Surgeons Faculty of Pre Hospital Care; Paramedic registered with the Health Care Professions Council; Specialist Advisor to the Care Quality Commission	Yes
Bethan Haskins	Executive Director of Nursing and Quality	No declarations	Yes
David Hammond	Executive Director of Finance and Corporate Services	No declarations	Yes
Ed Griffin	Executive Director of HR & OD	Lead editor of a Field Guide on Organisation Development which is aimed at HR professionals, line managers and consultants. Has a financial interest in this as he receives royalty payments. Has an extensive network of external consultants from having worked as a consultant. If there are times one of this network is involved in tendering for work with SECAmb he will declare an interest. Occasionally buys and sells antiques.	Yes
Fionna Moore	Executive Medical Director	Medical Advisor LAS; Medical Director, Location Medical Services	Yes
Joe Garcia	Executive Director of Operations	No declarations	Yes
Steve Emerton	Executive Director of Strategy & Business Development	KEFKAV Ltd, Interim NHS consultancy work	Yes

Appendix B - FPPT Annual Declaration

Fit and Proper Persons: Executive and Non-Executive Directors

All organisations regulated by the Care Quality Commission need to ensure that directors meet Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The criteria that must be met by a director of an NHS body are as follows:

a) the individual is of good character;
b) the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;
c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;
d) the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and
e) none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual (e.g. bankruptcy, sequestration and insolvency, appearing on barred lists and being prohibited from holding directorships under other laws).

In assessing an individual's character for the purposes of (a), the matters considered must include those listed in Part 2 of Schedule 4. Specifically, a director will fail the 'good character' test if they:

- have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence;
- have been erased, removed or struck-off a register of professionals maintained by a health care or social care regulator.

Please complete the self-declaration overleaf.

Fit and Proper Person Self-Declaration Form

Please complete this self-declaration form (delete as applicable for Qs 1-11), sign, date and return to declarations@secamb.nhs.uk

1. Have you got the qualifications, competence, skills and experience which are necessary for the position for which you are employed? **YES/NO**

2. Are you capable by reason of your health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which you are employed? **YES/NO**

3. Have you been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity? **YES/NO**

4. Have you been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence? **YES/NO**

5. Have you been erased, removed or struck-off a register of professionals maintained by a health care or social care regulator? **YES/NO**

6. Are you an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged? **YES/NO**

7. Have you been subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland? **YES/NO**

8. Have you been subject to a moratorium period under a debt relief order of the Insolvency Act 1986? **YES/NO**

9. Have you been subject to a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it? **YES/NO**

10. Have you ever been included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland? **YES/NO**

11. Are you prohibited from holding the relevant position under any other law e.g. Companies Act 2006 or the Charities Act 2016? **YES/NO**

If you have selected any answers which require further explanation, please explain the circumstances here:

I declare that the information I have given above is accurate:

Name:

Role:

Signed:

Date:

Please return the completed form to: declarations@secamb.nhs.uk