Trust Board Meeting Public

June

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South East Coast Ambulance Service NHS

NHS Foundation Trust

01. Agenda

02. Introduction

03. Trust Strategy

04. Quality & Performance

05. Closing

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

28 June 2018
10.00-12.30

Polegate MRC

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
Introduction					
39/18	10.01	Apologies for absence	**-**	-	GC
40/18	10.02	Declarations of interest	**-**	-	GC
41/18	10.03	Minutes of the previous meeting: 25 May 2018	**Y**	Decision	GC
42/18	10.05	Matters arising (Action log)	**Y**	Decision	GC
43/18	10.10	Patient story	**-**	Set the tone	
44/18	10.20	Chief Executive's report	**Y**	Information	DM
Trust strategy					
45/18	10.30	Delivery Plan	**Y**	Assurance	DM
46/18	10.40	Delivery Plan Deep Dives: a) Culture b) Hospital Handover Delays c) CQC Must/Should Do Tracker	 **N** **Y** **Y**	Assurance	 EG SE BH
47/18	11.00	Strategy Refresh Update	**N**	Information	SE
Quality & Performance					
48/18	11.05	Quality & Patient Safety Committee Escalation Report	**Y**	Assurance	LB
49/18	11.15	Accountable Officer for Controlled Drugs Annual Report	**Y**	Information	FM
50/18	11.20	Infection Prevention & Control Annual Report	**Y**	Information	BH
51/18	11.25	Clinical Review – Falls	**Y**	Information	FM
52/18	11.35	Integrated Performance Report	**Y**	Information	SE
53/18	11.50	Estates Summary Report	**Y**	Information	DH
54/18	11.55	Local Operating Unit Presentation	**Y**	Information	JG
Closing					
55/18	12.25	Any other business	**-**	Discussion	GC
56/18	-	Review of meeting effectiveness	**-**	Discussion	ALL
Close of meeting					

Date of next Board meeting: 26 July 2018
After the close of the meeting, questions will be invited from members of the public

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting,
25 May 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
Fionna Moore	(FM)	Executive Medical Director
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
Terry Parkin	(TP)	Independent Non-Executive Director

In attendance:

Peter Lee	(PL)	Trust Secretary
Janine Compton	(JC)	Head of Communications

20/18 Apologies for absence

Ed Griffin	(EG)	Executive Director of HR & OD
Tricia McGregor	(TM)	Independent Non-Executive Director

21/18 Declarations of conflicts of interest

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

22/18 Minutes of the meeting held in public on 26 April 2018

The minutes were approved as a true and accurate record.

23/18 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.

24/18 **Patient story** [10.01 – 10.11]
This story featured an elderly couple who experienced a long wait to receive help. It highlighted the different factors in the healthcare system that contributed to this, including hours lost handing over patients at A&E and the programme aimed at addressing this.

JG was keen to emphasise that handover delays is not the only factor contributing to the inability to respond more promptly to lower acuity patients. It is about being right-sized to be able to respond to everyone that requires help. In the meantime, we prioritise the more acute patients, which is reflected in our performance data. This particular call came from Care Line and FM confirmed that she has this nationally to explore how this group of patients could be supported in a different way. There are 230 Care Line calls each day, on average, and the majority do not require the assistance of an emergency ambulance.

DM added that while this is a national issue, we can do more to work across the local system to see what innovative solutions could be put in place so that 999 is not the default when there are elderly fallers. This is one of our priorities.

25/18 **Chief Executive's report** [10.11 – 10.18]
DM highlighted the issues as set out in his report.

There were no questions

26/18 **BAF Risk Report** [10.18 – 10.20]
PL set out the background and the work undertaken by board members to review the risks that should be included in the BAF risk report.

The Board approved the risks set out in the paper, and these will now form the revised BAF risk report.

Action:
PL will support the Executive leads for each risk to ensure the BAF risks are included in the risk register. A report setting out the controls and actions will be considered by the Audit Committee in July, before coming back to the Board.

27/18 **Delivery Plan** [10.20 – 10.54]
SE introduced this item and asked the director-leads to comment in the report, by exception.

Transformation – Hear & Treat remains Red due to slow progress in recruiting clinicians. Plans are in place to help attract clinicians; we have a requirement for 38 and we currently have 14 new clinical safety navigators. JG reinforced that we have been 100% compliant in providing clinicians to support pathways and EMAs. The gap related to our plan to increase hear and treat.

LB confirmed that at its most recent meeting the Quality & Patient Safety Committee recived a very good paper taking a holistic view of this, which provided assurance that the issues are well understood. For example, it heard that 23% of EOC leavers went in to different parts of the operational workforce. Recruitment is a challenge as is coping with the high level (20%) of call-backs. Despite this, the committee is assured with management grip and focus, and the energy to solve it, including the new clinical navigator role, which demonstrates patient safety is foremost in our minds.

TP confirmed that the Workforce and Wellbeing Committee is also exploring this issue from the perspective of recruitment. It too is assured by the with depth of understanding.

TH asked about hospital handovers and what level of delays has been built in to the demand and capacity review. JG explained that although we have had a significant reduction in lost hours, the hours lost remains a concern and the reduction is starting to plateau. The demand and capacity model includes the current level of delays. JG concluded by confirming that it is the first time that handover delays is lower than in the same period last year, indicating a green shoot of recovery.

Sustainability – DH confirmed the cost improvement programme (CIP) this year is £11.4m. The schemes are going through final sign off. As always, we will have a stretch target and, where a scheme does not work, we will stop it. All schemes will have a quality impact assessment, which will be considered before any scheme is approved.

The Business Intelligence software and IT deployment is in the implementation stage.

With regards the telephony system, we have been out to market and are now placing the order. The platform will be the same as many other ambulance services.

Due to the commercial sensitives, a detailed updated on the Electronic Patient Care Record will be provided in Part 2; we are on track with the objectives of the project.

Compliance – BH confirmed that within the incident management team, we now have substantive staff in place, with three additional posts to be recruited to. In terms of SIs and timeliness, we have been meeting targets during the last few months. We have interim support to help with the backlog, arising from the high number of incidents in January.

BH outlined the steps being taken to ensure thematic learning. We have started with serious incidents, reviewing with CCGs the cases over the past two years. The early findings link to delay, which is not unexpected. The final report will come to the Executive Management Board toward the end of June. At the same time, we are looking at the best model to embed learning.

LB asked about the rationale for safeguarding moving in to business as usual, despite still having significant issues within internal safeguarding. BH assured the Board that monthly oversight will be retained at the Clinical Board and the CCG is doing a deep dive at the quality review meeting in to how we transition. This will provide an external opinion.

Culture – DM confirmed this is Red due to the arrangements being put in place to strengthen the team responsible for leading the refresh of this programme. Once this is in place is will turn Amber.

Strategy – SE outlined the plan to update our strategy through the Steering Group. The schedule takes us to the end of August, and we are encouraging all staff to contribute.

Action:
Board away day to be scheduled for the strategy update.

The Board considered the following deep dives:

1. **Hear & Treat** – JG confirmed that we are not achieving the national target for call answer, but are making steady progress. The report to the Quality & Patient Safety Committee on this was far

reaching. In terms of recruitment, we are up to the establishment level and planning to exceed this. The next cohort in training will take us beyond the establishment. While have improving numbers, there remains a gap in effectiveness, which is being addressed through training. The sickness level in EOC is the lowest it has been during the past two years.

2. **Medical Devices** – JG explained this improvement plan is now in intensive support. The focus is on unblocking the issues hindering the achievement of objectives. There has been a significant improvement during this phase. No equipment goes out in to the service unless it is 100% compliant with testing/servicing. We are ready for the deep dive session with CQC on 6 June. We then report to the Quality & Patient Safety Committee.

   The Board reflected on the good progress being made and the efforts of a number of staff.

3. **Culture** – DM set out the significant amount of work across the Trust. We are looking to test the extent to which what we are doing is permeating through the organisation. Then we will test how the changes are being experienced by staff. We have a live webcast from executive planned on 30 May with an interactive Q&A session. JC added that this recognises the size of our patch and needing to increase accessibility. On 24 May we had a live session on infection prevention and control and since then it has received over 1000 views.

   DM ended by confirming that plans to launch the new Trust values on 12 June.

28/18 QPS Escalation Report [10.54 – 11.07]

LB described the issues arising from the last meeting as set out in the paper, noting specifically the significant step forward being demonstrated in quality assurance. GC thanked all staff involved.

The committee also highlighted the good practice now in undertaking clinical harm reviews.

In terms of internal safeguarding, the concern relates specifically to pre-employment checks and some potential gaps and the potential impact on patient safety. This has been escalated as a significant risk, and included in the BAF Risk Report. The executive is undertaking a full review and risk assessment. Looking at this positively, as we know about it we are able to take swift corrective action.

Finally, there was really positive independent feedback from the medicines governance review, which included holding the Trust up now as an exemplar for ambulance trusts, in some areas of medicines governance.

AT confirmed that the pre-employment checks issue has also been picked at by the Workforce and Wellbeing Committee, in the context of the HR-processes.

AR refereed to the independent view on medicines governance, and asked whether we could arrange the same approach to other areas. The Board discussed this and agreed to explore where this might be arranged in future, through the work of the board committees.

29/18 WWC Escalation Report [11.07 – 11.11]

TP reflected that the organisation has never known itself so well. The most significant issue for the committee relates to staff records. He reminded the Board that this came about from internal suspicion from management that things weren't quite right. They looked in to this and found the issues we now know about.

The committee will continue to oversee progress of the workforce plan and EG will be liaising with NEDs to ensure it meets all expectations.

Finally, TP noted that it is becoming increasingly clear we need better grip on health and safety. The committee will be scrutinising this to help demonstrate we are a safe organisation.

There were no questions.

30/18 **IPR** [11.11 – 11.46]

This report continues to be developed and as more improvement plans from the Delivery Plan move in to business as usual the KPIs will be included in the IPR to ensure we track performance.

Directors reported the following, by exception:

Safety – FM explained that November was a good month in terms of figures, but due to small numbers there is some variation. We have started a project to improve cardiac survival. FM explained the different reporting on page 8 of the report; STEMI and Stroke is reported on confirmed numbers as reported by hospitals.

FM asked whether the analysis breakdown on cardiac arrest data is still useful. The Board confirmed it is useful as it reinforces the small numbers, but it is not needed every month.

Action:
Analysis of cardiac arrest data to be included in the IPR on a quarterly basis.

Quality – BH confirmed we have exceeded hand hygiene target. Interviews are currently being held to recruit to the new Head of Health and Safety.

LB asked when we will start to report duty of candour for moderate harm, rather than just serious incidents.

Action:
IPR to include figures for duty of candour relating to moderate harm.

TH referred to the data on hand hygiene and asked how management approaches units not returning the target for audits. JG confirmed the metrics that build this report are considered carefully by each operating unit (OU) through the monthly area governance reviews and OUs that continue to not comply are held to account. DM added that some of this is about culture and poor performance management. To improve this we are establishing a new senior leadership team, which brings the executive and senior leaders closer together. In addition, the area governance review will be supported by a wider review by the executive of each OU and corporate directorate, to understand issues and blockages and help to resolve them.

The Board discussed whether the areas of non-compliance in a board report, indicates any lack of local pride. The executive explained the steps being taken to support staff in each area of the Trust to do the right things and understand why things need to happen.

AS asked whether it would be more helpful to pull together each section when populating the CQC domain sections

Action:
The CQC domain section of the IPR to include the summaries from each section of the report.

Operations - March was a challenging month for us and all services given the adverse weather. JG drew the link between the weather and hospital handover delays and the impact on Cat 1 and Cat 2 performance. The good news is that things have improved during April.

The Board discussed the merits of focussing too much on what happened in March, given we are now at the end of May. Instead, while the Board should receive this data, it needs to focus more on looking forward.

AT did not think the report identifies what is within the control of the Trust and what is not, which would help provide fuller context. The executive confirmed that more data is now available with the new BI tools and so we could build a dashboard as part of the review of IPR. The demand and capacity model will show the new trajectories, which we will be held to account against.

Finance – The Board recorded its thanks to management in getting through year-end in time.

There were no questions

Workforce – The Board noted that the turnover rate is still too high. The Workforce and Wellbeing Committee is reviewing the steps being taken to address this. SE added this is also part of the workforce planning being addressed through the demand and capacity review.

TH referred to the bullying and harassment cases and the need to obtain some assurance that these cases are being appropriately progressed. Action – WWC to explore how to do this.

Action:
WWC to scrutinise the controls in place to ensure all reported cases of bullying and harassment are well-managed, in line with policy.

[Break at 11.46-11.52]

31/18 Audit Committee Escalation Report [11.52 – 11.59]
AS explained that this was the meeting for end of year report/accounts. She thanked management and external and internal audit and confirmed that the papers were much improved from the year before. AS outlined the discussions and outcomes from the committee, as set out in the paper.

There were no questions

32/18 Learning from External Reviews [11.59 – 12.01]
This paper was taken as read. The committee chairs have been engaged in the recommendations.

The Board approved the actions.

Action:
Learning from External Reviews recommendations to be reviewed in December to confirm how the actions have been implemented.

33/18 Paramedic Re-Banding [12.01 – 12.02]

The paper was noted.

34/18 External Governance Review [12.02 – 12.05]
The paper was noted.

The Board explored the question of risk appetite and the decision taken earlier in the year by the Audit Committee to defer this until other elements of risk management are better embedded.

Action:
BH and AS to agree whether to prioritise developing a risk appetite statement earlier than initially planned, possibly in July/August.

35/18 Board Committee Annual Review [12.05 – 12.09]
The TOR were approved subject to the following:

- TP to be a member of Audit and not QPS
- Add to QPS 111 lead & deputy medical director as a member.
- BH to be a member of WWC
- Remove the section in the TOR relating to reporting to support the AGS, on the basis that any comments to inform the AGS should be made to the Audit Committee.
- Remove the requirement to attend 75% of meetings – instead it will be left to the Chairs to manage attendance appropriately.
- Remove the requirement to establish by consensus what to include in a board "escalation" report, on the basis that this is not practical. The chair should write the "escalation" report to the board, which is current practice.

36/18 Register of Interests [12.09 – 12.10]
The Board note the register of interests

37/18 Any other business
None

38/18 Review of meeting effectiveness
The Board agreed that it worked well to move the committee reports up the agenda.

There being no further business, the meeting closed at 12.12

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	The governance and assurance framework/strategy is scheduled to be considered first by the Audit Committee in July. It will then come to
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	June	FIC	C	Deep Dive on Board Agenda 28.06.2018
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	Added to the July Board Agenda
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	11/18 9	QPS to undertake a trend analysis for complaints	PL	TBC	QPS	IP	Added to the committee cycle of business
26.04.2018	13/18 10	The Audit Committee to provide deeper scrutiny of the internal controls relating to information governance.	PL	July	AUC	IP	Added to AUC Agenda for July
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	Added to AUC Agenda for July
26.04.2018	15/18 12	To confirm who the General Data Protection Officer is.	SE	May	Board	C	Caroline Smart
25.05.2018	26/18 13	PL will support the Executive leads for each risk to ensure the BAF risks are included in the risk register. A report setting out the controls and actions will be considered by the Audit Committee in July, before coming back to the Board.	PL	July	Board	IP	
25.05.2018	27/18 14	Board away day to be scheduled for the strategy update.	PL	July	Board	IP	
25.05.2018	30/18 15	Analysis of cardiac arrest data to be included in the IPR on a quarterly basis.	FM	July	Board	C	Will be included quarterly.
25.05.2018	30/18 16	IPR to include figures for duty of candour relating to moderate harm	BH	July	Board	IP	
25.05.2018	30/18 17	The CQC domain section of the IPR to include the summaries from each section of the report	SE	June	Board	IP	
25.05.2018	30/18 18	WWC to scrutinise the controls in place to ensure all reported cases of bullying and harassment are well-managed, in line with policy.	EG	TBC	WWC	IP	Added to cycle of business
25.05.2018	32/18 19	Learning from External Reviews recommendations to be reviewed in December to confirm how the actions have been implemented.	PL	December	Board	IP	

25.05.2018	34/18 20	BH and AS to agree whether to prioritise developing a risk appetite statement earlier than initially planned, possibly in July/August.	BH	August	Board	IP	

Key

- Not yet due
- Due
- Overdue
- Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

	Item No

Name of meeting	Trust Board
Date	
Name of paper	Chief Executive's Report
Executive sponsor	Chief Executive
Author name and role	Daren Mochrie
Synopsis (up to 120 words)	The Chief Executive's Report provides an overview of the key local, regional and national issues involving and impacting on the Trust and the wider ambulance sector.
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.
Why must **this** meeting deal with **this** item? (max 15 words)	To receive a briefing on key issues, as noted above.
Which strategic objective does this paper link to?	2. Culture

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

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S REPORT TO THE TRUST BOARD

1. Introduction

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

2. Local issues

2.1 Recruitment to the Executive Team

2.1.1 I am very pleased to confirm that, following a recruitment and selection process, including a stakeholder event, Dr Fionna Moore has been appointed as the Trust's substantive Medical Director.

2.1.2 Fionna has been a tremendous asset to the Trust during her time as Interim Medical Director and I know we will continue to benefit from her experience and commitment to patient care.

2.1.3 Fionna's appointment also means that we now have a full and substantive Executive Team in place. Whilst we have been fortunate to have been supported by a number of very good interims, having a permanent team in place now enables us to move forwards on a firm foundation.

2.2 Engagement with local stakeholders

2.2.1 During recent weeks, I have continued to meet with a range of key internal and external stakeholders, including meeting the leads for two of the four Sustainability & Transformation Partnership (STPs) in our region.

2.2.2 On 22 May, I met with Bob Alexander, Chair of the Sussex and East Surrey STP and on 14 June with Dr Claire Fuller, the Senior Responsible Officer for the Surrey Heartlands STP. Both meetings were extremely useful and provided a good opportunity to discuss how SECAmb can continue to engage fully with and play an active part in our regional STPs.

2.2.3 On 5 June, I met with Sir Roger Gale, MP for Thanet. During our meeting, we discussed a range of issues, including recruitment, response time performance and changes in the wider NHS system.

2.3 Care Quality Commission (CQC) inspection

2.3.1 This year we will receive two inspections from the Care Quality Commission (CQC) – an unannounced Core Services Inspection and a new-format, announced Well-Led inspection.

2.3.2 We have now been informed by the CQC that the announced Well-Led inspection will take place on 22 and 23 August. During this visit, inspectors will focus on how 'well-led' the Trust is; they will primarily speak to the management team and look at the Trust's governance processes.

2.3.3 Whilst unannounced, we are expecting the Core Services inspection to be in July. This inspection will focus on how we deliver patient care and they will measure us on safety, responsive, caring and effectiveness. The inspection team will spend time out and about across the Trust, speaking to staff and observing the care we provide.

2.3.4 I very much see the CQC inspections as an opportunity for us to demonstrate the big improvements that I know have been made in many areas. We do have more to do and this is only the first year of our improvement journey but we have made a really positive start.

2.4 Executive Management Board (EMB)

2.4.1 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.

2.4.2 As part of it's 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
- Discussed our Culture Programme and how this is being rolled out through the whole Trust
- Approved a number of Business Cases for investment in key areas, including an automated system for medicines temperature monitoring and the roll-out of a GRS app
- Reviewed the Trust's Cost Improvement Programme for the year, ensuring that we are focussing in the right areas

2.4.3 On 30th May, we held our first live Chief Exec 'webcast', which involved all of the Executive Team. It was advertised in advance and a link provided so staff could log in 'live' at the start of the session.

2.4.4 After a brief presentation, the majority of the session was given over to Q&As. We had a great response, with over 350 staff viewing 'live' and total views reaching over 1,000. A wide variety of questions were asked and answered during the session by myself and other members of the Exec Team.

2.4.5 I intend for these to be regular sessions moving forward, with a different theme for each one. The next session will take place on 27th June, focussing on quality and safety.

2.5 Improving the culture of the Trust

2.5.1 On 12th June, we formally launched the new Trust values and behaviours, which have been developed with staff and which are a key strand of our Culture Programme.

2.5.2 To improve awareness of the values, the launch saw the first 'value cubes' being presented by each Executive Director, to members of staff who they believed had clearly demonstrated one of the Trust's values. The presentations took place across the Trust, with each presentation being 'live streamed' on the Trust's internal Facebook page and which has since been viewed thousands of times.

2.5.3 The launch was just the start of roll-out of the values. Each week, the values cubes will be passed on by the previous recipient, to someone who they feels deserves the recognition and so on. Postcards have also been issued across the Trust, to allow any member of staff to recognise the achievements of colleagues, or simply say 'thank you' as part of the values launch.

2.5.4 As part of the Culture Programme, individual coaching sessions for Directors and other senior leaders utilising 360 degree feedback provided by peers and by direct reports are continuing and are being positively received. Feedback such as this is key to making improvements and I know will have a real impact as we move forward.

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

3. Regional issues

Nothing to note

4. National issues

4.1 NHS Horizons' Event

4.1.1 On 28 June, a day-long event is being held in London, hosted by NHS Horizons, to allow ambulance staff to share ideas and suggestions with colleagues nationally, to improve the services provides by the ambulance sector.

4.1.2 It follows the recent announcement by Simon Stevens, Chief Executive of NHS England, of a year-long project to implement the improvement ideas of ambulance staff across the country.

4.1.3 Every ambulance trust has been asked to nominate a team to send to the event to help design and develop the project. I am delighted that we have had an excellent response from staff interested in attending and will be sending a team of nineteen staff from right across the Trust to the event.

4.1.4 This is a great opportunity to solve problems and help to make a real difference across the whole country. I am very much looking forward to hearing feedback from our staff who are attending and also seeing how the broader project develops.

4.2 NHS 70

4.2.1 5 July 2018 makes the 70th anniversary of the creation of the NHS and activities are taking part across the country to mark this achievement.

4.2.2 Within SECAmb, our staff are taking part in a range of different activities as part of the celebrations, including:

- On 9 June, a number of our staff in Kent took part, in uniform, in an NHS 70 Parkrun, running with Dame Kelly Holmes
- On 1 July, a Songs of Praise 'NHS 70 Special' will be shown on the BBC featuring footage filmed with SECAmb Paramedic Chris Treves & SECAmb Chaplain Tim Parsons in Medway
- On 5 July two SECAmb members of staff (Terry Baker & Carole-Anne Davies Jones) will be attending a special NHS 70 Garden Party at Westminster Abbey, together with our Director of Nursing & Quality, Bethan Haskins
- On 5 July Chris Grayling, MP for Epson & Ewell, will be spending a shift with front-line staff in his constituency
- On 5 July ITV Meridian will broadcast a feature looking at the 'modern ambulance service', followed a filmed ride-out with ambulance staff in Brighton
- National ITV Productions have already filmed in our West EOC to promote the multi-agency Maternity Line, in partnership with NHS England – this will be broadcast as part of the NHS 70 celebrations

5. Recommendation

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

Daren Mochrie QAM, Chief Executive

21st June 2018

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	45/18

Name of meeting	Trust Board
Date	28 June 2018
Name of paper	Delivery Plan
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	• To review the dashboard to be fully sighted on the current progress of the Delivery Plan • To note the developments of the CQC Task and Finish Groups • To note the new projects being monitored

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

Introduction

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

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

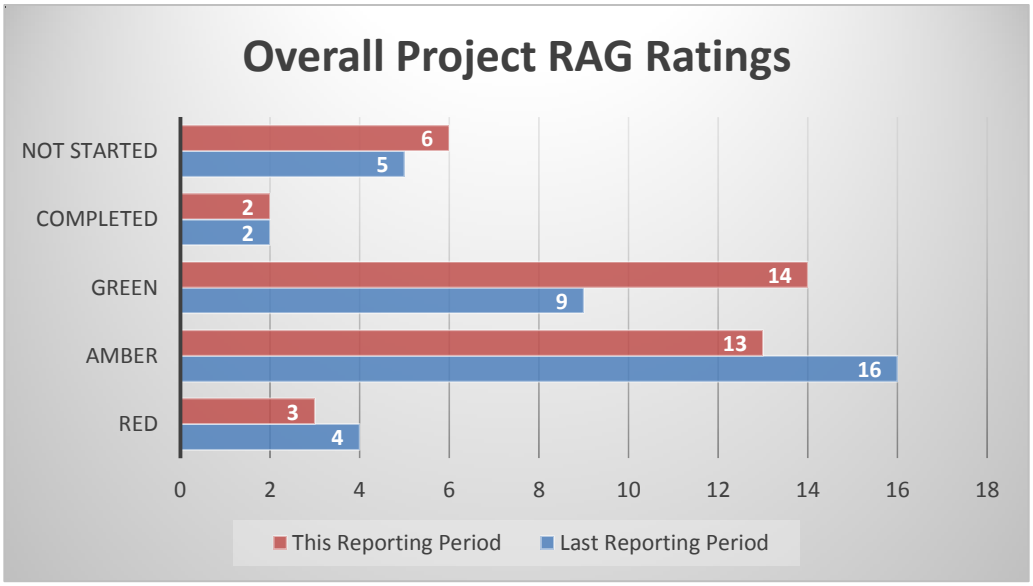
1.1 The Dashboard gives high level commentary and associated Key Performance Indicators (KPIs) for this reporting period where appropriate. As projects come to completion the reader should note that project closure processes will be enacted to ensure that continued and sustained delivery moves into Business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

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

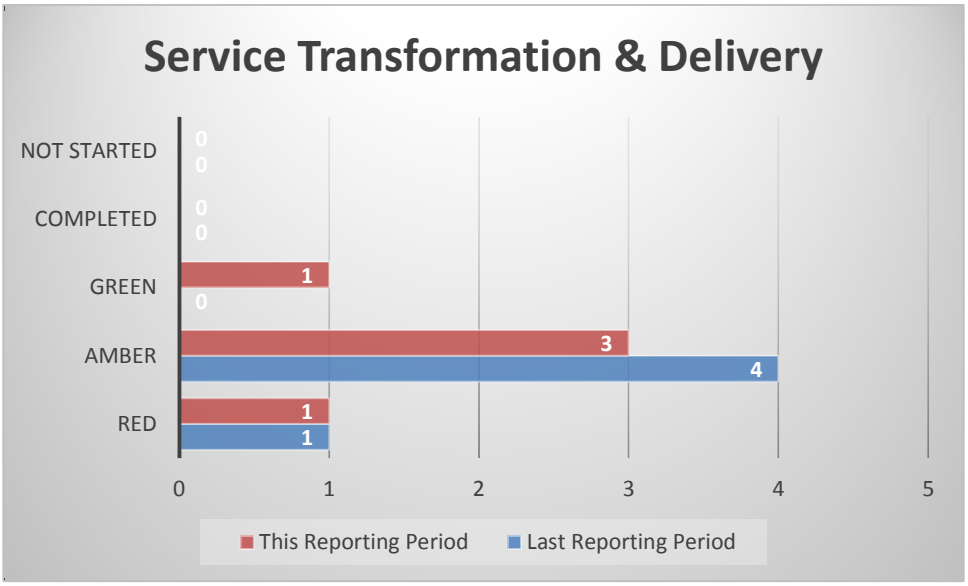
1.3 The Delivery Plan Dashboard (Appendix A) provides a summary of progress within this reporting period. For information the RAG status is defined as follows:

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

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



Service Transformation & Delivery



2.0 **ARP Demand and Capacity Delivery** – The project remains Amber until such time the Demand and Capacity Review is published and KPIs are defined. Operating Unit (OU) Meetings have taken place to discuss the recruitment effort required to meet the demand and capacity review. A consensus has been reached that the recruitment strategy for front-line staff will move from a centralised approach to local, OU level, recruitment. OU Level recruitment pipelines are being developed which will describe the target workforce numbers, by month, for each OU, for each grade. No risks or issues highlighted in this reporting period.

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 complete a delivery trajectory to compliance with ARP standards at the time of writing. The review is also considering modelling of the EOC as well as ARP compliance. As such, modelling is 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 and final report by the end of June 2018

2.2 **Hospital Handover –** The project RAG remains at Amber A national objective has recently been set to have no hospital handover delays >30 minutes by September. The programme is now incorporating this new objective into the overall plan.

Six hospital trusts within SECAmb's area are able to access additional support from NHSI in order to meet the objective. At some hospitals, good progress made notably East Surrey, who have significantly reduced handover delays.

Some hospitals are in a much better position compared to the same time last year. There are some however where significant challenges remain. The overall improvements made so far are positive, but caution is required as some of this may be due to seasonal variation.

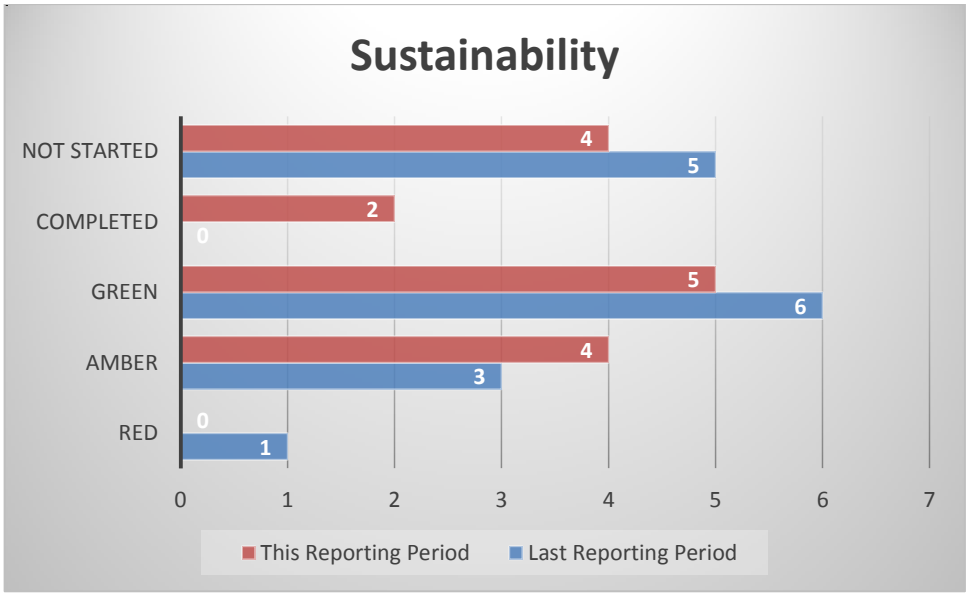
Reports with granular detail are being rolled out across SECAmb's Operating Units to support improving crew to clear times

2.3 **Increased Hear and Treat** – The project remains RAG rated Red due to the numbers of Clinical Supervisors in post in EOC remaining static. However there have been a significant improvement with regards to Hear and Treat performance since November 2017. Nationally we reside in 6th place for April compared to other 999 providers. May has just finished with our performance currently at 6.1% for Hear and Treat which puts the Trust just 0.4% below the leading Ambulance Trust when compared to April's overall performance data.

We have now appointed 10 Clinical Safety Navigators and are scheduled to go-live on rota from 25th June 2018. These staff will ensure clinical queue risk mitigation and add safety measures to recognise our vulnerable patients, ensure continued 100% NHS pathways licence compliancy and complete a series of new initiatives to evaluate our risk mitigation measures in queue management (including Clinical Tail Audits).

2.4 **National Ambulance Resilience Unit** – The project RAG moves from Amber to Green due to the successful completion of a number of activities within the agreed timescales. The following metrics related to the project are now being reported: Commander Competency, HART capacity and rota performance and Initial Operational Response (IOR), through the delivery of Key Skills within operations. The project team are confident that they can deliver within the timeframe, subject to risks and issues being managed. There is a risk that a documented process for parking at both Ashford and Gatwick HART cannot be provided due to the limitations of each sites logistics leading to potential impact on staff morale and ability to meet contractual standards. Gatwick site limitations are partially mitigated with Sky Chef option. Discussion around the impact of Ashford limitations need to be held.

Sustainability



3.0 The Cost Improvement Programme (CIP) target remains 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 continue to 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. The PMO Finance Team is in the course of discussions with the Operations senior team on a methodology for valuing frontline efficiencies achieved during the year to date. 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 Cost Improvement Programme is rated Amber. (see appendix B & C for further details)

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:

- Automated Temperature Monitoring
- Banstead PoP
- Business Intelligence Improvement
- Corporate IT systems resilience (formerly Trust Backup Strategy)
- Cyber Security
- ePCR
- GP Connect
- GRS App
- Incident Management Software
- Provider Connect
- Replacement Fleet Management system
- Replacement of Telephony and Voice Recording
- Spine Connect
- Station Upgrades

A pipeline of upcoming digital projects (year ahead view) is in development and will be shared with the Board in due course.

3.2 **Automated Temperature Monitoring** – This is a new project 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 was recently approved at Executive Management Board and the project will be expected to commence shortly.

3.3 **Banstead POP** – The project remains RAG rated Green. The remaining item is the network connectivity, due for delivery 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. No risks or issues highlighted in this reporting period.

3.4 **Business Intelligence Improvement** – The project RAG moves from Amber to Green. A cancellation will be issued to Call Vision and the project moves into closure phase. No risks or issues highlighted in this reporting period.

3.5 **Corporate IT Systems Resilience** – This is a new project to align the Trust Business Continuity Plans with IT resilience systems to ensure that the Trust has wider system availability and data recovery is far more effective than the current plan. Project resource is currently being sought to move this project into implementation phase.

3.6 **Cyber Security** – This project remains RAG rated Green. The project planning workshop is now complete and a project timeline has now been produced. A solutions design document and statement of works document is currently in the process of being developed with a full project plan and activity list agreed in coming weeks. There is a risk that the timescale to replace the network infrastructure is to be completed by end of July 18 may not be achievable and that a September date is more realistic. Mitigation will be concurrent running of both projects.

3.7 **ePCR** – This project RAG moves from Red to Amber. A draft specification has been produced to run a mini procurement. A Business Case, Project Mandate and QIA will be developed towards the end of July 2018. No risks or issues highlighted in this reporting period.

3.8 **GP Connect** – This project is RAG rated Blue as it is now complete. The integration with Docman system provides a seamless transfer of documents through IBIS to primary care following an episode of treatment. It also provides system functionality for automatic filing of IBIS GP Summaries, Falls Referrals/Notifications and Hypoglycaemia notification into GP clinical systems.

3.9 **GRS App** – This is a new project 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. A business case was recently approved at Executive Management Board and the project will be expected to commence shortly.

3.10 **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. A training schedule is to be devised prior to the closure of this project. No risks or issues highlighted in this reporting period.

3.11 **Provider Connect** – This project is RAG rated Blue as it is now complete. A generic IBIS interface capable of pulling care plan data from external systems has now been developed. Front line ambulance crews have now got access to mental health crisis care plans (where available) to support the reduction of the number of patients conveyed to hospital. The STP Programme Lead is now engaged with the 3 mental health providers.

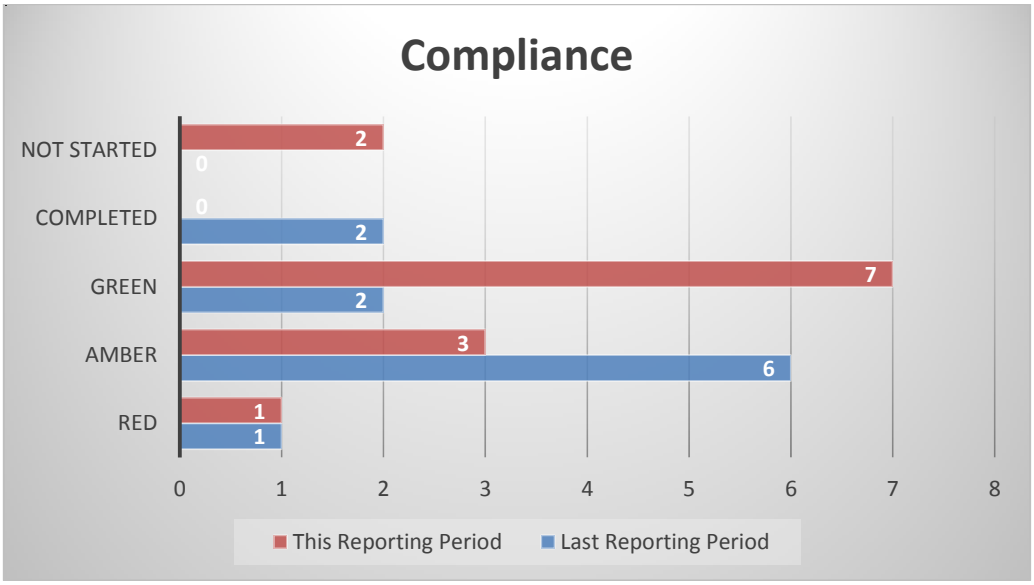
3.12 **Replacement Fleet Management System** – The project RAG moves from Green to Amber due to the identification of further costs, which will require executive approval. A project plan is currently being developed which will outline clear deliverables and defined timescales. Hardware is under review to establish full requirements for the proposed system. A kick off meeting with the provider is scheduled for 14/06/18.

3.13 **Replacement of Telephony and Voice Recording system** – The project RAG moves from Amber to Green. A Project Mandate and QIA has now been formally signed off by Executive Sponsor. The contract has been awarded to 4Net who will deliver a new AVAYA Telephony Platform and NICE Recording System into the Trusts Emergency Operations Centres by the end of October 2018. No risks or issues highlighted in this reporting period.

3.14 **Spine Connect** – The project RAG moves from Green to Amber. The system has been handed over to EOC to commence formal testing (PDS only). The longer term development of Spine Connect is currently hampered by issues around the accessibility of Smartcards to EOC Clinicians. However, plans are being put in place for KMSS111 to offer support in managing and issuing smartcards in the interim.

3.15 **Station Upgrades** – This is a new project. 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. A business case was recently approved at Executive Management Board and the project will be expected to commence shortly.

Compliance



4.0 The Compliance Steering Group has now been refocused to address the gaps that were identified in the PIR and Self-Assessment. On a weekly basis the Steering Group will now have oversight of the following areas:

- Recruitment (recruitment plan and safer recruitment)
- Governance and Risk
- Care of Patients with Complex Needs.

Progress made on each of those work streams is contained within this reporting period.

4.1 **EOC** *(CQC Must Do)* – The project delivery remains red as EOC clinical establishment remains below target levels, although there has been recent improvement. Having established the Clinical Framework foundations, Manchester Triage has been finalised and will be the enabler to increase clinical capacity within EOC.

Audit compliance is under the trajectory required to meet the project's objectives within the deadline. Audits on calls in May are being conducted retrospectively until the result meets the objective.

Answer 5 second performance also fell slightly under trajectory for May. The QPS paper on EOC Call Answering Performance and Impact on Patient Safety provided the information required to discuss the issues and gave assurance that there is management grip and a clear understanding of what needs to be done.

4.2 **Governance, Health Records & Clinical Audit** *(CQC Must Do)* – The project RAG remains Green. The project has now commenced formal project closure and is expected to be signed off at Compliance Steering Group on 19 June 2018. No risks or issues highlighted in this reporting period.

4.3 **Governance and Risk** – This is a new project. A Task and Finish Group has now been established which meets weekly. A Project Mandate and QIA are currently in development. Once the documentation has been completed a project plan will be developed and monitored by the Compliance Steering Group.

4.4 **Incident Management** *(CQC Must Do)* – The project is now RAG rated Green. Whilst a number of actions are open and remain under development, the project has now commenced formal project closure, with open actions being reviewed for transition into the new Governance and Risk project, overseen by the Compliance Steering Group during June 18. Supporting evidence for the completed actions has been validated. All project risks have been reviewed and closed.

4.5 **Infection Prevention and Control** *(CQC Must Do)* – The project RAG remains Amber due to the ongoing issues around discrepancies in training figures between the 2 systems - ESR and Discover – as well as a fall in compliance for Deep Clean (DC) completion at Make Ready Centres. The new Infection Prevention Ready Procedure was approved earlier this month.

4.6 **Medical Devices** *(CQC Must Do)* – The project RAG moves from Amber to Green. The majority of the actions are marked complete with the associated supporting evidence having been validated also. The CQC Deep Dive was held on 6 June 2018 with the CQC noting the significant improvements made. Work will now commence to plan the transition of the project into BAU and move towards project closure, overseen by the Compliance Steering Group. No risks or issues highlighted in this reporting period.

4.7 **Medicines Governance** *(CQC Must Do)* – The project RAG remains Green. The project has commenced formal project closure and is expected to be signed off at Compliance Steering Group on 19 June 2018. Medicines Governance will however continue to report into Compliance Steering Group on a weekly basis as part of business as usual.

4.8 **Patients with Complex Needs** – This is a new project. A gap analysis for long term conditions is currently underway which will inform a proposal to move forward with the intervention required to understand and meet the needs of complex patients. Once this has been completed, a project mandate and QIA will be developed.

4.9 **Performance Targets and AQIs** *(CQC Must Do)* – The project RAG moves from Amber to Green. Performance has continued to improve through reducing lost operational hours, better meeting the needs of service users, and enhanced fleet and recruitment strategy. All actions are now complete or transferred to the ARP Demand & Capacity Delivery project, and we continue to see a positive trend towards meeting or exceeding C1/2 targets. Incomplete milestones on this workstream have been identified to move to BAU or transferred to other projects. The project has commenced formal project closure and is expected to be signed off at Compliance Steering Group on 19 June 2018.

4.10 **Recruitment Plan (ECSW & AAP)** – This is a new project to recruit 200 ECSWs and 100 AAPs (to enter training) by 1 November 2018. The project scope will include defining and implementing recommendations as to how to address some of the issues identified, including: assessor constraints; C1 driving qualification funding; fitness test issues; local area recruitment challenges; and training capacity. A Task & Finish Group has now been established. A Project Mandate & QIA are currently in development which will inform the project plan. Progress of the project will report into the Compliance Steering Group on a weekly basis.

4.11 **Risk Management** *(CQC Must Do)* – The project RAG moves from Amber to Green. Whilst a number of actions are open and remain under development, the project has now commenced formal project closure, with open actions being reviewed for transition into the new Governance and Risk project, overseen by the Compliance Steering Group during June 18. Supporting evidence for the completed actions has been validated.

4.12 **Safer Recruitment** – This is an outcome of new projects that sits under the HR Transformation programme (People Risks and Process Improvement Workstreams). The projects will initially be looking at the risks around non-compliance of DBS checks and all personnel files with a view of getting compliance to 100%. The process improvement workstream will be looking at how the process will be improved for the future to ensure the Trust maintains 100% compliance at all times and the risk is mitigated. It will also review the end to end recruitment process to ensure this is safe and streamlined.

4.13 **999 Call Recording** *(CQC Must Do)* – The Project remains RAG rated Green as there is a clear process to replace the telephony system. Weekly audits remain ongoing until the replacement system has been implemented. IT and the external suppliers are managing some issues with the current system (instances of both conjoined and fragmented call recordings) through auditing. These issues are not impacting on the Trust's ability to deliver the service as IT have been able to locate any missing calls.

Culture and Organisational Development

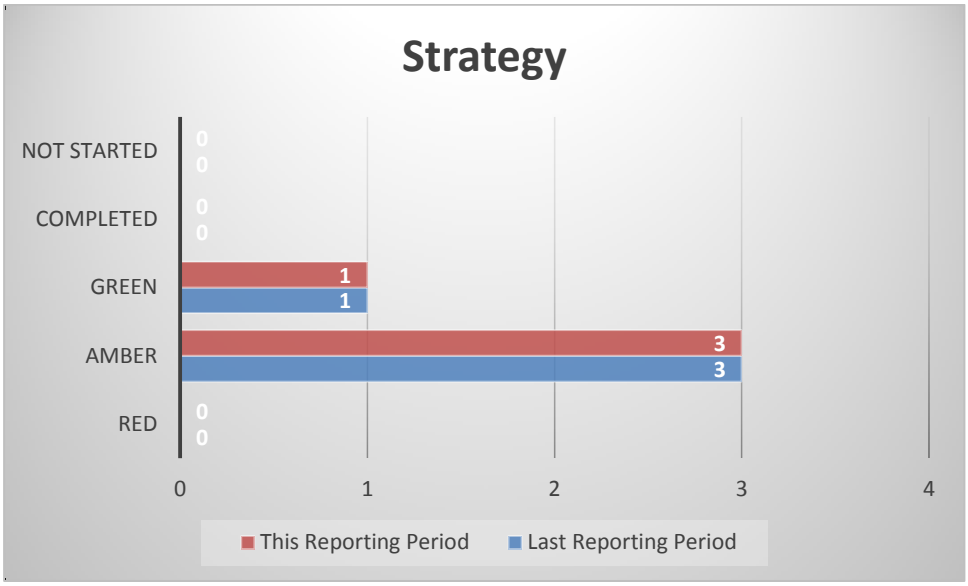
5.0 **Culture Change** – This now forms part of the HR Transformation Programme and has the support and guidance of a dedicated Programme Manager. This additional support has enabled us to revise the project plan which focuses on 3 main areas; Engaging Staff, Managing Behaviours and Building an enabling infrastructure.

The refreshed Trust Values were launched on 12th June 2018 and was received really well, at the same time the staff recognition programme has been launched and again has been received well with a high uptake of values cards being presented and received which has created a real positive atmosphere across most areas of the Trust.

The Behaviours Training is currently being delivered to the Executive and Senior Leadership Teams with the imminent launch of training for middle management.

The Culture Change Team are actively attending operational meeting e.g. Teams A,B,C and EOC meetings to share the culture programme work and to also identify areas for support. In addition to these, the Culture team are continuing ASK HR sessions and Quality Assurance Visits.

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. We have begun discussions with internal stakeholders and are planning meetings with external stakeholders. The update will take into account the implications and opportunities arising from our Joint Demand and Capacity Review.

6.1 **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 this month completing the review of all the contract schedules to reflect changes in the last year and in national policy. These will be finalised by the end of June 2018.

6.2 **Commissioner and Stakeholder Alignment** – This project remains RAG rated Green. Engagement sessions are taking place and being planned in line with and as part of our strategy refresh. 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).

6.3 **Enabling Strategies** – These are the suite of enablers of our Five-year plan and include a range of items listed in Appendix D. This project is RAG rated Amber. The Trust is ensuring that Board members are able to contribute and comment earlier in the process.

To that end Workforce, Fleet, Estates, ICT, Research and Development and Clinical are under way, with ICT and Research and development due to be completed this month. Our Commercial strategy is to be started this month.

6.4 **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.

Delivery Plan Dashboard

Reporting period:
01 May to 31 May 2018

RAG Key:

Red	At significant risk of failure due to circumstances which can only be resolved with additional support
Amber	Risk of failure but mitigating actions in place which can be 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 Date	Forecast Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
Service Transformation & Delivery Steering Group	ARP Demand and Capacity Delivery	Amber	Amber	Rob Mason	Joe Garcia	N/A	01/04/2021	The project RAG remains Amber. Operating Unit (OU) Meetings have taken place to discuss the recruitment effort required to meet the demand and capacity review. A consensus has been reached that the recruitment strategy for front-line staff will move from a centralised approach to local, OU level, recruitment. OU Level recruitment pipelines are being developed which will describe the target workforce numbers, by month, for each OU, for each grade.	KPIs to be defined.	N/A	N/A	N/A	No risks or issues highlighted in this reporting period.
	Demand and Capacity Review	Amber	Amber	Jayne Phoenix	Steve Emerton	N/A	30/06/2018 (previously 13/04/2018)	The project remains RAG rated Amber. The Demand and Capacity review is nearing completion with Deloitte and ORH working to complete a delivery trajectory to compliance with ARP standards at the time of writing. The review is also considering modelling of the EOC as well as ARP compliance. As such, modelling is 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 and final report by the end of June 2018	Creation of fit for purpose, agreed operational model and service level options, together with evidenced costs and aligned resource, for agreement with commissioners				No risks or issues highlighted in this reporting period.
	Hospital Handover	Amber	Amber	Gillian Wieck	Joe Garcia	N/A	31/03/2019 (previously 30/04/2018)	The project remains RAG rated 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 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)	307	N/A	0	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	44.50%	85%	85%	
	Increased Hear and Treat	Red	Red	Scott Thowney	Joe Garcia	N/A	25/07/2018	The project remains RAG rated Red due to the numbers of Clinical Supervisors in post in EOC remaining static. We have seen a significant improvement with regards to Hear and Treat performance since November 2017. Nationally we reside in 6th place for April compared to other 999 providers. May has just finished with our performance currently at 6.1% for Hear & Treat. This puts the Trust just 0.4% below the leading Ambulance Trust when compared to April's overall performance data. We have appointed 10x Clinical Safety Navigators and on completion of training for these are scheduling the go-live on rota from 25th June 2018. These staff will ensure clinical queue risk mitigation and add safety measures to recognise our vulnerable patients, ensure continued 100% NHS pathways licence compliancy and complete a series of new initiatives to evaluate our risk mitigation measures in queue management (including Clinical Tail Audits). Crew Call back activity has been approved to be absorbed within the clinical supervisor role of EOC as we work with HR and Union JPF to absorb this activity and PP staffing appropriately.	45 clinical supervisors in post in EOC	32	45	45	The Project delivery remains red as we have not achieved the required Clinical Supervisor WTE's as specified. However, the Clinical framework foundations in finalising Manchester Triage will be an enabler to increase clinical capacity within EOC.
									Hear and Treat Performance	6.1%	10%	10%	
	National Ambulance Resilience Unit	Green	Amber	Chris Stamp	Joe Garcia	N/A	31/10/2018	The project RAG moves from Amber to Green due to the successful completion of a number of activities within the agreed timescales. The following metrics related to the project are now being reported: Commander Competency, HART capacity and rota performance and Initial Operational Response (IOR), through the delivery of Key Skills within operations. The project team are confident that they can deliver within the timeframe, subject to risks and issues being managed.	Awareness training of HART response time standards for Command Teams	Data not available	98%	98%	There is a risk that a documented process for parking at both Ashford and Gatwick HART cannot be provided due to the limitations of each sites logistics leading to potential impact on staff morale and ability to meet contractual standards. Gatwick site limitations are partially mitigated with Sky Chef option. Discussion around the impact of Ashford limitations need to be held.
									Commanders at all levels within Trust are trained and developed.	90.0%	95%	95%	
									IOR Training compliance for frontline staff	23.0%	95%	95%	
									HART operational capacity to meet national standards incorporating staff absence and turnover.	86.0%	95%	95%	
									To meet the Response times standards for deployment	Data not available	95%	95%	
Service Transformation & Delivery Steering Group	CIP	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 Pipeline Tracker and Delivery Tracker provide more detail on the construction of the CIP Programme. Project mandates have been completed for some xx% of the schemes and have been signed off by the Executive Sponsors or await sign-off at the time of writing. Other mandates are in the course of completion including mandates for new schemes. The Deputy Clinical Director has completed the Quality Impact Assessments (QIA) for all the mandates submitted for QIA. The current versions of the Pipeline Tracker and Delivery Tracker have been included with this update.	Current CIP schemes fully validated	TBC	£11.4	£11.4m	The RAG rating for the CIPs programme has been adjusted from green to amber to reflect the transition into a new financial year and the uncertainties surrounding the four Sustainability Transformation Programmes (STP), the recently introduced Ambulance Response Programme (ARP), the Demand and Capacity Review and the impact of handover delays at A&E Departments. A CIP allocation of £2.9m has been included for operations efficiencies but no detailed workings are available for these reasons. The PMO Finance Team is in the course of discussions with the Operations senior team on a methodology for valuing frontline efficiencies achieved during the year to date.
	Automated Temperature Monitoring	White	White	Timothy Poole / Jason Tree	David Hammond	N/A	TBC	This is a new project 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. The business case has recently been approved and the project will now be able to commence shortly.	All stations to have automated temperature monitoring	N/A	100%	100%	No risks or issues highlighted in this reporting period.
	Banstead Point of Presence (POP)	Green	Green	Stewart Edwards	David Hammond	N/A	Mid August 2018 (TBC) (previously 31/10/2018)	The project remains RAG rated Green. The remaining item is the network connectivity, due for delivery 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 installed at Crawley	No data available	Relocation of servers to Crawley	No risks or issues highlighted in this reporting period.
	Business Intelligence Improvement	Green	Amber	Alex Croft	David Hammond	N/A	01/06/2018	The project RAG moves from Amber to Green. A cancellation will be issued to Call Vision as the project begins the closure process. It is anticipated that the project will have completed project closure in the next reporting period.	A consistent approach of reporting by developing a new data warehouse structure that improves consistency of reporting				No risks or issues highlighted in this reporting period.
	Corporate IT Systems Resilience	White	White	Jason Tree	David Hammond	N/A	TBC	This is a new project to align the Trust Business Continuity Plans with IT resilience systems to ensure that the Trust has wider system availability and data recovery is far more effective than the current plan. Project resource is currently being sought to move this project into implementation phase.	KPIs to be defined	N/A	N/A	N/A	No risks or issues highlighted in this reporting period.
	Cyber Security	Green	Green	James Fox	David Hammond	N/A	31/10/2018 (previously 31/03/18)	This project remains RAG rated Green. The project planning workshop is now complete and draft project timeline has now been produced. A solutions design document and statement of works document is currently in the process of being developed with a full project plan and activity list agreed in coming weeks.	All software and hardware is deployed and operational.				The Trust has confirmed that the work to replace the network infrastructure is to be completed ideally by end of July 18. There is a risk that this timescale will not be achievable and that a September date is more realistic which will put pressure on delivery of Cyber within timescales. Mitigation will be concurrent running of both projects.
	Electronic Patient Clinical Records ("EPCR")	Amber	Red	Phil Smith	David Hammond	N/A	31/03/2019	This project RAG moves from Red to Amber. It has recently been approved that a mini procurement exercise will need to be sought. A draft specification has been produced. A Business Case, Project Mandate and QIA will be developed towards the end of July 2018.	KPIs to be defined				No risks or issues highlighted in this reporting period.
		Blue						This project is RAG rated Blue as it is now complete. The integration with Docman system provides a seamless	Percentage of selected referrals successfully delivered to the GP system	No historical data available.		95%	

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive Lead	CQC Deep Dive Date	Forecast Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
Sustainability St	GP Connect	Blue	Green	Phil Smith	David Hammond	N/A	31/05/2018	transfer of documents through IBIS to primary care following an episode of treatment. It also provides system functionality for automatic filing of IBIS GP Summaries, Falls Referrals/Notifications and Hypoglycaemia notification into GP clinical systems.	Percentage of selected referrals received via Docman inbox in primary care	Future KPI/Outcome data will be available once the service is implemented		60%	Project is complete.
									Percentage of selected referrals successfully filed within the GP system			80%	
	GRS App	White	White	Jason Tree	David Hammond	N/A	TBC	This is a new project 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. A business case has now been approved and the project will be started shortly.	KPIs to be defined	N/A	N/A	N/A	No risks or issues highlighted in this reporting period.
	Incident Management Software	Green	White	David Wells	David Hammond	N/A	30/09/2018	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. A training schedule is to be devised prior to the closure of this project.	New software programme implemented that can be used to manage large or protracted incidents.				No risks or issues highlighted in this reporting period.
	Provider Connect	Blue	Green	Phil Smith	David Hammond	N/A	31/05/2018	This project is RAG rated Blue as it is now complete. A generic IBIS interface capable of pulling care plan data from external systems has now been developed. Front line ambulance crews have now got access to mental health crisis care plans (where available) to support the reduction of the number of patients conveyed to hospital. The STP Programme Lead is now engaged with the 3 mental health providers.	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%	Project is complete.
									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%	
	Replacement Fleet Management System	Amber	Green	John Griffiths	David Hammond	N/A	01/10/2018	The project RAG moves from Green to Amber due to the identification of further costs, which will require executive approval. 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. A kick off meeting with the provider is scheduled for 14/06/18.	The Fleet Management system will be replaced and implemented.				No risks or issues highlighted in this reporting period.
	Replacement of Telephony and Voice Recording System	Green	Amber	Phil Smith	David Hammond	N/A	31/10/18 (previously 01/05/2018)	The project RAG moves from Amber to Green. A Project Mandate and Quality Impact Assessment (QIA) has now been formally signed off by Executive Sponsor. Contract has been awarded to 4Net who will deliver a new AVAYA Telephony Platform and NICE Recording System into the Trusts Emergency Operations Centres by the end of October 2018.	New Telephony and Voice Recording system delivered.				No risks or issues highlighted in this reporting period.
	Spine Connect	Amber	Green	Phil Smith	David Hammond	N/A	31/07/2018	The project RAG moves from Green to Amber. The system has been handed over to EOC to commence formal testing (PDS only), however there is a potential issue regarding issuing and management of smartcards.	NHS Number Capture: percentage of C3/C4 calls are matched to an NHS Number.	60%	No data available	60%	Spine Connect is currently hampered by issues around the accessibility of Smartcards to EOC Clinicians. Plans are in place for KMSS 111 to offer support in the interim.
									Summary Care Record: percentage of SCR accessed records where available and appropriate for the type of call.	No data available	No data available	50%	
									Child Protection Information Sharing: percentage of calls where CPIS flag queried	No data available	No data available	80%	
	Station Upgrades	White	White	Jason Tree	David Hammond	N/A	31/03/2019	This is a new project. 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. A business case was recently approved at Executive Management Board and the project will be commencing shortly.	KPIs to be defined	N/A	N/A	N/A	No risks or issues highlighted in this reporting period.
	EOC	Red	Red	Sue Barlow	Joe Garcia	02/05/2018	31/08/2018	The project delivery remains red as EOC clinical establishment remains below target levels, although there has been recent improvement. Having established the Clinical Framework foundations, Manchester Triage has been finalised and will be the enabler to increase clinical capacity within EOC. Audit compliance is below the trajectory to meet the project's objectives within the deadline. Audits on calls in May are being conducted retrospectively until the result meets the objective. Answer 5 second performance also fell slightly under trajectory for May. The QPS paper on EOC Call Answering Performance and Impact on Patient Safety provided the information required to discuss the issues and gave assurance that there is management grip and an understanding of what needs to be done.	Clinical supervisors in post in EOC	32	45	45	The risk to meeting call answer time national standards have slightly reduced but remains 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. All three risks are recognised as corporate level and have been categorised and managed accordingly. 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. Deployment of EOC Recruitment and Retention phase 1 is in place to manage the issue of high staff turnover, and technology enabler activities are being scheduled to manage live performance metric issues. Increased call volumes, linked primarily to an increased duplicate calls, will be managed by increasing support call taker establishment to provide welfare caller resources required.
									Number of audits per month	68.2%	100.0%	100.0%	
									95% of calls answered within 5 seconds.	78.0%	85.0%	95.0%	
									FTE EMAs in post within EOC	183	171	200	
	Governance, Health Records & Clinical Audit	Green	Green	Dean Rigg	Fionna Moore	19/01/2018	19/06/2018 (previously 31/03/2018)	The project RAG remains Green. The project is currently undergoing formal project closure and is expected to be signed off at Compliance Steering Group on 19 June 2018.	Patient Records will be completed accurately	54.0%	0.0%	90.0%	No risks or issues highlighted in this reporting period.
									Incidents will have Patient Clinical Record linked	87.8%	N/A	90.0%	
									STEMI (care bundle)	61.20%	81%	73.80%	
									Stroke (care bundle)	94.60%	98%	97.50%	
									Cardiac Arrest Survival (Combined)	4%	N/A	N/A	
									ROSC (Combined)	23.10%	N/A	N/A	
	Governance and Risk	White	White	Peter Lee	Daren Mochrie	TBC	TBC	This is a new project. A Task and Finish Group has now been established which meets weekly. A Project Mandate and QIA are currently in development. Once the documentation has been completed a project plan will be developed and monitored by the Compliance Steering Group.	KPIs to be defined.				No risks or issues highlighted in this reporting period.

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive Lead	CQC Deep Dive Date	Forecast Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
Compliance Steering Group	Incident Management	Green	Amber	Nicola Brooks	Bethan Haskins	08/11/2017	01/08/2018	The project is now RAG rated Green. Whilst a number of actions are open and remain under development, the project has now commenced formal project closure, with open actions being reviewed for transition into the new Governance and Risk project, overseen by the Compliance Steering Group during June 18. Supporting evidence for the completed actions has been validated. All project risks have been reviewed and closed.	20% increase in overall incident reporting (Monthly)	724	583	583	No risks or issues highlighted in this reporting period.
									>75% of incidents closed within time target [SECAmb Target]	84.0%	75.0%	75.0%	
									90% of Serious Incident investigations will be completed within 60 working days.	0.0%	90.0%	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	97.0%	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%	
	Infection Prevention and Control	Amber	Amber	Adrian Hogan	Steve Lennox	N/A	31/08/2018	The project RAG remains Amber due to the ongoing issues around discrepancies in training figures between the 2 systems - ESR and Discover – as well as a fall in compliance for Deep Clean (DC) completion at Make Ready Centres. The new Infection Prevention Ready Procedure has now been produced.	Hand Hygiene Staff Compliance	90%	No data available	90%	No risks or issues highlighted in this reporting period.
									Bare Below the Elbow	95%	No data available	90%	
									Vehicle Cleanliness Compliance	73%	No data available	75%	
									Station Cleanliness - Buildings Compliant	68%	No data available	100%	
									Station Cleanliness - Buildings Completed	100%	No data available	100%	
	Medical Devices	Green	Amber	Nicola Brooks	Steve Lennox	06/06/2018	30/09/2018	The project RAG moves from Amber to Green as previously projected. The majority of the actions are marked complete with the associated supporting evidence having been validated also. Of those still open, clear plans are in place to ensure their development as required and all outstanding actions are progressing as per the plan. The CQC Deep Dive was held on 06/06/18 with the CQC noting the significant improvements made. Work will now commence to plan the transition of the project into BAU and move towards project closure, overseen by the Compliance Steering Group.	Double Crewed Ambulances (DCAs) and Single Response Vehicles (SRVs) Audited per Quarter.	277	160	240	No risks or 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	98%	100%	100%	
									Number of CFRs who have provided their defib asset register details to the Voluntary Services Team	454	333	500	
	Medicines Governance	Green	Green	Carol-Anne Davies-Jones	Fionna Moore	19/02/2018	19/06/2018 (was previously) 31/03/2018	The project RAG remains Green. The project will be formally signed off by the Compliance Steering Group as closed on 19 June 2018. Medicines Governance will however continue to report into Compliance Steering Group on a weekly basis as part of business as usual.	Medical Quiz Passes	2343	2425	2425	
									Compliance per Operating Unit	94.00%	97.50%	97.50%	
									DCA Drug cabinet key losses (Cumulative Total Nov 17 to Present) Three keys lost in month of April significant reduction.	159	N/A	N/A	
									CD Breakages (April Total)	12	0	0	
	Patients with Complex Needs	White	White	Sara Songhurst	Bethan Hasksins	TBC	TBC	This is a new project. A gap analysis for long term conditions is currently underway which will inform a proposal to move forward with the intervention required to understand and meet the needs of complex patients. Once this has been completed, a project mandate and QIA will be developed.	KPIs to be defined	N/A	N/A	N/A	No risks or issues highlighted in this reporting period.
	Performance Targets and AQIs	Green	Amber	Chris Stamp	Joe Garcia	31/08/2018	30/09/2018	The project RAG moves from Amber to Green. Performance has continued to improve through reducing lost operational hours, better meeting the needs of service users, and enhanced fleet and recruitment strategy. All actions are now complete or transferred to the ARP Demand & Capacity Delivery project, and we continue to see a positive trend towards meeting or exceeding C1/2 targets. Incomplete milestones on this workstream have been identified to move to BAU or transferred to other projects. The project has commenced formal project closure and is expected to be signed off at Compliance Steering Group on 19 June 2018.	Category 1 Mean	07:42	07:00	07:00	No risks or issues highlighted in this reporting period.
									Category 1 90th Centile	14:17	15:00	15:00	
									Category 2 Mean	17:18	18:00	18:00	
									Category 2 90th Centile	32:17	40:00	40:00	
	Recruitment Plan (ECSW & AAP)	Amber	White	Sophie May	Ed Griffin	TBC	01/11/2018	This is a new project to recruit 200 ECSWs and 100 AAPs (to enter training) by 01/11/18. The project scope will also include defining and implementing recommendations as to how to address some of the issues identified, including: assessor constraints; C1 driving qualification funding; fitness test issues; local area recruitment challenges; and training capacity. A Task & Finish Group has now been established. A Project Mandate & QIA are currently in development which will inform the project plan. Progress of the project will report into the Compliance Steering Group on a weekly basis.	Recruitment of ECSWs	101	200	200	Main risks are surrounding our ability to offer enough candidates' positions. We are resolving this by encouraging more applications with the use of the BKSB numeracy and literacy test. We are also exploring the opportunity for us to fund C1 licenses and change the fitness assessment so it is more in line with the requirements of the role. Each of these actions form part of our overall project IAP.
									Recruitment of AAPs	?	100	100	
	Risk Management	Green	Amber	Nicola Brooks	Bethan Haskins	19/01/2018	31/08/2018	The project RAG moves from Amber to Green. Whilst a number of actions are open and remain under development, the project has now commenced formal project closure, with open actions being reviewed for transition into the new Governance and Risk project, overseen by the Compliance Steering Group during June 18. Supporting evidence for the completed actions has been validated.	Individual Risks Reviewed on Datix With Principle Risk Lead (includes training & awareness)	140	140	140	No risks or issues highlighted in this reporting period.
									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	13	27	27	
	Safer Recruitment	Amber	White	Isla MacDonald	Ed Griffin	TBC	TBC	This is an outcome of new projects that sits under the HR Transformation programme (People Risks and Process Improvement Workstreams). The projects will initially be looking at the risks around non-compliance of DBS checks and all personnel files with a view of getting compliance to 100%. The process improvement workstream will be looking at how the process will be improved for the future to ensure the Trust maintains 100% compliance at all times and the risk is mitigated. It will also review the end to end recruitment process to ensure this is safe and streamlined.	KPIs to be defined.				No risks or issues highlighted in this reporting period.
	999 Call Recording	Green	Green	Barry Thurston	David Hammond	N/A	31/10/2018 (previously 31/03/2018)	The Project remains RAG rated Green as there is a clear process to replace the telephony system. Weekly audits remain ongoing until the replacement system has been implemented. IT and the external suppliers are managing some issues with the current system (instances of both conjoined and fragmented call recordings) through auditing.	100% of all 999 calls recorded				Some further issues located this month although confirmation of no lost calls – issues remain with conjoined and fragmented calls making it difficult to locate calls quickly. These issues are not impacting on the Trust's ability to deliver the service as IT have been able to locate any missing calls.
									Auditing of calls take place on a weekly basis from 05 January 2018 (circa 2500 calls)				
									Approx. 15 sample calls carried out				

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive Lead	CQC Deep Dive Date	Forecast Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
Culture & Organisational Development Steering Group	Culture & OD	Red	Red	Clare Irving	Ed Griffin	N/A	08/08/2018	This now forms part of the HR Transformation Programme and has the support and guidance of a dedicated Programme Manager. This additional support has enabled us to revise the project plan which focuses on 3 main areas; Engaging Staff, Managing Behaviours and Building an enabling infrastructure. The refreshed Trust Values were launched on 12th June 2018 and was received really well, at the same time the staff recognition programme has been launched and again has been received well with a high uptake of values cards being presented and received which has created a real positive atmosphere across most areas of the Trust. The Behaviours Training is currently being delivered to the Executive and Senior Leadership Teams with the imminent launch of training for middle management. The Culture Change Team are actively attending operational meeting e.g. Teams A,B,C and EOC meetings to share the culture programme work and to also identify areas for support. In addition to these, the Culture team are continuing ASK HR sessions and Quality Assurance Visits.	KPIs to be defined.				
Strategy	Annual Planning	Amber	Amber	Jayne Phoenix Philip Astell	Steve Emerton	N/A	August 2018 (previously 30/04/2018)	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 and the demand and capacity review.	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.
	Commissioner and Stakeholder Alignment	Green	Green	Jayne Phoenix	Steve Emerton	N/A	Ongoing	Further engagement sessions for staff have commenced and further engagement sessions are being planned. in line with our strategy refresh. The Trust has now drafted a clinical case for change and assessment of risk of harm in support of the Demand and Capacity Review	Alignment of commissioner and stakeholder expectations with delivery and operating plans for 2018/19				No risks or issues highlighted in this reporting period.
	Enabling Strategy	Amber	Amber	Jayne Phoenix	Steve Emerton	N/A	30/09/2018	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 list of strategies.	All strategies completed by agreed timescales.				This project remains RAG rated Amber due to the interdependencies and links to the Delivery and Capacity Review.
	Quality Improvement	Amber	Amber	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 remains RAG rated Amber given clear dependencies into the Demand and Capacity review.

Programme for 2018/19 to deliver a minimum of £11.4m savings to achieve the planned £0.8m control total deficit.

Financial Reporting Period: Month 2 - May 2018

Programme Summary:

1. Validated or scoped schemes of £5.8m against the target of £11.4m. Further proposed schemes to be developed in conjunction with Budget Leads.

2. Awaiting Exec Sponsor and/or QIA approvals for some Project Mandates. Fully validated CIP schemes are moved to the Delivery Tracker after approval.

3. Positive engagement with Execs and CIP Project Leads along with effective participation in Financial Sustainability Steering Group meetings. CIP Programme governance framework and processes are fully functioning in the business and were recently given "Substantial Assurance" by Internal Audit.

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

5. A CIP allocation of £2.9m has been included for operations efficiencies but no detailed workings are yet available due to uncertainties around Sustainability Transformation Programmes (STP), the recently introduced Ambulance Response Programme (ARP), the Demand and Capacity Review and Handover Delays. The PMO Finance Team is in the course of discussions with the Operations Senior Team on a methodology for valuing frontline efficiencies achieved during the year to date.

CIP Opportunity Classification - KEY

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

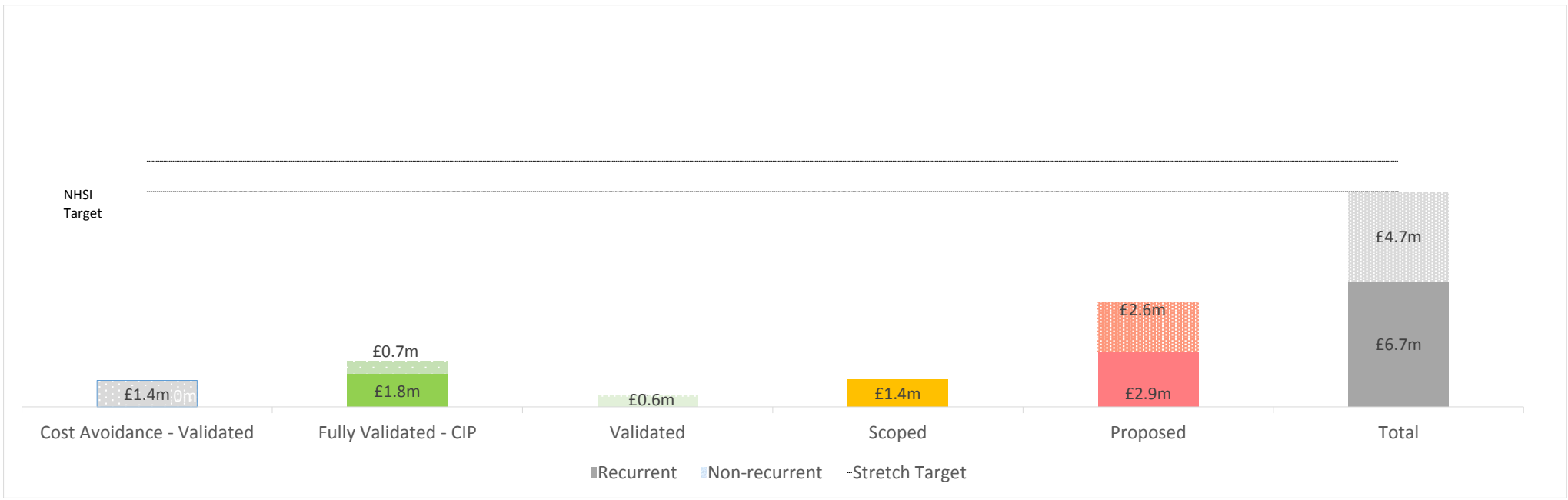
CIP Pipeline and Delivery: Risks and Issues

	Risk	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Risk that the 2018/19 CIPs target of £11.4m will not be fully delivered due to uncertainties within the Operations Directorate.	Monthly meetings with Budget Holders. Other potential CIP schemes are under review.	Kevin Hervey	Amber	Amber	30-Sep-18

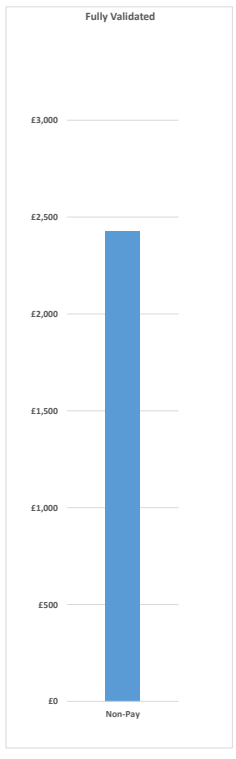
	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	New Lease Cars policy to be agreed.	Awaiting updates from John Griffiths (Response Capable Managers) and Ed Griffin (all other staff)	John Griffiths/ Ed Griffin	Amber	Amber	30-Jun-18
2	Medical Consumables - procurement cost savings to be considered.	Proposed medical consumables to be considered	Kirsty Booth/ Paul Ranson	Amber	Amber	30-Jun-18
3	HCA/Excess Mileage - consider scope for savings.	Trustwide Pay Costing Template to be reviewed	Graham Petts/ Priscilla Ashun-Sarpy	Amber	Amber	30-Jun-18
4	Agency Staff - Re-iterate to Managers the process for acquiring interim staff.	Recruitment to draft a comms message to go out from ED Griffin.	Penny Compton / Ed Griffin	Amber	Amber	30-Jun-18
5	Rates Rebate - evaluate potential savings.	Develop a CIP based on rates review	Paul Ranson	Amber	Amber	31-Dec-18
6	E-Expenses & E-Payslips - potential savings from automation.	Awaiting evaluation by Finance.	Priscilla Ashun-Sarpy	Amber	Amber	30-Jun-18
7	Agency Staff - Potential cost avoidance CIP	Recruitment to provide update	Claire Pullen	Amber	Amber	30-Jun-18
8	Develop Operations CIP schemes.	Discuss with Ops Director. Consider if a CIP can be constructed on operational efficiencies.	Kevin Hervey/ Graham Petts	Amber	Amber	30-Jun-18
9	Devise mechanism for recoveries of old staff overpayments	Discuss with Payroll Manager	Kevin Hervey	Amber	Amber	30-Jun-18

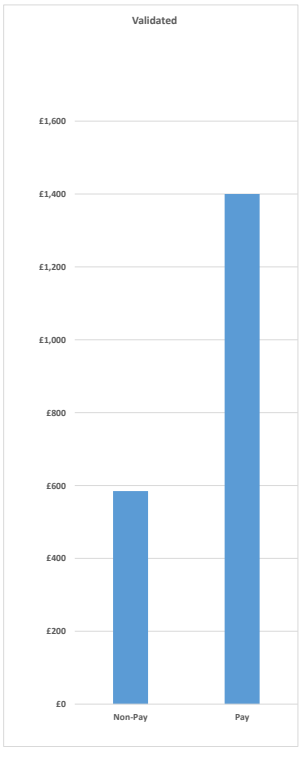
CIP Pipeline Summary

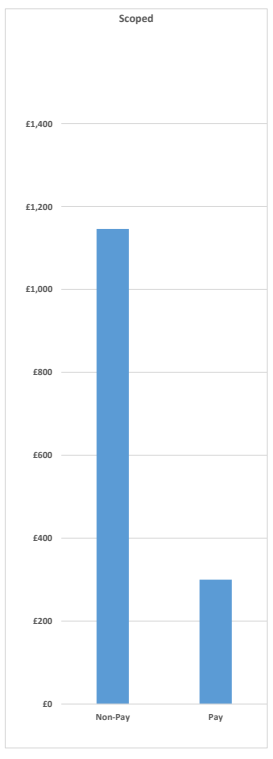
Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£1,400	£2,430	£585	£1,446	£5,553	£11,412

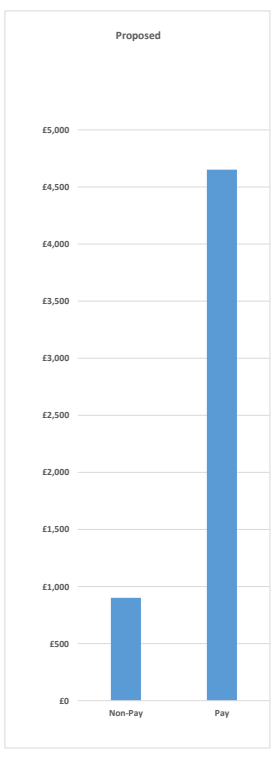


Pay / Non-Pay / Income Breakdown and scheme summary









Scheme Category	Full Year 2018/19				
	Fully Validated £000	Validated £000	Scoped £000	Proposed £000	Grand Total £000
111 Efficiency	33	-	-	-	33
Agency Premiums	-	1,400	-	-	1,400
Books & Subscriptions	17	-	-	-	17
Discretionary Non Pay	56	6	-	-	62
Estates and Facilities management	6	188	547	-	741
External consultancy & contractors	253	100	-	-	353
Furniture & Fittings	-	50	-	-	50
Insurance	661	-	-	-	661
IT Productivity and Phones	20	138	140	-	298
Medicines Management - Consumables	200	-	94	-	294
Medicines Management - Drugs	150	-	-	-	150
Medicines Management - Equipment	107	-	-	-	107
Meeting room hire	57	59	-	-	115
Operations efficiency	-	-	-	1,500	1,500
Procurement contracts review	-	-	200	-	200
Public relations	4	-	-	-	4
Recruitment delays - clinical	-	-	-	1,393	1,393
Recruitment delays - non clinical	-	-	-	1,759	1,759
Single HQ /EOC Benefits realisation	-	-	300	-	300
Staff Uniforms	-	-	100	-	100
Stationery	39	-	-	-	39
Top Slice - all directorates	-	-	-	901	901
Training courses & accommodation	431	17	-	-	448
Travel & Subsistence	197	27	65	-	289
Fleet - Fuel: Telematics & Price Differential	200	-	-	-	200
Grand Total	2,430	1,985	1,446	5,553	11,412

South East Coast Ambulance Service: CIP Workstream

CIP Delivery Dashboard

Reporting Month May-18

Programme for 2018/19 to deliver a minimum of £11.4m savings to achieve the planned £0.8m control total deficit.

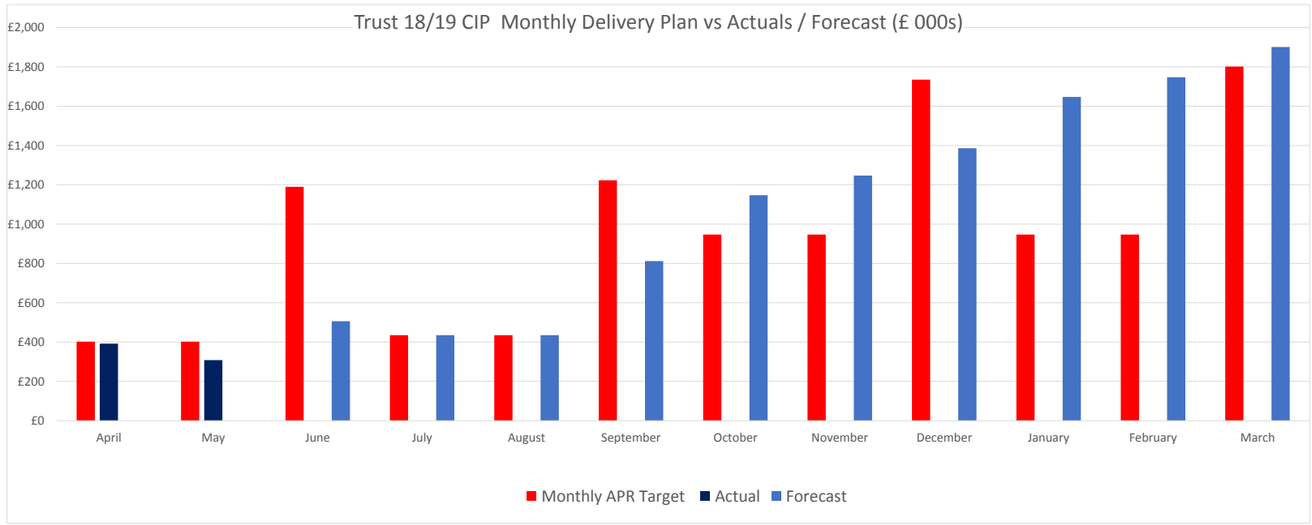
Programme Summary: (See Pipeline Tracker for Risks and Issues)

1. The CIPs target remains at £11.4m for the 2018/19 financial year.
2. £2.4m of fully validated savings have been transferred to the Delivery Tracker as at the Month 2 reporting date.
3. The schemes continue to 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. The PMO Finance Team is in the course of discussions with the Operations senior team on a methodology for valuing frontline efficiencies achieved during the year to date. 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 Cost Improvement Programme is rated Amber.

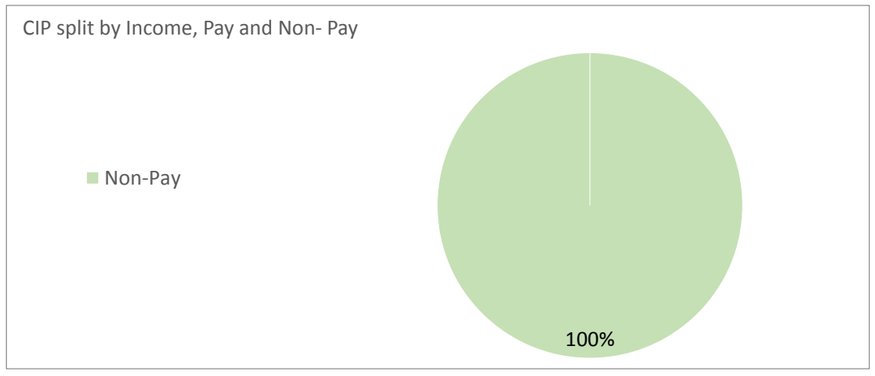
4. Regular review meetings with Budget Leads and Finance Business Partners continue to take place. These are currently focused on identifying new schemes to build a sustainable pipeline of recurrent schemes for 2018/19.

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

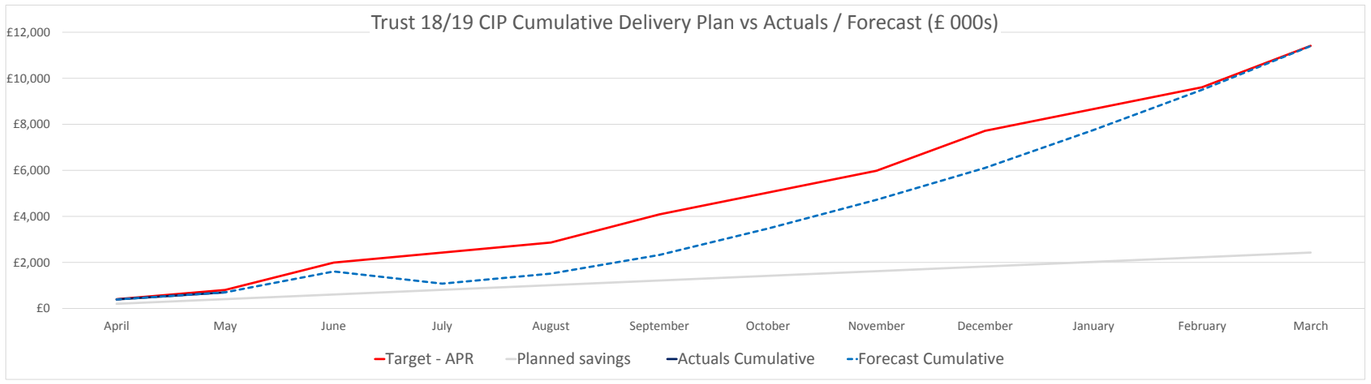
CIP Target for 18/19 £000's	Total planned savings on delivery tracker £000's - as at 14 June 2018	Total forecast savings on delivery tracker £000's - as at 31 May	YTD May 18 - Target Savings £000's	YTD May 18 - Actual Savings £000's	YTD May 18 - variance £000's
11,412	2,429	2,429	804	700	(£104)



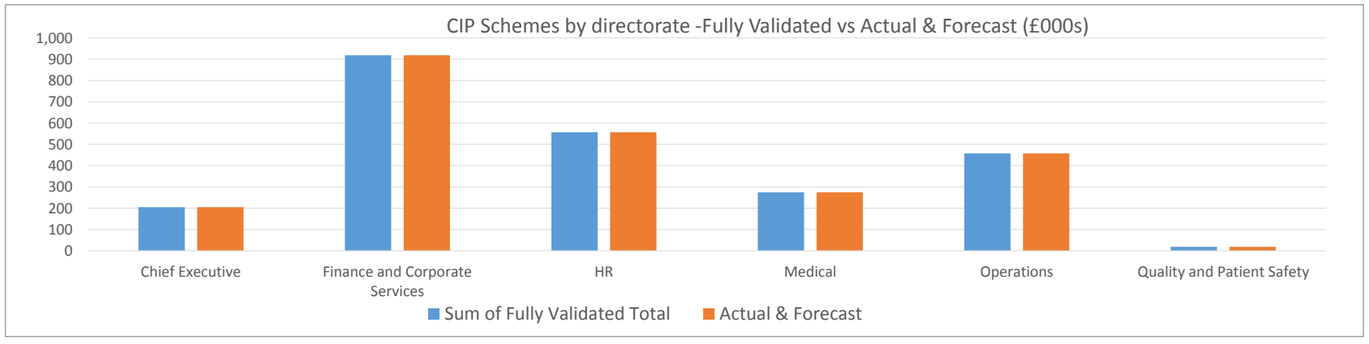
2. CIP - Planned savings split by income, pay and non-pay: as at 31 May



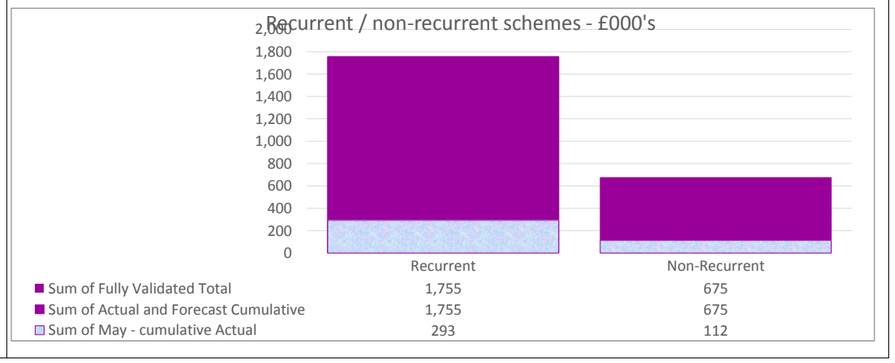
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2018/19



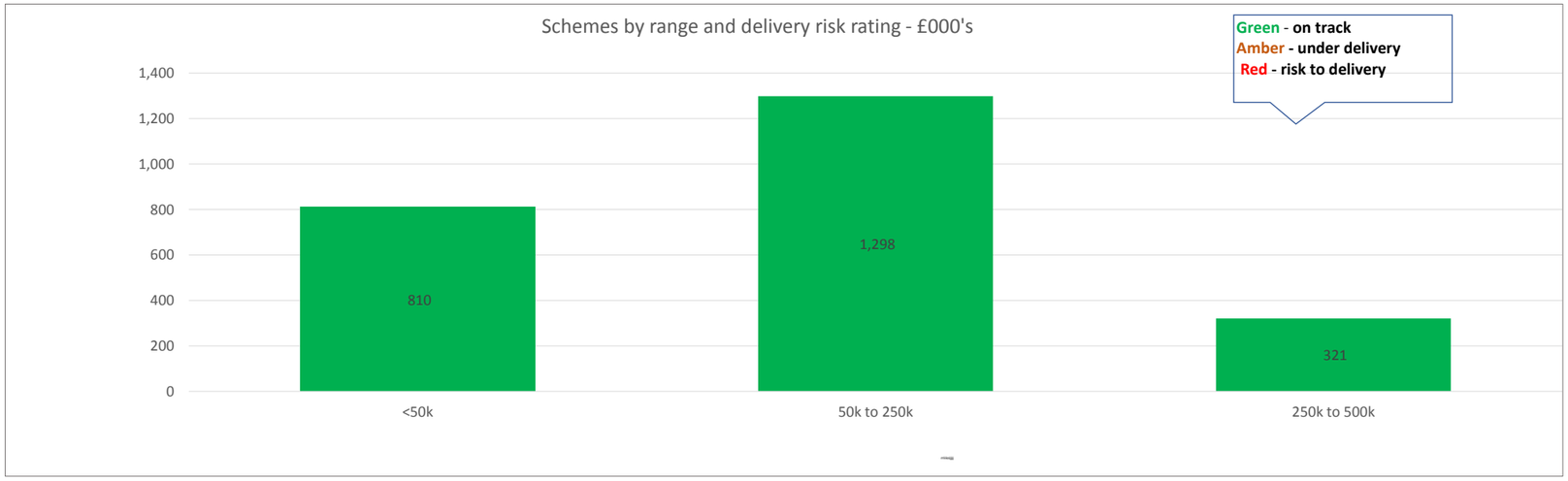
4. CIP schemes by directorate - Fully Validated vs Actual & Forecast 2018/19



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



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



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

Scheme Category	2018/19 Value of Fully Validated Schemes - £000	2018/19 Forecast Value £000	Full Year Variance £000	YTD Planned / Fully Validated Schemes Savings (Month 2): £000	YTD Actuals (Month 2): £000	YTD Variance £000	Comments (+/- £20k variance)
External consultancy & contractors	£253	£253	£0	£42	£42	£0	-
Meeting room hire	£56	£56	£0	£9	£9	£0	-
Public relations	£4	£4	£0	£1	£1	£0	-
Stationery	£39	£39	£0	£6	£6	£0	-
Travel & Subsistence	£197	£197	£0	£33	£33	£0	-
Medicines Management - Equipment	£107	£107	£0	£18	£18	£0	-
Medicines Management - Consumables	£200	£200	£0	£33	£33	£0	-
Books & Subscriptions	£17	£17	£0	£3	£3	£0	-
111 Efficiency	£34	£34	£0	£6	£6	£0	-
Fleet - Fuel: Telematics, Bunkered Fuel & Price Differential	£200	£200	£0	£33	£33	£0	-
Estates and Facilities management	£6	£6	£0	£1	£1	£0	-
IT Productivity and Phones	£20	£20	£0	£3	£3	£0	-
Discretionary Non Pay	£56	£56	£0	£9	£9	£0	-
Training courses & accommodation	£431	£431	£0	£72	£72	£0	-
Medicines Management - Drugs	£150	£150	£0	£25	£25	£0	-
Insurance	£661	£661	£0	£110	£110	£0	-
Existing Fully Validated Schemes	£2,430	£2,430	£0	£405	£405	£0	
Other planned schemes budget awaiting sign off	£2,062	£2,062	£0	£399	£295	(£104)	Difference between Fully Validated Schemes and Schemes removed from budget or included in NHSI target
Grand Total	£4,492	£4,492	£0	£804	£700	(£104)	

Enabling Strategies

Status at 20/6/18

Complete	In Progress	To Do
Health & Wellbeing *Lead: Angela Rayner*	People Strategy *Lead: Ed Griffin*	Volunteers *Lead: TBC*
Medicines Optimisation *Lead: Carol-Anne Davies-Jones*	Clinical Education *Lead: Fionna Moore*	Communications & Engagement *Lead: Janine Compton*
Safeguarding *Lead: Philip Tremewan*	Clinical Strategy *Lead: Fionna Moore*	
Inclusion Strategy *Lead: Isobel Allen*	Governance *Lead: Peter Lee*	
	Research & Development *Lead: Julia Williams*	
	Fleet *Lead: John Griffiths*	
	Estates *Lead: Paul Ranson*	
	Digital & ICT *Lead: Barry Thurston*	
	Partnership/Commercial *Lead: Jon Amos*	

South East Coast Ambulance Service NHS
NHS Foundation Trust

Handover Delays – May 2018 Performance Summary

8th June 2018

Your service, your call

Key Highlights

- The project plan has been reframed to take into account the national objective of having no hospital handover delays >30 minutes by September 2018. Hospitals are now revisiting their plans to reduce ambulance handover delays to reflect this .
- A work plan is being drawn up with NHSI to provide extra support to those trusts within SECAmbs footprint where handover delays are a particular challenge.
- Engagement with hospitals in the West is good and they are now liaising with each other direct ,in order to share good practice .In the East engagement is more of a challenge due to recent senior leadership changes. This however is improving as new relationships are established .
- Most hospitals have demonstrated improvement, notably over the last month particularly East Surrey, Eastbourne DGH . There has been some deterioration however at Medway over the last few months .Extra support is being deployed from ECIP
- Crew to clear time – reports with granular detail (Operating Unit , Dispatch desk , Team and individual level) about crew to clear time performance are now available , a communication brief has been developed to support team leaders. The reports are being rolled out to 4 Operational Units initially - Guildford , Gatwick and Redhill , Thanet and Weald.

Key Highlights

- A live **joint** review of all conveyances (SECAmb , hospital staff and community services) has been tested out at EDGH. The aim of the review was to ensure that the right pathways, particularly community ones were being maximised .
- The review established that all appropriate community pathways had been considered before conveyance to hospital. The review was in the day time (0700 -1900) and will now be repeated during out of hours .
- The review was really helpful in refining the tool and now it has been finalised the next two hospitals to have a review undertaken will be East Surrey and QEQM .

May 2018 – performance

SECAmb totals for May 2018 hours lost >30 minute turnaround

- Total patient handovers 35869, Total hours lost > 30mins turnaround 4404.8 and per journey 0.12 (7.2 minutes)
- **Overall there was a collective decrease of 19% in hours lost comparing May 2018 to May 2017**
- Surrey hospitals had the largest collective decrease of **33%** with East Surrey Hospital showing the largest decrease of **59%.**
- Sussex hospitals had a collective decrease of **21%** with Eastbourne DGH showing the largest decrease of **48%.**
- Kent hospitals had a collective decrease of **7%**
- **Overall there was an 11% decrease in hours lost compared to the same period last year.(April – May 2018 to April - May 2017)**

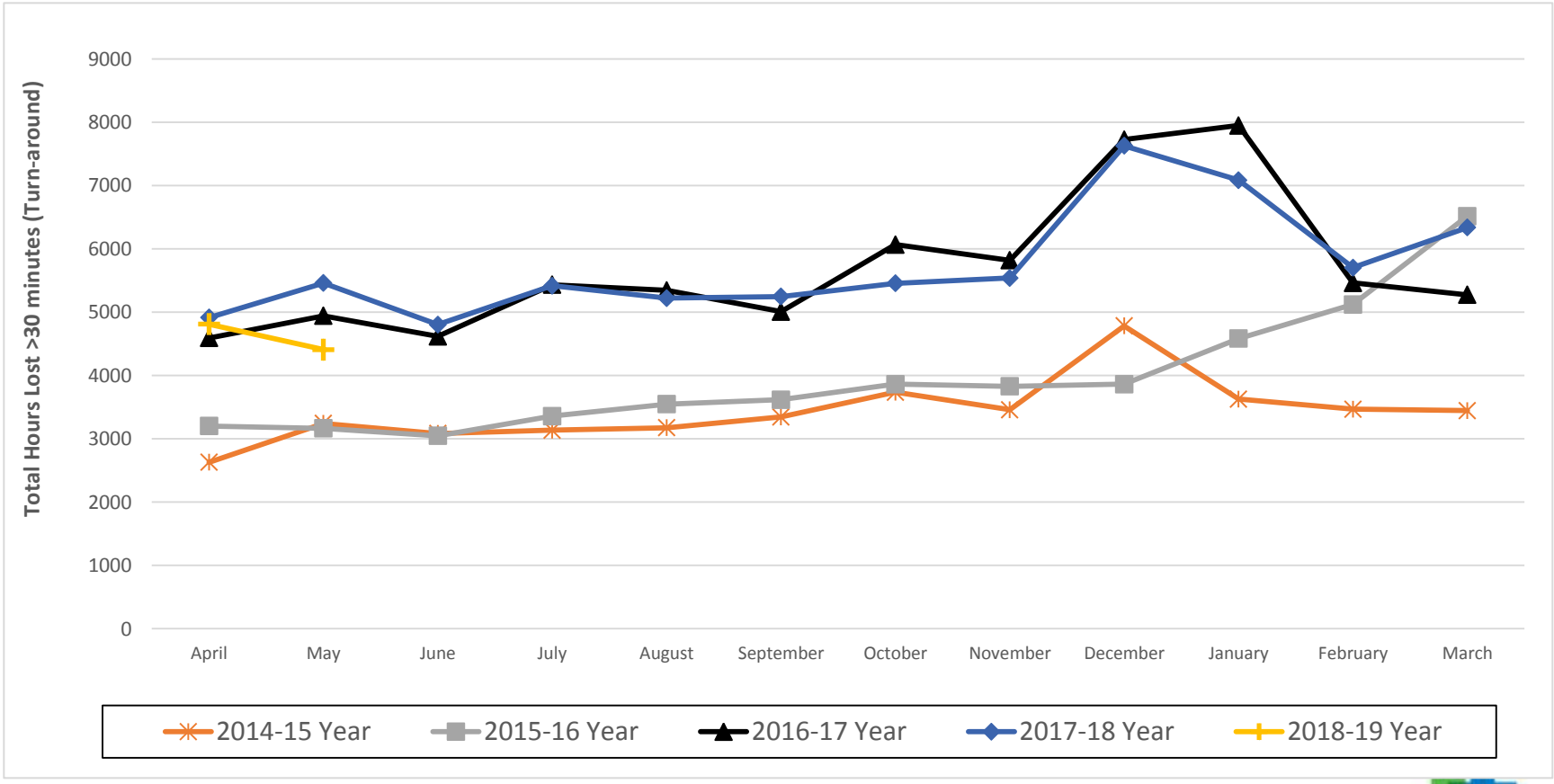
May 2018 – East Narrative

- Number of handovers > 30mins: Conquest had the highest increase of 29 in May, William Harvey had the biggest reduction of 120
- Number of handovers > 60mins: Medway and QEQM both had the highest increase of 8 in May, William Harvey had the biggest reduction of -26
- Total hours lost over > 30mins turnaround : Medway had an increase of 23.1 in May, William Harvey had the biggest reduction of -49.9
- Total hours lost > 30mins per journey: Medway had an increase of 0.01 in May, William Harvey and Eastbourne had the biggest reduction of -0.02
- Total hours lost >30mins turnaround : Medway had the highest total hours lost > 30mins turnaround for May at 533 and Maidstone had the lowest at 86.2
- Total East Hours Lost >30mins turnaround was 2370.8 for May a reduction of -26 from April, and a daily average of 76.5 hours

May – West Narrative

- Number of handovers > 30mins: Frimley Park Hospital had an increase of 26 in May, East Surrey had the biggest reduction of -166
- Number of handovers > 60mins: There were no increases compared to last month, East Surrey had the biggest reduction of -46
- Total hours lost > 30mins turnaround : Frimley Park had an increase of 28.2 in May, East Surrey had the biggest reduction of -110.8
- Total hours lost > 30mins per journey: Frimley Park had an increase of 0.01 in May, Royal Surrey County had the biggest reduction of -0.05
- Total hours lost > 30mins turnaround : Royal Sussex County had the highest total hours lost over 30mins for May at 452.8 and Princess Royal had the lowest at 65
- Total West Hours Lost > 30mins turnaround was 2034 for May a reduction of -380 from April, and a daily average of 65.6 hours

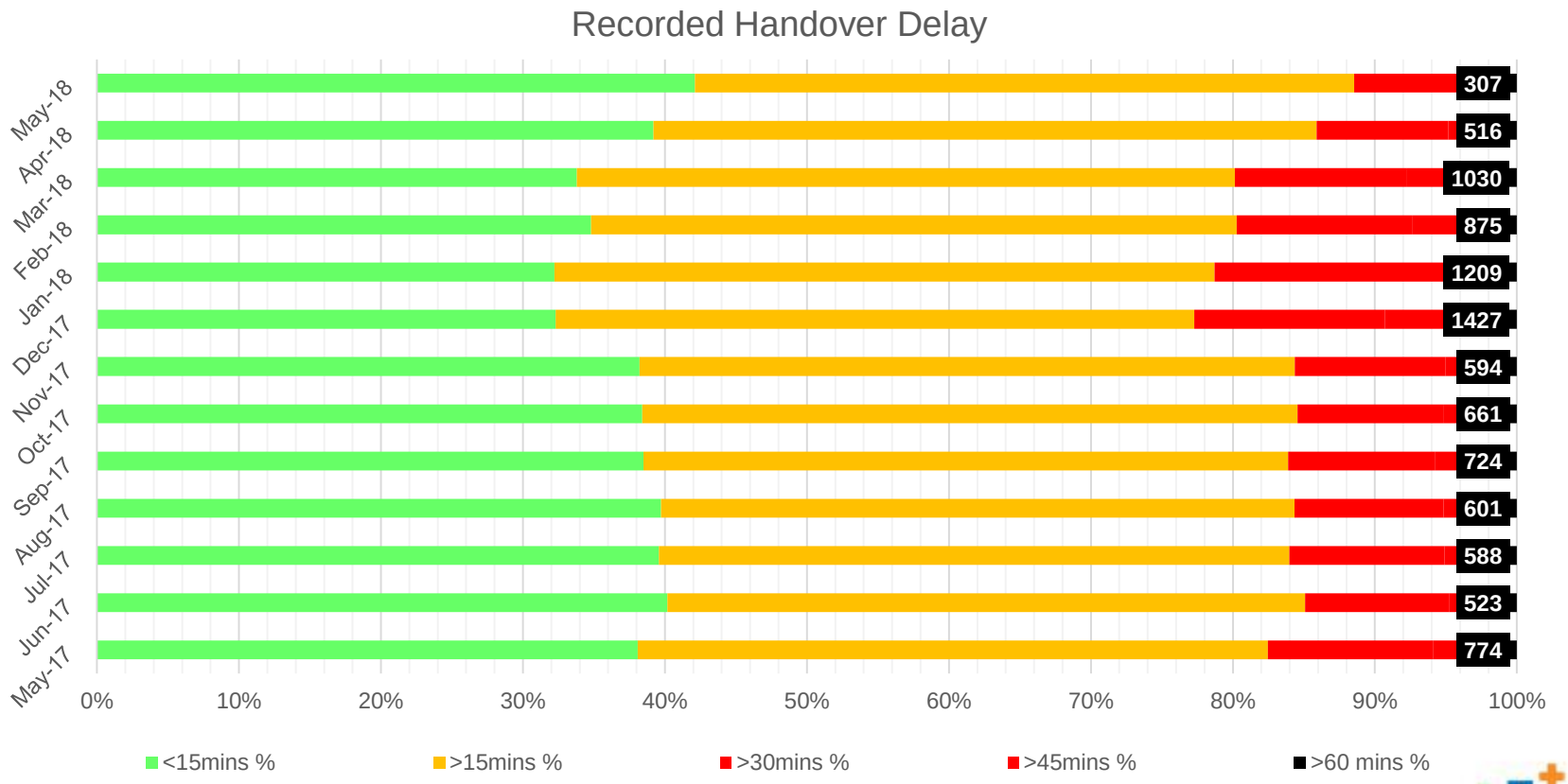
Monthly hours lost > 30 minute turnaround



May 2018 performance breakdown

East EOC	Total Patient Handover	% of Handovers (Arrive to H/O) within 15mins	% Crew to Clear within 15 minutes	Hospital Handover Total Hrs Lost (over 30mins)	Total Hrs Lost (over 30mins)/Transport Journey	% of Handovers (Arrive to H/O) > 30mins	% of Handovers (Arrive to H/O) > 45mins	Volume of Handovers (Arrive to H/O) > 60mins	% of Handovers (Arrive to H/O) > 60mins	Recorded Handover Compliance
Conquest Hospital	2010	42.0%	43.5%	247.5	0.12	11.4%	2.1%	5	0.3%	72.60%
Darent Valley Hospital	1948	37.9%	45.4%	285.9	0.15	16.4%	5.9%	33	1.8%	92.80%
Eastbourne DGH	1761	42.3%	33.8%	248.1	0.14	12.9%	2.9%	6	0.4%	81.70%
Kent and Canterbury Hospital	118	42.0%	80.0%	6.8	0.06	6.0%	2.0%	1	2.0%	42.40%
Maidstone Hospital	1225	54.9%	42.9%	86.2	0.07	4.2%	0.7%	2	0.2%	88.20%
Medway Hospital	3179	35.8%	41.7%	533	0.17	17.9%	5.7%	61	2.1%	92.10%
QEQM	2844	44.4%	59.7%	270.6	0.1	9.4%	2.8%	23	0.9%	93.10%
Tunbridge Wells Hosp	2348	48.7%	38.5%	252.1	0.11	11.2%	3.1%	25	1.2%	92.00%
William Harvey AF	3070	25.8%	62.4%	440.6	0.14	16.2%	3.8%	21	0.9%	76.20%
West EOC	**Total Patient Handover**	**% of Handovers (Arrive to H/O) within 15mins**	**% Crew to Clear within 15 minutes**	**Hospital Handover Total Hrs Lost (over 30mins)**	**Total Hrs Lost (over 30mins)/Transport Journey**	**% of Handovers (Arrive to H/O) > 30mins**	**% of Handovers (Arrive to H/O) > 45mins**	**Volume of Handovers (Arrive to H/O) > 60mins**	**% of Handovers (Arrive to H/O) > 60mins**	**Recorded Handover Compliance**
East Surrey	2846	66.0%	34.6%	226.5	0.08	3.1%	0.2%	3	0.1%	96.80%
Epsom General Hospital	982	28.7%	49.1%	117.6	0.12	11.1%	1.5%	2	0.2%	88.30%
Frimley Park Hospital	2032	40.2%	40.6%	261.8	0.13	8.4%	2.0%	7	0.4%	96.20%
Princess Royal	687	53.0%	39.8%	65	0.09	8.1%	1.1%	4	0.7%	89.50%
Royal Surrey County Hospital	1349	23.5%	48.5%	182.2	0.14	10.9%	1.9%	6	0.5%	91.40%
Royal Sussex County	3027	44.1%	41.5%	452.8	0.15	16.9%	5.5%	59	2.2%	88.20%
St Peters Hospital, Chertsey	2471	35.5%	48.8%	291.2	0.12	10.1%	1.8%	4	0.2%	89.80%
St Richards	1830	41.1%	44.1%	208.7	0.11	11.1%	3.9%	28	1.6%	93.90%
Worthing	2142	46.6%	35.8%	228.2	0.11	8.3%	1.8%	17	0.9%	88.00%
Total	**35869**	**42.1%**	**44.5%**	**4404.78**	**0.12**	**11.5%**	**3.0%**	**307**	**1.0%**	**88.70%**

Hospital handover - trend



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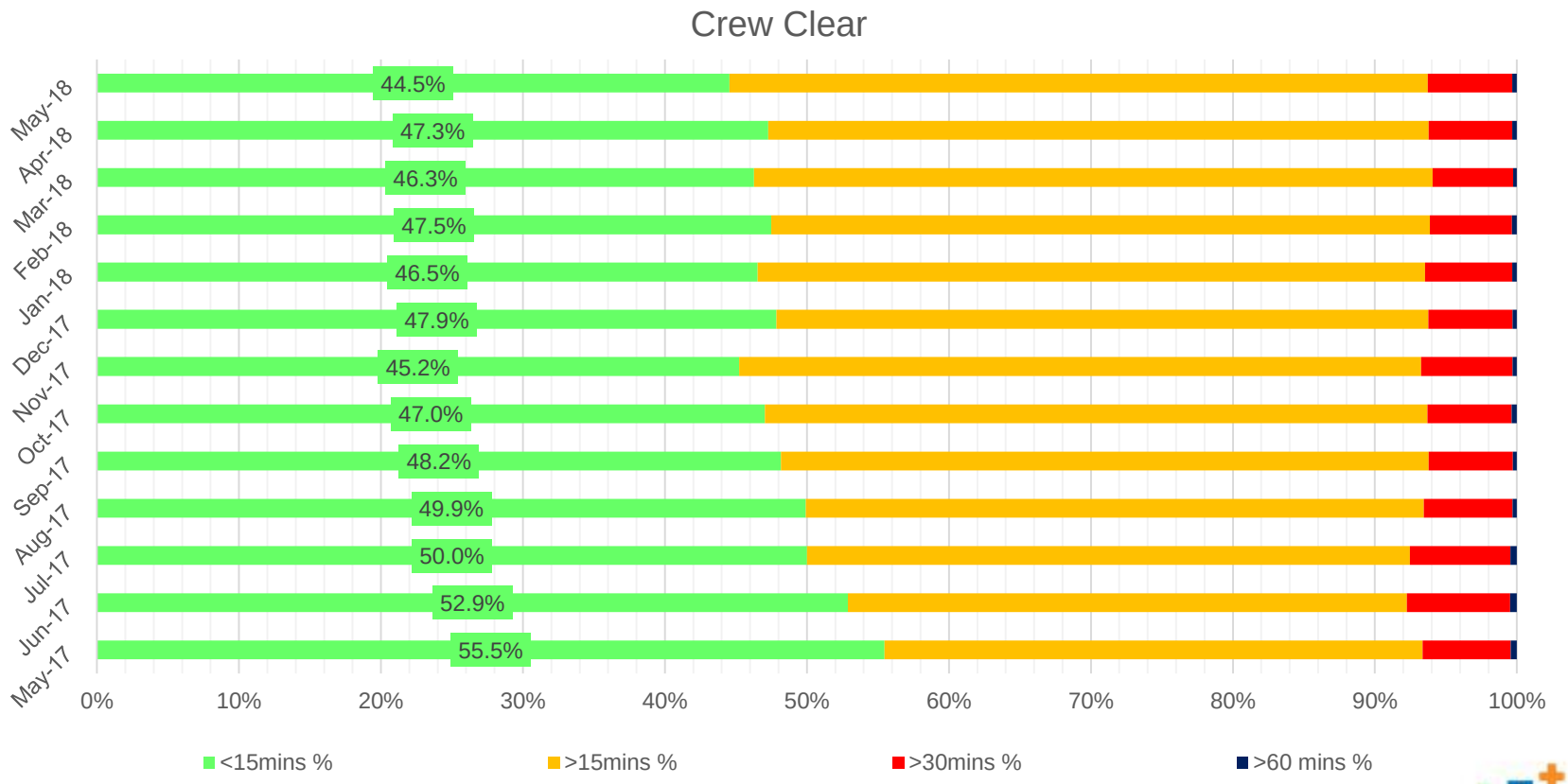
Crew to clear – trend



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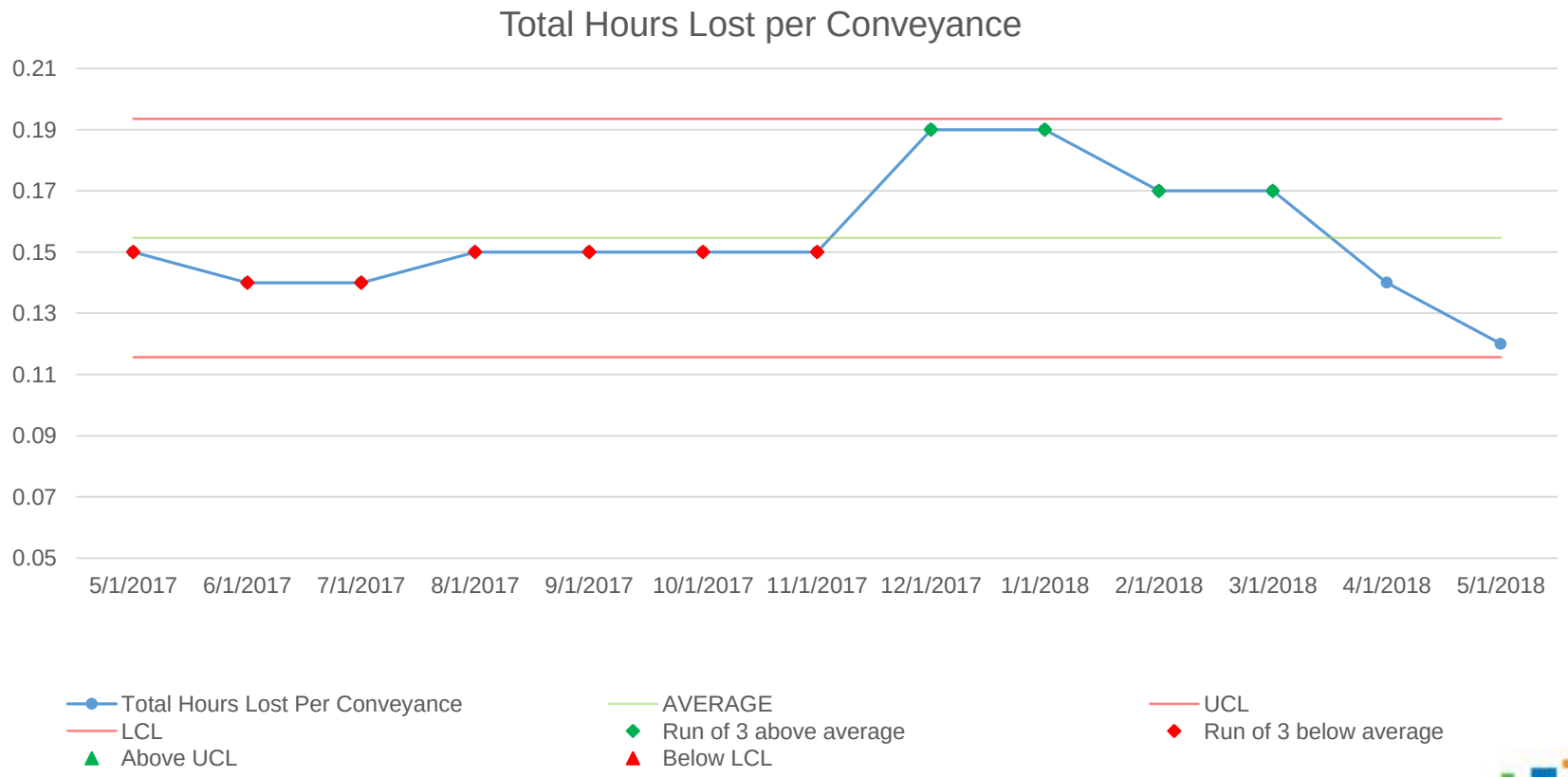
Total hours lost per conveyance – trend



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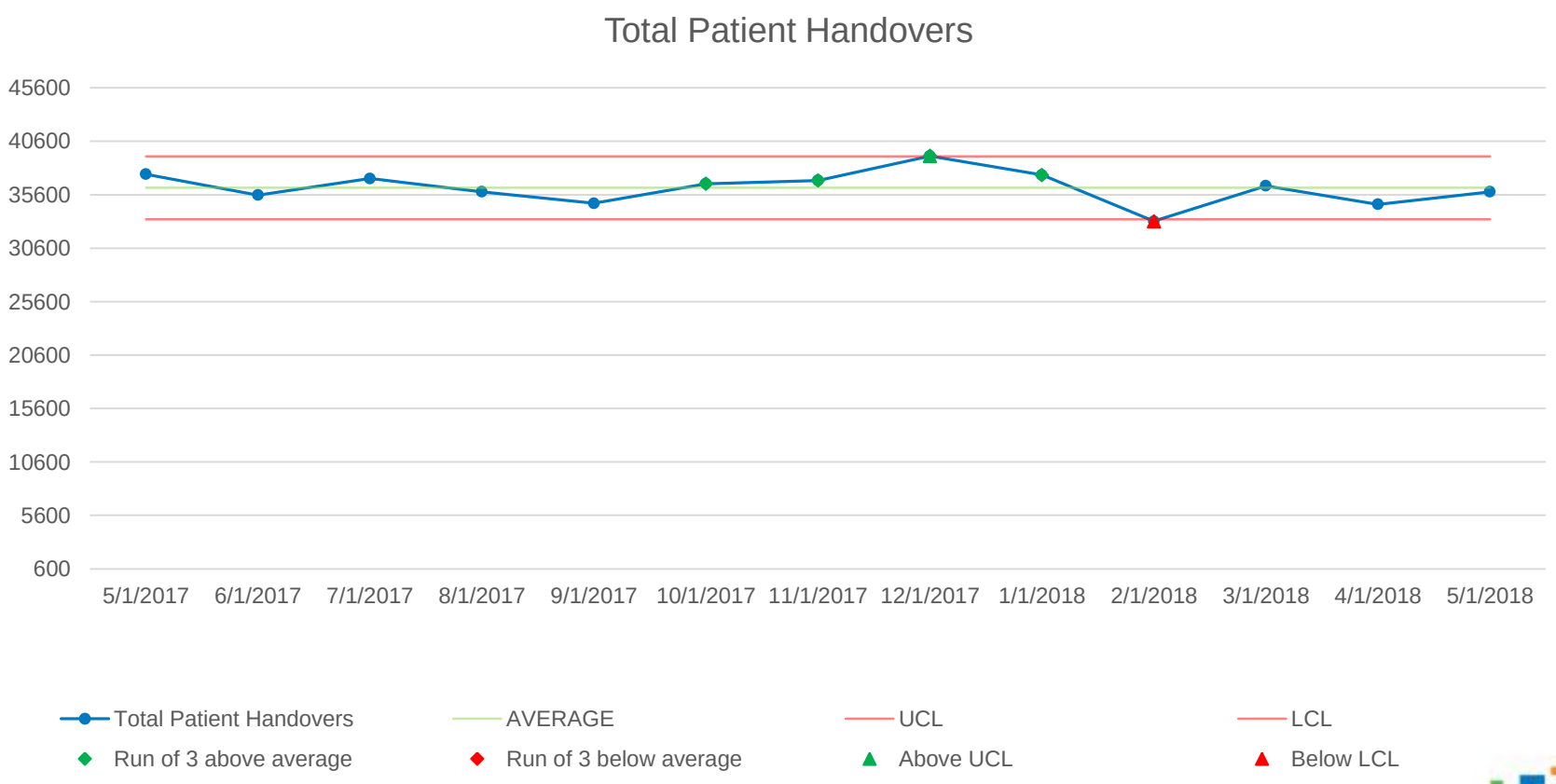
Total patient handovers – trend



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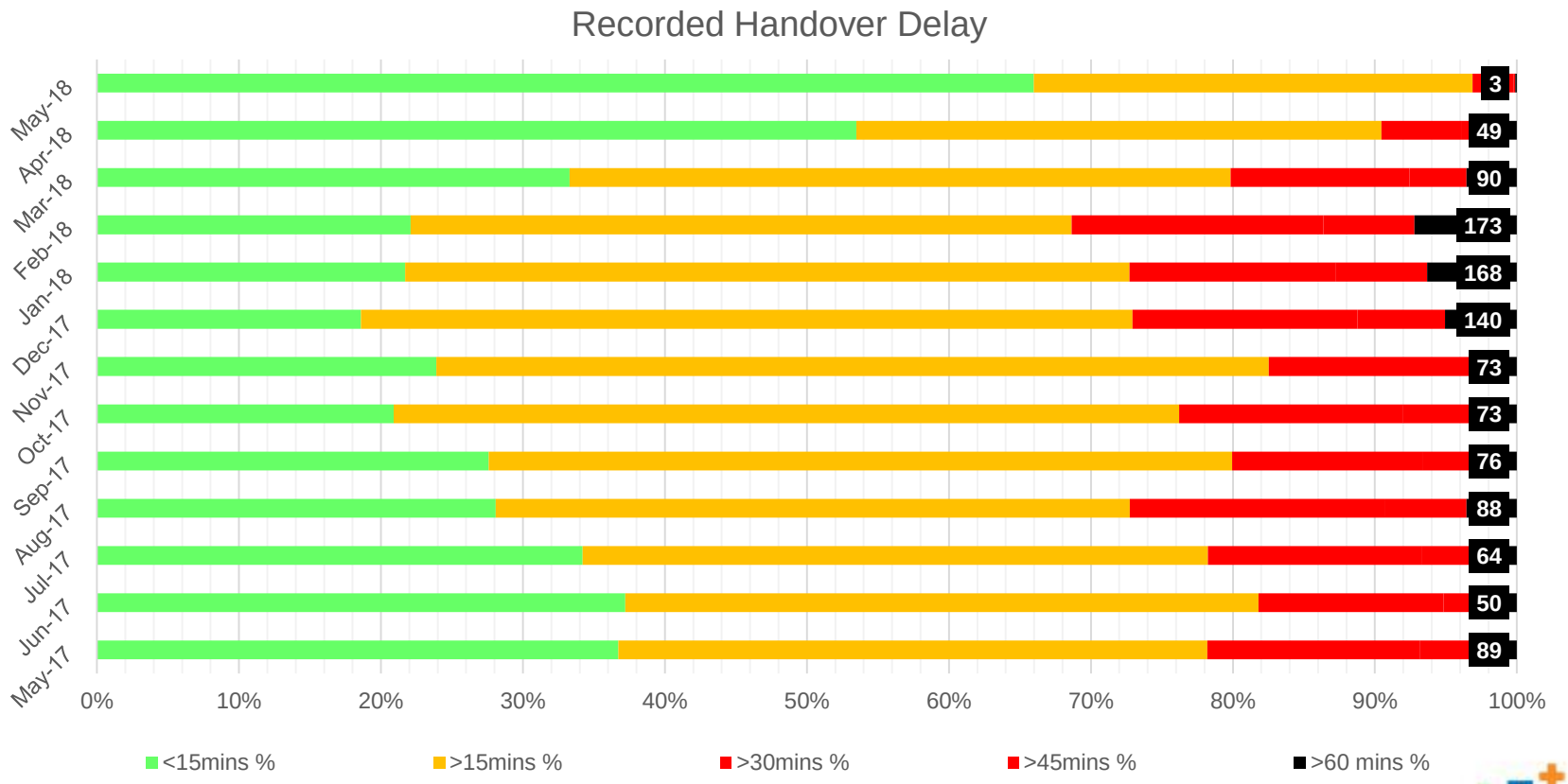
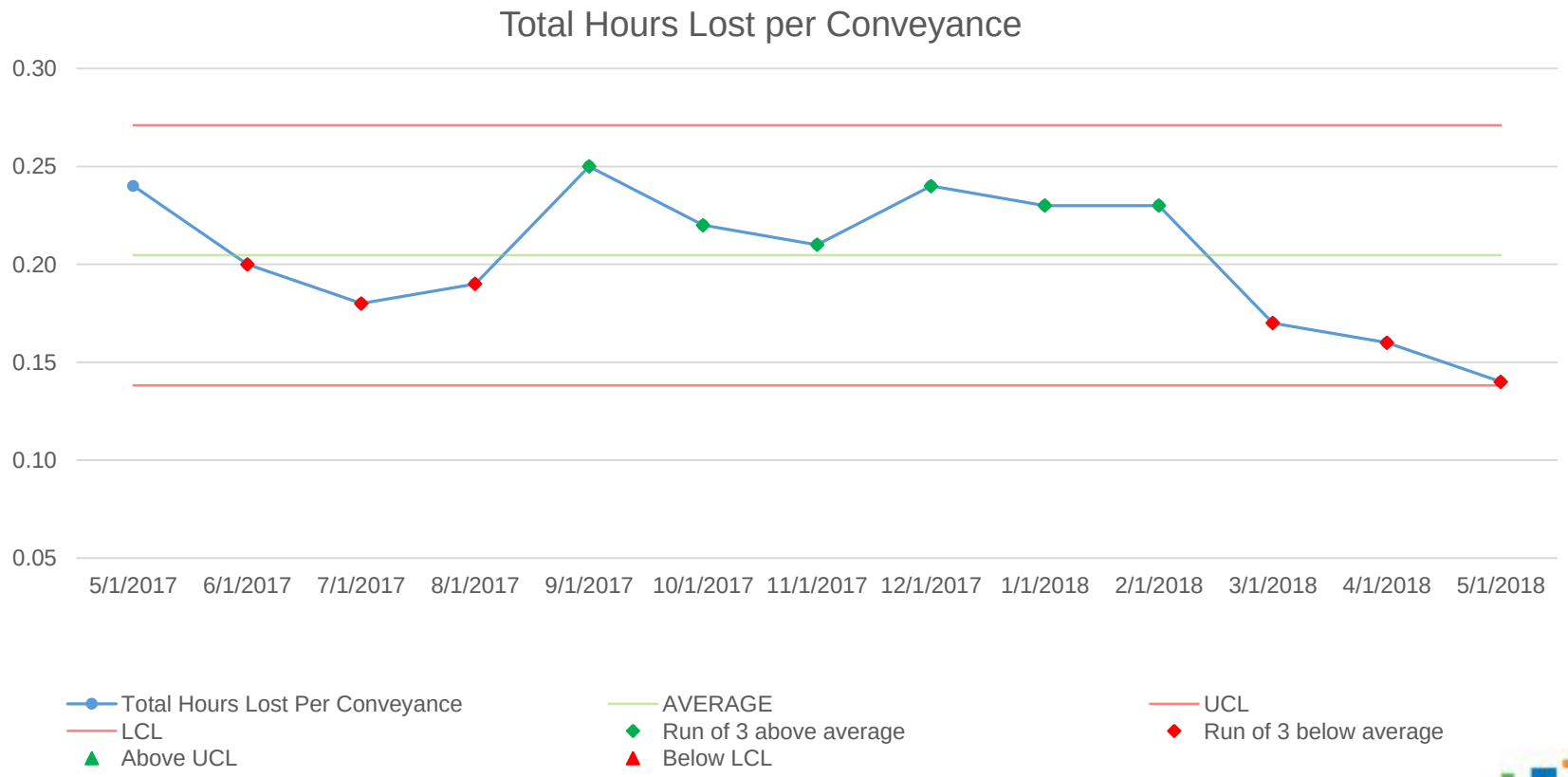
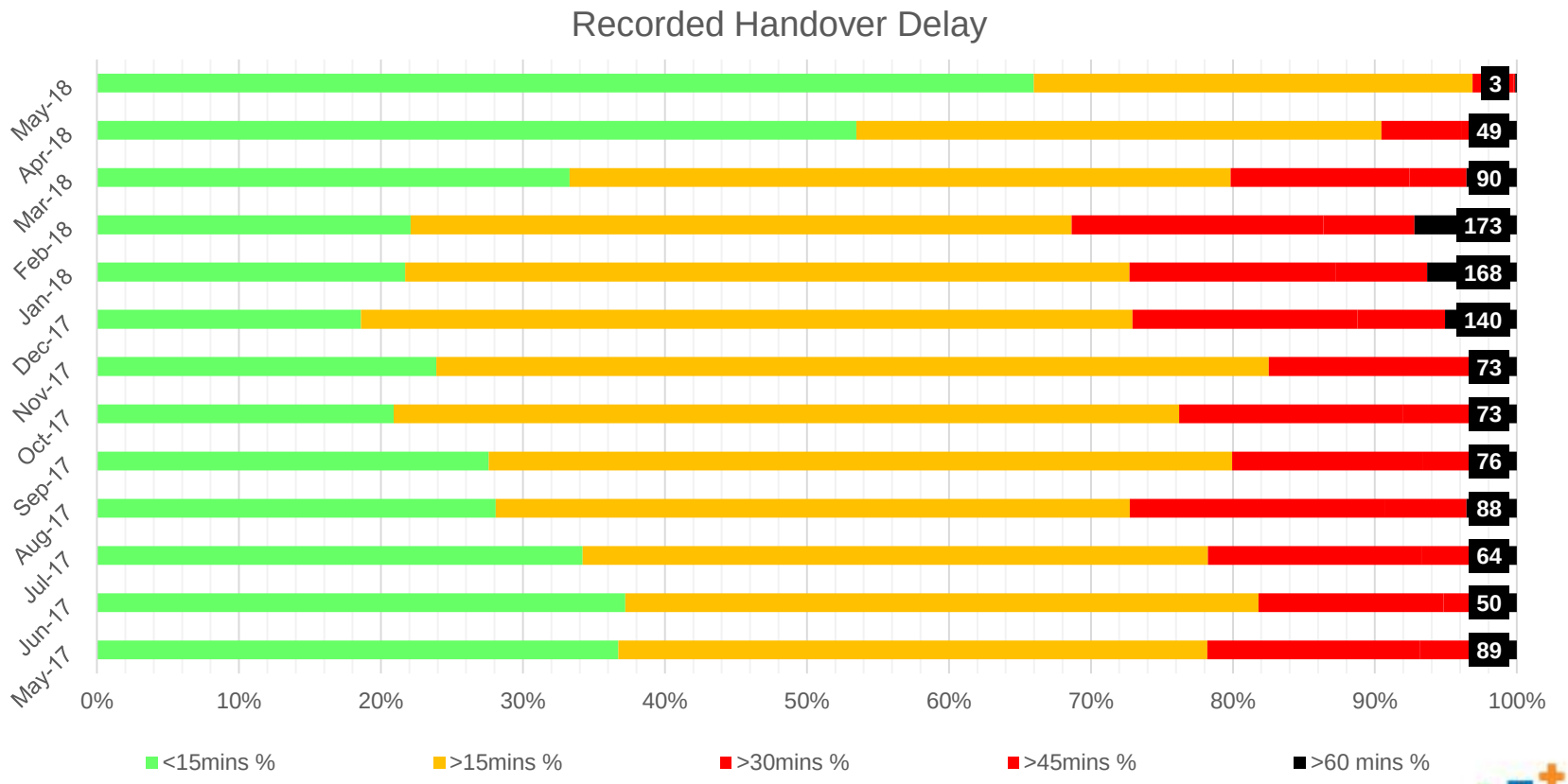
Eastbourne – trend



Eastbourne – trend

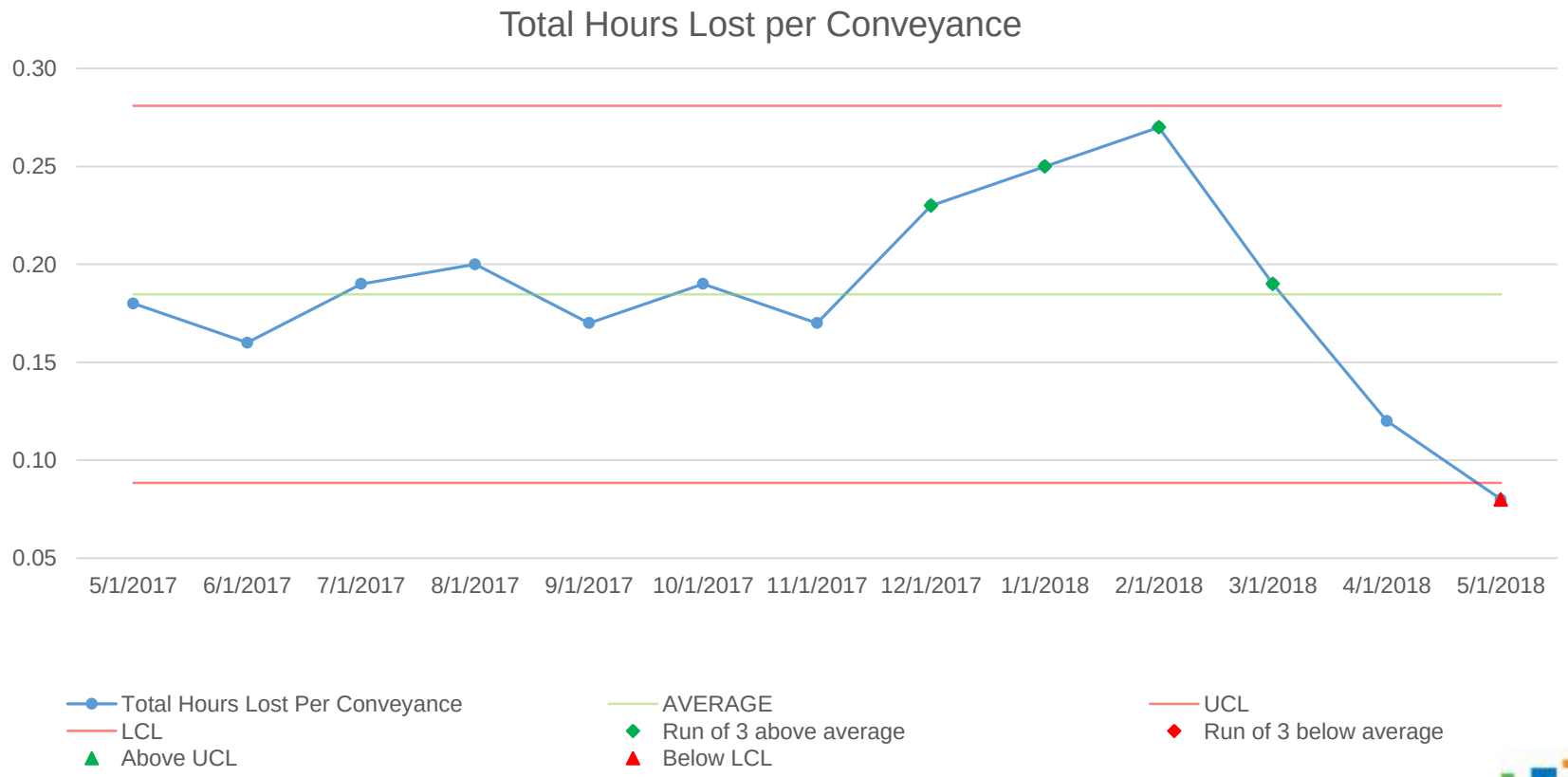


East Surrey – trend



Your service, your call

East Surrey – trend



SECAMB Board

QPS Committee Escalation report to the Board

Date of meeting	21 June 2018
Overview of issues/areas covered at the meeting:	Prior to the meeting, a sub-group of the committee met to review the risk register. The aim was to review all risks linked to the committee, to establish the extent to which the risks identified are relevant and up-to-date. The committee was assured that it has good visibility of the areas identified by each of the risks, specifically those rated high and extreme. There was one exception relating to the software that the Trust uses to analyse ECG downloads. The system is overdue an upgrade and the committee has asked for an update in July. Although there were no obvious gaps in the risk register, the committee did ask management to confirm whether all the risks are captured related to the 111 service. It was apparent that some risks were not up to date. Management is aware of this and taking corrective action. There were also a number of risks allocated to the committee that were related to resource / recruitment and to business continuity. These will be reallocated to the most relevant committee. Overall, this was a helpful exercise, which the committee will repeat every 6 months. In the interim, it will receive a regular high-level summary report relating to the relevant risks, which will include the BAF risks. The committee considered a number of ***Management Responses*** (*response to previous items scrutinised by the committee)*, including: **CFR Governance Partial Assurance** The committee received a very detailed response from management, setting out the governance framework for how the Trust engages with and supports community first responders (CFRs). Central to this is the appointment of a Head of Community Engagement. Much has been done to improve the governance in this area and the committee acknowledged the positive outcome of the assessment by the National Council of Voluntary Organisations (NCVO). NCVO determines if organisations meet the UK standard for quality volunteer management. The Trust met this standard, with some conditions. A re-assessment will take place in September 2018. Management is clear about the areas requiring further improvement. The committee will review progress in November 2018 and, in the meantime, asked for a risk to be added to the register relating to use of CFRs not up to date with training and / or practicing infrequently. **MDT Action Plan Review Assured** The committee reviewed the outstanding actions from this Serious Incident and was assured with the management oversight and scrutiny. A final closure report will be received in September.

Patient Experience Group **Assured**
Earlier in the year, a Governor asked about the priority given to the Patient Experience Group. The committee explored this and is assured that this Group is in place and an integral part of the management governance structure.

Safeguarding (internal) **Assured**
The committee sought assurance on the current review of pre-employment screening. Substantial progress has been made and there is management grip. The committee will receive a further update at its meeting next month.

Two annual reports were considered:

Accountable Officer for Controlled Drugs
The committee considered this review of the arrangements in place to manage controlled drugs during the past year, and noted the significant strengthening of medicines governance during this period.

The committee felt it was a very thorough report, which reflects the significant work done, and recommends it to the Board.

Infection Prevention and Control
The committee reviewed the steps taken over the year to improve infection prevention and control, as set out in the report. It asked management to make some relatively minor amendments to make areas clearer, but otherwise the committee recommends the report to the Board. The committee recognises there still remains challenges in this areas for 2018/19.

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;

External Safeguarding **Assured**
The committee scrutinised the controls in place for external safeguarding, specifically in how we are meeting our statutory obligations. There is good management grip and focus in this area, in particular with how we engage with safeguarding boards and ensuring staff are up to date with training.

999 NHS Pathways License Compliance **Assured**
This paper focussed on the requirements for NHS Pathways and our levels of compliance. Call audits has been a particular challenge during the year and the committee was assured that we are now on target to be 100% complaint from May 2018, resulting in the Trust being compliant with all license conditions.

The committee explored how feedback is provided following these audits to ensure quality improvement and noted the plan to redevelop the quality team model in EOC to ensure sustained improvement, with less reliance on support from 111. The challenge will be to sustain this and the committee will review compliance again in October 2018.

	Medical Equipment **Assured** The committee tested the metrics relating to management of medical devices. It has not been assured in this area for some time and so was really pleased that management is now able to demonstrate that 100% of all equipment in live operation is up to date with servicing. An issue was found with the adhesive on some labels, but the new Fleetman system can now be cross-referenced to evidence that the equipment has been serviced. This is great progress. An ongoing audit is now in place as business as usual. In light of this, the committee is assured by the system of control now in place. **Vehicle Cleanliness** **Partial Assurance** The committee received a good paper demonstrating via the dashboard that deep cleans are in place. However, the paper did not include the outcome of swab testing so the committee was unable to be assured with the effectiveness of the deep cleans. This will be covered at the meeting next month, via a management response.
Reports *not* received as per the annual work plan and action required	None
Changes to significant risk profile of the trust identified and actions required	None
Weaknesses in the design or effectiveness of the system of internal control identified and action required	None
Any other matters the Committee wishes to escalate to the Board	In July, the committee will be scrutinising the progress with patient care records. In advance of that, the meeting in June received a verbal update giving a good degree of assurance that management now truly understand the reasons why some PCRs cannot be reconciled with the CAD. The committee remains assured that records are not being lost and noted the openness with which management is approaching this long-standing issue

South East Coast Ambulance Service NHS Foundation Trust

Item No	49/18

Name of meeting	Trust Board
Date	28 June 2018
Name of paper	Accountable Officer for Controlled Drugs Annual Report
Executive sponsor	Dr Fionna Moore, Executive Medical Director
Author name and role	Carol-Anne Davies-Jones, Chief Pharmacist
Synopsis	This report sets out the arrangements in place for 2017/18 to help support the safe and effective management of controlled drugs.
Recommendations, decisions or actions sought	For Information

South East Coast Ambulance Service NHS
NHS Foundation Trust

Controlled Drugs Accountable Officer Annual Report 2017 – 2018

1. Introduction

1.1. This is the CDAO annual report prepared by South East Coast Ambulance Service (SECAmb). Health and social care organisations are responsible for making sure that they have arrangements in place to assure the safe and effective management of Controlled Drugs (CDs) and for making sure that these systems are working effectively. In addition, all healthcare professionals have a duty to ensure that Controlled Drugs in their own practice are managed safely

1.2. SECAmb is committed to continuing to improve and align its policies and procedures for the management of medicines including controlled drugs, to ensure that good practice is consistently applied across SECAmb and that all staff are aware of their responsibilities.

1.3. This report highlights the areas of improvement introduced within the past 12 months.

1.4. The CDAO for the Trust is the Executive Medical Director.

2. Background

2.1. In August 2012 the legislation covering medicines for human use was revised and consolidated into a new act – The HUMAN MEDICINES REGULATIONS 2012. This legislation updated the 1968 medicines act and incorporated various changes introduced by EU legislation together with all the updates and variations to the original act.

2.2. There is a degree of complexity surrounding the laws relating to medicines and CDs, but in general terms the main legislative points to note are:

2.2.1. The Misuse of Drugs Act 1971 (MDA 1971) .This act primarily covers the illegal use of drugs and provides a schedule system for classification of these drugs. This system of classification provides the courts with guidance on the maximum sentences to be imposed if this law is broken (Schedules A, B & C).

2.2.2. The Misuse of Drugs Regulations 2001 (MDR 2001) (and subsequent amendments). In response to the activities of Dr Harold Shipman legislative changes were introduced into the 2006 Health Bill strengthening the governance arrangements for Controlled Drugs in England. These arrangements were described in detail in the Controlled Drugs (Supervision of Management and Use) Regulations 2006. This regulation came into force in January 2007. The Controlled Drugs (Supervision of Management and Use) Regulations 2013 came into effect on 1 April 2014 and will cease to have effect at the end of 31st March 2020.

2.3. The two main provisions for ensuring safe management of CDs are:

2.3.1. The appointment of CD Accountable Officers (CDAOs), and

2.3.2. Sharing information between organisations, regulators and agencies through local intelligence networks (CD LINs).

2.4. The Misuse of Drugs Regulations 2001 defines those persons who are authorised to supply and possess controlled drugs while acting in their professional capacities, and describes the conditions under which these activities may be carried out. In these regulations consideration must be given to such activities as supply, possession, prescribing, audit and record keeping relevant to that particular drug

2.5. The controlled drugs (CDs) used within SECAmb are:

2.5.1. Morphine sulphate injection (Schedule 2)

2.5.2. Ketamine injection (Schedule 2)

2.5.3. Midazolam injection (Schedule 3)

2.5.4. Diazepam emulsion for injection (e.g. diazemuls) – (Schedule 4 part 1)

2.5.5. Diazepam rectal tubes (Schedule 4 part 1)

2.6. SECAmb manages all controlled drugs under the control levels required of Scheduled 2 Controlled Drugs. This is irrespective of which Controlled Drugs schedule they all under. This is to ensure increased control around Controlled Drugs activities within SECAmb. The only exception to this is Diazepam rectal tubes (Schedule 4 part 1).

3. Role of Controlled Drugs Accountable Officer

3.1. SECAmb as a designated body must appoint a Controlled Drugs Accountable Officer (CDAO) who is responsible for overseeing governance arrangements for management of CDs within SECAmb. The SECAmb CDAO is the Executive Medical Director, who is also a member of the Board.

3.2. The SECAmb CDAO must be registered with Care Quality Commission (CQC). The CQC must be informed when a SECAmb CDAO is removed and a new CDAO appointed.

3.3. The CDAO must ensure that all concerns about incidents that involve or may have involved improper management or use of CDs by a healthcare professional (or other staff, responsible individual or medical practitioner working on behalf of the trust) are properly recorded. This task may be delegated to an appropriate member of staff by the CDAO.

3.4. To ensure that SECAmb complies with all relevant legislation around the storage, supply and use of controlled drugs (CDs).

4. CQC Domains (Safe; Caring; Responsive; Effective; Well led)

4.1. Although controlled drugs are addressed under the CQC medicines management standards which are part of the 'safe' CQC domain, these also relate to all the other CQC domains.

4.2. CQC report published on 5th October2017 from their inspection in May 2017 identified inconsistent management of controlled drugs was compromising safety and security at SECAmb.

4.3. The medicines governance Phase 1 and 2 action plans identified areas for improvement in CD management and increased the governance and security around CD activity in the Trust.

4.4. The CQC scrutinise and report on how well NHS trusts and other agencies work together to ensure the sharing of intelligence/information on the safe management and use of controlled drugs by relevant people.

4.5. As part of this work the CQC publish their findings annually, together with recommendations on how the safe use and management of CDs can be improved

5. Controlled Drug License

5.1. The Chief Pharmacist renewed SECAmb Home Office Controlled Drugs license at the end of 2017. It was issued in February 2018. SECAmb have a named authorised witness on the license to supervise the destruction of CDs in accordance with regulation 27(3).

5.2. A T28 license was obtained for 38 sites in the Trust for denaturing of CDs in June 2017.

6. Management of Controlled Drugs

6.1. During 2017/18 the following SOPs were published to improve the safety, security and governance of controlled drugs.

6.1.1. Administration of Controlled Drugs

6.1.2. Controlled Drugs Possession Using Body Worn Pouches

6.1.3. Changing Security Codes for Medicines Storage

6.1.4. Controlled Drug Stock Checks and Reconciliation

6.1.5. Disposal of Controlled Drugs

6.1.6. Expiry Date Checking and Rotation of Medicines

6.1.7. Ordering and Distribution of Medicines (in draft)

6.1.8. Receipt of Medicines from External Suppliers (in draft)

6.1.9. Record Keeping and Controlled Drug Register Entries

6.1.10. Use of the Omnicell Emergency Access Barcode

6.2. Policies

6.2.1. The new Medicines Policy was approved in March 2018.

6.2.2. Controlled Drugs Policy (Trust wide consultation June 2018).

7. Internal Governance of the Management of CDs

7.1. Incident reporting (Datix)

7.2. Potential concerns are raised either directly with the Trust's CDAO or Chief Pharmacist or via reported medication incidents from the Trust's Datix database. The CDAO and Chief Pharmacist receive all CD incidents.

7.3. Concerns or issues around CDs relate to: (a) unaccounted for, (b) governance, (c) patient-related incidents or (d) an individual or particular concern.

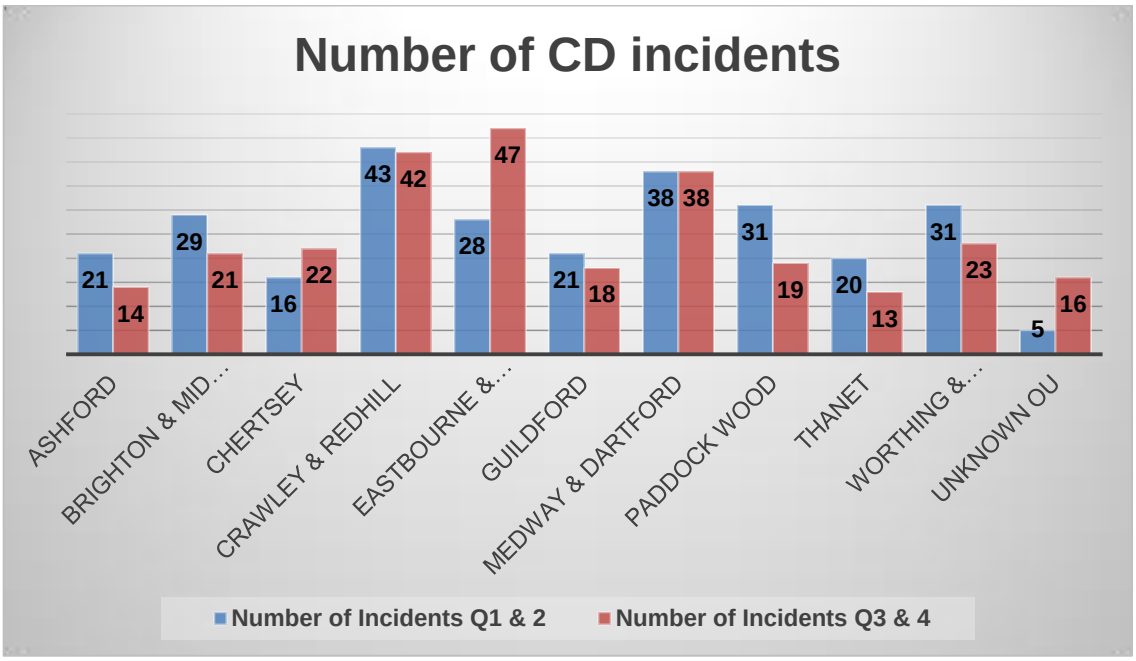


Figure 1 Total Number of CD incidents reported comparing Q1 & 2 vs Q3 & 4

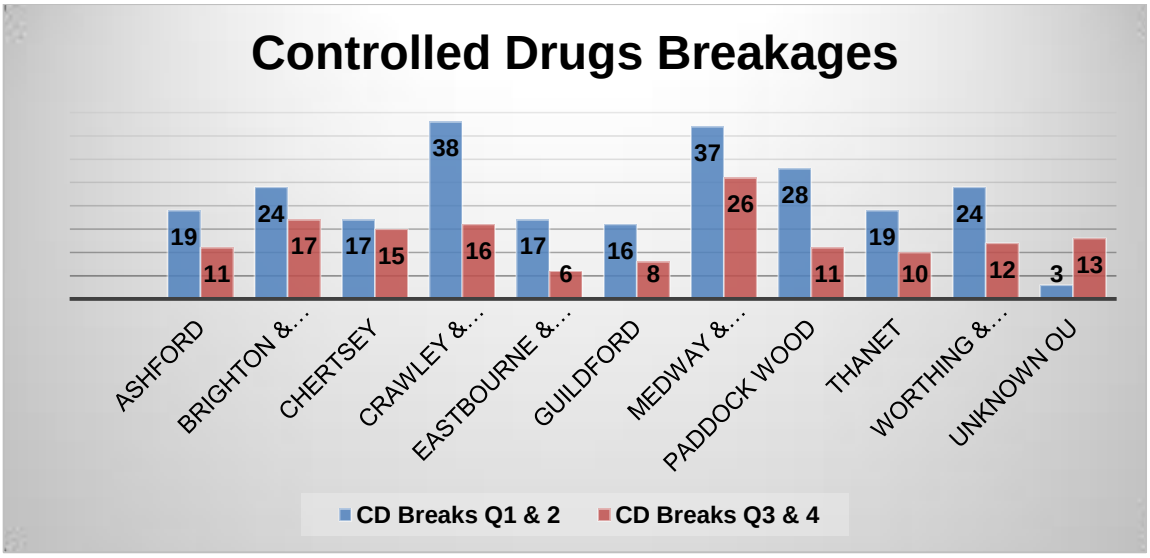


Figure 2 Number of CD Breaks reported as a comparison between Q1 & 2 vs Q3 & 4

Q1 & 2 - Apr-Sep 2017/18 Incidents					
	OOD	**Drug Recording Error**	**Other CD Errors**	**Administration errors**	**Single signatures**
Ashford	1	4	1		
Brighton & Mid Sussex		3	2	1	30
Chertsey				1	
Crawley & Redhill		2	1	1	
Eastbourne & Hastings	4	2	5		
Guildford		3	3	1	29
Medway & Dartford		2	3		32
Paddock Wood		1	5		3
Thanet	2		1		
Worthing & Chichester			7		
Unknown OU			1		13
	7	**17**	**29**	**4**	**107**

Table 1 The number of CD incidents during Q1 & 2

Q3 & 4 - Oct-Mar 2017/18 Incidents					
	CD's Taken Home	Doop / Wastage Errors	Other CD Errors	Administration errors	Single signatures
Ashford	0	2	0	1	0
Brighton & Mid Sussex	0	3	1	0	10
Chertsey	0	4	3	0	0
Crawley & Redhill	9	10	7	0	48
Eastbourne & Hastings	10	13	18	0	0
Guildford	2	4	4	0	48
Medway & Dartford	3	5	4	0	44
Paddock Wood	3	3	2	0	0
Thanet	1	1	1	0	0
Worthing & Chichester	2	8	1	0	11
Unknown OU	1	1	1	0	0
	31	**54**	**42**	**1**	**161**

Table 2 The number of CD incidents during Q3 & 4

7.4. The graphs and tables above show the number of IWR-1s submitted during 2017 – 2018. Table two above shows the positive impact that the additional governance and SOPs put in place in September 2017 had on CD incidents and breakages.

7.5. Q1 and Q2 only Omnicell sites reported on single witness signatures due to use of Omnicell emergency barcode. During Q3 and Q4 the operating team leaders now report on single witness signatures from non-Omnicell sites.

7.6. Broken Controlled Drugs

7.6.1. There has been a significant reduction in CD breaks seen across the year. Figures three and four are a comparison showing before and after the new medicines governance systems were implemented.

7.6.2. There is a 31% reduction in CD breaks in Q3 and Q4. This is due to the implementation of CD belt worn pouch and improved governance.

7.6.3. Figures three and four show higher number of breakages this is due to the system of reporting, an IWR-1 would be classed as one incident, however if a Pelicase (CD secure storage) was dropped this could incur 2 – 3 broken vials.

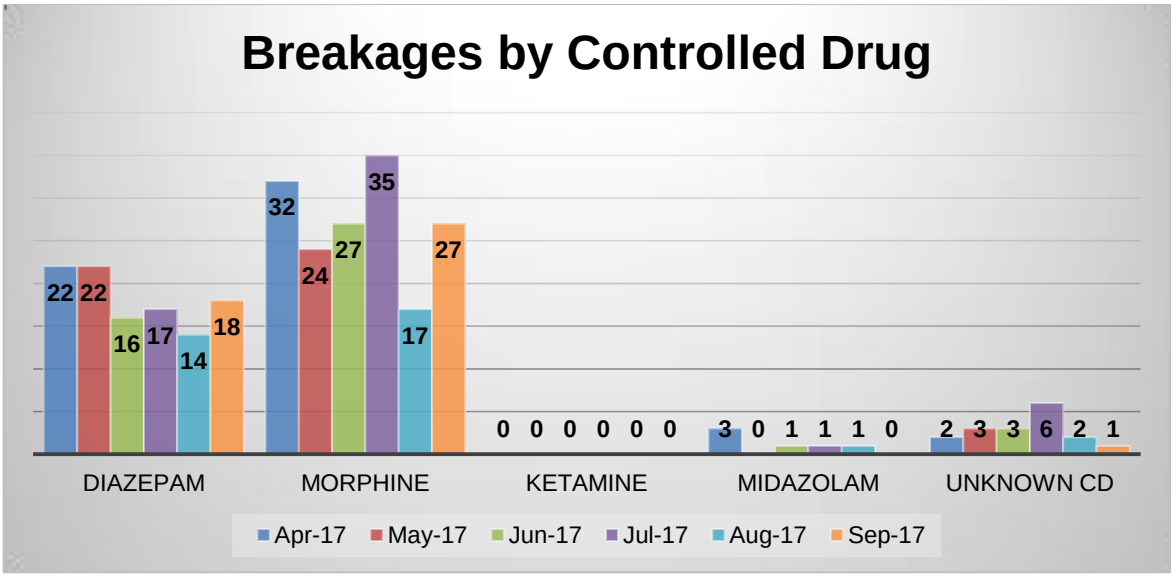


Figure 3 Q1 & 2 Breakages by Controlled Drug type

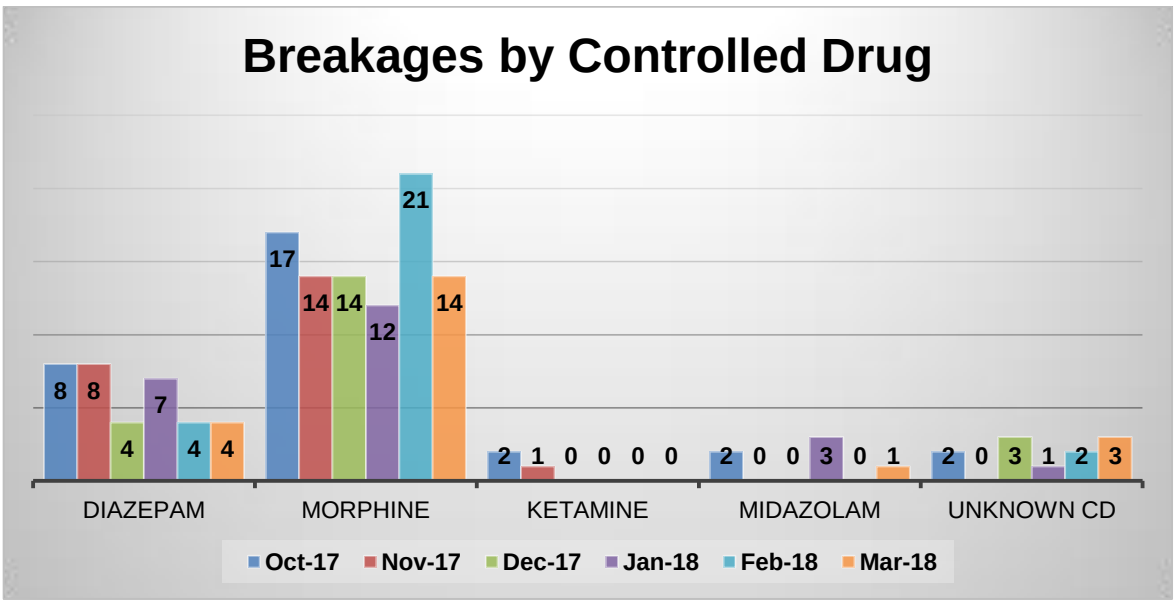


Figure 4 Q3 & 4 Breakages by Controlled Drug type

7.6.4. New personal CD pouch system implemented in October 2017. This is a new process and a significant change in practice. Some staff have inadvertently taken their CDs home in their pouch. These incidents are recorded as incidents and followed up by local managers. Medicines governance team monitoring for repeat offenders.

7.6.5. Increased governance and monitoring around single signatures on CD registers. Medicines Governance administrator monitors all single signatures on Omnicell sites use of emergency barcode. 161 single signatures across the Trust were recorded for Q3 and Q4 2018/18 due to this increased governance around management of CDs.

7.6.6. The quantity of morphine issued to each Paramedic was reduced from 40mg to 20mg on 20 April 2017.

7.6.7. The unknown CD category refers to an incident that has been reported where the CD name was not included in the report.

7.6.8. The Medicines Governance Group meets monthly, CD reports are presented at each meeting, examples of these reports can be found in **Appendix A**.

7.6.9. An example of an administration error recorded was where a crew were responding to an End of life Care (EoLC) patient and took a verbal order for Midazolam. This was incorrectly understood and the patient got the incorrect dose.

7.6.10. During September 2017 SOPs were introduced around the safe and secure management of CDs. An example of CD incidents now reported and recorded is around the recording of the wastage of CDs after administration (see table 2 for incidents around wastage/DOOP). These are all monitored in the weekly Operational Team Leader audit checks.

7.7. Lessons Learned

7.7.1. On 06 February 2018 DATIX was updated to incorporate a drop down box to identify those incidents where CDs were involved, this change allowed the Trust to accurately report CD incidents.

7.7.2. During quarter three 2017/18 the Trust introduced body worn CD pouches, to help reduce the number of CD breakages. It also physically separated the antidote to opiates which was previously carried in the same container.

Figure 5: Body worn CD Pouch

7.7.3. Track & trace for all quantities of CDs

7.7.4. Waste reduction and stock holding reviewed

7.7.5. Increased governance around non-Omnicell sites in relation to single signatures. During OTL weekly checks the single signatures are reported to

medicines team. For Omnicell sites OTLs must report back on all emergency barcode use in relation to single signatures.

7.7.6. Medicines policy now includes a section on verbal orders and instructs staff not to accept verbal orders of CDs. It is registered Paramedics only that administer CDs to our patients.

7.7.7. Each 'unauthorised' single signature is recorded as a Datix incident and investigated for ALL sites.

8. External Governance of the Management of CDs

8.1. Role CD Local Intelligence Networks (CD LINs)

8.1.1. Local agencies are required to share information and intelligence about the use of CDs in the health and social care sector. The CD LIN allows for sharing of information across several organisations including the Care Quality Commission and the police. This provides access to a network where particular concerns can be discussed

8.1.2. SECAmb CDAO reports to the CDAO for NHS England (Kent, Surrey and Sussex) via quarterly reports and attendance at the Controlled Drugs (CDs) Local Intelligence Network (LIN) meetings

8.1.3. The Medicines Governance team compile a quarterly occurrence report. The occurrence report should contain details of any concerns that the ambulance Trust has regarding its management or use of CDs; or confirmation that it has no concerns to report regarding its management and use of CDs.

8.1.4. Copies of the quarterly reports to the CD LIN can be found in the **Appendix B**.

8.2. Role Police Controlled Drugs Liaison Officer (CDLO)

8.2.1. The Police Controlled Drugs Liaison Officer (CDLO) may carry out unannounced spot checks of CD reconciliation.

8.2.2. There is a record of 10 unannounced CDLO visits for 2017/18 across the Trust

8.2.3. The Chief Pharmacist contacts the CDLO for all incidents involving missing CDs for investigation.

8.3. National Benchmarking

8.3.1. This is not able to be shared widely due to the confidential nature of the data and the permission to share the data has not been granted by individual organisations. This data is shared with the Ambulance Pharmacist Network (APN).

8.3.2. Historically the Trust has had the largest number of CD breakages. In March 2018 we were showing improvement in this area. We will continue to monitor and improve in this area through regular reporting through MGG and communications to Operational staff.

9. Auditing of CDs

9.1. Quarterly Medicines Inspections

9.1.1. The Medicines Governance inspection reviews the safe and secure handling of CDs. **Appendix C**.

9.1.2. Reconciliation checks of all CDs, this looks at activity (sign in/out) and administration.

9.2. OTL weekly audits

9.2.1. The checks which include the safe and secure handling of CDs are completed weekly using the App on their trust issued iPAD and collected across the Trust by the Quality Improvement Hub.

9.3. Unannounced CDLO Inspections

9.3.1. The CDLO will produce a standard report from an unannounced visit for the CDAO and Chief Pharmacist

10. Recommendations

10.1. The Quality and Patient Safety Committee is assured that Controlled Drugs (CDs) are managed to a safe level within SECAmb and comply with the CD regulations. SECAmb needs to continue to be vigilant in its governance of CDs and ensure their safe and appropriate clinical use and to continue to make improvements.

10.2. CD Consumption data (easy on Omnicell, shortfall for non Omnicell)

10.3. Review of SOPs in September 2018

10.4. An audit of safety and effectiveness of analgesia in the Trust is planned for 2018/19. This includes CDs.

10.5. Medicines governance team to work with PowerBI team to create a dashboard on reporting of CD data Trust wide.

Appendices

Appendix	Title	Document
A	Medicines Governance Monthly CD Report	 MGT Report for MGG Dec 2017 V2.1  MGT Report for MGG Jan 2018 V2.1  MGT Report for MGG Feb 2018 V2.1  MGT Report for MGG Mar 2018 V2.1
B	Quarterly CD LIN Reports	 CD Lin report Q1 2017-18.doc  CD Lin report Q2 2017-18.doc  NHS England Occurrence Report  NHS England Occurrence Report
C	Quarterly Medicines Inspections	 Quarterly Medicines Governar

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

June 2018

Taking Pride | Striving for Continuous Improvement | Acting With Integrity | Demonstrating Compassion and Respect | Assuming Responsibility

Contents

SECAmb CQC Rating and Oversight Framework

Use of Resources Metric (Financial Risk Rating)	1
Segmentation	Segment 4 (Special Measures)
IG Toolkit Assessment	Level 2 - Satisfactory
REAP Level	3

Chart Key

Data Point	This represents the value being measured on the chart
Run of 3 above average Run of 3 below average	These points will show on a chart when the value is above or below the average for 3 consecutive points. This is seen as statistically significant and an area that should be reviewed.
Above UCL Below LCL	When a value point falls above or below the control limits, it is seen as a point of statistical significance and should be investigated for a root cause.
AVERAGE	This line represents the average of all values within the chart.
UCL LCL	These lines are set two standard deviations above and below the average.
Target	The target is either and Internal or National target to be met, with the values ideally falling above or below this point.

SECAmb Executive Summary

This report provides an update to the Trust Board in the areas of Clinical Safety, Clinical Quality, Operations 999 and 111, Workforce and Finance. The report should be read in conjunction with the Trust Delivery Plan and supporting narrative. The Trust Board will note that contemporary performance information relating to response time is provided to Board members on a weekly basis and discussed with commissioners with this frequency.

Further work with commissioners is being undertaken to ensure that triangulation between operational response times (long waits) and the risk of harm and complaints is underway.

As has been requested, a greater level of detail has been provided under the workforce section showing the detailed planning and implementation of improvement work. As of June, the Trust has detailed trajectories by OU showing the planned workforce mix by the six key frontline roles – i.e. ECSW, Technician, NQPs, Paramedics, PPs, and CCPs. Our Resourcing plans will be planned to the corresponding level. As we track progress against the trajectory we will also be tracking attrition, moves and sickness at this level too so that we can manage the plan accordingly.

CQC Must do and Should do items continue to be included for reference and work is in progress to demonstrate to commissioners that an effective and controlled handover / transition from project status to Business As Usual including the continuation of risk management. The forecast dates for projects that will be transitioning into BAU shortly is as follows:

Incident Management – there are still some gaps in project closure documentation so date for project closure not yet confirmed
Medical Devices – seeking approval at Compliance Steering Group on 3 July 2018 for project closure
Risk Management – this project is proposed to go through project closure and any uncompleted activities will be transferred to the new Governance and Risk Task and Finish group which meets for the first time tomorrow
Performance and AQI –project closure approved at Compliance Steering Group on 19 June 2018
Governance and Health Records and Clinical Audit – seeking approval at Compliance Steering Group on 3rd July 2018
Medicines Governance – there are still some gaps in project closure documentation so date for project closure not yet confirmed

SECAmb Our Patients

Call recording continues to be monitored weekly. The system remains stable with a very small number of conjoined or fragmented calls, making identification difficult, but no lost 999 calls and no issues found when interrogating the recordings.

Call answering is improving with a much more robust recruitment plan and better retention. We remain below the national target but the number of long waits is continuing to decrease.

Our response times to the most unwell patients in Categories 1 and 2 remains above the national average. Performance for categories 3, 4 and calls to Health Care Professional referrals remains challenged, despite improvements in hospital handover times freeing up resources.

A project to improve survival from out of hospital cardiac arrests, based on recommendations from the Global Resuscitation Alliance, is focussing on areas highlighted in ‘A Call to Action’.

Other areas focussing on patient care include infection prevention and control, medicines governance, and improved maternity advice to patients and support within the Control Rooms.

SECAmb Financial Performance

The Trust has achieved its planned deficit of £1.0m for the month of April.

The Trust is forecasting delivery of its control total for the year of £0.8m deficit.

The Trust achieved a Cost Improvements of £0.4m in line with plan. The target for the full year is £11.4m.

The Trust’s Use of Resources Risk Rating (UoRR) is a 3, in line with plan.

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.

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: All Patient Clinical Records (PCRs) are now validated on arrival at the scanning department (the backlog has been cleared). Since the Trust moved to a 4 digit CAD number (on 18th April), the percentage of unreconciled PCRs has fallen to 12.2%, as expected and is now in line with national figures.

Medicines Management: A review of the medicines pouch system is underway. Although this system has advantages, it is time consuming, resource intensive, and prone to tagging errors (inconsistent tagging of partially used pouches). Operational Team Leaders (OTLs) continue to regularly audit medicines management at Operating Unit (OU) level, demonstrating high levels of compliance (>95%). Quality Assurance Visits (announced and unannounced) provide further evidence of compliance. Temperature monitoring is undertaken daily at all sites, with central monitoring through the OTL checks. Whilst effective, this is also 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 December 2017 performance (national three month data lag to enable the attainment of outcome data (survival to discharge) from hospitals and validation of the national returns to the Department of Health.

The data now reflects national changes in the Quality Indicators dataset, with only confirmed STEMIs and Strokes being included (using data submitted as part of the Myocardial Infarction National Audit Programme (MINAP) and SSNAP (stroke) projects). The number of patients in each group is small, leading to month on month variation in performance. In terms of annual performance, the Trust is generally just below the national average for both indicators; however an improvement on last years data is evident. Reduced performance in the December data is thought to be reflective of the increased pressures on both call taking and operational performance.

The care bundles for Stroke and STEMI tell a similar story. Changes to national reporting requirements will result in the Trust continuing to report monthly data internally, however only one month's data will be reported in the national figures.

SECAmb Clinical Safety - Responsive

Demand management: : The Trust introduced the Surge Management Plan (SMP) 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. The most recent version of the SMP was circulated on 26/06/2018.

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.

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)

	Oct-17	Nov-17	Dec-17	12 Month's
Actual %	50.0%	51.2%	27.8%	
Previous Year %	48.1%	46.9%	48.6%	
National Average %	55.1%	47.4%	46.5%	

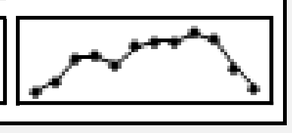
Cardiac ROSC - ALL

	Oct-17	Nov-17	Dec-17	12 Month's
Actual %	25.2%	24.1%	20.7%	
Previous Year %	27.8%	25.1%	28.5%	
National Average %	30.2%	28.5%	28.1%	

Cardiac Survival - Utstein

	Oct-17	Nov-17	Dec-17	12 Month's
Actual %	30.8%	32.5%	14.7%	
Previous Year %	15.4%	4.8%	8.8%	
National Average %	28.3%	27.3%	23.2%	

Cardiac Survival - All

	Oct-17	Nov-17	Dec-17	12 Month's
Actual %	10.9%	9.9%	6.0%	
Previous Year %	4.3%	2.4%	3.7%	
National Average %	10.2%	8.3%	7.1%	

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

	Oct-17	Nov-17	Dec-17	12 Month's
Actual %	57.4%	70.6%	71.8%	
Previous Year %	63.1%	67.6%	62.8%	
National Average %	76.4%	76.0%	77.6%	

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

	Oct-17	Nov-17	Dec-17	12 Month's
Mean (hh:mm)		02:11	02:19	
National Average		02:12	02:18	
90th Centile (hh:mm)		02:45	02:59	
National Average		02:58	03:07	

Stroke - call to hospital arrival

	Oct-17	Nov-17	Dec-17	12 Month's
Mean (hh:mm)		01:08	01:12	
National Average		01:13	tbc	
50th Centile (hh:mm)		01:01	01:04	
National Average		01:06	tbc	
90th Centile (hh:mm)		01:38	01:49	
National Average		01:49	tbc	

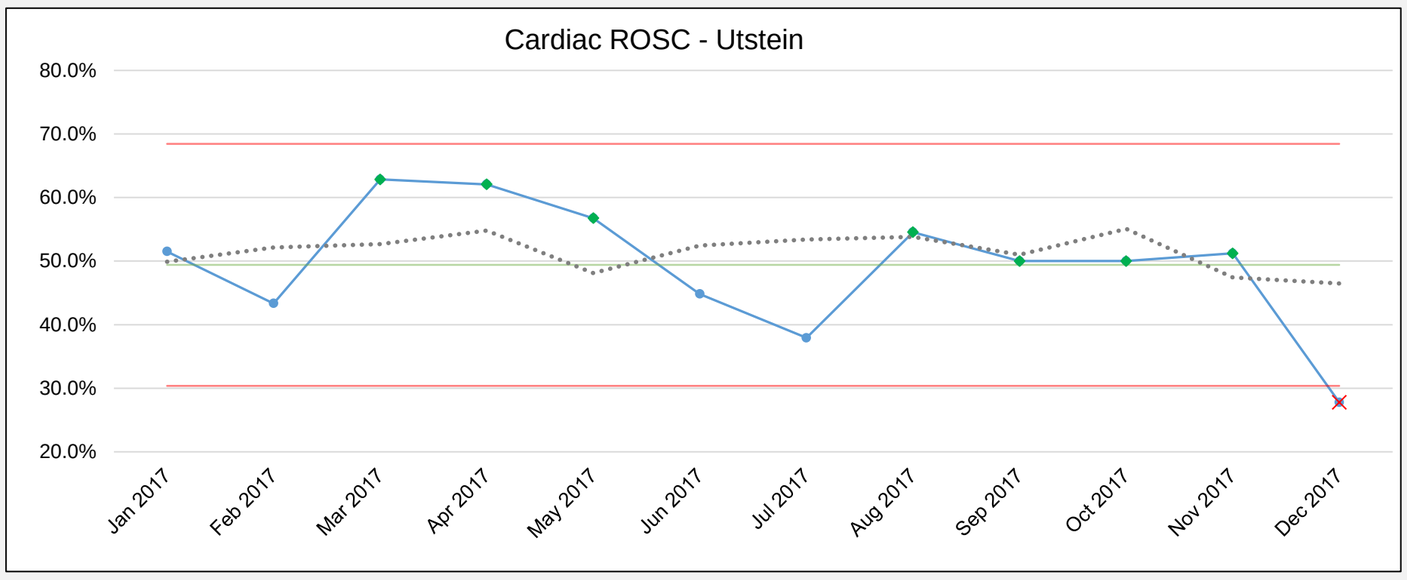
Stroke - assessed F2F diagnostic bundle

	Oct-17	Nov-17	Dec-17	12 Month's
Actual %	93.5%	96.2%	95.2%	
Previous Year %	95.4%	96.3%	95.6%	
National Average %	97.1%	97.0%	97.2%	

Medicines Management

	Feb-18	Mar-18	Apr-18	12 Month's
Actual	97.57%	97.50%	97.81%	
Number of audits	190	201	190	

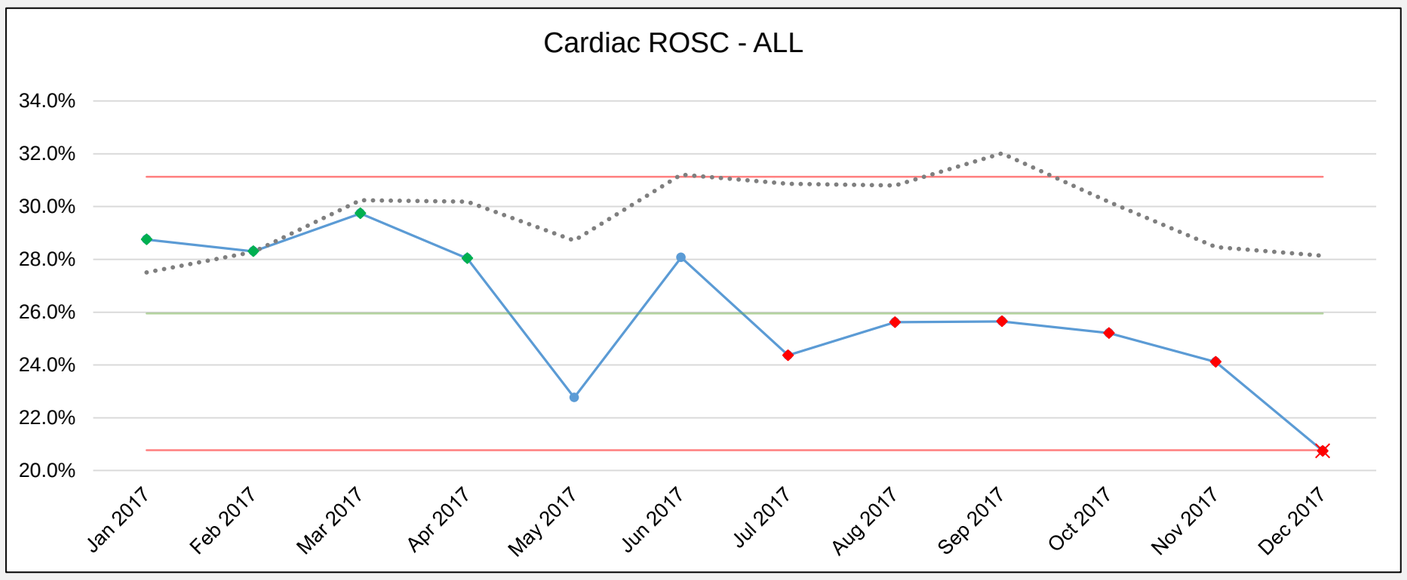
SECAmb Clinical Safety Charts



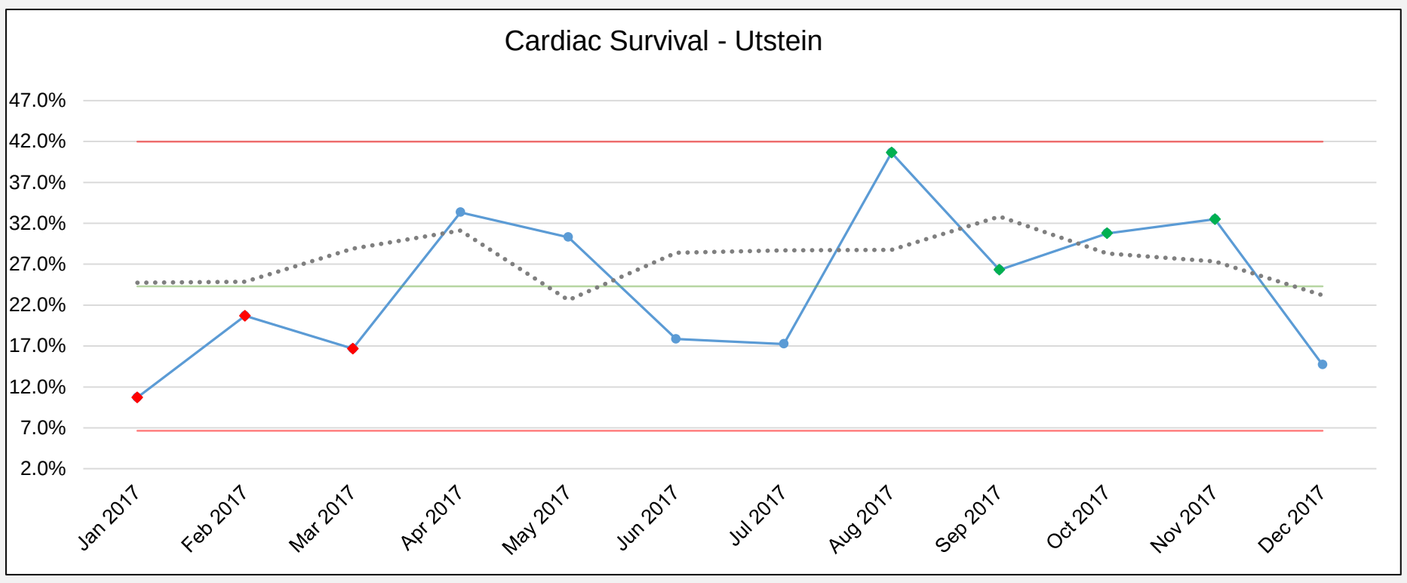
Performance for the cardiac arrest ROSC indicator for the Utstein group for December 2017 is below the SECAmb YTD and the national average. It is also outside of the expected levels of month to month variation.

It is suspected that this is due to heavy demand and delayed response times in the time period.

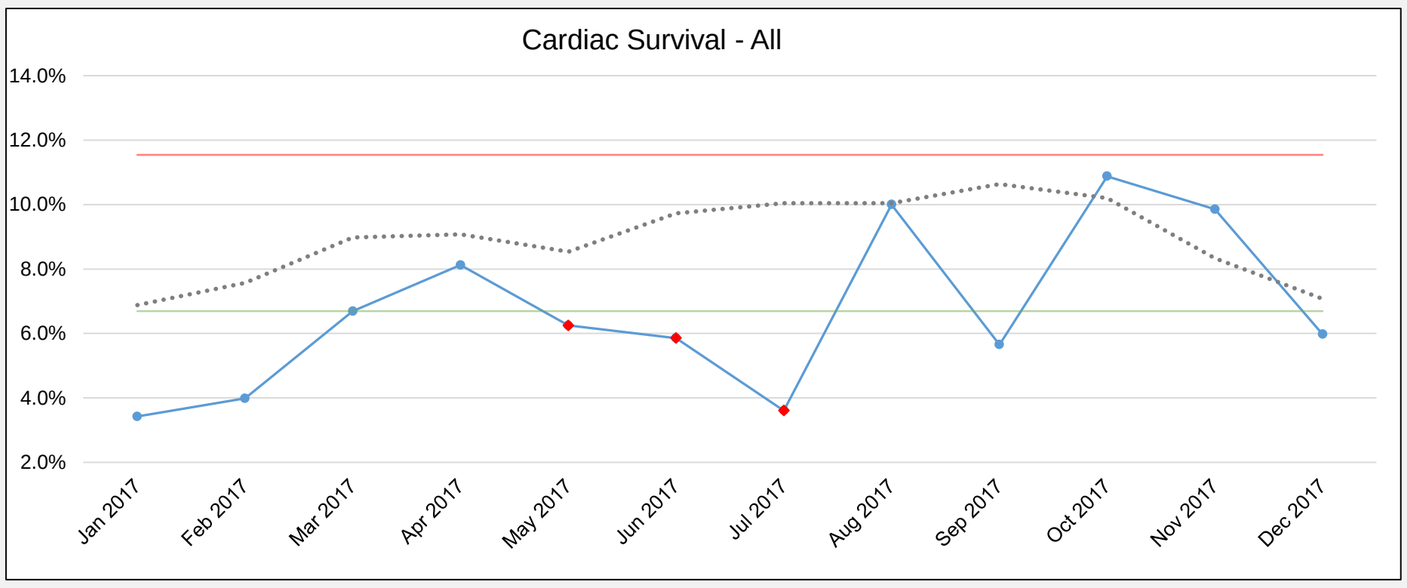
The medical directorate has allocated a senior clinician to lead on the Trust's cardiac arrest survival improvement programme from May to July initially. Areas of focus include improving call answering time, developing a standardised debriefing process and producing a standard operating procedure for resuscitation.



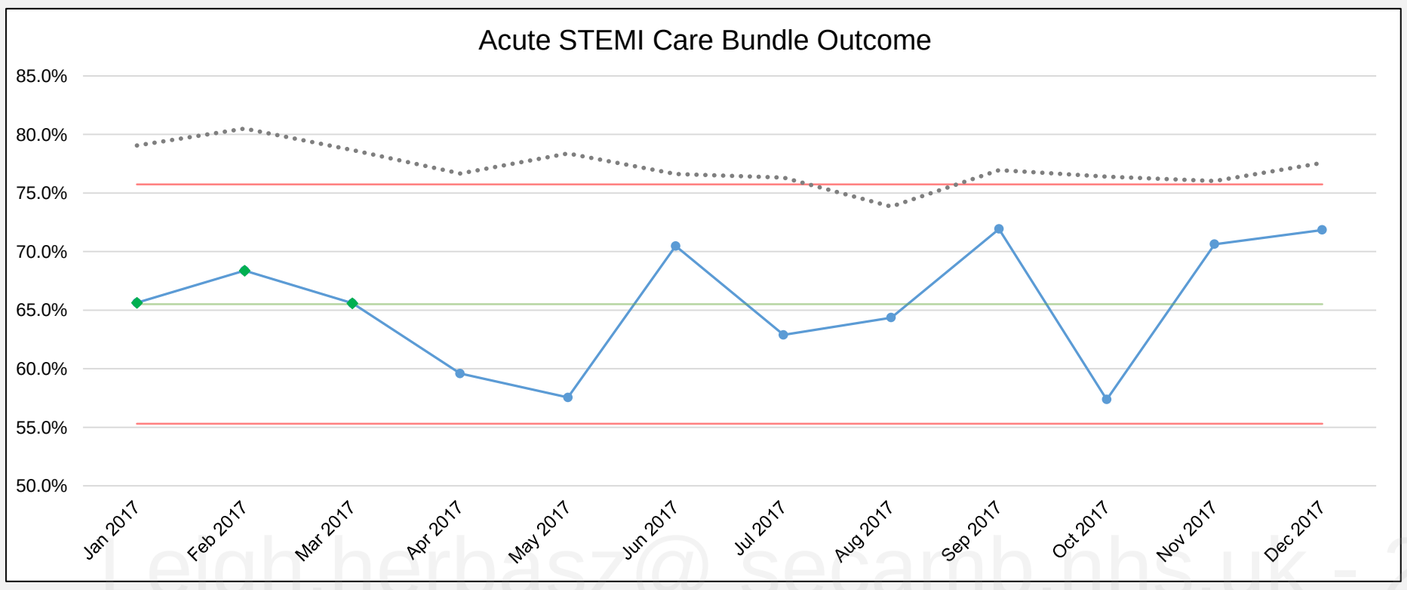
In December 2017 our performance for ROSC in all patient groups remains below the SECAmb YTD average.



In December 2017, survival to discharge for the Utstein group was below the SECAmb and the national average. The data continues to show normal patterns of variation.



In December 2017, our survival for all cardiac arrest patients was below the SECAmb and the national average. This appears to be in line with normal patterns of variation.

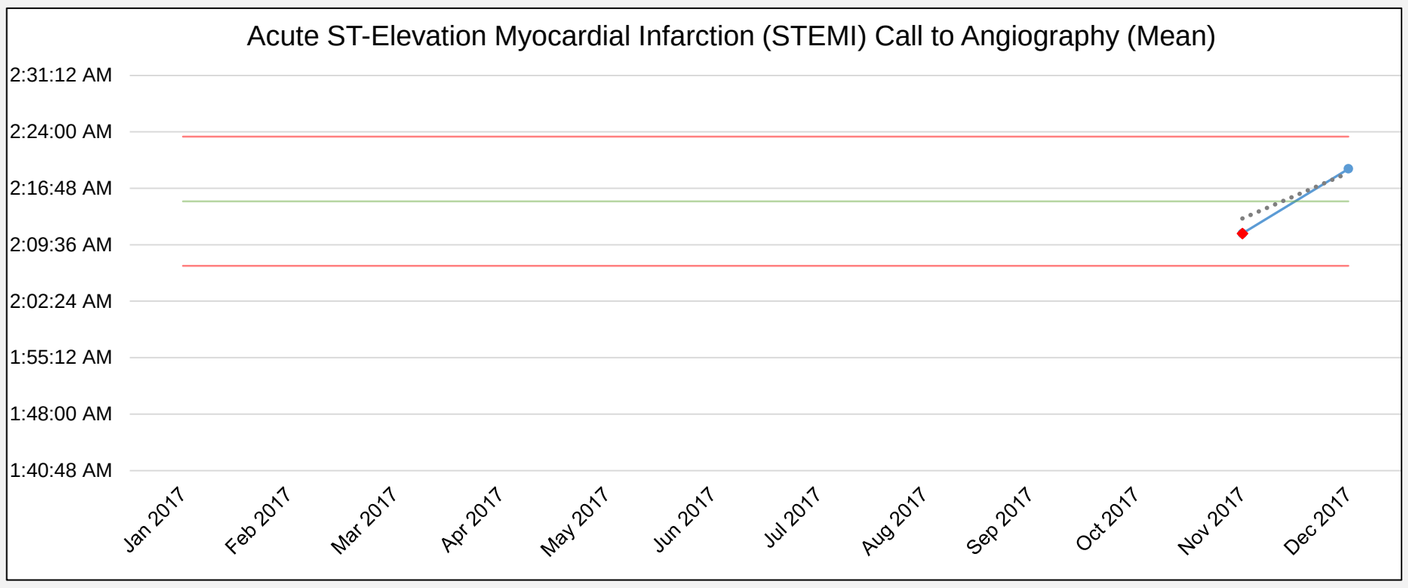


Performance for December 2017 was above the national average.

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.

Focussed improvement work is planned for operating units whose average performance is outside of the expected parameters.

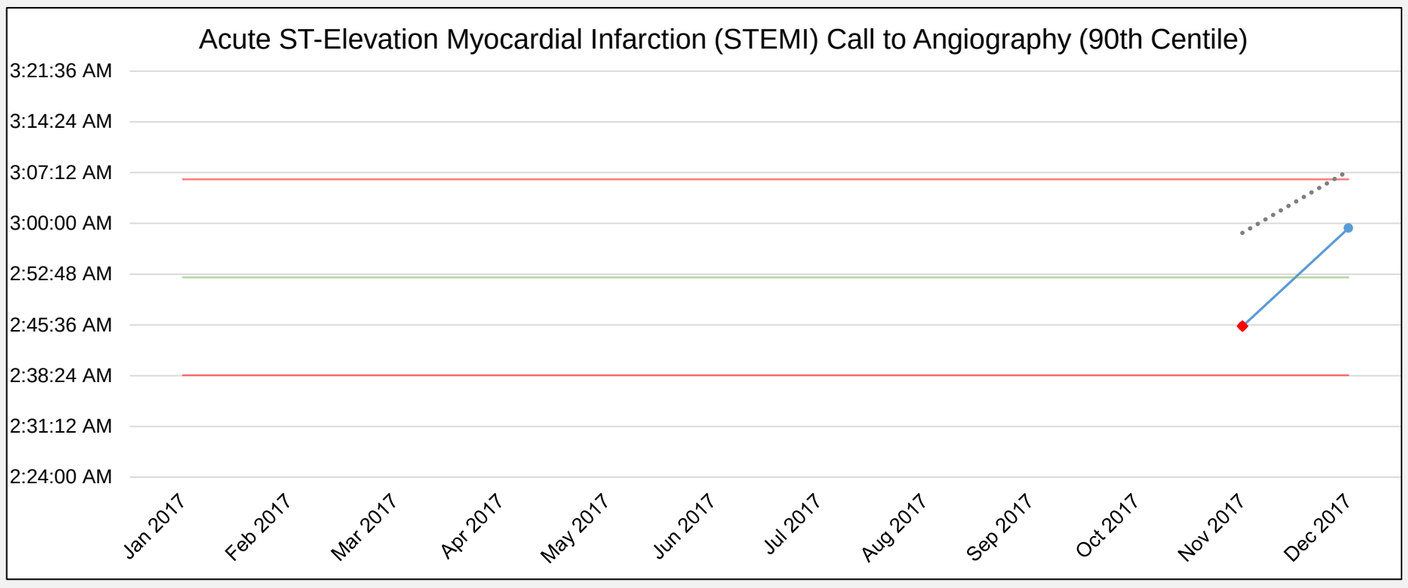
SECAmb Clinical Safety Charts

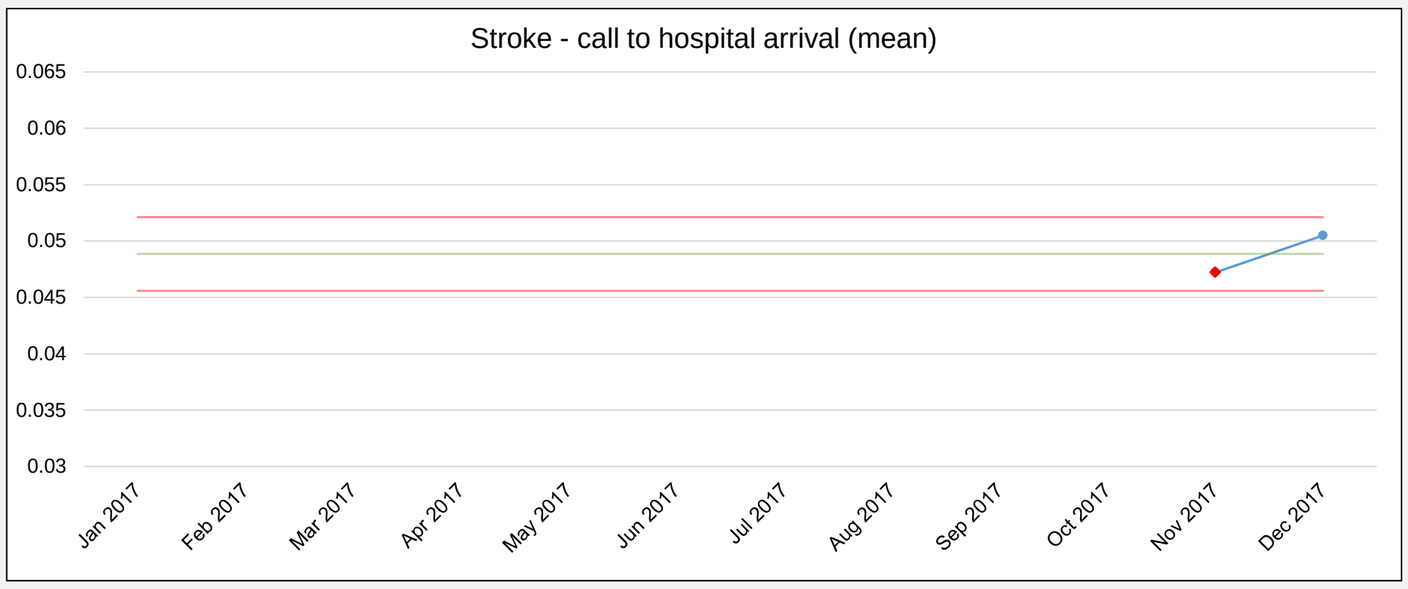


In November 2017 the method for measuring the timeliness of care delivered to STEMI patients changed to a measure of mean and 90th centile call to angiography (the procedure used to visualise the blood vessels that supply the heart).

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.

Mean performance is in line with the national average. Our 90th centile performance is below the national average. Which sows that stroke patients that SECAmb care for tend to receive more timely stroke care.



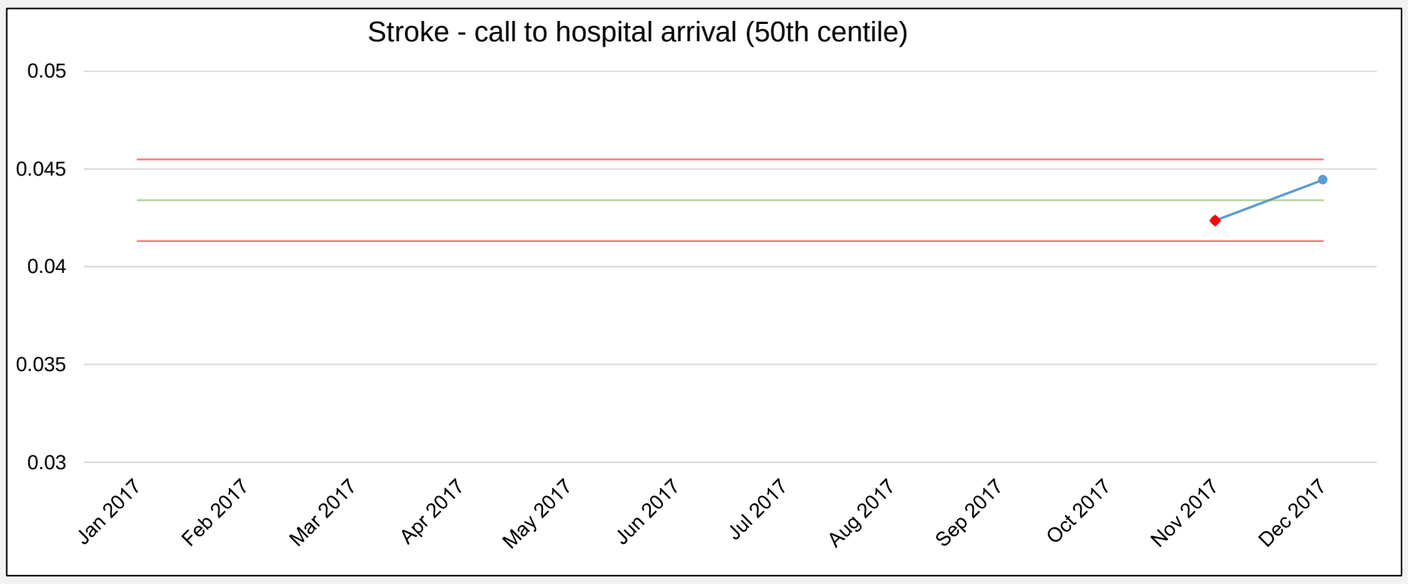


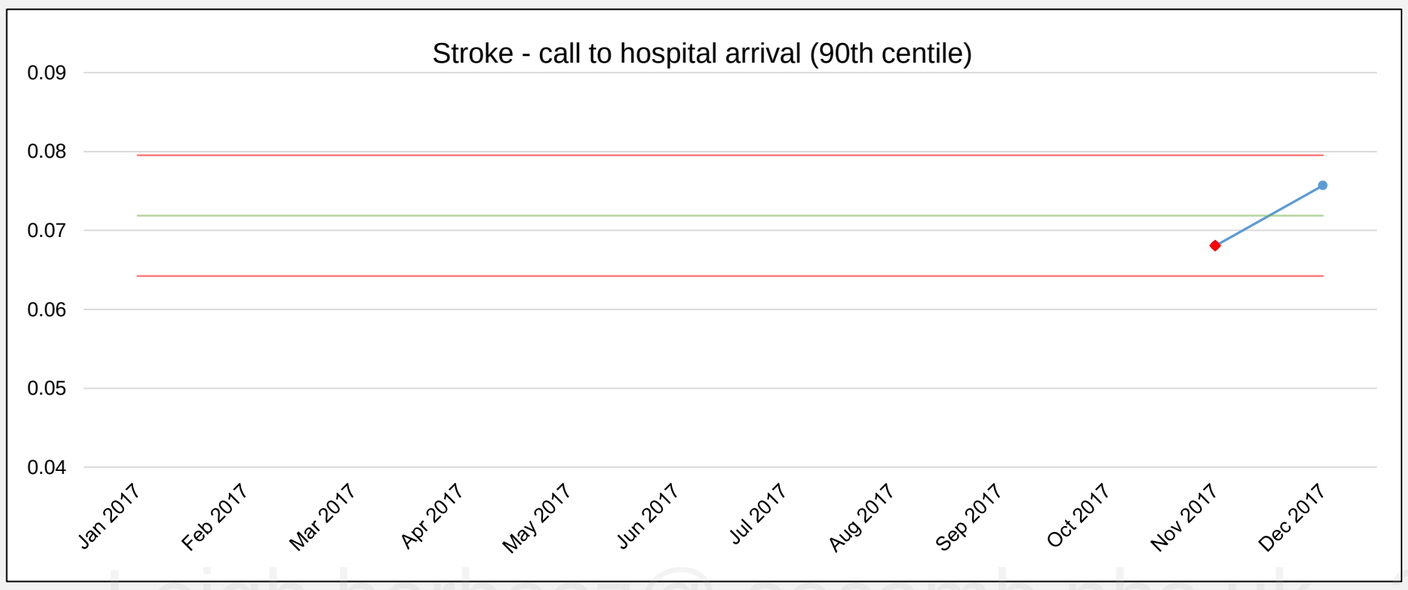
In November 2017 the method for measuring the timeliness of care delivered to stroke patients changed to a measure of mean and 90th centile call to arrival at a hyper-acute stroke centre.

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.

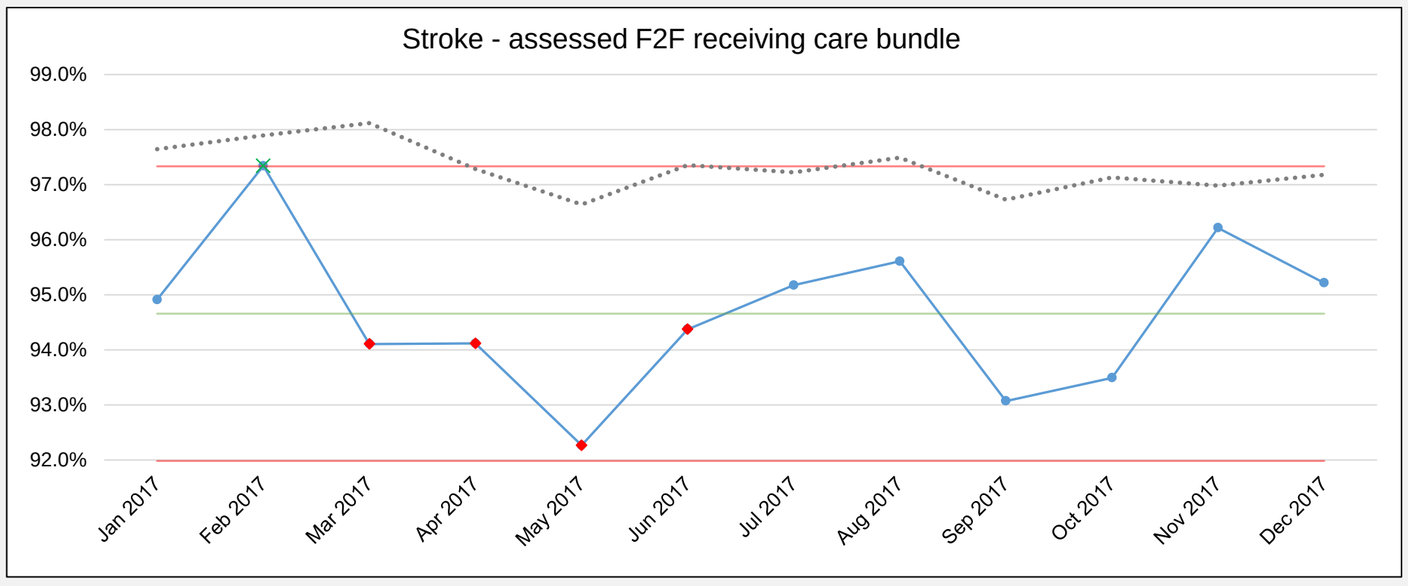
SECAmb performance is in line with the national performance.

Please note: December National data for the following 3 charts will be available with January 2018 data according to the NHS E data release.





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.

Focussed improvement work is planned for operating units whose average performance is outside of the expected parameters.

Analysis of Cardiac Arrest Data – December 2017

Total number of cardiac arrests identified = 778

Number of resuscitation attempts = 323 (41.5%)
(excluding DNACPR 62 / DOA 379 / Hospital transfer 1 / No Resus by SECAmb 8 / Post arrest 5)

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

Cardiac Arrests (Utstein incs) = 36 (11.1%)

Cardiac Arrests (All incs) = 323 (100%)

ROSC sustained to hospital (Utstein)
= 10 (27.8%) + 4 non ROSC

ROSC sustained to hospital (All)
= 67 (20.7%) + 15 non ROSC

Outcomes for ROSC at hospital and non ROSC at hospital patients		
Utstein	Details	Overall
5	Patient survived to discharge	19
7	Patient died in hospital	58
1	Patient still in hospital*	1
1	Outcome unknown* (Patient identifiable data incomplete)	4

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

Survival to Discharge (Utstein) = 5 (14.7%)

Survival to Discharge (All incs) = 19 (6.0%)

Additional Information – Resuscitation Attempts

Cardiac Rhythm	Overall Totals	ROSC at Hospital	Non ROSC at Hospital
Asystole	176 (54.5%)	19	7
PEA	66 (20.4%)	17	0
VF	68 (21.1%)	26	8
Non-shockable	2 (0.6%)	0	0
Not recorded	11 (3.4%)	5	0

CPR Bystander – 200 (61.9%)

EMS Witnessed arrest – 38 (11.8%)

Cardiac Arrest downloads received for Dec-	10 continuous reports to be checked for resus attempt
Cardiac Arrest download reports sent to crew	0

SECAmb Clinical Quality - Safe

Incident reporting onto DATIX incident reporting continues to increase as per the plan. The increase in April is primarily due to the central logging of incidents identified on the Quality Assurance Visits.

The most reported incidents were regarding medicines management issues (ampule breakages and medicines storage issues).

Hand hygiene audits remain overall above 90%

SECAmb Clinical Quality - Caring

The Trust received less complaints in April (93) compared to March (112) which is a continuous decline since February. 31 of the complaints were in respect of poor staff behaviours which is a slight increase from last month's 28.

13 complaints were identified as 'complaints in respect of triage' and 10 of these related to 111.

SECAmb Clinical Quality - Effective

Make Ready Centre (MRC) deep clean (DC) rates have improved to 99% following the substantive recruitment to staff establishment.

The revised Infection Prevention Ready Policy has been circulated to staff for consultation, and is scheduled for approval at the forthcoming JPF meeting.

SECAmb Clinical Quality - Responsive

The Trust continues to achieve complaints responses consistently above 90% since February as per the plan. Current performance is 98%.

100% compliance with of Duty of Candour within the internal target time of 10 days continues.

SECAmb Clinical Quality - Well Led

NRLS reporting remains consistent at 107. 536 incidents were closed during April.

SECAmb Clinical Quality Scorecard

Number of Incidents Reported

	Feb-18	Mar-18	Apr-18	12 Month's
Actual	591	627	721	
Previous Year	465	495	545	

Number of Incidents Reported that were SI's

	Feb-18	Mar-18	Apr-18	12 Month's
Actual	6	12	17	
Previous Year	5	6	5	

Duty of Candour Compliance (SIs)

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

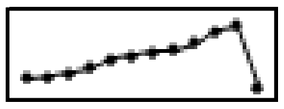
Number of Complaints

	Feb-18	Mar-18	Apr-18	12 Month's
Actual	127	112	93	
Previous Year	96	87	71	
Complaints Timeliness (All	98.2%	97.7%	97.9%	
Timeliness Target	95%	95%	95%	

Compliments

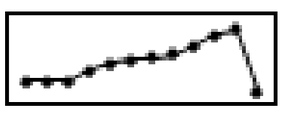
	Feb-18	Mar-18	Apr-18	12 Month's
Actual	139	123	133	

Safeguarding Training Completed (Adult) Level 2

	Feb-18	Mar-18	Apr-18	12 Month's
Actual %	85.66%	94.62%	6.33%	
Previous Year %	89.07%	90.90%	0.44%	
Target	85%	85%	85%	

*** Safeguarding training is completed each financial year, which explains the significant drop for April 2018**

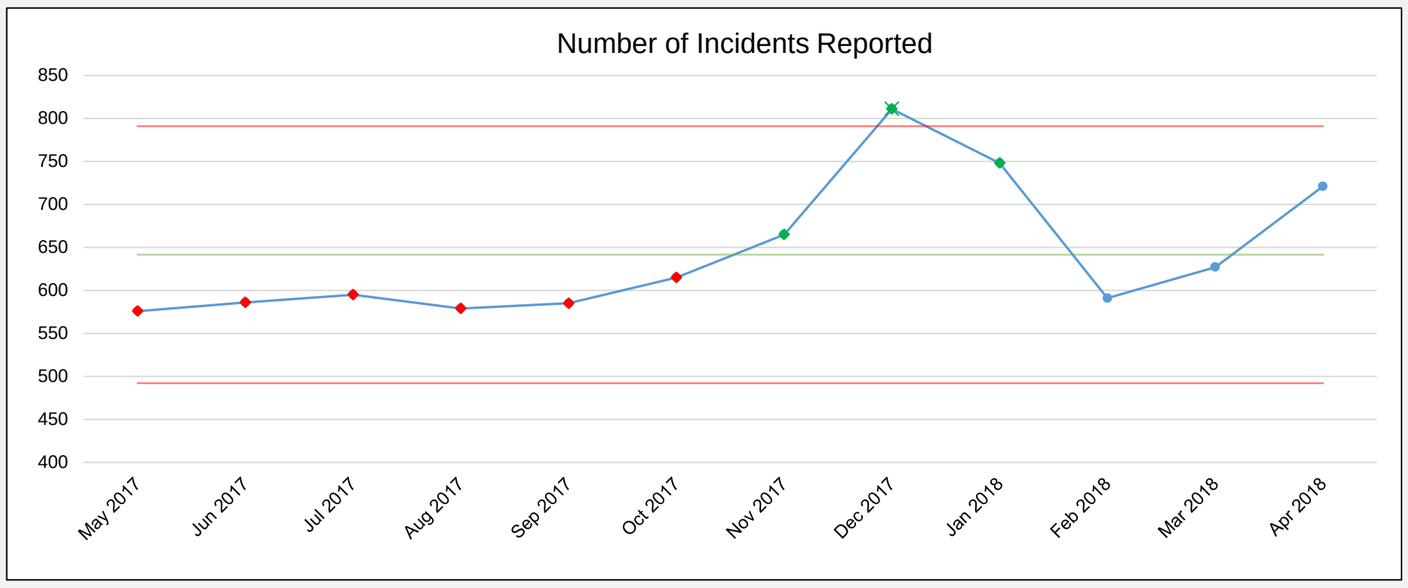
Safeguarding Training Completed (Children) Level 2

	Feb-18	Mar-18	Apr-18	12 Month's
Actual %	84.36%	93.99%	6.51%	
Previous Year %	89.79%	9170%	0.56%	
Target	85%	85%	85%	

Hand Hygiene

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

SECAmb Clinical Quality Charts

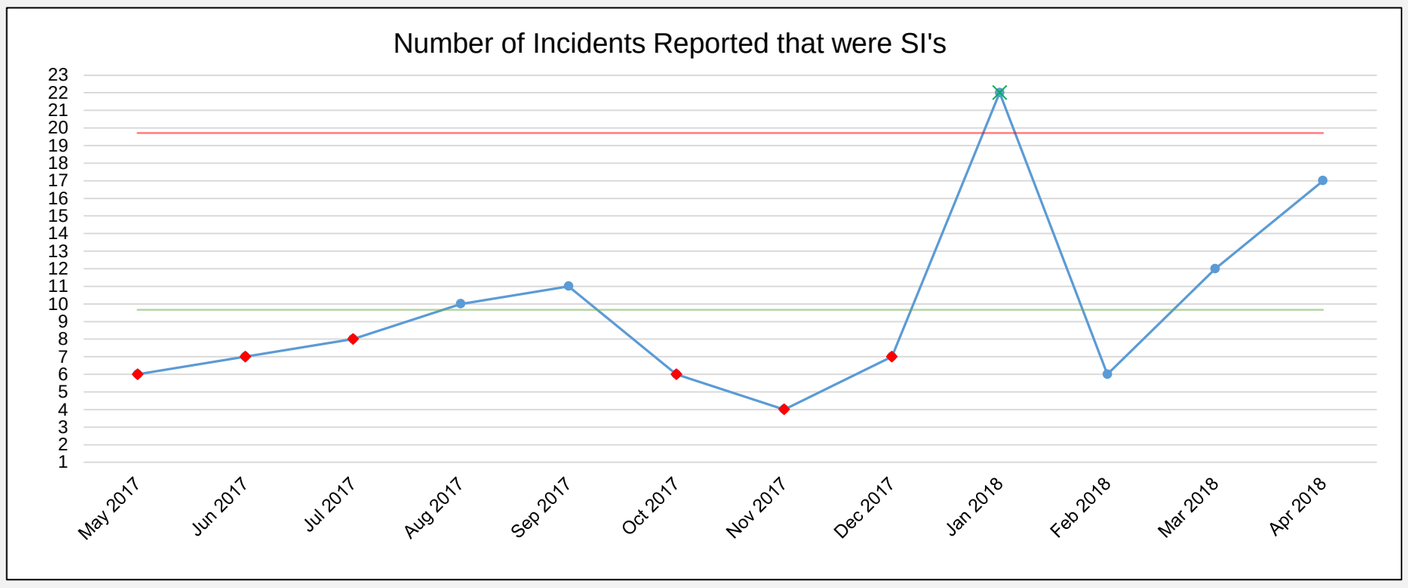


There were 721 incidents reported in April.

April figures were helped by the inclusion of Quality Assurance Visit which are reporting on their visits to sites with potential issues with Health and Safety, Medicines, Equipment and other categories being flagged on Datix.

The most reported incident were around medicine error in which 61 were reported across the Trust. These were mainly for ampoule breakages/storage of drugs. In terms of operating units Polegate & Hastings reported the most with 106.

The Trust reported 107 incidents to NRLS in April 2018. Following on from this the Trust closed 536 records in April.

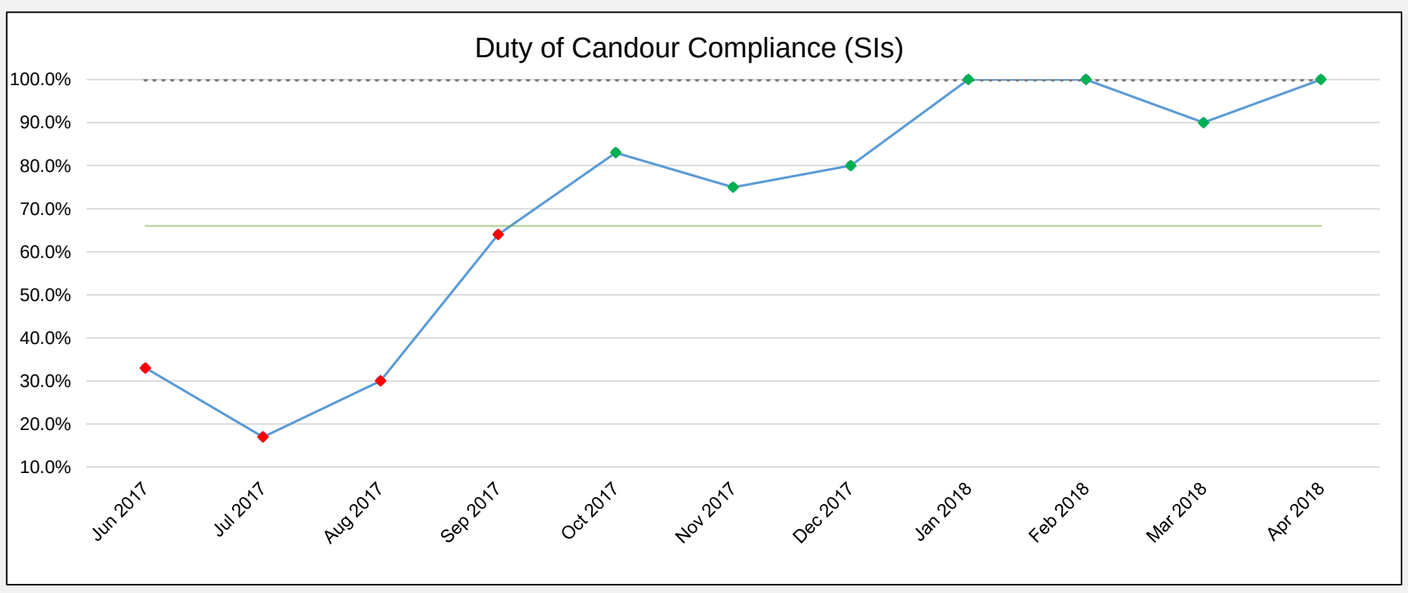


17 Serious Incidents reported this month.

Reasons for reporting:	
Triage/call management	4
Delayed Attendance	3
Patient Care	3
Staff conduct	2
Call answer delay	1
Contractor Issues	1
IT systems	1
Information governance	1
Delayed attendance / Call answer delay	1

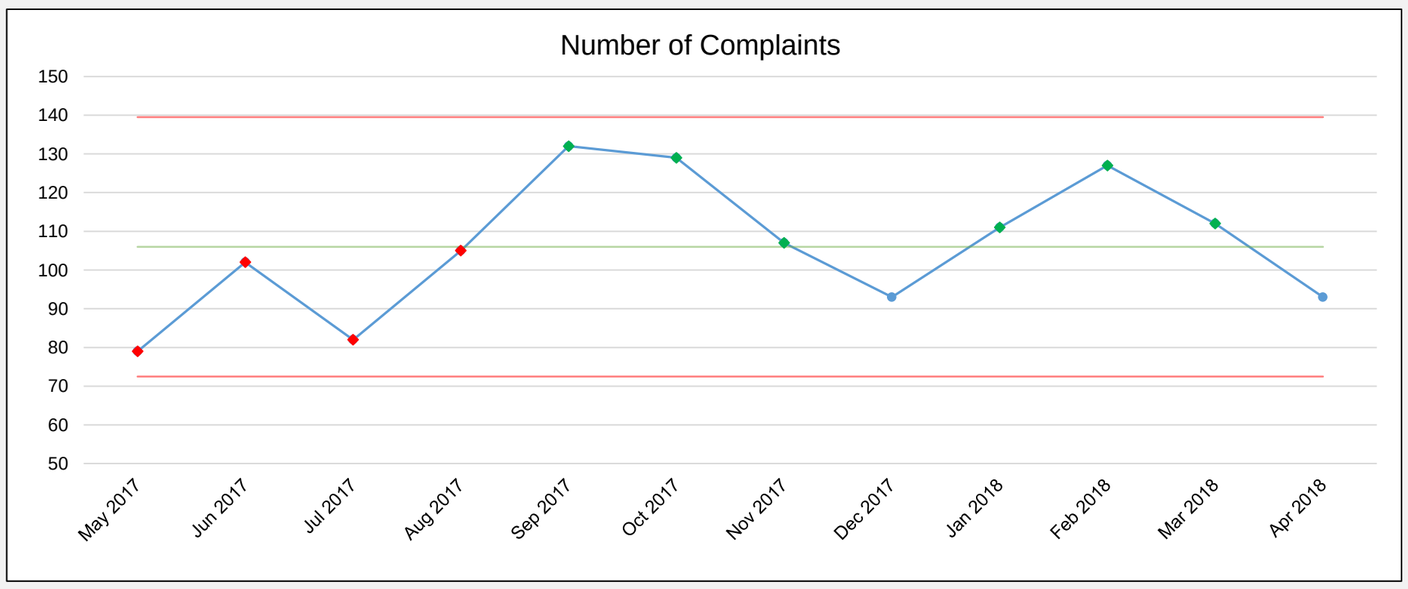
Lead Service Areas are:

A&E - Ops	4
EOC	6
Finance (IT)	1
HR	2
KMSS111	3
Quality & Safety	1



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

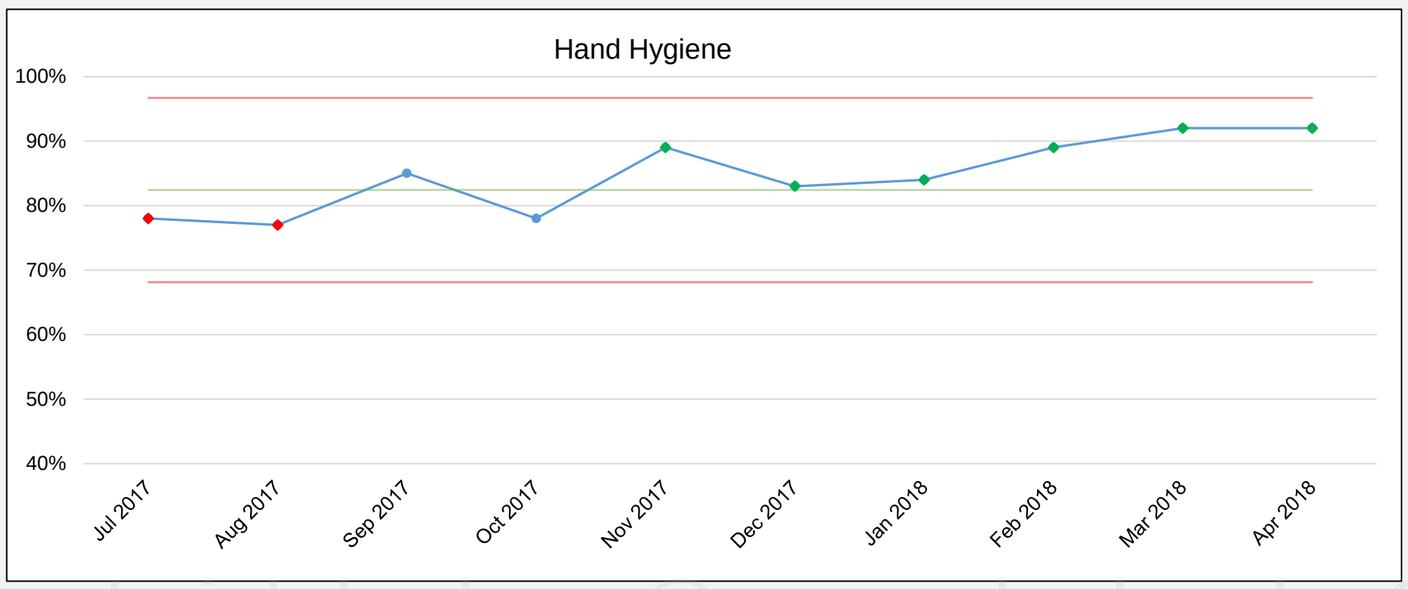
100% for those SIs requiring Duty of Candour were completed this month. All were within the Trust's internal 10 day deadline.



The Trust received and opened 93 complaints in April 2018, compared to 112 in March and against a monthly average of 104 for the year 17/18.

The subjects with the highest number of complaints for SECAmb in April were timeliness and staff behaviours, with 31 complaints each, compared to 45 and 28 respectively in March. 'Patient care', which includes triage (Pathways) as well as care provided by our clinical field ops staff, received the third highest number of complaints with 24, and of these, 13 were about call triage with 10 relating to NHS111 and three relating to EOC.

In April 97.91% of complaints were responded to within timescale, and the Trust has concluded in excess of 90% of complaints within timescale each week since the beginning of February.



Infection Prevention & Control (IPC) is now RAG rated AMBER due to the improvements in hand hygiene / Bare Below the Elbows compliance and Deep Clean (DC) completion at MRCs. Hand Hygiene (HH) and Bare Below the Elbows (BBE) compliance is still being audited using observational audit tools by local OTL's and IPC Champions and we have seen compliance targets met once again for both HH and BBE. The IPC Lead has instructed his team to carry out some audits of their own to compare to some of the OU's that are showing 100% compliance. The MRC DC rate is above the 99% target this month, which is the first time since the staffing levels were reviewed and staff put back into the system. Vehicle Preparation Programme (VPP) is just below the target, but this was due to some of the vehicles due a DC being off road.
The main concern for April was the lack of environmental audits completed. The IPC Team will be speaking to local OTL's and IPC Champions and looking for improvements during May.
A new risk has been placed on the Trusts Risk Register, which describes the need to have a central data base for staff vaccination history. This has come about following recent measles contamination incidents and we have had to exclude two staff for 21 days already. The risk will be jointly managed by HR and the IPC Team for resolution.
The Task and Finish Group for IPC is working well and the third draft of the IP Ready Procedure has now been shared with Staff Side and the Senior Operations team for comment.

SECAmb Health and Safety Reporting

Introduction

Following interviews, we have appointed a Head of Health and Safety who starts on 16th August having completed pre-employment checks. This new role will enhance our H&S team allowing greater strategic oversight and freeing up the H&S managers to work more closely with our front line staff. In the interim period, we have appointed an interim who will start on the 2nd July.

Our external report has now been finalised and will form the basis of a focused improvement plan. It will be shared with the CHSWG on the 20th June and a small task and finish group will be set up to work on the plan, initially with the interim Head of H&S.

The Central Health and Safety Working Group on the 20th June will focus predominantly on risks and RIDDOR.

A second IOSH for Directors course took place in May and there is a final one planned for August where ROMs and the Head of Fleet and Head of Estates will be attending to embed the importance of a safety culture.

The first Patient and Staff safety leadership walk round will take place in July which will allow Board members and senior managers to consider safety issues first hand, engage with front line staff and managers and will also provide an opportunity for OU teams to ask any strategic questions they may have.

Violence and Aggression Incidents - See Figure 1 below
We have seen an increase in reports over the last two months which will require further analysis by our security manager. This may be related to warmer weather and increased alcohol consumption.

Manual handling Incidents - See Figure 2 below

Manual handling incidents have fallen each month this calendar year and in April fell below the trend line for the first time since November. By default these will be relatively low harm as they are not RIDDOR reportable. The plan to allow Community First Responders to access DATIX directly did not work due to an issue with the SECAmb firewall. The DATIX team are now going to implement a paper form for CFRs, private providers and co-responders as an alternative.

H&S incidents - See Figure 3 below

The sharp rise in reported H&S incidents is as a direct result of learning from the Quality Assurance Visits (QAV). Following each visit all issues found are now added to DATIX by the QAV coordinator to ensure they are captured. This will then be used to encourage greater reporting of low and no harm issues by the local teams rather than relying on QAVs, which can be discussed at area forums to share learning.

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

RIDDOR reporting is an area where we need to improve our compliance with HSE regulations as we continue to miss the 15 day reporting deadline. We will look for a solution that allows the QI hub to monitor on a weekly basis. A direct notification from GRS has not yet provided us with the early notification that we had hoped for.

Figure 1

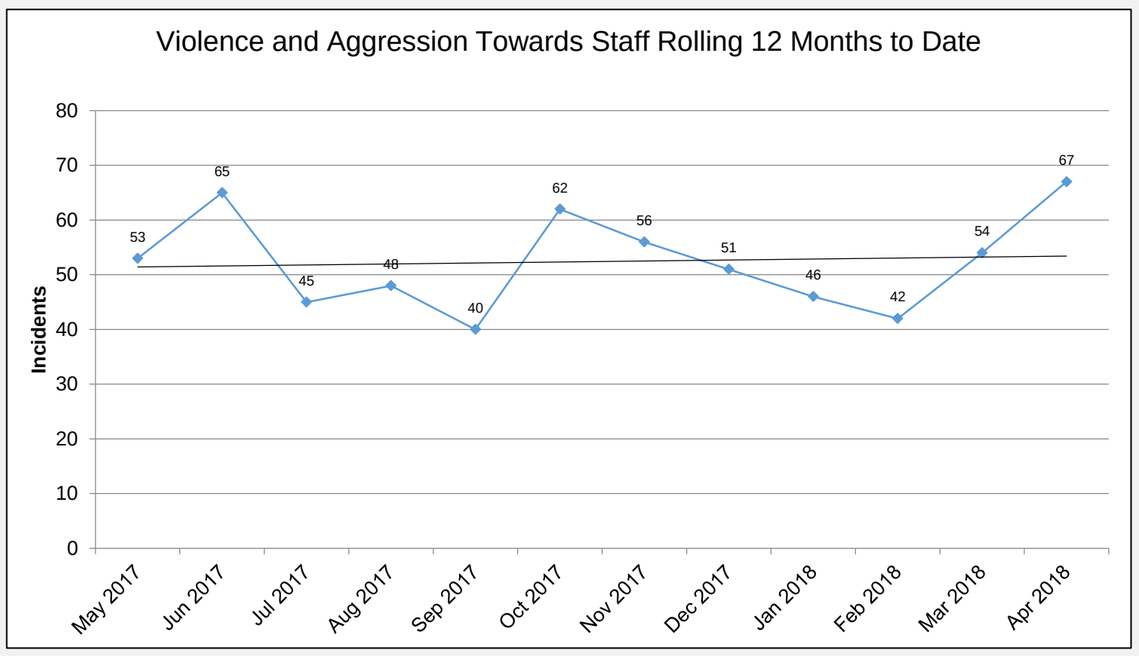


Figure 2

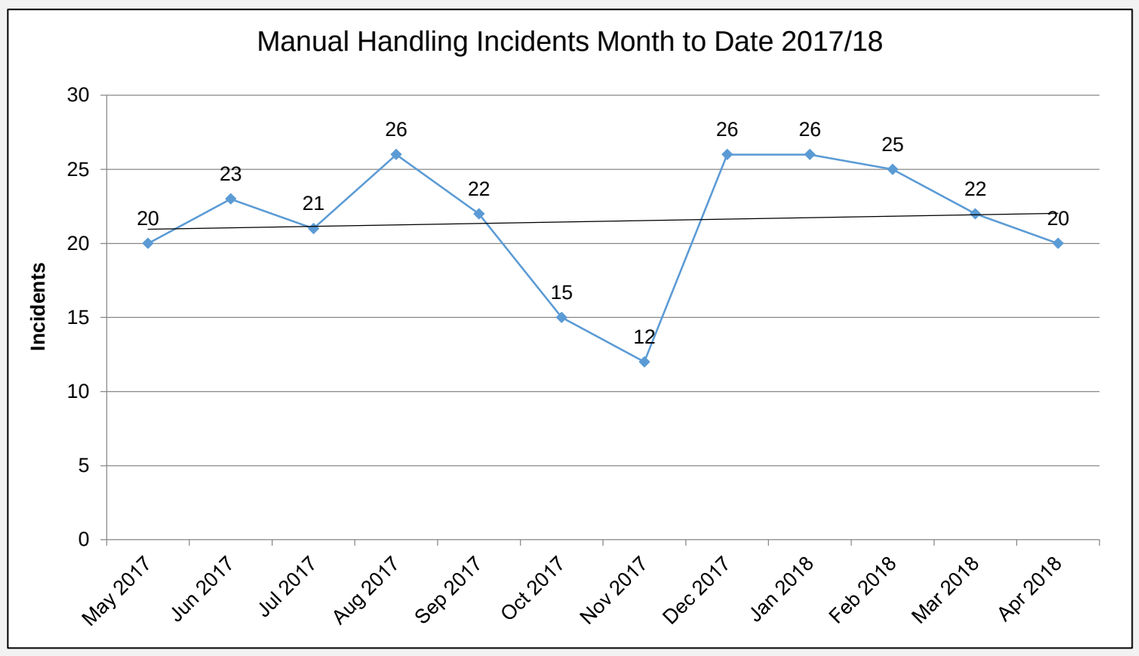


Figure 3

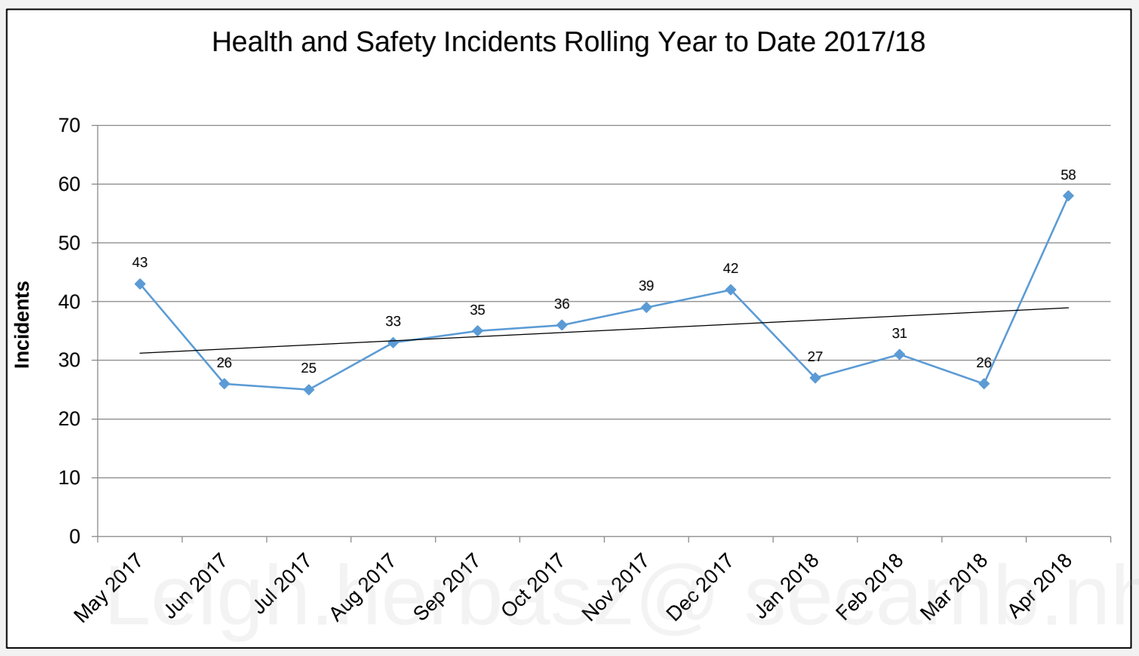
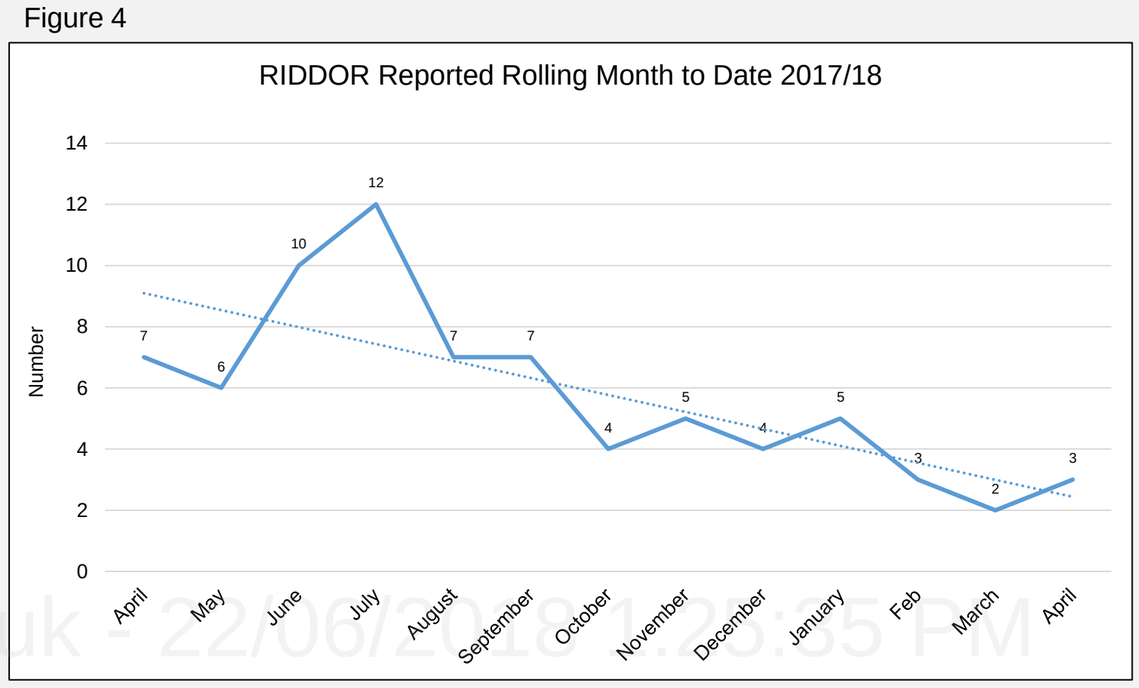


Figure 4



SECAmb Operations 999 - Safe

Call Answer Performance: Call answer performance is now included in the Emergency Operations Centre (EOC) action plan to address the CQC requirement of improving Ambulance Quality Indicators (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 Estimated Time of Arrival (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.

C3 and C4 Performance. Additional fleet vehicles have been acquired in line with the recruitment plan to improve our responses to within the C3 and C4 lower acuity cohort of patients.

SECAmb Operations 999 - Caring

Surrey Heartlands Pregnancy Advice Line: This continues, based in EOC. A review will be completed in June, following 2 months in operation. This will involve call volumes, nature of calls, disposition, feedback from EOC, Field Crews and Callers as appropriate.

Well Being Hub is now in permanent operation which will provide ongoing well being support to all staff and volunteers at SECAmb.

Staff Engagement programme is being actively continuing throughout the Trust, including at local station level.

SECAmb Operations 999 - Effective

Response Time Performance Targets: C1 performance has significantly improved on prior month. C2 response continues to perform within target consistently. However, the Trust is not meeting C3 and C4 response time targets due to resourcing levels. A Demand and Capacity Review continues 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 (SMP): 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 being revised in line with comments received following these reviews. It is proposed to review the escalation triggers to mirror OPEL. This is now going through the Trusts governance process with a timeline of the revised policy by the end of June 2018. The SMP will be subject to further reviews once agreed.

Handover Improvement Project: Handover delays continue to improve with a significant reduction in patients waiting greater that 60 minutes. The Task and Finish group continue to focus on handovers and improving patient flow and releasing resource availability.

SECAmb Operations 999 - Well Led

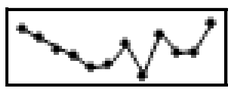
Key Skills Training: This has commenced throughout the Trust for Operational staff. In addition, objectives are currently being set for the Operations Team. Key skills were placed on hold during the Bank Holiday weeks to release resources back to the frontline.

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. Area Governance Reviews are also attended by Executives.

Risk. Management of Risk remains high on the operational agenda. All meetings with the A-F Team structure actively review risks.

SECAmb 999 Operations Performance Scorecard

Call Handling

	Feb-18	Mar-18	Apr-18	12 Month's
5 Sec Performance (95% Target)	60.5%	61.8%	84.0%	
Mean Call Answer Time (secs)	40	43	15	
95th Centile Call Answer (Secs)	185	205	97	
National Mean Call Answer	13	15	6	
National 95th Centile Call Answer	68	73	31	

Cat 1 Performance

	Feb-18	Mar-18	Apr-18	12 Month's
Mean (00:07:00)	00:08:18	00:08:14	00:07:24	
90th Percentile (00:15:00)	00:14:57	00:15:09	00:13:45	
Mean Resources Arriving	1.76	1.75	1.77	
Count of incidents	2998	3426	3201	
National Mean	00:08:16	00:08:22	00:07:38	

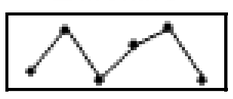
Cat 1T Performance

	Feb-18	Mar-18	Apr-18	12 Month's
Mean (00:19:00)	00:11:20	00:11:28	00:10:21	
90th Percentile (00:30:00)	00:20:28	00:21:37	00:19:36	
Mean Resources Arriving	2.80	2.85	2.85	
Count of incidents	1886	2108	1988	
National Mean	00:13:46	00:13:36	00:12:09	

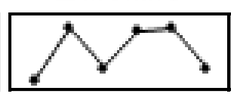
Cat 2 Performance

	Feb-18	Mar-18	Apr-18	12 Month's
Mean (00:18:00)	00:17:40	00:19:37	00:16:08	
90th Percentile (00:40:00)	00:33:03	00:37:17	00:30:17	
Mean Resources Arriving	1.12	1.12	1.13	
Count of incidents	26004	29758	26663	
National Mean	00:25:34	00:27:07	00:20:15	

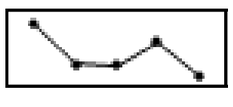
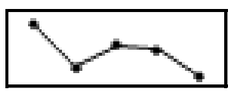
Cat 3 Performance

	Feb-18	Mar-18	Apr-18	12 Month's
Mean (01:00:00)	01:27:53	01:41:02	01:04:25	
90th Percentile (02:00:00)	03:19:44	03:52:06	02:32:34	
Mean Resources Arriving	106	107	106	
Count of incidents	20432	20983	21571	
National Mean	01:08:48	01:14:56	00:49:37	

Cat 4 Performance

	Feb-18	Mar-18	Apr-18	12 Month's
Mean	02:25:56	02:29:08	01:41:15	
90th Percentile (03:00:00)	05:41:05	05:54:23	04:10:57	
Mean Resources Arriving	1.03	1.07	1.06	
Count of incidents	1046	1082	1148	
National Mean	01:33:27	01:37:45	01:13:42	

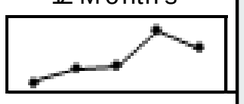
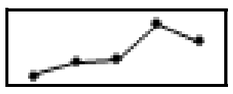
HCP

	Feb-18	Mar-18	Apr-18	12 Month's
HCP 60 Mean	01:51:20	02:23:29	01:36:21	
HCP 60 90th Percentile	04:32:06	06:23:58	03:42:35	
HCP 120 Mean	02:53:41	02:48:18	02:07:37	
HCP 120 90th Percentile	06:13:50	06:53:24	05:12:08	
HCP 240 Mean	03:43:00	04:09:59	02:14:38	
HCP 240 90th Percentile	08:54:04	10:56:32	05:03:46	

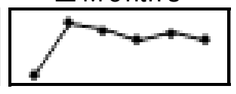
Call Cycle Time

	Feb-18	Mar-18	Apr-18	12 Month's
Avg Allocation to Clear at Scene	01:15:27	01:16:49	01:14:01	
Avg Allocation to Clear at Hospital	01:49:26	01:49:55	01:46:02	
Handover Hrs Lost at Hospital (over 30mins)	5697	6338	4804	
Number of Handovers >60mins	875	1032	516	

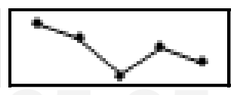
Incident Outcome AQI

	Feb-18	Mar-18	Apr-18	12 Month's
Hear & Treat	5.2%	5.7%	5.5%	
See & Treat	33.9%	33.0%	33.4%	
See & Convey	60.9%	61.3%	61.1%	

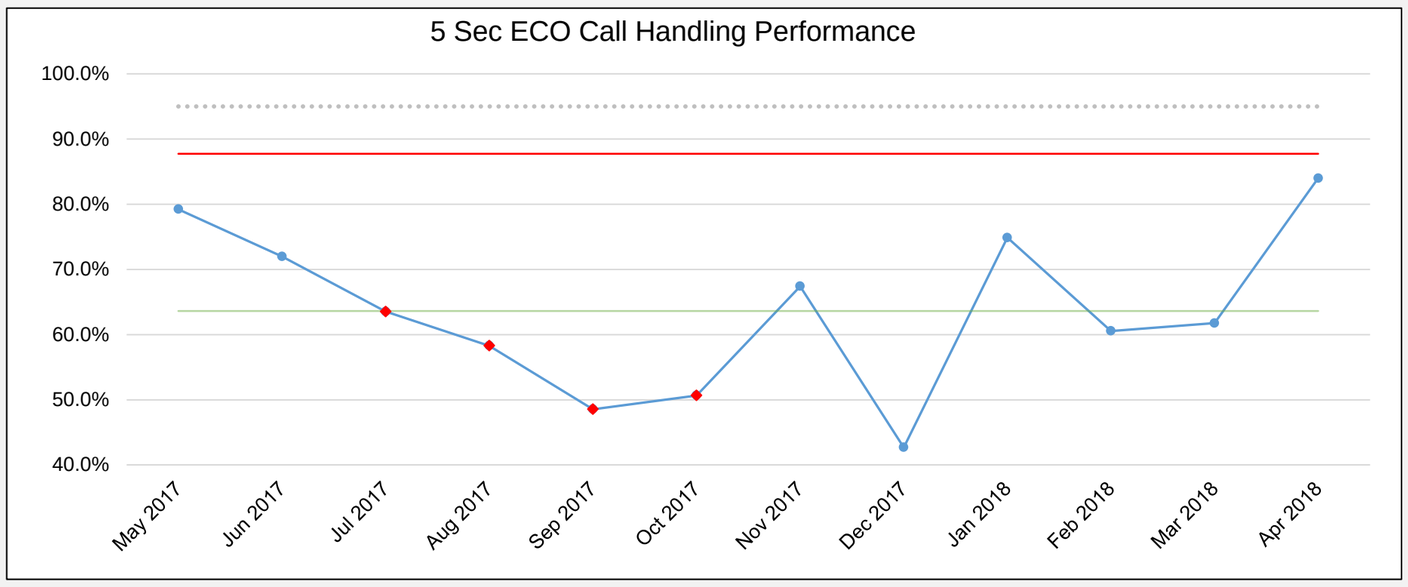
Community First Responders

	Feb-18	Mar-18	Apr-18	12 Month's
Volume of incidents Attended	1599	1889	1608	

Demand/Supply AQI

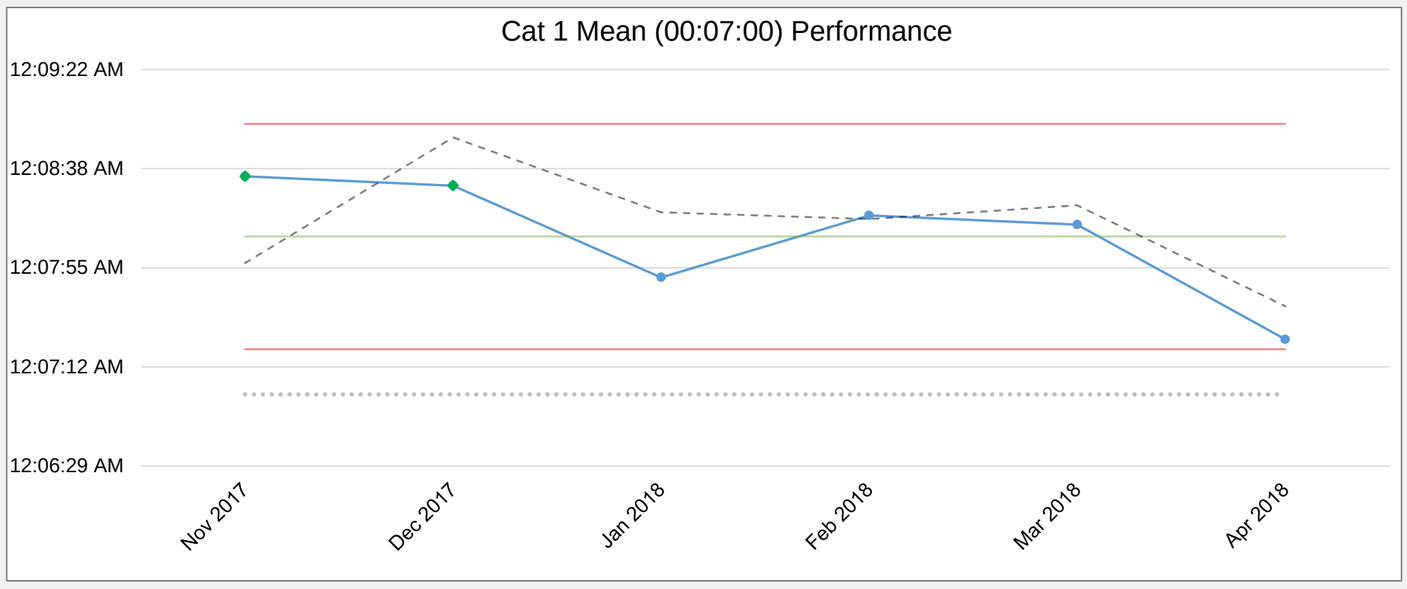
	Feb-18	Mar-18	Apr-18	12 Month's
Calls Answered	57932	67732	58773	
Incidents	55323	60659	57890	
Transports	33711	37170	35368	

SECAmb 999 Operations Performance Charts



Call answering performance for April has improved significantly with almost a 3 fold improvement on the mean call pick up time to 15 seconds compared to March, this is representative of the reduction in activity following the significant pressures created by the late winter pressures experienced in March. Call volume was also significantly down on the previous month by almost 9000 calls and this has contributed to a number of other positive improvements in performance.

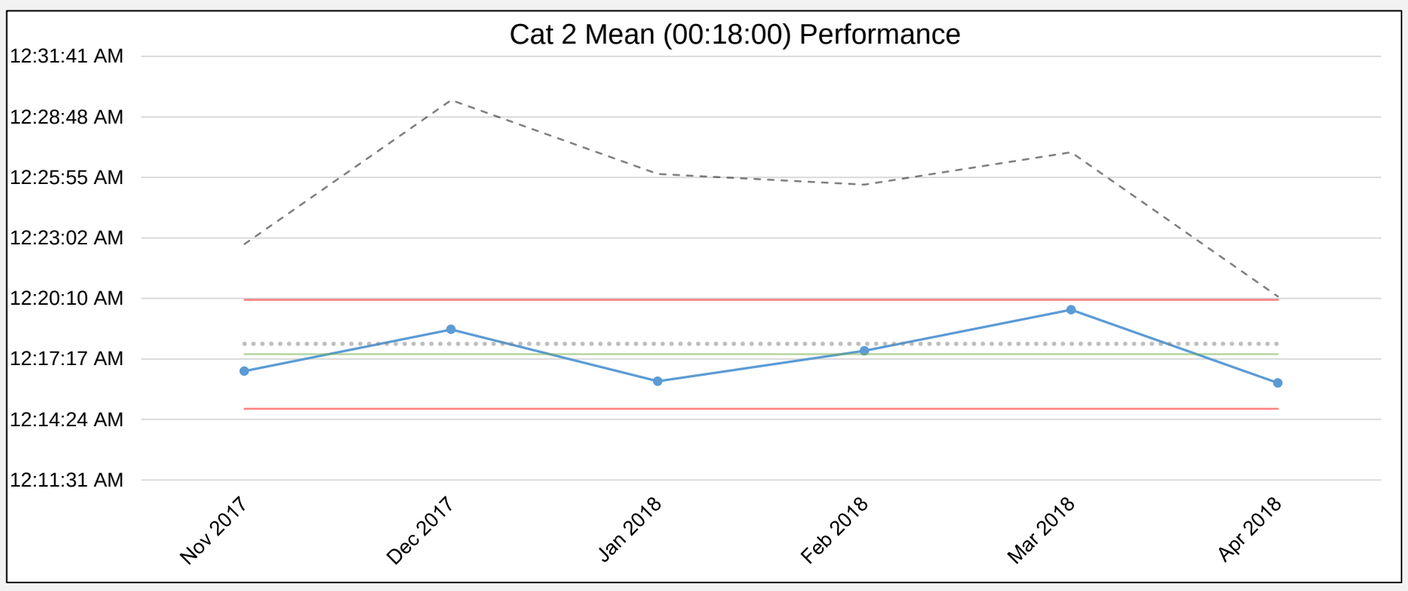
Call answer performance is covered in great detail in the EOC action plan that is tracking the actions of the EOC task and finish group to address the CQC must do requirement of demonstrating improvement against this key target, along with recruitment and staff retention. Significant scrutiny still being placed on call handling performance with all efforts being made to improve this and a further cohort has been recruited for June which now takes the established whole time equivalents way beyond the funded establishment by up to 20 WTE.



As advised in the detail above the Category 1 mean response performance has seen a significant improvement on the previous month, indicative of the details highlighted above. Whilst we are not yet delivering the ambulance response program target of seven minutes, both our mean performance and 90th percentile performance are tracking consistently within the middle of the pack when measured against all other English ambulance services. This consistency in delivery demonstrates the significant focus given to the high acuity patient groups.

Analysis of the data shows that the response performance to Category 1 incidents identified through nature of call (NoC) or as cardiac arrest is significantly higher than the generic mean response for this category by almost 1 minute.

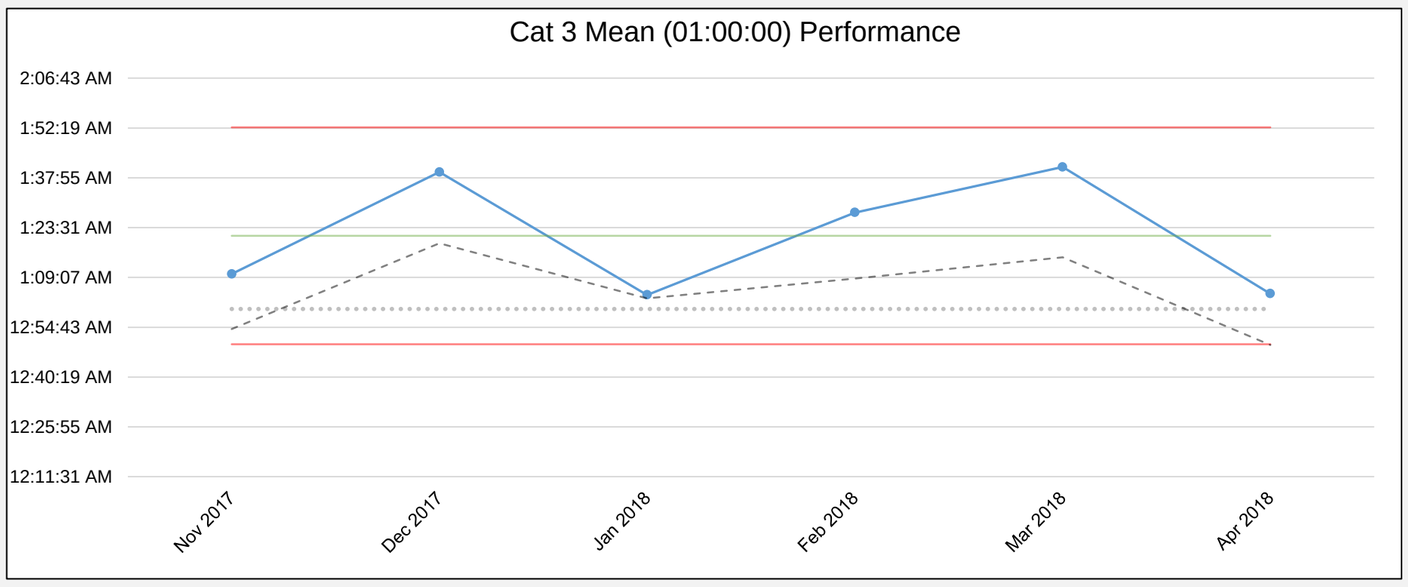
----- National Mean



Category 2 mean and 90th centile performance has been and remains a particularly successful delivery for SECAmb with both targets remaining within target requirements and when measured against our peers we continue to track in the upper quartile of performance when measured against all other English Trusts. This is a further indication of the importance placed on the higher acuity patient group.

This improvement alongside the other metrics recorded for April have been influenced by the reduction in activity as the winter pressures have eased and in particular a significant reduction in lost hours through hospital handover delays providing more available resource to meet this reduced activity.

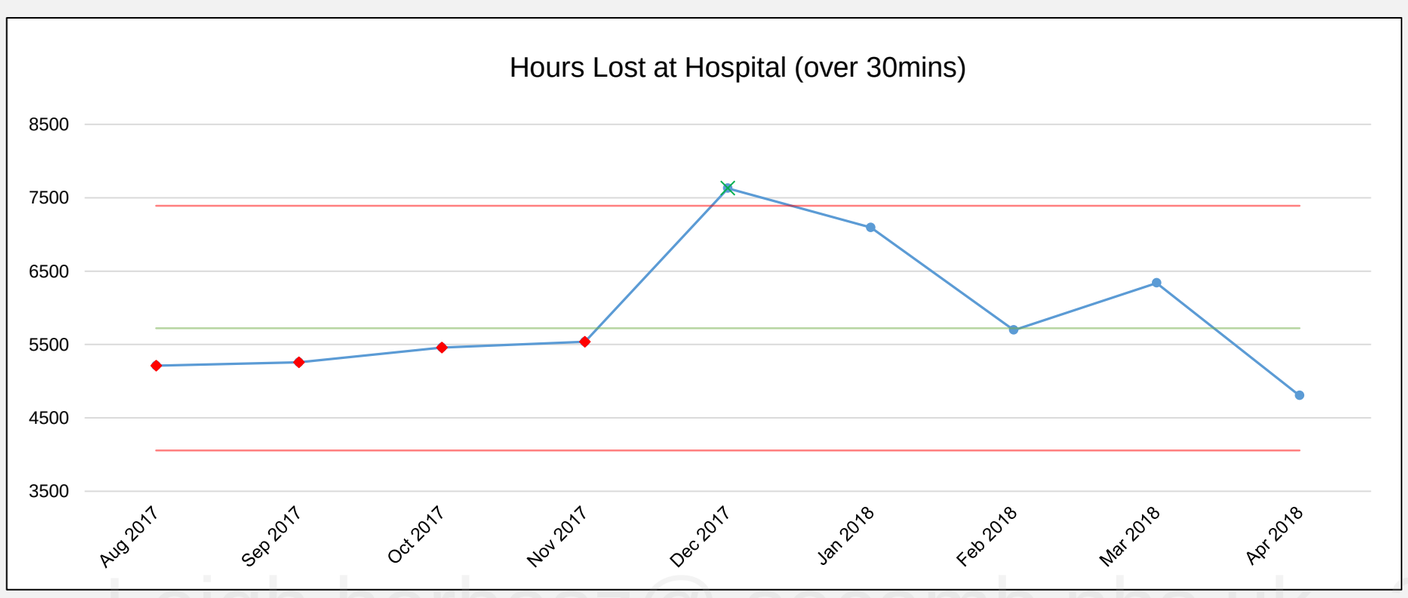
----- National Mean



This particular dataset has been introduced from this month to provide the Board with oversight on the significant pressure against the performance requirements for this patient group.

Since the introduction of the Ambulance Response Program (ARP) in late November 2017 performance against the Category 3 standard has been extremely challenged, this is a clear measure of the well rehearsed arguments surrounding the 'right sizing' of the response capabilities of SECAmb and whilst we have seen a significant improvement on both the mean and 90th centile performance targets for this patient group in April compared with March, we still remain in the bottom quartile when compared with the other English Ambulance Trusts.

----- National Mean



The hours lost to operational response capability through hospital delays for April has seen a significant reduction to the point where the lost hours for April now comparable with those lost for the same period last year. Whilst there is always a seasonal reduction following the winter pressures period this is the first time that the hours lost has reduced to comparable level for the previous year.

There has been significant progress through the task and finish groups focused on hospital handover delays and this is now being evidenced through the recorded data and subsequent increased availability of resources which contributed to improve the performance metrics above.

Whilst this reduction is a significant success for April, it still accounted for an average of 1200 hours a week, but importantly saw a halving of handovers greater than 60 minutes to only 516 for The period. The improvement was equivalent to a whole week's worth of lost hours, equating to appropriately 133 12 hour shifts being put back into our response capability for the month.

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 operational performance in quarter four of 17/18. 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 level of complaints remained static at the beginning of Q1 18/19, despite an increased level of service activity experienced year on year. Once again, no complaint reports were breached 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 which we have continued to experience in Q1 of 18/19.

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 and this has resulted in the creation of a "Culture Club" in the service's Ashford 111 Contact Centre. Fortnightly meetings of the Culture Club have been held in April and May. 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 and at the Ashford site in particular. 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 and this includes coaching booths, a "relaxation" break-out area and the initiation of a Gardening Club for our colleagues in Ashford.

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 in collaboration with its Commissioners to address any issues and the current Operational Recovery Plan (ORP) was written in conjunction with Commissioners and progress against this is reviewed on a weekly conference call for which an action log is maintained. The service also has senior managers present on the Trust's Hear & Treat Programme Board and the Joint Commissioner Pilot (JCP) of 111/999 integration which commenced in 18/19 has continued in to this financial year with best practice from both 111 and 999 being shared across services.

SECAmb Operations 111 - Responsive

The service continues to reach out and engage with all stakeholders including patients, Commissioners, NHS E and other providers. 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 May bank holiday periods when the service was able to protect multiple providers when there was a period 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. A monthly bulletin and poster is shared with all colleagues identifying the learns from the previous month and also sharing the compliments and positive comments made about the service and its people.

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 noted 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 at the beginning of Q1 of 18/19.

SECAmb 111 Operations Performance Scorecard

Calls Offered

	Feb-18	Mar-18	Apr-18	12 Month's
Actual	92798	112748	93916	
Previous Year	79876	83545	99575	

Calls answered in 60 Seconds

	Feb-18	Mar-18	Apr-18	12 Month's
Actual %	49.2%	45.1%	73.6%	
Previous Year %	92.5%	92.5%	95.5%	
Target %	95%	95%	95%	

Calls abandoned - (Offered) after 30secs

	Feb-18	Mar-18	Apr-18	12 Month's
Actual %	13.4%	15.7%	4.8%	
Previous Year %	0.7%	0.9%	0.5%	
Target %	2%	2%	2%	

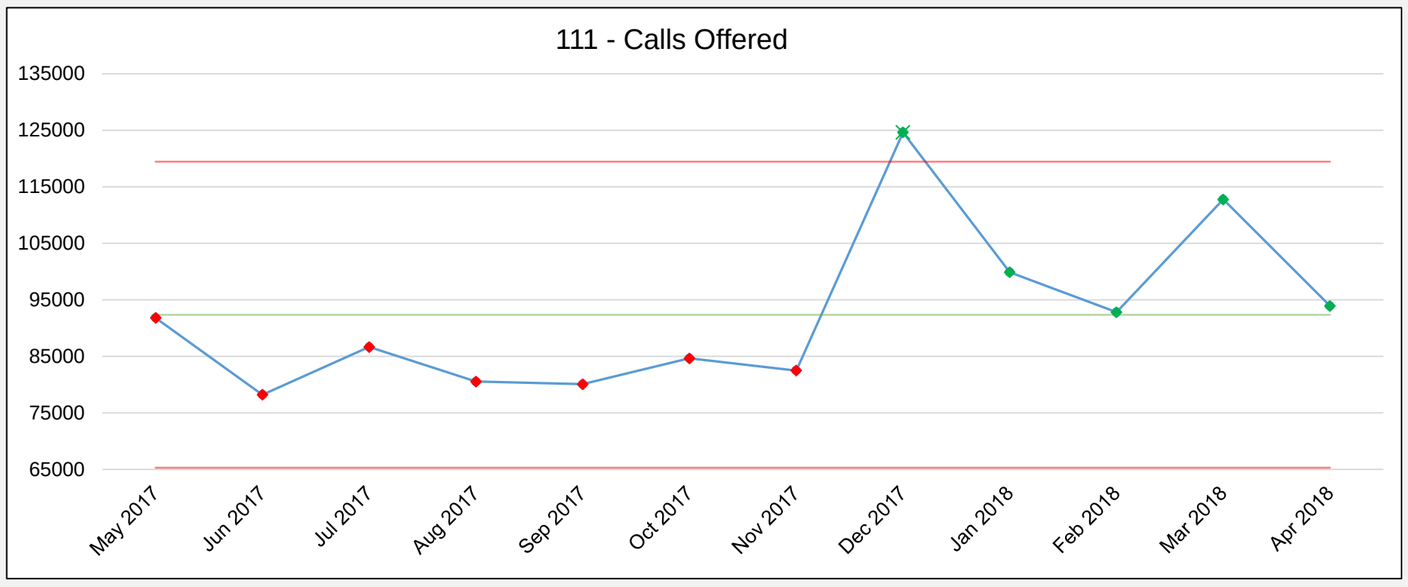
Combined Clinical KPI

	Feb-18	Mar-18	Apr-18	12 Month's
Actual %	71.4%	71.9%	68.9%	
Previous Year %	73.6%	73.6%	80.4%	
Target %	90%	90%	90%	

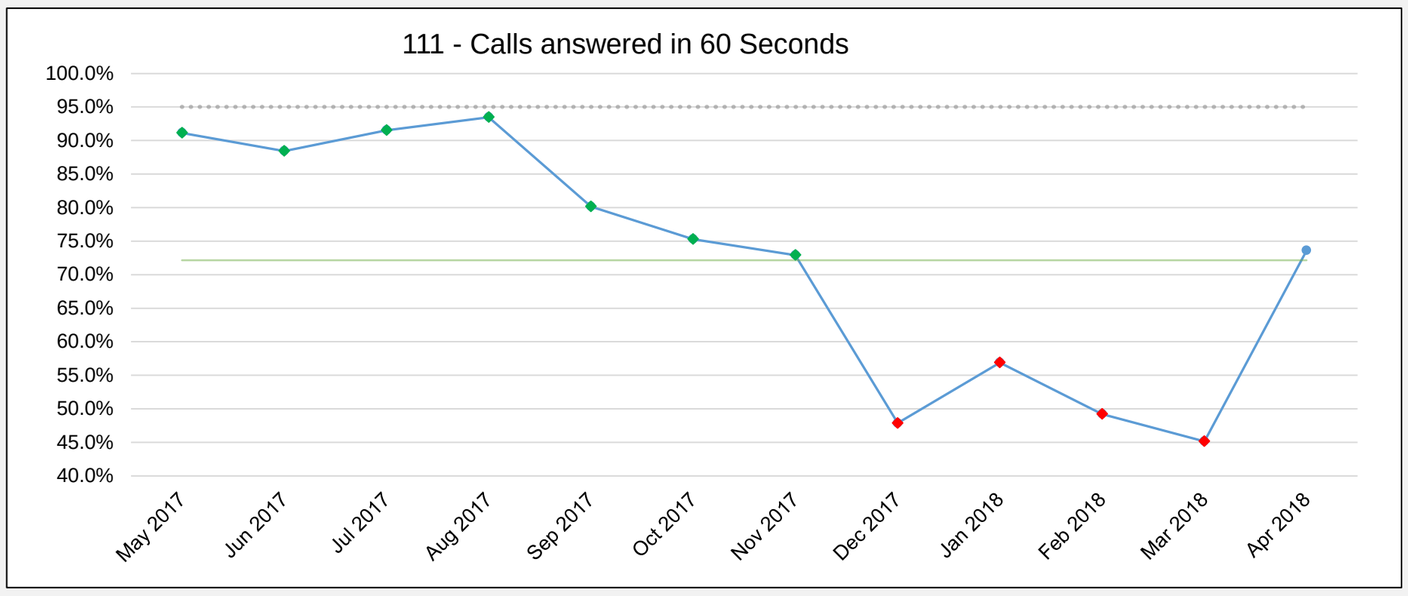
Outcomes

	Feb-18	Mar-18	Apr-18	12 Month's
999 Referrals % (Answered Calls)	11.7%	10.5%	10.7%	
999 Referrals (Actual)	9129	9627	9578	
A&E Dispositions % (Answered Calls)	7.2%	7.3%	7.9%	
A&E Dispositions (Actual)	5604	6756	6337	
Home Management %	tbc	tbc	tbc	

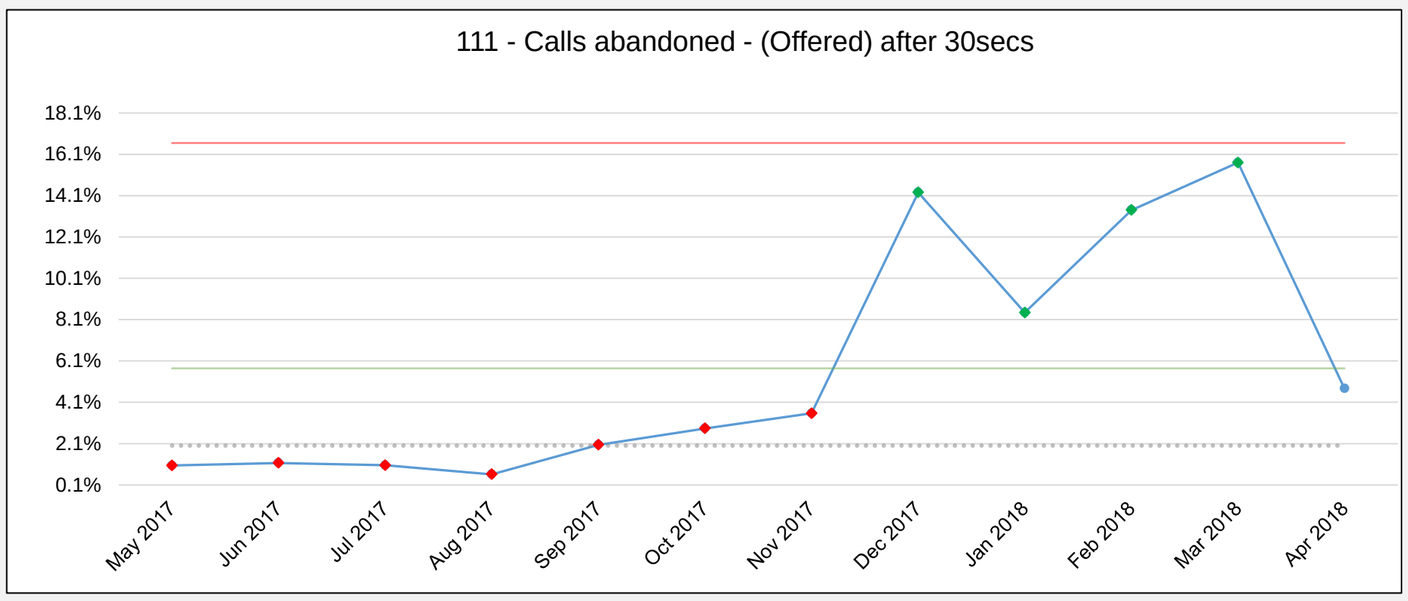
SECAmb 111 Operations Performance Charts

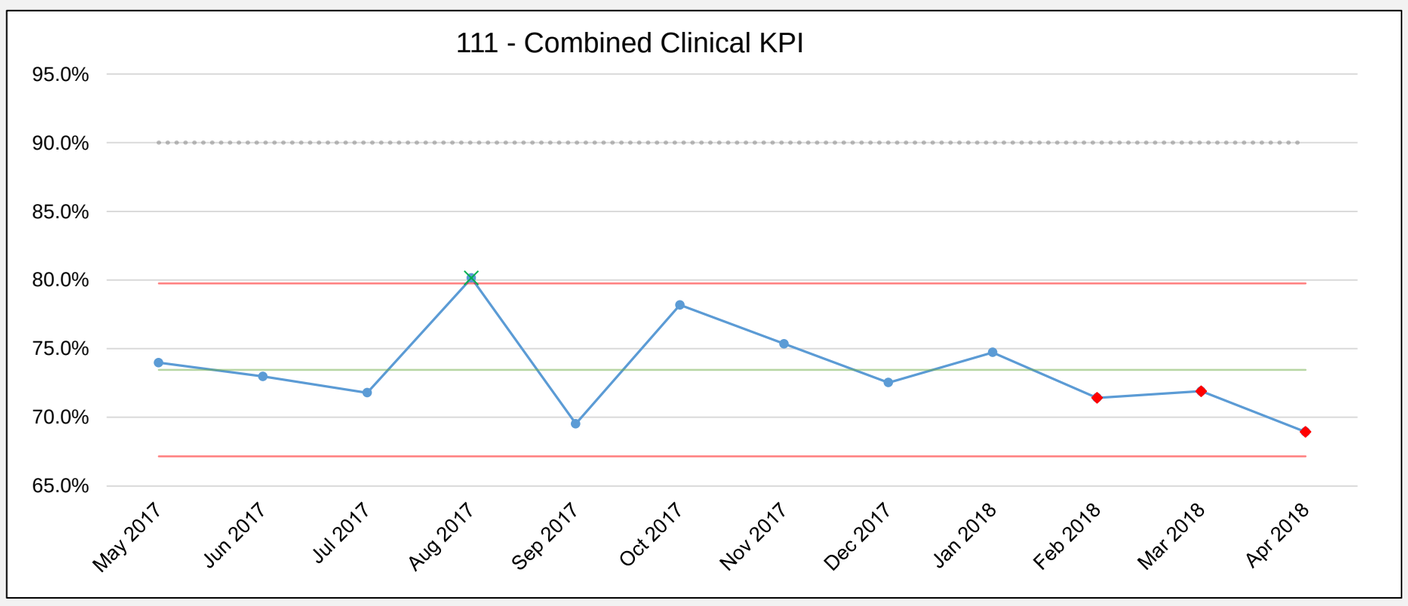


Call Volumes decreased during April 2018, as winter pressures finally ended. Consequently the service was able to improve Service Level and to significantly reduce the Average Speed to Answer, back to 60 seconds.

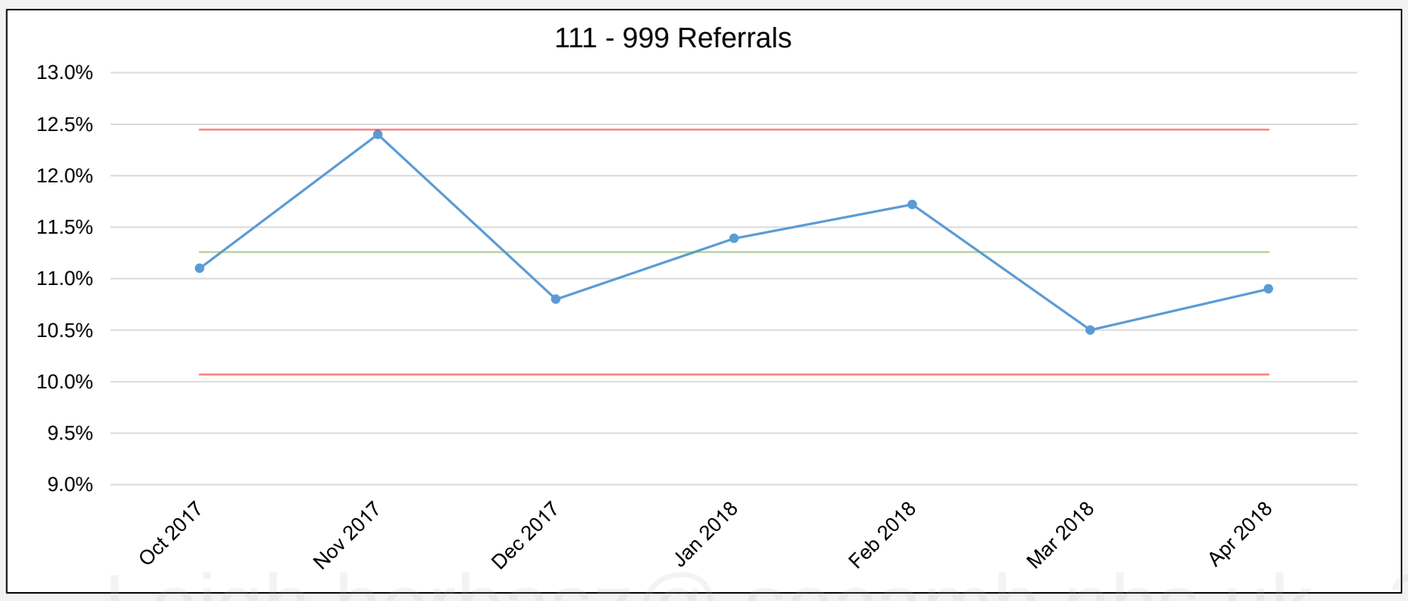


KMSS 111 achieved a significant turnaround in “Answered in 60” service level for April, improving the performance to 73.6%. Average Handling Time decreased, and the service continued to optimise rotas and recruit and train new Health Advisors. The performance was also supported by the introduction of Service Advisors on weekday evenings, handing Repeat Prescriptions and call backs.





Clinical performance dipped slightly in April 2018 but remained best-in-class among large-scale 111 providers.
Rota shortfalls are being addressed, and mitigated by integrated queue supervision across the service, in addition to a key focus on prioritisation of clinical cases.



The KMSS 111 Ambulance referral rate rose slightly to 10.7% in April, but was marginally below the National average for April.
Clinical Inline Support continues to downgrade significant volumes of AMB dispositions, despite capacity challenges due to clinician rota issues.

SECAmb Workforce - Safe

Recruitment in EOC has been a strong focus together with work on improving retention in the EOCs.
Work has been done to identify appropriate planning and incentives to ensure cover during the May Bank Holiday weekends.
Work has been underway in April on building the workforce trajectory for the frontline of SECAmb to enable us to meet the developing ambulance needs of the South East region to 2021. The first phase of the trajectory is aligned with staffing requirements/mix for the ARP.

SECAmb Workforce - Caring

We have reviewed the work and impact of the Well-being Hub. Usage levels have been high and the combined focus particularly through mental health advisors and physios has been very positively received. Anecdotally the Well-being Hub is also contributing to staff feeling it is a safe place with appropriate confidentiality and support. The EMB have now agreed to make the provision of the Hub permanent.

SECAmb Workforce - Effective

The HR Transformation Programme has specific outcomes to improve the effectiveness of the HR function. The process re-design work will ensure that we have people processes that are measurable and improvable as part of the design to ensure good value and continuous improvement.

SECAmb Workforce - Responsive

We are working with Commissioners and HEE on the workforce trajectory to ensure that there is a system-wide collaboration in how we meet the ambulance needs of the region.

SECAmb Workforce - Well Led

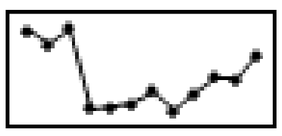
As part of the Culture Programme, the Executive Team are having regular facilitated off sites to review how we are working and the impact of our behaviour.

We have started the roll-out of four leadership development modules targeted at the EMB and senior leadership team. This group of senior leaders is using 360 feedback and external coaches to support a behaviour change.

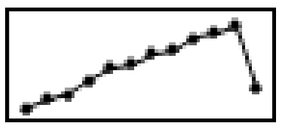
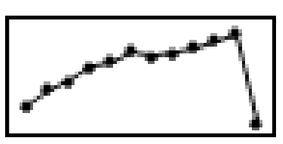
A key component of the focus on leadership development is managing for both task delivery and the right behaviours – this is a specific focus of leadership development modules.

SECAmb Workforce Scorecard

Workforce Capacity

	Feb-18	Mar-18	Apr-18	12 Month's
Number of Staff WTE (Excl bank & agency)	3079.8	3077.0	3118.3	
Number of Staff Headcount (Excl bank and agency)	3350	3349	3381	
Finance Establishment (WTE)	3527.29	3532.29	3552.29	
Vacancy Rate	12.65%	12.82%	12.23%	
Vacancy Rate Previous Year	8.23%	9.64%	10.75%	
Adjusted Vacancy Rate + Pipeline recruitment %	9.20%	9.83%	8.09%	

Workforce Compliance

	Feb-18	Mar-18	Apr-18	12 Month's
Objectives & Career Conversations %	83.95%	91.95%	23.65%	
Target (Objectives & Career Conversations)	80.00%	80.00%	80.00%	
Statutory & Mandatory Training Compliance %	86.32%	93.24%	6.54%	
Target (Stat & Mand Training)	95.00%	95.00%	95.00%	
Previous Year (Stat & Mand Training) %	81.90%	85.00%	8.26%	

*** Objectives & Career Conversations and Statutory & Mandatory training has been measured by financial year. The completion rate is reset to zero on 01/04/2018**

Workforce Costs

	Feb-18	Mar-18	Apr-18	12 Month's
Annual Rolling Turnover Rate %	17.74%	17.19%	16.50%	
Previous Year %	16.60%	16.70%	16.65%	
Annual Rolling Sickness Absence	5.26%	5.12%	5.26%	
Target (Annual Rolling Sickness)	5.00%	5.00%	5.00%	

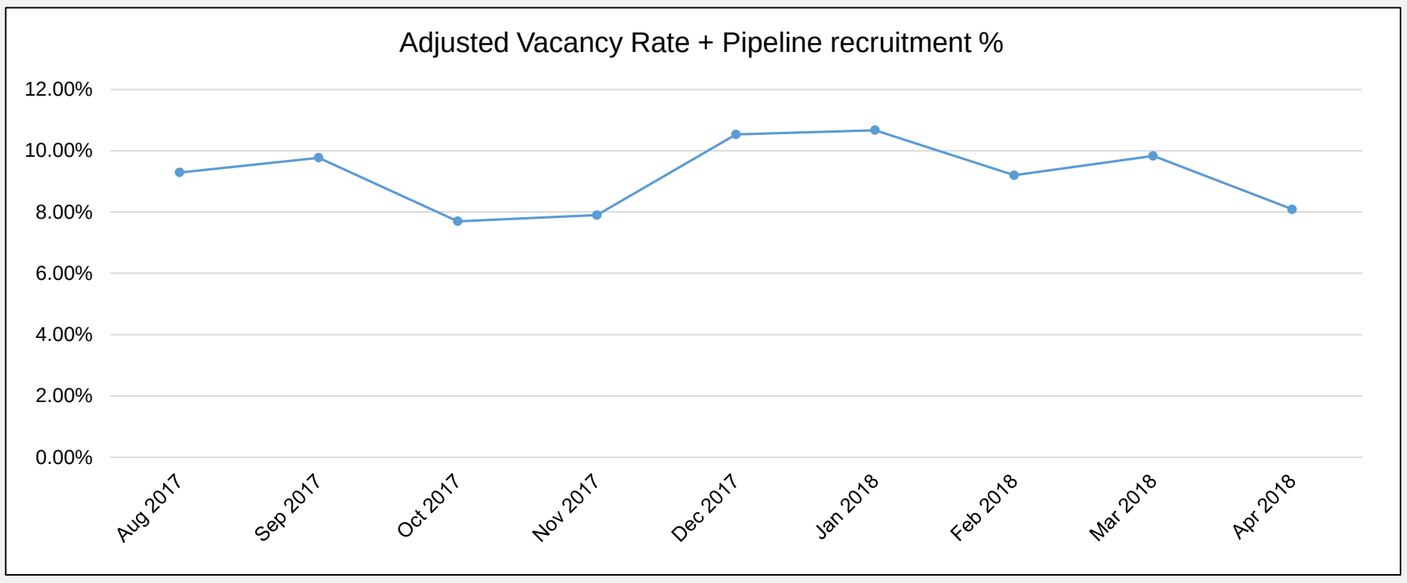
Employee Relations Cases

	Feb-18	Mar-18	Apr-18	12 Month's
Disciplinary Cases	6	4	9	
Individual Grievances	6	5	9	
Collective Grievances	1	3	1	
Bullying & Harassment	2	1	2	
Bullying & Harassment Prev Yr	0	3	1	
Whistleblowing	1	0	0	
Whistleblowing Previous Year	0	0	0	

Physical Assaults (Number of victims)

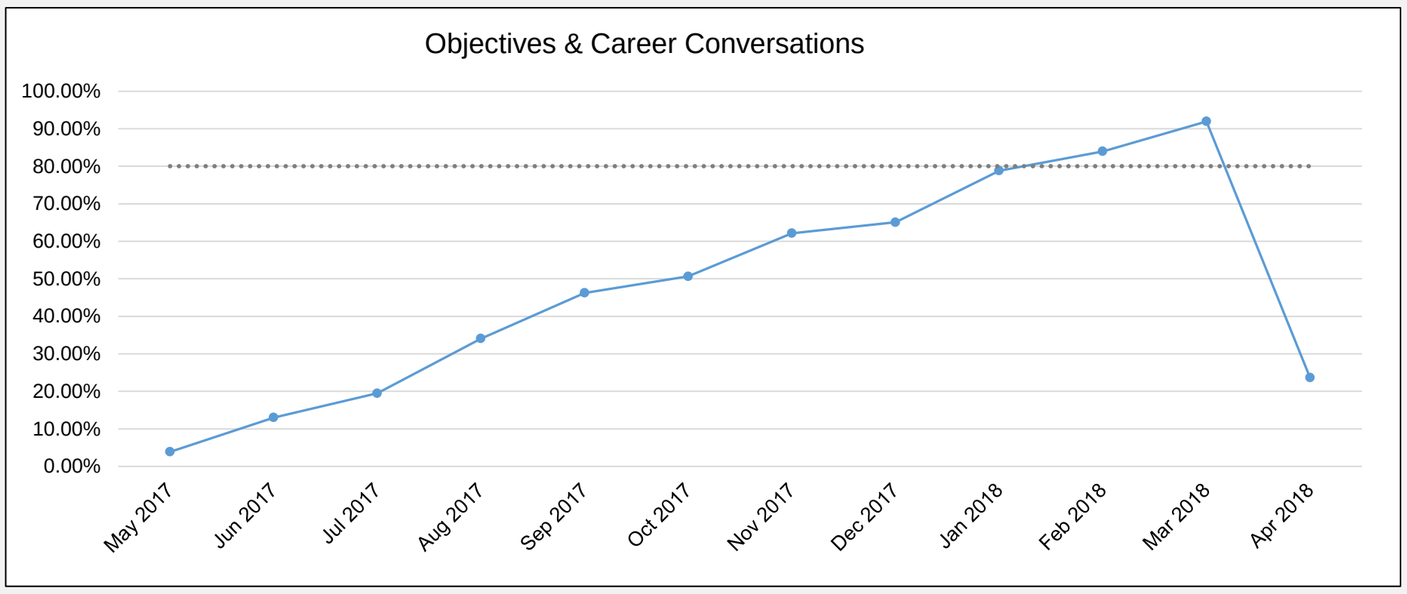
	Feb-18	Mar-18	Apr-18	12 Month's
Actual	15	17	22	
Previous Year	16	18	19	
Sanctions	3	9	5	

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.

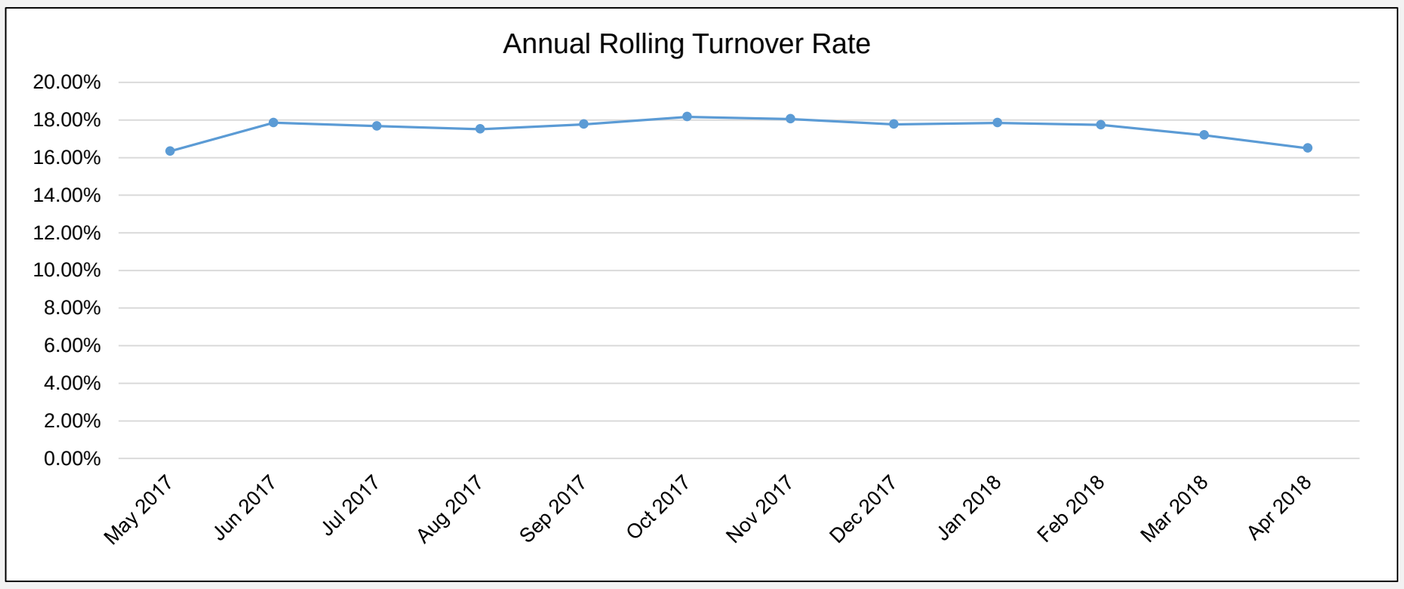


In March we exceeded the end of year target of 80%, we achieved 91.95%.

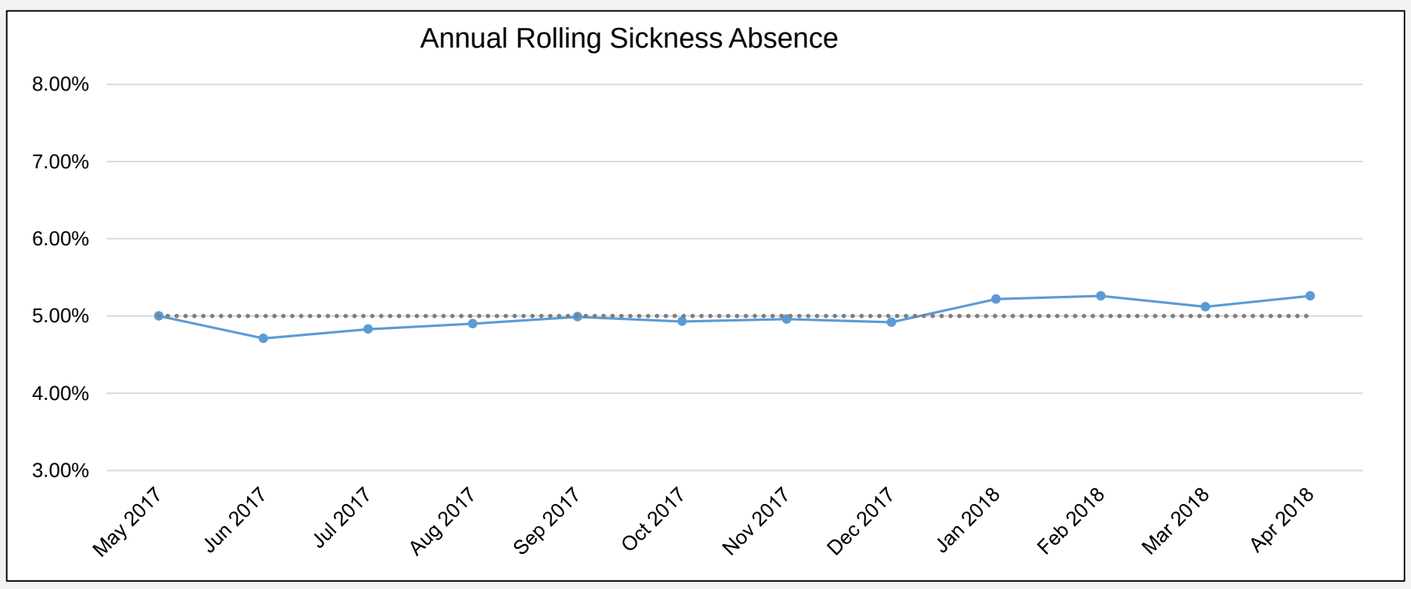
Managers continue to be supported to deliver on objectives and fully understand their accountability in this regard via area Governance.

Training on the delivery of good appraisals has been commissioned and is currently being delivered to managers during May and June.

* Objectives & Career Conversations training is completed each financial year, which explains the significant drop for April 2018

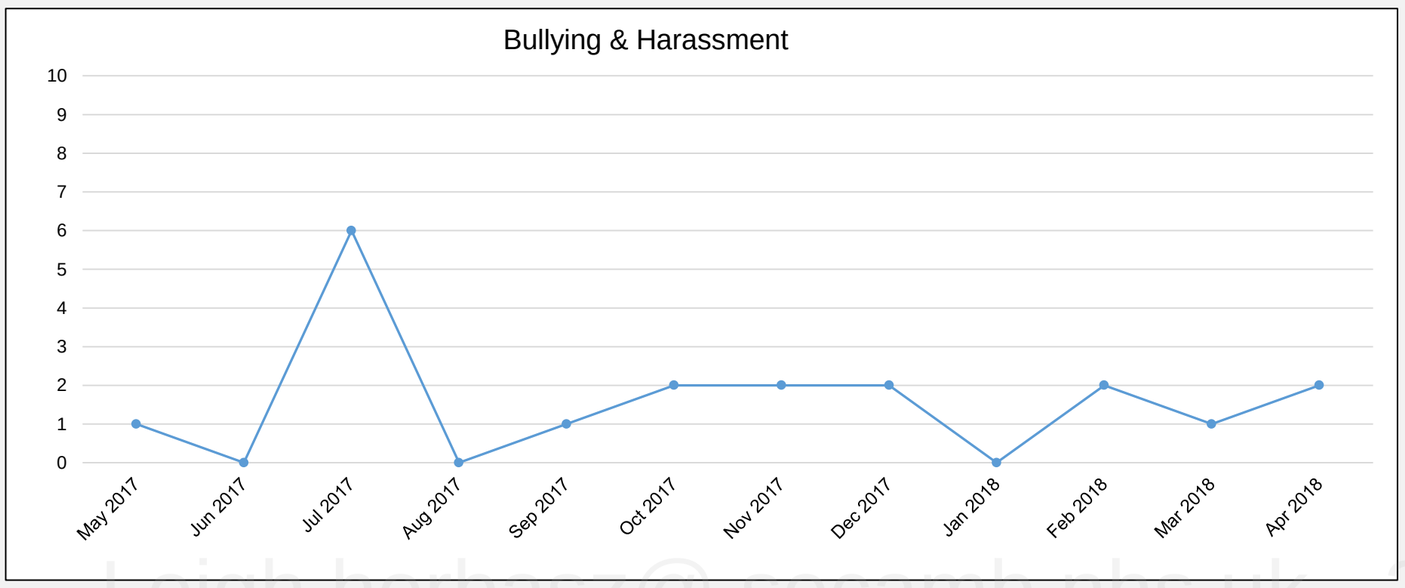


The Trust turnover rate remains constant although a high turnover rate is still seen in EOC and 111 should be noted. This continues to be monitored by the EOC Task and Finish Group.



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 Workforce Additional Information

For April we are including workforce data broken down by directorate and operating unit. Whilst this provides more content for this report it reflects the level at which planning and management of the workforce is now happening. This has been driven in part by the work being done on the workforce trajectory as part of the Demand and Capacity Review. As of June, we have detailed trajectories by OU showing the planned workforce mix by the six key frontline roles – i.e. ECSW, Technician, NQPs, Paramedics, PPs, and CCPs. Our Resourcing plans will be planned to the corresponding level. As we track progress against the trajectory we will also be tracking attrition, moves and sickness at this level too so that we can manage the plan accordingly.

	Key Performance Indicator	Trust wide	Chief Executive Office	Director of Finance & Corporate Services	Director of Human Resources	Director of Operations	Director of Quality & Safety	Director of Strategy & Business Development	Medical Director
	Workforce Capacity								
1	Number of Staff WTE (excl. bank and agency)	3,118.30	45.1	42.36	81.29	2,866.01	30.57	12.33	40.63
2	Number of Staff Headcount (excl. bank and agency)	3381	49	43	84	3116	32	13	44
3	Number of New Starters Headcount	67	3	1	4	59	0	0	0
4	Number of Leavers Headcount	25	0	0	0	22	1	1	1
5	Finance Establishment (WTE)	3,552.29	0.2	37.64	5.75	359.92	5.8	11.67	13.38
6	Vacancy Rate (%)	12.23%	0.44%	47.05%	6.60%	11.16%	15.94%	48.64%	24.77%
new	Adjusted Vacancy Rate + PIPELINE recruitment until 31/03/2018 %	8.09%	44.00%	47.05%	4.30%	6.73%	13.19%	48.64%	22.92%
new	Adjusted Vacancy Rate + PIPELINE - INTERIMS/AGENCY until 31/03/2018 WTE								
	Workforce Efficiency								
7	Annual Rolling Turnover Rate (%)	16.50%	15.85%	40.56%	20.25%	15.49%	48.64%	42.19%	21.82%
8	Headcount Stability Rate (%)	84.73%	75.00%	67.35%	74.67%	86.08%	57.14%	50.00%	64.00%
	Workforce Costs								
9	Annual Rolling Sickness Absence (%)	5.26%	0.83%	0.64%	0.95%	2.18%	0.33%	2.42%	1.08%
10	Short Term (%)	2.20%	0.48%	1.61%	2.08%	3.13%	0.29%	3.75%	3.11%
11	Long Term (%)	3.06%	1.31%	2.25%	3.03%	5.31%	0.62%	6.17%	4.19%
	Employee Relations								
12	Employee Relations New Cases (Total)	25							
13	Disciplinary Cases	9		1		8			
14	Individual Grievances	9				9			
15	Collective Grievances	1				1			
16	Bullying & Harassment	2				2			
17	Employment Tribunal	1	1						
18	Suspensions	1				1			
19	Whistleblowing	0							
20	Appeals	2				2			

Key Performance Indicator	111	EOC East	EOC West	Ashford	Brighton	Chertsey
Workforce Capacity						
Number of Staff WTE (excl. bank and agency)	157.94	141.65	224.8	129.04	167.87	144.84
Number of Staff Headcount (excl. bank and agency)	204	157	249	137	186	159
Number of New Starters Headcount	7	4	16	4	0	5
Number of Leavers Headcount	5	3	3	1	1	0
Finance Establishment (WTE)	15.15	-9.59	13.17	19.07	4.84	15.82
Vacancy Rate (%)	8.75%	-7.26%	5.56%	12.88%	2.79%	9.94%
Adjusted Vacancy Rate + PIPELINE recruitment until 31/03/2018	2.40%	-1.22%				
Adjusted Vacancy Rate + PIPELINE - INTERIMS/AGENCY until 31/03/2018 WTE						
Workforce Efficiency						
Annual Rolling Turnover Rate (%)	45.46%	26.12%	43.86%	11.34%	3.78%	15.74%
Headcount Stability Rate (%)	68.63%	78.08%	68.16%	84.72%	90.67%	81.76%
Workforce Costs						
Annual Rolling Sickness Absence (%)	9.00%	8.00%	7.00%	5.00%	5.00%	6.00%
Short Term (%)	4.00%	4.00%	4.00%	2.00%	2.00%	2.00%
Long Term (%)	5.00%	4.00%	3.00%	3.00%	3.00%	4.00%
Employee Relations						
Employee Relations New Cases (Total)	4	2	1	3	1	1
Disciplinary Cases	3					
Individual Grievances		1		3	1	1
Collective Grievances		1				
Bullying & Harassment						
Employment Tribunal						
Suspensions	1					
Whistleblowing (anonymous)						
Appeals			1			

SECAmb Workforce Additional Information

Key Performance Indicator	Dartford & Medway	Gatwick & Redhill	Guildford	Paddock Wood	Polegate & Hastings	Tangmere & Worthing	Thanet
Workforce Capacity							
Number of Staff WTE (excl. bank and agency)	219.35	264.93	153.05	135.52	226.05	210.08	171.97
Number of Staff Headcount (excl. bank and agency)	240	289	163	143	241	225	188
Number of New Starters Headcount	3	7	0	3	5	1	4
Number of Leavers Headcount	2	1	3	1	0	0	0
Finance Establishment (WTE)	50.23	37.36	10.11	42.22	-1.71	14.85	36.39
Vacancy Rate (%)	18.63%	12.32%	6.23%	23.75%	-0.77%	6.62%	17.55%
Adjusted Vacancy Rate + PIPELINE recruitment until 31/03/2018							
Adjusted Vacancy Rate + PIPELINE - INTERIMS/AGENCY until 31/03/2018 WTE							
Workforce Efficiency							
Annual Rolling Turnover Rate (%)	15.89%	8.28%	8.65%	8.11%	9.71%	11.31%	9.43%
Headcount Stability Rate (%)	80.08%	88.32%	85.44%	79.22%	86.69%	82.22%	87.13%
Workforce Costs							
Annual Rolling Sickness Absence (%)	5.00%	5.00%	4.00%	4.00%	7.00%	5.00%	7.00%
Short Term (%)	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
Long Term (%)	3.00%	3.00%	2.00%	2.00%	5.00%	3.00%	5.00%
Employee Relations							
Employee Relations New Cases (Total)	2		2		2	4	1
Disciplinary Cases			1		1	2	1
Individual Grievances	2		1				
Collective Grievances							
Bullying & Harassment					1	1	
Employment Tribunal							
Suspensions							
Whistleblowing (anonymous)							
Appeals						1	

SECAmb Finance Performance Scorecard

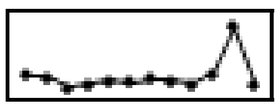
Income

	Feb-18	Mar-18	Apr-18	12 Month's
Actual £	£ 16,810	£ 25,743	£ 16,830	
Previous Year £	£ 17,179	£ 16,787	£ 15,229	
Plan £	£ 16,109	£ 17,367	£ 16,983	

Expenditure

	Feb-18	Mar-18	Apr-18	12 Month's
Actual £	£ 16,032	£ 22,806	£ 17,794	
Previous Year £	£ 17,576	£ 17,154	£ 16,126	
Plan £	£ 15,400	£ 16,576	£ 18,001	

Capital Expenditure

	Feb-18	Mar-18	Apr-18	12 Month's
Actual £	£ 780	£ 3,190	£ 299	
Previous Year £	£ 1,356	£ 1,859	£ 268	
Plan £	£ 856	£ 856	£ 391	
Actual Cumulative £	£ 4,658	£ 7,848	£ 299	
Plan Cumulative £	£ 14,980	£ 15,836	£ 391	

Cost Improvement Programme (CIP)

	Feb-18	Mar-18	Apr-18	12 Month's
Actual £	£ 1,380	£ 1,406	£ 392	
Previous Year £	£ 488	£ 764	£ 899	
Plan £	£ 1,380	£ 1,409	£ 402	
Actual Cumulative £	£ 14,116	£ 15,522	£ 392	
Plan Cumulative £	£ 13,691	£ 15,100	£ 402	

CQUIN (Quarterly)

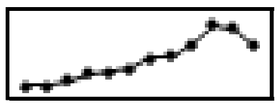
	Q3 17/18	Q4 17/18	Q1 18/19
Actual £	£ 846	£ 847	£ 283
Previous Year £	£ 952	£ 1,019	£ 716
Plan £	£ 848	£ 848	£ 283

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

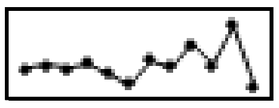
Surplus/(Deficit)

	Feb-18	Mar-18	Apr-18	12 Month's
Actual £	£ 778	£ 2,937	-£ 964	
Actual YTD £	-£ 1,639	£ 1,298	-£ 964	
Plan £	£ 709	£ 791	-£ 1,018	
Plan YTD £	-£ 1,794	-£ 1,003	-£ 1,018	

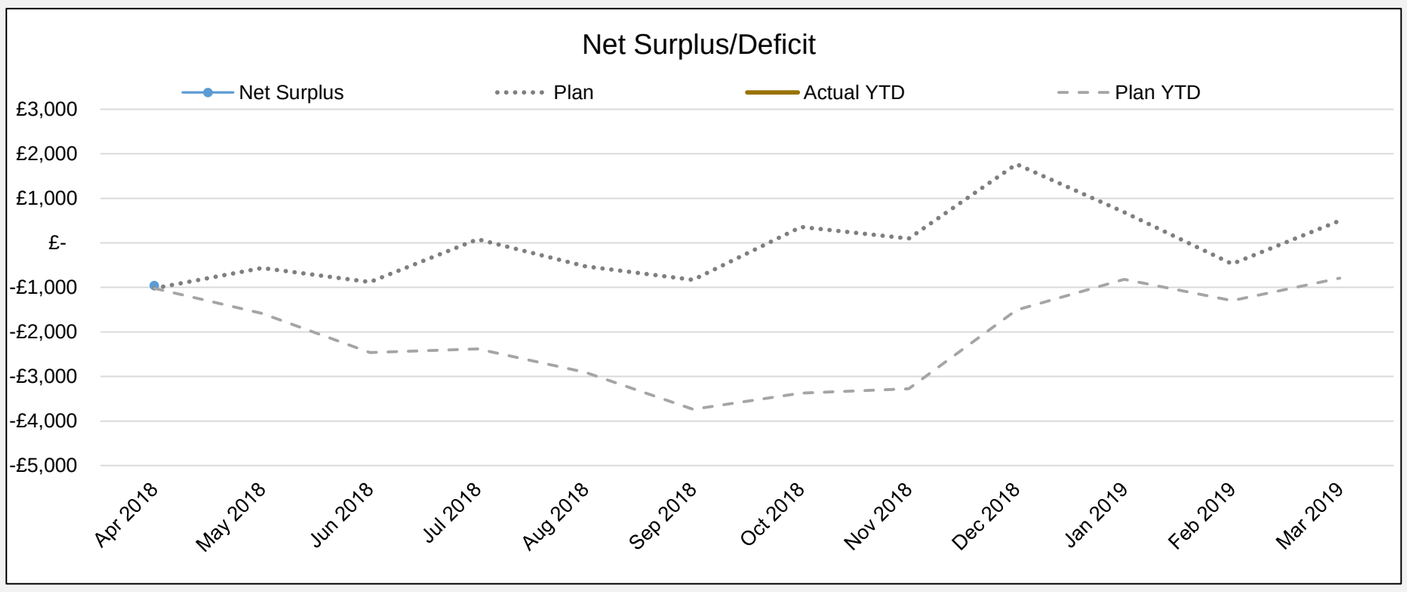
Cash Position

	Feb-18	Mar-18	Apr-18	12 Month's
Actual £	£ 23,953	£ 22,892	£ 19,244	
Minimum £	£ 10,000	£ 10,000	£ 10,000	
Plan £	£ 5,728	£ 5,459	£ 16,152	

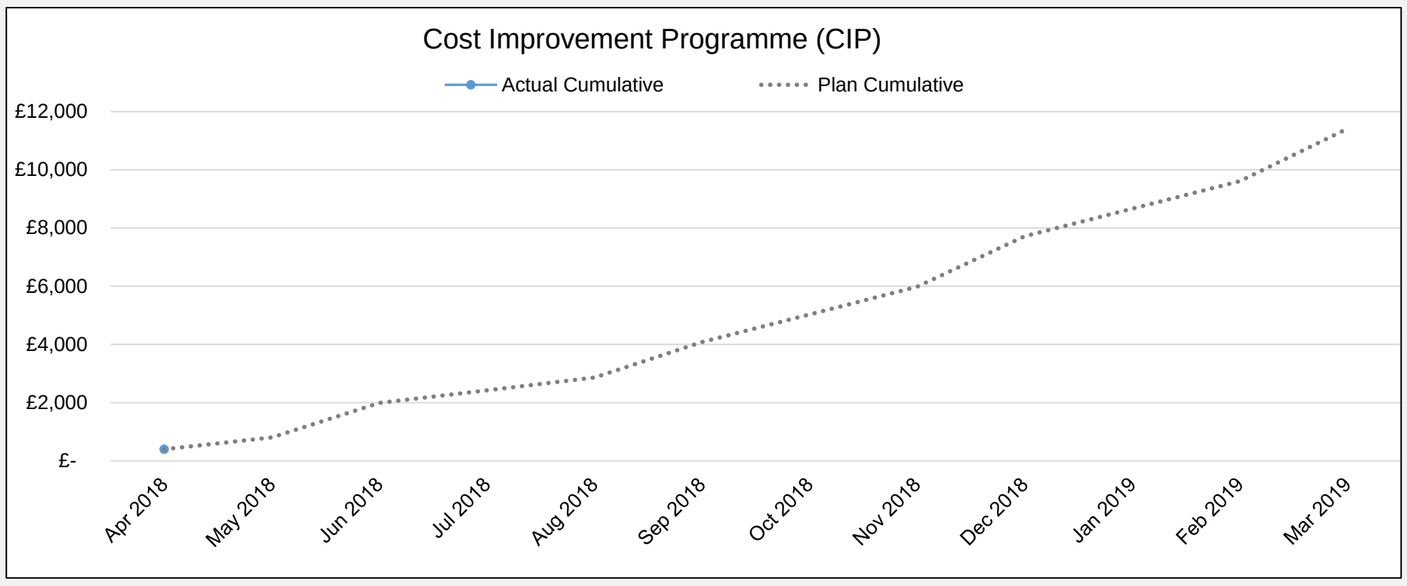
Agency Spend

	Feb-18	Mar-18	Apr-18	12 Month's
Actual £	£ 223	£ 413	£ 119	
Plan £	£ 328	£ 325	£ 240	

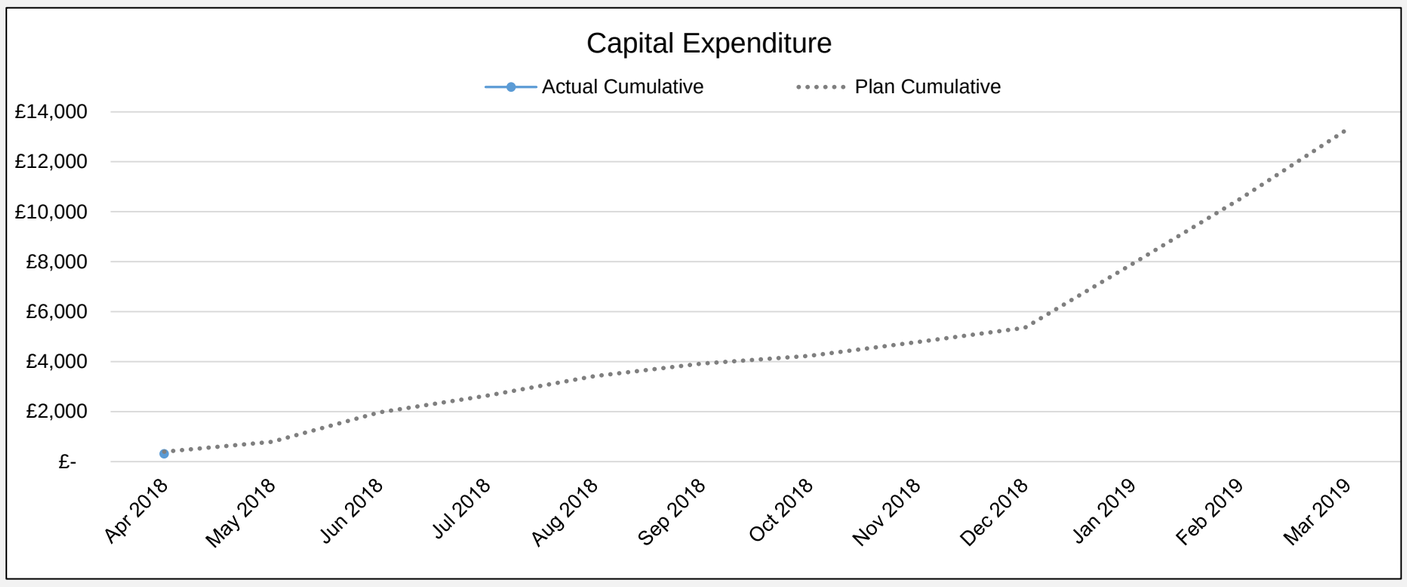
SECAmb Finance Performance Charts



The Trust has met its control total for month1, having recorded a deficit of £1.0m.

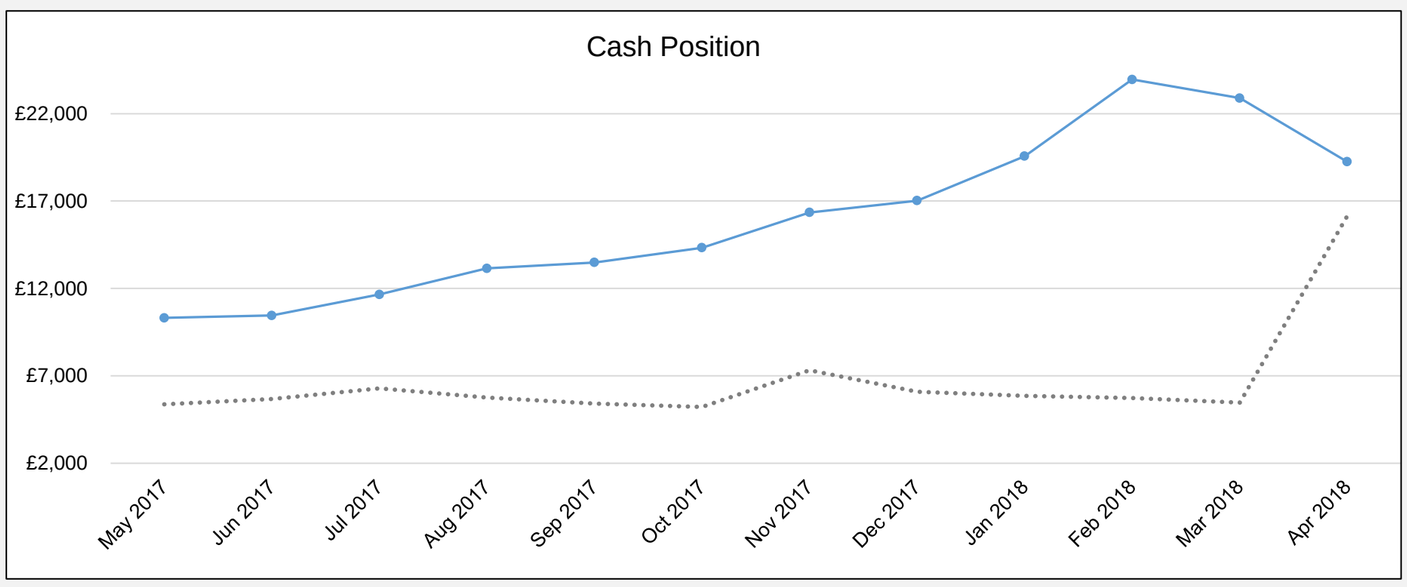


CIP schemes to the value of £0.4m were delivered in the month, in line with plan. The target for the full year is £11.4m.

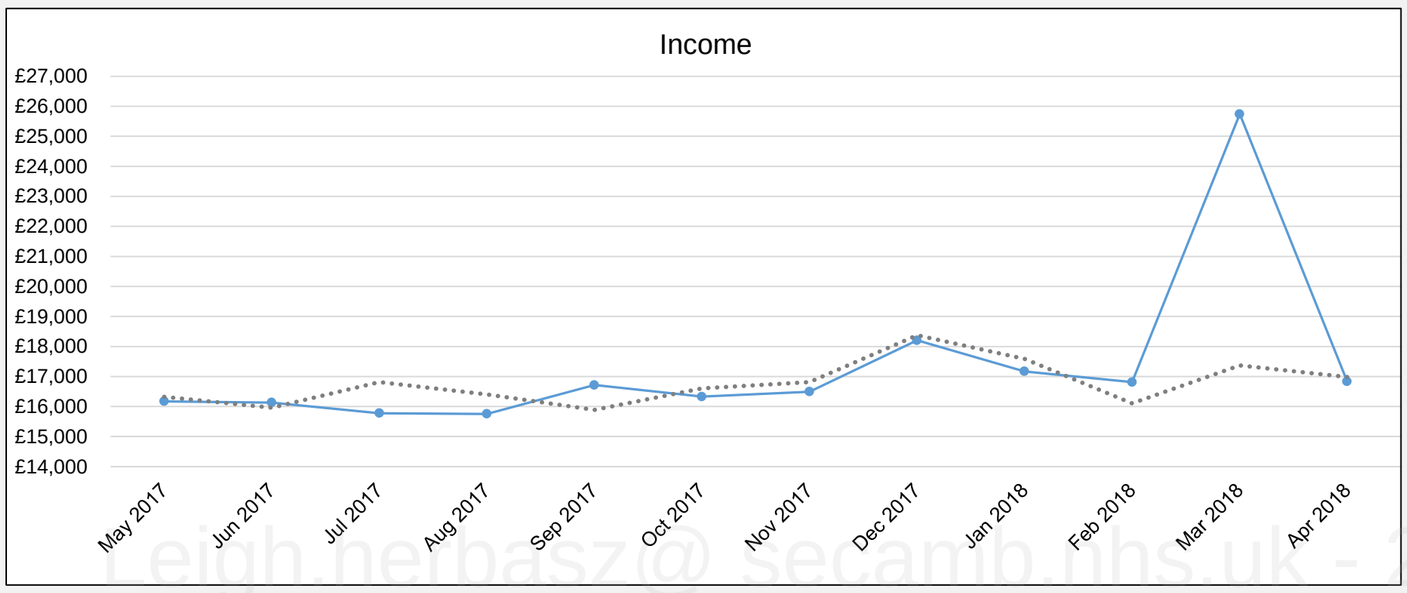


Capital spend in the month was £0.3m, which was £0.1m behind plan.

The Trust has made a bid for nearly £10m of capital funding in the first part of the national ambulance capital bidding process. This is for bids that will improve performance against Ambulance Response Programme (ARP) targets in the current financial year. The second part of the exercise relates to longer-term improvements.

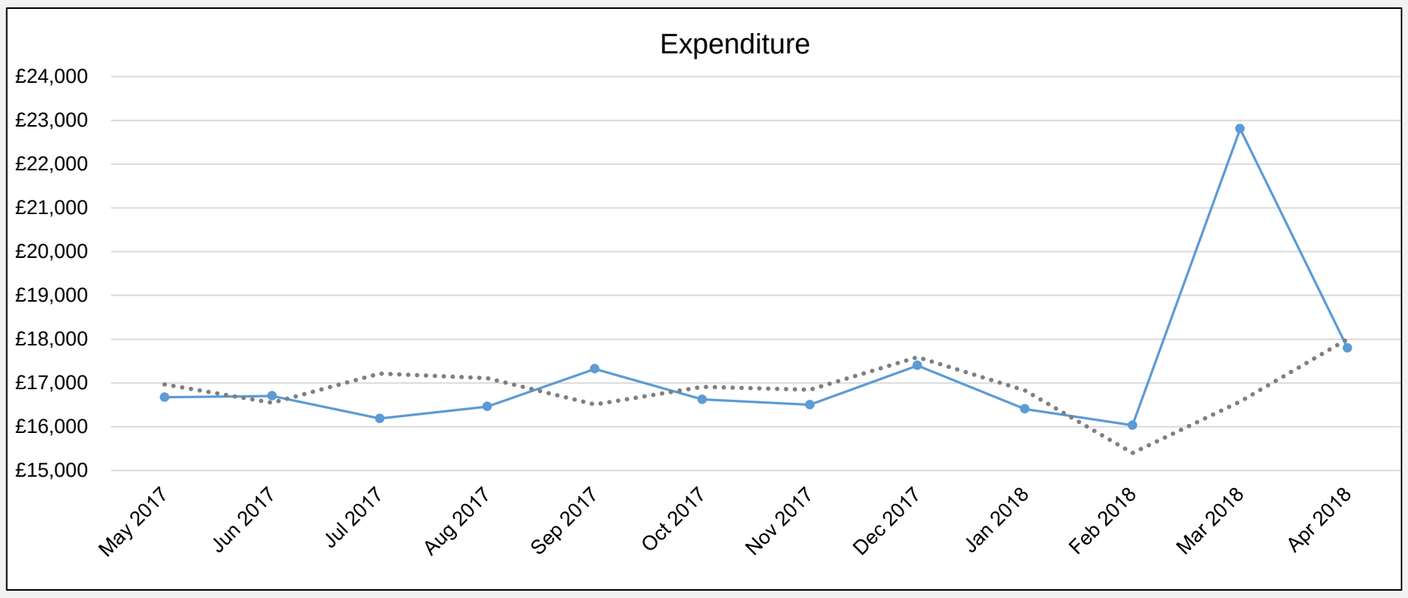


The cash position on 30 April was £19.2m, compared to the planned level of £16.2m. The year-end balance was £22.9m



Income was £0.2m behind plan, the shortfall being placement support funding from Health Education England and Apprenticeship Levy funding.

SECAmb Finance Performance Charts



Expenditure was marginally below plan.

South East Coast Ambulance Service NHS Foundation Trust

Item No	53/18

Name of meeting	Trust Board
Date	28 June 2018
Name of paper	Estates Summary Report June 2018
Executive sponsor	David Hammond, Executive Director Finance & Corporate Services
Author name and role	Paul Ranson, Acting Head of Strategic Estates
Synopsis, including any notable gaps/issues in the system(s) you describe (up to 150 words)	The Estates strategy (which will be shared with the Board next month) details the business as usual work streams as well as the strategic priorities. Progress against each is set out in this report.
Recommendations, decisions or actions sought	For Information

Estates Summary Report June 2018

Executive Summary

The Estates strategy (which will be shared with the Board next month) details the business as usual work streams as well as the strategic priorities. Progress against each is set out in the report below. The condition of the Trust estate is varied and the available resources are split between backlog maintenance of the aged estate, and the upkeep of the new state of the art Make Ready Centres (MRC).

The Trust continues to plan for further MRC's at Brighton, Medway and in Surrey as well as drive the Lord Carter NHS productivity agenda and encourage the best use of the 'Public Estate'.

The SECAmb Estates team restructure is currently being worked through with colleagues from HR and interim resources are supplementing the current structure. In 2017 the Trust outsourced facilities maintenance to Rydon who provide a 24/7 response.

1. Estates / Rydon Helpdesk

1.1 The Estates Helpdesk received 396 works requests during May. The Trust has a Service Level Agreement with Rydons for the management of all requests.

1.2 On receipt of a work request, a job number is automatically issued to confirm receipt of the request, and allow for progress tracking. However, the outstanding work requests are also monitored by the Estates team to ensure compliance with the SLA. Rydons also provide reports at the monthly Performance Review Meetings. Works requests are prioritised into the follow categories and actioned accordingly:

Cat.1 – within 4 hour response - business critical, major H&S, security
Cat.1 – within 24 hour response – urgent but non critical repairs
Cat.3 – within 7 day response – non urgent, non-critical repairs

1.3 The process and contact details, which has been issued to all locations is as follows:
For all maintenance requests and repairs:

Between the hours of 8am & 5pm - email Rydon Helpdesk **ErithHelpdesk@rydon.co.uk**
Between the hours of 5pm & 8am weekdays & weekends call Rydon via **0808 164 3959**. If you send an email out of hours, it will not be picked up until the next working day.
For all out of hours' callouts, an engineer will attend within 4 hours.

2. Nexus House Users

2.1 To report all maintenance requests and repairs at Nexus House, you can either

i) Visit the main reception desk on the ground floor and report your fault to the guard on duty or
ii) send an email to **nexusbuilding4@gmail.com** or
iii) call **07921 425 226**

General Estates enquiries email; **Estates@secamb.nhs.uk**

2.2 Key points of contact are:

Paul Ranson, Acting Head of Strategic Estates for any escalation issues; email paul.ranson@secamb.nhs.uk mob tel 07917 58150
Marcia Williams, FM Contracts Manager for any repairs or maintenance issues; email Marcia.williams@secmb.nhs.uk mob tel 07775 413269

2.3 We are exploring the option of an internal Estates Helpdesk facility to replace the Estates general email. This will allow track and trace of all non Rydon Helpdesk enquiries.

3. Examples of BAU Issues

3.1 There has been a recent spate of insect / pest issues at both EOC's. A treatment plan has been implemented at both sites to address the immediate problem. The treatment process appears to have resolved the issues as no further issues have been reported however the final set of 3 spraying session will be completed by end of June. An on-going treatment plan to prevent future issues is also being established.

3.2 Temperature control at Nexus has been improved, although there are still some further works to be completed by the Managing Agents anticipated completion 29 June. The full system has been reviewed and any maintenance or servicing implemented to resolve the inconsistent temperature.

3.3 Grass cutting at Banstead was completed on Sat 16 June. The circumstances of why the grounds maintenance contractor did not attend as per the agreed schedule is being investigated and remedial action taken.

3.4 The refurbishment of staff rest room at Nexus House was completed on 11 June with the installation of the TV. All the improvements were agreed in collaboration with staff side and feedback.

3.5 Carpet cleaning for Nexus is being arranged, anticipated by the end of June. This is to clear the food and drink spillages and general wear. We are also obtaining costs for an alternative flooring in the rest room as this area is particularly prone to spillage and probably not best suited to a light coloured carpet.

4. Operational Activity

4.1 Medicines Management – a number of sites are experiencing increased temperature in the medicines rooms. Estates have completed work at Redhill and are now working on Epsom, anticipated completion Monday 26 June. The solutions are varied depending on the site but typically include additional ventilation and air movement or installing air conditioning units to support temperature control. We are working with MM to address other sites as temperature issues are identified from the weekly monitoring.

4.2 QAV / H&S – Estates is working closely with the QAV team to ensure that any Estates related issues are actioned in a timely manner. All remedial works to comply with the recommendations identified in the Fire and Water Risk Assessments were completed at the end of May 2018. To ensure completeness we have commissioned a follow up review of all the recommendations. The review and actions will be completed by end of June.

5. Site Improvement Works

5.1 Site specific improvement works to improve staff welfare facilities such as toilets, showers kitchens crew rooms and H&S issues such as additional electrical sockets have been completed at Chertsey, Haselmere, Farnborough, Guildford, Hove and Burgess Hill. Hastings is currently underway and will be completed mid-July. This is a significant scope of work and will transform staff experience and welfare.

5.2 Improvement works at Brighton and Medway will be commencing this month. The works are to ensure the sites are fit for purpose until the new MRC's in those regions are available in 2020/21.

5.3 There is a second tranche of site improvements, particularly focused in the West OU's. The scope of work and cost estimates have been obtained however we need to prioritise the sites with the relevant OM Managers.

6. Make Ready Programme

6.1 Medway - we have reached agreement with Kent Fire & Rescue to support SECAMB as the preferred bidder for the land. Medway Council have supported the collaboration and are providing grant funding from the One Public Estates to contribute towards the pre planning costs. We are currently appointing in partnership with KF&RS a 'valuer' to establish the fair market cost for the land acquisition.

6.2 Brighton – the Trust is required to discharge its pre planning conditions, prior to commencement of 'meaningful' works on site before the existing planning consent expires in March 2019 and must be based on the existing design. The works are targeted to commence by Dec 2018. The design team has been appointed, Chawton Hill Associates are acting as our Employer's Agent to lead on the project.

6.3 Tongham/ Farnborough/ Chertsey – similar to Banstead OU the region will require a feasibility study to inform a strategic plan.

6.4 The Worthing Business Case is to be approved to create a central reporting facility. Work on site will commence following BC approval.

6.5 Sheppey is also being reviewed to support the central location for Driver Training. Estates are producing an Outline Business Case for the possible options to redevelop the site and costs. Anticipated completion of the BC by mid-July

7. North Surrey

7.1 Banstead – the are a number of possible options for Banstead and the surrounding stations. A feasibility study to include the current market values of all the properties in the OU has been completed and will help inform the meeting scheduled for 21 June with the Director of Operations.

Paul Ranson
Acting Head of Strategic Estates
June 2018