South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

26 July 2018
10.00-12.30

Crawley HQ

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
Introduction					
57/18	10.01	Apologies for absence	-	-	GC
58/18	10.02	Declarations of interest	-	-	GC
59/18	10.03	Minutes of the previous meeting: 28 June 2018	Y	Decision	GC
60/18	10.05	Matters arising (Action log)	Y	Decision	GC
61/18	10.10	Patient story	-	Set the tone	
62/18	10.20	Chief Executive's report	Y	Information	DM
Trust strategy					
63/18	10.30	Delivery Plan	Y	Assurance	DM
64/18	10.45	Delivery Plan Deep Dives: a) Culture b) EOC c) CQC Must/Should Do Tracker	 Y Y Y	Assurance	 EG JG BH
65/18	11.05	Finance & Investment Committee Escalation Report	Y	Information	AS
66/18	11.10	ICT Interim Enabling Strategy		Decision	DH
Governance & Risk Management					
67/18	11.15	Audit Committee Escalation Report	Y	Information	AS
68/18	11.20	Board Assurance Framework Risk Report	Y	Decision	PL
69/18	11.30	Charitable Funds Committee Report	Y	Information	AS
Quality & Performance					
70/18	11.35	Quality & Patient Safety Committee Escalation Report	Y	Information	LB
71/18	11.40	Incidents and SIs Annual Report	Y	Information	BH
72/18	11.50	Integrated Performance Report	Y	Information	SE
73/18	12.10	Workforce & Wellbeing Committee Escalation Report	Y	Informaiton	TP
74/18	12.15	Freedom to Speak Up Annual Report	Y	Informaiton	BH
Closing					
75/18	12.25	Any other business	-	Discussion	GC
76/18	-	Review of meeting effectiveness	-	Discussion	ALL
Close of meeting					

Date of next Board meeting: 30 August 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,
28 June 2018

Polegate MRC
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
David Hammond	(DH)	Executive Director of Finance & Corporate Services
Ed Griffin	(EG)	Executive Director of HR & OD
Fionna Moore	(FM)	Executive Medical Director
Laurie McMahon	(LM)	Independent Non-Executive Director
Lucy Bloem	(LB)	Independent Non-Executive Director
Tim Howe	(TH)	Independent Non-Executive Director
Tricia McGregor	(TM)	Independent Non-Executive Director
Terry Parkin	(TP)	Independent Non-Executive Director

In attendance:

Peter Lee	(PL)	Trust Secretary
Janine Compton	(JC)	Head of Communications
Sue Barlow	(SB)	Associate Director of Operations

39/18 Apologies for absence

Bethan Haskins	(BH)	Executive Director of Nursing & Quality
Joe Garcia	(JG)	Executive Director of Operations
Steve Emerton	(SE)	Executive Director of Strategy & Business Development

40/18 Declarations of conflicts of interest

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

41/18 Minutes of the meeting held in public on 26 May 2018

The minutes were approved as a true and accurate record.

42/18 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.

43/18 Patient story [10.02 – 10.10]

This related to a patient who was a 'frequent caller' and had been helped by the frequent caller team to get a more appropriate response to her needs, rather than relying on an emergency 999 response.

The Board reflected that this was a good example of a patient with complex needs that we have been able to support. It is one example of many where the frequent caller team supports individuals to ensure they receive an appropriate response, whilst reducing demand on emergency 999. FM outlined for the Board how the team works and the sorts of patients they support, emphasising the importance of getting to know the patients and local teams.

44/18 Chief Executive's report [10.10 – 10.18]
DM referenced the issues set out in his report.

Questions:
TM confirmed that in relation to engagement, there is a NED forum for Surrey Heartlands STP which she is attending.

GC asked about the national funding announcement recently. DH confirmed that we have made some capital bids which will help to deliver APR. We have the demand and capacity review and there is a clear overlap, to ensure a fully funded ambulance service.

45/18 Delivery Plan [10.18 – 10.28]
DM introduced the structure of the report and then asked the relevant directors to provide an update by exception.

Transformation
SB confirmed that hear and treat is Red due to recruitment of clinicians. However, the clinical navigators have been appointed to improve clinical safety and SB explained how we use Make Ready Centres as bases for providing this service.

LB added that the quality and patient safety committee has recently reviewed the clinical tail audits, which are now established.

Action:
Deep Dive on the 'tail' and how we are maintaining patient safety to come to the Board in August.

SB highlighted progress with the EOC project, which is also RAG-rated Red. There are some green shoots here, particularly with recruitment.

Sustainability
DH confirmed that the Steering Group is now well established. He highlighted that we have moved the EPCR project from Red to Amber, and there will be a more detailed update on the procurement in Part 2, due to the commercial sensitivity.

Telephony has moved to Green, in light of the good progress regarding procurement and the implementation plan for the new system. LB reinforced how important this is and asked about the formal process. DH explained that the procurement and go live process will run in the same way as the CAD; it is the same project team. The same process will apply to ECPR too.

Action:
A NED to be identified to sit on the Telephony Project Board.

Compliance
FM confirmed the IPC annual report is on the agenda otherwise most things are on track.

Culture
EG explained that the focus has been on launching the values and establishing the leadership development programme. The full culture programme plan is being developed, as will be described in the deep dive.

46/18 Delivery Plan Deep Dives [10.28 – 11.10]

Culture
EG tabled a presentation updating Phase 2 of the culture change programme, a culture story board outlining the steps already taken and the HR transformation plan.

EG took the Board through the story board, which described some of the action taken in response to feedback from the Prof. Lewis report and the Staff Survey. For example, we knew from the Prof. Lewis report that the values on paper did not reflect what staff were experiencing. In response, we engaged in the refreshed values and sets of behaviours, the latter being critical to change what is experienced, and supported a process to help ensure these are well embedded, e.g. the values cards and cubes which are presented to staff by their peers to recognise when the values have been clearly demonstrated. In addition, the leadership programme is helping to support staff identify poor behaviours and how best to tackle this in a positive manner. We will agree how often to create these story boards.

The Board explored the broader communication approach to ensure there is a balanced and direct focus on the positives and impact this is having on the workforce. DM added that the 'review of the year' document that is due to be published sets out all the good work we have done. There is also a poster with key achievements.

TH asked about the pace of the programme of work, noting that in the past it has been a bit stop start. EG explained there is now clearer ownership and focus and clarity about the type of culture we want to build, whereas in the past there was lots of focus on where we wanted to move away from. Now we are clear where we want to get to, which is critical. We are trying to get maximum impact on the workforce, by focussing next on OTLs and OUMs, in addition to setting up some work to shift the relationship between dispatch and crews on the road.

The Board agreed the importance of members improving visibility and continually conveying key messages.

AT asked how the executive is helping to get in to the organisation to improve relationships and clarify the signs of success. EG explained that he and JG are meeting teams to confirm the values and reinforcing they are not negotiable. Meetings are also being held with all the OTLs to support them to engage better with their teams.

GC summarised that culture change is a longer-term game plan. The storyboard is helpful as a start to show what we are doing and the impact of this. There is now greater opportunity for the board through the leadership walk round programme to test the impact of what we are doing.

Hospital Handover
DM explained that we brought in a project lead from Sussex Community Trust to help support the system address the hospital handover delays. The Steering Group is chaired by a Chief Executive from an acute Trust and the two Task & Finish Groups are chaired by acute Chief Operating Officers. The impact has been positive and is showing some improvement, compared to last year. We are working closely with NHSI too, as this is a national issue. There is good engagement across most hospitals.

An emerging focus is not just to improve overall delays, but what more the Trust can do to improve crew to clear time. We will start to benchmark across OUs to spread best practice and understand where improvements are not being made.

GC confirmed that he has met a number of Chairs recently and there appears to be recognition that this is a significant issue and how we are supporting the pathway is seen really positively.

The Board acknowledged the good work and improving picture from last year, but noted caution that we are still losing more hours than in 2014-15, when the Board then felt it was unsustainable. The risk is that the new reality becomes more acceptable, in light of the recent improvement, when in fact it continues to still be a significant issue.

DM reassured the Board that there is no complacency; everyone in the system involved in this work recognises the huge amount still to do. DH added that there is much emphasis on this in the winter planning. The demand and capacity is based on current reality of handover delays so there is clear recognition of the impact of this in the ambulance service being able to meet performance targets.

CQC Must/Should Do
DM introduced this tracker.

Questions:
LB explained that at the last meeting of the quality and patient safety committee, there was a presentation on the reasons we still have unreconciled records. Effectively, making it clear it will not be resolved fully until we have ECPR in place.

LB asked about the Should Do relating to ensuring patients with an IBIS record are immediately flagged to staff taking calls 24 hours a day, seven days a week, and how quickly we can improve IBIS. SB explained we are looking to recruit to help this service.

Action:
IBIS Should Do (currently Red0 to include a timeframe to give clarity on expected progress

DM mentioned that IBIS is another potential area of outstanding practice; other trusts are visiting us to learn from what we do.

LB asked about the Should Do regarding competency of staff. DM confirmed the executive team discussed this recently and will ensure we explain what we are actually doing.

JC confirmed we had nine CQC focus groups this week, ahead of the core inspection. The initial feedback was that they were well facilitated by the CQC. No issues were raised that we weren't aware of. Overriding message seems to be that while there is still lots to do, we are making significant progress.

47/18 Strategy Refresh [11.10 – 11.12]
DM explained SE is working with LM and other NEDs on the steps for the strategy refresh. In the meantime, we continue to work on reinforcing our current strategy, which is coming to the end of year one.

We have a date in diary for a board strategy day in July and the strategy refresh roadshows are also scheduled to ensure good engagement with staff.

48/18 QPS Escalation Report [11.12 – 11.22]
LB took the Board through the report, acknowledging the assurance received as set out in the report.

There was discussion about medical equipment and the move to the new Fleet Man system.

Action:
FIC to scrutinise the Fleet Man system

TM added that the patient care records presentation at the quality committee, which LB mentioned earlier, helped to demonstrate that the OUM had created a culture for people to speak up so the issues underlying this were identified so that action could be taken. There is a clear link here between culture and patient safety.

49/18 Accountable Officer for Controlled Drugs [11.22 – 11. 29]
FM confirmed that this is her first annual report as accountable officer for controlled drugs, and its aim it so to provide assurance that we have safe and effective management of controlled drugs. To put this in to context, the Trust only uses four controlled drugs, each one managed as schedule 2, so very rigorously. In terms of improvements:

- Medicines governance and implementation of 10 new SOPs and getting policy up to date.
- Work on practical ways CDs are managed
- Reduced morphine use
- Changed the way CDs are carried – less breakages by 31% since personal issue belt pouch.
- Better signing in and out of CDs

In summary, there have been a number of lessons learned and we can now better evidence how we manage controlled drugs.

The Board noted the good work, and reflected that medicines is the one area most transformed.

50/18 IPC Annual Report [11.29 – 11.30]
The Board noted this report and had no questions

51/18 Clinical Review - Falls [11.30 – 11.46]
FM talk to the slides explaining that the fear of falling impacts significantly on this group of patients. So it is not just about how quickly we get to these patients. The impact of the service responding to these calls is illustrated by the stats in the slides. The conveyance rate relatively low. There is concern about the time we take to get to some patients, although this has improved slightly from December 2017. The examples provided highlights the challenges and the last slide sets out the steps being taken to mitigate the risks when delays do occur.

DM explained there are number of pilots being undertaken, and the next step is to evaluate these to determine the best operating model going forward, engaging with the wider system.

Action:
Update on falls patients to the Board in October 2018

52/18 **IPR** [11.46 – 11.54]
Questions:

The Board asked about how we reflect the data from March to April and a number of indicators have dropped sharply. EG explained that we are exploring how to improve the data so we do not have such a drop.

Action:
SE to reflect the trajectory for each KPI and in the meantime, ensure a footnote confirms why there is a drop from March in to the following year.

On clinical outcomes, FM outlined some of the work looking at trusts that perform well on care bundles to understand what they are doing. It appears to be more to do with documentation than patient care. We are only looking at confirmed STEMI and confirmed strokes so the numbers are even smaller.

SB confirmed that improvement with Cat 3 continued in to May and there is a plan in place to respond to the recent increase in calls.

53/18 **Estates Summary Report** [11.54 – 12.03]
DH explained that this is a brief update on the work of estates ahead of a deep dive by the finance and investment committee in July. DH took the board through the issues detailed in the paper, adding that we are constantly reviewing the structure of the relatively small estates team to ensure it meets the needs to the Trust.

GC summarised that this paper was requested given recent estates challenges, and this demonstrates the work to ensure continual improvement.

[Comfort Break 12.03-12.07]

54/18 **Local OU Presentation** [12.07 -12.43]
[Hastings and Polegate OUM and members of the team joined the meeting to give a presentation]

GC thanked the team for joining the meeting to explain some of the work done in this OU.

The team spoke to a presentation outlining the geography of the operating unit and the services provided, and the highlights of the presentation included the following:

- With so many people in the area over 65 the OU model supports a more tailored service.
- Low levels of vacancies.
- Work on the estate – two MRCS, the trust's oldest and newest. Work over the past year to integrate. Great facilitates at Polegate, although still a few estate-issues / snag-list.
- Fleet – still some old vehicles in use. Positive about the new Fiat DCAs at Polegate.
- How the significant improvements were made with the team between December 2017 and March 2018.
- Recent QAV yet to feedback, but hoping to get Good. Really positive about the QAVs. We now do peer to peer reviews too.
- System of accountability now in place, supported by scorecards.

- OTL Development Days established.
- System for contemporaneous PCR audit – to ensure real-time feedback on how PCRs can be improved.
- Introduction of mental health practitioners in the Trust to support staff wellbeing.
- Local performance is at odds with trust, where the OU meets C3 & C4 but not C1s, due to some of the rural areas within the geography.
- Pathways being developed with local stakeholders to make it more user-friendly.
- Systems in place locally to ensure learning by introducing a 'potential for learning' forum.
- Progress with handover delays at A&E departments.
- Values being embraced positively.

The Board thanked the team for this update and the really positive progress being made locally. It asked management to explore how to replicate this across the other nine OUs.

55/18 Any other business
None

56/18 Review of meeting effectiveness
AR felt that this was the best board meeting for some time, which efficient use of time on agenda items. Honest and good responses from management. The QPS report gave a good level of detail to help provide reassurance. A great presentation at the end, which helps to support some of the improvement being made.

There being no further business, the meeting closed at 12.43

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	August	Board	IP	
27.03.2018	195 5	The Board will receive a further update on the actions taken in response to the Bullying & Harassment Report.	EG	June	Board	C	received in July as part of the Culture Deep Dive - StoryBoard
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	C	received on 23.07.2018
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	C	Received on 11.07.2018. The Committee was not assured and has asked for the action plan to come back to the Sept meeting - see link to BAF Risk ID 239
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	C	As above
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	c	On agenda
25.05.2018	27/18 14	Board away day to be scheduled for the strategy update.	PL	July	Board	c	18.07.2018
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	

28.06.2018	45/18 21	Deep Dive on the 'tail' and how we are maintaining patient safety to come to the Board in August.	JG	August	Board	IP	
28.06.2018	45/18 22	A NED to be identified to sit on the Telephony Project Board.	DH	August	Board	IP	
28.06.2018	46/18 23	IBIS Should Do relating to ensuring patients with an IBIS record are immediately flagged to staff taking calls 24 hours a day, seven days a weekto include a timeframe to give clarity on expected progress	JG	August	Board	IP	
28.06.2018	48/18 24	FIC to scrutinise the Fleet Man system	DH	TBC	FIC	IP	
28.06.2018	51/18 25	Update on falls patients to the Board in October 2018	FM	October	Board	IP	
28.06.2018	52/18 26	SE to reflect the trajectory for each KPI in the IPR and in the meantime, ensure a footnote confirms why there is a drop from March in to the following year.	SE	Sept	Board	IP	

Key

- Not yet due
- Due
- Overdue
- Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	63/18

Name of meeting	Trust Board
Date	26 July 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 the monthly update on the progress made with the Delivery Plan
Recommendations, decisions or actions sought	The board is asked to • review the dashboard to be fully sighted on the current progress of the Delivery Plan • note the developments of the CQC Task and Finish Groups • 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

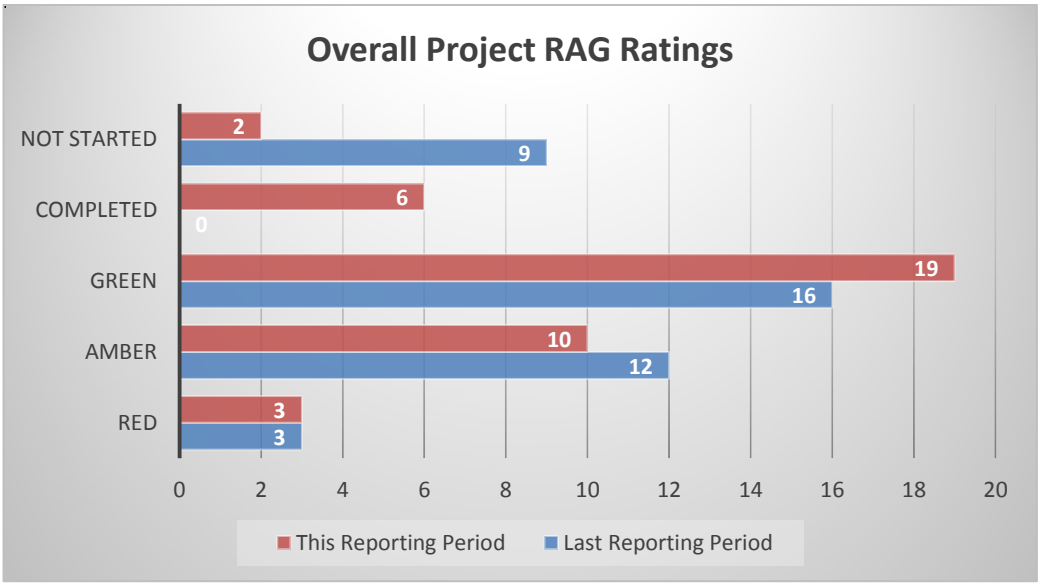
1.1 The Dashboard gives high level commentary and associated Key Performance Indicators (KPIs) for this reporting period where appropriate. As projects come to completion the reader should note that project closure processes will be enacted to ensure that continued and sustained delivery moves into Business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

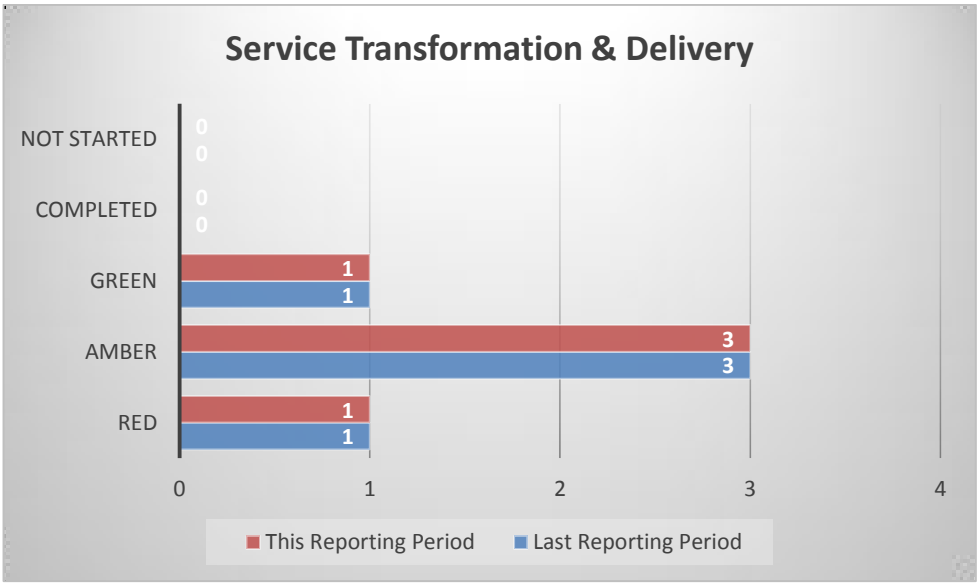
1.3 The Delivery Plan Dashboard (Appendix A) provides a summary of progress within this reporting period. For information the RAG status is defined as follows:

- 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 / formally closed
- 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** – This project is RAG remains Amber due to resources not yet in place to deliver. Recruitment pipelines have been developed for each Operating Unit to fulfil the establishment requirements of the Demand & Capacity review. Discussions are taking place with OU Managers, Resourcing and Training colleagues to determine the actions required at each Operating Unit to undertake recruitment campaigns and staff training within each OU. The timeline for delivery has been moved from 2020/2021 to 2019/20 as agreed by commissioners and providers.

2.1 **Demand and Capacity Review** – This project remains Amber. The Demand and Capacity review is nearing completion and final discussions are taking place to agree the delivery trajectories for the remainder of 2018/19 and subsequent years to meet full Ambulance Response Compliance and to agree the immediate and subsequent years contracting approach. This is in the context of all parties having committed to support the agreed delivery profile for its full duration. It is expected that the final details will be agreed for enactment by the end of July 2017.

2.2 **Hospital Handover –** The project remains RAG rated Amber. Over the coming weeks, the Programme Director and the Chair of the Operational working groups will revisit all of the acute sites and 'hold them to account' on their action plans to improve hospital handover delays. All sites have made efforts to improve this to date with some performing considerably better than others. A paper will be going to Executive Management Board to ensure the Trust is sighted on progress and of the risks/ issues within the programme.

A Job Cycle Time report has now been launched to report on the Trust's Hospital handover to crew clear has been launched with a face to face roll out across the whole trust on an OU by OU basis. This has been received well and we are hoping to see improvements imminently.

2.3 **Increased Hear and Treat** – The RAG status for this project remains at Red. With the current milestones in place, the project is unable to demonstrate the requisite increased capacity of the Clinical Supervisors in post in EOC. In addition, the original Hear & Treat target of 10% is now not achievable (at a national level) because of the changes and impact of the introduction of the ARP.

As a result, the subsequent benefits that are realised from the introduction of the Clinical Framework as part of the Hear & Treat project, despite being hugely beneficial from a patient safety perspective, do not change the project status from remaining Red overall.

The Project Board Chair will be submitting a change control request to amend the current project milestones which do not reflect actual requirement and the reality of Hear & Treat following the introduction of Ambulance Response Programme and the trajectory selected by commissioners and providers that 10% Hear and Treat rates will come into play from Q1 2019/20.

However, we have successfully appointed 8 of the 14 Clinical Safety Navigators roles to post with an advert for the remaining vacancies staying active until the full recruitment process is complete. In addition, the four Operational Clinical Manager roles have been filled following a rigorous recruitment process.

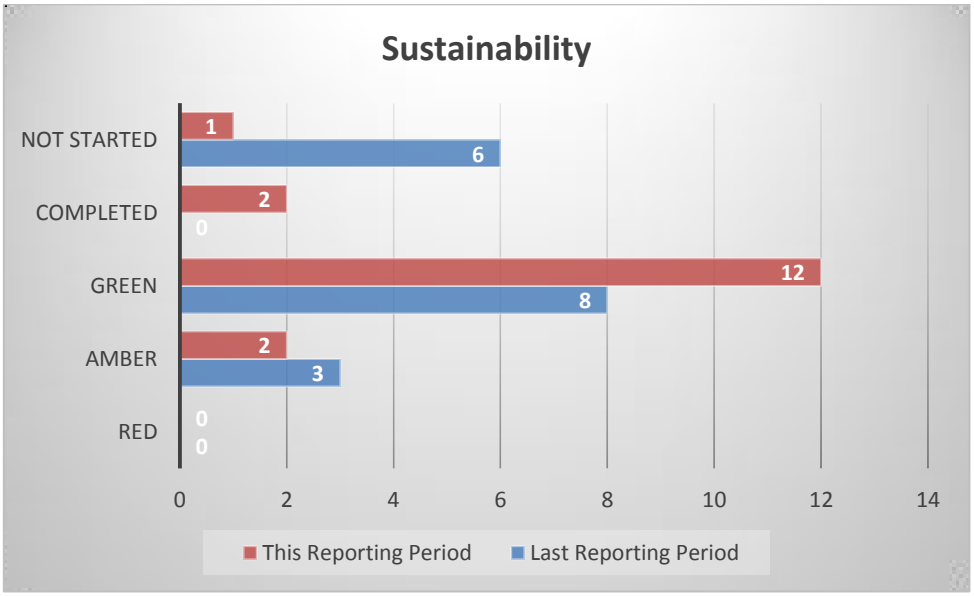
Having finalised the Manchester Triage System (MTS) code matching work stream and submitting the associated guidance notes for final approval to the Trust's Professional Standards group, we have initiated pilot work to recruit clinical staff from local MRC's to support CS activity within EOC, hence filling the staffing shortfall created by the inability to appoint against the substantive CS recruitment plan. Further pilots include centralising the governance processes, introducing a QA framework, telephony and recording of crew call-backs within the Thanet PP pilot and others in development

Rota reviews have been delayed due to lack of staff attendance at the planned engagement sessions however, the risk created by this is mitigated by pro-active staff profiling by the clinical safety navigators and scheduling in overtime and additional hours whilst the Clinical Safety Navigator role should bring additional resilience to the rotas. The clinical leadership team is working with HR to finalise the process and align rotas to match demand activity.

Risks are continued to be managed within the Trust Risk register where a new risk has been added within this period, identifying the need to increase staff engagement in one to ones as staff feedback on surveys has identified the need for improved engagement and involvement of developing initiatives. The monthly Clinical update newsletter and the monthly Trust-wide clinical skype calls are part of the action plan that is in place to mitigate the risk.

2.4 **National Ambulance Resilience Unit** – The project remains Green and continues to make good progress. The project team are confident that they can deliver within the timeframe, subject to risks and issues being managed. The parking risk highlighted in the last report has now been mitigated to some extent through NARU. There are no major issues around the project.

Sustainability



3.0 Digital Programme

Since the last reporting period, one new project have now been reported into the Digital work stream, Expansion of First Floor Crawley. Further detail is contained within this report.

3.1 **Automated Temperature Monitoring** – This project has now started and is RAG rated Green. 4 supplier meetings have now taken place and IT are currently awaiting for quotes and project schedules to be produced.

3.2 **Banstead POP** – This project remains RAG rated Green. Work will be completed by the end of July and then decommissioning continuing until the end of August 2018.

3.3 **Business Intelligence Improvement** – This project remains RAG rated Green. Work is progressing to move all existing reports to the new environment by the end of August 2018. Lightfoot reporting working off the new system and embedded within Operations. Work is progressing with telephony reporting. Project closure is currently being completed and this project is expected to be formally closed by the next reporting period.

3.4 **Corporate IT Systems Resilience** – This project has not yet commenced. ICT have tried to align this to the Trusts Business continuity arrangements but they are still being reviewed and therefore the project has separated this element from backups and therefore eliminating single points of failure.

3.5 **Cyber Security** – This project remains RAG rated Green. The project is on track with the first 3 milestones completed. The Telehouse migration on the new kit has now been completed.

3.6 **ePCR** – This project is RAG rated Green from Amber. A new Project Mandate and QIA is in development. Supplier presentation days are being arranged for early August 2018. The Procurement Award paper will be produced for the August Trust Board. It is likely a subsequent business case will be required for the approval for additional resourcing costs.

3.7 **GP Connect** – This project is now RAG rated Blue as it is now complete. The Trust now has the functionality to automatically create secure referrals and notifications to GP systems and the automatic filing of IBIS GP Summaries, Fall Referrals and Hypoglycaemia notifications into GP Clinical Systems.

3.8 **GRS App** – This project has now started and is RAG rated Green. The IT elements are now completed. The application will go live in early August 2018 as planned. Briefing packs are currently being prepared.

3.9 **Incident Management Software** – This project is now RAG rated Green. All the IT elements are now complete and training is now underway and the project is on track to complete by the end of September 2018.

3.10 **Provider Connect** – This project is now RAG rated Blue as it is now complete. The Trust now has the functionality to pulling care plan data from external systems which provides front line ambulance crews with mental health crisis care plans to reduce the number of patients conveyed to hospital.

3.11 **Replacement Fleet Management System** – This project is now RAG rated Green from Amber. A project plan has now been received from the supplier with a target go live date of November 2018.

3.12 **Replacement of Telephony and Voice Recording system** – This project remains RAG rated Green. The Project Mandate and Full QIA has now been approved. A project plan with clear project timescales will be produced shortly. An update to Executives on a fortnightly basis is now in place to provide additional oversight and assurance.

3.13 **Spine Connect** – This project remains Amber. EOC testing is due to commence shortly with the aim to go live at the end of the month. Project is on track to complete.

3.14 **Station Upgrades** – This project has now started and is RAG rated Green. The Business Case has recently been approved. Over the coming weeks, a project mandate and QIA will be prepared for Executive sign off.

3.15 **Expansion of First Floor Crawley HQ –** This project has now started and is RAG rated Green. The Business Case has now been approved to provide an additional 24 desks on the first floor of Nexus House. The completion date of this project will be the end of August 2018.

3.16 **Financial Sustainability Group**

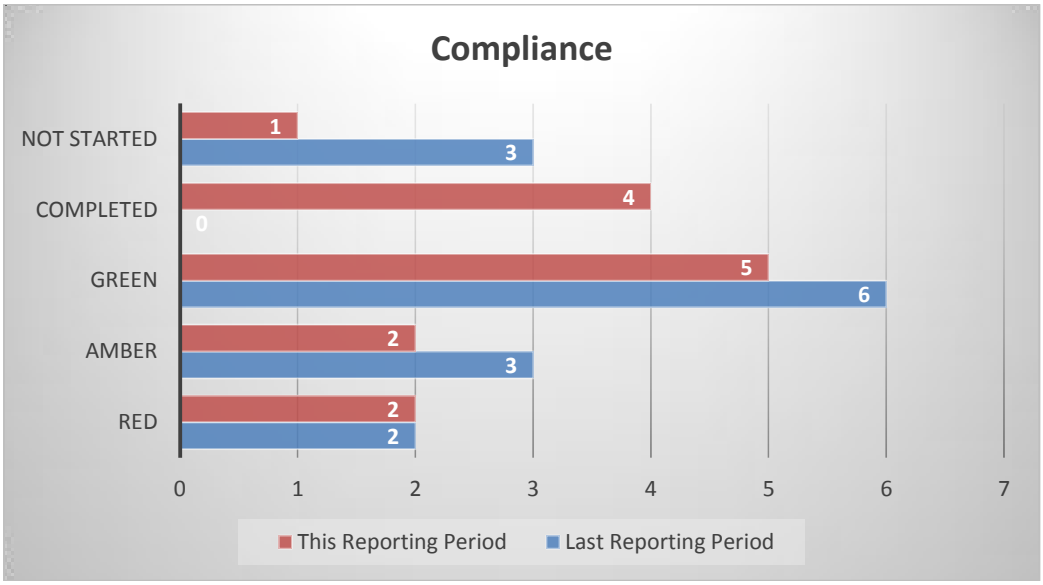
3.17 **CIP -** The Trust has reported a CIP target of £11.4m to NHSI as part of the 2018/19 Budget and Plan. The Pipeline Tracker and Delivery Tracker provide more detail on the construction of the CIP Programme. Project mandates have been completed for the majority of the schemes agreed at budget setting and have been signed off by the Executive Sponsors. 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 (Appendix B) and Delivery Tracker (Appendix C) have been included with this update.

3.18 **Estates & Procurement Update**

The Trust now has a pipeline of projects which will be overseen by the Sustainability Steering Group (Appendix D provides further details). As projects start, monthly updates will be provided within this report.

3.19 **Worthing Make Ready** – This project has now formally started with the Business Case approved recently. The scope and specification will be produced shortly with an anticipated start date on site in September

Compliance



4.0 CQC have now conducted 10 Deep Dives since November 2017. Appendix D provides a revised schedule of the forthcoming CQC Deep Dives with Culture Change Deep Dive on Wednesday 8th August 2018 and the Review & Evaluation of the Inspection in September 2018.

4.1 **EOC** *(CQC Must Do)* – Delivery of the project remains red as EOC clinical establishment remains below target levels and answer 5 second performance remains below trajectory. Audit performance is being realised but there are delays to meeting the target.

The Manchester Triage System (MTS) will be the enabler to increase clinical capacity within the EOC. MTS will allow clinical roles throughout the Trust to support EOC clinical care delivery. OUMs have been engaged and expressions of interest have been gathered from relevant staff. MTS has been presented to the EOC Governance Group and will be presented to the JPF for approval. EOC Systems are due to add in the required functionality to Cleric once the changes require to ARP have been facilitated.

Audit compliance has been met for May and work will continue on June to meet the same compliance. The target is to meet 100% compliance every month. Additional audit resource has been sourced to support this objective.

Answer 5 second performance saw a drop for June into July due to a number of factors including the hot weather and the World Cup leading to significant increases in 999 call demand. July's performance has improved in the middle of the month and is now showing an improvement compared to June's call answer performance.

4.2 **Governance, Health Records & Clinical Audit** *(CQC Must Do)* – This project is RAG rated Blue as it is now formally closed. The Trust now has an annual clinical audit plan and CPIs have now been introduced for the 2018/2019 plan. Other activities contained within the plan which have not yet been completed within the project timeframe are now part of Business as Usual with regularly reporting into the Quality Safety report, Clinical Audit Subgroup and East and West Governance Group.

4.3 **Governance and Risk** – The project has now started and the RAG is Green. The aim of the project is to establish the resource, leadership and governance which enables effective and sustainable implementation of the risk management policy and procedure. The project will also review the current management governance structure to enable effective management and oversight of services provided by the Trust including the continuation of embedding the system of monitoring and oversight of policies and procedures so that they remain updated in line with current guidance, available and understood by the relevant staff, and evaluated to ensure they are effective. No risks or issues highlighted in this reporting period.

4.4 **Incident Management** *(CQC Must Do)* – The project RAG is Green. Project closure was deferred by the Compliance Steering Group, pending further review of a number of open actions. A detailed review of the open actions and associated evidence was undertaken on 17th July 2018. A number of actions have been closed pending evidence validation. An updated plan is being submitted to the next Compliance Steering Group for consideration regarding readiness to commence the transition to project closure phase. No risks or issues highlighted in this reporting period.

4.5 **Infection Prevention and Control** *(CQC Must Do)* – This project RAG has moved from Amber to Green following a period in Intensive Support and a CQC Deep Dive, which has progressed the IAP work streams significantly. The IP Ready procedure is now in place and communications have started to embed the procedure across the Trust. The project plan is on track with no issues or risks to report within this reporting period.

4.6 **Medical Devices** *(CQC Must Do)* – This project is RAG rated Blue as it is now formally closed. All Medical Devices used are now recorded on a formal register and appropriately serviced within the pre-requisite timeframes. The Trust also has a medical devices management system that is fit for purpose. Other activities contained within the plan which have not yet been completed within the project timeframe are now part of Business as Usual with clear owners identified.

4.7 **Medicines Governance** *(CQC Must Do)* – This project RAG remains Green. The project will be formally closed once the data in the existing plan is transferred on to Power BI, which should be completed by the end of the month. Medicines Governance will continue to report into Compliance Steering Group on a weekly basis as part of Business as Usual.

4.8 **Patients with Complex Needs** – This project has not formally started. A draft project mandate, QIA, Terms and Reference has been developed but yet signed off.

4.9 **Performance Targets and AQIs** *(CQC Must Do)* – This project is RAG rated Blue as it is now formally closed. The Trust's performance against national targets, ensuring a bariatric resource arrives on scene within the target and reduction in the mean time spent on scene will now form part of Business As Usual.

4.10 **Resourcing Plan *(was previously known as ECSW & AAP Recruitment)*** – This project RAG moves from Amber to Red due to the current planned number of Emergency Care Support Worker (ECSW) and Associate Ambulance Practitioner (AAP) training courses not providing enough capacity to deliver 300 new external operational staff by 4th December

2018. There is also an increased risk in the ability to deliver current scheduled courses due to the delay in sourcing additional course facilitators. Options are currently being explored to mitigate this risk and to attract the numbers required.

The assessment process is under review and will be presented to Intensive Support group at the end of July which will help to further support the attraction of new candidates into the Trust.

4.11 **Risk Management** *(CQC Must Do)* – This project is RAG rated Blue as it is now formally closed. This project has now transitioned into the new Governance and Risk project (item 4.3). All open actions have been reviewed and transferred into the new plan with some activities now formed part of Business as Usual.

4.12 **Personnel Files** ***(was previously known as Safer Recruitment)*** – This project remains Amber due to the scale of the work to undertaken. Additional resource is being sought to support this work to ensure an inventory of all paper files across the Trust is set up and all electronic personnel files are reviewed in order to comply with the Data Protection Act 2018. The project will also ensure all necessary pre-employment checks are correctly stored in the personnel files.

The project team are currently undertaking the inventory of paper personnel files as well as reviewing electronic files. A mandate, QIA, and project plan are in development.

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.

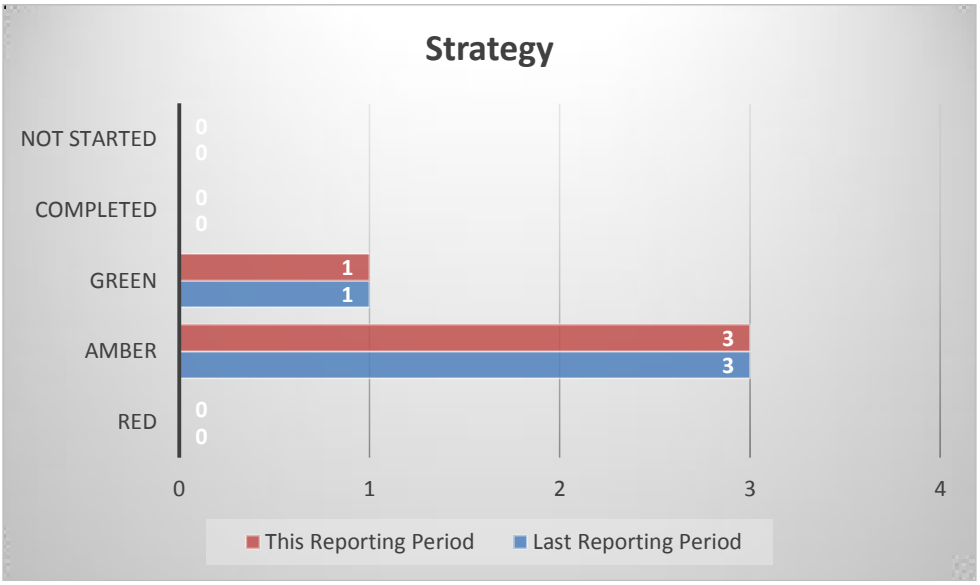
4.14 **Culture Change** – This project RAG is moves from Red to Amber. The project mandate has been revised to focus on three main areas; Engaging Staff, Managing Behaviours and Building an enabling infrastructure.

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 for Executive and Senior Leadership Teams will be fully delivered by the end of the month. In the coming months, Behaviour Management Training will be delivered to Operating Unit Managers, Operating Managers and Operational Team Leaders. Tackling Bullying and Harassment Workshops are also planned to commence in early September and will run throughout the rest of the year.

The Culture Change Team are actively attending operational meeting e.g. Teams A,B,C, 111 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



5.0 The Trust continues in its work to review and update our Five Year Strategic Plan 2017-2022. During the past month this work has focused on engagement with internal stakeholders, diagnostic work considering changes in the following:

- Population needs
- Activity demands and performance
- Local and national policy
- Internal and external changes
- STP and partners

The Trust is currently seeking views from external engagement sessions and other meeting opportunities to find out what has improved over the last year and what difference it has made. It is also used as an opportunity to further explore what else needs to change, develop and improve.

5.1 **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 which has not yet reported. The second submission and operating plan was submitted in April 2018 and a final iteration will be published including any feedback received, once we have the final output of the Demand and capacity review. An agreement has been made to continue year two of the 2017/19 contract until the completion of the Demand and Capacity Review. This has been enacted through a contract variation including changes to the national NHS contract. We are currently finalising all of the contract schedules to append to this, and to adapt for the contract following the demand and capacity review.

5.2 **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. We are also using all other engagement opportunities via quality visits and internal and external meeting to gather intelligence for our strategic work.

5.3 **Enabling Strategies** – This project RAG remains at Amber with workforce, Fleet, Estates, ICT, Research and Development, Clinical, Governance, and Partnership/ commercial all underway.

5.4 **Quality Improvement** – This project RAG remains at Amber. The Trust has developed 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 procurement process is currently being planned.

Delivery Plan Dashboard

Reporting period:
01 June to 30 June 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	01/04/2020 (previously 01/04/2021)	This project remains RAG rated Amber. Recruitment pipelines have been developed for each Operating Unit to fulfil the establishment requirements of the Demand & Capacity review. Discussions are taking place with OU Managers, Resourcing and Training colleagues to determine the actions required at each Operating Unit to undertake recruitment campaigns and staff training within each OU. The timeline for delivery has been moved from 2020/2021 to 2019/20 as agreed by commissioners and providers.	KPIs to be defined.	N/A	N/A	N/A	There is a risk that there isn't capacity to support delivery however approval has recently been sought to bring in additional resource which should mitigate this risk
	Demand and Capacity Review	Amber	Amber	Jayne Phoenix	Steve Emerton	N/A	31/07/2018 (previously 30/06/2018)	This project remains Amber. The Demand and Capacity review is nearing completion and final discussions are taking place to agree the delivery trajectories for the remainder of 2018/19 and subsequent years to meet full Ambulance Response Compliance and to agree the immediate and subsequent years contracting approach. This is in the context of all parties having committed to support the agreed delivery profile for its full duration. It is expected that the final details will be agreed for enactment by the end of July 2017.	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. Over the coming weeks, the Programme Director and the Chair of the Operational working groups will revisit all of the acute sites and 'hold them to account' on their action plans to improve hospital handover delays. All sites have made efforts to improve this to date with some performing considerably better than others. A paper will be going to Executive Management Board to ensure the Trust is sighted on progress and of the risks/ issues within the programme. A Job Cycle Time report has now been launched to report on the Trust's Hospital handover to crew clear has been launched with a face to face roll out across the whole trust on an OU by OU basis. This has been received well and we are hoping to see improvements imminently.	Handover delay no more than 60mins (by March 2018)	250	N/A	0	There is a risk to relationships and partnership working between SECAmb and hospitals as a result of unmatched progress towards achieving standards i.e. improvement in hospital handover times but no improvement in crew to clear times, which may lead to a breakdown in relationships The overall aim of the programme (to reduce hours lost at hospital sites consistently and across all sites) may not be met as a result of competing priorities both within individual hospitals and SECAmb, which may lead to hours lost at hospitals not reducing significantly and consistently.
									Crew to Clear time within 15mins 85% of the time	44.00%	85%	85%	
	Increased Hear and Treat	Red	Red	Scott Thowney	Joe Garcia	N/A	25/07/2018	The Trust has successfully appointed 8 of the 14 Clinical Safety Navigators roles to post with an advert for the remaining vacancies staying active until the full recruitment process is complete. In addition, the four Operational Clinical Manager roles have been filled following a rigorous recruitment process. Having finalised the Manchester Triage System (MTS) code matching work stream and submitting the associated guidance notes for final approval to the Trust's Professional Standards group, we have initiated pilot work to recruit clinical staff from local MRC's to support CS activity within EOC, hence filling the staffing shortfall created by the inability to appoint against the substantive CS recruitment plan. Further pilots include centralising the governance processes, introducing a QA framework, telephony and recording of crew call-backs within the Thanet PP pilot and others in development	45 clinical supervisors & clincal safety navigators in post in EOC	31.79	45	45	There is an increasing challenge to meet the Hear and Treat Performance target of 10% however, the Trust has agreed with Commissioners that it will not be able to achieve this level of Hear & Treat performance until September 2019. The Project Board Chair will be submitting a change control request to amend the current project milestones which do not reflect actual requirement and the reality of Hear & Treat following the introduction of ARP. As a result, we cannot achieve the original target (agreed prior to the introduction of ARP) within the project completion date, however, the recruitment of the Clinical Safety Navigators, Rota Review and other process improvements will help to support the mitigation of this risk and the service continues to deliver an improving trajectory of Hear & Treat performance over the past six months. Rota reviews have been delayed due to lack of staff attendance at the planned engagement sessions however, the risk created by this is mitigated by pro-active staff profiling by the clinical safety navigators and scheduling in overtime and additional hours whilst the Clinical Safety Navigator role should bring additional resilience to the rotas. The clinical leadership team is working with HR to finalise the process and align rotas to match demand activity. Risks are continued to be managed within the Trust Risk register where a new risk has been added within this period, identifying the need to increase staff engagement in one to ones as staff feedback on surveys has identified the need for improved engagement and involvement of developing initiatives. The monthly Clinical update newsletter and the monthly Trust-wide clinical skype calls are part of the action plan that is in place to mitigate the risk.
									Hear and Treat Performance	6.26%	10%	10%	
	National Ambulance Resilience Unit	Green	Green	Chris Stamp	Joe Garcia	N/A	31.10.2018	The project remains Green and continues to make good progress. The project team are confident that they can deliver within the timeframe, subject to risks and issues being managed. The car parking risk highlighted in the last report has now been mitigated to some extent through NARU. There are no major issues around the project.	Awareness training of HART response time standards for Command Teams	Data not available	98%	98%	No risks or issues highlighted in this reporting period.
									Commanders at all levels within Trust are trained and developed.	91.0%	95%	95%	
									IOR Training compliance for frontline staff	34.0%	95%	95%	
									HART operational capacity to meet national standards incorporating staff absence and turnover.	97.0%	95%	95%	
									To meet the Response times standards for deployment	Data not available	95%	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 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 the majority of the schemes agreed at budget setting and have been signed off by the Executive Sponsors. 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 (Appendix B) and Delivery Tracker (Appendix C) have been included with this update.	Current CIP schemes fully validated	£2.6m	11.4m	£11.4m	The RAG rating for the CIPs programme remains at amber reflecting 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. To this end a non cash releasing CIP of £92k relating to improvements in Handover Delays for the first three months has been recognised.
	Automated Temperature Monitoring	Green	White	Timothy Poole / Jason Tree	David Hammond	N/A	TBC	This project has now started and is RAG rated Green. 4 supplier meetings have now taken place and IT are currently awaiting for quotes and project schedules to be produced.	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)	This project remains RAG rated Green. Work will be completed by the end of July and then decommissioning continuing until the end of August 2018.	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	Green	Alex Croft	David Hammond	N/A	01/06/2018	This project remains RAG rated Green. Work is progressing to move all existing reports to the new environment by the end of August 2018. Lightfoot reporting working off the new system and embedded within Operations. Work is progressing with telephony reporting. Project closure is currently being completed and this project is expected to close 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 project has not yet commenced. ICT have tried to align this to the Trusts Business continuity arrangements but they are still being reviewed and therefore the project has separated this element from backups and therefore eliminating single points of failure.	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 is on track with the first 3 milestones completed. The Telehouse migration on the new kit has now been completed.	All software and hardware is deployed and operational.				No risks or issues highlighted in this reporting period.
	Electronic Patient Clinical Records ("EPCR")	Green	Amber	Phil Smith	David Hammond	N/A	31.03.2019	This project is RAG rated Green from Amber. A new Project Mandate and QIA is in development. Supplier presentation days are being arranged for early August 2018. The Procurement Award paper will be produced for the August Trust Board. It is likely a subsequent business case will be required for the approval for additional resourcing costs.	KPIs to be defined				No risks or issues highlighted in this reporting period.
	Expansion of Crawley 1st Floor	Green	White	Paul Ranson	David Hammond	N/A	31.08.2018	This project has now started and is RAG rated Green. The Business Case has now been approved to provide an additional 24 desks on the first floor of Nexus House. The completion date of this project will be the end of August 2018.	KPIs to be defined	N/A	N/A	N/A	No risks or issues highlighted in this reporting period.
	GP Connect	Blue	Green	Phil Smith	David Hammond	N/A	31.05.2018	This project is now RAG rated Blue as it is now complete. The Trust now has the functionality to automatically create secure referrals and notifications to GP systems and the automatic filing of IBIS GP Summaries, Fall Referrals and Hypoglycaemia notifications into GP Clinical Systems.	Percentage of selected referrals successfully delivered to the GP system	No historical data available. Future KPI/Outcome data will be available once the service is implemented		95%	Project is complete.
									Percentage of selected referrals received via Docman inbox in primary care			60%	
									Percentage of selected referrals successfully filed within the GP system			80%	
	GRS App	Green	Green	Jason Tree	David Hammond	N/A	TBC	This project has now started and is RAG rated Green. The IT elements are now completed. The application will go live in early August 2018 as planned. Briefing packs are currently being prepared.	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	This project is now RAG rated Green. All the IT elements are now complete and training is now underway and the project is on track to complete by the end of September 2018.	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 now RAG rated Blue as it is now complete. The Trust now has the functionality to pulling care plan data from external systems which provides front line ambulance crews with mental health crisis care plans to reduce the number of patients conveyed to hospital.	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	Green	Amber	John Griffiths	David Hammond	N/A	01/11/2018 (previously 01/10/2018)	This project is now RAG rated Green from Amber. A project plan has now been received from the supplier with a target go live date of November 2018.	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	Green	Phil Smith	David Hammond	N/A	31/10/18 (previously 01/05/2018)	This project remains RAG rated Green. The Project Mandate and Full QIA has now been approved. A project plan with clear project timescales will be produced shortly. An update to Executives on a fortnightly basis is now in place to provide additional oversight and assurance.	New Telephony and Voice Recording system delivered.				No risks or issues highlighted in this reporting period.
	Spine Connect	Amber	Amber	Phil Smith	David Hammond	N/A	31.07.2018	This project remains Amber. EOC testing is due to commence shortly with the aim to go live at the end of the month. Project is on track to complete.	NHS Number Capture: percentage of C3/C4 calls are matched to an NHS Number.	No data available	No data available	60%	No risks or issues highlighted in this reporting period.
									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	Green	White	Jason Tree	David Hammond	N/A	31.03.2019	This project has now started and is RAG rated Green. The Business Case has recently been approved. Over the coming weeks, a project mandate and QIA will be prepared for Executive sign off.	KPIs to be defined	N/A	N/A	N/A	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
	Worthing MRC	Green	White	Joe Garcia	David Hammond	N/A	TBC	This project has now formally started with the Business Case approved recently. The scope and specification will be produced shortly with an anticipated start date on site in September 2018.	KPIs to be defined	N/A	N/A	N/A	No risks or issues highlighted in this reporting period.
Compliance Steering Group	EOC	Red	Red	Sue Barlow	Joe Garcia	02.05.2018	31.08.2018	Delivery of the project remains red as EOC clinical establishment remains below target levels and answer 5 second performance remains below trajectory. Audit performance is being realised but there are delays to meeting the target. The Manchester Triage System (MTS) will be the enabler to increase clinical capacity within the EOC. MTS will allow clinical roles throughout the Trust to support EOC clinical care delivery. OUMs have been engaged and expressions of interest have been gathered from relevant staff. MTS has been presented to the EOC Governance Group and will be presented to the JPF for approval. EOC Systems are due to add in the required functionality to Cleric once the changes require to ARP have been facilitated. Audit compliance has been met for May and work will continue on June to meet the same compliance. The target is to meet 100% compliance every month. Additional audit resource has been sourced to support this objective. Answer 5 second performance saw a drop for June into July due to a number of factors including the hot weather and the World Cup leading to significant increases in 999 call demand. July's performance has improved in the middle of the month and is now showing an improvement compared to June's call answer performance.	Clinical supervisors in post in EOC	33	45	45	The risk to meeting call answer time national standards remains one of the Trust's highest risks and formal approval of an increase in EMA establishment, along with consultation with the Association of Ambulance Chief Executives, is underway to control the risk and the issue of increased call volume. The resolution to the issue of increased call demand linked to ETA calls is dependent upon a combination of resolutions including: Appropriate and sufficient resource provision; development of "dispatch on disposition" ensuring the right resource is sent the first time, every time; working collaboratively with our acute partners in minimising hospital handovers; and improvements within See & Treat and Hear & Treat to support apposite ambulance patient outcomes and conveyance. These resolutions are managed outside of this project. The risk to meeting audit compliance requirements is now moderate thanks to consistently meeting improvement trajectory, but remains a risk since 100% compliance is now being sought monthly and delays in meeting this target need to be managed and reduced in order to sustain ongoing performance. Telephony, system and data challenges linked to EOC reporting and functionality remains a high risk with procurement of a new telephony system in October as the proposed solution.
									Number of audits per month	100% (May) 50.3% (June)	100.0%	100.0%	
									95% of calls answered within 5 seconds.	73.2%	92.5%	95.0%	
									FTE EMAs in post within EOC	182	171	187	
	Governance, Health Records & Clinical Audit	Blue	Green	Dean Rigg	Fionna Moore	19.01.2018	19/06/2018 (previously 31/03/2018)	This project is RAG rated Blue as it is now formally closed. The Trust now has an annual clinical audit plan and CPIs have now been introduced for the 2018/2019 plan. Other activities contained within the plan which have not yet been completed within the project timeframe are now part of Business as Usual with regularly reporting into the Quality Safety report, Clinical Audit Subgroup and East and West Governance Group.	No KPIs reported within this reporting period as project formally closed.				Project is complete.
	Governance and Risk	Green	White	Peter Lee	Daren Mochrie	TBC	31.03.2019	The project has now started and the RAG is Green. The aim of the project is to establish the resource, leadership and governance which enables effective and sustainable implementation of the risk management policy and procedure. The project will also review the current management governance structure to enable effective management and oversight of services provided by the Trust including the continuation of embedding the system of monitoring and oversight of policies and procedures so that they remain updated in line with current guidance, available and understood by the relevant staff, and evaluated to ensure they are effective. No risks or issues highlighted in this reporting period.	KPIs to be defined.				No risks or issues highlighted in this reporting period.
	Incident Management	Green	Green	Nicola Brooks	Bethan Haskins	08.11.2017	01.08.2018	The project RAG is Green. Project closure was deferred by the Compliance Steering Group, pending further review of a number of open actions. A detailed review of the open actions and associated evidence was undertaken on 17th July 2018. A number of actions have been closed pending evidence validation. An updated plan is being submitted to the next Compliance Steering Group for consideration regarding readiness to commence the transition to project closure phase. No risks or issues highlighted in this reporting period.	20% increase in overall incident reporting (Monthly)	712	583	583	No risks or issues highlighted in this reporting period.
									>75% of incidents closed within time target [SECAmb Target]	92%	75.0%	75.0%	
									90% of Serious Incident investigations will be completed within 60 working days.	50%	90.0%	90.0%	
									100% of Serious Incidents compliant with 72 hour STEIS reporting	100%	100.0%	100.0%	
									96% of incidents graded as near miss, no harm or low harm	96%	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	Green	Amber	Adrian Hogan	Bethan Haskins	N/A	31.08.2018	This project RAG has moved from Amber to Green following a period in Intensive Support and a CQC Deep Dive, which has progressed the IAP work streams significantly. The IP Ready procedure is now in place and communications have started to embed the procedure across the Trust. The project plan is on track with no issues or risks to report within this reporting period.	Hand Hygiene Staff Compliance	88%	No data available	90%	No risks or issues highlighted in this reporting period.
									Bare Below the Elbow	92%	No data available	90%	
									Vehicle Cleanliness Compliance	81%	No data available	75%	
									Station Cleanliness - Buildings Compliant	81%	No data available	100%	
									Station Cleanliness - Buildings Completed	100%	No data available	100%	
	Medical Devices	Blue	Green	Nicola Brooks	Bethan Haskins	06.06.2018	30.09.2018	This project is RAG rated Blue as it is now formally closed. All Medical Devices used are now recorded on a formal register and appropriately serviced within the pre-requisite timeframes. The Trust also has a medical devices management system that is fit for purpose. Other activities contained within the plan which have not yet been completed within the project timeframe are now part of Business as Usual with clear owners identified.	Double Crewed Ambulances (DCAs) and Single Response Vehicles (SRVs) Audited per Quarter.	373	240	240	No risks or issues highlighted in this reporting period.
									Submission of QUARTERLY Site Security Assessments in 2018/19 (MRCs, Stations, Crawley HQ, Fleet VMC)	97%	100%	100%	
									% of checked vehicles locked whilst unattended	100%	100%	100%	
									Number of CFRs who have provided their defib asset register details to the Voluntary Services Team	501	501	501	
	Medicines Governance	Green	Green	Carol-Anne Davies-Jones	Fionna Moore	19.02.2018	19/06/2018 (was previously) 31/03/2018	This project RAG remains Green. The project will be formally closed once the data in the existing plan is transferred on to Power BI, which should be completed by the end of the month. Medicines Governance will continue to report into Compliance Steering Group on a weekly basis as part of Business as Usual.	Medical Quiz Passes	Target achieved	2425	2425	No risks or issues highlighted in this reporting period.
									Compliance per Operating Unit	95.50%	97.50%	97.50%	
									DCA Drug cabinet key losses (Cumulative Total Nov 17 to Present) Three keys lost in month of April significant reduction.	3	N/A	N/A	
									CD Breakages (April Total)	15	0	0	
	Patients with Complex Needs	White	White	Sara Songhurst	Bethan Haskins	TBC	TBC	This project has not formally started. A draft project mandate, QIA, Terms and Reference has been developed but yet signed off.	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
	Performance Targets and AQIs	Blue	Amber	Chris Stamp	Joe Garcia	31.08.2018	30.09.2018	This project is RAG rated Blue as it is now formally closed. The Trust's performance against national targets, ensuring a bariatric resource arrives on scene within the target and reduction in the mean time spent on scene will now form part of Business As Usual.	Category 1 Mean	07:01	07:00	07:00	Project is complete.
									Category 1 90th Centile	13:44	15:00	15:00	
									Category 2 Mean	17:18	18:00	18:00	
									Category 2 90th Centile	34:03	40:00	40:00	
	Resourcing Plan (was previously known as Recruitment ECSW & AAPs)	Red	Amber	Alison Littlewood	Ed Griffin	TBC	04.12.2018	This project RAG moves from Amber to Red due to the current planned number of Emergency Care Support Worker (ECSW) and Associate Ambulance Practitioner (AAP) training courses not providing enough capacity to deliver 300 new external operational staff by 4th December 2018. There is also an increased risk in the ability to deliver current scheduled courses due to the delay in sourcing additional course facilitators. Options are currently being explored to mitigate this risk and to attract the numbers required. The assessment process is under review and will be presented to Intensive Support group at the end of July which will help to further support the attraction of new candidates into the Trust.	Recruitment of 300 external operational staff (ECSW & AAP) • ECSWs to be operational • AAPs to be in training	24	266	300	There is a risk that the project will not achieving 300 new external operational staff by December 2018 and the current scheduled ECSW courses do not provide enough training spaces to meet the required number of ECSWs. To mitigate this, a realistic trajectory for when the Trust will meet its intended target is currently being worked on and will be submitted to Intensive Support for review on 24th July 2018. A risk mitigation paper is also being written and will be submitted to EMB for approval at the end of the month. There is also a risk that the project costs may not be signed off in time to effectively recruit additional training and recruitment resource and this could add delays to obtaining pre-employment checks for candidates offered. There are also no training facilitators available to deliver the planned additional August ECSW course. This problem could extend into September & October. To mitigate this, a business case is currently being developed and will be going to EMB for a decision at the end of the month. Clinical Education are also actively exploring all options for alternative and internal facilitators to train in August 2018.
									Recruitment of 100 AAPs (Internal + External)	60	132	100	
	Risk Management	Blue	Green	Nicola Brooks	Bethan Haskins	19.01.2018	31.08.2018	This project is RAG rated Blue as it is now formally closed. This project has now transitioned into the new Governance and Risk project (item 4.3). All open actions have been reviewed and transferred into the new plan with some activities now formed part of Business as Usual.	Individual Risks Reviewed on Datix With Principle Risk Lead (includes training & awareness)	140	140	140	Project is complete.
									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	
	Personnel Files (was previously known as Safer Recruitment)	Amber	White	Isla MacDonald	Ed Griffin	TBC	TBC	This project remains Amber due to the scale of the work to undertaken. Additional resource is being sought to support this work to ensure an inventory of all paper files across the Trust is set up and all electronic personnel files are reviewed in order to comply with the Data Protection Act 2018. The project will also ensure all necessary pre-employment checks are correctly stored in the personnel files. The project team are currently undertaking the inventory of paper personnel files as well as reviewing electronic files. A mandate, QIA, and project plan are in development.	KPIs to be defined.				There is a risk that the Trust is not compliant with the Data Protection Act 2018 due to personnel files existing in both paper and electronic formats and not being available at one central location resulting in potential fines and reputational damage. The undertaking of this project will help to mitigate against this risk. There is a risk that the Trust is not always able to provide evidence of the relevant pre-employment checks, as a result of inadequate internal controls / record keeping, which may lead to sanctions and reputational damage. In order to mitigate against this, a DBS tracker has been developed to monitor the statuses of pre-employment checks.
	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.	100% of all 999 calls recorded				
									Auditing of calls take place on a weekly basis from 05 January 2018 (circa 2500 calls)				
									Approx. 15 sample calls carried out				
	Culture Change	Amber	Red	Clare Irving	Ed Griffin	N/A	30.04.2019	This project RAG is Amber. The project mandate has been revised to focus on three 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 for Executive and Senior Leadership Teams will be fully delivered by the end of the month. In the coming months, Behaviour Management Training will be delivered to Operating Unit Managers, Operating Managers and Operational Team Leaders. Tackling Bullying and Harassment Workshops are also planned to commence in early September and will run throughout the rest of the year. The Culture Change Team are actively attending operational meeting e.g. Teams A,B,C, 111 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.	20% of staff will report good communication between senior managers and staff - 2018 staff survey. 28% of staff reporting harassment, bullying or abuse from staff in the last 12 months. Less than 30 new grievances and 7 new cases of bullying and harassment reported from Oct 2018 or March 2019. Evaluation results from OTLs and staff training resources - evaluation methodology to be redesigned and targets to be set. n95% of staff participation in objective setting conversation, PDPs, career conversations and appraisal. Quality of appraisal 2.96. Overall staff engagement 3.45 45% of staff able to contribute to improvements at work. Recognition and value of staff by manager and organisation 3.01. Staff recommendation of seam as a place to work or receive treatment 3.44 Staff motivation at work assessed 3.65.				No risks or issues highlighted in this reporting period.
Strategy	Annual Planning	Amber	Amber	Jayne Phoenix Philip Astell	Steve Emerton	N/A	August 2018 (previously 30/04/2018)	This is the annual enactment of our strategy. This project remains RAG rated Amber given clear dependencies with the Demand and Capacity review which has not yet reported. The second submission and operating plan was submitted in April 2018 and a final iteration will be published including any feedback received, once we have the final output of the Demand and capacity review. An agreement has been made to continue year two of the 2017/19 contract until the completion of the Demand and Capacity Review. This has been enacted through a contract variation including changes to the national NHS contract. We are currently finalising all of the contract schedules to append to this, and to adapt for the contract following 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.				No risks or issues highlighted in this reporting period.
	Commissioner and Stakeholder Alignment	Green	Green	Jayne Phoenix	Steve Emerton	N/A	Ongoing	This project remains RAG rated Green. Engagement sessions are taking place and being planned in line with and as part of our strategy refresh. We are also using all other engagement opportunities via quality visits and internal and external meeting to gather intelligence for our strategic work.	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	This project RAG remains Amber, with Workforce, Fleet, Estates, ICT, Research & Development, Clinical, Governance, and Partnership/Commercial all underway.	All strategies completed by agreed timescales.				No risks or issues highlighted in this reporting period.
	Quality Improvement	Amber	Amber	Jon Amos	Steve Emerton	N/A	30.11.2018	This project RAG remains at Amber. The Trust has developed 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 procurement process is currently being planned.	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.				No risks or issues highlighted in this reporting period.

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 3 - June 2018

Programme Summary:

1. Validated or scoped schemes of £6.5m 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.To this end a non cash releasing CIP of £92k relating to improvements in Handover Delays for the first three months has been recognised.

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

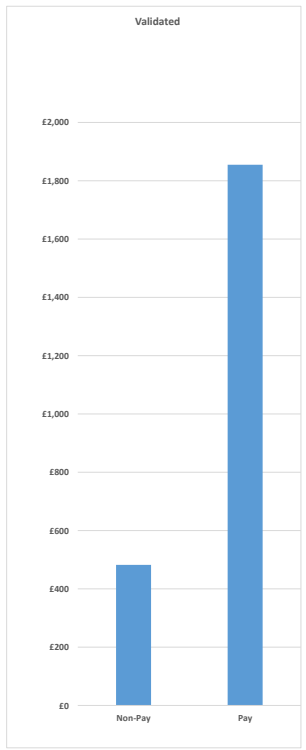
	Risk	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Risk that the 2018/19 CIPs target of £11.4m will not be fully delivered due to uncertainties within the Operations Directorate.	Monthly meetings with Budget Holders. Other potential CIP schemes are under review.	Kevin Hervey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

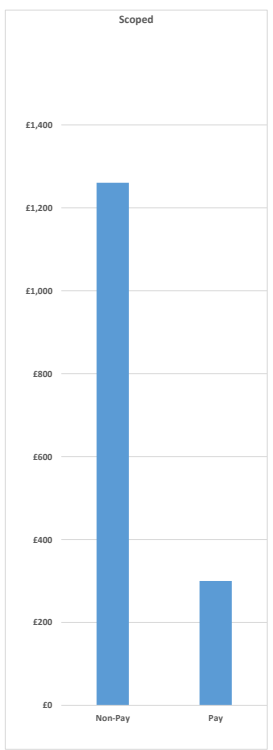
	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	New Lease Cars policy to be agreed.	Awaiting updates from John Griffiths (Response Capable Managers) and Ed Griffin (all other staff)	John Griffiths/ Ed Griffin	Amber	Amber	31-Aug-18
2	Medical Consumables - procurement cost savings to be considered.	Proposed medical consumables to be considered	Kirsty Booth/ John Hughes	Amber	Amber	31-Jul-18
3	HCA/Excess Mileage - consider scope for savings.	Trustwide Pay Costing Template to be reviewed	Graham Petts/ Priscilla Ashun-Sarpy	Amber	Amber	31-Jul-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	31-Jul-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	31-Jul-18
7	Agency Staff - Potential cost avoidance CIP	Recruitment to provide update	Claire Pullen	Amber	Amber	31-Jul-18
8	Develop Operations CIP schemes.	Discuss with Ops Director. Consider if further CIPs can be constructed for operational efficiencies.	Kevin Hervey/ Graham Petts	Amber	Amber	31-Jul-18
9	Devise mechanism for recoveries of old staff overpayments	Ongoing discussions with Payroll Manager/HR Director	Kevin Hervey	Amber	Amber	31-Aug-18

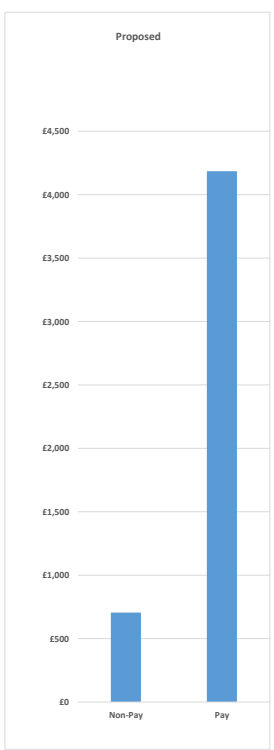
CIP Pipeline Summary

Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£1,400	£2,625	£937	£1,560	£4,890	£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	62	-	-	-	62
Estates and Facilities management	6	188	624	-	818
External consultancy & contractors	253	100	140	-	493
Furniture & Fittings	10	20	-	-	30
Insurance	661	-	-	-	661
IT Productivity and Phones	126	22	149	-	297
Medicines Management - Consumables	200	94	-	-	294
Medicines Management - Drugs	130	-	-	-	130
Medicines Management - Equipment	107	-	17	-	124
Meeting room hire	79	17	8	-	103
Operations efficiency	-	-	-	1,045	1,045
Procurement contracts review	-	-	200	-	200
Public relations	4	-	-	-	4
Recruitment delays - clinical	-	-	-	1,393	1,393
Recruitment delays - non clinical	-	-	-	1,747	1,747
Single HQ /EOC Benefits realisation	-	-	300	-	300
Staff Uniforms	-	-	100	-	100
Stationery	39	-	-	-	39
Top Slice - all directorates	-	-	-	705	705
Training courses & accommodation	433	17	-	-	450
Travel & Subsistence	267	25	23	-	314
Fleet - Fuel: Telematics & Price Differential	200	-	-	-	200
Handover Delays	-	92	-	-	92
Clinical Assessment Team Vacancies	-	363	-	-	363
Grand Total	2,625	2,337	1,560	4,890	11,412

South East Coast Ambulance Service: CIP Workstream

CIP Delivery Dashboard

Reporting Month Jun-18

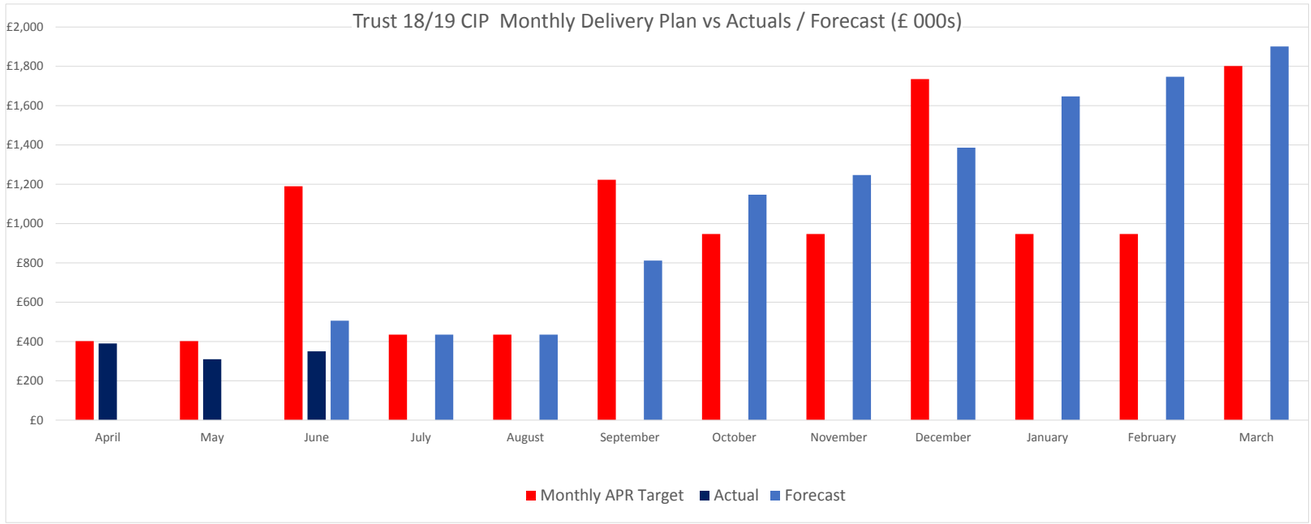
Programme for 2018/19 to deliver a minimum of £11.4m savings to achieve the planned £0.8m control total deficit.

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

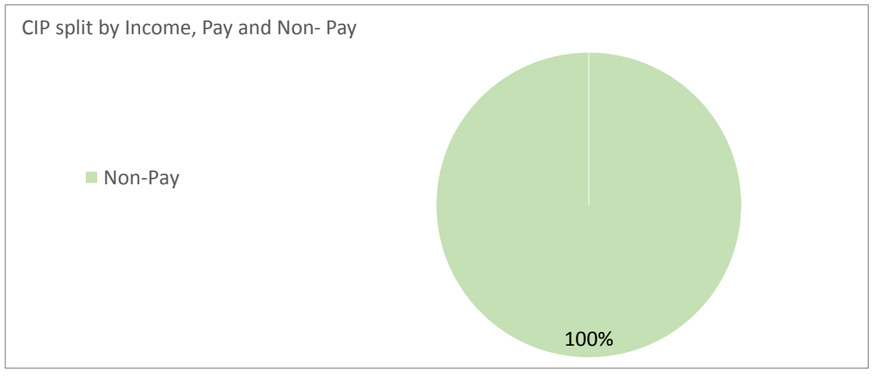
1. The CIPs target remains at £11.4m for the 2018/19 financial year.
2. £2.6m of fully validated savings have been transferred to the Delivery Tracker as at the Month 3 reporting date.
3. The schemes continue to take no account of any changes that might arise from the actions of the four Sustainability 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. To this end a non cash releasing CIP of £92k relating to improvements in Handover Delays for the first three months has been recognised. 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 30 June 18

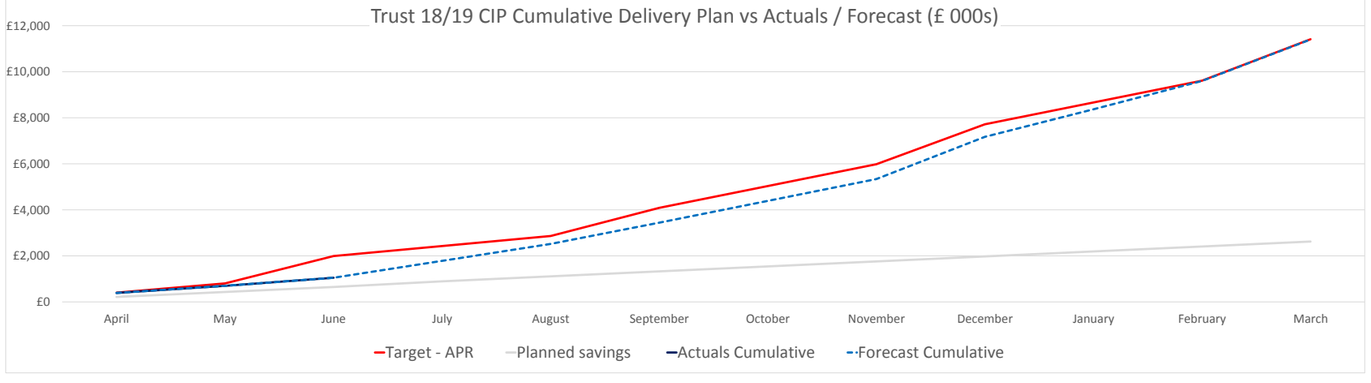
CIP Target for 18/19 £000's	Total planned savings on delivery tracker £000's - as at 30 June 2018	Total forecast savings on delivery tracker £000's - as at 30 June	YTD June 18 - Target Savings £000's	YTD June 18 - Actual Savings £000's	YTD June 18 - variance £000's
11,400	2,624	2,624	1,994	1,219	(£775)



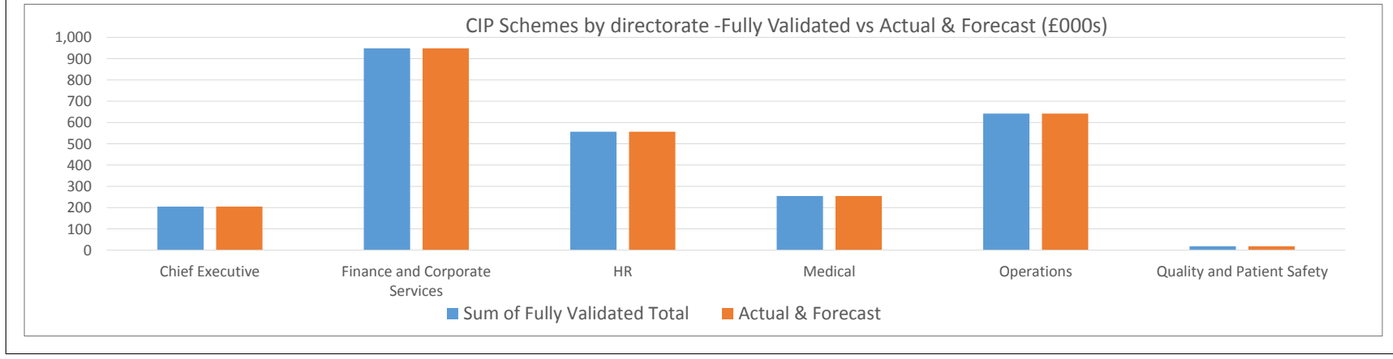
2. CIP - Planned savings split by income, pay and non-pay: as at 30 June



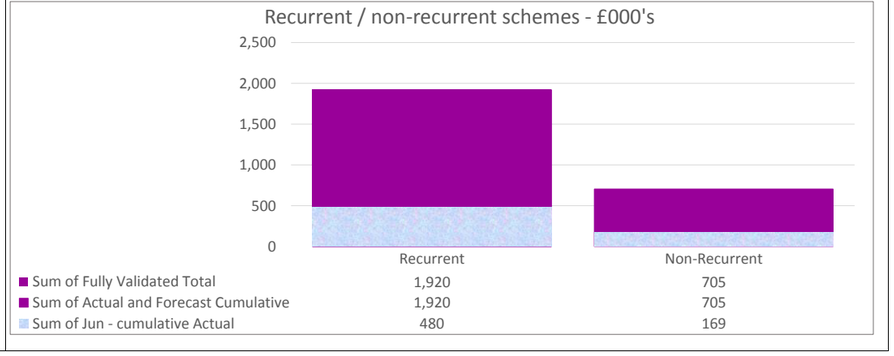
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2018/19



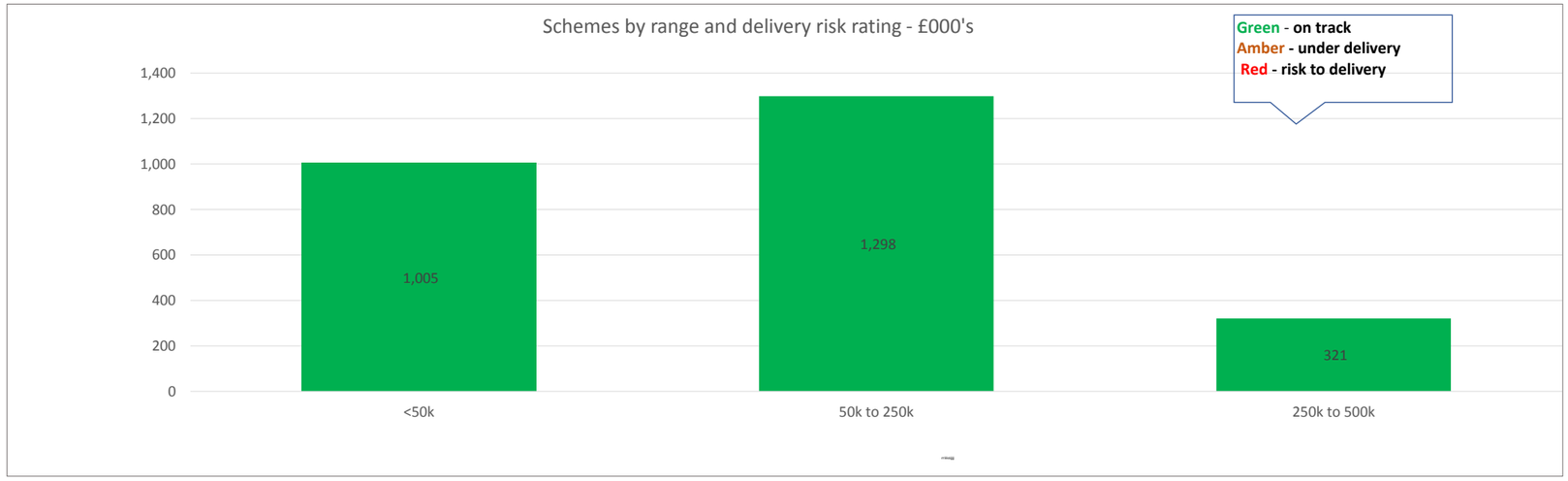
4. CIP schemes by directorate - Fully Validated vs Actual & Forecast 2018/19



5. Value of forecast recurrent and non-recurrent savings - 30 June 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 3): £000	YTD Actuals (Month 3): £000	YTD Variance £000	Comments (+/- £20k variance)
External consultancy & contractors	£253	£253	£0	£63	£63	£0	-
Furniture & Fittings	£10	£10	£0	£3	£2	(£0)	-
Meeting room hire	£78	£78	£0	£20	£20	£0	-
Public relations	£4	£4	£0	£1	£1	£0	-
Stationery	£39	£39	£0	£10	£10	£0	-
Travel & Subsistence	£266	£266	£0	£67	£67	£0	-
Medicines Management - Equipment	£107	£107	£0	£27	£27	£0	-
Medicines Management - Consumables	£200	£200	£0	£50	£50	£0	-
Books & Subscriptions	£17	£17	£0	£4	£4	£0	-
111 Efficiency	£33	£33	£0	£8	£8	£0	-
Fleet - Fuel: Telematics, Bunkered Fuel & Price Differential	£200	£200	£0	£50	£50	£0	-
Estates and Facilities management	£6	£6	£0	£1	£1	£0	-
IT Productivity and Phones	£126	£126	£0	£24	£24	£0	-
Discretionary Non Pay	£62	£62	£0	£15	£15	£0	-
Training courses & accommodation	£433	£433	£0	£108	£108	£0	-
Medicines Management - Drugs	£130	£130	£0	£33	£33	£0	-
Insurance	£661	£661	£0	£165	£165	£0	
Grand Total	£2,624	£2,624	£0	£649	£649	£0	-
Other planned schemes budget awaiting sign off	£2,234	£2,234	£0	£1,345	£570	(£775)	Difference between Fully Validated Schemes and Schemes removed from budget or included in NHSI target
Grand Total	£4,858	£4,858	£0	£1,994	£1,219	(£775)	

Sustainability Steering Group – Estates & Procurement Update – July 2018

Estates

1. **Brighton Make Ready Centre:** This project has started in terms of discharging our pre planning conditions to allow for a 'meaningful' start on the site early Jan 2018. The Employers Agent and Design Team have been appointed. The negotiation of the legal terms for the land purchase is nearing conclusion. The Business case has been produced and issued to the STP as part of the Capital Bid programme but requires formal sign off by the Trust Exec. A Project Mandate and QIA will be produced. Completion of the project is anticipated mid 2020.

2. **Medway Make Ready Centre:** The project has not started. We have identified land and are in negotiations with the Kent Fire & Rescue Service for the purchase. One Public Estates funding has been secured from Medway Council toward the cost of the planning application. A draft Business Case has been produced and submitted to the STP Capital Big programme but requires formal sign off by the Trust Board. A Project Mandate and QIA will also be produced. Anticipated start on site date is end of 2019.

3. **Banstead/ North Surrey:** The project has not started. The decision has been made in the Estates Strategy to redevelop the Banstead site for a new Make Ready and Fleet Hub. Community funding of £300K has been allocated towards the project. A Business Case has been submitted to the STP Capital Bid programme but requires sign off by the Trust Board. A Project Mandate and QIA will be completed. There will be some disposal of property in the region such as Epsom which will be subject to Board approval. Anticipated start on site date end 2019.

4. **2nd Floor at Nexus:** the project has not started. A Head of Terms for the lease of the 2nd floor has been agreed with the Landlords, Surrey County Council. A fit out plan will need to be agreed for the space. A Business Case has been submitted to the STP Capital Bid programme but requires sign of by the Trust Board. A Project Mandate and QIA will be produced. Anticipated start date is early 2019

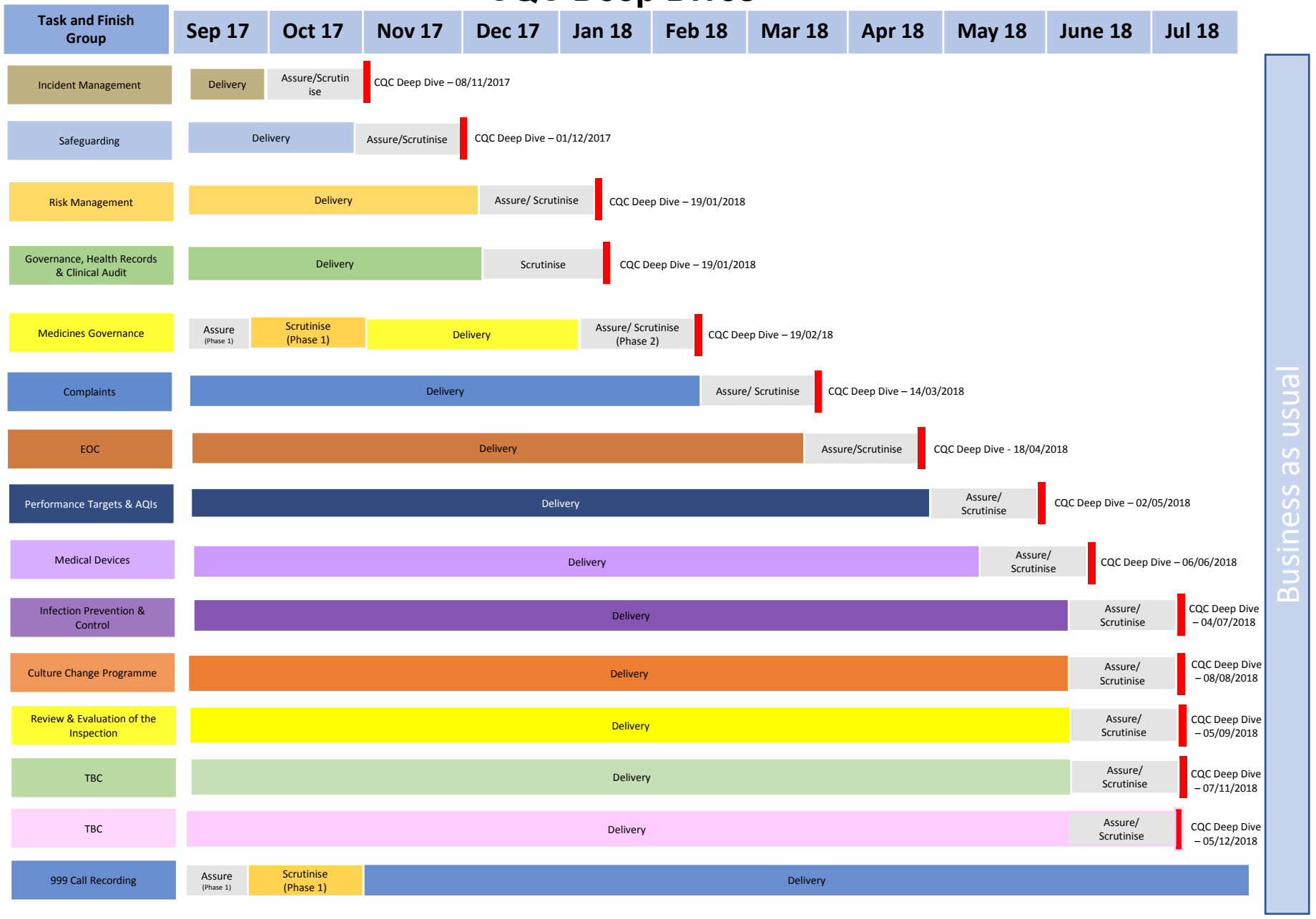
Procurement

1. **Premises Cleaning :** the current contract expires in April 2019. The tendering process is about to commence under EU Procurement Regulation and a project team is being assembled. The project team will review and agree the specification and undertake the bid evaluation and contract award. A Project Mandate and QIA will be produced

2. **Make Ready Vehicle Preparation :** The current contract expires in April 2019. The Tendering process is about to commence under EU Procurement Regulations. The project team will review and agree the specification and undertake the bid evaluation and contract award. The Trust may wish to submit and 'internal bid'. If so, there will need to be a separate project team to produce the bid. The in house team will not be able to participate in the specification and evaluation stages. A Project Mandate and QIA will be produced.

3. **Payroll:** the current contract is on a annual rolling basis and expires in 2019. Should the Trust wish to submit and in house bid the same process as Make Ready will need to be followed. A Project Mandate and QIA will be produced.

CQC Deep Dives



NOTE: After the scrutiny phase, the project will move into Sustainability (BAU), with quarterly station visits. Aim is to do every station every quarter. Results feed into Area Governance Meetings and Executive Committee. If assurance is not provided, project will go back to delivery stage.

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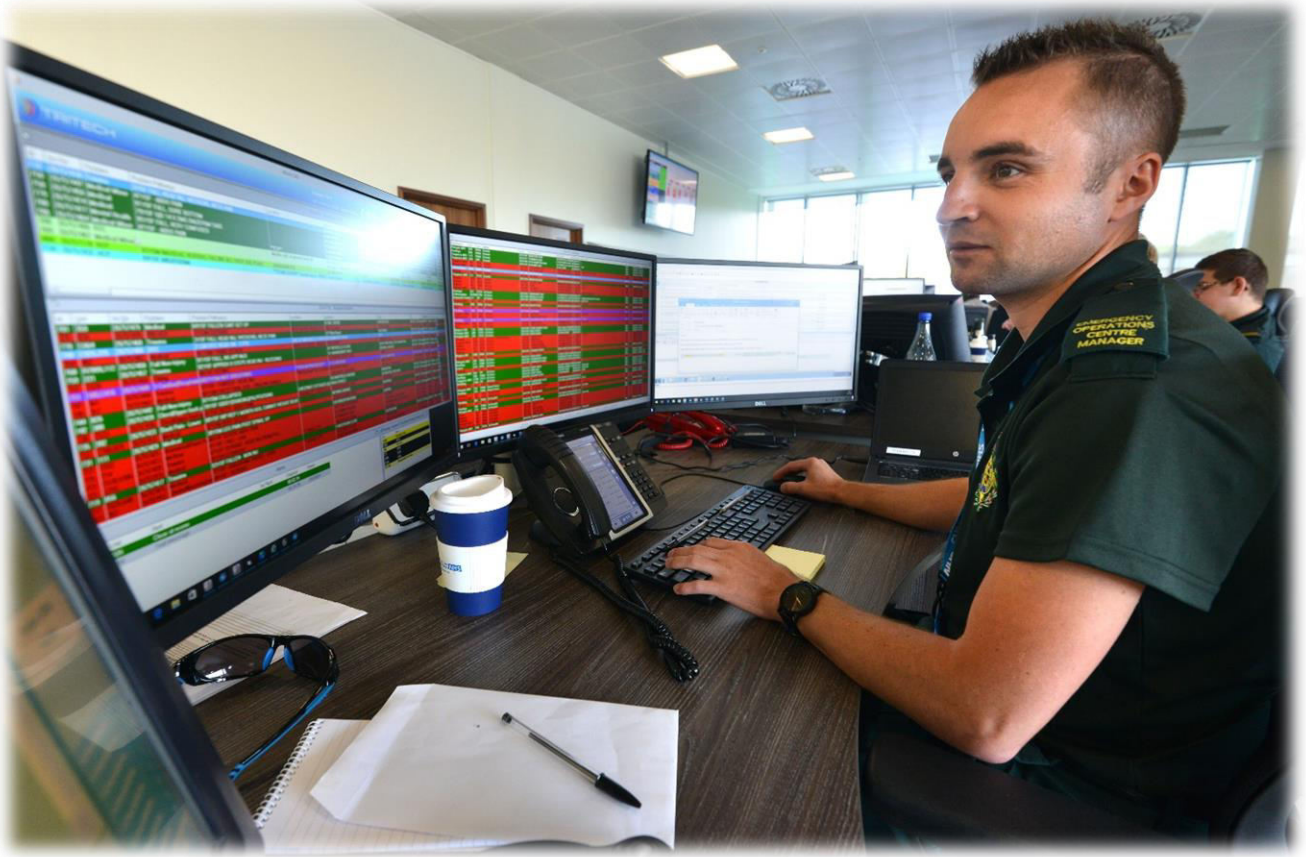
Emergency Operations Centre



Improvement Plan

July 2018

From the CQC report

South East Coast Ambulance Service NHS Foundation Trust

Findings in 2017

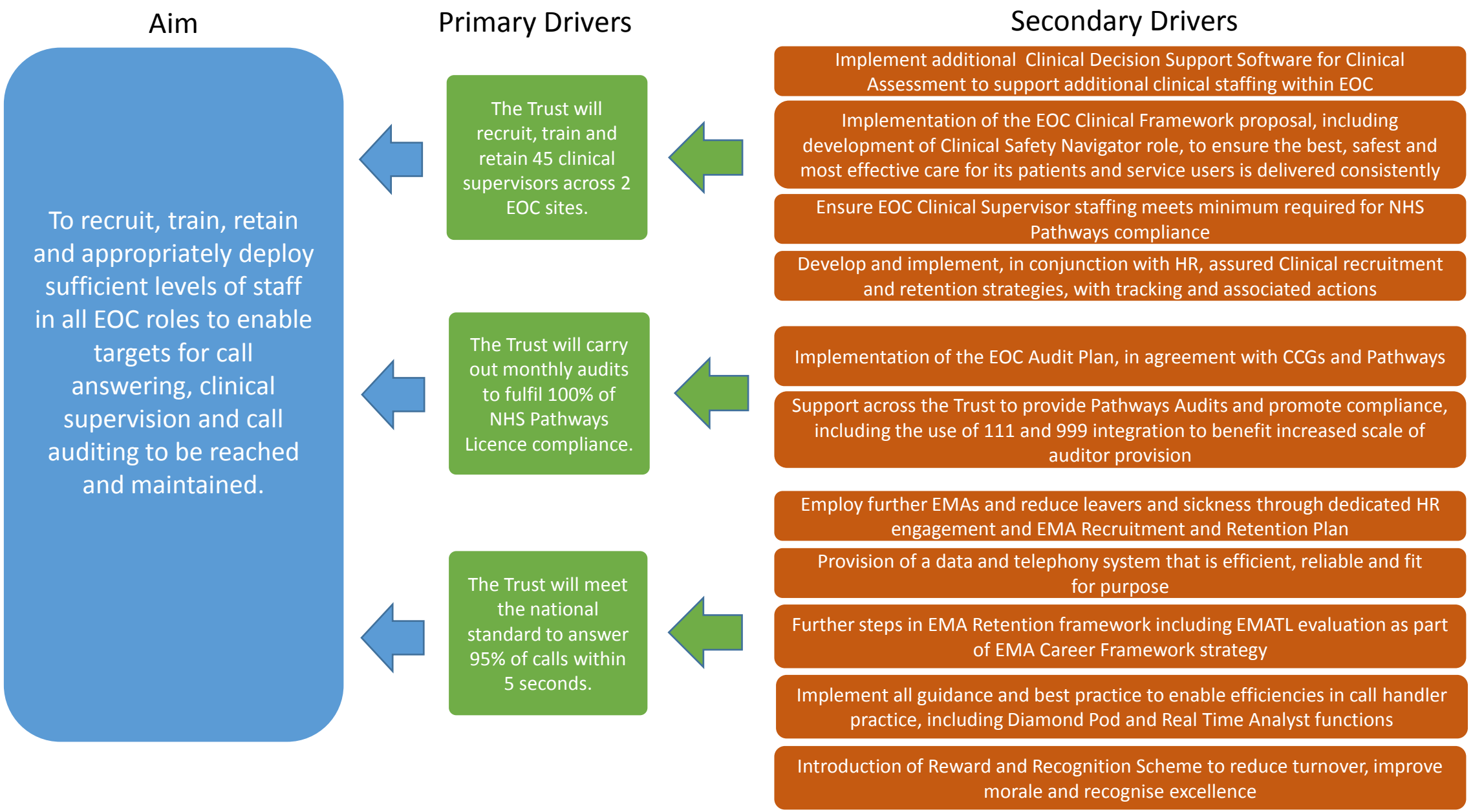
Must Do

- 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 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 must continue to ensure there are adequate resources available to undertake regular audits and robust monitoring of the services provided.
- The trust must take action to meet national performance targets (National Ambulance Quality Indicator (AQI) standards expected ambulance services to answer 95% of all 999 calls within five seconds.).

Should Do

- The trust should take action to audit 999 calls at a frequency that meets evidence-based guidelines.

EOC Driver Diagram



South East Coast Ambulance Service NHS Foundation Trust

Created an improvement plan

Emergency Operations Centre (EOC) - Improvement Action Plan

Project Reference	COC-07-2017
Project Title	Emergency Operations Centre
Project Lead	Sue Barlow
Executive Lead	Jon Garcia
Date Updated	30/04/2018
Version	See Footer

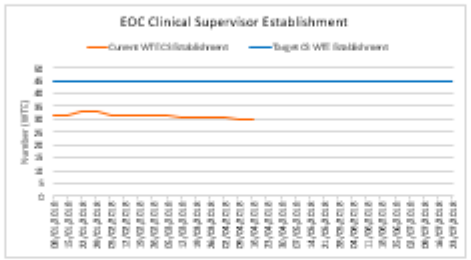
Root Cause:
The Trust has not invested sufficiently in recruitment and retention within the EOC, including the impact of moving EOC West to Crawley. Staffing and supervision levels are impacting significantly on the Trust's ability to meet the requirements for clinical supervision, call answering and call auditing set out in NHS Pathways.

Aim of the Improvement Plan:
To recruit, train, retain and appropriately deploy sufficient levels of staff in all EOC roles to enable to targets for call answering, clinical supervision and call auditing to be reached and maintained

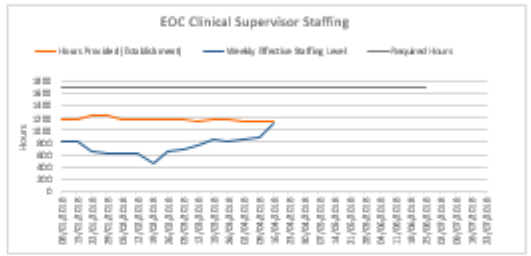
Objective 1: Clinical Supervisor Staffing - Measurables accurate as of: 27/04/2018

1a. EOC Clinical Supervisor Establishmentto meet minimum required Staffing for NHS Pathways Compliance (Weekly)

1b. EOC Clinical Supervisor Establishment (SECAmb) against target (Weekly)

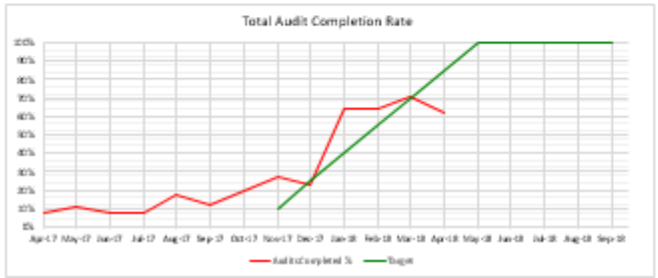


1c. EOC Clinical Supervisor Staffing - Establishment / Effective (Weekly)

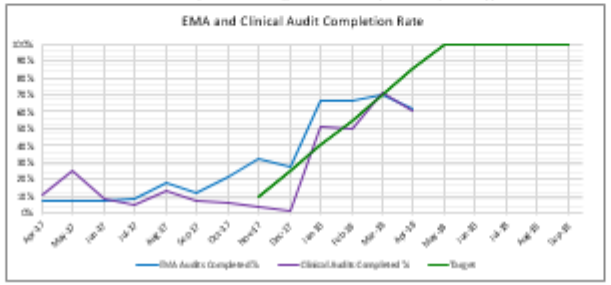


Objective 2: Audit - Measurables accurate as of: 30/04/2018

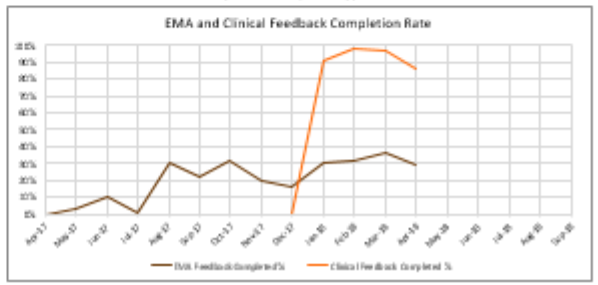
2a. Total Audit Completion rates against NHSI' requirement(Monthly)



2b. EMA and Clinical Audit completion rates against NHSI' requirement(Monthly)



2c. EMA and Clinical Feedback Completionrate (Monthly)



South East Coast Ambulance Service NHS Foundation Trust

Identified objectives

Objective 1:

- By 31/08/2018 there will be 45 Clinical Supervisors trained and in post across the 2 EOC sites.
- 1. EOC Clinical Supervisor Establishment will meet minimum required staffing for NHS Pathways compliance.

Objective 2:

- By 31st March 2018, the Trust will be performing at least 70% of required audits per month, achieving 100% of required audits by 31st May 2018 and thereby fulfilling NHS Pathways Licence compliance.
- 1. Audit pass rate will be monitored to evaluate quality of service provided.

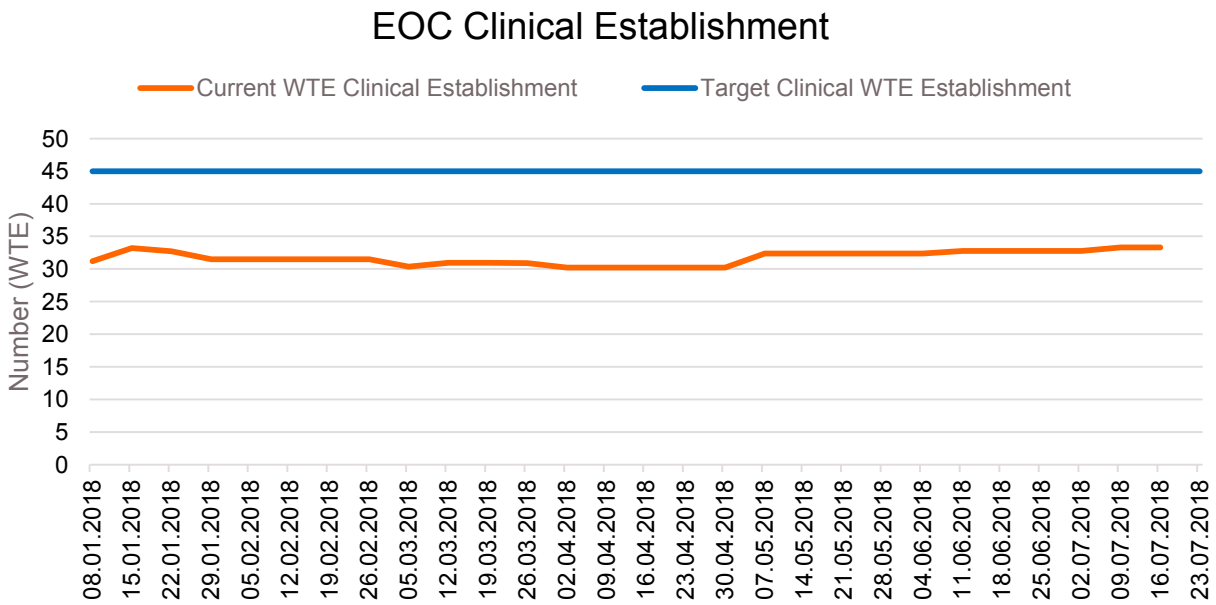
Objective 3:

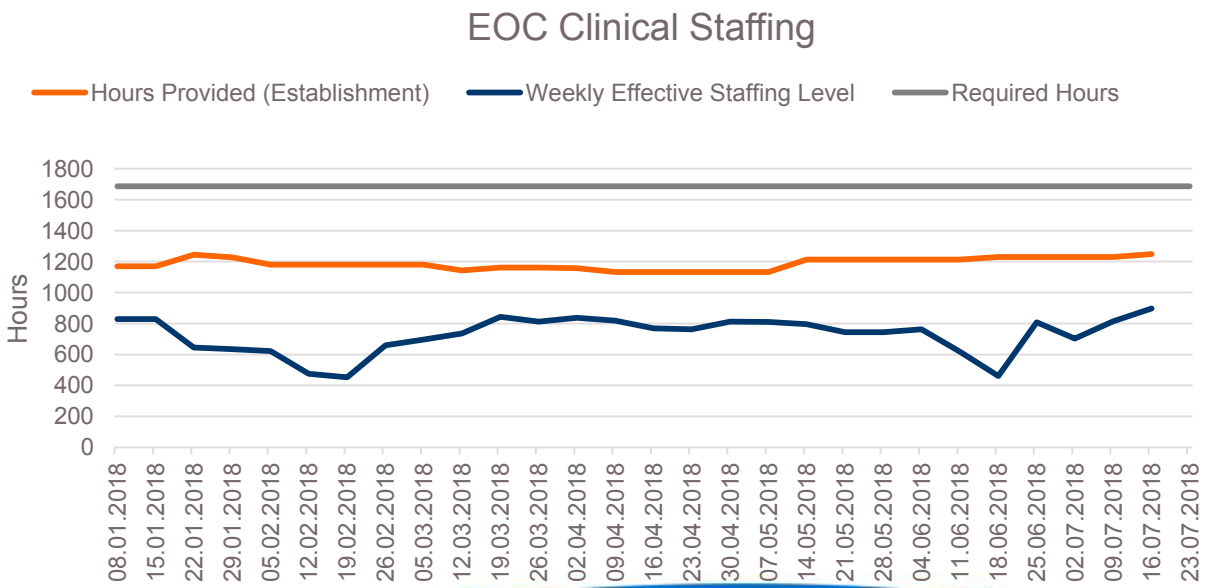
- By 31/08/2018 the trust will have improved call answering time to align within the national standard of 95% within 5 seconds
- 1. Employ new EMAs to the establishment of 171.
- 2. Reduce the number of leavers on average per month
- 3. All guidance and best practice in place to enable improvements in call answering times.
- 4. EMA training and rota fill plans are in place to support requirements.
- 5. The trust has the technology required to maintain call answer at 5 seconds.
- 6. Reduce the EMA Sickness rate to 4%.
- 7. Produce and implement a new Rota scheme to contribute towards better staff recruitment and retention levels.
- 8. Implement EMA Career Framework Strategy

Impact so far

Objective 1:

By 31/08/2018 there will be 45 Clinical Supervisors trained and in post across the 2 EOC sites.





South East Coast Ambulance Service NHS Foundation Trust

Impact so far

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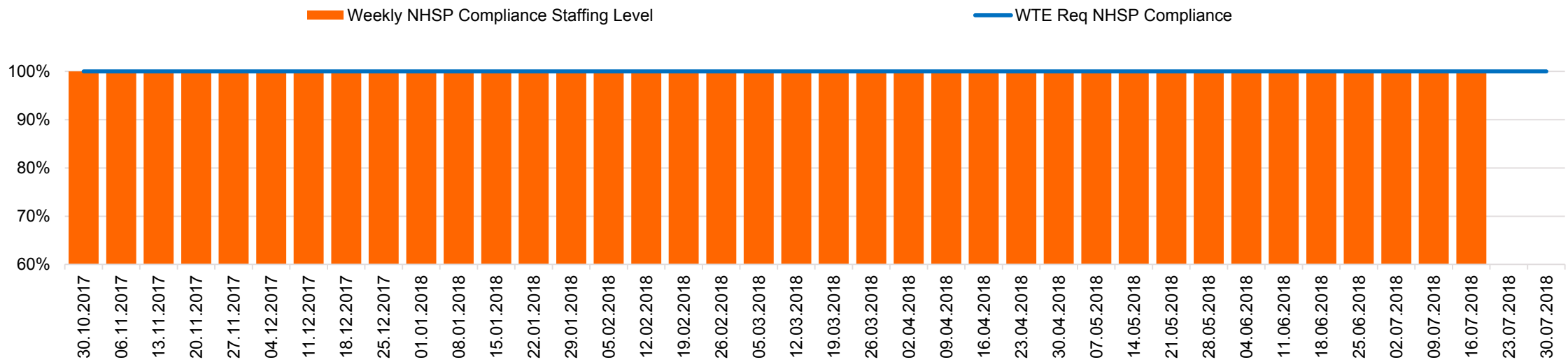

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Impact so far

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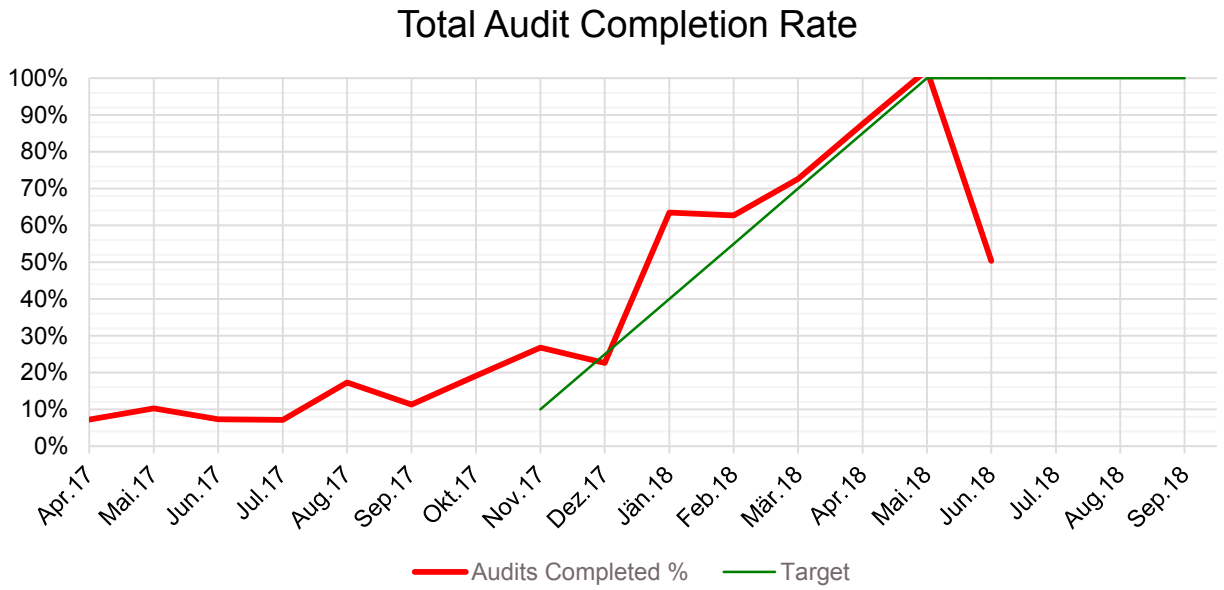

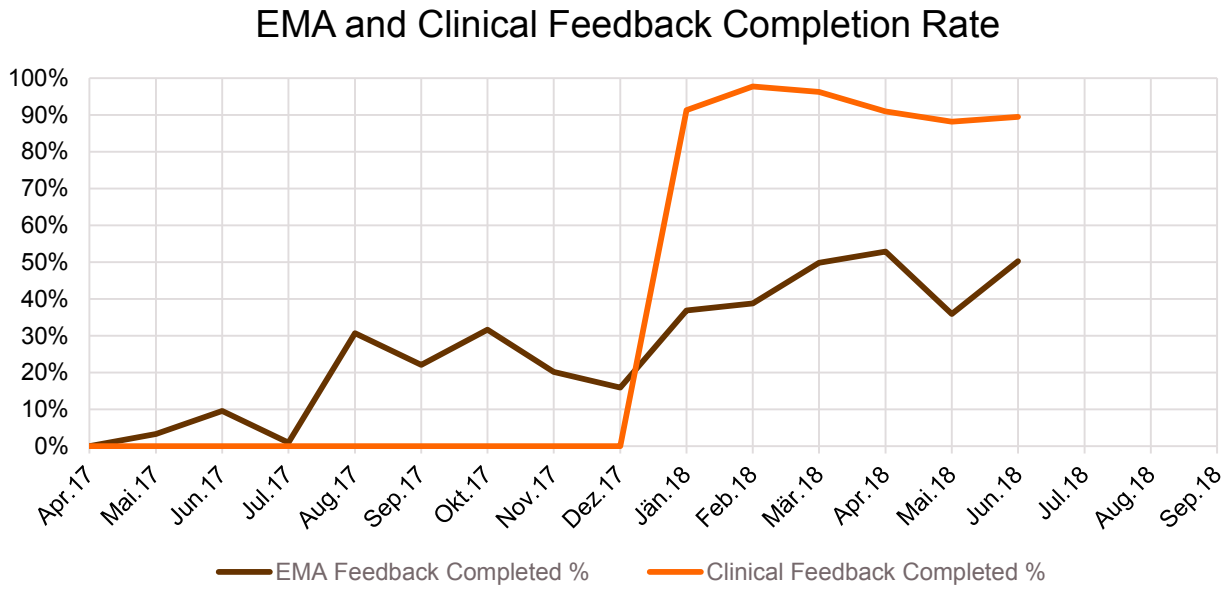

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Impact so far

Objective 2:

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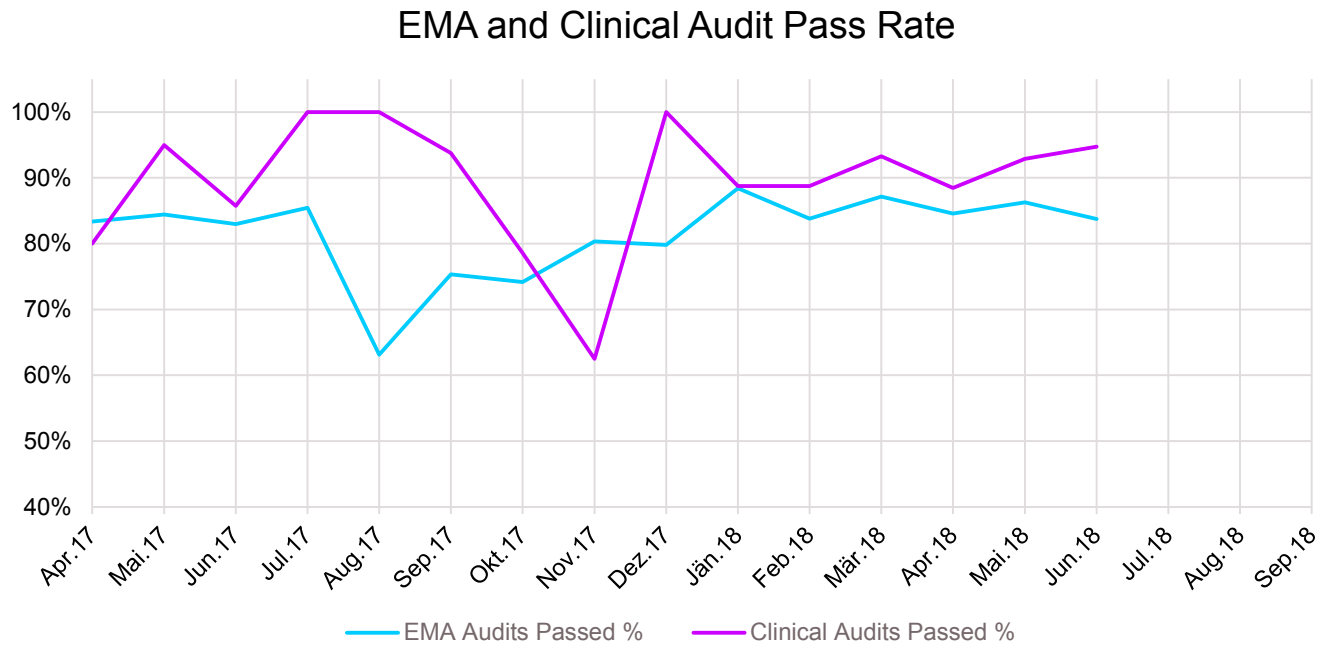


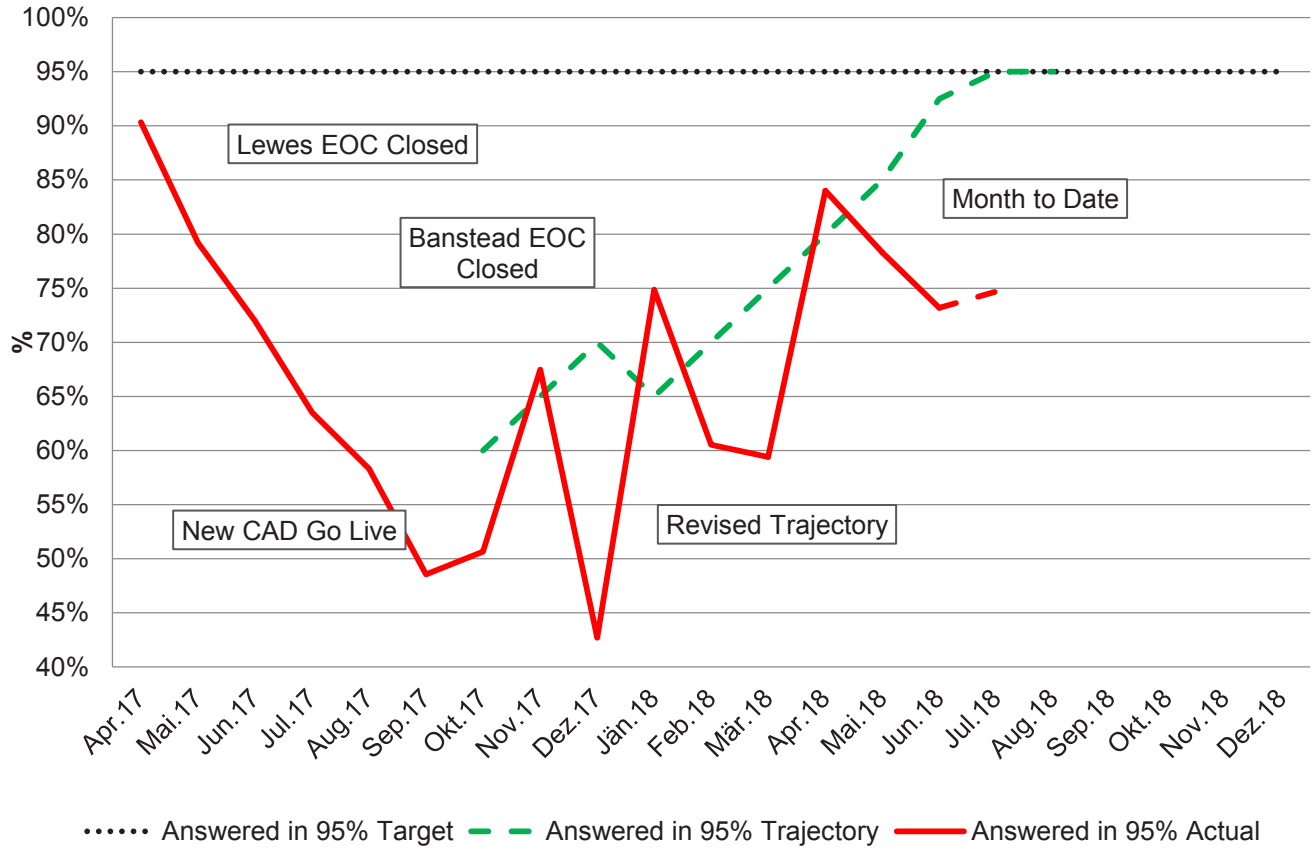
Objective 3 summary

Summary impact so far

Objective 3:

By 31/08/2018 the trust will have improved call answering time to align within the national standard of 95% within 5 seconds

Percentage of calls answered in 5 seconds

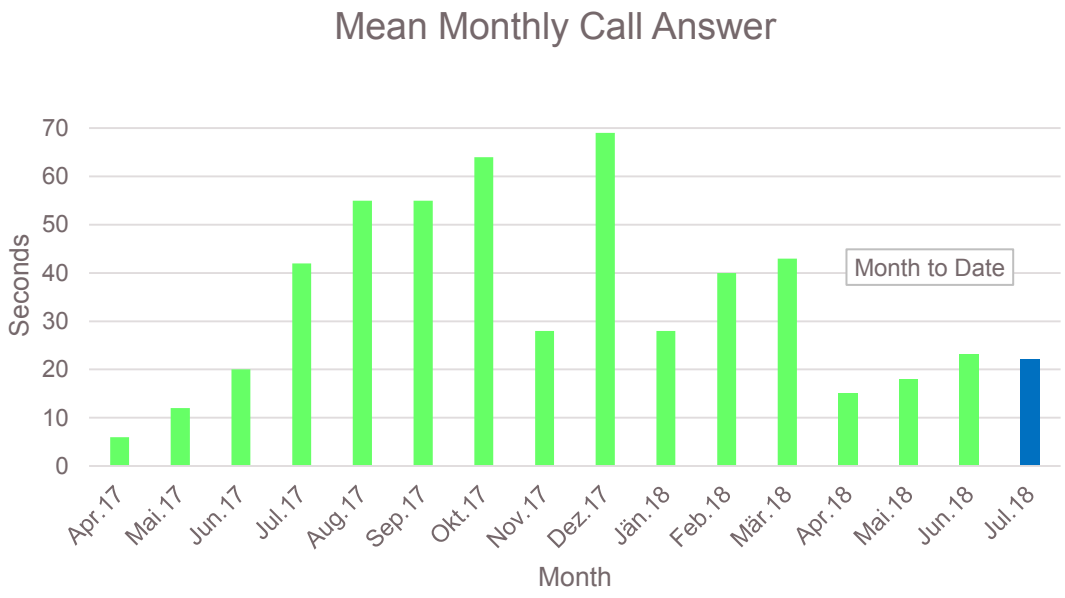


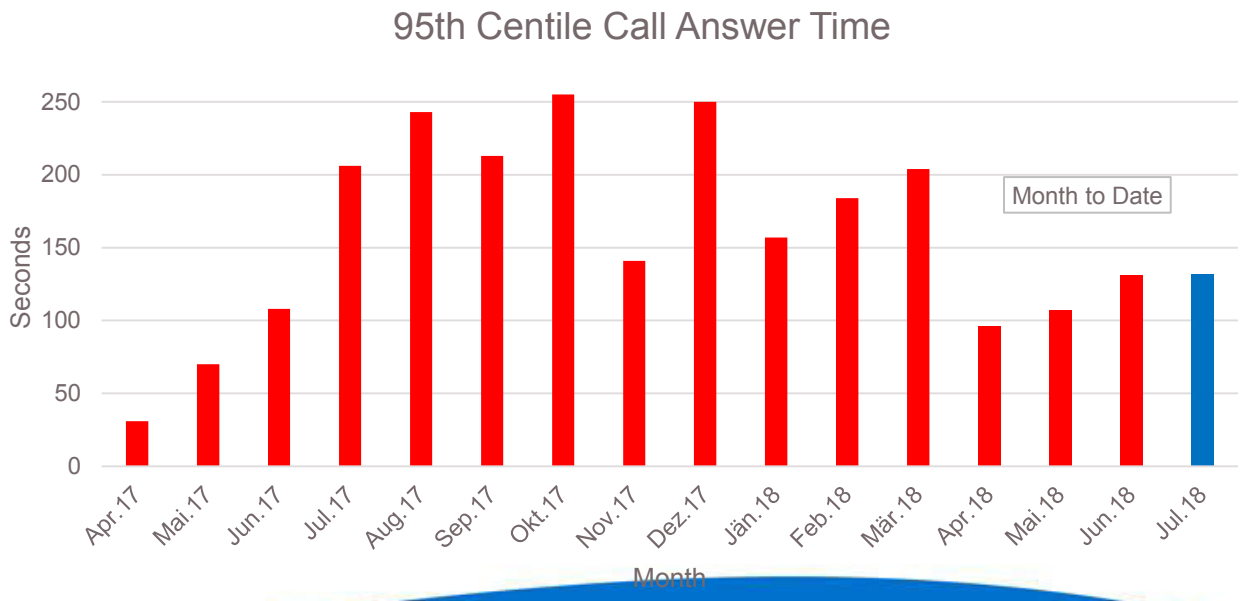
South East Coast Ambulance Service NHS Foundation Trust

Summary impact so far

Objective 3:

By 31/08/2018 the trust will have improved call answering time to align within the national standard of 95% within 5 seconds





Impact so far

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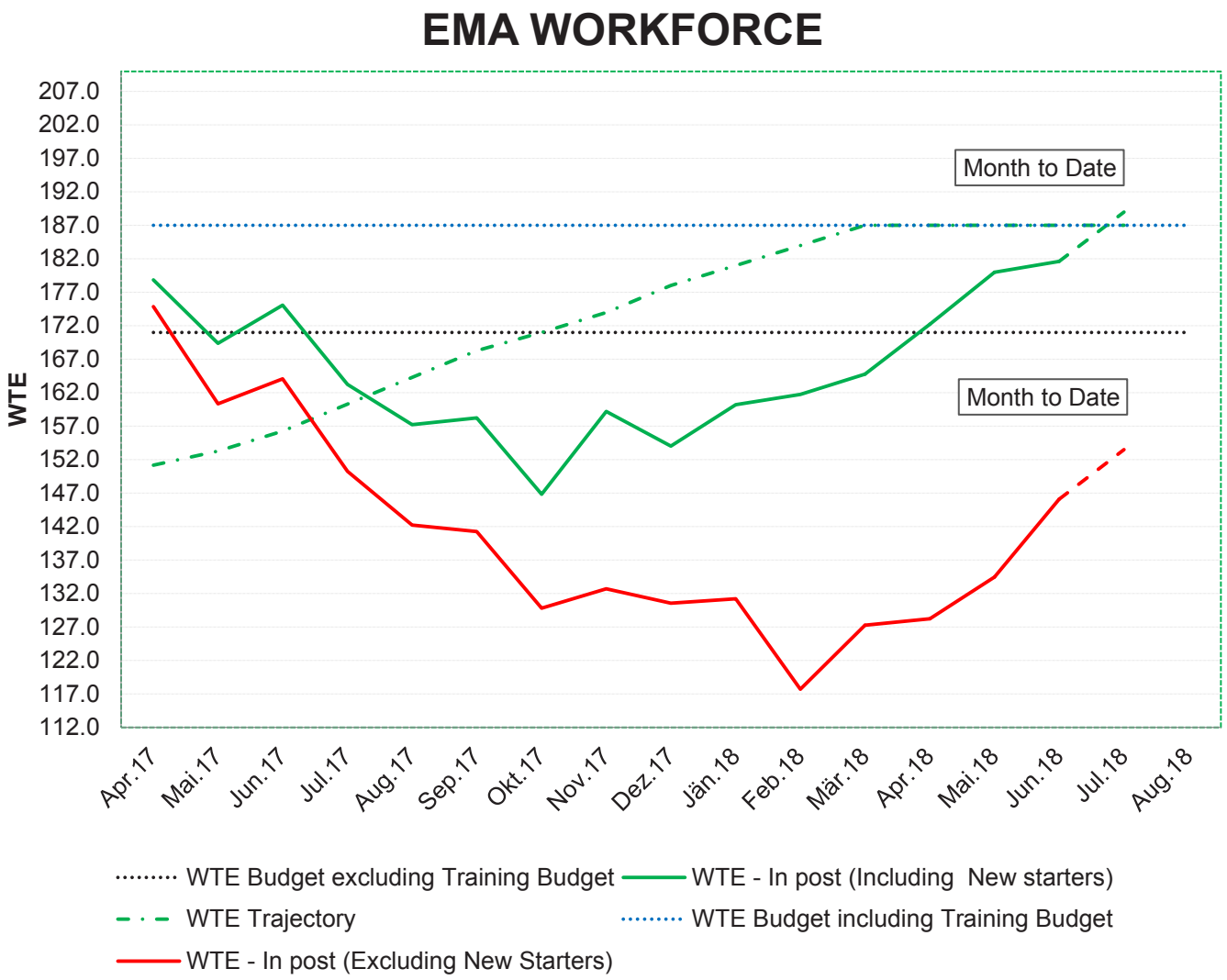
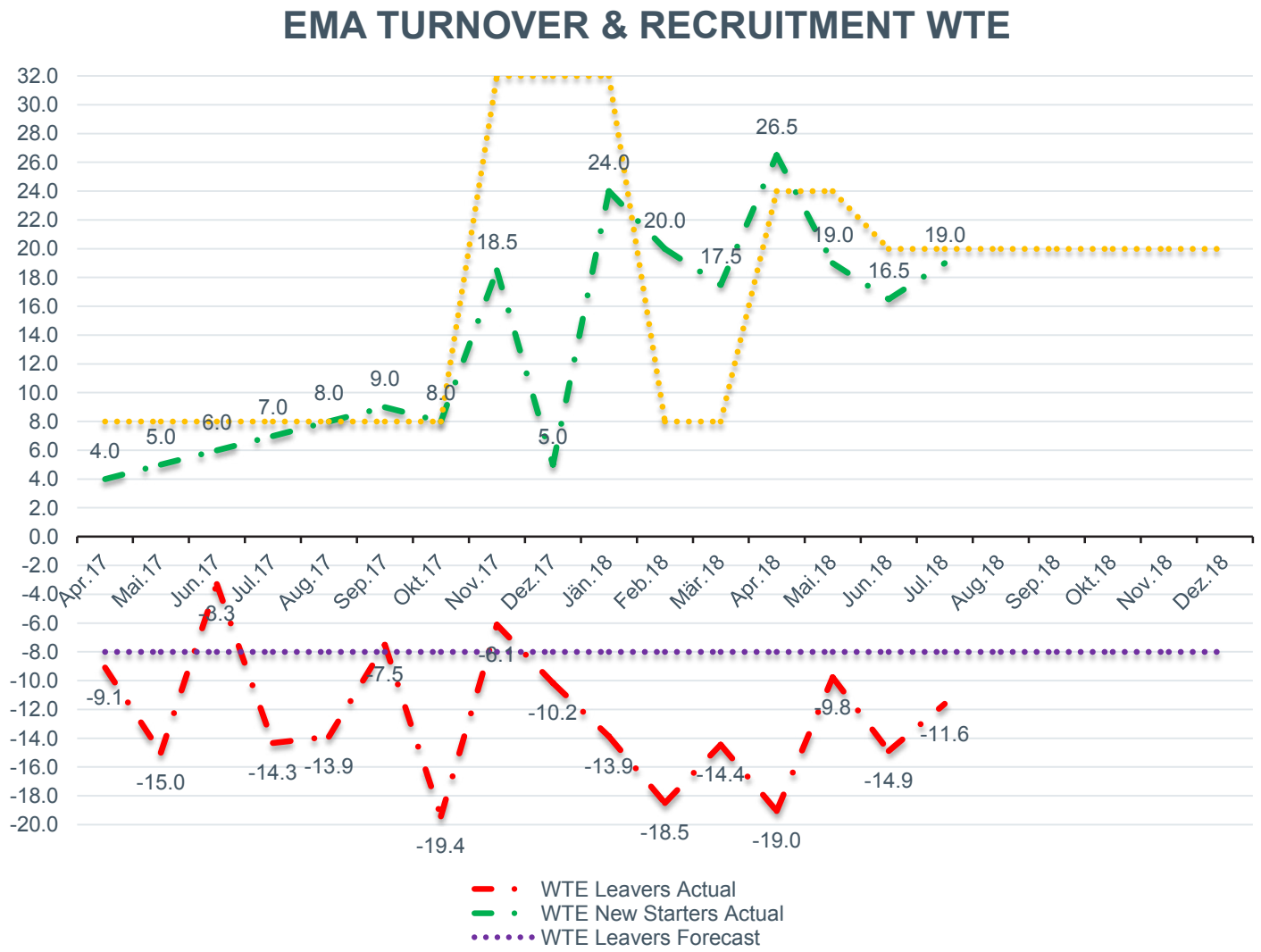


Impact so far

Objective 3:

By 31/08/2018 the trust will have improved call answering time to align within the national standard of 95% within 5 seconds

2) Reduce the number of leavers on average per month



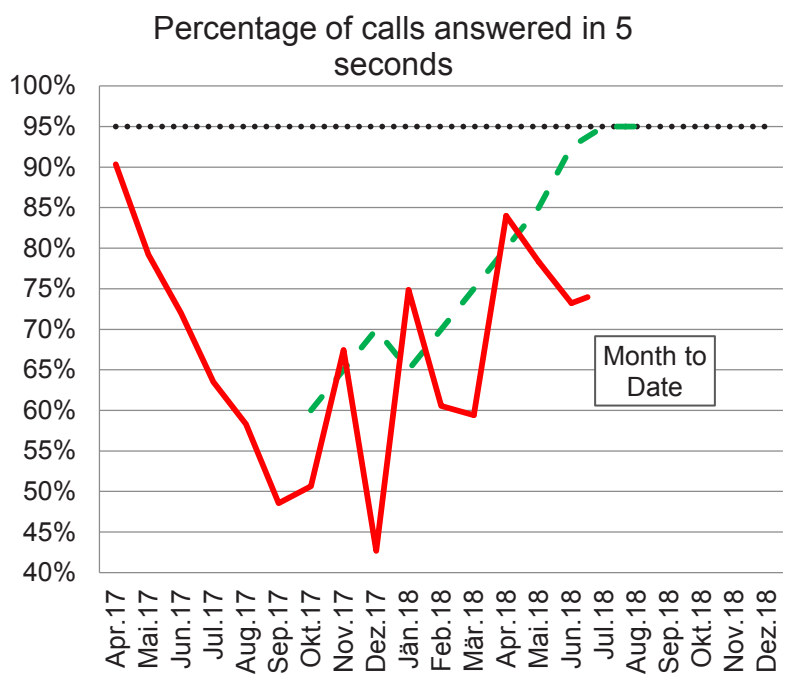
Impact so far

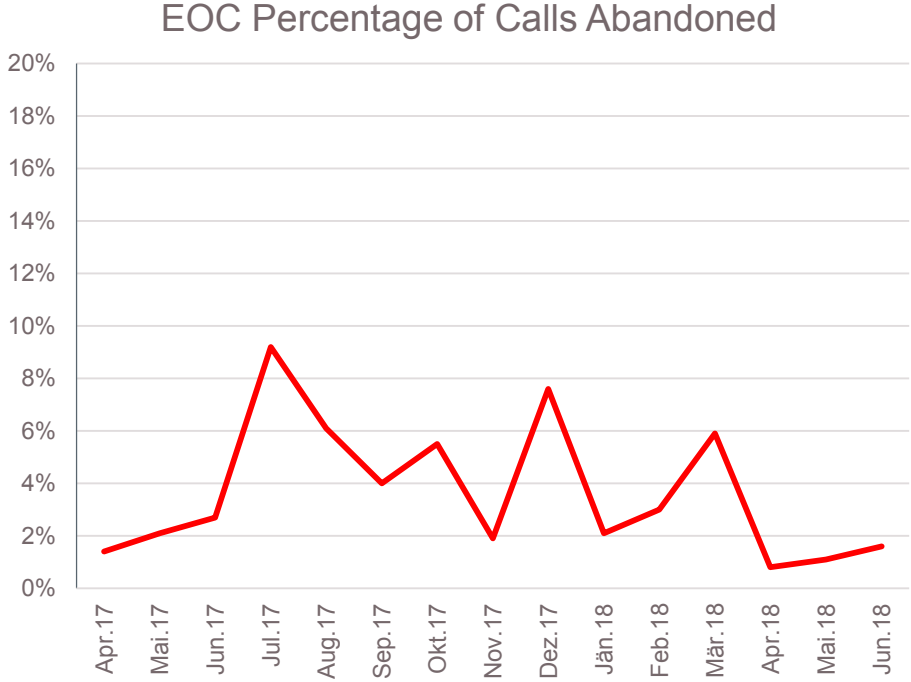
Objective 3:

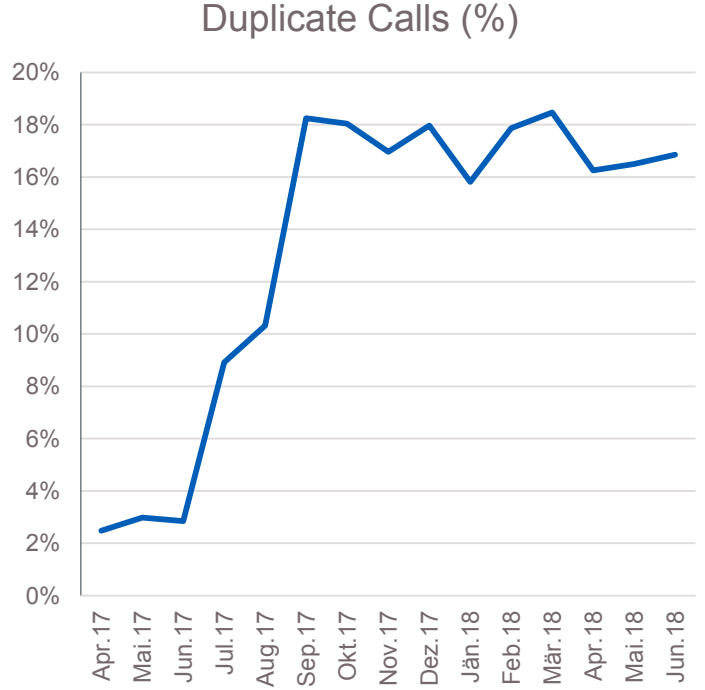
By 31/08/2018 the trust will have improved call answering time to align within the national standard of 95% within 5 seconds

3) All guidance and best practice in place to enable improvements in call answering times.

This will be tracked with Average Handling Time going forward. Informatics are putting together a baseline.







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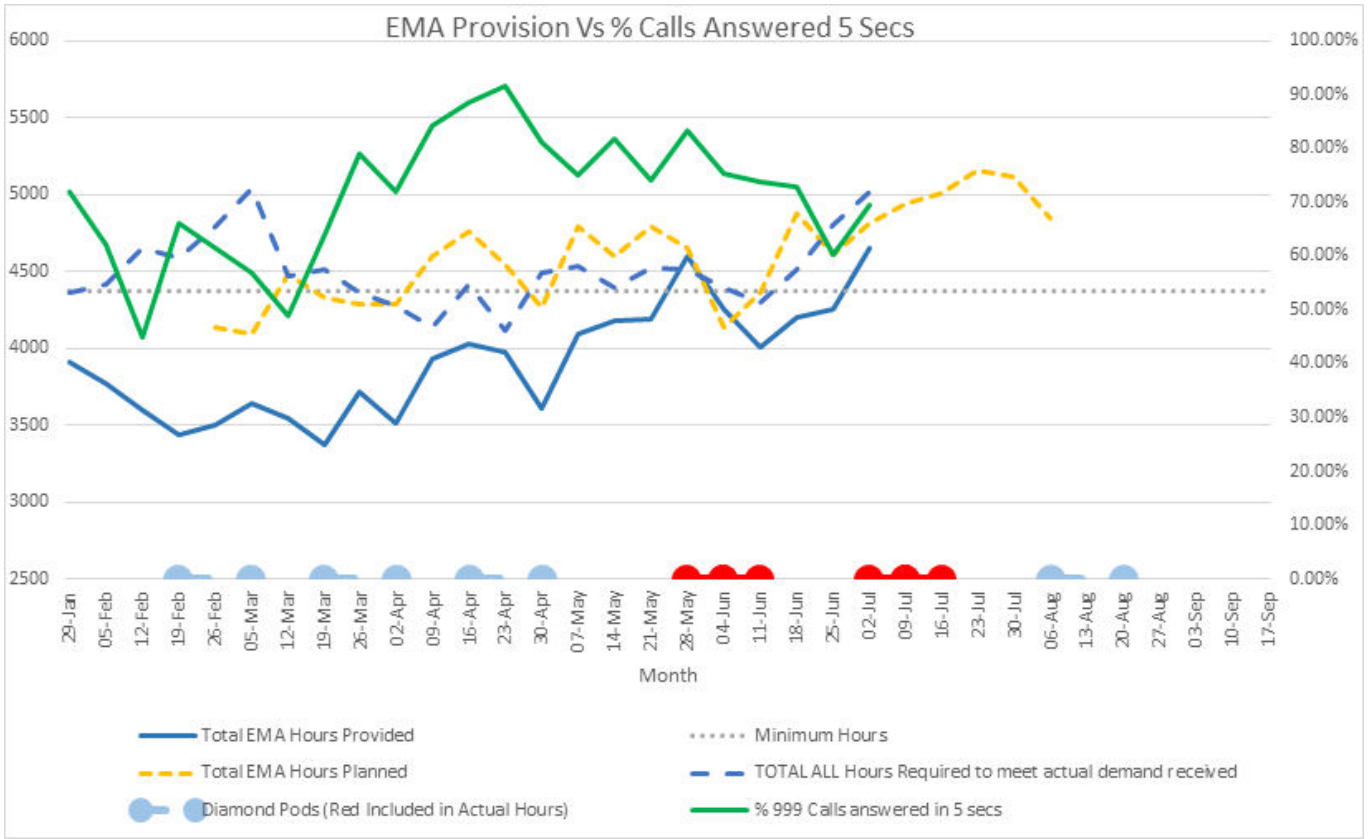
Impact so far

Objective 3:

By 31/08/2018 the trust will have improved call answering time to align within the national standard of 95% within 5 seconds

4) EMA training and rota fill plans are in place to support requirements.



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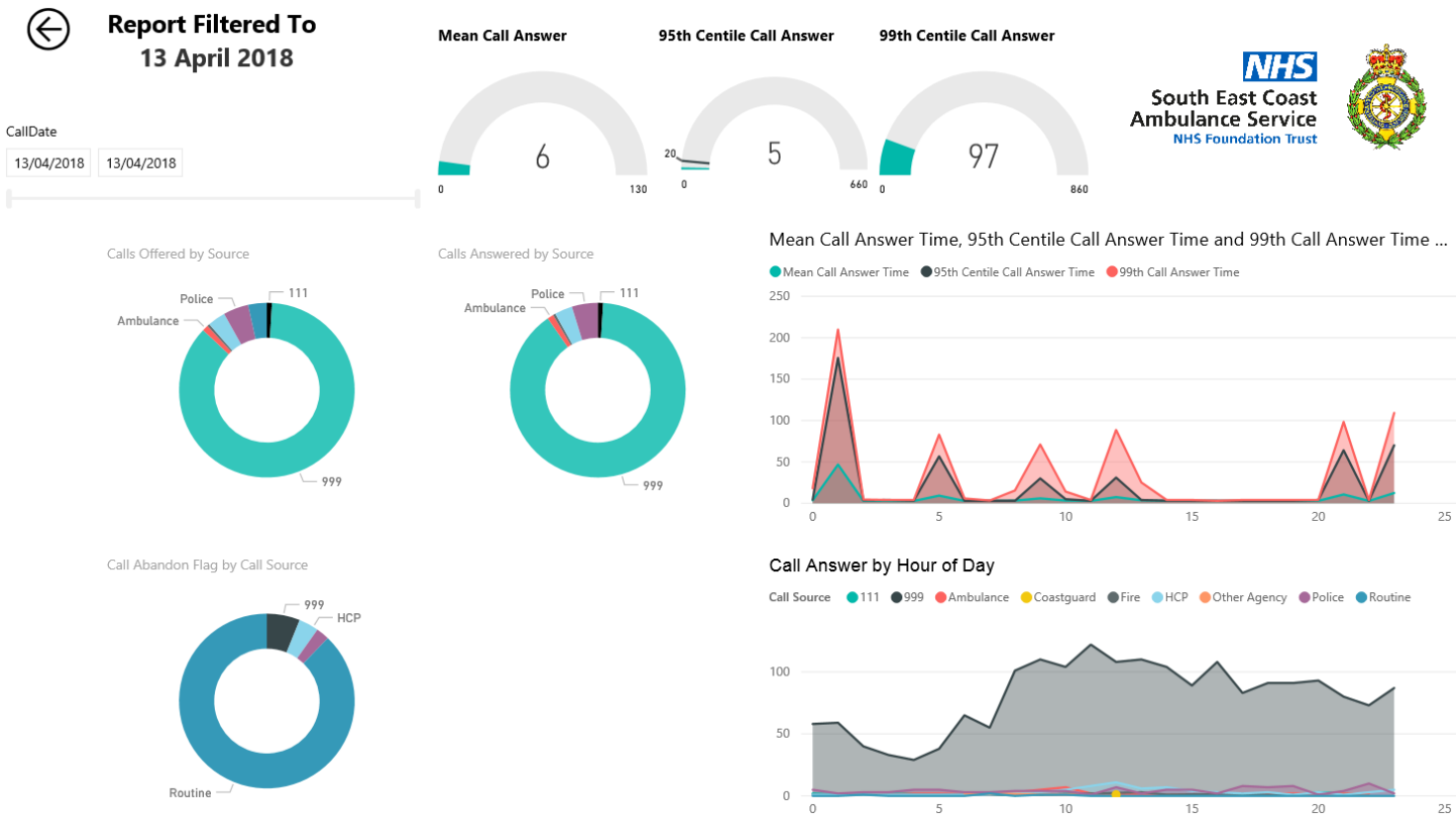
Objective 3:

By 31/08/2018 the trust will have improved call answering time to align within the national standard of 95% within 5 seconds

5) The trust has the technology required to maintain call answer at 5 seconds.



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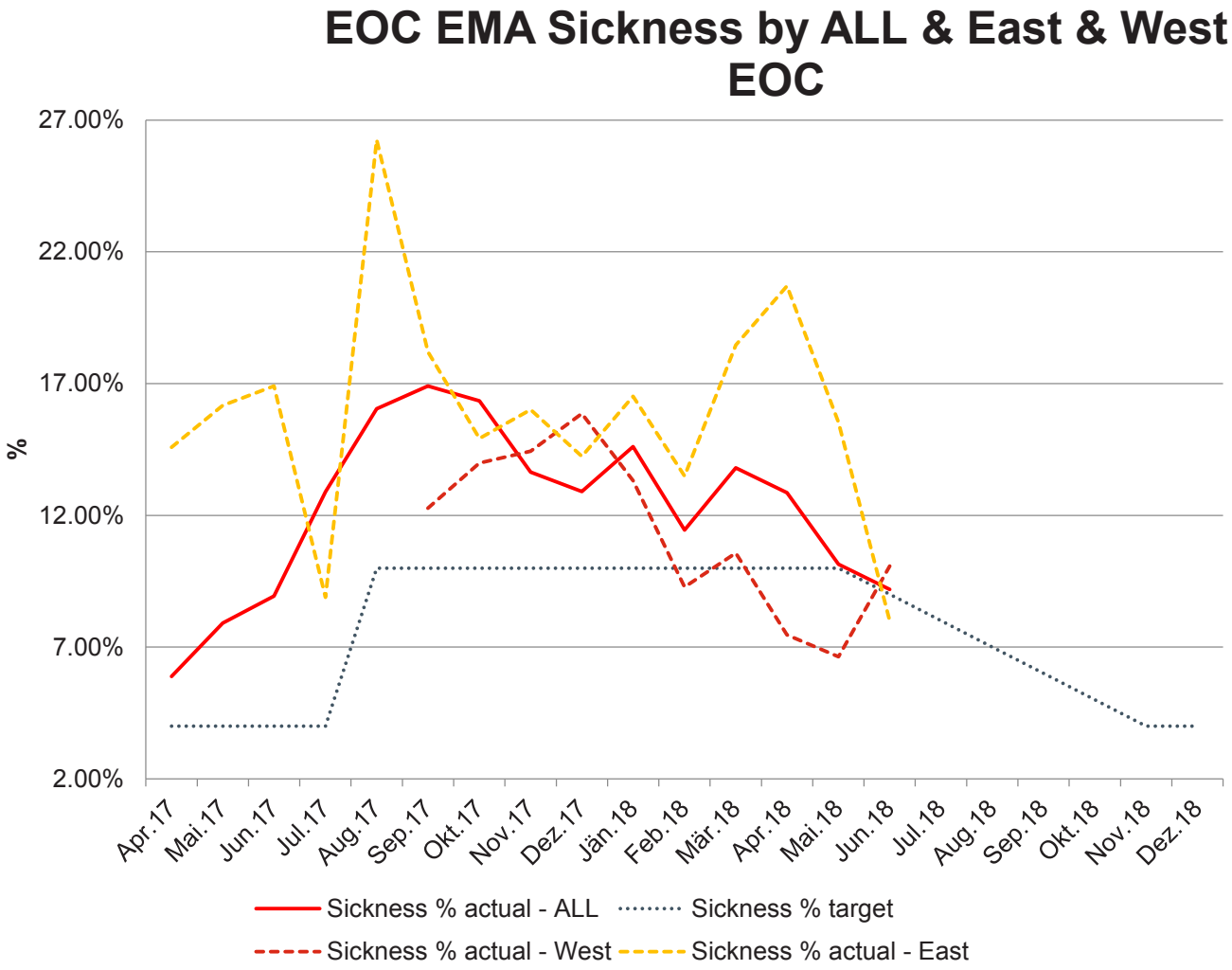
Objective 3:

By 31/08/2018 the trust will have improved call answering time to align within the national standard of 95% within 5 seconds

6) Reduce the EMA Sickness rate to 4%.



Impact so far

Objective 3:

By 31/08/2018 the trust will have improved call answering time to align within the national standard of 95% within 5 seconds
7) Produce and implement a new Rota scheme to contribute towards better staff recruitment and retention levels.

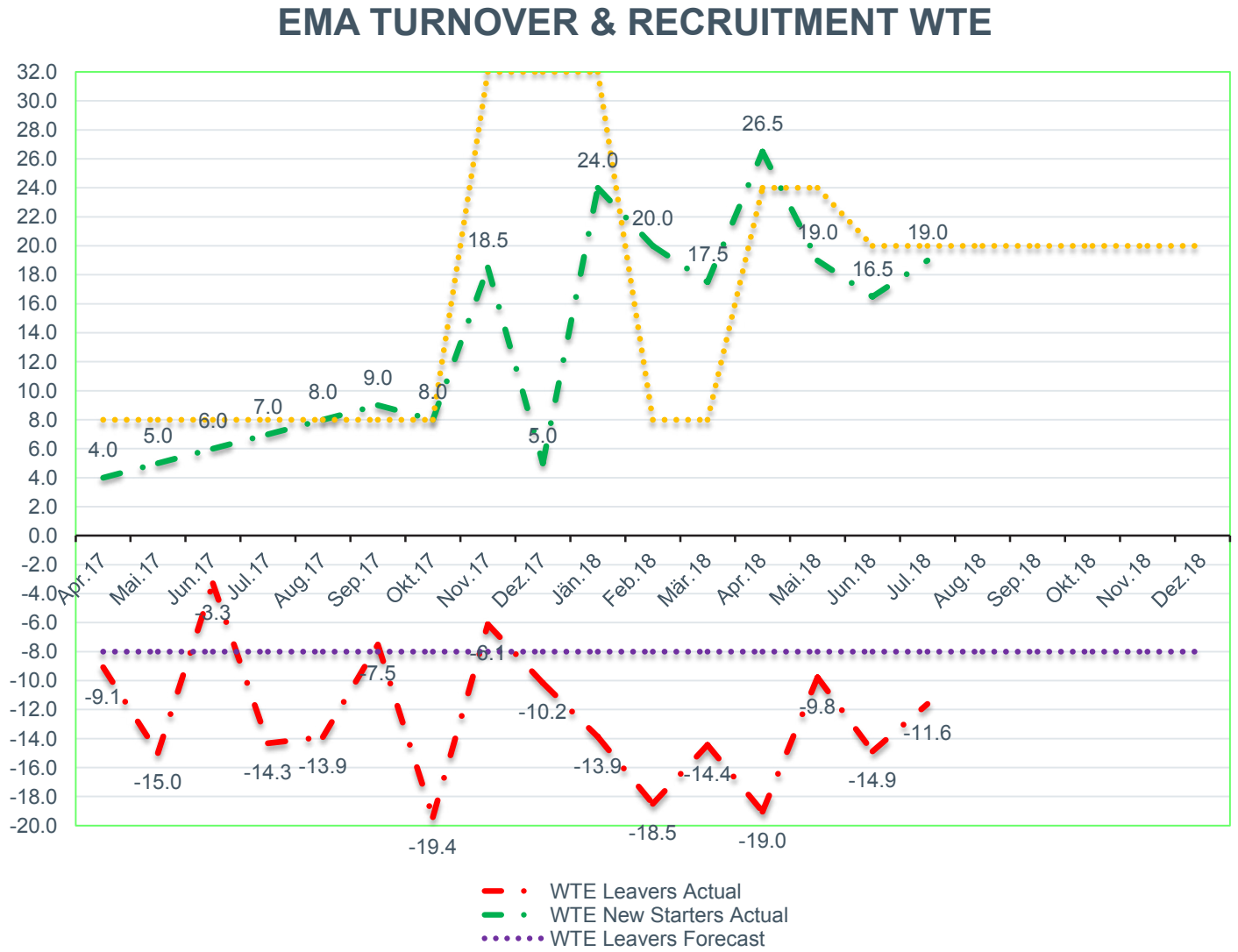
- Local EOC scheduling teams validate and sign off planning every week.
- Flexible working options and local incentives to be communicated across a variety of mediums.
- New rota parameters and unsocial hours plan signed off.
- Last meeting for rota review took place 3rd July. Next steps agreed and EOC Scheduling team are arranging workshops and meeting for 7th September to review the rotas from these workshops.

Impact so far

Objective 3:

By 31/08/2018 the trust will have improved call answering time to align within the national standard of 95% within 5 seconds

8) Implement EMA Career Framework Strategy



South East Coast Ambulance Service NHS Foundation Trust

Ongoing actions: Leadership

- Human factors awareness training – All EOC staff groups
- EOC manager induction days – 7 new EOC Managers inducted
- Engagement sessions – EOC representation on Staff Barometer Group
- Themed 6-weekly calls to team leaders and managers – Innovation
- Increased visibility of senior teams – Exec visibility
- More communication mediums – Face to Face – Virtual – Webinars
- Daily Shift Huddles – What did we learn that we can change
- Surge Management Plan – Prioritising resources during operational challenges
- Real Time Analyst – supporting EOC Management Team by monitoring flow of EOC activity and escalating concerns

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Ongoing actions: Safety and Complaints

- Working with staff to ensure reporting of IWR-1s and distribution of Shared Learning reports from incidents – Learning Culture
- Reduce number of overdue incidents – Reduce Potential Harm & Risk
- Dedicated complaints investigator – Consistency in investigations
- Shared learning from complaints, IWR-1s and SIs
- ‘Change Wednesdays’ – Pace, Govern & Control the level of change
- Risk register – Regular risk controls review
- Clinical Safety Navigator Role – oversight and management of cases pending dispatch
- Diamond Pod – close support with experienced EMATLs as EMAs transition from mentoring to independent call handling

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Ongoing actions: Technology

- Procurement of new Telephony System – Industry standard approach
- Regular audits of voice recordings – Monitoring
- CAD user group – Peer review and pooled innovation
- Ambulance Radio Programme – Engagement in new and emerging technologies
- Peer Partnerships – Exploring resilience opportunities
- Orbit – Providing granular detail on performance, weekly meetings
- Power BI – providing real-time reporting on meal breaks, performance and SMP status

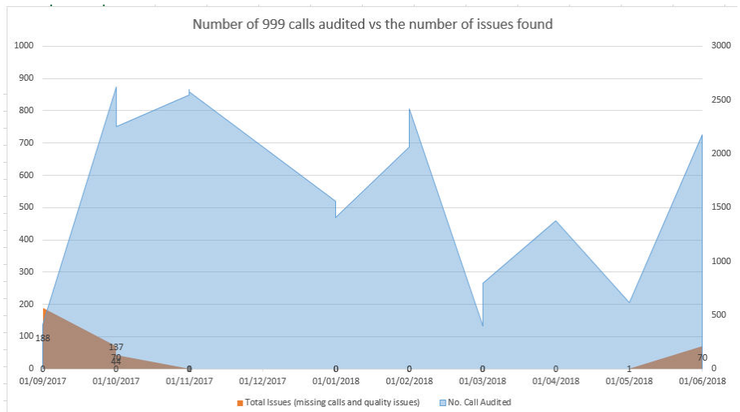
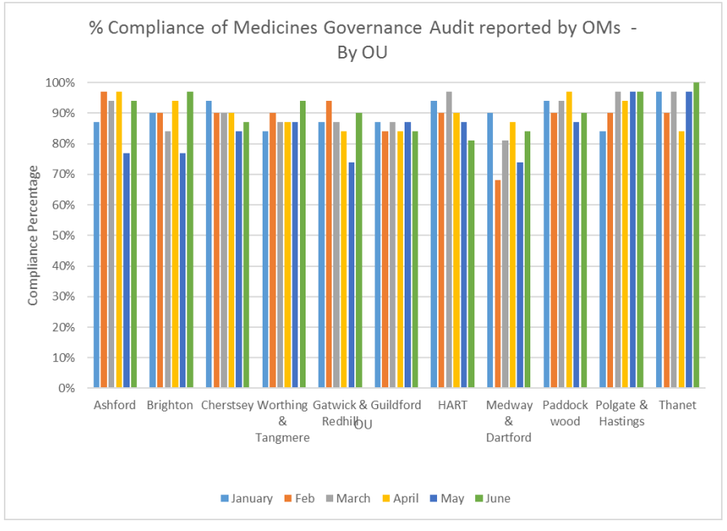
Care Quality Commission 'Must and Should Do' Oversight and Assurance Report
July 2018

South East Coast Ambulance Service NHS
NHS Foundation Trust

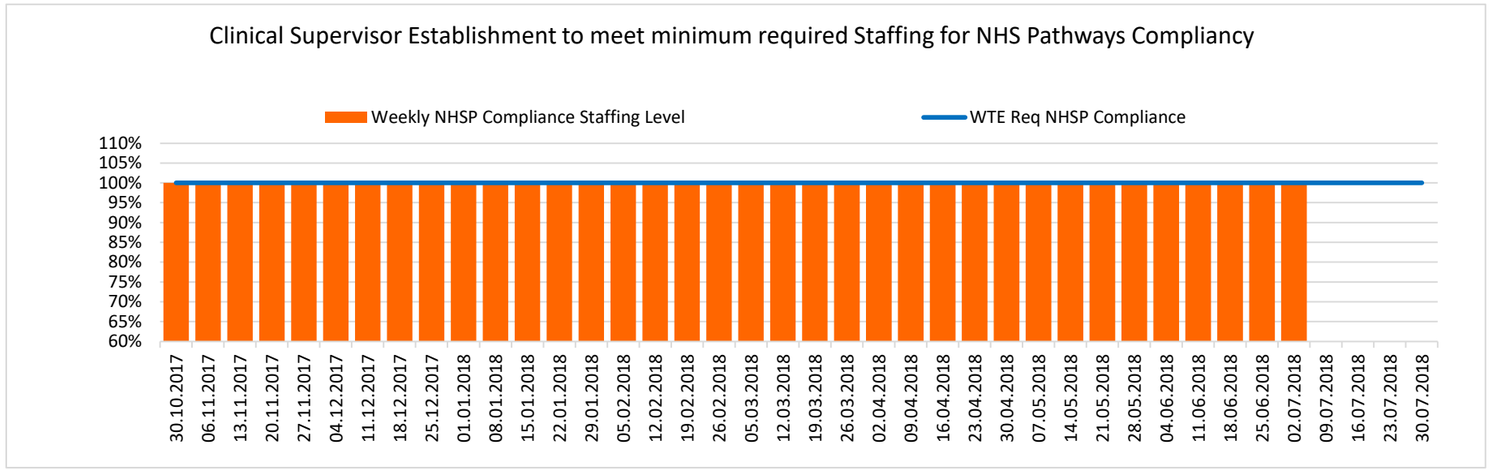
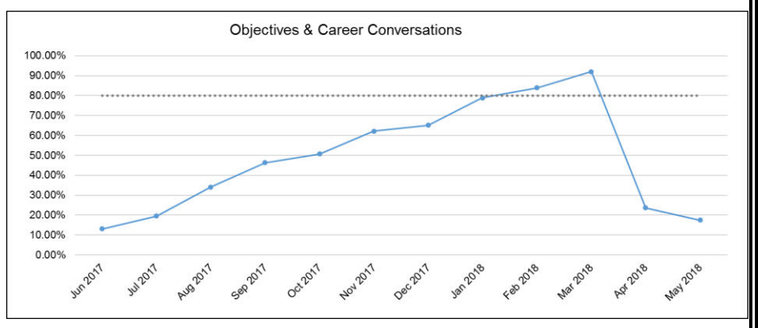
Item No	64/18 c

Name of meeting	Trust Board
Date	26.07.2018
Name of paper	Should and Must Do Assurance
Executive sponsor	Bethan Haskins, Executive Director of Nursing & Quality
Author name and role	Steve Lennox, Associate Director of Nursing & Quality
Synopsis, including any notable gaps/issues in the system(s) you describe (up to 150 words)	This is an update to the Board on the previous report in April on the progress of the CQC Must and Should do's. There are three RAG rated indicators with each improvement area. RAG 1 is an indication as to current progress against the KPI. RAG 2 is the anticipated progress against the KPI towards project closure and RAG 3 is an indication of grip. Some projects may miss their KPI but still be able to demonstrate strong oversight and grip. This is the position in the last report for the "KPI now" There are 13 Green Must do improvement areas There are 4 Amber Must do improvement areas There are 0 Red Must do improvement areas There are 5 Green Should do improvement areas There are 9 Amber Should do areas There are 2 Red Should do areas Total = 33 This is the position in this report for the "KPI now" There are 13 Green Must do improvement areas There are 4 Amber Must do improvement areas There are 0 Red Must do improvement areas There are 5 Green Should do improvement areas There are 9 Amber Should do areas There are 2 Red Should do areas Total = 33 No change. The projects are monitored through the compliance steering group. Some of the Improvement Projects have been closed as specific projects (safeguarding & Complaints) a few more will be closed soon. There are strict criteria for closure which includes the Compliance Steering Group membership being satisfied that there is a place for the developed metrics to have continued oversight. As many of the projects are now going through closure there is less delivery to report upon as the focus has changed to closure governance and BAU oversight. The current assurance paper suggests significant progress and this is being sustained across the majority of areas.
Recommendations, decisions or actions sought	For information.

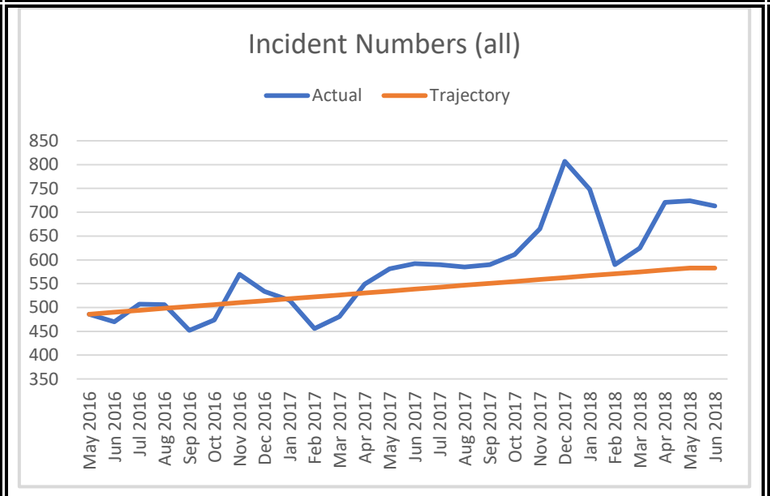
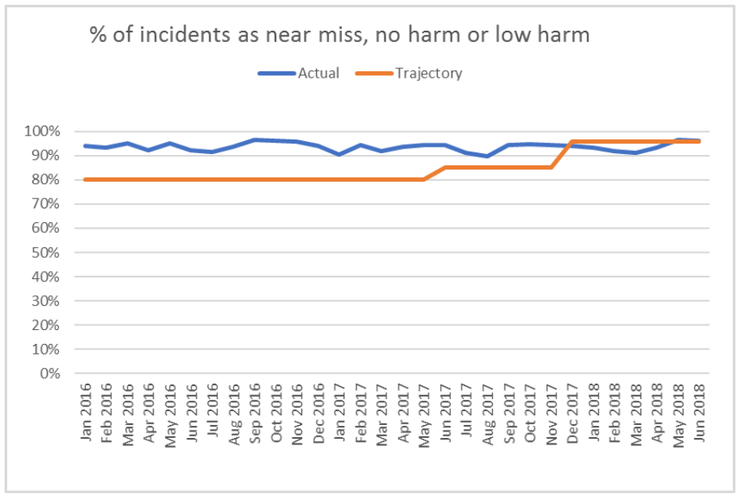
South East Coast Ambulance Service NHS Foundation Trust

Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Safe	The Trust **must** take action to ensure they keep a complete and accurate recording of all 999 calls. Source of data (IT)		Not applicable	**KPI Now** **No Change on Previous**	The 64 calls reported in June have been investigated. No clinical impact. Two issues from the 64 calls 1) Split calls – calls transferred are recorded as two parts (resolved) 2) conjoined calls – individual calls being joined in one long recording (resolved).
				KPI Future **No Change on Previous**	Plan is in place to replace the telephony and voice recording system
				Pace & Grip **No Change on Previous**	Call recording audited weekly (now undertaken locally and not through IT) and reports into compliance by exception. Trust has strong oversight. Plan remains to move to IPR for Board oversight.
Safe	The Trust **must** protect patients from the risks associated with the unsafe use and management of medicines in line with best practice and relevant medicines licences. This should include the appropriate administration, supply, security and storage of all medicines, appropriate use of patient group directions and the management of medical gas cylinders. Source (Quality Improvement Hub)			**KPI Now** **Change from Amber on Previous**	KPIs currently within compliance standards. The slight drop in May has been recovered due to some estate changes resulting in improved temperature compliance.
				KPI Future **No Change on Previous**	Oversight of medicines management continues. Six medicines indicators are now are on Trust IPR.. Improvement Plan due for closure but medicines management (as a subject) will remain in the Compliance work-stream until completely assured by stable compliance metrics.
				Pace & Grip **No Change on Previous**	Medicines governance dashboard will demonstrate grip and pace through Improvement Plan.

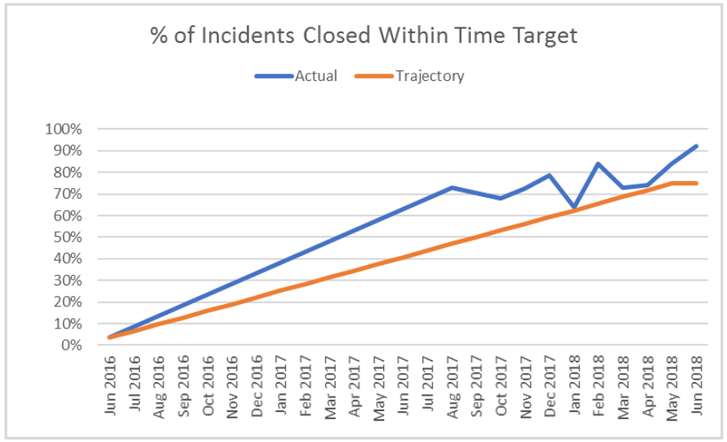
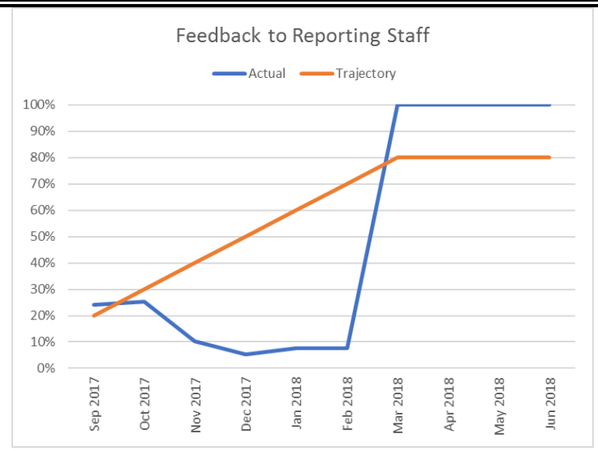
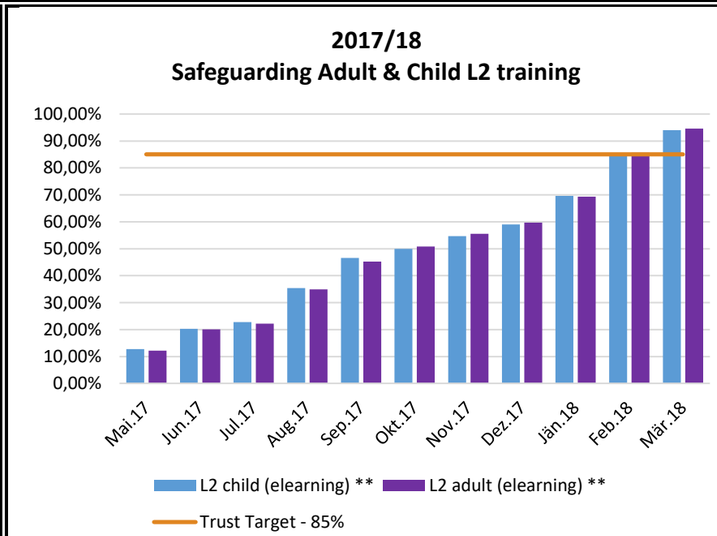
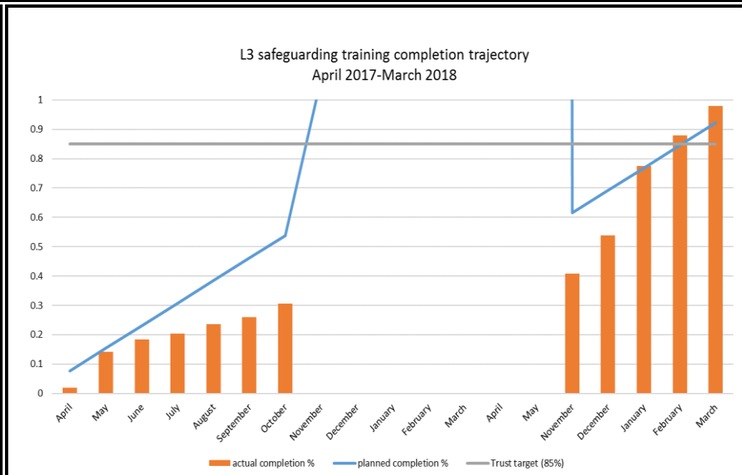
South East Coast Ambulance Service NHS Foundation Trust

Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Safe	The Trust **must** take action to ensure there are a sufficient number of clinicians in each EOC at all times in line with evidence-based guidelines. Source of data (EOC/H&T IAP)	 Graph updated		**KPI Now** **No Change on Previous**	Currently meet the minimum requirement for Pathways. With 32 band 6s and 13 band 7s there are now 45 members of staff having responsibility for clinical oversight.
				KPI Future **No Change on Previous**	No identified risk to this KPI changing.
				Pace & Grip **No Change on Previous**	Whilst confident that the actual KPI will be complaint there are wider gaps in clinical oversight which is acknowledged in the risk register. Plan to put minimum staffing on the IPR.
Well Led	The Trust **must** take action to ensure all staff receive an annual appraisal in a timely way so that they can be supported with training, professional development and supervision. Source of data (IPR) Improvement Project Closed: Target Reached			**KPI Now** **No Change on Previous**	End of year compliance reached. Project now part of BAU and Culture work stream. Appraisals compliance is integrated into the IPR (graph replicated here for simplicity)
				KPI Future **No Change on Previous**	No identified risk to this KPI changing.
				Pace & Grip **No Change on Previous**	Grip demonstrated through IPR measure. Recognition of importance demonstrated through action to improve the quality of appraisals through 2018/19.

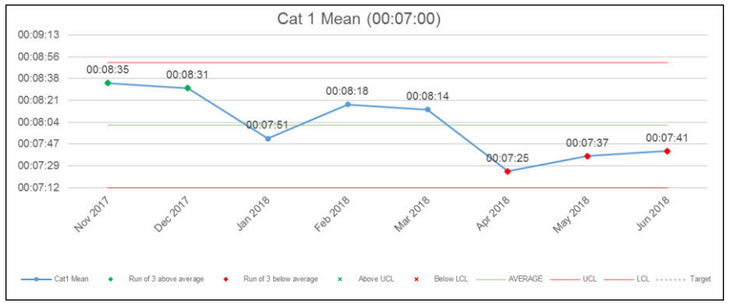
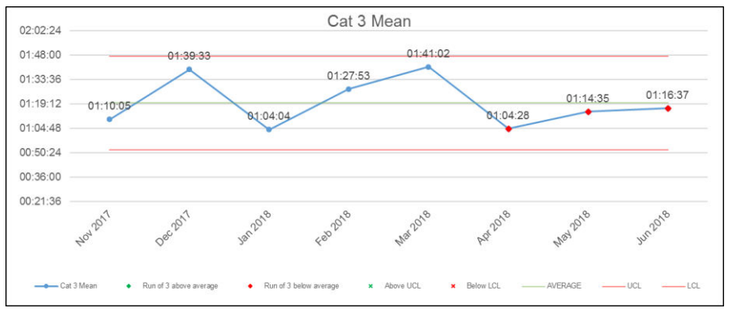
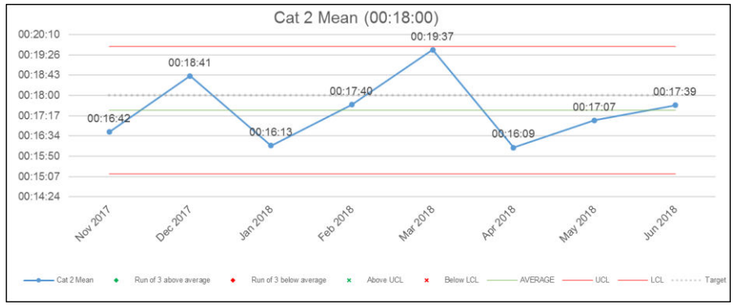
South East Coast Ambulance Service NHS Foundation Trust

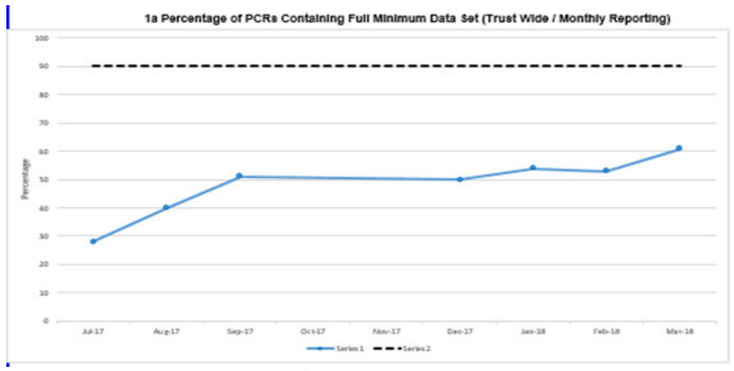
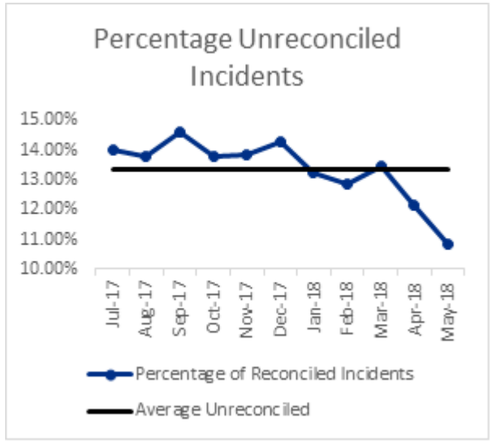
Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Safe	The Trust **must** take action to ensure all staff understand their responsibilities to report incidents. Source of data (Incident Management IAP)			**KPI Now** **No Change on Previous**	KPI remains above target.
				KPI Future **No Change on Previous**	No identified risk to this KPI changing.
				Pace & Grip **No Change on Previous**	Grip demonstrated through IPR measure. Recognition of importance demonstrated through action to improve reporting in the Improvement Plan.
Safe	The Trust **must** ensure improvements are made on reporting of low harm and near miss incidents. Source of data (Incident Management IAP)			**KPI Now** **Change on Previous from Amber to Green**	KPI remains above trajectory. This is an smbitious trajectory and there will be occasional months where there is a slight drop in numbers.
				KPI Future **No Change on Previous**	No identified risk to this KPI changing.
				Pace & Grip **No Change on Previous**	Grip to be demonstrated through inclusion in IPR and Pace to be demonstrated through Improvement Plan actions.

South East Coast Ambulance Service NHS Foundation Trust

Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Safe	The Trust **must** investigate incidents in a timely way and share learning with all relevant staff. Source of data (Incident Management IAP)		 Graph Updated	**KPI Now Change on Previous from Amber to Green**	Incident closure above trajectory. System established on datix to share incident outcome and staff now receiving automated feedback 100% of the time.
				KPI Future No Change on Previous	No anticipated risks of this changing..
				Pace & Grip No Change on Previous	Grip to be demonstrated through inclusion in IPR and Pace to be demonstrated through Improvement Plan actions.
Safe	The Trust **must** ensure all staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns receive an appropriate level of safeguarding training. Improvement Project Closed: Target Reached			**KPI Now No Change on Previous**	KPI reached for L3 KPI reached for L2 Safeguarding training is also mandatory for 2018/19 (bespoke training on supporting staff to identify possible power imbalance and harmful coercive/controlling behaviours). 36% of clinicians have received this to date.
				KPI Future No Change on Previous	No identified risk to this KPI not reaching compliance threshold.
				Pace & Grip No Change on Previous	Grip to be demonstrated through inclusion in IPR and pace to be demonstrated through Improvement Plan actions. Project moved out of Compliance Steering Group and into business as usual with the internal safeguarding group leading assurance of continued delivery to the clinical group.

South East Coast Ambulance Service NHS Foundation Trust

Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Effective	The Trust **must** take action to meet national performance targets. Source of data (IPR) Improvement Project Closed: Moving to BAU	 		**KPI Now** **No Change on Previous**	KPIs have improved since 2017 CQC visit and there are occasions where the Trust performs well against peer Trusts. However, this is not consistent for all four targets. Improvement project now closed as BAU oversight is robust and frequent.
				KPI Future **No Change on Previous**	No risks identified to impact on the KPIs
				Pace & Grip **No Change on Previous**	A comprehensive improvement plan is in place and performance has improved. However, ultimately the plan is focussed on abstractions and vacancy factor which are factors challenging to mitigate.

Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Safe	The Trust **must** ensure patient records are completed, accurate and fit for purpose, kept confidential and stored securely. Source of data (Head of Clinical Audit) Improvement Project closing: Moving to BAU	1a Percentage of PCRs Containing Full Minimum Data Set (Trust Wide / Monthly Reporting)  Graph updated.	2a. Percentage Incidents on Info.SECAmb with PCR Attached (Reconciled Records) [MONTHLY UPDATE]  Graph updated	**KPI Now** **No Change on Previous**	The main reason the Trust is unable to reconcile is through data inaccuracies rather than lost records. The big improvement has been achieved through the introduction of the four digit number.
				KPI Future **No Change on Previous**	An improvement plan is in place and moving to BAU but this may not be fully recovered prior to CQC inspection.
				Pace & Grip **No Change on Previous**	The Trust will be able to demonstrate that it is not through "lost" records but through documentation that records are unable to be reconciled. The Trust can demonstrate that this is now audited and discussed.
Safe	The Trust **must** ensure the CAD system is effectively maintained. Source of narrative (IT) Improvement Project closed	**Narrative unchanged**: The CAD system is maintained by the Trust ICT Department, Supplier Organisations and Third Party Companies bought in to carry out specific areas of maintenance. The critical system infrastructure supplying the control room are made up of a number of systems – CAD, telephony, voice recording, triage, mobile data and the radio system. The systems are duplicated at Crawley and Coxheath and significant work recently undertaken by the Trust has been to move the systems from Banstead to Crawley to reduce the risk of network failure having an impact on the system. Every month, a Third Party checks and tests the underpinning infrastructure whilst live in failover mode – this means that whilst it's being used, the live system is switched off and failed over to Coxheath and then back again. The data/information is held in a number of different places as copies are on both the Crawley and Coxheath sites. Live data is regularly archived to keep the system lean in terms of volumes of records which ensures that the system runs quickly and efficiently.		**KPI Now** **No Change on Previous**	CAD failure on risk register and being monitored through Business as Usual and has been replaced since the 2017 CQC visit
				KPI Future **No Change on Previous**	No risks identified to impact on the KPIs
				Pace & Grip **No Change on Previous**	CAD maintenance to be placed on IPR.

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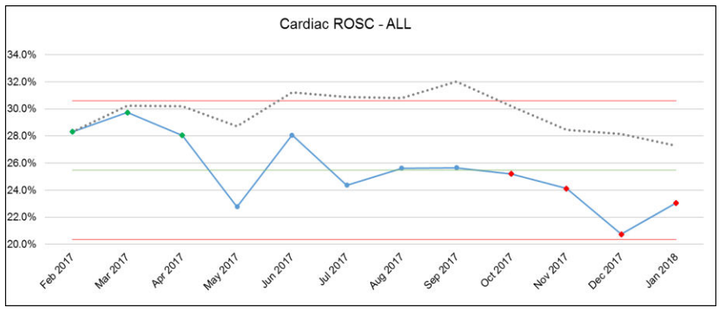
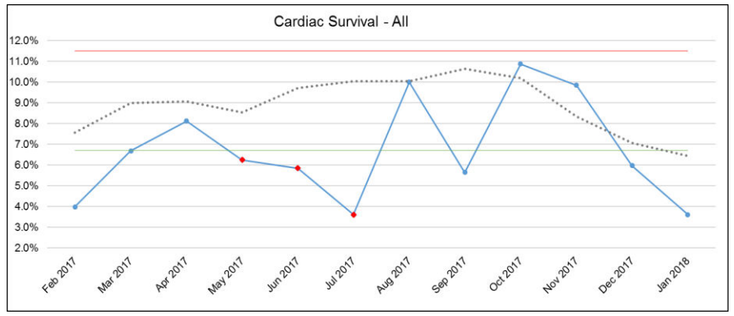
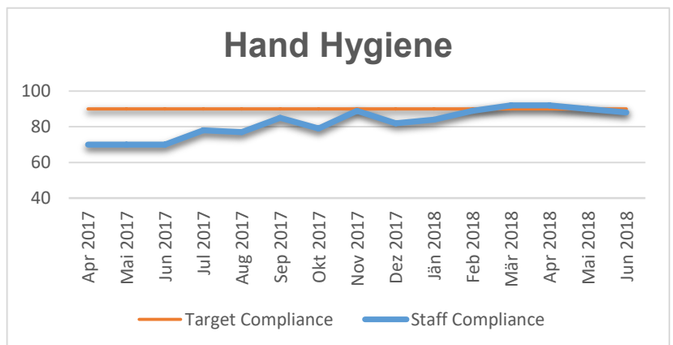
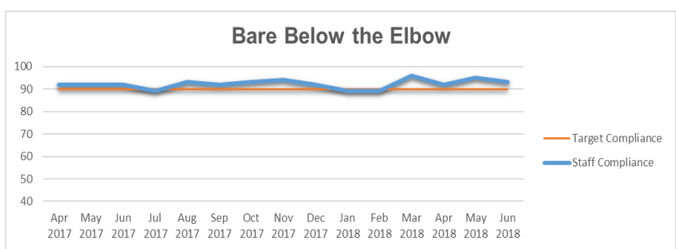
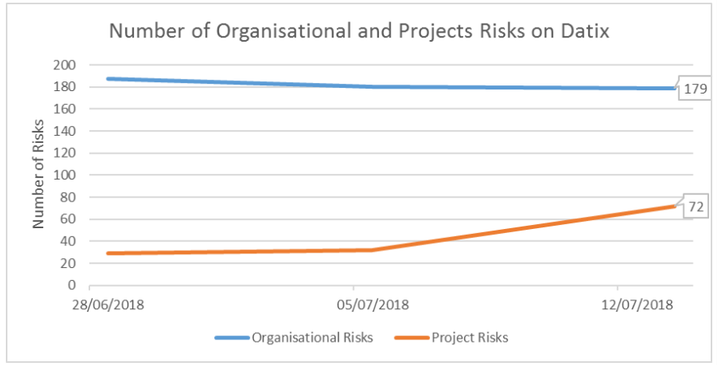
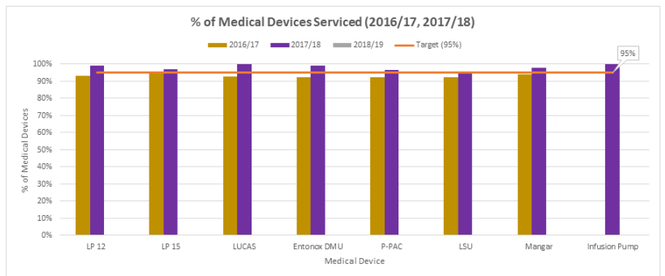
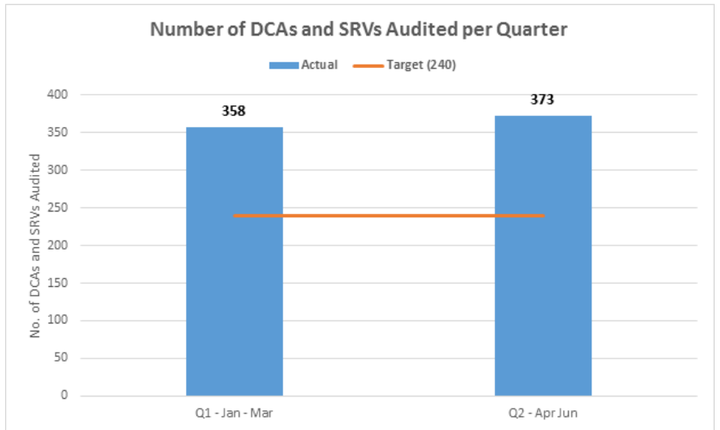
Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Effective	The Trust **must** improve outcomes for patients who receive care and treatment. Source of data (Integrated Performance Report)			**KPI Now** **No Change on Previous**	Cardiac survival is one of the three quality improvement priotirties for 2018/19 (Quality Account). Strategy being developed with specific improvements identified.
				KPI Future **No Change on Previous**	Low confidence that this can be significantly improved prior to CQC inspection.
				Pace & Grip **No Change on Previous**	Grip can be demonstrated through inclusion in quality dashboard and discussion every month with OUMs at Area Governance and also reported in the monthly Quality & Safety Report as a narrative by Clinical Audit. New project lead appointed.
Safe	The Trust **must** ensure the risk of infection prevention and control are adequately managed. This includes ensuring consistent standards of cleanliness in ambulance stations, vehicles and hand hygiene practices, and uniform procedure followed. Source of data (Infection Prevention & Control IAP)	**5a. % of staff who are compliant with hand hygiene audits carried out (monthly data)** 	**5b. % staff compliance against target of BBE audits carried out (monthly data)** 	**KPI Now** **No Change on Previous**	New strategy launched and auditing at A&E suggesting improved compliance with hand hygiene.
				KPI Future **Change from Amber on Previous**	New strategic plan and supporting improvement plan developed. High confidence of delivery.
				Pace & Grip **No Change on Previous**	Grip and Pace can be demonstrated through IPC dashboard and escalated meeting (now monthly).

South East Coast Ambulance Service NHS Foundation Trust

Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Well Led	The Trust **must** ensure that governance systems are effective and fit for purpose. This includes systems to assess, monitor and improve the quality and safety of services. Source of data (Risk Delivery Lead)	 Graph format changed from last month. New graphs are being developed for Governance & Risk project to provide clearer oversight on Organisational and Project risks.	Not applicable	**KPI Now** **No Change on Previous**	Risk management progressing and the graph for risk is illustrating that the Trust is actively using the risk register. RAG rated amber as governance has been established as a new project to help bridge some identified gaps.
				KPI Future **No Change on Previous**	Risk management progressing well and new improvement plan for governance being developed.
				Pace & Grip **Change from Amber to Green on Previous**	At present not yet assured that all governance processes will be in place but new corporate governance strategy due for publication prior to the CQC 2018 Well Led visit and improvement plan will be in place.
Safe	The Trust **must** ensure all medical equipment is adequately serviced and maintained. Source of data (Medical Devices Management IAP) Improvement Project closing: Moving to BAU			**KPI Now** **Change from Red to Green on Previous**	KPI showing as compliant. Project to move to BAU once metrics have a clear BAU oversight.
				KPI Future **Change from Amber to Green on Previous**	Predict that KPI will be reliable but at present not confident of the level of compliance.
				Pace & Grip **No Change on Previous**	Grip will be demonstrated by adding this to the IPR and the associated improvement plan will illustrate improvements.

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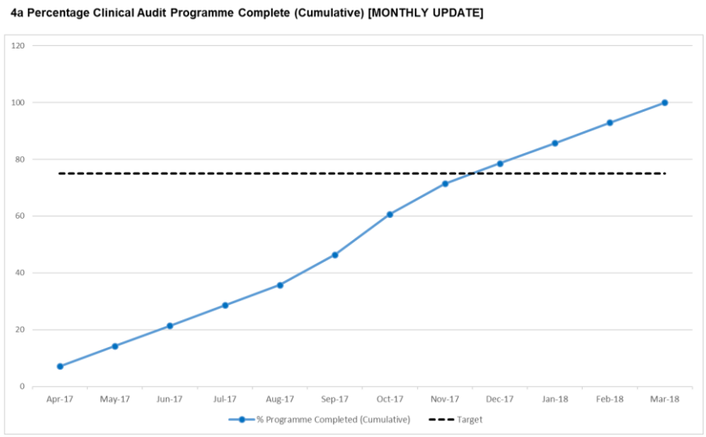
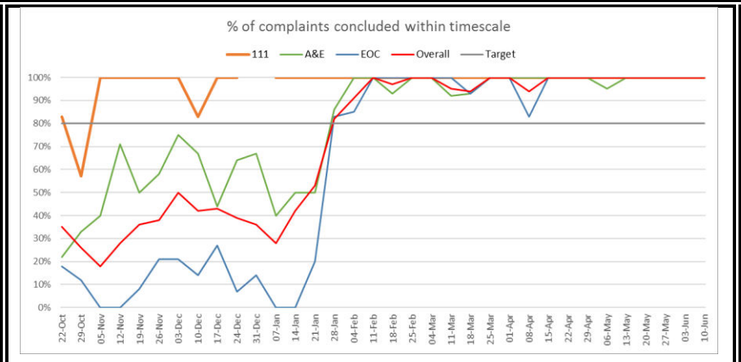
Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Effective	The Trust **must** continue to ensure there are adequate resources available to undertake regular audits and robust monitoring of the services provided. Source of data (IPR) Target achieved for 2017/18. Improvement Project closing: Moving to BAU			**KPI Now** **No Change on Previous**	End of year KPI target. Improvement project to be closed next month and project to be overseen by BAU.
				KPI Future **No Change on Previous**	End of year KPI target.
				Pace & Grip **No Change on Previous**	To be added to IPR.
Responsive	The Trust **must** ensure the systems and processes in place to manage, investigate and respond to complaints, and learn from complaints are robust. Source of data (Complaints IAP) Improvement Project Closed: Target Reached			**KPI Now** **No Change on Previous**	Initial performance targets now reached and sustained. Improvement project now closed and transferred to BAU.
				KPI Future **No Change on Previous**	Initial performance targets now reached however, plans to address learning just launched but confident they will deliver.
				Pace & Grip **No Change on Previous**	Enhanced complaints monitoring on IPR and patient experience group to have metrics.

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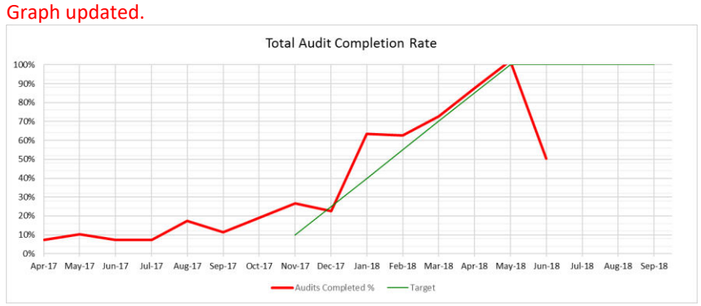
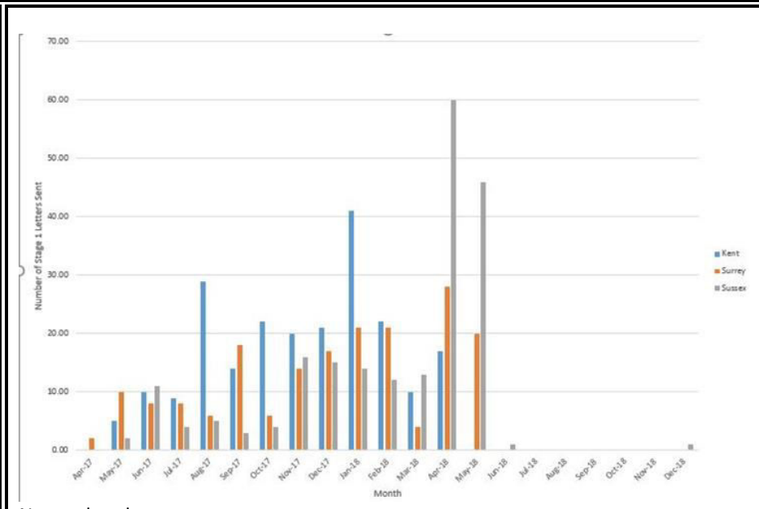
Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Safe	The Trust **should** take action to audit 999 calls at a frequency that meets evidence-based guidelines Source of data (EOC IAP)	Graph updated. 		**KPI Now** **No Change on Previous**	100& reached for May but creating capacity pressure for auding June so RAG rated Amber.
				KPI Future **No Change on Previous**	Currently on trajectory but current improvement plan is delivering the required improvements.
				Pace & Grip **No Change on Previous**	Confident that auditing will stay on track but on risk register as dependent on staff retention. Decision made to retain Improvement Plan in Compliance.
Responsive	The Trust **should** ensure 100% of frequent callers have an Intelligence Based Information System (IBIS) or other personalised record to allow staff taking calls to meet their individual needs Source of data (Frequent Caller Lead, Clinical Development Team)	N.B. Stage 1 letters denote the start of the journey through the frequent caller management process and subsequently have an IBIS record created at the time of the letter being sent. There is no specific target for this measure as the team have a large remit and the input to create a record is lengthy.	 Not updated.	**KPI Now** **No Change on Previous**	No update for July. Not subject to an improvement plan but part of business as usual with management team making improvements.
				KPI Future **No Change on Previous**	No risks identified to suggest KPIs will not be met.
				Pace & Grip **No Change on Previous**	Yet to be defined

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Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Responsive	The Trust **should** take action to ensure all patients with an IBIS record are immediately flagged to staff taking calls 24 hours a day, seven days a week.	Data not available to produce a graph.	The IBIS desk in EOC has only 'closed' a handful of times over the last six months, On these occasions we have usually been able to plug the gap with either our IBIS Trainer or a Clinical Data Assistant from HQ. **Current mitigations in place to reduce risk to patients:** 1) All 'critical' patient records (e.g. DNACPRs, PSIs and frequent caller management plans) have an associated at-risk marker on CAD so that attending staff will still be notified 2) Development of a 'patient search' function which allows EOC clinicians to undertake a 'backdoor search' of IBIS, so they can find a patient's care record on behalf of front-line colleagues, in the event the desk is unmanned 3) IBIS on iPad has been extended to Trust computers so that front-line staff can complete referrals at an ACRP/MRC in the event their iPad will not work and there is not IBIS desk cover to complete over the phone. **Current plans to improve IBIS desk staffing**: 1) Approval given to train the Response Desk Coordinators in IBIS so that, in a time of last minute IDA sickness, they would be able to match care records whilst we look for cover 2) Conversations with the EOC leadership team regarding the potential integration of IBIS Data Assistant duties into the Support Call Taker role in EOC.	**KPI Now No Change on Previous**	Currently no performance graph in order to provide assurance. To be identified where the BAU oversight takes place as part of governance review.
				KPI Future No Change on Previous	
				Pace & Grip No Change on Previous	
Responsive	The Trust **should** consider reviewing the arrangements for escalation under the demand management plan (DMP) so that patients across The Trust receive equal access to services at times of DMP. Project Closed:	The SMP went live in March 2018 - part of the implementation process included a SMP review group to monitor the implementation. Anne Harvey (Senior Contingency Planning & Resilience Manager – acting) has since been asked to update the SMP as some changes were needed. The plan has been updated to reflect these changes and the updated version went to EMB 13/06/2018 for review.		**KPI Now Change from Red on Previous**	Surge plan is now live
				KPI Future No Change on Previous	New Surge Management Plan is implemented when the Trust is unable to meet operational demand or is likely to experience operational challenges.
				Pace & Grip No Change on Previous	The Trust will manage its demand effectively across the Trust. Potential KPI to be placed on Integrated Performance Report (IPR) regaarding use of Surge

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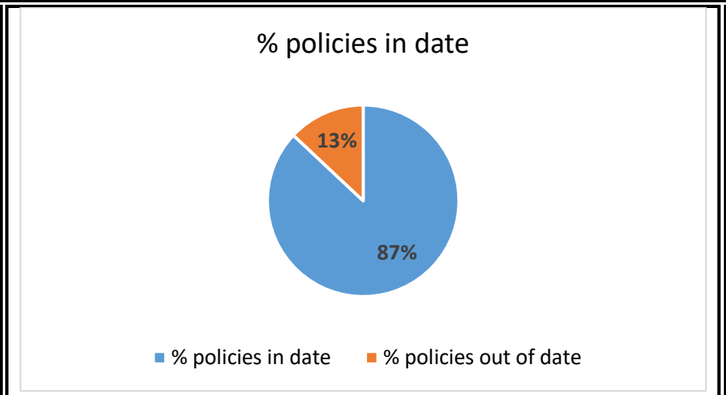
Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Well Led	The Trust **should** consider improving communications about any changes are effective and timely, including the methods used	Review of communications completed and final report with CEO		**KPI Now No Change from Amber on Previous**	No specific KPI.
				KPI Future No Change on Previous	Procedure agreed and will be in place.
				Pace & Grip No Change on Previous	Procedure agreed and will be in place.
Safe	The Trust **should** review all out of date policies. Source of data (Governance & Risk IAP)			**KPI Now No Change on Previous**	Majority of policies currently within date. Another call for policies has been made to reconfirm baseline.
				KPI Future No Change on Previous	Considerable work has been undertaken to ensure suite of policies are in date. Assurance requested regarding policies that go out of date in 2018. To be considered as part of governance review.
				Pace & Grip No Change on Previous	Being considered as part of IPR when refreshed.

<table>
<tr><th>Domain</th><th>CQC Findings
('Must or Should Do')</th><th>Metric 1</th><th>Metric 2</th><th colspan="2">Confidence</th></tr>
<tr><td rowspan="3">Safe</td><td rowspan="3">The Trust should ensure all first aid bags have a consistent contents list and they are stored securely within the bags.

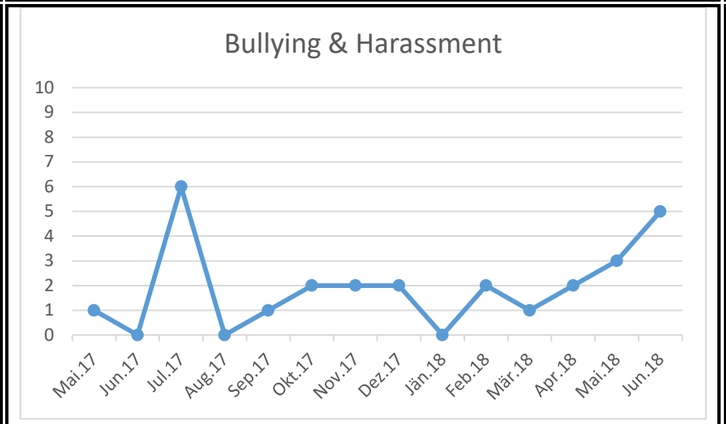
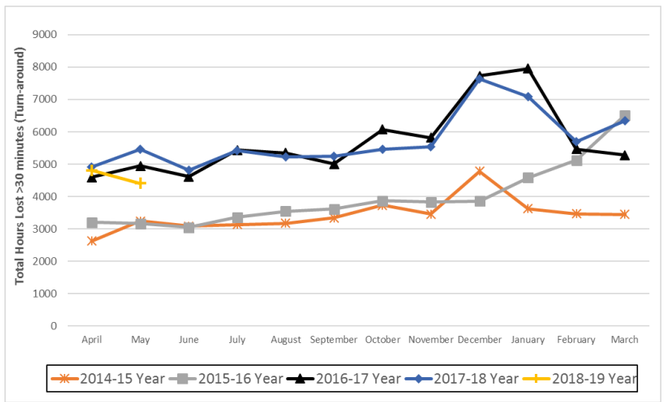
Improvement Project Closed: Achieved</td><td rowspan="3"> 
</td><td rowspan="3">Not applicable</td><td>KPI Now
No Change on Previous</td><td>Action completed</td></tr>
<tr><td>KPI Future
No Change on Previous</td><td></td></tr>
<tr><td>Pace & Grip
No Change on Previous</td><td></td></tr>
<tr><td colspan="6"></td></tr>
<tr><td rowspan="3">Well Led</td><td rowspan="3">The Trust should engage staff in the organisation's strategy, vision and core values. This includes increasing the visibility and day to day involvement of The Trust executive team and board, and the senior management level across all departments.

Source of data
PIR return</td><td rowspan="3">(not updated from previous month)

Director Visits Total for past 12 months (up to June 2018)
Daren 57 | Tim 21 | Graham 10
Joe 60 | Terry 22 | Laurie 2
David 35 | Al 12 | Tricia 2
Bethan 0 | Lucy 31
Ed 6 | Angela 9
Fionna 19
Steve E 5

Not all visits may have been captured. This is a minimum. Please also note the Non Executive Directors do not have a specific Trust base therefore Crawley has been included in their collection of data, unlike the Executive Directors and the Chairman who are based at Crawley and therefore this has not been included as visited Trust location.</td><td rowspan="3"></td><td>KPI Now
No Change on Previous</td><td>More work to be undertaken on capturing Board visits and Safety Walkarounds..</td></tr>
<tr><td>KPI Future
No Change on Previous</td><td>Plans are in place to increase the profile of the Board across the Trust and aspects of communication are being reviewed.</td></tr>
<tr><td>Pace & Grip
Change from Green on Previous</td><td></td></tr>
</table>

South East Coast Ambulance Service NHS Foundation Trust

Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Well Led	The Trust **should** continue to sustain the action plan from the findings of staff surveys, including addressing the perceived culture of bullying and harassment Source of data (HR)			**KPI Now No Change on Previous**	Staff still sighting examples of B&H and cases being rasied. However, not increasing.
				KPI Future Change from Green to Amber on Previous	Culture improvement plan is being revised and not yet in place.
				Pace & Grip No Change on Previous	CQC Deep dive on culture is ahead of the Well Led inspection. Plan is to lay out everything that has been undertaken.
Responsive	The Trust **should** continue to address the handover delays at acute hospitals Source of data (Hospital Turnaround Lead)	 Not updated from last month.		**KPI Now No Change on Previous**	No update on last month
				KPI Future No Change on Previous	Project is in place that includes sector wide engagement.
				Pace & Grip Change from Amber on Previous	Weekly oversight of some metrics at Exec Board and clear project lead should give an indication of pace and grip.

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

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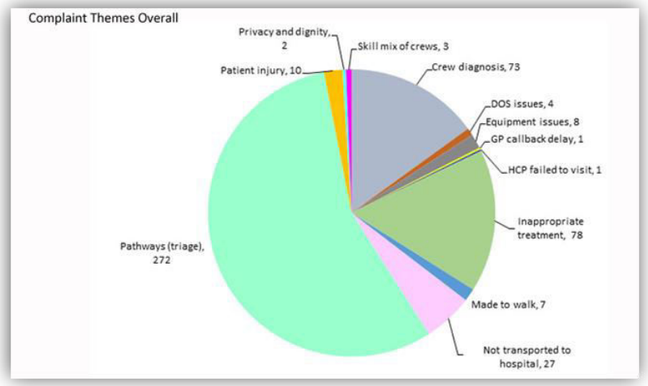
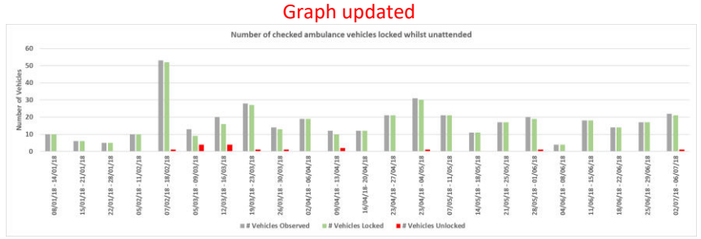
NHS Foundation Trust

Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Confidence	
Caring	The Trust **should** ensure that patients are always treated with dignity and respect Source of data Quality Accounts/Complaints Lead	 Not been updated.		**KPI Now No Change on Previous**	No update. Intentionally not progressed as a specific project. Diginity monitored through complaints process and assurance visits and addressed on a case by case basis.
				KPI Future No Change on Previous	
				Pace & Grip No Change on Previous	Currently considering how this can be specifically monitored.
Safe	The Trust **should** ensure all ambulance stations and vehicles are kept secured. Source of data (Medical Devices Management IAP)	Graph updated 	**97% submission for Quarterly Site Security Assessments for Q1 2018 - 19** **95% compliance for number of checked ambulance vehicles locked whilst unattended during 2 July to 9 July 2018**	**KPI Now No Change on Previous**	KPI for vehicles in place and demonstrates compliance. KPI for stations in place but audit returns are currently poor. Being addressed through operations with OUMs.
				KPI Future No Change on Previous	No risks identified to suggest KPIs will not be met.
				Pace & Grip No Change on Previous	Security to be on IPR when refreshed.

South East Coast Ambulance Service NHS Foundation Trust

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Safe	The Trust **should** ensure all vehicle crews have sufficient time to undertake daily vehicle checks within their allocated shifts.	Quality Improvement Hub is creating a SOP which will include the following elements; • Allow a 15min window at start of shift for completion of vehicle checks and preparation. • Ensure first action for crew is to book themselves "on duty" via MDT. • Second action to complete VDI on MDT. • During the 15min window for vehicle checks and general preparation, only C1 calls can be allocated to the crew.		**KPI Now Change from Amber on Previous**	Software to enable vehicle checks will soon be available for the Mobile Data Terminals (MDT). This will be piloted in the first instance.
				KPI Future Change from Red on Previous	Software implemented in all MDTs so all vehicle checks are undertaken. This will be made available from April 2018.
				Pace & Grip Change from Amber on Previous	SOP and software will be in place.
Responsive	The Trust **should** ensure individual needs of patients and service users are met. This includes bariatric and service translation provisions for those who need access. Source of narrative (Operational Team Leader)	Some of the bariatric equipment has changed and we have a number of new OTLs that are not trained on the equipment. We are in the process of planning the training on a train the trainer cascade system. In addition, it used to be the OMs that were contacted to attend a bariatric patient if a crew called for one, however it is now the OTLs that do this since taking over the 'Operational' (Bronze) role, hence the required training programme. A new Improvement Plan is being developed on Patients with complex needs and this will include Bariatric care.		**Pace & Grip Change from unclassified on Previous**	
				KPI Future Change from unclassified on Previous	
				Pace & Grip Change from Amber on Previous	Anticipate that an Improvement Plan/Mandate will be in place for patients with Complex Needs with oversight by Compliance Steering Group.