South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

30 August 2018
10.00-11.15

Crawley HQ

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
Introduction					
77/18	10.01	Apologies for absence	**-**	-	GC
78/18	10.01	Declarations of interest	**-**	-	GC
79/18	10.02	Minutes of the previous meeting: 26 July 2018	**Y**	Decision	GC
80/18	10.03	Matters arising (Action log)	**Y**	Decision	GC
81/18	10.05	Chief Executive's report	**Y**	Information	DM
Trust strategy					
82/18	10.15	Delivery Plan	**Y**	Assurance	DM
83/18	10.30	Delivery Plan Deep Dives: a) Hospital Handover b) EOC c) Hear & Treat	 **Y** **Y** **Y**	Assurance	 JG JG JG
Quality & Performance					
84/18	11.50	Integrated Performance Report	**Y**	Information	DM
Closing					
85/18	11.10	Any other business	**-**	Discussion	GC
86/18	-	Review of meeting effectiveness	**-**	Discussion	ALL
Close of meeting					

Date of next Board meeting: 28 September 2018
After the close of the meeting, questions will be invited from members of the public

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting,
26 July 2018

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

Present:

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

In attendance:

Peter Lee	(PL)	Trust Secretary

57/18 Apologies for absence

Angela Smith	(AS)	Independent Non-Executive Director
Janine Compton	(JC)	Head of Communications

58/18 Declarations of conflicts of interest

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

59/18 Minutes of the meeting held in public on 28 June 2018

The minutes were approved as a true and accurate record.

60/18 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.

61/18 Patient story [10.02 – 10.10]

This patient story related to a patient who suffered potentially life-saving injuries, and the good work from the attending crew.

The Board reflected on this really positive story and the great work of the paramedic crew that attended. FM expressed how impressed she was with the teamwork shown, especially between the EOC and crew.

62/18 Chief Executive's report [10.10 – 10.18]
DM took members through the issues set out in his report.

GC asked for an update on the position with the 111 services. SE confirmed that the outcome of the Surrey procurement is imminent. The procurement in Sussex and Kent has paused, and the Trust is working with commissioners to help ensure service continuity in the meantime.

63/18 Delivery Plan [10.18 – 10.20]
SE introduced the report, which continues to be refined. It highlights areas we are making progress against and should be read in conjunction with the integrated performance report. We are working closely with commissioners on projects we move in to business as usual.

In light of the deep dives, the overall report was noted.

64/18 Delivery Plan Deep Dives [10.20 – 11.13]

<u>Deep Dive 1: EOC</u>
JG explained that the presentation sets out the areas we have been focussed on. JG highlighted specific aspects including;

Recruitment – there is significant improvement as we now exceed the funded establishment. There are some staff leaving but unlike before, a significant majority are moving on to different roles within the Trust, as part of their career progression. In terms of impact, we are still challenged with the high number of secondary calls, which at times is as high as 30%.

LB asked about clinical supervisors as we were looking for 45 and this appears to have flat-lined. JG confirmed that this is an aspirational target to grow our structure toward and integrated clinical advice service. This includes the addition of a clinical navigator to support existing supervisors. These types of roles have been difficult to attract and this is why we have developed the career structure. In addition, we have implemented the Manchester Triage Tool. This provides a more efficient pathway through training. All this aims to deliver at least 10% of activity as hear and treat – currently 6%. The additional 4% will be supported by the clinicians we plan to recruit.

GC asked about 111 and JG set out the steps being taken to integrated 999 and 111 clinical service. We are using some of the lessons from 111 in how agile they can be, e.g. clinicians working from home / remotely.

TH asked about the national target of 95% call answer. JG explained that we are getting closer. We can now deliver the hours needed, but there is still an issue with increased calls through call backs as a result of additional pressures with the current heat wave. In the last couple of weeks we have delivered over 80% but it is fragile for the reasons described. When looking at the mean average we are in a better position, relatively speaking.

DM reminded the Board of the peer review work undertaken and the various pilots with our partners. In addition, we have invested in an additional 30 ambulances, which will be ready for September, and focussed specifically on Cat 3 patients.

The Board explored the governance of the delivery plan, in the context of when a project misses targets, e.g. many targets for EOC are 31 August 2018. JG explained the process of intensive support, and reinforced the process whereby any changes to internal targets will be approved by the executive management board. Any changes to targets dates of overall projects will come to the Trust Board for approval.

SE added that we are nearing completion of the demand and capacity review, which needs to be factored in given the additional resources that will be provided as a result. SE also reinforced JG's point about the Trust taking the decision to provide additional resource in advance of the demand and capacity, e.g. vehicles and recruitment.

GC summarised that the Board recognises all the work ongoing, but we are not where we would want to be.

Culture

EG explained that the papers in the pack refer to the areas within the culture programme. The phasing of the work is such that we started from the point of responding to a number of negative findings, e.g. Prof. Lewis. Now we have defined a culture we want to move towards. In terms of governance of the programme, we have been reliant on external support and we are now building internal capacity and capability.

We intentionally focussed initially on the executive and senior managers and the re-launch of our values. We have shifted focus from what is wrong to what is expected, through the values and behaviours. In addition, some of the work via the HR transformation programme helps address some of the negative feedback, including the employee relation issues. There was a session held recently with middle and senior managers within operations on the move towards the new culture, ensuring the support they required is in place. EG confirmed there was some positive feedback from this, relating to the good level of support and opportunity for development. The behaviour training is now being delivered to OTLs and their teams to help strengthen the sense of team.

The Freedom to Speak Up Guardian appointment is key to demonstrating the different avenues for staff to speak up, in addition to 'phone in confidence' and, of course, contact with line managers, which is something we are seeing more of.

EG then outlined some of the other work ongoing, including the work on the diversity of our workforce, and how culture links to areas such an incident and risk management.

SE added that this is directly linked to the strategy development engagement and the really good feedback from operational staff about how they are able to influence and shape our strategy.

TP confirmed that the workforce and wellbeing committee explored how culture impacts all parts of the organisation. For example, the committee considered one existing policy that it believed felt like the old SECAMB, whereby it reflected how we do things to people, rather than with them. Management was asked to revise the policy to better align with the Trust's new values.

DM added that our relationship with union colleagues is good and very collaborative. EG agreed, and explained that as part of the redesign of the HR function, we will ensure even better working between employees, unions, and line managers.

AT asked about some of the basics and how we measure success of the programme. JG explained that the session mentioned earlier was the first delivered to a team. We all recognise the need to change. In terms of the basics, EG set out the work on payroll, working with our provider (weekly meetings) to ensure issues are quickly resolved. In terms of measuring success there are leading and lagging measures. Leading measures include supporting managers through the programme, and reviewing pulse / staff surveys, grievance and

sickness metrics, which we would expect to improve over time. Keeping staff happy and positive will improve retention.

TM noted that the project has moved from Red to Amber, but this is based on inputs rather than outputs and he challenged some of the KPIs. EG explained that the programme is in intensive support, which is a significant shift in terms of driving some of the inputs. In terms of whether staff would see the shift from Red to Amber, EG felt there would be different views. SE reinforced the definition of the RAG rating where Amber still indicated a risk of failure, but management believe it could be delivered within existing resource. Red is a risk, which requires additional resource.

GC reinforced the need to be able to constantly monitor progress and impact.

CQC Tracker
BH introduced the paper.

On 999 calls, DH updated the Board on the work to address the issues since last year and confirmed that by November will have a new system in place. A new issue of conjoined calls was identified in June. This is where a call is recorded continuously with the consequence of including several calls in one recording. Therefore, if we need to retrieve these calls there is a process in place but it takes a little longer than calls that are not conjoined. The resolution is being explored with the provider, until the new system is in place. The weekly audit are overseen by the compliance steering group with escalation to the executive management board.

JG added that that all calls are recorded and reinforced that there has been no incident of being not able to find a call.

65/18 Finance & Investment Committee [11.13 – 11.17]
In AS's absence, LB outlined the areas reviewed by the committee as set out in the report. Significant concern was explored by the committee relating to the 111 procurement. The committee supported the interim ICT strategy and expect the new head of ICT to develop the full strategy.

As instructed by the Board, the committee considered and approved the station IT upgrade.

Finally, the relevant BAF risks were considered and the committee will undertake a deep dive of the identified finance and investment risks recorded in the risk register, at its next meeting.

66/18 ICT Interim Enabling Strategy [11.17 – 11.28]
DH confirmed that this is an interim strategy/delivery plan, to help ensure delivery of some of the significant objectives over the next 6 months, e.g. IT upgrade, ECPR, telephony etc. The document sets this out and as part of the Trust strategy refresh, we will look much further forward in terms of IT enabling operational delivery. This will be included in the final enabling strategy in early 2019.

AT supported DH's summary. The work outlined by DH ensures resilience.

TH felt we are retrofitting strategy to what we are doing, rather than agreeing strategy first to ensure we do things against agreed principles. The Board agreed.

LM added that now we are beginning to look further in to the future, IT will also affect clinical work and asked if the investment is sufficiently robust. DH felt it would bring us up to speed to deliver the efficiency we know we need to deliver the best patient care we can.

JG confirmed that one of the benefits of improving infrastructure in the estate is that it enables clinicians to work more locally. Therefore, we are already enabling what we are trying to achieve longer term.

DM reminded the Board that 15 months ago we did not have a strategy or any enabling strategies. We said last year we would refresh the strategy now, so we are in a much better place.

GC agreed adding that we just need to think hard about how we use IT to improve patient care.

Decision:
Board approved the ICT Interim Enabling Strategy

67/18 Audit & Risk Committee Report [11.28 – 11.32]
In AS's absence, AR outlined the issues set out in the report. On the point about the fraud questionnaire, AR explained that the committee balanced this with other data, which seems to indicate that that there isn't the same reluctance of staff to raise concerns, as we have examples where staff are speaking up. DH supported this and confirmed this was a specific survey by counter fraud. The number of referrals of fraud have been consistent and so the evidence does not suggest staff are not raising fraud issues.

68/18 BAF Risk Report [11.32 – 11.38]
PL took the Board through the structure of the report, reinforcing the progress made and the oversight provided by the committees of the Board.

The aim is to use the BAF to drive the Board and Committee agendas, which it is currently doing.

The Board;

a. Supported the progression of the BAF Risk report.

b. Noted that the Executive Management Board will review the BAF risks in August to reflect some of the feedback from the recent committee meetings, and ensure the controls and progress section are more complete.

c. Noted that the Executive Management Board will review risk 518 and re-focus it on specific aspects of the fundamental standards of care.

d. Agreed the recommendation of the Workforce and Wellbeing Committee to amend the description of risk 362 (remove the word 'pre' in order to reflect that the risk is more broadly about employment checks, not just those pre-employment).

e. Did not agree the recommendation of the Executive, to receive this report at every other meeting of the Trust Board. Instead, the Board asked for the report at every meeting, for the time being.

69/18 Charitable Funds Committee Report [11.38 – 11.38]
The report was noted.

70/18 QPS Committee Report [11.39 – 11.58]
LB outlined the issues covered by the committee as set out in the report.

The Board acknowledged that the ECG analysis is one important element of the work to improve cardiac arrest care.

On Swab Testing JG explained the gap between the outputs of the tests and our IPC team follow up.

LB reinforced that the committee was heartened by the progress in Clinical Audit. FM updated that the challenge of the team has been with capacity and we now have a much stronger team in place with improved governance. We are working with national teams to update the ACQIs.

There was a thematic review of delays was considered by the committee immediately before this Board meeting. It received a detailed analysis of where we experience delays and the related complaints and incidents, and then looked at the mitigating actions, which includes recruitment and how we retain staff; SMP; staff welfare; EOC clinical oversight and the pilot schemes. The committee has asked for more evidence and better articulation of the improvements we have made and intend to make. In addition to a deeper thematic review of SIs.

BH updated the Board on the approach we are taking to ensure more effective management of private ambulance providers.

71/18 Incidents & SIs Annual Report [11.58 – 12.00]
BH reflected her view that this is a positive report, despite the further improvements needed. She highlighted some of the issues in section 8 (learning) and confirmed that there is still a resource issue, which is being mitigated through the current recruitment plan.

There were no questions.

72/18 IPR [12.00 – 12.24]
SE introduced the report, which continues to evolve and should be read in conjunction with the delivery plan.

Clinical safety:
FM highlighted the improving position with clinical records. In terms of cardiac arrest we have a project manager in place to help ensure improvement in out of hospital cardiac arrest. There is also further work ongoing to further improve Care Bundles.

Quality:
BH confirmed that we have included duty of candour for moderate harm and updated verbally that, as of May, we are up to 26% and have a trajectory of improvement in place.

Hand hygiene audits is at the required target of 90% and we have introduced monthly A&E visits and talk to staff about a number of issues, including comparison between observation and audits (which match) to provide an additional level of assurance.

Performance:
Cat 1 and 2 performance is consistent since APR in November 2017 and we compare favourably nationally. Conversely, Cat 3 remains a challenge, and a number of initiatives are in place to improve this and safety, as mentioned earlier.

Handover delays continues to have positive impact, which we hope will be sustained through winter.

JG set out some of the challenges during July with heat wave and world cup. This had an impact on the whole system, including A&E. Some of the benefits of the infrastructure for handover delays is that we are much better now at working together.

Workforce:
EG emphasised that during this period our workforce planning team has focussed on the workforce trajectory of the demand and capacity review, which for the first time gives a clear picture of workforce through to March 2021. This allows us to plan our activities in a way not possible before. EG explained the work on improving reporting in specific areas, e.g. grievances and disciplinary, to help improve how things are resolved.

DM asked about statutory and mandatory training and career conversations. JG assured the Board that this is a focus of the area governance reviews. The aim is to get to 90% by December so we have more staff available during this busy period; we are on track with this.

AR asked about the variance in vacancy rates by OU. JG explained there is a 4% vacancy rate in Sussex and it is much higher in Kent and Surrey, for different reasons. The solution is how we devolve recruitment and selection and training more locally. We are working with HR and the OUMs to ensure focus on this localised recruitment approach.

TM was pleased to see more focus on health and safety, but asked how far we are missing the deadline for RIDDOR. BH did not have the specific detail but would confirm the same. RIDDOR is within the new project plan.

Action:
EG to confirm the response figures for RIDDOR reporting to show the extent to which we miss the target.

Finance:
We are on plan at month 3. DH highlighted that the finance business partner function is now well embedded. We have undertaken budget holder training in the last few months and we continue to invest in fleet and vehicles, some of which is in addition the plan.

73/18 WWC Report [12.24 – 12.31]
TP reassured the Board that despite the number of partial reassurances in the report, the committee was very assured by how well the Trust knows itself now, compared to before. The committee understands that the biggest single issue/risk is workforce planning, hence its recommendation to the Board to schedule time for strategic planning.

As the Board meeting in August was scheduled as an additional meeting, the Board agreed to hold a shortened meeting to cover the delivery plan and IPR, and use the rest of the time for strategic planning for delivery of ARP post the outcome of the demand and capacity review.

Action:
Board to hold a strategic planning session on 30 August, to consider the outcome of the demand and capacity review and how the Trust will deliver ARP.

TP explained that the committee explored the metrics for culture and the risk of chasing a metric, and not allowing the climate to be fixed.

With regards the health and safety review, management identified issues and the independent review confirmed what we needed to do. The need for pace is important and so the committee supported the project approach.

74/18 FTSU Report [12.31 – 12.36]
BH updated the Board that the FTSU Guardian has been appointed and due to start in September. We are due to advert shortly for the 15 advocate roles (internal staff) and we are using the national lead two days per week to help drive this agenda. The plan is to have a Board seminar in September facilitated by the national lead.

TH felt this was a very good paper and asked whether there should be a whistleblowing NED. The Board explored this and agreed to await the new Guardian to be in post and make a decision then.

75/18 Any other business
None

76/18 Review of meeting effectiveness
Papers out on time and comprehensive.

There being no further business, the meeting closed at 12.36

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	The governance and assurance strategy / framework is due to be receive dby the Audit Committee on 19 Spet and then to Board on 28th
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	
26.04.2018	11/18 9	QPS to undertake a trend analysis for complaints	PL	TBC	QPS	C	Added to the committee cycle of business
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 IPR includes a CQC domain section agaisnt each sectiosn. The Board has asked for one overall summary.	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	C	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	September	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	
26.07.2018	72/18 27	EG to confirm the response figures for RIDDOR reporting to show the extent to which we miss the target.	EG	August	Board	IP	

26.07.2018	73/18 28	Board to hold a strategic planning session on 30 August, to consider the outcome of the demand and capacity review and how the Trust will deliver ARP	GC	August	Board	C	Scheduled for 30.08.2018

Key

- Not yet due
- Due
- Overdue
- Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	81-18

Name of meeting	Trust Board
Date	30.08.2018
Name of paper	Chief Executive's Report
Executive sponsor	Chief Executive
Author name and role	Daren Mochrie
Synopsis (up to 120 words)	The Chief Executive's Report provides an overview of the key local, regional and national issues involving and impacting on the Trust and the wider ambulance sector.
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.

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

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S REPORT TO THE TRUST BOARD

1. Introduction

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

2. Local issues

2.1 Chair recruitment

2.1.1 On 24 August 2018 we announced that the Council of Governors had formally appointed David Astley as our new, substantive Chair following a rigorous recruitment and selection process.

2.1.2 David, from Kings Hill in Kent, has over 40 years' management and leadership experience in the NHS and abroad and will take up his post in late September. He was awarded an O.B.E in 2006 for services to the NHS and has held a number of very senior roles in the NHS including Chief Executive of East Kent University Hospitals NHS Trust between 1999 and 2006 and Chief Executive of St George's Healthcare NHS Trust between 2006 and 2011.

2.1.3 I am pleased that we have been able to appoint such a highly-experienced person as David as our Chair and look forward to working with him to continue to improve the services we provide.

2.1.3 I would also like to express my thanks to Graham Colbert, who took on the role of Chair on an interim basis in April, for all of his hard work and support.

2.2 Engagement with local stakeholders & staff

2.2.1 On 31 July 2018, I met with Anne Eden, the NHS Improvement Executive Regional Managing Director for the South East, to discuss how we are performing as a Trust and our key areas of focus. In turn, on 24 August 2018, I was pleased to welcome Anne and her team to our Crawley HQ, where she spent time in the EOC, seeing how we work in practice.

2.2.2 On 7 August 2018, I met with Marianne Griffiths, the Chief Executive of Brighton & Sussex University Hospitals NHS Trust and Western Sussex Hospitals NHS Foundation Trust in Brighton. It was an extremely useful meeting, providing an opportunity to discuss key challenges and opportunities facing our region.

2.3 Care Quality Commission (CQC) inspection

2.3.1 Following the CQC's core services inspection of the Trust, which took place between 18 and 20 July 2018, the Well Led aspect of the inspection took place on 22 and 23 August 2018.

2.3.2 This started with our Trust's presentation to the CQC inspectors and was followed by three focus groups and eighteen interviews, with senior managers from across the Trust. Thank you to everyone who took part.

2.3.3 After these two intensive days of inspection, and the previous core services inspection, we will now await the draft report in October. Although we do not anticipate any further CQC visits, related to this year's inspection the CQC, as part of their new model of inspection, will continue to monitor our performance and progress remotely and through ongoing meetings. Part of this new way of working could also involve visits to any of our sites at any point during the year.

2.3.4 We expect our final report to be published in October/November this year.

2.4 Executive Management Board (EMB)

2.4.1 The Trust's Executive Management Board (EMB), which meets weekly, is a key part of the Trust's decision-making and governance processes.

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

- Spent time focussing on the CQC Inspection – supporting staff during the Core Services phase of the inspection and preparing for the Well Led inspection
- Continued to monitor the progress of the Demand & Capacity Review, as it moves towards completion
- Closely monitored delivery of the Trust's Recruitment Plan
- Discussed the on-going NHS 111 contract tenders

2.4.3 On 5 September 2018, we will hold our third live Chief Exec 'webcast'. As previously, the session will be advertised in advance and a link provided so staff can log in 'live' at the start of the session.

2.4.4 The session on 5 September will feature myself and Ed Griffin, Director of HR & OD and will focus on the work underway to change the culture of the Trust.

2.5 Brighton Pride

2.5.1 I was delighted to see that a huge turnout from staff, volunteers and representatives from other ambulance services nationally, saw record numbers walk for SECAmb in the parade at Brighton Pride on 4 June 2018.

2.5.2 I understand that 187 people walked alongside the specially-decorated ambulance, kindly sponsored by the Trust's Unison and GMB unions – a fantastic turn-out! Thank you to the Pride network and everyone involved in supporting our involvement.

2.5.3 I was sorry not to be able to attend myself this year but am pleased that Fionna Moore and Joe Garcia were able to attend. From speaking to them and others involved, it sounds like it was a great weekend and a real opportunity to come together to celebrate the diversity both of SECAmb and of our local communities.

2.5.4 Thank you also to everyone working operationally during the Pride weekend, as I know it was a really busy period.

3. Regional issues

3.1 South East Region System Leaders Event

3.1.1 On 29 August 2018 I attended the above event, which was jointly hosted by NHS England and NHS Improvement. There was a varied agenda covering a number of regional issues including operational performance, STPs and system working nationally going forwards.

3.1.2 As part of the event I was asked to give a joint presentation with Daniel DeRozarieux, the Regional Director for Urgent & Emergency Care, about planning for winter, including learning lessons from last winter.

3.1.3 This was a good opportunity to highlight the key role that SECAmb plays as part of the broader system, especially during periods of high demand.

3.2 Hospital Handover Project

3.2.1 As part of the system-wide approach to tackling hospital handover delays, good progress continues to be made at some hospital sites and despite considerable additional pressure in July, those hospitals sites have managed to maintain their performance.

3.2.2 However, progress is not uniform across all sites and there are some outliers where hours lost at hospital sites have increased from the same period last year and some where the position has continued to deteriorate. This is a real concern as we move into winter.

3.2.3 More focussed work is being undertaken at these sites, working with the Emergency Care Improvement Programme (ECIP) and also by undertaking peer reviews in order to share good practice and provide additional support to the more challenged sites.

3.2.4 In terms of our own performance, there has not been the expected improvement in crew to clear performance, with some significant variance between sites and between individual teams. However, more visibility of crew to clear times is now available which will support operational managers in improving performance.

4. National issues

4.1 NHS Horizons' 'Project A' event

4.1.1 As shared previously, staff from across SECAmb have been working with their colleagues nationally as part of 'Project A' – an initiative led by NHS Horizons to allow ambulance staff to share ideas and suggestions with colleagues nationally, to improve the services provides by the ambulance sector.

4.1.2 Since the kick-off event in June, NHS Horizons have received more than 400 ideas and suggestions so far from staff, which have been broken down into five key

areas. Staff have until 31 August 2018 to either come forward with new ideas or to vote for ideas which have already been put forward.

4.1.3 There has been a tremendous response from staff nationally and I am delighted that our staff have played a part in this. I look forward to seeing the outputs of this work.

5. Recommendation

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

Daren Mochrie QAM, Chief Executive

23 August 2018

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	83/18

Name of meeting	Trust Board
Date	30th August 2018
Name of paper	Delivery Plan Update
Responsible Executive	Steve Emerton, Director of Strategy and Business Development
Author	Eileen Sanderson, Head of PMO
Synopsis	This paper provides a brief update on the progress made to the Delivery Plan
Recommendations, decisions or actions sought	The board is asked to • review the dashboard to be fully sighted on the current progress of the Delivery Plan • 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 the Trust's Delivery Plan. The plan includes an update on the following Steering Groups:

- Service Transformation and Delivery
- Sustainability
- Compliance
- Strategy

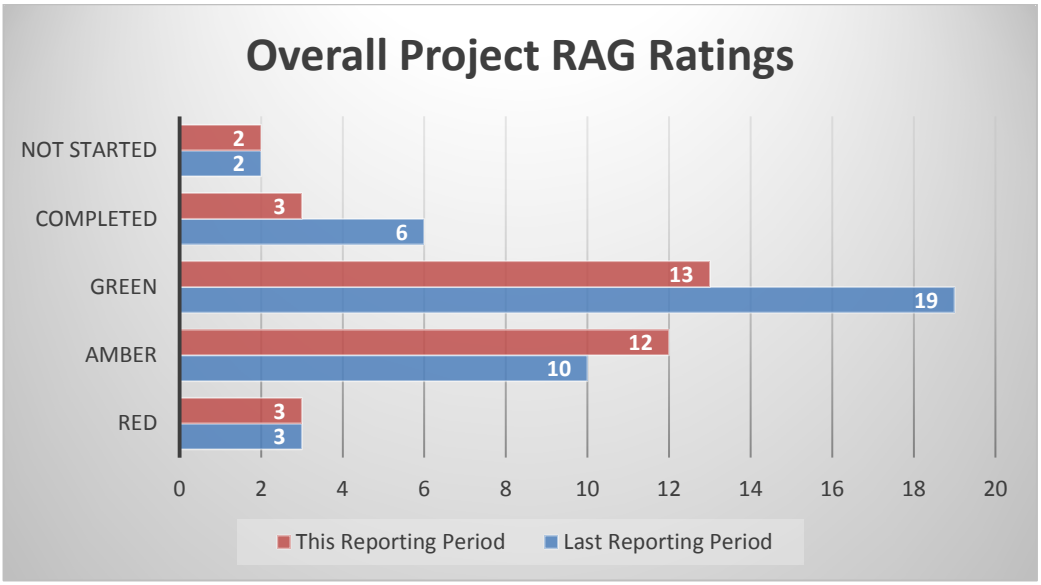
1.1 The Dashboard gives high-level commentary and associated Key Performance Indicators (KPIs) for this reporting period where appropriate. As projects come to completion the reader should note that project closure processes will be enacted to ensure that continued and sustained delivery moves into Business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

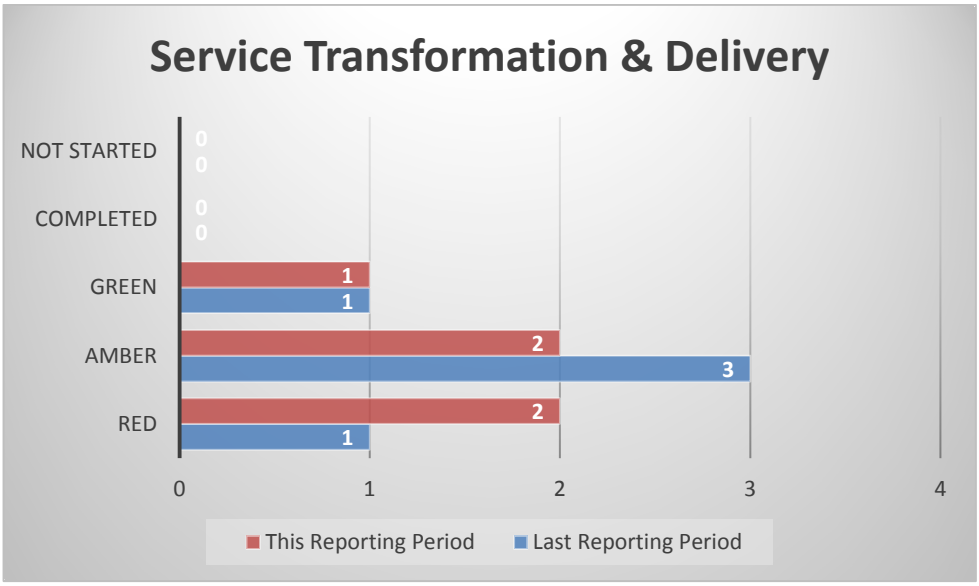
1.3 The Delivery Plan Dashboard (Appendix A) provides a summary of progress within this reporting period. For information the RAG status is defined as follows:

- 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 RAG remains Amber due to resources not yet in place to deliver. Operating Unit level recruitment pipelines have been developed to ensure establishment reaches 2,413 by April 2021. Local recruitment campaigns will begin in October 2018 to provide candidates for ECSW courses delivered within local operating units commencing February 2019. Planning is underway to deliver new rotas for all staff commencing in April 2019.

2.1 **Demand and Capacity Review** – This project remains Amber. The Demand and Capacity review is nearing completion with review taking place of the draft final report. 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 planned that the report will be agreed and completed by mid September 2018 and agreed for enactment by the end of September 2018.

2.2 **Hospital Handover –** The project is RAG rated Red from Amber. There has been significant progress made at several sites to reduce hospital handover delays, mainly in Surrey and Sussex with some significant outliers in Kent and Medway. Further support is in place for those sites including Peer Review Visits so that best practice and learning can be shared between hospitals.

Crew to Clear performance is also varied across hospital sites with some outliers. The Job Cycle Time report is now available for managers across SECAmb which provides granular reports to support improvement in Crew to Clear time. More focus is being placed on improving Crew to Clear times within individual Operating Units and at individual sites.

2.3 **Increased Hear and Treat** – The project RAG remains Red. Hear and Treat performance has gone from strength to strength since November 2017. We now reside in fourth place at 6.5% for Hear and Treat performance in July compared to other National 999 Providers. We are 0.8 percentage points above the national average and 1.1 percentage points behind the East of England, the highest performing Trust at 7.6%.

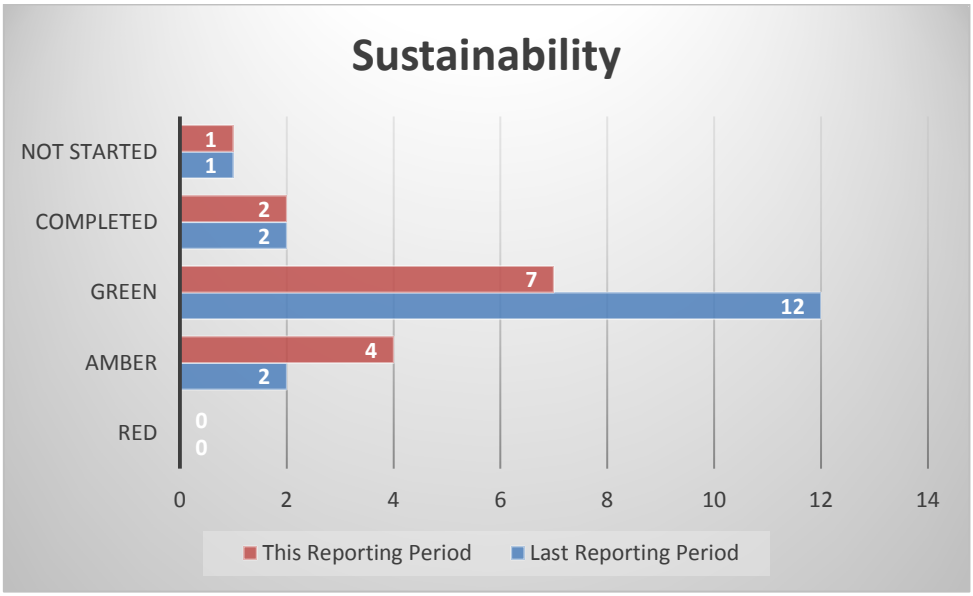
The current Clinical Supervisor establishment remains at 24.8 Full Time Equivalent (FTE) following Clinical Safety Navigator recruitment. The requirement for optimal staffing levels has been reviewed following Clinical Framework structure to 38 FTE.

The Trust are seeing improvements in our recruitment pipeline, with another 6 shortlisted applications for July, above the 11 applications reviewed for June and a total of 8 staff booked onto courses between September and October 2018.

Further opportunities to increase Hear and Treat performance are expected to be realised in the near future as we plan to implement the new Clinical Decision Support tool, Manchester Triage System. The changes required to Cleric have been delivered and are currently in in the testing phase. We are also taking steps to increase our Support Call Taker establishment to ensure sufficient welfare calls are undertaken on patients in the "Pending Dispatch" queue.

2.4 **National Ambulance Resilience Unit** – The project remains RAG rated 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 previous reports has now been mitigated to some extent through NARU

Sustainability



3.0 Digital Programme

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

3.1 **Automated Temperature Monitoring** – This project is RAG rated Amber from Green. Supplier quotes were inconsistent which has led to the engagement of the Procurement team to develop a set of requirements. Once a supplier has been selected, a project will plan will be developed.

3.2 **Banstead POP** – This project remains RAG rated Green. Relocation work now completed and decommissioning continuing until the end of August 2018. On track to complete. No risks and issues highlighted within this reporting period.

3.3 **Business Intelligence Improvement** – This project is now RAG rated Blue as it is now complete. The Trust reporting is now via the new reporting platform. A number of individual reports continue to be migrated from old to new platforms. This activity will be on-going for some time and is being picked up as BAU activity.

3.4 **Corporate IT Systems Resilience** – This project has not started due to the Trust not yet identified requirements. However, IT have met with the preferred supplier for replacement backup solution to understand capacity requirements in order for supplier to provide a proposal. Further reporting will not begin until directorate requirements have been outlined.

3.5 **Cyber Security** – This project is RAG rated Amber from Green. Forecast completion date has now moved from 31 October 2018 to 30 November 2018 and the scope of the project will now include the eight Make Ready Centre upgrades. The project is currently going through the change control process to seek Executive Sponsor approval.

This revised approach will minimise risk and impact on user base. The change in this timeline does not impact the 999 Telephony Project.

3.6 **ePCR** – This project remains RAG rated Green. Project Mandate and QIA are complete and currently going through approval process. Supplier presentation days have been undertaken. The Procurement Award paper will be produced for a future Trust Board. Project Team will need to be resourced following Supplier award. Pilot planned for early December 2018.

3.7 **GRS App** – This project RAG is now Blue as it is now complete and formally closed by the Digital Programme Board. The GRS application went live earlier this month.

3.8 **Incident Management Software** – This project remains RAG rated Green. There are no further outstanding IT elements, with just operational training to be completed. The training is expected to be completed by 31 December 2018.

3.9 **Replacement Fleet Management System** – This project remains RAG rated Green. The supplier has provided an updated project plan, which is on track for completion by 16 November 2018. Regular bi-weekly progress calls are due to be established between Fleet, IT and the supplier to monitor progress.

3.10 **Replacement of Telephony and Voice Recording system** – This project is RAG rated Amber from Green. The forecast completion date has been extended to the end of November 2018. Escalation planning session with the Supplier was completed in early August 2018 and project plans revised following potential delays with key deliverables (end date was drifting towards February 19). Work now back on track and being closely monitored.

3.11 **Spine Connect** – This project is reported as RAG rated Green from Amber. Forecast completion date has been extended following a number of delays due to the competing priorities of the Cleric developments for PDS, SCR and CP-IS. The project is currently going through formal change control.

EOC testing has now commenced for PDS, MTS, CQC updates and 10 miscellaneous Requests for Change. GoodSAM is also expected to be part of this system update (no change of scope to this project)

3.12 **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. Currently in the process to sign off new managed contracts for new network links at station to replace the existing N3 contracts. Once completed schedule of installations will be shared as they progress. Dates to be agreed for installation of secure network infrastructure following Cyber Phase 1

3.13 **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. Work to be commence after 10th September 2018. Project lead has now been appointed to manage this project.

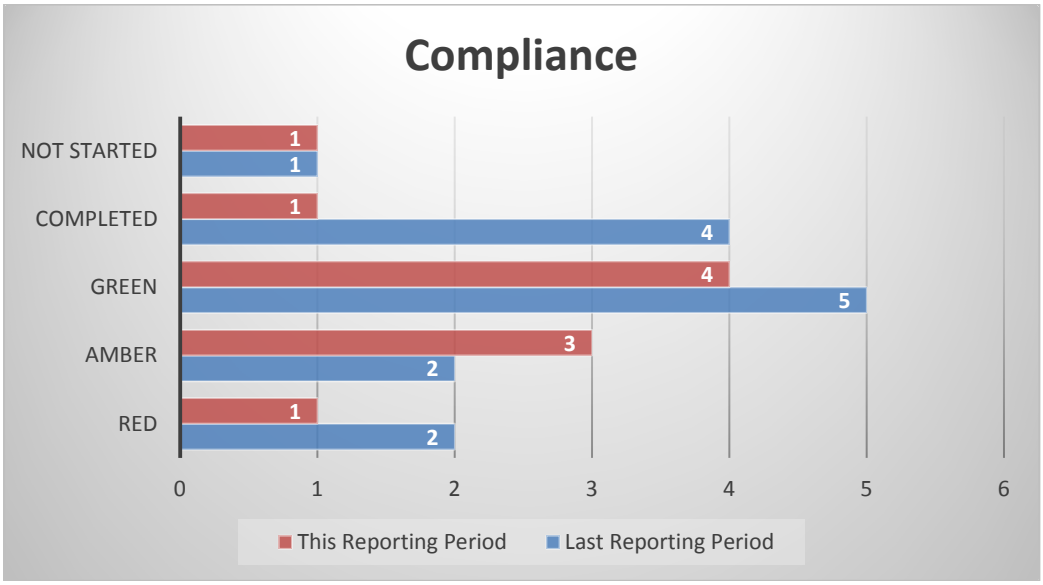
3.14 Financial Sustainability Group

3.15 **CIP -** The Trust has reported a CIP target of £11.4m to NHSI as part of the 2018/19 Budget and Plan. £4.9m of fully validated savings have been transferred to the Delivery Tracker as at the Month 4 reporting date, of which £2.4m have been delivered to date in line with Plan. The Pipeline Tracker and Delivery Tracker provide more detail on the construction of the CIP Programme. Project mandates have been completed for all of the fully validated schemes and have been signed off by the Executive Sponsors. The Deputy Clinical Director has completed Quality Impact Assessments (QIA) for all the mandates submitted for QIA. Other mandates for new schemes are in the course of completion. The current versions of the Pipeline Tracker (Appendix B) and Delivery Tracker (Appendix C) have been included with this update.

3.16 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.

Compliance



4.0 Compliance Steering Group

Since the last reporting period, a new programme has recently commenced, Private Ambulance Providers (PAPs) which will start reporting into Compliance Steering Group on a regular basis. The aim of the programme is to improve governance and ensure that the Trust manages and contracts PAPs appropriately. A Programme Mandate has now been developed which outlines key focus areas that need to be addressed. Project and Action plans will be established over the coming weeks to track and monitor progress.

4.1 **EOC** *(CQC Must Do)* – This project RAG 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.

Clinical Supervisor establishment has remained stable, with the only recent drop in Clinical Supervisor establishment due to the appointment of Clinical Safety Navigators from the Clinical Supervisor pool. Additional Clinical Supervisor numbers are being recruited and appointed. Requirement for optimal staffing levels has been reviewed following Clinical Framework structure to 38 FTE. This will be formalised in the project with a forthcoming Change Control Request.

Audit compliance is at 85.7% for June and 44.9% for July. Work will continue on June and July to meet 100% compliance. The target is to meet 100% compliance every month. Additional audit resource has been sourced and is being advertised to support this objective. Work is also underway to evaluate audit team establishment.

EMA establishment has experienced month-on-month growth. However this growth has slowed due to higher than targeted turnover. Call demand has also grown, with the last 5 weeks seeing the longest run of above average call demand since ARP went live. A paper designed to explore the reasons for not meeting call answering target and solutions for this, and a proposal for revised trajectory and options considered to mitigate further risks of not achieving the target, is being produced for submission to the Executive Team.

Over the coming weeks, it is intended that this plan will be refreshed project to form an over-arching EOC Clinical Safety improvement plan.

4.2 **Governance and Risk** – The project RAG remains Green. Good progress is being made and a formal Task and Finish group has now been established. The project is going through formal change control to extend the timeline of capturing Health and Safety risks on to Datix from end of August 2018 to end of September 2018. No risks or issues highlighted in this reporting period.

4.3 **Incident Management** *(CQC Must Do)* – The project RAG remains Green. The Project Closure process has formally commenced as agreed by the Compliance Steering Group on 7th August 2018. CSG will continue to have oversight of BAU activities for the foreseeable future.

It was also agreed that this project would be one which the Quality Commissioners could follow in terms of end to end closure processes, given the overlap with the Commissioners existing monthly Incident Task and Finish Group. All submitted evidence to date has been validated and work continues to close the small number of open actions; a large number of which are dependent upon the development of the revised Serious Incidents Procedure by end September 2018; and the documentation of 'honest mistakes' in revised Trust HR policies for which assurance is currently being sought. No risks or issues have been highlighted in this reporting period.

4.4 **Infection Prevention and Control** *(CQC Must Do)* – The project RAG remains Green and is planned to move to BAU at the end of August as forecast. The IP Ready procedure is now in place and the new audit tools for the procedure are being worked on and will be in place by the end of August 2018. The IPC Team are planning Roadshows to help support the introduction of new procedure throughout August and September 2018. Completion of Station Cleanliness audits has been RAG rated as Amber for July and the team will be communicating with all areas to ensure that these are completed for August 2018.

4.5 **Medicines Governance** *(CQC Must Do)* – This project RAG is now Blue as it is now complete and formally closed by Compliance Steering Group on 7 August 2018 (subject to confirmation that the Medicines Governance dashboard is presented to the Medicines Governance Group on a routine basis). The Medicines Optimisation Annual Plan will continue to report into Compliance Steering Group on a weekly basis as part of Business as Usual.

4.6 **Patients with Complex Needs** – This project has not formally started. Further reporting will not begin until we are clear on the direction of travel for this project.

4.7 **Resourcing Plan** – This project is RAG is rated Amber from Red due to the Executive Director of Operations agreeing in principle that the current trajectory would be accepted although this needs to be formally approved by EMB. September and October ECSW courses are currently full and an additional 42 spaces have been made available for November. There are currently 150 candidates shortlisted and ready for the assessment phase of ECSW recruitment. Revised fitness test has been agreed and is now out for 3-week consultation.

4.8 **Personnel Files** – This project remains Amber due to the scale of the work to undertaken. Additional resource has been brought in 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.

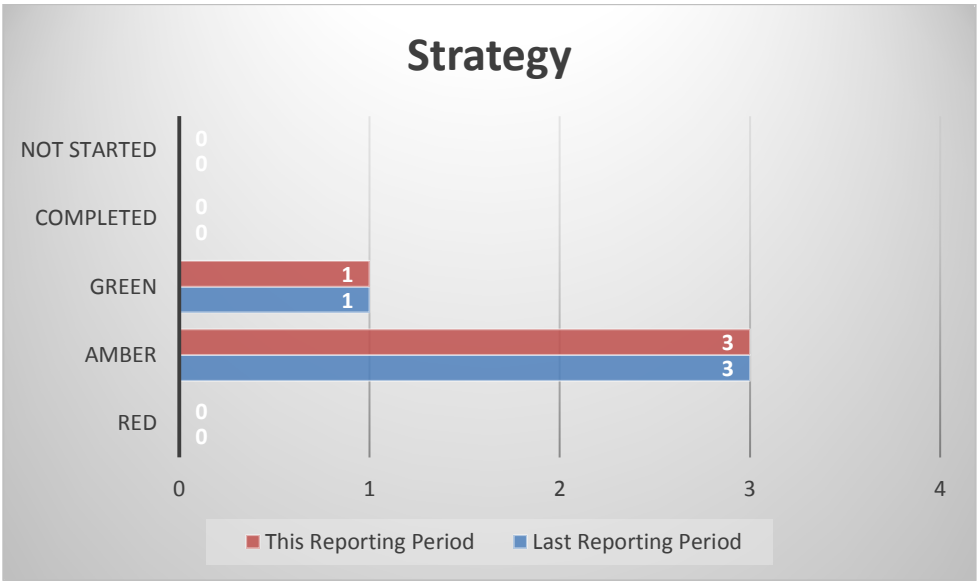
4.9 **999 Call Recording** *(CQC Must Do)* – The project RAG remains Green. The Project has been ongoing since November 2017 with a number of faults resolved. Primary fault is missing calls but also includes conjoined and part recorded calls. Weekly audits taking place, fixes still lodged with telephony and recording suppliers, notice set out to staff and a SOP established for dealing with audits. System is unlikely to improve but oversight will ensure rapid action can be taken should further faults occur.

4.10 **Culture Change** – This project RAG remains Amber. The project recently had a CQC deep dive session and it was agreed that more regular metrics need to be included to measure success. The resource to deliver the programme is currently being reviewed and there is a risk that the team to deliver may change which could impact on pace of delivery.

The Annual Staff Survey extensive communications plan has been developed.

Following the completion of senior leadership training, Operating Team Leader behaviour management training will commence at the end of August and run through to mid November 2018. The content for the digital training aspect has been developed with a decision yet to be made on how the modules will be delivered.

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 work stream 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 have finalised most of the contract schedules to append to this, and to adapt for the contract following the demand and capacity review. We are finalising the last ones during the week of 20th August 2018. Work is also being completed regarding updating all appendices to the contracts from both the Trusts and our commissioners

5.2 **Commissioner and Stakeholder Alignment** – This work stream 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 work stream remains RAG remains Amber with workforce, Fleet, Estates, ICT, Research and Development, Clinical, Governance, and Partnership/ commercial all underway. ICT and Estates are both being considered at the August Board meeting

5.4 **Quality Improvement** – The project RAG remains at Amber. Concurrent to the procurement process that is being planned, the Trust has recently completed a Request for Information from potential suppliers. The results of which will be shared with the Trust's Executive Management Board for a decision to be made on next steps.

Delivery Plan Dashboard

01 July to 31 July 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)	The project RAG rating remains Amber. Operating Unit level recruitment pipelines have been developed to ensure establishment reaches 2,413 by April 2021. Local recruitment campaigns will begin in October 2018 to provide candidates for ECSW courses delivered within local operating units commencing February 2019. Planning is underway to deliver new rotas for all staff commencing in April 2019.	In post WTE	1806	1824	2413	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
									Leavers WTE	45	55	461	
									Joiners WTE	67	70	1052	
									Movers WTE	24	0	TBA	
									Number of rotas planned	TBA	TBA	TBA	
									Number of rotas in negotiation	TBA	TBA	TBA	
									Number of rotas agreed	TBA	TBA	TBA	
									Number of roats implemented	TBA	TBA	TBA	
	Demand and Capacity Review	Amber	Amber	Jayne Phoenix	Steve Emerton	N/A	30/09/2018 (previously 31/07/2018)	The Demand and Capacity review is nearing completion with review taking place of the draft final report. 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 planned that the report will be agreed and completed by mid September 2018 and agreed for enactment by the end of September 2018.	Creation of fit for purpose, agreed operational model and service level options, together with evidenced costs and aligned resource, for agreement with commissioners				No risks or issues highlighted in this reporting period.
	Hospital Handover	Red	Amber	Gillian Wieck	Joe Garcia	N/A	31/03/2019 (previously 30/04/2018)	The project is RAG rated Red from Amber. There has been significant progress made at several sites to reduce hospital handover delays, mainly in Surrey and Sussex with some significant outliers in Kent and Medway. Further support is in place for those sites including Peer Review Visits so that best practice and learning can be shared between hospitals. Crew to Clear performance is also varied across hospital sites with some outliers. The Job Cycle Time report is now available for managers across the Trust which provides granular reports to support improvement in Crew to Clear time. More focus is being placed on improving Crew to Clear times within individual Operating Units and at individual sites.	Handover delay no more than 60mins	400	N/A	0	There is a risk to relationships and partnership working between the Trust and hospitals as a result of disparate progress towards achieving standards i.e. improvement in hospital handover times but no improvement in Crew to Clear times. 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 the Trust, which may lead to hours lost at hospitals not reducing significantly and consistently.
									Crew to Clear time within 15mins 85% of the time	43.00%	85%	85%	
	Increased Hear and Treat	Red	Red	Scott Thowney	Joe Garcia	N/A	25/07/2018	The project RAG remains Red. Hear and Treat performance has gone from strength to strength since November 2017. We now reside in fourth place at 6.5% for Hear and Treat performance in July compared to other national 999 Providers. We are 0.8 percentage points above the national average and 1.1 percentage points behind the East of England, the highest performing Trust at 7.6%. The current Clinical Supervisor establishment remains at 24.8 Full Time Equivalent (FTE) following Clinical Safety Navigator recruitment. The requirement for optimal staffing levels has been reviewed following Clinical Framework structure to 38 FTE. The Trust are seeing improvements in our recruitment pipeline, with another 6 shortlisted applications for July, above the 11 applications reviewed for June and a total of 8 staff booked onto courses between September and October 2018. Further opportunities to increase Hear and Treat performance are expected to be realised in the near future as we plan to implement the new Clinical Decision Support tool, Manchester Triage System. The changes required to Cleric have been delivered and are currently in in the testing phase. We are also taking steps to increase our Support Call Taker establishment to ensure sufficient welfare calls are undertaken on patients in the "Pending Dispatch" queue.	45 clinical supervisors & clinical safety navigators in post in EOC	24.8	45	45	The Hear and Treat programme still remains at Red due to our historical objectives. A Change Request is in development to align objectives with targets based on what is achievable in the scope of the evolving emergency call environment.
									Hear and Treat Performance	6.50%	10%	10%	
	National Ambulance Resilience Unit	Green	Green	Chris Stamp	Joe Garcia	N/A	31/10/2018	The project remains RAG rated 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 previous reports has now been mitigated to some extent through NARU	Awareness training of HART response time standards for Command Teams	Data not available	98%	98%	There is a slight risk around continued engagement from the action owners, as the lifetime of the project is nearing complition and there are still open actions which need to be completed
									Commanders at all levels within Trust are trained and developed.	95.0%	95%	95%	
									IOR Training compliance for frontline staff	1362	614	2250	
									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	Amber	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. £4.9m of fully validated savings have been transferred to the Delivery Tracker as at the Month 4 reporting date, of which £2.4m have been delivered to date in line with Plan. The Pipeline Tracker and Delivery Tracker provide more detail on the construction of the CIP Programme. Project mandates have been completed for all of the fully validated schemes and have been signed off by the Executive Sponsors. The Deputy Clinical Director has completed Quality Impact Assessments (QIA) for all the mandates submitted for QIA. Other mandates for new schemes are in the course of completion. The current versions of the Pipeline Tracker (Appendix B) and Delivery Tracker (Appendix C) have been included with this update.	KPIs are embodied in the Delivery Tracker. The Outcome will be successful achievement of the CIP Programme.	£4.9m	£11.4m	£11.4m	The RAG rating for the CIPs programme remains at Amber as at month 4, reflecting the position one third of the way through the 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. The CIPs programme is unlikely to move to Green until the final quarter of 2018/19. In the meantime the PMO Finance Team has agreed with the Operations Senior Team a methodology for evaluating frontline efficiencies. These relate to improved sickness rates, reduced handover delays and reductions in task cycle time. CIPs to the value of £1.4m for the year covering these efficiencies have been developed, of which £0.4m have been achieved at month 3. The efficiencies will be monitored on an ongoing monthly basis. 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.
	Automated Temperature Monitoring	Amber	Green	Timothy Poole / Jason Tree	David Hammond	N/A	TBC	This project RAG moves from Green to Amber. Supplier quotes were inconsistent which has led to the engagement of the Procurement team to develop a set of requirements. Once a supplier has been selected, a project will plan will be developed.	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	31 August 2018 (previously 31/10/2018)	This project remains RAG rated Green. Relocation work now completed and decommissioning continuing until the end of August 2018. On track to complete.	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	Blue	Green	Alex Croft	David Hammond	N/A	01/06/2018	This project is now RAG rated Blue as it is now complete. The Trust reporting is now via the new reporting platform. A number of individual reports continue to be migrated from old to new platforms. This activity will be on-going for some time and is being picked up as BAU activity.	A consistent approach of reporting by developing a new data warehouse structure that improves consistency of reporting				Project completed and closed.
	Corporate IT Systems Resilience	White	White	Jason Tree	David Hammond	N/A	TBC	This project has not started due to the Trust not yet identified requirements. However, IT have met with preferred supplier for replacement backup solution to understand capacity requirements in order for supplier to provide a proposal. Further reporting will not begin until directorate requirements have been outlined.	KPIs to be defined	N/A	N/A	N/A	No risks or issues highlighted in this reporting period.
	Cyber Security	Amber	Green	Phil Smith	David Hammond	N/A	31/10/2018 (previously 31/03/18)	This project is reported as RAG rated Amber from Green. Forecast completion date has now moved from 31 October 2018 to 30 November 2018 and the scope of the project will now include the eight Make Ready Centre upgrades. The project is currently going through the change control process to seek Executive Sponsor approval. This revised approach will minimise risk and impact on user base. The change in this timeline does not impact the 999 Telephony Project.	All software and hardware is deployed and operational.				No risks or issues highlighted in this reporting period.
	Electronic Patient Clinical Records ("EPCR")	Green	Green	Phil Smith	David Hammond	N/A	30/06/2019 (previously 31/03/2019)	This project continues to be RAG rated Green. Project Mandate and QIA are complete and are currently going through approval process. Supplier presentation days have been undertaken. The Procurement Award paper will be produced for a future Trust Board. Project Team will need to be resourced following Supplier award. Pilot planned for early December 2018.	KPIs documented on Mandate, pending sign off prior to detailing.				No risks or issues highlighted in this reporting period, however the Project will need resourcing with appropriate staff post Supplier award.
	Expansion of Crawley 1st Floor	Green	Green	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. Work to be commence after 10th September 2018. Project Lead appointed to manage project.	KPIs to be defined				No risks or issues highlighted in this reporting period.
	GRS App	Blue	Green	Jason Tree	David Hammond	N/A	01/08/2018	This project RAG is now Blue as it is now complete and formally closed by the Digital Programme Board. The GRS application went live earlier this month.	Project complete				Project completed and closed.
	Incident Management Software	Green	Green	David Wells	David Hammond	N/A	31/12/2018 (previously 30/09/2018)	This project remains RAG rated Green. There are no further outstanding IT elements, with just operational training to be completed. The training is expected to be completed by 31 December 2018.	New software programme implemented that can be used to manage large or protracted incidents.				No risks or issues highlighted in this reporting period.
	Replacement Fleet Management System	Green	Green	John Griffiths	David Hammond	N/A	16/11/2018 (previously 01/11/2018)	This project is reported RAG rated Amber from Green. The supplier has provided an updated project plan, which is on track for completion by 16 November 2018. Regular bi-weekly progress calls are due to be established between Fleet, IT and the supplier to monitor progress.	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	Amber	Green	Phil Smith	David Hammond	N/A	30/11/2018 (previously 31/10/2018)	This project moves from Green to Amber. The forecast completion date has been extended to the end of November 2018. Escalation planning session with the Supplier was completed in early August 2018 and project plans revised following potential delays with key deliverables (end date was drifting towards February 19). Work now back on track and being closely monitored.	New Telephony and Voice Recording system delivered.				No risks or issues highlighted in this reporting period.
	Spine Connect	Green	Amber	Phil Smith	David Hammond	N/A	31/10/2018 (previously 31/07/2018)	This project is reported as RAG rated Green. Forecast completion date has been extended following a number of delays due to the competing priorities of the Cleric developments for PDS, SCR and CP-IS. The project is currently going through formal change control to extend project from 31 October 2018. EOC testing has now commenced for PDS, MTS, CQC updates and 10 Miscellaneous Requests for Change. GoodSAM is also expected to be part of this system update (no change of scope to this project)	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	Green	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. Currently in the process to sign off new managed contracts for new network links at station to replace the existing N3 contracts. Once completed schedule of installations will be shared as they progress. Dates to be agreed for installation of secure network infrastructure following Cyber Phase 1.	KPIs to be defined				No risks or issues highlighted in this reporting period.

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive Lead	CQC Deep Dive Date	Forecast Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
Compliance Steering Group	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. Clinical Supervisor establishment has remained stable, with the only recent drop in Clinical Supervisor establishment due to the appointment of Clinical Safety Navigators from the Clinical Supervisor pool. Additional Clinical Supervisor numbers are being recruited and appointed. Requirement for optimal staffing levels has been reviewed following Clinical Framework structure to 38 FTE. This will be formalised in the project with a forthcoming Change Control Request. Audit compliance is at 85.7% for June and 44.9% for July. Work will continue on June and July to meet 100% compliance. The target is to meet 100% compliance every month. Additional audit resource has been sourced and is being advertised to support this objective. Work is also underway to evaluate audit team establishment. EMA establishment has experienced month-on-month growth. However this growth has slowed due to higher than targeted turnover. Call demand has also grown, with the last 5 weeks seeing the longest run of above average call demand since ARP went live. A paper designed to explore the reasons for not meeting call answering target and solutions for this, and a proposal for revised trajectory and options considered to mitigate further risks of not achieving the target, is being produced for submission to the Executive Team. Over the coming weeks, it is intended that this plan will be refreshed to form an over-arching EOC Clinical Safety improvement plan.	Clinical supervisors in post in EOC	24	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 and solutions to stem turnover, provided in the Call Answer Report Executive paper, and consultation with the Association of Ambulance Chief Executives, is underway to control the risk and the issue of increased call demand. 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 due 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 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.	72.7%	92.5%	95.0%	
									FTE EMAs in post within EOC	182	171	187	
	Governance and Risk	Green	Green	Peter Lee	Daren Mochrie	N/A	31/03/2019	The project RAG remains Green. Good progress is being made and a formal Task and Finish group has now been established. The project is going through formal change control to extend the timeline of capturing Health and Safety risks on to Datix from end of August 2018 to end of September 2018. No risks or issues highlighted in this reporting period.	Risks reviewed within their Last Review Date	96%	90%	90%	No risks or issues highlighted in this reporting period.
									Policies in date	89%	100%	100%	
	Incident Management	Green	Green	Nicola Brooks	Bethan Haskins	08/11/2017	01/08/2018	The project RAG remains Green. The Project Closure process has formally commenced as agreed by the Compliance Steering Group on 7th August 2018. CSG will continue to have oversight of BAU activities for the foreseeable future. It was also agreed that this project would be one which the Quality Commissioners could follow in terms of end to end closure processes, given the overlap with the Commissioners existing monthly Incident Task and Finish Group. All submitted evidence to date has been validated and work continues to close the small number of open actions; a large number of which are dependent upon the development of the revised Serious Incidents Procedure by end September 2018; and the documentation of 'honest mistakes' in revised Trust HR policies for which assurance is currently being sought. No risks or issues have been highlighted in this reporting period.	20% increase in overall incident reporting (Monthly)	772	583	583	No risks or issues highlighted in this reporting period.
									>75% of incidents closed within time target [SECAmb Target]	98%	75.0%	75.0%	
									90% of Serious Incident investigations will be completed within 60 working days.	0%	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	Green	Adrian Hogan	Bethan Haskins	N/A	31/08/2018	The project RAG remains Green and will hopefully move to BAU at the end of August as forecast. The IP Ready procedure is now in place and the new audit tools for the procedure are being worked on and will be in place by the end of August 2018. The IPC Team are planning Roadshows to help support the introduction of new procedure throughout August and September 2018. Completion of Station Cleanliness audits has been RAG rated as Amber for July 2018 and the team will be communicating with all areas to ensure that these are completed for August 2018.	Hand Hygiene Staff Compliance	89%	No data available	90%	The number of Station Cleanliness audits being completed has been raised as a risk, but actions are already in place to rectify the issue.
									Bare Below the Elbow	94%	No data available	90%	
									Vehicle Cleanliness Compliance	77%	No data available	75%	
									Station Cleanliness - Buildings Compliant	83%	No data available	100%	
									Station Cleanliness - Buildings Completed	46%	No data available	100%	
	Medicines Governance	Blue	Green	Carol-Anne Davies-Jones	Fionna Moore	19/02/2018	19/06/2018 (was previously) 31/03/2018	This project RAG is now Blue as it is now complete and formally closed by Compliance Steering Group on 7 August 2018 subject to confirmation that the Medicines Governance dashboard is presented to the Medicines Governance Group on a routine basis. The Medicines Optimisation Annual Plan will continue to report into Compliance Steering Group on a weekly basis as part of Business as Usual.	KPIs not reported as this project is now complete.				Project completed and closed.
	Patients with Complex Needs	White	White	Steve Lennox	Bethan Haskins	TBC	TBC	This project has not formally started. Further reporting will not begin until we are clear on the direction of travel for this project.	KPIs not reported as the project has not started.				Project not started.
	Resourcing Plan	Amber	Red	Alison Littlewood	Ed Griffin	TBC	04/12/2018	The project RAG has moved from Red to Amber due to the Executive Director of Operations agreeing in principle that the current trajectory would be accepted although this needs to be formally approved by EMB. September and October ECSW courses are currently full and an additional 42 spaces have been made available for November. There are currently 150 candidates shortlisted and ready for the assessment phase of ECSW recruitment. Revised fitness test has been agreed and is now out for 3-week consultation.	Recruitment of 300 external operational staff (ECSW & AAP) • ECSWs to be operational • AAPs to be in training	220	266	300	C1 licences and DBS delays are causing candidates to defer their ECSW courses which is leaving course spaces unfilled. Courses will be overbooked by 5 FTE to accommodate no shows and drop outs.

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
	Personnel Files	Amber	Amber	Isla MacDonald	Ed Griffin	N/A	30/06/2019	This project remains RAG rated Amber due to the scale of the work to undertaken. Additional resource has been brought in 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.	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)	This project remains RAG rated Green. Project ongoing since November 2017 with a number of faults resolved. Primary fault is missing calls but also includes conjoined and part recorded calls. Weekly audits taking place, fixes still lodged with telephony and recording suppliers, notice set out to staff and a SOP established for dealing with audits. System is unlikely to improve but oversight will ensure rapid action can be taken should further faults occur.	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				No risks or issues highlighted in this reporting period.
	Culture Change	Amber	Amber	Clare Irving	Ed Griffin	N/A	30/04/2019	This project RAG remains Amber. The project recently had a CQC deep dive session and it was agreed that more regular metrics need to be included to measure success. The resource to deliver the programme is currently being reviewed. The Annual Staff Survey extensive communications plan has been developed. Following the completion of Senior Leadership Training, Operating Team Leader behaviour management training will commence at the end of August and run through to mid November 2018. The content for the digital training aspect has been developed with a decision yet to be made on how the modules will be delivered.	KPIs to be defined.				There is a risk that the team to deliver may change, which could impact on pace of delivery.
Strategy	Annual Planning	Amber	Amber	Jayne Phoenix Philip Astell	Steve Emerton	N/A	August 2018 (previously 30/04/2018)	This work stream 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 have finalised most of the contract schedules to append to this, and to adapt for the contract following the demand and capacity review. We are finalising the last ones during the week of 20th August 2018. Work is also being completed regarding updating all appendices to the contracts from both the Trusts and our commissioners	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 work stream 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	Ongoing	This work stream remains RAG remains Amber with workforce, Fleet, Estates, ICT, Research and Development, Clinical, Governance, and Partnership/ commercial all underway. ICT and Estates are both being considered at the August Board meeting	All strategies completed by agreed timescales.				No risks or issues highlighted in this reporting period
	Quality Improvement	Amber	Amber	Dean Rigg	Steve Emerton	N/A	30/11/2018	The project RAG remains at Amber. Concurrent to the procurement process that is being planned, the Trust has recently completed a Request for Information from potential suppliers. The results of which will be shared with the Trust's Executive Management Board for a decision to be made on next steps.	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 4 - July 2018

Programme Summary:

1. Validated or scoped schemes of £8.3m against the target of £11.4m. Further proposed schemes to be developed in conjunction with Budget Leads.
2. 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 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. 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 nearing completion but the outcome in terms of CIPs cannot yet be determined. In the meantime the PMO Finance Team has agreed with the Operations Senior Team a methodology for evaluating frontline efficiencies. These relate to improved sickness rates, reduced handover delays and reductions in task cycle time. CIPs to the value of £1.4m for the year covering these efficiencies have been developed, of which £0.4m have been achieved at month 3. The efficiencies will be monitored on an ongoing monthly basis.
6. 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.

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

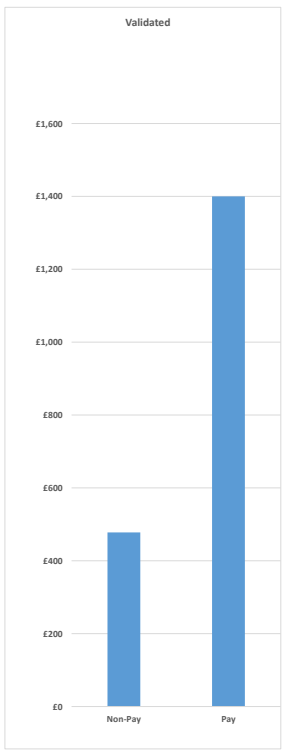
	Risk	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Risk that the 2018/19 CIPs target of £11.4m will not be fully delivered due to uncertainties within the Operations Directorate.	Monthly meetings with Budget Holders. Other potential CIP schemes are under review.	Kevin Hervey	Amber	Amber	31-Dec-18

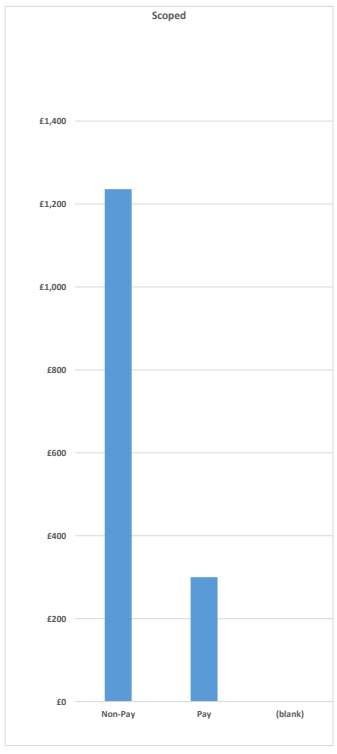
	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	New Lease Cars policy to be agreed.	Awaiting updates from John Griffiths (Response Capable Managers) and Ed Griffin (all other staff)	John Griffiths/ Ed Griffin	Amber	Amber	31-Aug-18
2	Medical Consumables - procurement cost savings to be considered.	Proposed medical consumables to be considered after meeting with NHS Supply Chain in August.	Kirsty Booth/ John Hughes	Amber	Amber	31-Aug-18
3	HCA/Excess Mileage - consider scope for savings.	Trustwide Pay Costing Template has been created and savings identified. Awaiting confirmation from Budget Holders before developing a Project	Graham Petts/ Priscilla Ashun-Sarpy	Green	Amber	31-Jul-18
4	Agency Staff - Re-iterate to Managers the process for acquiring interim staff.	A comms message was sent to all managers by ED Griffin in July. Issue now closed.	Penny Compton / Ed Griffin	Green	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.	Project Mandate signed off for E-Payslips. E-Expenses has not yet gone live.	Priscilla Ashun-Sarpy	Amber	Amber	30-Sep-18
7	Agency Staff - Potential cost avoidance CIP	PMO/Finance to develop a Project Mandate	Priscilla Ashun-Sarpy/ Kevin Hervey	Amber	Amber	31-Aug-18
8	Develop Operations CIP schemes.	Project Mandates have been agreed. Savings will be monitored monthly.	Kevin Hervey/ Graham Petts	Amber	Amber	Ongoing
9	Devise mechanism for recoveries of old staff overpayments	Ongoing discussions with Payroll Manager/HR Director	Kevin Hervey	Amber	Amber	30-Sep-18

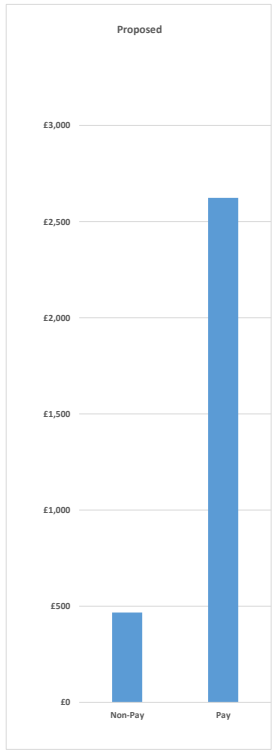
CIP Pipeline Summary

Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£1,400	£4,896	£478	£1,536	£3,091	£11,400

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
Operations efficiencies	1,398	-	-	800	2,198
Insurance	820	-	-	-	820
Recruitment delays & recharges - clinical	478	-	-	730	1,208
Training courses & accommodation	445	2	-	-	447
External consultancy & contractors	298	100	140	100	638
Travel & Subsistence	285	38	7	-	330
Fleet - Fuel: Telematics, Bunkered Fuel & Price Differential	200	-	-	-	200
Medicines Management - Consumables	200	94	-	-	294
IT Productivity and Phones	138	19	140	-	297
Medicines Management - Drugs	132	-	-	-	132
Medicines Management - Equipment	127	-	17	-	144
Meeting room hire	78	17	8	-	103
Recruitment delays & recharges - non clinical	65	-	-	1,094	1,159
Estates and Facilities management	56	188	624	-	868
Stationery	41	-	-	-	41
Discretionary Non Pay	40	-	-	-	40
111 Efficiency	33	-	-	-	33
Printing & Postage	32	-	-	-	32
Books & Subscriptions	17	-	-	-	17
Furniture & Fittings	10	20	-	-	30
Public relations	4	-	-	-	4
Agency Premiums	-	1,400	-	-	1,400
Staff Uniforms	-	-	100	-	100
Procurement contracts review	-	-	200	-	200
(blank)	-	-	-	-	-
Single HQ /EOC Benefits realisation	-	-	300	-	300
Top Slice - all directorates	-	-	-	367	367
	4,896	1,878	1,536	3,091	11,400

South East Coast Ambulance Service: CIP Workstream

CIP Delivery Dashboard

Reporting Month Jul-18

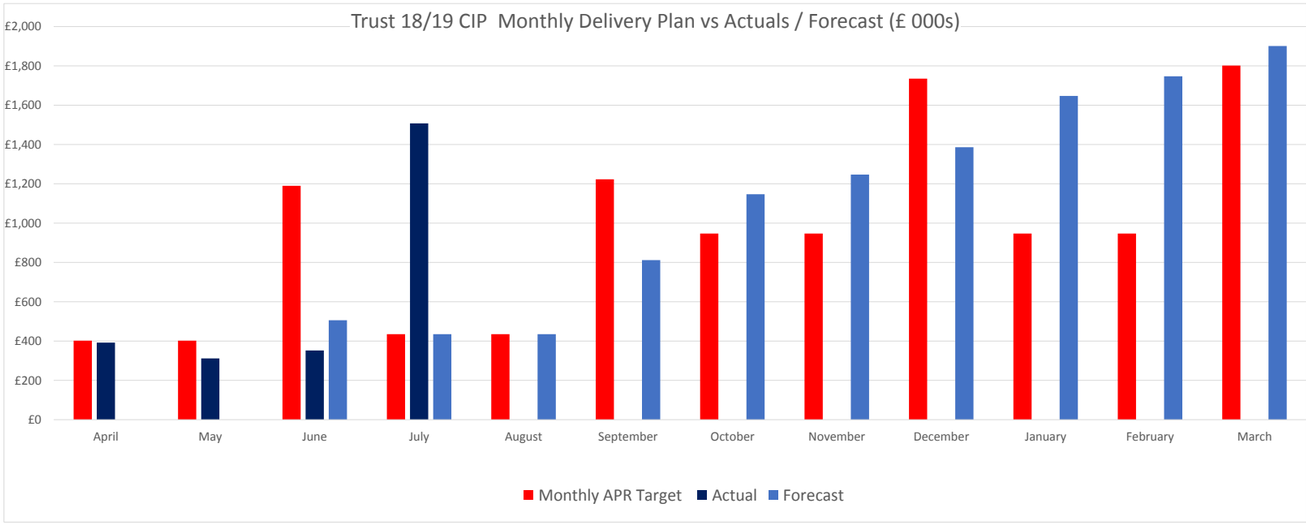
Programme for 2018/19 to deliver a minimum of £11.4m savings to achieve the planned £0.8m control total deficit.

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

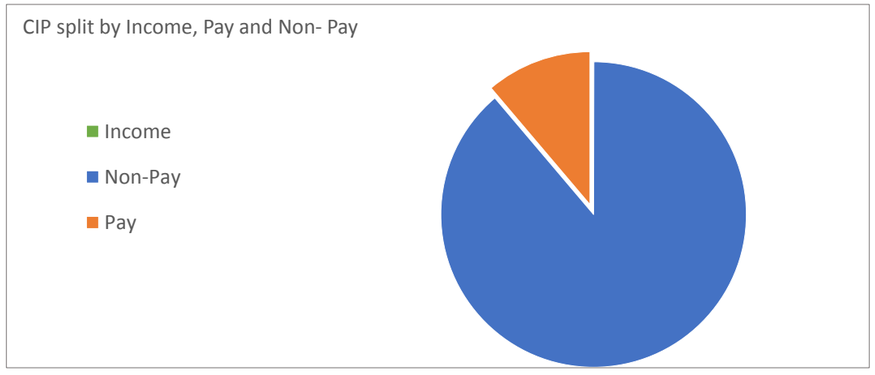
1. The CIPs target remains at £11.4m for the 2018/19 financial year.
2. £4.9m of fully validated savings have been transferred to the Delivery Tracker as at the Month 4 reporting date, of which £2.4m have been delivered in line with Plan.
3. The schemes continue to take no account of any changes that 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 nearing completion but the outcome in terms of CIPs cannot yet be determined. In the meantime the PMO Finance Team has agreed with the Operations Senior Team a methodology for evaluating frontline efficiencies. These relate to improved sickness rates, reduced handover delays and reductions in task cycle time. CIPs to the value of £1.4m for the year covering these efficiencies have been developed, of which £0.4m have been achieved at month 3. The efficiencies will be monitored on an ongoing monthly basis. The Trust intends to develop CIP schemes for 2018/19 beyond the value of the £11.4m target to provide a buffer against any schemes which do not deliver. At this early stage of the financial year, the Cost Improvement Programme is rated Amber.
4. Regular review meetings with Budget Leads and Finance Business Partners continue to take place. These are currently focused on identifying new schemes to build a sustainable pipeline of recurrent schemes for 2018/19.

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

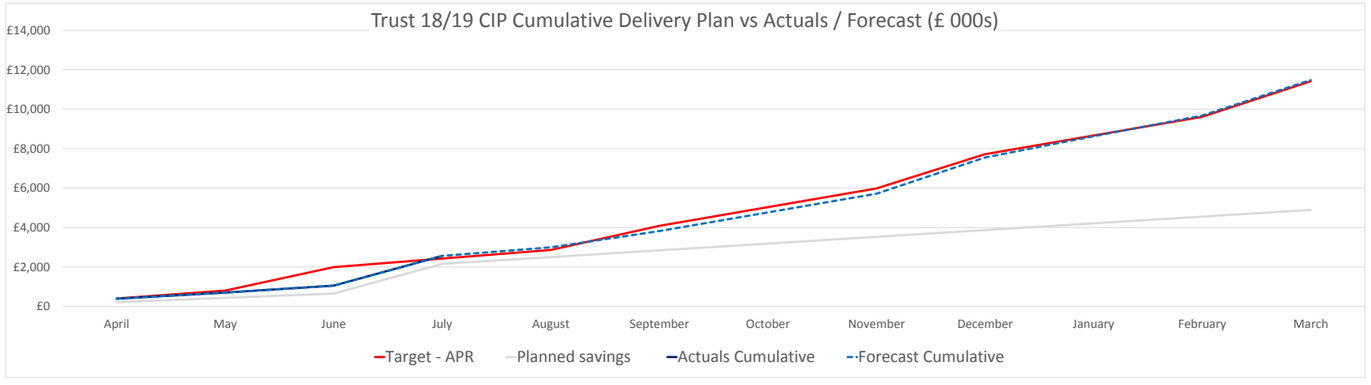
CIP Target for 18/19 £000's	Total planned savings on delivery tracker £000's - as at 31 July 2018	Total forecast savings on delivery tracker £000's - as at 31 July 2018	YTD July 18 - Target Savings £000's	YTD July 18 - Actual Savings £000's	YTD July 18 - variance £000's
11,400	4,896	4,895	2,429	2,419	(£10)



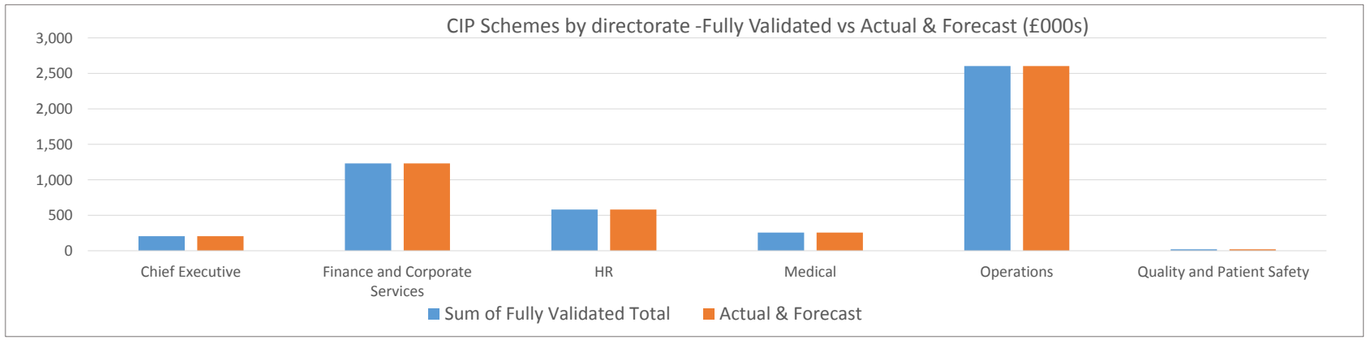
2. CIP - Planned savings split by income, pay and non-pay: as at 31 July



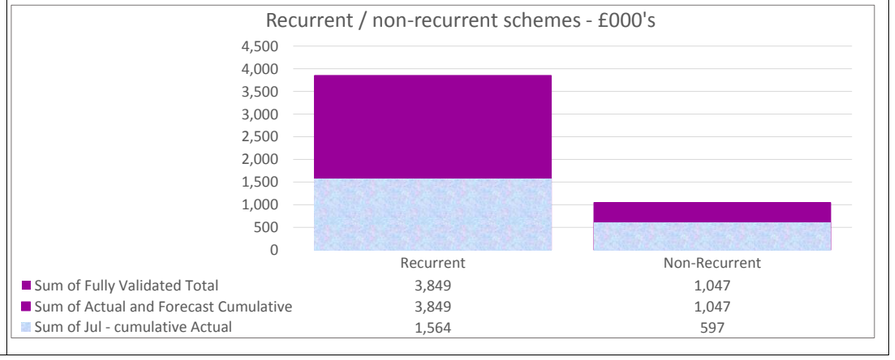
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2018/19



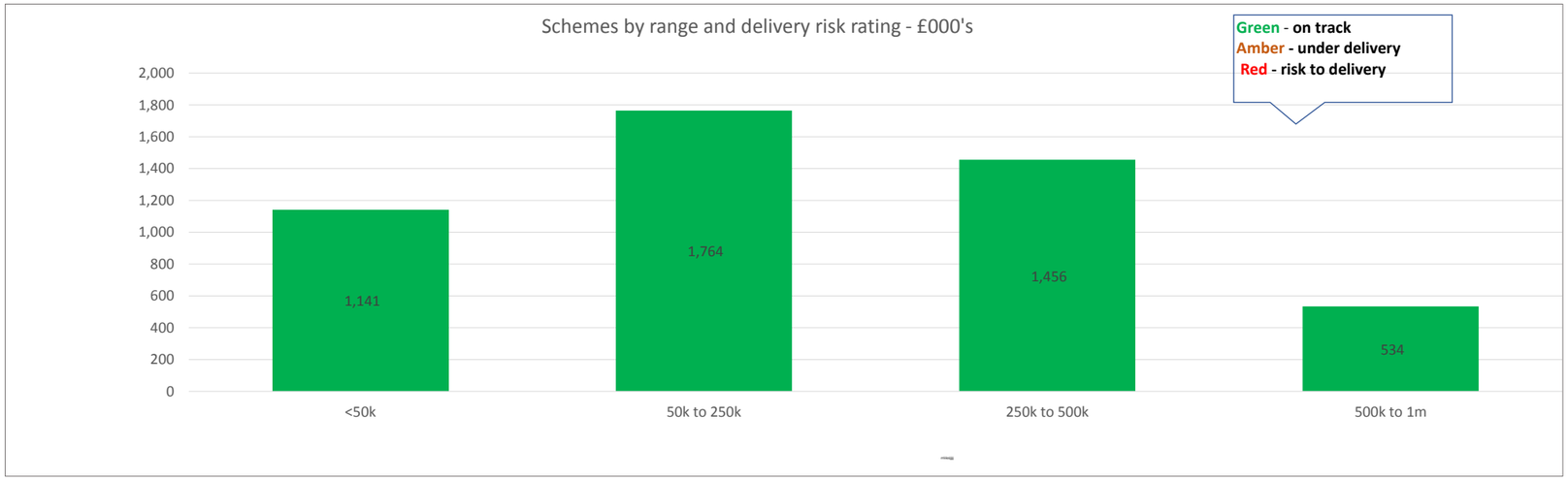
4. CIP schemes by directorate - Fully Validated vs Actual & Forecast 2018/19



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



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



7. YTD Identified CIPs to Date and Savings - July 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 4): £000	YTD Actuals (Month 4): £000	YTD Variance £000	Comments (+/- £20k variance)
External consultancy & contractors	£298	£298	£0	£129	£129	£0	-
Furniture & Fittings	£10	£10	£0	£3	£3	£0	-
Meeting room hire	£78	£78	£0	£26	£26	£0	-
Public relations	£4	£4	£0	£1	£1	£0	-
Stationery	£41	£41	£0	£15	£15	£0	-
Travel & Subsistence	£279	£279	£0	£101	£101	£0	-
Medicines Management - Consumables	£200	£200	£0	£67	£67	£0	-
Books & Subscriptions	£17	£17	£0	£6	£6	£0	-
111 Efficiency	£33	£33	£0	£11	£11	£0	-
Fleet - Fuel: Telematics, Bunkered Fuel & Price Differential	£200	£200	£0	£67	£67	£0	-
Estates and Facilities management	£56	£56	£0	£52	£52	£0	-
IT Productivity and Phones	£138	£138	£0	£66	£66	£0	-
Discretionary Non Pay	£40	£40	£0	£20	£20	£0	-
Training courses & accommodation	£445	£445	£0	£150	£150	£0	-
Medicines Management - Drugs	£132	£132	£0	£45	£45	£0	-
Insurance	£820	£820	£0	£379	£379	£0	
Printing & Postage	£32	£32	£0	£11	£11	£0	
Operations Efficiencies	£1,398	£1,398	£0	£451	£451	£0	
Recruitment delays & recharge - non clinical	£165	£165	£0	£122	£122	£0	
Recruitment delays & recharges - clinical	£383	£383	£0	£383	£383	£0	
Recharges income	£2	£2	£0	£2	£2	£0	-
Grand Total	£4,896	£4,896	£0	£2,161	£2,161	£0	-
Other planned schemes budget awaiting sign off	£468.00	£468.00	£0	£268	£258.00	(£10)	Difference between Fully Validated Schemes and Schemes removed from budget or included in NHSI target
Grand Total	£5,364	£5,364	£0	£2,429	£2,419	(£9)	

Finance Sustainability Steering Group

Estates & Procurement Update August 2018

Estates

1. An Estates Working Group has been established, reporting into the Finance Sustainability Steering Group. Terms of Reference have been agreed. The Group will oversee these projects

2. **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 2019. The negotiation of the legal terms for the land purchase is anticipated for conclusion end of Aug 2018. The Business Case requires review and formal sign off by the Trust Board, PR to action by end of Aug. A Project Mandate and QIA is required. Completion of build and occupancy is anticipated mid 2020.

3. **Medway Make Ready Centre:** The project has not started. Currently negotiations are underway with Kent Fire & Rescue Service for the land purchase – SECAMB and KF&RS have appointed a joint valuer. One Public Estates funding has been secured from Medway Council toward the cost of the planning application. We have commissioned a site plan feasibility with a view to seeking a Pre Planning consultation meeting in Oct/ Nov 2018. A draft Business Case has been produced but requires review and formal sign off by the Trust Board. A Project Mandate and QIA to be produced. Anticipated start on site date is mid to late 2019.

4. **Banstead Make Ready Centre:** The project has not started. A new Make Ready and Fleet Hub will be constructed on the Banstead site for North Surrey. We have commissioned a site plan feasibility study with a view to seeking a Pre Planning consultation meeting Oct/ Nov. A Business Case draft Business Case has been produced but requires sign off by the Trust Board. PR to action by end of Aug. A Project Mandate and QIA will be required. Epsom AS has been allocated for sale. Anticipated start on site date end 2019.

5. **2nd Floor at Nexus:** The project has not started. There are two options available to the Trust. Heads of Terms have been agreed for a) 2/3rds of the second floor or b) the whole of the 2nd or 3rd floor. Consultation meetings are being progressed with staff to discuss/ agree what services/ departments would occupy the new floor. The discussions will inform the 'fit out' plan. A Business Case requires sign off by the Trust Board. A Project Mandate and QIA will be produced. Anticipated start date is late 2018

6. **Tongham Make Ready/Redevelopment**: The project has not stated. The is a possibility of acquiring additional land at Tongham to enable to the existing site to be redeveloped. We have commissioned a site plan feasibility to be produced. Meeting on site with Dan Garret arranged to progress. A Business Case / Project Mandate and QIA will be required.

7. **Worthing Redevelopment (Estates element):** Estates are currently agreeing the detail for the scope of works. This will be tendered as a minor work contract. Employers Agents have been appointed. Start on site anticipated late 2018.

Finance Sustainability Steering Group

Estates & Procurement Update August 2018

Procurement

1. A Procurement Working Group has been established reporting into the Finance Sustainability Steering Group. ToR have been agreed. The Group will oversee these projects

2. **Premises Cleaning:** The current contract expires in April 2019. The Tendering process is about to commence under EU Procurement Regulations A project team is being assembled to inform the specification and evaluation process. 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

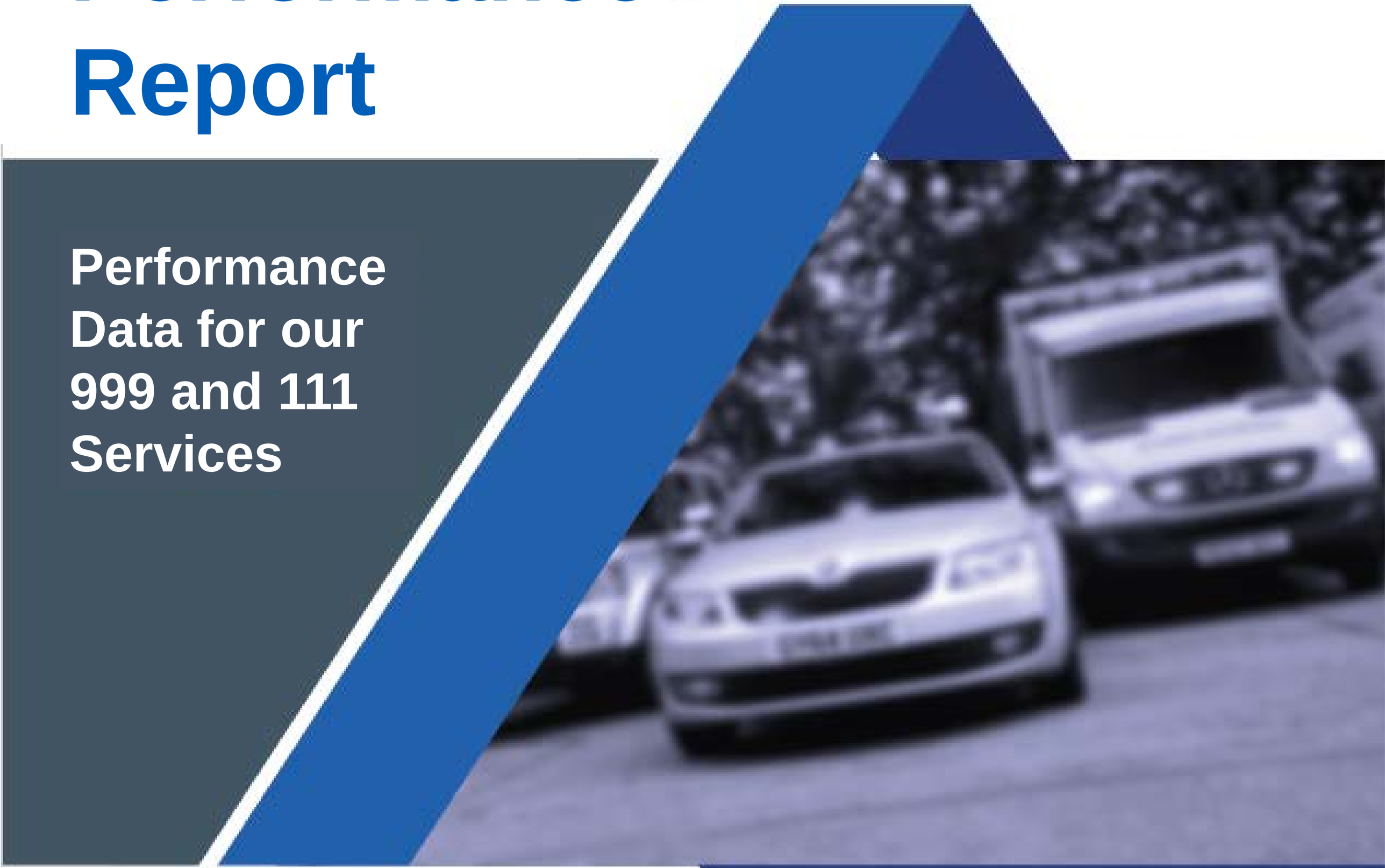
3. **Make Ready Vehicle Preparation:** The current contract expires in April 2019. The Tendering process is about to commence under EU Procurement Regulations. A project team is being assembled to inform the specification and evaluation process. The Trust may wish to submit and 'internal bid'. The in house team will not be able to participate in the specification and evaluation stages. A Project Mandate and QIA will be produced.

4. **Payroll:** The current service is a rolling annual contract and expires in 2019. The tendering process will be via national procurement framework. 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.

South East Coast Ambulance Service
NHS Foundation Trust

Integrated Performance Report

Performance Data for our 999 and 111 Services



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

Board Meeting

August 2018

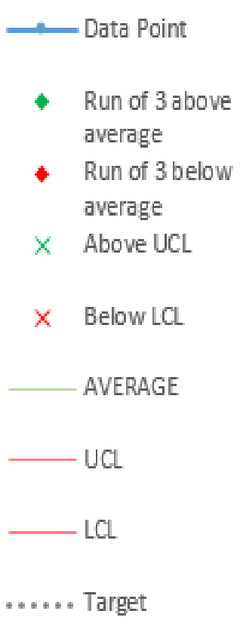
Taking Pride | Striving for Continuous Improvement | Acting With Integrity | Demonstrating Compassion and Respect | Assuming Responsibility

Contents

SECAmb CQC Rating and Oversight Framework

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

Chart Key



This represents the value being measured on the chart
These points will show on a chart when the value is above or below the average for 3 consecutive points. This is seen as statistically significant and an area that should be reviewed.

When a value point falls above or below the control limits, it is seen as a point of statistical significance and should be investigated for a root cause.

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

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

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

SECAmb Executive Summary

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

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

Medicines Governance – This project was formally closed by Compliance Steering Group on 17th July 2018 with the condition that the Medicines Dashboard continues to report into the Medicines Governance Group
Governance and Health Records - This project was formally closed by Compliance Steering Group on 17th July 2018 and has now transitioned into Business as Usual
Medical Devices - This project was formally closed by Compliance Steering Group on 17th July 2018 and has now transitioned into Business as Usual
Performance and AQI - This project was formally closed by Compliance Steering Group on 17th July 2018 and has now transitioned into Business as Usual
Incident Management – Formal project closure will be enacted shortly once the gaps have been addressed.

SECAmb Our Enablers

SECAmb Financial Performance

The Trust has achieved its planned deficit of £0.9m for the month of June. Cumulative year to date performance is marginally better than plan by £0.1m.

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

The Trust achieved Cost Improvements of £0.5m which was £0.7m lower than plan. The target for the full year is £11.4m.

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

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

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

Safe

CQC Findings ('Must or Should Do')

- The Trust must take action to ensure they keep a complete and accurate recording of all 999 calls.
- The Trust must protect patients from the risks associated with the unsafe use and management of medicines in line with best practice and relevant medicines licences. This should include the appropriate administration, supply, security and storage of all medicines, appropriate use of patient group directions and the management of medical gas cylinders.
- The Trust must take action to ensure there are a sufficient number of clinicians in each EOC at all times in line with evidence-based guidelines.
- The Trust must take action to ensure all staff understand their responsibilities to report incidents.
- The Trust must ensure improvements are made on reporting of low harm and near miss incidents.
- The Trust must investigate incidents in a timely way and share learning with all relevant staff.
- The Trust must ensure all staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns receive an appropriate level of safeguarding training.
- The Trust must ensure patient records are completed, accurate and fit for purpose, kept confidential and stored securely.
- The Trust must ensure the CAD system is effectively maintained.
- The Trust must ensure the risk of infection prevention and control are adequately managed. This includes ensuring consistent standards of cleanliness in ambulance stations, vehicles and hand hygiene practices, and uniform procedure followed.
- The Trust must ensure all medical equipment is adequately serviced and maintained.
- The Trust should take action to audit 999 calls at a frequency that meets evidence based guidelines.
- The Trust should review all out of date policies.
- The Trust should ensure all first aid bags have a consistent contents list and they are stored securely within the bags.
- The Trust should ensure all ambulance stations and vehicles are kept secured.

Caring

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

Effective

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

Responsive

- The Trust must ensure the systems and processes in place to manage, investigate and respond to complaints, and learn from complaints are robust.
- The Trust should ensure 100% of frequent callers have an Intelligence Based Information System (IBIS) or other personalised record to allow staff taking calls to meet their individual needs.
- The Trust should take action to ensure all patients with an IBIS record are immediately flagged to staff taking calls 24 hours a day, seven days a week.
- The Trust should consider reviewing the arrangements for escalation under the demand management plan (DMP) so that patients across The Trust receive equal access to services at times of DMP.
- The Trust should continue to address the handover delays at acute hospitals.
- The Trust should ensure individual needs of patients and service users are met. This includes bariatric and service translation provisions for those who need access.

Well Led

- The Trust must take action to ensure all staff receive an annual appraisal in a timely way so that they can be supported with training, professional development and supervision.
- The Trust must ensure that governance systems are effective and fit for purpose. This includes systems to assess, monitor and improve the quality and safety of services.
- The Trust should consider improving communications about any changes are effective and timely, including the methods used.
- The Trust should engage staff in the organisation's strategy, vision and core values. This includes increasing the visibility and day to day involvement of The Trust executive team and board, and the senior management level across all departments.
- The Trust should continue to sustain the action plan from the findings of staff surveys, including addressing the perceived culture of bullying and harassment.

SECAmb Clinical Safety - Safe

Patient records: All Patient Clinical Records (PCRs) are validated on arrival at the scanning department. The Health Records team is up to full strength and there is a minimal backlog of records awaiting scanning. The percentage of unreconciled PCRs is now 10.86% (June data) and is now in line with national figures.

Medicines Governance: A review of the medicines pouch system is underway. Although this system has advantages, it is time consuming, resource intensive, and prone to tagging errors (inconsistent tagging of partially used pouches). Operational Team Leaders (OTLs) continue to regularly audit medicines management at Operating Unit (OU) level, demonstrating high levels of compliance (>95%). Quality Assurance Visits (announced and unannounced) provide further evidence of compliance. Temperature monitoring is continuing daily at all sites, with central monitoring through the OTL checks. A business case has been approved to source reliable electronic monitoring and selection of an appropriate product is underway . The recent heatwave posed significant challenges; drugs in any location where temperatures were consistently above 25 degrees were withdrawn, and the programme of installing air conditioning units was accelerated. Only two sites (both Fire Brigade site) do not now have temperature control, and crews operating from these collect their drugs from other SECAmb sites.
We continue to manage incidents where Paramedics inadvertently take their Controlled Drugs home at the end of their shift. These are small numbers and these incidents are being actively managed locally. A clinical bulletin highlighting the legal requirement to return CDs has been issued. OUMs and the Controlled Drugs Accountable Officer (CDAO) will continue to monitor the situation and provide support where this behaviour is repeated.

SECAmb Clinical Safety - Caring

No safety escalations within the caring domain

SECAmb Clinical Safety - Effective

National performance targets: The clinical indicator data summarises February 2018 performance (national three month data lag to enable the attainment of outcome data (survival to discharge) from hospitals and validation of the national returns to the Department of Health).
The data now reflects national changes in the Quality Indicators dataset, with only confirmed STEMIs and Strokes being included (using data submitted as part of the Myocardial Infarction National Audit Programme (MINAP) and SSNAP (Stroke projects). The number of patients in each group is small, leading to month on month variation in performance. In terms of annual performance, the Trust is generally just below the national average for both indicators; however an improvement on last year's data is evident. The care bundle for Stroke is showing improvement but the STEMI care bundle figures continue to be below the national average. OUMs now have access to their area's data and are in a better position to encourage and support change. Changes to national reporting requirements will result in the Trust continuing to report monthly data internally, however only one month's data will be reported in the national figures.

SECAmb Clinical Safety - Responsive

Demand management: The Trust introduced the Surge Management Plan (SMP) on 19th February 2018, superseding the Demand Management Plan (DMP). This allows the Trust to prioritise responses to the most seriously ill and injured patients at times when demand exceeds the available resource. The most recent version of the SMP was circulated on 26/06/2018
On occasions when the higher escalation levels to Purple and Black permit alternative scripts to be used, clinical review is undertaken to ensure the safety of these decisions. The Trust is actively reviewing the way the stack of outstanding calls is monitored by clinicians in the Control Rooms, to see if there are further improvements that can be made.

Clinical Practice Developments: The Deteriorating Patient Group has been established and recruitment to the ambassador's role will be complete by the end of August 2018. A number of falls and other pathways pilots are in place.

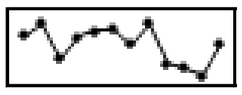
Clinical Audit: the 2018/19 Clinical Audit annual plan is on track and national requirements for the collection and submission of data are being met.

SECAmb Clinical Safety - Well Led

Recruitment: The Trust has recruited to Senior Medical and Consultant Paramedic posts to provide additional clinical input and resilience. We have recruited a Consultant Midwife who will be joining the Trust in the autumn.

SECAmb Clinical Safety Scorecard

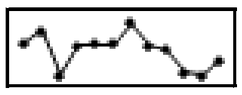
Cardiac Return of Spontaneous Circulation (ROSC) - Utstein (a set of guidelines for uniform reporting of cardiac arrest)

	Dec-17	Jan-18	Feb-18	12 Months
Actual %	27.8%	35.7%	36.4%	
Previous Year %	48.6%	51.5%	43.3%	
National Average %	46.5%	45.1%	51.0%	

Cardiac ROSC - ALL

	Dec-17	Jan-18	Feb-18	12 Months
Actual %	20.7%	23.1%	22.4%	
Previous Year %	28.5%	28.8%	28.3%	
National Average %	28.1%	27.3%	29.6%	

Cardiac Survival - Utstein

	Dec-17	Jan-18	Feb-18	12 Months
Actual %	14.7%	10.7%	25.8%	
Previous Year %	8.8%	10.7%	20.7%	
National Average %	23.2%	22.5%	25.5%	

Cardiac Survival - All

	Dec-17	Jan-18	Feb-18	12 Months
Actual %	6.0%	3.6%	8.0%	
Previous Year %	3.7%	3.4%	4.0%	
National Average %	7.1%	6.5%	8.6%	

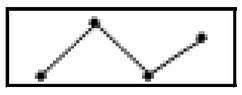
Acute ST-Elevation Myocardial Infarction (STEMI) Care Bundle Outcome

	Dec-17	Jan-18	Feb-18	12 Months
Actual %	71.8%	61.2%	58.1%	
Previous Year %	62.8%	65.6%	68.4%	
National Average %	77.6%	75.3%	tbc	

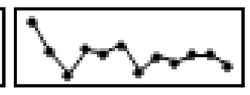
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography

	Dec-17	Jan-18	Feb-18	12 Months
Mean (hh:mm)	02:19	02:12	02:12	
National Average	02:18	02:12	02:11	
90th Centile (hh:mm)	02:59	03:03	03:12	
National Average	03:07	03:00	03:01	

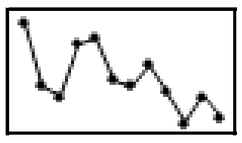
Stroke - call to hospital arrival

	Dec-17	Jan-18	Feb-18	12 Months
Mean (hh:mm)	01:13	01:08	01:11	
National Average	01:22	01:24	01:19	
50th Centile (hh:mm)	01:04	01:03	01:01	
National Average	01:13	01:10	01:11	
90th Centile (hh:mm)	01:49	01:41	01:45	
National Average	02:09	02:00	01:57	

Stroke - assessed F2F diagnostic bundle

	Dec-17	Jan-18	Feb-18	12 Months
Actual %	95.2%	94.6%	96.4%	
Previous Year %	95.6%	94.9%	97.3%	
National Average %	97.2%	97.2%	96.9%	

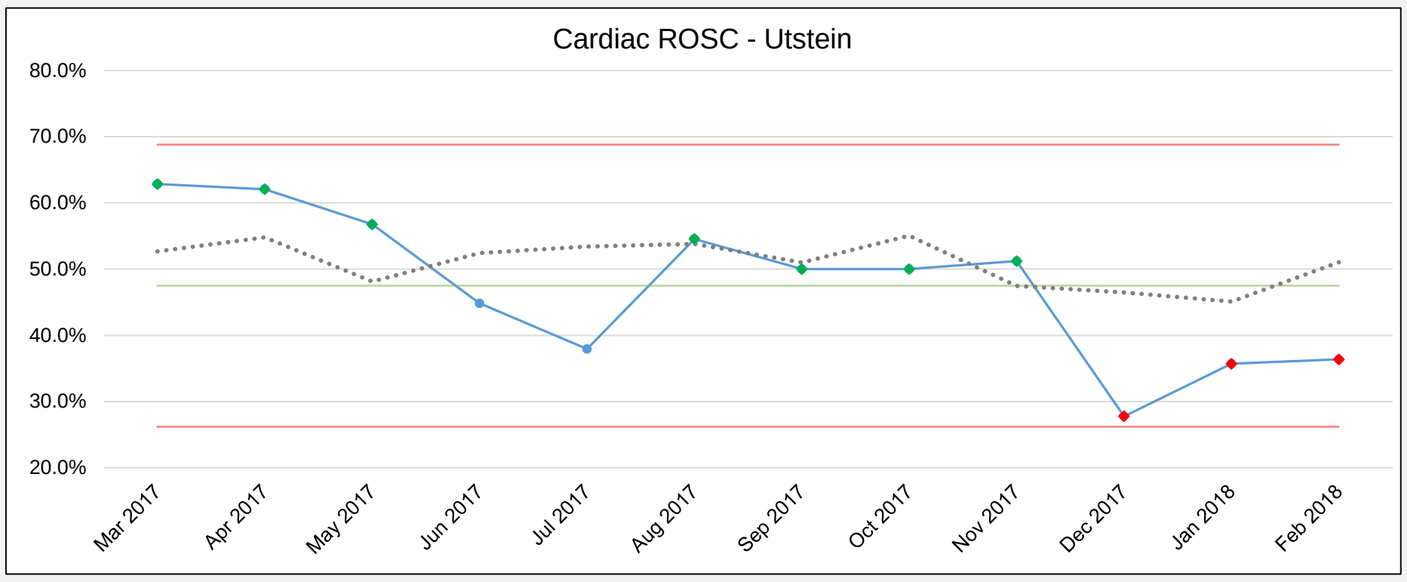
Medicines Governance

	Apr-18	May-18	Jun-18	12 Months
Total Number of Medicines Incidents	83	129	78	
Single Witness Sig/Inapt Barcode Use CDs Omnicell	9	14	10	
Single Witness Sig/Inapt Barcode Use CDs Non-Omnicell	2	6	0	
Total Number of CD Breakages	14	14	15	
PGD Mandatory Training	379	270	136	
Key Skills Medicine Governance	213	527	474	

Medicines Management

	Apr-18	May-18	Jun-18	12 Months
Number of Audits	190	172	200	
Number of audits %	98%	98%	98%	

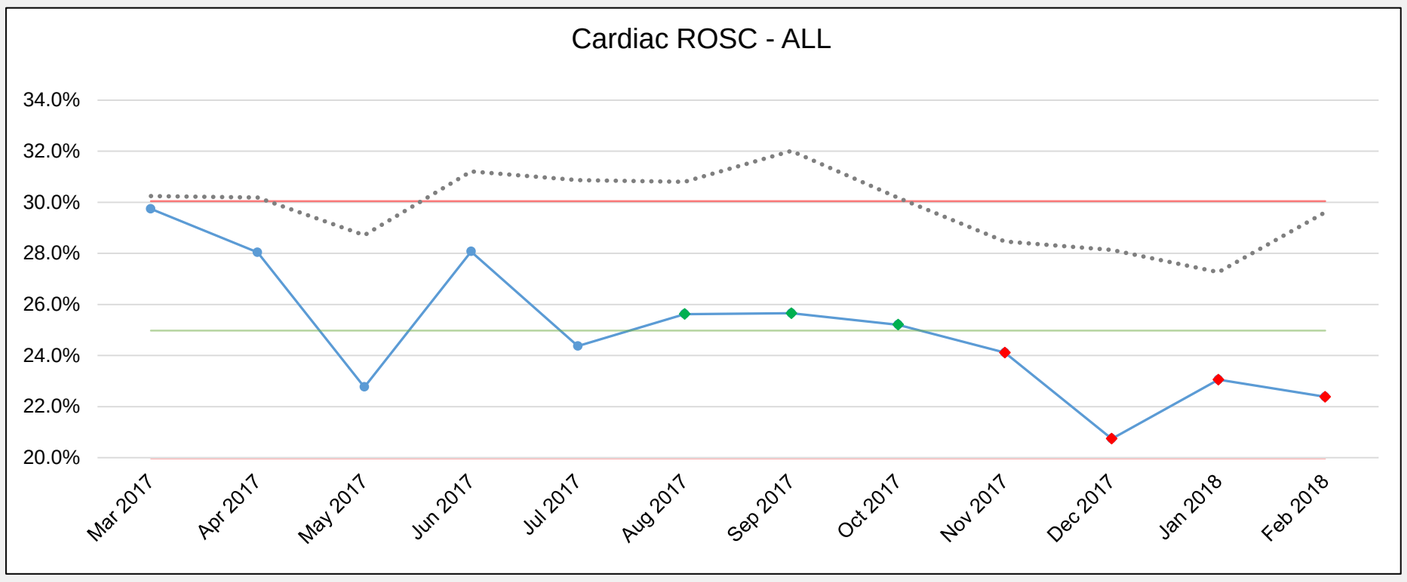
SECAmb Clinical Safety Charts



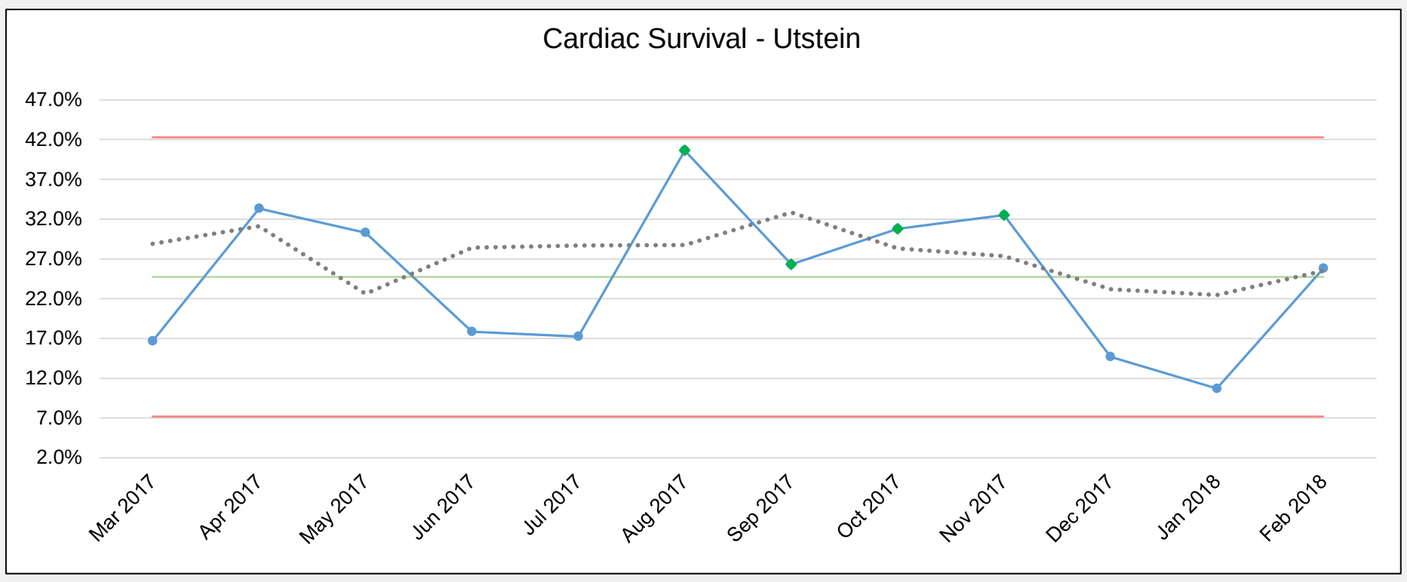
Performance for the cardiac arrest ROSC indicator for the Utstein group for February 2018 is below the SECAmb YTD and the National Average. However, there is an improvement on the previous month.

The Medical Directorate has allocated a Senior Clinician to lead on the Trust's Cardiac Arrest Survival Improvement Programme from May to July initially. Areas of focus have included developing a Cardiac Arrest Registry, Trust guidelines for the Management of Cardiac Arrest, developing our database of Public Access Defibrillators, rolling out LUCAS devices to OTLS and exploring use of the GoodSam App.

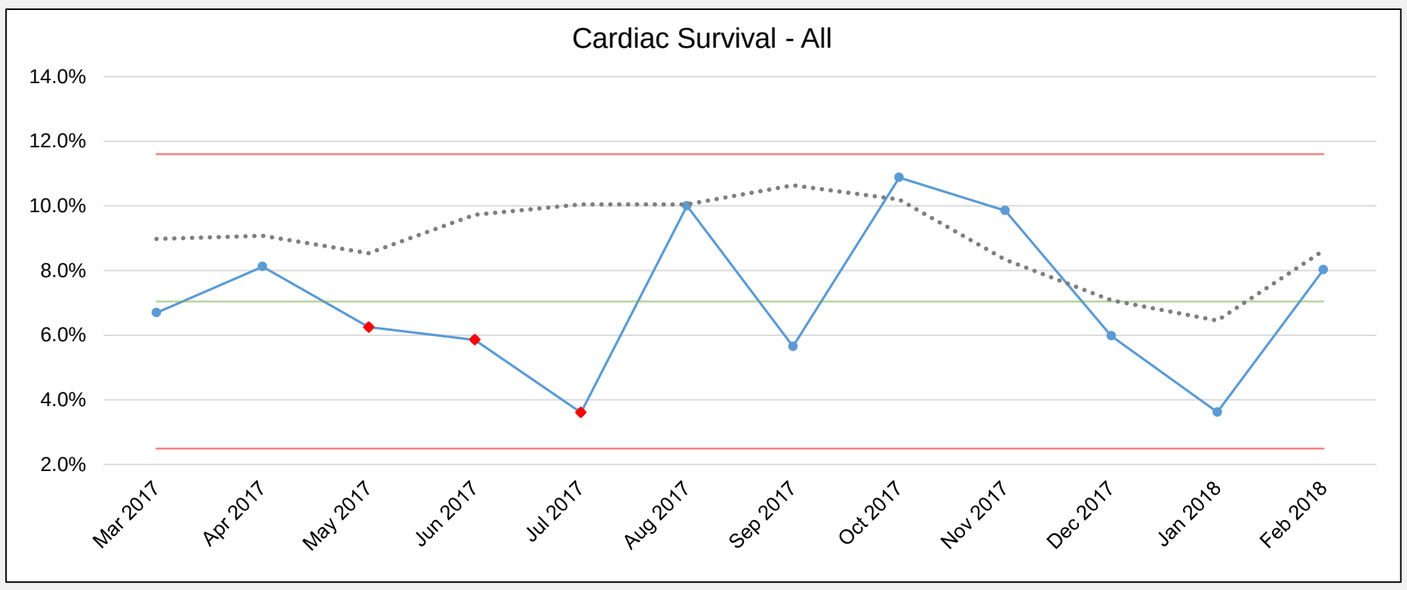
Key skills training for 2018/19 is underway and includes resuscitation training.



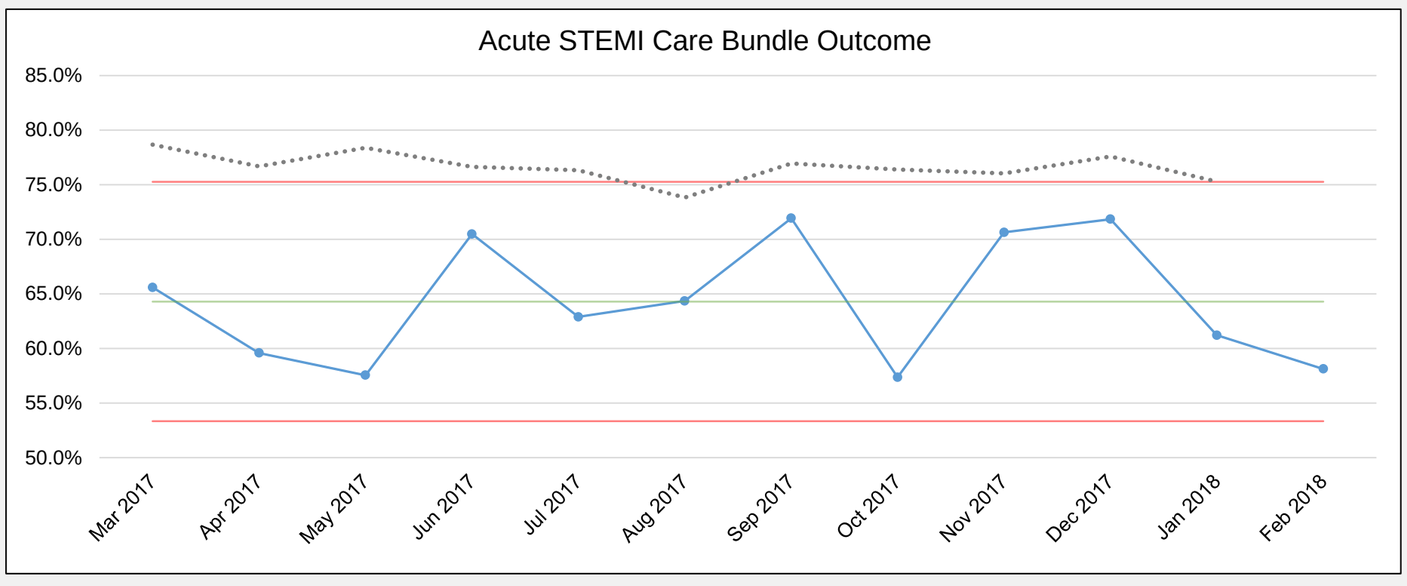
In February 2018 our performance for ROSC in all patient groups remains below the SECAmb YTD average.



In February 2018, survival to discharge for the Utstein group was above the SECAmb average and below the National Average. The data continues to show normal patterns of variation.



In February 2018, our survival for all cardiac arrest patients was above the SECAmb average and below the National Average. This appears to be in line with normal patterns of variation

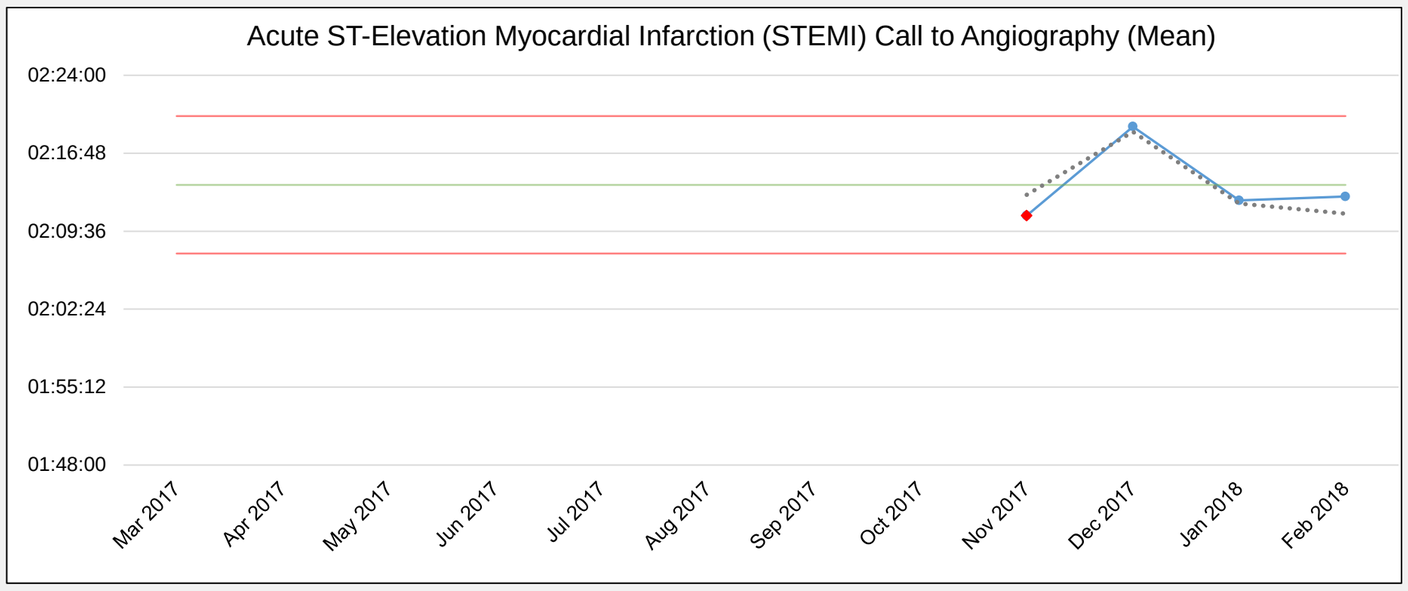


Performance for February 2018 was below the National Average and the SECAmb.

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

Focussed improvement work is planned for OUs whose average performance is outside of the expected parameters

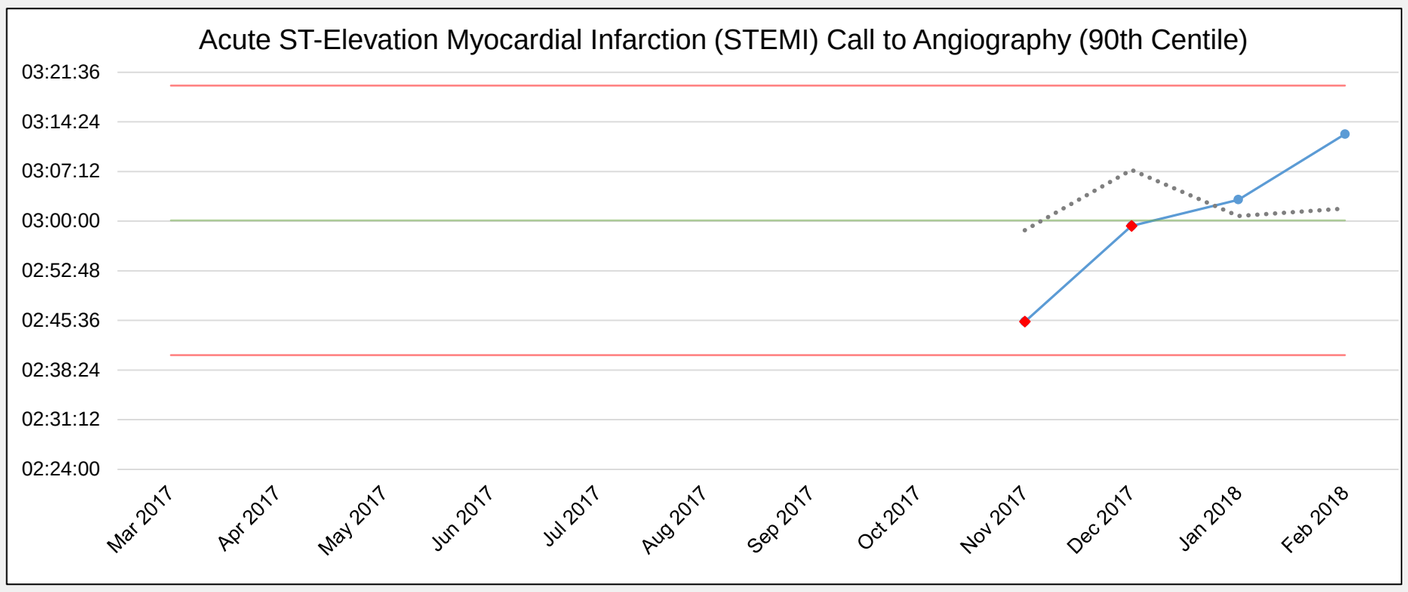
SECAmb Clinical Safety Charts

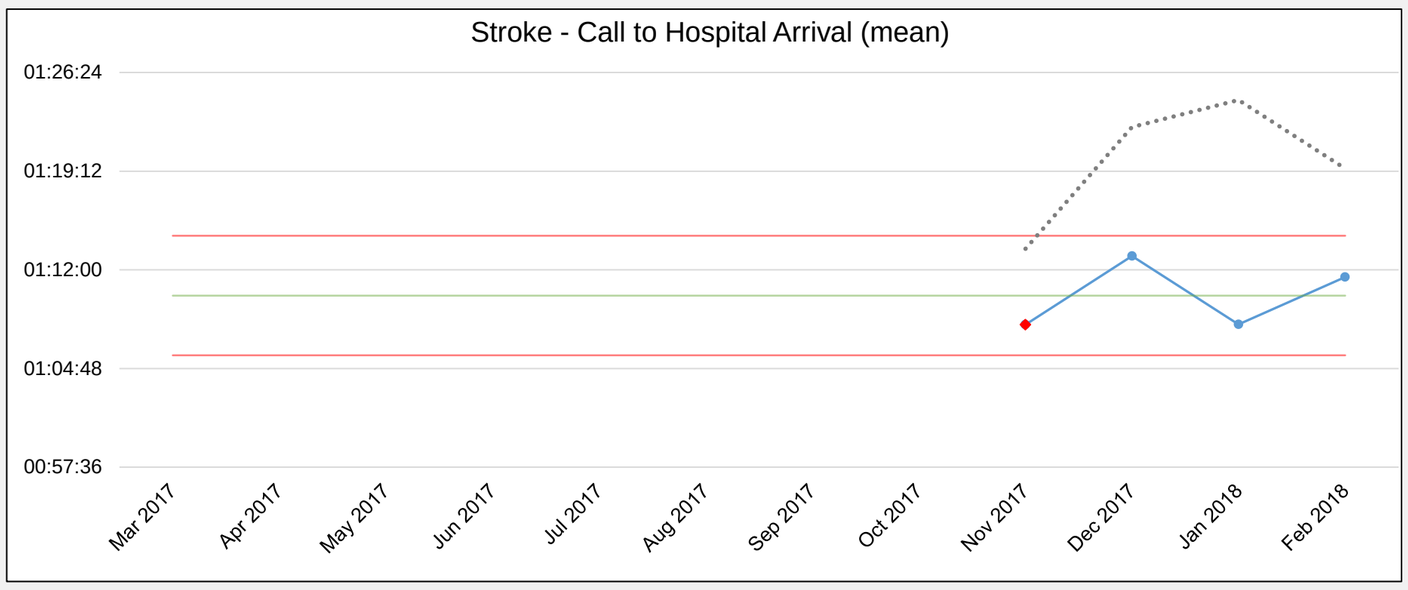


In November 2017 the method for measuring the timeliness of care delivered to STEMI patients changed to a measure of mean and 90th centile Call to Angiography (the procedure used to visualise the blood vessels that supply the heart).

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

Mean performance is above with the National Average. Our 90th centile performance is above the National Average. Which shows that STEMI patients that SECAmb care for tend to receive more timely STEMI care.

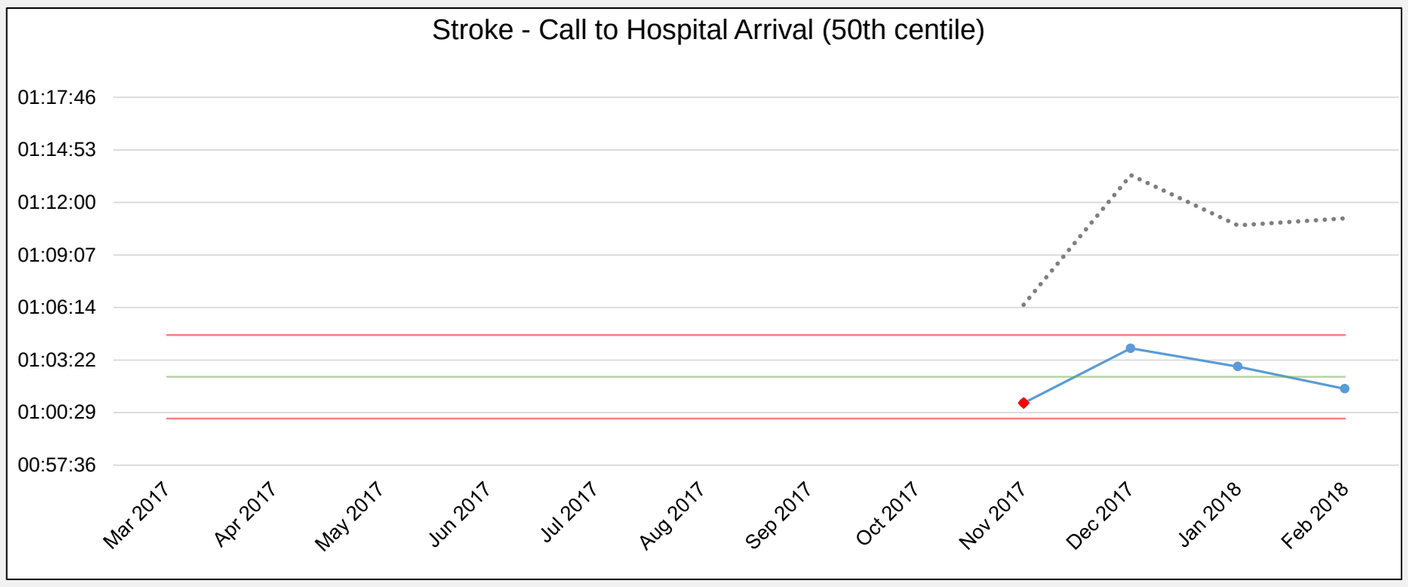


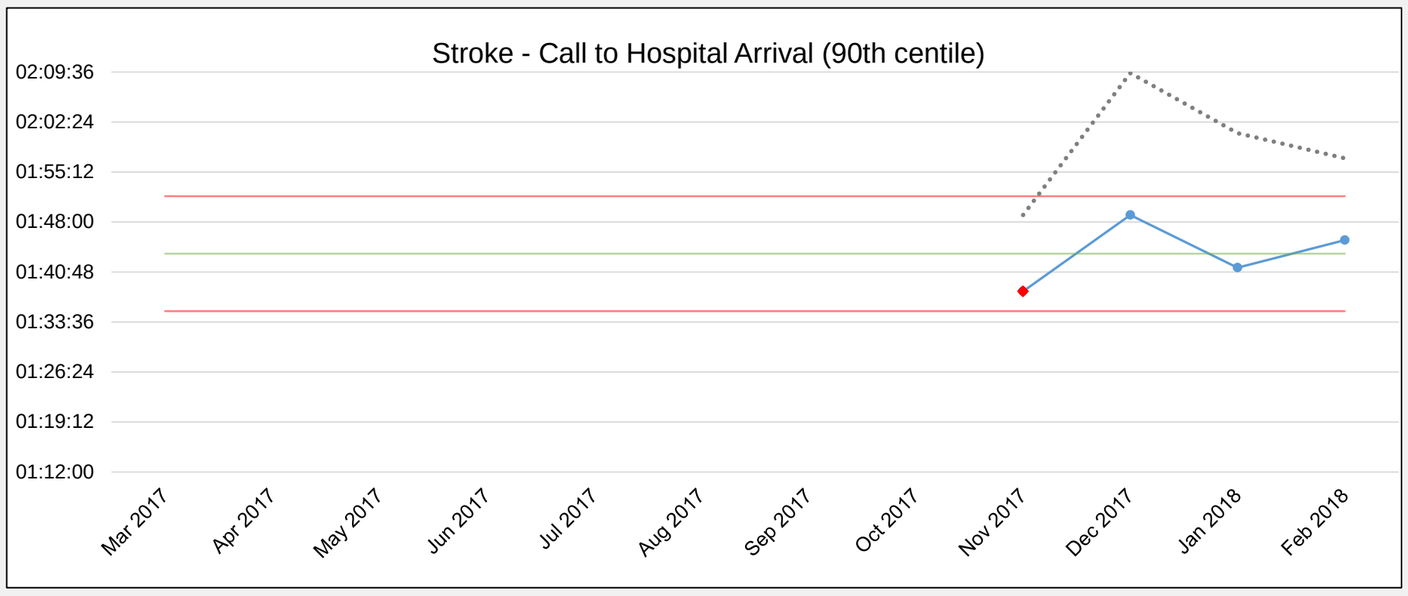


In November 2017 the method for measuring the timeliness of care delivered to stroke patients changed to a measure of mean and 90th centile call to arrival at a hyper-acute stroke centre.

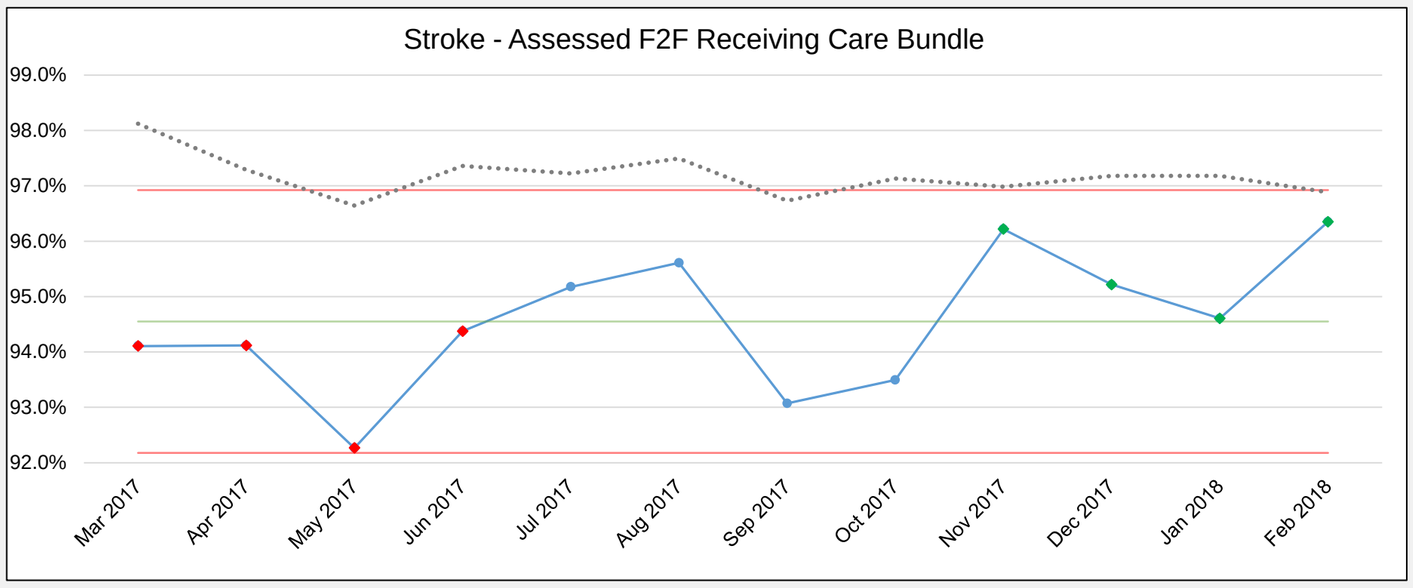
This data is reported by acute Trusts into the Sentinel Stroke National Audit Programme (SSNAP) database. This database only contains confirmed strokes, rather than suspected strokes that this measure was previously based upon.

The data shows normal patterns of variation. Our performance for February 2018 was above the SECAmb average.





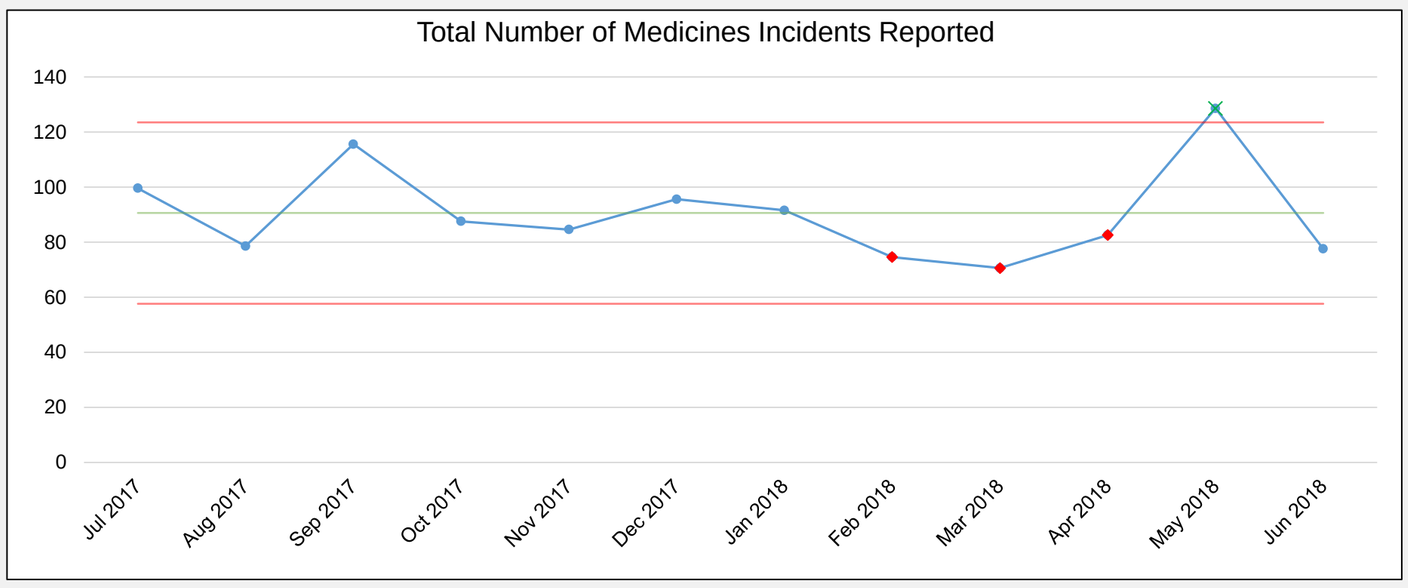
SECAmb Clinical Safety Charts



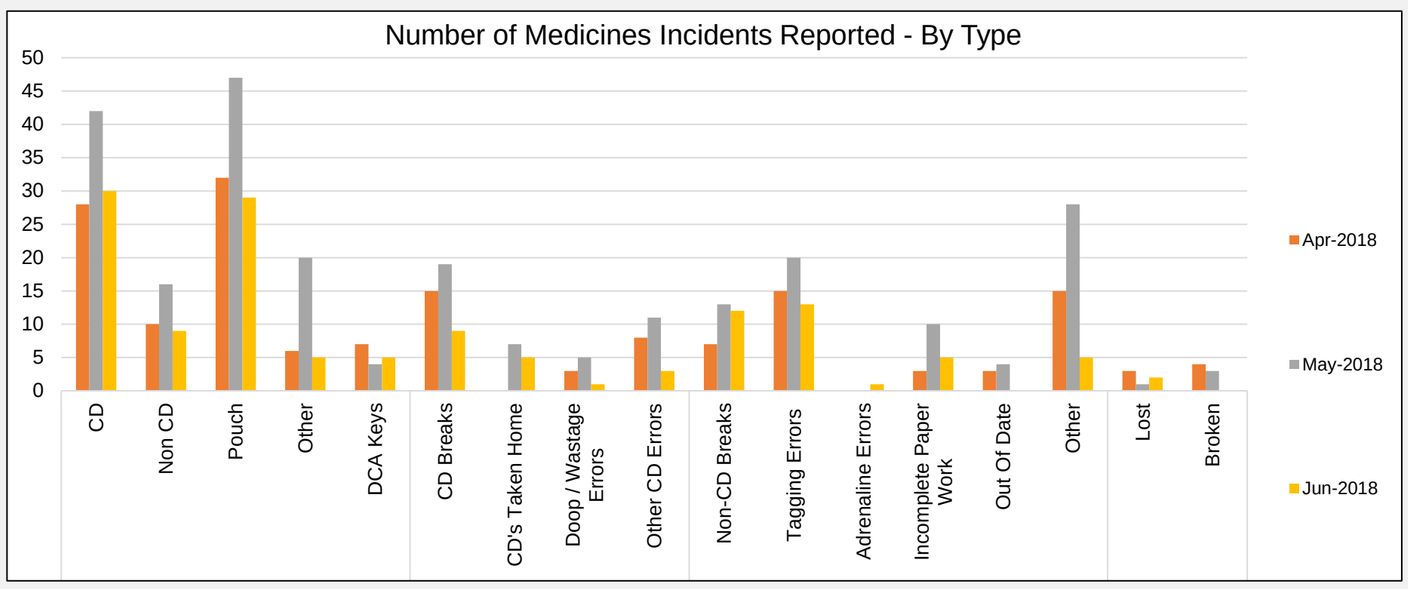
Performance in completing the Stroke Care Bundle is below National Average. However, it has been above the SECAmb average for the last four months.

Dashboards showing local performance levels have now been shared with OUs to facilitate focussed quality improvement. Regular reminders of the importance of the completion of care bundles are placed in staff communications. A suite of feedback tools and information sheets has also been developed.

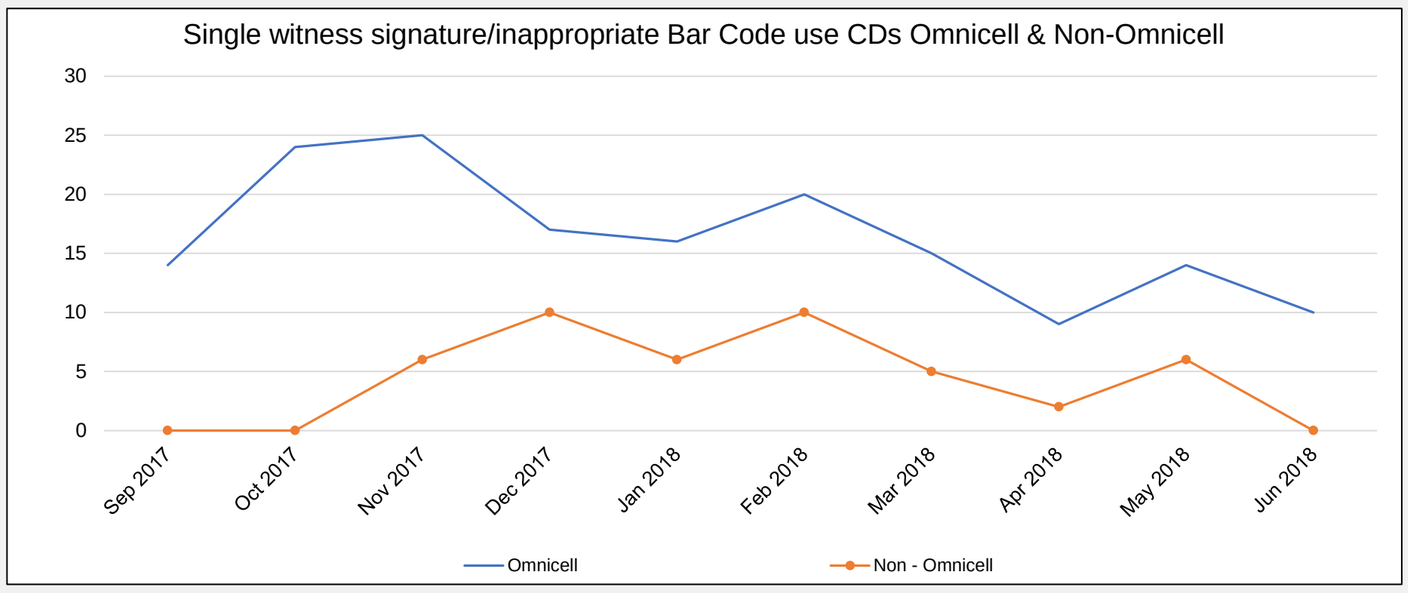
Focussed improvement work is planned for operating units whose average performance is outside of the expected parameters.



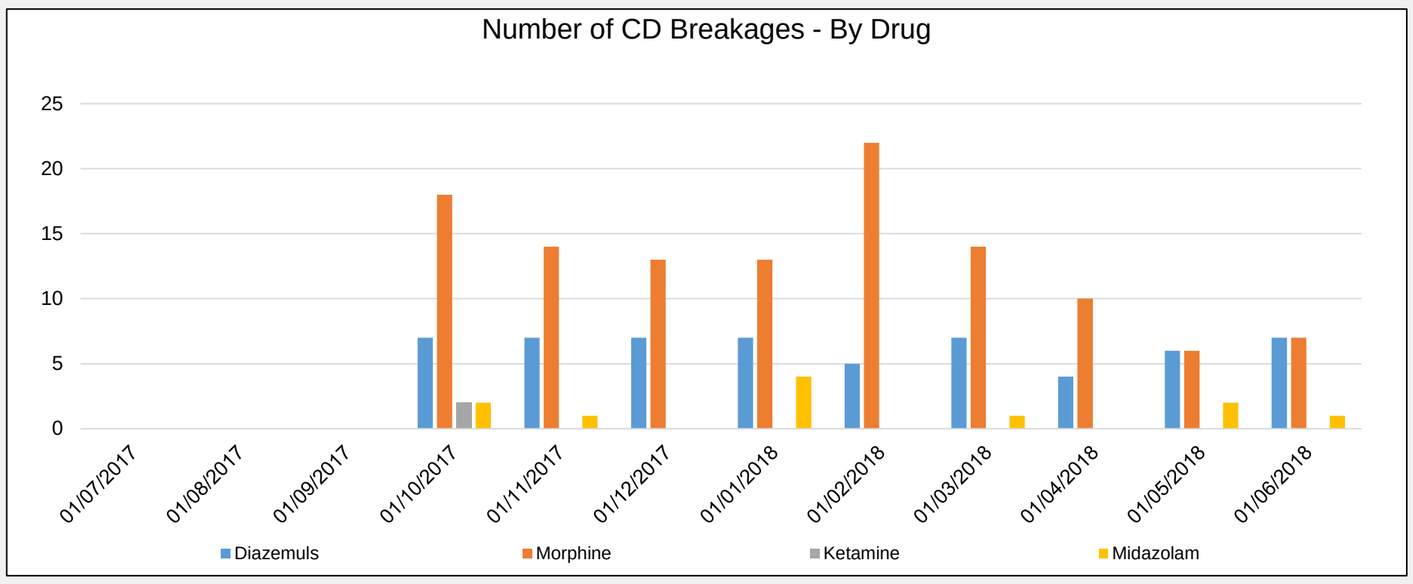
May appears to have been an outlier in terms of incident reporting. June has seen a return to previous levels. There is no obvious cause for the May peak. A small number of drug administration errors are being reported and used as learning exercises. There are still incidents occurring where staff take Controlled Drugs home at the end of their shifts. A process is in place to ensure the drugs are returned without delay, and feedback is provided targeting any repeat offenders.



This relates to graph 1 (above). Of note the number of key losses has remained low.
May appears to have been an outlier in terms of incident reporting. In June numbers are more in keeping with previous months.
We are continuing to see a reduction in CDs taken home, CD breakages and wastage errors.

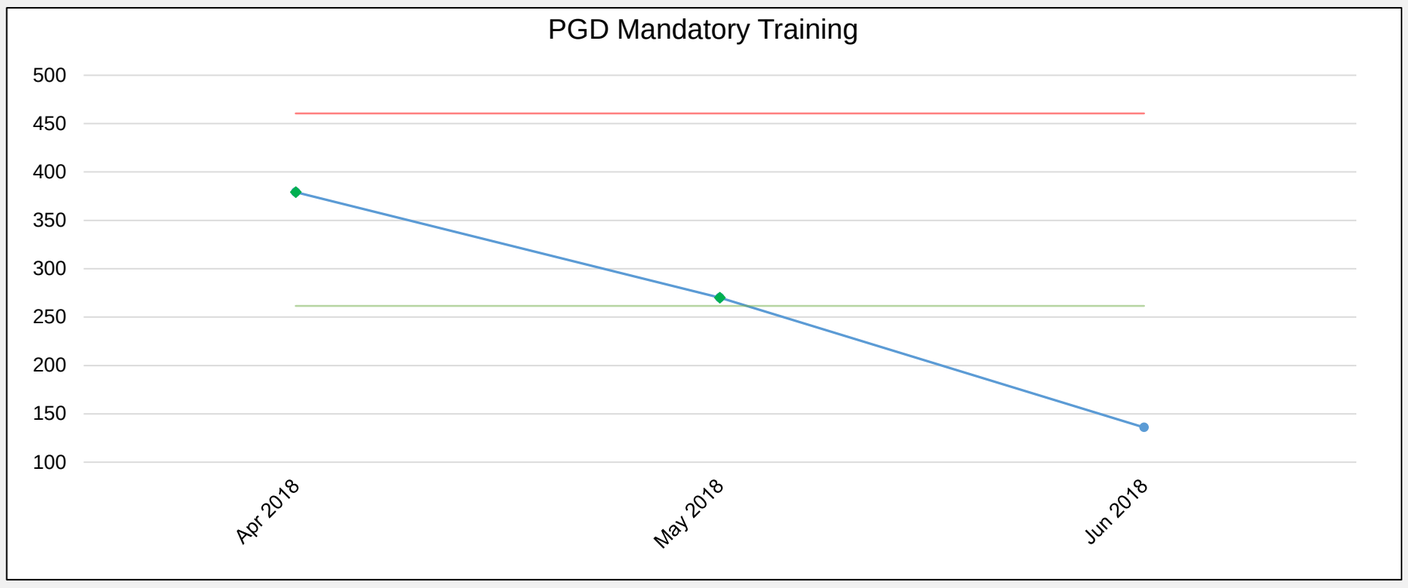


The number of single signatories for Omnicell sites has decreased significantly. Generally it is possible to find another staff member to provide second witness. This is not always as easy in the non Omnicell sites, but the numbers here are small, and generally decreasing.

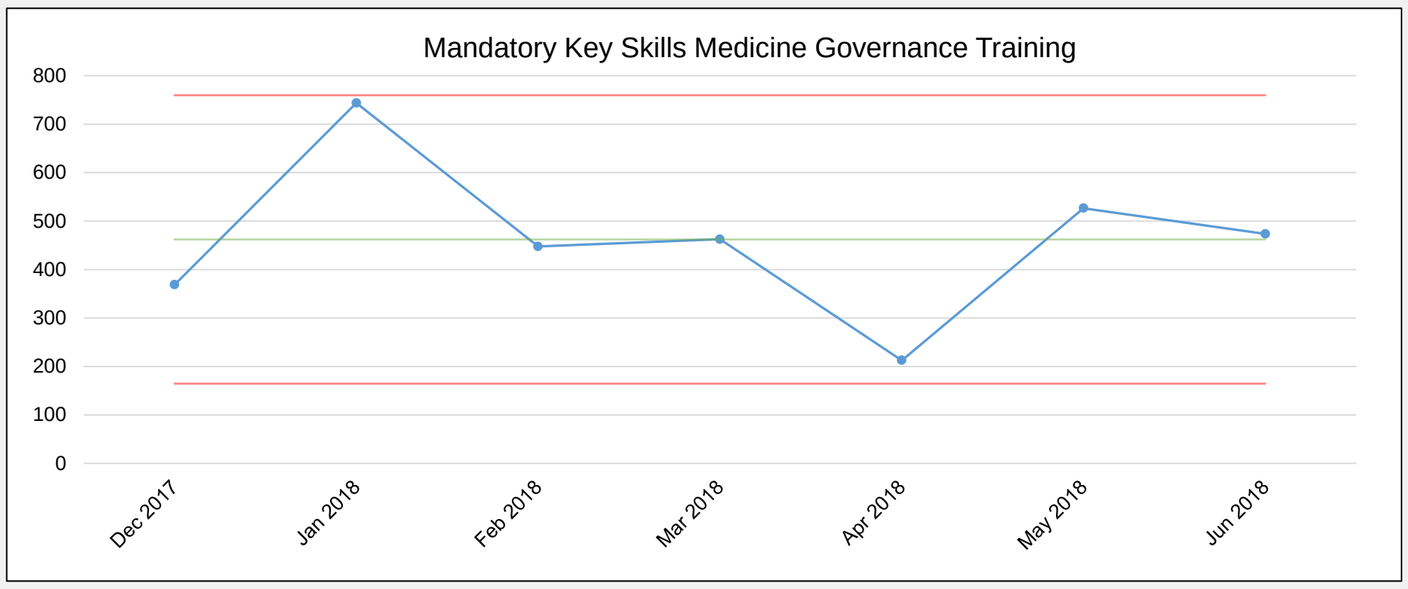


The highest breakage rate is for morphine, almost certainly because this drug is more commonly used than diazepam. However total breakages are reduced by 60% when compared to 2017. However, the trend is down, and the breakage rate for diazepam remains fairly consistent. Midazolam and ketamine are only available to CCPs whereas morphine and diazemuls are used by all Paramedics.

SECAmb Clinical Safety Charts



The reduced numbers reflect the position that most Paramedics, CCPs and PPs have now undertaken the required training. There will always be training required for new staff joining the Trust.



Consistent levels of statutory and mandatory training

Analysis of Cardiac Arrest Data - February 2018

Total number of cardiac arrests identified = 742

Number of resuscitation attempts = 277
excluding DNACPR 35, DOA 408, No Resus by SECAmb 12,
Did not convey 1 , Post arrest 8, ADRT 1

Utstein definition
Bystander witnessed
Presenting rhythm VF
Cardiac in origin

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

Cardiac Arrests (Utstein incidents) = 33 (12%) **Cardiac Arrests (All incidents) = 277 (100%)**

ROSC sustained to hospital (Utstein)
= 12 (36%) 0 non ROSC

ROSC sustained to hospital (All) = 62
(22%) + 12 non ROSC

Outcomes for ROSC at hospital and non ROSC at hospital patients		
Utstein	Details	Overall
8	Patient survived to discharge	22
2	Patient died in hospital	49
2	Patient still in hospital*	2
0	Outcome unknown* (Patient identifiable data incomplete)	1

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

Survival to Discharge (Utstein) = 8 (26%)

Survival to Discharge (All) = 22 (8%)

Additional Information - Resuscitation Attempts

Cardiac Rhythm	Overall Totals	ROSC at Hospital	Non ROSC at Hospital
Asystole	132 (48%)	17	5
PEA	65 (23%)	14	3
VF	62 (22%)	21	3
Non-shockable	8 (3%)	3	1
Not recorded	10 (4%)	7	0

CPR Bystander - 148

EMS Witnessed arrest - 33

Cardiac Arrest downloads received for Feb 18	0
Cardiac Arrest download reports sent to crews	0

Analysis of Cardiac Arrest Data by area - February 2018

Number of resuscitation attempts = 275
this figures excludes 2 incidents as PAS & VAS crew (1 of which attained ROSC at Hospital)

Cardiac Arrests (Utstein) East = 16 (6%)	Cardiac Arrests (All) East = 148 (54%)
Cardiac Arrests (Utstein) West = 17 (6%)	Cardiac Arrests (All) West = 127 (46%)

ROSC sustained to hospital (Utstein) East = 3 (19%)	ROSC sustained to hospital (All) East = 28 (19%) + 7 non ROSC
ROSC sustained to hospital (Utstein) West = 9 (53%)	ROSC sustained to hospital (All) West = 33 (26%) + 5 non ROSC

Outcomes for ROSC at hospital and non ROSC at hospital patients

Area	Utstein	Details	Overall
East	2	Patient survived to discharge	10
West	6		12
East	1	Patient died in hospital	25
West	1		23
East	0	Patient still in hospital*	0
West	2		2
East	0	Outcome unknown* (Patient identifiable data incomplete)	0
West	0		1

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

Survival to Discharge (Utstein) East = 2 (13%)	Survival to Discharge (All) East = 10 (7%)
Survival to Discharge (Utstein) West = 6 (40%)	Survival to Discharge (All) West = 12 (10%)

Mental Health Care - June 2018 data

Rag Ratings:

Within ARP Cat 2 18 mins	=	GREEN
Outside Cat 2 ARP 18 mins, up to 40 mins	=	AMBER
Outside Cat 2 ARP 18 mins, beyond 40 mins	=	RED
Within 90th Percentile 40 mins	=	GREEN
Outside 90th Percentile 40 mins, up to 1 hour	=	AMBER
Outside 90th Percentile 40 mins, beyond 1 hour	=	RED

Overall RAG Rating = GREEN

1. The mental health indicator has changed this month from Green to Amber as the mean response measures are slightly outside of ARP standards. Cat 2 = 00.18.41. 90th Centile=40.17

Mental Health Response Times (Section 136 MHA)

2. During June 2018 there were 136 Section 136 related calls to the service.119 of these calls received a response (87.5%) resulting in a conveyance to a place of safety by an ambulance on 114 (83.8% of total calls; in May this was 81.9% of total calls) on these occasions.

3. The overall performance mean shows a response time across the service as 00.18.41 (May was 00.17.29). Against the 90th centile measure, the response was 00.40.17 (May was 00.31.48).

4. There were five transports of under 18's during June.

5. There were 17 occasions when SECAmb did not provide a response. This is down from 19 in May, however the activity is slightly lower. This report RAG rates against both mean ARP standards within Cat 2; these being 18 minutes and the 90th percentile within 40 minutes. The report also details conveyances measured under Cat 3, Cat 4, C60 HCP, C120 HCP and C240 HCP (these are likely to be secondary conveyances and are not RAG rated) and these are as follows:

Cat 3:	Total calls 5	Total responses 2	Total transports 2
Performance Mean 00.36.46	90th centile 00.55.51		
Cat 4:	Total calls 0	Total responses 0	Total transports 0
C60 HCP:	Total calls 12	Total responses 7	Total transports 7
Performance Mean 01.02.35	90th centile 02.22.02		
C120 HCP:	Total calls 4	Total responses 3	Total transports 3
Performance Mean 01.02.21	90th centile 02.16.06		
C240 HCP	Total calls 0	Total responses 0	Total transports 0

(These responses are collectively reported by Operational Unit on the attached dashboard)

6. Although the data within this report indicates that the majority of OU's are reaching a good standard, both performance means are slightly outside of ARP standards for the first time since ARP was introduced.

SECAmb Quality - Safe

- The Trust must take action to ensure they keep a complete and accurate recording of all 999 calls.
  Since the June audit revealed a number of conjoined calls a retrospective audit has been undertaken which has revealed a number of other conjoined calls. Weekly auditing has commenced with oversight at the Compliance Steering Group.
- 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.
  This project is now part of BAU and reported elsewhere in the IPR
- 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.
  EOC remains compliant with pathways requirements. Plans in place for recruitment of other members of staff.
- The Trust must take action to ensure all staff understand their responsibilities to report incidents.
  Incident reporting remains well beyond trajectory.
- The Trust must ensure improvements are made on reporting of low harm and near miss incidents.
  Compliance is slightly below the target of 96% of reported incidents being of low harm or near miss.
  The Trust must investigate incidents in a timely way and share learning with all relevant staff.
  Compliance for timely investigation of incidents is above target.
- 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.
  Having achieved the training target this project is now part of BAU.
- The Trust must ensure patient records are completed, accurate and fit for purpose, kept confidential and stored securely .Data not available at time of writing report. Last data revealed a marked improvement in May.
- The Trust must ensure the CAD system is effectively maintained.
  Having replaced the system this project is now closed
- 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.
  Hand hygiene has improved over recent months and continues to be over 75%
- The Trust must ensure all medical equipment is adequately serviced and maintained.
  Having reached trajectory this project is now closed and moved to BAU.
- The Trust should take action to audit 999 calls at a frequency that meets evidence based guidelines.
  This is proving challenging for the team to maintain with each month being used to catch up for the previous month.
  Currently compliant up to end of May and June still being undertaken.
- The Trust should review all out of date policies.
  89% of identified policies within date. New improvement plan for governance will address the remaining 11% and also focus on supporting procedures.
- The Trust should ensure all first aid bags have a consistent contents list and they are stored securely within the bags.
  Compliant and project closed.
- The Trust should ensure all ambulance stations and vehicles are kept secured.
  95% compliance for checks undertaken in July.
- The Trust should ensure all vehicle crews have sufficient time to undertake daily vehicle checks within their allocated shifts.
  New process being implemented

SECAmb Quality - Caring

- The Trust should ensure that patients are always involved in their care and treatment.
  Information not collated qualitatively but Quality Assurance Visits continue to monitor and this is regarded as an area of strength.
- The Trust should ensure that patients are always treated with dignity and respect.
  Information not collated qualitatively but Quality Assurance Visits continue to monitor and this is regarded as an area of strength

SECAmb Quality - Effective

- The Trust must take action to meet national performance targets.
  This project is now closed and performance is reported elsewhere in this report.
- The Trust must improve outcomes for patients who receive care and treatment.
  This project is now closed and performance is reported elsewhere in this report.
- The Trust must continue to ensure there are adequate resources available to undertake regular audits and robust monitoring of the services provided.
  Having achieved the audit plan 2017/18 this project is now closed and part of BAU.
- The Trust should ensure there are systems and resources available to monitor and assess the competency of staff.
  This was not part of a formal project in 2017/18 although the changes to the Team Leader role has supported improvements in oversight of staff. However, how the Trust assures itself that staff adherence to policy will be considered in 2018/19 as part of the governance project.

SECAmb Quality - Responsive

- The Trust must ensure the systems and processes in place to manage, investigate and respond to complaints, and learn from complaints are robust.
  The achievement in February of over 80% of complaints being closed within 25 days has been sustained.
- 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.
  This is not part of a formal project, is part of BAU and is not routinely reported.
  The Trust should take action to ensure all patients with an IBIS record are immediately flagged to staff taking calls 24 hours a day, seven days a week.
  The number of stage 1 letters has decreased in June but still remains at a higher level than the pre-April months.
- 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.
  This project is closed now that the Surge plan was implemented.
- The Trust should continue to address the handover delays at acute hospitals.
  The last reported figure was 993.51 hours lost (30/07/18) which is an improvement.
- 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.
  This is not part of a formal project and is part of BAU and is not routinely reported. No issues reported

SECAmb Quality - 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.
  This project was closed and moved to BAU and is reported elsewhere in this report.
- 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 risk register has been used to measure this. Activity on the risk register is at its highest in July.
- The Trust should consider improving communications about any changes are effective and timely, including the methods used.
  Not a specific project but part of a corporate review.
- 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.
  Tracker not reported in July.
- The Trust should continue to sustain the action plan from the findings of staff surveys, including addressing the perceived culture of bullying and harassment.
  Culture improvement plan now in place with KPIs identified and Task & finish group now meeting weekly.

SECAmb Clinical Quality

During July 2018, the monthly Quality and Patient Safety Report reported against June 2018 data (wherever possible) :

a) A 22% increase in safeguarding referral rates between Q1 2017/18 and Q1 2018/19 has been observed. To date the 2018/19 training for operational staff on harmful behaviours (coercive and controlling) has a 39.69% completion rate; training on Level 2 child safeguarding for all operational staff is at 38.18%; and for Level 2 adult safeguarding (both elearning) is 37.97%

b) The Trust has seen an increase in incident reporting with a total of 712 reported in June. The allocation of investigators has increased to 87. Timeliness of the investigation (deadline for completion is 20 working days) has increased to 194 in June (from 148 in May). The number of overdue incidents investigated within 20 working days is 80.

c) Serious Incidents (SIs) and Duty of Candour (DoC): ten SIs were reported in June. 61 SIs were open on STEIS at the end of June (a slight increase from May). An increase to 19 (from 8 in May) were overdue for first submission to the CCG; none were closed this month - 4 were considered but additional information was sought. The Trust achieved 100% compliance with DoC requirements for SI's during June and 100% compliance was achieved for DoC made/attempted within deadline. The Trust achieved 100% compliance with DoC requirements for SI's during June (82% in May). 100% compliance was achieved for DoC made/attempted within deadline.

d) 89 complaints were received and opened in June against a monthly average for the year of 104. 98% of complaints were due for conclusion, and of those, 49% were upheld and 15% partly upheld. A reduction in complaints for A&E timeliness, triage, and complaints against staff was noted. Falls is the theme with the highest number (16). The significant improvement in complaints response timeliness continues, with 99% (97/98) of complaints responded to within the Trust's 25 working day timescale this month. Circa 130 compliments continue to be received each month across the Trust.

e) The mental health indicator demonstrates there were 136 Section 136 related calls to the service in June. Of these 87.5% received a response resulting in 114 conveyances to a place of safety by an ambulance. However, the RAG for this indicator has changed from Green to Amber this month, as both performance means are slightly outside of ARP standards for the first time since ARP was introduced.

f) No progress to report on falls this month.

g) Quality Account Priorities Q1 Review:
Priority Area 1 - Improving outcomes from out-of-hospital cardiac arrests: A senior manger is leading a project to reform Out of Hospital Cardiac Arrest survival, based on implementing the 10 steps of the Global Resuscitation Alliance:' A Call to Action'.

Priority Area 2 - Learning from incidents, complaints and safeguarding reviews: A number of metrics are already in place, with others being developed for learning. A Shared Learning Discussion Group has been established and to oversee the learning from complaints and incidents.

Priority Area 3 - Patient-facing staff adequately trained to manage safeguarding concerns and to report them appropriately: Safeguarding training is now a mandatory requirement for 2018/19 and other metrics are under development.

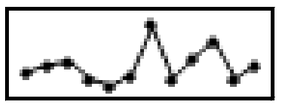
Security: An increase to 84% compliance with submission of weekly site security checks was achieved in June. Issues of poor submission by Ashford MRC have been addressed. 98% of quarterly site security submissions were received for Q1. Work is underway to quantify quality as well as submission jointly with Medicines Management.

SECAmb Clinical Quality Scorecard

Number of Incidents Reported

	Apr-18	May-18	Jun-18	12 Months
Actual	721	722	712	
Previous Year	545	576	586	

Number of Incidents Reported that were SI's

	Apr-18	May-18	Jun-18	12 Months
Actual	17	6	10	
Previous Year	5	6	7	

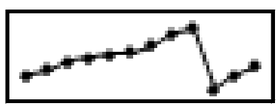
Duty of Candour Compliance (SIs)

	Apr-18	May-18	Jun-18	12 Months
Actual %	100%	100%	100%	
Target	100%	100%	100%	

Compliments

	Apr-18	May-18	Jun-18	12 Months
Actual	133	131	133	

Safeguarding Training Completed (Adult) Level 2

	Apr-18	May-18	Jun-18	12 Months
Actual %	6.33%	26.05%	37.97%	
Previous Year %	0.44%	20.00%	21.07%	
Target	85%	85%	85%	

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

Safeguarding Training Completed (Children) Level 2

	Apr-18	May-18	Jun-18	12 Months
Actual %	6.51%	25.88%	38.18%	
Previous Year %	0.56%	21.00%	21.33%	
Target	85%	85%	85%	

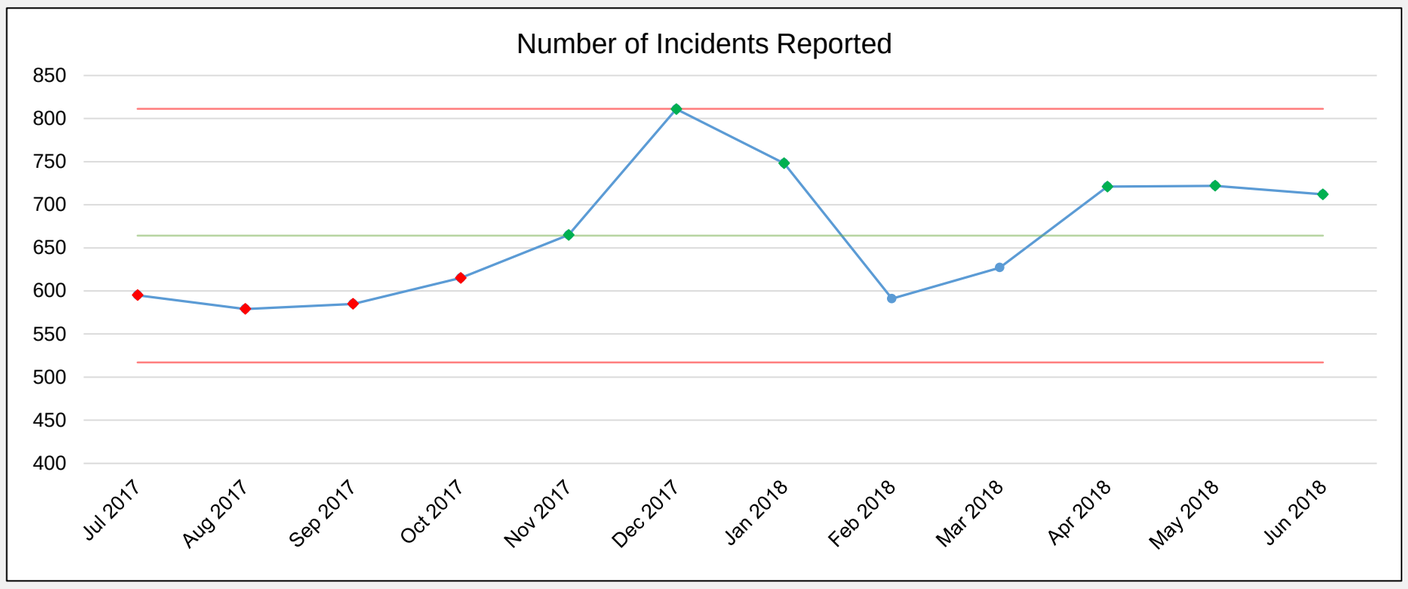
Number of Complaints

	Apr-18	May-18	Jun-18	12 Months
Actual	93	101	88	
Previous Year	71	79	102	
Complaints Timeliness (All	97.9%	99.1%	99.0%	
Timeliness Target	95%	95%	95%	

Hand Hygiene

	Apr-18	May-18	Jun-18	12 Months
Actual %	92%	90%	88%	
Target	90%	90%	90%	

SECAmb Clinical Quality Charts

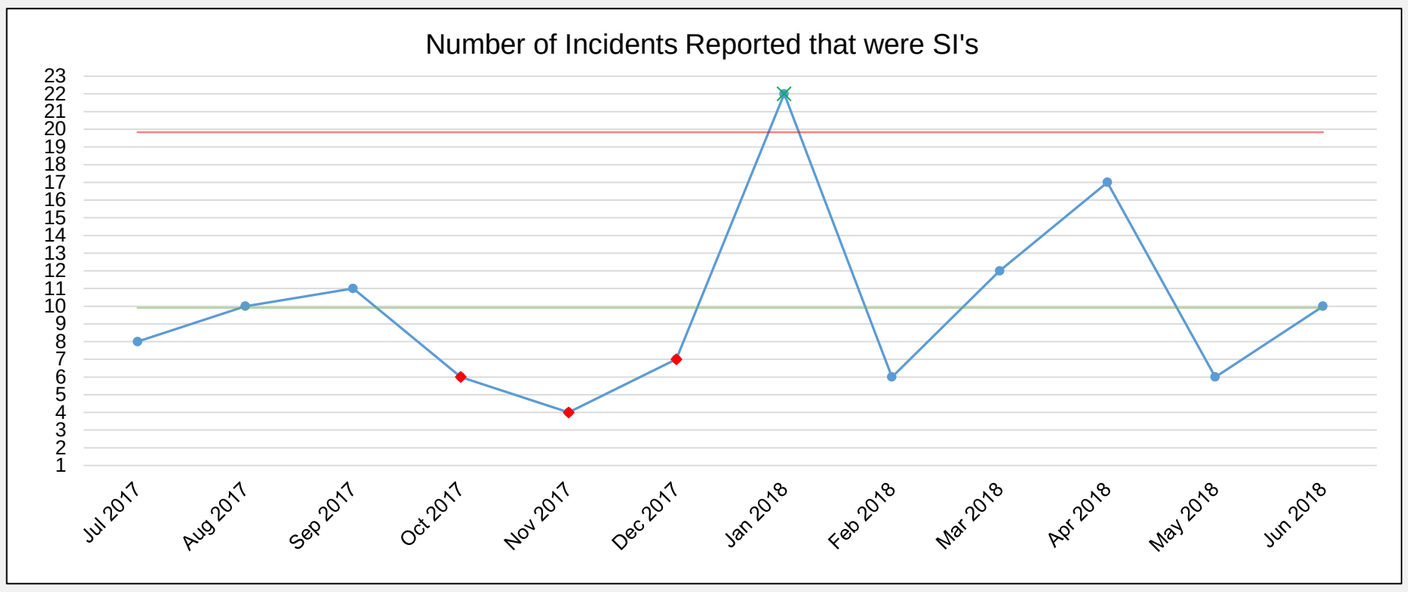


There were 712 incidents reported in June.

June figures remain high due to increased reporting on Medicine Management but also in that the Trust being in multiple levels of surge for the duration of the month.

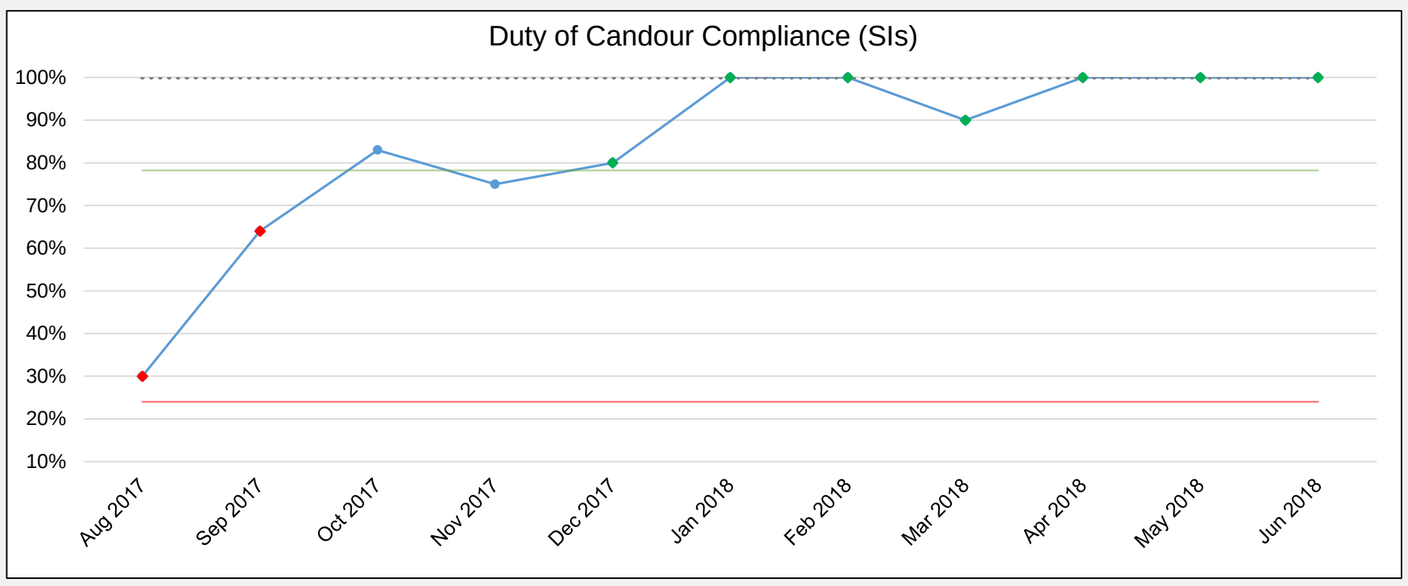
The most reported incidents were around medicine error in which 39 were reported across the Trust. These were mainly for ampoule breakages/storage of drugs. In terms of Operating Units (OUs) Polegate & Hastings reported the most with 80.

The Trust reported 178 incidents to NRLS in June 2018. Following on from this the Trust closed 665 records in June.

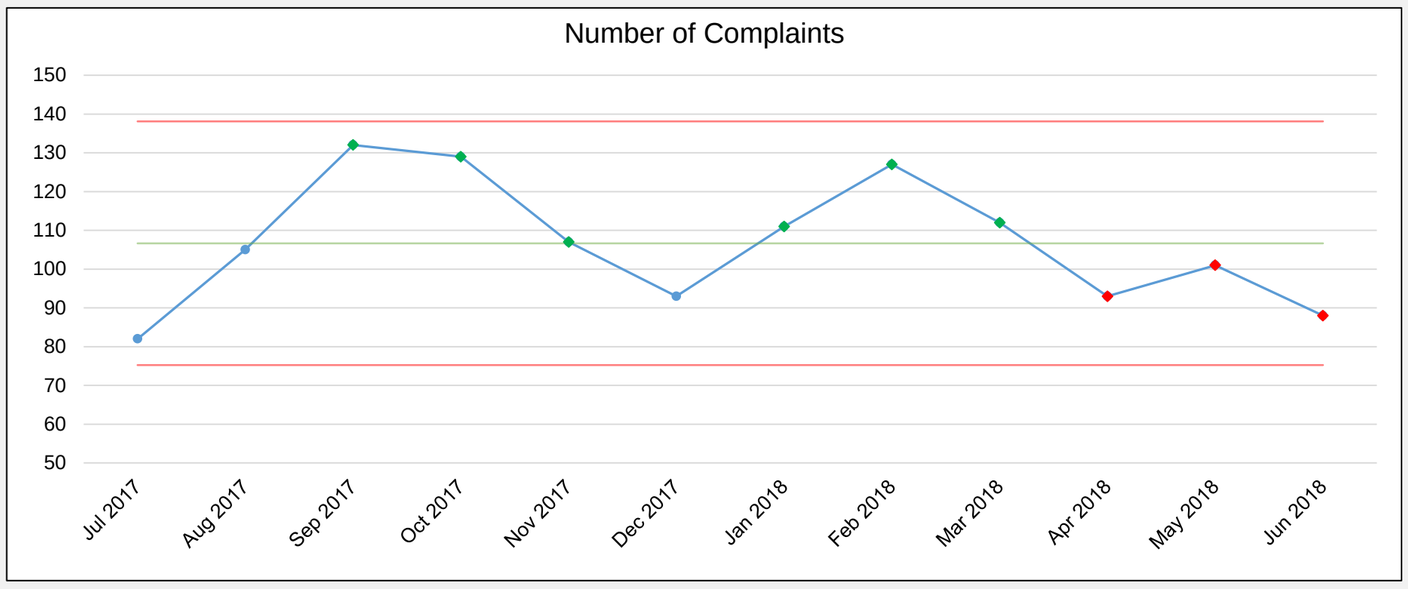


10 Incidents declared in June

Call Answer Delay	3
Delayed Attendance	5
Staff Conduct	1
Patient Care	1



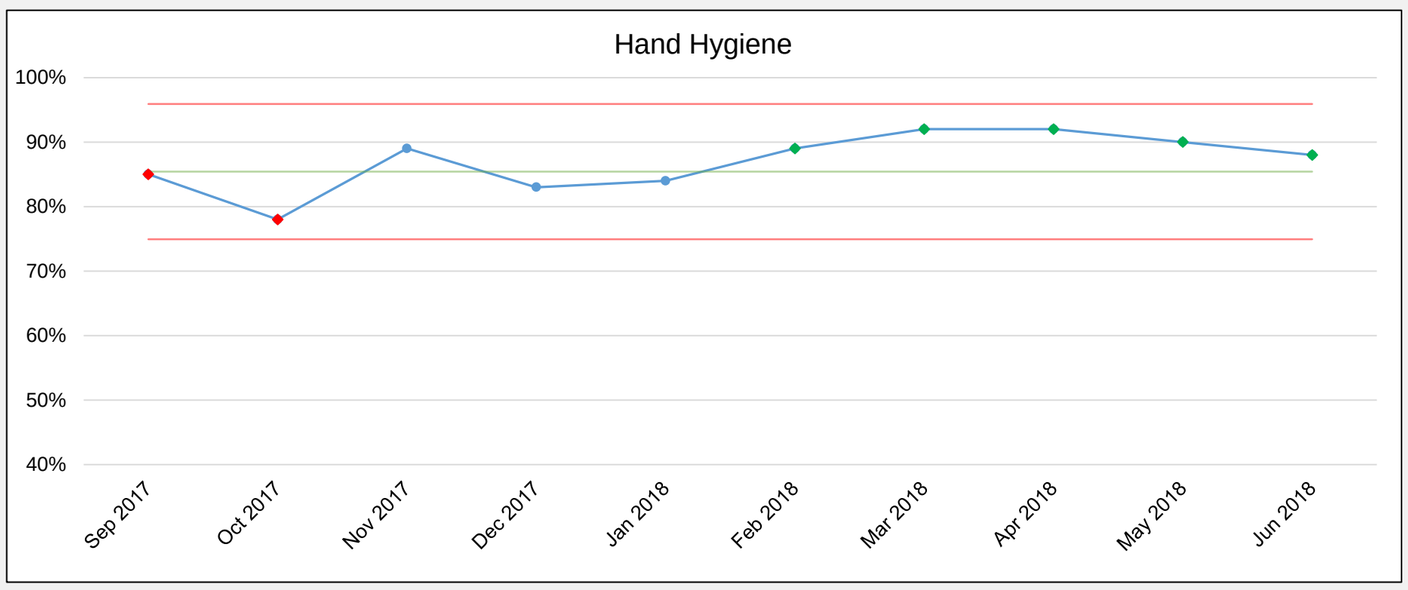
All Duty of Candour (DoC) initial contact within 10 days has been achieved. Datix has been updated to capture SI DoC data and evidence.



The Trust received and opened 88 complaints in June 2018 compared to 101 in May, and against a monthly average of 104 for the year 17/18. This was the lowest number received since July 2017.

In June the top three complaints sub-subjects were timeliness, staff behaviour, and NHS Pathways (triage). A&E timeliness complaints have reduced by four against last month, with 23, and are much reduced against the 41 in February and 42 in March. Complaints about triage and patient care overall have also reduced against last month, as have complaints about staff.

The significant improvement in complaints response timeliness since the end of January has been maintained, with 99% (97/98) of complaints responded to within the Trust's 25 working day timescale in June.



Hand Hygiene is just below the 90% compliance rate for June at 88%

Bare Below the Elbow compliance (last month of recording it as BBE) was 92% for the month above the 90% target.

Deep Cleans are also just below the 99% target and this was due to the high levels of activity throughout the month.

Environmental cleanliness compliance this month has improved to 85% from 75% this month, due to the recent improvements in standards being maintained. June is showing an 82% compliance rate.

The new Infection Prevention Ready Procedure is now in place and the IPC Team are undertaking a programme of engagement / communications with staff to help with embedding this into practice.

SECAmb Health and Safety Reporting

Introduction

The mandate for the Health & Safety (H&S) Improvement Plan was presented to Workforce and Wellbeing Committee (WWC) and there will now be a full Improvement Action Plan developed with the Programme Management Office (PMO) and Non Executive Directors (NED) support, set to begin in September 2018. This will be driven by the new Head of Health and Safety and will go to the weekly compliance steering group for scrutiny. The Central Health and Safety Working Group (CHSWG) on the 20th June 2018 agreed to set up a Task and Finish Group which will inform the Improvement Action Plan (IAP).
The third Institution of Occupational Safety and Health (IOSH) for Directors course took place on 16th August 2018 and was attended by 7 Senior managers, one Director and One Non Executive.
Patient and Staff Safety Leadership walk rounds began in July and are enabling further access for staff to board members and direct contact and assurance to the board regarding staff concerns, welfare, and estate and environmental issues.
A new H&S manager was successfully recruited and will start in early September 2018. Unfortunately one of our substantive H&S managers has resigned and will be leaving in September so we advertising for their replacement.

Violence and Aggression Incidents - See Figure 1 below
This data relates to all reported incidents of violence and aggression including verbal abuse. This has fallen again in June but the trend remains steady.

Manual handling Incidents - See Figure 2 below

Reported manual handling incidents remain below the trend line.

Health &Safety Incidents - See Figure 3 below

We continue to report an increasing trend for low/no harm H&S incidents, 25% increase over this time last year, in line with our overall aim to increase reporting rates.

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

RIDDOR incidents reported in June remain high with 60% reported within the statutory 14 day period. Two of the incidents occurred in February and March and were not reported until June. RIDDOR is on the agenda for the Central Health & Safety Working Group (CHSWG) and will form part of the proposed Improvement Plan, which will include reporting time compliance.

Figure 1

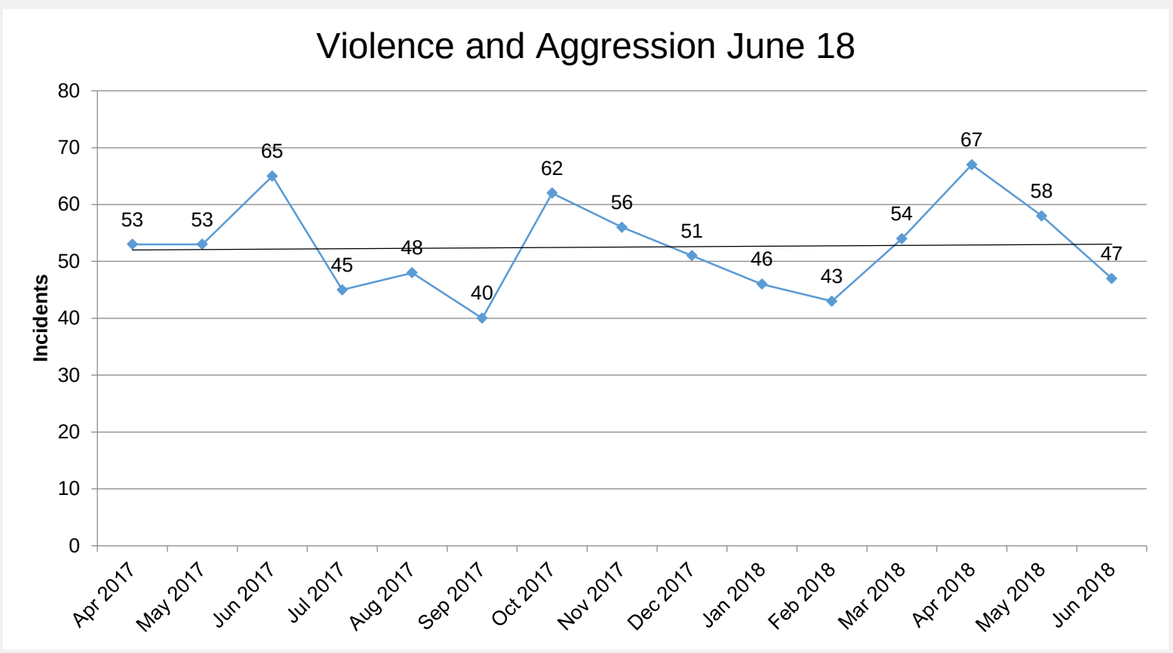


Figure 2

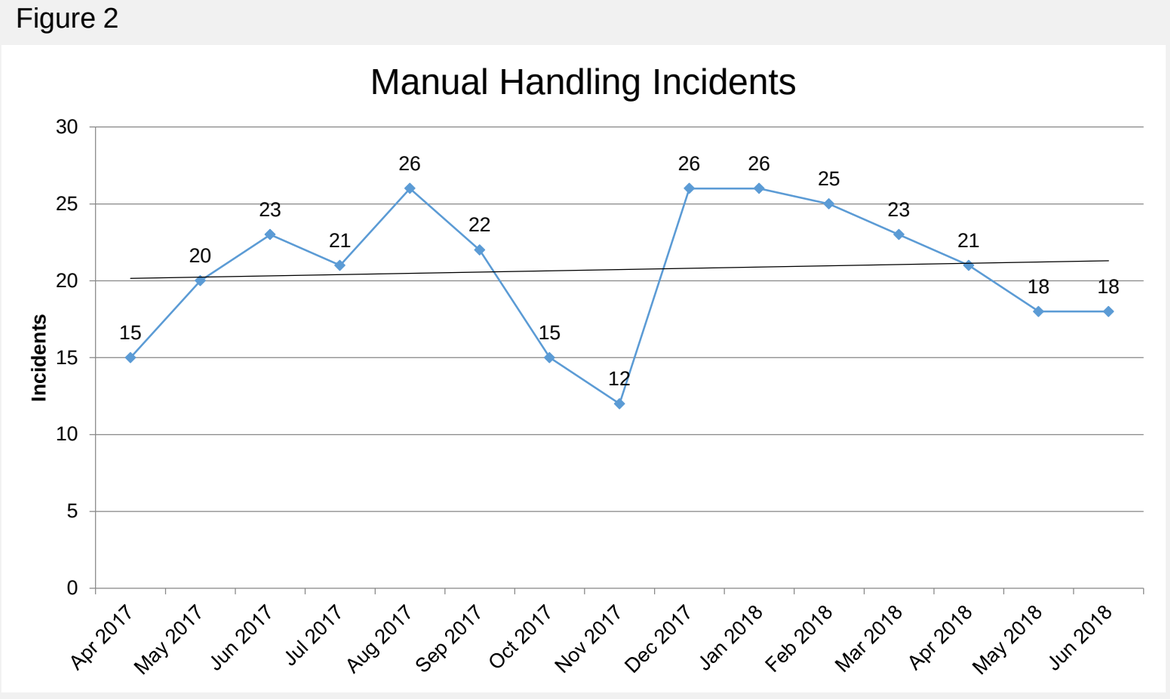


Figure 3

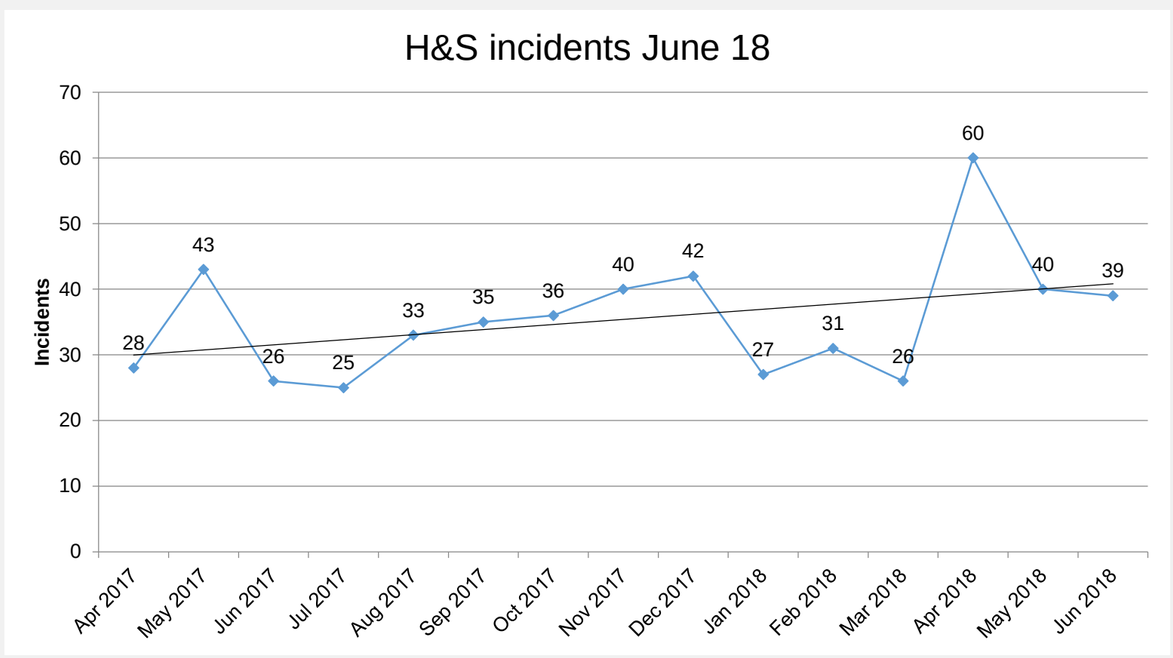
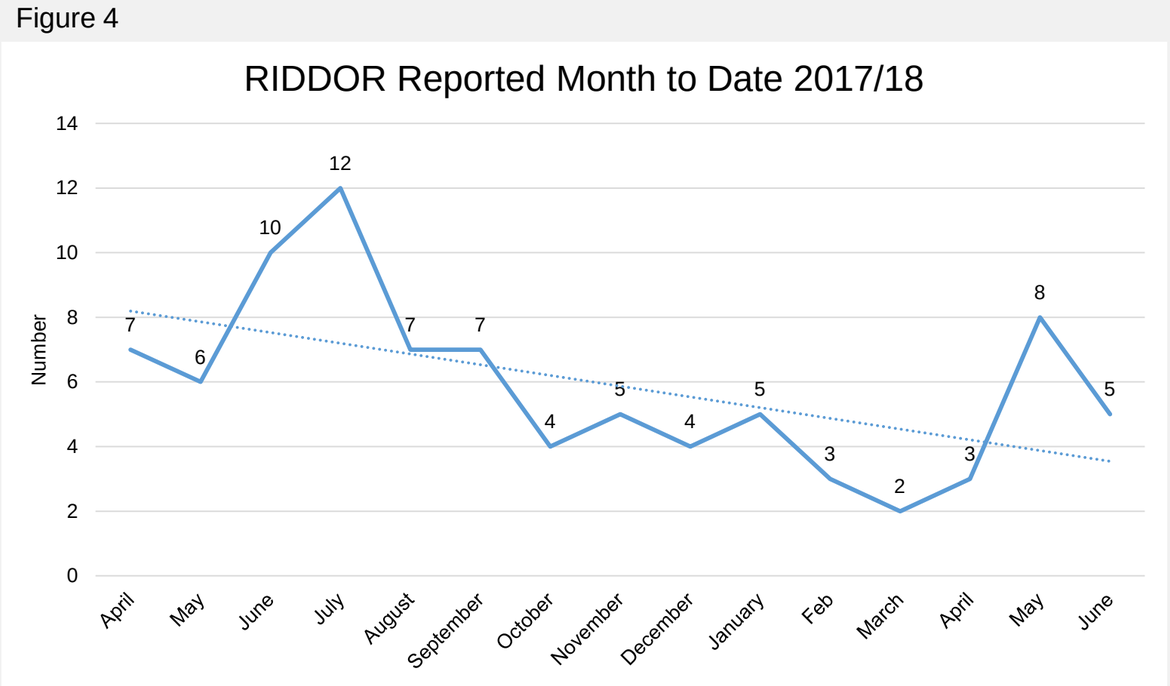


Figure 4



SECAmb Operations 999 - Safe

Call Answer Performance: Call answer performance is now included in the Emergency Operations Centre (EOC) action plan to address the CQC requirement of improving Ambulance Quality Indicators (AQI), recruitment and staff retention. Significant scrutiny is still being placed on call handling performance, with all efforts being made to improve this. The intended objective was that the Trust will meet the 95% performance trajectory by August 2018, this is proving to be a very challenging objective under the current increased call demand, the EOC Leadership team are now exploring every element of the call handling process to improve the efficiency of the Emergency Medical Advisors (EMAs).

Duplicate Calls: The surge in duplicate Estimated Time of Arrival (ETA) calls is continuing to cause a significant strain on call answering. The percentage of duplicate calls increased sharply over August and September 2017 and has remained at between 16-18% since the introduction of the Ambulance Response Programme. Analysis of data is continuing to understand the reasons for this increase (i.e. time of day etc). The revised position of a hard deck (Minimum number of vehicles) of 100 Double Crewed Ambulances (DCAs) at night, together with the recruitment of 300 new Operational staff by the end of November 2018 continue to be the key objectives that the operations teams are striving to achieve.

SECAmb Operations 999 - Caring

Surrey Heartlands Pregnancy Advice Line: This continues, based in the EOC. A review will be completed at the beginning of July 2018 following 2 complete months in operation. This will involve call volumes, nature of calls, disposition, feedback from EOC, Field Crews and Callers as appropriate. Feedback so far, is that this service has been received positively by patients and EOC staff.
Well Being Hub: is now in permanent operation which will provide ongoing well being support to all staff and volunteers at SECAmb.
Staff Engagement programme: is being actively continuing throughout the Trust, including at local station level. There is now a clear escalation and cascade process for issues and ideas.
Culture Change programme: has now been rolled out to field operations that recognises the values and the valuable contribution of staff. This has been met with mixed engagement from staff at this time. However, its very early in the plan and further development is planned.

SECAmb Operations 999 - Effective

Response Time Performance Targets: Category 1 (Cat 1) performance has reduced slightly on the prior month. Category 2 (Cat 2) responses continue to perform within target consistently. However, the Trust is not meeting Category 3 (Cat 3) and Category 4 (Cat 4) response time targets due to resourcing levels. A Demand and Capacity Review continues to ensure SECAmb understand the structural gaps in funding and resourcing in this respect. Additional vehicles are also being brought into the Trust to ensure the correct mix to meet patient needs, which will consist of 16 new Fiat van conversions, 85 new Mercedes box bodies and 30 second-hand Fiat conversions from West Midlands Ambulance Service.

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

SECAmb Operations 999 - Responsive

Surge Management Plan (SMP): The SMP has been in active use since its introduction and subsequent reviews, with a further review of the plan and its associated triggers scheduled for early August. The Business Information tools that have been developed to provide a very structured understanding of the levels of surge being experienced by SECAmb have matured into a Surge Escalation Warning Trigger (SEWT) which is able to consistently indicate where a surge point is being experienced within the Region. This has been further developed to be able to provide a historic view of the surge situation to support retrospective analysis.

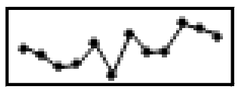
Handover Improvement Project: Handover delays continue to improve and remain stable in a portion of acute sites, however the pressures created by the extremely hot weather have exposed areas of weakness in some of the hospitals with the lost hours having now reached a plateau and starting to show an upward trend in patients waiting greater that 30 minutes. The Task and Finish group continue to focus on handovers and improving patient flow and releasing resource availability.

SECAmb Operations 999 - Well Led

Key Skills Training: This has commenced throughout the Trust for Operational staff. In addition, objectives are currently being set for the Operations Team. Key skills were placed on hold during the Bank Holiday weeks to release resources back to the frontline. Progress is however on track to deliver over 80% of key skills training before the end of September to avoid the added abstraction through the winter months.
Teams A-F Operational Meeting Structure: New structure in place, which standardises Operational meetings across all levels, ensuring that there is a consistent approach to escalation of risks and issues, together with information flow. Area Governance Reviews are also attended by Executives. The Resilience Group now meet monthly and report to the Executive on a quarterly basis.
Risk: Management of Risk remains high on the operational agenda. All meetings with the A-F Team structure actively review risks. Risk Management has been incorporated into the relevant Terms of Reference.

SECAmb 999 Operations Performance Scorecard

Call Handling

	Apr-18	May-18	Jun-18	12 Months
5 Sec Performance (95% Target)	84.0%	78.3%	73.2%	
Mean Call Answer Time (secs)	15	18	24	
95th Centile Call Answer (Secs)	97	108	4	
National Mean Call Answer	6	8	11	
National 95th Centile Call Answer	31	45	59	

Cat 1 Performance

	Apr-18	May-18	Jun-18	12 Months
Mean (00:07:00)	00:07:24	00:07:37	00:07:41	
90th Percentile (00:15:00)	00:13:45	00:14:06	00:14:22	
Mean Resources Arriving	1.77	1.79	1.78	
Count of Incidents	3201	3290	3298	
National Mean	00:07:38	00:07:46	00:07:37	

Cat 1T Performance

	Apr-18	May-18	Jun-18	12 Months
Mean (00:19:00)	00:10:21	00:10:20	00:10:47	
90th Percentile (00:30:00)	00:19:36	00:19:37	00:19:45	
Mean Resources Arriving	2.85	2.90	2.77	
Count of Incidents	1988	2033	2114	
National Mean	00:12:09	00:12:28	00:12:18	

Cat 2 Performance

	Apr-18	May-18	Jun-18	12 Months
Mean (00:18:00)	00:16:08	00:17:07	00:17:39	
90th Percentile (00:40:00)	00:30:17	00:32:29	00:33:14	
Mean Resources Arriving	1.13	1.14	1.13	
Count of Incidents	26663	27678	26791	
National Mean	00:20:15	00:21:17	00:21:38	

Cat 3 Performance

	Apr-18	May-18	Jun-18	12 Months
Mean (01:00:00)	01:04:25	01:14:35	01:16:37	
90th Percentile (02:00:00)	02:32:34	02:53:19	02:55:30	
Mean Resources Arriving	1.06	1.07	1.06	
Count of Incidents	21571	22133	20931	
National Mean	00:49:37	00:58:13	01:00:15	

Cat 4 Performance

	Apr-18	May-18	Jun-18	12 Months
Mean	01:41:15	02:02:13	02:01:01	
90th Percentile (03:00:00)	04:10:57	04:38:21	04:58:23	
Mean Resources Arriving	1.06	1.06	1.06	
Count of Incidents	1148	1202	1069	
National Mean	01:13:42	01:25:32	01:28:44	

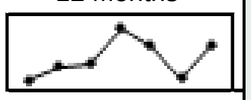
HCP

	Apr-18	May-18	Jun-18	12 Months
HCP 60 Mean	01:36:21	02:07:24	02:08:41	
HCP 60 90th Percentile	03:42:35	05:36:32	05:05:37	
HCP 120 Mean	02:07:37	02:15:20	02:20:03	
HCP 120 90th Percentile	05:12:08	05:17:52	05:07:17	
HCP 240 Mean	02:14:38	02:50:17	02:46:48	
HCP 240 90th Percentile	05:03:46	06:49:53	07:01:15	

Call Cycle Time

	Apr-18	May-18	Jun-18	12 Months
Avg Allocation to Clear at Scene	01:14:01	01:13:50	01:13:43	
Avg Allocation to Clear at Hospital	01:46:02	01:45:42	01:45:53	
Handover Hrs Lost at Hospital (over 30mins)	4804	4404	4263	
Number of Handovers >60mins	516	307	250	

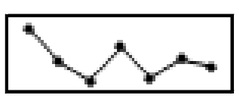
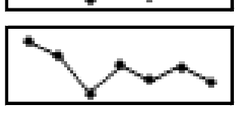
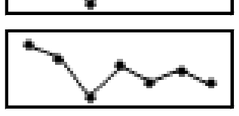
Incident Outcome AQI

	Apr-18	May-18	Jun-18	12 Months
Hear & Treat	5.5%	6.1%	5.8%	
See & Treat	33.4%	33.1%	33.1%	
See & Convey	61.1%	60.8%	61.1%	

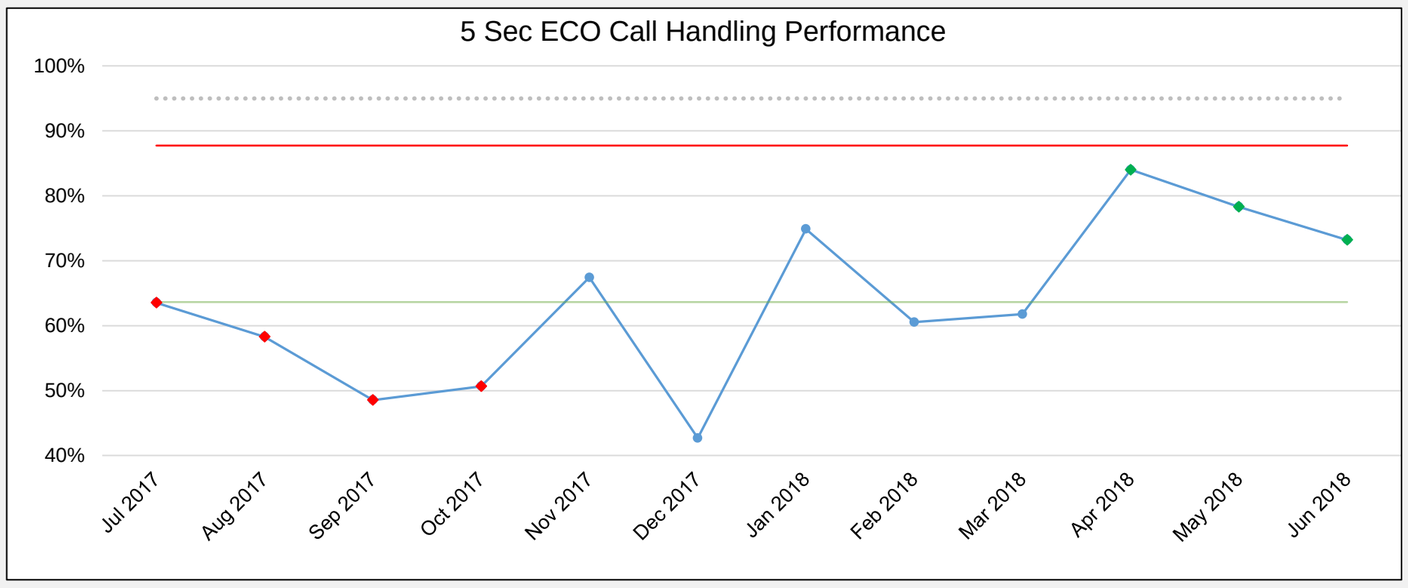
Community First Responders

	Apr-18	May-18	Jun-18	12 Months
Volume of Incidents Attended	1608	1556	1664	

Demand/Supply AQI

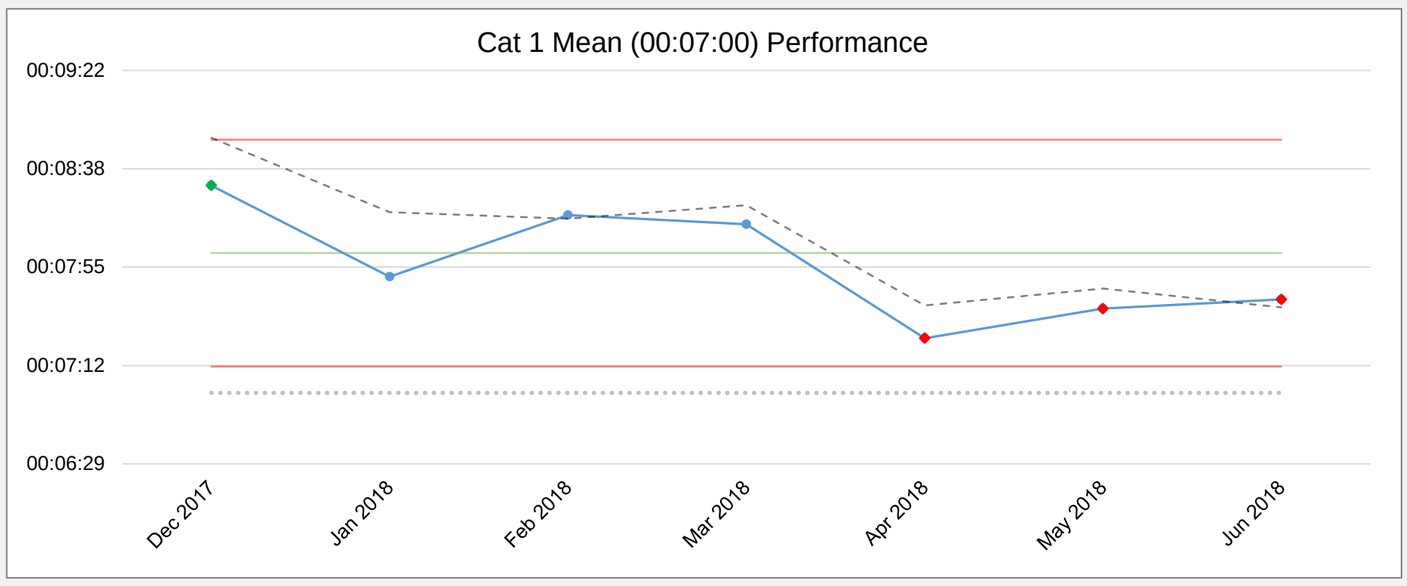
	Apr-18	May-18	Jun-18	12 Months
Calls Answered	58773	64186	62205	
Incidents	57890	60189	57556	
Transports	35368	36587	35168	

SECAmb 999 Operations Performance Charts



Call answering performance for June has continued to fall below an average of 80%. The volume of duplicate calls regarding ETA of responses is a major contributor to increase call volumes. In the short term, scrutiny on all forms of abstraction is being analysed to maximise resourcing with sickness absence being tightly managed and is consistently below 5% for the YTD within Operations.

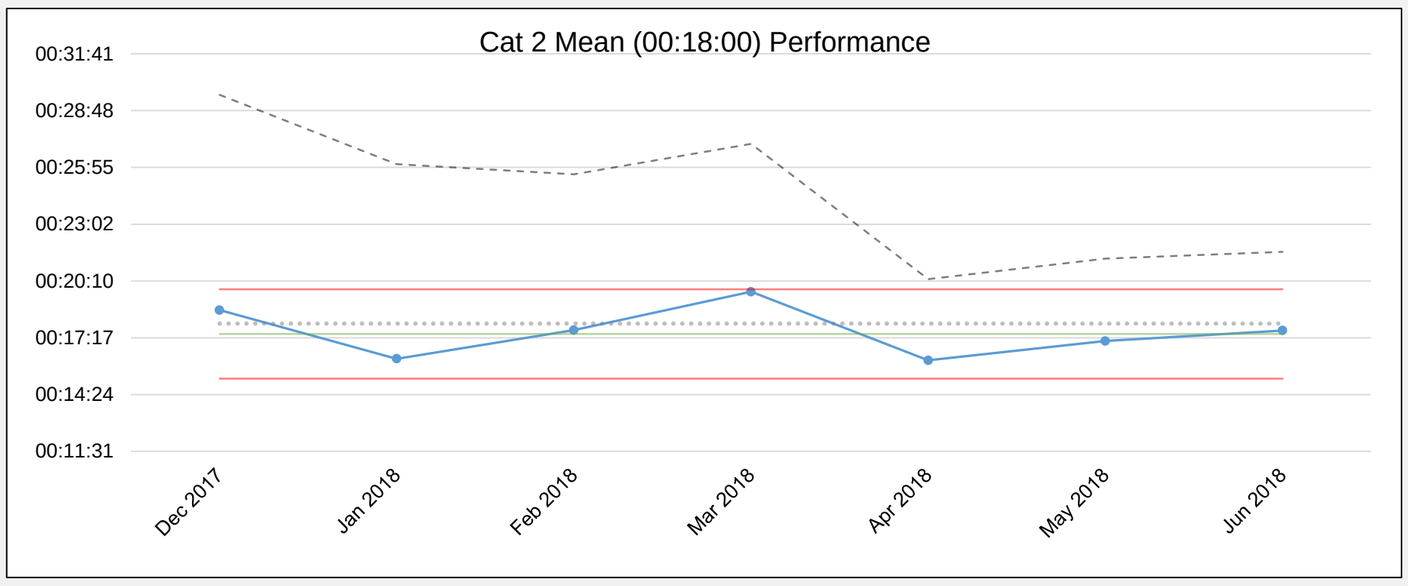
Call answer performance is covered in detail in the EOC action plan that is tracking the actions of the EOC task and finish group to address the CQC must do requirement of demonstrating improvement against this key target, along with recruitment and staff retention. Significant scrutiny is still being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



As shown in the graph the Cat 1 mean response performance has increased by 4 seconds on the previous month. Whilst we are not yet delivering the ambulance response program (ARP) target of seven minutes, both our mean performance and 90th percentile performance are tracking consistently within the middle of the pack when measured against all other English ambulance services. This consistency in delivery demonstrates the significant focus given to the high acuity patient groups.

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

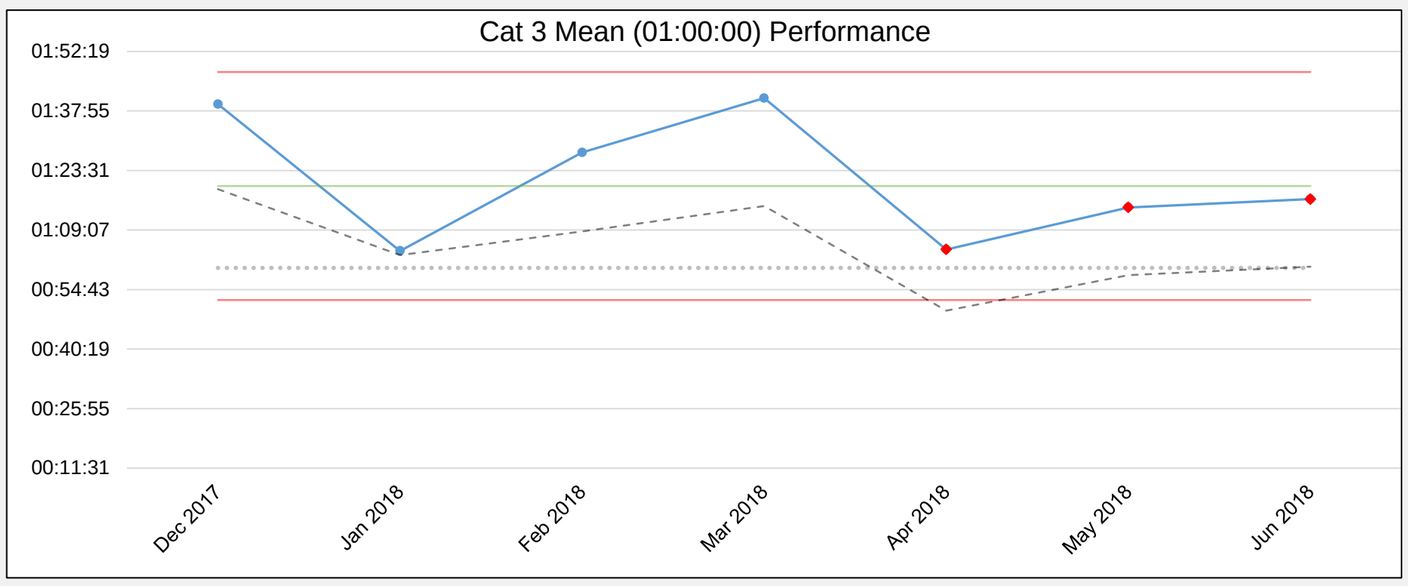
----- National Mean



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

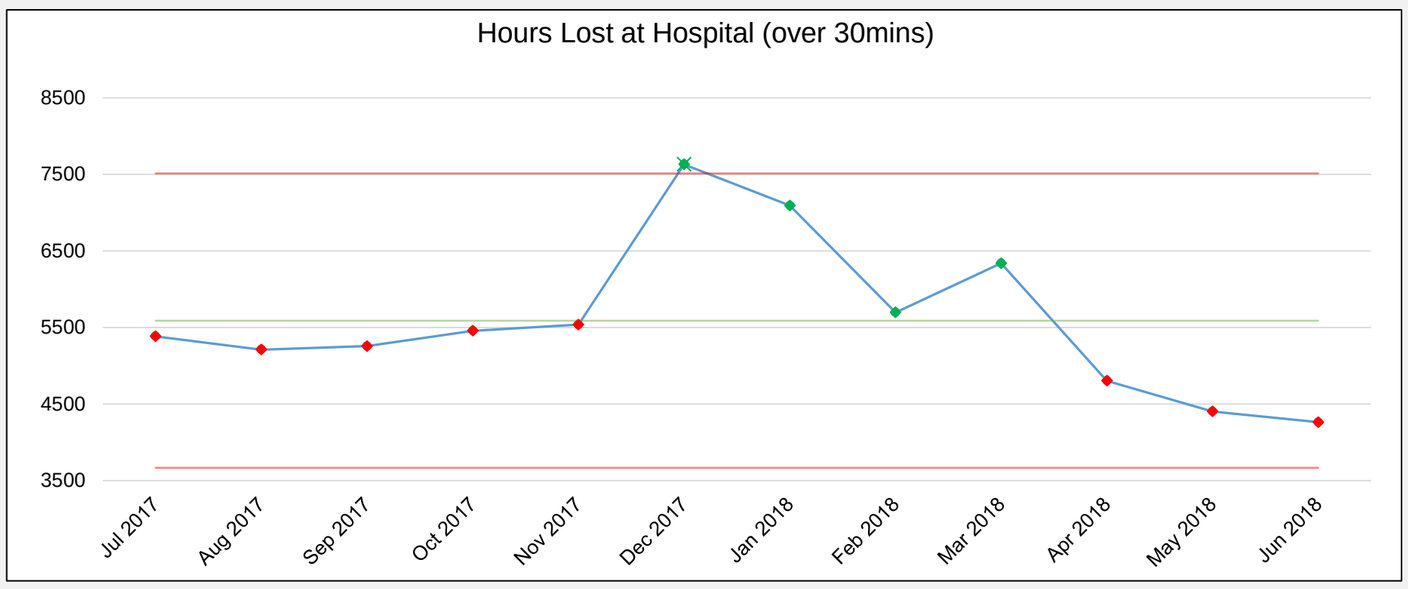
This improvement alongside the other metrics recorded for June have been influenced by the reduction in activity as the winter pressures have eased and in particular a significant reduction in lost hours through hospital handover delays providing more available resource to meet this reduced activity. However, this should be balanced by the Duplicate Calls, the volume of which are significant.

----- National Mean



Cat 3 mean has been included to provide the Board with oversight on the significant pressure against the performance requirements for this patient group.
Since the introduction of the Ambulance Response Program (ARP) in late November 2017 performance against the Cat 3 standard has been extremely challenged, this is a clear measure of the well rehearsed arguments surrounding the 'right sizing' of the response capabilities of SECAmb and whilst we have seen a significant improvement on both the mean and 90th centile performance targets for this patient group compared with March, we still remain in the bottom quartile when compared with the other English Ambulance Trusts.
As highlighted SECAmb have invested heavily in obtaining new fleet that will be deployed to respond better to Cat 3/4 cohort of patients.

----- National Mean



The hours lost to operational response capability through hospital delays for June continues to improve at 4263 compared to 4400 in May.

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

Whilst this reduction is a significant success for June it is still accounted for an average of 1050 hours a week.

Further plans on crew to clear are being developed to improve any future lost hours.

SECAmb Operations 111 - Safe

Safety remains a key priority for 111 with performance continually monitored and reviewed. This is best demonstrated by the Operational Recovery Plan (ORP) created by the service to combat a deteriorating level of operational performance in Quarter 4 (Q4) of 17/18. Risk management is embedded across the whole service with good levels of reporting for incidents on Datix and a consistently high rate of successful completion of incident investigations. The level of complaints remained static across Q1 18/19, despite an increased level of service activity experienced year on year. Once again, no complaint reports were breached in terms of investigation responses back to the Trust's Patient Experience Team.
The service continues to refine its staff workforce planning tool to deploy resource and prioritise when call handlers (especially clinicians) are most needed to meet demand, even with the erratic call profiles and fluctuating demand which we have continued to experience in the first half of 18/19, often weather-related. The service has also managed to continue to deliver a stable level of service despite significant changes in terms of the operating configuration undertaken by our service provider partner.

SECAmb Operations 111 - Caring

The service's mission statement is "Caring for Patients and Each Other" and this remains central to the service's ethos. A huge effort has been made with regards to staff engagement and this has resulted in the creation of a "Culture Club" in the service's Ashford 111 Contact Centre. Fortnightly meetings of the Culture Club have been held throughout Q1 of 18/19. This forum is aimed at facilitating colleague feedback and enabling a more collaborative approach to dealing with issues, concerns and opportunities that arise in the service and at the Ashford site. The introduction of a designated staff room (the Little Well-Being Room) with an ambient atmosphere designed to "de-stress" colleagues has been incredibly popular and beneficial. There has also been a number of other initiatives which are on-going in terms of engagement with external stakeholders to improve the patient experience and also with respect to making the 111 Contact Centre a more enjoyable place to work and this includes Coaching Booths, a "relaxation" break-out area and the initiation of a Gardening Club for all our colleagues in Ashford. The service has also fully embraced the re-launch of the Trust Values with the associated livery mounted across the contact centre to raise staff awareness and to ensure that this remains alive

SECAmb Operations 111 - Effective

Daily, weekly and monthly monitoring and analysis is undertaken to benchmark the service against its contractual Key Performance Indicators (KPI's) and against National NHS E 111 performance. The service continues to work in collaboration with its Commissioners to address any issues and the current Operational Recovery Plan (ORP) was written in conjunction with Commissioners and progress against this is reviewed on a weekly conference call for which an action log is maintained. The service also has senior managers present on the Trust's Hear & Treat Programme Board whilst the Joint Commissioner Pilot (JCP) of 111/999 integration, which commenced in 17/18 has continued in to this financial year with best practice from both 111 and 999 being shared across services. Although the service has not yet returned to achieving its full operational KPI's, its performance in 2018/19 is significantly better than the second half of 2017/18 and is moving in the right direction.

SECAmb Operations 111 - Responsive

The service continues to reach out and engage with all stakeholders including Patients, Commissioners, NHS E and other providers. An example of this was the collaboration with another local provider to develop a specific script to manage patient expectations for that service when it is in escalation. The same process has been replicated for our own 999 service when it is in elevated levels of escalation for the Surge Management Plan (SMP). This has been particularly useful throughout Q1 of 18/19 when our 111 service has been able to protect multiple providers (including 999) when there was a period of incredibly high demand within the urgent and emergency care system.
The service has detailed recruitment and retention plans and uses a Workforce Planning tool to endeavour to match resources to demand. Issues such as recruitment, retention and shrinkage are also monitored and included within the service's 111 ORP. Complaints and incidents in relation to the 111 service are managed effectively and the learning and improvements which are subsequently identified, are shared and embedded within the service and across the Trust to promote best practice. A monthly bulletin and poster is shared with all colleagues identifying the learns from the previous month and also sharing the compliments and positive comments made about the service and our colleagues.

SECAmb Operations 111 - Well Led

The service has a clearly defined Management Structure in place with daily and weekly meetings taking place to ensure that the service's Senior Leadership Team (SLT) has a clear understanding of performance, risks and what actions are required to ensure that the service stays on track with its plans. The SLT has developed an Operational Recovery Plan (ORP) in collaboration with Commissioners which has provided a clear focus on what actions are required to deliver the level of performance and milestones that patients and all stakeholders (internal and external) have a right to expect.
The Governance meetings, both internal and external continue to take place with risks noted and opportunities explored, to ensure that patient safety and quality is maintained and this includes the service's Quality and Patient Safety Group which meets every six weeks. KMSS 111 remains clinically-led and the service continues to be fully compliant with its NHS Pathways license requirements (including with respect to NHS Pathways audit), this is despite the challenges of incredibly high service activity and erratic call volume profiles during Q1 of 18/19.

SECAmb 111 Operations Performance Scorecard

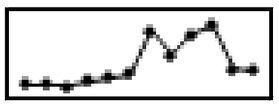
Calls Offered

	Apr-18	May-18	Jun-18	12 Months
Actual	93916	92737	84042	
Previous Year	99575	91789	78212	

Calls answered in 60 Seconds

	Apr-18	May-18	Jun-18	12 Months
Actual %	73.6%	74.0%	71.7%	
Previous Year %	95.5%	91.1%	88.4%	
Target %	95%	95%	95%	

Calls abandoned - (Offered) after 30secs

	Apr-18	May-18	Jun-18	12 Months
Actual %	4.8%	4.7%	4.8%	
Previous Year %	0.5%	1.0%	1.2%	
Target %	2%	2%	2%	

Combined Clinical KPI

	Apr-18	May-18	Jun-18	12 Months
Actual %	68.9%	68.6%	64.5%	
Previous Year %	80.4%	74.0%	73.0%	
Target %	90%	90%	90%	

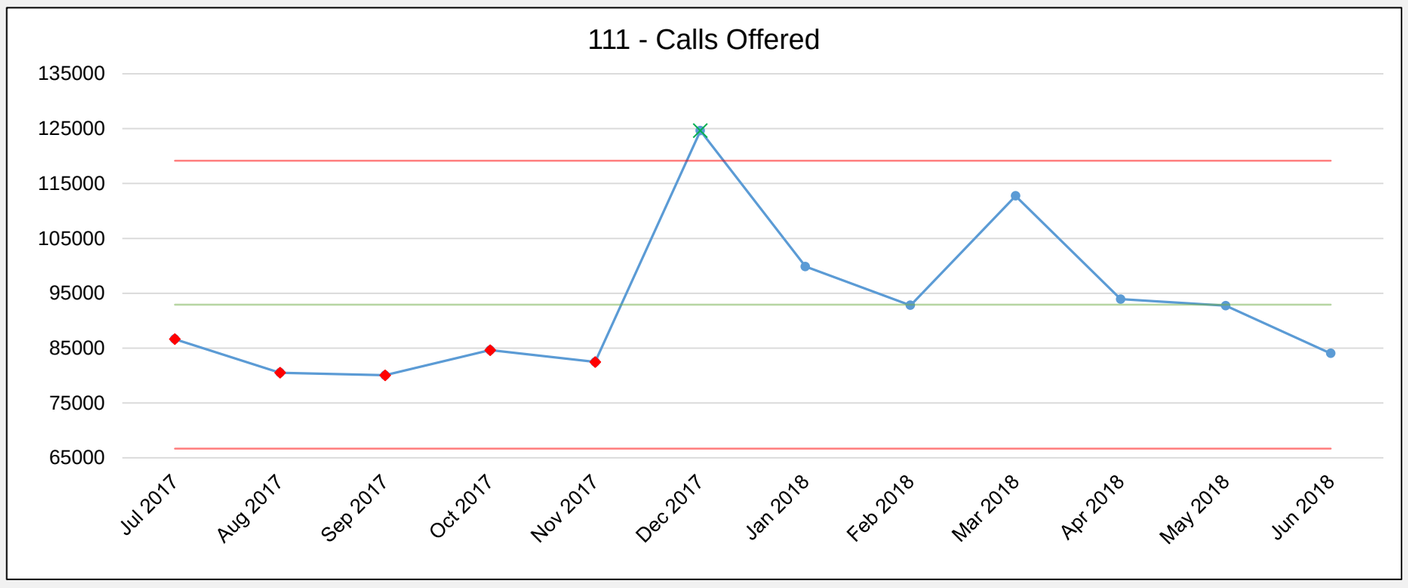
999 Referrals

	Apr-18	May-18	Jun-18	12 Months
999 Referrals % (Answered Calls)	10.9%	10.7%	11.2%	
999 Referrals (Actual)	9578	9311	8828	
National	10.7%	10.7%		

A&E Dispositions

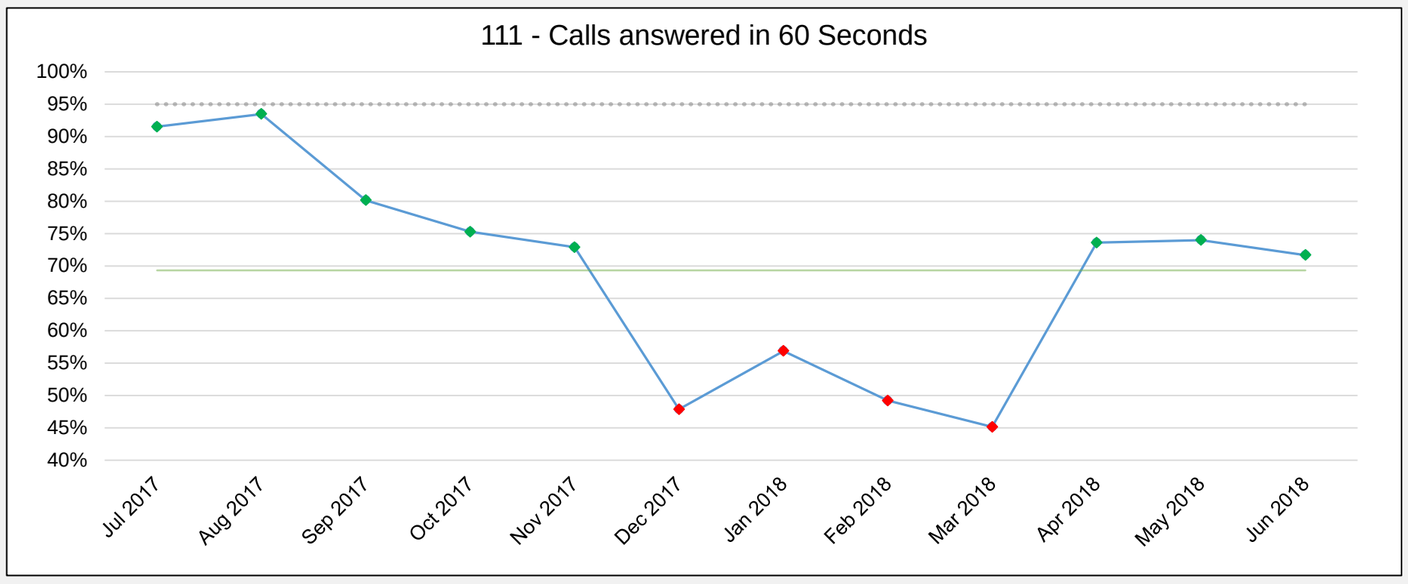
	Apr-18	May-18	Jun-18	12 Months
A&E Dispositions % (Answered Calls)	7.2%	7.9%	8.4%	
A&E Dispositions (Actual)	6337	6890	6582	
National	7.7%	8.1%		

SECAmb 111 Operations Performance Charts



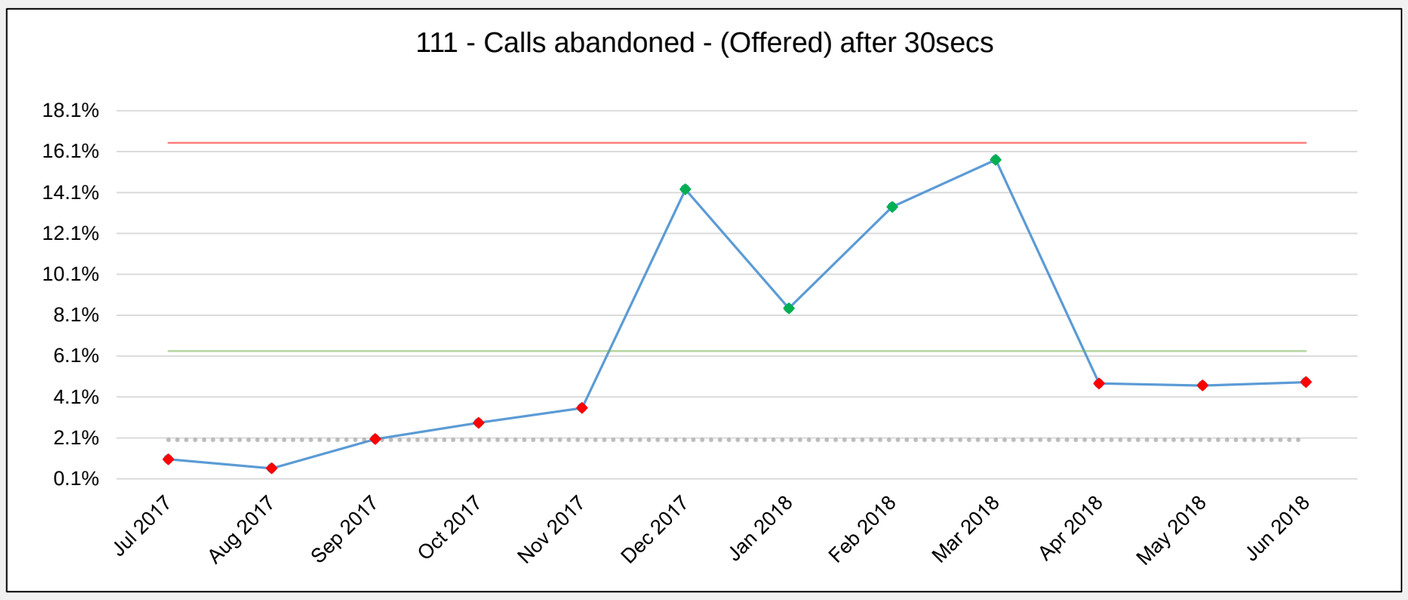
The monthly Call Volume of 84042 for June 2018 represented a like-for-like increase of 5% against June 2017. This increase was mostly concentrated into the final week of the month as heatwave volumes and differential call profiles commenced during w/c Monday 25th June.

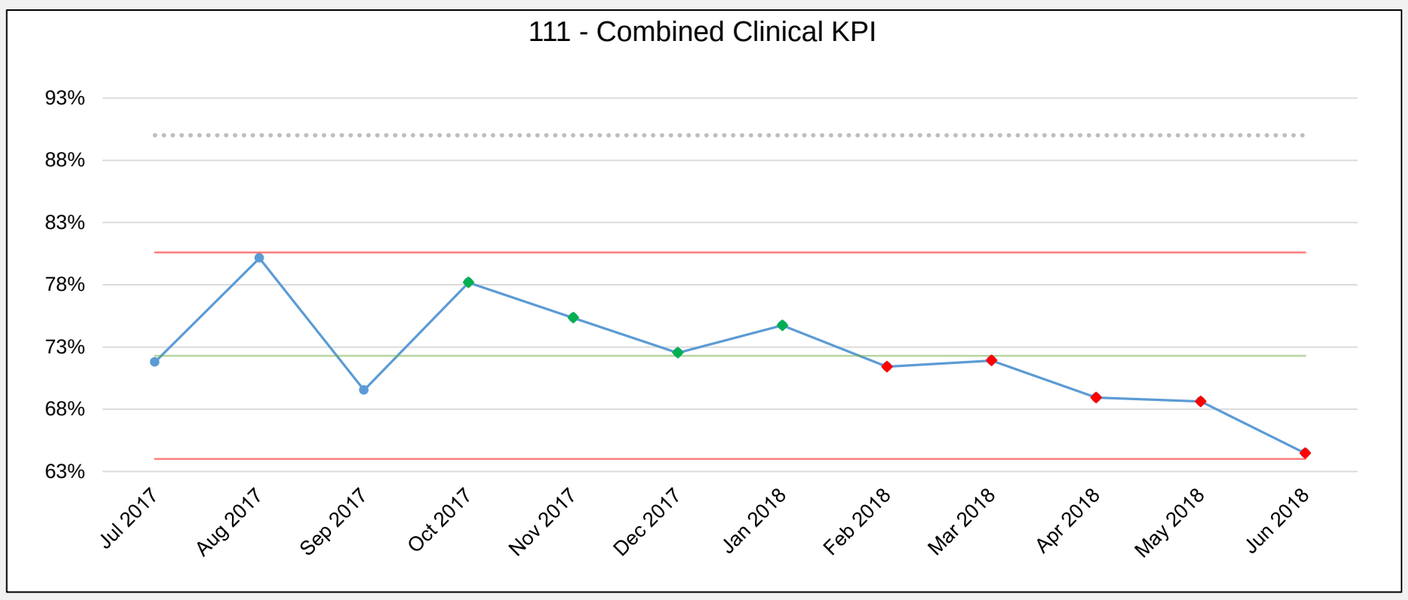
The service succeeded in avoiding a significant increase in Speed to Answer, coming in at 65 seconds for the month.



KMSS 111's service level fell by circa 2% due predominantly to the exceptional volumes in the final week of the month. This small decline in service level was replicated at a national level.

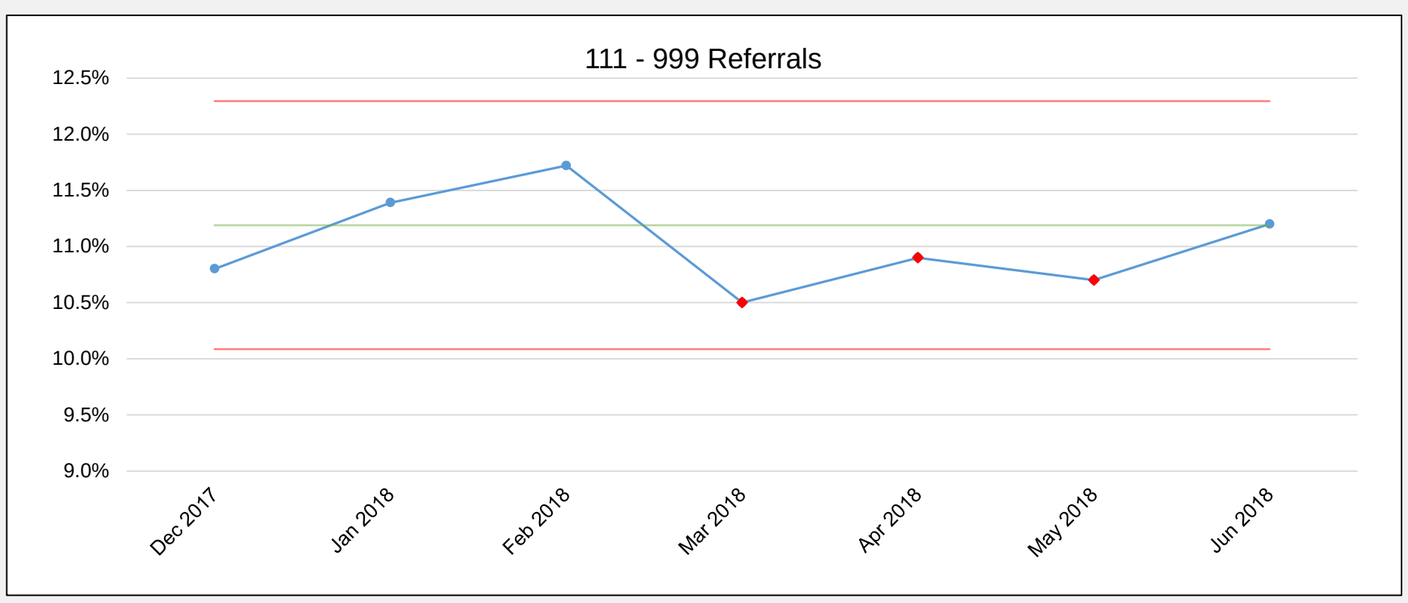
In addition to higher than expected call volumes and unusual call profiles, the service also focused on significant training commitments (e.g. Pathways v15) which had an impact on the Operational Performance. Additionally the service regularly allocated Health Advisors to act as Patient Safety callers during SECAmb escalation, compromising our Operational Performance but maximising support for the wider system.





Clinical performance fell slightly compared to the previous month, but again this was replicated nationally, and KMSS continues to outperform other National 111 / IUC providers in a clinical context.

Our Clinical Inline Support faced very high activity due to the twelve days in which Surge Management Plan (SMP) escalation was invoked. We activated the "No Send" policy for Category 3 and Category 4 ambulance dispositions and ensured that these dispositions were ratified or downgraded, via the CIS or via the clinical queue.



The KMSS 111 Ambulance referral rate was slightly higher than the National Average in June, despite the significant amount of mitigation as described above.

Conversely our referral rate to A&E services was lower than the National Average. These two metrics are directly linked, and the combined referral rate compares favourably with other providers.

SECAmb Workforce - Safe

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

Resourcing have formulated a Resourcing Task and Finish Group, focusing on delivery of 200 Emergency Care Support Workers (ECSW) and 100 Associate Ambulance Practitioners (AAPs). This uplift in Operational staffing will assist us with the delivery of operational hours across winter pressures, particularly focusing on Category 3 calls. We are also increasing capacity within EOC to manage duplicate calls. These additional staff will move forward into our workforce trajectory up until 2021.

SECAmb Workforce - Caring

We have reviewed the work and impact of the Well-being Hub. Usage levels have been high and the combined focus particularly through Mental Health Advisors and Physiotherapists has been very positively received. Anecdotally the Well-being Hub is also contributing to staff feeling it is a safe place with appropriate confidentiality and support. The Executive Management Board (EMB) have now agreed to make the provision of the Hub permanent.

SECAmb Workforce - Effective

The HR Transformation Programme has specific outcomes to improve the effectiveness of the HR function. The process re-design work will ensure that we have people processes that are measurable and improvable as part of the design to ensure good value and continuous improvement. The Process Improvement project has recently recruited a Process Improvement Analyst that will be mapping and designing the recruitment process.

SECAmb Workforce - Responsive

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

SECAmb Workforce - Well Led

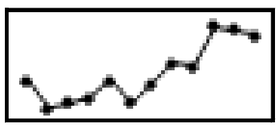
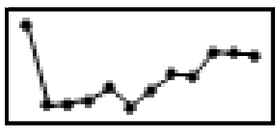
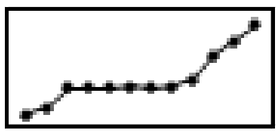
The Culture Change Programme mandate and improvement details the 4 key objectives that the Plan will deliver by 30 April 19. These are built around the 4 main work streams which are Communication, Engagement, Behaviours and Infrastructure. The key activities have focused to date on the delivery of Behaviour Management Leadership Training which has now been completed by the Executive Team, Senior Leadership Team (SLT), Operating Unit Managers (OUMs) and is now being rolled out to the remainder of the Trust starting with the Operational Team Leaders (OTLs) and Operating Managers (Oms) at the end of August. The Executive Team and SLT have also completed 5 1:1 coaching sessions and 360 degree feedback. The Executive Team have completed team development days.

In conjunction with the HR team delivery of a Bullying & Harassment Workshop to support both Managers and Staff will commence in Sept 18.

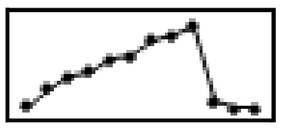
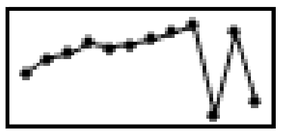
The Pulse Survey Quater 1 results are now out and this shows an increase from 47% in 2017 to 63% in 2018 of staff that completed the survey stating that The Executive Team leads the Organisation effectively. There is also an increase in My Local Leadership is Effective which an increase from 2017 of 65% to 70% in 2018.

SECAmb Workforce Scorecard

Workforce Capacity

	Apr-18	May-18	Jun-18	12 Months
Number of Staff WTE (Excl bank & agency)	3118.3	3114.1	3107.7	
Number of Staff Headcount (Excl bank and agency)	3381	3377	3375	
Finance Establishment (WTE)	3552.29	3563.29	3576.89	
Vacancy Rate	12.23%	12.63%	13.08%	
Vacancy Rate Previous Year	10.75%	11.85%	12.37%	
Adjusted Vacancy Rate + Pipeline recruitment %	8.09%	7.78%	7.16%	

Workforce Compliance

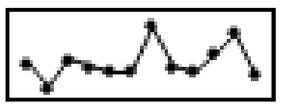
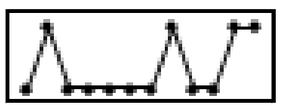
	Apr-18	May-18	Jun-18	12 Months
Objectives & Career Conversations %	23.65%	17.42%	18.11%	
Target (Objectives & Career Conversations)	80.00%	80.00%	80.00%	
Statutory & Mandatory Training Compliance %	6.54%	85.68%	18.11%	
Target (Stat & Mand Training)	95.00%	95.00%	95.00%	
Previous Year (Stat & Mand Training) %	8.26%	23.49%	38.55%	

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

Workforce Costs

	Apr-18	May-18	Jun-18	12 Months
Annual Rolling Turnover Rate %	16.50%	17.42%	15.17%	
Previous Year %	16.65%	16.34%	17.85%	
Annual Rolling Sickness Absence	5.26%	5.12%	5.21%	
Target (Annual Rolling Sickness)	5.00%	5.00%	5.00%	

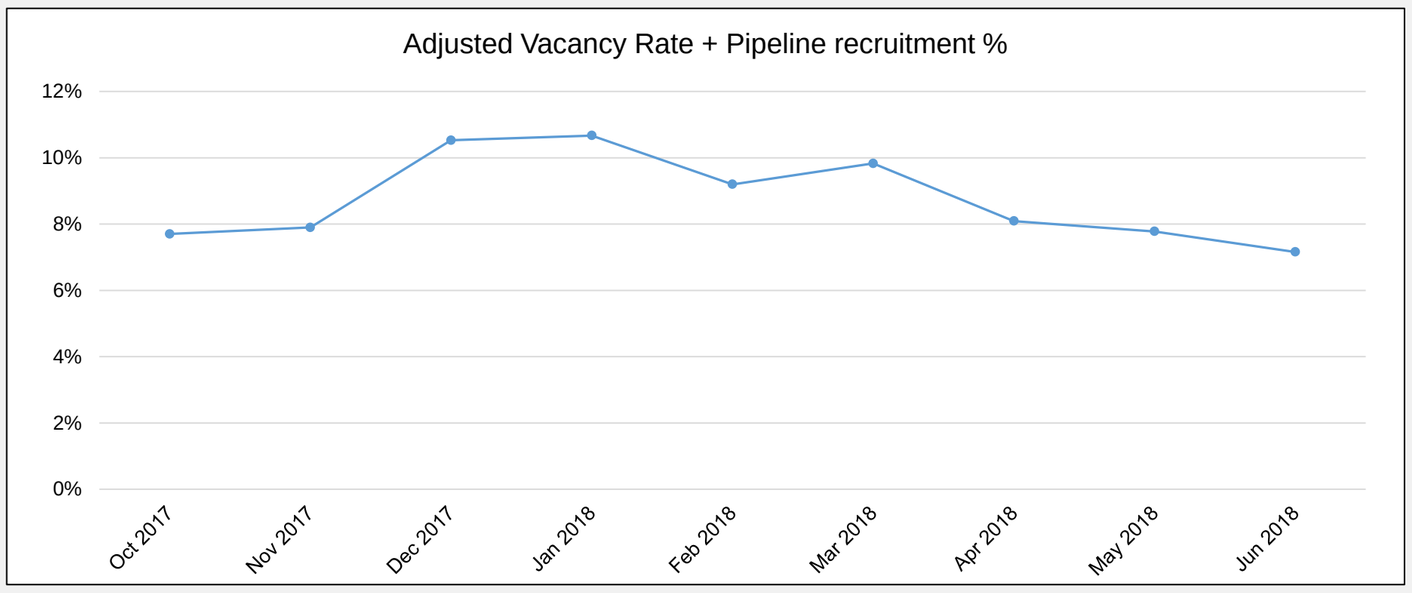
Employee Relations Cases

	Apr-18	May-18	Jun-18	12 Months
Disciplinary Cases	9	2	14	
Individual Grievances	9	14	4	
Collective Grievances	1	2	4	
Bullying & Harassment	2	3	5	
Bullying & Harassment Prev Yr	1	1	0	
Whistleblowing	0	1	1	
Whistleblowing Previous Year	0	0	0	

Physical Assaults (Number of victims)

	Apr-18	May-18	Jun-18	12 Months
Actual	22	13	14	
Previous Year	19	14	16	
Sanctions	5	4	6	

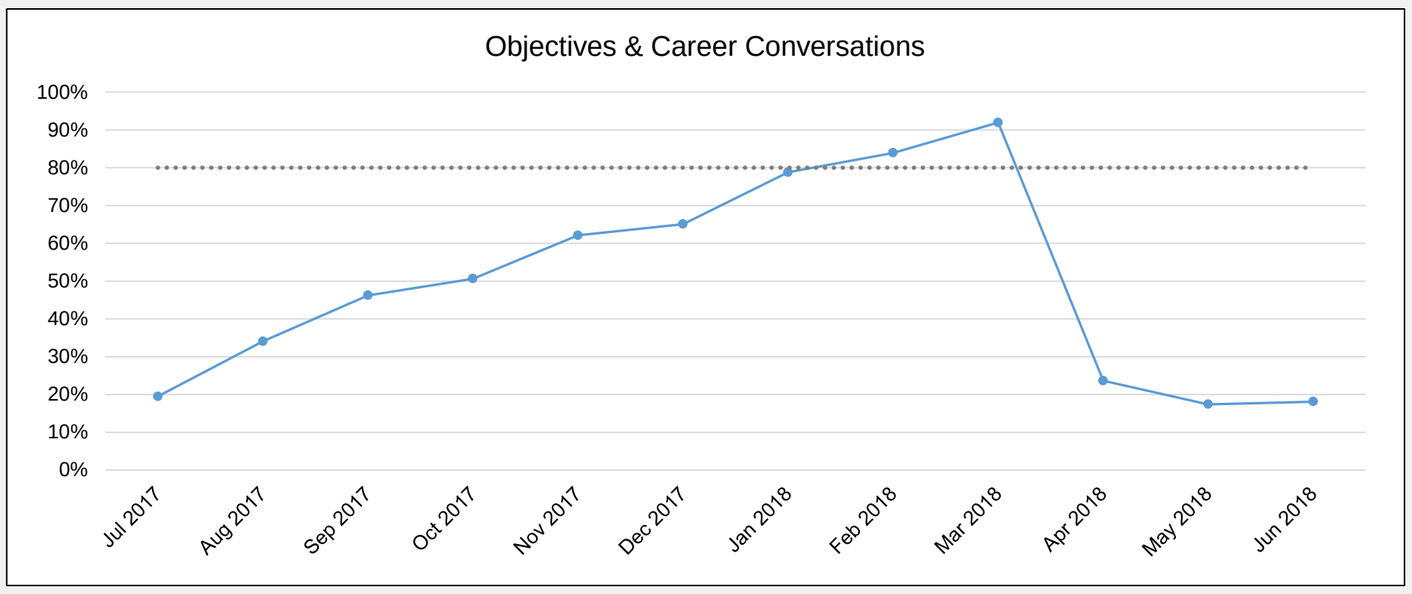
SECAmb Workforce Charts



The assessment process has been reviewed to ensure more candidates can be invited to recruitment assessment centres (from 20 to 60).
The on-going and increased numbers being invited to assessment centres have resulted in a continued increase in the pipeline (offers of employment) which supports the sustained decrease in vacancies for May and June.

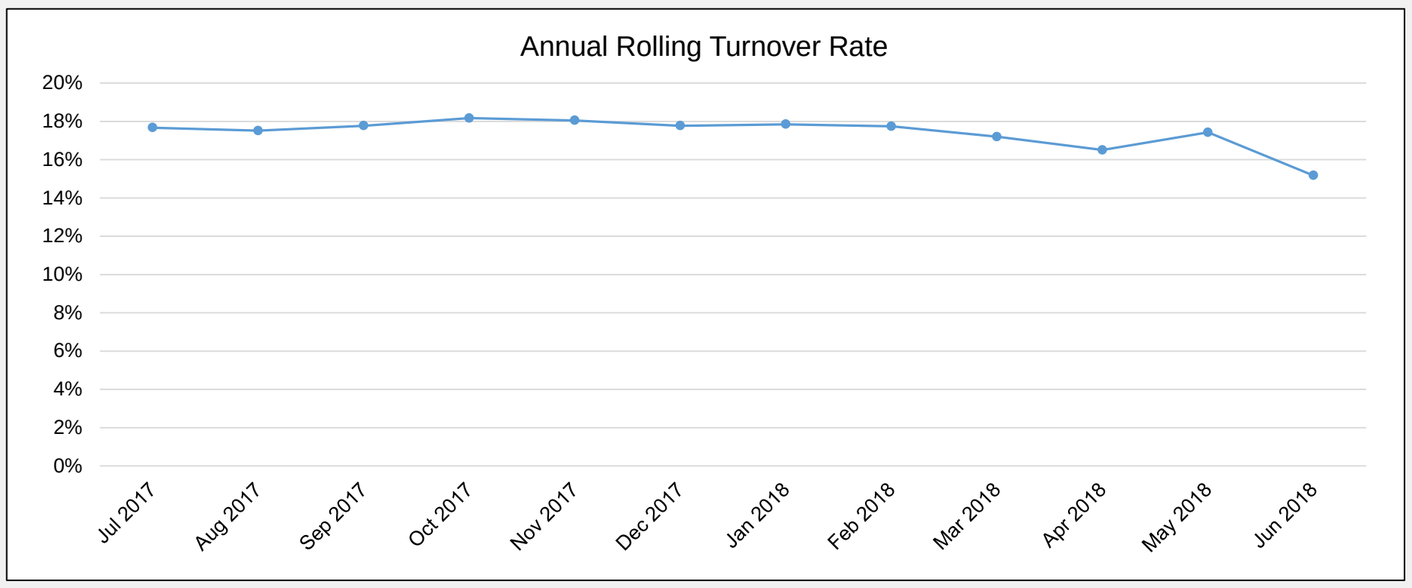
The C1 business case has been signed off. This will help to attract the additional 300 external ECSWs and AAPs.

A set of resourcing principles have been agreed and are in the process of being updated *into an action plan for roll out and sharing across the Trust.*

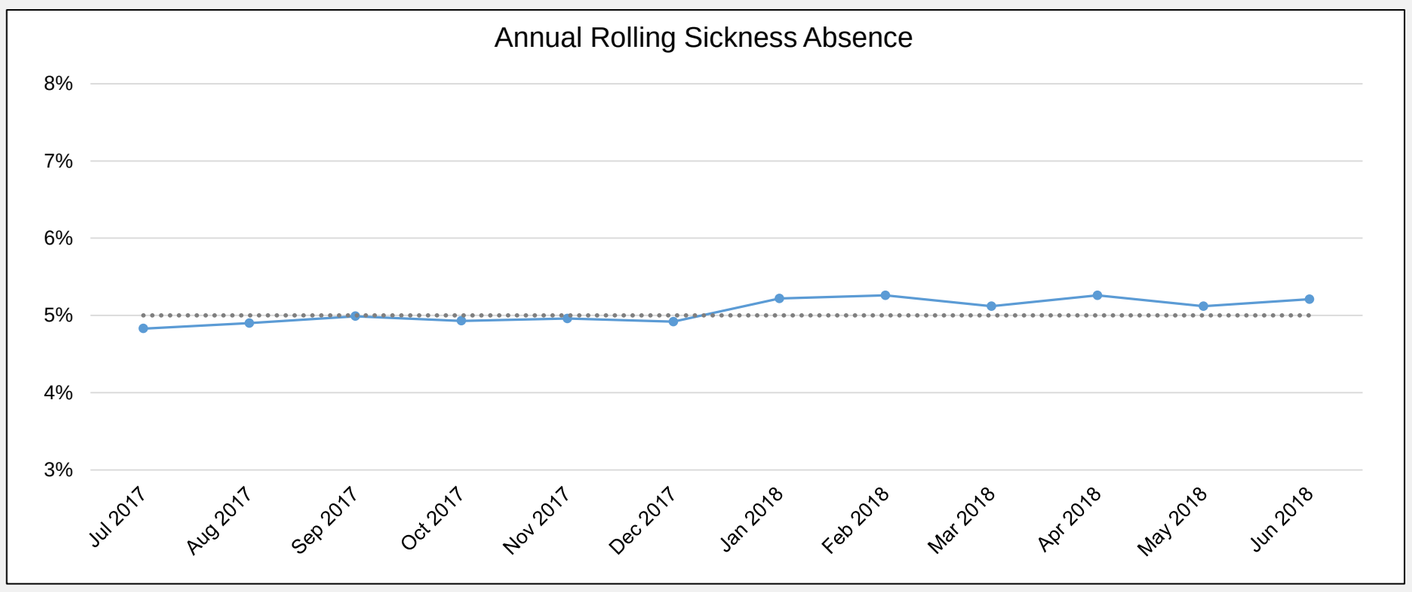


The appraisal cycle runs from April on an annual basis. Early figures started positively recording 23.65% in month one. A negligible drop to 23.43%, is recorded in May and June. This variance was due to a realignment of data collection and a change in the data collection parameters. Only published appraisals were totalled; agreed completed objectives removed.

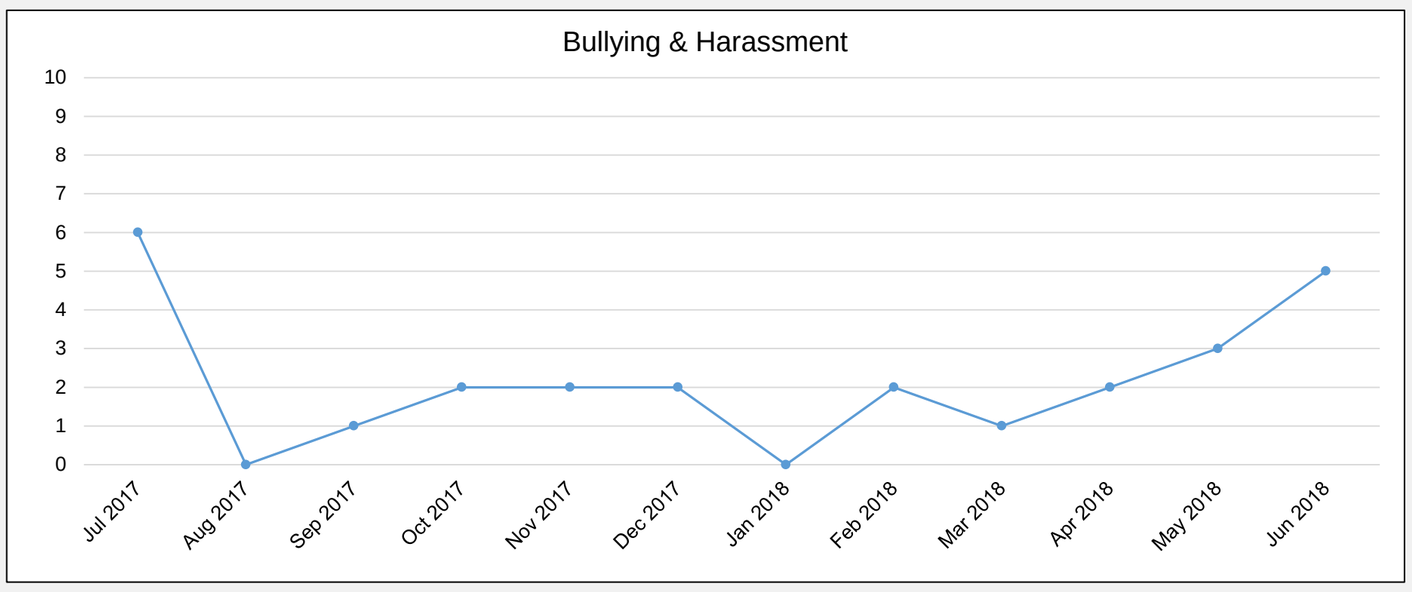
We aim to achieve an increase of 10% compliance each month. Regular progress reporting to managers will enable them to maintain focus on this target.



Whilst there has been a reduction in turnover, this is an indicator that is key in building our workforce in line with the Demand and Capacity Review. We will be tracking the impact of the Culture Programme on turnover and how that is contributing to workforce growth.



Monitoring sickness levels will become a measure tracked within the Culture Programme. There are a number of actions that we are taking to improve the effectiveness of the management of sickness, grievances, and disciplinary cases. This includes a review of our approach to Employee relations and how we support managers when we implement or amend our policies



There was an increase in Bullying and Harassment (B&H) cases reported in June. We believe that staff are becoming more willing to discuss and report issues in relation to B&H. We are now piloting a new approach to rolling out the leadership training related to our refreshed values. This includes specific components on B&H. We have run an initial workshop with the senior operational leadership team, and then focused on development for the team of Operational Team Leaders (OTLs).

SECAmb Finance Performance Scorecard

Income

	Apr-18	May-18	Jun-18	12 Months
Actual £	£16,830	£ 17,205	£ 17,208	
Previous Year £	£ 15,229	£ 16,174	£ 16,132	
Plan £	£16,983	£ 17,566	£ 17,258	

Expenditure

	Apr-18	May-18	Jun-18	12 Months
Actual £	£ 17,794	£ 17,756	£ 18,069	
Previous Year £	£ 16,126	£ 16,673	£ 16,704	
Plan £	£ 18,001	£ 18,131	£ 18,138	

Capital Expenditure

	Apr-18	May-18	Jun-18	12 Months
Actual £	£ 299	£ 142	£ 1,589	
Previous Year £	£ 268	£ 670	£ 582	
Plan £	£ 391	£ 401	£ 1,180	
Actual Cumulative £	£ 299	£ 441	£ 2,030	
Plan Cumulative £	£ 391	£ 792	£ 1,972	

Cost Improvement Programme (CIP)

	Apr-18	May-18	Jun-18	12 Months
Actual £	£ 392	£ 308	£ 519	
Previous Year £	£ 899	£ 910	£ 1,302	
Plan £	£ 402	£ 402	£ 1,190	
Actual Cumulative £	£ 392	£ 700	£ 1,219	
Plan Cumulative £	£ 402	£ 804	£ 1,994	

CQUIN (Quarterly)

	Q4 17/18	Q1 18/19	Q2 18/19
Actual £	£ 846	£ 847	£ 283
Previous Year £	£ 952	£ 1,019	£ 716
Plan £	£ 848	£ 848	£ 283

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

Surplus/(Deficit)

	Apr-18	May-18	Jun-18	12 Months
Actual £	-£ 964	-£ 551	-£ 861	
Actual YTD £	-£ 964	-£ 1,515	-£ 2,376	
Plan £	-£ 1,018	-£ 565	-£ 880	
Plan YTD £	-£ 1,018	-£ 1,583	-£ 2,463	

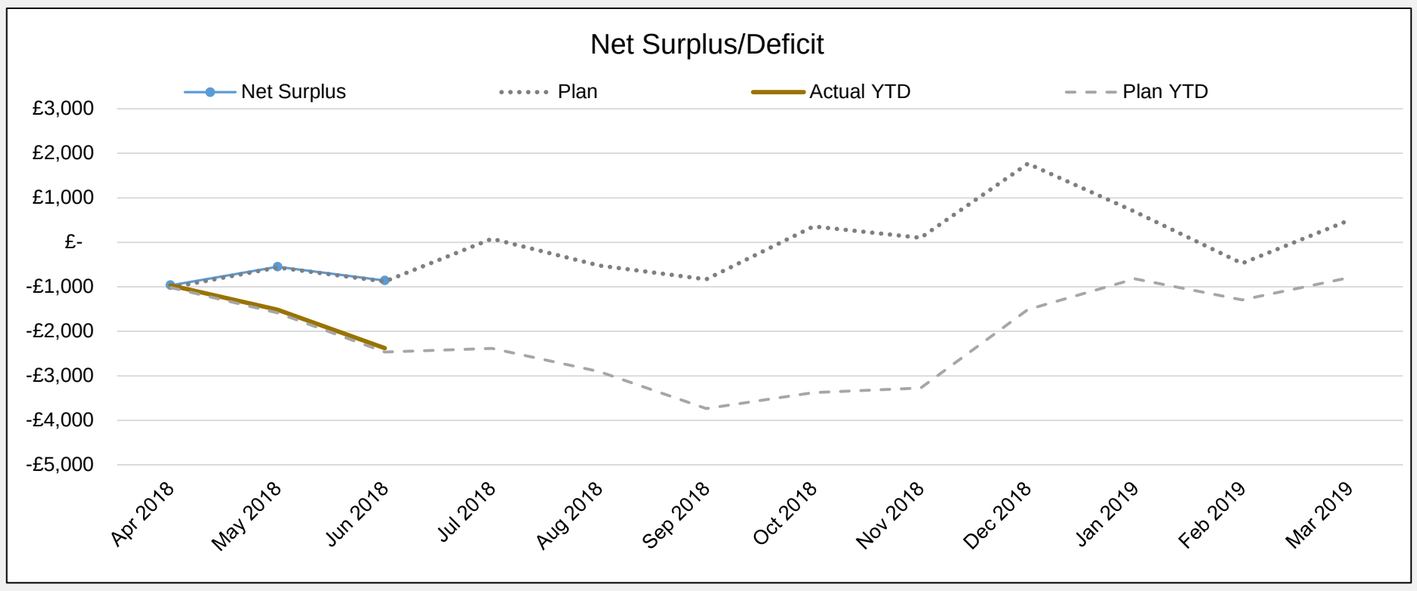
Cash Position

	Apr-18	May-18	Jun-18	12 Months
Actual £	£ 19,244	£ 21,762	£ 22,527	
Minimum £	£10,000	£10,000	£10,000	
Plan £	£ 16,152	£16,428	£16,694	

Agency Spend

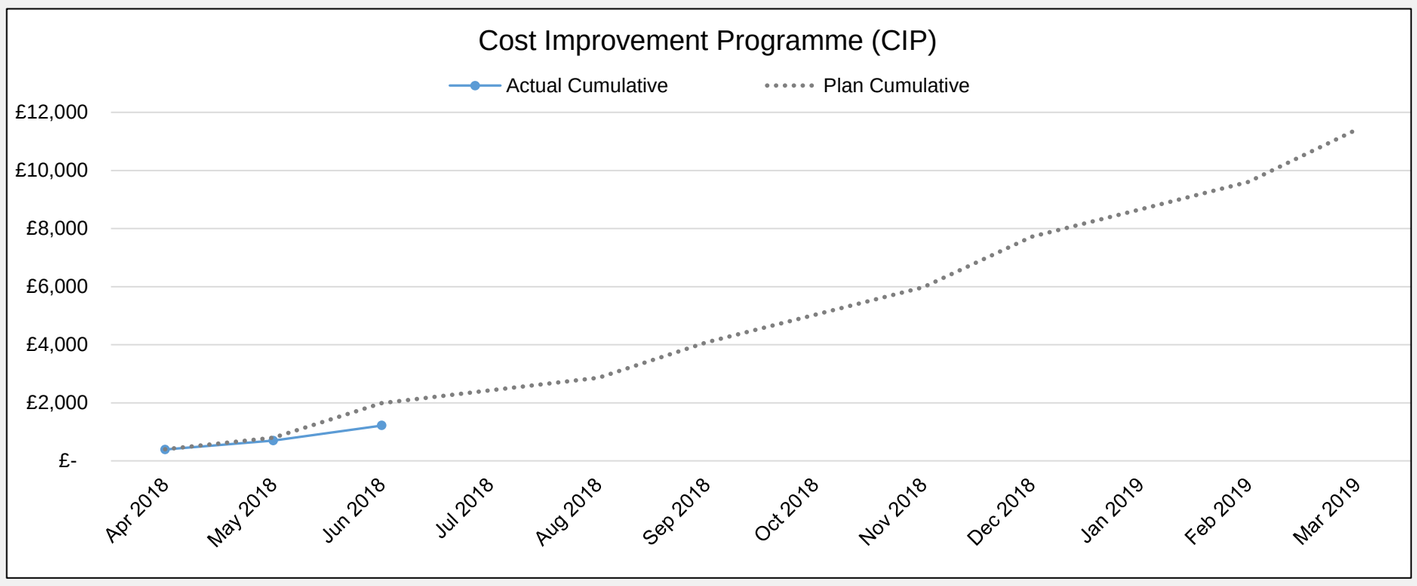
	Apr-18	May-18	Jun-18	12 Months
Actual £	£ 119	£ 329	£ 229	
Plan £	£ 240	£ 236	£ 233	

SECAmb Finance Performance Charts



The Trust's I&E position in Month 3 was a deficit of £0.9m, which was as planned.

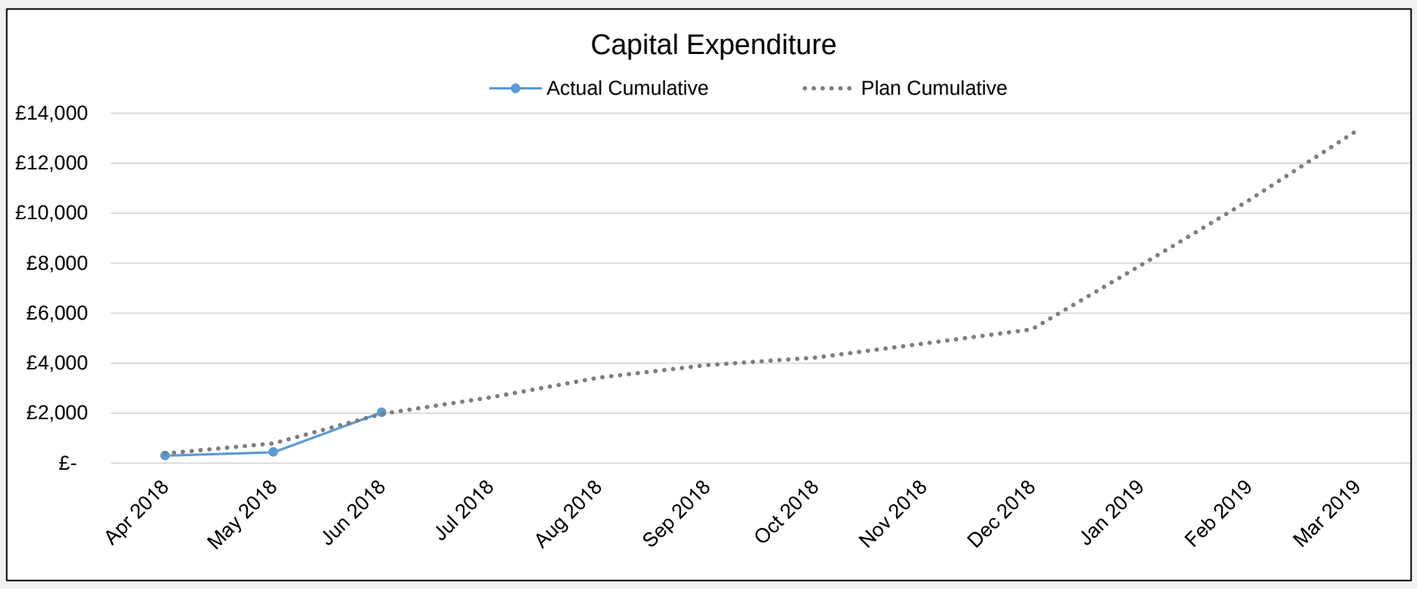
This increased the cumulative deficit to £2.4m, which is £0.1m better than plan.



CIP schemes delivered a benefit of £0.5m in the month compared to the planned level of £1.2m.

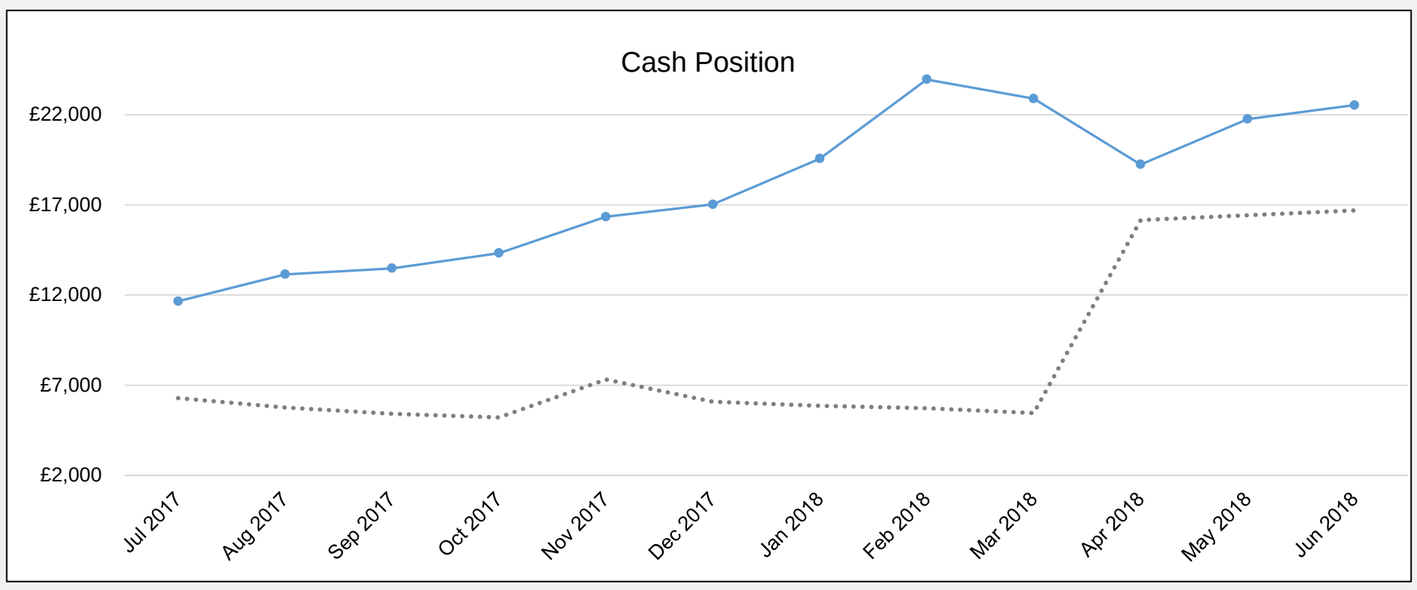
Cumulative CIPs of £1.2m are £0.8m behind plan.

The target for the full year is £11.4m. A number of schemes are being imminently evaluated, following which there is a likelihood that this shortfall will be reduced to £0.2m.



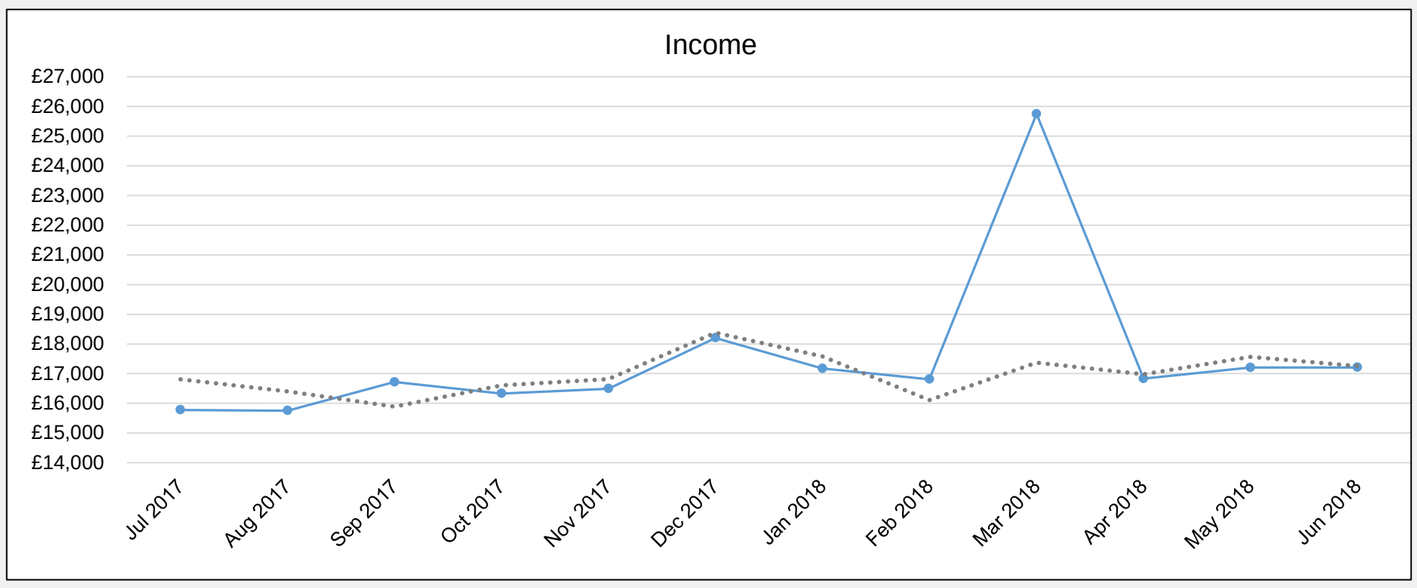
Capital spend in the quarter was £2.0m, marginally above plan.

The Trust has submitted capital bids worth nearly £39m via NHS Improvement as part of the 'Wave 4' capital bidding process managed through and supported by Sustainability and Transformation Partnerships. The invitation to bid is for schemes that will improve performance against ARP targets, both in the current year and longer-term, while also improving efficiency. The main areas being targeted for investment are new and replacement ambulances, expansion of 'Make Ready' facilities and resilience in EOC.



The cash position at 30 June increased further to £22.5m, which was £5.8m better than plan. The year-end balance was £22.9m. Cash is better than plan due to success in collection of trade debt, receipt of 'Commissioning for Quality and Innovation' (CQUIN) reserve funding in respect of 2017/18 and lower than planned payroll costs. The last item is largely one of timing, as catch up in private ambulance invoices will partly offset this benefit in due course.

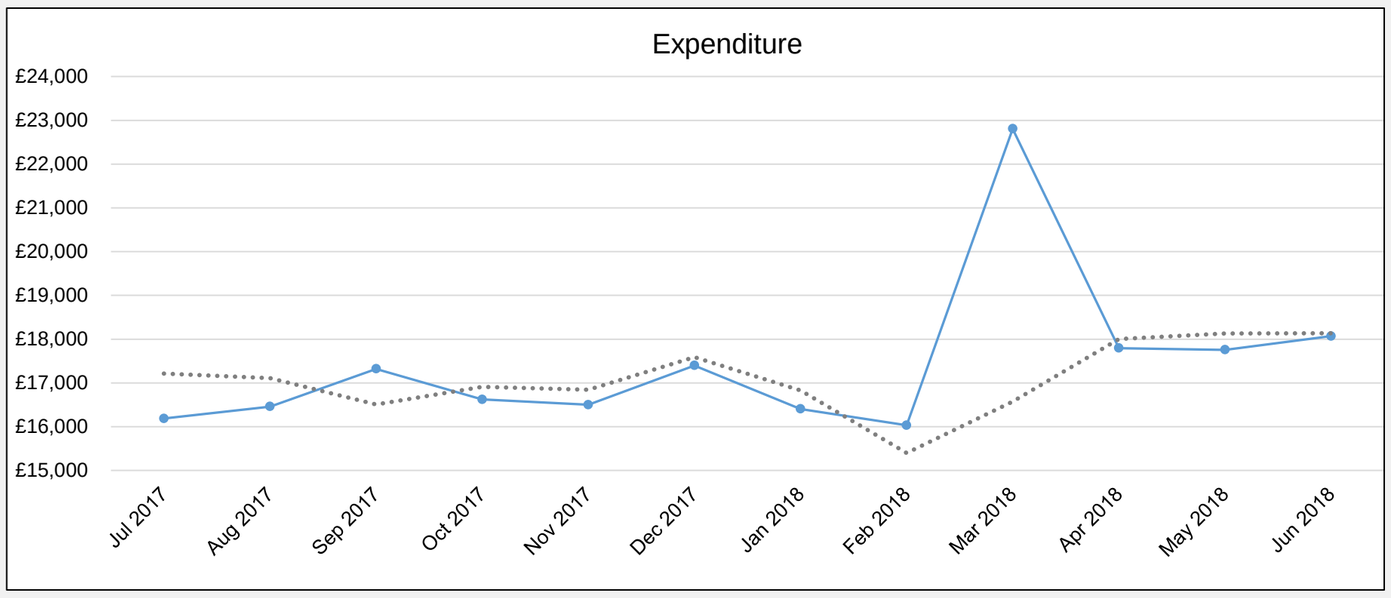
There have been further improvements in performance against public sector payment to suppliers, with 94.7% compliance by value. The target is 95%.



Total Income in the month of £17.2m was very slightly below plan. The cumulative shortfall against plan is £0.6m. The main reason for the shortfall was a £0.3m reduction in income for the East Kent Hospitals (KCH) ambulance divert resulting from a reduced level of resource being applied. A further £0.2m was against Placement Support and Apprenticeship Levy pending confirmation of the Trust's entitlement.

The Trust has assumed full achievement of planned Sustainability and Transformation Funding (STF) in the first quarter, at £0.3m.

SECAmb Finance Performance Charts



Total Expenditure was underspent by £0.1m in month and cumulatively £0.7m better than plan.

Pay costs in the month were underspent by £0.2m. Cumulatively pay costs are underspent by £0.1m, mainly from the reduced availability of resources to support East Kent Hospitals (KCH).

Non-pay costs were close to plan in the month, but are underspent by £0.8m in the three months to date. The two main causes were efficiencies in drugs and consumables £0.2m and the delay in deployment of new leased ambulances £0.4m.

Non-operating costs, were overspent by £0.2m. This was attributable to the delayed timing of planned ambulance station disposals.