South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

28 September 2018
10.00-12.30

Crawley HQ

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
Introduction					
87/18	10.01	Apologies for absence	-	-	DA
88/18	10.01	Declarations of interest	-	-	DA
89/18	10.02	Minutes of the previous meeting: 30 August 2018	**Y**	Decision	DA
90/18	10.03	Matters arising (Action log)	**Y**	Decision	DA
91/18	10.05	Patient Story	-	Set the tone	DA
92/18	10.10	Chief Executive's report	**Y**	Information	DM
Trust strategy					
93/18	10.20	Delivery Plan Deep Dives: ▪ EOC / Call answer performance ▪ Incident Management	**Y**	Information	SE JG BH
94/18	10.50	Clinical & Quality Enabling Strategy	**Y**	Decision	FM
95/18	11.00	Mental Health Provision Business Case	**Y**	Decision	BH
Governance & Risk Management					
96/18	11.10	Audit Committee Escalation Report	**Y**	Information	AS
97/18	11.20	Board Assurance Framework Risk Report	**Y**	Decision	PL
98/18	11.30	Major Incident Plan	**Y**	Information	JG
Quality & Performance					
99/18	11.35	Quality & Patient Safety Committee Escalation Report	**Y**	Information	LB
100/18	11.45	Integrated Performance Report	**Y**	Information	SE
Workforce					
101/18	12.15	Workforce Race Equality Standard Summary Report	**Y**	Information	EG
Closing					
102/18	12.25	Any other business	-	Discussion	DA
103/18	-	Review of meeting effectiveness	-	Discussion	ALL
Close of meeting					

Date of next Board meeting: 25 October 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,
30 August 2018

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

Present:

Graham Colbert	(GC)	Interim Chair
Daren Mochrie	(DM)	Chief Executive
Alan Rymer	(AR)	Independent Non-Executive Director
Angela Smith	(AS)	Independent Non-Executive Director
Bethan Haskins	(BH)	Executive Director of Nursing & Quality
David Hammond	(DH)	Executive Director of Finance & Corporate Services
Ed Griffin	(EG)	Executive Director of HR & OD
Fionna Moore	(FM)	Executive Medical Director
Graham Colbert	(GC)	Independent Non-Executive Director & Deputy Chair
Laurie McMahon	(LM)	Independent Non-Executive Director
Tim Howe	(TH)	Independent Non-Executive Director
Tricia McGregor	(TM)	Independent Non-Executive Director
Terry Parkin	(TP)	Independent Non-Executive Director

In attendance:

Jayne Phoenix	(JP)	AD Strategy
Sue Barlow	(SB)	AD Operations (EOC)
Janine Compton	(JC)	Head of Communications
Isobel Allen	(IA)	Assistant Company Secretary

77/18 Apologies for absence

Adrian Twyning	(AT)	Independent Non-Executive Director
Lucy Bloem	(LB)	Independent Non-Executive Director
Steve Emerton	(SE)	Executive Director of Strategy & Business Development
Joe Garcia	(JG)	Executive Director of Operations
Peter Lee	(PL)	Trust Secretary

78/18 Declarations of conflicts of interest

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

79/18 Minutes of the meeting held in public on 26 July 2018

The minutes were approved as a true and accurate record save for one update from TM. TM would send a note to IA clarifying the point she had sought to make.

80/18 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.

81/18 Chief Executive's report

David Astley had been appointed as Chair by the Council of Governors and would start with the Trust at the end of September. DM thanked GC for his work as Interim Chair.

DM had met with Anne Eden (NHSI) a few weeks ago followed by a meeting with Anne and her team who had visited the Trust: they were very impressed with our progress. He also met with Marianne Griffiths CEO of Brighton and Sussex University Hospitals regarding joint working and improving handover delays, which had been a very positive meeting.

On the CQC, DM advised that inspectors had been back last week and he thanked everyone. The CQC's high level feedback was that they had received a very warm welcome and received everything they requested.

Recent Executive Management Team meetings had focused on the CQC, the outcomes of the Demand and Capacity (D&C) review, on speeding up recruitment across the organisation, and on 111 tenders.

A third live CEO webcast would take place on 5 September alongside EG. 187 staff attended Brighton Pride this year; FM and JG were there and well done to everyone. The operational input to that event is also enormous and it was a very busy day: DM thanked all staff who worked there as well.

Yesterday there had been a system leaders' event with NHSI and NHS England: system leaders for the South East had attended. DM had presented on winter including some of our ongoing demand and capacity and improvement work. Lots of positive feedback had been received.

Hospital handover remained a focus, winter preparations were underway.

An NHS Horizons project was underway involving the whole ambulance sector and the Trust had a number of staff involved.

On the CQC reporting timeline, BH advised that we were technically still in the well-led inspection and key people were due to be interviewed next Friday due to leave over the Summer period. We had a final presentation on Wednesday to cover our Private Providers. We expected the draft report around 8 October. We then had ten days to check for accuracy and agree with them a timeline for publication, but it would likely be the end of October/beginning November. If this was the case it would come to the public Board in November.

AR noted that our internal hospital handover project had moved from amber to red and asked what the Board could do to help. DM advised that good progress was made but it was not yet necessarily sustainable. This was a challenge for the whole region. The Board should continue to support having a resource like Gillian Wieck in place, continue to prioritise it as a Trust and work with the system on this. There had been a lot of discussion at the system leaders' event yesterday. We had proposed NHSI basing themselves in our strategic Command Centre next door over winter to see how sharing real time information could be used to improve system management. Real time information about handover delays was available, and we had an interactive surge management app to show waiting patients, plus there was a system called Shrewd Resilience, about acute beds in hospitals and if we could join up and share this intelligence real-time this would help.

DM noted that he would work with David Astley when he starts to help unblock anything at the Chair level. GC noted progress that the acutes recognise they need to help. It was important to understand why acutes were slipping back and whether this was systematic. AR believed it was important to keep ahead of the issue. DM noted that we needed to play our part in being good across OU areas in terms of crew to clear time.

AS noted that there was no sense we had lapsed working on this, but we were still losing roughly 1000 hours a week and this had seemed stable for a while. AS was concerned about the pace of progress: we would be in winter soon. DM noted the improvement and agreed that we had not improved enough, it was a complex environment and there were lots of system pressures across acutes, primary and community services. SB noted that on the hours lost most were in Kent but in Surrey and Sussex we were seeing more significant improvement. We were also doing more on crew to clear and operational managers were able to monitor this. Some OUs were very good and others not so much and we needed to understand why. It was often down to processes in hospital internally. DM believed we would see the same improvement in Kent if we keep doing what we're doing.

DH advised that on 111 we were still working with Commissioners in Surrey. In Kent and Sussex, we were working on a possible extension pending re-procurement. GC noted that the commissioning approach was now to fragment 111 as opposed to the current approach.

82/18 Delivery Plan

Service transformation and delivery:
SB advised that hear and treat levels were rag rated red but we were mid-table nationally, and we were seeing improvements in staffing on the H&T desk.

AS noted that 4/5 indicators were red. She would like to see the road map through which we intend to meet our national standards, which may be contingent on the D&C outcomes. DM noted that the Board would consider this in the development session that afternoon, and get into more detail about how the D&C would be enacted and when,

Sustainability:
DH noted that the Sustainability Steering Group had not met since the previous Board meeting.

Automated temperature monitoring had moved to amber from green: we had dealt well with the high temperatures over July and the rag rating related to the sustainability of air conditioning units longer term and he was confident. Security had moved to amber due to a month's slippage on this to make sure the right solution was put in. Replacement of telephony was back on track but tight to the timeframes given winter, EOC colleagues were working with IT around alternative ways to deploy the system. An update would be provided when available. The Spine project was almost deployed and sitting within EOC in testing phase. DH had no concerns.

On further space in this building, we were negotiating with Surrey County Council, and we would not sign anything without Board approval.

Compliance:
FM noted that the medicines management project was closed, but continued to report on a monthly basis. On EOC, SB advised that we were compliant with our call-taking audit for Pathways for July, we had created a plan around clinical navigators and call stacks, and our call answer had experienced growth month on month in numbers of staff in EOC. There had been a higher turnover than was planned, and also highest core demand for the last 12 weeks which had started to subside.

On private providers, BH noted that we used 5 different providers to provide security/flexibility, and internally we have started a large project to consider 17 specific areas in relation to strengthening governance on PAPs. We could be better at ensuring the same level of safeguarding training etc.

AS noted that in the CQC interviews she had taken part in, there appeared to be a focus on mental health and CQC seemed to think it was appropriate that NEDs had seen the dementia strategy. Were the Executives happy that we met the formal standards concerning mental health? BH confirmed this was the case, and it had been praised in the CQC's high level feedback. In particular, we were leading the way around mental health for staff.

TH asked whether the difference of opinion regarding the data on Section 136 transfers had been resolved. This was coming to the Quality and Patient Safety committee on Thursday. JP advised that Gary Davies-Ebsworth was working on this at present. Work was underway with mental health providers on looking at some of the vehicle models we used for 136 transfers.

EG noted that the resourcing plan was being managed on a weekly basis. Good progress had been made on attracting more suitable candidates, but there were challenges with the scheduling of blue light training. It was important to address attraction issues across the patch as they were different based on locality.

On personnel files, compliance had been reviewed on pre-employment screening. We now had assurance, however more work was being done on the standards required. We were also reviewing all staff files.

The culture change programme held a deep dive as part of the CQC inspection which had helped us identify that we should review the scope and resourcing as we move into the next phase. EG had attended the LGBT national network and had been pleased that the Trust had such an influence and impact. We won four gold awards.

TM asked about the deadline for more regular metrics on the culture programme. EG advised that he had concerns about over-reliance on staff survey data, and the team were looking at quarterly pulse surveys, which showed some progress in some areas but it was too early to identify trends. It was important to integrate a positive narrative re the staff survey. We should also look at improving Ask HR sessions to push messages out as well as collect them, and track the issues raised to identify trends.

TM asked for the Board to have a stocktake of the staff survey action plan and work related to it mid-year.

ACTION: Staff survey action plan to come to the Board in October

Strategy:
JP advised that the focus was on bringing all the components together. Staff engagement around the strategy refresh had been taking place, and she had been overwhelmed by everyone's openness and honesty around what was working and what less so. They had used existing meetings to engage with other stakeholders as well to ensure our partners were aware and able to shape our direction. This might help us look afresh at our priorities.

On enabling strategies, ICT came to the July Board and the Clinical Strategy, Estates and Research and Development should come in September.

AR asked about the fleet enabling strategy. JP was not sure having just come back from leave. JP would provide an update outside the meeting.

AR noted that elements of the strategy should be clear regardless of the D&C review and overall numbers. AS noted that the Finance and Investment Committee would meet to consider the estates strategy and it may make sense to include fleet.

ACTION: Add fleet strategy to the FIC agenda for October

83/18 Delivery Plan Deep Dives

Deep Dive 1: Hospital handover
The focus was on making improvements in Kent and on crew to clear.

Deep Dive 2: EOC
SB advised that the D&C review would potentially bring more investment and it would be necessary to consider the current plan and map it to the D&C and a roadmap with CQC safe elements included.

We would continue to focus on retention and recruitment; on long waits and reviewing the stack in points of escalation; and on how we manage the queue. There was a manual process to enable clinical navigators to see the stack and help to identify who needs to move up the queue. There were changes being made to the CAD to help with this too.

Deep Dive 3: Hear and Treat (H&T)
SB advised that we were mid-table compared to other services on H&T. We had seen some good progress recruiting clinicians to the EOC to support the existing staff with H&T and we were looking at how operational team leaders can provide support out in the field.

We were introducing Manchester Triage which would enable us to train staff more quickly and provide a framework enabling us to triage patients more adequately in times of pressure, from a safety perspective.

We would be seeking to maximise our use of appropriate H&T. GC asked whether the national comparator provided useful data – was it helpful to measure across the 11 Trusts? SB believed that everyone measured things slightly differently so this was something that needed to be looked at nationally, both in relation to H&T and also call answer. It was important to benchmark against accurate measures.

AR asked whether there was a sensible figure in the D&C review that we could work to. SB confirmed there was. FM agreed that in measuring Ambulance Clinical Quality Indicators (ACQI) Trusts also struggled with consistent measures, though this was improving.

GC also noted the complexities around 111 and how this might impact H&T depending on whether ambulances were controlled by 111 providers.

84/18 IPR
Clinical safety:
FM highlighted the improving position with clinical records. The team was now at full strength and the backlog had been managed effectively. The 4-digit CAD number had led to a fall in unreconciled Patient Clinical Records (PCRs) and we were back within the pack on this.

The hot weather caused significant issues with the storage of medicines. We decided to remove any drugs exposed to consistent high temperatures and we had good responsiveness from Estates to introduce air conditioning.

The ACQIs, cardiac arrest survival and the care bundle for stroke had improved. The care bundles for STEMI continued to be a concern but local data was now available and we hoped to improve things. We had appointed a Consultant Midwife and 3 Consultant Paramedics.

Quality:
BH noted that the Duty of Candour continued to be an area of focus. Safeguarding training had been completed but the way we reported training compliance was unhelpful. Finally, there had been progress in

relation to health and safety work, and a Head of Health and Safety had been appointed. We had a project plan in place for improvement. AR believed that the Board would gain assurance from a report on the actions taken.

BH had also completed a thematic review of SIs and it would be good to have a summary of this to the Board too.

ACTION: BH to bring a report to the Board on the actions taken to improve health and safety.

ACTION: BH to bring to the Board the thematic review of SIs.

Performance:
SB had covered much of this earlier. Category 3 and 4 responses remained areas of concern around long waits, and there was a process in place to manage waiting calls safely. Operational hours provided had seen a slight dip but we had seen good progress on delivery against key skills, one to ones and appraisals.

AR noted that in July we were underspent on staffing, which may relate to the concern that we hadn't put the hours anticipated out. SB advised that we had vacancies, so this accounted for some of the under-spend. We had done lots of key skills training and it was right to prioritise this in the start of the year. We had tried to match the demand late evening with overtime, plus it was a high time for annual leave and less overtime had been used. Finally, Private Ambulance Providers (PAPs) also had high annual leave and we experienced PAP unreliability during the Summer. We were moving to a more robust PAP framework to improve this.

DH noted that although we may show an underspend due to vacancies, we need to consider the PAP provision. We were able to take proactive decisions to ensure incentivisation on the right days. We made sure we provided as many hours as possible – there were not financial constraints. AR noted that our lack of resilience was notable without the additional resources available as we used the quiet times to do appraisals etc.

AS noted that at FIC they had asked the Executive to ensure that patients and staff were the primary factor and finance secondary. DM agreed that this was the approach, including still doing appraisals, training etc prior to winter. The Trust was in a good position going into winter.

Workforce:
EG advised that there were similar issues as described around safeguarding with training statistics not being provided on a rolling basis. EG was increasingly looking at the relationship between a good employee experience and better patient-care. There was a much more granular recruitment plan for the frontline and we needed to move into the rest of the organisation. We had also started to look at senior levels in terms of succession planning. For many of our senior roles there were a small pool of people to draw from so we needed to look ahead.

Employee relations cases were sometimes collective grievances and then the figures spiked. As management capability and confidence developed we would see some further spikes in our measures, e.g. an increase in the number of disciplinary cases and in claims of bullying and harassment. Many managers were afraid of tackling poor performance for fear of B&H claims. As we get better at this we need to hold our nerve. EG had been working with JG on helping staff understand the lines between acceptable and unacceptable behaviours in relations between managers and their staff.

EG noted that we needed to understand the impact of a growing workforce more broadly. TP asked whether we were conducting exit interviews for those leaving EOC, given the rise in turnover? SB advised that exit interviews were undertaken, and primarily the reasons for leaving were:

- Failing the training – we are looking into why this is
- Development within the Trust to take ECSW/AP roles
- Working patterns – we are working with staffside and encouraging part-time staff and more flexible working patterns, which are helping people stay longer
- We have reviewed the recruitment process around resilience and mental health, and how we prepare call takers for the EOC environment.

SB noted that in Coxheath and Maidstone we found recruitment easier than in Crawley.

TM asked for assurance regarding honest mistakes and a culture of learning, that we will be sighted on the possibility that a rise in disciplinaries would also be not holding to the honest mistake principle. EG agreed and noted the ongoing robust discussions internally around this.

LM noted that it sounded as if everything was being done that could be done to recruit enough staff: he wondered whether we would ever catch up due to the geography of Crawley. Longer term, might there be a strategy to use technology to distribute work around the patch? SB advised that we were considering this with Manchester Triage for example i.e. whether this could be done from our Make Ready Centres. This would be trialled once the governance was in place. Integrating 111 and 999 would also bring flexibility and compensate for peaks and troughs.

DH noted that in the strategy we needed to get the base foundation and infrastructure in place to allow flexibility. EG added that we needed to be clear about our employer brand. AS noted that we should be conscious that distance makes it more difficult to establish control over elements and we would need to consider that if moving to more remote working.

Finance:
We are on plan at month 3 and DH had no concerns at present.

85/18 Any other business
AS advised that the FIC would have an extra meeting in order to discuss estates.

There were no questions from the public.

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

Date _____

South East Coast Ambulance Service NHS FT Trust Board 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	October	Board	IP	The governance and assurance strategy / framework is due to be received by the Audit Committee at an exceptional meeting in October ahead of the Board on 25th
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	
25.05.2018	30/18 16	IPR to include figures for duty of candour relating to moderate harm	BH	Sept	Board	IP	30.08.2018 Update: BH confirmed that there was an issue with data collection, which is being resolved. The aim is to include the correct data from September
25.05.2018	30/18 17	The IPR includes a CQC domain section agaisnt each section. The Board has asked for one overall summary.	SE	Sept	Board	IP	30.08.2018 update: Executive confirmed that the iam would be to
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	Added to agenda
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	Apr.19	Board	C	This action has been transferred to the audit and risk committee - see September Board escalation report
28.06.2018	45/18 21	Deep Dive on the 'tail' and how we are maintaining patient safety to come to the Board	JG	October	Board	IP	This has been reviewed by the quality and patient safety committee and will come to the Board in October.
28.06.2018	45/18 22	A NED to be identified to sit on the Telephony Project Board.	DH	August	Board	IP	DH to follow up on this
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 week - to include a timeframe to give clarity on expected progress	JG	August	Board	C	August update: Work is underway to develop an integrated solution and at present a manual workaround is in place.
28.06.2018	48/18 24	FIC to scrutinise the Fleet Man system	DH	TBC	FIC	IP	Added to FIC annual plan
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	C	This action related to workforce compliance and a foot note has been included

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	C	These are now included in the IPR
30.08.2018	82/18 a	Staff survey action plan to come to the Board in October	EG	25.10.2018	Board	IP	
30.08.2018	82/18 b	Fleet Strategy to be considered by FIC in October	JG	18.10.2018	FIC	IP	Added to FIC agenda
30.08.2018	84/18 a	BH to bring a report to the Board on the actions taken to improve health and safety.	BH	25.10.2018	Board	IP	Added to Board agenda
30.08.2018	84/18 b	BH to bring to the Board the thematic review of Sis	BH	18.10.2018	Board	IP	Added to Board agenda

Key

	Not yet due
	Due
	Overdue
	Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	92/18

Name of meeting	Trust Board
Date	28.09.2018
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 August and September 2018.

2. Local issues

2.1 Chair/NED recruitment

2.1.1 Following our announcement that David Astley had been appointed as the Trust's new substantive Chair, I am pleased to confirm that David will formally start with SECAmb on 25 September 2019.

2.1.2 An induction programme has been developed for David, which will see him meeting a range of internal and external stakeholders during forthcoming weeks.

2.1.3 I would also like to thank Graham Colbert and Tim Howe, who will both be standing down as Non-Executive Directors at the end of September 2018. Both Tim and Graham have given many years of service to SECAmb and I would like to thank them both for their commitment and hard work.

2.1.4 We have already welcomed Laurie McMahon to the Board, to cover Tim's previous focus areas. Laurie spent much of the 1980s as a Senior Fellow at the King's Fund College and in 1989, co-founded the Office for Public Management and co-founded and directed Realisation Collaborative, which specialises in helping large, multi-stakeholder organisations manage strategic change. He is also Honorary Visiting Professor in Strategy and Organisational Design at Cass Business School in London.

2.1.5 I am also pleased to announce that the Council of Governors have recently appointed Michael Whitehouse as a new Non-Executive Director. Michael will join the Trust on 24 October 2018 for a three-year term of office and brings a wealth of experience of audit and financial oversight across the public sector. Michael, who lives in Surrey, is a qualified accountant and until 2017 was Chief Operating Officer of the National Audit Office.

2.2 Engagement with local stakeholders & staff

2.2.1 On 12 September 2018, I was very pleased to welcome the High Sheriff of East Sussex Major General John Moore-Bick and the High Sheriff of West Sussex Mrs Caroline Nicholls to our Crawley HQ.

2.2.2 Mrs Nicholls, a former journalist with The Argus, and Major General John Moore-Bick, who had an extensive career in the Army including commanding the British forces in Germany, were given a tour of our Emergency Operations Centre (EOC), as well as an overview of some of our vehicles. They met and chatted with

staff from HQ and EOC and were very impressed with the dedication and commitment of our staff.

2.3 Annual Members Meeting (AMM)

2.3.1 The Trust's Annual Members Meeting (AMM) was held on 14 September 2018 at Lingfield Racecourse. It was very well-attended, with over 250 people registered. There was a great range of people there from staff, patients and the public to volunteers and people from partner organisations including Health Watch and the British Heart Foundation.

2.3.2 I was proud to see the number of stalls where colleagues were exhibiting their different areas of work in the Trust and I hope everyone enjoyed promoting their work. I was also proud and pleased at the turnout and general 'feel' of the event, with good presentations from Giles Adams and Nathan Daxner on our quality improvement programmes as well as the usual formal presentations of my view of the year, Trust finances and the Lead Governor's report on behalf of the Council. The Question and Answer session included many useful and thought-provoking questions and I hope everyone had the chance to ask their questions.

2.3.3 I'd like to thank Katie Spendiff (Corporate Governance Coordinator) and her small army of helpers for organising such a positive and vibrant event.

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

- Closely monitored delivery of the Trust's Recruitment Plan on a weekly basis
- Discussed the on-going NHS 111 contract tenders
- Considered progress in the on-going Demand & Capacity Review
- Provided oversight of the Trust's Delivery Plan and Board Assurance Framework

2.4.3 On 5 September 2018, we held our third live Chief Exec 'webcast', featuring myself and Ed Griffin, Director of HR & OD. The session focussed on the work underway to change the culture of the Trust and the forthcoming NHS Staff Survey. Thank you to everyone who joined the session live, posed questions and watched the video afterwards.

2.4.4 The next webcast will take place in November and will feature myself and Joe Garcia, Director of Operations. The main focus of the session will be on how we are preparing for winter.

2.5 Appointment of Freedom to Speak up Guardian

2.5.1 I was very pleased to announce to our staff recently that we had appointed Kim Blakeburn as SECAmb's new dedicated Freedom to Speak Up Guardian (FTSUG). Kim has picked up the reins from Bethan Haskins, Executive Director of Nursing and

Quality, as the expanding remit and plans for the role have made the FTSUG a full-time job.

2.5.2 The FTSUG is an important role, identified in Sir Robert Francis' Freedom to Speak Up review, that needs to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation.

2.5.3 The FTSUG also has oversight of the channels, available to staff, to raise concerns and importantly, have the ability to hold the Trust Board to account, if needed, on FTSU areas of concern. These areas of concern could include both patient safety and staff issues of bullying and harassment.

2.5.4 I look forward to seeing Kim's role develop as we move forwards.

2.6 Care Quality Commission (CQC) up-date

2.6.1 Since the inspection, our internal Trust CQC Hub has reviewed all the preparation carried out for both inspections (Core Services and Well-led) and have captured all activities, including pre, during and post inspection, on a timeline. The timeline gives an insightful and visual overview of the last twelve months and has allowed The Hub to review what worked well and what to improve, going forwards.

2.6.2 One output from this work is that the virtual team which responded to the Provider Information Request (PIR) required by the CQC, will continue to meet regularly, updating all PIR information proactively and on a quarterly basis.

2.6.3 In addition, the CQC Hub are reviewing the priority work areas, highlighted by the CQC in their end-of-inspection initial feedback. They will tie the on-going improvement journeys into local staff forums, to develop local ownership and to create a two-way channel for information sharing.

2.6.4 The Hub have also been looking at the implications of the new CQC format for a Core Services inspection. A Core Services inspection will no longer happen over three consecutive days, as it did this year. Instead, in the future, there will be multiple unannounced, shorter inspection visits, covering the improvement focus areas, highlighted by the CQC's findings.

2.6.5 We are expecting to receive a draft report from the CQC in mid-October for factual accuracy checking, with the final report then expected in mid-November.

3. Regional issues

3.1 Preparing for winter

3.1.1 Preparations are well underway for this coming winter, including working closely with NHS Improvement and NHS England at a national level and our regional partners locally.

3.1.2 One key element is ensuring as many NHS staff as possible receive the flu vaccination to protect themselves, colleagues and patients. Within SECAmb, we will

be running an extensive campaign to encourage as many staff as possible to have the vaccination, which is starting shortly.

3.1.3 On 6 September 2018, a team from SECAmb attended a regional event led by NHS Improvement called 'Delivering resilient services for winter (and beyond)'. This focussed on how the regional NHS can work together more effectively during the winter and especially during periods of high demand; SECAmb obviously has a key role to play in this.

3.1.4 Ahead of winter, all Trusts have also received a letter recently from Pauline Phillips, National Director of Urgent and Emergency Care for NHS England and NHS Improvement, asking for focus on a number of key areas during winter. Again, SECAmb has a key, system role to play in almost every area mentioned and the Executive Management Board will continue to closely monitor our on-going preparations for winter during coming weeks.

4. National issues

4.1 The Assaults on Emergency Workers (Offences) Bill

4.1.1 On 13 September 2018, I was pleased to see that a new Bill, designed to protect ambulance staff along with other emergency workers, received Royal Assent in the House of Lords. I welcome anything which acts as a further deterrent to the small minority of individuals who seem to think it is acceptable to assault people who are trying to help others.

4.1.2 The Bill will mean a change in the law so that the maximum prison sentence for common assault will double, from six months to one year, if the victim is an NHS worker, police and prison officer, firefighter, search and rescue volunteer or anyone who is attacked while assisting an emergency worker. It also means judges must consider an offence committed against an emergency worker as an aggravating factor when handing down any sentence.

4.1.3 I see this as an important step to further protect staff. No one should ever be made to feel that violence, or indeed even the threat of violence, is a part of the job and please be reassured that we will do everything we can to ensure people who attack our staff are held accountable for their actions.

5. Recommendation

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

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	93/18

Name of meeting	Trust Board
Date	28 September 2018
Name of paper	Delivery Plan Progress Update
Responsible Executive	Steve Emerton, Director of Strategy and Business Development
Author	Eileen Sanderson, Head of PMO
Synopsis	This paper provides an update on the progress made to the Delivery Plan. The Board should be particularly drawn to the change controls agreed by the Executive Management Board, relating to the Hear and Treat and Incident projects. In addition, and as confirmed in August, the EOC project is due to be replaced with a new EOC Clinical Safety improvement plan, which will reflect the new trajectory (see BAF risk report) for meeting the national target for call answer. The aim is that this new plan will be established during October.
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

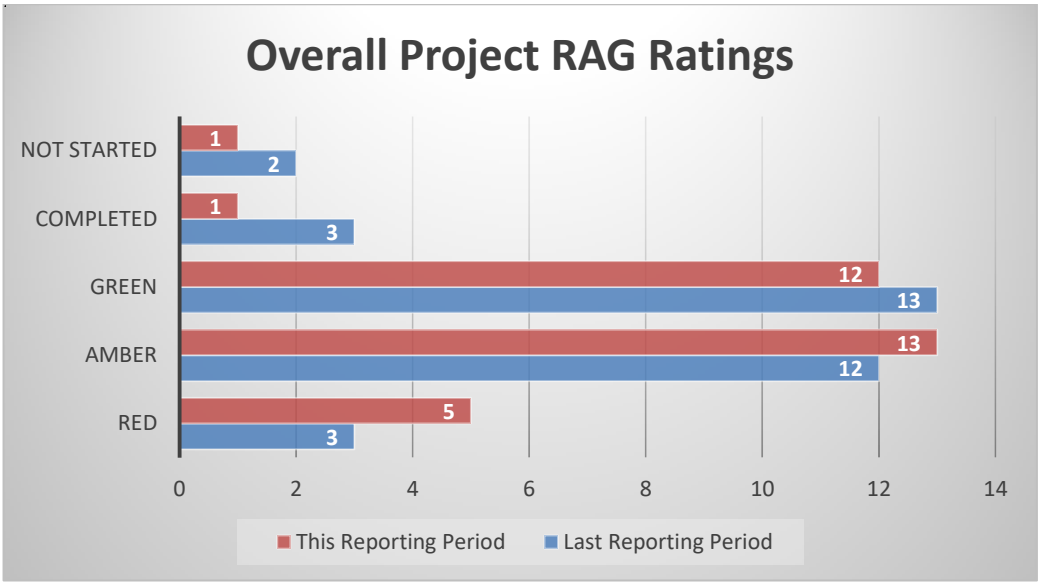
1.1 The Dashboard gives high level commentary and associated Key Performance Indicators (KPIs) for this reporting period where appropriate. As projects come to completion the reader should note that project closure processes will be enacted to ensure that continued and sustained delivery moves into Business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

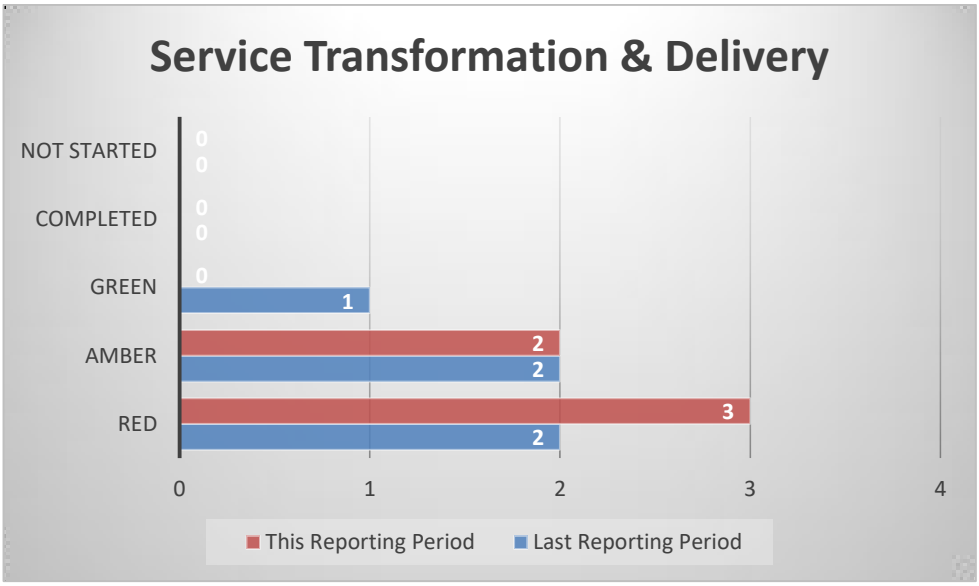
1.3 The Delivery Plan Dashboard (Appendix A) provides a summary of progress within this reporting period. For information the RAG status is defined as follows:

- 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 there being only one dedicated resource to support delivery. Recent attempts to provide additional capacity have been unsuccessful and work continues to secure dedicated resource to support delivery. Local recruitment campaign dates for ECSW courses have been agreed with Resourcing and Clinical Education. Meetings are taking place with each OU to develop and agree new rotas for implementation in April 2019. Governance design and resource requirements are being developed with a view to making a case to provide dedicated resource to support delivery of the programme.

2.1 **Demand and Capacity Review** – This project remains Amber. Following the review, a plan has been developed that would enable the provider to meet the required standards and deliver the following benefits:

- Better care for patients: Response times are estimated to improve from the outset as the plan is introduced and continue as the improvements are fully implemented
- Benefits to frontline staff: A recent staff survey showed that staff viewed the Ambulance Response Programme as a positive development.
- SECAmb could become operationally and financially sustainable for the long-term, whilst also meeting national performance standards and supporting the wider system
- Commissioners would see improvements in performance as the standards are achieved and have greater certainty around their expenditure and service performance.

In order to deliver the required improvements, significant additional investment has been agreed by commissioners for 2018/19, which will be enacted via a Contract Variation by the end of September 2018 for mobilisation from October 2018. Once initiated, implementation of the plan will being overseen by a Strategic Oversight Group and progress will be closely monitored by commissioners to ensure improvements in performance are being delivered within agreed timescales.

2.2 **Hospital Handover –** The project remains RAG rated Red. There has been significant progress made at several sites to reduce hospital handover delays, mainly in Surrey and Sussex, however there are still some significant outliers. Further support is in place for

those individual sites. Peer review visits are continuing as part of that support 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.

2.3 **Increased Hear and Treat** – The project RAG remains Red. The project currently remains at Red for RAG status. Hear and Treat suffered a slight drop to 5.2 % but this was in line with a national trend, remaining above the national average and is now on its way up again to 5.6% for last week. EMB approved the change request in target to Hear and Treat target from 10% to 6% by September 2018. The target for Q1 2020/2021 will remain in line with ARP.

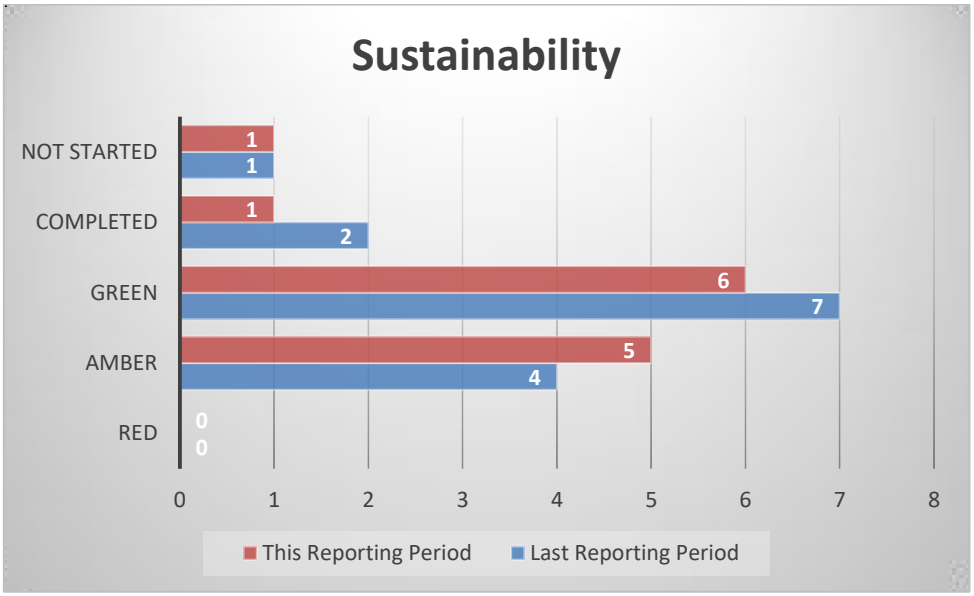
The current Full Time Equivalent (FTE) for the Clinical Supervisor role is 23.35 out of a required 38. There are 3 heads due to join over the next two weeks on various hours' agreements and 6 are due to starting training in October. However, a HR issue has arisen with regards to contract implications associated with the NHS England Annex 2 changes coming in to effect in September 2018. The EOC Clinical Leadership team is working with HR in attempting to resolve this complication.

The Trust is seeing improvement in its recruitment pipeline, with another 6 clinician applicants shortlisted from July, above the 11 applications reviewed for June and a total of 8 staff booked onto courses between September and October 2018.

The Manchester Triage System (MTS) has a planned go live date of the 10th October and all of the Clinical Safety Navigators (CSN's) and most of the Clinical Supervisors are now trained in this system. There has been relatively good uptake from non-EOC staff with the course in October now full and another course planned for the 19th November. The rotational Paramedic Practitioners who work in EOC are also being trained on this triage software.

2.4 **National Ambulance Resilience Unit -** The project RAG status has moved from Green to Amber during this period, as the project is nearing the end of the agreed project lifetime and there are still actions needing to be completed. Some of these actions are at risk and will potentially need to be transferred to EPRR action plan for 2019.

Sustainability



3.0 Digital Programme

3.1 **Automated Temperature Monitoring** – This project remains RAG rated Amber due to a lack of clarity around the scope. However, a supplier has now been identified with further work to commence in coming weeks.

3.2 **Banstead POP** – This project is now complete – all of the kit has been installed in the Crawley server room and the remaining kit at Banstead has been decommissioned.

3.3 **Corporate IT systems back up** – This project has not yet started and is therefore RAG rated White. The supplier has been identified and a meeting scheduled with Procurement is taking place this week to agree a framework. In the coming weeks, project documentation will be completed for sign off by end of October 2018. The allocation of funds has been confirmed. This project will be complete prior to winter.

3.4 **Cyber Security** – This project remains RAG rated Amber; a performance issue caused a delay to the schedule, but this has now been resolved. The completion date is still expected to be met, with the project likely to return to a Green RAG rating next month.

3.5 **ePCR** – This project remains RAG rated Green. The contract has been signed by the Director of Finance and the order is due to be placed with Cleric this week. Recruitment for the two outstanding project team members (operational and clinical representatives) is underway. A Project Board has now been established and will be meeting on Monday 24th September 2018

3.6 **Incident Management Software** – This project remains RAG rated Green and will remain open until training has been delivered – this is on track for completion by the end of October 2018.

3.7 **Replacement Fleet Management System** – The project RAG rating moves from Green to Amber. A further software request has been made (data for assets on ambulances). Data migration is still outstanding – the data transfer between existing and new supplier is in progress, but is slow due to data size. This has resulted in a two-week delay to the project, however this could be regained during rollout.

3.8 **Replacement of Telephony and Voice Recording system** – This project RAG moves from Amber to Green. The functional design and technical specification have been approved and will be formally signed off by 20 September 2018.

3.9 **Spine Connect** – This project RAG remains Green. The system was loaded last week. Progressive go live of each element to complete with Summary Care Records by 31 October 2018. PDS due to go live next Tuesday.

3.10 **GoodSAM** – This is the first reporting period of this project. GoodSAM (Smartphone Activated Medics) Cardiac system integrates with the CAD system to trigger bystander response while the ambulance service is on route. It provides a Community First Responder (CfR) dispatch system dispatching advance care beyond cardiac arrest. The application is due to go live by 30 September 2018.

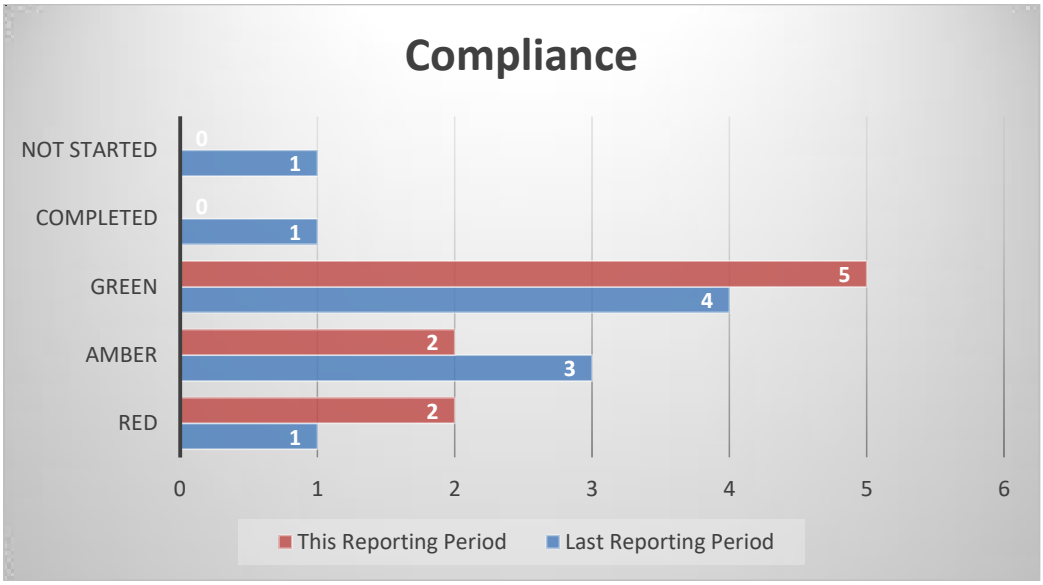
3.11 **Station Upgrades** – This project remains RAG rated Green with a planned completion date 31 March 2019. A timetable will be produced detailing the developments which will take place at each station and when these are planned for.

3.12 **Expansion of First Floor Crawley HQ –** This project RAG moves from Green to Amber as the project has not completed within the expected timescales due to contractors unable to complete the work has planned. All IT elements are complete. The project is now due to complete by the end of the month.

3.13 **Financial Sustainability Group**

3.14 **CIP -** The Trust has reported a CIP target of £11.4m to NHSI as part of the 2018/19 Budget and Plan. £6.4m of fully validated savings have been transferred to the Delivery Tracker as at the Month 5 reporting date, of which £2.9m have been delivered to date, an increase of £0.1m against 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 (QIAs) for all the mandates submitted for QIAs. Other mandates for new schemes are in the course of completion. The current versions of the Pipeline Tracker Dashboard (Appendix B) and Delivery Tracker Dashboard (Appendix C) have been included with this update.

Compliance



4.0 Compliance Steering Group

4.1 **EOC** *(CQC Must Do)* – This project RAG remains Red as EOC clinical establishment remains below target levels and call answer performance has missed the end target to achieve 95% in 5 seconds for August 2018. Audit performance is being realised but there are delays to meeting the target.

Clinical Supervisor establishment has remained fairly stable since the introduction of the Clinical Safety Navigators. There has been one resignation this week but several new members of staff start in October. Currently in post there are 8 Clinical Safety Navigators out of a required 14. By mid-October there will be a further two Clinical Safety Navigators acting up and two in training.

Audit compliance is at 67.2% for July and 22.8% for August. Work will continue working to meet the 100% compliance for each month. An additional coach has been recruited for a 3-month secondment to concentrate on audits to help reach this target. Moving forwards evaluations are ongoing to understand what is required for the audit team to ensure targets are met and how the audit data can be used to highlight training areas needed. Work has commenced to introduce live auditing which will help in the completion of the audits and the delivery of timely, quality feedback. A new audit tool is being developed which will be more user friendly and feedback friendly to help increase audits completed and feedback delivered. This will also enable us to look at trends within audits and respond to those trends appropriately.

EMA establishment fell for the first time in 8 months, mainly caused by turnover running at double the budgeted/forecasted level and a lack of new starters in August caused by phasing of EMA courses. Call answer was better than expected due to a drop in call demand below the annual average for much of August. A paper was approved by the Executive Team which detailed reasons for missing the end target and agreeing a revised trajectory. The EOC Leadership Team are working on strategies to expedite against the revised trajectory by increase training capacity whilst trying to reduce turnover.

A refreshed project to form an over-arching EOC Clinical Safety improvement plan is being developed to replace the closure of the existing project.

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, meeting fortnightly. 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 was undertaken and presented at the Compliance Steering Group on 18th September 2018 however it was agreed that the project would not close until significant improvement has been made with the current backlog and the turnaround of Serious Incidents, which is also being monitored weekly at the SI Group, and overseen by the Exec and lead Commissioners. Temporary additional resources have been secured to assist the SI lead, pending recruitment to the three substantive vacancies in the SI team, and the Head of Patient Safety post, all of which are now actively underway.

A formal change control to extend the project timelines will be undertaken which will move the completion date of delivery to end of October 2018.

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 September 2018. The IP Ready procedure is now in place and the new audit tools for the procedure are being used in all areas of the Trust. The IPC Team are planning Roadshows to help support the introduction of new procedure throughout September and October 2018, with the first one being at the Annual Members Meeting on the 14th September 2018. Completion of Station Cleanliness audits has seen a marked improvement for August 2018. The IP Team have now recruited an Administrator who will be starting with the team on the 24th September 2018, which will help support the work being carried out.

4.5 **Private Ambulance Providers -** This work stream currently is RAG Green. Whilst PAPs are not formally recognised as a programme or a project within the Trust, this work stream is currently in intensive support until 9 October 2018. All specific action plans relating to key areas of speciality that underpin PAP Governance have now been passed to each Subject Matter Expert (SME) to manage and implement directly as part of BAU with no requirement for additional sub-projects being highlighted.

4.6 **Resourcing Plan** – The project remains at Amber. The mitigating options paper is in progress with EOC and scheduled to go to EMB on 26 September 2018 for formal approval. A decision was made by the Executive Management Board to prioritise Blue Light training for Emergency Care Support Workers (ECSWs) over Newly Qualified Paramedics (NQPs). The revised Fitness test was signed off by JPPF and is currently being piloted.

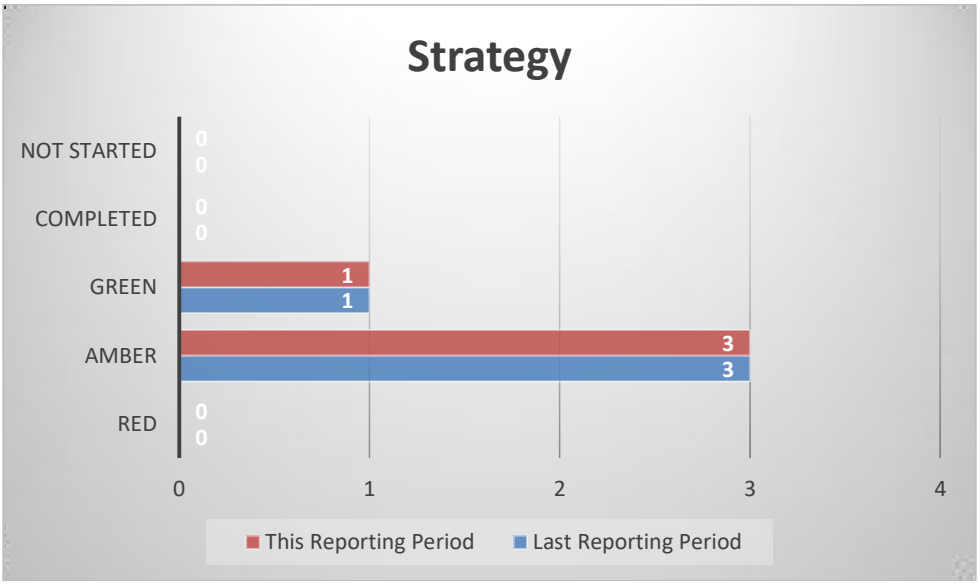
4.7 **Personnel Files** – This project remains Amber due to the scale of the work to undertaken. Additional resource has been brought in to support this work to ensure an inventory of all paper files across the Trust is set up and all electronic personnel files are reviewed in order to comply with the 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 ensuring all pre-employment checks are in place. They are also ensuring that the Trust have all the DBS checks up to date, as of the end of May 2018.

4.8 **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 sent 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. Audits continue with 1200 completed in August and approximately 2500 audits have taken place this month to date.

4.9 **Culture Change** – The project RAG moves from Amber to Red. The existing project plan is currently going through project closure with the view a new project mandate will be created to ensure it defines the future culture which is to be effective, safe, attractive and inclusive.

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** – see item 2.1 regarding this for further information.

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, Research and Development, Clinical, Governance, and Partnership/ commercial all underway. Clinical, and Research and Development are both scheduled to be considered at the September 2018 Board meeting.

5.4 **Quality Improvement** – The project RAG remains at Amber. The Trust is now initiating a procurement process.

Delivery Plan Dashboard

1 August 2018 to 31 August 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

Service Transformation & Delivery Steering Group

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
	ARP Demand and Capacity Delivery	Amber	Amber	Rob Mason	Joe Garcia	N/A	01/04/2020 (previously 01/04/2021)	Local recruitment campaign dates for ECSW courses have been agreed with resourcing and clinical education. Meetings are taking place with each OU to develop and agree new rotas for implementation in April 2019. Governance design and resource requirements are being developed with a view to making a case to provide dedicated resource to support delivery of the programme.	In post WTE	1832	1832	2413	There is a risk that there isn't capacity to support delivery; recent attempts to provide additional capacity have been unsuccesful and work continues to secure dedicated resource to support delivery.
									Leavers WTE	66	68	461	
									Joiners WTE	112	100	1052	
									Movers WTE	22	35	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 review set out to identify a realistic timescale for the ambulance service to meet national performance standards (that form part of the new national Ambulance Response Programme) and the additional resources (in terms of both staff and finances) needed to achieve this. The scope also included the development of a contracting framework that would support implementation and delivery of the plan. Following this review, a plan has been developed that would enable the provider to meet the required standards and deliver the following benefits: • Better care for patients: Response times are estimated to improve from the outset as the plan is introduced and continue as the improvements are fully implemented • Benefits to frontline staff: A recent staff survey showed that staff viewed the Ambulance Response Programme as a positive development. • SECAmb could become operationally and financially sustainable for the long-term, whilst also meeting national performance standards and supporting the wider system • Commissioners would see improvements in performance as the standards are achieved and have greater certainty around their expenditure and service performance. In order to deliver the required improvements, significant additional investment has been agreed by commissioners for 2018/19, which will be enacted via a Contract Variation by the end of September for mobilisation from October. Once initiated, implementation of the plan will being overseen by a Strategic Oversight Group and progress will be closely monitored by commissioners to ensure improvements in performance are being delivered within agreed timescales.	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	Red	Gillian Wieck	Joe Garcia	N/A	31/03/2019 (previously 30/04/2018)	The project remains RAG rated as Red. There has been significant progress made at several sites to reduce hospital handover delays, mainly in Surrey and Sussex. There are however some signifiicant outliers. Further support is in place for those individual sites. Peer review visits are continuing as part of that support 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	447	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	46.00%	85%	85%	
	Increased Hear and Treat	Red	Red	Scott Thowney	Joe Garcia	N/A	25/07/2018	The project RAG remains Red. The project currently remains at Red for RAG status. Hear and Treat suffered a slight drop to 5.2 % but this was in line with a national trend, remaining above the national average and is now on its way up again to 5.6% for last week. EMB approved the change request in target to Hear and Treat target from 10% to 6% by September 2018. The target for Q1 2020/2021 will remain in line with ARP. The current Full Time Equivalent (FTE) for the Clinical Supervisor role is 23.35 out of a required 38. There are 3 heads due to join over the next two weeks on various hours' agreements and 6 are due to starting training in October. However, a HR issue has arisen with regards to contract implications associated with the NHS England Annex 2 changes coming in to effect in September 2018. The EOC Clinical Leadership team is working with HR in attempting to resolve this complication. The Trust is seeing improvement in its recruitment pipeline, with another 6 clinician applicants shortlisted from July, above the 11 applications reviewed for June and a total of 8 staff booked onto courses between September and October 2018. The Manchester Triage System (MTS) has a planned go live date of the 10th October and all of the Clinical Safety Navigators (CSN's) and most of the Clinical Supervisors are now trained in this system. There has been relatively good uptake from non-EOC staff with the course in October now full and another course planned for the 19th November. The rotational Paramedic Practitioners who work in EOC are also being trained on this triage software.	45 clinical supervisors & clinical safety navigators in post in EOC	23.35	45	45	No risks or issues highlighted in this reporting period.
									Hear and Treat Performance	5.60%	6%	6%	

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
	National Ambulance Resilience Unit	Amber	Green	Chris Stamp	Joe Garcia	N/A	30/10/2018 (previously 31/10/2018)	The project RAG status has moved from Green to Amber during this period, as the project is nearing the end of the agreed project lifetime and there are still actions needing to be completed. Some of these actions are at risk and will potentially need to be transferred to EPRR action plan for 2019. Progress continues to be made against the actions and objectives set, with some due for completion in the next two weeks, and the project team are confident that the majority of the objectives can deliver within the timeframe, subject to risks and issues being managed.	Awareness training of HART response time standards for Command Teams	Data not available	98%	98%	There are some risks around the operational capacity to deliver the number of HART paramedics per shift in line with national standards, which is linked to overall staffing levels. In addition, there is a risk that we can not accurately monitor the response time standards for HART in line with the core standards. Both of these risks are linked to objectives with the project and are being managed and escalated by the project team.
									Commanders at all levels within Trust are trained and developed.	95.0%	95%	95%	
									IOR Training compliance for frontline staff	1664	825	2268	
									To meet the Response times standards for deployment	Data not available	95%	95%	
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. £6.4m of fully validated savings have been transferred to the Delivery Tracker as at the Month 5 reporting date, of which £2.9m have been delivered to date, an increase of £0.1m against 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.	£6.4m	£11.4m	£11.4m	The RAG rating for the CIPs programme remains at Amber as at month 5, reflecting the position at this point in 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, reductions in task cycle time and an increase in key skills training for frontline staff. CIPs to the value of £1.9m for the year covering Operations efficiencies have been developed, of which £0.6m have been achieved at month 4. 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	Amber	Timothy Poole / Jason Tree	David Hammond	N/A	TBC	This project remains RAG rated Amber due to a lack of clarity around the scope. However, a supplier has now been identified with further work to commence in coming weeks.	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)	Blue	Green	Stewart Edwards	David Hammond	N/A	31 August 2018 (previously 31/10/2018)	This project is now complete – all of the kit has been installed in the Crawley server room and the remaining kit at Banstead has been decommissioned.	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.
	Corporate IT Systems Resilience	White	White	Jason Tree	David Hammond	N/A	TBC	This project has not yet started and is therefore RAG rated White. The supplier has been identified and a meeting scheduled with Procurement is taking place this week to agree a framework. In the coming weeks, project documentation will be completed for sign off by end of October 2018. The allocation of funds has been confirmed. This project will be complete prior to winter.	KPIs to be defined.				No risks or issues highlighted in this reporting period.
	Cyber Security	Amber	Amber	Phil Smith	David Hammond	N/A	31/10/2018 (previously 31/03/18)	This project remains RAG rated Amber; a performance issue caused a delay to the schedule, however this has now been resolved. The completion date is still expected to be met, with the project likely to return to a Green RAG rating next month.	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 remains RAG rated Green. The contract has been signed by the Director of Finance and the order is due to be placed with Cleric this week. Recruitment for the two outstanding project team members (operational and clinical representatives) is underway. A Project Board has now been established and will be meeting on Monday 24th September 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	Amber	Green	Paul Ranson	David Hammond	N/A	31/08/2018	This project RAG moves from Green to Amber as the project has not completed within the expected timescales due to contractors unable to complete the work has planned. All IT elements are complete. The project is now due to complete by the end of the month.	KPIs to be defined				No risks or issues highlighted in this reporting period.
	GoodSAM	Green	First reporting period	Dave Hawkins	David Hammond	N/A	TBC	This is the first reporting period of this project. GoodSAM (Smartphone Activated Medics) Cardiac system integrates with the CAD system to trigger bystander response while the ambulance service is on route. It provides a Community First Responder (CFR) dispatch system dispatching advance care beyond cardiac arrest. The application is due to go live by 30 September 2018.	KPIs to be defined.				No risks or issues highlighted in this reporting period.
	Incident Management Software	Green	Green	David Wells	David Hammond	N/A	31/12/2018 (previously 30/09/2018)	This project remains RAG rated Green and will remain open until training has been delivered – this is on track for completion by the end of October 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	Amber	Green	John Griffiths	David Hammond	N/A	16/11/2018 (previously 01/11/2018)	The project RAG rating moves from Green to Amber. A further software request has been made (data for assets on ambulances). Data migration is still outstanding – the data transfer between existing and new supplier is in progress, but is slow due to data size. This has resulted in a two week delay to the project, however this could be regained during rollout.	The Fleet Management system will be replaced and implemented.				No risks or issues highlighted in this reporting period.
	Replacement of Telephony and Voice Recording System	Green	Amber	Phil Smith	David Hammond	N/A	30/11/2018 (previously 31/10/2018)	This project RAG moves from Amber to Green. The functional design and technical specification have been approved and will be formally signed off by 20 September 2018.	New Telephony and Voice Recording system delivered.				No risks or issues highlighted in this reporting period.
	Spine Connect	Green	Green	Phil Smith	David Hammond	N/A	31/10/2018 (previously 31/07/2018)	This project RAG remains Green. The system was loaded last week. Progressive go live of each element to complete with Summary Care Records by 31 October 2018. PDS due to go live next Tuesday.	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 remains RAG rated Green with a planned completion date 31 March 2019. A timetable will be produced detailing the developments which will take place at each station and when these are planned for.	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	This project RAG remains Red as EOC clinical establishment remains below target levels and call answer performance has missed the end target to achieve 95% in 5 seconds for August 2018. Audit performance is being realised but there are delays to meeting the target. Clinical Supervisor establishment has remained fairly stable since the introduction of the Clinical Safety Navigators. There has been one resignation this week but with several others starting in October. Currently in post there are 8 Clinical Safety Navigators out of a required 14. By mid-October there will be a further two Clinical Safety Navigators acting up and two in training. Audit compliance is at 67.2% for July and 22.8% for August. Work will continue working to meet the 100% compliance for each month. An additional coach has been recruited for a 3-month secondment to concentrate on audits to help reach this target. Moving forwards evaluations are ongoing to understand what is required for the audit team to ensure targets are met and how the audit data can be used to highlight training areas needed. Work has commenced to introduce live auditing which will help in the completion of the audits and the delivery of timely, quality feedback. A new audit tool is being developed which will be more user friendly and feedback friendly to help increase audits completed and feedback delivered. This will also enable us to look at trends within audits and respond to those trends appropriately. EMA establishment fell for the first time in 8 months, mainly caused by turnover running at double the budgeted/forecasted level and a lack of new starters in August caused by phasing of EMA courses. Call answer was better than expected due to a drop in call demand below the annual average for much of August. A paper was approved by the Executive Team which detailed reasons for missing the end target and agreeing a revised trajectory. The EOC Leadership Team are working on strategies to expedite against the revised trajectory by increase training capacity whilst trying to reduce turnover. A refreshed project to form an over-arching EOC Clinical Safety improvement plan is being developed to replace the closure of the existing project.	Clinical supervisors in post in EOC	23	45	45	No risks or issues highlighted in this reporting period.
									Number of audits per month	67.2% (July) 22.8% (August)	100.0%	100.0%	
									95% of calls answered within 5 seconds.	81.0%	92.5%	95.0%	
									FTE EMAs in post within EOC	164	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, meeting fortnightly.	Risks reviewed within their Last Review Date	96%	90%	90%	No risks or issues highlighted in this reporting period.
									Policies in date	94%	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 was undertaken and presented at the Compliance Steering Group on 18th September 2018 however it was agreed that the project would not close until significant improvement has been made with the current backlog and the turnaround of Serious Incidents, which is also being monitored weekly at the SI Group, and overseen by the Exec and lead Commissioners. Temporary additional resources have been secured to assist the SI lead, pending recruitment to the three substantive vacancies in the SI team, and the Head of Patient Safety post, all of which are now actively underway. A formal change control to extend the project timelines will be undertaken which will move the completion date of delivery to end of October 2018.	20% increase in overall incident reporting (Monthly)	808	576	576	No risks or issues highlighted in this reporting period.
									>75% of incidents closed within time target [SECAmb Target]	88%	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 September, which is one month later than forecast due to issue with the procurement of the ATP swab kits. The IP Ready procedure is now in place and the new audit tools for the procedure are being used in all areas of the Trust. The IPC Team are planning Roadshows to help support the introduction of new procedure throughout September and October, with the first one being at the AMM on the 14th September.	Hand Hygiene Staff Compliance	89%	No data available	90%	The new IP Ready audit tools are now in place and the results shown opposite show the new terminology used for hand hygiene (3R's) and Clinically Ready (BBE). The number of Station Cleanliness audits being completed seen a marked improvement this month, but still needs local management to ensure we capture 100%.
									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	69%	No data available	100%	
	Resourcing Plan	Amber	Amber	Alison Littlewood	Ed Griffin	N/A	03/12/2018 (previously 04/12/2018)	The project remains at Amber. The mitigating options paper is in progress with EOC and scheduled to go to EMB on 26 September 2018 for formal approval. A decision was made by the Executive Management Board to prioritise Blue Light training for Emergency Care Support Workers (ECSWs) over Newly Qualified Paramedics (NQPs). The revised Fitness test was signed off by JPPF and is currently being piloted.	Recruitment of 300 external operational staff (ECSW & AAP) • ECSWs to be operational • AAPs to be in training	221	266	300	No risks or issues highlighted in this reporting period.
	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. They are also ensuring that the Trust have completed all required DBS checks to the end May 2018.	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.

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
	999 Call Recording	Green	Green	Barry Thurston	David Hammond	N/A	31/10/2018 (previously 31/03/2018)	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. Audits continue with 1200 completed in August and approximately 2500 audits have taken place this month to date.	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	Red	Amber	Clare Irving	Ed Griffin	N/A	30/04/2019	The project RAG moves from Amber to Red. The existing project plan is currently going through project closure with the view a new project mandate will be created to ensure it defines the future culture which is to be effective, safe, attractive and inclusive.	KPIs to be defined.				Project is currently paused and a review is currently being undertaken
	Private Ambulance Providers (PAPs)	Green	First reporting period	Chris Stamp/ Michael Bell	Bethan Haskins	10/10/2018	31/03/2018	Private Ambulance Provider Governance currently is RAG Green. Whilst PAPs are not formally recognised as a programme or a project within the Trust, this work stream is currently in intensive support until October 9th 2018. It has recently been confirmed that all specific action plans relating to key areas of speciality that underpin PAP Governance have now been passed to each Subject Matter Expert (SME) to manage and implement directly as part of BAU with no requirement for additional sub-projects being highlighted.	PAP KPIs will be aligned and formed using the current schedule KPIs for the Trust.				No risks or issues highlighted in this reporting period.
Strategy	Annual Planning	Amber	Amber	Jayne Phoenix Philip Astell	Steve Emerton	N/A	August 2018 (previously 30/04/2018)	Please refer to Deamnd and Capacity Review	Completion of budget planning, CIP planning, strategy review, workforce planning and operating plan – different components will develop during the period now until 31st May 2018 with final outcome being subject to outcome of the Demand and Capacity plan.				No risks or issues highlighted in this reporting period
	Commissioner and Stakeholder Alignment	Green	Green	Jayne Phoenix	Steve Emerton	N/A	Ongoing	This 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, , Research and Development, Clinical, Governance, and Partnership/ commercial all underway. Clinical, and Research and Development are both scheduled to be considered at the September 2018 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. The Trust is now initiating a procurement process.	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.

South East Coast Ambulance Service: CIP Workstream

CIP Delivery Dashboard

Reporting Month Aug-18

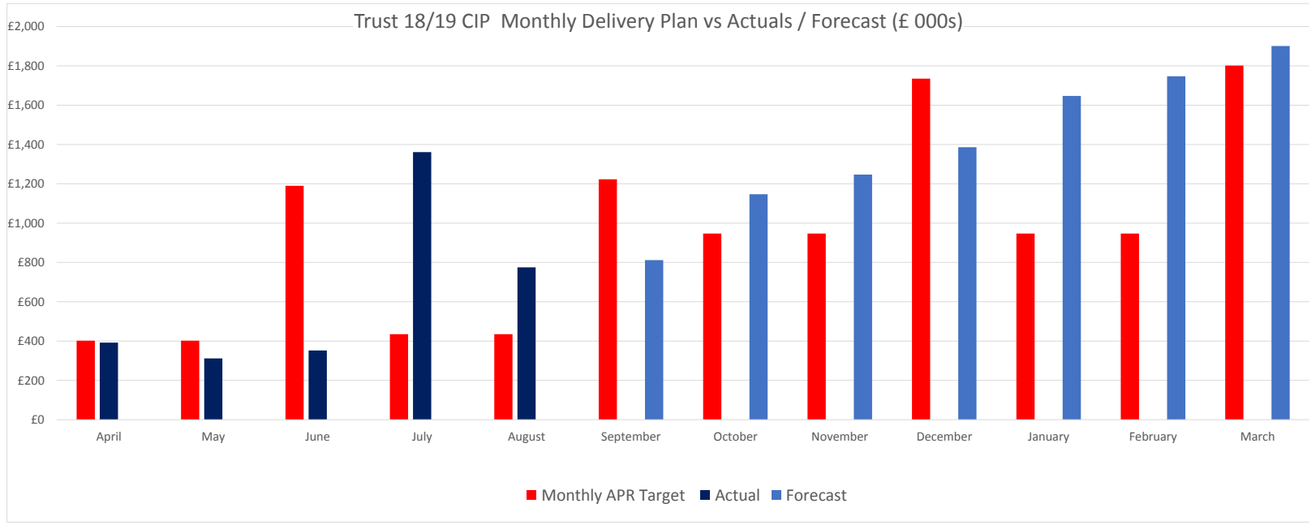
Programme for 2018/19 to deliver a minimum of £11.4m savings to achieve the planned £0.8m control total deficit.

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

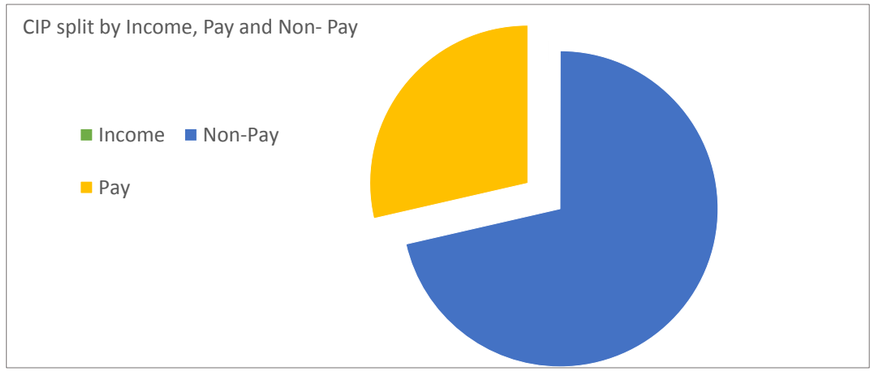
1. The CIPs target remains at £11.4m for the 2018/19 financial year.
2. £6.4m of fully validated savings have been transferred to the Delivery Tracker as at the Month 5 reporting date, of which £2.9m have been delivered against the Plan delivery of £2.8m.
3. The schemes continue to take no account of 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 is unlikely to create any CIP opportunities for this financial year 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 £1.9m for the year covering these efficiencies have been developed, of which £0.6m have been achieved. 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 31August 18

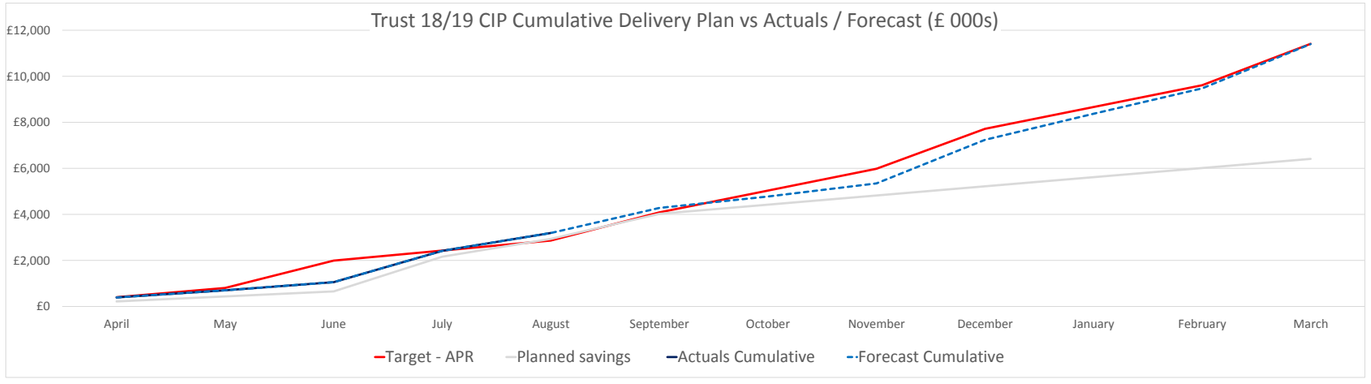
CIP Target for 18/19 £000's	Total planned savings on delivery tracker £000's - as at 31 August 2018	Total forecast savings on delivery tracker £000's - as at 31 August 2018	YTD August 18 - Target Savings £000's	YTD August 18 - Actual Savings £000's	YTD August 18 - variance £000's
11,400	6,412	11,400	2,864	2,936	£72



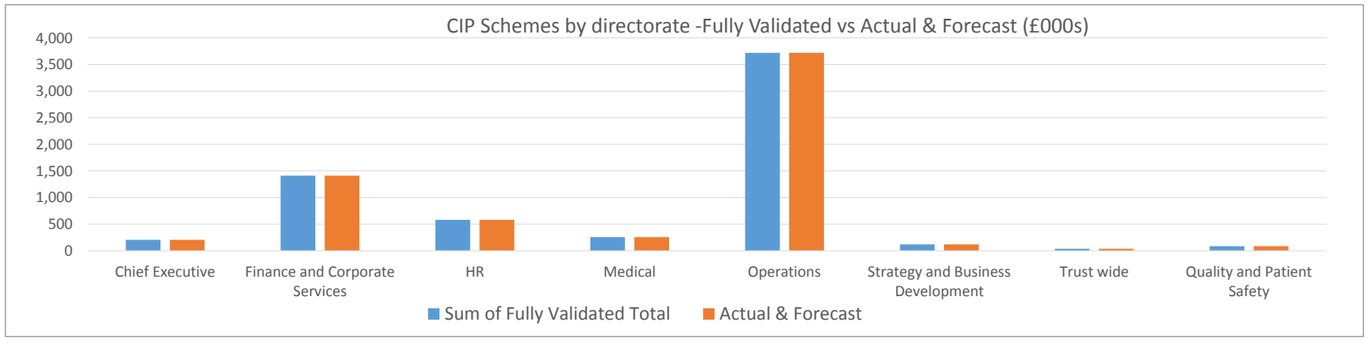
2. CIP - Planned savings split by income, pay and non-pay: as at 31 August



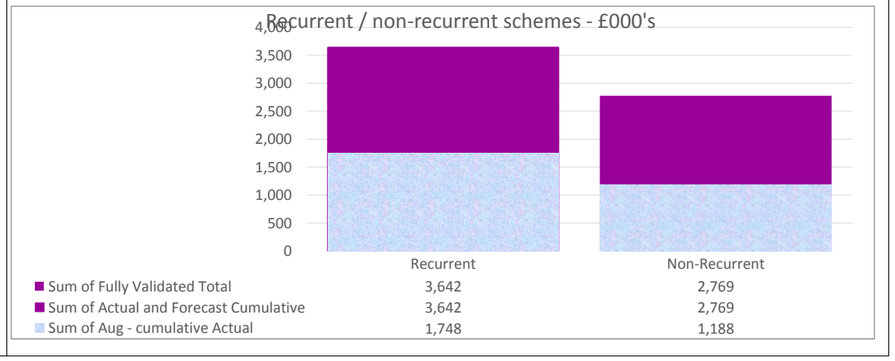
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2018/19



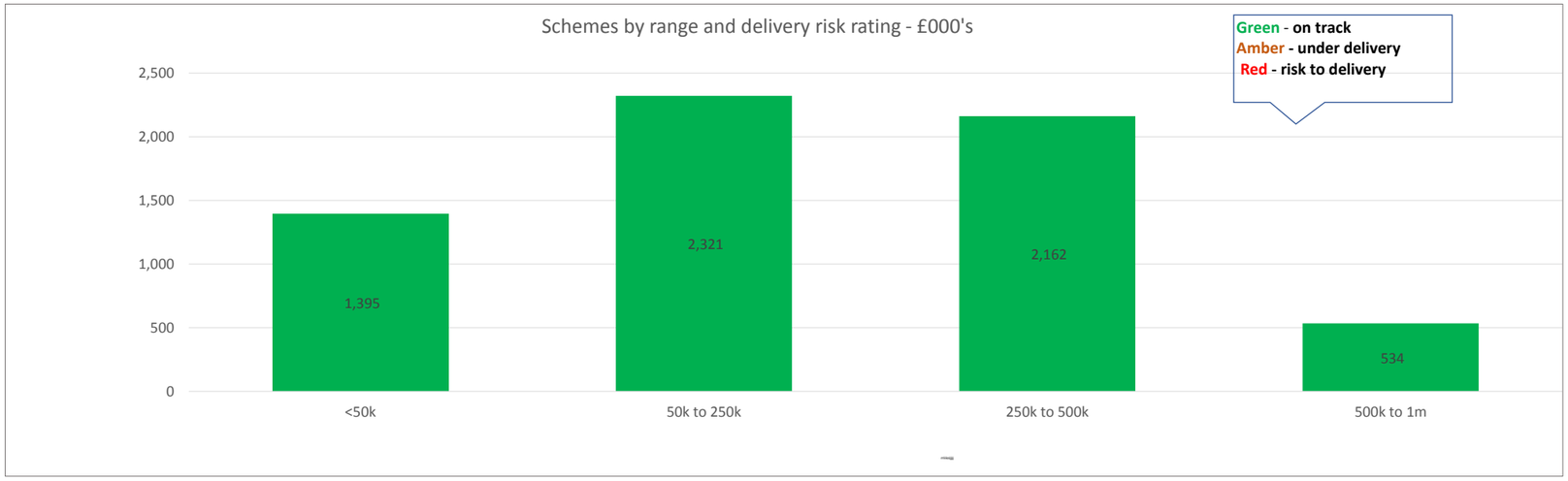
4. CIP schemes by directorate - Fully Validated vs Actual & Forecast 2018/19



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



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



7. YTD Identified CIPs to Date and Savings - August 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 5): £000	YTD Actuals (Month 5): £000	YTD Variance £000	Comments (+/- £20k variance)
External consultancy & contractors	£498	£498	£0	£292	£292	£0	-
Furniture & Fittings	£30	£30	£0	£13	£13	£0	-
Meeting room hire	£95	£95	£0	£40	£40	£0	-
Public relations	£4	£4	£0	£2	£2	£0	-
Stationery	£41	£41	£0	£18	£18	£0	-
Travel & Subsistence	£287	£287	£0	£132	£132	£0	-
Medicines Management - Equipment	£127	£127	£0	£64	£64	£0	-
Medicines Management - Consumables	£200	£200	£0	£83	£83	£0	-
Books & Subscriptions	£17	£17	£0	£7	£7	£0	-
111 Efficiency	£33	£33	£0	£14	£14	£0	-
Fleet - Fuel: Telematics, Bunkered Fuel & Price Differential	£200	£200	£0	£83	£83	£0	-
Estates and Facilities management	£56	£56	£0	£52	£52	£0	-
IT Productivity and Phones	£148	£148	£0	£79	£79	£0	-
Discretionary Non Pay	£40	£40	£0	£23	£23	£0	-
Training courses & accommodation	£445	£445	£0	£186	£186	£0	-
Single HQ /EOC Benefits realisation	£183	£183	£0	£76	£76	£0	-
Medicines Management - Drugs	£132	£132	£0	£56	£56	£0	
Insurance	£820	£820	£0	£434	£434	£0	
Printing & Postage	£32	£32	£0	£13	£13	£0	
Operations Efficiencies	£1,934	£1,934	£0	£558	£558	£0	
Recruitment delays & recharges - clinical	£807	£807	£0	£465	£465	£0	
Recharges income	£2	£2	£0	£2	£2	£0	-
Recruitment delays & recharges - non clinical	£283	£283	£0	£245	£245	£0	-
Total Fully Validated Schemes	£6,412	£6,412	£0	£2,936	£2,936	£0	-
Variance to Year To Date (YTD) Target			£0	(72)		£72	Positive variance between Fully Validated Schemes and YTD Control Total Target
Grand Total	£6,412	£6,412	£0	£2,864	£2,936	£72	

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 5 - August 2018

Programme Summary:

1. Current Pipeline schemes of £12.7m against an internal stretch target of £13m.
2. Validated or Scoped schemes of £9.8m against the NHSI target of £11.4m. Further proposed schemes to be developed in conjunction with Budget Leads.
3. Fully validated CIP schemes are moved to the Delivery Tracker after QIA approval.
4. 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.
5. Continuing to work in collaboration with Project Leads and Execs to develop schemes to meet the 2018/19 CIPs target of £11.4m.
6. 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 is unlikely to create any CIP opportunities in 2018/19. In the meantime the PMO Finance Team has agreed with the Operations Senior Team a methodology for evaluating Operations efficiencies. These relate to improved sickness rates, reduced handover delays and reductions in task cycle time. CIPs to the value of £1.9m for the year covering these efficiencies have been developed, of which £0.6m have been achieved. The efficiencies will be monitored on an ongoing monthly basis.
7. 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 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	

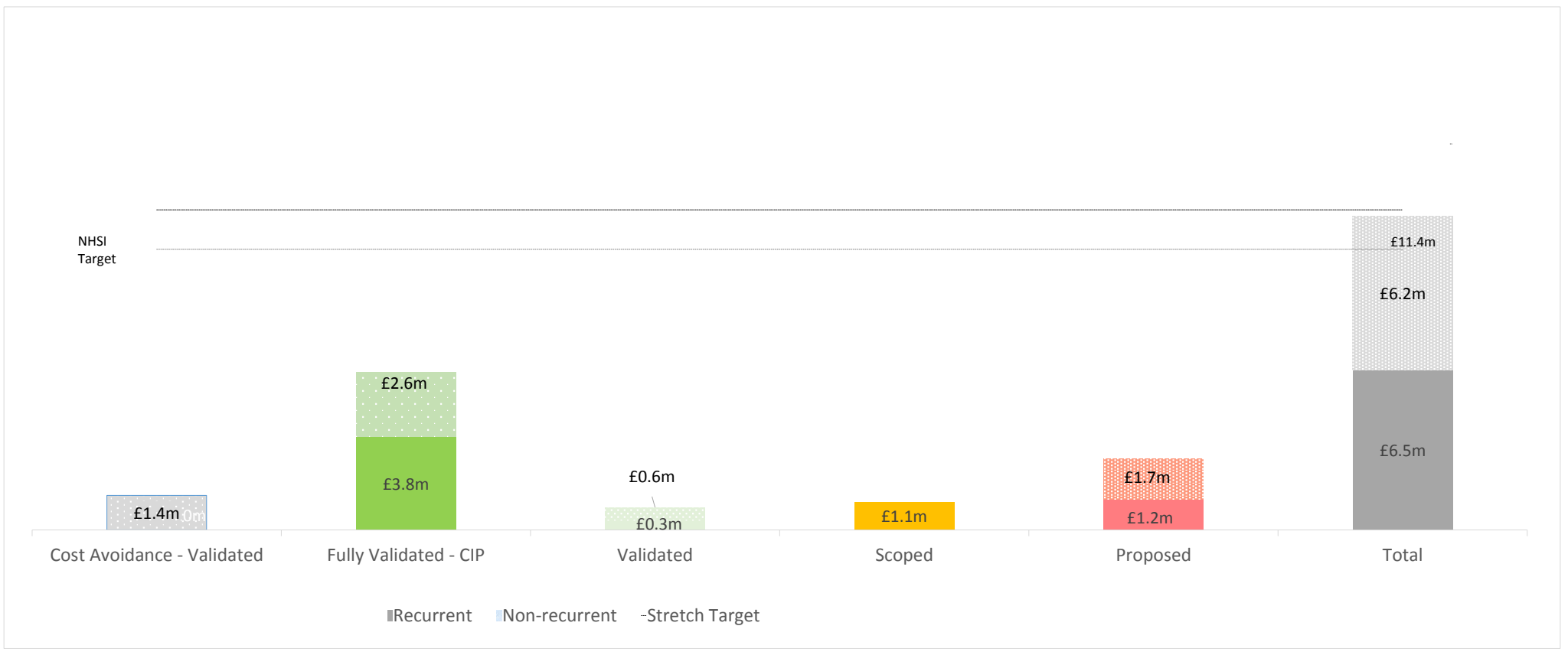
CIP Pipeline and Delivery: Risks and Issues

	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

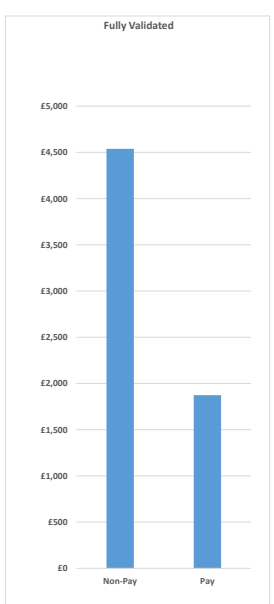
	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	New Lease Cars policy to be agreed.	Awaiting updates from John Griffiths (Response Capable Managers) and Ed Griffin (all other staff)	John Griffiths/ Ed Griffin	Amber	Amber	30-Sep-18
2	Medical Consumables - procurement cost savings to be considered.	Proposed medical consumables savings to be considered after meeting with NHS Supply Chain in September.	Kirsty Booth/ John Hughes	Amber	Amber	30-Sep-18
3	Rates Rebate - evaluate potential savings.	Develop a CIP based on rates review	Paul Ranson	Amber	Amber	31-Dec-18
4	E-Expenses and 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
5	Agency Staff - Potential cost avoidance CIP	PMO/Finance to develop a Project Mandate	Priscilla Ashun-Sarpy/ Kevin Hervey	Amber	Amber	30-Sep-18
6	Develop Operations CIP schemes.	Project Mandates have been agreed. Savings will be monitored on a monthly basis.	Kevin Hervey/ Graham Petts	Amber	Amber	Ongoing
7	Determine if an efficiencies CIP can be developed to evaluate the increased levels of training achieved by Clinical Education	Awaiting data from Clinical Education and Operations	Sally W-James/ Greg Walsh/ Graham Petts	Amber	Amber	30-Sep-18
8	Devise a mechanism for recoveries of old staff overpayments	Ongoing discussions with Payroll Manager/HR Director	Kevin Hervey	Amber	Amber	30-Sep-18

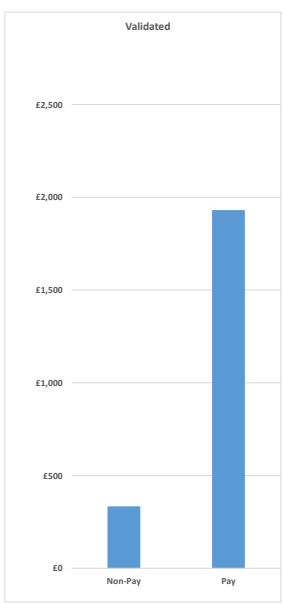
CIP Pipeline Summary

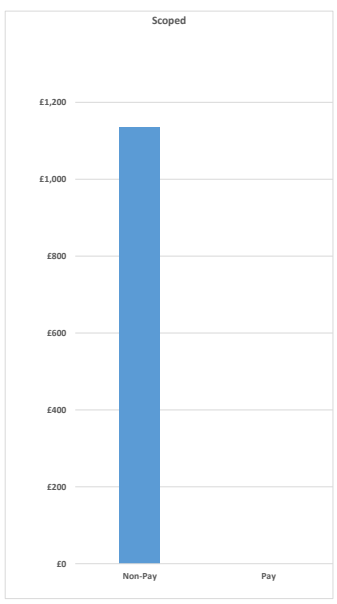
Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£1,400	£6,413	£865	£1,136	£2,902	£12,715

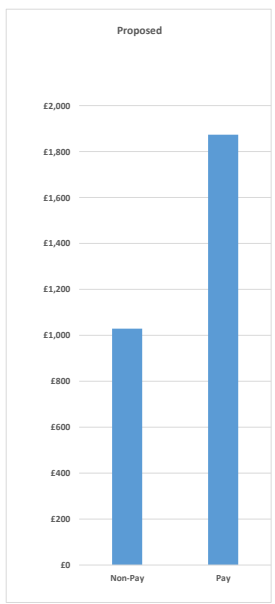


Pay / Non-Pay / Income Breakdown and scheme summary









Scheme Category	Full Year 2018/19				
	Fully Validated £000	Validated £000	Scoped £000	Proposed £000	Grand Total £000
Operations efficiencies	1,942	-	-	410	2,352
Recruitment delays & recharges - clinical	880	20	-	1,168	2,068
Insurance	820	-	-	-	820
External consultancy & contractors	498	-	140	-	638
Training courses & accommodation	445	2	-	100	547
Travel & Subsistence	285	38	7	-	330
Recruitment delays & recharges - non clinical	205	25	-	296	526
Fleet - Fuel: Telematics, Bunkered Fuel & Price Differential	200	-	-	-	200
Medicines Management - Consumables	200	94	-	-	294
Single HQ /EOC Benefits realisation	183	-	-	-	183
IT Productivity and Phones	148	9	140	100	397
Medicines Management - Drugs	132	-	-	-	132
Medicines Management - Equipment	127	-	17	-	144
Meeting room hire	95	-	8	-	103
Estates and Facilities management	56	188	624	-	868
Stationery	41	3	-	-	44
Discretionary Non Pay	40	-	-	-	40
111 Efficiency	33	-	-	-	33
Printing & Postage	32	-	-	-	32
Furniture & Fittings	30	-	-	-	30
Books & Subscriptions	17	-	-	-	17
Public relations	4	-	-	-	4
Staff Uniforms	-	-	100	-	100
Abstractions for Training - 2 days to 3 days	-	486	-	-	486
Business Cases Savings 18/19	-	-	-	829	829
Procurement contracts review	-	-	100	-	100
Agency Premiums	-	1,400	-	-	1,400
Grand Total	6,412	2,265	1,136	2,902	12,715

Call Answer Performance Review

6-20 September 2018

Call Answer Performance 4th- 20th 2018

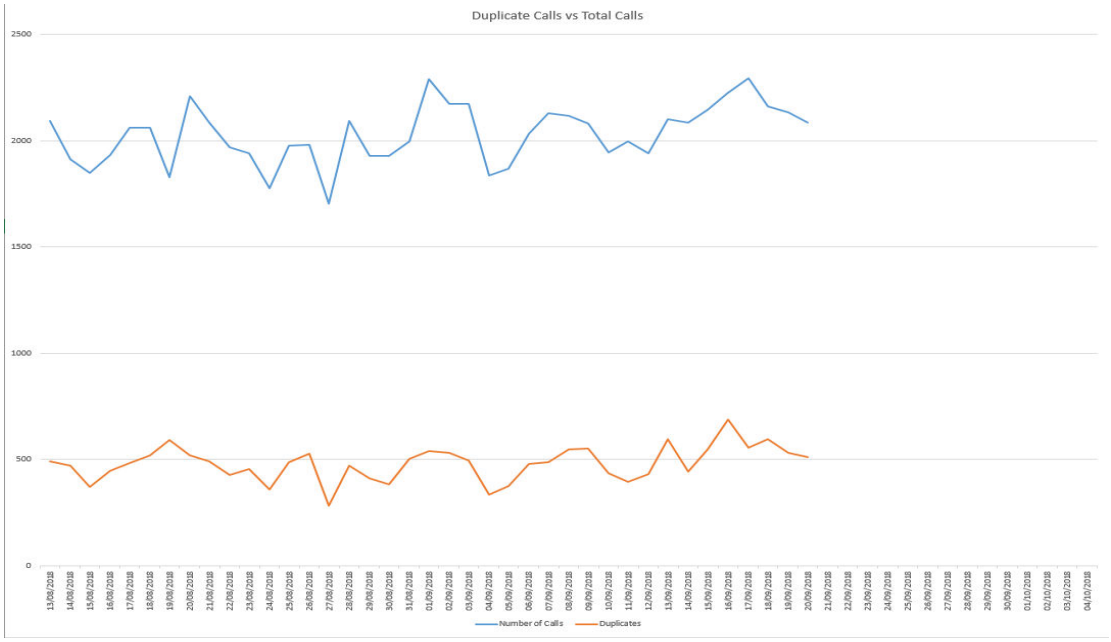
Date	Performance	EMA Actual	Number of Calls	Duplicates	Make Busy East	Make Busy West	Target Make Busy	Fields Ops Hard Deck
04/09/2018	98.70%	-0.67%	1837	334	28.00	25.00	25	
05/09/2018	96.60%	-1.57%	1869	375	30.00	25.00	25	
06/09/2018	80.20%	-10.60%	2032	478	34.30	27.60	25	
07/09/2018	79.20%	-13.35%	2129	487	32.20	27.10	25	
08/09/2018	86.50%	-13.64%	2118	547	33.00	28.00	25	
09/09/2018	92.60%	-13.23%	2080	551	33.00	27.00	25	
10/09/2018	98.00%	-13.23%	1945	436	27.00	27.00	25	97.4
11/09/2018	94.90%	1.65%	1997	393	28.00	28.00	25	101.9
12/09/2018	93.20%	-13.61%	1939	431	31.00	25.00	25	98.5
13/09/2018	81.80%	-7.52%	2101	596	33.00	29.00	25	100
14/09/2018	89.50%	-14.91%	2085	444	33.00	27.00	25	97
15/09/2018	83.30%	-20.36%	2145	546	30.00	28.00	25	89.9
16/09/2018	87.90%	-21.54%	2225	688	31.00	28.00	25	89.7
17/09/2018	76.90%	-20.80%	2295	555	31.00	28.00	25	
18/09/2018	67.50%	-27.97%	2162	595	33.00	30.00	25	
19/09/2018	62.10%	-27.37%	2132	529	33.00	30.00	25	
20/09/2018	67.00%	-20.03%	2083	510	34.00	31.00	25	

**Yellow is the start of a new week

Sickness

Call Answer Performance has taken a dip over the last four days, coinciding with high levels of sickness. Since 18 September, seven EMAs in the West EOC have booked sick for duty, although there are no trends in their absence. There are currently in total 14 EMAs booked sick in the West, one long term and 13 short term sickness. East EOC presently has five members of staff booked sick, four in the last five days, although none are long term sick.

Call Volume and Duplicate Calls

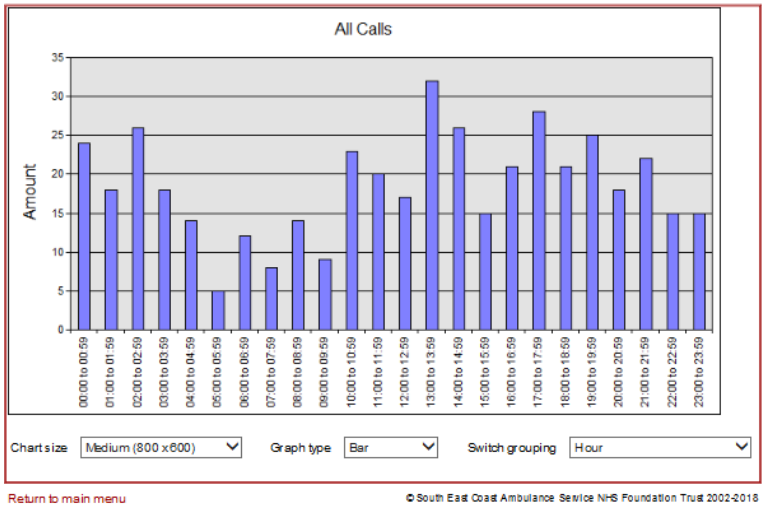


Call volume over the last week has increased and, as a result, the rate of duplicate calls has also increased. Support Call Takers have been rostered for all shifts and should there be no Support Call Takers on shift, other functions within the EOC have completed these; EMAs have solely been concentrating on answering the phone. Due to high sickness levels, an increase in call demand and duplicate calls, it was the “perfect storm” for more challenging call answer.

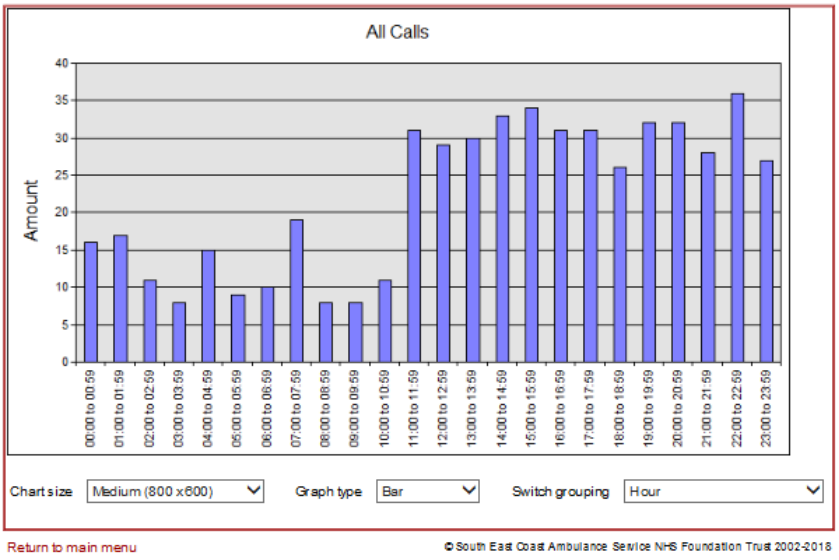
Duplicate Calls vs Time of Day

Analysis on duplicate call rate by the hour

10/9/2018 – Call Answer Performance 98%, EMA UHU -13.23, Field Ops Provided 97.4



19/9/2018 – Call Answer Performance 62%, EMA UHU -27.37, Field Ops Provided Unknown



The volume of duplicate calls is greater after 11:00 hrs, and much higher in the evening as the Surge Level increases.

Make Busy

"Make Busy" is a system where staff can make themselves unavailable to take calls. This could be due to meal breaks or because they have taken a complex call and need to write up notes before closing the call. However, we know we experience challenges with staff making themselves unnecessarily busy.

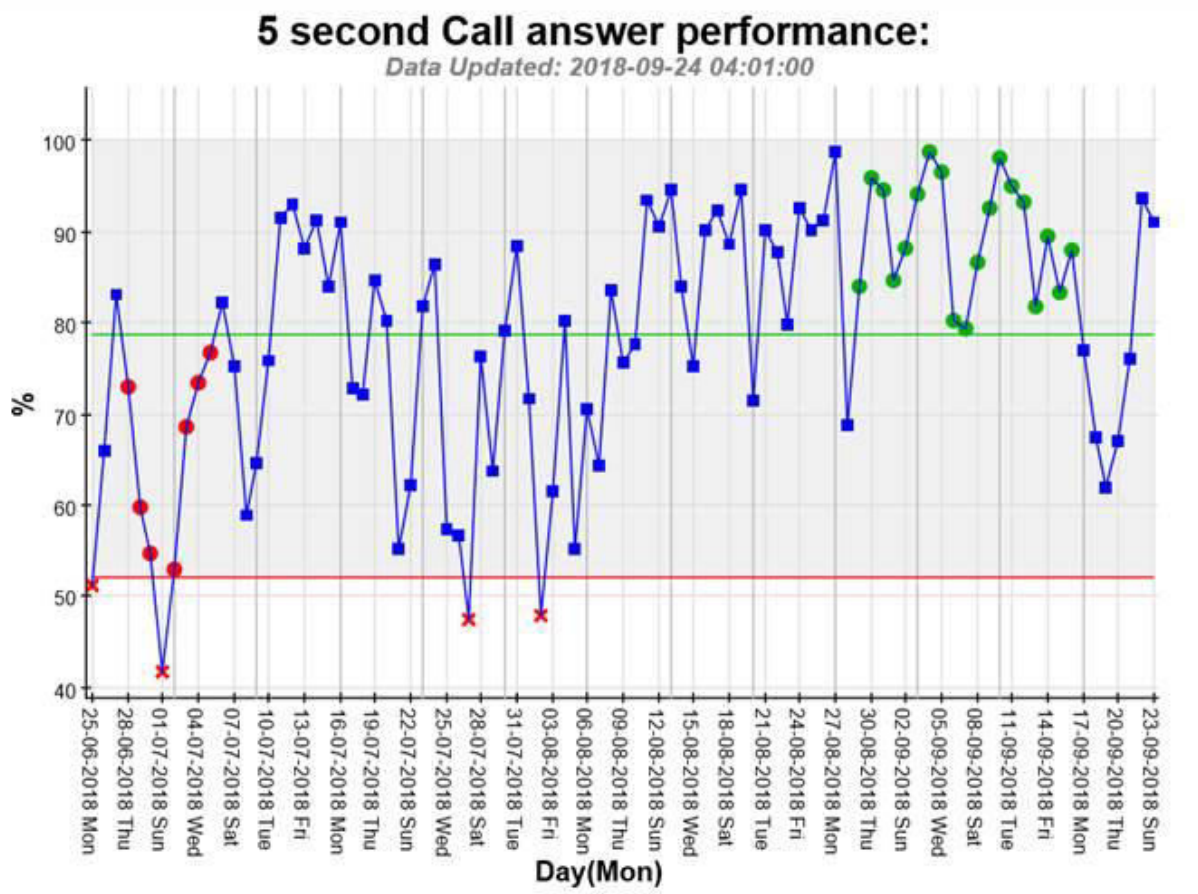
On a weekly basis, EOCMs are sent a Make Busy report broken down to the individual EMA. West has always been better at Make Busy; East has no continuous EOCM presence in the EMA/Clinical Supervisor part of the Emergency Operations Centre as they normally sit in

Dispatch. The Real Time Analyst is only covered on overtime and, therefore, there is no constant level of additional support for the EMATL to help manage Make Busy. West has managed to achieve Make Busy at 25% on a number of occasions but both sites have seen an increase in Make Busy over the past week.

Actions

- Make Busy reports are now sent weekly to the EOCM and EOC OUMs to identify and quickly action review with EMAs that continue to have high Make Busy.
- HR Advisor, Roberta Lines, sends out each Friday to all EOCMs a list of any member of staff that requires a sickness review.
- An EMATL meeting arranged for 25 September will go through management of Make Busy moving forwards, prepared by HR to support them manage a member of staff through capability or disciplinary.
- Weekly scheduling meetings take place every Thursday where future planned hours are signed off and additional overtime opportunities are authorised to reduce gaps in EOC cover. Additionally, abstractions and a review of annualised staff to ensure they are on top of their hours worked also takes place.
- During the weekend commencing 22 September two 2 diamond pods are scheduled, one in the East and one in the West.
- An Operational Instruction has been drafted and a QIA has been completed on the closing/surge instructions which will go live on Wednesday, 26 September; this should reduce the number of duplicate calls received.
- West Midlands Ambulance Service are visiting SECAmb on 27 September to help us implement “Attend” incident, which is linked to CAD. This is a quicker and more robust way of dealing with calls that do not need to be triaged through NHS Pathways and will replace the Emergency Rule. This is work in progress although Sue Barlow has requested we proceed as quickly as possible in order that this can be put in place for October Half Term/Halloween.
- Week commencing 15 October there are three weeks of diamond pods again planned in East and West.
- We have 40 new starters for East and West EOC, made up of clinicians and Emergency Medical Advisors starting in October who will commence taking calls in EOC on 19 November following completion of their classroom training and a period of one to one mentoring.
- There were 17 leavers last month (August) and to date for September three from West and two from East EOC, which is a significant improvement in our recruitment and retention plan.
- The East EMATL has been tasked as part of project work for two weeks to establish how our other Emergency Services are obtaining addresses to improve our call connect to address confirmation in 60 seconds.
- There have been three trial shifts of an EMA Coach Support Line in West EOC. The EMA coach will always answer the last call waiting to be answered and will otherwise be available to speed up the time it takes an EMA to obtain/provide advice/support on the line; EMATLs are then free to lead the room rather than just floor walking, a particular problem in the West.
- There is a need for staff to have awareness and accountability when calls are kept waiting in the queue in order to improve patient safety. We are seeking advice from staff and staff side representatives as to how we can best achieve this without impacting further upon morale.

- The EOC Code of Conduct and Uniform Policy will be reintroduced into EOC with effect from 1 October 2018.



South East Coast Ambulance Service NHS Foundation Trust

Item No	94/18

Name of meeting	Trust Board
Date	28.09.2018
Name of paper	Clinical & Quality Strategy
Executive sponsor	Fionna Moore, Medical Director & Bethan Haskins. Executive Director of Nursing & Quality
Author name and role	Kathy Jones. Consultant & Steve Lennox. Deputy Clinical Director (RGN)
Synopsis, including any notable gaps/issues in the system(s) you describe (up to 150 words)	This is the draft clinical & quality strategy (approved by the Executive Management Board). The strategy has been in development for a number of months. Initially led by a consultant who undertook a number of brief engagement exercises to establish any emerging themes. It became apparent that the majority of people were citing the same issues so a decision was made not to undertake a large scale consultation. As there has not been a large scale consultation and also to reflect the rapid improvements the organisation is making a 3yr time limit has been suggested on this strategy. It is also possible that the strategy could expire before this time as it is possible many of the projects will deliver in a faster time scale. Through engagement the strategy identifies three quality themes and 11 quality priorities within these themes. **Being Excellent at the Basics** • Leadership • Guidelines • Records **Thinking about time** • Getting it Right First Time • Giving patients time • Acting quickly • Planning ahead • Working in partnership **Caring about safety** • Continuous improvement • Safeguarding • Reporting incidents and risk The plan is not to give a prescriptive pathway on how these quality priorities are going to be improved. The current evidence suggests that quality improvement needs to come from within an organisation and owned by the workforce. Therefore, this strategy identifies these

	priorities and asks each improvement project that is established from this point in time to clearly state how it may benefit each of these quality priorities. At the point of project closure the closure QIA will ask the project to illustrate if it was successful. These QIAs will then form the evaluation over time. The strategy then outlines the eight clinical priorities. These are; • Cardiac arrest • Stroke • Mental health • Changing clinical priorities • Paediatric emergencies • Older people who fall • Sepsis • Infection prevention The strategy gives a brief overview of each project (some are more advanced than others) and to illustrate the quality requirement they indicate how they will improve the 11 quality priorities. Consideration will be given how best to launch the strategy with our communications team.
Recommendations, decisions or actions sought	Board approval is sought prior to Trust launch with our clinicians

South East Coast Ambulance Service
NHS Foundation Trust

Basics, Time & Safety

Our Clinical & Quality Strategy 2018-2021

Our Overall Trust vision

Aspiring to be

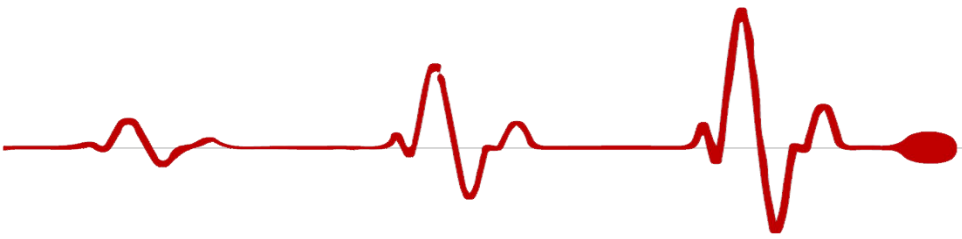
Better Today and Even Better Tomorrow

for our people and our patients

Our Five Year Strategic Plan 2017-2022 details our overall Trust vision.

There are also a number of Trust strategies that influence this Clinical & Quality Strategy. These are:

Our Clinical Education Strategy
Our Volunteers Strategy
Our Medicines Optimisation Strategy
Our Safeguarding Strategy
Our Research & Development Strategy



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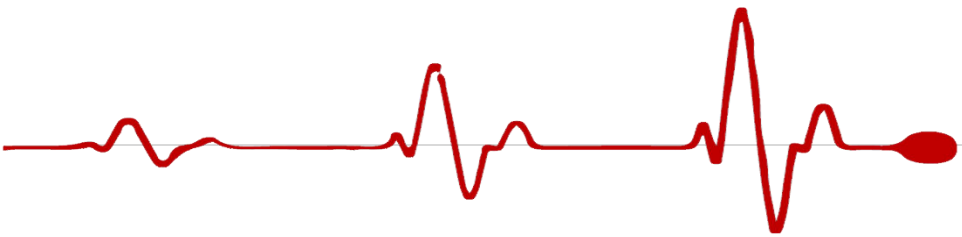


Section 1. Introduction

The purpose of a joint strategy

Introduction

An introduction from our two clinical directors

Director of Nursing & Quality

Our 2017 unannounced Care Quality Commission inspection found that the quality of our services were inadequate. Whilst this is disappointing we must acknowledge the feedback and develop high quality services.

We want to demonstrate the highest possible standards of quality in everything we do. This applies equally to clinical care and the services that support our clinicians. We want the exemplary calibre of our people and our performance to be apparent at all times.

Our definition of quality is defined by our patients. In short, it is our service users' judgement that decides whether the service they have received from us has met their identified needs. Therefore, we are developing an important patient experience strategy which will underpin our methodology for evaluating the effectiveness of what we do.

We have however identified three priorities that we know are important to patients: *basics, time & safety.* It is essential we address the basics first otherwise we will never reach our quality goal.

We know having time to care and responding quickly are important to patients and finally safety is important for all. By focussing on these three elements we believe we will have the right foundations in place from which to build further improvements.

Bethan Haskins, Executive Director of Nursing & Quality

Medical Director

Our clinical services are at the very centre of our business. We want to offer the very best clinical services possible. This means we need strong clinical leadership, highly trained clinicians and effective support services.

The role of the ambulance service has radically changed in recent years. People used to rely on the ambulance service to take them to hospital. Now, the ambulance service is a key service both for preventing hospital admissions and determining the most appropriate destination for some of our most unwell patients. We can only fully undertake this role if we become more multi-professional and continue to develop our clinicians so that they have a wide range of knowledge and skills.

Our clinicians face the widest range of situations in the NHS. In addition to the familiar medical emergencies we receive calls for assistance from care homes, from patients facing mental health crisis and from people whose labour has progressed quicker than expected. Such a diversity in our services requires strong clinical leadership and clinical experts.

We will continue to improve all clinical services but we have identified eight priority areas which will receive specific focus. We will ensure the three quality priorities are addressed as part of the improvement work but will aim to use clinical audit, research awareness, best practice guidance and innovation to ensure our patients receive the best clinical outcomes possible.

Fionna Moore, Executive Medical Director

Introduction

About this strategy

A joint approach to quality and clinical care

This Clinical and Quality Strategy sets out, as simply as possible, our clinical and quality objectives as a Trust.

We believe that quality and clinical care are so interlinked that discussing them in isolation does not present the whole strategic picture. Therefore, we have developed this combined strategy which identifies our next quality and clinical priorities.

The Trust has come under a lot of scrutiny in the last few years and its failings have been well-aired. But through it all our staff have been recognised as professional and caring. Our staff are committed to providing patients with quality care from the moment we answer the call until the time we hand the patient into the care of someone else. Staff are caring, and they are also resilient and committed to learning and to change.

We have a reputation for being forward thinking and innovative, for example in the development of professional roles like the Critical Care Paramedic and Paramedic Practitioner. We are also still leaders in initiatives for individual patient care, for example through the use of our Intelligence Based Information System (IBIS), which allows us to record the circumstances of thousands of patients across Surrey, Sussex and Kent and thereby know the best way of responding to their needs when an emergency arises.

Some of the Trust's other developments were not backed by good governance and careful evaluation.

During 2017/18 the leadership of the Trust has been concentrating on putting right some of the problems identified by the CQC and others.

Although a strategy document is mainly about the future, this document does spend some time describing some of those achievements. Why? Because we want to acknowledge the efforts of the many staff who are responsible for making the improvements, and also to give the reader an idea of where the starting point is for the new strategy.

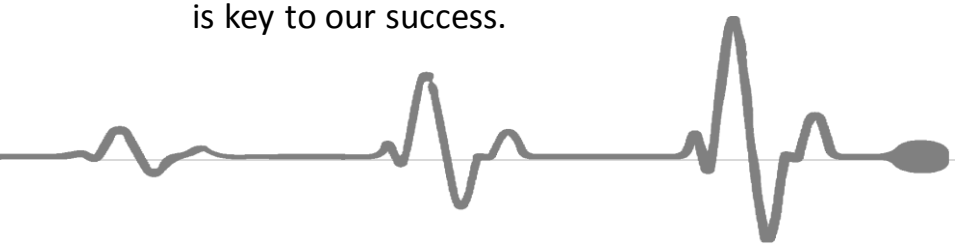
The strategy is structured chronologically. It looks at how the strategy was developed and discusses our recent priorities and achievements in order to show the direction of travel, then looks at immediate priorities and finally at longer term ambitions and challenges.

Introduction

Summary of this section

Main points

1. We see quality and clinical care as interlinked.
2. We want to demonstrate the highest quality and the very best clinical services.
3. We regard patient experience as so essential that this will have its own strategy.
4. We need to become more multi-professional
5. We need strong clinical leadership
6. Development of skills and knowledge amongst our staff is key to our success.



Section 2. Quality

Our approach

There is no single definition or a unified approach to quality within the NHS. Experience is revealing that overarching broad strategies do not deliver the necessary improvements[1].

The King's Fund now recommend that quality is led from within the organisation. This strategy embraces this direction by identifying quality themes and priorities but empowers our staff to be responsible for quality by asking them to identify *how* they plan to make the associated changes to quality through all improvement projects.

Quality

Three themes for quality

How we identified our quality themes

Ideally we would have involved as many staff as possible in the development of this clinical and quality strategy. We understand the importance of engagement for gaining ownership and achieving delivery. However, the Trust is not yet in an ideal situation. A comprehensive engagement exercise had only recently been concluded for the Trust's overarching business strategy. Also, many of the priorities remain obvious and there was a danger of engaging for engagement sake.

However, a number of staff were interviewed. The interview notes were distilled into themes but the majority of staff had very similar thoughts and themes were very apparent.

These thoughts have led to the development of this strategy. However, as the Trust progresses through the identified priorities and as we become more focused on improvement this strategy will be revisited with wider engagement.

Staff acknowledged that good progress had already been made in relatively little time. However, there is still work to be done on the foundations of good clinical care in the Trust.

Much of this is not about *changing* what we do, but getting better at *recording* what we do, so that we have evidence that we are providing the best possible care. This is one example of "being excellent at the ***basics***", which is identified as a quality priority and key theme within this strategy and this was discussed extensively at the interviews.

Another theme of this strategy is "thinking about ***time***". We are proud of the progress we have made in securing the right care for patients rather than automatically taking them to an emergency department. We know that this means that sometimes we will spend a long time with patients and, while this is right for those patients, it can mean that our clinicians are not available to respond to the next 999 call.

It is hard to strike the balance between the needs of the patient that we are with now and the patient who is waiting for us to respond. We want everyone in the service to think about this balance all the time. Sometimes we need to be quicker in our actions. For example, for patients with cardiac arrest we need to be quicker in delivering the first shock with a defibrillator.

The third priority and theme of the strategy is "*caring about* ***safety***". This means carrying out risk assessments; reporting safeguarding concerns, and incidents and "near-misses"; carrying out good infection control procedures; and also, crucially, looking after each other by watching for signs of stress in our colleagues and providing support.

These are our three key quality themes. They will feature as a thread through our improvement work and will be the foundation for the eight clinical priorities that this strategy identifies. These eight priorities are discussed in detail later within this strategy.

Quality

Eleven quality priorities

How we identified our quality priorities

In addition to our quality themes, we have identified eleven key quality priorities that underpin the delivery of our themes.

These eleven areas are dominated by the Trust's initial response to the Care Quality Commission's re-inspection in 2017. They were areas where we needed to improve. We have had success in many of the areas but during the interviews it was revealed that we needed to maintain the focus. The most frequent priorities have been classified under the three quality themes and it is by addressing these priorities that we will make improvements within our strategic quality themes.

Under the theme of "*being excellent at the **basics***" we have identified three quality priorities that are essential ingredients in getting the basics right. These are as follows:

Basics

1.1 Leadership
1.2 Guidelines
1.3 Records

Under the theme of "*thinking about **time***" we have identified five quality priorities that are essential components in our ability to manage time better. These are as follows:

Time

2.1 Getting it right first time
2.2 Giving patients the correct time
2.3 Acting quickly
2.4 Planning ahead
2.5 Working in partnership with others

Under the theme of "*caring about "caring about **safety***" we have identified three quality priorities that are key to the Trust becoming a safer service. These are as follows:

Safety

3.1 Continuous improvement
3.2 Safeguarding staff and patients
3.3 Reporting incidents and risks

Rather than identify an organizational approach to each of the eleven quality priorities we will invite each improvement project to identify how the project will make improvements to each of the eleven areas. This commences with the eight clinical priorities identified in this strategy. The final section illustrates our initial plans for each of these areas.

This approach will allow us to make the biggest impact in each of the eleven areas but also support the approach that improving quality is everyone's responsibility.

Quality

A summary of this section

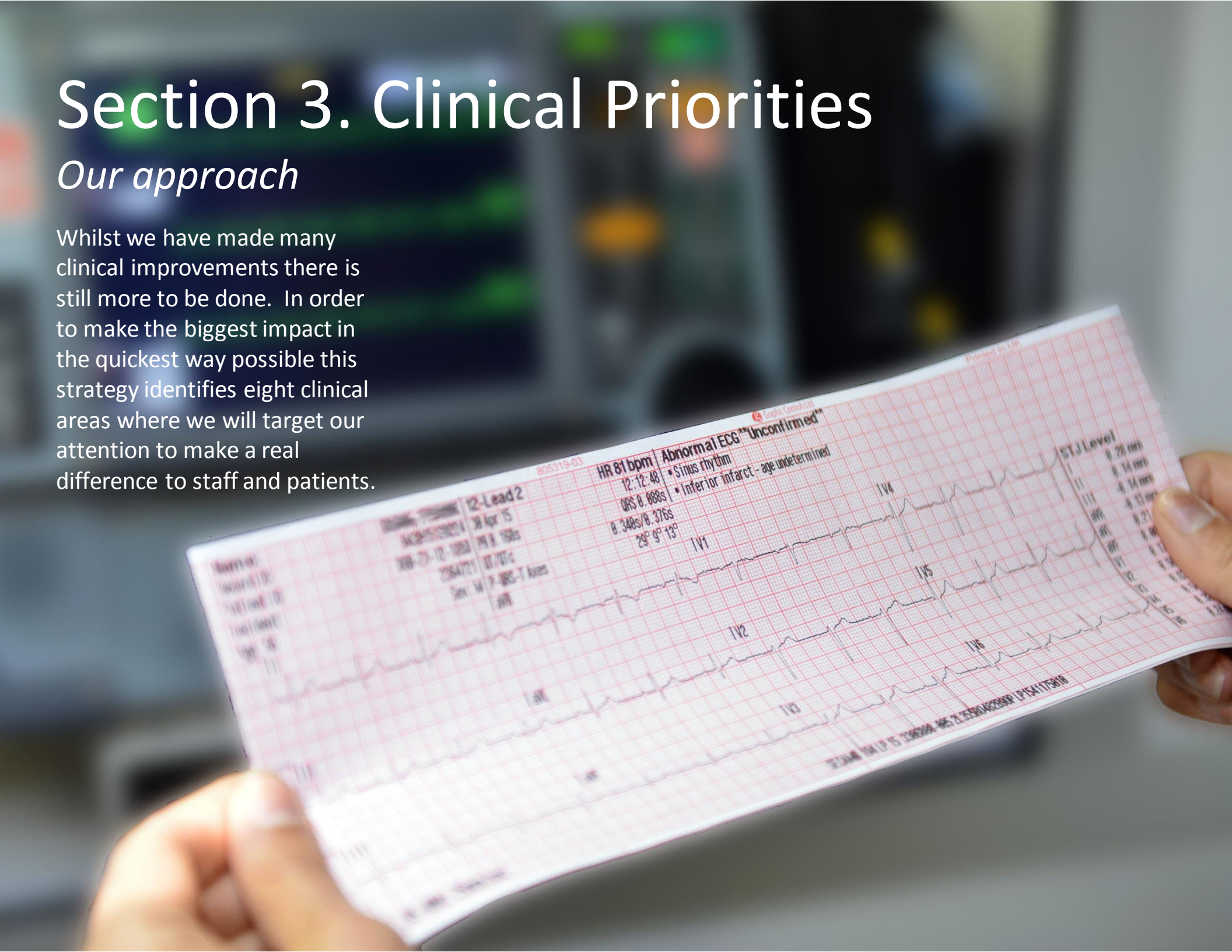
Quality themes & priorities

1. Being excellent at the ***basics***
   - 1.1. Leadership
   - 1.2. Guidelines
   - 1.3. Records
2. Thinking about ***time***
   - 2.1. Right first time
   - 2.2. Giving patients time
   - 2.3. Acting quickly
   - 2.4. Planning ahead
   - 2.5. Working in partnership
3. Caring about ***safety***
   - 3.1. Continuous improvement
   - 3.2. Safeguarding
   - 3.3. Reporting incident and risk

Section 3. Clinical Priorities

Our approach

Whilst we have made many clinical improvements there is still more to be done. In order to make the biggest impact in the quickest way possible this strategy identifies eight clinical areas where we will target our attention to make a real difference to staff and patients.



Our Recent Clinical Priorities

Our achievements

What we have achieved so far

Immediately following our 2017 Care Quality Commission's re-inspection, our priority was to bring greater stability to the systems that support the provision of safe high-quality care.

This work included the creation of enabling strategies, developing associated improvement plans and refocusing priorities. Examples of this work are:

Medicines Management

Our new Medicines Optimisation Strategy sets out a significant programme of work to ensure that we govern the use of medicines in the Trust according to the law and best practice. We have set up a system for auditing that the rules are followed and drugs stored securely.

Safeguarding

Our new Safeguarding Strategy sets out how we will ensure that patients are protected from harm and report concerns when we come across patients who are at risk of abuse. It also addresses the importance of the safety and wellbeing of our staff.

Learning from incidents and complaints

We have encouraged greater reporting of incidents and concerns and are pleased that more are being reported. We have improved the process for investigating serious incidents and for learning from them. We still have to improve the speed of investigation.

IBIS

The Intelligence Based Information System team has been supported and now contains details for 41,386 patients (Aug 2018) individual patients, including those receiving palliative care.

Strengthening clinical leadership

We have appointed to key positions that were vacant, including both clinical director posts and created additional clinical consultant posts.

Employing further clinical support

Over the past 18 months we have recruited into new clinical posts. These include: a chief pharmacist, mental health nurses, a consultant midwife, two further consultant paramedics and an assistant medical director. We will now be recruiting into a new deputy medical director post and a further assistant medical director post.

Infection Prevention and Control

We have developed a brand new approach to infection management called Infection Prevention Ready.

Technology support

We have issued portable devices to all front line staff, facilitating two-way communication, on-line learning and completion of incident and safeguarding forms. This has enabled us to implement further electronic tools such as the electronic Joint Royal Colleges Ambulance Liaison Committee Clinical Guidelines. These are now on the portable devices and provide up to date clinical guidance at the patient side and also permit the Trust to upload SECAmb specific information.

Our New Clinical Priorities

Our intentions

Our eight new priorities

Having addressed the immediate issues, we can now adopt a more strategic approach to clinical improvements. This section provides an overview. The final section of this strategy provides a more detailed view of the specific actions we plan to take in order to generate the intended improvements and how each of the projects will also address the quality priorities.

Cardiac Arrest

The Trust is currently not meeting the national standards for the management of cardiac arrest. For example we are taking longer to administer the first shock than the target time of two minutes from arrival. It is important that we improve this performance.

In addition, this trust is one of few that has invested in defibrillators that can transmit cardiac arrest data at the touch of a button. This is only happening in about 50% of cases at the moment and we want that figure to improve so that we have a better understanding of how we are looking after these patients.

We are starting to train staff in the ten steps to improve Out of Hospital Cardiac Arrest (OHCA) survival developed by the Global Resuscitation Alliance(GRA).

Stroke

Improvements in outcomes for SECAmb's stroke patients is part of a wider NHS initiative to make sure that the diagnostic and treatment facilities are available 24/7 in all the hospitals we take stroke patients to. Progress is being made across Surrey, Sussex and Kent to improve the availability of these services and we will play our full part in ensuring that patients are taken to the right place for the care they need. Kent & Medway have consulted on changes to how they care for stroke patients. Progress in other areas is slightly slower but we will be ready to cooperate with all initiatives.

Mental Health

Patients with mental health problems presenting to the ambulance service range from people who need help to find the right mental health service support (as opposed to a trip to A&E) to those in severe crisis who are detained under the Mental Health Act for their own or others' safety.

In all cases we need to liaise with other agencies including Mental Health Trusts or the police service. We want to improve our procedures and our performance for this group of patients.

Changing Clinical Priorities

We have helped shape local services. For example, some vascular emergencies require very quick action and life-saving surgery. These are not always easy to recognize and increasingly vascular surgeons are considering how to ensure 24 hour availability of surgery. Therefore, we have been required to play a significant role in providing effective system redesign.

We need to ensure our ability to respond to local need is a high priority for our clinicians.

Paediatric emergencies

While most emergencies involving children can be dealt with at their local hospital, some illnesses and injuries require specialists. We will work with the hospitals in our area as they begin to develop networks for paediatric care.

Ourselves, we will convey all patients under one-year-old because of the risk that very young children can deteriorate quickly (and of course are not in a position to explain what is wrong) and we will improve training and risk management for this group of patients.

Older people who fall

At the moment we are not always in a position to respond quickly to patients who do not seem to have serious illness and injuries. However, we know that some patients can suffer consequences while they are waiting. For example an older person who has fallen may be at risk of developing pressure sores if their skin is already vulnerable. We are investigating whether our team of community first responders (CFRs) and colleagues from the Fire and Rescue Service (FRS) could be deployed to make a person comfortable and safe while the ambulance is on its way.

Recognition of acute symptoms including Sepsis

More than 40% of cases of sepsis occur in the community and it is therefore important that ambulance service staff are able to recognise the signs of symptoms of sepsis. Work in the ambulance sector has found that knowledge was not as widespread as it could be [2]. The Royal College of Physicians has developed and now updated the National Early Warning Score (NEWS2) which we are adopting to ensure that we improve recognition and treatment of the signs and symptoms of sepsis and other acute conditions. We will work with partners to ensure that patients receive the right onward transport and care.

Infection prevention

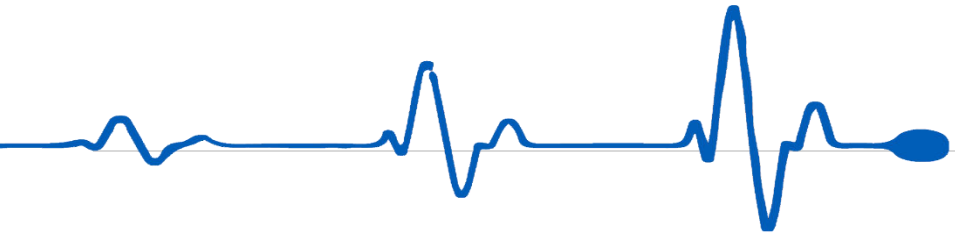
We have recently launched a new strategic approach to infection control. This acknowledges that we are only part of a patient's pathway and that we recognize we need to ensure our practice is as safe as possible in order to protect patients later in their care. We will implement and monitor the effectiveness of this new approach.

Our Clinical Priorities

A summary of this section

Eight clinical priorities

1. Cardiac arrest
2. Stroke
3. Mental health
4. Changing clinical priorities
5. Paediatric emergencies
6. Older people who fall
7. Sepsis
8. Infection prevention



Section 4. Context

Our ambitions and our enablers

This section explores some of the context in which we operate and identifies a number of the key enablers to us making successful improvements.

Our context

Our future ambitions

The context in which our improvements operate

The biggest challenge facing ambulance services, and indeed the whole NHS, is how to provide care to an aging population with limited resources. Achieving that will require unprecedented cooperation between NHS organisations and a willingness to think differently about how we and our partners respond to patient need. Ambulance services can make a big difference to the way that health and social care resources are used as a result of the decisions they make about where to take patients or what alternative care and support to secure for them.

SECAmb serves a population of almost 5 million people across the counties of Kent, Sussex, Surrey as well as a small part of Hampshire. The population is set to grow, with significant housing developments in some parts of our area.

About three quarters of our Clinical Commissioning Group (CCG) areas have numbers of over 65-year-olds and 85-year-olds higher than the England average. Older people, of course, have greater levels of frailty and have more long term conditions and multiple conditions than younger people.

In England as a whole we have seen a "sharp rise in the number of emergency admissions for patients aged 85 years or older (up 58.9%) and in admissions for patients with multiple health conditions. One in three patients admitted to hospital as an emergency in 2015/16 had five or more health conditions, compared with just one in ten in 2006/07 (a percentage increase of 271%). In fact, the number of emergency admissions for patients with just one condition fell over the same period (by 34%)."[3]

999 patients with multiple conditions may not need life-saving care, but they are often the patients who need complex and sophisticated decision-making. A diabetic patient who is developing dementia may be neglecting their medication. They may not need hospital but they may need long-term support in taking their medications that will prevent a diabetic emergency hospital admission. An elderly patient may present with reduced mobility and confusion. This could have a number of causes.

Understanding the range of possibilities and establishing the best response for these patients is a significant skill. When we are called to a patient who has fallen, our main job has been to check for injuries and take the patient to hospital if they need it. But as NICE Guidelines[4] state, first time fallers should receive a multifactorial assessment, and the ambulance service can facilitate that happening.

We are committed to working with geriatricians and specialists in long term conditions in our area to develop pathways for care for this important group of patients.

Our Enablers

And our dependencies

Things we need to consider

Our staff

Although it is these days a cliché to say that our staff are our greatest asset, it is nonetheless true that staff from the control room to the front line, and all our support staff too, are going to be the reason that our clinical care improves.

We will:

- Provide appropriate training and guidance for everyone at every level
- Work towards ensuring that everyone has time to keep their skills up, including time to practice the skills they use rarely
- Value and develop the specialist paramedic staff, expanding and maximising their use, and providing career progression opportunities
- Develop a multi-professional response capability, especially around mental health, pharmacy expertise, and other allied health care skills (either by employing people directly or in cooperation with other Trusts)

Technology enablers

Staff need the tools to do their jobs and there are more and more ways now becoming available that can improve the quality and efficiency of what we do. They often require considerable financial investment, although it is just as important to provide training and support to staff as new technologies are brought in.

We will:

- Provide and maintain appropriate equipment and replace and improve it as resources allow
- Develop information systems, including an electronic patient record tool by April 2019
- Investigate telemedicine to help frontline staff to seek support in their decisions. This is already working well in Kent for Stroke care and we will seek further opportunities for expanding the use of this technology.

Learning as an enabler

Further improvement will come from educations and training; reflective learning; learning from successes and mistakes, and assessing what we do through audit.

We will:

- Encourage reporting of incidents and near misses, investigate quickly and thoroughly and communicate learning
- Preserve time for staff to undertake training and development
- Develop our clinical audit programme and act on the results of audits

Partnership as an enabler

Much quality patient care depends on how people in different organisations work together. From what happens in hospital for the patient we have successfully resuscitated, to how a community mental health team is able to respond to someone in crisis, so that they don't have to go to the emergency department, almost all of the patient care we provide is part of a chain of care provided by the whole NHS.

We also rely on our commissioners to make decisions on investment for patient care.
We are going to:

- Communicate our plans and seek feedback
- Keep our partners updated on our clinical performance and our progress
- Invest in managers who will develop local plans for patient pathways in partnership with other Trusts
- Initiate, where appropriate, new ways of responding to patients, bringing partners together to develop solutions to serve patients better

Measuring success

There are many ways we could measure our success in implementing this strategy.
These include:

- Performance against the national Ambulance Quality Indicators (AQIs)
- Feedback from partners in the NHS that the ambulance service is playing its full part in developments
- Staff satisfaction, particularly with training and having a clear sense of direction from clinical leaders
- Clinical audit reports and evidence that we have improved as a result of them
- Learning from incidents and complaints and evidence that we have improved

Context & enablers

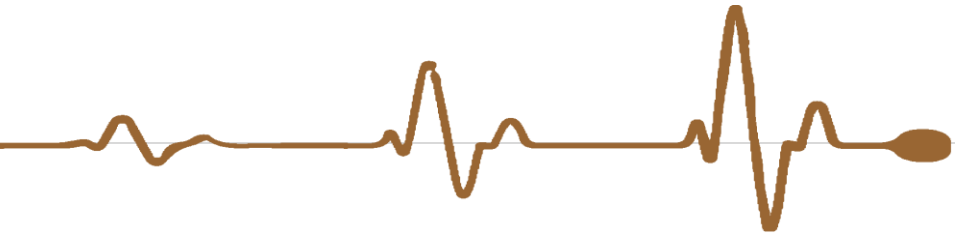
A summary of this section

Context

1. Aging population
2. Limited resources
3. Growing population in the South
4. More patients with multiple problems
5. The need to think differently

Enablers

1. Our staff
2. Technology
3. Learning
4. Measuring success



Section 5. Overview

Overview documents

The aim of our eight clinical priorities is to either improve clinical outcomes, improve safety, or improve the patient experience. However, we are also asking each project to identify how it will impact on our quality priorities. The following section gives a brief outline of each clinical priority and identifies how each one of them will address the improvements in our eleven quality priorities.

This section also includes an infographic that summarises our clinical and quality priorities.

Clinical Priority 1

Cardiac Arrest Survival

Project Outline	Quality Priority	Project Action
Cardiac Arrest Survival **Project aim: *To develop a complimentary cardiac care strategy for the Trust***	Leadership	*Leading the development of a cardiac care strategy will provide an excellent development opportunity for the identified lead*
	Guidelines	*A new cardiac arrest Standard Operating Procedure and a new policy will be developed*
	Records	*The strategy will include guidance on what to document and how best to document our interventions*
	Getting it right first time	*The cardiac care strategy will include clear educational and development guidance for our clinicians*
	Giving patients time	*The focussed work in our Emergency Operations Centre and our 111 centre will ensure patients are identified quickly and afforded the correct time*
	Acting quickly	*The strategy will include a focus on our Emergency Operations centre to ensure we are able to improve our average time to start CPR time from 3.5 minutes*
	Planning ahead	*The development of a strategic approach to cardiac care will accommodate, as best as possible, future needs*
	Working in partnership	*The strategy will be developed in collaboration with colleagues from other providers*
	Continuous improvement	*Cardiac care will feature within our audit plans and we will widely publicise our outcome data across the organisation*
	Safeguarding	*There is no specific aim to improve safeguarding within this initiative*
	Reporting incidents & risk	*The cardiac care guidance will give a clear indication on when staff should report cardiac related incidents*

Clinical Priority 2

Accommodating Changing Clinical Priorities

Clinical Priority	Quality Priority	Action
Changing Clinical Priorities **Project: *To develop a clinical vision and clinical approach that identifies our intention to be responsive and adaptable to changing clinical need.***	Leadership	*This is more of an "approach" rather than a project. We are asking the organisation and our clinical leaders to be responsive and adapt to changing circumstances. As a result, we have already strengthened clinical leadership by the appointment of a Consultant Midwife, additional Paramedic Consultants, Medical Consultants and a new Safeguarding Consultant*
	Guidelines	*Where possible, we will ensure all our guidance is linked to evidence so that our clinicians have the right information at the time needed. We would expect with the introduction of a Consultant Midwife that we will have stronger guidance and support for our staff regarding midwifery care*
	Records	*By ensuring we are able to respond to changing needs we will make every effort to ensure any changes to documentation are as future proof as possible*
	Getting it right first time	*We have the ambition to always get it right first time and the way we will adapt to future changes will ensure this ambition remains at the forefront*
	Giving patients time	*Our adaptive approach includes the way we respond to the demands made of our operational colleagues. We will continue to support and challenge the operational teams' requirement to be more efficient with the requirement to provide appropriate clinical time*
	Acting quickly	*Our vision will ask for senior clinicians to be adaptive and responsive which fulfils our quality priority requirement to act quickly*
	Planning ahead	*Through horizon scanning we will ensure we have a senior clinical leadership team that is able to lead on future clinical issues*
	Working in partnership	*Our vision will clearly identify our need to work in partnership with others*
	Continuous improvement	*We intend to strengthen our clinical audit programme and attempt to engage more clinicians in the audit process and ensure the results influence practice*
	Safeguarding	*We have already introduced a Safeguarding Consultant to the team and anticipate that this role will bring real benefit to the way we manage safeguarding*
	Reporting incidents & risk	*We will encourage incident reporting by asking our clinical leaders to learn and to evaluate service changes through incident analysis*

Clinical Priority 3

Paediatric Care

Clinical Priority	Quality Priority	Action
Paediatrics **Project: *To review current conveyance guidance for children***	Leadership	*The review of paediatric guidance has Executive Clinical Leadership*
	Guidelines	*This project has intention of strengthening guidance for staff by ensuring the guidance is evaluated and new guidance is evidence based*
	Records	*Any new guidance issued will give a clear indication on what our clinicians need to record in the patient record*
	Getting it right first time	*This project has intention of strengthening our ability to get it right first time by having robust evidence based guidance in place*
	Giving patients time	*The new guidance will not specifically address the need to give patients time as it will clearly indicate when conveyance is*
	Acting quickly	*The new guidance will ensure, when appropriate, staff act quickly*
	Planning ahead	*The project does not specifically address this quality priority*
	Working in partnership	*The review is being undertaken in partnership with a university and any consequential changes will have the appropriate partnership discussions*
	Continuous improvement	*The review of the current guidance is being undertaken relatively recently after issuing guidance for staff. This si an indication of our intention to continuously review and improve*
	Safeguarding	*Whilst the guidance does not specifically address the safeguarding quality priority the issuing of clear guidance will have an indirect benefit*
	Reporting incidents & risk	*Any new guidance will clarify when to undertake an incident report*

Clinical Priority 4

Infection Prevention

Clinical Priority	Quality Priority	Action
Infection Prevention **Project: *To develop and implement a whole new approach to Infection Prevention which will engage staff and improve awareness, knowledge and partnership working.***	Leadership	*Infection Prevention has Executive Clinical Leadership*
	Guidelines	*The improvement plans identify the need to have strong clear guidance under the new approach of "Infection Prevention Ready"*
	Records	*There is no specific record-keeping component to the plan but the project has a catalogue of audit tools which will be used to record compliance to the procedures for Infection Prevention Ready and cleanliness standards for vehicles and the built environment*
	Getting it right first time	*As part of our review work we will ensure our Emergency Operations Centre is able to identify infection prevention issues right at the point of contact*
	Giving patients time	*Patients with infection are always given the necessary time and therefore this does not feature in our planned improvement work*
	Acting quickly	*The new guidance will ensure the Trust acts quickly when serious infection is anticipated*
	Planning ahead	*The plans include the intention to develop a fit for purpose Infection Ready Team which is supported by local Champions. This will enable us to regularly review the procedure and its effectiveness*
	Working in partnership	*The new plans and procedures will be developed in partnership with Public Health England, the IPC Lead from the NHS Improvement Team, Patient Representatives from the Trust*
	Continuous improvement	*National and international guidance will be continuously reviewed in the line with the procedure. A library of training and awareness videos are being developed for staff to access*
	Safeguarding	*There is no specific safeguarding component to our infection prevention improvement work*
	Reporting incidents & risk	*The work will raise the profile of Infection prevention and ask staff to ensure they report all relevant infection incidents for the Trust's reporting system*

Clinical Priority 5

Sepsis Care

Clinical Priority	Quality Priority	Action
Sepsis ***Reviewing current Trust practice against national best practice***	Leadership	*We now have a number of clinical consultants. Specifically, the consultant paramedics Chair the Trust's "Deteriorating Patient Group". The DPG comprises "Deteriorating Patient Ambassadors"; operational clinicians from each Operating Unit who are responsible for disseminating information and leading CPD in their localities. This provides leadership and a point of reference for staff in these critically important practice areas*
	Guidelines	*We will be undertaking a review of all practice guidance relating to sepsis*
	Records	*The review of the current documentation will include the ability to record the Quality Indicators for sepsis and NEWS2 scoring*
	Getting it right first time	*We have a good track record of managing sepsis, on the back of the early adoption of the Patient Safety Alert issued in 2014. This project will ensure we continue to aim for rapid identification of potential sepsis*
	Giving patients time	*The outcome for patients with severe sepsis worsens if treatment is delayed. Mortality can increase by up to 7.8% per hour without definitive treatment in hospital. By responding quickly, screening for sepsis and treating accordingly, we promote outcomes and give more time to patients and their families*
	Acting quickly	*Through our partnership working across the region, facilitated by the Academic Health Science Network, we promoted the use of the term "Red Flag Sepsis" among community teams to use when calling for ambulances. Partnership working will continue through the duration of the project*
	Planning ahead	*Our Deteriorating Patient Group will provide resource to ensure that we stay ahead of the curve; reviewing evidence and updating practice accordingly*
	Working in partnership	*This project requires us to work in partnership with the academic network and other provider Trusts*
	Continuous improvement	*Audit data is a vital aspect of evidencing what we do for patients with sepsis, and to help shape better care. This project will involve clinical audit in our ability to evidence improvement and learn*
	Safeguarding	*Making sure our EOLC Lead and Safeguarding leads work together to learn from cases where these very complex patients call 999 has proved vital for promoting care for patients and respecting the limits of care they wish to receive as they near the end of their life*
	Reporting incidents & risk	*We already receive incident reports relating to the care of septic patients. This project will continue to promote recording*

Clinical Priority 6

Patients who Fall

Clinical Priority	Quality Priority	Action
Patients who fall ***Project Aim: to review the current variation in the way we manage patients who have fallen and make best practice recommendations***	Leadership	*Leading this project with the support of a designated Consultant Paramedic will provide excellent leadership development for this important Trust and sector-wide project*
	Guidelines	*The project will result in clearer guidelines and the project will support the development of a falls flowchart for our Emergency Operations Centre*
	Records	*The project will strengthen the documentation currently held on our vulnerable patients database (IBIS)*
	Getting it right first time	*We will evaluate a variety of initiatives such as the Specialist Falls response vehicle crewed by an OT and Paramedic to provide rapid response and full medical and falls risk assessments to patients to ensure we are getting our response right first time*
	Giving patients time	*The project will include the proposal to introduce Community Guardians to provide post fall pastoral care to patients who have fallen to improve psychosocial factors of falling*
	Acting quickly	*This project will allow us to act quicker with the correct response*
	Planning ahead	*By having an agreed approach to patient who have fallen will enhance our ability to maintain a service at times of high demand*
	Working in partnership	*This review will require us to work with a number of provider organisations as some of our approaches to patients who have fallen are a joint venture with partner Trusts*
	Continuous improvement	*We will endeavour to ensure we continually improve by measuring referral rates to falls providers, measuring impact of falls response vehicles, Increased training to EOC and road staff on impact of falls*
	Safeguarding	*Many of these patients are frail and vulnerable. The project will engage with our safeguarding team*
	Reporting incidents & risk	*The project will encourage the use of incident reporting as a method of capturing issues with our falls service*

Clinical Priority 7

Stroke Care

Clinical Priority	Quality Priority	Action
Stroke **Project: *Work in partnership with a major review of stroke services across the three counties***	Leadership	*The Specialist Pathways Lead and Consultant Paramedic will maintain Trust leadership of the project. This is an excellent opportunity to lead and represent the organisation at a sector level*
	Guidelines	*The project will give the need for the Trust to review the current guidance that we have for staff*
	Records	*The documentation of stroke care is currently audited as part of our Quality Indicators. This project is likely to make a positive impact on record keeping*
	Getting it right first time	*SECAmb is also participating in an in-depth analysis (SPRINT audit) with the William Harvey Hospital analysing the entire patient journey from 111 or 999 call to needle (thrombolysis). This data will enable us to streamline the existing journey and identify areas where care can be further improved*
	Giving patients time	*The time it takes us to care for a stroke patient is monitored as part of our Clinical Outcomes data. It is possible that this project lengthens the initial time we spend with some patients but the result is an improvement in getting it right first time*
	Acting quickly	*SECAmb is jointly leading a feasibility study on the use of telemedicine in ambulances for better stroke triage. It is hoped this will not only cut times from call to needle, but prevent patients who are having stroke 'mimics' from bypassing their local ED unnecessarily once the new HASUs have been set up*
	Planning ahead	*The review work will require the Trust to consider current practice and the educational needs of our clinicians for the future*
	Working in partnership	*The whole project is about working in partnership. But specifically the Trust is working in partnership with stroke units in Surrey and Sussex to promote and enable direct calls to stroke nurses. We are also working in close partnership with other Trusts on telemedicine (in one area) and the Get It Right First Time (GRIFT) programme and thrombectomy travel times*
	Continuous improvement	*This project is grounded in sharing best practice across the sector and ensuring that the sector also learns from what has been undertaken in other areas of the country*
	Safeguarding	*There is no specific safeguarding component to our stroke improvement work*
	Reporting incidents & risk	*There are stroke liaison managers in each county who have links with local HASUs/stroke units. They investigate relevant issues. These are fed back and we will make every effort to ensure these are being appropriately captured on our incident reporting system.*

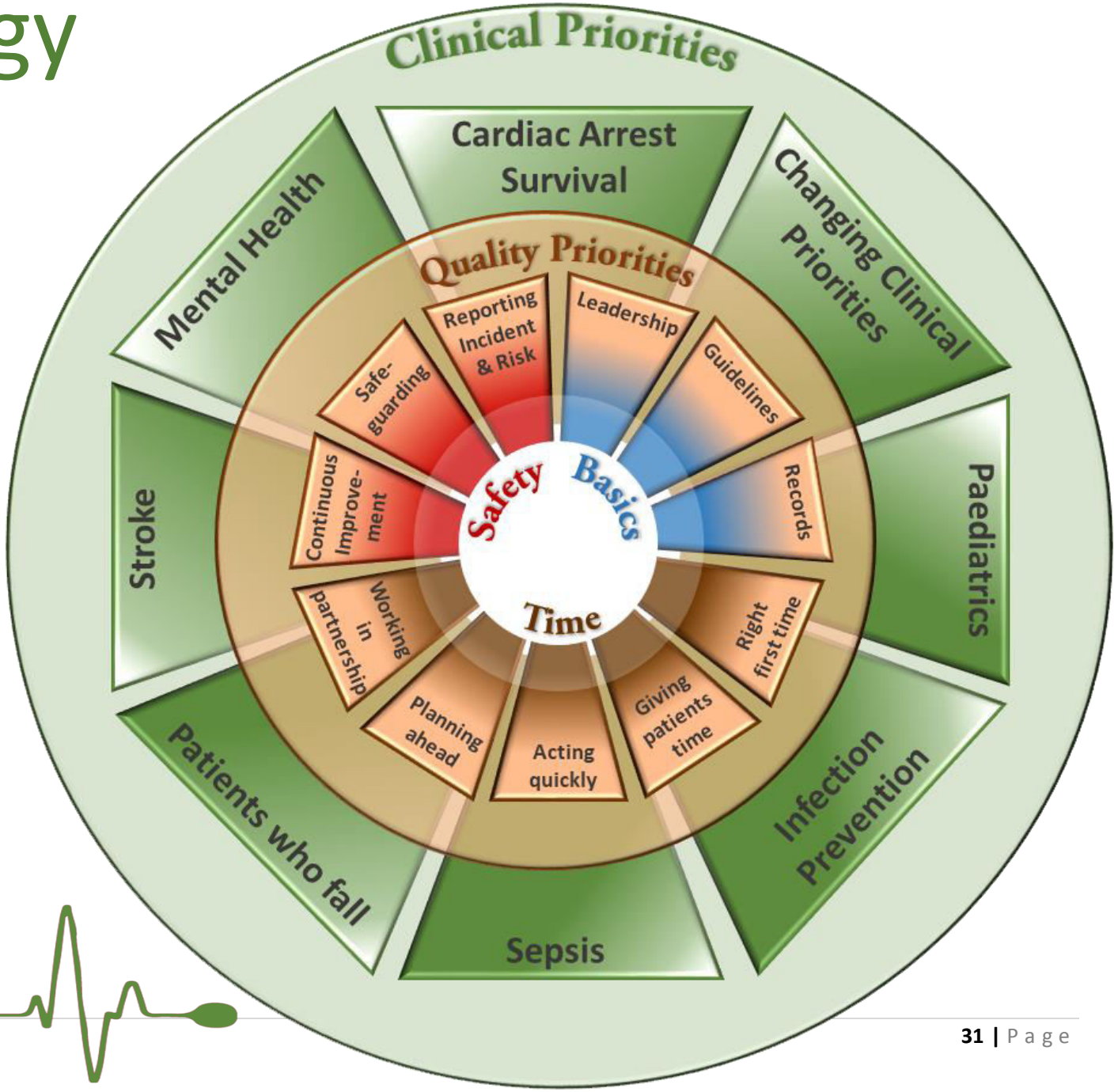
Clinical Priority 8

Mental Health Care

Clinical Priority	Quality Priority	Action
Mental health **Project: *To develop a cohesive and strategic approach to mental health care in the Trust***	Leadership	*Our Mental Health Strategy will be led by our Consultant Mental Health Nurse*
	Guidelines	*Our clinical interventions will be informed by the most current national and local legislation and guidelines e.g. NICE. We will continuously monitor and review our current related policies and procedures to reflect service developments internally and with our partner agencies*
	Records	*We will further develop our specialist clinical assessment tools e.g. Mental Health Risk Assessment to enable their use is compatible with our clinical recording systems and audit processes*
	Getting it right first time	*We will ensure that our frontline staff receive the most up to date and role commensurate training to enable accurate assessment and clinical decision-making. We will explore various delivery methods to ensure the effective engagement of the same. We will recruit mental health professionals to our Emergency Operations Centres to provide interventions, advice and guidance to our frontline staff*
	Giving patients time	*By implementing Registered Mental health professionals into the Emergency operations Centre we will improve our ability to give patients the appropriate level of intervention at the point of contact*
	Acting quickly	*We will ensure that via training and simulation, that our frontline staff our able to confidently assess and plan appropriate clinical outcomes in time critical situations*
	Planning ahead	*Via our representation at various external forums e.g. National Ambulance Mental Health Group and partner agency meetings e.g. Crisis Care Concordats, we will horizon scan for pending developments nationally and locally and make service preparations accordingly*
	Working in partnership	*We will continue to work with our partner agencies and stakeholders e.g. mental health providers, police and commissioners*
	Continuous improvement	*We will benchmark and audit our processes in line with national best practice guidelines via internal audit and continue to report as required to the Executive team e.g. mental health conveyancing*
	Safeguarding	*There will be close collaboration with the Mental Health and Safeguarding Teams to monitor the use of the Mental Capacity Act and safeguarding processes in relation to specific cases involving patients with mental health challenges*
	Reporting incidents & risk	*The Consultant Mental Health Nurse have an overview of all Mental Health specific incidents, and subsequent required changes to practice and points of learning that may arise will be circulated as appropriate*

Our Strategy

Plan on a page



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[3] Steventon, A. Deeny, S. Friebel, R. Gardner, T. and Thorlby, R. Briefing: Emergency hospital admissions in England: which may be avoidable and how? Health Foundation, May 2018, pp 5-6

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South East Coast Ambulance Service NHS
NHS Foundation Trust

		Agenda No	95-18
Name of meeting	Trust Board		
Date	28 September 2018		
Name of paper	Mental Health Provision Business Case		
Responsible Executive	Bethan Haskins, Executive Director of Nursing & Quality		
Author	Gary Davies-Ebsworth - Consultant Mental Health Nurse		
Synopsis	This business case is recommended by the Executive Management Board. It required Trust Board for approval due the whole life costs exceeding the delegated limits (£300k). The case sets out the preferred option (1) aimed at enhancing the provision of mental health support at the Trust.		
Recommendations, decisions or actions sought	The Trust Board is asked to approve the Business Case.		
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).		**Yes~~/No~~**	

BUSINESS CASE PROFORMA

ENHANCEMENT OF MENTAL HEALTH PROVISION

11th September 2018

Author(s): Gary Davies-Ebsworth - Consultant Mental Health Nurse
Steve Norman – Mental Health Education Lead
Natalie Cole – Operational Team Leader Mental Health Team
In consultation with:
Sue Barlow, Head of Emergency Operations Centres
Scott Thowney, Senior Clinical Operations Manager
Andy Collen, Consultant Paramedic
Executive Lead: Bethan Haskins, Executive Director of Nursing and Quality
Directorate: Nursing and Quality
Concept Proposal Ref:
Version: 4
Date of approved summary QIA:
Final Decision:

Date proposal reviewed	By	Decision made
	Which committee/group reviewed the final submission	*(Approve, reject, request further detail)*

Document Control:

Version Control:

Please record all key changes made to the document and how these have been approved (either person or committee				
Version	Date	Author and title	Summary of key changes	Approval by
V3	15/08/18	Gary Davies-Ebsworth		
V4	11/09/18	Rachel Murphy	Finance Tables and updated format	

Distribution list:

Please ensure you capture all persons/groups/committees (both internal and external) you have shared the document with and why				
Version shared	**Person and title or Committee**	**Date reviewed**	**Reason for distribution**	**Comments**
V3	Rachel Murphy	11/09/18	Finance Input and review	
V4	Gary Davies-Ebsworth			

Review and Approvals log:

Please ensure you log (in chronological order) all reviews and approvals to show the audit trail for support for your proposal				
Version shared	**Person and title or Committee**	**Date reviewed**	**Recommendation given (reviewed and support, approved, reject)**	**Rationale**
	Executive Sponsor			
	Associate Director of Finance			
	Sustainability Steering Group – All Cases			
	EMB – All Cases with a whole life cost of more than £100k			
	FIC and Board – Cases with a whole life cost of more than £300k			

Proposal overview

1. Please provide a brief description of your proposal

This should be in summary form (five to six sentences) and include the current state, the issue or problem, the options and the preferred Solution.

At present, we have in post a Band 7 Mental Health Education Lead who is an experienced mental health professional. He currently leads and develops training in this area and supports the Mental Health Consultant Nurse (MHCN) in representing the service with stakeholders in the Kent Locality. Our education in this area has greatly benefited from having an expert in the field leading the design and delivery and has freed the Clinical Education Department to concentrate on delivery in areas commensurate with their expertise. To date the post holder has delivered specialist training to over 300 staff, and is about to develop the mental health assessment pathway within the Manchester Triage system for the Integrated Care and Assessment Service (ICAS). The support in the Kent locality has allowed SECAmb representation in key stakeholder forums, in particular the concordat meetings. It must be noted however that the support provided to the Kent locality by the current post holder is not a feature of the current job description as this post is primarily an educator role. The post is currently funded by Health Education Kent, Surrey and Sussex (HEKSS) and this funding is due to expire in November this year. The proposal is to substantiate this post within SECAmb with a revised job description to highlight the required additional responsibilities required for these posts, as well as replicating the post in the Western locality. This will enhance the provision of mental health expertise within the Trust. Propagating a positive attitude towards mental health via high quality training will complement the culture change programme on which the service has embarked. It is also proposed to enhance the current post to include the supervision and clinical governance arrangements of mental health professionals (via ICAS) based in EOC, and to provide oversight and therefore enhance safety and clinical effectiveness for mental health triage in EOC. The post holders will also work closely with the Frequent Caller Team and hold a small caseload of complex cases. This fits strategically with the recent appointment of two Frequent Caller Leads for the East and West Localities of the Trust. The post holders will also assume the roles of locality dementia champions as described in the AACE Dementia Best Practice Guidelines. The post holders will also formally provide cover for the MHCN as required. Within this proposal there is provided feedback from a number of sources, which highlight the value of the educational aspect of the role. As the proposed posts have a number additional roles and responsibilities it would not be meaningful to draw on the effectiveness of the current post holder over the previous year as a comparator to envisage the future benefits of the proposed new posts, as the new posts are very different.

2. Does the proposal make strategic sense?

a) What will happen if we do not support the proposal? Is it a must do i.e. due to a regulatory requirement? Please highlight if this relates to a risk on the Corporate Risk Register

Health Education Kent Surrey and Sussex have funded the post until November 2018, the funding ceases at this point. If the post is lost:

- The current momentum for mental health education will be lost
- The responsibility to deliver mental health education will fall back to the Clinical Education Team and they do not have the expertise or capacity to deliver the same effectively.
- The entire mental health strategic and training agenda will fall to a single person

and there will be additional lost momentum in periods of the post holder's absence e.g. leave periods.

- Mental health professionals recruited via ICAS will not have access to clinical supervision
- One of our proposed clinical priorities is to enhance the effectiveness of our response to mental health and this priority will be difficult to realise without the expertise in the service (current response to sec 136 open risk on Risk register within risk 283).
- The National Training Priorities for ABD (our current training deficit for ABD is current on the Risk Register no. 568), dementia, and suicide will not effectively be met.

b) How does the proposal fit with the Trust's current strategy?

This proposal fits in the following aspects of the Trust's 5 Year Strategic Plan 2017-2022:
The vision and mission sets the scene for this.
Our Vision - Support our staff to provide a caring, high quality and efficient urgent and emergency care service to our communities.
Our Mission - To deliver our aspiration of being better today and even better tomorrow for our people and our patients. p.8

1. To deliver sustainable services, secure best possible outcomes for our patients. P.6
The Trust receives in the region of 2500 mental health related calls each month, therefore a significant number of our patients have mental health difficulties. Our EOC staff are now receiving bespoke training; however, this will not provide them with expertise to manage complex mental health presentations that they currently have to do. This often causes great anxiety in staff, and we have evidence that this does become pathological requiring treatment. To provide a caring service staff must be cared for. Our crews/EOC/111 will be best prepared for this by receiving the best quality education, delivered by a trainer with professional expertise.
Leane Stephens, Assurance Co-ordinator reported concerns expressed by crews in relation to lack of mental health training during QAV visits across the organisation in March 2018, reporting:
"Crews have singled out MH (specific) training as something that would be helpful over any other training (in addition to what's already included in Key Skills)."

Roy Mathams Senior Clinical Trainer stated of the current post holder:
xxxxx has been an asset not just with the ability to deliver mental health education but his knowledge and experience is of the best.
xxxxx has been attending ECSW courses since his arrival and delivering Mental health training, he has also helped in redevelopment of the session to meet the needs of the student and patient.
He is currently delivering Key skills, train the trainer and mental health sessions. The OTLs have found his extra knowledge of high importance to assist them with delivery. He developed the session and the guidelines for the OTLs.
Feedback from students is always good with no complaints only further questions, which shows the engagement he encourages in his sessions.
He would be a loss to the education of the staff and to enhance their care for the mental health patient".
Assessment of risk in relation to mental health is a core component of mental health education and this would be lost without the expertise of a mental health practitioner delivering the training.
The mental health aspect of key skills is reported by OTL's as the most difficult aspect of training for them to deliver. The Clinical Education Department will be looking to mental health

practitioners to deliver this when the training programme is reviewed, therefore we will require the expertise in service to deliver this.

2. …we need to work in increasing partnership with other agencies….
There are 4 large mental health trusts within the SECAmb footprint, all of which have generated a number of forums, which require SECAmb representation. Representation from SECAmb in the form of mental health professionals who understand these services, MH legislation (in particular Section 136 of the Mental Health Act and who can utilise relationships formed through previously working within them has provided closer collaboration and better understanding of respective services. Within these collaborations, we have also commenced discussions in the area of collaborative mental health risk assessment with our mental health providers and look to develop a risk assessment tool for mental health conveyancing. We are also working in collaboration with said services to reduce conveyancing under Section 136 (our current low response to Sec 136 is on the Corporate Risk Register) by integrating our proposed ICAS mental health professionals with street triage services and the police control rooms. We will require a senior mental health professional in each locality (East and West) to provide clinical supervision to ICAS staff and to co-ordinate this interface (in particular the ability to form and maintain closer links with crisis services and the police in co-ordinating an effective mental health response to those in mental health crisis). Without these key posts, these frameworks will be significantly compromised.
3. 5 year plan: We will develop and deliver an integrated clinical model that meets the needs of our communities whilst ensuring we provide consistent care which achieves our quality and performance standards
The integrated clinical model includes mental health. This will require maintenance of quality education as well as input for its development from mental health professionals.

4. 2 year plan: Work with STPs to design and deliver generalist and specialist care pathways for patients requiring an acute hospital attendance
There is a large piece of work required to harmonise the MH care pathway across Kent, Surrey, and Sussex e.g. admission avoidance 'v' street triage, conveyancing priorities etc.
5. Clinical Education. As the needs of patients get more complex and the role of the ambulance service continues to evolve, particularly in light of the recently announced Ambulance Response Programme, we need to ensure that our staff have the appropriate skills and education, to effectively support our patient's needs. P.16
With mental health professionals based within EOC, being supervised by a senior mental health practitioner, we will be in a position to focus and improve our mental health pathways and specifically link in with our mental health provider pathways more effectively.
6. Mental Health Promotion and Illness Reduction p.16
The post (Mental Health Education Lead) currently supports the Well-Being Hub out of hours and provides support for staff experiencing mental health difficulties. As the Wellbeing Hub evolves, these posts will be able to provide supervision to the mental health wellbeing practitioners.

3. Summary of options

a) What options have been considered? Please provide a high level summary narrative of the options:

Options	*Brief description*	*Benefits*	*Downsides/risks*
Do Nothing or Do Minimum	Post will expire and cease to be in November 2018. The current situation in	None evident	The current post will cease in November. The current momentum

	E0C/111 pertaining to staff support, clinical input and links to other services remains the same. This is not commensurate with the aspirations within the Trust's 5 year Strategic Plan		for mental health education and relationships with stakeholders in the Kent locality will be lost. The responsibility to deliver mental health education will fall back to the Clinical Education Team and they do not have the expertise or capacity to deliver the same effectively. This must be delivered by clinicians with the commensurate expertise. (Education in the areas of acute behavioural disturbance (ABD), Suicide and Dementia are National Priorities). This would represent a significant risk to the organisation. The entire mental health agenda will fall to a single person (MHCN) and there will be lost momentum and no resource during periods of his absence e.g. leave periods. The MHCN would have to review commitment to duties not core to JD e.g. staff support in order to meet core strategic requirements of post. There will be no supervision route for mental health professionals recruited via ICAS. We will not have a crucial links with mental health provider services across the service at times of managing mental health crisis.
Option 1 (preferred option)	To substantiate current post to take responsibility for the East of the service and introduce a second post to take responsibility	This would be a strategic fit with the current intended service configuration and provides equity of resource across the service.	None evident

	for the West.	It would double the capacity and activity of current mental health education and enable the delivery of national education priorities of suicide, ABD and dementia thus reducing risk to the service. This will deliver significant educational improvement in the area of mental health. It will enable the development of further training programmes across wider mediums of delivery, e.g. e-learning modules. It would enable the NCMH to increase his capacity on strategic issues and take on more of a national role. To represent the service. (This is often sought but unfortunately declined due to capacity issues). There will be a provision for supervision and support of EOC based mental health professionals recruited via ICAS. East and West EOC's will have allocated oversight from a mental health professional. The Frequent Caller Team will have allocated oversight from a mental health professional East and West, which is strategic fit with the newly appointed Frequent Caller Locality leads. We will have locality Dementia Champions as per AACE Dementia Best Practice Guideline recommendations. All of the above will lead to improved patient experience. This would be commensurate with realising the 5-year strategy.	
Option 2	Substantiate current post with additional responsibilities.	The current mental health team is maintained	The anticipated benefits outlined in option 1 will not be realised.
Option 3			

b) What is the Net Present Value (NPV) and Return on Investment (ROI) of each of the options?

	Do Nothing	Option 1 (Preferred Option)	Option 2
Net Present Value at 3.5%, £	0	509,101	254,551

All of the above has been confirmed by: *include name of Finance BP*	Rachel Murphy

4. Preferred Option *(all sections from now refer to the preferred option)*

a) Please expand upon the preferred option and provide rationale for why this will be the best way forward. Include consideration to strategic fit, deliverability, ease of implementation, clinical, quality and financial benefits, and mitigation of risks

There is currently a mental health professional in post under a fix term contract under HEKSS funding. In addition to the core-funded role of Mental Health Education Lead, the post holder has taken on additional responsibilities strategically in the Kent locality and has covered the MHCN during leave periods. Therefore, a continuation of this post substantively has a strategic fit with the current mental health agenda with adaptability to take on the additional role of providing leadership to the proposed mental health professionals in EOC. The post will also continue with the established and ever evolving mental health-training programme, thus mitigating the risk of losing loss of continuity with the education programme. The current post holder has to date provided specialist training to over 300 staff. As post is already established, there are no obvious difficulties with implementation. Replication of this post in the Western locality fits the current model of East and West split and will enable mental health leadership in Coxheath and Crawley EOC's.
Clinical benefits include availability of bespoke training to staff, delivery of national training priorities inclusive of clinical staff, EoC/111 and staff facing personnel e.g. HR. Training will be designed and delivered by an experienced mental health professional. The Clinical Education Team will be able to continue to focus their resources to areas in which they are best experienced and qualified to educate.
Financial benefits realised include removing the necessity to "buy in" training programmes e.g. mental health first aid and resilience, etc. There is also scope to generate income as an approach has been made for us to provide mental health awareness training from a private health provider.

There is currently no provision for substantive mental health expertise in EOC with the current provision. ICAS will provide front line mental health practitioners but not a facility for their supervision, which is an essential requirement for such posts. These posts would address this deficit. Senior mental health practitioners present in East and West localities provide a strategic fit to current organisational configuration. Clinically this would provide accessible expertise in the area of mental health, which will enhance patient outcomes. It will also allow for closer clinical working relationships with mental health provider services and the police, further enhancing clinical outcomes for patients.
Potential financial benefits include:

- Cost savings associated with reductions in conveyancing mental health patients
- Reduction in resource allocated to frequent callers
- Reduction in staff sickness associated with stress
- Retention of staff
- Savings associated with reduction in job cycle times related to mental health
- Negating the need to "buy in" training.

b) How will you measure the benefits of the preferred option? What Key performance indicators

(KPIs) will you use? Please note that proposals will be rejected if there is no benefits realisation plan					
Benefit	**Indicator and how is it recorded**	**Current and Target Measure and Change**	**Financial Saving if applicable**	**Timescale**	**Assumptions**
Reduction in mental health job cycle times	Job Cycle Time	Currently between 1.5 and 5 hours			There will be interdependencies with clinical education with the development and delivery of training programmes and with the integration of these posts in EOC. This proposal is supported in both areas and there are no anticipated barriers.
Reduction in mental health conveyances	Mental Health Conveyances	currently in the region of 800 per month			
Potential reduction in staff absence (EOC)					
Improvement in the retention of EOC					
Potential reduction of sickness absence of EOC staff for stress and other mental health problems					
The establishment and achievement of training targets in area of mental health					
Potential reduction in related complaints					
Reduction in Sec 136 conveyance					
Ability to support staff on site (EOC)					

following traumatic incidents					
Staff feedback and engagement					

c) When will the post project evaluation be completed?

Benefits realisation expected at 6 months although some benefits with have variable realisation points. In view of this project, evaluation will take place at 6 months and at 3 monthly intervals thereafter.

5. Financial Analysis and Affordability *(of preferred option)*

Please include VAT, where not claimable, within all costs stated.

a) Whole life costs of the preferred option (Please specify what this spend is related to)

Whole Life Costs, £	**Year One**	**Year Two**	**Year Three**	**Year Four**	**Year Five**	**Total**
Operating Expenditure/(Savings)						
Additional Costs						
Mental Health Education Lead * 2	112,756	112,756	112,756	112,756	112,756	563,781
Total Operating Expenditure/(Savings)	**112,756**	**112,756**	**112,756**	**112,756**	**112,756**	**563,781**
Whole Life Cost	**112,756**	**112,756**	**112,756**	**112,756**	**112,756**	**563,781**

b) Impact on the Trusts Statement of Comprehensive Income (SoCI) (please specify what this spend is related to and if operating or non-operating)

Statement of Comprehensive Income, £	**Year One**	**Year Two**	**Year Three**	**Year Four**	**Year Five**
Net Operating Expenditure/(Savings)	112,756	112,756	112,756	112,756	112,756
Non-Operating Expenditure					
Depreciation	0	0	0	0	0
PDC Dividend	0	0	0	0	0
Total Non-Operating Expenditure	**0**	**0**	**0**	**0**	**0**
Total Impact on I&E	112,756	112,756	112,756	112,756	112,756

c) Impact on the Trusts Cash Flow

Cash flow, £	**Year One**	**Year Two**	**Year Three**	**Year Four**	**Year Five**
Capital	0	0	0	0	0
Net Operating Expenditure/(Savings)	112,756	112,756	112,756	112,756	112,756
PDC Dividend	0	0	0	0	0
Impact on Cash flow	**112,756**	**112,756**	**112,756**	**112,756**	**112,756**

All of the above has been confirmed by: *include name of Finance BP*	Rachel Murphy

d) Please provide answers to all the assessment categories, working with your relevant finance business partner. If not applicable then insert N/A

Categories	**Detailed answer:**	**Confirmed by: name**

		of Finance BP
Has any capital spend been included in the current year's capital plan?	N/A	Rachel Murphy
Has any revenue expenditure been included in this year's planning, as a cost pressure?	No	Rachel Murphy
Has any external funding been sought?	No	Rachel Murphy
Please state the virement required to cover any additional revenue expenditure, include financial coding.	Virement 2018-19 Education Budget - £37,583 Reserves - £37,583	Rachel Murphy
What savings will be generated because of this investment?		Rachel Murphy
e) Please include narrative of workings of costs, savings and all financial and activity assumptions		

6. Quality Impact assessment of preferred option

Please embed the signed summary Quality Impact Assessment (QIA) below. . For guidance and template please follow link below.
https://secamb.sharepoint.com/:x:/r/sites/intranet/knowledge/corporate/_layouts/15/Doc.aspx?sourcedoc=%7B49F03F54-7D90-4FED-A225-885E640EF06C%7D&file=Quality%20Impact%20Assessment%20Template%20v2.1.xlsx&action=default&mobileredirect=true

Mental Health Resource QIA.xlsx

7. Equality Analysis of preferred option

Please embed the completed equality impact screening below. For guidance, please see guidance document and webpage link.
http://www.secamb.nhs.uk/about_us/inclusion_equality__diversity/equality_analysis.aspx

8. Risk Assessment

Please ensure you undertake a thorough assessment of the risks associated with implementing the proposal and mitigating actions (using the Trust Risk Management Approach). Include the top five here

Risk Description	Mitigation	Likelihood (1-5)	Consequence (1-5)	Owner
Potential difficulty of not recruiting to both posts	We have an existing post holder on a temporary contract which could be extended subject to approval to cover deficit until successful recruitment is achieved	2	4	GDE

9. Implementation planning:

a) Please explain how you intend to deliver the proposal?

To recruit to band 7 posts and then integrate the new responsibilities within the revised job description with the relevant departments, e.g. EOC, Frequent Caller Team.

b) What resources will be required to deliver the proposal? Are these existing or new, and where will funding come from?

There will be a requirement for initial training for working in EOC and supporting the Frequent Caller Team. These requirements can be realised within existing resources.

c) Please indicate if any front-line staff will need to be abstracted to implement the proposal? Please include details of how abstractions will be minimised and expected backfill arrangements

There will be no abstractions required.

d) Please include a high level implementation plan and key milestones? This must be included otherwise the proposal will be rejected

Phase 1. Review current job description and submit for evaluation.
Phase 2. Recruit to band 7 post
Phase 3. Commence training, induction and integration to service

e) How will you track implementation and demonstrate the benefits?

The MHCN will be present at all phases, benefits realisation and review is detailed above

f) What measures will you put in place after implementation to ensure the improvements are maintained and escalated where issues might occur?

The measures (in addition to those described) will be agreed in collaboration with the EOC/ICAS leads and will be monitored by the MHCN.

10. Stakeholder engagement/ consultation
a) Does the proposal require commissioner, STP or other external support? If yes, provide evidence of discussions
No
b) Does the proposal have a requirement for consultation (staff/union/JPF/public)? If yes, what consideration have you given to enacting this?
The MHCN has discussed this proposal with a staff side representative (Ariel Mammana), and the proposal was positively received.

SECAMB Board

Summary Report on the Audit & Risk Committee (AUC) Meeting of 19th September 2018

Date of meeting	**19 September 2018**
Overview of issues/areas covered at the meeting:	The key areas covered in this meeting were • Good progress with outstanding Internal Audit actions • Further development of the BAF Risk Report • A new "bottom up" / "Risk Register" based Risk Report • Preliminary proposals on Risk Appetite • GDPR benchmark against the London Ambulance Service • An update on Business Continuity developments • Internal Audit reports covering Patient Records and Mobile Devices • Discussion as to the linkages between AUC and other Board Committees • A Self-Assessment report on the work of the Audit Committee and the performance of the Chair In general, and subject to the minutes of the meeting and the commentary below, AUC observed good progress
Internal Audit	AUC was pleased to note good progress with outstanding Audit actions. Almost all outstanding actions now relate to HR and should be addressed through the HR transformation program (which will be overseen by WWC) **Patient Records Audit.** AUC was concerned that some SECAMB locations were not carrying out their 10% random sample compliance checks; however, AUC was pleased to note the improving compliance profile shown by those stations carrying out sample testing. Fire management arrangements at Paddock Wood are to be re-tested by the Audit team. **Mobile Devices Audit**. This demonstrated clear opportunities to improve our management/recording of assets, particularly in relation to leavers. AUC was given verbal assurance that Cyber Risks are negligible. AUC noted that a paper on Cyber Risk will be presented to FIC in October. Linkage between AUC and other committees was discussed. AUC took the view that the inclusion of the Chairs of other committees within AUC was sufficient; however, AUC encouraged the Executive and/or Internal Audit to discuss findings with other Board Committees directly if/as appropriate
Board Assurance Risk Report and Risk Register Risk Report	AUC commended further development of the BAF Risk Report presented at the meeting. Subject to amendments proposed at the meeting, AUC was happy to support presentation of the report at the next Board meeting. There was considerable discussion at AUC in relation to some risk scores, proposed changes to the list of top risks and call answer performance.

	AUC received the first version of a new report on risk management driven by "bottom up" "risk register" considerations. Whilst the report will benefit, In the future, from an executive summary, AUC commended the interpretative information and insight offered. AUC received preliminary proposals in respect of Risk Appetite. Considerable discussion and debate followed. AUC recommend research to identify best practice within the NHS and linkage of Risk Appetite to strategic goals/plans/objective and regulation. AUC expects to see further Risk Appetite proposals in due course. A draft target date of March 2019 was proposed in the light of other priorities within the trust.
Board Assurance Framework	An additional AUC will take place in October to consider a paper setting out the Board Assurance Framework at SECAMB. A short paper was tabled at this meeting setting out draft headings and intended comment. Members were asked to send comments to Peter Lee
Policy Suite Review	The policy on Freedom to Speak (Whistleblowing) was withdrawn. A revised policy will be presented to AUC in due course. There was insufficient time to consider the (live) policy on conflicts of interest which will now be discussed at an extra AUC in October.
GDPR	A paper summarising a peer review of GDPR between LAS and SECAMB was presented. AUC noted good progress. AUC asked that the current SECAMB GDPR action plans and status "dashboard" be sent to members.
Audit Committee Self-Assessment	AUC received an "anonymous 360 style" summary self-assessment report using standard HFMA NHS Audit Committee questions. The vast majority of the contributors to the report were supportive of the Chair and the committee; however there was some less positive feedback that the Chair will take on board to help further improve the effectiveness of the committee.
Business Continuity	An update paper was presented; the executive gave extensive and comprehensive verbal assurances that, outwith the administrative parts of the trust at Head Office, all significant operational parts of the trust have effective and fully tested business continuity plans. AUC asked for a presentation/workshop on Business Continuity to be arranged after its next ordinary meeting (December) with a follow up paper to the following AUC covering any remaining points of significance.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	97/18

Name of meeting	Trust Board
Date	28.09.2018
Name of paper	Board Assurance Framework Risk Report version 2018 1.2
Responsible Executive	Executive Team
Author	Peter Lee, Company Secretary
Synopsis	At its meeting in May 2018 the Board agreed the risks to be included in the revised BAF risk report. Since then work has been undertaken to set out the controls, assurances, and actions, which have been reviewed by the relevant Board committees to inform this version (2018 1.2) of the BAF risk report. This was considered by the Audit & Risk Committee on 19 September – as set out in the committee's escalation report.
Recommendations, decisions or actions sought	The Board is asked to support the progression of the BAF Risk report and the changes recommended in section 5, and confirm its level of assurance that it is sufficiently focussed on the right high-risk areas

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

Board Assurance Framework Risk Report (version 2018 1.1)

1. Background

In May 2018, the Board agreed 13 risks to be included in the BAF risk report. The executive management board considers this every month, to ensure the risks reflect the current position, and to consider whether any risks should be added or removed.

2. Structure of the BAF Risk Report

This report helps to focus the Executive and Board of Directors on the principal risks to achieving the Trust's strategic goals and to seek assurance that adequate controls are in place to manage the risks appropriately.

There are currently 13[1] BAF risks, with each being aligned to one of the four strategic goals and linked to the 16 corporate objectives, as illustrated in the **Dashboard** below. Where applicable, the Dashboard confirms the link between the risk and the Strategic Delivery Plan.

Appendix A describes the controls, actions, and assurances against each risk. These are the fields within Datix; the database used by the Trust to record all risks.

The **Risk Radar** provides an illustration of the risk score (with controls) against each strategic goal. This will also confirm where there has been movement in score from the previous version.

The risks are quantified in accordance with the 5x5 matrix in Figure 1 below. The guide used to assess the likelihood and impact is found at Appendix C[2].

	Likelihood				
Impact	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
Catastrophic 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
Negligible 1	1	2	3	4	5

Low	Moderate	High	Extreme

Figure 1

[1] Subject to the Board approving the removal of risk 518 and addition of 579
[2] Included at the request of the Audit & Risk Committee 19.09.2018

3. Board Committee Review

Each BAF Risk is aligned to a committee of the Board, with the relevant risks being considered at each meeting. In addition, the Audit & Risk Committee takes an overview of all BAF risks.

The Workforce & Wellbeing Committee meeting on 23 July 2018 had substantive items on each of the relevant BAF Risks 111 (workforce) 362 (safer recruitment) 334 (culture) and 517 (Health & Safety). The Trust Board subsequently agreed this committee's recommendation to amend the description of risk 362 to remove the word 'pre' in order to reflect that the risk is more broadly about employment checks, not just those pre-employment.

The Quality and Patient Safety Committee last met on 6 September 2018. It asked the executive review risk 518 to focus on a more specific aspect of the fundamental standards of care (see section 4).

4. Management Review

The Executive Management Board (EMB) considers the BAF Risk Report every month. As set out in Appendix A, each risk has a nominated scrutinising forum, where the subject matter experts consider the risk. Where the forum is not EMB, it will make recommendations to EMB about any changes to the risk. When applicable, EMB will recommend removal and / or an addition of a BAF risk(s).

EMB specifically considered including Risk 521 – Private Ambulance Provider Governance. It was assured with the current arrangements and controls and agreed it should not be recommended for inclusion at this stage.

5. Management Recommendation(s) to the Audit & Risk Committee 19.09.2018

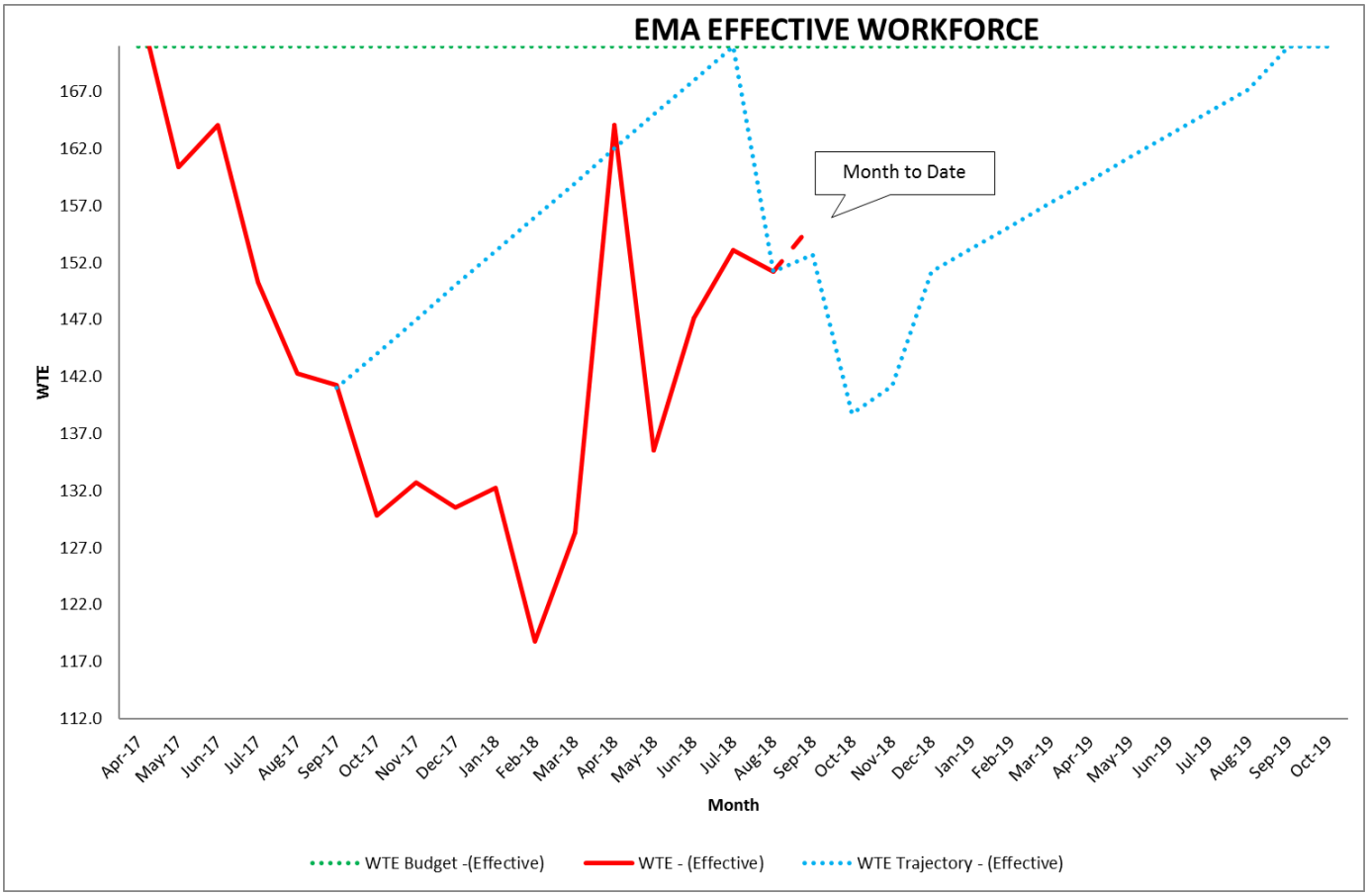
Risk 518 – care and treatment
The Executive Management Board asked the committee to support its recommendation (to the Trust Board) to close this risk, and replace it with a new **risk – 579** (see Appendix A). This was because, on reflection, and taking account of the feedback from the Quality and Patient Safety Committee, it felt that risk 518 was too broad. Instead, risk 579 identifies the most current care and treatment risk, related to how patients waiting for a response are clinically triaged. This links to Regulation 12 (Fundamental Standards of Care) – safe care and treatment.

The committee explored this in some detail, agreeing to support the recommendation in the basis that there should be specific focus on delivering the best possible care. It acknowledged that the risk outlined in BAF risk 579 is currently the principal clinical risk.

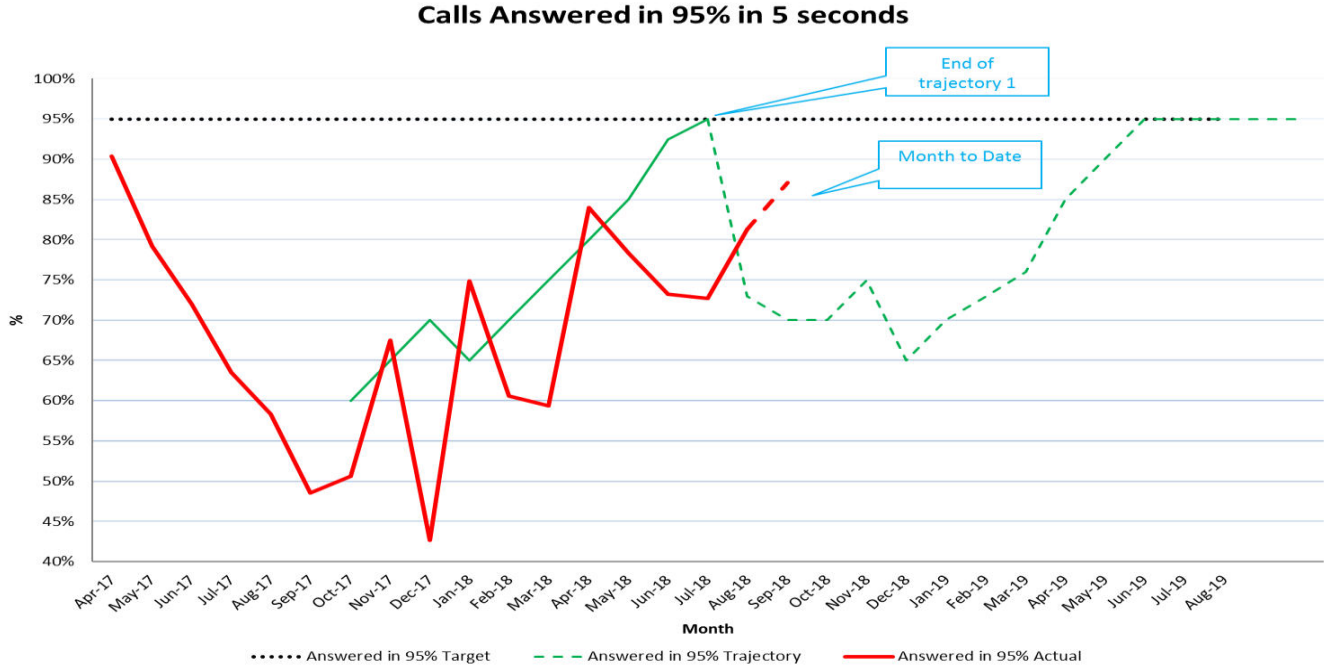
Risk 269 – EOC Call Answer
The committee was asked to support the change in target risk score (confirmed in the dashboard) from 31.08.2018 to 30.06.2019. This is in light of the demand and capacity review where the EMA establishment required is 204, plus 16 training post by the end of June 2019, to achieve the call-answer performance standards.

The committee challenged management on the rationale for this, especially against the background of the Delivery Plan where the EOC project aimed to deliver national call answer performance by September 2018. This is one of the deep dives on the Board agenda (item 93/18).

The graph below shows a revised recruitment trajectory based on current retention and recruitment averages.



A revised call answer trajectory has been developed in line with known recruitment and retention averages in the last six months and factors in the current issues around duplicate calls and the likelihood that this will not improve in the short term or across winter. This graph represents a plan to return to 95% call answer on a sustained monthly basis by June 2019".



The committee also explored risk 529 and the ability of Trust to influence the wider health system. It felt this needed better articulation. It also challenged management to consider whether the target risk score is too low; suggesting this might always be a high risk. This will be explored by EMB ahead of the version that comes to Board in October.

EMB will also consider at the request of the committee, whether the current issues related to risk 334 (culture) are fully documented and, in relation to risk 522 (business continuity plans), how to more clearly define the actual risk/impact.

6. Conclusion

The Executive believes that the BAF risk report is sufficiently focussed on the right high-risk areas that affect the Trust's ability to meet its strategic goals. The Executive Management Board will continue to refine the report, so that is clearly sets out the controls, actions and sources of assurance it relies on.

The BAF risk report will also continue to be used by the Board and its committees, to ensure a risk-based approach is taken to seeking assurance that the risks are being robustly managed.

Dashboard

Links to objectives	Link to Delivery Plan (current RAG)	Risk ID / Theme	BAF Dashboard	Inherent Score	Residual Score	Target Score	Target Date	Board Oversight
5,6, 7, 8, 9, 11	ARP D&C Delivery	Risk ID 123 ARP	Risk that the Trust does not consistently achieve ARP standards as a result of insufficient resources, which may lead to patient harm.	25	25	10	01.04.2020	FIC
5, 6, 7, 8	EOC	Risk ID 269 EOC	Risk that we do not consistently answer at least 95% of 999 calls within 5 seconds as a result of; •non-delivery of the planned workforce [see separate workforce risk ID 111] •design of the processes and technology within EOC This may lead to patient harm due to delay in providing care and treatment	25	25	5	31.08.2018 [30.06.2019][3]	QPS
2, 3, 4	ARP D&C Delivery Resourcing Plan	Risk ID 111 Workforce	Risk that we will not deliver the planned workforce as a result of; •inability to recruit to the current gaps •not retaining current staff •inability to recruit to the future needs Due to; •not having optimal HR support functions •not having optimal education and training This may lead to poor patient (and staff) outcomes and experience, and not meeting national performance targets.	25	20	10	01.04.2020	WWC
6, 9	N/A	Risk ID 284 111 (future)	Risk of not being able to mobilise for / exit from the 111 contract as a result of delay and differential timelines of procurement,	16	16	8	01.04.2019	FIC

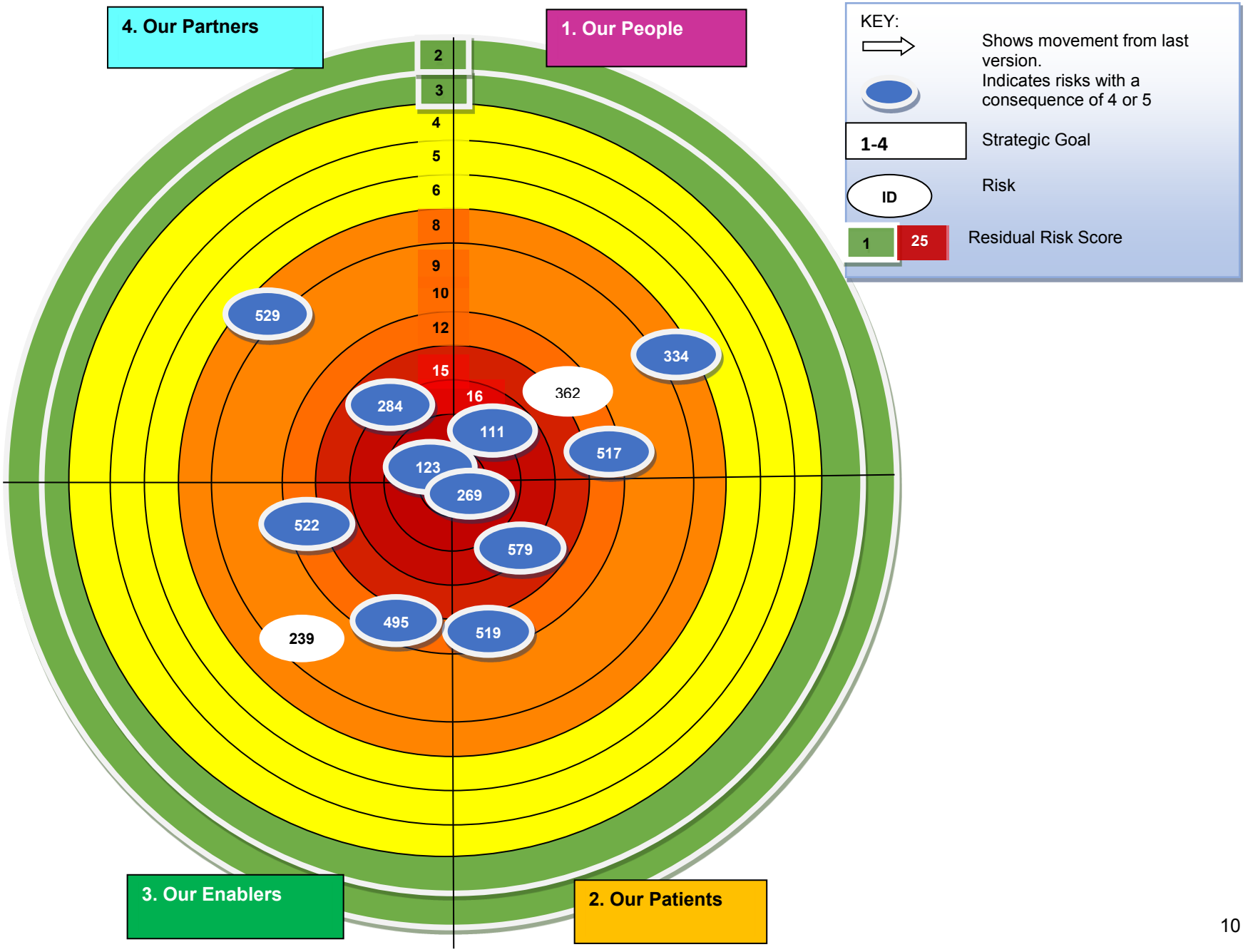
[3] Revised date subject to Board approval

			which may lead to clinical harm, financial loss, adverse pressure on 999 and the Trust not meeting its strategic aim of integration.						
2, 7	Personnel Files	Risk ID 362 Safer Recruitment	Risk that the Trust is not able to always provide evidence of the relevant employment checks, as a result of inadequate internal controls / record keeping, which may lead to sanctions and reputational damage.		15	12	6	30.06.2019	WWC
7	H&S (project yet to start)	Risk ID 517 H&S	Risk that we do not comply with H&S legislation as a result of sub optimal infrastructure and governance, which may lead to harm to staff and related sanctions on the Trust and / or individual directors.		16	12	4	01.09.2019	WWC
2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16	N/A	Risk ID 518[4] Care & Treatment	Risk that the Trust does not consistently meet the fundamental standards of care (as set out in section 2 of the Heath & Social Care Act 2008 (Regulated Activities) Regulations 2014), as a result of in effective leadership, policies and internal controls, which may lead to patient harm and being in breach of CQC registration / Provider License.		16	12	4	31.03.2019	QPS
5, 6, 7, 8, 9, 10	N/A	Risk ID 579 Care & Treatment	Risk that patients waiting for a response are not appropriately triaged, as a result of lack of clinical resource; suboptimal IT systems; and an inability to respond to demand, which may lead to patient harm.		16	16	4	TBC	QPS
5, 6, 7, 8	N/A	Risk ID 519 111 (current)	Risk that the Trust does not achieve operational standards for 111 as a result of increased pressure on the service, which		16	12	4	30.09.2018	QPS

[4] To be removed from the BAF risk report subject to Board approval

			may lead to patient harm.						
10	Corporate IT systems resilience Cyber Security	Risk ID 495 IT	Risk that IT does not enable delivery of services as a result of; •system development maturity and integration not achieved at right pace •inability to respond to a major cyber crime This may lead to inability or delay to provision of care		16	12	4	TBC	FIC
7, 8	N/A	Risk ID 522 Resilience	Risk that the Trust does not have appropriate business continuity plans, which may result in non-delivery of service(s)		16	12	4		AuC
7	N/A	Risk ID 239 IG	Risk that the Trust does not adhere to Information Governance requirements and standards as a result of inadequate systems, resourcing and controls, which may lead to sanctions from the ICO and reputational damage.		9	9	3	01.04.2019	AuC
1, 2, 3, 4, 7	Culture & OD HR Transformation Programme	Risk ID 334 Culture	Risk of not improving the culture and behaviours within the Trust, as a result of; •not embedding the Trust's values and behaviours •poorly developed leadership and management styles This may lead to low staff morale, issues with retention, adverse impact on patient care and reputational damage.		12	8	4	28.06.2019	WWC
13, 14, 15	N/A	Risk ID 529 Change	Risk that the Trust is unable to influence system change as a result of; •capacity to engage with STPs and system partners •complexity of the environment, e.g. STPs		12	8	4	TBC	Trust Board

			at different stages This may lead to non-delivery of the Trust strategy.						


4. Our Partners
1. Our People
3. Our Enablers
2. Our Patients
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111
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123
269
522
579
495
519
239
KEY:
Shows movement from last version.
Indicates risks with a consequence of 4 or 5
1-4
Strategic Goal
ID
Risk
1
25
Residual Risk Score

Appendix A
(BAF Risks version 2018 1.1)

Goal 1 Our People	**BAF Risk ID 111** Workforce – planned workforce	**Date risk opened: 14.04.2016**

Underlying Cause / Source of Risk:		
Risk that the Trust will not delivery the planned workforce as a result of; •inability to recruit to the current gaps •not retaining current staff •inability to recruit to the future needs Due to; •not having optimal HR support functions •not having optimal education and training This may lead to poor patient (and staff) outcomes and experience, and not meeting national performance targets.	**Accountable Director**	Director of HR & OD
	Scrutinising Forum	HR Working Group
	Inherent Risk Score	**25** (Consequence 5 x Likelihood 5)
	Residual Risk Score	**20** (Consequence 5 x Likelihood 4)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**10** (Consequence 5 x Likelihood 2)

Controls in place (what are we doing currently to manage the risk)
HR transformation programme underway Resourcing improvement plan (IP) aimed at recruiting 300 Operational external staff by December 2018. This will be made up of ECSWs and AAPs Resourcing IP now in 'intensive support'. Improved recruitment in to the EOC, which is now over-established (see BAF risk ID 269) Having established the Clinical Framework foundations, Manchester Triage has been finalised and will be the enabler to increase clinical capacity within EOC. C1 Business Case Approved Board Workshop in August
Gaps in Control
HR transformation programme runs to June 2019 Recruitment Strategy Recruitment IP is dependent on the C1 Business Case to address the funding for up to 300 external candidates – this business case is yet to be approved.

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Internal Audit - sickness absence reporting (2016/17) (-) Internal Audit – training (2015/16) In the 2018/19 Plan (+) improved sickness rates (+) leavers reduced. (+) WWC in July was assured that the size and complexity of the task is well understood and that there are processes in place to support the plan(s).	Internal Audit – roster planning (in 2018/19 plan) Internal Audit – training (in 2018/19 plan)

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. HR transformation programme > June 2019 2. Resourcing approach development 3. C1 Business Case implementation.	1. Current state assessment report completed. Process improvement assessment and plan completed. Operating model approved. Programme resources in place. 2. Resourcing Plan in place (see Delivery Plan)

Last management review	19.09.2018 Executive Management Board	**Last committee review**	19.09.2018 Audit & Risk Committee 23.07.2018 Workforce & Wellbeing Committee

Goal 1 Our People	**BAF Risk ID 362** Safe Recruitment – evidencing employment checks	**Date risk opened: 26.03.2018**

Underlying Cause / Source of Risk:	**Accountable Director**	Director of HR & OD
Risk that the Trust is not able to always provide evidence of the relevant employment checks, as a result of inadequate internal controls / record keeping, which may lead to sanctions and reputational damage.	**Scrutinising Forum**	HR Working Group
	Inherent Risk Score	**15** (Consequence 3 x Likelihood 5)
	Residual Risk Score	**12** (Consequence 3 x Likelihood 4)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**06** (Consequence 3 x Likelihood 2)

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

Project established to review the various issues relating to personnel files; this sits under the HR Transformation programme, and includes the management actions from the Internal Audit report.

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.

DBS checks is a particular issue and the project has helped to establish the number of outstanding DBS checks. A DBS tracker has been created with weekly tracking for online applications, ID verification and complete DBS returned. Where there are gaps, risk assessments are in place.

Gaps in Control

Task & Finish Group to be established

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) WWC in July was assured that there is grip and focus (-) Internal Audit Report – pre-employment checks (2017/18) (+) Delivery Plan showing project as Amber – reflecting that the objectives can be met within existing resources.	Internal Audit – staff records (in 2018/19 plan)

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
A number of actions are underway as set out in the project plan, which forms part of the Delivery Plan.	Actions are on track.

Last management review	19.09.2018 Executive Management Board	**Last committee review**	19.09.2018 Audit & Risk Committee 23.07.2018 Workforce & Wellbeing Committee

Goal 1 Our People	**BAF Risk ID 334** Culture – Improving the Trust's culture	**Date risk opened:** **11.10.2017**

Underlying Cause / Source of Risk:	**Accountable Director**	Director of HR & OD
Risk of not improving the culture and behaviours within the Trust, as a result of; •not embedding the Trust's values and behaviours •poorly developed leadership and management styles This may lead to low staff morale, issues with retention, adverse impact on patient care and reputational damage	**Scrutinising Forum**	HR Working Group
	Inherent Risk Score	**12** (Consequence 4 x Likelihood 3)
	Residual Risk Score	**08** (Consequence 4 x Likelihood 2)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)
Launch of the new values and behaviours framework Launch of the staff recognition programme. Leadership development programme Modules 1-3 (of 4) completed for senior managers (>Band 8B) Exec and Senior Managers individual and team coaching Culture project plan focus on a) engaging staff b) Managing behaviours and c) building an enabling infrastructure. Culture change team are attending operational areas / meetings to share the principals behind the programme and identify support requirements. Ask HR sessions in place / Wellbeing Hub Honest Mistakes Policy implemented 80 staff engagement champions in place Staff Appraisals
Gaps in Control
Core behaviours development programme for all managers Coaching network

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) feedback from staff following the launch of the values and behaviours (+) 93% staff appraisals completed for 2017/18 (+) Over 1250 interactions with the Wellbeing Hub (-) LCFS Annual Report – on the question of an open culture (-) Prof. Lewis Report (-) 2017/18 Staff Survey	2018/19 Staff Survey CQC inspection findings – July/Aug 2018

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Roll out of the core behaviours development programme for all managers 2. Development of a coaching network	1. Some sessions have been held, others planned. 2. Due to be developed by December.

Last management review	19.09.2018 Executive Management Board	**Last committee review**	19.09.2018 Audit & Risk Committee 23.07.2018 Workforce & Wellbeing Committee

Goal 1 Our People	**BAF Risk ID 517** Health & Safety Legislation	**Date risk opened:** **23.04.2018**

Underlying Cause / Source of Risk: Risk that we do not comply with Health & Safety legislation as a result of sub optimal infrastructure and governance, which may lead to harm to staff and related sanctions on the Trust and / or individual directors.	**Accountable Director**	Director of Nursing & Quality
	Scrutinising Forum	Central H&S Working Group
	Inherent Risk Score	**16** (Consequence 4 x Likelihood 4)
	Residual Risk Score	**12** (Consequence 4 x Likelihood 3)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

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

Management agreed an enhanced H&S team
A number of specific H&S risks have been identified (on the risk register) with related mitigating actions, for example in contractor controls assurance; fleet ergonomic assessments; incidents of violence and aggression; MSK and manual handling injuries; fire safety; and working from heights.
A H&S dashboard for the H&S working group has been developed to ensure focus in the right areas
The H&S Group has gone from quarterly to monthly meetings and reports directly to the executive management board
Introduced a range of H&S metrics into the Integrated Performance Report
Some Board members have completed IOSH training
The Board receives a Q report – first one in Q4 of 2017/18.
Independent Review commissioned to establish the robustness of health and safety governance.

Gaps in Control

Recruitment to the H&S Team
Completion of IOSH training for all Board members
Improvement Plan in response to the recommendations from the independent H&S review

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) HSE inspection visit in February 2018 focussing on Muscular Skeletal Disorders (+) violence and aggression to staff showing a slow downward trend. (-) manual handling incidents high (+) increase in H&S reporting – showing greater awareness (-) Independent Review (-) WWC July	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Improvement Plan (in response to the independent H&S review) is being developed 2. Recruitment to the H&S Team 3. Third and final IOSH training session	1. Due to come to Board in September 2. Head of H&S has started. H&S Manager recruitment ongoing. 3. To be scheduled during Q3.

Last management review	19.09.2018 Executive Management Board	**Last committee review**	19.09.2018 Audit & Risk Committee 23.07.2018 Workforce & Wellbeing Committee

Goal 2 Our Patients	**BAF Risk ID 269** EOC – national call answer performance targets	**Date risk opened: 24.10.2017**

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Operations
Risk that the Trust does not consistently answer at least 95% of 999 calls within 5 seconds as a result of; •non-delivery of the planned workforce (see separate workforce risk) •design of the processes and technology within EOC This may lead to patient harm due to delay in providing care and treatment	**Scrutinising Forum**	Teams A/B (EOC)
	Inherent Risk Score	**25** (Consequence 5 x Likelihood 5)
	Residual Risk Score	**25** (Consequence 5 x Likelihood 5)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**05** (Consequence 5 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)	
Weekly EOC Task & Finish Group EMA recruitment – workforce from 147 to 182 (now over-established) Diamond Pod to ensure new EMAs are supported Clinical Safety Navigator in place to provide oversight and management of patients waiting Surge Management Plan ensures resources are prioritised to patients with the greatest clinical need NHS Pathways clinician at each EOC 24/7 Peer support from AACE re call handling processes Introduction of real-time analyst role reviewing non-productive call handling time	33 EOC clinicians in post Established the Clinical Framework foundations / Manchester Triage Real Time Analyst in place Incentive schemes at period of expected high demand EOC are managing scheduling locally to improve resourcing at evenings and weekends Daily leadership conference calls
Gaps in Control	
Newly recruited EMAs require training Further EOC clinicians to recruit (see risk 579) ECSW recruitment will and have recruited from EMA workforce – so these need back filing. EOC not always sighted on transfer of individuals, which affects rotas Technology – latency in transfer of calls	New Telephony platform secured for implementation There is a recruitment plan to recruit 300 field staff to fill the current vacancies, with the target of increasing field DCA's.

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) call response still below the trajectory (-) 20% call volume is ring backs asking for an ETA (+) QPS Committee assured in May that management had clarity in the holistic understanding of the issues relating to call answer performance, and the related improvement plan. (+) June Audit compliance 100%	The recruitment plan for 300 field staff is drawing EMAs out of EOC
Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**

1. EMA training in place 2. Recruitment to find additional EOC clinicians 3. Telephony system approved/ being implemented			1. Training ongoing 2. Recruitment ongoing 3. Due to be installed in November 2018
Last management review	19.09..2018 Executive Management Board	**Last committee review**	19.09.2018 Audit & Risk Committee 06.09.2018 Quality & Patient Safety Committee

Goal 2 Our Patients	BAF Risk ID 518[5] Care & Treatment – minimum standards of care	Date risk opened: 25.05.2018

Underlying Cause / Source of Risk:		
Risk that the Trust does not consistently meet the fundamental standards of care (as set out in section 2 of the Heath & Social Care Act 2008 (Regulated Activities) Regulations 2014), as a result of in effective leadership, policies and internal controls, which may lead to patient harm and being in breach of CQC registration / Provider License.	**Accountable Director**	Director of Nursing & Quality
	Scrutinising Forum	Executive Management Board
	Inherent Risk Score	**16** (Consequence 4 x Likelihood 4)
	Residual Risk Score	**12** (Consequence 4 x Likelihood 3)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)
Compliance Steering Group established to ensure focus on the areas identified that relate to adherence to the fundamental standards of care Task & Finish Groups and related project mandates / plans Leadership and culture work as set out in Risk ID 334 Policies updated

Gaps in Control
Policies and Procedures overdue for review Policy evaluation tool

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) CQC inspection report Sept 2017 (-) Internal Audit – Safeguarding (2016/17) (- & +) Delivery Plan Board Report (+) Pre CQC inspection self-assessment (+) 'Must / Should Do' Board Assurance Report – June (+) Medicines Governance Independent Review	Internal Audit – AQIs (in 2018/19 Plan) CQC Inspection 2018

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Continued focus on areas of improvement through the CSG	1. CSG meets weekly and updated EMB each week. CSG informs the Delivery Plan Report received by the Trust Board at each meeting.

Last management review	19.09.2018 Executive Management Board	Last committee review	19.09.2018 Audit and Risk Committee 06.09.2018 Quality & Patient Safety Committee

[5] To be removed subject to Board approval

Goal 2 Our Patients	**BAF Risk ID 579** [link to Risk 123] Care & Treatment – clinical management of calls waiting.	**Date risk opened: 13.09.2018**

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Nursing & Quality
Risk that patients waiting for a response are not appropriately triaged, as a result of lack of clinical resource; suboptimal IT systems; and an inability to respond to demand, which may lead to patient harm.	**Scrutinising Forum**	Executive Management Board
	Inherent Risk Score	**16** (Consequence 4 x Likelihood 4)
	Residual Risk Score	**16** (Consequence 4 x Likelihood 4)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)
CAD upgrade underway to provide better visibility of the types of calls requiring triage. Live testing commenced on Monday 10 September, go live w/c 17 September. Specific improvement plan is in place, overseen by the Compliance Steering Group, and by the CQC via a weekly update Recruitment – EMB approved an overseas recruitment fair (aim to make 15 clinical appointments)

Gaps in Control
Overseas recruitment fair

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) CQC - concerns expressed during the recent core services inspection (+) CQC – assured that improvements are being made resulting in bi-weekly updates being reduced to weekly. There has been no enforcement action.	Audit of the effectiveness of the CAD upgrade scheduled for October.

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Overseas recruitment fair scheduled for November 2018, led by the Executive Director of Nursing & Quality.	

Last management review	19.09.2018 Executive Management Board	**Last committee review**	19.09.2018 Audit and Risk Committee

Goal 2 Our Patients	**BAF Risk ID 519** 111 (current) –operational standards	**Date risk opened: 25.05.2018**

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Operations
Risk that the Trust does not consistently achieve operational standards for 111 as a result of increased pressure on the service, which may lead to adverse patient experience and / or harm.	**Scrutinising Forum**	Teams A/B (111)
	Inherent Risk Score	**16** (Consequence 4 x Likelihood 4)
	Residual Risk Score	**12** (Consequence 4 x Likelihood 3)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

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

Operational Recovery Plan (ORP) created in Q4 of 2017/18 to address issues currently affecting performance. This is reviewed fortnightly in meetings with Commissioners (CCG Leads for performance and quality).
Monthly internal Governance meetings to review performance are conducted by the Director of Operations
Contract meetings with Commissioners have moved from bi-monthly to monthly
The deployment of additional Service Advisors and the use of Patient Safety callers have helped call answering and clinical performance respectively

Gaps in Control

The current sub-contract in place to manage the partner provider is not effective - it has been challenging to facilitate formal monthly contract meetings with the partner provider to address issues
A lack of resilience within the service to cope with the current elevated seasonal call volumes
The current clinical staffing levels in Ashford are lower than planned due to higher than predicted attrition, lower than expected recruitment and rota inequalities
Commissioners re-procurement of 111 service

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) clinical performance (+) The Ashford Contact Centre is now almost fully staffed (Health Advisors) against its recruitment trajectory (+) Impact of the additional Service Advisors and the use of Patient Safety callers	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Discussions with the partner provider to explore improved ways of working 2. Full clinician rota review and introduction of the Trust's new Clinical Framework 3. Seeking additional agency clinicians to support clinical performance. 4. In discussion with commissioners about extending the contract.	1. Ongoing – scheduled to end partnership March 2019 2. [TBC] 3. Agreed plan and clinicians being sourced 4. Ongoing negotiations following Board support in August.

Last management review	19.09..2018 Executive Management Board	Last committee review	19.09.2018 Audit and Risk Committee 06.09.2018 Quality & Patient Safety Committee

Goal 3 Our Enablers	BAF Risk ID 123 ARP – national standards	Date risk opened: 13.04.2017

Underlying Cause / Source of Risk:		
Risk that the Trust does not consistently achieve ARP standards as a result of insufficient resources, which may lead to patient harm.	**Accountable Director**	Director of Operations
	Scrutinising Forum	Executive Management Board
	Inherent Risk Score	**25** (Consequence 5 x Likelihood 5)
	Residual Risk Score	**25** (Consequence 5 x Likelihood 5)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**10** (Consequence 5 x Likelihood 2)

Controls in place (what are we doing currently to manage the risk)
102 new vehicles EMA over recruitment in the EOC (see BAF Risk ID 269) Recruitment campaign to recruit 300 new staff by November – ECSWs / AAPs. Demand and Capacity Review (in meantime resources to circa 9000 hours per day) Daily/Weekly monitoring of Cat 1 – 4 performance, including risk mitigation in real time, including weekly progress updates to EMB. Review of scheduling and make ready processes External review through AACE of EOC Practice & Process completed External review of EOC by NHS I Commissioned Project (National work) Demand and Capacity Review agreed.

Gaps in Control
Recruitment of ECSWs & AAPs Agreed the demand and capacity review – yet to agree the contract terms / investment to be provided.

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) Cat 1 and Cat 2 performance (-) Cat 3 and Cat 4 performance (-) Call handling performance (+) Trajectory to meet recruitment plan	Commissioner approval of the contract / investment to ensure improving trajectory and full compliance with APR by April 2021.

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Recruitment supported by the resourcing improvement plan and interim specialists 2. Transaction of the D&C review	1. Recruitment plan in intensive support, led by executive. 2. In discussion with commissioners and NHSI / E.

Last management review	19.09.2018 Executive Management Board	Last committee review	19.09.2018 Audit & Risk Committee 18.07.2018 Finance & Investment Committee

Goal 3 Our Enablers	**BAF Risk ID** 495 IT – enabling service delivery	**Date risk opened: 25.05.2018**

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Finance & Corporate Services
Risk that IT does not enable delivery of services as a result of; •system development maturity and integration not achieved at right pace •inability to respond to a major cyber crime This may lead to inability or delay to provision of care	**Scrutinising Forum**	IT Group
	Inherent Risk Score	**16** (Consequence 4 x Likelihood 4)
	Residual Risk Score	**12** (Consequence 4 x Likelihood 3)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)	
Carecert monitoring process in place Completion of two Penetration tests have identified areas that have been addressed. Those areas not viable for treatment have been mitigated with technical solutions Multiple versions of AV on systems – separated between server and desktop Advisory notices sent to staff – recent phishing attack dealt with by systems Significant monitoring in place and maintained by the helpdesk staff (identified phishing attack very early) Contracts in place with third party providers for all network equipment and updated regularly to reflect Trust business objectives Data backed up and offsite copies maintained for critical systems Appropriate power protection in place	SAN storage used extensively and systems progressively being migrated EOC systems duplicated in Crawley and Coxheath / Failover tested regularly Environment simplified and streamlined to ensure easy maintenance New monitoring system in place (SolarWind) Trust owned penetration testing software purchased Purpose built datacentre used in Crawley – regularly check by maintenance company (FutureTech) New WAN links between Crawley and Coxheath purchased designed to be diverse and resilient All projects now managed by Digital Programme Board

Gaps in Control
New Firewall provision being implemented (Fortinet) New patching systems being implemented as part of Cyber response Trust owned penetration testing software purchased and being implemented that will allow specific testing

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) Digital Programme Board	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. New Firewall provision being implemented (Fortinet) 2. New patching systems being implemented as part of Cyber response 3. Trust owned penetration testing software purchased and being implemented that will allow specific test	1. To be completed by October 2. To be completed by October 3. To be completed by October 4. TBC

4. Station IT Upgrade (following BC approval by Board in June)			
Last management review	19.09.2018 Executive Management Board	**Last committee review**	19.09.2018 Audit and Risk Committee 18.07.2018 Finance & Investment Committee

Goal 3 Our Enablers	**BAF Risk ID 239** Information Governance	**Date risk opened: 21.08.2017**

Underlying Cause / Source of Risk: Risk that the Trust does not adhere to Information Governance requirements and standards as a result of inadequate systems, resourcing and controls, which may lead to sanctions from the ICO and reputational damage.	**Accountable Director**	Director of Strategy
	Scrutinising Forum	Information Governance Group
	Inherent Risk Score	**09** (Consequence 3 x Likelihood 3)
	Residual Risk Score	**09** (Consequence 3 x Likelihood 3)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**03** (Consequence 3 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)
IG Framework in place IG Working Group established and now meets on a monthly basis IG training, including corporate induction IG Toolkit IG escalation routes in place through current incident and SI processes. Also internal reporting line where concerns are escalated from IG Lead to SIRO and Caldicott G The GDPR Action plan has been updated and an overarching Dashboard is now in place
Gaps in Control
Create a centralised repository for records management (see link to BAF Risk ID 362) Create and complete a GDPR compliant Information Asset Register – this is required under Article 30 of the GDPR Outstanding actions from the GDPR Action Plan Lack of resource – IG Manager JD currently under review, this is to be formally advertised September 2018 Registration Authority process needs to be adequately resourced

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) 2017/18 IG Annual Report (+) Internal Audit Report – against the IG Toolkit (+) Over 95% compliance with IG training (+) IG Toolkit Level 2	A Peer-to-Peer review with London Ambulance Service took place on the 20 August 2018 – a summary report will be presented to the September Audit Committee and IG Working Group.

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Undertake an organisation wide records review. Create a centralised repository for records management. 2. Create a new GDPR compliant Information Asset Register this will link	1. Information obtained from the review will be used to create a robust centralised records repository. This will ensure that the Trust is compliant with Article 30 of the GDPR 'Records of Processing Activities'. This action forms part of the standing agenda items for the IG

into the organisational wide records review and records management repository 3. GDPR Action Plan			Working Group, which now meets on a monthly basis. 2. There are Information Asset Owners in place and this will remain a standard agenda item for the monthly IGWG meetings. Work is to commence on implementing the new IAR during Quarter 3 2018 3. PMO engaged. The 'Peer to Peer' review of the revised GDPR Action plan took place with London Ambulance Service on 20 August 2018. A summary report and updated GDPR action plan will be presented to the Audit Committee and IGWG in September 2018.
Last management review	19.09.2018 Executive Management Board	**Last committee review**	19.09.2018 Audit & Risk Committee

Goal 3 Our Enablers	BAF Risk ID 522 Resilience – continuity planning	Date risk opened: 25.05.2018

Underlying Cause / Source of Risk:		
Risk that the Trust does not have appropriate business continuity plans, which may result in non-delivery of service(s)	**Accountable Director**	Director of Operations
	Scrutinising Forum	Resilience Group
	Inherent Risk Score	**16** (Consequence 4 x Likelihood 4)
	Residual Risk Score	**12** (Consequence 4 x Likelihood 3)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)
Business Continuity Management Policy, Business Continuity Management Plan, Departmental Business Continuity Plans. The Resilience Forum has been established to take oversight of BC arrangements and planning Executive resilience committee established This Contingency Planning and Resilience team are now co-ordinating the review of Departmental BC plans. The Resilience Forum will have oversight of this piece of work.

Gaps in Control
Although we have departmental business continuity plans some re not up to date and gap in testing. Corporate IT Systems Resilience Project to be established to align the Trust Business Continuity Plans with IT resilience systems to ensure that the Trust has wider system availability and data recovery is far more effective than the current plan.

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) NARU inspection findings (+) Critical friend review from AACE showing improvement since NARU inspection (+) Delivery Plan - aspects of resilience (+) Executive resilience committee – sighted in all activities / winter plans in place / major incident plan reviewed	

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. All Departments have been asked to review and update their plans. 2. Business Continuity training is being planned for departmental BC champions. 3. Project resource is currently being sought to move the Corporate IT Systems Resilience Project into implementation phase	1. Departments have been asked to review and update their BIA & BC plans. 2. BC champions identified and training date arranged for 22 October 2018. 3. Corporate IT systems resilience has been put on hold at DPB until the review of BCP's is completed which should help us identify what needs to be delivered in that piece of work.

Last management review	19.09.2018 Executive Management Board	Last committee review	19.07.2018 Audit & Risk Committee

Goal 4 Our Partners	BAF Risk ID 284 111 (future) – 111 service(s) procurement	Date risk opened: 30.11.2017

Underlying Cause / Source of Risk:		
Risk of not being able to mobilise for / exit from the 111 contract as a result of delay and differential timelines of procurement, which may lead to clinical harm, financial loss, adverse pressure on 999 and the Trust not meeting its strategic aim of integration.	**Accountable Director**	Director of Strategy
	Scrutinising Forum	Executive Management Board
	Inherent Risk Score	**16** (Consequence 4 x Likelihood 4)
	Residual Risk Score	**16** (Consequence 4 x Likelihood 4)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**08** (Consequence 4 x Likelihood 2)

Controls in place (what are we doing currently to manage the risk)
Participate in procurements and bid accordingly with partners where able (Surrey) Discuss timeline risk with Lead Commissioners and define actions to mitigate differential timelines / delay (Kent and Sussex) Alert Trust Board, FIC and Commissioners to operational / resourcing risk if stated aim is to conduct multiple activities within a limited timeframe (further compounded by Winter Pressures) Programme Director, Programme Manager, Business Support Manager and finance support in place

Gaps in Control
Agreement on how the services will be provided from April 2019 Uncertainty regarding the Surrey bid

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) Sussex and Kent integrated urgent care (incl. 111) bids put on hold by commissioners.	Ability to interface entering / exiting and current operations (111 working with 999) in the context of the Surrey Procurement and any potential interim arrangements in Kent and Sussex

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Commissioners have requested that SECAmb defines and interim solution to manage the risk of there being no service in Kent and Sussex although the ability to mobilise and cover the costs of required architecture remains unclear 2. Discussions with Surrey commissioners	1. Support received by the Board in August to continue discussions with commissioners about extending the contract until the procurement re-starts. 2. Ongoing

Last management review	19.09.2018 Executive Management Board	Last committee review	19.09.2018 Audit & Risk Committee 18.07.2018 Finance & Investment Committee

Goal 4 Our Partners	BAF Risk ID 529 Change – influencing the healthcare system	Date risk opened: 25.05.2018

Underlying Cause / Source of Risk:		
Risk that the Trust is unable to influence system change as a result of; •capacity to engage with STPs and system partners •complexity of the environment, e.g. STPs at different stages This may lead to non-delivery of the Trust strategy.	**Accountable Director**	Director of Strategy
	Scrutinising Forum	Executive Management Board
	Inherent Risk Score	**12** (Consequence 4 x Likelihood 3)
	Residual Risk Score	**08** (Consequence 4 x Likelihood 2)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)
Members of each STP programme board –Kent and Medway, Surrey Heartlands, and Sussex East Surrey for the last 15 months Contact made with Frimley Health to join their board Chief Executive attends the Executive Board for Sussex East Surrey Executive Directors aligned to each of the four STPS to provide continuity Deputy Director attends core work streams of each STP or assign senior staff to them including local care, acute care, finance, estates, Integrated Care Partnership Boards Attendance at all STP related sessions and work done to feed the STP needs and returns are monitored logged and reported. The relevant work and programmes are reflected in our strategy and delivery plan, and are being fed into the strategy refresh Associate Director seconded in to the Kent and Medway STP CQUIN focussed on STP support and engagement filly met for 17/18 and year to date 18/19
Gaps in Control
Formal engagement with Frimley Health STP Board and respective work streams STPs and Commissioning are not always aligned however this is an external issue which we mitigate when it impacts on our work

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) Fully met the STP CQUIN for 2017/18). (+) Labour Line	

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

1. Awaiting invitation from Frimley Health STP			
Last management review	19.09.2018 Executive Management Board	**Last committee review**	19.09.2018 Audit & Risk Committee

Appendix B
Strategic Goals & Objectives

Our Themes	Our People	Our Patients	Our Enablers	Our Partners
Our five year goals	We will respect, listen to and work with our staff and volunteers to provide development and support that enables them to provide consistent, quality care to our patients	We will develop and deliver an integrated clinical model that meets the needs of our communities whilst ensuring we provide consistent care which achieves our quality and performance standards	We will develop and deliver an efficient and sustainable service underpinning by fit for purpose technology, fleet and estate	We will work with our partners in STPs and blue light services to ensure that our patients receive the best possible care, in the right place, delivered by the right people
Our two year objectives	With the support and engagement of staff and volunteers, refresh the Trust values and behaviours	Develop and deliver a clinically led process to prioritise patient need at the point of call, increasing referral to alternative services where clinically appropriate	Ensure our services are efficient and sustainable and that they are supported by appropriate levels of funding	Work with STPs to achieve the best care for our patients through emerging local out of hospital care systems
	Develop effective leadership and management at all levels, through our new selection, assessment and development processes	Further integrate and share best practice between NHS 111 and 999 services, striving for Integrated Urgent Care service where this is considered viable	Develop and deliver a digital plan which supports integration with the health system and enables the clinical model and our approach to continuous improvement	Work with STPs to design and deliver generalist and specialist care pathways for patients requiring an acute hospital attendance
	Ensure all staff and volunteers have clear objectives, and a plan for their development, set through regular appraisal	Further improve and embed governance and quality systems across the organisation, building capacity and capability for continuous improvement	Ensure that our fleet is fit for purpose and supports the clinical model	Work with education and STP partners to develop career pathways that support our staff to make effective clinical decision making
	Improve staff and volunteer	Improve clinical outcomes	Ensure that our estate is fit for	Work with blue light partners

	health and wellbeing	and operational performance, with a particular focus on life threatening emergencies	purpose and supports the clinical model	to ensure collaboration supports patient outcomes and efficient service delivery

Appendix C

Table of Consequences					
	Consequence Score and Descriptor				
	1	2	3	4	5
Domain:	Negligible	Minor	Moderate	Major	Catastrophic
Injury or harm Physical or Psychological	Minimal injury requiring no / minimal intervention or treatment No Time off work required	Minor injury or illness requiring intervention Requiring time off work < 4 days Increase in length of care by 1-3	Moderate injury requiring intervention Requiring time off work of 4-14 days Increase in length of care by 4-14 days RIDDOR / agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident leading to fatality Multiple permanent injuries or irreversible health effects
Quality of Patient Experience / Outcome	Unsatisfactory patient experience not directly related to the delivery of clinical care	Readily resolvable unsatisfactory patient experience directly related to clinical care.	Mismanagement of patient care with short term affects <7 days	Mismanagement of care with long term affects >7 days	Totally unsatisfactory patient outcome or experience including never events.
Statutory	Coroners verdict of natural causes, accidental death or open No or minimal impact of statutory guidance	Coroners verdict of misadventure Breech of statutory legislation	Police investigation Prosecution resulting in fine >£50K Issue of statutory notice	Coroners verdict of neglect/system neglect Prosecution resulting in a fine >£500K	Coroners verdict of unlawful killing Criminal prosecution or imprisonment of a Director/Executive (Inc. Corporate Manslaughter)
Business / Finance & Service Continuity	Minor loss of non-critical service Financial loss of <£10K	Service loss in a number of non-critical areas <6 hours Financial loss £10-50K	Service loss of any critical area Service loss of non- critical areas >6 hours Financial loss £50-500K	Extended loss of essential service in more than one critical area Financial loss of £500k to £1m	Loss of multiple essential services in critical areas Financial loss of >£1m
Potential for patient complaint or Litigation / Claim	Unlikely to cause complaint, litigation or claim	Complaint possible Litigation unlikely Claim(s) <£10k	Complaint expected Litigation possible but not certain Claim(s) £10-100k	Multiple complaints / Ombudsmen inquiry Litigation expected Claim(s) £100-£1m	High profile complaint(s) with national interest Multiple claims or high value single claim .£1m
Staffing and Competence	Short-term low staffing level that temporarily reduces patient care/service quality	On-going low staffing level that reduces patient care/service quality	On-going problems with levels of staffing that result in late delivery of key objective/service	Uncertain delivery of key objectives / service due to lack of staff	Non-delivery of key objectives / service due to lack/loss of staff

	<1day Concerns about skill mix / competency	Minor error(s) due to levels of competency (individual or team)	Moderate error(s) due to levels of competency (individual or team)	Major error(s) due to levels of competency (individual or team)	Critical error(s) due to levels of competency (individual or team)
Reputation or Adverse publicity	Rumours/loss of moral within the Trust Local media 1 day e.g. inside pages or limited report	Local media <7 days' coverage e.g. front page, headline Regulator concern	National Media <3 days' coverage Regulator action	National media >3 days' coverage Local MP concern Questions in the House	Full public enquiry Public investigation by regulator
Compliance Inspection / Audit	Non-significant / temporary lapses in compliance / targets	Minor non-compliance with standards / targets Minor recommendations from report	Significant non-compliance with standards/targets Challenging report	Low rating Enforcement action Critical report	Loss of accreditation / registration Prosecution Severely critical report

Description	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
Frequency (How often might it / does it occur)	This will probably never happen/recur Not expected to occur for years	Do not expect it to happen/recur but it is possible it may do so Expected to occur at least annually	Might happen or recur occasionally Expected to occur at least monthly	Will probably happen/recur, but it is not a persisting issue/circumstances Expected to occur at least weekly	Will undoubtedly happen/recur, possibly frequently Expected to occur at least daily
Probability	Less than 10%	11 – 30%	31 – 70 %	71 - 90%	> 90%

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	98-18

Name of meeting	Trust Board
Date	28 September 2018
Name of paper	Major Incident Plan and Additional Contingencies
Responsible Executive	Joe Garcia Executive Director for Operations
Author	Anne Harvey Senior Contingency Planning & Resilience Manager (Acting)
Synopsis	This is the latest iteration of the SECAmb Major Incident Plan and Additional Contingencies. Whilst the plan is updated regularly, it should be considered a live document which will be amended in the light of any planning that is undertaken through attendance at any large or significant major incident.
Recommendations, decisions or actions sought	For information

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

PLAN

South East Coast Ambulance Service
NHS Foundation Trust

Major Incident Plan and Additional Contingencies

Resilience and Specialist Operations

OFFICIAL

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

August 2018

Foreword

This Major Incident Plan sets out how the South East Coast Ambulance Service NHS Foundation Trust (SECAmb) will respond to a significant or major incident irrespective of the cause. This plan is intended to be flexible enough to meet the demands of a range of circumstances and provides the underpinning detail to the Emergency Preparedness, Resilience and Response (EPRR) processes of the Trust.

The geographical area covered by the Trust includes a number of hazards as well as being subject to threats, each having the potential to become a major incident. These are broad in nature and are regularly reassessed in conjunction with other emergency services and partners.

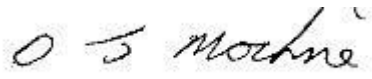
This plan, together with other local inter-agency plans, provides a framework, which draws together all the inter-agency emergency preparedness procedures, and identifies agreed arrangements for the response regardless of the cause of the major incident.

Scenarios for potential incidents are regularly practised and exercised with our partner Category 1 responders (Police, Fire, Acute Hospitals, NHS England, Local Authorities, Public Health England, Maritime and Coastguard Agency and Environment Agency),and Category 2 responders.

This plan will be the subject of a three yearly review process initiated by the Contingency Planning and Resilience team. However, it may be necessary to update this plan from time to time in the light of experiences gained from incidents, which have occurred, or through exercises, it is therefore essential that all Trust staff regularly familiarise themselves with all parts of this document.

The effectiveness of the response depends on the co-operation of everyone and a clear understanding of the role, of all those involved. Please ensure that you read and are thoroughly acquainted with this document as disasters will invariably strike suddenly, there will be no time to read this plan and then consider your response.

This Major Incident Plan has been adopted and approved by the Trust Board.



Daren Mochrie
Chief Executive

PREFACE

The area of Emergency Preparedness, Resilience and Response (EPRR) is dynamic and evolutionary, requiring constant monitoring and updating. For any queries in relation to this plan or if you would like to know more about the Trust's Resilience and Specialist Operations activities please contact CP&R@secamb.nhs.uk

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Approved by:	Executive Resilience Committee
Date approved:	15th August 2018
Name of originator/ author:	Anne Harvey /Contingency Planning & Resilience Team
Date issued:	20th August 2018
Date next review due:	August 2021
Target audience:	All Staff
Replaces:	V4 .0

SECTION 1

MAJOR INCIDENT

PLAN

IF A MAJOR INCIDENT HAS BEEN DECLARED

REFER IMMEDIATELY TO YOUR

MAJOR INCIDENT

ACTION CARD

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1. Introduction

1.1. Experience in disaster management has repeatedly demonstrated the value of detailed planning, preparation and training for dealing with emergency situations.

1.2. The aim of this Major Incident Plan is to provide a framework for the South East Coast Ambulance Service NHS Foundation Trust (referred to in this document as "the Trust") to be able to safely respond to a major incident, in that the response is patient focused, clinically led and effectively managed, while maintaining its critical activities.

1.3. The objectives of this Plan are to:

- Ensure all staff have an understanding of the procedure.
- Form a basis for major incident training.
- Ensure an effective and coordinated response to a major incident.
- To assist in the identification and mobilisation of specialist resources.
- Ensure an effective command structure has been instigated.
- Ensure that the Trust responds to a major incident as an integral part of the NHS team.

1.4. This Major Incident Plan is issued for the instruction and guidance of all Trust personnel concerned in both managing and dealing with a Significant or Major Incident.

1.5. It outlines the responsibilities of the Trust as participants in the emergency response. No plan can ever be complete against all possible contingencies and therefore it is essential that all personnel exercise their judgment and initiative when confronted with such a situation.

1.6. **Statutory and Contractual obligations**

1.6.1. This document forms part of our planning process and thus assists with meeting the statutory and contractual obligations placed upon the Trust by;

- The Civil Contingences Act (2004)
- The Health and Social Care Act (2012)
- NHS Standard Ambulance Contract
- NHS England EPRR Core Standards

1.7. The Trust undertakes to work with partner agencies within the three Local Resilience Forums and the Local Health Resilience Partnerships areas that the Trust covers in order to fulfil the requirements, as a Category 1 responder, as appropriate, under the above legislation.

1.8. It is recognised that the Ambulance Service is the gatekeeper to the National Health Service (NHS), and as such is responsible for the alerting the wider NHS and mobilising of NHS resources necessary to deal with the incident. The Trust's role will spread from the scene of the incident to Receiving Hospitals, where liaison functions will be carried out.

1.9. **Joint Emergency Services Interoperability Principles. (JESIP)**

1.9.1. This document has been written in line with the JESIP Joint Doctrine. The purpose of which is to provide Operational and Tactical commanders with a framework to enable them to effectively respond together.

1.9.2. The Joint Doctrine sets out what responders should do and how they should do it in a multi-agency working environment to achieve a successful joint response and has been designed so that it can be applied to smaller scale incidents, wide-area emergencies and pre-planned operations.

1.9.3. Principles for Joint Working

1.9.3.1. The Joint Doctrine promotes the key principles of:

- Co-location
- Communication
- Co-ordination
- Joint Understanding of Risk
- Shared Situational Awareness

1.9.4. The Joint Decision Model

1.9.4.1. The Joint Decision Model (JDM) provides a common framework for decision making at incidents attended by multiple agencies. It establishes a common language to ensure that decisions are reached in a structured way and in a manner understood by all.

1.9.4.2. The JDM is cyclical where each step logically follows another and allows for continued reassessment of the situation or incident enabling previous steps to be revisited.

1.10. For further information on the JESIP, please refer to the JESIP website.

1.11. **Risks and Planning Assumptions**

1.11.1. The potential hazards and threats, which may contribute to a major incident, have been identified using the Community Risk Registers for Kent, Surrey and Sussex; these are based on the National Risk Register of Civil Emergencies.

1.11.2. This list is not intended to be exhaustive but represents those hazards assessed to post a realistic risk to the Trust area. A major incident may be caused by something not identified below.

1.11.3. Specific Risks identified within the Trust's Operational Area:

- Seven sites with off-site plans under the COMAH regulations (1999)
- Liquid and Gas fuel pipelines
- Gatwick Airport,
- The Channel Tunnel and Dover docks
- Extensive road and rail transport infrastructure
- Sporting, leisure, exhibition and shopping venues
- Events and festivals
- Flooding
- Adverse Weather
- Malicious Attacks

2. Definition

2.1. There is no standard definition of a 'Major Incident', which would satisfy the Health Service, the Emergency Services and Local Authorities, each tending to look at such incidents from the point of view of its own responsibilities.

2.2. The Civil Contingencies Act defines an 'emergency' as "an event or situation which threatens serious damage to human welfare or to the environment in the United Kingdom, or war or terrorism, which threatens serious damage to the United Kingdom's security."

2.3. Emergency Service organisations tend to align to the definition given under JESIP, which defines a 'major incident' as "an event or situation with a range of serious consequences which requires special arrangements to be implemented by one or more emergency responder agency".

2.4. For the NHS, incidents are classed as either:

- Business Continuity Incident
- Critical Incident
- Major Incident

2.5. Each will impact upon service delivery within the NHS, may undermine public confidence and require contingency plans to be implemented.

2.6. Business Continuity Incident

2.6.1. A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed)

2.7. Critical Incident

2.7.1. A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.

2.8. Major Incident

2.8.1. A major incident is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented. For the NHS this will include any event defined as an emergency as in sections 2.2/2.3.

2.9. Types of Incidents

2.9.1. The following list provides commonly used classifications of types of incident. This list is not exhaustive and other classifications may be used as appropriate.

- **Big Bang** – a serious transport accident, explosion, or series of smaller incidents;

- **Rising Tide** – a developing infectious disease epidemic, or a capacity/staffing crisis or industrial action;

- **Cloud on the Horizon** – a serious threat such as a significant chemical or nuclear release developing elsewhere and needing preparatory action;

- **Headline news** – public or media alarm about an impending situation;

- **Internal incidents** – fire, breakdown of utilities, significant equipment failure, hospital acquired infections, violent crime;

- **CBRN** – Deliberate (criminal intent) release of chemical, biological, radioactive, nuclear materials or explosive device;

- **HAZMAT** – used to describe the accidental release of a hazardous material, which could be chemical, biological, radiological or nuclear'

- **Mass Casualty** – A disastrous single or simultaneous event(s) or other circumstances where the normal major incident response of several NHS organisations must be augmented by extraordinary measures in order to maintain an effective, suitable and sustainable response. (See Additional Contingencies, Section 6 for further information).

3. SECAmb Strategic and Tactical Intention

3.1. Strategic Intention

- The saving of life, in conjunction with other emergency services and responding organisations.

- To coordinate with local and national health partners and other responding agencies to help mitigate and minimise the impact of the incident on the community, partners and the wider NHS.

- To ensure public messaging is coordinated with other responding agencies and partners to enable public confidence to be maintained.

- Ensure sufficient assets and operational capacity are available to manage the event(s)/incident(s) and core activity to maintain service delivery to national standards.

- Ensure the safety and continued welfare of Trust staff involved in the response to the incident.

- Ensure a swift and considered response to new normality.

3.2. Tactical Intention

- To provide an effective and co-ordinated response to the major incident, in line with national and local plans and procedures.

- To implement an effective and appropriate command structure in line with agreed national frameworks.

- To undertake appropriate risk assessments ensuring the Health and Safety of all NHS staff at scene and that they are able to undertake their role as safely as possible.

- To establish effective on-scene communications to support the response and recovery from the incident

- To respond as part of the wider NHS team and help facilitate the best possible outcome for patients involved in the incident.

- To ensure that the Trust treats those involved as individuals and in the enormity of the situation that we do not lose sight of the needs of patients.

4. Roles and Responsibilities

4.1. CSCATTT Approach to Ambulance Service Responsibilities

4.1.1. The generic responsibilities of the ambulance service are set out below using the key principles of **C**ommand, **S**afety, **C**ommunication, **A**ssessment, **T**riage, **T**reatment and **T**ransport (CSCATTT).

Command	Ensure that appropriate command of the incident is established; by instigate a command and control structure, which includes strategic, tactical and operational commanders to provide management of resources, co-ordination of the NHS response and liaison with other services.
Safety	Commanders must protect the health, safety and welfare of all health service personnel onsite and allocate a safety officer to take responsibility for this function.
Communications	Ensure that effective communications are established at the incident, both internally and externally.
Assessment	To carry out a full assessment of the incident, using all available information, intelligence, risk assessments, policies and procedures. Establish the type and level of resources required to manage the incident Ensure regular **METHANE** report undertaken and ensure these are communicated to appropriate partner organisations.
Triage	To ensure that the casualties are treated in the most appropriate manager, instigate the use of a triage sieve and triage sort on all casualties prior to evacuation from scene.
Treatment	Following casualty Triage, treatment priorities can commence in line with the needs of the casualties. Commanders will need to ensure that the appropriate level of equipment and resources are available to undertake this function.
Transportation	Arrange and maintain appropriate means of transporting the injured to receiving hospitals including helicopter where available. Determine the priorities for the evacuation of casualties, ensuring even and simultaneous dispatch to the receiving hospital(s).

4.1.2. It is not possible to list the full range of responsibilities that may need to be undertaken, however there are a number of frameworks that will assist in this process, therefore, guidance should be taken from the NARU Command and Control Guidance and National Major incident Cards.

4.2. Other Responders

4.2.1. The roles and responsibilities of Category 1, Category 2; Voluntary and Military responders are detailed in full within the Cabinet Office guidance Emergency Response and Recovery (Cabinet Office, 2013).

5. Command Structure

5.1. The Strategic, Tactical and Operational (STO) levels of command are key principles by which Integrated Emergency Management (IEM) is established and it is vital that this structure is fully understood by the Trust.

5.2. In the event of a Major Incident being declared, the Trust will bring into operation the Strategic, Tactical and Operational levels of Command in common with all other Category 1 responders and in line with National Frameworks and guidance.

5.3. All Managers, responding to or involved in the incident must respect the chain of command and correct routes for communication as this eliminates duplication and ambiguity and helps to ensure patient safety.

5.4. The structure will be as follows:

5.5. **Strategic**

5.5.1. The strategic function will take place within the Trust where support for the Trust's response to the incident will be formulated, and any actions necessary to sustain that response will be undertaken.

5.6. **Tactical**

5.6.1. Tactical Command may operate either remotely or at the scene where they can maintain effective tactical command of the incident. The chosen location where tactical command will take place is a command decision and is based on the available information.

5.7. **Operational**

5.7.1. Operational Command will take control at the incident site and request deployment of necessary Trust resources. As the incident develops and more resources are required functional roles will become necessary and be implemented by the Operational Commander.

5.7.2. There are number of roles which are identified within the National Ambulance Resilience Unit (NARU) Major Incident Action Cards, all functional roles will operate at the Operational level of command reporting back to the Operational Commander.

5.8. On-Call Executive Director

5.8.1. In support of the STO levels the Trust proves an on-call executive director, who will work outside of the Strategic, Tactical and Operational command structure and is concerned primarily with the corporate direction. This gives the Trust a level of resilience, but also provides a "Guiding Mind" for the Strategic Commander. However, the Executive Director does **not** provide a command function, which is discharged through the STO structure.

5.9. The Strategic Co-ordinating Group

5.9.1. For Major Incidents occurring within the Trust's area, the Strategic Co-ordinating Group (SCG) will be established at the nominated Police Headquarters.

5.9.2. The locations within the Trust's region are:

Kent Police HQ Sutton Road. Maidstone. ME15 9BZ	Surrey Police HQ Mount Browne Sandy Lane Guildford GU3 1HG	Sussex Police HQ 1 Malling House Church Lane Lewes BN7 2DZ

5.9.3. There may be occasion when the Trust will need to provide representation to a neighbouring SCG.

5.9.4. A representative of the Strategic Commander should attend the neighbouring SCG. This representative may be another director, or senior manager with delegated executive powers who is able to represent the Trust.

5.10. Multi-Sited Incidents

5.11. Strategic and Liaison with SCG(s)

5.11.1. In the event of a multi-sited incident a single SECAmb Strategic Commander should be instigated with liaison officers sent to each established Strategic Co-ordinating Group, as above.

5.11.2. There are a range of command structures that can be implemented to manage both single and multi-sited incidents. The Strategic Commander is responsible for defining these based on advice from the Tactical Advisor. (See Appendix 1 for options).

5.12. **Tactical**

5.12.1. Where a single incident crosses police boundaries, resulting in multiple Tactical Co-ordinating Groups (TCGs) a single Tactical Commander will be appointed with representation sent to each TCG.

5.12.2. Where a number of unrelated incidents occur simultaneously, each incident may be assigned a Tactical Commander with co-ordination of resource being undertaken at Strategic level.

5.13. **Operational**

5.13.1. Operational command should be established at each incident site in relation to the needs assessed, as outlined in the JESIP principles.

5.14. **Health Incident Co-ordination Centre** (ICC)

5.14.1. The Health ICC will serve as a focal point for all liaisons between NHS England (Area Team) and partner organisations regarding the incident.

5.14.2. Once established the Health ICC will have direct contact with all responding NHS providers. Its role is to remain informed of their current status and provide relevant information to the SCG Health Gold representative.

5.14.3. As appropriate a representative of the Trust may attend the Health ICC.

6. Training and Exercising

6.1. The Civil Contingencies Act Regulations require Category 1 responders to include provision for the carrying out of exercises and for the training of staff in emergency plans.

6.2. The Trust is committed to a regular and continuous process of training and exercising the Major Incident Plan.

6.3. **Training**

6.3.1. An appropriate introduction to the SECAmb Major Incident Plan will be provided to Trust staff during induction or initial training course(s).

6.3.2. Additional training will be incorporated into staff development programmes to provide skills and knowledge training, in accordance with the requirements set out in the NHS England Core Standards for Emergency Planning, Response and Resilience (published annually).

6.3.3. Commanders are required to attend training and maintain competencies in line with the agreed National Occupational Standards.

6.3.4. Should any changes to the Major Incident Plan be made, all staff will receive notification to ensure the continued effectiveness of the response.

6.3.5. All Major Incident training will seek to ensure an appropriate link to the Trust's Business Continuity Management Plan.

6.3.6. Details of all Major Incident response training will be held on the Trust's training database.

6.4. **Exercising**

6.4.1. Exercising of the response to a Major Incident will be in accordance with NHS guidance and the Trust's contractual requirements.

6.4.2. Exercises will be held to validate any alterations, either in part or whole, to any element of the Major Incident Plan.

6.4.3. The Trust will contribute to the exercise programme of other Category 1 responders where there is a clear benefit to the multi-agency response.

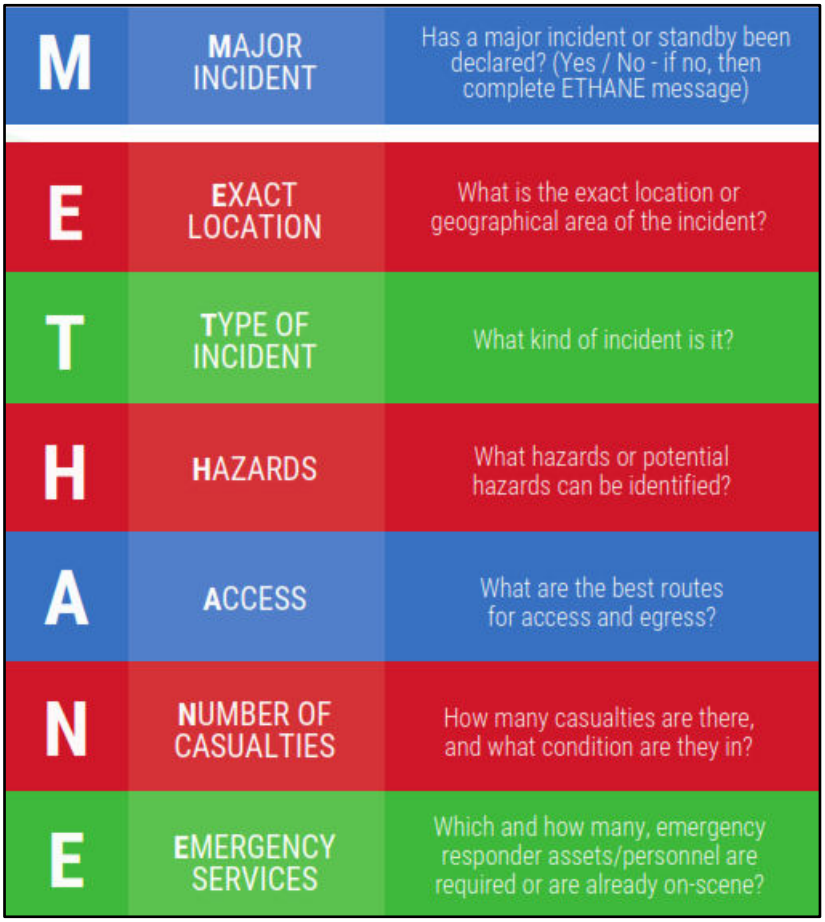
7. Initiation of The Major Incident Plan

7.1. The initial call to the Emergency Operations Centre indicating that a Major Incident has happened may come from a number of sources:

- A member of the public, via the “999” or “112” system;
- Another Category 1 or 2 responder;
- A hospital;
- Any member of the Trust’s staff.

7.2. It may not always be possible, in the first instance, based on the early information received, to identify that a Major Incident has occurred.

7.3. If it is considered that a Major Incident has occurred, it should be reported using the **METHANE** mnemonic (as detailed below), which has been adopted by all the emergency services and the NHS as a consistent way of providing the essential information.



7.4. The Major Incident Plan

7.4.1. As soon as the initial reports indicate that a Major Incident may have occurred, the EOCM on duty in the relevant Emergency Operations Centre will initiate the Major Incident Plan.

7.4.2. It is better to declare and then stand-down a Major Incident than not declare a Major Incident in the event of uncertainty.

7.4.3. If having instituted a Major Incident Standby/Declared it is found not to be required, it will be rescinded by the message "**Major Incident Cancelled**".

7.5. Business Continuity Management Plan

7.5.1. Should any element of the SECAmb Major Incident Plan be implemented in response to either a Major Incident Standby or Major Incident Declared, then the Strategic Commander, to ensure provision of service continuity, must invoke the Business Continuity Management Plan and a swift return to new normality is achieved.

8. Action by the Emergency Operations Centre

8.1. The Trust has two Emergency Operations Centres (EOC), who are an integral part of the Major Incident Management System.

8.2. The initial 999 emergency call will be received in the EOC who will dispatch the appropriate SECAmb resources. As soon as it is known or suspected that a Major Incident has occurred the EOC responsible for the operational dispatch area in relation to the location of the incident will assume responsibility for the management of the incident with support from the other.

8.3. In the initial stages of a Major Incident information can be confusing, conflicting and misleading, therefore Emergency Operations Centre staff should think “worst case” scenario until information can be substantiated and confirmed.

8.4. Once the Major Incident Plan has been brought into operation, Emergency Operations Centre staff must always be ready to use their initiative and to manage the unexpected. Consideration should be given as to whether the incident is single or multi-sited and/or if additional contingencies need to be employed to support the response.

8.5. The actions and tasks for the EOC are detailed within action cards held within each of the Emergency Operations Centres.

8.6. **Responsibilities of the Emergency Operations Centre**

8.6.1. It is the responsibility of the EOCM located in the relevant EOC to implement the Major Incident Plan.

8.6.2. If handover from the EOC to the Incident Command Hub takes place this must be managed to ensure that all the required alerting actions are completed.

8.6.3. It is the responsibility of the EOC Senior Manager (EOC Tactical) to ensure the continued management of the Trust response to the Major Incident whilst maintaining a response to core activity across the Trust region.

8.6.4. The key responsibilities of the EOC can be summarised as:

- Deployment of the Pre-Determined Response (PDR) in relation to the information received
- Alerting other Emergency services
- Initiating an alerting cascade to the wider NHS and other stakeholders

- Mobilising specialist resources and assets
- Mobilising Commanders
- Establishing a communications network with Trust Commanders
- Establishing communications with other responders, receiving hospitals and the wider NHS

WHEN THE PLAN IS ACTIVATED, TAKE THE ACTION CARDS FROM THE MAJOR INCIDENT CABINET IN THE EMERGENCY OPERATIONS CENTRE AND FOLLOW THE INSTRUCTIONS

8.7. Alerting Procedures by the Emergency Operations Centre

8.7.1. The following agencies will be notified by the EOC will be notified that Major Incident procedures have been put into operation and essential information about the location and nature of the incident will be given as per **METHANE** report.

- Police, Fire and Rescue Services (if they did not receive the initial call).
- The nearest appropriate receiving hospital(s), using the standard form of message.
- The wider NHS, including NHS England Area Team(s), and Public Health England.
- Neighbouring Ambulance Trusts
- Other agencies (e.g. HM Coastguard, Network Rail) as appropriate.

8.8. Standard Alerting Messages

8.8.1. The EOC should use the following standard alerting messages at all times in order to avoid any confusion.

8.8.1.1. Major Incident Stand-by

- This alerts the Trust and other organisations that a major incident may need to be declared and preparatory arrangements appropriate to the incident may be required.

8.8.1.2. Major Incident Declared

- This alerts the Trust and other organisations that we need to activate our Major Incident plan(s) and mobilise appropriate additional resources.

- Major Incident Declared" can be announced without introducing the "stand-by" phase if circumstances dictate.

8.8.1.3. **Major Incident Cancelled**

- If a Major Incident Standby/Declared has been declared and it is found not to be required, this message cancels the Major Incident Standby/Declared messages at any time.

8.8.1.4. **Casualty Evacuation complete**

- When confirmation is received from the Major Incident scene that the casualty evacuation is complete, all activated receiving hospitals will be informed. Where possible they will be informed if any casualties are still en-route.

- On notification, it is the responsibility of each NHS organisation to assess when it is appropriate for them to stand down.

8.8.1.5. **Major Incident Stand-down**

- The decision to order the 'stand down' of the Trust response rests with the Strategic Commander.

- The EOC will inform all alerted agencies and hospitals of Trust 'stand down'.

- An appropriate message should be given out to inform all trust personnel of Major Incident stand-down.

8.8.2. To avoid confusion all messages that are used to alert to a Major Incident Response must follow the standard format as detailed on the EOC Major Incident Action Cards

8.8.3. All alerting messages to receiving Hospitals **must** be passed through the Switchboard Operator on the designated Major Incident Number.

8.9. **Trust Internal Alerts**

8.9.1. It is necessary for the Trust's staff to be aware that the Trust is responding to a (potential) Major Incident, as all departments have a role to play in the Trust's response.

8.9.2. This will be achieved by any/all of the following methods:

- Group Call over airwave radio
- MDT group messaging
- Pager Alert as per the Action Card
- Individual telephone calls/SMS

- Messaging via Trust wide email /Trust Intranet

8.10. Off Duty Staff

8.10.1. Off duty personnel, wishing to report for duty in support of a Major Incident must not self-deploy to the incident scene but should notify clinical scheduling and await further instructions.

8.11. Key Contact Details

8.11.1. All key contact details required for the initiation of this plan, and response to a major incident are contained in the Emergency Operations Centres and by the Contingency Planning & Resilience Department.

9. Pre-determined Response Process

9.1. The Trust has a standard Pre-determined Response (PDR) process to allow for the identification of the resources required for the various types of incident we may respond to. (See Appendix 2)

9.2. In order to ensure that the incident is managed appropriately, as early as possible in the response the following a pre-determined response (PDR) will be considered.

9.3. **Major Incident Stand-by**

9.3.1. For a Major Incident Stand-by the pre-determined response will be set between Levels 2-3, variables that govern the level of response will include:

- The complexity of the incident
- The number of patients

9.4. **Major Incident Declared**

9.4.1. For a Major Incident Declared the pre-determined response will be set at Level 4, this consists of:

- 10 x DCA
- 5 x Operational Commanders
- 1 x Tactical Commander
- 1x Tactical Advisor
- 1 x Incident Support Unit
- 1 x Incident Command Vehicle with support staff.
- Hospital Ambulance Liaison Officers will be deployed to the notified receiving hospitals.

9.5. In all cases, it is essential to obtain an early **METHANE** report from the first crew at scene in order to confirm the response and identify if further managers and/or resources are required in order to establish the command structure and major incident footprint.

9.6. In order to balance the needs of the incident against delivering an effective service across the whole Trust area, it is the responsibility of the Incident commander to stand the resources down if they are not required.

9.7. **Specialist Resources**

9.7.1. Specialist resources which may be required to support the response include:-

- Hazardous Area Response Teams (HART)
- Critical Care Paramedics
- Paramedic Practitioners
- Air Ambulance/HEMS
- Special Operations Response Team (SORT)
- Tactical Advisor /NILO

9.7.2. Further information on the capabilities of the Trust specialist resources is detailed in the Additional Contingencies Section 4.

9.7.3. Incident Support Vehicles which may be required to support the response include:-

- Incident Command Vehicle(s)
- Incident Support Unit(s) (Equipment)
- Incident Support Unit(s) (Decontamination)
- Mass Casualty Equipment Vehicles

9.7.4. Further information on the Trust's Incident Support Vehicles and their locations is detailed in Section 18.

10. Acute Care

10.1. Receiving Hospitals

10.1.1. The Ambulance Service is responsible for selecting and alerting the most geographically appropriate Receiving Hospital(s), which may include Major Trauma Centres (MTC), Trauma Units (TU) and Local Emergency Hospitals (LEH).

10.1.2. Consideration will need be given to dispersal of casualties to these locations according to clinical need and available guidelines It should be recognised that patients may need to be transported to hospitals some distance away from the incident site or out of Trust area.

10.1.3. In some instances, to help mitigate the impact on the wider NHS it may be possible to use facilities at non-receiving hospitals e.g. LEH, walk in centres and minor injury units to treat the walking wounded. This should be requested and agreed with the hospital/unit to confirm their capacity and capability.

10.2. Receiving Hospital Responsibilities

10.2.1. The Receiving Hospital(s) are responsible for:

- Activating their Major Incident Plan in response to Ambulance Service alerting messages.
- The reception and treatment of casualties.
- Establishing an Incident Control Centre, staffed by a control team of Senior Managers and Clinicians to manage the hospital's response to the Incident.
- Alerting the Emergency Operations Centre to any requirement for casualty or in-patient transfers to another hospital, in liaison with the HALO/HALCO (this may also be done in conjunction with the Area Team Incident Co-ordination Centre (ICC)).
- Early notification to the Ambulance Incident Commander and Medical Advisor, of any circumstances affecting the hospital's capability to accept further casualties.
- Hospitals stand down arrangements following receipt of the "Casualty Evacuation Complete" message from the Emergency Operations Centre.

10.3. Initial Action at Receiving Hospitals

10.3.1. On receipt of the “Stand-by” message, the Switchboard Operator will implement the hospital’s Major Incident stand-by procedure.

10.3.2. On receipt of the “Declared” message, the Switchboard Operator will implement the hospital’s Major Emergency Plan.

10.3.3. The alerted receiving hospitals will provide/be contacted by the Emergency Operations Centre in order to establish the estimated number and type (Priority 1, 2 and 3) of casualties that can be taken in the early stages of the incident.

10.4. Ambulance “Turn Round” at Hospitals

10.4.1. The hospital will arrange a triage point, generally by the Ambulance entrance in the Emergency Department, at which casualties will be unloaded. Handover of casualties should take place at the triage point, ambulance personnel should not be delayed by carrying patients within the hospital beyond this point.

10.5. Clearing of Hospitals

10.5.1. Hospitals may decide to discharge/transfer some in-patients in order to make more staff and beds available for Major Incident casualties. The Trust’s HALO will liaise with the hospital(s) regarding arrangements for the transportation of these patients together with any outpatients awaiting return home. As the Trust does not provide PTS this will need to be undertaken in conjunction with the PTS/Ambulance provider.

10.6. Supporting Hospitals

10.6.1. Increasingly hospitals are part of wider specialist networks such as Major Trauma, Burns, Critical Care and Paediatric services, while some of these hospitals may not directly receive patients from the scene, they will be considered a supporting hospital for the incident.

10.6.2. If these specialist services are required, the Trust’s Medical Advisor will work with the NHS England Area Team to identify the most appropriate sites and mechanism for transportation.

10.6.3. The NHS England Area Team will decide if any non-receiving hospitals or specialist networks should be alerted and cascade as necessary.

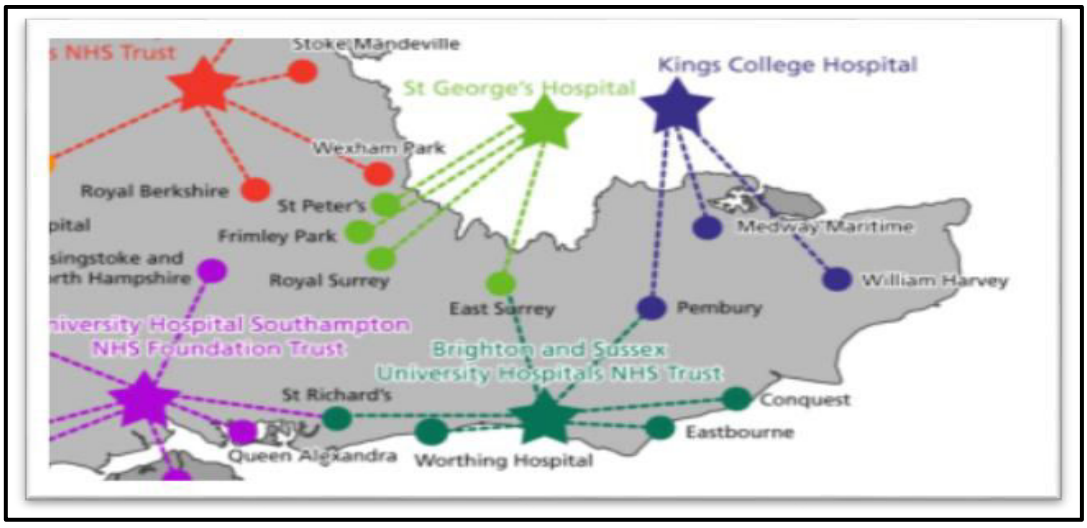
10.7. Receiving Hospitals within the Trust's region

County	Receiving Hospital	Trauma Network Designation
Kent	Tunbridge Wells Hospital, Pembury	Trauma Unit
	Maidstone Hospital	Local Emergency Hospital
	Darent Valley Hospital, Dartford	Local Emergency Hospital
	Medway Maritime Hospital, Gillingham	Trauma Unit
	William Harvey Hospital, Ashford	Trauma Unit
	QEQM Hospital, Margate	Local Emergency Hospital
Surrey	Royal Surrey Hospital, Guildford	Trauma Unit
	East Surrey Hospital, Redhill	Trauma Unit
	Ashford & St Peter's Hospital, Chertsey	Trauma Unit
	Frimley Park Hospital	Trauma Unit
	Kingston Hospital	Trauma Unit
Sussex	St Richards Hospital, Chichester	Trauma Unit
	Worthing Hospital	Trauma Unit
	Royal Sussex County, Brighton	Major Trauma Centre
	Conquest Hospital, Hastings	Trauma Unit
	Eastbourne District General Hospital	Local Emergency Hospital

10.8. Major Trauma Centres within the SE Trauma Network

Royal Sussex County, Brighton	Sussex Major Trauma Centre
St Georges Hospital, Tooting London	SW London & Surrey MTC
Kings College, Denmark Hill London	SE London & Kent & Medway MTC
Southampton General Hospital	Wessex MTC

10.9. Major Trauma Systems in the South East



11. Action by Ambulance Crews at Scene

11.1. In the majority of Major Incidents, the first representative of the Trust at the scene will be an ambulance crew. It is **essential** to remember that the priority of the initial crew arriving at a Major Incident is **not** to treat casualties or begin rescue attempts but to assess and inform.

11.2. Initial responders should ensure they conduct a rapid scene assessment which should be communicated to the Emergency Operations Centre using the **METHANE** mnemonic as a consistent way of providing the essential information.

11.3. Consider the following factors and if in doubt declare a major incident:

- Are there a large numbers of casualties?
- Will the incident overwhelm health services?

11.4. **Initial Crew on Scene** (refer to Action Cards)

11.4.1. The first ambulance resource to arrive at the scene will park as near to the scene as safety permits, leave visible warning lights on and act as the **Ambulance Control Point**.

11.4.2. If a Team Leader or Manager is a member of the first crew to arrive, he/she will act as the Operational Commander until relieved by a more senior manager, otherwise the following procedure will be adopted:

11.5. **Driver** (refer to Action Cards)

11.5.1. The driver will:

- Remain in the vehicle and act as the **Communications Officer on Site** until relieved.
- Remain in radio contact with the Emergency Operations Centre.
- Confirm the location with the Emergency Operations Centre and provide a **METHANE** report, giving any further information that is available, including the type of incident and which of the other emergency services are present.
- On the arrival of additional resources ensure that;
  - Staff are designated as **Primary Triage Officer** and **Ambulance Parking Officer**.
  - High visibility reflective jackets and safety helmets are worn by all staff.
  - All staff bring the triage cards from their vehicle.

11.6. **Attendant** (refer to Action Cards)

11.6.1. The attendant will:

- Act as the **Operational Commander** until relieved.
- Start an incident log.
- Carry out a reconnaissance of the scene, assess the situation and confirm “Major Incident Declared” message to the Emergency Operations Centre.
- Await confirmation that the message has been received and provide a full **METHANE** report.
- Liaise with Police and Fire Service Incident Commanders and establish:
  - Access and Egress Routes;
  - Ambulance Parking Point (Marshalling Area);
  - Casualty Clearing Station.
- Ensure that the Emergency Operations Centre is frequently updated.
- Prepare to brief the **Ambulance Commander** on their arrival.

11.7. **Subsequent Ambulance Crews sent to the Incident**

11.7.1. Subsequent Trust crews should be prepared to take a command role in the initial stages of the incident.

11.7.2. The second Trust crew will be designated as **Primary Triage Officer** and **Ambulance Parking Officer.**

11.7.3. **Initial Actions**

- Report as instructed by Emergency Operations Centre.
- Switch off blue lights when arriving on scene if safe to do so.
- Book on scene with Emergency Operations Centre or Incident Control Vehicle (if established) using the designated incident airwave talk-group.
- Report arrival to Ambulance Parking Officer if designated, if not report to the Ambulance Control Point indicated by its blue lights.
- Ensure high visibility jackets and safety helmets are worn.
- Ensure keys are left with the vehicle.

11.7.4. **Subsequent Actions**

- As directed carry out triage, treatment or transport.
- It is vital that the scene of the incident is managed and not congested with ambulances/Trust vehicles.
- All crews must therefore act under the direction of managers on scene.

11.8. When leaving the incident scene, the driver must report to the Emergency Operations Centre with the following information:-

- the number, ages and category of patients (P1, P2, P3) on board; and destination receiving hospital as advised by the Ambulance Loading Officer.

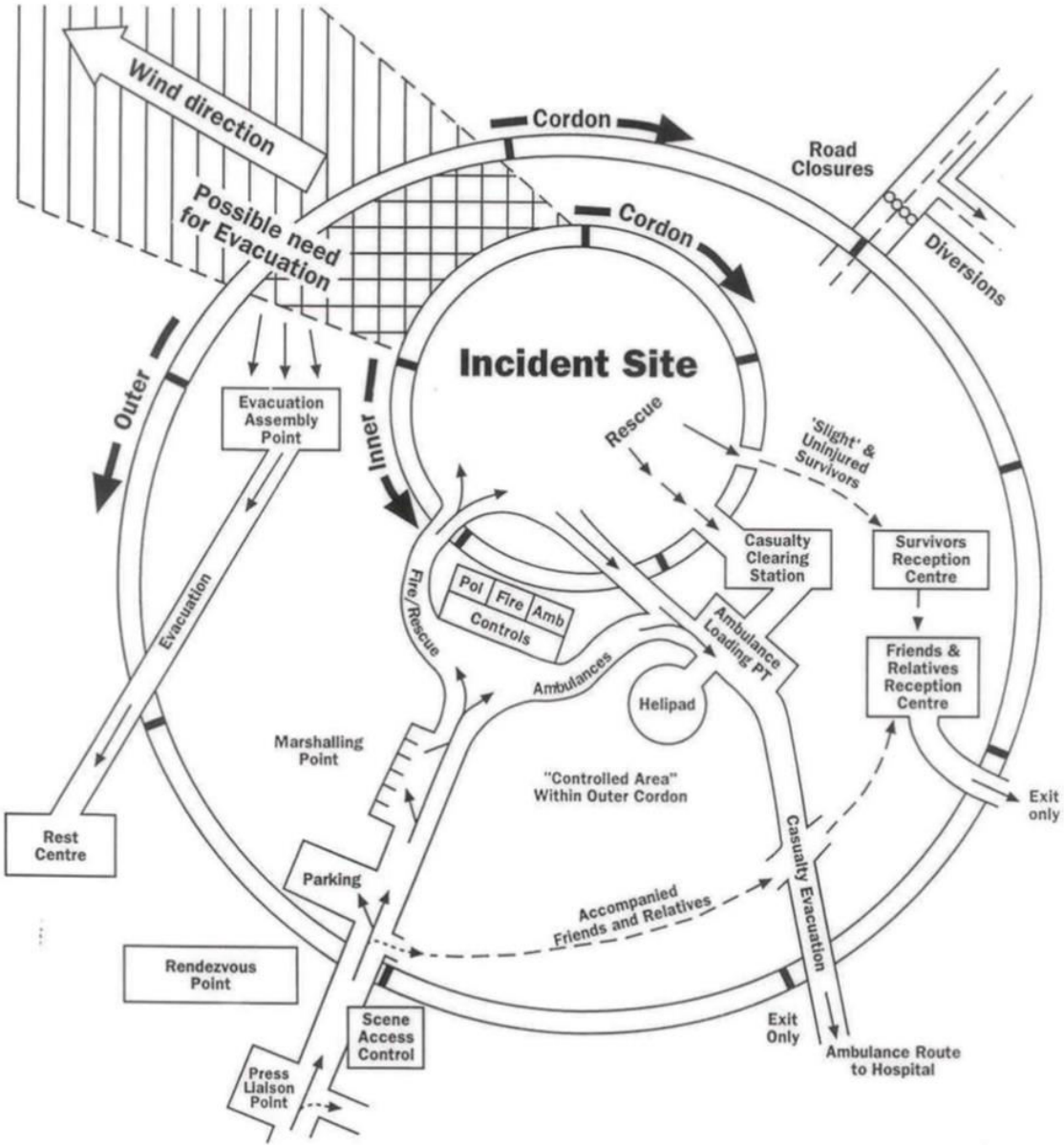
N.B. The above information is sufficient, full ASHICE details do **not** need to be passed.

11.9. When clear at hospital, report to the Hospital Ambulance Liaison Officer/Emergency Operations Centre for further instructions.

12. Establishing a Major Incident Footprint

12.1. Establishing a Major Incident footprint should be a priority for commanders once on scene of a Major Incident. The pictorial schematic below demonstrates an incident footprint with some functional roles included.

12.2. The footprint will consist of an inner and outer cordon and dependant on the type and size of the incident may vary in size and complexity.



12.3. It should be borne in mind that for a CBRN or HAZMAT incident that decontamination zoning should also be considered within the footprint.

12.4. Personal Protective Equipment (PPE)

12.4.1. All personnel engaged on duties at a Major Incident will wear their high visibility clothing and protective helmets when in the inner cordon unless instructed otherwise by the Safety Officer.

12.4.2. An **Ambulance Safety Officer** will be appointed and **ALL** NHS responders will follow the instructions given by the Ambulance Safety Officer following relevant dynamic risk assessment(s).

12.4.3. A Major Incident Bag is carried on Trust frontline Double Crewed Ambulances (DCA) and Single Response Vehicles (SRV) which contains additional PPE available to staff.

13. Communications

13.1. Airwave

13.1.1. Major Incident communications will be managed by moving managers and resources assigned to the Major Incident onto dedicated Major Incident Talkgroups.

13.1.2. All resources will remain on their normal “domestic” dispatch talkgroup until instructed by the Emergency Operations Centre to change talkgroups.

13.1.3. The Emergency Operations Centre will designate the Major Incident talkgroup(s) to be used and is responsible for ensuring that the talkgroup(s) is monitored and recorded.

Each of the Emergency Operations Centres has access to airwave handsets provided for Major Incident use. These can be accessed via the on-call EOC systems or EOC Tactical.

13.2. Airwave Interoperability

13.3. Interagency

13.3.1. Interoperability voice communications (IVC) is facilitated by all Police services and allows all the Emergency Services to communicate with each other using designated Airwave talkgroups.

13.3.2. At the discretion of the Incident Commanders, it may be decided to use an interoperability talkgroup to facilitate communication and exchange of information.

13.4. Mutual Aid

13.4.1. In the event of Mutual Aid being requested by the Trust from other Ambulance Services, Cells/vehicles attending may be directed onto a nominated Trust Mutual Aid Talkgroup after their initial call via SEC Hailing on arrival in the Trust.

13.5. The designated Talkgroups are detailed at Appendix 3.

13.6. Department of Health Resilience Airwave Handsets

13.6.1. The Department of Health have provided the Trust with additional Airwave Handsets, which are held by the Trust’s Radio Manager, for use during an incident, communications failure or national emergency. The Radio Manager, during an emergency can be paged by EOC.

13.6.2. These sets must also be made available (on request by Airwave) to other neighbouring Trusts. They will be collected by an Airwave representative and returned after use.

13.7. **Mobile Telephone Preferential Access Scheme** (MTPAS)

13.7.1. The majority of Commanders and the Tactical Advisors within the Trust have MTPAS enabled SIMs, which will ensure they will be prioritised for access to the mobile network once MTPAS is enabled by the Police and Network providers.

14. Major Incident Command Role Descriptions

14.1. The Ambulance Strategic Commander

14.2. The Ambulance Strategic Commander has responsibility for the overall command, response and recovery from any Major Incident.

14.3. The Strategic Commander is responsible for setting the Trust's strategic aims for the incident and providing a framework for the Tactical Commander to work within.

14.4. The Ambulance Tactical Commander

14.4.1. The Tactical Commander has the responsibility for developing the Tactical Plan, which will be developed within the framework of the strategic intent and strategy.

14.4.2. The Tactical plan will provide a set of parameters for the Operational Commander to operate within.

14.4.3. The Tactical Commander is responsible for supporting the Operational Commander to achieve their objectives, although must not get drawn into making operational decisions.

14.5. Ambulance Operational Commander

14.5.1. The Ambulance Operational Commander has responsibility for the activities undertaken at the scene and will be located alongside the Operational Commanders of the other responding agencies. They will provide leadership and management to the functional roles.

14.6. Operational / Functional Roles

14.6.1. The Operational Commander, who will delegate responsibility for a specific function, will assign the functional roles.

14.6.2. The functional roles will report to the Operational Commander, who has the responsibility to support them in discharging their duties as defined in the National Ambulance Resilience Unit (NARU) action cards.

14.6.3. The table below outlines the functional roles and call signs that may be assigned during a Major Incident. This is neither exhaustive nor prescriptive and best use of available resources should be made to reflect the nature of the incident.

Operational / Functional Roles	Call Sign
Sector Commander(s)	Sector (+ number)
Ambulance Safety Officer	Safety
Primary Triage Officer	Primary Triage
Ambulance Casualty Clearing Officer	CCS
Secondary Triage Officer	Secondary Triage
Ambulance Parking Officer	Parking
Ambulance Loading Officer	Loading
Ambulance Equipment Officer	Equipment
Ambulance Patient Liaison Officer	PLO
Ambulance Hospital Liaison Officer	HALO (Hosp Name)
Ambulance Communications Officer	
HART Team Leader	HART TL

14.7. **Command Support Roles**

14.7.1. In addition to the strategic, tactical and operational command roles there are a number of other support roles that would offer support at all levels of command.

14.8. **Strategic Medical Advisor**

14.8.1. Support and provides medical advice to the Strategic Commander in relation to the Trust's response to the incident as well as maintaining the continuity of our core service delivery.

14.8.2. The Strategic Medical Advisor is responsible for invoking of **'expected category'** of triage if required at a Mass Casualty incident.

14.9. **Medical Advisor**

14.9.1. The purpose of this role is to support the Operational and Tactical Commanders, by providing medical advice and has overall clinical responsibility for medical resources deployed to the scene.

14.10. **Tactical Advisor**

14.10.1. The Tactical Advisor is responsible for providing specialist advice at all levels of command on matters relating to the organisational major incident response.

14.10.2. The full list of the command and functional roles are detailed within the NARU Major Incident Action Cards, and must be referred to during a Major Incident.

14.10.3. The call signs for the command and functional roles are outlined in the NARU Major Incident Action Cards.

15. Casualty Management

15.1. At the scene of a Major Incident, the Trust may not be able to work in the standard way to manage the casualties due to the numbers or complexity involved. Therefore, it is important that a structured and methodical approach is adopted at these incidents.

15.2. The Operational Commander must at an early stage of the Major Incident establish the casualty management plan, assign the functional roles to the appropriate managers and clinicians and ensure it is communicated and understood.

15.3. In order to assist the Operational Commander and functional roles to assign clinicians appropriately at the scene and provide a clinically safe service, the clinical grade of staff must be clearly visible on their reflective jackets.

15.4. Key functional roles relating to casualty management are:

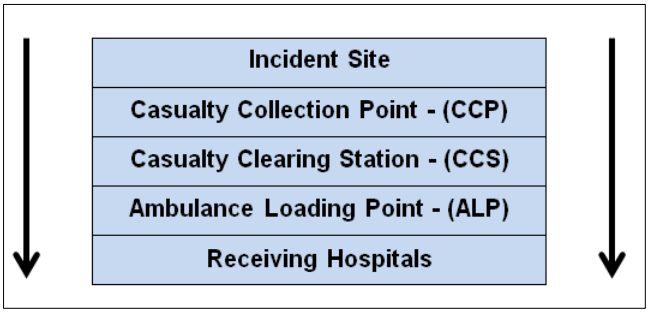
- Primary Triage Officer
- Casualty Clearing Officer
- Secondary Triage Officer

15.4.1. For further details regarding the functional roles, refer to the National Ambulance Resilience Unit (NARU) Major Incident Action Cards.

15.5. **Casualty Flow**

15.5.1. Due to the likely number of casualties at a Major Incident it will not be possible to convey all casualties directly to a receiving hospital, therefore, it is important that all casualties are managed effectively on scene and cared for through a structured casualty clearing process.

15.5.2. A casualty will take a distinct route from the incident site through to receiving definitive care at the most appropriate receiving hospital.



15.5.3. This route has been designed to allow clinical care to be given throughout the journey and to make the best use of the available clinical resources at the scene.

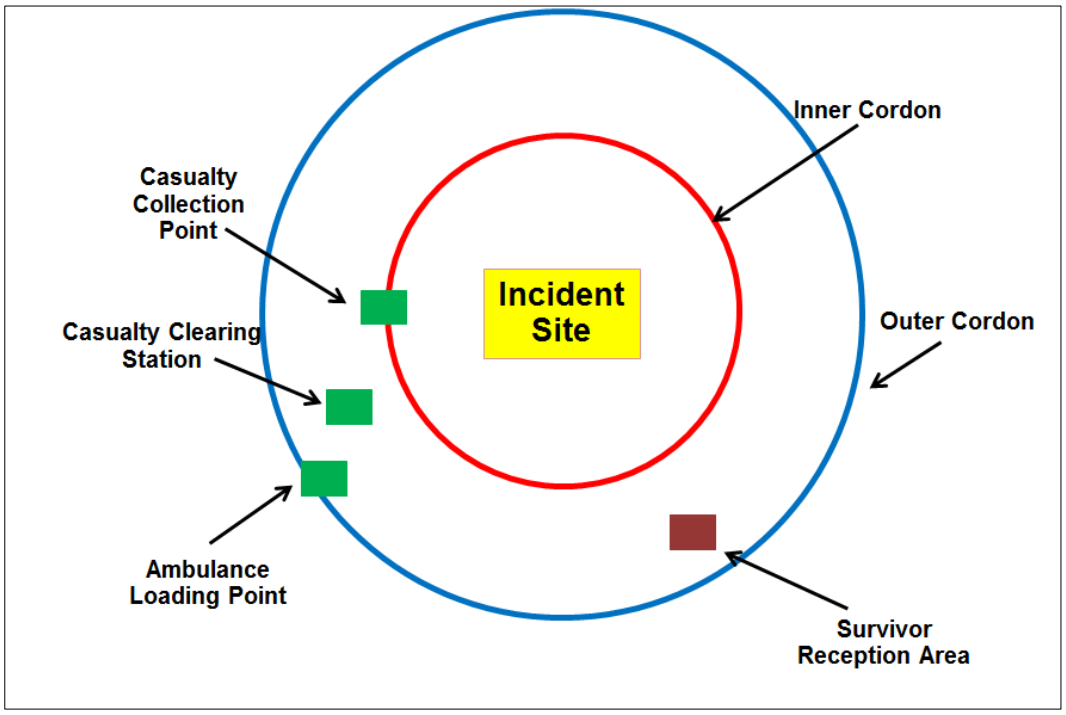
15.6. **Casualty Clearing Station**

15.6.1. The value of establishing Casualty Clearing Stations (CCS) is well established within major incident plans and it is the basic principles upon which this casualty management plan builds.

15.6.2. Where possible one larger CCS should be established, which will allow limited personnel and equipment to be centralised.

15.6.3. The equipment to support a CCS is carried in the Trust Incident Support Units (ISU) which should be deployed to the scene of a Major Incident at an early stage.

15.6.4. The location of the CCS must be carefully chosen to allow for quick access and egress from the scene and in close proximity to the Ambulance Loading Point.

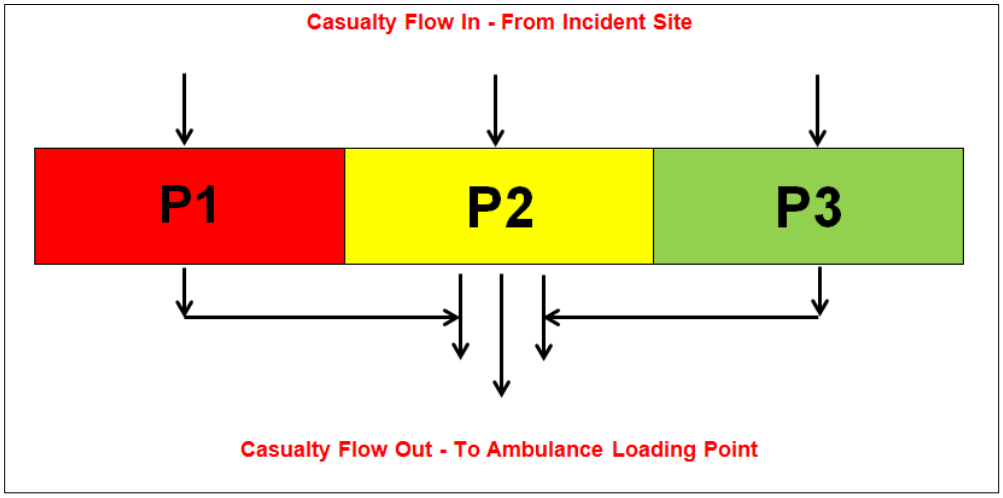


15.6.5. The Casualty Clearing Station (CCS) is key point in the casualties' journey and is where a significant amount of the on scene clinical care will take place; therefore, it is important that the appropriate clinicians are assigned to this area.

15.6.6. The Operational Commander should consider deploying the higher-level clinicians, such as HEMS Doctors, Critical Care Paramedics and Paramedic Practitioners to the CCS, where appropriate care can take place.

15.6.7. In order to minimise the impact on the wider health community, consideration should be given to using the higher-level clinicians to discharge some patients at scene, if appropriate. Where this course of action is chosen, it will be undertaken in line with the Trust's Scope of Practice and Clinical Standards Policy.

15.6.8. The Operational Commander should appoint a Casualty Clearing Officer who will coordinate activities at the CCS and establish specific areas for the different priority of casualties.



15.6.9. Establishing specific areas for the different priority of casualties will help to more easily identify those who require urgent clinical care and assign the appropriate clinical resource. A CCS should not be seen purely as a tented structure, but an area or location at the scene where casualties can be managed appropriately prior to being conveyed to a receiving hospital.

15.7. Casualty Triage

15.7.1. In situations where demand exceeds the resources available it is important that treatment priorities are established so that resources can be appropriately focused on those casualties most in need.

15.7.2. The process of triage is carried out to assess the clinical needs of individual casualties at a major incident, to ensure that we are able to prioritise the treatment given.

15.7.3. Without effective triage, casualties may well become unmanageable and, in the case of mass casualties, lesser injured may well receive treatment and be conveyed to hospital in preference to those requiring treatment more urgently.

15.7.4. It is essential that all casualties be labelled in accordance with the appropriate casualty triage category.

15.7.5. The standard labelling of casualties covers four categories:

Priority 1 - Immediate	**Red**
Priority 2 - Urgent	**Yellow**
Priority 3 - Delayed	**Green**
Deceased	**Black**

15.7.6. In the event of a Mass Casualty Incident a fifth category may be agreed to and introduced by the Strategic Medical Advisor:

Expected	**Red**

15.8. **Stages of Triage**

15.8.1. There are two distinct stages of triage used. These are defined as '**Triage Sieve'** and '**Triage Sort'**.

15.9. **Triage Sieve**

15.9.1. Casualties will initially be triaged using the principle of the "Triage Sieve" which is a clinically based assessment tool to identify the priority of each casualty.

15.9.2. It is best practice to undertake the triage sieve in pairs, one clinician to undertake the assessment and the other clinician to complete the documentation.

15.9.3. Casualties should be reassessed and re-triaged where appropriate at regular intervals and where practical no less than every 15 minutes. All observations will be recorded on the SMART Triage Tag.

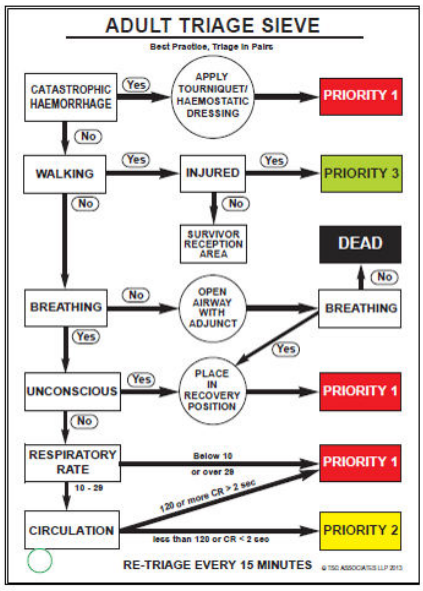
15.9.4. It should be highlighted that initial lifesaving treatment including the use of airway adjuncts and the management of critical haemorrhage must be considered during initial the triage sieve phase.

15.10. Triage Sort

15.10.1. 'Triage Sort' is a more detailed assessment process which utilises the Glasgow Coma Scale, Respiratory Rate and Blood Pressure and normally takes place within Casualty Clearing Station. This process refines the priorities for further treatment and transportation.

15.11. A Major Incident Bag is carried on every Trust frontline Double Crewed Ambulance (DCA) and Single Response Vehicle (SRV) which contains a SMART Tag Triage pack, which are the recognised triage method within the Trust.

Triage Sieve and Triage Sort Cards



TRIAGE SORT

Glasgow Coma Scale	13 - 15 = 4 9 - 12 = 3 6 - 8 = 2 4 - 5 = 1 3 = 0	(+)	(+)	(+)
Respiratory Rate	10 - 29 = 4 > 29 = 3 6 -9 = 2 4 - 5 = 1 0 = 0	(+)	(+)	(+)
Systolic BP	> 90 = 4 76 -89 = 3 50 -75 = 2 1 - 49 = 1 0 = 0	(=)	(=)	(=)
Total	12 = P3 11 = P2 10 > = P1			
Time		:	:	:

(Note: - for further information, refer to the SMART Tag Triage Cards)

15.12. Casualty Documentation

15.12.1. In a Major Incident it is unlikely that the standard Patient Clinical Record (PCR) can be accurately completed. However it is important that basic clinical observations and treatments are recorded using the SMART triage tags.

15.12.2. Ambulances must not be delayed at the scene in order to obtain personal details of individual casualties which will be obtained by the Police Documentation Teams at the receiving hospitals

15.13. **Informing Receiving Hospitals**

15.13.1. During a Major Incident all the hospitals likely to receive casualties from the incident would have already been placed on a “Major Incident declared” status and will be expecting triaged casualties using the P1, P2 and P3 categories.

15.13.2. Ambulance crews leaving the scene and conveying casualties to hospital should not pass an ASHICE, but should only communicate the **Age, Gender and Priority** of each casualty.

15.14. **Casualty Dignity**

15.15. A Major Incident presents unique challenges to the responding clinicians due to the numbers of casualties and complexity of the incident, coupled with the potential for stretched resources at the scene. However, while undertaking the care of the casualties it is important that we place their needs at the centre of our actions and as far as practicable be respectful of their dignity.

15.16. **Cultural and Religious Diversity**

15.17. Whilst the health and safety of casualties should be the paramount consideration at the scene of a Major Incident, it is important that staff should remain sensitive at all times to the concerns and requirements of different cultural and religious groups.

16. Children in Major Incidents

16.1. Many Major Incidents can involve children. In some cases, children are the main casualties.

16.2. The Trust may be called upon to respond to a Major Incident:

- Involving only children;
- Resulting in both adult and child casualties;
- In which only adults are injured, but children need to be cared for

16.3. Children present unique challenges in the management of injury due to the differing anatomy and physiology of these patients, and some of these challenges can be, but are not limited to:

- Airway management – smaller and differing anatomy.
- Differing drug absorption rates.
- More susceptible to extremes of temperature.
- Age related communication difficulties.

16.4. Always try to accommodate parents' wishes to remain with their children. Parents are likely to want to have close contact with their child, no matter how serious the injury may be. Attempting to stop parents seeing grossly disfigured or mutilated children is not appropriate.

16.5. If the Major Incident involves children on a school outing, then it may be necessary to liaise with the school and the Local Education Authority. Social Services Departments may also need to be involved in providing psychological and social support to children and their parents.

16.6. Accidents involving children are very high profile in the media and therefore an Ambulance Media Officer should be appointed at an early stage.

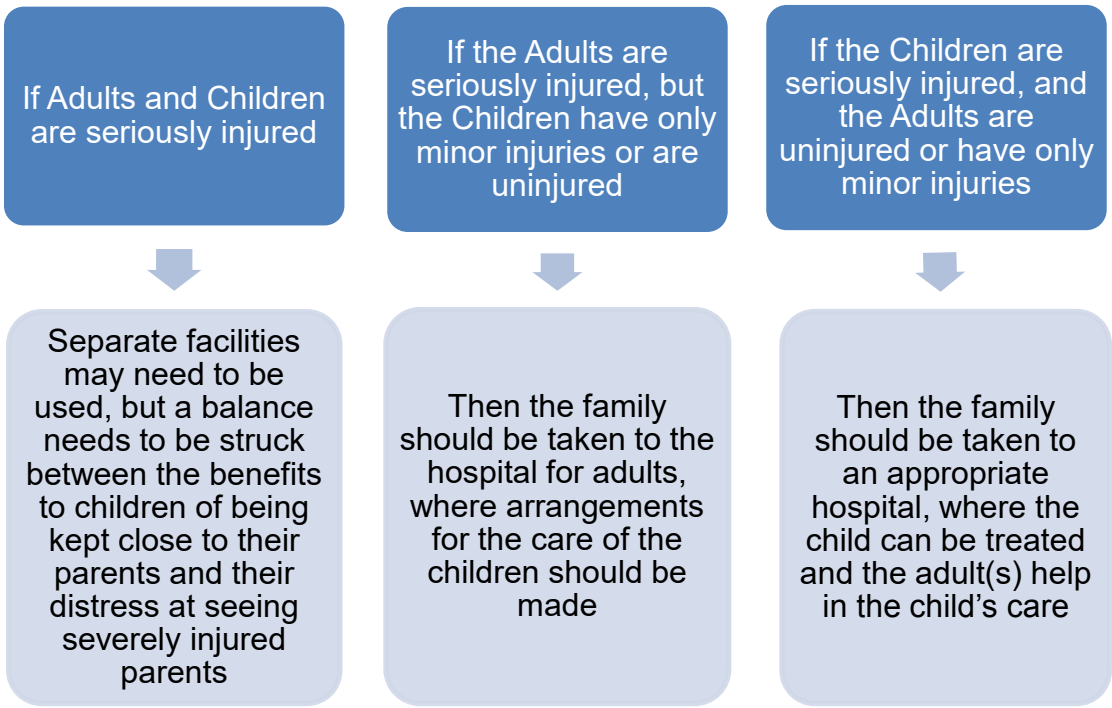
16.7. Following a Major Incident, children will need comfort from familiar adults, and wherever possible, the family should be kept together. However, the medical needs of both adults and children are the overwhelming consideration when planning where casualties should be taken.

16.8. It is essential that receiving hospitals are notified at the earliest opportunity that children may form part of the casualty numbers. As a general principle children involved and injured at a Major Incident will follow the Trusts **'Adult Trauma Decision Tree'** and conveyed to the appropriate receiving hospital, as any of the Trauma Units and

Trauma Centres can mount a clinical response to a sick child being conveyed to their department.

16.9. The following diagram may assist in the development of CASEVAC plans on occasions when adults and children from the same family are involved in a Major Incident and the facilities for adults and children are in separate hospitals.

16.10. Anyone involved in the response to a Major Incident may suffer from stress. This is particularly important in incidents where children are involved. Ambulance staff and parents, as well as the children involved, may be greatly distressed, and counselling and support will be required.



16.11. Additional paediatric equipment is available on the Mass Casualty Equipment Vehicles and Incident Support Units.

17. Deceased Persons

17.1. HM Coroner is responsible for all matters concerning deceased casualties, and the Police act under the instructions of the Coroner, taking temporary charge of the bodies. Other than to gain access to injured casualties, no deceased casualties should be removed without Police authority.

17.2. Patients are to be certified dead by a doctor, and a record made of the time and name of doctor certifying. This would normally take place at one of three locations:

- At the site
- Casualty Clearing Station
- Receiving Hospital

17.3. Recognition of Life Extinct (ROLE) may be performed by clinicians in accordance with Trust procedures.

17.4. If the site is out of the public view, then obvious fatalities should not be disturbed but left in situ to aid any Police investigation. If this is not practicable, then a Victim Holding Area, set up by the Police at the scene, should be used. The deceased must not be moved to a Victim Holding Area without permission from the Police. Sympathetic handling is required when moving/transporting the deceased.

17.5. For patients who are found to be dead on arrival at the receiving hospital, normal procedures will apply.

17.6. Arrangements have been made in the Trust's area to set up Emergency Mortuaries at key locations, details of which are restricted. The details will be made available by the Strategic Co-ordinating Group (SCG) in the event of an incident requiring their set up and use.

18. Logistical Support to the incident

18.1. Dependent on the size of the incident, consideration needs to be given to the resources required to sustain the Trust's response. The nature of the resourcing will include medical supplies, staff, vehicles, refuelling, feeding and welfare, communications and any specialist items of equipment relating to the incident.

18.2. The Trust's deployment to the incident may be made up of all, or any of the following:

- A& E Ambulances
- Single Response Vehicles;
- HART /fleet
- KSS Air Ambulance/HEMS
- Incident Support Unit(s) Equipment and/or Decontamination;
- Mass Casualty Equipment Vehicle(s)
- Patient Transport Vehicles

18.3. The person assuming the role of Ambulance Equipment Officer will review the requirements of the incident and arrange to secure additional resources as may be required.

18.4. **Logistical Support Vehicles**

18.4.1. Incident Support Units (Equipment)

18.4.1.1. The Incident Support Vehicles are part of the Trust's capability to respond to Major Incidents. These vehicles are stocked with enough equipment to establish a tented, heated casualty clearing station, external lighting, mass oxygen delivery system, patient handling equipment and additional clinical consumables

18.4.2. Mass Casualty Vehicles (MCV)

18.4.2.1. The Trust holds on behalf of the Department of Health 2 Mass Casualty Vehicles. These are placed at the Trusts HART bases. Each vehicle contains enough treatment packs, to provide emergency treatment for up to 100 P1 or P2, patients, with extra supplies for the casualty clearing station, including mass oxygen therapy and medication.

18.4.2.2. Nationally there are 24 MCVs distributed across the country. The vehicles can be deployed to other Ambulance and Acute Trusts to support incidents as required.

18.4.3. Major Incident Command Vehicles

18.4.3.1. The HART Forward Command Vehicles can be deployed to provide Communications and Command facilities on site.

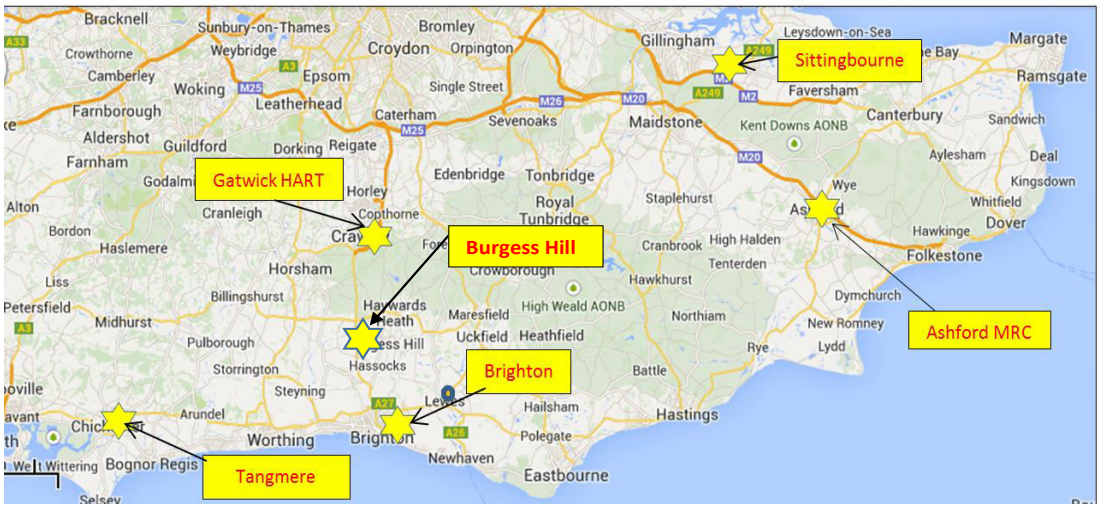
18.4.4. Incident Support Units (Decontamination)

18.4.4.1. The decontamination vehicles are part of the Trusts capability to respond to HAZMAT/ CBRN incidents and form part of the Home Office counter terrorism CONTEST strategy through the delivery of a “Model Response” at major cities and transport hubs.

18.4.4.2. These vehicles have enough equipment to establish an initial full Mobile Decontamination Unit (MDU) operational footprint to facilitate clinical decontamination of casualties. When deployed, they **must** be accompanied by an Incident Support Unit Equipment to provide all necessary equipment required, consideration should be given to moving further Chemical Decontamination Units towards the incident to provide resilience for ongoing decontamination.

18.5. Logistical Support Vehicle Locations

18.5.1. The Incident Support Units (ISU) and Mass Casualty Vehicles (MCEV) are strategically positioned across the Trust region. Their locations are shown below.



	ISU (Equipment)	ISU (Decontamination)	MCEV
Ashford HART	**X**	**X**	**X**
Gatwick HART			**X**
Burgess Hill	**X**	**X**	
Brighton	**X**	**X**	
Tangmere	**X**	**X**	
Sittingbourne	**X**	**X**	

18.5.2. A full list of the equipment carried on each of the specialist vehicles mentioned above is maintained, further details can be found on the Resilience & Specialist Operations site on Sharepoint.

18.6. Patient Transport Vehicles (PTS)

18.6.1. The Trust has a number of PTS vehicles within its fleet; these can be deployed at the request of the Ambulance Operational Commander to assist in the movement of casualties with minor injuries (P3s). Alternatively, PTS transport may be sourced from PTS providers through a Mutual Aid request.

18.7. Air Assets/ Helicopters

18.7.1. The Ambulance Operational Commander may, because of circumstances, wish to employ the use of helicopters for either the conveyance of extra medical resources to the site or the evacuation of casualties.

18.7.2. Initially KSS Air Ambulance/HEMS will be deployed by the HEMS Tasking desk, however where an incident occurs which involves a very high number of casualties, the National Ambulance Coordination Centre (NACC) will coordinate air assets and liaise with the appropriate Air Ambulance Provider's Control Room as to their availability.

18.7.3. MOD and Civil Search and Rescue (SAR) helicopters are co-ordinated through the Aeronautical Rescue Coordination Centre (ARRC) at the National Maritime Operations Centre, Fareham. The ARCC will appoint an Air Coordinating Officer (ACO) to work closely with the Ambulance Service to ensure the casualty movements are achieved through air asset management.

18.7.4. The RAF Flight Information Publication provides details of all Hospital Landing Sites.

19. Voluntary Aid Societies (VAS)

19.1. There are a number of voluntary agencies throughout the United Kingdom who are readily available to assist the medical services in an emergency situation

19.2. Throughout Kent, Surrey and Sussex, support can be requested from:-

- St John Ambulance;
- British Red Cross;
- The Women's Royal Voluntary Service;
- The Salvation Army;
- Kent, Surrey and Sussex Air Ambulance/HEMS

19.3. The Trust will maximise the use of the support offered by the Voluntary Aid Societies (VAS) during a Major Incident.

19.4. St John Ambulance/British Red Cross are able to provide teams of trained personnel for duties both at the scene of a Major Incident and in support roles at hospitals, Survivor Reception Centres and Rest Centres.

19.5. **Integrated VAS Response**

19.5.1. The Trust will be able to alert St John Ambulance/British Red Cross simultaneously in time of need for the earliest activation of plans. The VAS will then set in operation their individual Stand By/Call out plans.

19.5.2. The initial contact will be with to one person in each of the VAS. Following the instigation of their individual call out, each organisation will initiate and maintain lateral communication by appointing a Combined Resources Officer.

19.5.3. St John Ambulance and British Red Cross will if required deploy a Liaison Officer to the relevant Emergency Operations Centre to deal with management issues during VAS deployment.

19.5.4. Emergency Contact numbers for VAS are held by the Emergency Operations Centres and Clinical Scheduling Department

All members of the voluntary aid societies who attend a major incident must wear uniform, together with the appropriate protective clothing.

20. Media Liaison

20.1. Even ahead of media representatives arriving at the scene; social media activity is likely to begin almost immediately after the incident has occurred/started.

20.2. The media response; all supported by social media activity is likely to have three distinct phases:

- An immediate response by regional press, radio and television, followed quickly by support from their parent offices;
- A secondary response from the major United Kingdom outlets and news agencies;
- Substantial foreign press interest, particularly if foreign nationals are amongst the casualties.

20.3. Media activity will be handled at three levels:

- At sites such as the scene, hospitals, rest centres, etc.
- The Media Centre, if appropriate, which is defined as a building mutually suitable to the media and to the emergency services and other agencies involved, for media briefing and co-ordination of the media response.
- The Strategic Co-ordinating Group, where overall policy is determined.

20.4. Experience has shown that it is normally best to take and maintain the initiative by providing a regular flow of accurate information, rather than allow speculation to develop, which might cause public alarm, or adversely affect the management of the incident.

- This is key to managing the organisation's reputation and reassuring the public.
- On-going situation reports and information should be made available, as required.
- All Trust media statements should be copied to the Communications Manager of the NHS England Area Team and the Lead Clinical Commissioning Group in whose area the incident has occurred.
- A short Initial **holding statement** should be available within 10-30 minutes for those fielding the first media calls, where appropriate.

20.5. The Trust will provide:

- Factual details of the emergency response to the incident, i.e. numbers of ambulances, use of paramedics/doctors, etc.

20.6. The Trust will also give consideration to providing the following, depending on the incident:

- A Media Officer, identified with a tabard, at the Media Liaison Point;
- A Media Officer, identified with a tabard, at the Media Centre;
- For such duties as may be required, additional Media Officers as are available.

20.7. The Trust has a duty to provide information to the public before, during and post incident under the Civil Contingencies Act 2004 (Warning and Informing).

20.8. Pre-event information to the public is constantly accessible via the Trust's website: www.secamb.nhs.uk

20.9. It is the responsibility of the Head of Communications to ensure that the website contains appropriate and timely advice to the public.

20.10. It is also the responsibility of the Head of Communications to ensure that the Trust's social media channels are also up-dated appropriately.

20.11. Members of the Communications Department should refer to the department's MI Communication tool kit in the event of an incident.

21. Recovery

21.1. As part of the response to a Major Incident, it may be necessary to form a Recovery Team. It is expected that the Recovery Team will utilise the Trust Business Continuity arrangements as required to ensure the return to normal operations as the operational response to the incident reduces in the return to normal.

21.2. This team will consider, but not be limited to, the following:

- Managing the return to normal service and establishing what resources are required to achieve this
- Ensuring clinical oversight is in place to support the prioritising of outstanding non-incident calls and the management of requests for secondary transfers
- Staffing levels in the immediate, and near future
- Support of staff welfare including appropriate counselling
- Restocking of supplies and equipment
- Auditing and reporting of the Incident

21.3. **Post Incident Procedures**

21.3.1. Following the implementation of all or part of the Major Incident Plan, The Trust has a responsibility to ensure that a number of important activities take place. These are split into three areas:

- Operational Activities;
- Debriefing;
- Post Traumatic Activities

21.4. **Operational Activities**

21.4.1. Post Incident, the Trust has a duty to ensure that the Standard Operational Procedures are carried out to re-stock and refuel vehicles, in order to maintain the readiness of the Fleet.

21.4.2. Post Incident, the following operational activities will be carried out:

- A ‘hot debrief’ immediately after the incident, preferably chaired by the Ambulance Incident Commander;
- Welfare advice to all staff involved in the response;

- Trauma Risk Management (TRiM) referrals initiated where appropriate

- The re-stocking of all Trust areas involved in the response, including the replenishment of drugs, consumables and equipment as required.

- The re-stocking of all specialist response assets, including Major Incident Support Units, Decontamination Units and Command Vehicles;

- 'Stand Down' time for staff involved in the response;

- Feeding of staff, where necessary;

- The collation of all paperwork, voice recordings and Emergency Operations Centre Logs to form an initial response record;

- All Major Incident functional managers to submit a report, in accordance with relevant job descriptions.

21.5. Debriefing Activities

21.5.1. The full debriefing process should include arrangements to hold In-Service, NHS and Inter-Agency debriefing to review the response overall, to identify any lessons learned, and any revision requirements to the Major Incident Plan.

21.5.2. The debriefing process will be documented and any actions identified through lessons learned will be processed through an Action Plan to ensure that any changes are implemented and the integrity of the Major Incident Plan is maintained.

21.5.3. The Contingency Planning and Resilience Team will be responsible for initiating and documenting the debriefing process, and for incorporating resultant changes into the Major Incident Plan.

21.5.4. Inter-agency issues relating to training and procedures arising out of an incident will be addressed through the respective Local Resilience Forum.

21.6. Post Traumatic Activities

21.6.1. Post incident, the Trust has a moral and legal duty to consider the health needs, including psychological and emotional needs of staff following exposure to a potentially traumatic incident.

21.6.2. Despite their training, ambulance personnel may be affected psychologically after a Major Incident. The intensity and duration of the traumatic event can, in turn, influence the development of a post-traumatic illness. Managers should be vigilant for symptoms of stress in staff who have participated in a Major Incident and utilise TRiM Practitioners to undertake assessments within 72 hours of the event.

21.6.3. Examples of psychological and behavioural signs can include:

- Clear signs of psychological distress that are not improving;
- Distressing feelings of having 'changed';
- Panic attacks;
- Vague signs of inexplicable physical illness that were not present prior to the traumatic event;
- Persistent sleeping difficulties, especially if sleep is disturbed by nightmares;
- Persistent verbal or physical aggression;
- Overwhelming emotions such as guilt, depression, anger or anxiety that are not improving with time;
- Problems in relationships that were positive or enjoyable, prior to the traumatic event;
- A persistent desire to avoid work, socialising and any activities that were previously enjoyable;
- Heavy drinking or abuse of other substances;
- Strong feelings that one cannot cope or go on.

21.6.4. Managers are also advised to be alert to staff booking sick and should arrange for immediate referral to the Wellbeing Hub (consent required) if the reasons are related to stress, post-traumatic or otherwise, resulting from the incident. Early referral offers a far higher chance of recovery.

21.6.5. The Human Resources Department will ensure the following actions are carried out:

- Assist Line Managers, EOC and Scheduling with confirming the names and contact details of their staff involved in the incident;

- Actively promote the services of the Wellbeing Hub during sickness and welfare review meetings.

- Support Line Managers in making any necessary referrals to the Wellbeing Hub or where appropriate, our Occupational Health providers.

21.6.6. The Wellbeing Hub will ensure the following actions are carried out:

- Provide all staff with access to appropriate wellbeing support and advice;

- Ensure all staff are assessed and supported to access the most appropriate care pathway.

- Provide advice and support for Line managers making referrals to Occupational Health.

- Facilitate access to alternative duties to temporarily support staff where appropriate

- Manage TRiM

22. Legal Aftermath

22.1. The legal aftermath to any Major Incident can involve:

- A Public Enquiry
- A Health & Safety Executive investigation
- An investigation by other regulatory body
- An Inquest
- A Civil Claim
- A Criminal Prosecution

22.2. Some of these will be completed in a matter of weeks or months, whilst others may well go on for many years. In addition to the legal aftermath, there is also “Trial by Media” which will follow the incident over a relatively short space of time. The Trust will become involved in the legal aftermath.

22.3. There are five “keys to liability” **Who, What, When, Where, Why.** The first four are basically facts although they might not all be evident at the time of the incident. It is important therefore that facts are reported and **not** assumptions.

22.4. The fifth question, **Why**, is not factual but usually a matter of opinion and related to why the incident occurred. The media will ask “**Why**” within a matter of hours of the incident and it is important not to get involved into making assumptions or speculations.

22.5. **Immediate Actions to Preserve Evidence**

22.5.1. Immediate action needs to be taken to preserve documentary evidence. This will include letters, faxes, logs, minutes of meetings both at the time of the emergency and before, which relate to the incident. The immediate actions will include:

22.5.2. Suspend all document destruction and archiving procedures;

- Notify all staff of the duty of preservation. Locate, Preserve and Safeguard documents.
- Nominate an officer to co-ordinate the preservation of documentary evidence and collate the actions centrally.
- Retrieve internal copies of relevant correspondence.
- Documentary evidence includes computer data and anything received on electronic mail.

22.5.3. Therefore:

- Print relevant computer data (including electronic mail) to hard copy;
- Secure relevant computer data (including e-mail) on disc or tape.

22.6. **Follow Up Actions**

22.6.1. The next step is a process of confirmation which includes:

- Identifying any gaps in documentary evidence;
- Explain any gaps. Do not make up evidence but rather try to identify where any missing documents are and recover them;
- Establish the reasons for any loss of documentary evidence

22.7. The obligations in relation to documentary evidence will continue for many years and all staff must be aware of this.

22.8. Arrangements should be in place for the co-ordination and support to staff following requests to provide police statements and to attend interviews and coroner court hearings

23. Associated Plans and Documentation

23.1. The Major Incident Plan provides a generic system of managing any Major Incident and can be applied regardless of the cause.

23.2. For further guidance and information this Major Incident Plan should be read in conjunction with the following supporting documentation:

- SECAmb Emergency Preparedness, Resilience and Response Policy
- SECAmb Business Continuity Management Plan
- National Ambulance Resilience Unit (NARU) Major Incident Action Cards
- SECAmb Major Incident Action Cards.
- SECAmb Major Incident Communications Toolkit
- Kent, Surrey and Sussex Resilience Forum Plans
- Kent, Surrey and Sussex Community Risk Registers
- NHS England Emergency Preparedness, Resilience and Response Framework
- NHS England Core Standards for Emergency Preparedness, Resilience and Response
- Emergency Preparedness (2005) HM Government
- Emergency Response and Recovery (2007/2009/2010/2013) Cabinet Office
- National Resilience Planning Assumptions - Cabinet Office
- Initial Operational Response to a CBRN Incident- Home Office
- Local Health Resilience Partnership plans
- Trauma Network Plans

23.3. This list is not exhaustive and further information and incident specific guidance can be found on the Resilience and Specialist Operations page on sharepoint and at:

- NHS England: http://www.england.nhs.uk/ourwork/eprr/gf/
- Cabinet Office: https://www.gov.uk/

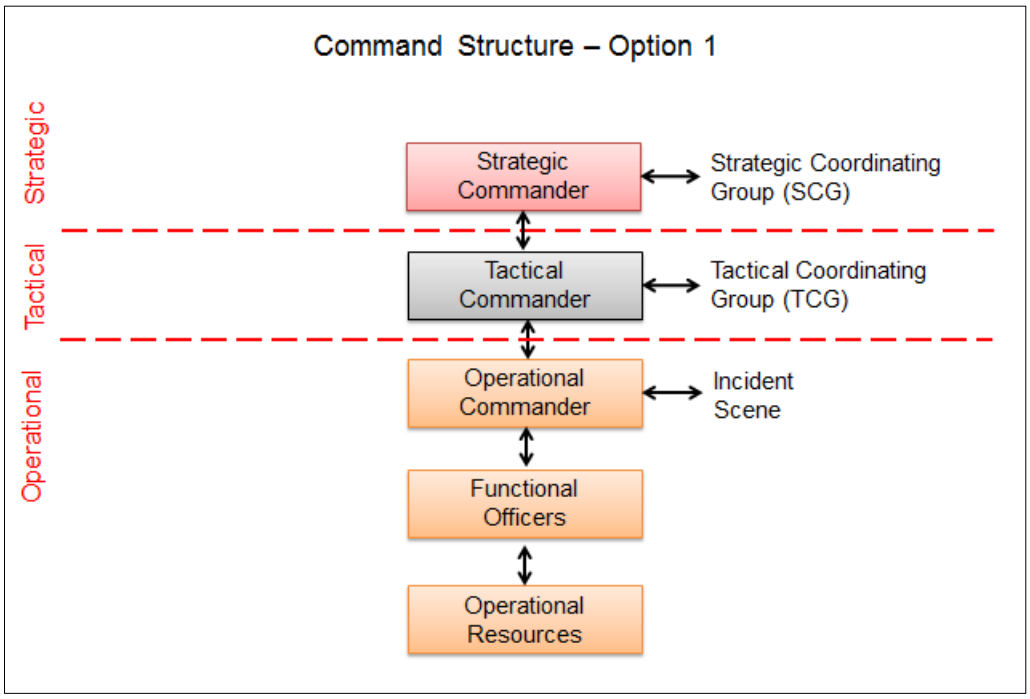
- JESIP website: http://www.jesip.org.uk/home
- NARU website: https://naru.org.uk/

23.4. Lexicon of Terms

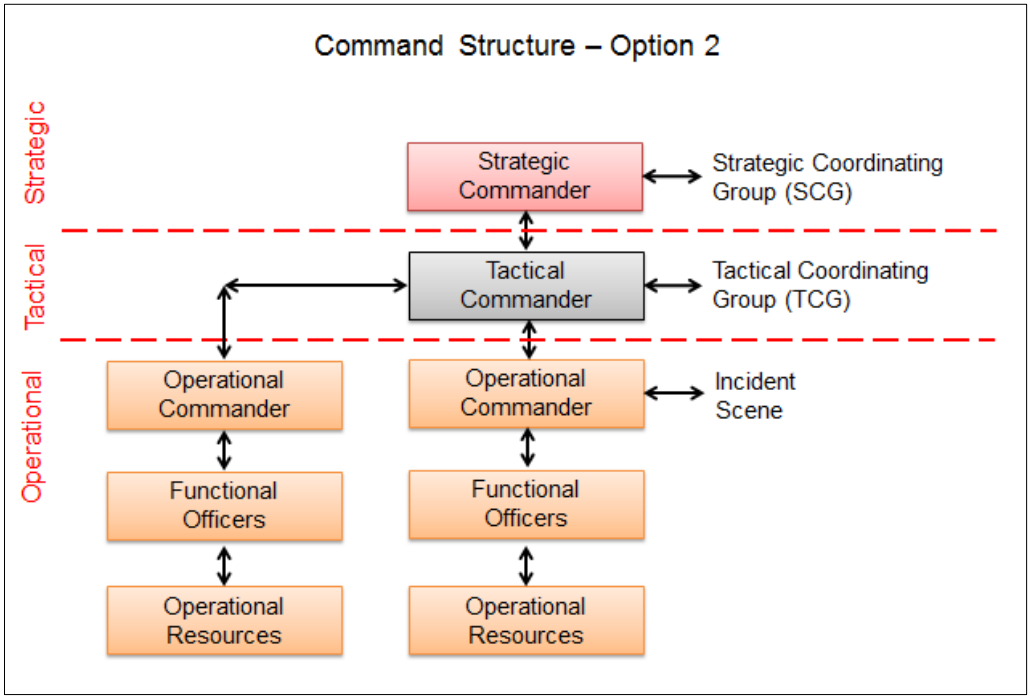
23.4.1. A comprehensive list of terminology and abbreviations can be found at: https://www.gov.uk/government/publications/

Appendix 1: Command Structure Options

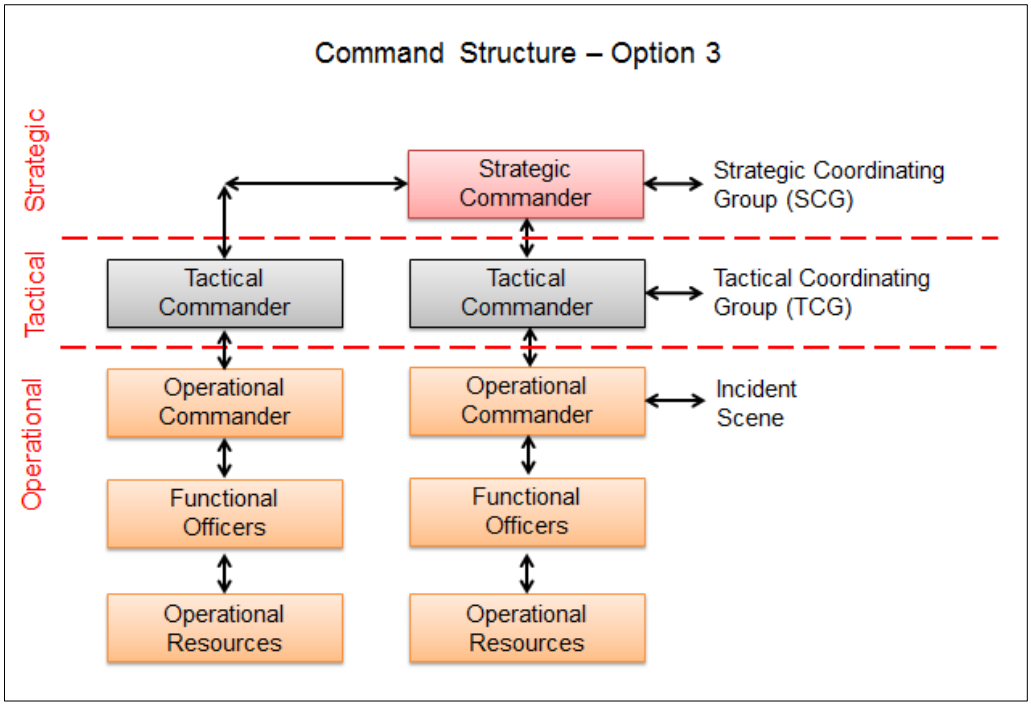
Option 1 - is a standard Major Incident command structure with a single incident site, within one Local Resilience Forum (LRF) area.



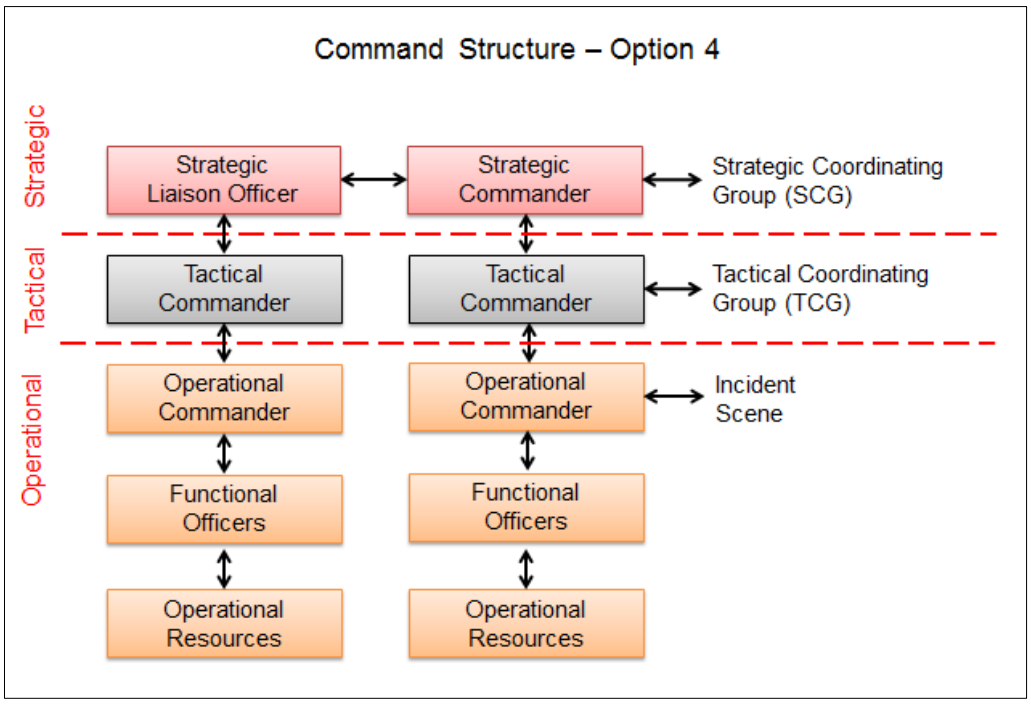
Option 2 - is one incident with two related incident sites, within one Local Resilience Forum (LRF) area, being managed via one Tactical Commander.



Option 3 - is two unrelated incidents, within one Local Resilience Forum (LRF) area, being commanded by two separate Tactical Commanders, but one Strategic Commander.



Option 4 - is two unrelated incidents, within two Local Resilience Forum (LRF) areas, with separate Tactical Commanders, but one Trust Strategic Commander. The second SCG would be attended by a strategic level liaison officer.



Appendix 2: Pre-Determined Response Process

1.1. In order to ensure that every incident is managed appropriately, as early as possible in the response a pre-determined response has been identified for incidents where the number and type of casualties threatens to overwhelm the service.

1.2. These may include incidents on the transport network, train crashes, CBRNe, MTFA etc. In addition there is an agreed pre-determined response for airport alerts and channel tunnel (refer to the relevant EOC action cards).

1.3. Variables that govern the level of response will include:

- The complexity of the incident
- The number of patients.

2. **Response Level**

2.1. There are four levels of response:

Level 1	Standard resourcing in line with ARP recommendation
Level 2	Standard resourcing in line with ARP recommendation with the addition of Command support and/or Tactical/Specialist advice.
Level 3	Significant Incident requiring additional resources and Command Structure including mobilisation of Specialist vehicles
Level 4	Full Major Incident Command Structure with Additional Mutual Aid requested and Mobilisation of Specialist vehicles

2.2. To allow for the identification of the required PDA for the type of incident, a Response Matrix will be used to identify the response level for the incident.

2.3. Time to respond, treat and transport is another factor that will affect patient care and normal service delivery. Therefore this will need to be taken into account in the decision making process.

3. Response Matrix

Number of Potential Casualties	Simple	Complex	Significant	Major	Mass Casualty Conventional or CBRN
>51	Level 4	Level 4	Level 4	Level 4	Level 4
40 to 50	Level 4	Level 4	Level 4	Level 4	Level 4
30 to 40	Level 3	Level 4	Level 4	Level 4	
20 to 30	Level 3	Level 3	Level 3	Level 3	
10 to 20	Level 2	Level 3	Level 3	Level 3	
<10	Level 2	Level 2	Level 2	Level 3	
<5	Level 1	Level 2	Level 2	Level 3	
1	Level 1	Level 2	Level 2	Level 3	
	Type of Incident *(See below for descriptor)*				

Simple: Any normal incident involving medical or trauma with no hazards present or specialist rescue required.

Complex: An incident requiring specialist advice or scene command management. (I.e. entrapment RTC)

Significant: An Incident of significant size or complexity that requires a large number of resources and extended command structure (hazardous, environmental & security factors).

Major: An incident of significant size or complexity that requires a large number of resources and extended command structure requiring declaration of a Major Incident and a need for mutual aid.

Mass Casualty: An incident of such size or hazard that requires the immediate declaration of a Major Incident and the request for large-scale mutual aid.

4. Pre-determined Response

4.1. This initial response is to be deployed on identification of the incident(s) without waiting for reports from the scene. The skill mix of DMA and the deployment of SRVs and specialist resources is to be considered at all levels.

4.2. It is essential to obtain an early **METHANE** report from the first crew at scene in order to confirm the response and identify if further managers, resources are required in order to establish the command structure and major incident footprint.

Level	Response
Level 1	Normal deployment procedures will apply
Level 2	2 x DCA 1 x Manager. On call/duty Tactical to be informed. Consideration will also be given to the deployment of specialist resources and Incident Support Units
Level 3	5 x DCA 3 x Operational Commanders 1 x Tactical Commander Inform/Deploy Tactical Advisor Consideration will also be given to the deployment of an Incident Support Unit and an Incident Command Vehicle with support staff.
Level 4	10 x DCA 5 x Operational Commanders 1 x Tactical Commander Inform/Deploy Tactical Advisor 1 x Incident Support Unit 1 x Incident Command Vehicle with support staff. Hospital Ambulance Liaison Officers should be deployed to the appropriate hospitals.

4.3. As the incident develops and as requested by the Incident Commander further resources may be required to support the response

Appendix 3: Major Incident Talkgroups

1. Specific use of the Major Incident talkgroups will be determined at the time of the incident, at the discretion of the Emergency Operations Centre Manager in liaison with the Ambulance Incident Commander.

2. An ICCS Operator in the Emergency Operations Centre must monitor all Talkgroups in use at an incident to ensure recording of all radio traffic.

3. All communication for major incidents will be **'talk through**'; therefore, the ICCS Operator must ensure that Group Repeat is disabled.

4. For ease of access MI Talkgroups have been allocated on the ICCS as below, EOC West will use those allocated to Banstead & Lewes ODA and EOC East will use those allocated to Coxheath ODA. If required further MI Talkgroups are available.

5. **SECAmb Major Incident Talkgroups**

Talkgroup	Talkgroup Name	ODA
Major Incident		
90	MI General 01	Banstead
91	MI General 02	Banstead
92	MI General 03	Coxheath
93	MI General 04	Coxheath
94	MI General 05	Lewes
95	MI General 06	Lewes
70	MI Silver	Banstead
71	MI Silver	Banstead
72	MI Silver	Coxheath
73	MI Silver	Coxheath
74	MI Silver	Lewes
75	MI Silver	Lewes

Talkgroup	Talkgroup Name
80	SECAmb Command
Hailing	
343	SEC Hailing
344	SEC Sharer
351	SEC Interagency
69	National Ambulance
Ambulance Mutual Aid	
345	S East Coast MA01
346	S East Coast MA02
347	S East Coast MA03
348	S East Coast MA04
349	S East Coast MA05
350	S East Coast MA06

6. **Multi-Agency Interoperability Talkgroups**

Function	Kent Police		Surrey Police		Sussex Police	
	TG Name	Talkgroup	TG Name	Talkgroup	TG Name	Talkgroup
Request for Interop	PKENTSHG1	650	PSYSHG1	772	PSXSHG1	778
Silver Interop	PKENT IC1	651	PSYIC1	773	PSX IC1	779
Bronze Interop	PKENT ES1	652	PSYES1	774	PSX ES1	780
General Interagency	02KENTIAT1	655	02PSYIAT1	777	02SXIAT1	783

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SECTION TWO

ADDITIONAL

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1. Adverse Weather

1.1. Introduction

1.1.1. This section of the plan deals with the Trust's response to extremes of weather; as identified in the Kent, Surrey and Sussex Community Risk Registers. Extremes of weather could be heavy rainfall, gales, heavy snowfall, ice, flooding, severe heat /cold and drought.

1.1.2. The Met Office and Environment Agency provide advance warnings to inform the public and emergency responders of severe or hazardous weather which has the potential to cause danger to life or widespread disruption.

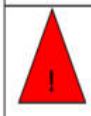
1.1.3. Met Office and Environment Agency warnings are monitored through the Trust's Contingency Planning & Resilience Department who act as a single point of contact for external agencies to alert for incidents or significant events.

1.2. The National Severe Weather Warning Service

1.2.1. The National Severe Weather Warning Service (NSWWS) is provided by the Met Office to warn the public and emergency services of severe or hazardous weather which has the potential to cause damage, widespread disruption and/or danger to life .This includes warnings about rain, snow, wind, fog and ice.

1.2.2. These warnings are given a colour depending on a combination of both the impact the weather may have and the likelihood of those impacts occurring.

Weather Warnings

	Severe weather is possible over the next few days and could affect you.
	There is an increased likelihood of bad weather which could potentially cause disruption.
	Extreme weather is expected.

Likelihood

High	• You may need to take action as we are expecting ... • There will be ...
Medium	• We should be prepared for ... • There is likely to be ...
Low	• Be aware of the potential/possibility ... • There is the small chance of ...
Very Low	• Be aware that there is a very small risk of ...

Further information and live mapping can be found on the Met Office website at http://www.metoffice.gov.uk/

1.2.1. Trust Response

1.2.1.1. Upon receipt of information that severe weather is forecast which will seriously affect the normal operations of the Trust; the Contingency Planning & Resilience Department will:

- Cascade notifications and information received to duty/ on-call commanders, relevant managers, functional heads and Emergency Operations Centres to enable Trust readiness.
- Attend/dial in to Local Resilience Forum severe weather meetings.
- Initiate an internal trust teleconference, and
- Provide tactical advice to support the trust's response to an adverse weather event.
- Constantly monitor the situation and update as necessary.

1.2.1.2. Should any extreme of weather have the potential to, or cause severe disruption, the Business Continuity arrangements of the Trust will be implemented to ensure the provision of core services.

1.2.1.3. The Trust operates a variety of vehicles with 4x4 capability across its geography and a range of operational staff across the organisation are trained to drive these vehicles. The Trust also maintains a contract to hire in additional 4x4 vehicles. These will be deployed under the direction of Tactical Commanders in preparation for or during any adverse weather.

1.2.1.4. All of the trust's ambulances/response cars have all-weather tyres fitted in readiness for adverse weather conditions.

1.2.1.5. The Trust also has Memorandum of Understandings (MOU's) in place with Voluntary Aid Societies (VAS) who can also mobilise 4x4 vehicles and ambulances as required to support operations. In addition, a number of Memorandum of Understandings (MOU's) are in place with volunteer 4x4 groups to provide assistance at times of severe weather.

1.2.1.6. The logistics department plans for the distribution of supplies of winter stock in advance of and throughout periods of adverse weather.

1.2.2. **Health & Safety**

1.2.2.1. The Health and Safety and welfare of all staff must remain a priority of the staff themselves and the Emergency Operations Centre. The wearing of PPE and personal communication radios must be undertaken at all times, and regular welfare contacts with attending crews must be made.

1.3. **Flooding**

1.3.1. Floods are mostly natural events that result either from excessive rainfall or during adverse weather conditions. Flooding can come from several sources including rivers, surface water, tidal/coastal and groundwater.

1.3.2. Flood incidents can vary in scale from low impact flooding of unpopulated floodplain to severe flooding of towns/cities involving a significant number of properties, or significant disruption to key parts of the infrastructure of Kent, Surrey and Sussex.

1.3.3. The Environment Agency (EA) operates a flood warning service, if flooding is forecast; three types of warning are issued: flood alerts, flood warnings and severe flood warnings.

1.3.4. Warning types are not issued as a sequence of messages; they are used to indicate the impact of flooding in a given area.

1.3.5. These warnings may require the implementation of special arrangements by the emergency services and the local authorities.

1.3.6. Flood Warnings:

The EA website gives details of flood alerts/ warnings in force, accessed at:
https://www.gov.uk/government/organisations/environment-agency

1.3.7. Trust Response

1.3.7.1. Upon receipt of information that severe flooding is forecast, which will seriously affect the normal operations of the Trust; the Contingency Planning & Resilience Department will:

- Cascade notifications and information received to duty/ on-call commanders, relevant managers, functional heads and Emergency Operations Centres to enable Trust readiness.
- Attend/dial in to Local Resilience Forum severe weather meetings.
- Provide Tactical Advice to support the Trust's response
- Constantly monitor the situation and update as necessary.

1.3.7.2. Consideration should be given to:

- Predicted geographical area affected;
- Time of day the severe weather (flooding) is expected.
- Planning of resources to meet additional demand
- Deployment of HART to support the multi-agency response in the event of evacuation.

1.3.8. Multi - Agency Response

1.3.8.1. Due to the dynamic and complex nature of flooding incidents the level of response is dependent on the severity of the flooding and the impact on the community.

1.3.8.2. In the event of flooding which requires a multi-agency response, the police will identify an Incident Command Post from which the response will be co-ordinated and will notify the Emergency Operations Centre of its location.

1.3.8.3. LFR and Local Flood Plans and Flood Maps are available on Resilience Direct and can be accessed through the Contingency Planning & Resilience Department

1.4. Heatwave

1.4.1. The Heatwave Plan for England

1.4.1.1. The Heatwave Plan for England is published annually and sets out the arrangements that will apply, and the actions required, in advance of, and during, a heatwave. It is a plan intended to protect the population from heat-related harm to health by raising awareness of the negative health effects of severe heat and enabling services and the public to prepare and respond appropriately. The plan can be found on the Gov.Uk website: www.gov.uk/ along with other guidance documents.

1.4.1.2. The Heatwave Plan for England is underpinned by the Heat-Health Watch service, which has been developed with the Met Office to alert key stakeholders to the likelihood of severe hot weather within different areas of England.

1.4.2. Heat Health Watch Alerts

1.4.2.1. The Heat Health Watch operates in England from 1st June to 15th September each year. During this period, the Met Office will issue Heatwave Alerts as defined by day and night-time temperatures and duration. These thresholds vary by region, but an average threshold temperature is 30 °C by day and 15 °C overnight.

1.4.2.2. There are five alert levels:

- Level 0 (long term planning, all year)
- Level 1 (heatwave and summer preparedness programme)
- Level 2 (heatwave is forecast – alert and readiness)
- Level 3 (heatwave action)
- Level 4 (major incident – emergency response, declared by central government)

1.5. Cold Weather

1.5.1. The Cold Weather Plan for England

1.5.1.1. The Cold Weather Plan for England is a framework intended to protect the population from harm to health from cold weather. It aims

to prevent the major avoidable effects on health during periods of cold weather in England by alerting people to the negative health effects of cold weather, and enabling them to prepare and respond appropriately.

1.5.1.2. The Cold Weather Plan for England is published annually and sets out the arrangements that will apply, and the actions required, in advance of, and during periods of severe cold weather.

1.5.1.3. The Cold Weather Plan for England can be found on the Gov.UK website: www.gov.uk/ along with other guidance documents.

1.5.2. **Cold Weather Alert Service**

1.5.2.1. To support the Cold Weather Plan, the Met Office will issue Cold Weather Alerts from 1 November to 31 March. Alerts will be issued if the mean temperature, in a particular region, will be at 2 °C or less for a period of 48 consecutive hours, or if a Weather Warning has been issued for heavy snow or widespread ice through the National Severe Weather Warning Service.

2. Aircraft Incidents

2.1. Introduction

2.1.1. This section details the types of airport and aircraft incidents that SECAmb may be called upon to attend. It should be read in conjunction with associated airport emergency plans and risk specific plans.

2.1.2. Major incidents involving aircraft in the United Kingdom are extremely rare, however smaller scale incidents involving aircraft are more prevalent and these may require a response from the ambulance service.

2.2. Airports and Aerodromes

2.2.1. The following are licensed aerodromes in the SECAmb area:

• London Gatwick Airport • Shoreham Airport • Goodwood Aerodrome	• Farnborough Airport • Redhill Aerodrome • Fairoaks Airport • Blackbushe Airport	• London Ashford Airport (Lydd) • Headcorn Airport • Rochester Airport

2.3. Definitions of Emergencies and Incidents

2.3.1. In order for the emergency services and aerodrome authorities to understand the nature of an emergency, they have been defined using the following categories for use during a declared incident.

2.3.2. Air Traffic Control (ATC) will make the initial decision on the category of the emergency and communicate this to the emergency services using dedicated channels.

2.4. Aircraft Emergencies

Aircraft Accident:

- If an aircraft accident has occurred on or in the vicinity of the airport.

Aircraft Accident Imminent:

- If an aircraft accident is considered inevitable on or in the vicinity of the airport.

Full Emergency

- If an aircraft in flight is known or suspected to be in such difficulty that there is danger of an accident.

Local Standby

- When an aircraft is known or suspected to have developed some defect, but one which would not normally involve any difficulty in effecting a safe landing.

Aircraft Accident off Airport

- Aircraft accidents occurring outside the airport boundaries.

Unlawful Act(s)

- Hijack, Bomb Warnings, etc. on an aircraft for which specific actions will need to be taken.

- Acts of Aggression including bomb warnings, actual or suspected bomb explosion, armed attack, CBRN incident, the taking of hostages and other acts of terrorism within the airport boundary. (Generally used by Gatwick Airport)

2.5. Non-Aircraft Emergencies

Domestic Fires and Special Services Procedure

- This applies to domestic fires, road traffic crashes and hazardous materials.

  - On the airport (other than that involving an aircraft).
  - Outside the airport boundary which is liable to constitute a danger to flying, or to airport property
  - Which the airport fire service should attend in response to calls from the public, police, or fire brigade on humanitarian grounds.

- Calls for assistance for which AFS appliances, equipment or personnel are necessary, e.g. traffic or industrial accidents, fuel spillages etc.

Fuel Farm Fire

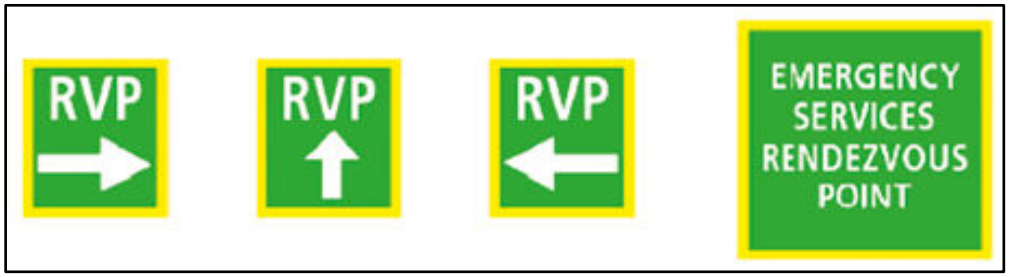
- Any fire within the fuel farm boundary which is liable to constitute a danger, or which the airport fire service should attend.

2.6. SECAmb Attendance at Incidents

2.6.1. The pre-determined response to aircraft alerts is in accordance with the Emergency Orders/plans for each of the listed aerodromes. However contributing factors such as the type, scale and location of the incident will also determine resourcing requirements.

2.6.2. Resources will initially be deployed to a designated rendezvous point; these are identified by appropriate signage around the airport to direct responding emergency services.

2.6.3. Example Rendezvous Point signs



2.7. Aircraft Safety

2.7.1. There are numerous hazards at aircraft accident sites and the safety of responding personnel is paramount.

2.7.2. Any response to an aircraft site must be approached upwind of any smoke plume from a fireball or post-crash fire as a wide variety of hazards may be present at air accident sites.

2.7.3. These hazards, generated by damage to aircraft structures, systems, components and aircraft contents, will be influenced by factors associated with the accident scenario (aircraft size and type, degree of damage, accident location, weather conditions,

environment, security, etc.) and can pose variable levels of risk to response personnel.

2.7.4. Some of the hazards that need to be considered are:

- Fuel and other flammable fluids,
- Polymer composites (previously known as MMMF)
- Sharp and jagged edges/aircraft debris/damaged and unstable structures
- Pressurised systems – hydraulics, cylinders
- Un-deployed safety devices – escape chutes, airbag systems in seatbelts
- Hazardous materials – cargo, lithium batteries, biological hazards

2.7.5. Staff must not place themselves at risk to injury and will ensure that suitable control measures and use of appropriate PPE is applied in order that risks are adequately controlled.

2.7.6. The senior fire officer at the site will provide advice and guidance about potential hazards when attending an aircraft accident.

3. Chemical, Biological, Radiological and Nuclear (CBRN)/ Hazardous Material Incidents

3.1. This section seeks to give background information on the Trusts arrangements for dealing with a Chemical, Biological, Radiological and Nuclear (CBRN), and Hazardous Material (HazMat) incident(s).

3.2. These arrangements relate to incidents which occur within the Trusts geographic boundaries or if requested to assist another Ambulance Trust under the mutual aid agreement. However, it does not cover an incident occurring at an NHS Acute Hospital site, as they are required to have the capability in place for dealing with such incidents.

3.3. Introduction

3.3.1. It is acknowledged that these incidents come in all sizes and complexities; therefore, it should not be assumed that all CBRN/HazMat incidents will produce large numbers of casualties. Therefore these arrangements aim to be scalable and place the needs of the casualty at the centre of our actions.

3.3.2. The following definitions should be used in relation to this type of incident:-

- **CBRN** - 'The term CBRN is used to describe the deliberate release of chemical, biological, radiological or nuclear materials'.

- **HazMat** - 'The term HazMat is used to describe the accidental release of a hazardous material, which could be chemical, biological, radiological or nuclear'.

3.3.3. The Trust will respond to both types of incident in exactly the same way, as the treatment of any casualties or potential casualties will not change, whether it is a deliberate or accidental release.

3.3.4. It is recognised however that a deliberate release of a CBRN agent will mean an increased involvement of police, as it will be considered a potential crime scene and an ongoing threat.

3.4. The Trust's Capability

3.4.1. The Trust has a number of specialist resources which can be used in relation to, or deployed to, confirmed or suspected CBRN/HazMat incidents. These are:-

- Hazardous Area Response Team (HART)
- Special Operations Response Team (SORT)
- Tactical Advisors (TacAd) /NILO

3.4.2. Further information on these resource capabilities is detailed in Section 12.

3.4.3. It should be remembered that although the Trust has specialist resources which can be deployed to a CBRN/HazMat incident, normal operational crews should also be used when safe to do so; as this is likely to facilitate a more timely response and provide early patient care.

3.5. National Strategy

3.5.1. As part of the Home Office counter terrorism CONTEST strategy the government seeks to address the CBRN threat, through the CBRN Resilience Programme. This programme aims to build and improve the UK's ability to respond to and recover from a terrorist attack using CBRN devices. It does this through the delivery of a "Model Response" at major cities and transport hubs.

3.5.2. The model response set out an idealistic response timeline that the Trust is required to plan for. Within our geographic area we have two model sites, Gatwick Airport and Dover Eastern Docks.

3.5.3. Following a Home Office review of the 2006 'Model Response' it was agreed by Ministers in December 2014 that a new National CBRN(e) Response framework would be implemented that consists of three main components:

- Initial Operational Response (IOR)
- Transition
- Specialist Operational Response (SOR)

3.5.4. The new National CBRN(e) Response is aligned to Joint Emergency Services Interoperability Principles (JESIP) and aims to create a faster, more agile, flexible, scalable and interoperable response which is readily available and proportionate to the risk.

3.6. Decontamination

3.6.1. The decontamination of a patient can be seen as taking a number of forms and is dependent on the level and type of contamination involved. The two main forms used are defined below:-

3.6.2. Dry Decontamination

- Dry Decontamination is considered as the default process, primarily for chemical contamination. This process will follow the guidance set out in the Initial Operational Response (IOR) to a CBRN Incident (2015). This guidance has been updated (Dec 2017) with a simplified message;

"REMOVE, REMOVE, REMOVE"

3.6.3. Wet Decontamination

- Wet Decontamination will be used in the presence of the signs and symptoms of a caustic substance only. This process will follow the guidance set out in the NARU CBRN/HazMat Guidance (2014).

3.7. Radiation Incidents

3.7.1. It is the Trusts aim that the On-Call Tactical Advisors are the appointed Ambulance Radiation Protection supervisors (ARPS) following completion of the recognised (ambulance-specific) radiation protection supervisors' course.

3.7.2. Their role is to support the incident commander and/or HART team leader with specialist advice through liaison with the on-call Public Health England Radiation Protection Advisor (RPA).

3.8. Logistical Support

3.8.1. A CBRN/HazMat incident has the potential for producing large numbers of casualties which would require the deployment of significant amounts of specialist equipment assets. The details of the Trusts arrangements in relation to this aspect are contained within section 18 of this document.

3.9. National Guidance Documents

3.9.1. It is not the intention to duplicate or deviate from published national guidance; therefore the Trust aims to following guidance set out in the national documents listed:-

- Guidance for the United Kingdom Emergency Services on Decontamination of People Exposed to Hazardous Chemical, Biological or Radiological Substance - Home Office (2004)
- Model Response (Restricted)
- Initial Operational Response Programme (2015) aligned to NHS England public information on responding to acid attacks (Sept 2017)
- The Ambulance Service Guidance on dealing with Radiological Incidents and Emergencies (2013)
- NARU - NHS Clinical Decontamination Unit and Associated Equipment User Guide (2014)
- JESIP – Responding to a CBRN(e) event, Joint Operating Principles for the Emergency Services (Sept 2016)

4. Helicopter Emergency Medical Services (HEMS)

4.1. Introduction

4.1.1. This section gives an overview of the way in which HEMS will be used during a declared Major Incident within the South East Coast Ambulance Service Foundation Trust (the Trust). This text should not however be seen as containing all the relevant information and should be read in conduction with other published specialist documents.

4.1.2. Due to the changing healthcare environment and specifically the introduction of the Trauma Networks it has become commonplace to convey patients further afield to receive appropriate care. This has meant that HEMS should be considered as an essential part of any resource options when dealing with a Major Incident.

4.1.3. The deployment of HEMS to the scene of a Major Incident will provide a higher level of enhanced clinical assessment, senior clinical decision-making, blood transfusions and surgical procedures, which will enhance the care given to the casualties at scene and support the established command structure.

4.1.4. Although this information has been written primarily for Major Incidents, many of the arrangements should be seen as best practice and applied to more routine incidents, as this will help to embed them in normal practice.

4.2. HEMS Availability

4.2.1. Within the Trust area there are currently two HEMS aircraft during daylight hours and one during the night, which are operated by the Kent Surrey Sussex Air Ambulance Trust (KSSAAT) and are potentially available to support a Major Incident.

4.2.2. In addition to the aircraft indicated above, there is the potential that aircraft from neighbouring areas will be available to assist in the event of a Major Incident, which while advantageous, does increase the need for clear coordination and guidance.

4.2.3. While it is normal practice to deploy a HEMS team in an aircraft, due weather or technical issues, they may deploy in a response car. This aspect must be considered when resourcing and developing a tactical plan.

4.3. Enhanced Care Team

4.3.1. As a standard crew HEMS will provide two clinicians in the form of an Enhanced Care Team (ECT) per aircraft or response car. This will be as a minimum one:

- HEMS Doctor
- HEMS Paramedic

4.3.2. During a Major Incident the ECT(s) will remain as one functional unit to deliver clinical care as appropriate and may be employed within a number of different areas and functions at the scene.

4.4. Arrival on Scene

4.4.1. In the event that the ECT have arrived on scene first at a Major Incident they will undertake the following:

- The HEMS Paramedic will assume the role of the Ambulance Incident Commander (AIC) and will initially follow those action set out in the 'First Resource on Scene – Attendant' action card.
- The HEMS Doctor will assist the AIC in establishing the incident footprint and to start developing a framework where 'Triage' may begin.

4.4.2. In the event that the ECT are subsequent resources arriving at scene they will report to the AIC for appropriate tasking, which is likely to be in the form of a 'Forward Medical Team' working with Trust clinicians to deliver appropriate clinical care at the incident site.

4.4.3. Where a second ECT is deployed to the scene they will either be tasked to assist within the 'Casualty Clearing Station' or as a team to Casevac casualties to the appropriate receiving hospital.

4.4.4. It is not possible to define the priority in which these functions will be undertaken by the ECT as each incident will have a unique set of circumstances. Therefore, the ECT will need to discuss the available options with the AIC who will make the decision on appropriate tasking.

4.4.5. The diagram below sets out the established command structure in which HEMS will work.

Command Structure

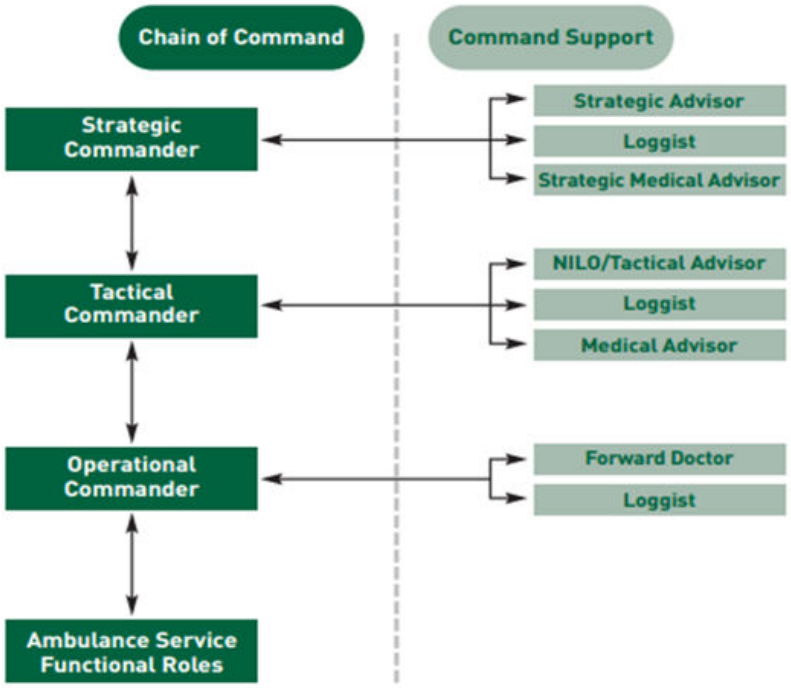


Figure 3 – The Chain of Command and Supporting Structures

National Ambulance Resilience Unit (NARU) Command & Control Guidance 2015

4.5. Mobile Emergency Response Incident Team (MERIT)

4.5.1. The Trust in partnership with KSSAAT have defined and developed a MERIT capability in line with the specifications and guidance issued by the Department of Health in 2010. Which is based on the following:

- Triage
- Treatment
- Appropriate specialist clinical interventions

4.5.2. The need for a MERIT capability is discharged through the availability and deployment of ECT(s) to the scene of an accident or incident to provide the enhanced clinical care to a patient or casualty as appropriate.

4.6. HEMS Coordination & Mutual Aid

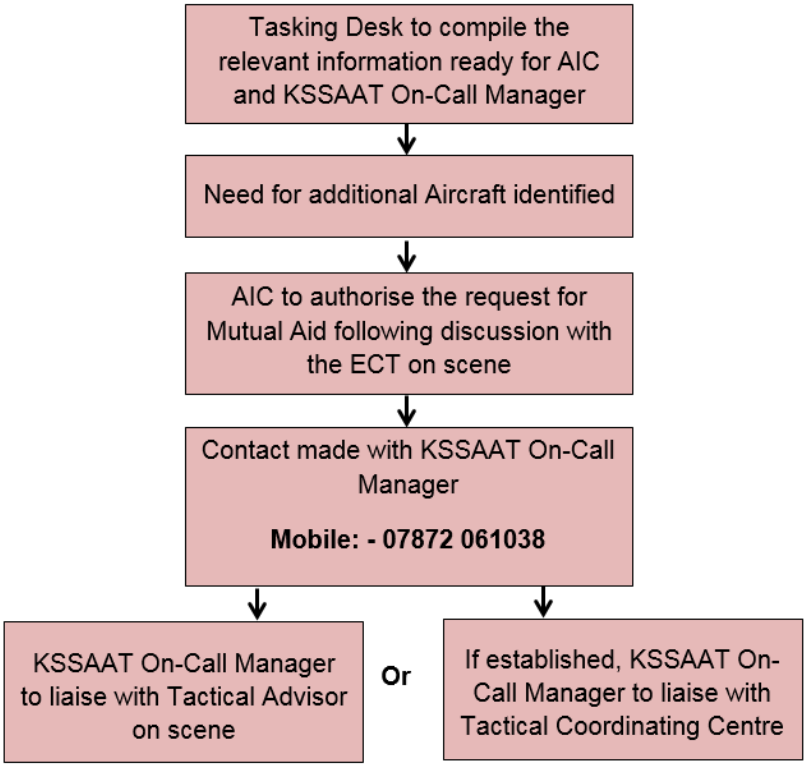
4.6.1. Due to the number or type of casualties involved in a Major Incident it may be useful to request additional HEMS and/or ECT(s) via agreed Mutual Aid arrangements, to support the treatment and transportation of casualties to hospitals further afield.

4.6.2. It is recognised that the use of multiple aircraft at the scene of any incident presents a unique set of risks and challenges, which needs to be managed carefully by the appropriate people. Therefore the initial request for additional HEMS will only be authorised by the AIC following advice from the ECT(s) on scene.

4.6.3. If the decision is made to request additional aircraft, this will be facilitated via the KSSAAT on-call manager, who will have the relevant contact details.

4.6.4. To assist this process, in the initial stages of the Major Incident the 'Tasking Desk' in the Trusts Emergency Operations Centre (EOC) will start to compile the information relating to aircraft availability, which will be passed to the KSSAAT on-call manager and/or AIC should a Mutual Aid request be considered.

Mutual Aid Process



4.6.5. Due to the numbers of aircraft involved or the duration of the incident. The KSSAAT on-call manager may consider establishing a 'Forward

Operating Base' close to the incident scene, where the incoming aircraft and crew can be safely managed and supported prior to deployment to scene. If this option is chosen the AIC and EOC will be kept informed.

4.6.6. Where a multi-agency Tactical Coordinating Centre (TCC) has been established the KSSAAT on-call manager will also keep them up to date on aircraft availability.

4.6.7. To help safely manage aircraft arrival and departure at the scene it may be useful to establish a Landing Site Liaison Officer (LSLO), who will act as the link between the AIC and the aircrew.

4.6.8. It is recognised that the use of Military Aircraft may also have a part to play in a Major Incident. Requests for such air assets be in line with 'Military Aid to a Civil Authority' arrangements.

4.6.9. As part of the Trusts response to a Major Incident, it is vital that KSSAAT are included in the recovery procedures outline in the plan. Therefore will be invited to the Trusts internal debrief processes. The Trust will then be in a position to represent KSSAAT as part of the Trusts response at any multi-agency debriefs as required.

5. Hospital Evacuation

5.1. All health and social care organisations are required to have procedures in place for evacuating areas in the event of major disruptions.

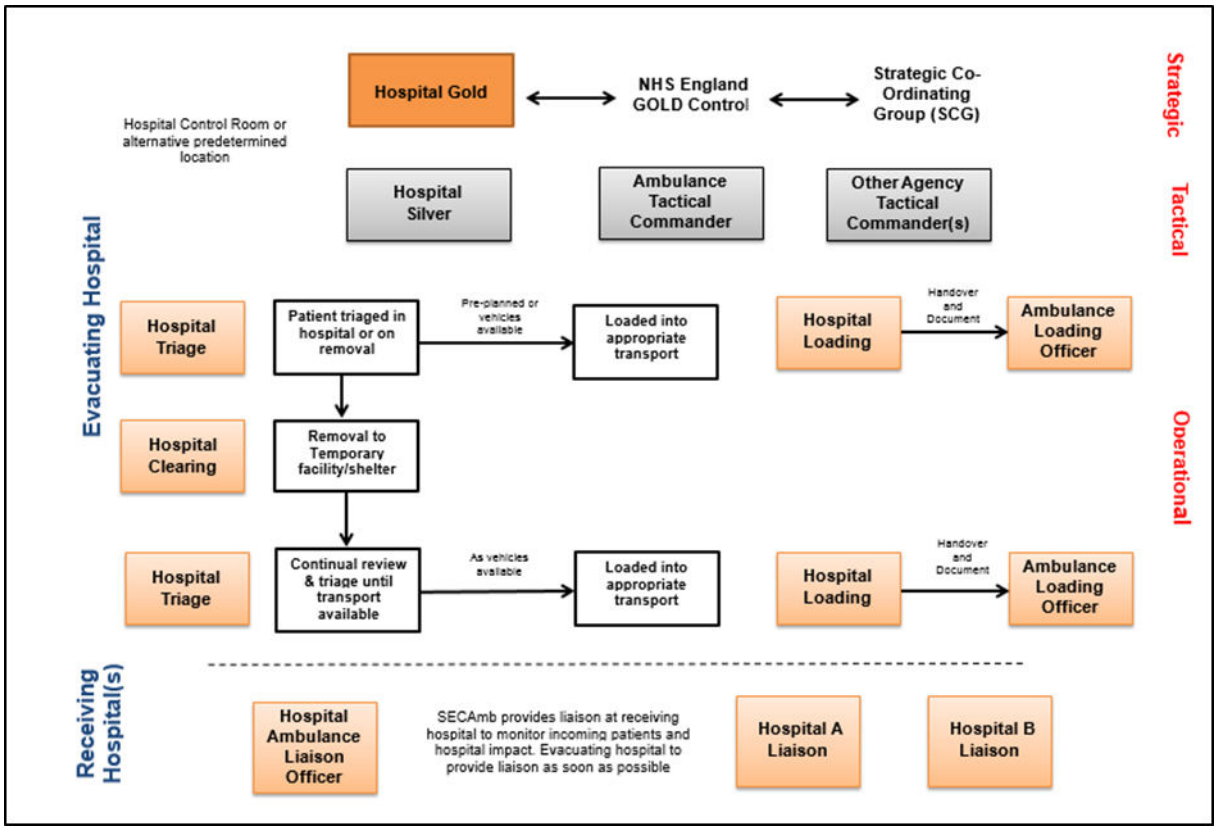
5.2. This section provides information on the role of SECAmb in the event of a hospital evacuation. For the ambulance service, a full hospital evacuation presents as a major incident with patients pre-treated and triaged.

5.3. Additional Roles and Responsibilities

5.3.1. Our primary response will be to establish liaison and provide transport where possible.

5.4. Command and Control

5.4.1. The diagram below provides information on the likely command and control required to interface with evacuating and receiving hospitals.



5.5. Safety

5.5.1. No safety considerations other than those already in place for clinical care and manual handling are expected to be required; however, dynamic assessment of risks is advised.

5.6. Communication

5.6.1. Alerting of receiving hospitals, PTS providers and voluntary aid societies may be required.

5.6.2. Support for communication between hospitals may be required through the provision of commanders to provide HALCO and HALO roles until Hospital Liaison Officers are put in place by the evacuating and receiving hospitals.

5.7. Assessment

5.7.1. Assessment of need should be made in discussion with the Hospital Incident Officer (Silver) of the evacuating hospital.

5.8. Triage

5.8.1. Clinical staff at the evacuating hospital should lead clinical prioritisation for evacuation and transport.

5.9. Treatment

5.9.1. Staff at the evacuating hospital will lead specific treatment with Trust clinicians providing support only where the evacuating hospital is unable to provide a specific function that SECAmb is able to support in the short term, such as provision of mass oxygen delivery.

5.10. Transport

5.10.1. Transportation should be provided by the most appropriate means available with agreement reached between the evacuating hospital and the Ambulance Incident Commander.

5.10.2. The following table is a proposed framework for the distribution of transport.

Very Dependent P1 Patients	• Transfer by ambulance service with appropriate medical/nursing escort. • Transfer by helicopter. • Transfer by private provider with appropriate medical/nursing escort.
Dependant P2 patients	• Transfer by ambulance service with medical/nursing escort if required. • Transfer by private provider with medical/nursing escort if required.
Independent P3 patients	• Transfer by PTS providers, St John Ambulance or Red Cross, • Transfer by private/ PTS provider. • Arrangements for local authority transport plan to be utilised

5.11. Specialist & Technical Information

5.11.1. Use of the following capabilities should be considered in the event of a hospital evacuation:

- A&E ambulances to support the transfer of P1 and P2 patients with the appropriate medical/nursing escort
- PTS ambulances/providers to support to the transfer of P2 and P3
- Mobilisation of ambulance service mutual aid
- Mobilisation of voluntary aid societies (St John Ambulance and Red Cross)
- Command officers to support the evacuating hospital and primary receiving hospitals
- Helicopter transfer for P1 patients
- Provision of mobile command and control facilities
- Clinical support at any temporary facility
- Support in evacuating patients from within the hospital
- Provision of ‘field hospital’ facilities for up to 20 patients
- Provision of Mass Casualty Equipment Vehicle(s) containing:

- Emergency medical equipment for 80 P1 adults and 20 P1 paediatrics
- Mass oxygen delivery for up to 40 patients

5.11.2. Pre-alerting receiving hospitals of incoming patients is best done directly by the evacuating hospital to allow discussion of speciality requirements, handover, timings etc. Requests for the ambulance service to arrange alerting should only be used in extremis e.g., when hospital communications are unavailable due to technical failure.

5.11.3. Specific information for this contingency can be gained from the Contingency Planning & Resilience team/ On-Call Tactical Advisor.

5.12. Associated Documents

- NHS England Shelter and Evacuation Guidance

6. Mass Casualty Incidents

6.1. Introduction

6.1.1. Major Emergencies of an extreme nature, could produce mass casualties which SECAmb and NHS resources would be unable to deal with using normal responses.

6.1.2. NHS England defines a Mass Casualty Incident for the health services as:

“”an incident (or series of incidents) causing casualties on the scale that is beyond the normal resources of the emergency and health services’ ability to manage”

6.1.3. A Mass Casualty Incident may involve hundreds or thousands of casualties with a range on injuries, the response to which will be beyond the capacity of normal Major Incident procedures to cope and require further measures to appropriately deal with the casualty numbers.

6.1.4. Mass casualty incidents are usually caused by sudden onset (big bang events) such as:

- Terrorist attacks (both conventional and unconventional)
- Severe weather and flooding
- Serious Transport Accident
- Natural disasters;
- Radiological disasters
- (Epidemic)

6.1.5. However several smaller incidents may combine to become a larger response, or be geographically diverse but may require a Mass Casualty response to be enacted due to the large number of simultaneous casualties.

6.2. Previous Mass Casualty Events

6.2.1. Examples of complex incidents which could produce numbers on a scale that could be described as mass casualty events include the following:

- Multiple bombings on Transport Network London 2005
- Mumbai attacks 2008
- Widespread Flooding or Severe Weather events;
- Marauding Terrorist with firearms and bombings, Paris 2015
- Vehicle borne terrorist with firearm, Nice 2016
- Mass shooting Las Vegas 2017 (leaving 58 people dead and 851 injured)

6.3. Identification of a Mass Casualty Incident

6.3.1. Consideration must be given to the possibility that the receipt of multiple calls for a developing Major Incident may be an early indication of a Multi-Sited/Mass Casualty event.

6.3.2. Care should be taken to map locations to determine whether calls to “separate” incidents are part of a larger, more widespread event.

6.3.3. Declaration of a Mass Casualty Incident

6.3.4. Any NHS organisation can declare a ‘mass casualty’ incident’. However, as a blue light responder, the ambulance service will usually often be the first to attend at an incident and therefore will, in most cases be the organisation to declare a Mass Casualty Incident.

6.3.5. Declaration of a Mass Casualty Incident will be will be cascaded by the EOC in the same way as in a Major Incident.

6.4. Immediate Response

6.4.1. The immediate response to a mass casualty event would be in accordance with existing Major Incident arrangements.

6.4.2. A Multi-Sited event would require a duplication of the same level of response needed for a single-site event, and would therefore present considerable resourcing implications.

6.5. Supporting the Response:

6.5.1. In line with the Trusts Major Incident procedure the following actions should be considered to increase the capacity of the SECAmb to deal with mass casualties:

- Deploy all available St John Ambulance and British Red Cross resources;
- Deployment of additional medical support; i.e. HEMS
- Deploy available Community Responders;
- The introduction of revised triage protocols into the EOC.
- Invoke the Ambulance Service Mutual Aid MOU
- Invoke MACA arrangements.

6.6. Mass Casualty Vehicles

6.6.1. In addition to the Incident Support Units and Mass Casualty Equipment Vehicles held within the Trust, there are additional Mass Casualty Equipment Vehicles available as part of the government's capabilities programme. These can be requested via the National Ambulance Co-ordination Centre (NACC).

6.7. Mutual Aid Arrangements

6.7.1. In order to manage such an incident, the combined resources of a number of Ambulance Services would be required. Depending on the scale of the incident this could be either from adjacent Trusts or on a national basis therefore arrangements must be initiated for Mutual Aid. These arrangements will be co-ordinated by the National Ambulance Co-ordination Centre (NACC) in the longer term.

6.7.2. Additional resources may be provided for under the MACC arrangements, via the Military. (See SECAmb Major Incident Plan; Additional Contingencies: Chapter 7)

6.8. Emergency Treatment Centres (ETC)

6.8.1. Due to the scale of a Mass Casualty incident, there will be a requirement to manage casualties on scene or within an Emergency Treatment Centre(s), located nearby. Ambulance resources will be required to manage the casualties within the Emergency Treatment Centre(s) for an extended period of time, therefore resource deployment should take account of numbers involved and likely duration of incident.

6.9. Dispersal of Casualties

6.9.1. A Mass Casualty Incident will present unique challenges around casualty dispersal and will bring immediate operational challenge to all healthcare systems, many of which are already functioning at or above capacity. These casualties are likely to have significant traumatic injuries and as such will be triaged in the P1 category. It is recognised that the Major Trauma Centres will be quickly overcome, therefore each of the Major Trauma Networks is required to have a Mass Casualty plan setting out their response arrangements and to indicate their initial capacity arrangement.

6.9.2. These plans are available on the Resilience and Specialist Operations sharepoint site.

6.10. Associated Documents

- NHS England Concept of Operations for Managing Mass Casualties (2017)
- NHS England South Mass Casualty Framework (2016)
- SELK&M Trauma Network Major Incident Plan
- SWLS Trauma Network Major Incident and Mass Casualty Guidance
- Sussex Trauma Network Mass Casualty Plan
- Pan-London TN MC Plan LRF Mass Casualty Plans

7. Marauding Terrorist Firearms Attack or Active Shooter Incident

7.1. This section gives a brief outline of the Trusts arrangements in relation to a Marauding Terrorist Firearms Attack (MTFA) or Active Shooter Incident and where appropriate refers to the relevant Trust and National Guidance.

7.2. Introduction

7.2.1. The Trust has a contractual requirement to develop and maintain a specialist capability to respond to high risk spontaneous incidents involving a full spectrum, of weapons which will include firearms. In the context of this Major Incident plan, these incidents have been defined as:-

A Marauding Terrorist Firearms Attack, which refers to a terrorist attack involving a full spectrum, from low sophistication methods of attack e.g. Improvised Explosive Devices (IEDs) and bladed weapons, up to and including a full scale multi sited firearms attack.in a way designed to inflict large numbers of casualties.

An Active Shooter Incident refers to an incident involving an armed person(s) who has used deadly force, on other persons and continues to do so, while having unrestricted access to additional victims.

7.2.2. Although the motivation for the above incidents may be very different, they both present significant challenges for the personnel that respond to and/or manage this type of incident. It is also clear that such incidents may be fast moving and dynamic, which requires those involved to have a specific knowledge and skill set.

7.3. The Trusts Specialist Capability

7.3.1. In order to mitigate these risks the Trust has developed the following specialist capability, which has been trained and equipped to work within the specialist operational environment. This capability includes:-

7.3.2. The Hazardous Area Response Team (HART)

- The **HART** would perform the role of an Ambulance Intervention Team (AIT) and work within the defined warm zone(s), in conjunction with Police and Fire & Rescue Service personnel.

- The HART capability forms the Trusts primary response in relation to patient facing at a MTFA or Active Shooter Incident and are available on a 24/7 basis.

7.3.3. Critical Care Paramedics (CCP)

- The Trusts **CCPs** will support the HART capability and will enter the warm zone as part of an AIT to treat casualties, where required. In addition to this function, the CCP may work at the Casualty Collection Points or Casualty Clearing Station where higher level clinical intervention can take place.

7.3.4. MTFA Authorised Managers

- A pool of **Authorised Managers** has been developed to command all Trust activities within the warm zone. These managers have had specific training regarding this type of incident and would work alongside the Trusts Major Incident command structure.

7.3.5. National Interagency Liaison Officer (NILO)

- A number of specifically trained Ambulance Officers who are able to work alongside the MTFA command structure and support the decision making and multi-agency liaison during a terrorist incident.

7.3.6. Although it is clear that the Trust does require specialist capability to respond to these incidents, it is acknowledged that these resources would need to work closely with conventional operational and clinical resources assigned to the incident.

7.3.7. Logistical Support

7.3.7.1. An MTFA or Active Shooter incident has the potential for producing large numbers of casualties with ballistic and/or blast injuries, which would require the deployment of significant amounts of equipment assets and/or clinical consumables. The details of the Trusts arrangements in relation to this aspect are contained within section 18 of the Major Incident Plan.

7.3.8. Trust MTFA Plan

7.3.8.1. The Trust has produced a number of documents that detail fully the method in which the Trust will respond and manage an MTFA or

Active Shooter incident. Due to the nature and sensitivity of such documents, these have been marked as 'Official Sensitive' and made available to appropriate personnel only.

7.3.8.2. These documents are:-

- Operational Plan - Responding to a Marauding Terrorist Firearms Attack or Active Shooter Incident, Version 4.0 (2018).

- Marauding Terrorist Firearms Attack or Active Shooter - Standard Operating Procedures, Version 2.0 (2018).

7.3.9. National Guidance Documents

7.3.9.1. In developing these plans the Trust has taken note and made reference to the core national guidance provided by the Home Office and National Ambulance Resilience Unit. These documents are:-

- Responding To A Marauding Terrorist Firearms Attack (Operation Plato) - Joint Operating Principles for The Emergency Services - Edition Four.

- National Ambulance Resilience Unit, Marauding Terrorist Firearms Attack, National Standard Operating Principles.

- National Ambulance Resilience Unit, Training DVD - Marauding Firearms.

- National Ambulance Resilience Unit, Training DVD – Treat and Leave Procedure.

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8. Military Aid to the Civil Authorities

8.1. Military Aid to the Civil Authorities (MACA) is the collective term used by the Ministry of Defence for the operational deployment of Armed Forces personnel in support of the civilian authorities, other Government departments or the community as a whole.

8.2. When commercial options have been exhausted and/or circumstances preclude the use of such, then MACA may be requested to support the response to a Major Incident. The Joint Regional Liaison Officer (JRLO) will provide advice and will act as the conduit for requests.

8.3. Routinely, such requests will require ministerial authorisation. However, in very exceptional circumstances, for example, grave and sudden emergencies, when there is an urgent need to protect life, alleviate distress and/or protect significant property, a local commander is empowered to deploy assets to deal with the situation without recourse to additional ministerial authority.

8.4. The military have the potential to provide a broad spectrum of capability including trained manpower, equipment and real estate. However, it should be recognised that any assets requested under the MACA arrangements, could take some time to be deployed and become available locally. Service personnel will work in organised bodies and will always remain under service command.

8.5. Treasury rules dictate that full charges will be levied to the requesting organisation.

8.6. Associated Guidance

- UK Operations: the Defence Contribution to Resilience and Security (Third Edition 2017)

8.6.1. A copy of this document can found on the Resilience and Specialist Operations Sharepoint Site.

9. Mutual Aid Arrangements

9.1. Introduction

9.1.1. This section provides details of the arrangements to be invoked in circumstances where the Trust requires Mutual Aid from other Services, or where Mutual Aid from the Trust is requested by another Service in order to support the response to a Major Incident.

9.1.2. It is recognised that a Major or Catastrophic Incident will place enormous demands on the Trust and the wider NHS, particularly in situations which result in Mass Casualties.

9.1.3. Every Ambulance Service must be able to respond to a major or catastrophic incident within its own operational area. Within the same arrangements, Ambulance Services must ensure they can provide support to other Ambulance Services during a request for mutual aid in the case of a major or catastrophic incident.

9.1.4. This section supports the NHS Ambulance Service National Mutual Aid for Spontaneous Incidents Memorandum of Understanding (MOU) and the Local Health Resilience Partnerships Mutual Aid arrangements.

9.1.5. The intention of this Section is to provide a uniform framework for the Trust in which to:

- Request Mutual Aid in support of a Major or Catastrophic Incident;
- Arrange assets in response to a request;
- Manage the reception of Mutual Aid assets into the Trust area;
- Respond to a request for Mutual Aid made by another Service.
- Strategic Principles

9.1.6. Mutual Aid to a Major Incident will be provided by any ambulance service (supporting service) at the request of that service, in whose operational area the incident occurs (host service), to the fullest extent practically possible. This should be consistent with the discharge of its statutory duties, including assets which can be reasonably made available by changes to the arrangements for dealing with normal core business.

9.1.7. The host service will have primacy at the scene and have command and control over all deployed resources.

9.1.8. Self-deployment by ambulance services or individual members of staff, must not take place, under any circumstances.

9.1.9. Capacity for mutual aid will be maximised by reducing the level of core activity, with the exception of life-threatening incidents utilising the Trust's Surge Management Plan.

9.1.10. Increasing capacity to provide mutual aid is a strategic decision for the Trust concerned as deploying resources on mutual aid to another service will inevitably reduce the ability of the service supplying aid to deal with its own core activity. This may generate circumstances where the service supplying aid may wish to consider declaring a major incident in its own right and manage the consequences accordingly.

9.2. Mutual Aid Assets

9.2.1. Mutual Aid assets are defined as human and material resources which, when the request for mutual aid is received by NARU, it is reasonably practicable for an Ambulance Service to make available to another Ambulance Service.

- A medical response Mutual Aid 'Cell' consists of 1 x Officer and 10 x Doubled Crewed Ambulances (Emergency Operations).

- A HART Mutual Aid response will consist of a full HART team and resources as appropriate to the incident and a Tactical Advisor.

- A CBRN(e) SORT decontamination response Mutual Aid 'Cell' consists of 2 x CBRN officers and 16 x CBRN trained staff plus specialist equipment.

9.2.2. Further information regarding Mutual Aid Assets can be found in the NHS Ambulance Service National Mutual Aid for Spontaneous Incidents Memorandum of Understanding (MOU).

9.3. Trust Action in Requesting for Mutual Aid

9.3.1. The primary criteria for implementing mutual aid arrangements is when the requesting Responding Ambulance Service cannot or is potentially unable to maintain a safe level of critical services through lack of operational or resource capacity.

9.3.2. Initially, requests for Mutual Aid will be made by the Emergency Operations Centre Manager (EOCM) on advice from the Tactical Commander.

9.3.3. The Strategic Commander will authorise any formal/significant requests and should communicate this to the NARU on-call. Requests for large scale Mutual Aid will be co-ordinated by the National Ambulance Co-ordination Centre (NACC).

9.4. Actions by the Emergency Operations Centre

9.4.1. A request for Mutual Aid from surrounding ambulance trusts will be made by the Emergency Operations Centre to the Emergency Operations Centre of the supporting service using a recorded line.

9.4.2. The exact resources required must be specified to the supporting service.

9.4.3. The Trust supplying mutual aid will nominate Form-up Points to which all Mutual Aid resources will be deployed in the first instance to be held there prior to deployment on the instructions of the Trust.

9.4.4. The Emergency Operations Centre Manager will nominate an Initial Rendezvous Point/Marshalling Area (for resources to be called forward to from the Form-up Points) and nominate an Officer to attend the location.

9.4.5. Resources will be deployed by supporting service(s) to this point. These will be in the form of Ambulance Cells commanded by an officer. As necessary, the attending resources will be further directed or escorted to other locations.

9.4.6. The supporting service(s)' Ambulance Cell Management Officer will when possible, inform SECAmb when their Ambulance Cell is enroute using the SECAmb Hailing Talkgroup.

9.4.7. Once the Ambulance Cell reaches the Initial Rendezvous Point command of the Cell will be passed to the Trust. The Supporting Service(s) Ambulance Cell Management Officer will then act as a Liaison Officer to the Ambulance Incident Commander, or deployed appropriately.

9.5. Closing Actions

9.5.1. Following "casualty evacuation complete", the Trust will inform the supporting service(s) when Mutual Aid is no longer required and will

then agree the procedure and timescale to return the Ambulance Cell(s).

9.5.2. Should the Trust no longer require Mutual Aid, the supporting service(s) will be notified at the earliest opportunity in order for mobilised cells to be recalled to their own region.

9.5.3. Arrangements to debrief deployed resources will be made by the supporting service(s).

9.6. Trust Action in Responding to a Mutual Aid Request

9.6.1. Requests for Mutual Aid from a host service will be received, in the first instance, by the Emergency Operations Centre. Significant requests for Mutual Aid will be notified to the Strategic Commander for authorisation.

9.6.2. The Trust will be designated a supporting service and the extent of support to be provided will be determined by the Strategic Commander at the time of the request, and where necessary reviewed in the light of changed circumstances as the incident develops or and local circumstances change. Considerations may include:

- Own Service capacity and capabilities
- Potential timescales of mutual aid requirements.
- Communications – external and internal.

9.7. Action by the Emergency Operations Centre

9.7.1. Details of the request for resources from a host service will be recorded in the Emergency Operations Centre.

9.7.2. The Emergency Operations Centre Manager will nominate the most appropriate Form-up Point and nominate a Form-up Point Officer to attend the location.

9.7.3. All SECAmb resources will be deployed to the nominated Form-up Point and arranged by the Form-up Point Officer into an ambulance cell commanded by an Ambulance Cell Management Officer.

9.7.4. Upon request from the host service the ambulance cell will be mobilised to the Initial Rendezvous Point inside the host service operational area.

9.7.5. Under no circumstances should Trust resources be mobilised without the express request of the host service and without passing through the Form-up Point.

9.8. Closing Actions

9.8.1. Following “casualty evacuation complete”, the host service will inform the Trust and will then agree the procedure and timescale to return Trust resources.

9.8.2. Should the host service wish to cancel a Mutual Aid request, the Trust will be notified without delay allowing resources to be returned to Trust at the earliest opportunity.

9.8.3. Arrangements will be made to debrief all Trust personnel sent to provide Mutual Aid.

9.9. Form-up Points

9.9.1. When responding to a Mutual Aid request, the following locations have been identified for potential use as Form-up Points.

9.9.2. Motorway services:

- Clacket Lane Services - M25 between junctions 5 and 6
- Cobham Services – M25 between junction 9 and 10
- Pease Pottage Services – M23 junction 11

9.9.3. Trust estates:

- Ashford Make Ready Centre
- Chertsey Make Ready Centre
- Crawley Make Ready Centre
- Tangmere Make Ready Centre
- Farnborough Ambulance Station
- Tongham Ambulance Station

9.9.4. When nominating a Form-up point consideration should be given to the location of trust resources to be deployed and the location of the Host Service /incident.

9.10. Strategic and Tactical Holding Areas

9.10.1. Within the Trust's operational area there are a number of identified Multi Agency Strategic/Tactical Holding Areas based upon road networks and likely risk sites.

- Strategic Holding Areas (SHAs) will be located at large intersections e.g. motorway services.

- Tactical Holding Areas (THAs) will be much closer to the incident site ready to move to the forward rendezvous point.

9.10.2. Mutual Aid resources deployed by a supporting service may initially attend a nominated Strategic or Tactical Holding area prior to being dispatched to assist the Trust. Details of these sites are available via the on-call Tactical Advisor.

9.11. Supporting Duties

9.11.1. Assets deployed to assist in the support of a Major Incident can be used for a variety of duties in support of a Major or Catastrophic Incident

9.12. Hospital Ambulance Liaison Officers

9.12.1. The provision of an HALO can be made from a supporting service under Mutual Aid. On attendance at the receiving hospital direct liaison must be established with the host service.

9.13. Communications

9.13.1. All ambulance assets should be controlled by the host service. Resources attending from other Ambulance Trusts may be directed onto the designated SECAmb Mutual Aid Talkgroups.

9.14. Associated Documents

- NHS Ambulance Service National Mutual Aid for Spontaneous Incidents Memorandum of Understanding (MOU)

- NHS/LHRP Mutual Aid Agreements

- LRF Multi Agency Strategic Holding Area Plans

10 Maritime Incidents

10.1. Within the South East of England we have some of the busiest coast line in the world with over 500 ships alone passing through Dover Straights on any one given day with the national shipping industry together with ports providing £1 million per hour to the UK economy.

10.2. The Maritime and Coast Guard Agency provides a response to Maritime Incidents conducting on average 20,000 rescues per year around the UK. This is co-ordinated through the National Maritime Operations Centre (NMOC) in Fareham supported by 10 other Coastguard Operations Centres (CGOC) around the United Kingdom.

10.3. All maritime incidents requiring a Search and Rescue (SAR) asset will go through MCA Risk Tasking; this will then provide the proforma to which the emergency services and assisting agencies will work to in formulating their risk assessment.

10.4. **Major Maritime Emergencies**

10.4.1. Major maritime emergencies involving HM Coastguard (HMCG) may include the rescue of large numbers of people from:

- Passenger carrying ships;
- Offshore installations;
- Isolated offshore or coastal landfalls;
- Numerous small craft simultaneously in distress;
- Ditched commercial passenger carrying aircraft;
- Any other form of ‘Major Incident’ at sea; or
- The potential or actual release of hazardous, noxious, pollutant materials, wreckage and cargo at sea or along the coast.

10.4.2. When a major maritime emergency occurs, HMCG will establish coordinating authority for the incident at the NMOC and transfer logistical command to the appropriate regional CGOC.

10.4.3. If the incident remains at sea and under HMCG jurisdiction but develops, the relevant Police force will be asked to establish an SCG at an appropriate location.

10.4.4. It is likely that as the incident at sea develops a secondary scene is likely to be located on land, at the designated Marine Landing Site(s). This co-ordination may consist of multiple locations depending on the SAR response and capability

10.5. Terror Threat Alerting

10.5.1. The CGOC coordinating the incident will establish if the Ship Security Alert System (SSAS) has been activated and this information should then be passed to all assisting agencies.

10.6. Operation Waypoint

10.6.1. Operation Waypoint is designed to provide early warning and information relating to a potential Mass Casualty incident in UK waters that is likely to involve large numbers of displaced, injured and / or deceased persons of various nationalities being landed at a port or other landing point (as circumstances permit) within a Resilience Group's boundary.

10.7. Trust Response

10.7.1. The ambulance service will be required to provide a liaison officer to attend at a nominated NMOC/ CGOC, dependant on the area of responsibility the incident occurs in.

10.7.2. The Trust does not currently have an off shore rescue capability; therefore, the Trust will support the provision of clinical care for patients who have been rescued once they are on land.

10.7.3. The Hazardous Area Response Teams (HART) can undertake Swift Water Rescue and owing to their hazardous environment speciality within alongside marine incidents, can assist with specialist knowledge safeguarding cordons and assisting with vessel knowledge and maritime working. NB: cordons as per Water Rescue SOPs will define all areas of working within 3 metres of the water.

10.8. MCA Locations

10.8.1. Within reach of the Trusts geographical area, there are two main centres, the NMOC in Fareham and the CGOC at Dover.

Fareham: Unit 12 Kites Croft Business Park Fareham PO14 4LW

Dover: HM Coastguard, Langdon Battery, Swingate, Dover, Kent CT15 5NA

10.9. Related Plans

- Maritime and Coastguard Agency Major Incident Plan
- Operation Waypoint
- Sussex Major Maritime Emergency Plan

11. Risk Sites and Response Plans

11.1. Introduction

11.1.1. This section details the arrangements in place for the Trust to identify risk sites and the corresponding Site Specific Response Plan (SSRP) should an incident occur at one of these sites.

11.2. Risk Sites

11.2.1. There are a number of specific risk sites within the trust area. These sites have been assessed and graded in priority of risk by the CP&R Team. Some of these sites may have their own Major Incident response plans or a multi-agency plan in place, for example, the COMAH sites, where a coordinated response has been agreed. The SSRP is designed to complement this plan and to provide Trust staff with the key information in a standard format.

11.3. Site Specific Response Plans

11.3.1. The Site Specific Response Plans provide the Trust Staff with a profile overview of the site along with an image of the location where possible. Along with this the SSRP will detail;

- Access and Egress Routes
- Rendezvous Points (RVP's)
- Known Risks and Hazards
- Location of any Joint Emergency Services Control Centres and any Communication Arrangements
- Initial Actions and Considerations
- Pre-determined Strategic/Tactical Holding Areas
- Reference Documents/plans
- Maps of the site / location and local risks and;
- Any other additional information that may support in the initial response.

11.3.2. These plans are subject to regular review as changes occur within these sites/locations but notwithstanding a full review should be undertaken every three years.

11.3.3. These plans are held and maintained by the Contingency Planning and Resilience Team and stored on SharePoint. Additionally, all staff can access these plans via the Content Locker where plans will be uploaded when they are updated and reviewed.

12. Specialist Resource Capabilities

12.1. The Trust has available a number of Specialist Resource Capabilities to support significant or major incidents. These resources are distributed across the Trust at key locations to ensure a timely response to incidents. Below looks at each of these capabilities.

12.2. Hazardous Area Response Teams (HART)

12.2.1. The Trust have two HART teams, strategically placed within the Trust to cover model response sites. HART can support both day to day operations and also significant and major incidents.

12.2.2. HART units provide paramedic care to patients within a hazardous environment that would usually be beyond the reach of NHS care. Working as part of the wider NHS and multi-agency response to incidents, HART will coordinate clinical assessment, initiate treatment and extraction of patients from hazardous or high risk environments. The fundamental principles of this is to increase patient survival rates and increase clinical outcomes.

12.2.3. HART capability consists of;

- Initial Response Unit; (IRU) dealing with hazardous materials (HAZMAT) incidents.
- Chemical, Biological, Radiation, Nuclear CBRN (e) allowing paramedic care within the inner cordon.
- Safe Working at Heights; (SWaH) Ability to provide paramedic care at unlimited height.
- Inland Waterway Operations; (IWO) Ability to deliver patient care during water rescue operations, working within boats and urban or rural flooding.
- Confined Space; Ability to provide paramedic care within a confined space for example a building collapse.
- Tactical Medicine Operations (TMO) Ability to provide patient basic patient care within a ballistically unsafe environment.

12.3. Specialist Operations Response Teams (SORT)

12.3.1. The Trust has a number of staff trained as Specialist Operation Response Teams (SORT) who are available to respond to CBRN incident to provide clinical decontamination should the need arise. These staff are taken from the operational pool of staff on duty at the time and a text based alerting system is in place for members of the team to respond if required.

12.3.2. The Incident Support units and the SORT teams can also be used to deal with a mass casualty incidents and the tents used for casualty clearing stations. Further details can be found on the CP&R SharePoint tab regarding load lists for incident support units.

12.4. Ambulance Intervention Team**.**

12.4.1. The Trust has a number of managers and operational staff who are appropriately trained, tested and exercised to provide clinical care to patients in the warm zone of a Marauding Terrorist Firearms Attack (MTFA).

12.4.2. In some areas the Fire and Rescue Service support this provision and assist within the team to provide clinical care. The Trust has a robust tested procedure for deployment of these staff should an incident occur.

12.5. Critical Care Paramedics (CCPs)

12.5.1. CCPs have a skills set over and above a Paramedic in dealing with traumatically injured patients. During a Major or Mass Casualty incident CCP's would be often placed in the casualty clearing station to provide clinical care to those with the most serious and challenging injuries.

12.6. Paramedic Practitioners (PP's)

12.6.1. The PP skill set is focused towards primary care and minor injuries (not a definitive list) and during a Major or Mass Casualty incident can often be best placed in dealing with P3 patients and where appropriate discharging at scene to survivor reception centres.

12.6.2. Often during the early phases of a significant incident many patients may be displaced from their medications, may be suffering from pre-existing medical conditions or a minor injury. PP's have the skills set to be able to deliver holistic care in the setting and where appropriate treat or refer the patient to a suitable health care setting rather than an Accident and Emergency Department.

12.7. Tactical Advisor/NILO

12.7.1. The Trust operates a 24/7 On-Call Tactical Advisor capability, in line with the Emergency, Preparedness Resilience and Response (EPRR) core standards, which are available via the Single Point of Contact (SPOC)

TAC AD SPOC: 07003 900765

12.7.2. The TacAd role is to provide specialist advice to the Ambulance Commanders, Emergency Operations Centre Manager and/or any operational resources in relation to any response.

12.7.3. Tactical Advisors who are qualified National Interagency Liaison Officers(NILO)are able to provide additional specialist interoperable advice and liaison to both Trust and other agency commanders

13. Sports Stadia and Public Events

13.1. This section in light of previous sports grounds and public event incidents offers a very brief overview around Sports Stadia and Events legislation and available guides. Best practice for planning is to utilise the relevant guides documented within this précis and to conform with legislation and evidenced based practice.

13.2. Safety at Sports Grounds

13.2.1. Legislation

13.2.2. The Safety at Sports Ground Act (1975) requires certification of all sports grounds with a capacity for over 10,000 people. The Safety at Sports Grounds (Accommodation of Spectators) Order (1996) places an additional requirement on all Football League and Premier League sports grounds having a safety certificate where capacity exceeds 5,000 people. The Fire Safety and Safety at Places of Sport Act (1987) also requires certification of individual stands with a capacity for over 500 people. Any certificated ground or stand is considered as designated.

13.3. Guide to Safety at Sports Grounds (The Green Guide)

13.3.1. The supporting guidance for sports ground safety, the Guide to Safety at Sports Grounds (2008), referred to as the Green Guide, provides a non-statutory framework for safety at both designated and non-designated sports grounds. Elements of guidance may however be made statutory by inclusion in the ground safety certificate where one is issued.

13.3.2. The Green Guide includes advice that ambulance trusts should be involved in advising owners and operators of sports grounds in safe practice. The guide clearly states however that this advice ‘does not however exonerate the ground management from its responsibility for spectator safety’.

13.3.3. Sports grounds should consult the ambulance service for advice on:

- Emergency plans
- Medical plan
- Major incident plan
- Access and egress of emergency vehicles
- Medical risk assessment

- Equipping of first aid rooms
- Use of sports grounds for alternative events.

13.4. In any Major Incident declared at a sports ground the Trust's Major Incident Plan would be invoked and the Trust would lead on the medical aspect of the incident.

13.4.1. Further Reading;

- Department for Culture, Media and Sport; *Guide to Safety at Sports Grounds* (2008). Fifth Edition 2008

http://www.safetyatsportsgrounds.org.uk/sites/default/files/publications/green-guide.pdf

13.5. Public Events

13.5.1. Legislation

13.5.1.1. Whilst public events are not directly covered by legislation, many require a licence under the Licensing Act (2003), use of public land, road closures or traffic alterations, all of which are granted by the local authority, Local Authority Emergency Planning Groups or, where they exist, Safety Advisory Groups (SAGs) are often the focal point for inter-agency advice to event planners.

13.6. The Purple Guide to Health, Safety and Welfare at Music and other Events (2014)

13.6.1. The Purple Guide provides a non-statutory framework for safety at public events. Elements of guidance may however be made statutory by inclusion in the event licence where one is issued.

13.6.2. The Trust has a statutory duty to provide a 999 service to all those within its geographical area including those attending public events. In recognition of the fact that public events can have a significant impact on the local health economy, the Purple Guide sets out good practice guidance for the provision of first aid, ambulance and medical staff to support the event and minimise the impact on local health services.

13.7. Role of the Ambulance Service

13.7.1. The ambulance service must ensure that impacts to the local community are minimised and that an effective response to any major incident is provided. This may include the presence of ambulance managers at the event. In order to ensure minimal disruption an event plan distributed internally and externally and appropriate liaison with the event should be considered.

13.7.2. In any Major Incident declared at a public event the Trust's Major Incident Plan would be invoked and the Trust would lead on the medical aspect of the incident.

13.7.3. Further Reading;

- The Purple Guide to Health, Safety and Welfare at Music and Other Events (2014)

13.7.4. As this manual is only available as an online subscription each manager within the Trust who may have responsibility for event planning has been given the opportunity to sign up to a paid subscription of the Purple Guide.

13.8. The Trust's documentation regarding events and planning can be found on the Resilience and Specialist Operations SharePoint site.

14. Transportation Incidents

14.1. Introduction

14.1.1. The South East Coast Ambulance Service covers an area of 3,600 square miles. Within this area there is a significant transportation network.

14.1.2. This section details the types of locations that the Trust may be called upon to attend. It should be read in conjunction with associated site and risk specific plans.

Motorways	M2, M3, M20, M23, M25, M26
Major Trunk Roads	A2, A3, A21, A23, A24, A25, A27, A29, A30 , A31, A217
Railway Network	• Major Commuter Networks • Channel Tunnel Rail Link
Shipping & Off Shore	• Dover Docks • Local Ports & Marinas • Off Shore wind farms • Sussex Major Maritime Emergency Plan
Road and Rail Tunnels	• Dartford River Crossing • Hindhead Tunnel • Southwick Road Tunnel • Channel Tunnel
Transport Hubs	• Mainline Railway Stations • Gatwick Airport

14.1.3. As detailed in the major incident plan the Trust will seek to implement the “major incident footprint” over any site or scene where an incident is occurring.

14.1.4. There are a number of site-specific plans that relate to the transportation network that should be referred to when responding to certain sites.

14.1.5. Plans will be available on the Resilience and Specialist Operations SharePoint site. A small number of plans are restricted and available via the Tactical Advisor/NILO through the Single Point of Contact Number. 0700 390 0765.

14.2. Transport Incidents Involving Dangerous Goods

14.2.1. Hazardous Chemicals and Dangerous Goods are transported throughout the United Kingdom, by road and by rail, every day. These goods include dangerous chemicals such as:

- acids
- toxins and carcinogenic substances
- explosives
- radioactive materials
- inflammable liquids
- volatile chemicals likely to spontaneously combust or react with air, water etc.; and
- inflammable, poisonous or compressed gases.

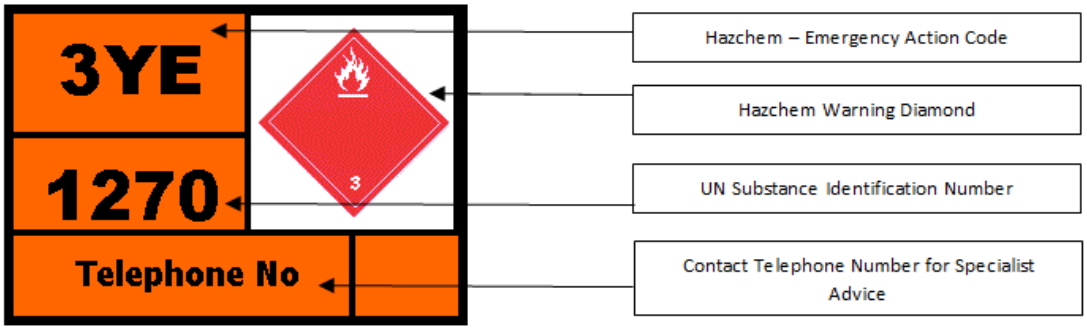
14.2.2. The carriage of dangerous goods creates risks to drivers, other road users, the public, and the environmental as well as for the emergency services. When responding to a transport incident, staff should be aware that any incident has the potential to involve hazardous materials.

14.2.3. There are a number of schemes in place to support the response to an incident involving hazardous goods.

14.3. Hazardous Chemical Placards

14.3.1. An orange-coloured plate is displayed on vehicles and containers carrying hazardous loads. The plate is a critical source of hazard information and is designed to alert emergency responders to the presence of hazardous materials in the event of an incident involving such vehicles or containers.

14.3.2. Information is displayed as follows:



Category	Violence	Protection	Substance control
P	V	Full	Dilute
R			
S	V	BA	
S		BA for fire only	
T		BA	
T		BA for fire only	
W	V	Full	Contain
X			
Y	V	BA	
Y		BA for fire only	
Z		BA	
Z		BA for fire only	
E	Consider evacuation		

14.4. RADSAFE

14.4.1. Emergency arrangements in event of an incident involving the transport of radioactive materials come under the RADSAFE scheme.

14.4.2. Further information can be found at http://www.radsafe.org.uk/

14.5. Local Authority & Emergency Service Information on Nuclear Weapon Transport Contingency Plans (LAESI)

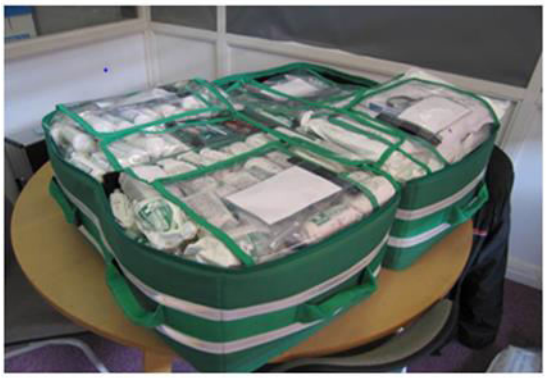
14.5.1. The LAESI plan provides guidance in relation to incidents involving Defence Nuclear Material.

14.5.2. Further information can be found at: https://www.gov.uk/government/publications/local-authority-emergency-services-information

14.5.3. Mass Casualties Dressing Packs

14.5.4. A number of transport Hubs throughout the country have Emergency Dressings Packs supplied by the Department of Health and pre-positioned to be used in the event of a Major and/or Catastrophic incident which results in Mass Casualties.

14.5.5. These packs are designed for use by members of the public and may be deployed prior to the arrival of ambulance resources. The packs contain quantities of dressings to provide urgent first aid treatment to casualties prior to the arrival of the ambulance service.



14.5.6. There are a number of mass casualty dressing packs situated at strategic locations across Kent, Surrey and Sussex, details of which are held by the Emergency Operations Centres.

15. UK Threat Level System

15.1. The United Kingdom Threat Level system is designed to give a broad indication of the likelihood of a terrorist attack. Threat levels are based on the assessment of a range of factors including current intelligence, recent events and what is known about terrorist intentions and capabilities.

15.2. There are five levels of threat:

- **Critical** - an attack is expected imminently.
- **Severe** - an attack is highly likely.
- **Substantial** - an attack is a strong possibility.
- **Moderate** - an attack is possible but not likely.
- **Low** - an attack is unlikely

15.3. Staff should always remain alert to the danger of terrorism and report any suspicious incidents or activity, either via the Trust's internal reporting mechanisms or directly to the police using the anti- terrorist hotline: **0800 789 321**

15.4. In the event of a threatened or an actual terrorist attack, the Trust would be called upon either to respond with a heightened state of readiness or to deal with any consequent casualties and/or survivors.

15.5. The Contingency Planning and Resilience Department will ensure that all Trust personnel are informed of the current Terrorist Threat Level and that key staff are informed immediately of any change.

15.6. The Threat Level for the UK is displayed on the Resilience and Specialist Operations SharePoint site.

15.7. All Trust localities should display the status of the current Threat Level.

15.8. The response actions detailed in the following table will apply in relation to each specific Threat Level. It should be noted that any move to **Critical** is regarded as a significant trigger and as such a Move to Critical Action Card applicable to all staff is available on the Resilience and Specialist Operations sharepoint site.

UK Threat Level	Trust Actions
Low **Moderate**	• Emphasis should be placed on site and vehicle security at all times. • All staff to carry Trust identity cards. • All Major Incident support vehicles to be regularly checked.
Substantial **Severe**	All measures as above, plus…... • R&SO to ensure all Major Incident support vehicles are checked and are operationally ready. • Staff to familiarise themselves with the Major Incident plan and action cards. • Staff to familiarise themselves with Major Incident Bags/PPE on front line vehicles.
Critical	All measures as above, plus …. • Refer to the Actions on the **Move to Critical Action Card**. This can be found on the R&SO SharePoint site.

16. VIP and VVIP Management

16.1. If Very Important Persons (VIP) or Very, Very Important Persons (VVIP) (including Heads of State, Royalty or other Dignitaries who travel with police close protection teams and entourage) are involved in an incident they may be taken to the nearest acute hospital depending on the severity of their injuries.

16.2. If this happens the receiving hospital must be pre-alerted by the EOC as the site will need to be prepared for an increased need for security and possible media interest.

16.3. If a VIP or VVIP has being treated by the Trust this should be cascaded to the Tactical and Strategic Commanders. In addition the Media team should be informed due to possible media interest.

16.4. Pre-planned Events/Visits

16.4.1. VIPs/VVIPs are known to attend a number of events/undertake visits to locations within the Trust's region. As required event specific planning will be undertaken to ensure that the appropriate arrangements are in place. Operational Orders will be issued for such events.

16.5. Operation Carbon Steeple

16.5.1. Operation Carbon Steeple covers the arrangements in the event of a VVIP under close police protection being attacked, contaminated and/or injured. Further information is available via the TAC Ad/NILO as required.

16.6. Post–Incident VIP visits

16.6.1. Visits by VIPs/VVIPs are now a regular occurrence following a Major Incident as it is recognised that they can lift the morale of those patients that were involved in the incident, as well as those staff members who were involved with the response. Where a VIP visit/event is planned to take place in the immediate aftermath of the major incident it will be the responsibility of the Head of Communications to liaise with the organiser in relation to Trust representation.

Document Control

Manager Responsible

Name:	Anne Harvey/ Contingency Planning & Resilience Team
Job Title:	
Directorate:	Operations

Committee/Working Group to approve	Executive Resilience Committee	
Version No. 5.0	Final	Date:15/08/18

Draft/Evaluation/Approval (Insert stage of process)

Person/ Committee	Comments	Version	Date
Executive Resilience Committee	For ratification	V5.0	15/08/18
Resilience Forum	For approval and submission to Executive Resilience Committee	V4.3	26/07/18
Anne Harvey	Minor amendments	V4.3	20/07/18
Resilience Forum	Circulated for review and comment	V4.3	11/07/18
Anne Harvey	Amendment to layout of Section 8 and inclusion of reference to responsibility of EOC tactical 8.6.3	V4.3	11/06/2018
Senior Operations Leadership Team (Teams A)	Approved, subject to inclusion of reference to responsibility of EOC tactical	V4.2	04/06/2018
Person/Committee	Comments	Version	Date
Senior Operations Leadership Team (Teams A)	For approval	V4.2	04/06/2018
Anne Harvey	Comments reviewed and plan amended accordingly	V4.2	23/05/2018
Sue Barlow; James Pavey; Andy Cashman; Chris Stamp; OUMs; Comms; Jane Mitchell; Lis Thowney; Greg Walsh; Karen Ramnauth; Angela Rayner; Richard de Coverly; Andy Collen; EOC Leadership; Resilience & Specialist Operations	Circulated to key stakeholders within the Trust for review and comment	V4.1	19/04/2018
Contingency Planning and Resilience Team	Initial Review of Major Incident Plan and Additional Contingencies	V4.1	Nov 2017-Mar 2018

	documents with input from Trust colleagues in relation to their area of expertise. New Chapters included in Additional Contingencies and Documents merged into a single document.		
RMCGC	Approved	V4	06/11/14
RMCGC	Recommended for approval	V3.2	06/11/14
OPGWG	Recommended for approval for submission to RMGCG	V3.2	30/09/14
Anne Harvey	Additional amendment following review	V3.2	04/08/14
SECAmb Resilience Group SCOT NHS England Area Team EPRR Leads FRS & Police EP colleagues	Circulated for review and comment	V3.1	11/07/14
Contingency Planning & Resilience Team	Review and Major rework of plan	V3.1	June/July 2014
RMCGC	Approved	V3	04/05/12
RMCGC	Recommended for approval	V3 0.2	04/05/12
Contingency Planning & Resilience Manager	Reformatted to reflect corporate format structure	V3 0.2	17/04/12
RMCGC	Recommended for approval	V3 0.1	12/03/12
Contingency Planning & Resilience Manager	Incorporated comments from Clinical Directorate members	V3 0.1	04/03/12
NHS EP Leads (PCT & SHA)	Review	V3 0.1	01/03/12
SECAmb Senior Operations Managers	Review	V3 0.1	24/02/12
SECAmb Resilience Group	Review	V3 0.1	24/02/12
Contingency Planning & Resilience Managers	Review of plan to reflect operational changes, new guidance, FT status and changes in roles following workforce review.	V3 0.1	Jan 2012
Chief Executive	Approved for use	V002	Sept 2010
Head of Emergency Preparedness	MI Plan reformatted for field operations use	V002	2010
Chief Executive	Approved for use	V001	May 2007

Circulation

Records Management Database	Date:

Internal Stakeholders	
External Stakeholders	
Active from (30 days after above signature):	Date:

Review Due

Manager	Head of Contingency Planning & Resilience	
Period	Every three years or sooner if new legislation, codes of practice or national standards are introduced	Date: August 2021

Record Information

Security Access/Sensitivity	SECAmb Domain
Publication Scheme	Yes
Where Held	Records Management database
Disposal Method and date:	In accordance with Records Management Retention and Disposal Guidelines

Supports Standard(s)/KLOE

	NHS Litigation Authority (NHSLA)	**Care Quality Commission (CQC)**	**Auditors Local Evaluation (ALE)**	**IG Toolkit**	**Other**

SECAMB Board

QPS Committee Escalation report to the Board

Date of meeting	6th September2018
Overview of issues/areas covered at the meeting:	This meeting considered a number of ***Management Responses*** (*response to previous items scrutinised by the committee)*, including: **Section 136**: to include the requirements and performance under the Mental Health Concordat **(Partially Assured)** There has been work undertaken to understand the disparity between SECAMB and the Police to understand the root cause of the issue. Issues have been identified and are being actioned and it is expected in September to see a much improved alignment of data and activity. In addition there is a gap in commissioning and this is being discussed with commissioners. The committee asked for an update on these items at the October and December meetings. **Vehicle Cleanliness** -Swab Testing **(Assured)** The committee reviewed the swab test results as requested at the July meeting for both MRC and VPP sites and is assured that these were overall with the tolerances set. However the committee has asked for a review and timeliness of the swab testing given new testing kits now in place and this is bought back to QPS. **Internal safeguarding** – Safer Recruitment **(Assured)** The committee is assured that the process to manage the issues relating to internal safeguarding is being actioned. It also noted the pre-appointment screening trial is being initiated and that the broader issue of the standards set is being reviewed. **111 Service** – Learning from incidents **(Assured)** This paper gave assurance that there is a robust process and mechanisms in place to embed learning from SIs and incidents not only within the 111 service but also across the Trust particularly into the EOC and that learnings are also shared across the 111 network. The committee had asked for this as a follow up to 111 Call Triage Paper received in July to test how the learnings identified are shared and embedded. The meeting also considered a number of ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas),* including; **SRV/DCA Crew Policy** (non-paramedic crewed vehicles). How do we plan a skill mix on DCAs and SRVs **(Partially Assured)** Following observations at the QAV visits of skill mix this paper outlined how the staff skill mix is considered and planned. It also highlighted that last minute staff issues can change the planned mix. The committee is assured that all decisions are taken at each stage of the planning process with the optimal mix in mind, but that this should be a documented process particularly given the planned move to local rostering.

	Private Ambulance Providers Governance Review (Assured) The committee reviewed the assurance document presented to the CQC on 5th September to provide an update and assurance on the work ongoing to ensure that the Trust's contractual arrangement with PAPS is robust and appropriate, and resolve any inconsistencies in quality and governance assurances and deliver principles to improve PAP service delivery. This includes a clinical safety project. The committee has asked that the results of the clinical safety project are bought back to committee and also that a bi-annual PAP report which covers all areas of PAPs is added to the annual cycle of business. The committee is assured that a robust and comprehensive review is being undertaken. **Obstetrics**: Assurance can deliver effective care and treatment (Policy/Procedures, Training, Incidents, Risk) **(Partially Assured)** This was a thorough review of our current obstetric care supported by an analysis of any SIs, incidents and complaints, our policies, training and education, medical equipment and practice guidelines which provides an adequate level of care. It was recommended that a follow up report is submitted in 6 months by our newly appointed Consultant Midwife. The committee noted the EOC Maternity Line that has been put in place and the very positive impact that this has had. **HART**: Overall review and specifically NARU Audit readiness assessment. **(Partially Assured)** The paper provided an update on governance, tasking and learning, skills assurance, care and treatment and recruitment and retention and an assessment undertaken with commissioners to review HART prior to the NARU Interoperable Capability Review scheduled for October. The committee was assured that a robust programme had been undertaken to largely address the areas where SECAMB was found to be non-compliant and the assessment undertaken reflected this. The Trust has taken significant steps to address these issues including training 80+ relief staff, new fleet, training and appointment of staff. However, the Trust is not always compliant with the requirement for 100% capacity within HART (6 in each team at all times) and the committee recommends that the Board reviews this so it has clarity on the potential consequences. The committee also asked management to ensure this is reflected on the risk register. **Crew to Clear Review** (including Hospital Handovers) – **Assured** The paper outlined the progress that has been made regarding hospital handovers and the performance on crew to clear times which is variable across the Trust but overall average sits somewhere around 16mins. There is an action plan to address this but the committee noted significant effort by two OUs that have only reached 60% compliance with the 15minute handover time and encouraged that the feasibility of this time should be reviewed at the different locations and that also engagement must be considered. The committee IS assured this had focus and grip. In addition the committee also received a report **on Infection Prevention and Control progress** against objectives and noted that progress that continues to be made in this area.

	Medicines Governance Quarterly Inspections report gave assurance that this area continues to be closely managed and that this process is able to identify issues and work to resolve them. In particular the committee noted that there had been much improved timely response by Estates to issues raised in these inspections. The committee was also assured that there is now a substantive team in place. In addition the committee was alerted to the new Fraudulent Medicines Directive which is required to be implemented by March 2019. The committee referred this to FIC in relation to the IT/Investment element and will receive a paper in October to outline the overall requirements and impact.
Reports *not* received as per the annual work plan and action required	The committee did not receive the following items, Thematic Review of SI's / patient delays This will be submitted in October
Changes to significant risk profile of the trust identified and actions required	N/A
Weaknesses in the design or effectiveness of the system of internal control identified and action required	N/A
Any other matters the Committee wishes to escalate to the Board	As referenced above, the Board should be aware that the Trust is not always compliant with the requirement for 100% capacity within HART (6 in each team at all times). It is commissioned to provide 6 staff in each team, but there are times due to unexpected leave (e.g. sickness) when this capacity is not always provided. The Board should therefore consider whether it needs to invest above that to which it is commissioned. A paper will come to the Board in October with further details and a recommendation.

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

September 2018

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

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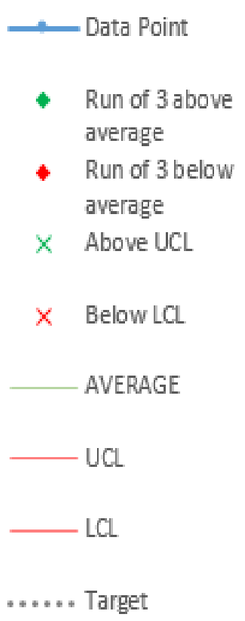
SECAmb CQC Rating and Oversight Framework

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 continues to progress to demonstrate that an effective and controlled handover / transition from project status to Business As Usual is taking place.

SECAmb Our Enablers

SECAmb Financial Performance

The Trust achieved its planned deficit of £0.1m for the month of July. The cumulative deficit of £2.3m is marginally better than plan, maintaining operational hours and performance.

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

The Trust achieved cost improvements of £1.2m in the month, which was £0.8m higher than plan. The target for the full year is £11.4m.

The Trust's Use of Resources Risk Rating (UoRR) at this point in the year is 3, in line with plan.

Risks to this plan include the delivery of CIP targets, the outcome of the Demand and Capacity review, delivery of performance targets, any financial impact of exiting CQC special measures, recruitment difficulties and any unfunded local pay pressures. Engagement with the Trust's stakeholders 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

Patient records: 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 11.04% (July data). This is now in line with national figures but shows a slight increase on the June figure which may be explained by the 4.7% increase in activity during July.
Medicines Governance: Operational Team Leaders (OTLs) continue to perform weekly 'safe and secure handling of medicines' audits at Operating Unit (OU) level, demonstrating high levels of compliance (93.5%). The Medicines Governance Team are currently performing their audits around medicines management across the Trust. Temperature monitoring is continuing daily at all sites, with central monitoring through the OTL checks. An automated temperature system is at pre contract stage and implementation should commence in October 2018. Temperatures are within manufacturers recommended ranges with recent installation of air con units. An increase in compliance to 93.5% (91.6% in June) was noted with the monthly OU checks.

Governance around controlled drugs (CDs) continues to be monitored on daily, weekly, monthly and quarterly basis. There is full track and trace on all CD activity with discrepancies escalated immediately for investigation. CDs taken home and single witness signatures are reported on a weekly basis and communicated out to operational staff. The CDAO is kept informed if an individual has taken CDs home more than once. . Six occurrences of non-compliance to the CD procedures were reported in July.
The Chief Pharmacist and Datix Incident Manager have worked on a reporting menu for medicines. Going forward this will help operational staff and medicines team report accurately, and monitor trends and engage learning. The medicines pouch system and tagging errors continue to be reported through the Datix system. A full review on the pouch system is required.
There are 1664 staff who have now completed the medicines governance key skills session.

National performance targets: The clinical indicator data summarises March 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. . STEMI Care Bundle performance has increased to 66% in March, which continues below the national YTD average of 76.4%. Stroke Diagnostic Bundle performance is above the national average achieving 97.1%. 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.

The SMP has been in active use since its introduction and subsequent reviews, with a further review of the plan and its associated triggers initiated in August 2018 with a follow up meeting scheduled for September 2018.

Clinical Practice Developments: The Deteriorating Patient Group has been established. Recruitment to nine OU's ambassador's role has been achieved. in all but one area. An education strategy and interactive training is under development. A number of falls and other pathways pilots are in place. Absences within the team have delayed the progress on migrating the falls dashboard to Power BI. A root and branch review of the PP programme has been agreed. IBIS has moved in its entirety to the Operations Directorate (EOC) as BAU for the life of the commissioned period with the Medical Directorate retaining governance and oversight. Work continues to progress NICE alerts as per the plan.

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

Recruitment: Dr Magnus Nelson, the newly appointed Assistant Medical Director joined the Trust on 4th September 2018. Julie Ormrod, Consultant Paramedic for Urgent Care commenced on 3rd September 2018. Our new Consultant Midwife, Dawn Kerslake, and Consultant Paramedic Michael Bradfield take up their posts in October 2018 and Dan Cody, Consultant Paramedic for Critical Care and Resuscitation will commence in early November 2018

SECAmb Clinical Safety Scorecard

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

	Jan-18	Feb-18	Mar-18	12 Months
Actual %	35.7%	36.4%	56.4%	
Previous Year %	51.5%	43.3%	62.9%	
National Average %	45.1%	51.0%	55.3%	

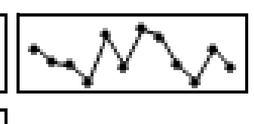
Cardiac ROSC - ALL

	Jan-18	Feb-18	Mar-18	12 Months
Actual %	23.1%	22.4%	22.9%	
Previous Year %	28.8%	28.3%	29.7%	
National Average %	27.3%	29.6%	28.3%	

Cardiac Survival - Utstein

	Jan-18	Feb-18	Mar-18	12 Months
Actual %	10.7%	25.8%	22.2%	
Previous Year %	10.7%	20.7%	16.7%	
National Average %	22.5%	25.5%	27.6%	

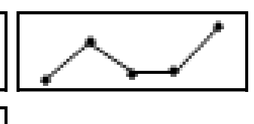
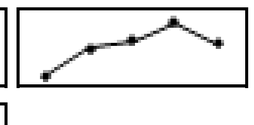
Cardiac Survival - All

	Jan-18	Feb-18	Mar-18	12 Months
Actual %	3.6%	8.0%	5.5%	
Previous Year %	3.4%	4.0%	6.7%	
National Average %	6.5%	8.6%	9.0%	

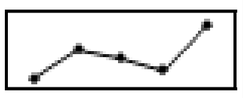
Acute ST-Elevation Myocardial Infarction (STEMI) Care Bundle Outcome

	Jan-18	Feb-18	Mar-18	12 Months
Actual %	61.2%	58.1%	67.8%	
Previous Year %	65.6%	68.4%	65.6%	
National Average %	75.3%	tbc	tbc	

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

	Jan-18	Feb-18	Mar-18	12 Months
Mean (hh:mm)	02:12	02:12	02:22	
National Average	02:12	02:11	02:16	
90th Centile (hh:mm)	03:03	03:12	03:01	
National Average	03:00	03:01	03:01	

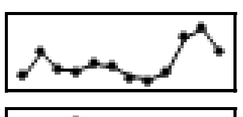
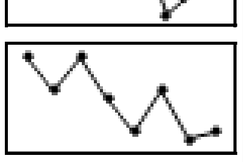
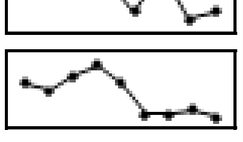
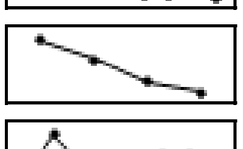
Stroke - call to hospital arrival

	Jan-18	Feb-18	Mar-18	12 Months
Mean (hh:mm)	01:08	01:11	01:14	
National Average	01:24	01:19	01:18	
50th Centile (hh:mm)	01:03	01:01	01:06	
National Average	01:10	01:11	01:12	
90th Centile (hh:mm)	01:41	01:45	01:49	
National Average	02:00	01:57	02:00	

Stroke - assessed F2F diagnostic bundle

	Jan-18	Feb-18	Mar-18	12 Months
Actual %	94.6%	96.4%	96.5%	
Previous Year %	94.9%	97.3%	94.1%	
National Average %	97.2%	96.9%	tbc	

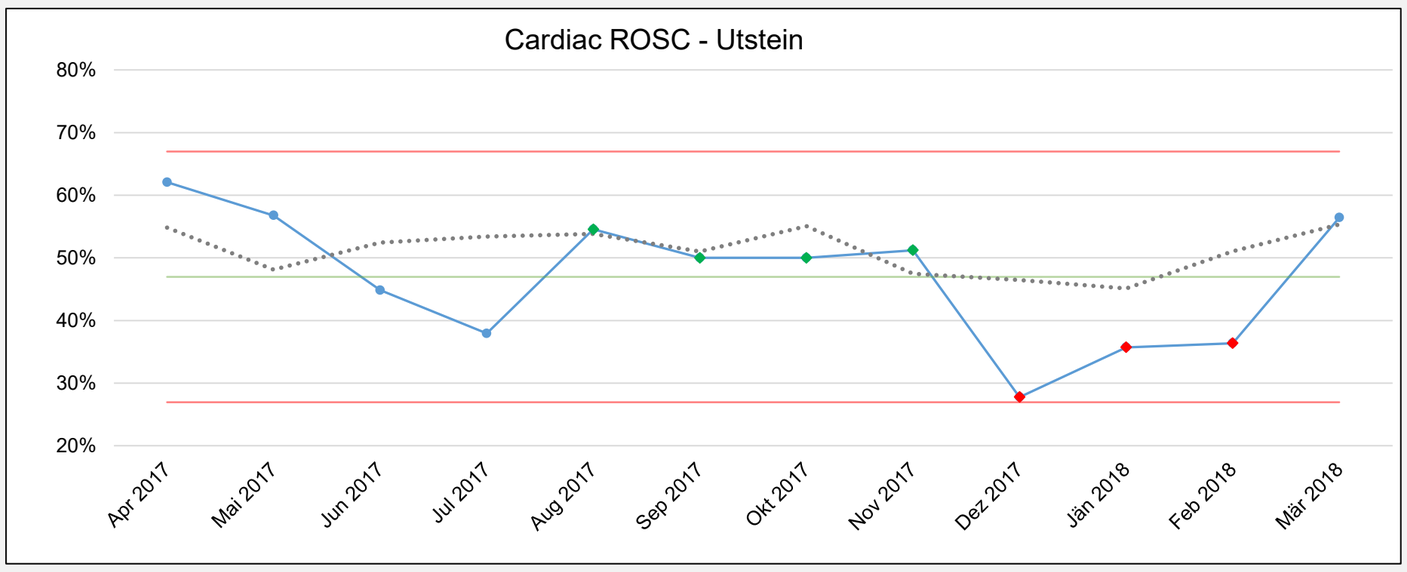
Medicines Governance

	May-18	Jun-18	Jul-18	12 Months
Total Number of Medicines Incidents	138	153	114	
Single Witness Sig/Inapt Barcode Use CDs Omnicell	10	17	12	
Single Witness Sig/Inapt Barcode Use CDs Non-Omnicell	6	0	1	
Total Number of CD Breakages	14	15	13	
PGD Mandatory Training	277	141	75	
Key Skills Medicine Governance	548	527	363	

Medicines Management

	May-18	Jun-18	Jul-18	12 Months
Number of Audits	172	200	184	
Number of audits %	98%	98%	97%	

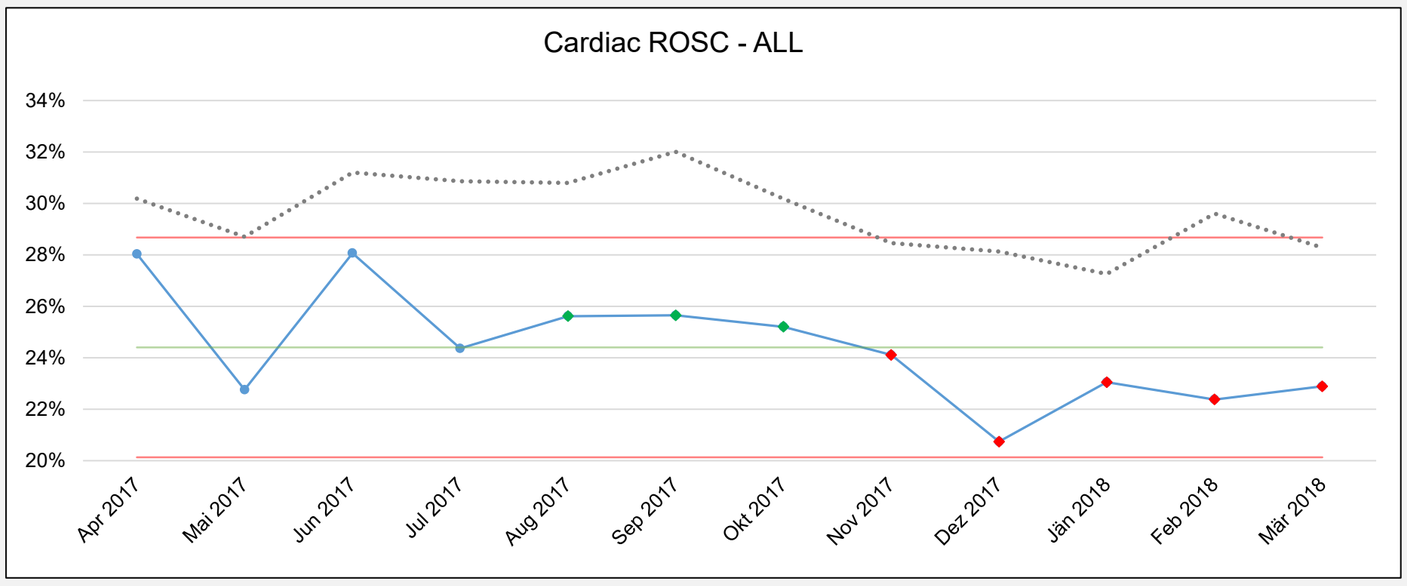
SECAmb Clinical Safety Charts



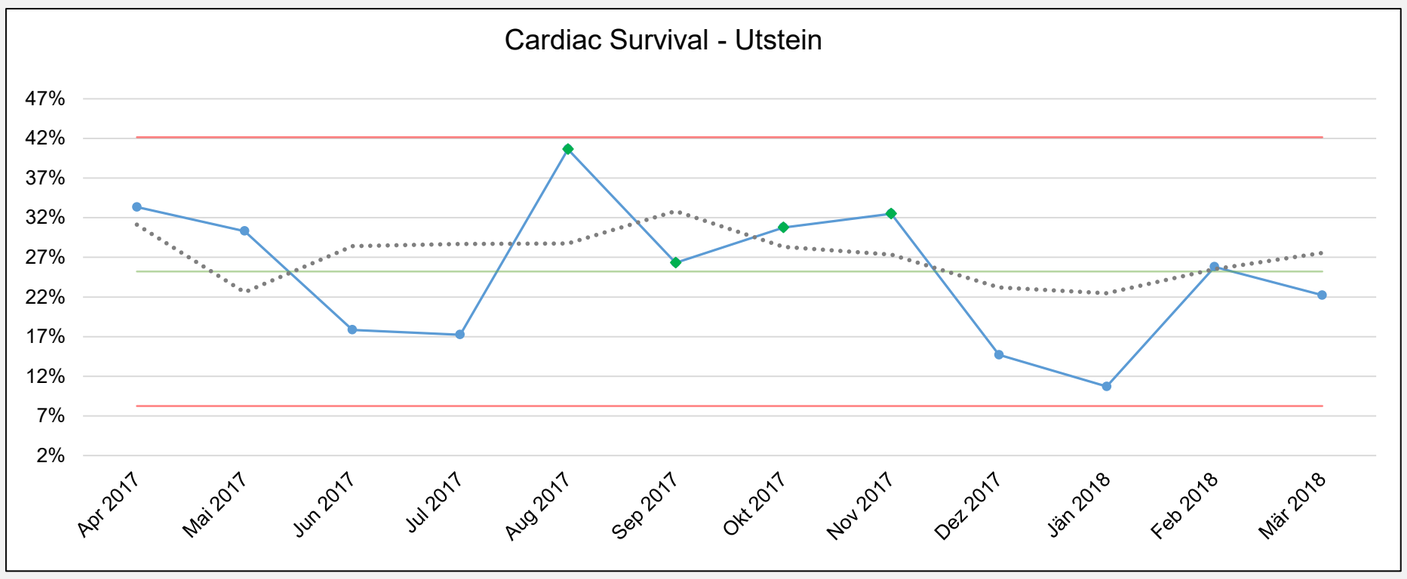
Performance for the cardiac arrest ROSC indicator for the Utstein group for March 2018 is above the SECAmb YTD and the National Average.

The Medical Directorate has allocated a Senior Clinician to lead on the Trust's Cardiac Arrest Survival Improvement Programme. 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.

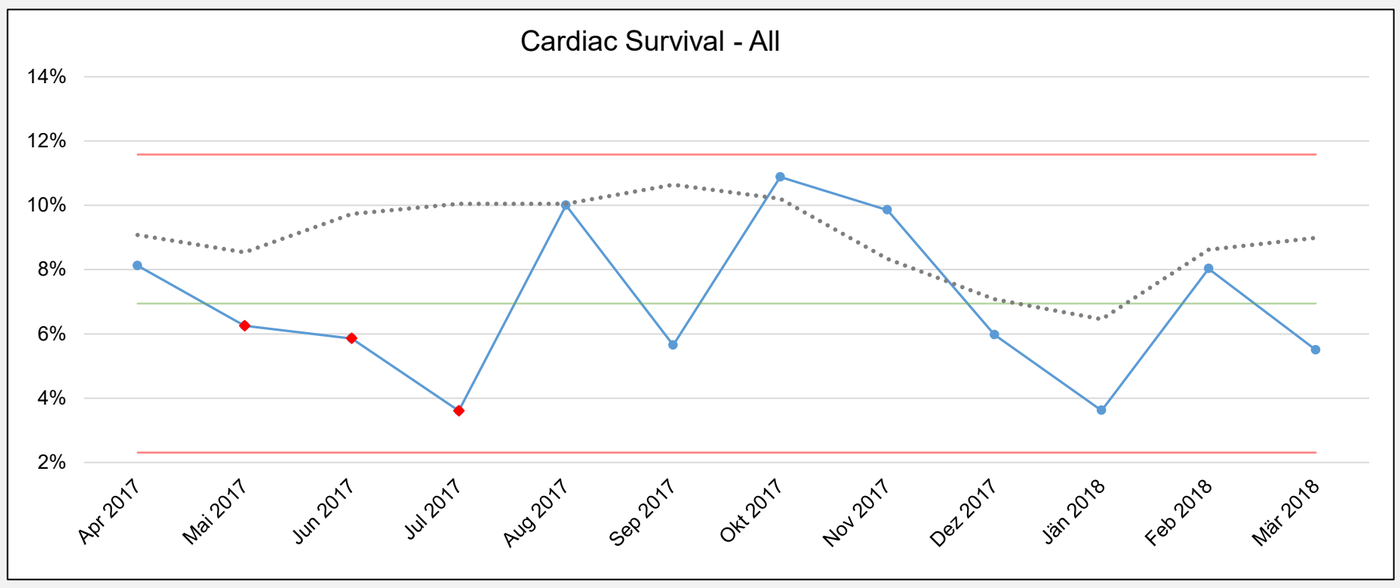
Key skills training for 2018/19 is underway and includes resuscitation training.



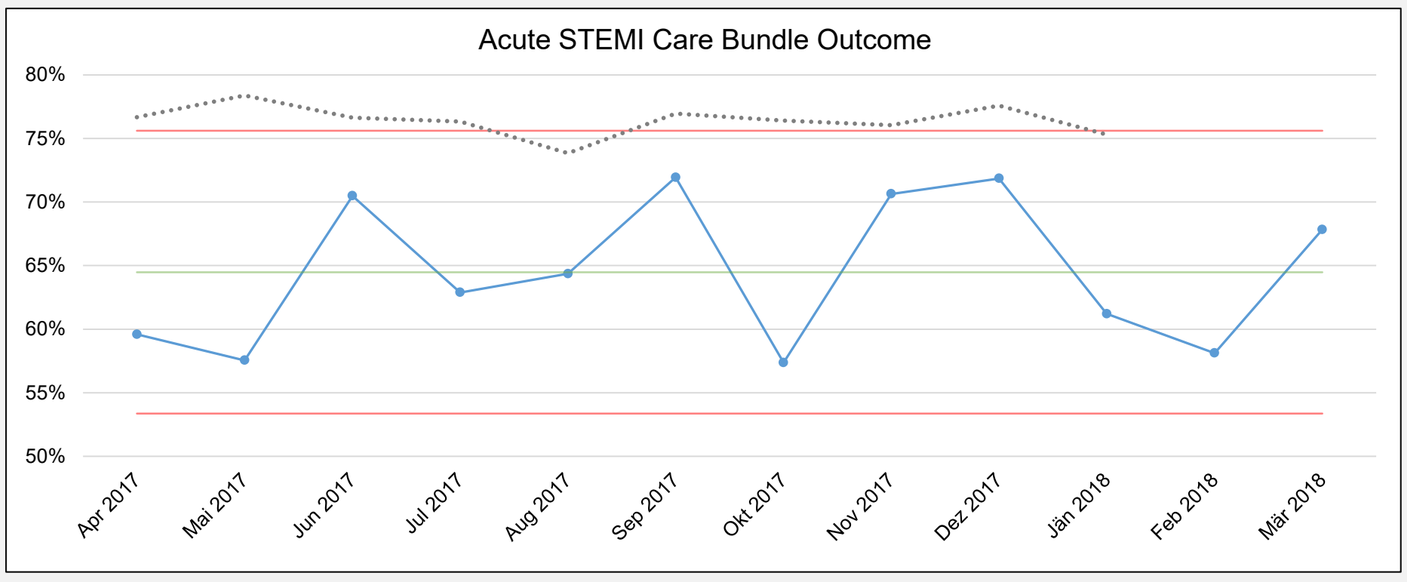
In March 2018 our performance for ROSC in all patient groups remains below the SECAmb YTD average and below the national average.



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



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

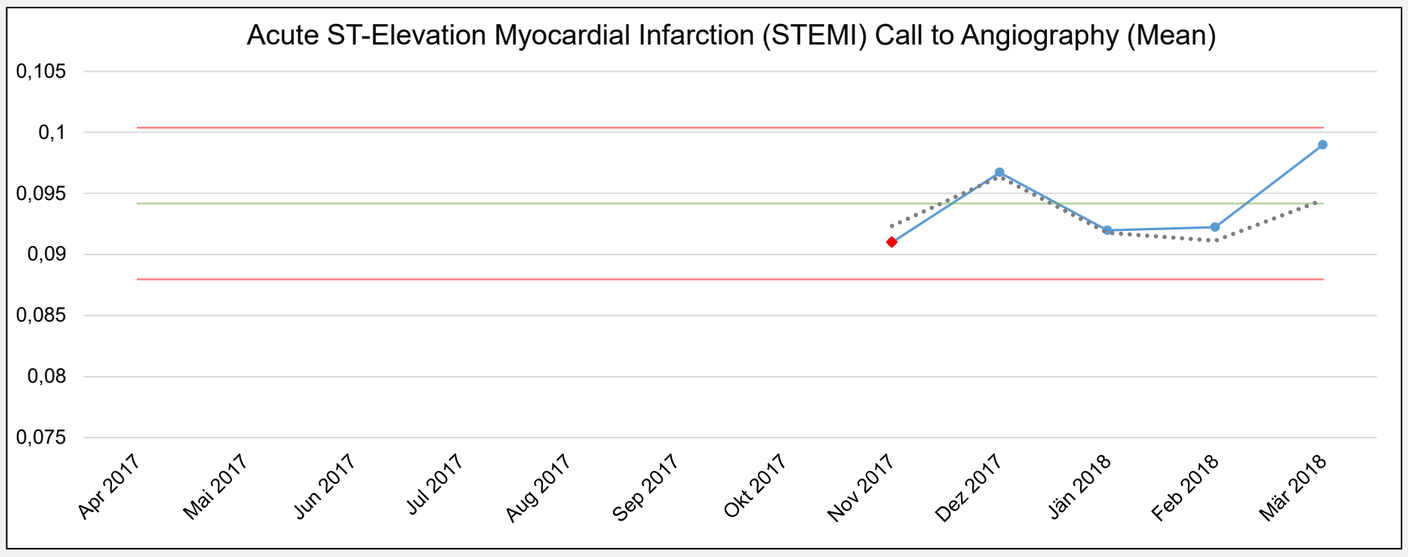


Performance for March 2018 was above the SECAmb average.

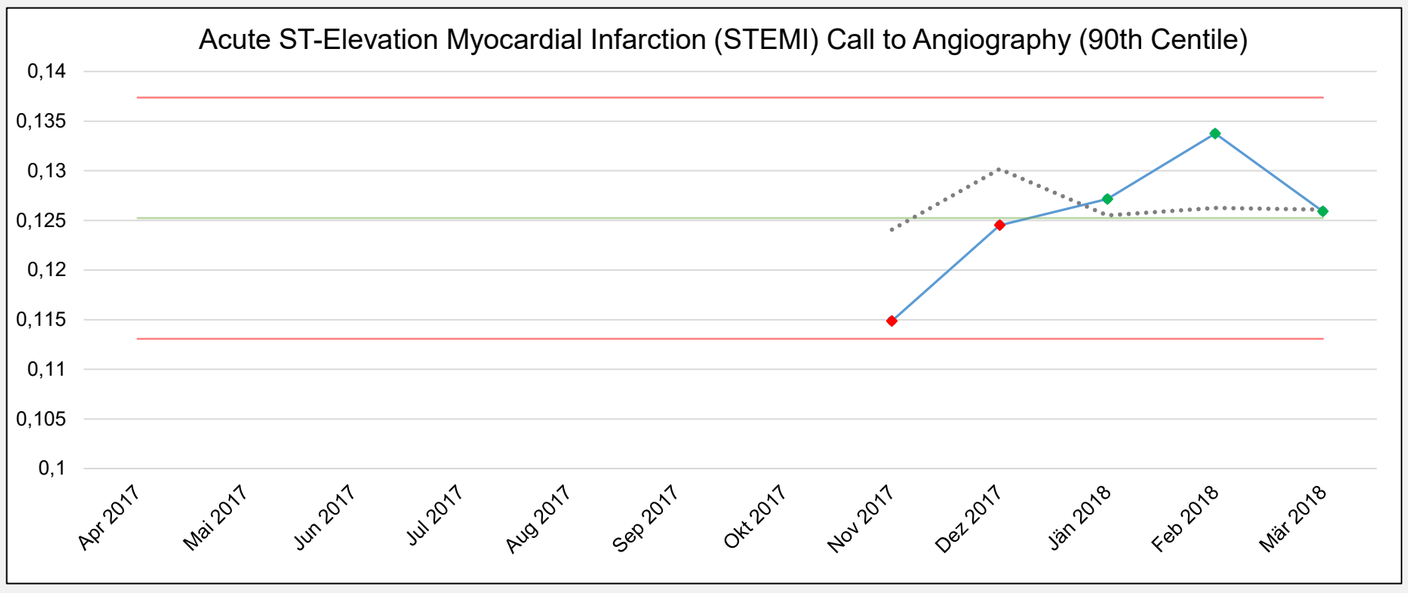
Dashboards and Quality Scorecards showing local performance levels are now routinely being shared with Operating Units (OUs) to facilitate focussed quality improvement. A suite of feedback tools and information sheets has also been developed.

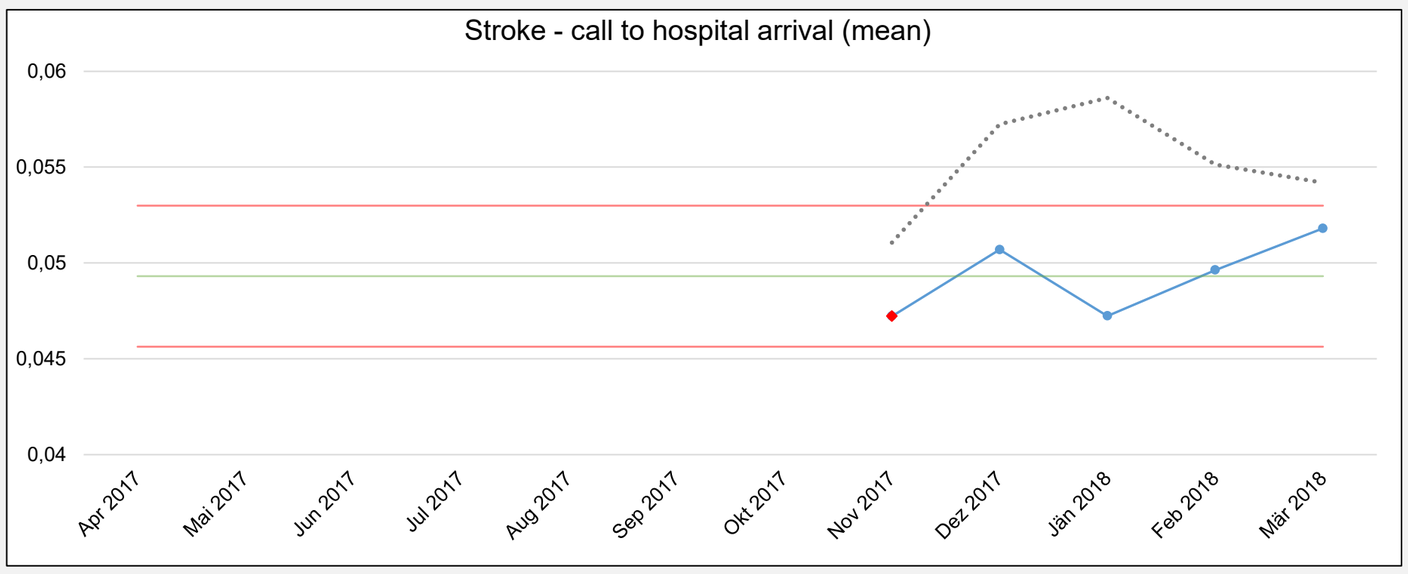
Focussed improvement work is planned for OUs whose average performance is outside of the expected parameters

SECAmb Clinical Safety Charts

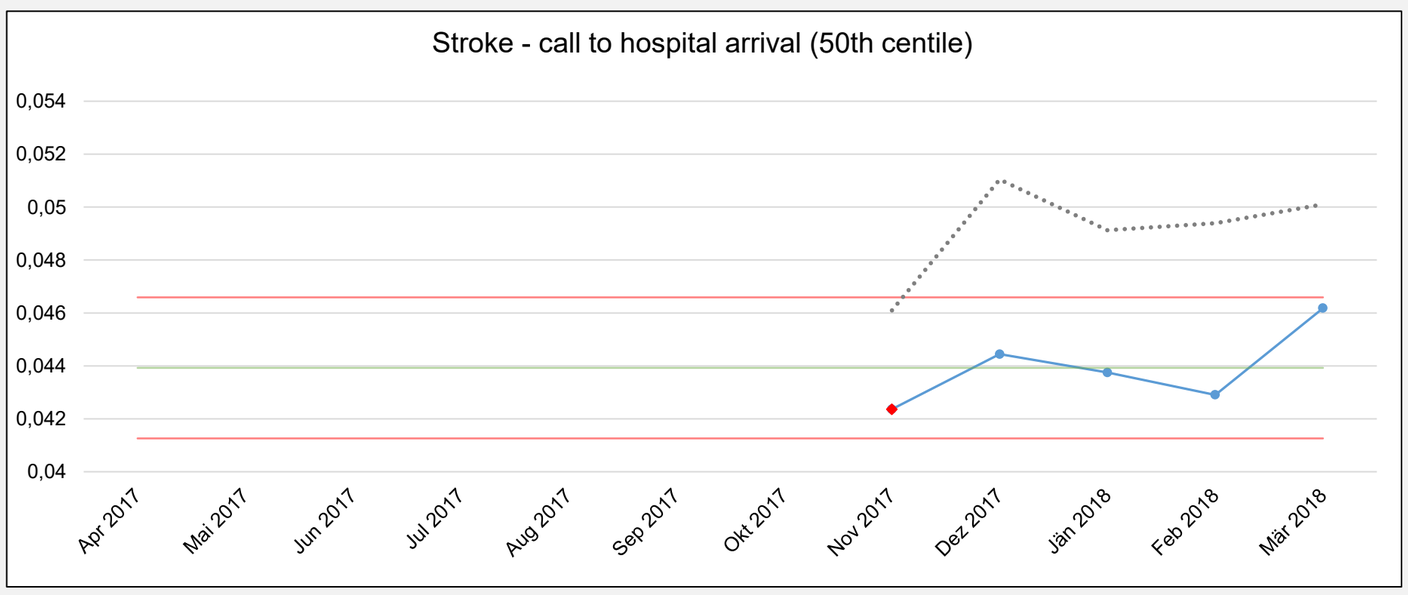


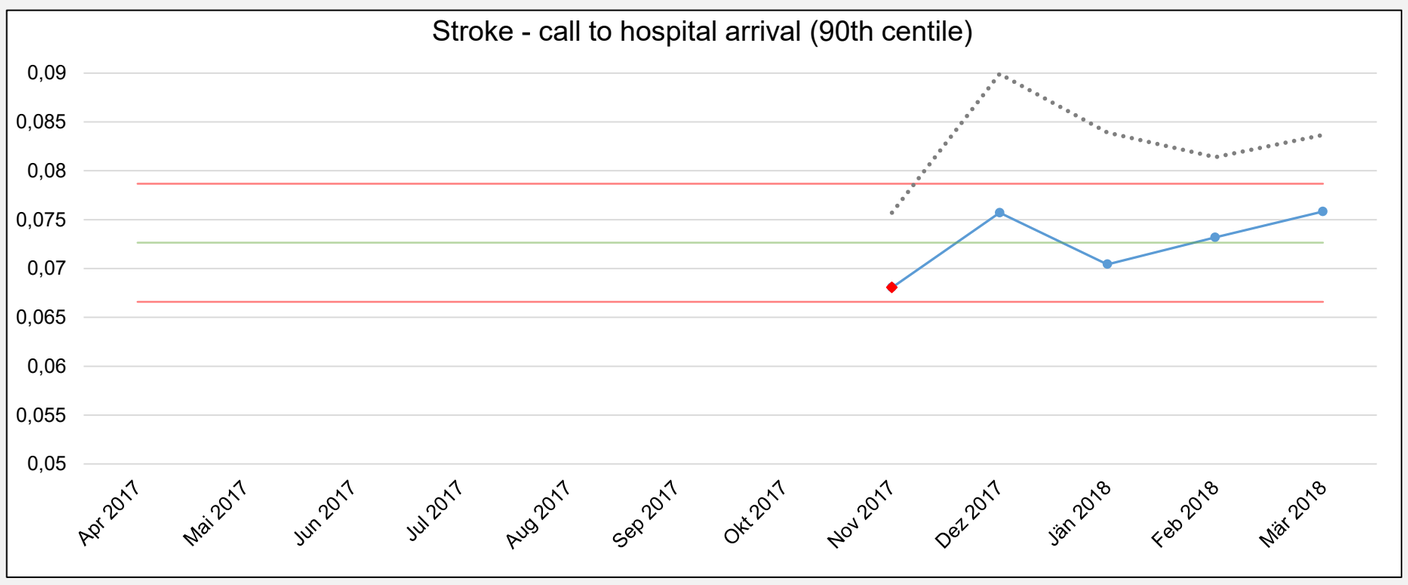
Mean performance is above with the National Average. Our 90th centile performance is above the National Average. Which shows that STEMI patients that SECAmb care for tend to receive more timely STEMI care.



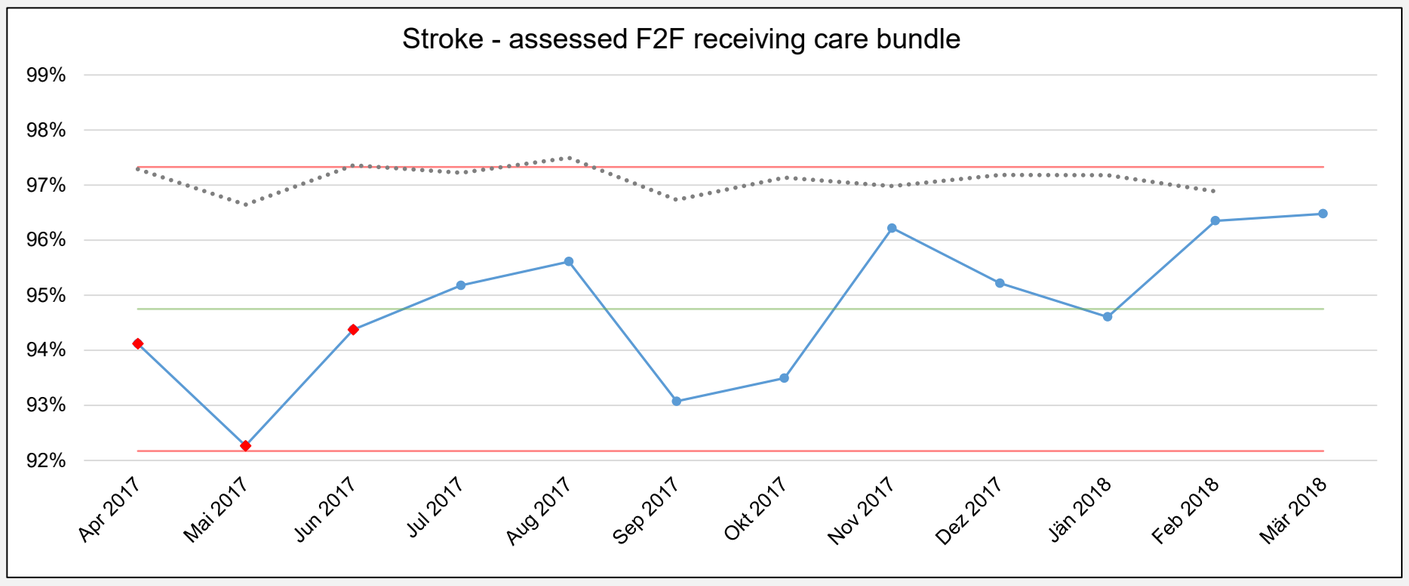


Our mean performance for March 2018 is above the SECAmb average, but below the national average. Our median performance was above SECAmb average, but below the national average. Our 90th centile time was above the SECAmb and below the national average.





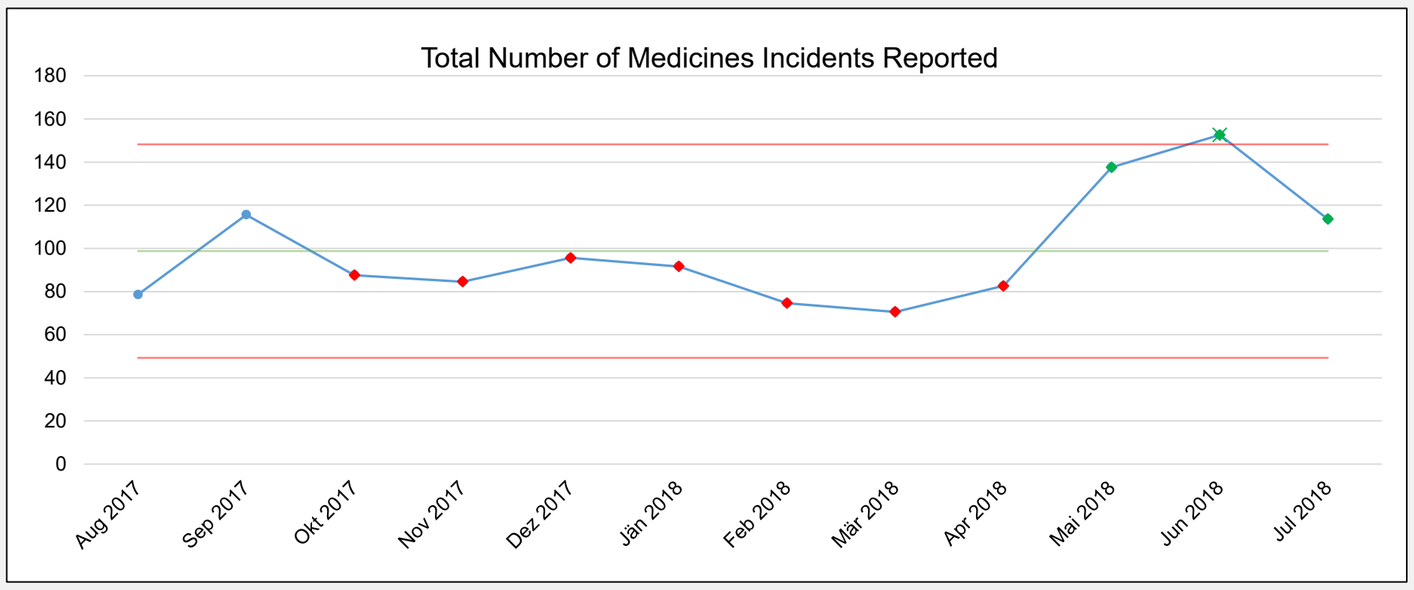
SECAmb Clinical Safety Charts



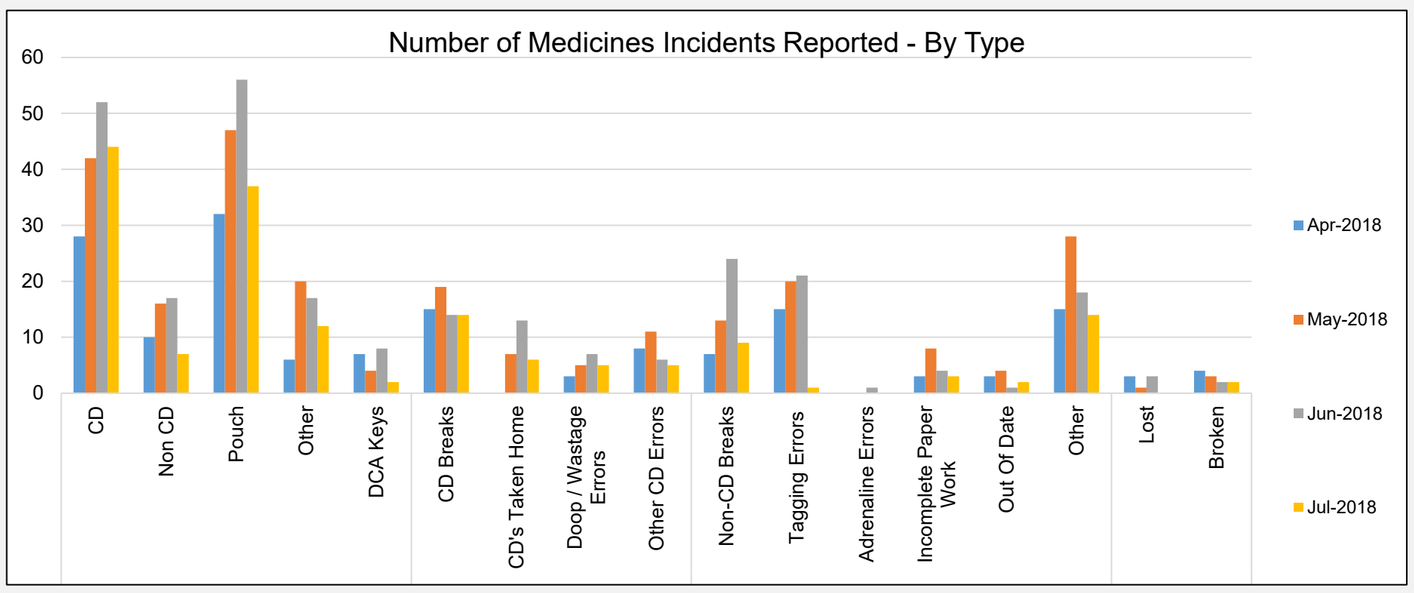
Performance in completing the Stroke Care Bundle is above the SECAmb national average.

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

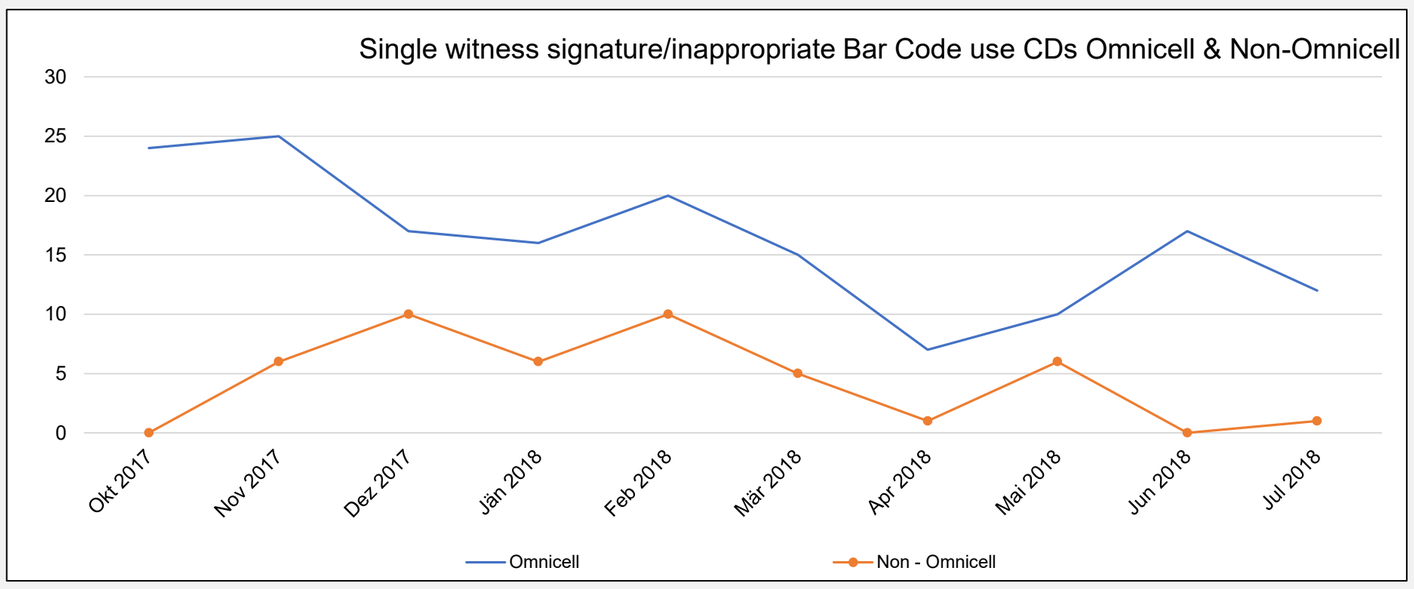
Focussed improvement work is planned for operating units whose average performance is outside of the expected parameters.



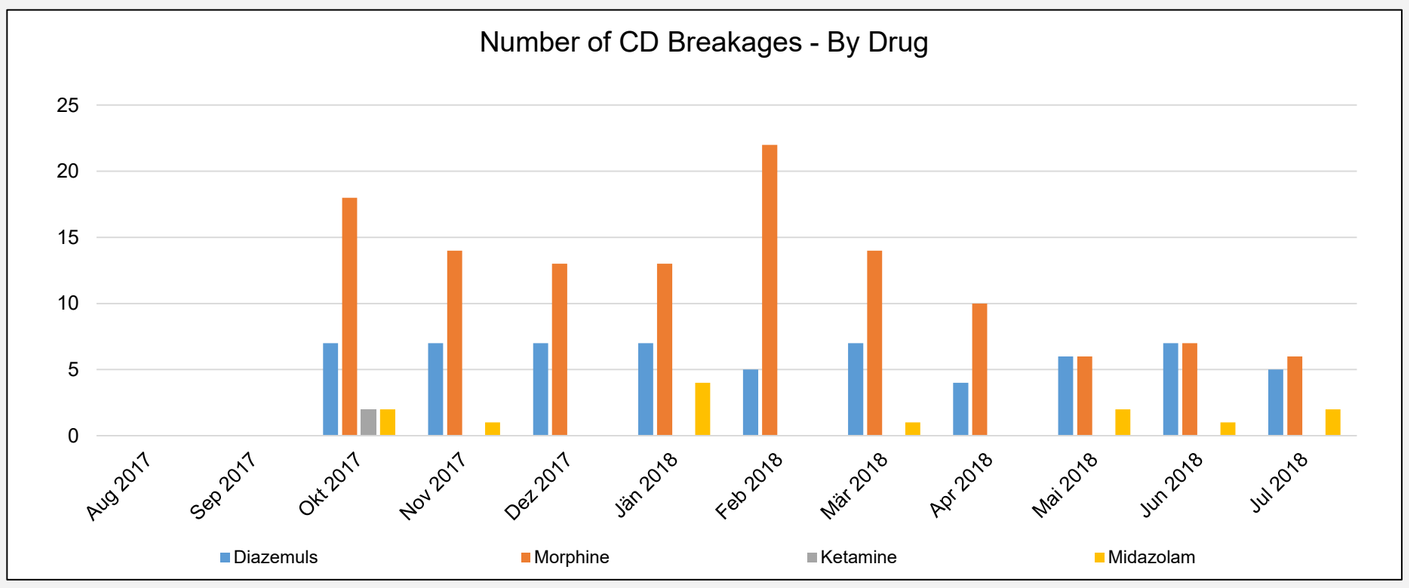
June appears to have been an outlier in terms of incident reporting. July has seen a return to previous levels. There are still incidents occurring where staff take Controlled Drugs home at the end of their shifts. A process is in place to ensure the drugs are returned without delay, and feedback is provided targeting any staff member who takes CDs home more than once.
A small number of drug administration errors are being reported and used as learning exercises. Medicines Governance Team are supporting with some of these incidents.



This relates to graph 1 (above).
Tagging errors with medicines pouches and incomplete paperwork continue to be reported by operational staff. Pouch review is required.
CDs incidents continue to be reported well around SOP compliance, breakages and full track and trace.

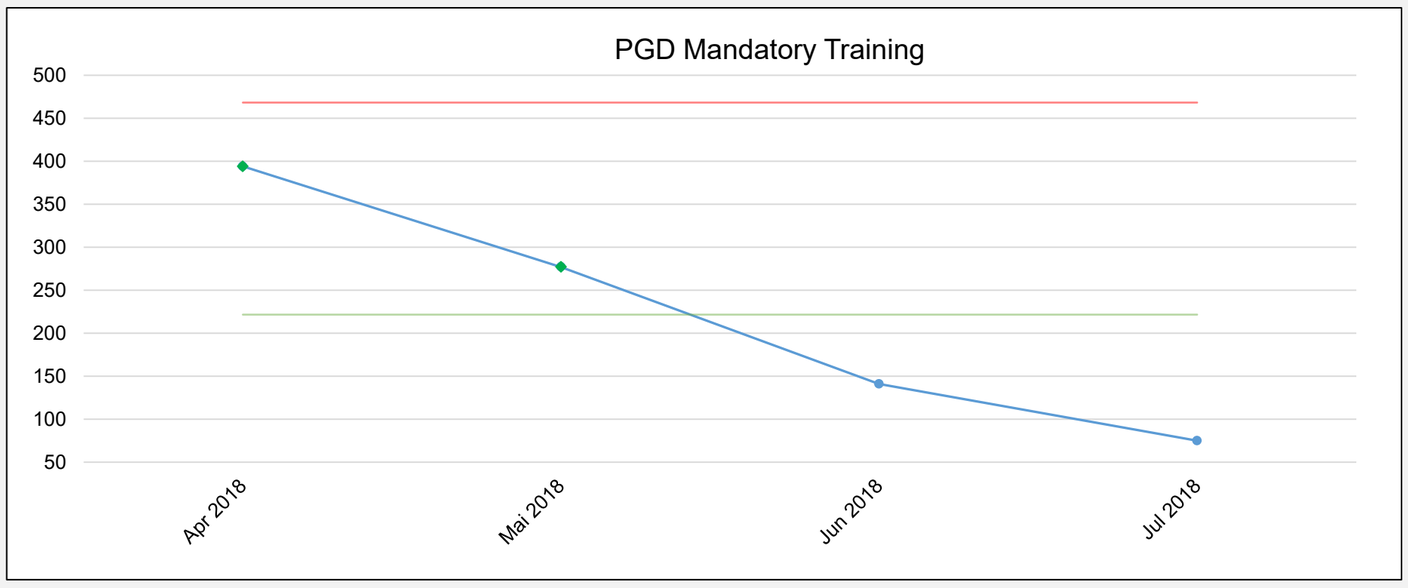


The number of single signatories for Omnicell sites has decreased significantly. Generally it is possible to find another staff member to provide second witness. This is not always as easy in the non Omnicell sites, but the numbers here are small, and generally decreasing. Weekly reports on this activity are sent to OTLs and reports are sent back to medicines governance team on authorised single witness signatures.

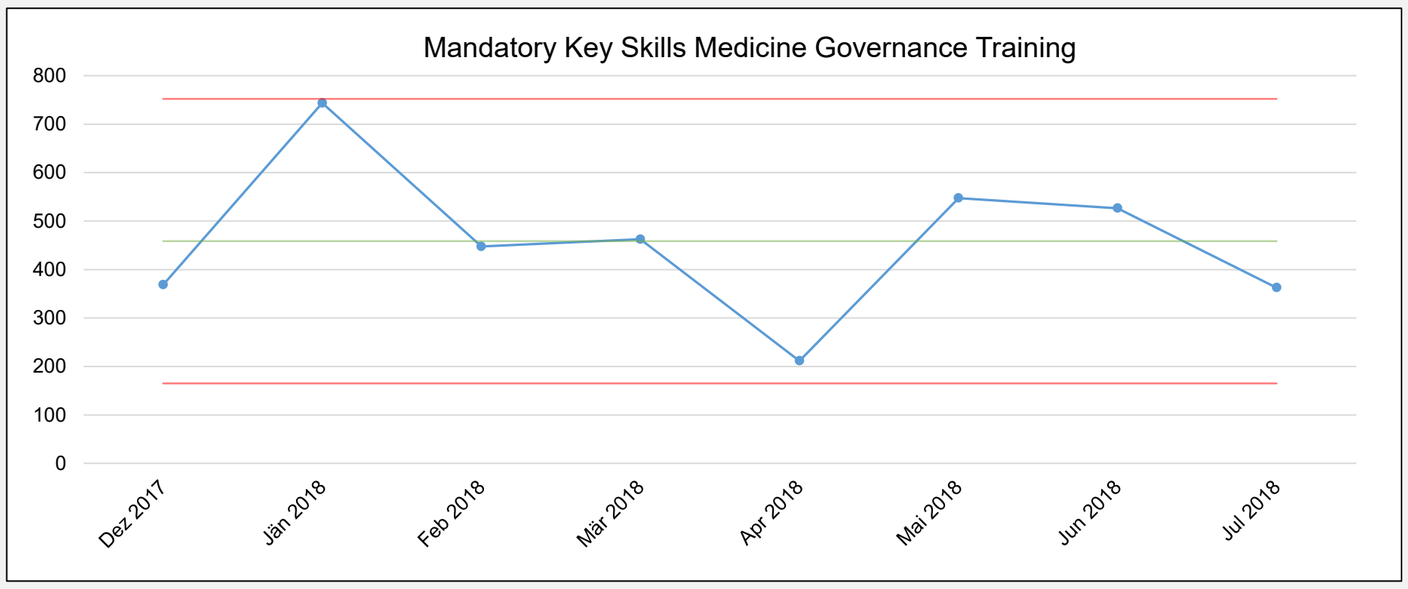


Total CD breakages are reduced by 76% for July 2018 when compared to same month in 2017. July 2017 saw 59 CD Breaks compared to only 14 during July 2018.
Midazolam and ketamine are only available to CCPs whereas morphine and diazemuls are used by all Paramedics.

SECAmb Clinical Safety Charts



Current numbers trained are in medicines governance key skills are 1664 members of staff



Current numbers trained are in medicines governance key skills are 1664 members of staff
Consistent levels of statutory and mandatory training are seen

Analysis of Cardiac Arrest Data - March 2018

Total number of cardiac arrests identified = 759

Number of resuscitation attempts = 297
excluding DNACPR (81) , DOA (371) , No Resus by SECAmb (8) ,
Did Not Convey (1), 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) = 39 (13%) **Cardiac Arrests (All incidents) = 297 (100%)**

ROSC sustained to hospital (Utstein) = 22 (56%) + 0 non ROSC

ROSC sustained to hospital (All) = 68 (23%) + 3 non ROSC

Outcomes for ROSC at hospital and non ROSC at hospital patients		
Utstein	Details	Overall
8	Patient survived to discharge	16
11	Patient died in hospital	49
1	Patient still in hospital*	2
2	Outcome unknown* (Patient data incomplete/unable to trace)	4

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

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

Survival to Discharge (All) = 16 (5.5%)

Additional Information - Resuscitation Attempts

Cardiac Rhythm	Overall Totals	ROSC at Hospital	Non ROSC at Hospital
Asystole	166 (56%)	21	3
PEA	60 (20%)	13	0
VF	55 (19%)	30	0
Non-shockable	1 (0%)	1	0
Not recorded	15 (5%)	3	0

CPR Bystander - 192

EMS Witnessed arrest - 40

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

Analysis of Cardiac Arrest Data by area - March 2018

Number of resuscitation attempts = 297

Cardiac Arrests (Utstein) East = 16 (5%)	Cardiac Arrests (All) East = 120 (40%)
Cardiac Arrests (Utstein) West = 23 (8%)	Cardiac Arrests (All) West = 177 (60%)

ROSC sustained to hospital (Utstein) East = 7 (44%)	ROSC sustained to hospital (All) East = 29 (24%) + 1 non ROSC
ROSC sustained to hospital (Utstein) West = 15 (65%)	ROSC sustained to hospital (All) West = 39 (22%) + 2 non ROSC

Outcomes for ROSC at hospital and non ROSC at hospital patients

Area	Utstein	Details	Overall
East	3	Patient survived to discharge	7
West	5		9
East	4	Patient died in hospital	21
West	7		28
East	0	Patient still in hospital*	0
West	1		2
East	0	Outcome unknown* (Patient data incomplete/unable to trace)	2
West	2	Outcome unknown* (Patient data incomplete/unable to trace)	2

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 = 3 (19%)	Survival to Discharge (All) East = 7 (6%)
Survival to Discharge (Utstein) West = 5 (25%)	Survival to Discharge (All) West = 9 (5%)

Mental Health Care – July 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 = AMBER

1. The mental health indicator has been rated AMBER as the mean response measures are just outside of cat 2 standard. Cat 2 = 00: 21:32 . 90th Centile= 00:43:38

Mental Health Response Times (Section 136 MHA)

2. During July 2018 there were 140 Section 136 related calls to the service.117 of these calls received a response (83.57%) (87.5% in June) resulting in a conveyance to a place of safety by an ambulance on 108 (77.14% of total calls; in June this was 83.8%of total calls) on these occasions.

3. The overall performance mean shows a response time across the service as 00:21.32 (June was 00.18.41). Against the 90th centile measure, the response was 00:43:38 (June was 00.40.17).

4. There were six transports of under 18's.

5. There were 23 occasions when SECAmb did not provide a response. This is down from 17 in June, however the activity is slightly higher. 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 7 Total responses 4 Total transports 4
Performance Mean 00.37:51 90th centile 01:27:59
Cat 4: Total calls 0 Total responses 0 Total transports 0
C60 HCP: Total calls 4 Total responses 2 Total transports 2
Performance Mean 00:42:22 90th centile 00:53:24
C120 HCP: Total calls 4 Total responses 2 Total transports 1
Performance Mean 01:30:46 90th centile 01:34:40
C240 HCP Total calls 0 Total responses 0 Total transports 0

The overall performance means are just outside of standard on both measures.

A data validation protocol has been initiated for all Sec 136 calls. This will be evaluated and any concerns/points of learning will be fed back to the EOCM, EMATL/DTL.

SECAmb Clinical Quality

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

a) Hand Hygiene compliance has increased slightly to 89% (against the target of 90%). Bare Below the Elbow compliance has also increased slightly to 94% this month. Make Ready Centre Deep Clean rates have increased slightly again to 95%, despite issues in Chertsey. Vehicle Preparation areas are below target at 97%, due to issues in Brighton. Environmental audit compliance remains low whilst staff adopt the new requirements.

b) Safeguarding referral rates continue to increase (currently a 23% increase compared to July 2017). Four new safeguarding data requests have been received this month for ongoing case reviews, totalling eleven year to date. 2018/19 training on harmful behaviours (coercive and controlling) has a 51% completion rate to date. Training on Level 2 child safeguarding for all operational staff is 57% and for Level 2 adult safeguarding (both e-learning) is 58%

c) The Trust continues to see an increase in incident reporting with a total of 772 reported in July (712 in June). The allocation of investigators has increased to 100 (87 in June). Timeliness of the investigation (deadline for completion is 20 working days) has increased to 206 (194 in June). The number of overdue incidents investigated within 20 working days is 117 (80 in June).

d) Nine serious incidents (SI) were reported in July (10 in June). 73 SIs were open on STEIS at the end of July (61 in June). An increase to 31 (19 in June) were overdue for first submission to the CCG; one was closed this month and a further four were submitted for closure. The Trust achieved 100% compliance with Duty of Candour requirements for SI's. 100% compliance was also achieved for DoC made/attempted within deadline.

e) The Trust received and opened 89 complaints in June against a monthly average for the year of 104. 98% of complaints were due for conclusion in June. 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 (n=16). The significant improvement in complaints response timeliness since the end of January 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.

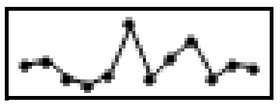
f) Quality Account Priorities
i) Priority Area 1 - Improving outcomes from out-of-hospital cardiac arrests: Key points at end Q1 include the average time to start CPR is circa 3.5 minutes; there is no routine training on cardiac arrest in EOC and No No Go is not being consistently deployed. Training to mitigate these is being planned.
ii) Priority Area 2 - Learning from incidents, complaints and safeguarding reviews: A number of metrics are already in place, and others will be developed for learning. A Shared Learning Discussion Group has been established and to oversee the learning from complaints and incidents.
iii) 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.

SECAmb Clinical Quality Scorecard

Number of Incidents Reported

	May-18	Jun-18	Jul-18	12 Months
Actual	722	712	770	
Previous Year	576	586	595	

Number of Incidents Reported that were SI's

	May-18	Jun-18	Jul-18	12 Months
Actual	6	10	9	
Previous Year	6	7	8	

Duty of Candour Compliance (SIs)

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

Number of Complaints

	May-18	Jun-18	Jul-18	12 Months
Actual	101	88	103	
Previous Year	79	102	82	
Complaints Timeliness (All	99.1%	99.0%	98.8%	
Timeliness Target	95%	95%	95%	

Compliments

	May-18	Jun-18	Jul-18	12 Months
Actual	131	133	177	

Hand Hygiene

	May-18	Jun-18	Jul-18	12 Months
Actual %	90%	88%	89%	
Target	90%	90%	90%	

Safeguarding Training Completed (Adult) Level 2

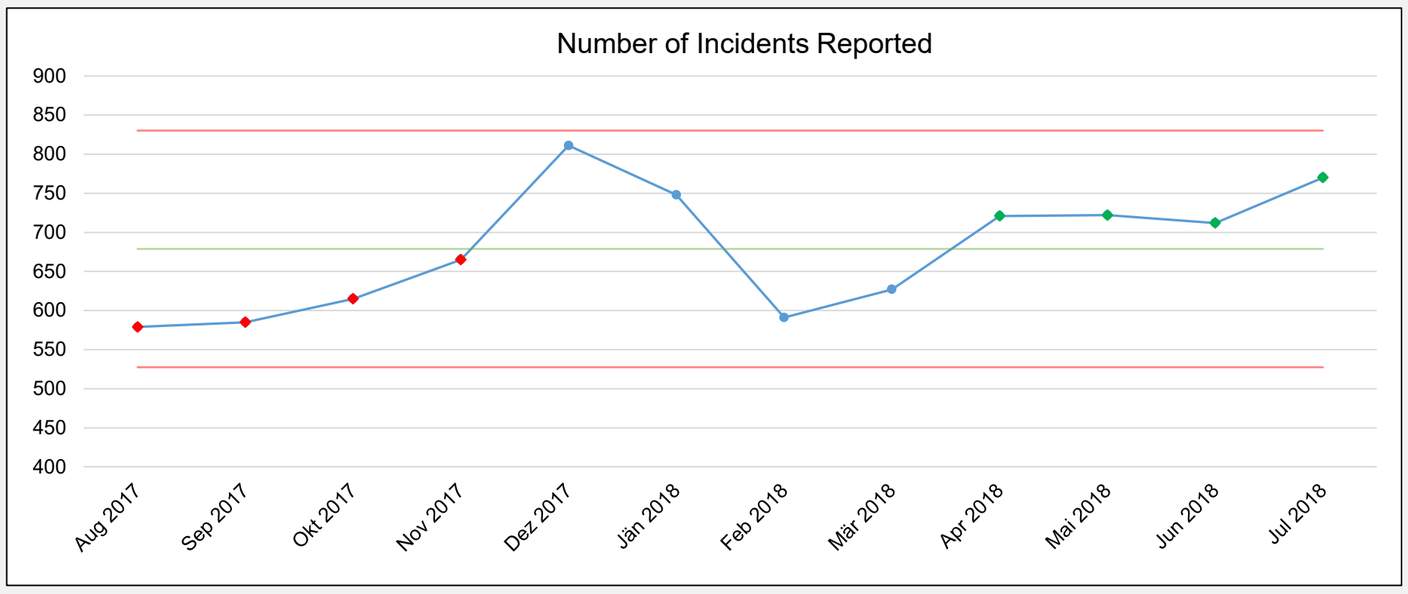
	May-18	Jun-18	Jul-18	12 Months
Actual %	26.05%	37.97%	58.69%	
Previous Year %	20.00%	21.07%	26.65%	
Target	85%	85%	85%	

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

Safeguarding Training Completed (Children) Level 2

	May-18	Jun-18	Jul-18	12 Months
Actual %	25.88%	38.18%	57.62%	
Previous Year %	21.00%	21.33%	20.54%	
Target	85%	85%	85%	

SECAmb Clinical Quality Charts

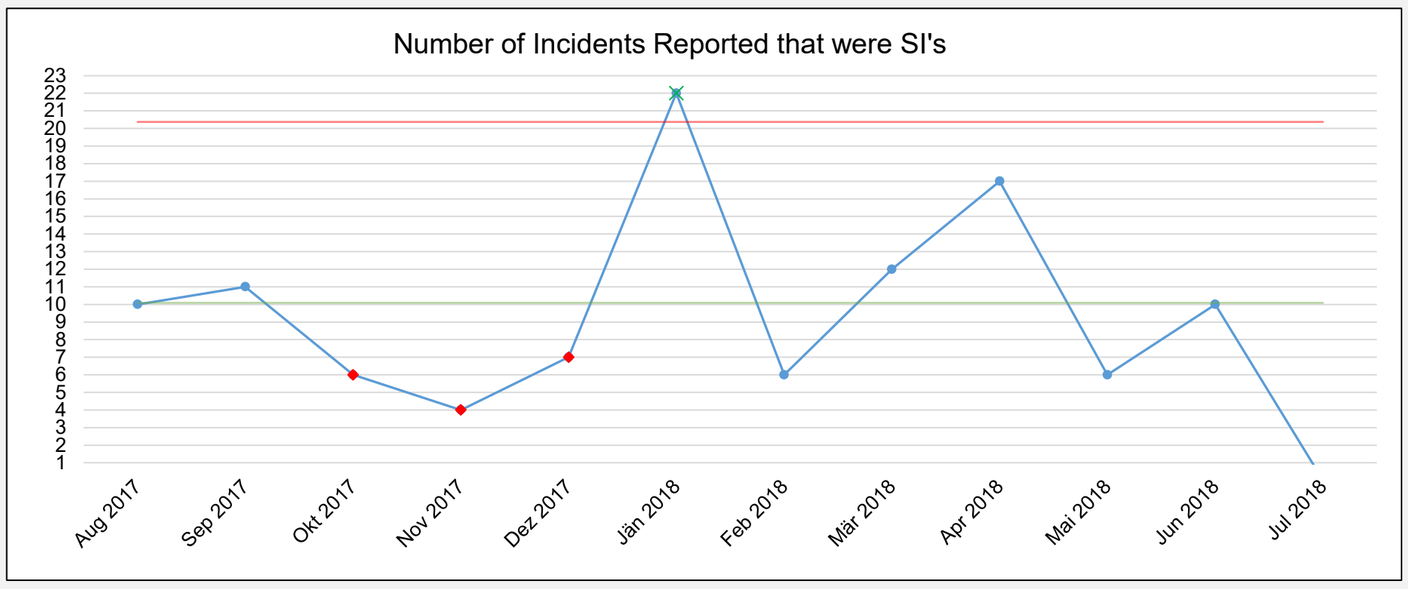


There were 772 incidents reported in July.

July 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 due to weather conditions.

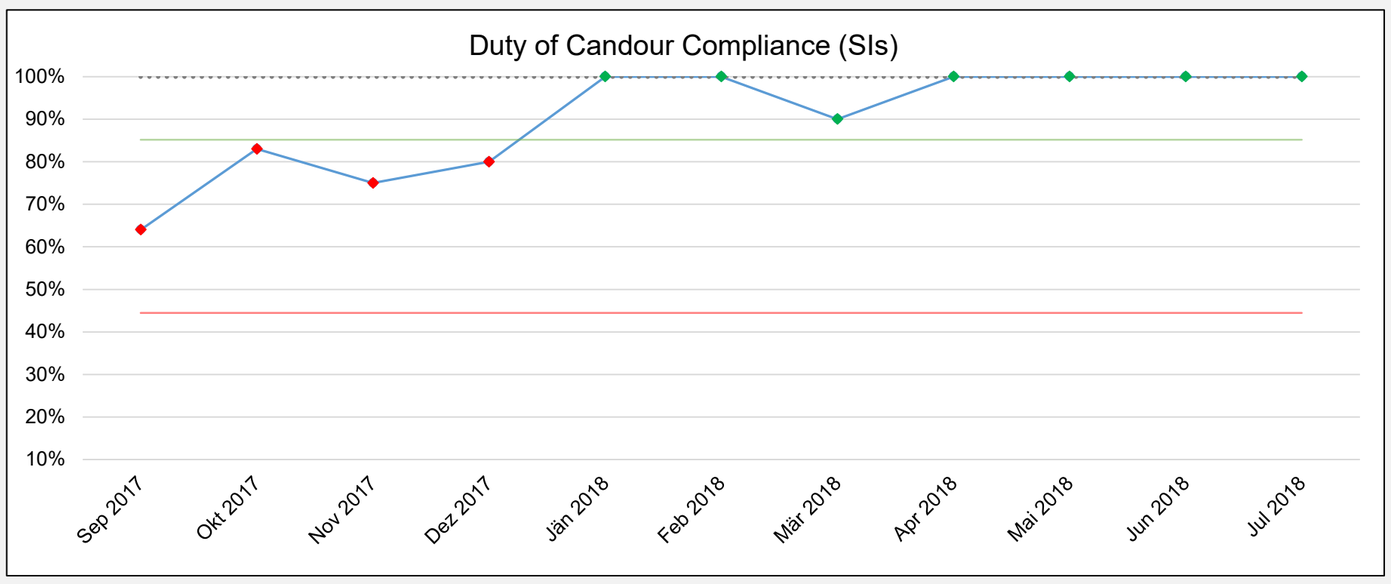
The most reported incidents were around meal breaks that crews didn't have the chance to take, with 67 reported across the Trust. In terms of Operating Units, Emergency Ops Control reported the most incidents with 186. The majority of these reported were around meal breaks.

The Trust reported 138 incidents to NRLS in July 2018. Following on from this the Trust closed 671 records in July.

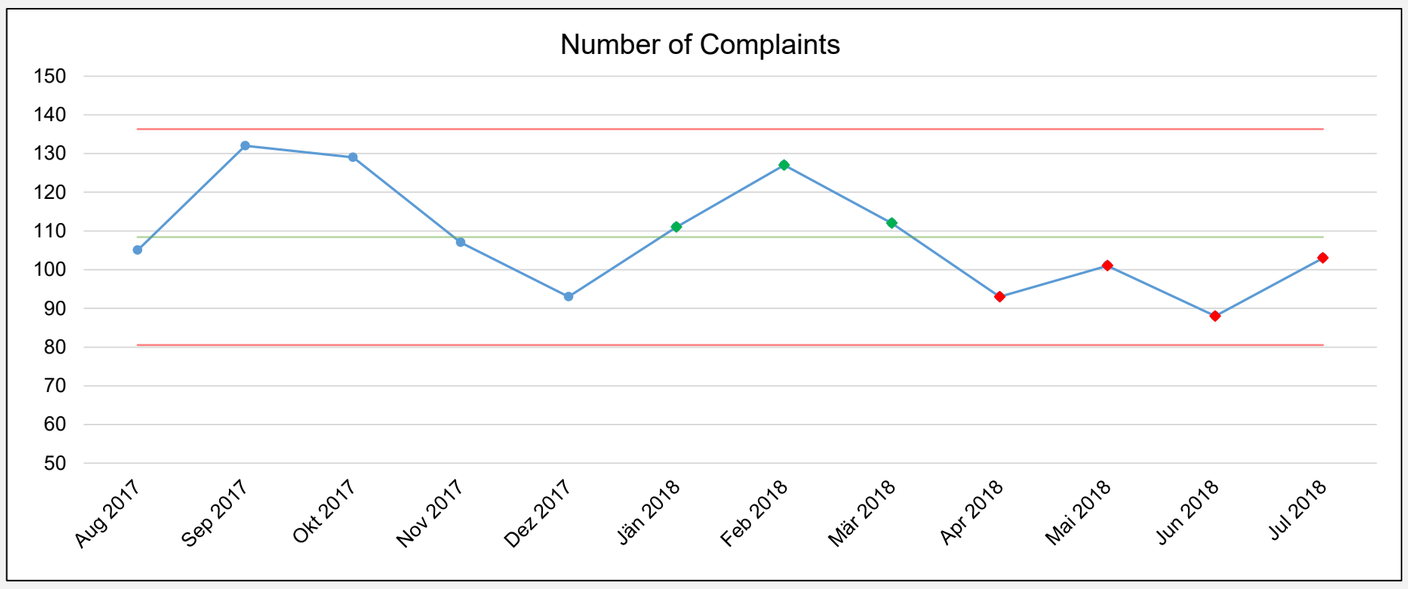


The Trust reported 9 SIs in July for the following reasons:

Call Answer Delay	2
Delayed Dispatch / Attendance	2
Staff Conduct	1
Power/ Systems failure	1
Treatment / Care	1
Triage / Call Management	2



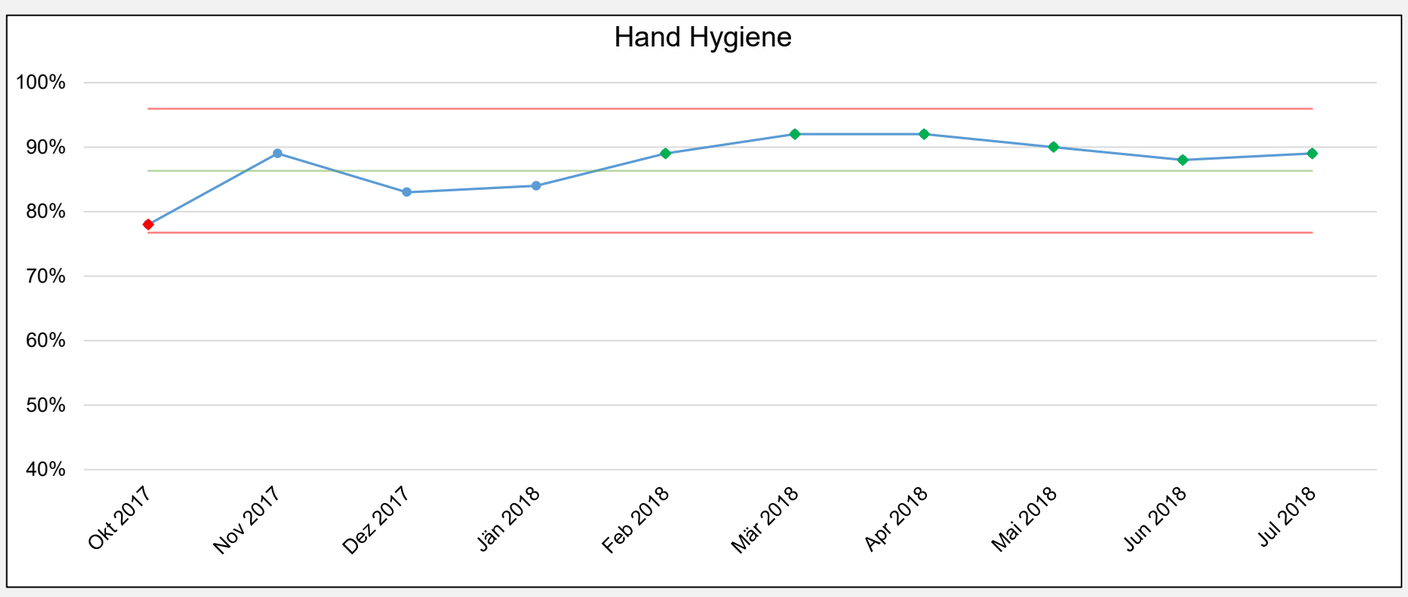
All Duty of Candour (DoC) initial contact within 10 days has been achieved for declared SIs. Datix has been updated to capture SI DoC data and evidence.



The Trust received and opened 102 complaints in July 2018, (88 in June and 101 in May), and against a monthly average of 104 for the year 17/18. The Trust also received a high number of compliments in July, with 176 received against a monthly average of 140 for the year 17/18.

In July the top three complaints sub-subjects were staff behaviour, A&E timeliness, and NHS Pathways (triage). A&E timeliness complaints have increased against last month, with 26 compared to 23 in June, but are still relatively low when compared to February and March. Complaints about triage have also increased, from 17 in June to 23 in July. Of more concern, however, is the increase in complaints about staff behaviours, which numbered 32 this month compared to 20 in June. This is the highest monthly number of complaints about staff behaviour since August *2016.* and will be reviewed at the Area Governance Meetings as part of the monthly QPS report review.

The significant improvement in complaints response timeliness continues, with 100% of complaints responded to within the Trust's 25 working day timescale in July 2018.



Hand Hygiene (HH) and Bare Below the Elbows (BBE) compliance is still being audited using observational audit tools by local OTL's, IPC Champions and some alternative duties staff. Once again we are just below the target of 90% for July but only by 1% (89%). However, BBE is still showing a compliance at 94% against the 90% target.

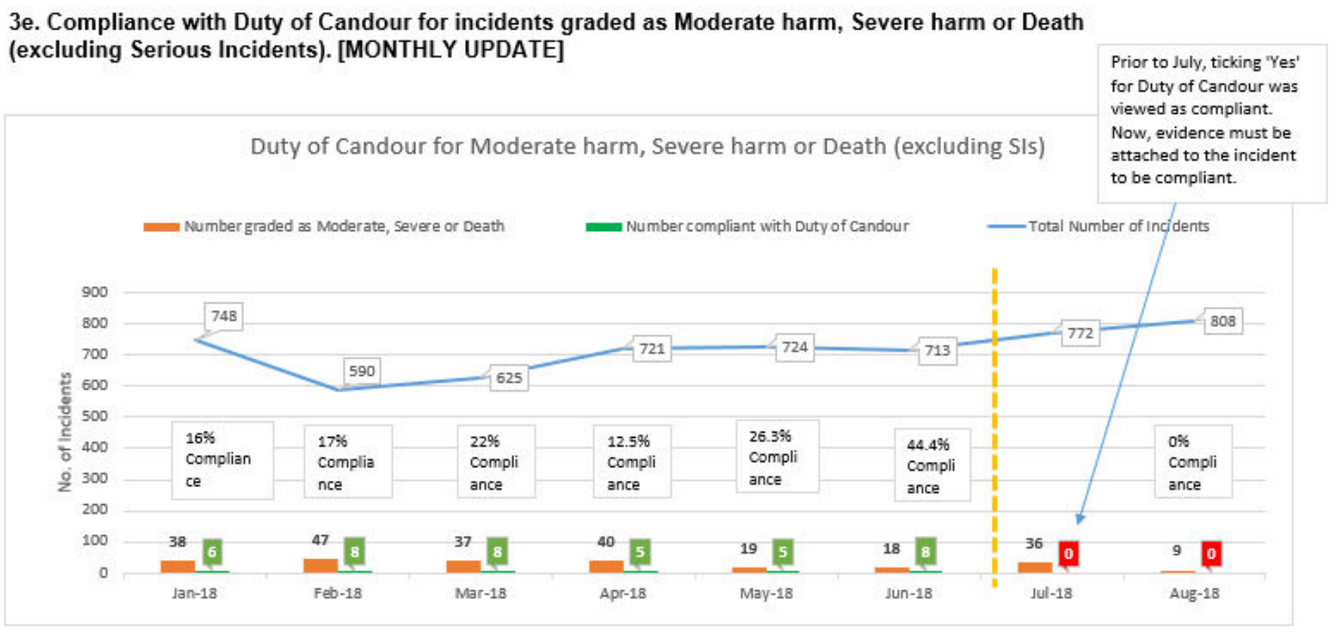
The MRC DC rate has dropped to 95% this month due to one of the sites showing poor returns to the 99% target. The IPC Practitioner for Chertsey will be visiting the site to discuss the reasons behind this drop. VPP are also below target at 97% due to Brighton only showing an 88% compliance level. Increased activity and demand for external event cover by the Brighton OU adversely impacted on their capacity to undertake the audits. The local IPC Champion will be addressing this with the local VPP/MRC Managers. The six weekly VPP deep clean arrangements continue.

SECAmb Duty of Candour and Moderate Harm

The Trusts Serious Incident Group reviews all moderate harm incidents to confirm the correct grade of harm has been recorded, and if not declared an SI these incidents are confirmed as requiring DoC with the Investigating Manager.

Incidents may be investigated as a Level 2 or Level 3 (with an internal Root Cause Analysis (RCA) investigation), however both require DoC.

Based on learning from 2017, a decision was taken to centralise the process and ensure a member of the SI team undertook the initial contact. By January 2018 this change in process facilitated a 100% compliance with the standard, which has been maintained. This is illustrated in the graph below



Compliance with DoC for SIs where DoC was required in July 2018 was: (due in the month):

a) SIs reported (where DoC due in July) – 8
   b) Number where DoC required - 8
   c) DoC made/attempted within deadline – 8

The Trust's MDT training for first line managers being introduced next month includes a session on Duty of Candour.

SECAmb Health and Safety Reporting

Our New Head of Health and Safety, Amjad Nazir, has now joined the Trust. His first task is to work with the project management office to produce an improvement action plan. Progress on this will be reported weekly to the compliance steering group and will go to the workforce and wellbeing committee in October 2018. This initial improvement plan will inform a three-year H&S strategy with the ultimate goal of obtaining ISO45001 accreditation for the Trust. ISO45001 represents a high standard of assurance for management systems of occupational health and safety.
One work stream already being progressed is the development of an audit tool which will allow immediate visibility of compliance data for the local teams and will lead to agreed local action plans improving ownership of H&S at operating unit level.
The third IOSH for Directors course took place and was well attended giving Amjad an opportunity to introduce himself to some of the senior leadership team.
Two further H&S managers were successfully recruited and will start in October 2018.
Multi-disciplinary training for all first line managers has started which will enhance H&S and Risk knowledge along with legislative awareness and responsibilities. It also focusses on the practical use of Datix to improve the quality of investigations and enhance the learning captured from incidents reported by staff.

Violence and Aggression Incidents - See Figure 1 below
This data relates to all reported incidents of violence and aggression including verbal abuse with the trend continuing to rise slowly. It is noted that the Assaults on Emergency Workers (Offences) Bill recently received royal assent, which will hopefully help in addressing this trend by doubling the maximum prison sentence to 12 months, for common assault against emergency workers

Manual handling Incidents - See Figure 2 below

The H&S team will work with clinical education to ensure appropriate lesson plans are developed for next year's statutory and mandatory training programme in order to reverse this upward trend. Improved investigations and shared learning will also increase awareness of best practice for moving and handling.

Health &Safety Incidents - See Figure 3 belowThe number of health and safety incidents reported has dropped, partly due to a temporary reduction in quality assurance visits necessitated by competing priorities.

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

RIDDOR incidents reported in July remain high with only 33% reported within the statutory 14 day period. One incident was reported late by the member of staff and one did not indicate an injury with the RIDDOR box not ticked. As H&S training continues for first line managers, awareness and compliance will improve. In addition to this Amjad is leading a review into our current RIDDOR (internal reporting) mechanism and exploring ways of how this can be improved.

Figure 1

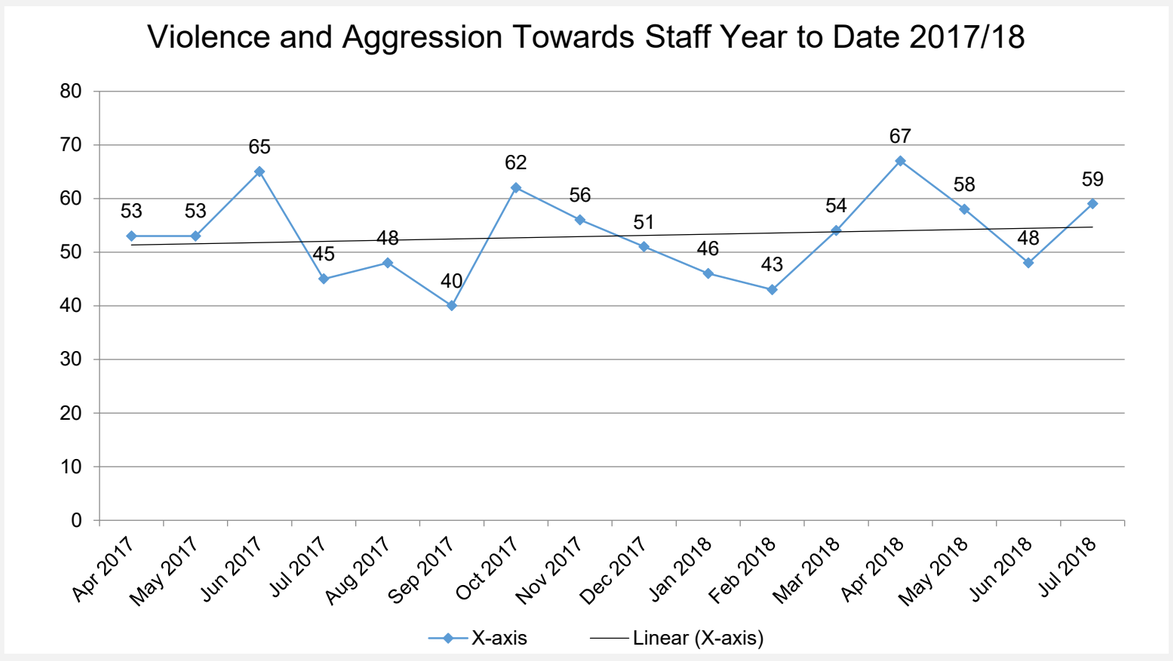


Figure 2

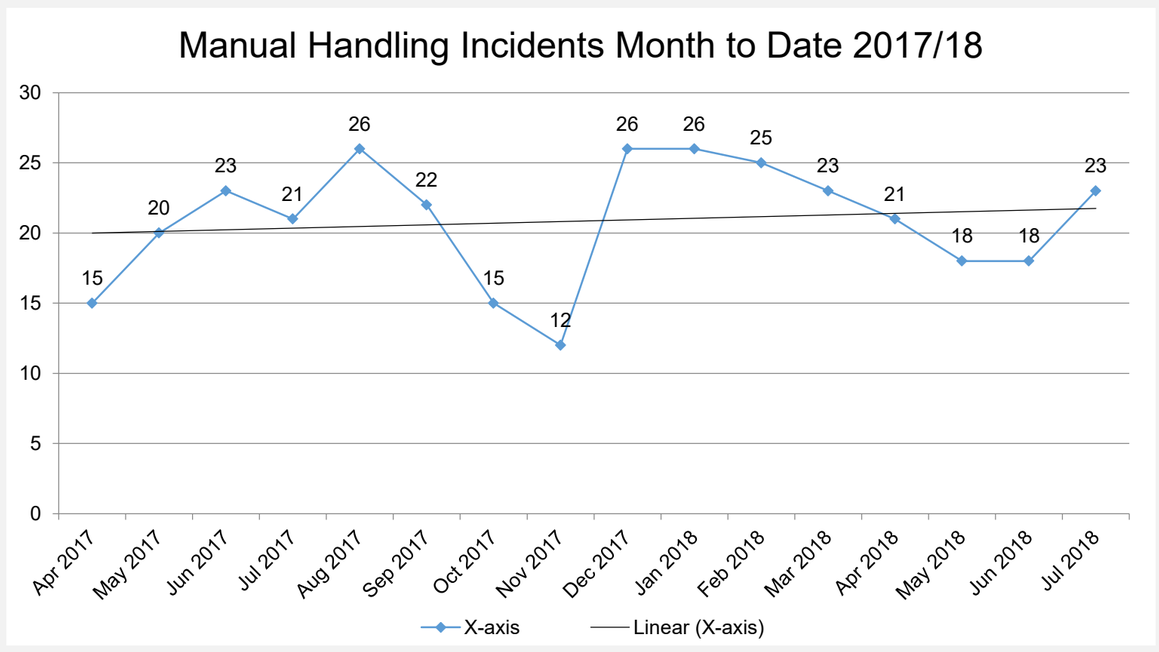


Figure 3

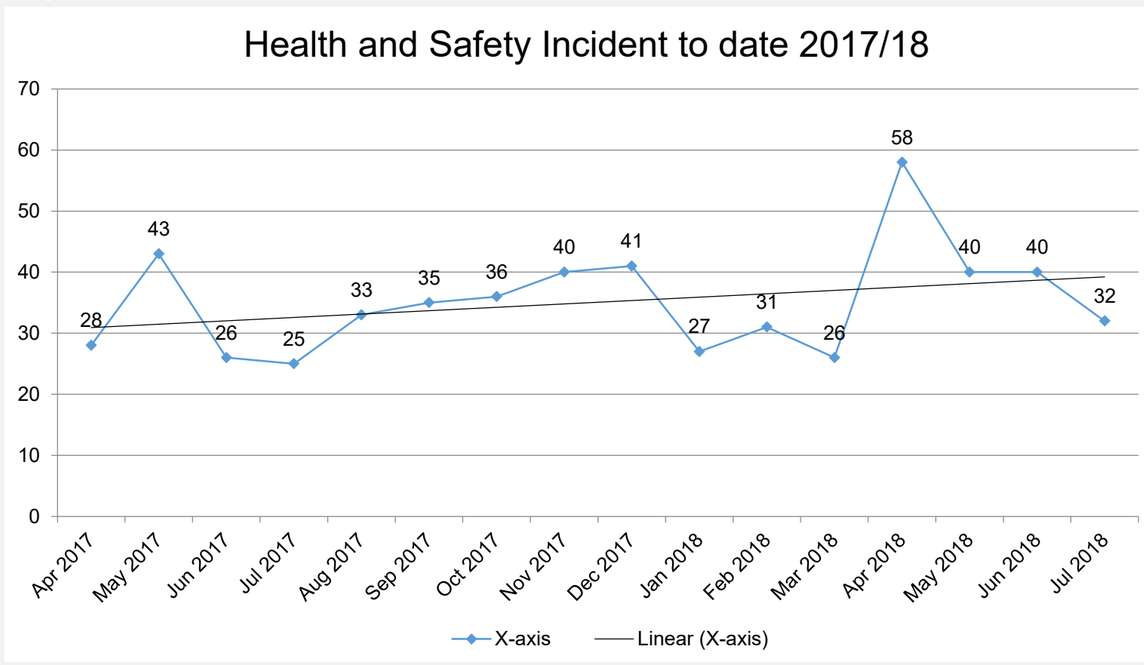
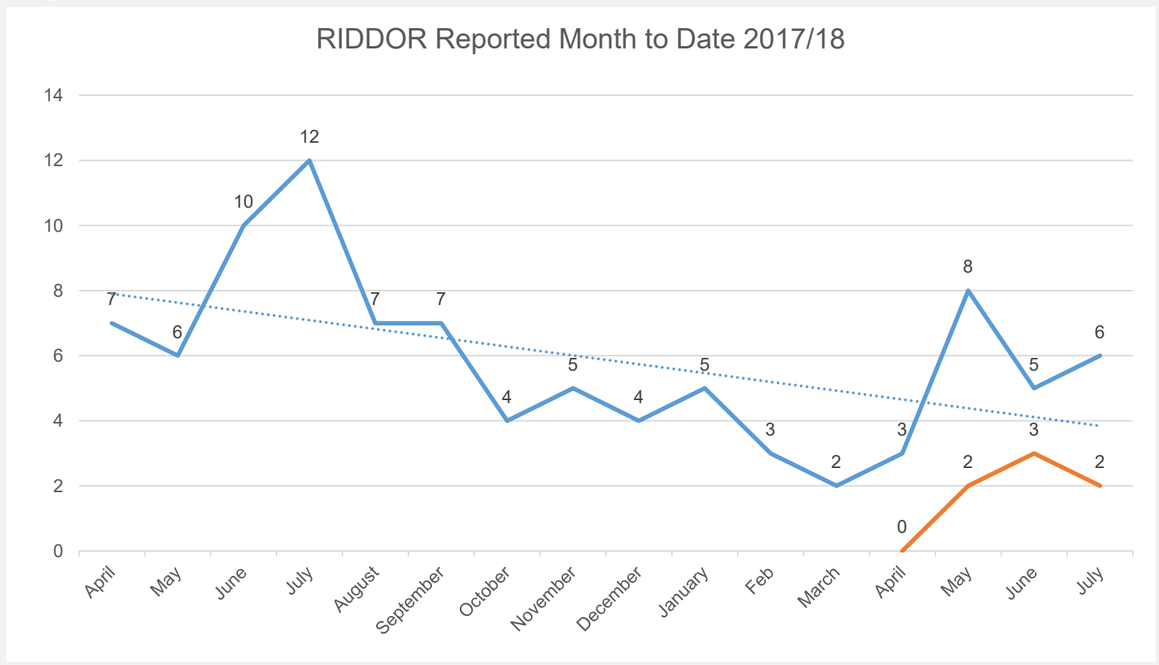


Figure 4



SECAmb Operations 999

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.

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. We are building the engagement with staff at this time, and further development is planned.

Response Time Performance Targets: Category 1 (Cat 1) performance has reduced further on the prior months. This has also had an impact on Category 2 (Cat 2) response performance which again has seen a worsening position due to the increased activity brought about by the hot weather within the region across the period of July. At the time of compiling this text, the Board should be reassured that performance has improved in C1 and C2 as we have come out of the hot weather period. However, the Trust is not meeting Category 3 (Cat 3) and Category 4 (Cat 4) response time targets due to resourcing levels. 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.

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 initiated in August 2018 with a follow up meeting scheduled for September 2018.. 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.

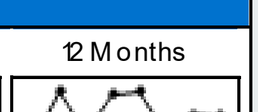
Key Skills Training: This has commenced throughout the Trust for Operational staff. In addition, objectives are currently being set for the Operations Team. Key skills were placed on hold during the Bank Holiday weeks to release resources back to the frontline. Progress is however on track to deliver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

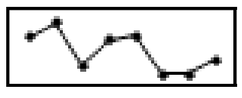
Call Handling

	May-18	Jun-18	Jul-18	12 Months
5 Sec Performance (95% Target)	78.3%	73.2%	72.7%	
Mean Call Answer Time (secs)	18	24	25	
95th Centile Call Answer (Secs)	108	132	143	
National Mean Call Answer	8	11	13	
National 95th Centile Call Answer	45	59	70	

Cat 1 Performance

	May-18	Jun-18	Jul-18	12 Months
Mean (00:07:00)	00:07:37	00:07:41	00:08:19	
90th Percentile (00:15:00)	00:14:06	00:14:22	00:15:12	
Mean Resources Arriving	1.79	1.78	1.75	
Count of Incidents	3290	3298	3590	
National Mean	00:07:46	00:07:37	00:07:37	

Cat 1T Performance

	May-18	Jun-18	Jul-18	12 Months
Mean (00:19:00)	00:10:20	00:10:47	00:10:52	
90th Percentile (00:30:00)	00:19:37	00:19:45	00:20:40	
Mean Resources Arriving	2.90	2.77	2.77	
Count of Incidents	2033	2114	2267	
National Mean	00:12:28	00:12:18	00:12:10	

Cat 2 Performance

	May-18	Jun-18	Jul-18	12 Months
Mean (00:18:00)	00:17:07	00:17:39	00:19:30	
90th Percentile (00:40:00)	00:32:29	00:33:14	00:37:39	
Mean Resources Arriving	1.14	1.13	1.13	
Count of Incidents	27678	26791	29416	
National Mean	00:21:17	00:21:38	00:22:41	

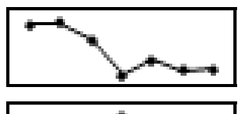
Cat 3 Performance

	May-18	Jun-18	Jul-18	12 Months
Mean (01:00:00)	01:14:35	01:16:37	01:33:35	
90th Percentile (02:00:00)	02:53:19	02:55:30	03:34:35	
Mean Resources Arriving	1.07	1.06	1.07	
Count of Incidents	22133	20931	20279	
National Mean	00:58:13	01:00:15	01:06:54	

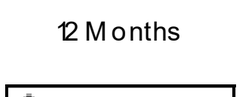
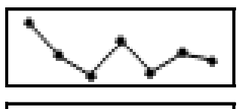
Cat 4 Performance

	May-18	Jun-18	Jul-18	12 Months
Mean	02:02:13	02:01:01	01:56:36	
90th Percentile (03:00:00)	04:38:21	04:58:23	04:34:20	
Mean Resources Arriving	1.06	1.06	1.05	
Count of Incidents	1202	1069	1037	
National Mean	01:25:32	01:28:44	01:32:37	

HCP

	May-18	Jun-18	Jul-18	12 Months
HCP 60 Mean	02:07:24	02:08:41	01:45:40	
HCP 60 90th Percentile	05:36:32	05:05:37	03:23:15	
HCP 120 Mean	02:15:20	02:20:03	02:22:35	
HCP 120 90th Percentile	05:17:52	05:07:17	05:13:05	
HCP 240 Mean	02:50:17	02:46:48	03:21:52	
HCP 240 90th Percentile	06:49:53	07:01:15	07:19:36	

Call Cycle Time

	May-18	Jun-18	Jul-18	12 Months
Avg Allocation to Clear at Scene	01:13:50	01:13:43	01:13:25	
Avg Allocation to Clear at Hospital	01:45:42	01:45:53	01:46:36	
Handover Hrs Lost at Hospital (over 30mins)	4404	4263	4764	
Number of Handovers >60mins	307	250	399	

Incident Outcome AQI

	May-18	Jun-18	Jul-18	12 Months
Hear & Treat	6.1%	5.8%	6.5%	
See & Treat	33.1%	33.1%	33.0%	
See & Convey	60.8%	61.1%	60.5%	

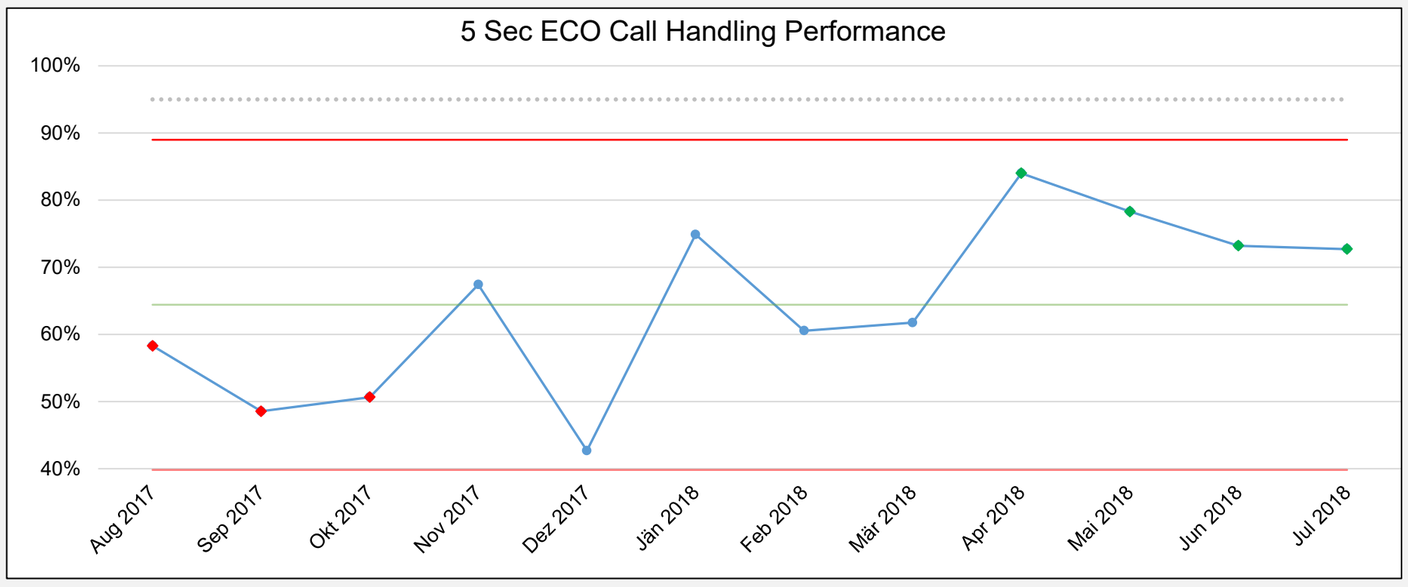
Community First Responders

	May-18	Jun-18	Jul-18	12 Months
Volume of Incidents Attended	1556	1664	1555	

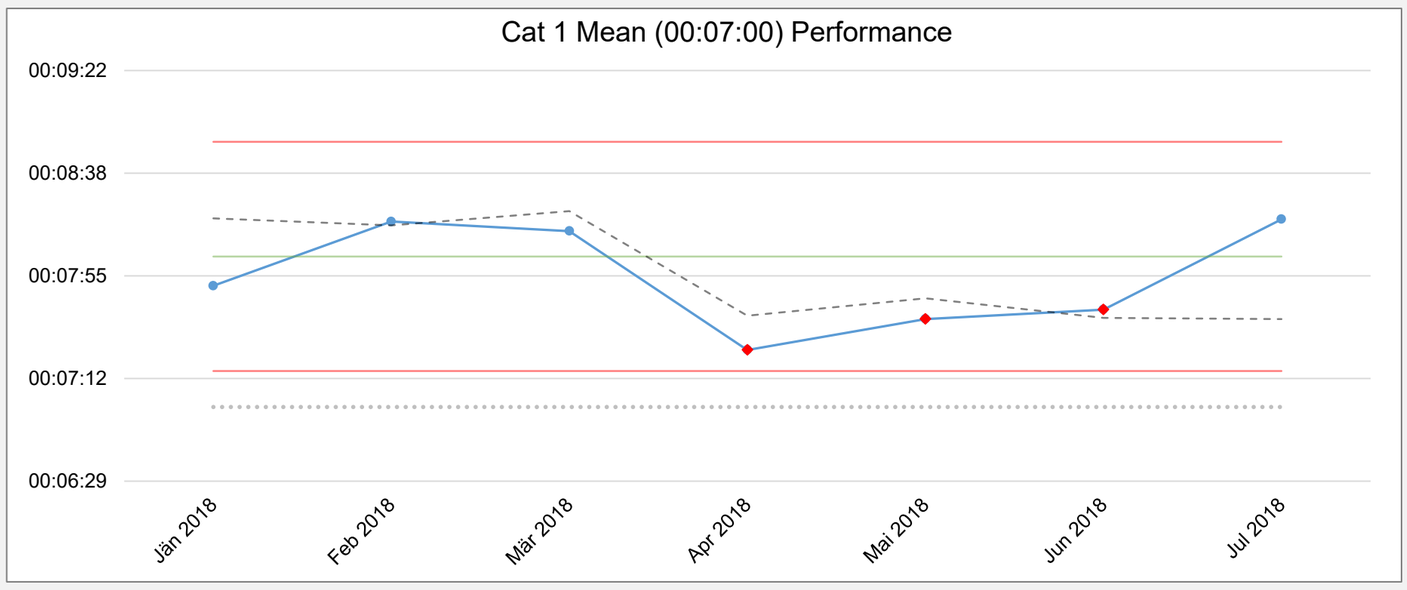
Demand/Supply AQI

	May-18	Jun-18	Jul-18	12 Months
Calls Answered	64186	62205	69779	
Incidents	60189	57556	60337	
Transports	36587	35168	36531	

SECAmb 999 Operations Performance Charts



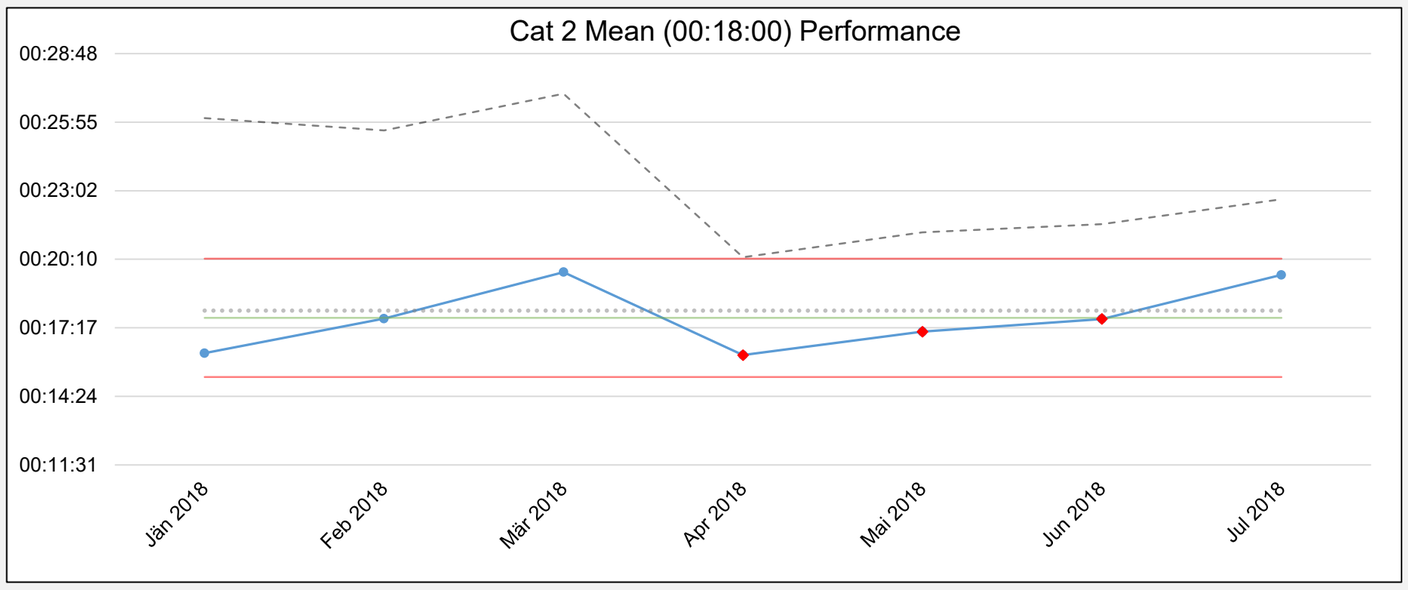
Call answering performance for July has continued to fall below an average of 80%. The volume of duplicate calls regarding ETA of responses is a major contributor to increase call volumes, together with the increase in temperature. In the short term, scrutiny on all forms of abstraction is being analysed 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, with a further cohort having been recruited for July, however, EOC leavers were double the number anticipated, resulting in a current effective establishment of 152 out of the 187 required.



As shown in the graph the Cat 1 mean response performance has increased by 38 seconds on the previous month. Whilst we are not yet delivering the ambulance response programme (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. However, due to the recent hot weather an increase in activity has again been seen.

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.

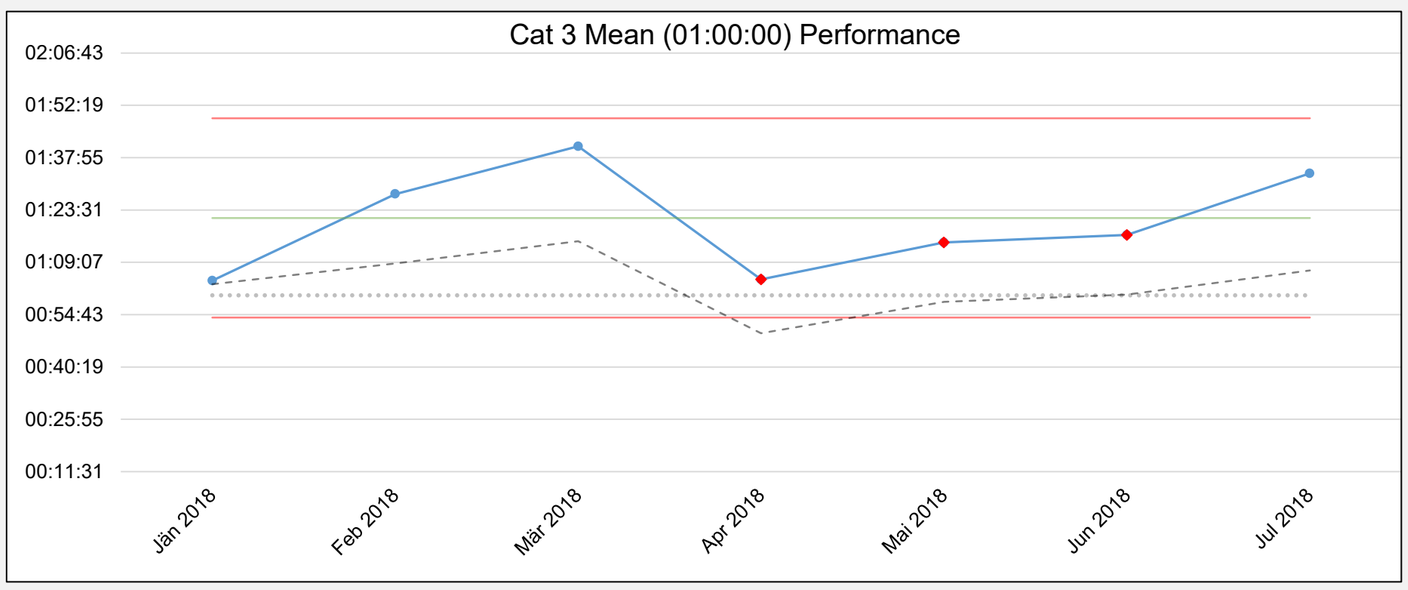
----- National Mean



For the first month since March 2018, Cat 2 mean performance is below target, partly due to the increase in activity and also our inability to consistently provide operational hours. However, the 90th centile performance has been and remains a particularly successful delivery for SECAmb.

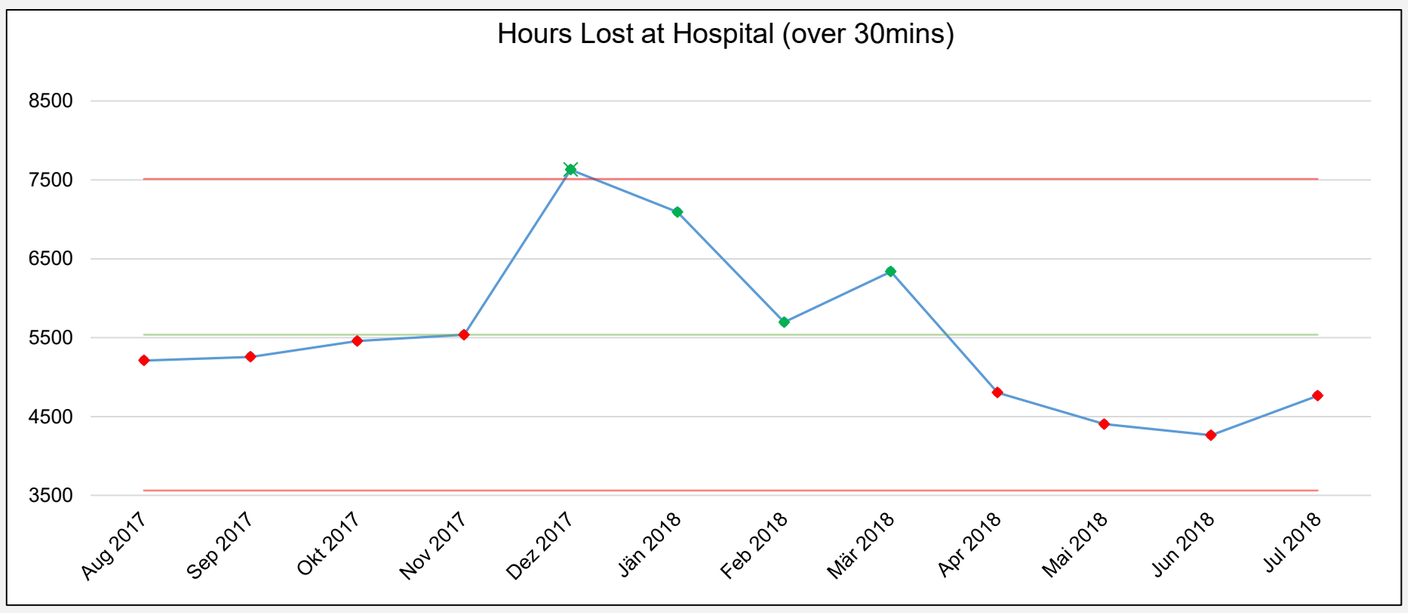
However, key skills training is progressing well, with a current completion rate of 75.86% against a trajectory of 60% completion by end-July 2018.

----- 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.
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



July was a challenging month in terms of increased pressure across all systems and the hours lost to operational response capability through hospital delays in July are 4769 compared to 4263 in June. All the sites where good progress has been made so far have however managed to maintain their performance in spite of additional pressure and of the three county areas, comparing July 2018 to July 2017, there was a collective 12% decrease in hours lost.
There are, however, outliers where there were significant increases in hours lost in July compared to last year, these being Medway, Darent Valley, Maidstone and Tunbridge Wells and Ashford and St Peter's. Medway hospital is a particular concern.
The operational groups have decided to change the format of their meetings and will now use the time to have on site peer review challenge sessions. The schedule has been agreed based on current performance. Medway and Darent Valley will be the first in the East, with Ashford and St Peter's and BSUH being the first in the West.
A paper with recommendations for improving crew to clear performance has been submitted to the SECAmb Executive Team since there has not been the expected improvement in performance.

SECAmb 111 Operations Performance Scorecard

Calls Offered

	May-18	Jun-18	Jul-18	12 Months
Actual	92737	84042	87586	
Previous Year	91789	78212	86640	

Calls answered in 60 Seconds

	May-18	Jun-18	Jul-18	12 Months
Actual %	74.0%	71.7%	68.9%	
Previous Year %	91.1%	88.4%	91.5%	
Target %	95%	95%	95%	

Calls abandoned - (Offered) after 30secs

	May-18	Jun-18	Jul-18	12 Months
Actual %	4.7%	4.8%	5.7%	
Previous Year %	1.0%	1.2%	1.1%	
Target %	2%	2%	2%	

Combined Clinical KPI

	May-18	Jun-18	Jul-18	12 Months
Actual %	68.6%	64.5%	63.3%	
Previous Year %	74.0%	73.0%	71.8%	
Target %	90%	90%	90%	

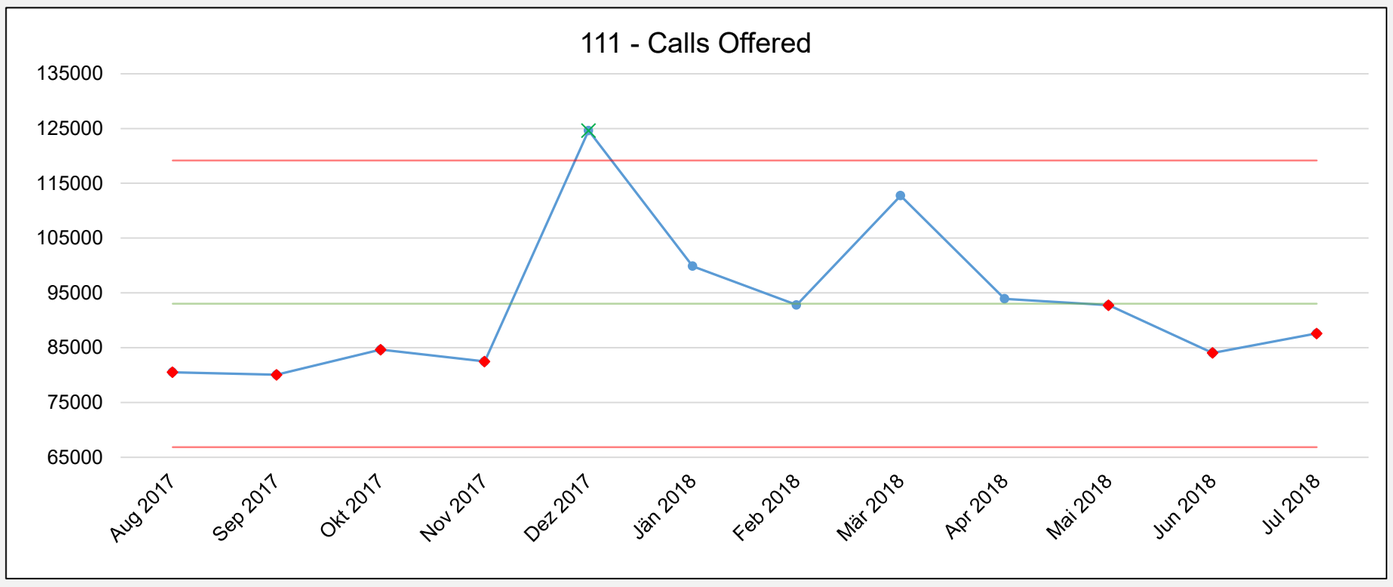
999 Referrals

	May-18	Jun-18	Jul-18	12 Months
999 Referrals % (Answered Calls)	10.7%	11.2%	11.0%	
999 Referrals (Actual)	9311	8828	8919	
National	10.7%	11.2%	11.0%	

A&E Dispositions

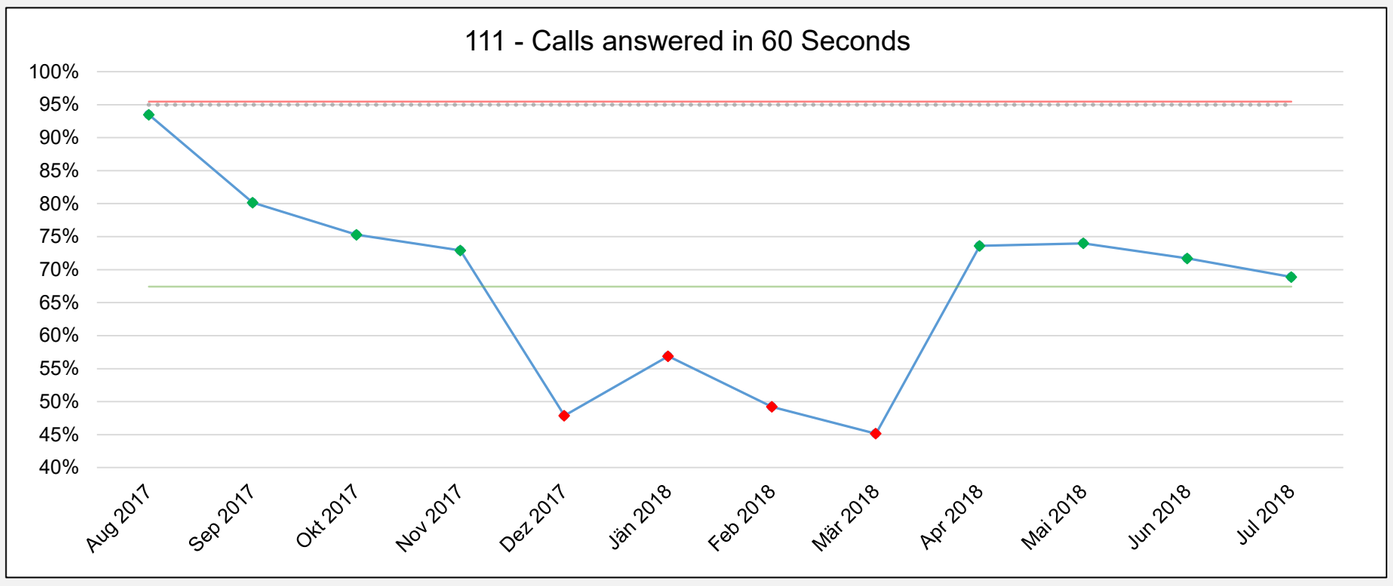
	May-18	Jun-18	Jul-18	12 Months
A&E Dispositions % (Answered Calls)	7.9%	8.4%	8.8%	
A&E Dispositions (Actual)	6890	6582	7160	
National	8.1%	8.4%	8.8%	

SECAmb 111 Operations Performance Charts



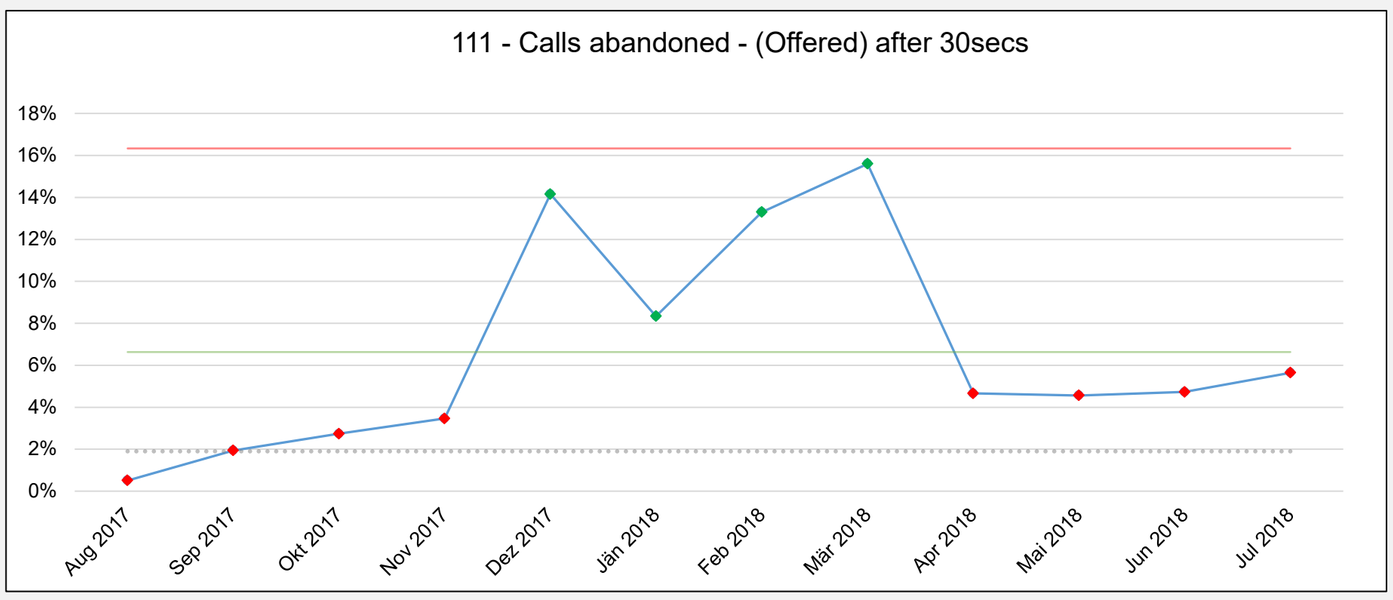
The KMSS 111 Call volume of 87586 for July, although not especially high for a summer month, presented its own challenges due to the skewed call profiles per day, and higher acuity than usual, due to the PHE-declared heatwave that continued throughout much of July.

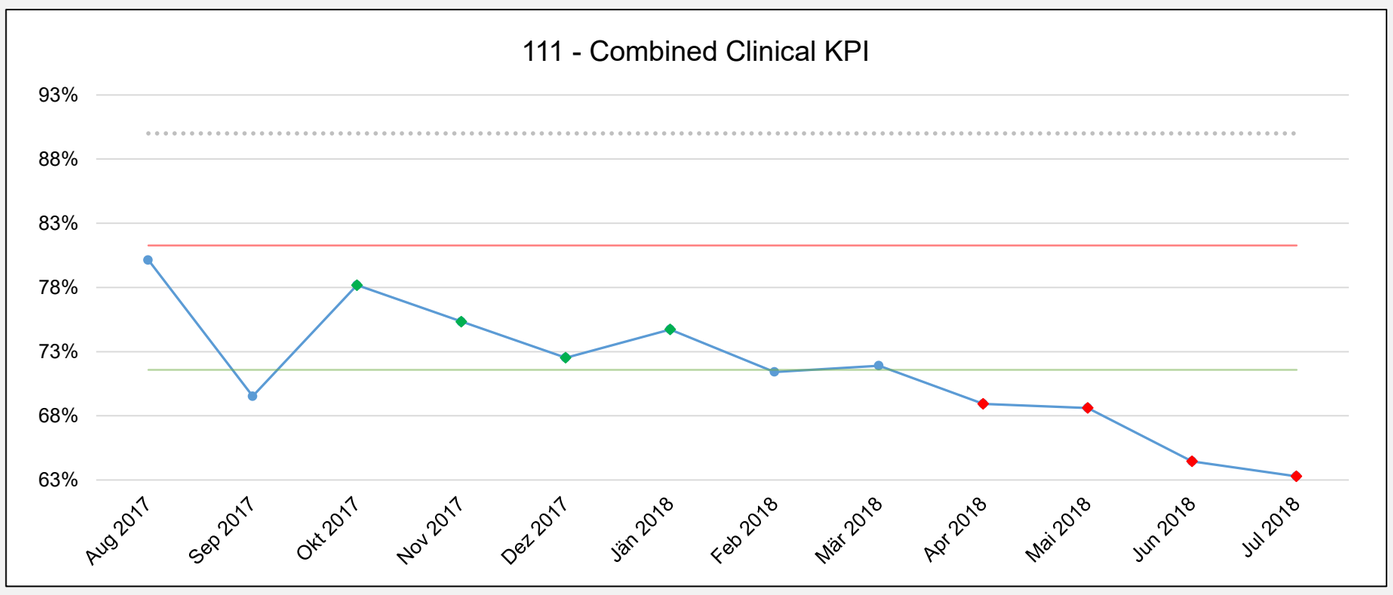
Volume surges in the evenings contributed to a reduction in service level.



The service's operation performance fell slightly to 68.9%, as a result of the skewed call profiles as detailed above. This trend was in line with national operational performance for 111; July was the poorest month in 2018-19 to date, across England, for 111 and IUC services.

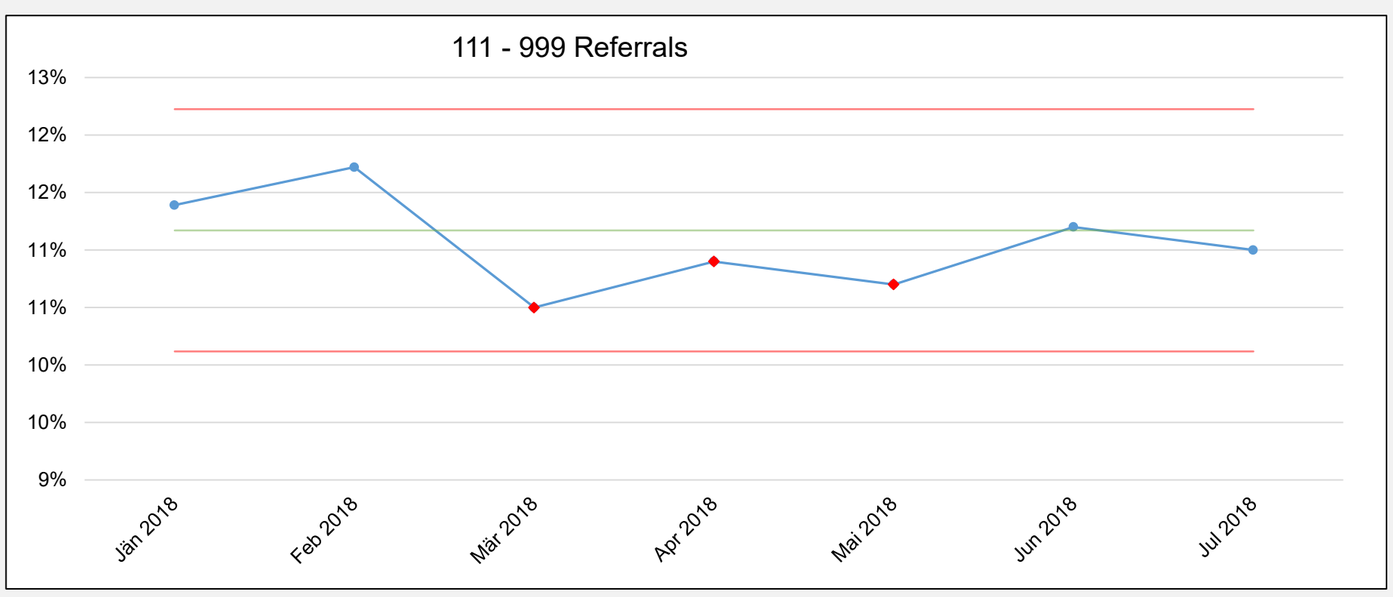
As will be explained later, the operational performance was slightly compromised in order to maximise patient safety.





Clinical performance fell slightly again in July 2018. Rota issues continue to inhibit our clinical performance, in addition to the high acuity cases seen during the heatwave.

The service made extensive use of experienced Health Advisors as "Patient Safety Callers", to provide a comfort calling service for cases in the clinical queue. This supported the clinical team by managing lower priority patients; closing some cases were appropriate, and also escalating in the event of worsening symptoms.

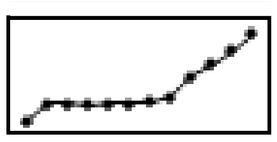
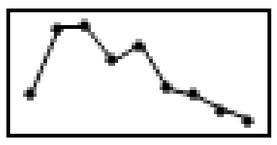


The KMSS 111 Ambulance referral rate was significantly lower than the national 999 referral rate in July 2018. This is testament to our focus on mitigating pressure on the Ambulance Service, via Clinical Inline Support, to validate or downgrade C3 / C4 dispositions.

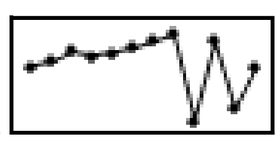
SECAmb was in escalation at SMP status purple or higher on 29 days in July, KMSS 111 responds to surge status by ensuring C3 / C4 dispositions are validated before sending. This was resource intensive during a challenging month but we succeeded in our objective.

SECAmb Workforce Scorecard

Workforce Capacity

	May-18	Jun-18	Jul-18	12 Months
Number of Staff WTE (Excl bank & agency)	3114.1	3107.7	3099.0	
Number of Staff Headcount (Excl bank and agency)	3377	3375	3367	
Finance Establishment (WTE)	3563.29	3576.89	3594.89	
Vacancy Rate	12.63%	13.08%	13.78%	
Vacancy Rate Previous Year	11.85%	12.37%	12.60%	
Adjusted Vacancy Rate + Pipeline recruitment %	7.78%	7.16%	6.74%	

Workforce Compliance

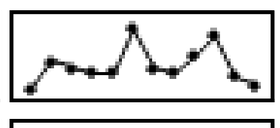
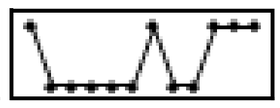
	May-18	Jun-18	Jul-18	12 Months
Objectives & Career Conversations %	17.42%	18.11%	26.54%	
Target (Objectives & Career Conversations)	80.00%	80.00%	80.00%	
Statutory & Mandatory Training Compliance %	85.68%	18.11%	58.99%	
Target (Stat & M and Training)	95.0%	95.0%	95.0%	
Previous Year (Stat & M and Training) %	23.49%	38.55%	47.66%	

* 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

	May-18	Jun-18	Jul-18	12 Months
Annual Rolling Turnover Rate %	17.42%	15.17%	15.37%	
Previous Year %	16.34%	17.85%	17.67%	
Annual Rolling Sickness Absence	5.12%	5.21%	5.02%	
Target (Annual Rolling Sickness)	5.0%	5.0%	5.0%	

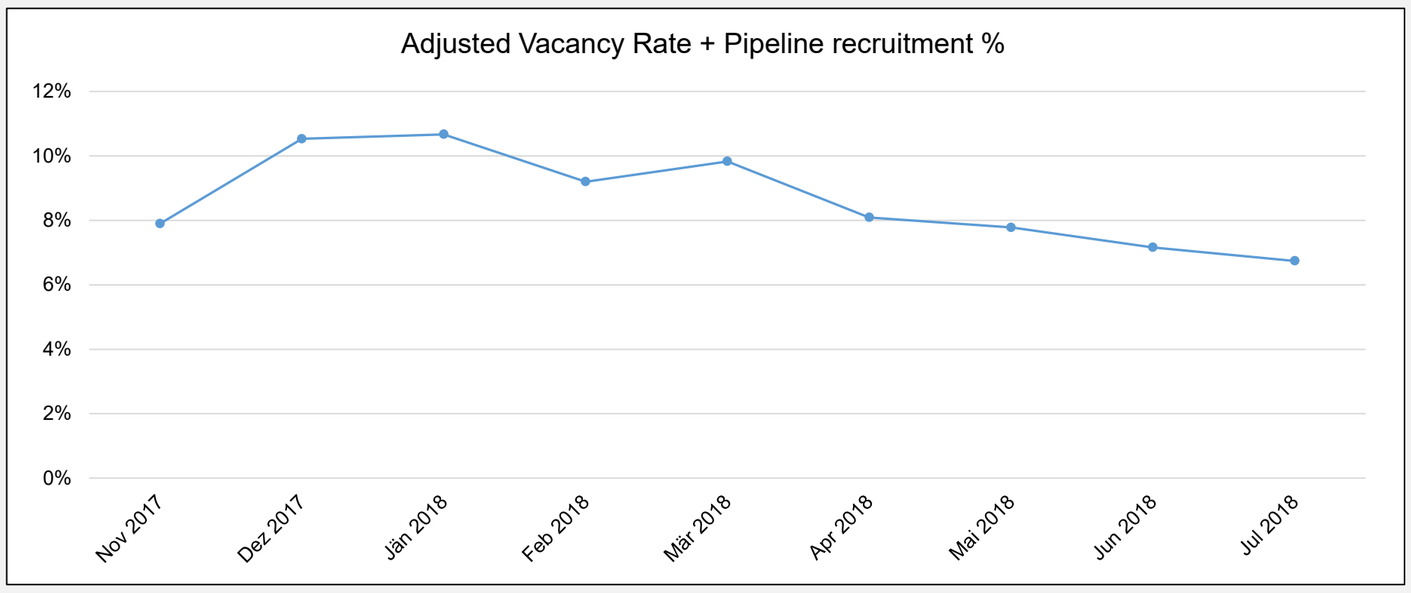
Employee Relations Cases

	May-18	Jun-18	Jul-18	12 Months
Disciplinary Cases	2	14	4	
Individual Grievances	14	4	2	
Collective Grievances	2	4	2	
Bullying & Harassment	3	5	2	
Bullying & Harassment Prev Yr	1	0	6	
Whistleblowing	1	1	1	
Whistleblowing Previous Year	0	0	0	

Physical Assaults (Number of victims)

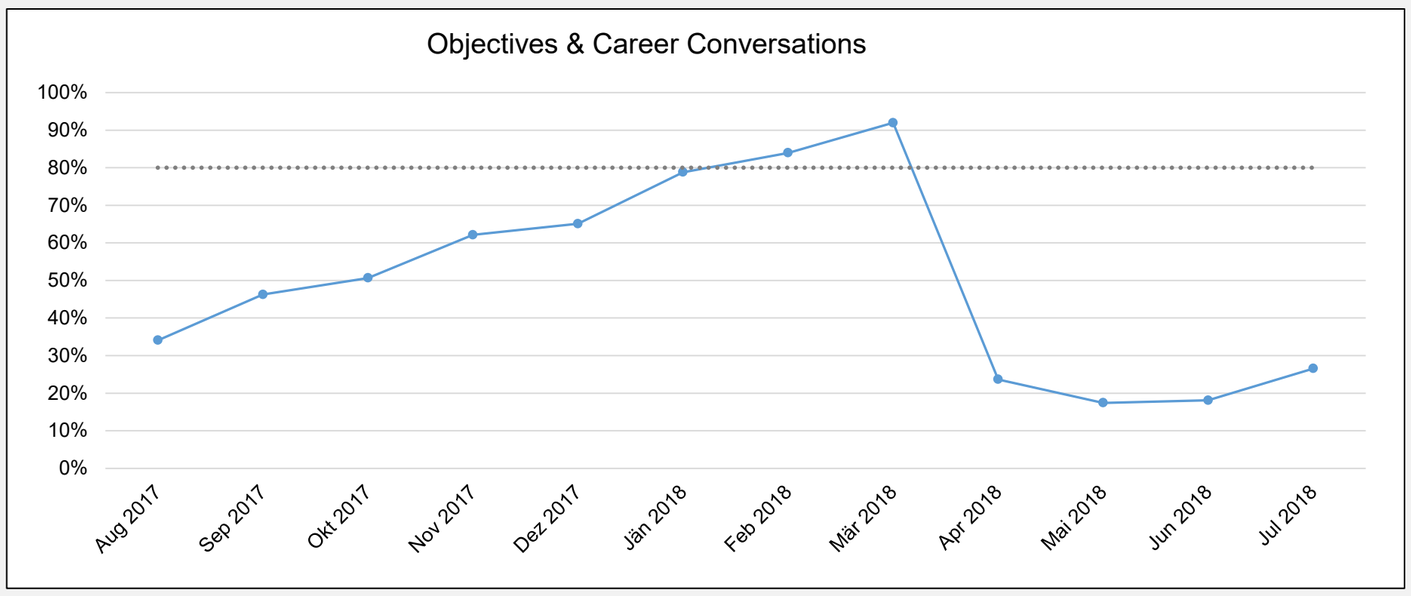
	May-18	Jun-18	Jul-18	12 Months
Actual	13	14	21	
Previous Year	14	16	21	
Sanctions	4	6	9	

SECAmb Workforce Charts

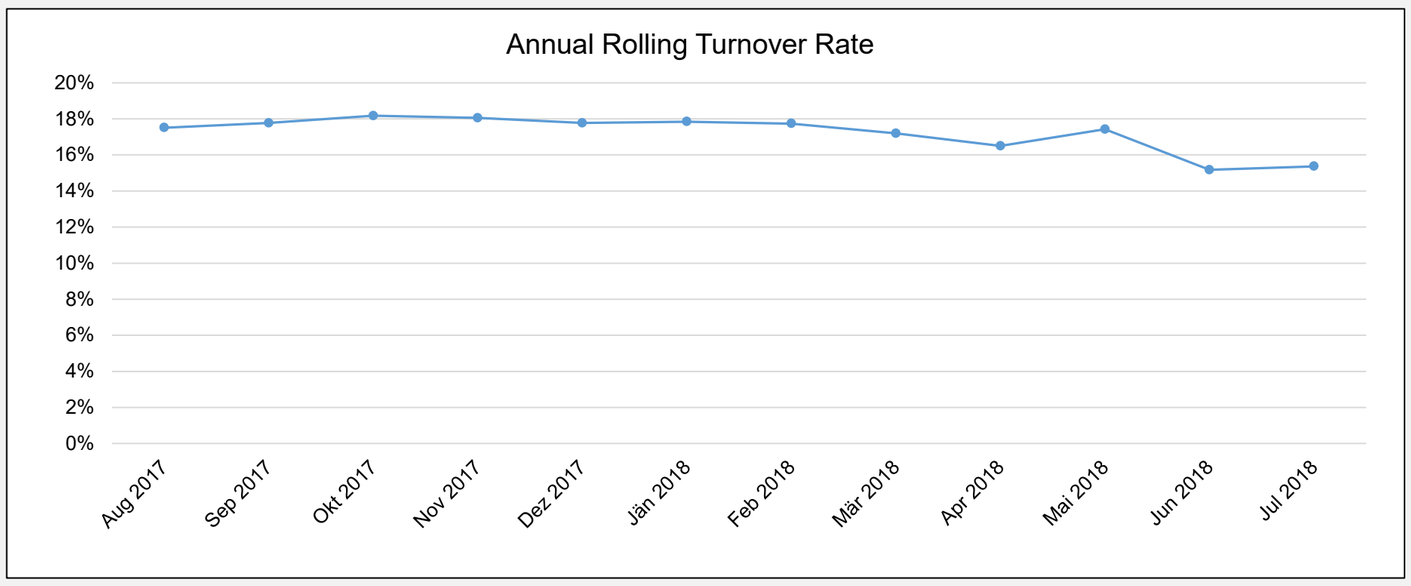


The fitness assessment has been through consultation and is awaiting sign off by Joint Partnership Policy Forum (JPPF) and Executive Management Board (EMB). Once approved, this will enable us to ensure that local fitness facilities and assessments can be utilised, creating a better candidate experience and a link to localised recruitment initiatives.

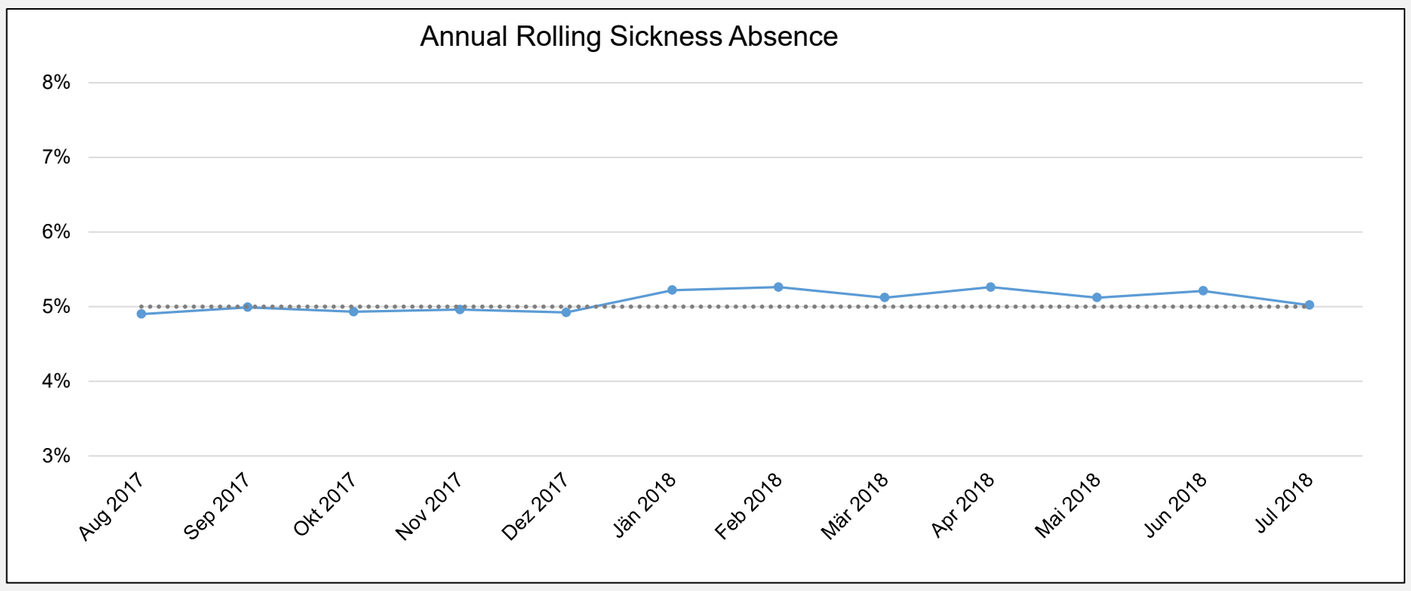
We have had to adapt our emergency driving courses, due to unforeseen availability issues with our course providers. A paper has been developed to overcome the operational demands this change will bring and has been approved by the Executive team. This will allow us to continue with our increased recruitment activity.



The objectives and career conversations are still steadily increasing with an increase from 23.43% to 26.54%. The importance of appraisals is still being highlighted to managers through various training sessions and how this links to supporting positive behaviours and improved performance.



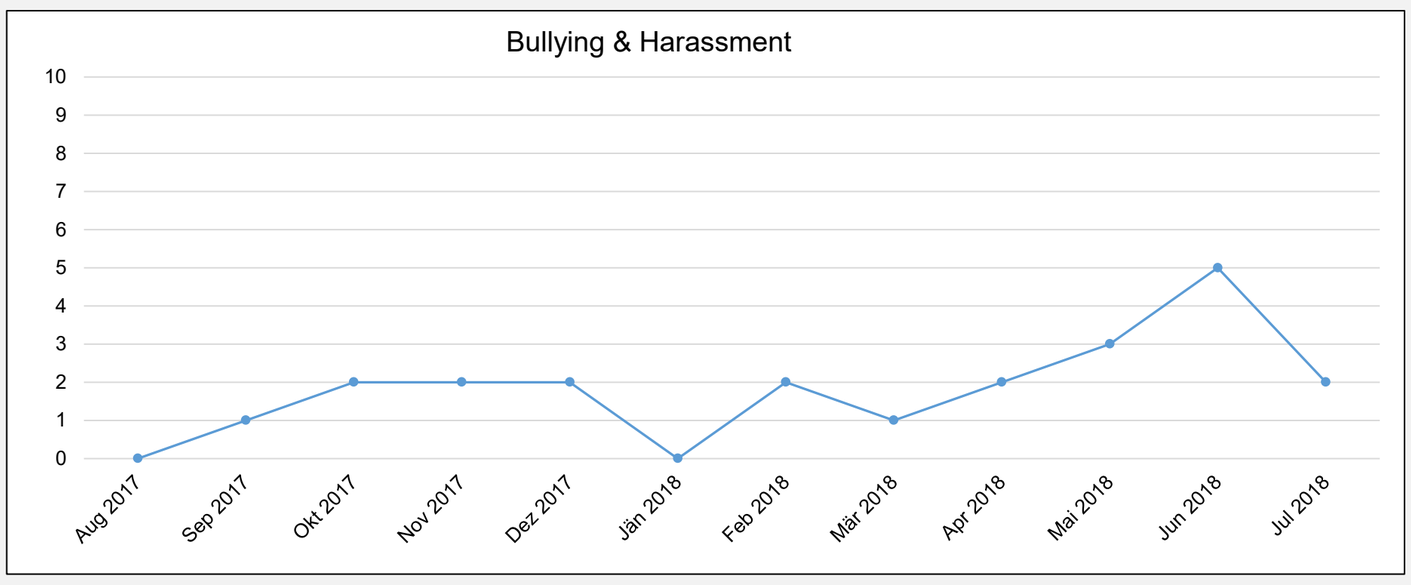
For the second consecutive month turnover has decreased which is extremely positive. The impact of the Culture Change Programme, Ambulance Response Programme, Recruitment, and the overall Demand and Capacity review would have contributed significantly to this.



A positive indicator of the aforementioned Culture Change Programme, Ambulance Response Programme, Recruitment, and the overall Demand and Capacity review is that absence has dropped to a seven month low of 5%.

Sickness absence will be a metric used as part of the Culture programme.

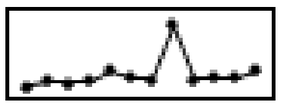
It is also being broken down to OU level so HR BP's and Advisors can support their area's more effectively.



There was a decrease in Bullying and Harassment (B&H) cases reported in July. This may be due to the behaviours training that is currently being rolled out across the Trust which is focusing on the values and the impact of poor behaviours. We need to continue to support staff with the confidence to report these issues and provide a safe process for them to do so.

SECAmb Finance Performance Scorecard

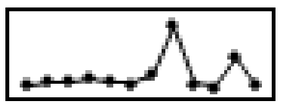
Income

	May-18	Jun-18	Jul-18	12 Months
Actual £	£ 17,205	£ 17,208	£ 18,211	
Previous Year £	£ 16,174	£ 16,132	£ 15,778	
Plan £	£ 17,566	£ 17,258	£ 18,011	

Expenditure

	May-18	Jun-18	Jul-18	12 Months
Actual £	£ 17,756	£ 18,069	£ 18,122	
Previous Year £	£ 16,673	£ 16,704	£ 16,185	
Plan £	£ 18,131	£ 18,138	£ 17,930	

Capital Expenditure

	May-18	Jun-18	Jul-18	12 Months
Actual £	£ 142	£ 1,589	£ 237	
Previous Year £	£ 670	£ 582	£ 69	
Plan £	£ 401	£ 1,180	£ 661	
Actual Cumulative £	£ 441	£ 2,030	£ 2,267	
Plan Cumulative £	£ 792	£ 1,972	£ 2,633	

Cost Improvement Programme (CIP)

	May-18	Jun-18	Jul-18	12 Months
Actual £	£ 308	£ 519	£ 1,200	
Previous Year £	£ 910	£ 1,302	£ 1,120	
Plan £	£ 402	£ 1,190	£ 435	
Actual Cumulative £	£ 700	£ 1,219	£ 2,419	
Plan Cumulative £	£ 804	£ 1,994	£ 2,429	

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

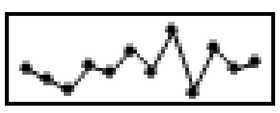
Surplus/(Deficit)

	May-18	Jun-18	Jul-18	12 Months
Actual £	-£ 551	-£ 861	£ 89	
Actual YTD £	-£ 1,515	-£ 2,376	-£ 2,286	
Plan £	-£ 565	-£ 880	£ 81	
Plan YTD £	-£ 1,583	-£ 2,463	-£ 2,382	

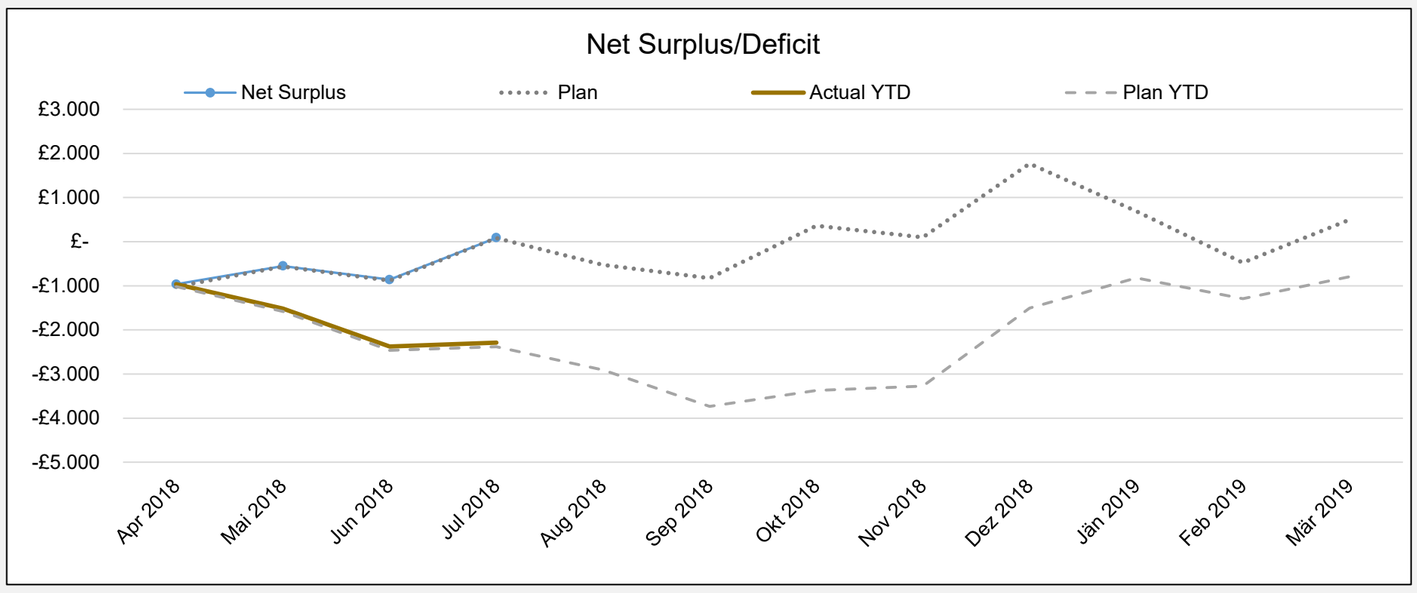
Cash Position

	May-18	Jun-18	Jul-18	12 Months
Actual £	£ 21,762	£ 22,527	£ 24,950	
Minimum £	£10,000	£10,000	£10,000	
Plan £	£16,428	£16,694	£16,893	

Agency Spend

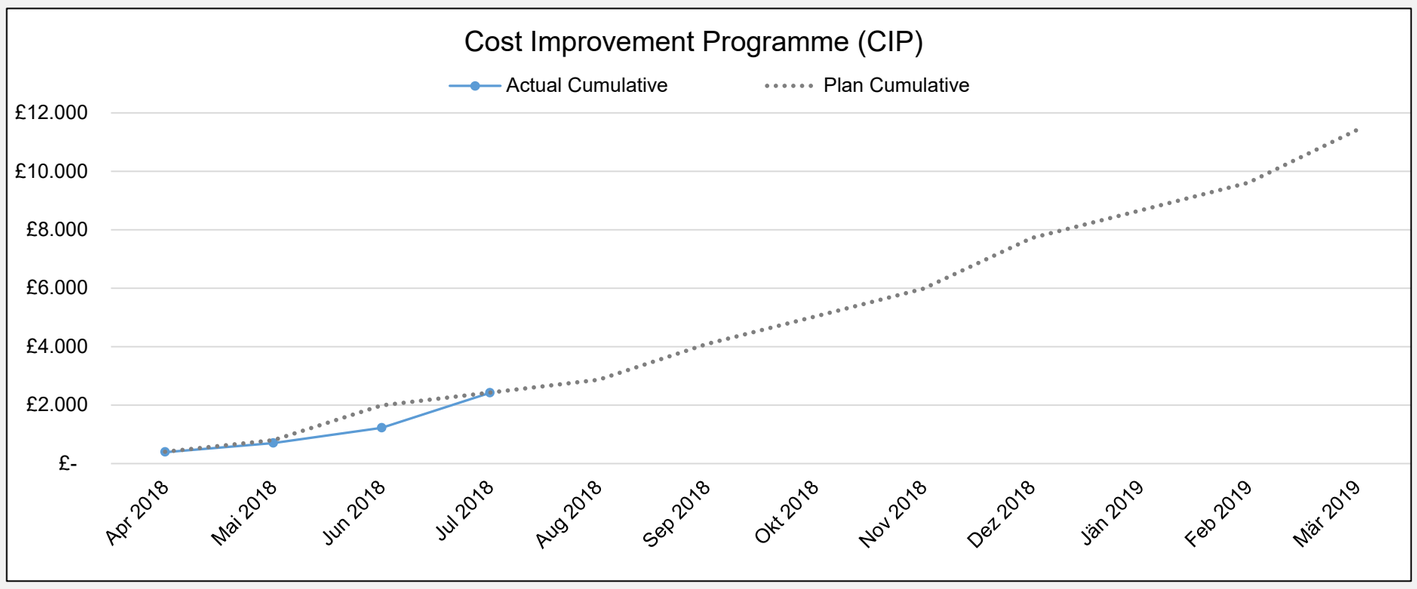
	May-18	Jun-18	Jul-18	12 Months
Actual £	£ 329	£ 229	£ 258	
Plan £	£ 236	£ 233	£ 229	

SECAmb Finance Performance Charts



The Trust's I&E position in Month 4 was a surplus of £0.1m, which was as planned.

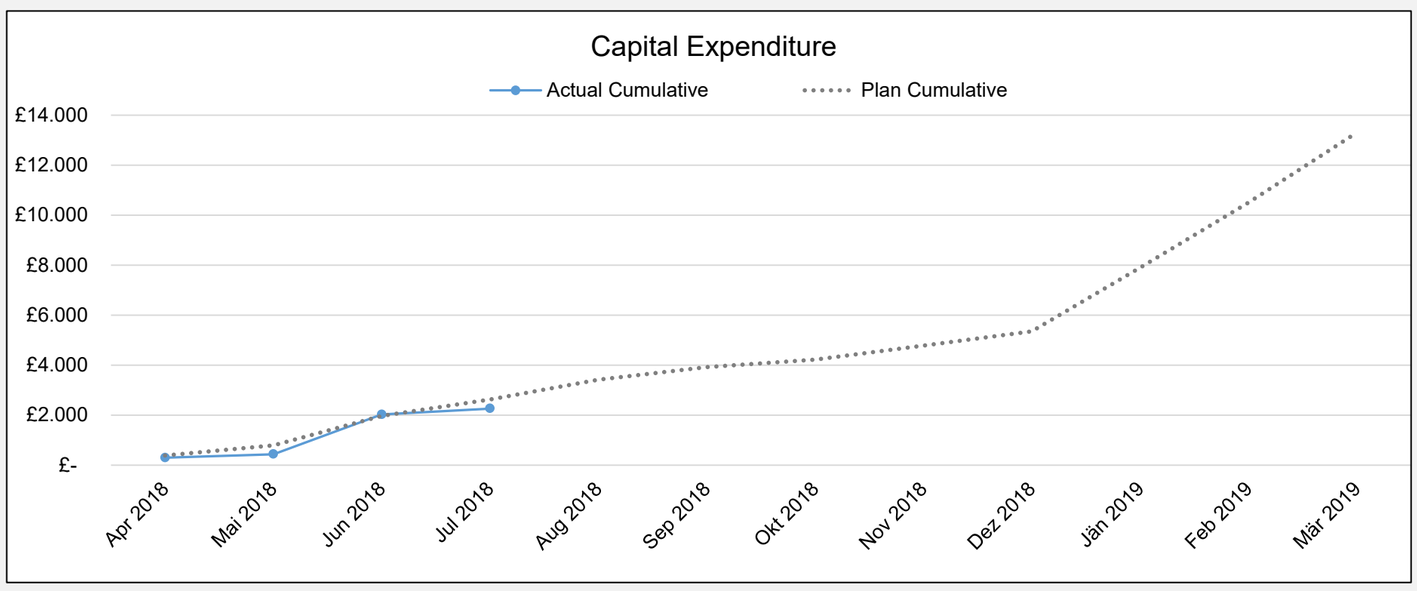
This reduced the cumulative deficit to £2.3m, which is £0.1m better than plan.



CIPs caught up with plan in the month, with the delivery of £1.2m of savings.

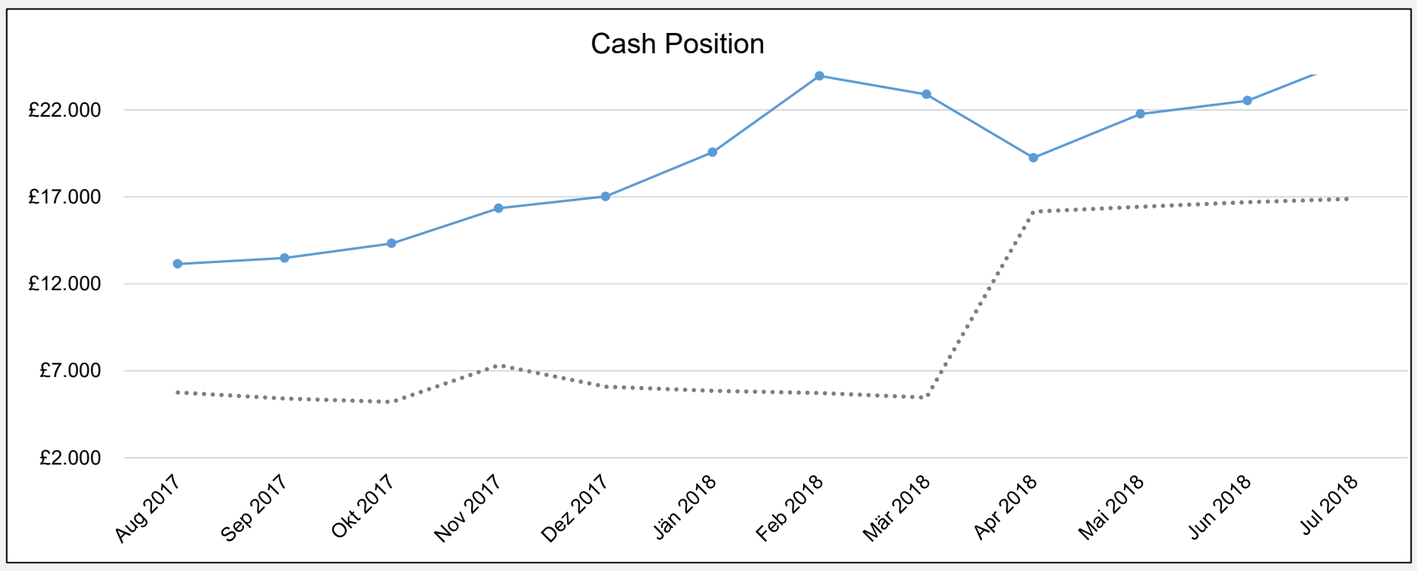
This brought year-to-date achievement to £2.4m.

It is projected that the full year target of £11.4m will be met, although this is not without risk.



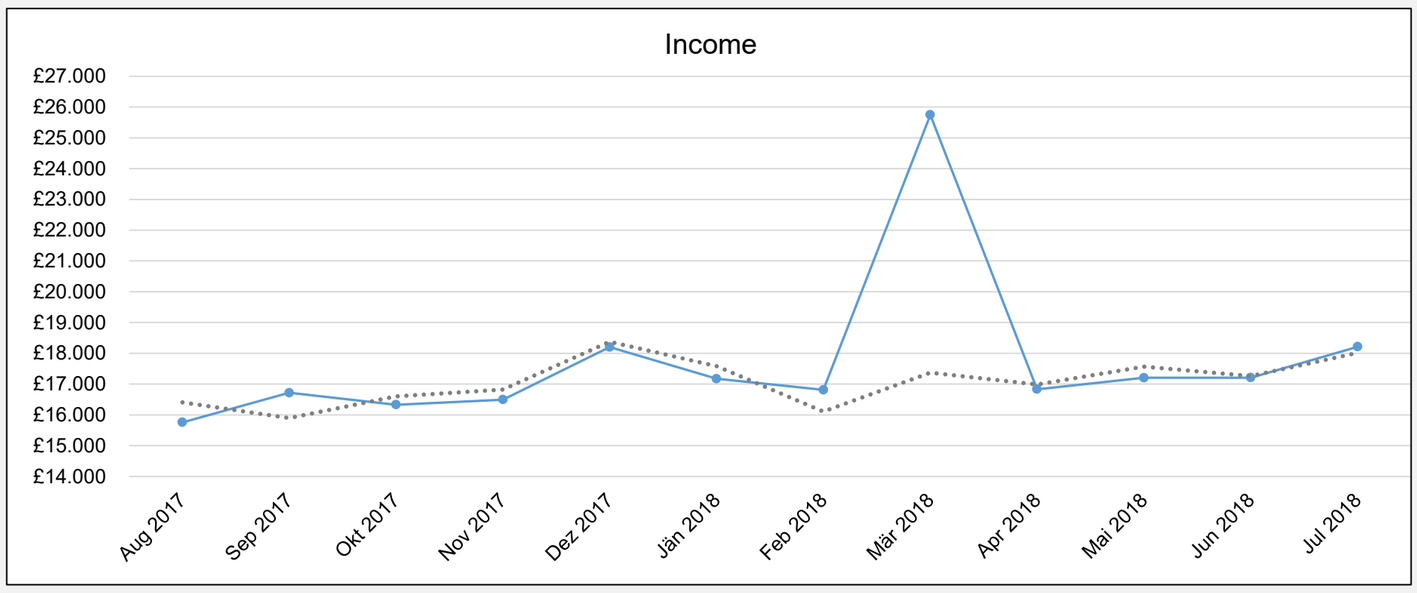
Capital spend in the four months was £2.3m, marginally below plan. For the full year there is a risk of slippage on delivery of the 42 Mercedes box chassis that have been ordered. This could result in an underspend on the capital programme of £6.0m, which could be partly mitigated by bringing forward other schemes.

There has not yet been any national announcement regarding the 'Wave 4' capital bidding process, against which the Trust has submitted bids worth nearly £39m. The Trust's bids, comprising new and replacement ambulances, expansion of 'Make Ready' facilities and resilience in EOC, are to support improved efficiency and the delivery of ARP targets.



The cash position at 31 July increased again to £24.9m, which was £8.0m better than plan and £2.5m up on June. The balance at 31 March was £22.9m. The cash balance benefited from the favourable I&E position in 2017/18, as reflected in the subsequent receipt of additional Provider Sustainability Fund income (PSF) and 'Commissioning for Quality and Innovation' (CQUIN) reserve funding for that year. The cash balance continues to be flattered by late billing by some of the Trust's suppliers.

There was a slip in performance against the public sector 'Better Practice Payment Code' for payment of suppliers, with 86.4% compliance by value. The target is 95% and the Trust is aiming to further improve its compliance.



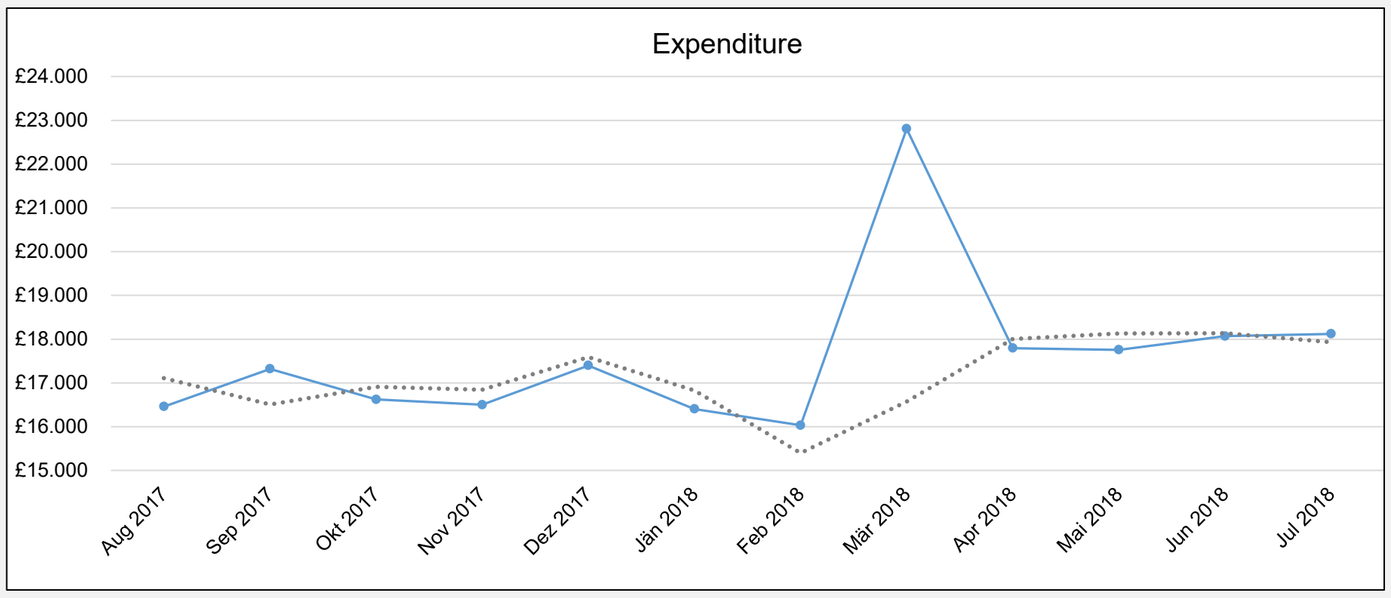
Total Income in the month was £18.2m, which was £0.2m better than plan.

The cumulative shortfall against plan fell to £0.4m.

The main reason was a £0.5m adverse variance on income for the East Kent Hospitals ambulance divert resulting from a reduced level of resource being provided. This is fully offset by a favourable variance on expenditure.

The Trust has assumed full achievement of planned Provider Sustainability Fund (PSF) in the first four months at £0.4m. The full year value is £1.8m and receipt of this funding is contingent on meeting income and expenditure trajectories on a quarterly basis.

SECAmb Finance Performance Charts



Total Expenditure was underspent by £0.2m in month and cumulatively £0.5m better than plan.

Pay costs in the month were underspent by £0.3m. Cumulatively pay costs are underspent by £0.3m, mainly from the reduced availability of resources to support East Kent Hospitals (KCH).

Non-pay costs were £0.4m worse than plan in the month, but are underspent by £0.5m in the four months to date. The main cause of this was the delay in deployment of new leased ambulances £0.4m.

Non-operating costs, were overspent by £0.3m. This was attributable to the delayed timing of planned ambulance station disposals.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Date	28 September 2018
Name of paper	NHS Workforce Race Equality Standard summary report 2018
Executive sponsor	Ed Griffin – Executive Director of HR & Organisation Development
Author name and role	Asmina Islam Chowdhury - Inclusion Advisor
Synopsis (up to 120 words)	This paper builds on WRES data shared at the workshop which took place on 27th March 2018, with members of the Board, Aspire, the Cultural Diversity network and the members of the Trust's Senior Leadership Team. It details the latest figures for the Trust's performance against the Workforce Race Equality Standard (WRES) metrics, which were submitted to NHS England in August 2018. It includes a new Integrated Equality Objective and WRES action plan. Going forward the Board will receive an annual report detailing refreshed plans and in year progress at the first Board following submission of the WRES
Recommendations, decisions or actions sought	For information only.

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).	**No** If yes and approval or ratification is required, a completed EA Record must be attached.

South East Coast Ambulance Service NHS Foundation Trust

Workforce Race Equality Standard (WRES) Summary Report 2018

1. Introduction

1.1. The purpose of this report is to provide an update on the progress achieved in the implementation of the Workforce Race Equality Standard (WRES), which was embedded within the NHS Contract from 2014/15, mandatory for all NHS Trusts.

1.2. It provides the outcomes of the WRES summary as submitted to NHS England and Lead Commissioners by 10th August 2018, Appendix 1.

1.3. The Inclusion Working Group (IWG) monitor the overarching action plan, which is updated each year to maintain and deliver progress against the metrics.

2. Background

2.1. The Workforce Race Equality Standard (WRES) was introduced by the NHS Equality and Diversity Council (EDC) for all NHS Trusts and Clinical Commissioning Groups in April 2015. This was in response to 'The Snowy White Peaks' a report by Roger Kline which provided compelling evidence that barriers, including poor data, are deeply rooted within the culture of the NHS. The report highlights a clear link between workforce diversity of NHS organisations and better patient access, experience, care and outcomes.

2.2. The WRES is a mandatory requirement embedded within the NHS Contract to ensure effective collection, analysis and use of workforce data to address the under-representation of Black Minority Ethnic (BME) staff across the NHS Research suggests the experience of BME staff is a very good barometer of the climate of respect and care for all within NHS trusts. Improvements made for any one group of staff also indirectly has a positive impact on all staff, because of changing cultures and increased awareness.

2.3. The WRES requires NHS organisations to demonstrate progress against nine indicators specifically focused at Race equality. The nine indicators are shown in more detail in the results of the 2017/18 WRES return, Appendix 1.

2.4. As of the 1 April 2015, the WRES formed part of the standard NHS Contract. From April 2016 it was also included as part of the CQC inspection standards.

The nine indicators cover:

- Four workforce metrics – data provided showing comparison of the experience of Black and Ethnic Minority (BME) employees and candidates

- Four NHS Staff Survey findings – Key Findings 18, 19, 27 and question 23b; all specifically focus on the experience of employees from an Equality and Diversity perspective.
- A metric aimed at achieving a Board that is broadly representative of the population served.

2.5. The WRES has clear links with the Equality Delivery System 2 (EDS2), which also became mandatory for NHS Trusts, including CCG's from April 2015. It also supports the EDS2 goal for representative workforce and the link to inclusive leadership (including the Board) and how organisations are well led and provide support and leadership across their workforce. The experience of BME staff is a very good barometer of the climate of respect and care for all within NHS trusts as identified in Michael West 2011 report, NHS Staff Management and Health Service Quality.

3. Summary of Key Findings 2017/18

3.1. This report and the results of the 2018 WRES return detailed in Appendix 1, have been shared with Sumona Chatterjee, Executive Director of Strategic Commissioning and the Trust's Lead Commissioner as mandated in the contract.

The key findings of the results are provided below:

3.1.1. There has been an increase in the BME workforce to 128 people across the Trust with the percentage rising from 3.5% to 3.8%. This equates to an increase of seven people against an overall workforce count of 3337 for 2018. However, it should be noted that 2018 saw a drop in headcount of 146 over the previous year.

It should be noted, the changes to NHS Agenda for Change pay bands for clinical staff grades for Operational Team Leaders and Paramedics prevent a direct comparison of data from the previous two years. Within non-clinical roles, there continues to be under representation, but there has been a positive change with a third of BME staff at pay bands 6 and above. The relocation of the Trust Headquarters to a more ethnically diverse area may have had positive impact.

3.1.2. Metric two of the WRES measures the likelihood of BME candidates from shortlisting in comparison to their white counterparts. This figure continues to show that BME candidates are less likely to be appointed from shortlisting than their White counterparts. The figure has slightly worsened since the 2016/17 submission, with BME staff now being 1.57 times less likely to be appointed following shortlisting than their White counterparts are, up from 1.26.

A number of actions have been undertaken since April 2016 to reduce the impact of bias, including the introduction of a multi-mini assessment process across roles requiring high volume recruitment in the Operations directorate. However, it is difficult to ascertain any direct impact between specific interventions and progress against this metric. The use of staff, who have not received the appropriate training before participating in interview panels and

assessment centres, also continues to be a risk to our ability to deliver fair and equitable recruitment processes.

3.1.3. The 2017/18 figures show an increased likelihood of BME staff being taken through the formal disciplinary process in comparison to White colleagues. This figure increased from 0.82 in 2016/17 to 1.38 for the reporting period, equating to seven cases over a two-year period, of which five were in the last 12 months.

Although, the numbers are small, the figures are calculated as a ratio and therefore comparable with data for employees who have declared ethnicity as White, or chosen not to declare. Further analysis is required to identify whether there any particular directorates or Operating Units where BME staff are more of less likely to be taken through a formal disciplinary process.

3.1.4. The 2017/18 submission saw a positive result in relation to BME staff undertaking non-mandatory training and CPD in comparison with White colleagues. This figure not only improved, but also in this reporting period BME staff were more likely than White colleagues to undertake non-mandatory training at a 0.84 likelihood.

SECAmb reports against all non-mandatory training and Continuing Professional Development (CPD) recorded on Online Learning Management (OLM) system. Further analysis is required to separate access to leadership development training within this, and to develop methods that are more robust to capture any training that this undertaken. Recruitment to the post of Apprenticeships and Quality Assurance Lead is currently taking place and this post holder will begin to scope processes for capturing non-mandatory and CPD training within the Trust.

3.1.5. All four staff survey related metrics saw improvements in BME staff experience in this reporting period. The 2017 staff survey saw an increased completion rate by BME staff with 53 respondents identifying as BME up from 34 the previous year. This made up 4% of the total survey responses for 2017. All four metrics reported positive changes for BME staff; however, we are unable to attribute these changes to any specific actions taken.

3.1.6. Metric five, the 2017 staff survey saw a decrease in both BME and White staff experiencing harassment, bullying and abuse from members of the public / patients. The figure fell from 60.22% to 50.99% for White staff and 58.82% to 30.77% for BME staff.

3.1.7. The latest staff survey figures show that for metric six 32.69% of BME staff and 42.13% White staff experienced harassment, bullying and abuse from colleagues. Whilst there was an 11% decrease for BME staff reporting against this indicator, there was a 3% increase for White staff.

3.1.8. Metric seven noted a 13% increase in BME staff believing the Trust provides equal opportunities for career progression. This figure increased from 48% to

61% in the 2017 staff survey. However, there was a small decrease of 3% for White staff on the previous year.

3.1.9. There have been decreases in both White and BME staff reporting discrimination from a manager / team leader or other colleagues in this reporting period. These were down in 2017 staff survey from 17.18% to 15.80% for White staff and 27.27% to 13.21% for BME staff.

3.1.10. The Trust reported an all-White Board in 2017/18. Although the Board continues to be non-representative in both voting membership and executive membership, there has been a significant improvement with all Board members now self-reporting their ethnicity status.

4. Next steps

4.1. The IWG monitor and discuss the requirements of the WRES at each meeting, and review progress against an approved action plan to ensure an upward trajectory. At the meeting on 1st August 2018, the results for this year's submission were discussed, and a subgroup met to recommend actions to deliver further progress over the coming year.

4.2. It was agreed that the WRES action plan would be integrated with the action plan for the Trust Equality Objective ('The Trust will improve the diversity of the workforce to make it more representative of the population we serve'). Progress against this will be monitored and reviewed at IWG meetings, with regular reports to go to the HR Group.

4.3. The Board are asked to note the contents of this report and demonstrate their commitment to delivering progress by ensuring that their Senior Managers are held to account and have measurable objectives for delivering on their responsibilities in relation to Diversity and Inclusion. In particular, it is vital that those responsible for delivering progress on associated action plans are supported to ensure commitments and timescales are met.

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Appendix 1. Summary of WRES Submission August 2018

Metric 1: Percentage of staff in each of the AfC Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce.

	Non Clinical 2018						Clinical 2018					
	WHITE		BME		Not Stated/ Not Given		WHITE		BME		Not Stated/ Not Given	
Under Band 1	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Band 1	2	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Band 2	142	88.2%	10	6.2%	9	5.6%	0	0.0%	0	0.0%	0	0.0%
Band 3	213	93.0%	11	4.8%	5	2.2%	381	95.3%	11	2.8%	8	2.0%
Band 4	235	89.0%	21	8.0%	8	3.0%	554	94.5%	8	1.4%	24	4.1%
Band 5	108	91.5%	5	4.2%	5	4.2%	159	93.5%	6	3.5%	5	2.9%
Band 6	132	91.0%	11	7.6%	2	1.4%	814	92.6%	27	3.1%	38	4.3%
Band 7	94	86.2%	7	6.4%	8	7.3%	139	90.3%	7	4.5%	8	5.2%
Band 8A	30	90.9%	1	3.0%	2	6.1%	24	92.3%	0	0.0%	2	7.7%
Band 8B	17	85.0%	0	0.0%	3	15.0%	12	100.0%	0	0.0%	0	0.0%
Band 8C	10	83.3%	2	16.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Band 8D	4	80.0%	1	20.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Band 9	3	75.0%	0	0.0%	1	25.0%	0	0.0%	0	0.0%	0	0.0%
VSM	8	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total by Ethnicity	998		69		43		2083		59		85	
Percentage	89.91%		6.22%		3.87%		93.53%		2.65%		3.82%	
Total workforce by Clinical/Non-Clinical	1110						2227					

	Non Clinical 2017						Clinical 2017					
	WHITE		BME		Not Stated/ Not Given		WHITE		BME		Not Stated/ Not Given	
Under Band 1	0	0.0%	0	0.0%	0	0.00%	0	0.0%	0	0.0%	0	0.00%
Band 1	2	100.0%	0	0.0%	0	0.00%	0	0.0%	0	0.0%	0	0.00%
Band 2	160	83.3%	16	8.3%	16	8.33%	0	0.0%	0	0.0%	0	0.00%
Band 3	282	92.2%	14	4.6%	10	3.27%	420	95.0%	11	2.5%	11	2.49%
Band 4	235	91.8%	12	4.7%	9	3.52%	559	94.4%	8	1.4%	25	4.22%
Band 5	115	88.5%	9	6.9%	6	4.62%	125	90.6%	9	6.5%	4	2.90%
Band 6	139	93.3%	6	4.0%	4	2.68%	986	92.7%	28	2.6%	50	4.70%
Band 7	90	86.5%	6	5.8%	8	7.69%	26	92.9%	0	0.0%	2	7.14%
Band 8A	24	92.3%	0	0.0%	2	7.69%	0	0.0%	0	0.0%	0	0.00%
Band 8B	16	88.9%	0	0.0%	2	11.11%	12	100.0%	0	0.0%	0	0.00%
Band 8C	12	92.3%	1	7.7%	0	0.00%	0	0.0%	0	0.0%	0	0.00%
Band 8D	0	0.0%	0	0.0%	0	0.00%	0	0.0%	0	0.0%	0	0.00%
Band 9	3	100.0%	0	0.0%	0	0.00%	0	0.0%	0	0.0%	0	0.00%
VSM	6	75.0%	1	12.5%	1	12.50%	0	0.0%	0	0.0%	0	0.00%
Total by Ethnicity	1084		65		58		2128		56		92	
Percentage	89.81%		5.39%		4.81%		93.50%		2.46%		4.04%	
Total workforce by Clinical/Non-Clinical	1207						2276					

			2016 -17	2017-18
2	Relative likelihood of staff being appointed from shortlisting across all posts	Relative likelihood of White staff being appointed from shortlisting compared to BME staff	1.26	1.57
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	0.82	1.38
4	Relative likelihood of staff accessing non-mandatory training and CPD	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	1.36	0.84
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients,relatives or the public in last 12 months	% White staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	62.22%	50.99%
		% BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	58.82%	30.77%
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in	% White staff experiencing harassment, bullying or abuse from staff in the last 12 months	39.48%	42.13%
		% BME staff experiencing harassment, bullying or abuse from staff in the last 12 months	44.12%	32.69%

			2016 -17			2017-18		
7	KF 21. Percentage believing that trust provides equal opportunities for career	% White staff believing that trust provides equal opportunities for career progression or promotion	62.73%			60.18%		
		% BME staff believing that trust provides equal opportunities for career progression or promotion	48.00%			61.29%		
8	Q17. In the last 12 months have you personally experienced discrimination at work from an	% White staff personally experienced discrimination at work from Manager/team leader or other colleagues	17.18%			15.80%		
		%BME staff personally experienced discrimination at work from Manager/team leader or other colleagues	27.27%			13.21%		
9	Percentage difference between the organisations' Board voting membership and its overall workforce Note: Only voting members of the Board should be included when considering this indicator		White	BME	Unknown / Null	White	BME	Unknown / Null
		Total Board members - % by Ethnicity	69.20%	0.00%	30.80%	100.00%	0.00%	0.00%
		Voting Board Members - % by Ethnicity	75.00%	0.00%	25.00%	100.00%	0.00%	0.00%
		Non - Voting Board members - % by Ethnicity	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%
		Executive Board members - % by Ethnicity	66.70%	0.00%	33.30%	100.00%	0.00%	0.00%
		Non-Executive Board Members - % by Ethnicity	71.40%	0.00%	28.60%	100.00%	0.00%	0.00%
		Overall Workforce - % by Ethnicity	92.20%	0.00%	4.30%	92.33%	0.00%	3.84%
		Difference (Total Board - Overall Workforce)	**-23.00%**	**-3.50%**	**26.50%**	**7.67%**	**-3.84%**	**-3.84%**

Appendix 2: Integrated Equality Objective and Workforce Race Equality Standard action plan 2018-19

Equality objective 2017-2021 - "The Trust will improve the diversity of the workforce to make it more representative of the population we serve"

Action	Sub- action	Lead
1. Increase the number of applications and appointments from candidates who are from underrepresented groups (particularly BME and disabilities)	1.1. Review Trust website and implement changes demonstrating SECAmb as an inclusive, attractive and safe employer.	Janine Compton, Head of Communications
	1.2. Develop a range of resources and utilise to .promote SECAmb as an inclusive, attractive and safe employer	Alison Littlewood, Head of Resourcing and Service Centre
	1.3. Produce a business case for a Community Development Worker who will work with external stakeholders to increase applications from BME candidates	Alison Littlewood, Head of Resourcing and Service Centre
	1.4. Ensure the requirements of the Disability Confident level 2 are taken forward and maintained, with clear progress towards the next level (3).	Alison Littlewood, Head of Resourcing and Service Centre
	1.5. To review the brief provided when engaging external agencies in recruitment to Executive and Non-Executive roles and senior management roles. The procurement process must include evidence that provides candidate ratios by BME / gender / disability etc.	A) Non-Executive recruitment - Isobel Allen, Assistant Company Secretary B) Executive and senior management recruitment, Alison Littlewood, Head of Resourcing and Service Centre

	1.6.	Develop key performance indicators to ensure the use of tailored messaging that promotes the importance of a diverse workforce is integrated throughout the Culture Change Programme. Ensure that Corporate and Local induction processes are included.	Ed Griffin, Director of HR and Organisation Development
	1.7.	Identify areas of higher diversity, and target community events and recruitment activities to build a more diverse pipeline.	Alison Littlewood, Head of Resourcing and Service Centre
2. Training requirements to support increasing appointments from underrepresented groups.	2.1.	Develop clear effective guidelines for Recruiting Managers to support inclusive shortlisting.	Alison Littlewood, Head of Resourcing and Service Centre
	2.2.	Ensure that staff who have not undergone interview training cannot be listed as the Recruiting Manager, and develop effective processes to support recruitment activity within affected teams.	Alison Littlewood, Head of Resourcing and Service Centre
	2.3.	Audit a monthly sample of unsuccessful BME candidates to identify and improve recruitment practices. This is to include non NHS Jobs applications.	Alison Littlewood, Head of Resourcing and Service Centre
	2.4.	Work with the Inclusion Team to ensure Diversity and Inclusion content of all management and assessment training, to ensure that it is appropriately embedded and regularly assessed.	Ed Griffin, Director of HR and Organisation Development
3. Improving retention of underrepresented groups.	3.1.	Undertake detailed data analysis of exit data to identify any trends relating to underrepresented groups are identified, and that learning is utilised to inform future action planning.	Ian Jeffries, Head of HRBP & Employee Relations
	3.2.	Ensure there is an agenda item on diversity and Inclusion at meetings between HR Business partners and local leadership, to develop an increased awareness of the benefits of a diverse workforce as well as its obligations under the Equalities Act.	Ian Jeffries, Head of HRBP & Employee Relations

4. Supporting the delivery of a more representative workforce.	4.1.	Develop quarterly workforce reports, which provide comparison with baseline data against all protected characteristics. Report should be both aggregated and broken down by OU.	Sally Spencer, Workforce Planning and Information Manager
	4.2.	Review the process of current recruitment monitoring reports for BME and / or disabled candidates with the support of Workforce Planning to ensure the most effective process is implemented and ensuring this is part of the HR transformation work stream.	Alison Littlewood, Head of Resourcing and Service Centre
	4.3.	Ensure the culture programme demonstrates the value of diversity monitoring, increasing staff declarations on ESR.	Ed Griffin, Director of HR and Organisation Development