South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

25 October 2018
10.00-12.30

Tangmere MRC

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
Introduction					
104/18	10.01	Apologies for absence	-	-	DA
105/18	10.01	Declarations of interest	-	-	DA
106/18	10.02	Minutes of the previous meeting: 28 September 2018	**Y**	Decision	DA
107/18	10.03	Matters arising (Action log)	**Y**	Decision	DA
108/18	10.05	Board Story	-	Set the tone	DA
109/18	10.10	Chief Executive's report	**Y**	Information	DM
Trust strategy					
110/18	10.20	Delivery Plan Deep Dive: ▪ Health & Safety	**Y**	Information	SE BH
111/18	10.50	Finance & Investment Committee Escalation Report	**Y**	Information	AS
Governance & Risk Management					
112/18	11.00	Board Assurance Framework Risk Report	**Y**	Decision	PL
Quality & Performance					
113/18	11.10	Quality & Patient Safety Committee Escalation Report	**Y**	Information	LB
114/18	11.20	Thematic Review of SIs	**Y**	Assurance	BH
115/18	11.35	Integrated Performance Report	**Y**	Information	SE
Workforce					
116/18	12.00	Workforce & Wellbeing Committee Escalation Report	**Y**	Information	TP
117/18	12.10	Staff Retention	**Y**	Assurance	EG
118/18	12.20	Staff Survey Action Plan update	**Y**	Information	EG
Closing					
119/18	12.30	Any other business	-	Discussion	DA
120/18	-	Review of meeting effectiveness	-	Discussion	ALL
Close of meeting					

Date of next Board meeting: 29 November 2018
After the close of the meeting, questions will be invited from members of the public

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting,
28 September 2018

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

Present:

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

In attendance:

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

87/18 Apologies for absence

Terry Parkin	(TP)	Independent Non-Executive Director

88/18 Declarations of conflicts of interest

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

89/18 Minutes of the meeting held in public on 30 August 2018

The minutes were approved as a true and accurate record.

90/18 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.

91/18 Patient story [10.03 – 10.12]

This patient story related to out of hours access to a mortuary and the difficulties some staff have experienced. The concerns were brought to attention of the hospital and lessons have been learnt to assist ambulance staff in the future and to ensure patient dignity.

The Board explored whether we are using the learning with other Trusts and established that the Quality Improvement (QI) Hub is supporting the operating units (OUs) to take this up with other hospitals.

92/18 Chief Executive's report [10.12 – 10.21]
DM took members through the issues set out in his report. In addition, DM confirmed that the Board is holding a freedom to speak up development session after the meeting, and that management has undertaken a look back review from how it prepared for and assisted the Care Quality Commission (CQC) for its inspection.

DM also made reference to the recent Carter Review report published this week, concerning the ten English ambulance Trusts. DH added that we have been working with the sector for quite some time on much of the issues within the recently published report, so it we are taking an integrated approach, rather than as standalone work-stream.

Action:
The executive will bring back a report to the Board in November outlining the work in relation to the Carter Review.

93/18 Delivery Plan [10.21 – 10.57]
SE introduced this report, reinforcing with members that this is a summary report, with a great deal of detail that sits behind each area of delivery. Directors were invited to report against their areas of responsibility, by exception.

Service Transformation:
JG outlined the plans, confirming that as there are still some decisions to be agreed with commissioners, arising from the demand and capacity review, more detail will need to be taken in the private (part 2) part of the meeting.

In terms of the red-rated areas, JG explained that despite it being unlikely to reach the target for hospital handover delays there has been some really good improvements. We have hit a plateau relating to 'crew to clear' and the management team is looking in detail at how this is improved; with specific focus on ensuring we work with the workforce who are already very stretched.

Increased Hear & Treat is rated red mainly due to recruitment of clinicians. Addressing some queries from the Board, JG explained that the number of supervisors is down due to the introduction of a new clinical framework which introduced a new role, that of Clinical Navigator. All of these posts were taken predominantly from the current Clinical Supervisor pool, which shifted the WTE numbers. We now have 12 out of 14 Clinical Navigator posts filled and the balance of Clinical Supervisors is now circa 24 out of a desired 38. Therefore, the total WTE in the team is 36. The language in the reporting refers to Clinical Supervisors and therefore the absolute number for this group now seems lower, but the overall numbers in the team has in fact increased.

The NARU project has moved from green to amber due to the core standards self-assessment and, specifically, the Trust's ability to guarantee two Hart teams of six people 24/7. This was picked up by the Quality and Patient Safety (QPS) Committee, as per the escalation report.

In response to a question from AT about 'crew to clear' JG confirmed the steps being taken to undertake a process map, as the 15 minute target is a very old metric and doesn't take account of some of the

complexities that currently exist. The process map will clarify what can be reasonably achieved. LB added that this was explored at the QPS committee, which supported this review.

LM asked about the Manchester triage system and the impact of this on 'hear and treat'. JG explained we are due to have this system in place by 10 October 2018, which will with a weeks' training make available clinicians to provide telephone clinical advice. This is outside of 'Pathways', which requires 12 weeks' training. JG was very positive about this, confirming the potential to run clinical hubs outside of EOCs; local clinicians providing support to local people.

Sustainability:
DH confirmed that the projects within the purview of the Sustainability Steering Group are going well. Telephony is one of biggest projects and this is back on track and the first Electronic Patient Care Record (EPCR) Project Board was held this week, attended by LB.

Compliance:
BH confirmed that infection prevention and control (IPC) is due to move to business as usual in October. The culture change project is now rated red on as the project is being re-scoped. EG added here that we have someone in post to undertake the review, but assured the Board that in meantime a number of areas will continue to be delivered.

AS asked about the rationale to re-scope this project, asking specifically for assurance that it is not because the executive no longer believe it will deliver. EG confirmed that all the items within the current plan will carry forward, and so it will in fact be even more robust.

Strategy:
SE confirmed we are in final stages of the strategy review. In terms of annual planning, the demand and capacity review has concluded and we are now in the process of working with commissioners to transact the additional investment to help the Trust achieve ARP. This would need deeper discussion in part 2 as some of the detail is yet to be finalised.

SE confirmed that the procurement for a quality improvement (QI) partner is due to be concluded within the next couple of weeks.

AS referred to community first responders (CFRs) and asked whether it would be helpful to include within the Delivery Plan the work we are doing with CFRs. SE agreed, explaining that the outcome of the demand and capacity review and the need to improve clinical outcomes, includes work with CFRs, and they are part of our strategy conversations. JG added that we are very conscious of the support provided by CFRs and the need to improve our governance arrangements. A new senior manager has been recruited to lead the team (joining 17 October) and this will give dedicated leadership focus. We will consider whether we need to include a task and finish-type approach to oversee activities.

Deep Dives:

1. EOC / Call Answer

JG confirmed this area has much focus. The report shows the last 91 days; the reasons for the challenges and the related series of actions being taken. There is now a stronger focus on process where we have benchmarked against the best in class to see what they are doing we can adopt to improve performance. For example, we have identified that we take 20 seconds longer (than the best in class) to validate an address. We are working through to understand why. This is the sort of detail we are getting in to, helped by now being more on top of recruitment and retention.

DA asked whether the Board is assured that management is doing all it can and whether there is any additional support it needed from the Board. This led to a discussion, in the context of how fragile performance is, about the difference between being right-sized and the impact of increased activity. JG confirmed we have less headroom when there is an increase in activity /sickness. For example, the report includes a graph where there is a direct correlation between a reduction in activity and significant improvement in performance.

The Board noted this and asked for assurance that management is improving resilience to respond better to spikes in demand, and even out the current dips in performance. JG confirmed that there is much work ongoing and reinforced the need to identify all the areas of efficiency that will support this - resilience comes with having efficient processes.

TM asked whether management is making the link between when staff 'make busy' and our culture. Is there something else going on management needs to look at, for example? JG acknowledged this.

LB expressed concern about some of the other direct consequences of lacking resilience. For example, call audits are likely to reduce given the trade-off between audit and training.

DA summarised that the executive are clearly focussed on all the areas the Board is concerned with. He asked the QPS committee to explore more deeply the question of resilience, especially heading in to winter and then report back to the Board.

Action:
QPS Committee to test the controls in place to improve operational resilience, in the context of responding to increased demand, and report back to the Trust Board.

2. Incident Management

BH confirmed that incident management remains under the scrutiny of the Quality and Compliance Steering Group. The project has been extended for a number of reasons, including the current backlog of serious incident (SI) reports being concluded. The recovery trajectory is in place, which is being monitored weekly internally and externally by the CCG. The forecast is to have no breached SIs by mid-October 2018. Currently, we have 75 open Sis; 20 of these are with CCGs, and of the remaining 55, 28 are under investigation and 27 are in sign off, and most of these are breaching.

BH outlined some of the causes for the delays, which include issues with the initial allocation and quality assurance. Additional resource has been identified to help close the gap and a mapping process is being undertaken in early October, with CCGs, to ensure a more robust process going forward.

DA summarised that the Board is encouraged by the work described.

94/18 Clinical & Quality Enabling Strategy [10.57 – 11.13]

FM introduced thus strategy, which is the plan for next three years. In developing it, we wanted it to be a living document and consulted a wide range of staff. The clinical and quality priorities are as set out and it is for Board approval. The next step will be to develop the related delivery plans, e.g. cardiac arrest and stroke.

The Board was supportive of the strategy and felt that it was presented in a way that was easy to understand. Some challenges from the independent non-executive directors were made, including;

- CFRs – no reference to CFRs or training for public. FM confirmed that CFRs are included in the cardiac arrest strategy and referenced the use of 'Good Sam'.

- Priorities – the link between the aims and how they are intended to be achieved. FM outlined the approach in some of the areas, and how they cross work streams both internally and externally.

- National standards / best practice – where do we stand against them? FM confirmed the current national standards are within the IPR (AQIs) and that the aim is to always meet national standards. This strategy and the AQIs pick up specific standards.

- Impact on external service reconfiguration, e.g. stroke. FM outlined the progress in our region in relation to stroke configuration and confirmed that with regards cardiac care, this is more work in progress; we are working closely with Ashford and East Sussex.

DA summarised by confirming this is an excellent document, which needs to cross reference national and local standards.

Decision:
Subject to linking to the relevant national / local standards, the clinical and quality enabling strategy was approved.

95/18 Mental Health Provision Business Case [11.13 – 11.18]
BH confirmed that mental health is one of clinical priorities within the clinical and quality strategy. This business case has been approved by the executive management board and before Board in line with the standing financial instructions (SFIs). Option 1 is recommended and the business case sets out the benefits.

AS did not think it was helpful, as a concept, to bring business cases to Board, that relate to appointment of staff. DH explained that we are trying to introduce whole life costs for non-funded investment to give visibility, until we review the SFIs.

There was also a discussion about which business cases are taken through board committees and DH agreed to pick this up outside of the meeting with AS and PL.

Decision:
Mental Health Provision Business Case (option 1) was approved by the Board

[Break at 11.18]

96/18 Audit Committee Escalation Report [11.29 – 11.32.]
AS confirmed that the substance of the meeting was about progress against Internal Audit management actions and risk management. The committee agreed there was good progress on the management actions, having expressed concern about this at its last meeting. On risk management the committee had a good discussion on the BAF risk report and felt it was good to see this is a live document, which is driving how the executive manage the business. There was also a good risk report, with good interpretive comment by the head of risk.

As also highlighted business continuity and the work underway. A presentation is planned for the next meeting.

97/18 BAF Risk Report [11.32 – 11.34]

PL set out the structure of the report, asking the Board to note the update against each risk, particularly the development and the challenge by the Audit & Risk Committee, which will be considered by the executive management board in October.

As set out in the report the Board was specifically asked to agree to removing risk 518 from the BAF, replacing it with risk 579, and agree the change in date for the EOC target risk score (confirmed in the dashboard) from 31.08.2018 to 30.06.201. PL explained that a report is due to come to the Board in October on how the Trust is managing clinical risk in the EOC (patients waiting).

DA reflected that this is a key document and AS reinforced the role of the Audit and Risk Committee is not to second guess the executive but test the process. The committee is assured that the BAF risks are now appropriately overseen by the Board and its committees.

Decision:
The Board agreed the changes to the BAF risks, as recommended in the report.

98/18 Major Incident Plan [11.34 – 11.47]

JG explained that the purpose of brining this to the Board is for awareness. It is updated every three years and delivered via I-Pads along with actions cards to operational staff. It is a reference document, has been reviewed with partner agencies, and includes learning from incidents, e.g. Shoreham, M20 RTC. In addition, we undertake regular training and exercises with partners, e.g. Gatwick, Channel Tunnel. Key Skills includes major incidents and JG outlined the key elements.

Action:
A Board seminar to be arranged to understand the broad generality of the Major Incident Plan and Board's responsibilities relating to other agencies.

AR asked about how we work with other agencies and issues of communication and interoperability. JG referred to the joint decision model and the command training, and confirmed that the operational team leader role is an operational command position. The first contact is all important and how this informs the overall dealing with the incident.

Action:
PL to circulate the NARU video on Board's responsibilities to each Board member.

In summary, DA confirmed that the Board has assurance that a plan is in place and updated as required. The Board thanked the staff responsible for pulling this together and responding to these types of incidents.

99/18 QPS Committee Report [11.47 – 11.55]
LB took the Board through the areas covered by the committee at its meeting in September, as set out in the report.

On the NARU assessment, which is binary, LB confirmed that the Trust will not be compliant and so is a specific escalation to the Board.

Action:
A paper to come to the Board in October, about being non-compliant with the NARU audit (on the basis of not being able to always guarantee two HART teams of six staff 24/7) with a recommendation.

On behalf of the Board, DA thanked the committee for its work and for this very comprehensive report.

100/18 Integrated Performance Report (IPR) [11.55 – 12.20]
SE introduced the IRP, reinforcing the link to the delivery plan, noting the timing of some of the data, and confirming that the executive reviews real-time performance data weekly.

Safety:
FM highlighted patient records and the improvement in unreconciled records, which is now more in line with the national average.

National ambulance quality indicators (AQIs) are reported against specific areas. We are below the national average for cardiac arrest, despite improvement from the previous year. Stroke and STEMI is also improving, but we are determined to improve further.

There were no questions.

Quality:
BH highlighted (on page 18) the improved information on health and safety (H&S), following appointment of the new Head of H&S. The improvement plan is due to come to the Workforce and Wellbeing Committee in October, and then to Trust Board. BH noted the concerns about RIDDOR reporting and confirmed the work ongoing to address this.

LB asked about the trajectory to achieving the requirement under duty of candour for incidents of moderate harm. BH confirmed that there is an open work stream for this, informed by the recent Internal Audit Report; we expect to see a recovery trajectory as part of this.

Operations:
JG outlined the scorecard data which relates to July's performance. This illustrates the pressures in July as discussed under the Delivery Plan. There is a dip for Cat 2 and Cat 3 / 4 remains a challenge, which directly links to the demand and capacity review and the need to be right-sized.

GC asked whether we are consistently ensuring we provide 9000 hours (per week). JG explained that we struggled through August due in part to key skills training and the need to get this done ahead of winter. The hours during September are however starting to climb.

The Board noted the direct correlation between hours and performance, strengthening the importance of the demand and capacity review and need for greater investment.

DA reflected on the good work there is to maintain a service. However, winter is coming and so the Board needs to support operations to deliver, by working with our partners in the system to ensure we are collectively able to deliver the best possible care to patients.

Workforce:
EG noted that a number of metrics will need to change over time, including timeliness of recruitment and vacancies filled. Also, while the number of cases is important, we need to report on the time to conclude bullying and harassment / grievances etc. This is work underway.

EG confirmed that we have now made 298 offers to ECSW and AAPs and there are 221 places on clinical education courses to ensure this recruitment is concluded by December 2018. Linking in with the HR transformation programme we can better identify bottle necks in process so that action can be taken. Once we get on top of resourcing we must also ensure we better understand retention issues; why staff are leaving.

In response to a challenge from LM, about the lack of detail on retention rates and where there might be hot spots, EG agreed to bring back to the Board a report on retention.

Action:
A paper to come to Board in October setting out the work to identify issues with retention and the action to improve retention rates.

Finance:
The Board noted that the Trust is on plan at month 5 and the work within the finance team to reforecast after month 6, which will be reported through the Finance and Investment Committee. DH explained that the Trust has received positive feedback from the finance business partner model. Also, his team had a meeting with NHS Improvement to discuss financial performance, the cost improvement programme, and planning for next year, which was positive. The executive is focussed on ensuring is has line of sight of everything we do given the number of things ongoing.

101/18 Workforce Race Equality Standard Summary Report [12.20 – 12.24]
This report is provided for information and EG took the opportunity of highlighting the importance of Asmina Islam Chowdhury, Inclusion Advisor, in driving this area.

EG also outlined why this is so important. For example, in terms of values we must have a workplace of equality of opportunity. Section 2.1 of the report outlines the benefits of a diverse and inclusive workforce and section 2.2 the positive impact on all staff. In other words, if we make inroads to set groups of people we will make progress across the wider trust.

EG noted the area of BME staff going through disciplinary processes, whereby some go through a more rigorous process than non-BME staff. He explained we are looking at providing training and awareness in this area, including awareness of unconscious bias.

DA thanked EG for the update and reinforced the importance of embracing this as a Board.

102/18 Any other business
None

103/18 Review of meeting effectiveness

Directors were satisfied that everyone had the opportunity to contribute.

DA noted the need to continue to improve and develop, which he will pick up with the Board to inform a bespoke board development programme.

There being no further business, the meeting closed at 12.26.

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	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	29.11.2018	Board	IP	The governance and assurance strategy / framework is due to be received by the Audit Committee at an exceptional meeting in November prior to Board on 29th
27.03.2018	197/17	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/EG	TBC	Board	IP	
25.05.2018	30/18	IPR to include figures for duty of candour relating to moderate harm	BH	Sept	Board	C	This is now included within the IPR
25.05.2018	30/18	The IPR includes a CQC domain section agaisnt each section. The Board has asked for one overall summary.	SE	Sept	Board	C	The executive recommend closing this action on the basis that is it reviewing the inclusion of this section as part of the response to the upcoming CQC inspection findings.
25.05.2018	32/18	Learning from External Reviews recommendations to be reviewed in December to confirm how the actions have been implemented.	PL	20.12.2018	Board	IP	Added to December Board agenda
28.06.2018	45/18 a	Deep Dive on the 'tail' and how we are maintaining patient safety to come to the Board	JG	29.11.2018	Board	C	Added to Board agenda in November
28.06.2018	45/18 b	A NED to be identified to sit on the Telephony Project Board.	DH	August	Board	C	This has been confirmed as Terry Parkin
28.06.2018	48/18	FIC to scrutinise the Fleet Man system	DH	TBC	FIC	IP	Added to FIC annual plan
28.06.2018	51/18	Update on falls patients to the Board in October 2018	FM	29.11.2018	Board	IP	This will now come to the Board in November 2018
30.08.2018	82/18 a	Staff survey action plan to come to the Board in October	EG	25.10.2018	Board	C	Added to October Board agenda
30.08.2018	82/18 b	Fleet Strategy to be considered by FIC in October	JG	18.10.2018	FIC	IP	The committee agreed that further engagement was required prior to it considering it for recommendation to the Board
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	C	Deep Dive on Agenda 25.10.2018
30.08.2018	84/18 b	BH to bring to the Board the thematic review of Sis	BH	25.10.2018	Board	C	On agenda

25.09.2018	92/18	The executive will bring back a report to the Board in November outlining the work in relation to the Carter Review.	DH	29.11.2018	Board	IP	Added to November Board agenda
25.09.2018	93/18	QPS Committee to test the controls in place to improve operational resilience, in the context of responding to increased demand, and report back to the Trust Board.	JG	25.10.2018	Board	C	Considered by QPS on 19.10.2018 - see escalation report
25.09.2018	98/18 a	A Board seminar to be arranged to understand the broad generality of the Major Incident Plan and Board's responsibilities relating to other agencies.	PL	TBC	Board	IP	
25.09.2018	98/18 b	PL to circulate the NARU video on Board's responsibilities to each Board member, and confirm it has been watched.	PL	29.11.2018	Board	C	PL sent the NARU video 01.10.2018 asking directors to confirm by email that they have watched it.
25.09.2018	99/18	A paper to come to the Board in October, about being non-compliant with the NARU audit (on the basis of not being able to always guarantee two HART teams of six staff 24/7) with a recommendation - see September QPS Committee escalation report	JG	25.10.2018	Board	C	On agenda - part 2
25.09.2018	100/18	A paper to come to Board in October setting out the work to identify issues with retention and the action to improve retention rates.	EG	25.10.2018	Board	C	On agenda

Key

Not yet due
Due
Overdue
Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

	Item No

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

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

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S REPORT TO THE TRUST BOARD

1. Introduction

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

2. Local issues

2.1 Engagement with local stakeholders & staff

2.1.1 On 20 September 2018, I attended the Association of Ambulance Chief Executive's (AACE) meeting for Chief Executives. As always, there was a varied agenda, with key national items discussed including paramedic prescribing and the recent Project A initiative, developed with NHS Horizons. We also met Steve Barclay MP, the Minister of State for Health to discuss ambulance performance and winter preparations.

2.1.2 On 24 September 2018, I was pleased to welcome Adam Doyle, Accountable Officer of the eight CCGs in Sussex and East Surrey to our Crawley HQ. During his visit, Adam was able to see some of our new vehicles, spend time in EOC listening in to 999 calls and meet with representatives of our Staff Networks, Unions and Public Representatives.

2.1.3 On 25 September 2018, I continued my programme of station visits with visits to Dorking, Leatherhead, Guildford and Redhill Ambulance Stations. As always, I thoroughly enjoyed chatting with staff, answering their questions and hearing about their issues and concerns.

2.2 Annual NHS Staff Survey

2.2.1 This year's national NHS Staff Survey launched in SECAmb on 24 September 2018 and will run for eight weeks, closing at the end of the week commencing 12 November 2018. All substantive SECAmb staff have been invited, by email, to take part in the online survey.

2.2.2 We have used a dedicated communications campaign, both in the run-up to and during the survey, to increase staff awareness and engagement. The communications have focused on illustrating some key improvements, delivered across the Trust over the past year, and the staff feedback that has helped to shape them.

2.2.3 At the end of the third week, the response rate to the survey was 20%, which is higher than at the same point last year. Recognising the importance of hearing from as many of our staff as possible, we are working hard to exceed last year's overall response rate of 44%.

2.3 Executive Management Board (EMB)

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

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

- Focussed closely on 999 performance, including response to lower categories of calls, provision of staff hours and call answer times
- Discussed the on-going NHS 111 contract tenders & future impact on the Trust
- Considered progress n the on-going Demand & Capacity Review & the related Service Transformation project

2.3.3 On 17 October 2019, as part of supporting national Freedom to Speak Up month within SECAmb, we held a live Exec 'web cast', featuring Ed Griffin, Executive Director of HR & OD, Bethan Haskins, Executive Director of Nursing & Quality and Kim Blakeburn, the Trust's Freedom to Speak Up Guardian.

2.3.4 The session allowed staff to join the session 'live' if they were able to or watch it afterwards, learn more about Freedom to Speak Up and ask questions of Ed and Bethan directly.

2.4 New electronic Patient Care Record (ePCR) solution

2.4.1 Following the pause of the previous project, we have now selected a new ePCR solution that will help to improve the quality, safety and efficiency of patient care and provide a useful tool for staff.

2.4.2 Cleric, who also provide the Trust's CAD, have been selected to provide a new ePCR solution to the Trust and to work with us on the development and customisation of their ePCR product to meet our needs. Importantly, it will also integrate fully with our CAD**.** This decision was made following a number of workshop sessions with potential suppliers, where staff were able to go through a selection of real life scenarios and frequently asked questions.

2.4.3 Following the selection of Cleric as the new supplier, a working group has been established including staff from across the Trust, which is meeting regularly and will work on the development of the new ePCR as well as new content for the iPADs. A pre-go live site has been selected where operational colleagues and others can test some of the detail and make amendments, which will allow us to incorporate lessons learned prior to wider roll out.

2.4.4 We will start rolling out the new ePCR solution from February next year and this should be complete by Summer 2019; I am excited about the benefits I am sure this will bring both for staff and patients.

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. The Trust's annual flu vaccination campaign got underway at the beginning of October and we have seen a good take up of the vaccination this year so far. For example, at our Crawley HQ, the Quality improvement (QI) Hub team, who have been delivering the vaccine to staff, vaccinated more than 100 staff within the first 24 hours –a great achievement.

3.1.3 This year, the Trust has opted to provide a course of medication or a vaccine (for a range of relevant diseases) to people in less developed countries when our staff have the flu vaccination. Staff are able to choose from one of five options and feedback so far suggests that this has gone down well with staff.

3.1.4 Along with other members of the Executive Team and our Chair, I have had my flu vaccination and see this has an important requirement for all staff, especially those who are patient-facing. I would encourage all staff to ensure they protect themselves, colleagues, patients and families from the spread of this virus.

4. National issues

4.1 Carter Review published

4.1.1 On 27 September 2018, NHS Improvement published 'Lord Carter's review into unwarranted variation in NHS ambulance trusts'. The report sets out a number of recommendations on how ambulance services can work more efficiently and collaboratively, moving forward, with technology and innovation highlighted as a key driver for improved performance.

4.1.2 Along with all ambulance services nationally, we have already been working closely with our NHS partners and commissioners locally, as well as NHS Improvement, to establish where we can make improvements that will make a greater impact on patient care. Examples include investing in a new CAD and EOC West, improvements in our fleet and working with our partners locally on initiatives including the new Pregnancy Advice Line with Surrey Heartlands Health and Care Partnership and a pilot service across Coastal West Sussex to help people who have suffered a fall at home.

4.1.3 Although the report highlights a number of ways in which we and other ambulance services can work more efficiently, I am pleased that it also highlights the significant contribution made by ambulance staff every day to provide excellent patient care, despite rising demand.

5. Recommendation

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

Daren Mochrie QAM, Chief Executive

17 October 2018

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	110/18

Name of meeting	Trust Board
Date	25 October 2018
Name of paper	PMO Delivery Progress Update
Responsible Executive	Steve Emerton, Director of Strategy and Business Development
Author	Eileen Sanderson, Head of PMO
Synopsis	This paper provides an overview of the progress of the Delivery Plan. The CQC tracker will be re-established following review of the most recent CQC inspection report, which is due to be published in November 2018.
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**

Executive Summary

The Board should be particularly drawn to the introduction of the Service Transformation and Delivery Programme (which was the ARP Demand and Capacity Delivery), Health and Safety & Interim 111 CAS projects. To note imminent project closures; Hear and Treat, EOC, NARU

Since the last reporting period, the following projects have now closed; Expansion of First Floor Crawley HQ and Infection Prevention and Control.

Post project evaluations will be conducted shortly for projects that were closed over 3 months ago; Complaints and Safeguarding.

Cyber, Replacement Telephony and Voice Recording and Fleet Management projects (under Digital Programme) have recently had change controls to amend the timeline which is now reflected in the Dashboard (Appendix A).

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
- Quality and Compliance
- Strategy

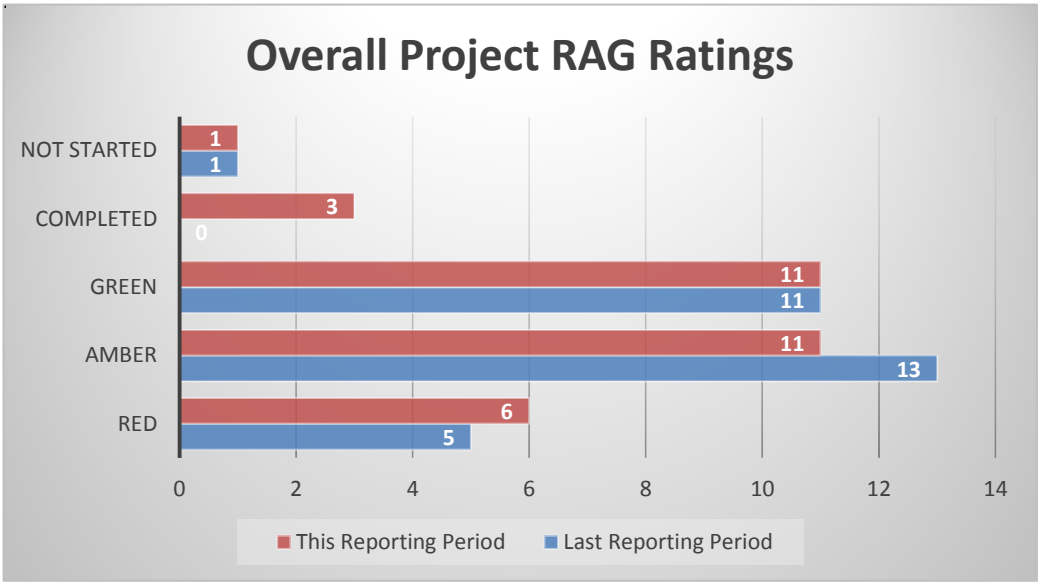
1.1 The Dashboard gives high level commentary and associated Key Performance Indicators (KPIs) for this reporting period where appropriate. As projects come to completion the reader should note that project closure processes will be enacted to ensure that continued and sustained delivery moves into Business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

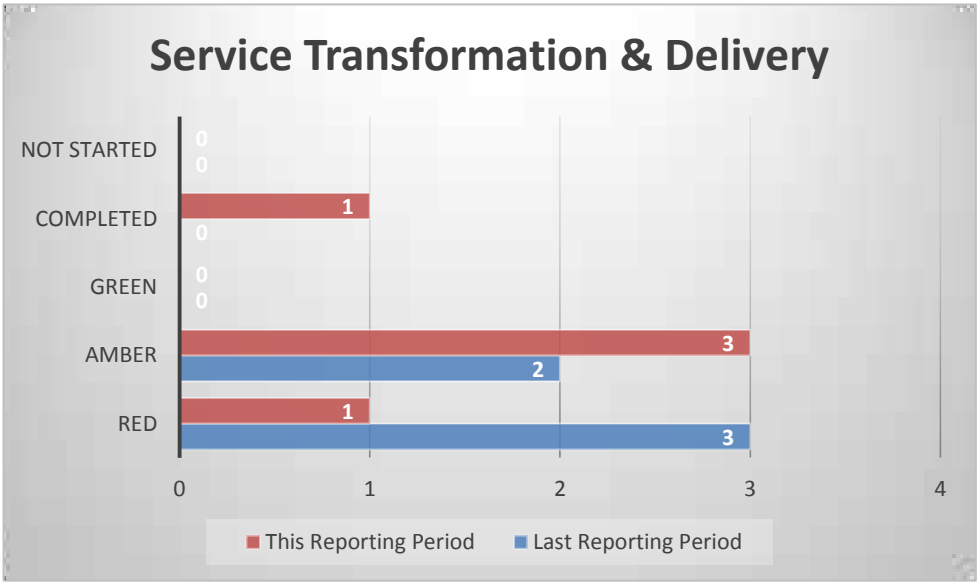
1.3 The Delivery Plan Dashboard (Appendix A) provides a summary of progress within this reporting period. For information the RAG status is defined as follows:

- 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 **Service Transformation Delivery Programme (Previously ARP Demand and Capacity Delivery)** – The project RAG is Amber due to inherent delivery risk which is being managed proactively. Additional personnel are being allocated to the programme and a full business case for external support was recently approved at the Business Review Group on 16th October 2018 to bring together existing work areas such as recruitment and fleet acquisition.

Implementation of the plan will be led by a Programme Board with system wide membership, and be overseen by a Strategic Oversight Group. Progress will be closely monitored by commissioners to ensure improvements in performance are being delivered within agreed timescales.

2.1 **Demand and Capacity Review** – The RAG for this work stream has moved from RAG rated Amber to Blue as the review is now complete.

In order to deliver the required improvements, significant additional investment has been agreed by commissioners for 2018/19, which is being enacted via an agreed Contract Variation for mobilisation from October 2018. Work to set the 2019/21 contract in the light of the review will be initiated in October 2018 for agreement by end of December 2018. The implementation of the review will now be oversee by the Service Transformation and Delivery Programme.

2.2 **Hospital Handover –** 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 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 has moved from Red to Amber. Hear and Treat increased to 5.7%, above the national average of 5.2%. The target for Q1 2020/2021 will remain in line with ARP.

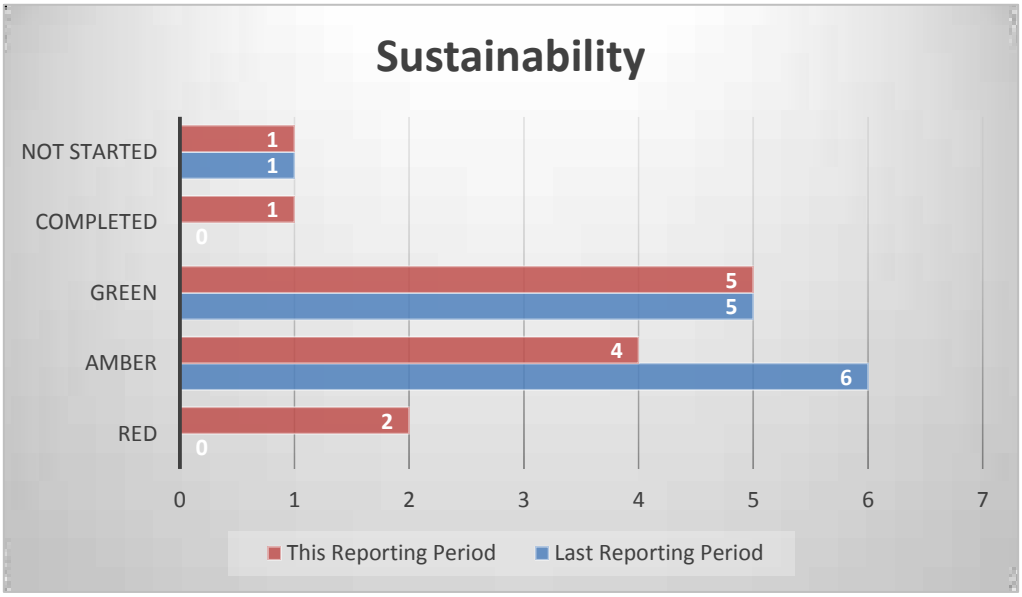
The current Whole Time Equivalent (WTE) for the Clinical Supervisor Presence within EOC is 41.48. This is comprised of 3 Clinical Operational managers, 13 Clinical Safety Navigators and 25.48 Clinical Supervisors.

The Manchester Triage System (MTS) has gone live on 10th October 2018 as planned. The training course in October 2018 is full with another course is planned for the 19th November 2018. The rotational Paramedic Practitioners who work in EOC are also being trained on the software.

The Hear and Treat project is currently going through project closure with the remaining uncompleted activities being absorbed as part of the Service and Delivery Transformation, EOC and 111 CAS Interim programmes.

2.4 **National Ambulance Resilience Unit -** The project remains RAG rated Amber. The project is nearing the end of the agreed project lifetime and there are still actions needing to be completed. Progress continues to be made on a number of the remaining actions during this period, however, there are some, which are at risk and will potentially need to be transferred to the EPRR action plan for 2019 following this year's Self-Assessment process. Over the coming weeks, the project will be going through formal project closure.

Sustainability



Since the last reporting period, 111 CAS Interim Service has now start reporting into the Sustainability Steering Group. Further detail is contained within this report.

Digital Programme

3.1 **Automated Temperature Monitoring** – This project RAG rating moves from Amber to Red. Although the contract has been awarded, the completion date is yet to be confirmed and there is a lack of clarity around the ownership of this project. However, a meeting is now planned between Operations, Medical and IT to discuss this further. The project is expected to move to Amber in the next reporting period.

3.2 **Corporate IT systems back up** – This project is RAG rated White as it has not yet started. A mapping exercise is underway to scope out what content needs to be backed up across the organisation. This project was due to be completed prior to winter however this is no longer possible. The Project Lead is currently conducting a risk assessment to measure the impact of this delay.

3.3 **Cyber Security** – This project RAG rating moves from Amber to Red. A bug in the software had been identified resulting in the requirement to pause the migration. The fix has now been received and in depth testing will take place this week. Providing the testing is successful, it is expected that the admin network migration will take place in the next week, with the CAD migration being paused until early 2019, once the change freeze period is complete. A Change Control has recently been approved to extend the timeline from end of October 2018 to mid February 2019.

3.4 **ePCR** – This project remains RAG rated Green and is on track for delivery as expected. A draft project plan has been presented to the Project Board and will be baselined with the 'point in time' plan. The Operations Lead has been appointed and is due to start at the end of October 2018. A Communication and Engagement Strategy is in development and it is

expected that the test platform will be available at the end of October 2018. Risks relating to stakeholder engagement, timelines and resourcing across the Trust remain the same.

3.5 **Incident Management Software** – This project remains RAG rated Green as all of the IT elements are complete. The operational training has begun; however an expected completion date has not yet been confirmed.

3.6 **Replacement Fleet Management System** – This project remains RAG rated Amber. The touch screens have been installed for testing and the scanners and printers have been ordered. However, a change control is underway as a two-week delay to the original completion date has been identified due to delays in the migration of the database to Jaama. This will impact on testing, which is at risk due to the availability of Fleet staff.

3.7 **Replacement of Telephony and Voice Recording system** – This project RAG rating moves from Amber to Green. The pre-staging elements are complete and the kit is undergoing installation at both the Crawley and Coxheath sites. The testing and migration approaches have been confirmed. The technical LLD and functional design will be completed in the next two weeks. A Change Control was recently approved to extend the end date of the project from mid November 2018 to mid December 2018 however the suppliers are continuing to work towards and earlier date of end of November 2018.

3.8 **Spine Connect** – This project remains RAG rated Green. PDS is now live in the EOC and user awareness is underway. SCR development is now complete and is expected to go live at the end of October. Formal assurance documents will need to be approved by NHS Digital prior to go live. However, whilst the functionality is ready from a technical perspective, EOC staff will not be able to access it without smartcards. A business case is in development for the expansion of the Registration Authority (RA) team.

3.9 **GoodSAM** – This project moves from Green to Amber RAG rating - the IT elements are complete, however go live has been postponed until December 2018 due to governance requirements with the clinical/ operational rollout.

3.10 **Station Upgrades** – This project remains RAG rated Green. Dates have been agreed with Switchshop for the WiFi upgrades and the broadband service provider has been selected. Site surveys are to be completed by the end of quarter one. The MRCs remain on track for upgrade before the winter period.

3.11 **Expansion of First Floor Crawley HQ –** This project is now complete and is therefore RAG rated Blue. An additional 24 desks and all of the accompanying IT equipment have been installed and are fully operational.

111 Clinical Advice Service Interim Service (Sussex, West Kent, North Kent and Medway)

3.12 **111 Clinical Advice Service Interim Service (Sussex, West Kent, North Kent and Medway) -** SECAmb (as the incumbent provider of NHS 111 in partnership with Care UK) has received a request from the Sussex and West Kent and North Kent & Medway commissioners to provide an interim NHS 111 Service for them (independently and without Care UK's involvement) for a period of one year from 1st April 2019. Our commitment to provide the interim service is in recognition of the opportunities to realise significant efficiencies in bringing NHS 111 onto the 999 Cleric and Avaya systems, therefore creating synergies between the two services, including: resilience of 999, workforce, data analytics, audit and frequent caller processes

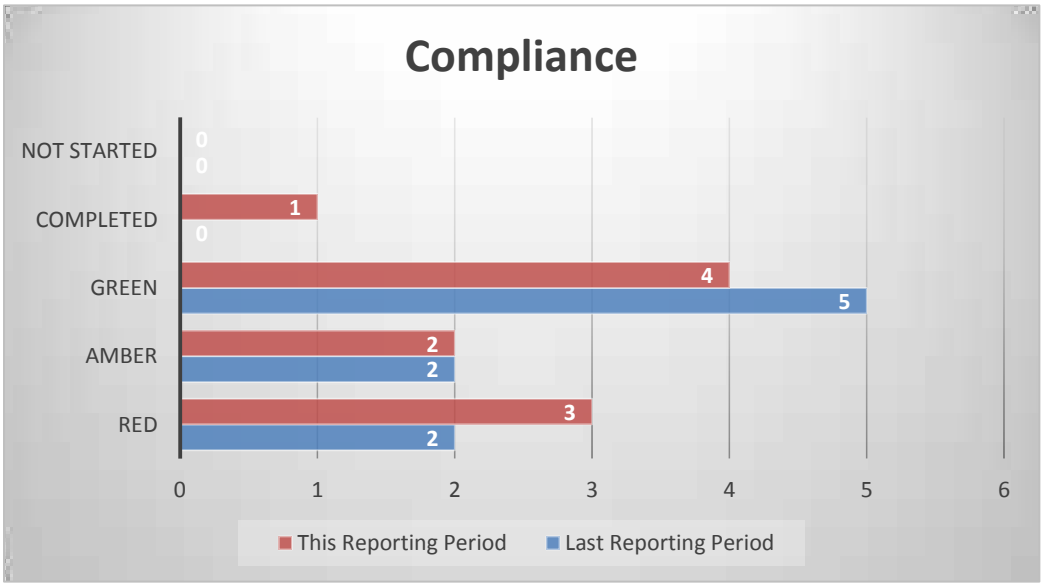
To ensure robust governance, an internal Project Board has been developed to oversee the various workstreams, with an external oversight group established to ensure assurance is provided to commissioners and to challenge or escalate where appropriate. A Programme Delivery Manager has been commissioned to support the process and control documents, including separate mandates which are currently being drafted. The first mandate details our approach to maintaining the current service, during the period of transition to the new service model on 1 April 2019. The second Mandate covers the 12-month contract outlining the new model and its phased approach to introducing a full Clinical Assessment Service (CAS).

We are still awaiting a contract from commissioners as we only have a letter of intent at this time, however we are mitigating this risk, as well as other risks, hence the RAG rating of Amber.

Financial Sustainability Group

3.13 **CIP -** The Trust has reported a CIP target of £11.4m to NHSI as part of the 2018/19 Budget and Plan. £7.9m of fully validated savings have been transferred to the Delivery Tracker as at the Month 6 reporting date, of which £4.2m 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



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.

September has seen an improvement in call answer performance compared to what was forecasted in the new trajectory, with 81.8% of calls answered within 5 seconds against a target of 70%.

45 Clinical Supervisor WTE was re-evaluated through Clinical Framework to 38 Clinical Supervisor WTE plus 14 Clinical Safety Navigator WTE. CSN Establishment is near full. The Trust has been unable to recruit new clinical supervisors to meet the target as there has been insufficient interest in the role.

Audit compliance is at 100% for July, 52.7% for August and 24.5% for September. 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.

The recruitment and retention of Emergency Medical Advisors remains an issue for the Trust. In September 19 EMAs joined and 14 left the role. Effective EMA establishment will reduce in October to 135 Whole Time Equivalent as the high turnover in July and August cycles through before improving in November.

The project closure for the existing EOC plan was presented to the Quality and Compliance Steering Group on Tuesday 16th October 2018 however it was not signed off as there were a couple of gaps. It is expected that the Project Closure will be re-presented at Quality and Compliance Steering Group at the end of the month and work can begin with setting up the new project plan.

4.2 **Governance and Risk** – The project RAG remains Green. The Task & Finish Group is assured of the progress made. In particular, there has been a positive engagement with the risk management training, which is central to this specific improvement objective. In addition, there is a focussed effort to reinforce the principles that underpin the management of policies and procedures, which includes the policy effectiveness review tool that has recently been developed.

4.3 **Incident Management** *(CQC Must Do)* – The project RAG moves from Green to Amber. Work continues to manage the current SI backlog and the turnaround of SI's, which is also being monitored weekly at the SI Group, overseen by the Executive Team and by the lead Quality Commissioners. Additional activities and metrics have been added to the plan to enable clear oversight of the management of the backlog and monitoring of compliance.

Temporary resources to support the team pending substantive recruitment continues. An offer has been made/accepted for the Head of Patient Safety (negotiation to bring forward the start date is underway); recruitment continues to the B7 vacancies in the team; and the SI Analyst interviews are scheduled for 18th October 2018.

4.4 **Infection Prevention and Control** *(CQC Must Do)* – The project is now complete and is therefore RAG rated Blue. The IPC Team are continuing with the Roadshows to help support the introduction of new procedure.

4.5 **Private Ambulance Providers –** This work stream RAG moves from Green to Amber. Significant work has been undertaken in recent weeks with the majority of the plans now being managed to Subject Matter Expert (SME) to manage and implement directly as part of BAU. The workstream is expected to move to Green in the next reporting period once assurance has been provided at Quality and Compliance Steering group that there is firm oversight of the plans.

4.6 **Resourcing Plan** – The project RAG has moved from Amber to Red due to the non-delivery of expected starters in October (44 candidates deferred training course due to C1 licence delay). Currently 174 ECSW candidates are expected to be operational by December 2018. 170 candidates are currently awaiting training spaces as November and January courses are currently full. The project has moved into Intensive Support to help unblock some of the issues.

4.7 **Personnel Files** – This project remains Amber due to the scale of the work to undertaken. Additional resource is now working on checking the electronic files with all paper files across the Trust have now been inventoried. The next step is to review the inventory and produce an options paper on recommendations for the Trust to consider how we manage paper files.

From the initial 92 employees showing as no initial DBS, all have completed the application, 8 are currently awaiting their completed certificate.

In relation to the number of staff requiring DBS renewals, out of 402, 70 have not completed their online application, 100 haven't provided ID with 131 do not currently have a renewed DBS. Over the coming weeks, the team will be giving specific focus to this objective.

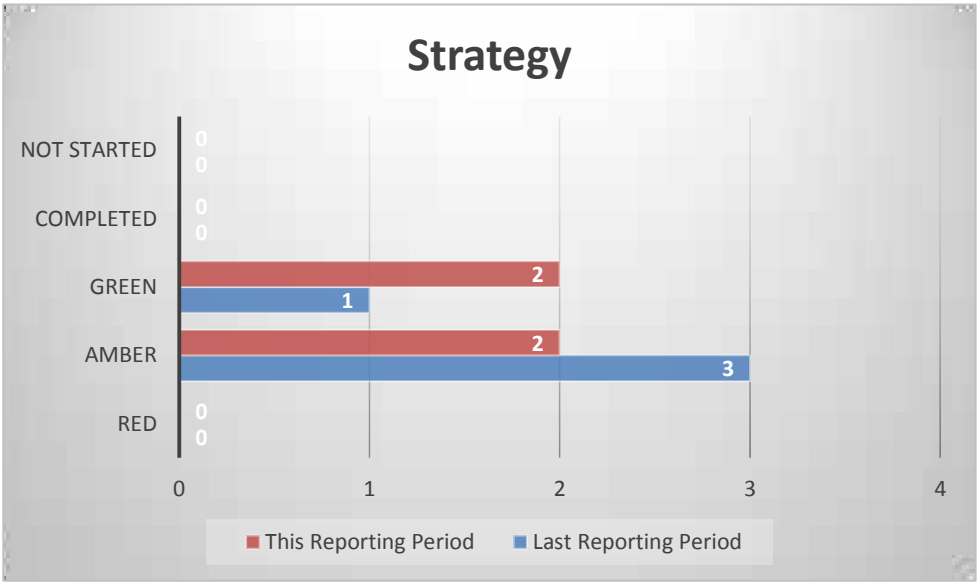
4.8 **999 Call Recording** *(CQC Must Do)* – The project RAG remains Green. The Project has been ongoing since November 2017 with a number of faults resolved. Primary fault is missing calls but also includes conjoined and part recorded calls. Weekly audits taking place, fixes still lodged with telephony 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 3276 audits having taken place this month to date.

4.9 **Culture Change** – The project RAG remains Red. Several phases of change have now been delivered in the SECAmb culture programme: the creation of and move to the new headquarters at Crawley, the refreshed values and behaviours and their accompanying collateral and recognition scheme, and recently the behavioural change initiatives including 360 feedback, four modules of training for leadership and senior managers, and a programme is currently being delivered for OMs and OTLS. The HR Director has taken the decision to call a pause to assess and re-calibrate the needs of the programme to ensure change is built upon and sustained. The existing project is in the process of being closed; a review is currently being undertaken and a new mandate will be delivered for approval in late October. During the review we are continuing the roll-out of leadership training across Operations, the 2018 Staff Survey, use of positive recognition to reinforce the Values and ongoing work around well-being and inclusion.

4.10 **Health & Safety Compliance Improvement Plan** – This is the first reporting period and the project RAG is Green. The Health & Safety Improvement Action Plan mandate and project plan has now been drafted and is expected to be signed off in the coming weeks. Progress will be provided to the Quality Compliance Steering Group on a fortnightly basis.

Furthermore, a task and finish group has now been formally established which will now meet every two weeks to aid the completion of the improvement plan.

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** – Please refer to 2.1. Demand and Capacity Review section

5.2 **Commissioner and Stakeholder Alignment** – This work stream remains RAG rated Green. Engagement sessions with staff and volunteers are taking place as part of our strategy refresh. Other engagement opportunities to gather intelligence for strategic work is also being utilised, for example, quality visits, internal and external meetings.

5.3 **Enabling Strategies** – This work stream remains RAG remains Amber with Workforce, Fleet, Estates, Research and Development, Volunteers, Governance, and Partnership/ commercial all underway. The Clinical and Quality Strategy was approved at the September 2018 Trust Board. Subject to committee approval the Fleet, Estates and

Governance strategies will be presented for approval at the October 2018 Trust Board. The Research and Development will be presented at the November Trust Board 2018.

5.4 **Quality Improvement** – The project RAG remains at Amber. The Trust is working on a business case that will then enable progression of the procurement process to select the methodology.

Delivery Plan Dashboard

1 September 2018 to 30 September 2018

RAG Key:

Red	At significant risk of failure due to circumstances which can only be resolved with additional support
Amber	Risk of failure but mitigating actions in place which can be delivered within current capacity
Green	On track and scheduled to deliver on time and with intended benefits
Blue	Completed
White	Not yet started

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive Lead	CQC Deep Dive Date	Forecast Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
Service Transformation & Delivery Steering Group	Service Transformation & Delivery Programme (previously ARP Demand & Capacity Delivery)	Amber	Amber	Rob Mason	Steve Emerton	N/A	01/04/2020 (previously 01/04/2021)	The project RAG is Amber due to inherent delivery risk which is being managed proactively. Additional personnel are being allocated to the programme and a full business case for external support was recently approved at the Business Review Group on 16th October 2018 to bring together existing work areas such as recruitment and fleet acquisition. Implementation of the plan will be led by a Programme Board with system wide membership, and be overseen by a Strategic Oversight Group. Progress will be closely monitored by commissioners to ensure improvements in performance are being delivered within agreed timescales.	In post WTE	1880	1878	2413	There is a risk that there isn't capacity to support delivery; however a business case for additiional resource has recently been approved at the Business Review Group (16/10)
									Leavers WTE	81	81	461	
									Joiners WTE	178	146	1052	
									Movers WTE	31	42	TBA	
									Number of rotas planned	0	10	10	
									Number of rotas in negotiation	0	10	10	
									Number of rotas agreed	0	10	10	
									Number of rotas implemented	0	10	10	
	Demand and Capacity Review	Blue	Amber	Jayne Phoenix	Steve Emerton	N/A	30/09/2018 (previously 31/07/2018)	The RAG for this work stream has moved from RAG rated Amber to Blue as the review is now complete. In order to deliver the required improvements, significant additional investment has been agreed by commissioners for 2018/19, which is being enacted via an agreed Contract Variation for mobilisation from October 2018. Work to set the 2019/21 contract in the light of the review will be initiated in October 2018 for agreement by end of December 2018. The implementation of the review will now be oversee by the Service Transformation and Delivery Programme.	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 to project delivery as the project has now been completed
	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 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.	Handover delay no more than 60mins	361	N/A	0	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.This risk will increase we move into winter when system wide pressures increase
									Crew to Clear time within 15mins 85% of the time	48%	85%	85%	
	Increased Hear and Treat	Amber	Red	Scott Thowney	Joe Garcia	N/A	25/07/2018	The project RAG has moved from Red to Amber. Hear and Treat increased to 5.7%, above the national average of 5.2%. The target for Q1 2020/2021 will remain in line with ARP. The current Whole Time Equivalent (WTE) for the Clinical Supervisor Presence within EOC is 41.48. This is comprised of 3 Clinical Operational managers, 13 Clinical Safety Navigators and 25.48 Clinical Supervisors. The Manchester Triage System (MTS) has gone live on 10th October 2018 as planned. The training course in October 2018 is full with another course is planned for the 19th November 2018. The rotational Paramedic Practitioners who work in EOC are also being trained on the software. The Hear and Treat project is currently going through project closure with the remaining uncompleted activities being absorbed as part of the Service and Delivery Transformation, EOC and 111 CAS Interim programmes.	45 clinical supervisors & clinical safety navigators in post in EOC	41.48	45	45	Challenges with attracting Clinical Supervisors to the role have been a project blocker. Part of project closure and new activities to deliver desired outcome will include project activities linked to achieving this benefit, which will require HR involvement in order to assure success.
									Hear and Treat Performance	5.70%	6%	6%	
	National Ambulance Resilience Unit	Amber	Amber	Chris Stamp	Joe Garcia	N/A	30/10/2018 (previously 31/10/2018)	The project remains RAG rated Amber. The project is nearing the end of the agreed project lifetime and there are still actions needing to be completed. Progress continues to be made on a number of the remaining actions during this period, however, there are some, which are at risk and will potentially need to be transferred to the EPRR action plan for 2019 following this year's Self-Assessment process. Over the coming weeks, the project will be going through formal project closure.	Awareness training of HART response time standards for Command Teams	107	130	224	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. However the data is currently being developed within the Power BI system. 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.	97.0%	95%	95%	
									IOR Training compliance for frontline staff	1856	1226	2452	
									To meet the Response times standards for deployment	Data not available	95%	95%	

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive Lead	CQC Deep Dive Date	Forecast Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
Sustainability Steering Group	CIP	Amber	Amber	Kevin Hervey	David Hammond	N/A	31/03/2019	The Trust has reported a CIP target of £11.4m to NHSI as part of the 2018/19 Budget and Plan. £7.9m of fully validated savings have been transferred to the Delivery Tracker as at the Month 6 reporting date, of which £4.2m 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.	KPIs are embodied in the Delivery Tracker. The Outcome will be successful achievement of the CIP Programme.	£7.9m	£11.4m	£11.4m	The RAG rating for the CIPs programme remains at Amber as at month 6, 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 £2.4m for the year covering Operations efficiencies have been developed, of which £0.7m have been achieved at month 6. 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.
	111 Clinical Advice Service Interim Service (Sussex, West Kent, North Kent and Medway)	Amber	First reporting period	Mark Featherstone	David Hammond	N/A		SECAmb (as the incumbent provider of NHS 111 in partnership with Care UK) has received a request from the Sussex and West Kent and North Kent & Medway commissioners to provide an interim NHS 111 Service for them (independently and without Care UK's involvement) for a period of one year from 1st April 2019. Our commitment to provide the interim service is in recognition of the opportunities to realise significant efficiencies in bringing NHS 111 onto the 999 Cleric and Avaya systems, therefore creating synergies between the two services, including: resilience of 999, workforce, data analytics, audit and frequent caller processes To ensure robust governance, an internal Project Board has been developed to oversee the various workstreams, with an external oversight group established to ensure assurance is provided to commissioners and to challenge or escalate where appropriate. A Programme Delivery Manager has been commissioned to support the process and control documents, including separate mandates which are currently being drafted. The first mandate details our approach to maintaining the current service, during the period of transition to the new service model on 1 April 2019. The second Mandate covers the 12-month contract outlining the new model and its phased approach to introducing a full Clinical Assessment Service (CAS). We are still awaiting a contract from commissioners as we only have a letter of intent at this time, however we are mitigating this risk, as well as other risks, hence the RAG rating of Amber.	We are still awaiting a contract from commissioners as we only have a letter of intent at this time. The contract will detail the KPIs and QIs that we will need to meet and these form part of the Project Mandates. The first manadate details our approach to maintaining the current service, during the period of transition to the new service model on 1 April 2019. The second Mandate covers the 12-month contract outlining the new model and its phased approach to introducing a full Clinical Assessment Service (CAS).	TBC	TBC	TBC	Risks are still being documented, however current discussions have highlighted the following: • IT and BI: BT delivery of the fundamental deliverables, especially the primary network – escalated to BT senior managers • Estates: Two electricity supplies into the building that we need to bridge or find another solution, Water pipe running within the server room which needs moving, AC and parking a concern • Workforce: modelling detail to feed financial model, recruitment and training unclear • Clinical, Contingency and Risk: Developing relationships with local/external providers to ensure we can keep the lights on and to provide ongoing resilience; Lack of contract, clarity of new model and phasing milestones
	Automated Temperature Monitoring	Red	Amber	Timothy Poole / Jason Tree	David Hammond	N/A	31/03/2019 (anticipated)	This project RAG rating moves from Amber to Red. Although the contract has been awarded, the completion date is yet to be confirmed and there is a lack of clarity around the ownership of this project.	All stations to have automated temperature monitoring	N/A	100%	100%	To mitigate the risk of ownership, meeting is now planned between Operations, Medical and IT to discuss this further. The project is expected to move to Amber in the next reporting period.
	Corporate IT Systems Back-ups	White	White	Jason Tree	David Hammond	N/A	31/03/2019 (anticipated)	This project is RAG rated White as it has not yet started. A mapping exercise is underway to scope out what content needs to be backed up across the organisation. This project was due to be completed prior to winter however this is no longer possible. The Project Lead is currently conducting a risk assessment to measure the impact of this delay.	KPIs to be defined.				No risks or issues highlighted in this reporting period.
	Cyber Security	Red	Amber	Phil Smith	David Hammond	N/A	15/02/2019 (previously 31/10/18)	This project RAG rating moves from Amber to Red. A bug in the software had been identified resulting in the requirement to pause the migration.	All software and hardware is deployed and operational.				The fix has now been received and in depth testing will take place this week. Providing the testing is successful, it is expected that the admin network migration will take place in the next week, with the CAD migration being paused until early 2019, once the change freeze period is complete. A Change Control has recently been approved to extend the timeline from end of October 2018 to mid February 2019.
	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 and is on track for delivery as expected. A draft project plan has been presented to the Project Board and will be baselined with the 'point in time' plan. The Operations Lead has been appointed and is due to start at the end of October 2018. A Communication and Engagement Strategy is in development and it is expected that the test platform will be available at the end of October 2018. Risks relating to stakeholder engagement, timelines and resourcing across the Trust remain the same.	KPIs documented on Mandate, pending sign off prior to detailing.				No risks or issues highlighted in this reporting period.
	Expansion of Crawley 1st Floor	Blue	Amber	Paul Ranson	David Hammond	N/A	31/08/2018	This project is now complete and is therefore RAG rated Blue. An additional 24 desks and all of the accompanying IT equipment have been installed and are fully operational.	Number of desks	24	24	24	No risks or issues highlighted in this reporting period.
	GoodSAM	Amber	Green	Dave Hawkins	David Hammond	N/A	01/12/2018	This project moves from Green to Amber RAG rating - the IT elements are complete, however go live has been postponed until December 2018 due to governance requirements with the clinical/ operational rollout.	GoodSAM system implemented.				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 as all of the IT elements are complete. The operational training has begun; however an expected completion date has not yet been confirmed.	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	Amber	John Griffiths	David Hammond	N/A	28/11/2018 (previously 16/11/2018)	This project remains RAG rated Amber. The touch screens have been installed for testing and the scanners and printers have been ordered. However, a change control is underway as a two-week delay to the original completion date has been identified due to delays in the migration of the database to Jaama. This will impact on testing, which is at risk due to the availability of Fleet staff.	The Fleet Management system will be replaced and implemented.				A change control is underway as a two-week delay to the original completion date has been identified due to delays in the migration of the database to Jaama. This will impact on testing, which is at risk due to the availability of Fleet staff. Meeting will be taking place with Operations and Fleet to trry to minimise impact.
	Replacement of Telephony and Voice Recording System	Green	Amber	Phil Smith	David Hammond	N/A	12/12/2018 (previously 30/11/2018)	This project RAG rating moves from Amber to Green. The pre-staging elements are complete and the kit is undergoing installation at both the Crawley and Coxheath sites. The testing and migration approaches have been confirmed. The technical LLD and functional design will be completed in the next two weeks. A Change Control was recently approved to extend the end date of the project from mid November 2018 to mid December 2018 however the suppliers are continuing to work towards and earlier date of end of November 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 remains RAG rated Green. PDS is now live in the EOC and user awareness is underway. SCR development is now complete and is expected to go live at the end of October. Formal assurance documents will need to be approved by NHS Digital prior to go live. However, whilst the functionality is ready from a technical perspective, EOC staff will not be able to access it without smartcards. A business case is in development for the expansion of the Registration Authority (RA) team.	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%	

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
Quality & Compliance Steering Group	Station Upgrades	Green	Green	Jason Tree	David Hammond	N/A	31/03/2019	This project remains RAG rated Green. Dates have been agreed with Switchshop for the WiFi upgrades and the broadband service provider has been selected. Site surveys are to be completed by the end of quarter one. The MRCs remain on track for upgrade before the winter period.	KPIs to be defined				No risks or issues highlighted in this reporting period.
	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. September has seen an improvement in call answer performance compared to what was forecasted in the new trajectory, with 81.8% of calls answered within 5 seconds against a target of 70%. 45 Clinical Supervisor WTE was re-evaluated through Clinical Framework to 38 Clinical Supervisor WTE plus 14 Clinical Safety Navigator WTE. CSN Establishment is near full. The Trust has been unable to recruit new clinical supervisors to meet the target as there has been insufficient interest in the role. Audit compliance is at 100% for July, 52.7% for August and 24.5% for September. 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. The recruitment and retention of Emergency Medical Advisors remains an issue for the Trust. In September 19 EMAs joined and 14 left the role. Effective EMA establishment will reduce in October to 135 Whole Time Equivalent as the high turnover in July and August cycles through before improving in November. The project closure for the existing EOC plan was presented to the Quality and Compliance Steering Group on Tuesday 16th October 2018 however it was not signed off as there were a couple of gaps. It is expected that the Project Closure will be re-presented at Quality and Compliance Steering Group at the end of the month and work can begin with setting up the new project plan.	Clinical supervisors in post in EOC	25	38	38	The recruitment and training team has highlighted a risk to delivering the mentoring required for trainee Health Advisors due to a surge in trainee numbers and a lack of coaches. Experienced EMAs are being identified for development to support the requirement. Another risk is the shortfall in trainers required for the November EMA course. 111 have been contacted and requested to provide training support. It was recently identified that the EMA Dashboard did not show a "live picture" of the EMA Unit Hour Utilisation. The EMA Dashboard below only updated once a day and any new sickness, continued sickness and abstractions would not show until the update at 06:00 each morning. This issue gave the EOC Leadership Team no time to plan ahead and be proactive rather than reactive. EOC Scheduling have spoken to the developers of the software and updates will now take place at 06:00, 12:00 and 18:00 daily which will give more up-to-date information to plan ahead.
									Number of audits per month	100% (Jul) 52.7% (Aug) 24.5% (Sep)	100.0%	100.0%	
									95% of calls answered within 5 seconds.	81.8%	70.0%	95.0%	
									FTE EMAs in post within EOC	135	171	187	
	Governance and Risk	Green	Green	Peter Lee	Daren Mochrie	N/A	31/03/2019	The project RAG remains Green. The Task & Finish Group is assured of the progress made. In particular, there has been a positive engagement with the risk management training, which is central to this specific improvement objective. In addition, there is a focussed effort to reinforce the principles that underpin the management of policies and procedures, which includes the policy effectiveness review tool that has recently been developed.	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	Amber	Green	Nicola Brooks	Bethan Haskins	08/11/2017	31/10/2018	The project RAG moves from Green to Amber. Work continues to manage the current SI backlog and the turnaround of SI's, which is also being monitored weekly at the SI Group, overseen by the Executive Team and by the lead Quality Commissioners. Additional activities and metrics have been added to the plan to enable clear oversight of the management of the backlog and monitoring of compliance.	20% increase in overall incident reporting (Monthly)	838	576	576	Temporary resources to support the team pending substantive recruitment continues. An offer has been made/accepted for the Head of Patient Safety (negotiation to bring forward the start date is underway); recruitment continues to the B7 vacancies in the team; and the SI Analyst interviews are scheduled for 18th October 2018
									>75% of incidents closed within time target [SECAmb Target]	85%	75.0%	75.0%	
									90% of Serious Incident investigations will be completed within 60 working days.	11%	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	97%	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	Blue	Green	Adrian Hogan	Bethan Haskins	N/A	31/08/2018	The project is now complete and is therefore RAG rated Blue. The IPC Team are continuing with the Roadshows to help support the introduction of new procedure.	Hand Hygiene Staff Compliance	89%	No data available	90%	No risks or issues highlighted as project is now complete
									Bare Below the Elbow	97%	No data available	90%	
									Vehicle Cleanliness Compliance	71%	No data available	75%	
									Station Cleanliness - Buildings Compliant	83%	No data available	100%	
									Station Cleanliness - Buildings Completed	69%	No data available	100%	
	Resourcing Plan	Red	Amber	Alison Littlewood	Ed Griffin	N/A	03/12/2018 (previously 04/12/2018)	The project RAG has moved from Amber to Red due to the non-delivery of expected starters in October (44 candidates deferred training course due to C1 licence delay). Currently 174 ECSW candidates are expected to be operational by December 2018. 170 candidates are currently awaiting training spaces as November and January courses are currently full. The project has moved into Intensive Support to help unblock some of the issues.	Recruitment of 300 external operational staff (ECSW & AAP) • ECSWs to be operational • AAPs to be in training	174	266	300	Delays to candidates obtaining their C1 licences will mean a large number of people will be awaiting course spaces in 2019. There are not enough courses to meet this need due to the trust moving to a new apprenticeship approach in January 2019.
	Personnel Files	Amber	Amber	Isla MacDonald	Ed Griffin	N/A	30/06/2019	This project remains Amber due to the scale of the work to undertaken. Additional resource is now working on checking the electronic files with all paper files across the Trust have now been inventoried. The next step is to review the inventory and produce an options paper on recommendations for the Trust to consider how we manage paper files. From the initial 92 employees showing as no initial DBS, all have completed the application, 8 are currently awaiting their completed certificate. In relation to the number of staff requiring DBS renewals, out of 402, 70 have not completed their online application, 100 haven't provided ID with 131 do not currently have a renewed DBS. Over the coming weeks, the team will be giving specific focus to this objective.	No. of staff with no initial DBS	8	0	0	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.
									No. staff requiring renewal of DBS	131	0	0	
									No. of electronic files	1441	2282	3723	
	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 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 3276 audits having taken place this month to date.	100% of all 999 calls recorded				No risks or issues highlighted in this reporting period.
									Auditing of calls take place on a weekly basis from 05 January 2018 (circa 2500 calls)				
									Approx. 15 sample calls carried out				

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive Lead	CQC Deep Dive Date	Forecast Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
	Culture Change	Red	Red	Clare Irving	Ed Griffin	N/A	30/04/2019	The project RAG remains Red. Several phases of change have now been delivered in the SECAmb culture programme: the creation of and move to the new headquarters at Crawley, the refreshed values and behaviours and their accompanying collateral and recognition scheme, and recently the behavioural change initiatives including 360 feedback, four modules of training for leadership and senior managers, and a programme is currently being delivered for OMs and OTLS. The HR Director has taken the decision to call a pause to assess and re-calibrate the needs of the programme to ensure change is built upon and sustained. The existing project is in the process of being closed; a review is currently being undertaken and a new mandate will be delivered for approval in late October. During the review we are continuing the roll-out of leadership training across Operations, the 2018 Staff Survey, use of positive recognition to reinforce the Values and ongoing work around well-being and inclusion.	No KPIs have been defined. Project is currently going through closure and new mandate will be produced by the end of October 2018				No risks or issues highlighted in this reporting period.
	Health & Safety	Green	First reporting period	Amjad Nazir	Bethan Haskins	N/A	TBC	This is the first reporting period and the project RAG is Green. The Health & Safety Improvement Action Plan mandate and project plan has now been drafted and is expected to be signed off in the coming weeks. Progress will be provided to the Quality Compliance Steering Group on a fortnightly basis. Furthermore, a task and finish group has now been formally established which will now meet every two weeks to aid the completion of the improvement plan.	KPIs to be defined.	TBC	TBC	TBC	No risks or issues highlighted in this reporting period.
	Private Ambulance Providers (PAPs)	Amber	Green	Chris Stamp	Bethan Haskins	10/10/2018	31/03/2019	This work stream RAG moves from Green to Amber. Significant work has been undertaken in recent weeks with the majority of the plans now being managed to Subject Matter Expert (SME) to manage and implement directly as part of BAU.	PAP KPIs will be aligned and formed using the current schedule KPIs for the Trust.				There is a risk regarding oversight of the plans. Once assurance has been provided at Quality and Compliance Steering group that there is firm oversight of the plans, this will be expected to move to Green in the next reporting period.
Strategy	Annual Planning	Green	Amber	Jayne Phoenix Philip Astell	Steve Emerton	N/A	August 2018 (previously 30/04/2018)	Please refer to Demand & Capacity Review project update (row 17)	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 with staff and volunteers are taking place as part of our strategy refresh. Other engagement opportunities to gather intelligence for strategic work is also being utilised, for example, quality visits, internal and external meetings	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, Volunteers, Governance, and Partnership/ commercial all underway. The Clinical and Quality Strategy was approved at the September 2018 Trust Board. Subject to committee approval the Fleet, Estates and Governance strategies will be presented for approval at the October 2018 Trust Board. The Research and Development will be presented at the November Trust Board 2018.	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 working on a business case that will then enable progression of the procurement process to select the methodology.	The Trust has approved to adopt a QI methodology and an implementation plan is in place for roll-out across the Trust supported by a QI team.				No risks or issues highlighted in this reporting period.

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

Financial Reporting Period: Month 6 - September 2018

Programme Summary:

1. Current Pipeline schemes of £13.4m against an internal stretch target of £13.5m.
2. Validated or Scoped schemes of £9.9m 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,reductions in task cycle time and increases in key skills training. CIPs to the value of £2.4m for the year covering these efficiencies have been developed, of which £0.7m 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 half way 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	

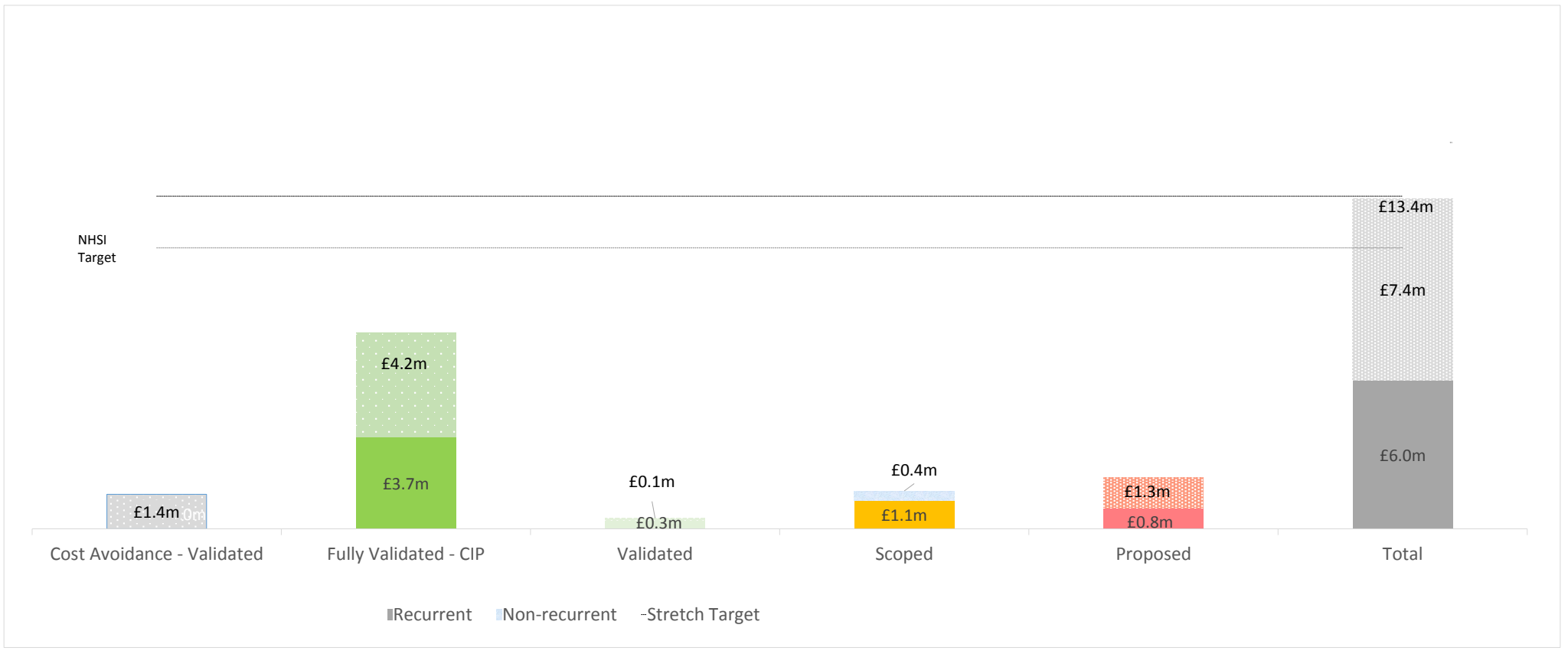
CIP Pipeline and Delivery: Risks and Issues

	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

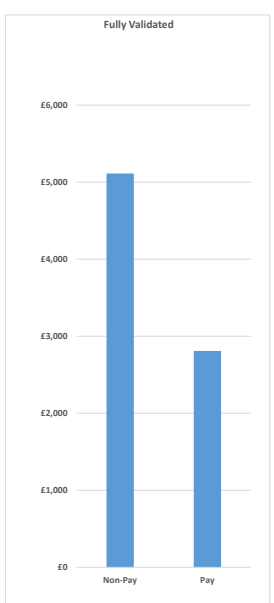
	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	New Lease Cars policy to be agreed.	Awaiting updates from John Griffiths (Response Capable Managers) and Ed Griffin (all other staff)	John Griffiths/ Ed Griffin	Amber	Amber	30-Nov-18
2	Medical Consumables - 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	31-Oct-18
3	Rates Rebate - evaluate potential savings.	Develop a CIP based on rates review	Paul Ranson	Amber	Amber	31-Dec-18
4	E-Expenses - potential savings from automation.	E-Expenses has not yet gone live.	Priscilla Ashun-Sarpy	Amber	Amber	31-Oct-18
5	Agency Staff - Potential cost avoidance CIP	PMO/Finance to develop a Project Mandate	Priscilla Ashun-Sarpy/ Kevin Hervey	Amber	Amber	31-Oct-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	Devise a mechanism for recoveries of old staff overpayments	Ongoing discussions with Payroll Manager/HR Director	Kevin Hervey	Amber	Amber	30-Nov-18

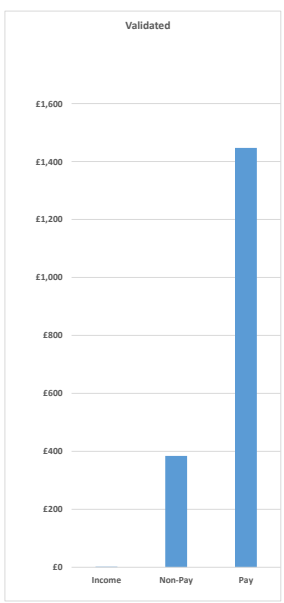
CIP Pipeline Summary

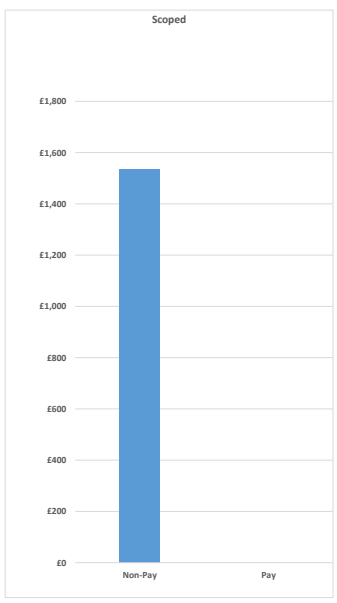
Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£1,400	£7,922	£433	£1,536	£2,097	£13,387

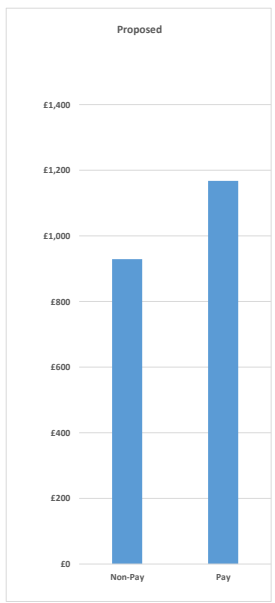


Pay / Non-Pay / Income Breakdown and scheme summary









Scheme Category	Fully Validated	Validated	Scoped	Scoped	Grand Total
Operations efficiencies	2,365	6	-	-	2,370
Recruitment delays & recharges - clinical	880	10	-	-	2,058
Insurance	820	4	-	-	824
External consultancy & contractors	713	10	140	140	863
Training courses & accommodation	672	12	-	-	683
Fleet - Lease costs - ambulances	390	-	400	400	790
Recruitment delays & recharges - non clinical	342	31	-	-	373
Travel & Subsistence	307	52	7	7	366
Medicines Management - Consumables	200	94	-	-	294
Fleet - Fuel: Telematics, Bunkered Fuel & Price Differential	200	-	-	-	200
Single HQ /EOC Benefits realisation	183	-	-	-	183
Medicines Management - Equipment	150	-	17	17	167
IT Productivity and Phones	148	9	140	140	397
Medicines Management - Drugs	132	-	-	-	132
Meeting room hire	99	-	8	8	107
Discretionary Non Pay	85	-	-	-	85
Estates and Facilities management	56	188	624	624	868
Stationery	44	3	-	-	47
111 Efficiency	33	-	-	-	33
Books & Subscriptions	32	-	-	-	32
Printing & Postage	32	-	-	-	32
Furniture & Fittings	30	-	-	-	30
Fleet - Uniforms and Contract Refuse	6	-	-	-	6
Public relations	4	-	-	-	4
Income	-	2	-	-	2
Legal fees	-	13	-	-	13
Business Cases Savings 18/19	-	-	-	-	829
Staff Uniforms	-	-	100	100	100
Agency Premiums	-	1,400	-	-	1,400
Procurement contracts review	-	-	100	100	100
	7,921	1,833	1,536	1,536	13,387

South East Coast Ambulance Service: CIP Workstream

CIP Delivery Dashboard

Reporting Month Sep-18

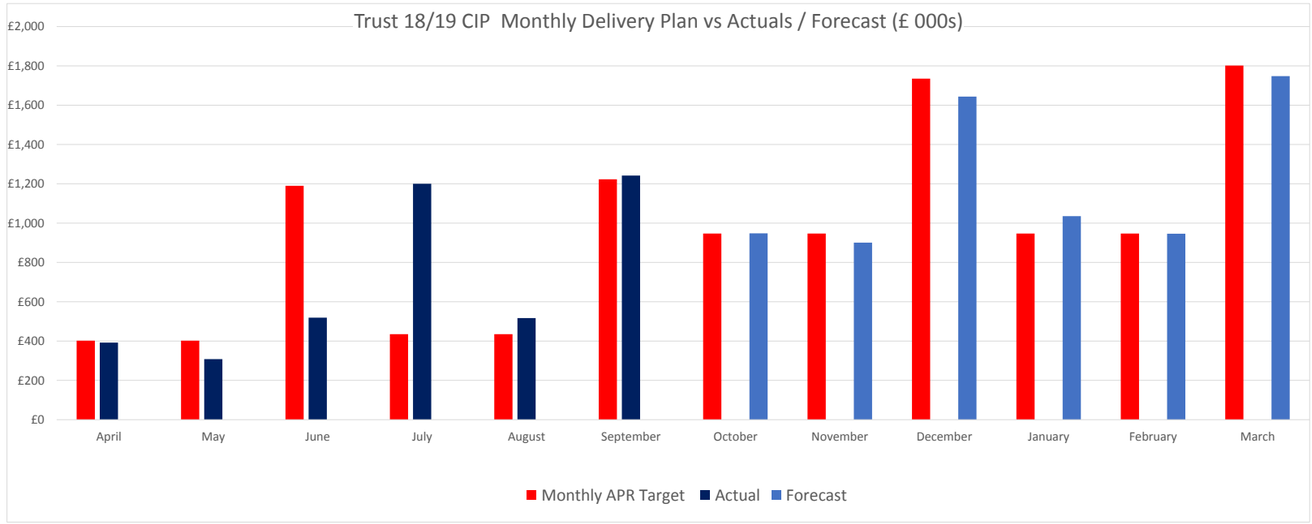
Programme for 2018/19 to deliver a minimum of £11.4m savings to achieve the planned £0.8m control total deficit.

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

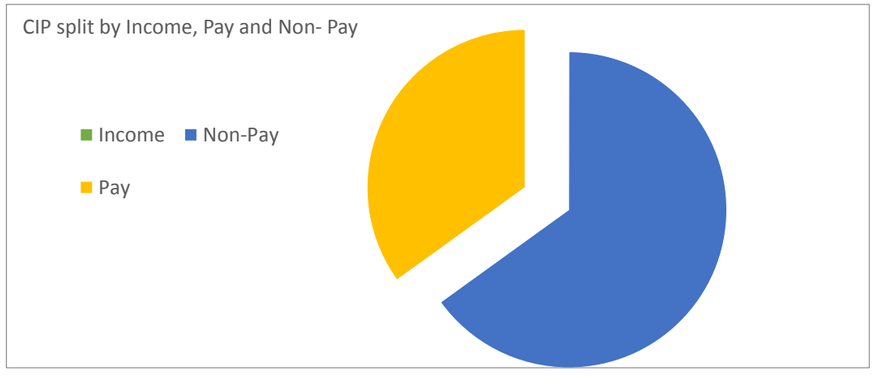
1. The CIPs target remains at £11.4m for the 2018/19 financial year.
2. £7.9m of fully validated savings have been transferred to the Delivery Tracker as at the Month 6 reporting date, of which £4.2m have been delivered against the Plan delivery of £4.1m.
3. The schemes continue to take no account of 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 the current financial year. 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 increases in key skills training. CIPs to the value of £2.4m for the year covering these efficiencies have been developed, of which £0.7m 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 30 September 18

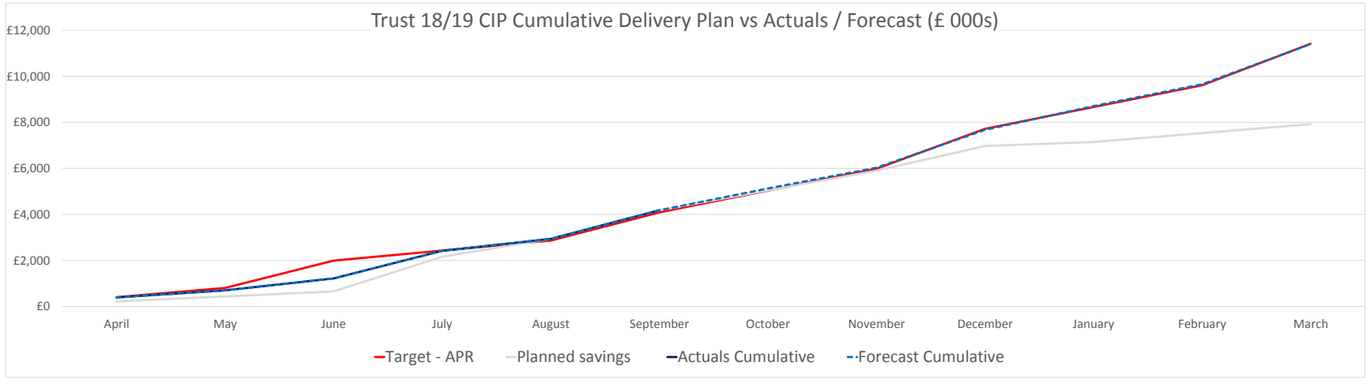
CIP Target for 18/19 £000's	Total planned savings on delivery tracker £000's - as at 30 September 2018	Total forecast savings on delivery tracker £000's - as at 30 September 2018	YTD September 18 - Target Savings £000's	YTD September 18 - Actual Savings £000's	YTD September 18 - variance £000's
11,400	7,921	11,401	4,087	4,178	£91



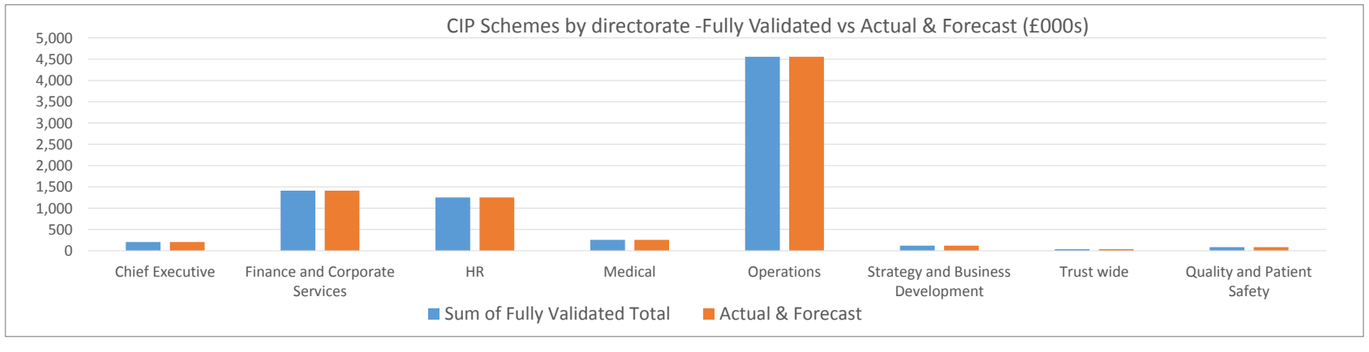
2. CIP - Planned savings split by income, pay and non-pay: as at 30 September



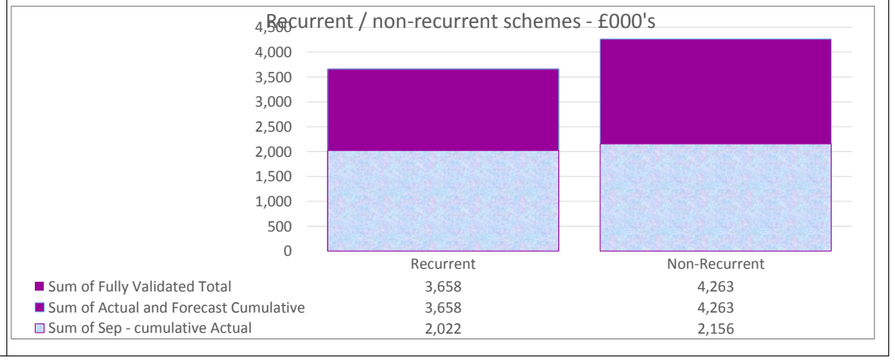
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2018/19



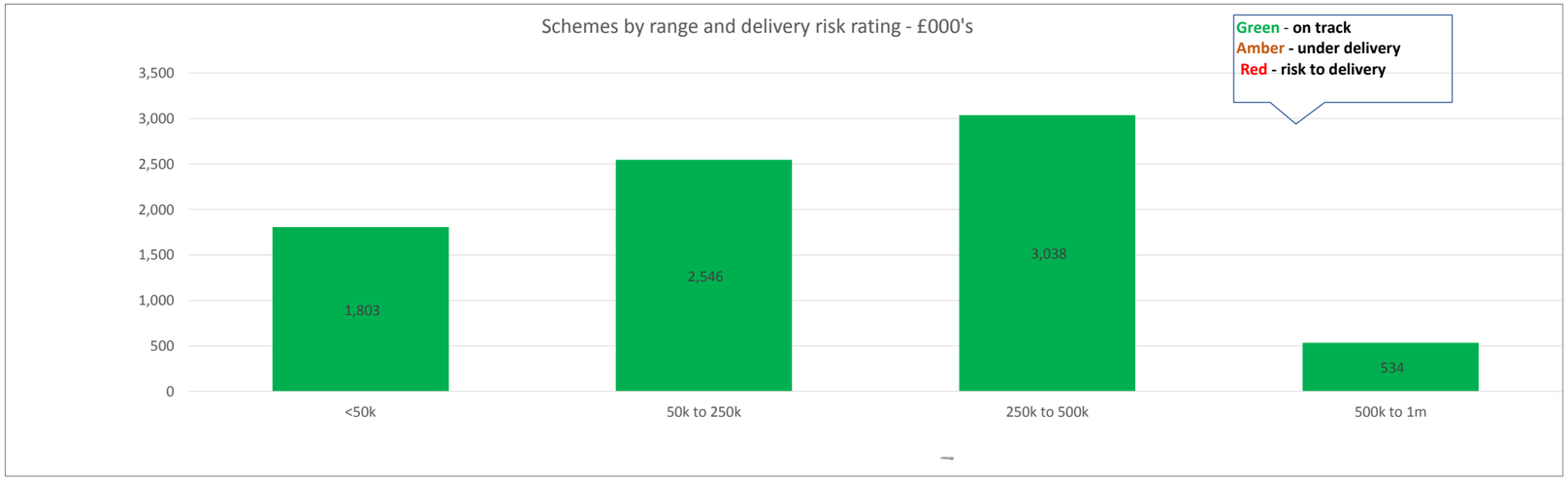
4. CIP schemes by directorate - Fully Validated vs Actual & Forecast 2018/19



5. Value of forecast recurrent and non-recurrent savings - 30 September 2018



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



7. YTD Identified CIPs to Date and Savings - September 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	£713	£713	£0	£421	£421	£0	-
Furniture & Fittings	£30	£30	£0	£15	£15	£0	-
Meeting room hire	£99	£99	£0	£52	£52	£0	-
Public relations	£4	£4	£0	£2	£2	£0	-
Stationery	£44	£44	£0	£24	£24	£0	-
Travel & Subsistence	£309	£309	£0	£176	£176	£0	-
Medicines Management - Equipment	£150	£150	£0	£96	£96	£0	-
Medicines Management - Consumables	£200	£200	£0	£100	£100	£0	-
Books & Subscriptions	£32	£32	£0	£24	£24	£0	-
111 Efficiency	£33	£33	£0	£16	£16	£0	-
Fleet - Fuel: Telematics, Bunkered Fuel & Price Differential	£200	£200	£0	£100	£100	£0	-
Estates and Facilities management	£59	£59	£0	£56	£56	£0	-
IT Productivity and Phones	£148	£148	£0	£89	£89	£0	-
Discretionary Non Pay	£85	£85	£0	£30	£30	£0	-
Training courses & accommodation	£672	£672	£0	£450	£450	£0	-
Single HQ /EOC Benefits realisation	£183	£183	£0	£91	£91	£0	-
Medicines Management - Drugs	£132	£132	£0	£67	£67	£0	
Insurance	£820	£820	£0	£490	£490	£0	
Printing & Postage	£32	£32	£0	£16	£16	£0	
Operations Efficiencies	£2,356	£2,356	£0	£696	£696	£0	
Recruitment delays & recharges - clinical	£807	£807	£0	£475	£475	£0	
Recharges income	£2	£2	£0	£2	£2	£0	-
Recruitment delays & recharges - non clinical	£420	£420	£0	£298	£298	£0	-
Uniform	£3	£3	£0	£3	£3	£0	-
Fleet - Lease costs	£390	£390	£0	£390	£390	£0	-
Total Fully Validated Schemes	£7,921	£7,921	£0	£4,178	£4,178	£0	-
Variance to Year To Date (YTD) Target				(91)		£91	Positive variance between Fully Validated Schemes and YTD Control Total Target
Grand Total	£7,921	£7,921	£0	£4,087	£4,178	£91	

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	110a/18

Name of meeting	Trust Board
Date	25.10.2018
Name of paper	Health & Safety Improvement Plan
Executive sponsor	Bethan Haskins, Executive Director of Nursing and Quality
Author name and role	Amjad Nazir, Head of Health & Safety
Purpose of paper	This paper provides an overview of the steps being taken to improve health and safety within the Trust, informed by the findings of an independent health and safety review. This project forms part of the Trust Delivery Plan and the detail of the project was scrutinised by the Board's Workforce and Wellbeing Committee at its meeting on 19 October 2018 (see escalation 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).	**No**

South East Coast Ambulance Service NHS Foundation Trust

Board of Directors

Health & Safety improvement plan update

1. Introduction

An independent Health & Safety review was commissioned earlier this year, to help management establish what improvements were needed to improve the arrangements in place.

The main weaknesses identified by the independent review included:

- Policies and management systems
- Management of Health & Safety related risks
- Lack of competent Health & Safety practitioners/managers within the corporate team
- Communication
- Training for Team Leaders and Managers
- Statutory and Mandatory Health & Safety training for all employees
- Refresher periods for Health & Safety related training
- Contractor Management controls
- RIDDOR compliance
- Visibility of statutory Planned Preventative Maintenance records
- Limited availability of statutory documentation for example Legionella Assessments, Electrical testing etc.
- Fire Safety Management
- Auditing

2. Improvement Plan / Governance

Since receiving the independent report an improvement plan had been created. This has been transferred into a project, led by the Head of Health & Safety, and overseen by a Task & Finish Group, which reports on progress every two weeks, to the Quality Compliance Steering Group.

In addition, some more immediate action has been taken, including;

- Recruitment of the Head of Health & Safety
- Recruitment of three Health & Safety Managers
- Identified an independent Non-Executive Director lead for H&S (Al Rymer)
- IOSH Safety training delivered to Board members
- Ownership of the contractor management policy assigned to Health & Safety
- Phase one review of the contractor management policy
- DSE policy completed
- Manual handling policy (awaiting ratification)
- Specific training for our operational team leaders covering H&S and Risk Assessment.

3. Outcome

The implementation of our Health & Safety improvement plan will create a safety management system (SMS). This is a management system designed to manage safety elements in the workplace. It includes policy, objectives, plans, procedures, organisation, responsibilities and other measures.

The longer-term objective (3 years) is to obtain ISO45001 accreditation. The implementation of ISO 45001, Occupational health and safety management systems provides a framework to improve employee safety, reduce workplace risks and create better safer working conditions. Obtaining certification is an added endorsement that demonstrates to external parties that we have achieved full compliance with a specific standard.

SECAMB Board

Finance and Investment Committee (FIC) Escalation report to the Board

Date of meeting	**18 October 2018**
Overview of issues/areas covered at the meeting:	This meeting was not quorate, being attended by one NED member (the chair) and two Executive members. The meeting was observed by one Governor (Nigel Willmont-Coles) **Business Cases** The committee asked that future business cases should consider the impact on post demand and capacity review longer term financial projections. The committee noted the extra level of scrutiny now being carried out by the management through the "Business Review Group". (Other than in the matter of Personal Issue Kits, which was delegated by the Board for decision) the committee has no formal approval powers so the word "approval" below should be understood to be "the committee recommends to the full Board that the business case be approved". • Nexus House Second Floor. This was approved as it represented an attractive and low risk short term opportunity consistent with longer term consolidation concepts previously discussed at Board. • Ambulance Technician. This was approved • Service Transformation Delivery Program Team. This was approved with emphasis placed on stakeholder communication and obtaining the right skills mix quickly • 111 Contract Extension. The committee felt that this paper was premature and could not yet be recommended (particularly as the proposal presented sat outside agreed Board financial parameters). • QI methodology. The committee reviewed the paper and noted potential benefits; however, there was concern about timing given the DRC program. The proposal was not approved at this time • Personal Issue Kits. This was approved in line with power delegated to the committee at the September Board meeting **Fleet and Estates Enabling Strategies** The Chair deferred consideration of the Fleet Strategy and asked the Executive to discuss the paper more widely with Board members before formal consideration in due course. The Committee discussed the proposed Estates Strategy and recommends it to the Board with the following caveats: • The financial numbers should be removed and will need more detailed review in due course. • Estates strategy will need review in the light of the service transformation delivery • Whilst representing considerable effort, the paper is stuck between a strategy and a delivery plan. • The Executive were asked to clarify in due course which principles, projects and initiatives already had approval so that the committee could focus on forward looking

	matters • It is not clear why the 11 MRC number is the right target for the Trust to aim at. This should be one element considered in the forthcoming iteration of the Estates Strategy. **Financial Performance** The executive tabled a brief Powerpoint summary of financial performance over the first half of our financial year. Whilst financial performance is broadly satisfactory, three particular concerns were discussed; • The relatively low number of frontline hours currently being generated – a fuller update will be provided to the October Board. • The high level of Financial Risks suggested for the second half of the year – the committee concluded that risks were overstated. • A lack of longer-term forecast in the context of the Demand and Capacity Review – the executive agreed to provide longer term forecasts at future meetings. Whilst a full paper will be circulated in due course, one of the roles of the committee is to provide detailed scrutiny and challenge of financial performance on behalf of the full Board. The timing of meetings needs to be amended to ensure that the committee has a full opportunity to examine financial performance and forecasts. An additional FIC meeting will be arranged in November to focus on forecasting, business plans and (if feasible) the month 7 finance pack **Cyber / IT** The committee was assured that the Trust was well positioned in relation to Cyber Security and noted the extensive IT projects underway. **Risk Management** The committee discussed an improved, but not yet satisfactory, FIC risk management report. Suggestions were made to improve future reports
Reports *not* received as per the annual work plan and action required	Fleet Strategy – as above
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	Too many Papers were submitted late to this meeting. The executive were asked to review with the Chair the number, timing and format of meetings to ensure that the committee can best support the Trust whilst providing appropriate scrutiny and challenge on behalf of the full Board.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	97/18

Name of meeting	Trust Board
Date	25.10.2018
Name of paper	Board Assurance Framework Risk Report version 2018 1.3
Responsible Executive	Executive Team
Author	Peter Lee, Company Secretary
Synopsis	The BAF Risk Report includes the principal risks to meeting the Trust's strategic goals, It sets out the controls, assurances, and actions, which have been reviewed by the relevant Board committees to inform this version (2018 1.3) of the report.
Recommendations, decisions or actions sought	The Board is asked to support the progression of the BAF Risk report, and confirm its level of assurance that it is sufficiently focussed on the most relevant 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 (BAF) Risk Report - version 2018 1.3

1. Introduction

The BAF risk report is considered by the executive management board (EMB) every month to ensure the risks reflect the current position. Specific risks are also scrutinised by the relevant Board committee.

Should EMB consider it necessary to add or remove a risk, it will make a recommendation to the Trust Board, for decision. There are no such proposals this month.

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 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.

	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

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 Finance and Investment, Quality and Patient Safety, and Workforce & Wellbeing committees met on 18 and 19 October 2018. The following table illustrates how their focus reflects the current BAF risks:

Committee	Agenda Item	BAF Risk
Finance and Investment	Cyber Security	495
	Service Transformation Delivery	123
	111 Service	284
Quality and Patient Safety	Operational Resilience	269 & 579
Workforce and Wellbeing	Workforce planning	111
	HR transformation	362 & 334
	Health & Safety	517

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).

At its meeting in September, the Audit and Risk Committee asked management to review the description of BAF risk 522, to more clearly define the risk and impact. This version includes this update.

The Board is also asked to specifically note the following, which EMB is due to consider at its meeting on 24 October;

BAF risk 284 (111 – Future)
In light of the current position due to be discussed at the October Board meeting in private, a proposal about the emerging risk, which is a different risk to that currently set out, will come to the Trust Board in November.

BAF risk 529 (Change)
Given the good progress in engaging the wider healthcare system, EMB is considering whether a proposal should be made for this risk to be removed from the BAF risk report.

5. Conclusion

Save for the two areas outlined in section 4, 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.

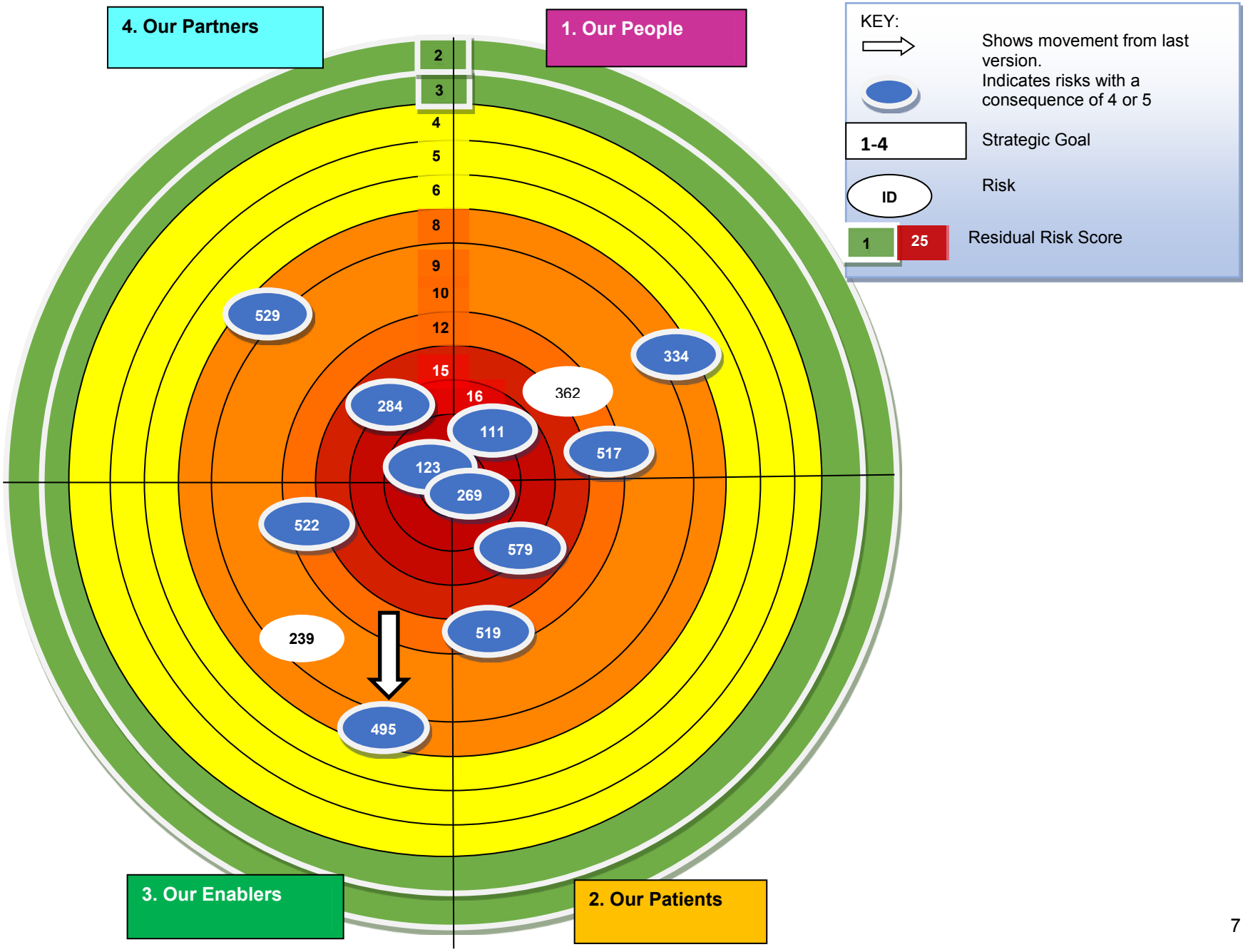
The BAF risk report will also continue to be used by the Board and its committees, to ensure a risk-based approach is taken to seeking assurance that the risks are being robustly managed.

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	Service Transformation 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	30.06.2019	QPS
2, 3, 4	Service Transformation 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, which may lead to clinical harm, financial loss, adverse pressure on 999 and the	16	16	8	01.04.2019	FIC

			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	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
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 may lead to patient harm.		16	12	4	30.09.2018	QPS
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	08 ⇩	4	31.03.2019	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	31.03.2019	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 at different stages This may lead to non-delivery of the Trust strategy.		12	8	4	31.03.2019	Trust Board


4. Our Partners
1. Our People
3. Our Enablers
2. Our Patients
2
3
4
5
6
8
9
10
12
15
16
529
334
362
284
111
517
123
269
522
579
239
519
495
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 1.3)

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 19.10.2018 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 19.10.2018 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 19.10.2018 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:	**Accountable Director**	Director of Nursing & Quality
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.	**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 19.10.2018 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 in May assured that management had clarity in the holistic understanding of the issues relating to call answer performance, and the related improvement plan. (+) Compliance with NHS Pathways License incl. audit	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 19.10.2018 Quality & Patient Safety Committee

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 19.10.2018 Quality and Patient Safety 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. 5. Project Management of new contract to support transition	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. 5. PMO preparing the project team

Last management review	19.09..2018 Executive Management Board	**Last committee review**	19.09.2018 Audit and Risk Committee 19.10.2018 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:	**Accountable Director**	Director of Operations
Risk that the Trust does not consistently achieve ARP standards as a result of insufficient resources, which may lead to patient harm.	**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 / additional funding agreed for 2018/19

Gaps in Control

Recruitment of ECSWs & AAPs
Agreed the demand and capacity review – yet to agree the contract terms / investment to be provided from 2019/20.

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 3. Service Transformation Delivery	1. Recruitment plan in intensive support, led by executive. 2. In discussion with commissioners and NHSI / E. 3. Delivery Plan being implemented / developed

Last management review	19.09.2018 Executive Management Board	**Last committee review**	19.09.2018 Audit & Risk Committee 18.10.2018 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	**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)	
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. Penetration testing software being implemented 4. Station IT Upgrade 5. Upgrading of East control including new UPS and resilient distribution boards 6. Fast track Cyber Essential Plus programme with support from NHS Digital	1. To be completed by November 2. To be completed by October 3. To be completed by October 4. MRCs by November – all stations by June 2019 5. December 2018 6. April 2019

Last management review	19.09.2018 Executive Management Board	**Last committee review**	19.09.2018 Audit and Risk Committee 18.10.2018 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
Data Security & Protection Toolkit (IG Toolkit)
IG training, including corporate induction
IG escalation routes (incident / SI), plus internal reporting lines from IG Lead to SIRO and Caldicott Guardian
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)
Registration Authority process needs to be adequately resourced and an operational business model implemented within the Trust.
New Smartcard printers need to be sourced - IG Lead is currently reviewing with suppliers and is awaiting further information from IT/Suppliers around integration.
Review of resource and processes to manage FOI requests

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) 2017/18 IG Annual Report (-) FOI compliance (+) Internal Audit Report – against the IG Toolkit (+) Over 95% compliance with IG training (+) IG Toolkit Level 2 (+) An independent 'Peer' review was completed in August 2018 with LAS.	

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 Delivery 4. IG Manager recruitment 5. FOI process mapping underway			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 was presented to the Audit Committee and IGWG in September 2018. 4. Interviews scheduled for 29/10/18 5. Due to report to senior leadership committee in November
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**	**Date risk opened:**

	Resilience – continuity planning	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). This would include being unable to respond effectively: • at periods of high demand and prolonged escalation • to Winter pressure demands • for bank holidays • for Major Incidents • for significant events e.g. Pride • for CBRN or other Terrorist events • for weather extremes	**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	19.09.2018 Audit & Risk Committee

Goal 4 Our Partners	**BAF Risk ID 284** ***[THIS RIKS IS UNDER REVIEW]*** 111 (future) – 111 service(s) procurement	**Date risk opened: 30.11.2017**

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Strategy
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.	**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 19.10.2018 Finance & Investment Committee

Goal 4 Our Partners	**BAF Risk ID 529** ***[THIS RIKS IS UNDER REVIEW]*** Change – influencing the healthcare system	**Date risk opened:** **25.05.2018**

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Strategy
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.	**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 health and wellbeing	Improve clinical outcomes and operational performance, with a particular focus on life threatening emergencies	Ensure that our estate is fit for purpose and supports the clinical model	Work with blue light partners 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 <1day Concerns about skill mix / competency	On-going low staffing level that reduces patient care/service quality Minor error(s) due to levels of competency (individual or team)	On-going problems with levels of staffing that result in late delivery of key objective/service Moderate error(s) due to levels of competency (individual or team)	Uncertain delivery of key objectives / service due to lack of staff Major error(s) due to levels of competency (individual or team)	Non-delivery of key objectives / service due to lack/loss of staff 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	Non-significant / temporary	Minor non-compliance with	Significant non-compliance with	Low rating	Loss of accreditation / registration

Inspection / Audit	lapses in compliance / targets	standards / targets Minor recommendations from report	standards/targets Challenging report	Enforcement action Critical report	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%

SECAMB Board

QPS Committee Escalation report to the Board

Date of meeting	19 October 2018
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: **Incident Reporting to NRLS (Partially Assured)** The committee was assured that we are now reporting incidents to NRLS, following issues identified on 2017. However, we appear to be over-reporting, which management is seeking to correct. The committee will receive an update in January 2019. **OU Management Capacity (Assured)** The committee followed up its concern from earlier in the year about management capacity, given some of the vacancies that existed. It was assured that the right capacity is now in place (no OTL vacancies), which has resulted in better grip of issues that arise at OU-level. The committee also noted the ongoing work to review the broader restructure, and this will be picked up by the Workforce and Wellbeing Committee. **Data Availability (Partially Assured)** This management response related to how staff are provided access to key information. The committee was assured that substantive staff have good access via I-Pads to policies, JRCALC, operational and clinical bulletins etc. However, there was not the same level of access for BANK staff (this is a risk on the risk register - ID 465) and this led to a wider discussion about our approach to the BANK, especially in the context of the service transformation delivery. The committee has asked the Workforce & Wellbeing Committee to seek assurance that this area is being addressed. The committee also explored the steps taken to ensure critical policies are read and understood (not just received). It noted the work underway as part of the governance and risk project, as part of the Delivery Plan, and has asked the Audit and Risk Committee to seek assurance. **Safer Recruitment (Partially Assured)** The committee is assured that we are legally compliant with the initial DBS checks being up to date and that work continues to ensure all renewals are up to date, in line with Trust policy. The DBS working group is exploring the right level / frequency of checks needed for the different groups of staff, to agree a Trust position. **Mobile Data Terminal Action Plan closure report (Assured)** The committee was pleased to be assured that the actions relating to this historic SI have now been completed. There was one other issue arising (but separate) from the SI, relating to information sharing agreements. This is being picked up by the Information Governance Group, and the committee has asked the Audit & Risk Committee to add this to its cycle of business, so that it can in due course test the governance we have in place.

Single Response Vehicle /Double Crew Ambulance Skill Mix (Assured)
This follows the scrutiny item in September, and how management ensure the right skill mix for each shift. It was assured by the system in place and asked for this to be included in a written procedure.

Falsified Medicines Directive (Assured)
The committee asked for an update on the approach to be taken following this new (EU) regulation. It is yet to be confirmed if it will apply to ambulance Trusts and there is some uncertainty vis-à-vis Brexit as it is an EU directive. It is a complex issue and the paper received provided a really helpful update on progress.

It is on risk register and the next steps include developing a business case, potentially in conjunction with other Trusts. In the meantime, management will escalate any clinical implications, as required.

SI Investigations (Not Assured)
The committee received a verbal update on the work to manage the backlog of SI investigations. It noted that we are meeting the trajectory agreed with commissioners and that we are mapping the process to ensure effective controls going forward. However, until these new controls are put in place the committee is not assured.

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;

SI Thematic Review (Partially Assured)
The committee explored the detail within the report and the challenge in being able to clearly draw out the real themes, especially given they are relatively few in number. The report lacked some of the actions being taken in response to SI findings / learning, and so the committee asked management to ensure this is included for future reports; the committee will receive this on a quarterly basis

999 NHS Pathways License (Partially Assured)
The committee tested the level of compliance with the Pathways licence conditions, noting the 100% audit completion since May 2018 and compliance with having the requisite Pathways trained clinicians.

There was some concern about the sustainability of the audits given the pull between training and audit, and the committee also asked for further information about the outcomes of the audits and the related learning / action. This will come back as a management response in December.

Duty of Candour (Partially Assured)
As part of the annual planning for Internal Audit in January, the committee asked for an audit of Duty of Candour. At this meeting, the head of Internal Audit attended to present the findings. This included positive comment about the focus at board level for duty of candour relating to serious incidents. However, more work is needed to strengthen the controls for non-serious incidents. The audit found that understanding

	of the policy was inconsistent, which led the broader point about how we ensure key policies are read and understood (linked to the action above – Data Availability). The committee is confident in the action plan to address the findings, most of which are due by December. In the meantime, the Board will see the level of compliance via the integrated performance report. **QIA mid-year review (Assured)** This report provided a review of the 232 quality impact assessments completed since January 2019. Every cost improvement programme (CIP) had a quality impact assessment, and just over a quarter of all new / updated policies. Management is reviewing the process to ensure proportionality. **111 Contract (Assured)** The committee explored the operational and patient safety risks and mitigations, relating to the Trust's exit from Surrey 111, and the mobilisation of the interim service in Kent and Sussex. It acknowledged the complexities and the efforts of management to ensure a careful transition. The committee will review the risks again in January. **Operational resilience (Partially Assured)** At its meeting in September the Trust Board asked the committee to test the resilience within operations, to meet the fluctuations in demand, especially coming into winter. This was in the context of increased demand adversely impacting performance. Management very helpfully set out in good detail all the work underway to mobilise the additional workforce as part of service transformation delivery. This assured the committee that we are taking action to more robustly manage the demand that can reasonably be expected. However, it noted the reliance on the wider system's resilience. The Winter Room this year is being run from Nexus House, which will be an opportunity to highlight issues sooner. In summary, the Board can be assured by the comprehensive set of actions and plans in place, which provides better anticipation of risk and clearer actions to be taken as a consequence, and also focusses on getting much quicker to lower acuity patients that are waiting longest. However, the reality is that in all likelihood, performance will continue to be adversely affected by any significant increased demand. In addition the committee also monitored performance in two areas; **Safeguarding (Partially Assured)** The committee received a 6-month review, noting that there is now a fully established safeguarding management structure, including the new Freedom to Speak up Guardian now being in place. Training, in particular the face-to-face Level 3 training, was cited as having a really positive impact on culture and awareness. There has been a 29% increase in referrals over the first 6 months and the committee is confident that there is capacity in place to manage this workload. Overall the committee felt that this helpful report demonstrated good progress. It asked for more specific detail to be included in future about the learning and related

	actions. **Clinical Audit Quarterly Report (Assured)** The committee felt that the whole Board should see this quarterly report (Appendix A), as it really helpfully describes the progress against our clinical outcomes. The committee is assured that the audit plan will be delivered. The report shows where we are against the relevant indicators and the reasons, and the stability of unreconciled records is duly noted.
Reports *not* received as per the annual work plan and action required	The committee did not receive the following items, Quarterly Quality & Safety Report – deferred to December.
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	As stated, the controls in place to manage **SI investigations** are currently not well designed and therefore not effective. Management is taking immediate steps to map the process, and implement changes and the committee will keep this under its review.
Any other matters the Committee wishes to escalate to the Board	The excellent Clinical Audit report is included for the Board's awareness. The committee felt that, given the way clinical outcome data is collated, it might be more meaningful for the Board to review clinical outcomes on a quarterly basis, rather than each month as part of the IPR. The Board is invited to discuss this.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	121/18

Name of meeting	Quality & Patient Safety Committee
Date	19 October 2018
Name of paper	Clinical Audit Program Q2 2018/19 Update
Responsible Executive	Dr Fionna Moore, Executive Medical Director
Author	Dean Rigg, Head of Clinical Audit
Synopsis	This report provides an update on the achievement of the Trust Internal Clinical Audit Programme for Q2 2018/19
Recommendations, decisions or actions sought	The committee is asked to discuss this report.

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

Clinical Audit Plan 2017/18 Update

1. Introduction

1.1. This report describes the progress made achieving the trust's Clinical Audit Programme for 2018/19

1.2. The 2018/19 Clinical Audit Programme includes both national Ambulance Clinical Quality Indicators, which are reported to NHS England and our own internal clinical audit programme.

1.3. The Clinical Audit team is committed to delivering the annual clinical audit programme with the aim to continually improve patient outcomes and experience.

2. Staffing

2.1. The Clinical Audit team currently consists of:

2.1.1. Head of Clinical Audit x 1

2.1.2. Clinical Audit Lead x 1

2.1.3. Clinical Audit Supervisor x 1

2.1.4. Clinical Audit Coordinators x 2

2.1.5. Clinical Audit Administrator x 1

2.2. A band 7 Clinical Audit Lead and a Band 4 Clinical Audit Administrator have recently been appointed and will join the team in Q2 2018/19.

2.3. We have failed to recruit to our vacant Clinical Audit Coordinator post after three rounds of recruitment. In order to increase the appeal of this role, we have segmented the duties to cardiac arrest analysis and advertised the post as a Cardiac Arrest Analyst.

3. Governance

3.1. The frequency of the Clinical Audit and Quality Sub-Group (CAQSG) meets monthly. This allows for frequent review of group risks, approval of and shared learning from Clinical Outcome Indicators and review of recommendations arising from clinical audit activity.

3.2. Recommendations from clinical audits are tracked and discussed at each CAQSG and evidence of completion is collated once recommendations are closed.

3.3. Measures from the Trust's Health Records function are also reviewed at CAQSG..

4. Risk Management

4.1. The CAQSG currently has nine open organisational risks. Five of which are graded as high and four moderate. Controls and plans for reduction/resolution are in place for each risk.

4.2. Risks are reviewed at each CAQSG.

4.3. Current risk status is shown below:

Datix Ref.	Adequacy of Controls E (Effective) N (Non-Effective)	Risk Grade(s) Reviewed Y (Yes) N (No)	Review Date Met Y (Yes) N (No)	Status Review O (Open) P (Proposed for Closure)	Narrative Reviewed Y (yes) N (no)
270 – Health Records Capacity	E	Y	Y	P	Y
311 – PCR Security	E	Y	Y	O	Y
391 – PCR Completion	E	Y	Y	O	Y
343 – Below Average AQI Performance	E	Y	Y	O	Y
276 – Codestat Failure	E	Y	Y	O	Y
213 – Unreconciled PCRs	E	Y	Y	O	Y
339 – Clinical Audit Capacity	E	Y	Y	O	Y
238 – Health Records H&S	E	Y	Y	O	Y
430 – Storage of ECG Results	N	Y	Y	O	Y

5. Internal Clinical Audit Plan 2018/19

5.1. Our 2018/19 internal clinical audit plan is comprised of 20 clinical audits. Six of these audits are in progress.

5.2. The Clinical Audit Programme has experienced minor delays; however, these delays do not put the delivery of the plan at risk. Delays have been due to gaining sample data from Codestat and CCP Base. An audit of the management of suspected spinal injuries in older adults has been put on hold, as a programme of significant improvement work is already underway.

5.3. The table below summarises the progress of each of the 2018/19 clinical audits

Audit Title	Expected Start Date	Expected Finish Date	Status
Spinal Injuries in Older Adults	17/07/18	29/07/18	On Hold
Time at Scene	03/09/18	28/09/18	Approved
Pain Management	03/09/18	19/10/18	In Progress
Step-Wise Airway Management	27/08/18	26/10/18	In Progress
Care Under Mental Health Act	01/10/18	02/11/18	In Progress
Use of Rectal Diazepam and IV Diazepam	12/11/18	14/12/18	Not Due
Use of Oxygen, Salbutamol and Aspirin by CFRs	19/11/18	28/12/18	Not Due
ECG Interpretation	02/07/18	20/07/18	Delayed
Activated Charcoal	29/10/18	30/11/18	Not Due
Assessing the Sick Child	21/01/19	22/03/19	Not Due
PP Antimicrobials and Corticosteroids	24/12/18	29/03/19	Approved
PP Mild to Moderate Pain for See & Treat	24/12/18	29/03/19	Not Due
Management of Children with Mild to Severe Croup	21/05/18	20/08/18	Awaiting Approval
Use of PGDs by CCPs: Herparin, Ketamine, Midazolam, Magnesium Sulphate 50%, (IV & Neb), Rocoronium, NaCl 5%, Flumazenil, Calcium Chloride 10%.	16/07/18	31/08/18	Delayed
Assessment of Haemorrhage in Telephone Triage	TBC	TBC	Not Due
PP Use of 2nd Line Treatment in COPD	24/12/18	29/03/19	Not Due
Midazolam use in Seizures	19/11/18	14/11/18	Not Due
Assessing Levels of Consciousness in Telephone Triage	TBC	TBC	Not Due
Post-Partum Haemorrhage and Use of TXA	21/01/19	01/02/19	Not Due
Manual Handling	07/01/19	25/01/19	Not Due
Use of the Mental Capacity Act	18/02/19	22/03/19	Not Due

6. National Ambulance Clinical Quality Indicators

6.1. Previously Ambulance Quality Indicator performance data were collected and submitted to NHS England on a monthly basis; however, the requirement for submitting care bundle measures has now been reduced to quarterly. This means that it will not be possible to benchmark performance against the national average on a monthly basis.

Measure	NHSE Data Period
Stroke Diagnostic Bundle	Feb, May, Aug, Nov
Sepsis Care Bundle	Jun, Sep, Dec
STEMI Care Bundle	Apr, Jul, Oct
Post-ROSC Care Bundle	Apr, Jul, Oct
ROSC & Survival to Discharge	Monthly

6.2. The Trust has taken the decision to continue to measure performance at monthly intervals for internal reporting while we seek to improve performance. This means that, in addition to the 5,250 incidents currently reviewed, the Clinical Audit team will review an additional 1,925 incidents per quarter.

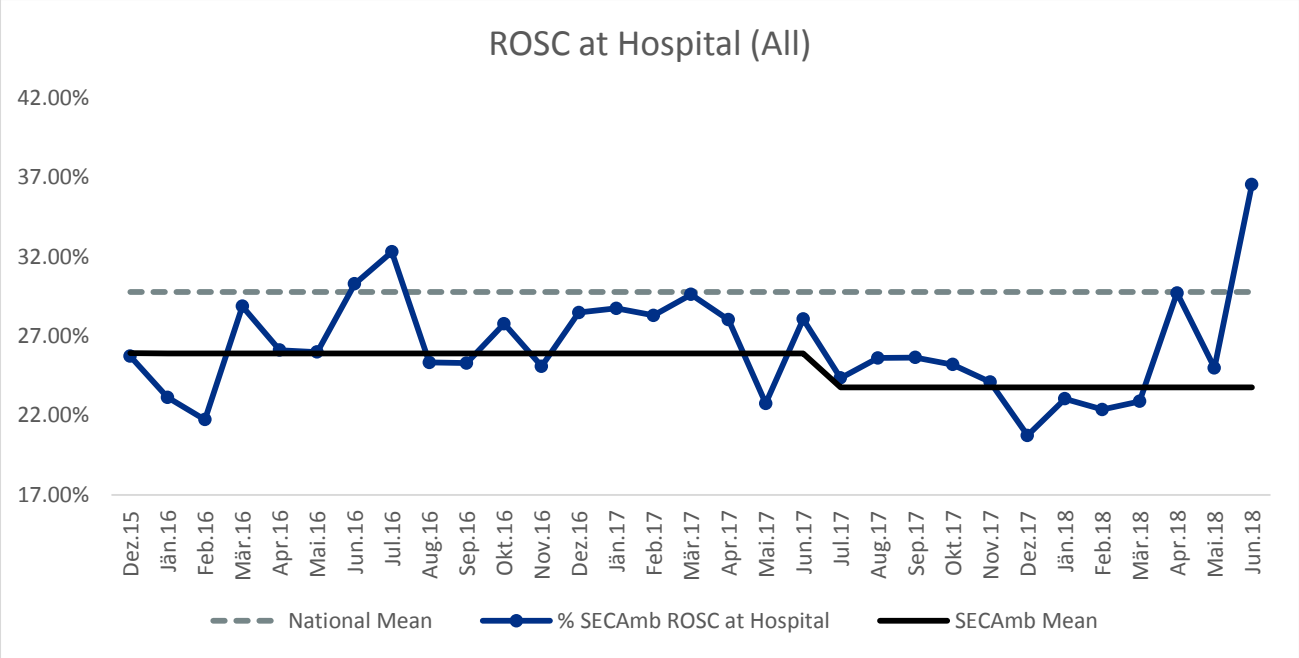
6.3. Data are collected 3 months in arrears and so the figures below discuss our Q1 performance for 2018/19.

6.3.1. **Cardiac Arrest – Return of Spontaneous Circulation (ROSC) at Hospital**

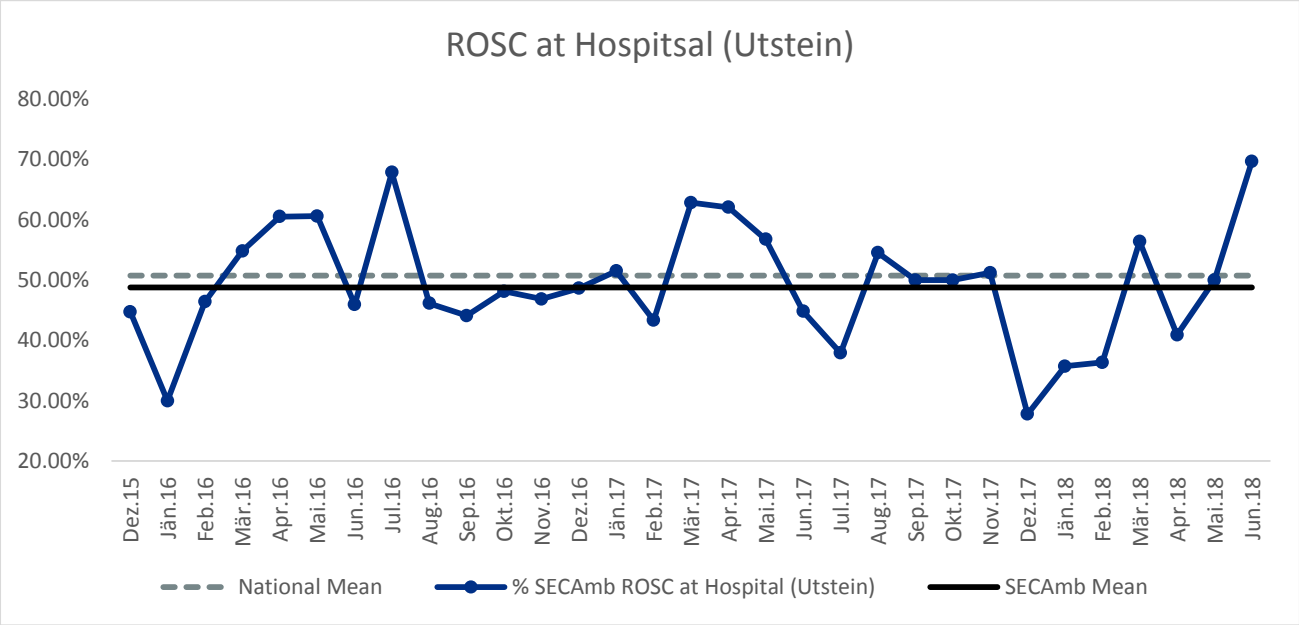
6.3.1.1. All Patients - Proportion of those who were resuscitated who had return of spontaneous circulation on arrival at hospital

6.3.1.2. Utstein comparator Group - Proportion of those who were resuscitated who had return of spontaneous circulation on arrival at hospital, where the arrest was bystander witnessed and the initial rhythm was VF or VT.

6.3.1.3. In Q1 of 2018/19 the range for performance was 25-36.55%, against a national performance level of 29.78%.



6.3.1.4. In Q1 of 2018/19 the range for performance for ROSC in the Utstein group was 30.91-69.70%. Our mean performance against this indicator is 48.79% and is comparable to the national YTD average, which is 50.77%. The data continues to show normal patterns of variation.

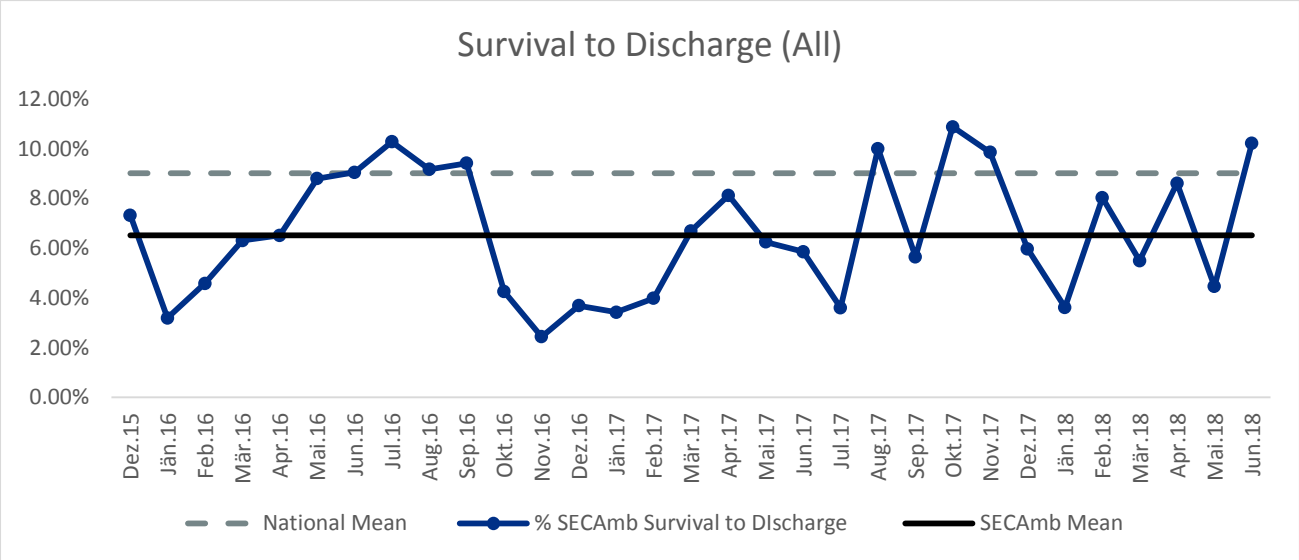


6.3.2. **Cardiac Arrest – Survival to Discharge (StD)**

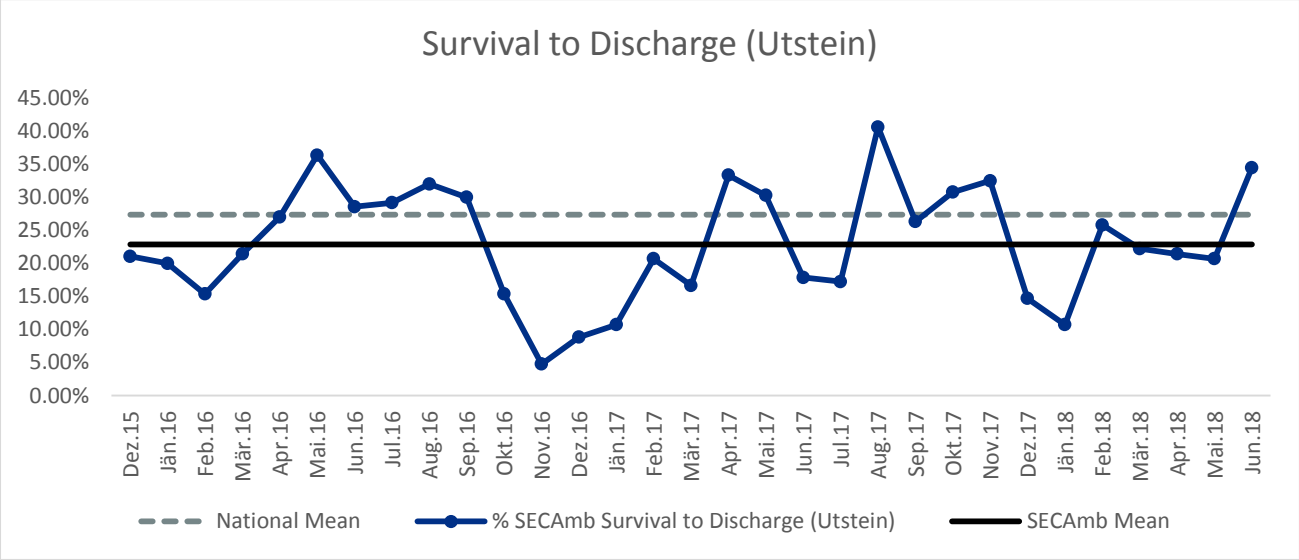
6.3.2.1. All Patients - Number of patients who had resuscitation commenced/continued by ambulance service following an out-of-hospital cardiac arrest, who were discharged from hospital alive.

6.3.2.2. Utstein comparator Group - Number of patients who had resuscitation commenced/continued by ambulance service following out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was VF or VT, who were discharged from hospital alive.

6.3.2.3. In Q1 of 2018/19 our performance against this indicator for all patients ranged from 4.46-10.22%. Our mean performance against this indicator is 6.52%, which is below the national YTD performance of 9.01%. The data continues to show normal levels of variation.



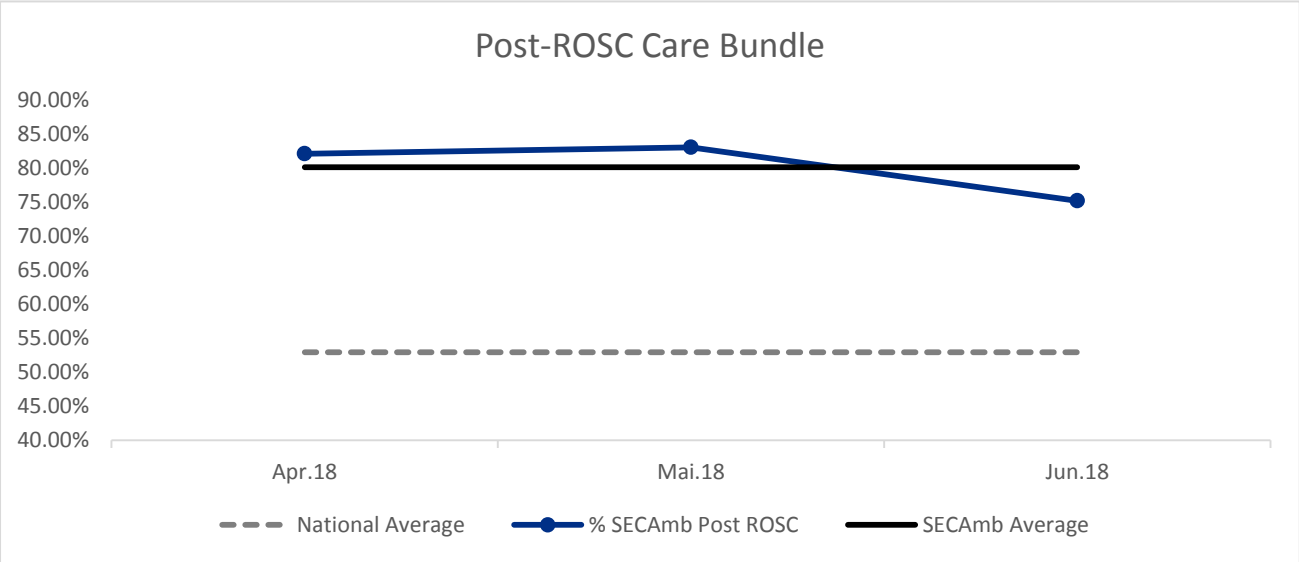
6.3.2.4. In Q1 of 2018/19 our performance against this indicator for patients in the Utstein group ranged from 20.69-34.48%. Our mean performance against this indicator is 22.87%, compared to a national average of 27.38%. The data continue to show normal patterns of variation.



6.3.3. **Post-ROSC Care Bundle**

6.3.3.1. NHS England introduced a new care bundle for 2018/19 to measure the proportion of people who received an appropriate care bundle after being successfully resuscitated from cardiac arrest. The care bundle comprises of recording a 12-lead ECG where necessary, administering oxygen where required, administering intra-venous fluids where required and measuring blood glucose.

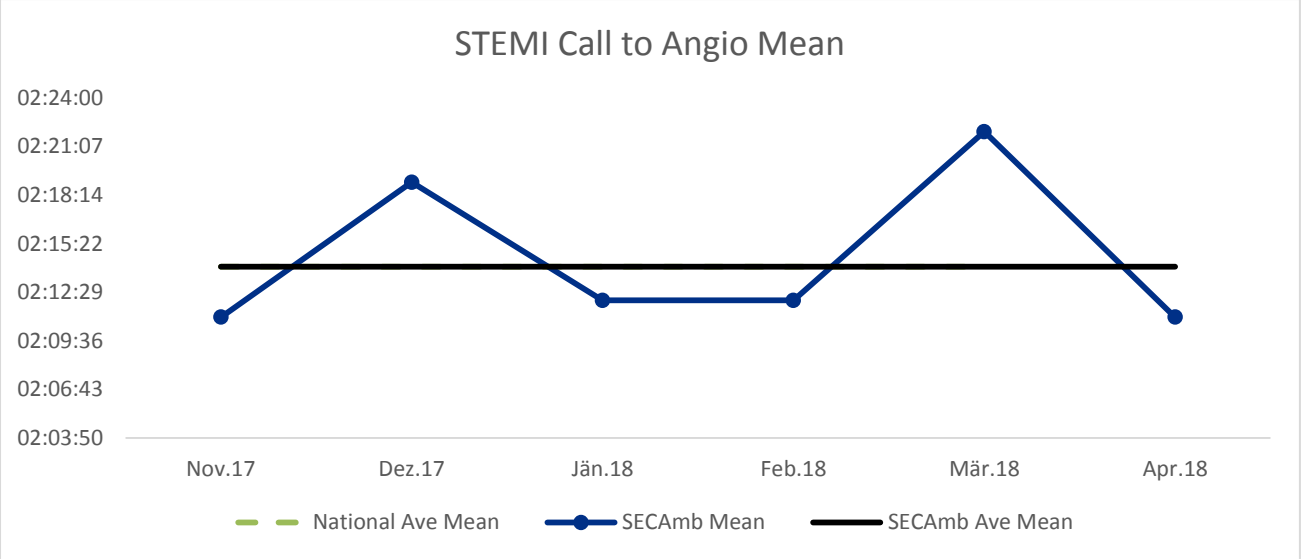
6.3.3.2. Our performance in the post-ROSC care bundle ranged from 75.24-83.1%. Our average for the period was 80.16% against a national average of 52.97%. However, other ambulance services have reported inaccuracies with their data due to difficulties with interpretation of the new care bundle and technical problems with a new data submission platform, so this national average is expected to change.

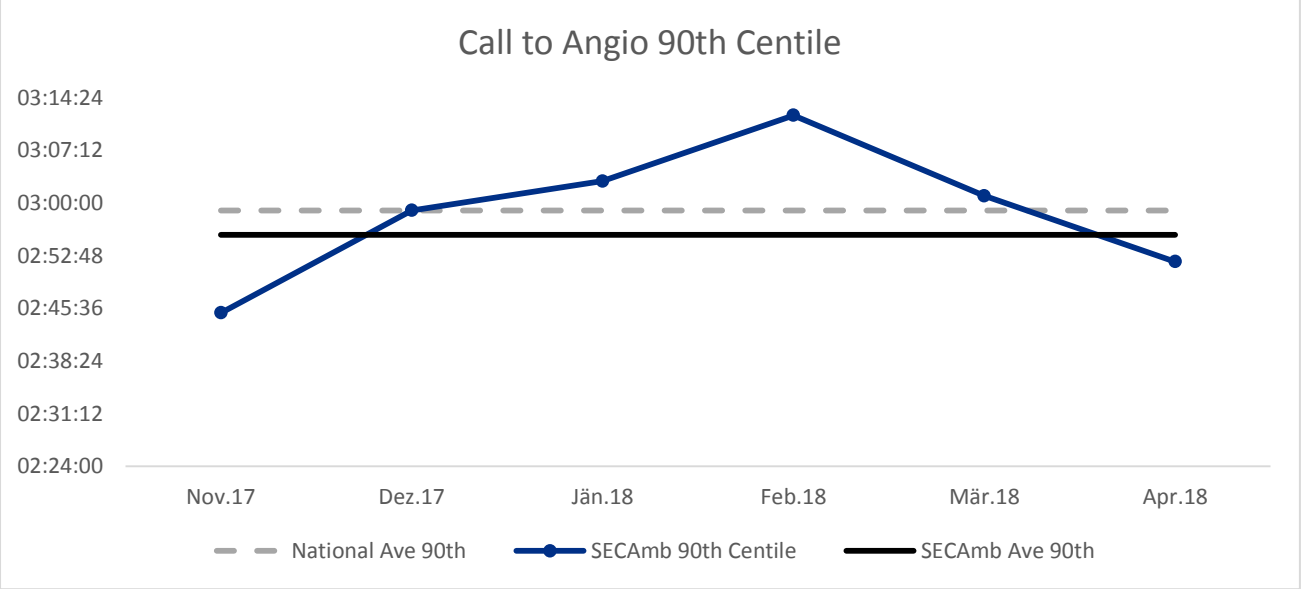


6.3.4. **STEMI Timeliness**

6.3.4.1. In November 2017 the method for measuring the timeliness of care delivered to STEMI patients changed to a measure of mean and 90th centile call to angiography (the procedure used to visualise the blood vessels that supply the heart). This measure is no longer collated internally and is taken directly from the national MINAP database of confirmed STEMIs. The latest available measure is from April 2018.

6.3.4.2. In Q4 of 2017/18 our mean performance matched the national average (national average obscured by SECAmb average on graph. Our 90th centile performance ranged from two hours and fifty-two minutes to three hours and one minute.

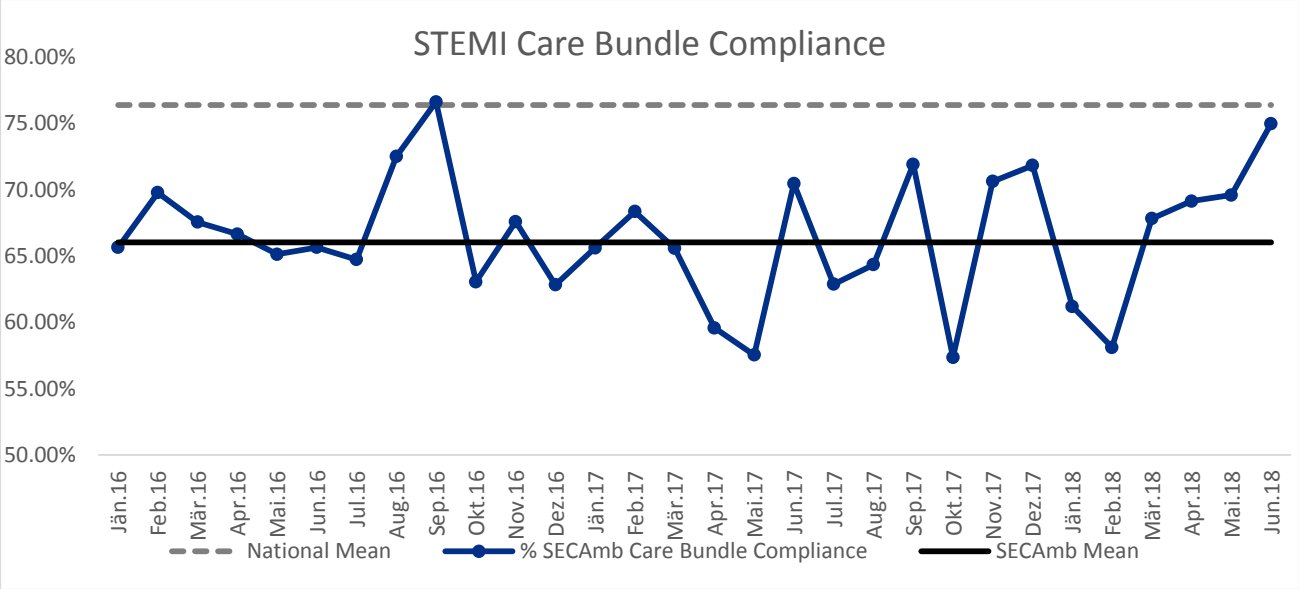




6.3.5. **STEMI Care Bundles**

6.3.5.1. The proportion of patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction confirmed on ECG who received the STEMI care bundle.

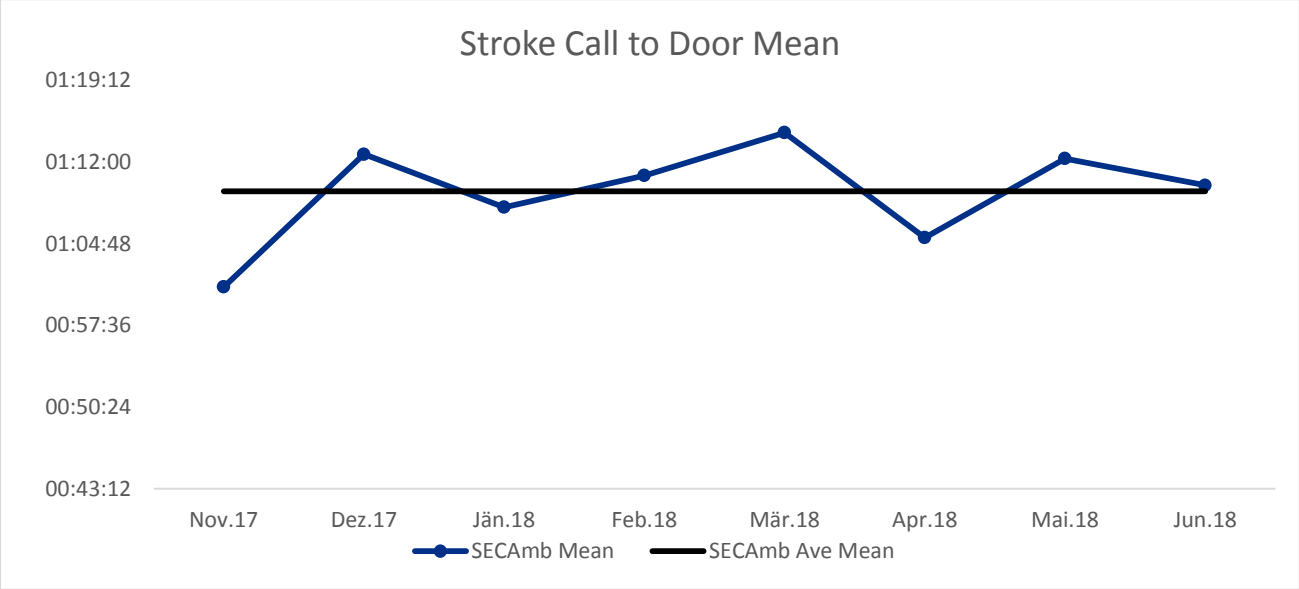
6.3.5.2. In Q1 of 2018/19 our performance against this indicator was in line with previous patterns of variation. It ranged from a proportion of 69.15-75%.

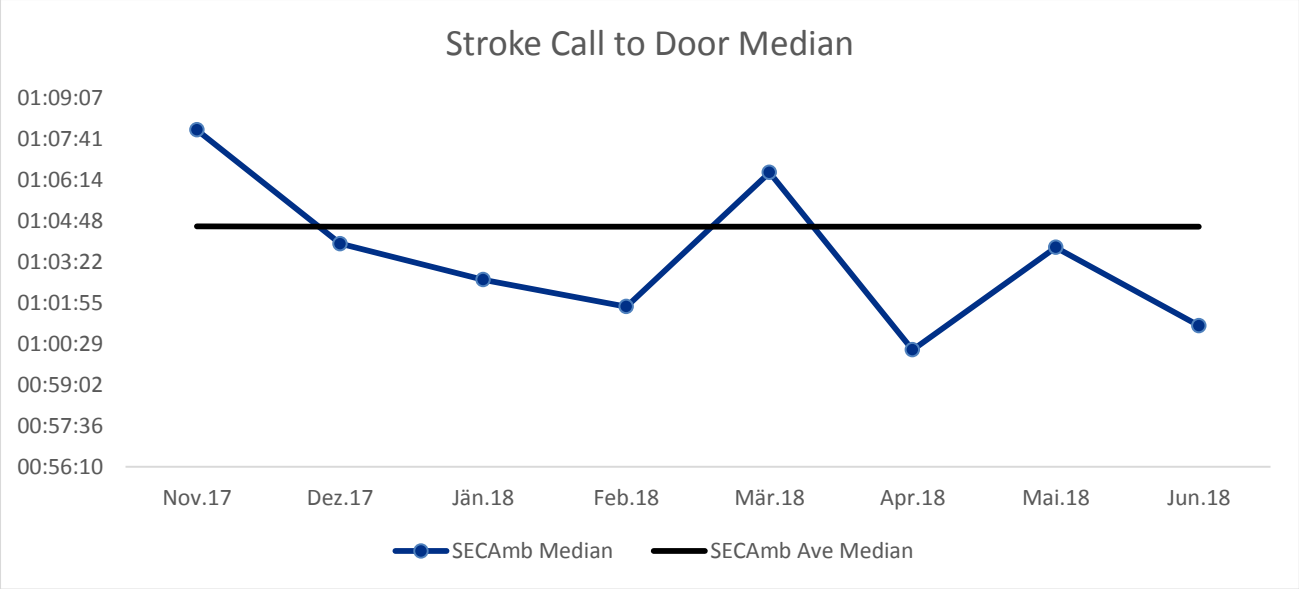


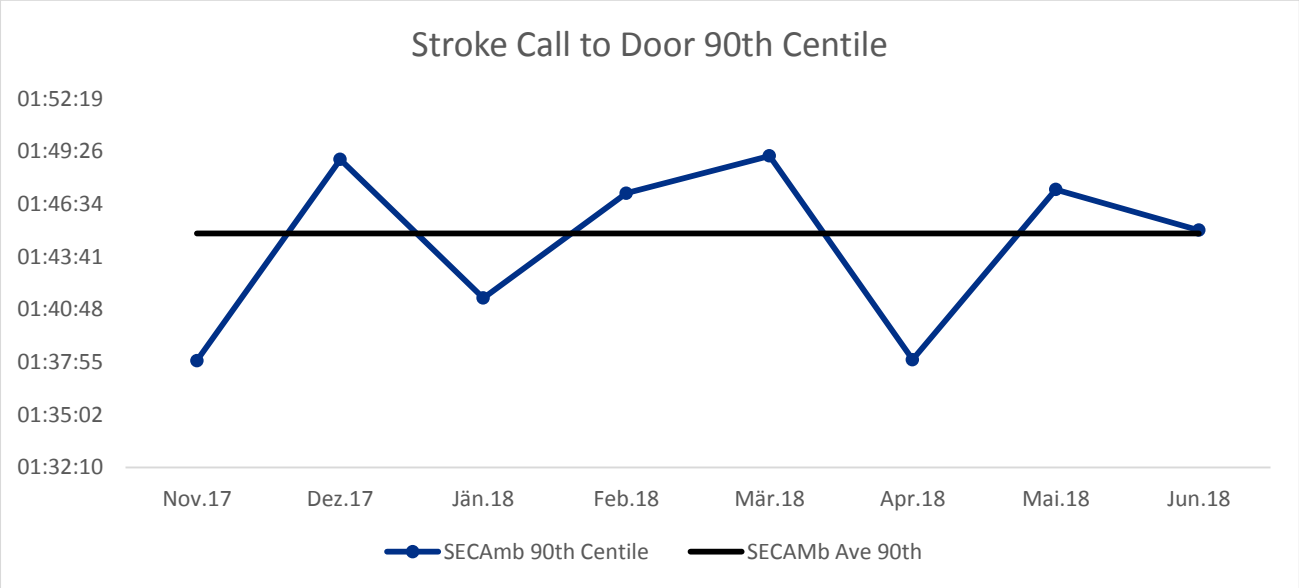
6.3.6. **Stroke Timeliness**

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

6.3.6.2. In Q1 of 2018-19 our performance against this indicator ranged from one hour and eight minutes to one hour and fourteen minutes. National data for this measure are not yet available.



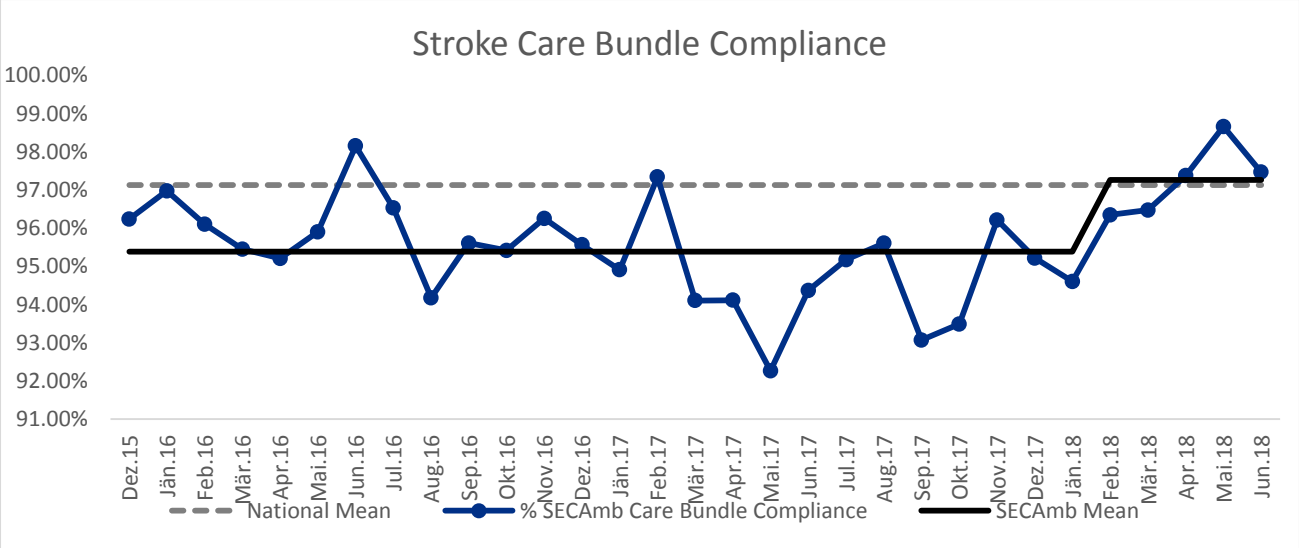




6.3.7. **Stroke Care Bundles**

6.3.7.1. Proportion of suspected stroke or unresolved transient ischaemic attack patients assessed face to face who received an appropriate care bundle.

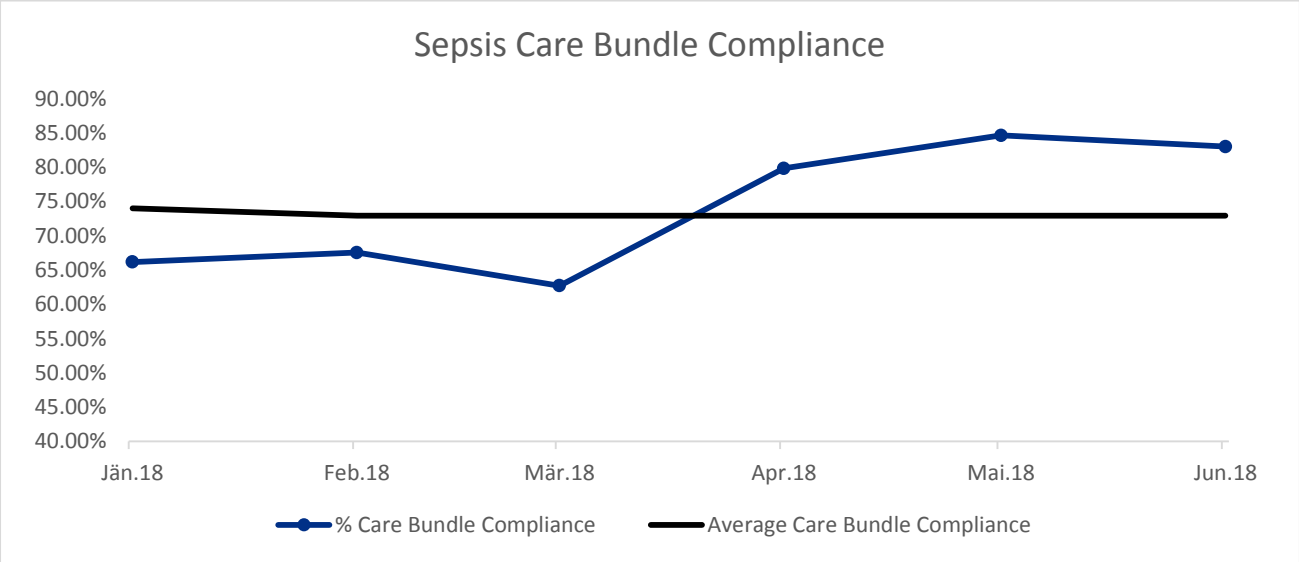
6.3.7.2. In Q1 of 2018/19 there was a shift in our average performance in the stroke care bundle that has brought us into line with the national average. Our performance ranged from 97.27-98.67%. This shift is associated with a change in the national guidelines for measuring this indicator.



6.1.7. **Sepsis Care Bundle**

6.1.7.1. The sepsis care bundle is a new measure for the 2018/19 Clinical Audit Plan. The Clinical Audit team commenced collection of this measure for the data period Q4 2017/18. All patients with a National Early Warning Score of seven or more will receive high flow oxygen, sodium chloride, a full set of observations and a hospital pre-alert call will be provided.

6.1.7.2. In Q1 of 2018/19 our performance against this indicator ranged from 79.83-84.65%. Our mean performance against this indicator is 72.91%. National average performance is not yet available for this measure. Failure to provide a pre-alert call is the most common reason for reduced performance in this measure.



7. Health Records

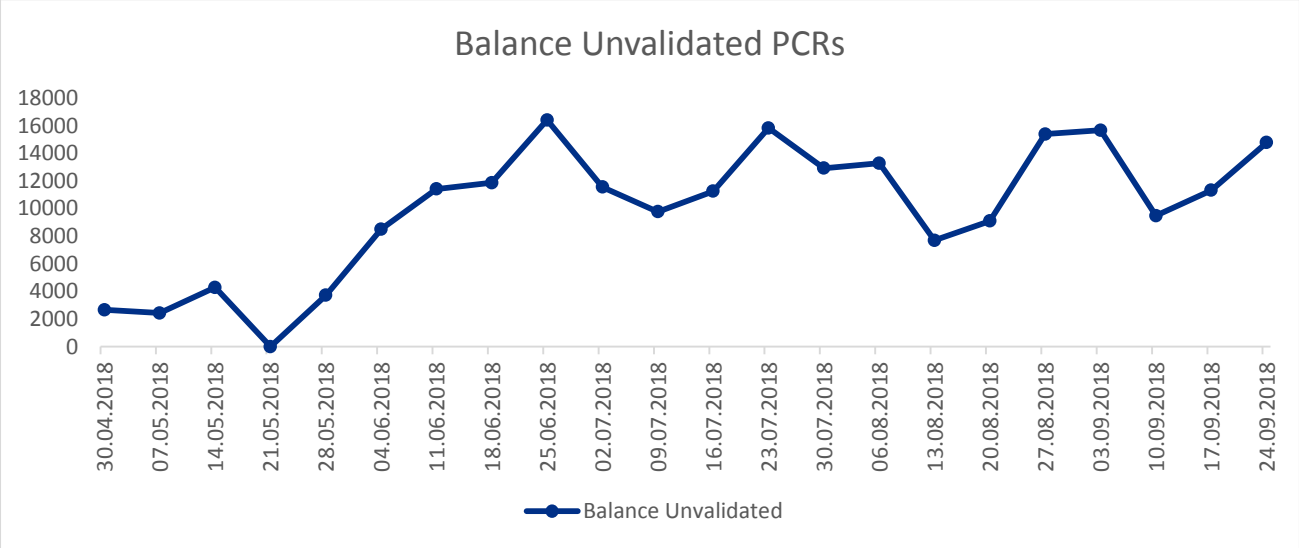
7.1. There are three main measures of success for our Health Records function; these are:

7.1.1. The Trust's ability to respond to demand and scan and validate all of the PCRs created (Balance of Unvalidated PCRs).

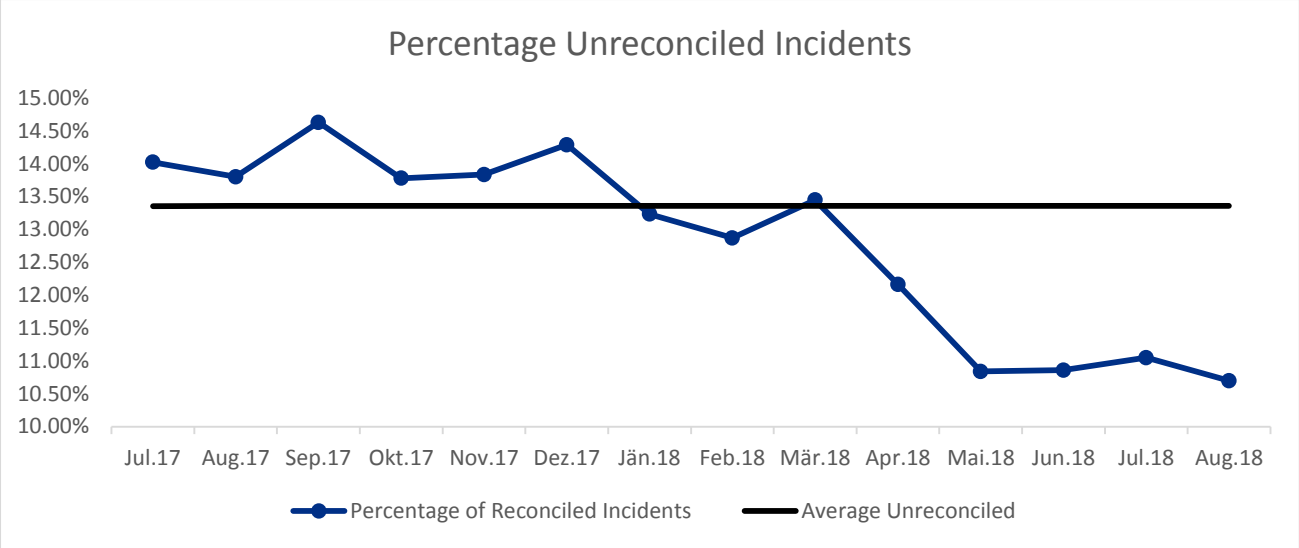
7.1.2. The proportion of incidents that are matched to a PCR (Proportion of Unreconciled Incidents).

7.1.3. The proportion of PCRs that have the full Minimum Data Set completed.

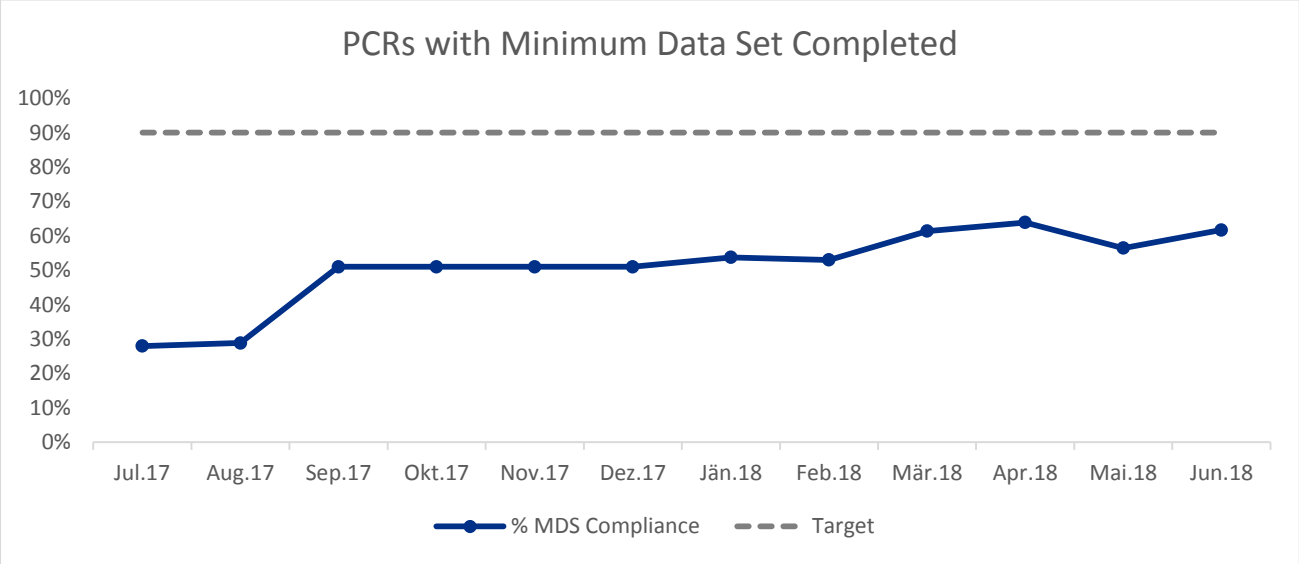
7.2. The balance of PCRs to be validated now sits at an acceptable level and is monitored by the Head of Clinical Audit through a weekly report from the Health Records Manager.



7.3. The proportion of unreconciled incidents is now at the lowest is has been in the last ten months. This has been achieved through focussed improvement in outlier Operating Units and the introduction of a four-digit incident number to reduce recording errors.



7.4. The proportion of incidents that contain the full minimum data set has increased from 40% to 62% after a focussed effort from local leadership teams. We will continue to work towards our target of 90% through intensive support for outliers in performance and by making the elements of the minimum data set more widely available for crews. A redesign of the patient clinical record will also make the elements of the minimum data set more explicit.



8. Quality Improvement

8.1. Clinical Audit Plan

8.1.1. All audits from the Clinical Audit Plan are currently in the data collection phase. Analysis and recommendations for quality improvement will follow.

8.1.2. A backlog of recommendations from previous clinical audits has now been cleared and evidence of their completion collected.

8.2. Cardiac Arrest

8.2.1. Whilst a Consultant Paramedic for Critical Care and Resuscitation is recruited, the Medical Directorate has appointed a Critical Care Paramedic to lead the delivery of an improvement plan. The main actions from this plan include:

8.2.1.1. Development of a Cardiac Arrest Registry – The project lead is exploring the development of a live registry, where crews contact the Critical Care Desk in EOC for data to be entered into the registry.

8.2.1.2. Resuscitation Procedure – A task and finish group has been formed to develop a resuscitation procedure for the Trust that will supersede the Resuscitation Clinical Bulletin issued by the previous Consultant Paramedic for Critical Care and Resuscitation. This procedure is nearing the final stages of approval.

8.2.1.3. Public Access Defibrillators – Work is ongoing to develop a Public Access Defibrillation strategy. A registry is planned to ensure public can find their nearest defibrillator, in conjunction with the British Heart Foundation.

8.2.1.4. LUCAS Mechanical CPR Devices – Ten devices are ready for deployment to OTLs. A training plan is approved. Following a QIA training will commence. Finding a location to store the devices on OTL vehicles is ongoing.

8.2.1.5. GoodSAM – The Trust is exploring the use of GoodSAM to dispatch qualified members of the public and healthcare professionals to cardiac arrest. The objective is to shorten time to quality CPR.

8.2.1.6. Codestat – A resolution to hardware issues with the Codestat system has now been found. Transition to Codestat V10 and a new Trust server has taken place and analysis of cardiac arrest downloads will resume when a cardiac arrest analyst is recruited.

8.2.1.7. Key Skills training – Approximately 50% of staff have completed this year's key skills training which includes a refresher on resuscitation skills.

8.3. **STEMI**

8.3.1. In the latter part of 2017/18 the Clinical Audit team began disaggregating care bundle performance data by Operating Units. This has allowed us to identify those who are outliers in performance and those who would benefit from intensive support.

8.3.2. A programme of work is in the early stages of development with the education department.

8.4. **Stroke**

8.4.1. As above, we have also identified the outlier Operating Units in this performance measure and will provide focussed support.

8.5. **Sepsis**

8.5.1. The main reason for reduced performance in this measure is failure to provide a pre-alert call to the receiving hospital. A reminder of the importance of providing a pre-alert call will be issued as part of publication of the new care bundles.

8.6. **Improving Data Quality & Timeliness**

8.6.1. A business case has been developed for the procurement of an integrated health records and clinical audit system. The system has the following features:

8.6.1.1. Immediate notification of reconciliation between clinical records and CAD incidents.

8.6.1.2. Ability to search CAD for correct incident details when a PCR does not match, leading to reconciliation for every PCR received.

8.6.1.3. Automation of clinical audit processes (including both paper and electronic records), only requiring auditor intervention to check non-compliant incidents for evidence of compliance in free-text etc., enabling audit team to meet additional demand created by growing ambulance quality indicators.

8.6.1.4. Leadership and clinicians able to log into the system to view their own compliance.

8.6.1.5. All forms (ePCR, main PCR & associated forms) can be accessed for review as required (depending on access rights), eliminating the need for governance teams to request forms from the health records team.

8.6.1.6. Eliminates ‘batching’, meaning that audit becomes a continuous flow as PCRs are received.

8.6.1.7. Automatic reporting.

8.6.1.8. Ability to feed data to business information systems

9. Clinical Audit & Health Records Improvement Plan

9.1. The Clinical Audit & Health Records Improvement Plan has now been closed. Measures are now tracked through the Trust's business as usual governance structures.

10. Summary

10.1. Improvements in staffing, governance and risk management have been sustained.

10.2. The 2018/19 Clinical Audit Plan has suffered minor delays, however these delays do not place delivery of the plan at risk.

10.3. The number of incidents reviewed for Ambulance Quality Indicators has increased significantly and a business case has been developed to enable the audit team to meet growing demand.

10.4. Improvement actions are planned to improve clinical outcomes following cardiac arrest, STEMI, stroke and sepsis.

10.5. The Clinical Audit and Health Records Improvement Action plan has been closed and measures are now tracked through business as usual governance structures.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	114/18

Name of meeting	Trust Board
Date	25 October 2018
Name of paper	**Serious Incidents** Thematic Review
Responsible Executive	Bethan Haskins, Executive Director of Nursing & Quality
Author	Colin Taylor & Catherine Bell
Synopsis	This thematic review of the serious incidents reported between July 2017 and August 2018 was scrutinised by the Quality & Patient Safety Committee on 19 October 2018 (see escalation report) The committee felt that the paper was helpful in terms of informing the Board of the types of serious incidents, but believed it lacked the detailed enough analysis of the key messages and the actions needed / taken. For example, the numbers of SIs in West EOC appeared relatively high, but the committee established that there might be different reasons for this, including a better reporting culture and the way incidents relating to delay, in particular, might be allocated to EOC despite being due to resources. The committee agreed that the report should come to the Trust Board, and asks directors to note this summary and be aware that the committee will receive a thematic review, taking account of the feedback, once each quarter.
Recommendations, decisions or actions sought	For information

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

Serious Incidents Thematic Review

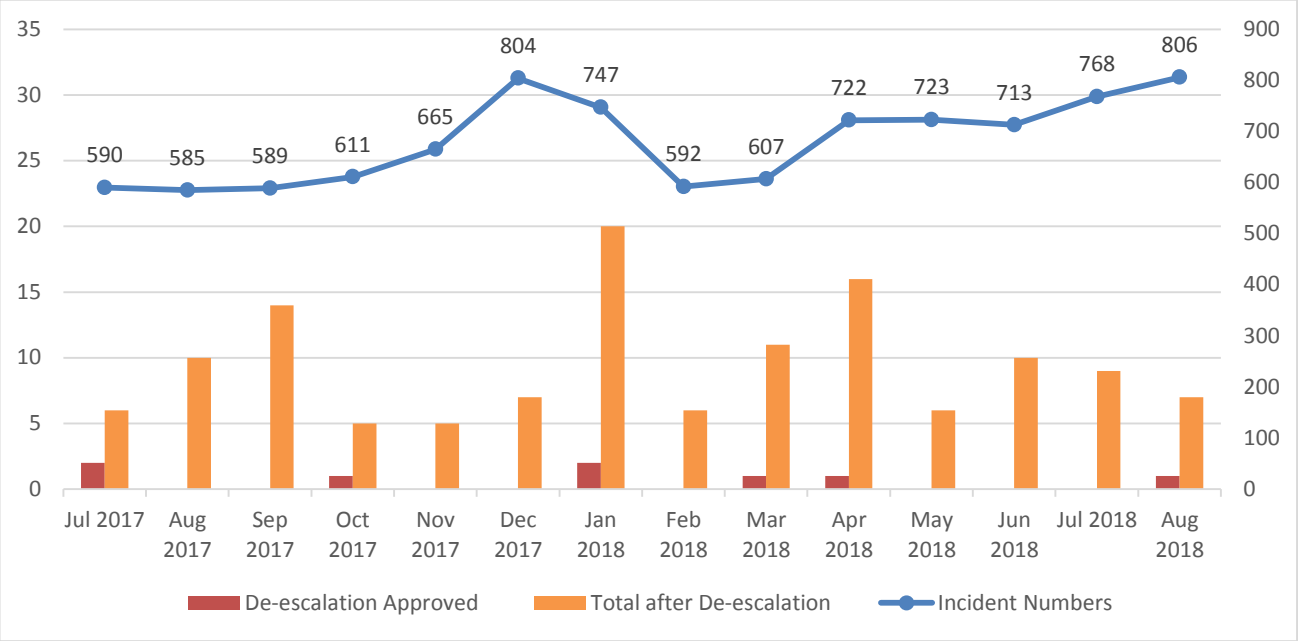
1. Introduction

1.1 This report includes Serious Incidents (SIs) reported during the timeframe July 2017-August 2018 (14 months).

1.2 The Trust reported 140 SIs and have de-escalated 8 with agreement of the Trust's Lead Clinical Commissioning Group for SIs making a net reported figure of 132 SIs.

1.3 56 of the reported SIs have been closed by the CCG, learning and actions will be identified from these.

2. SIs Reported (by SI Reported Date)



Graph 1 Serious Incidents and Incidents Reported

2.1 Average reporting rates are 9 serious incidents per month. There were three exceptional reporting months, September 2017 (14 reported) this reflects on the high demand and under resourcing of staff with the EOC to meet demand alongside the change in CAD provider and EOC move. January 2018 (20 reported) reflecting operational activity in December 2017, and April 2018 (16 reported).

Incident reported in September 2017

Row Labels	Sep
Call Answer Delay	2
Delayed Dispatch / Attendance	8

Other (Concerns about recruitment checks)	1
Triage / Call Management	3
Grand Total	**14**

Incident reported in January 2018

SI Type	**Jan**
Call Answer Delay	2
Delayed Dispatch / Attendance	10
Non-Conveyance / Condition deteriorated	1
Other (Tail lift failure)	1
Other (Vehicle Fire on Trust Premises)	1
Patient / Third Party Injury	1
Treatment / Care	3
Triage / Call Management	1
Grand Total	**20**

Incidents reported in April 2018

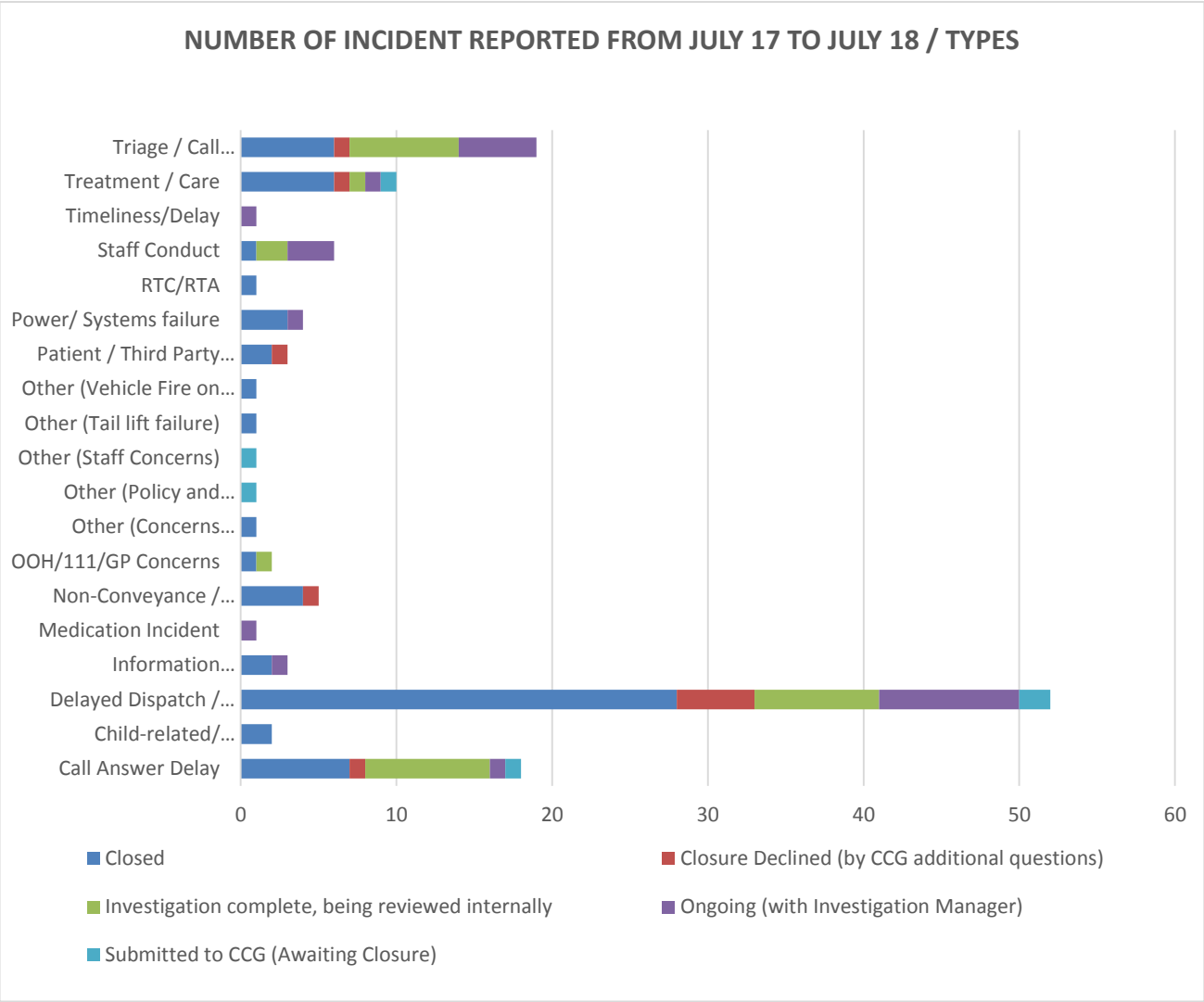
SI Type	**Apr**
Call Answer Delay	2
Delayed Dispatch / Attendance	4
Information Governance Breach	1
Non-Conveyance / Condition deteriorated	1
Other (Staff Concerns)	1
Staff Conduct	2
Treatment / Care	2
Triage / Call Management	3
Grand Total	**16**

3. SIs Reported (by Reporting Reason)

3.1 The top four reasons for reporting are:

1. Delayed despatch / attendance (52)
2. Call answer Delay (18)
3. Triage/Call Management (19)
4. Treatment / Care (10)

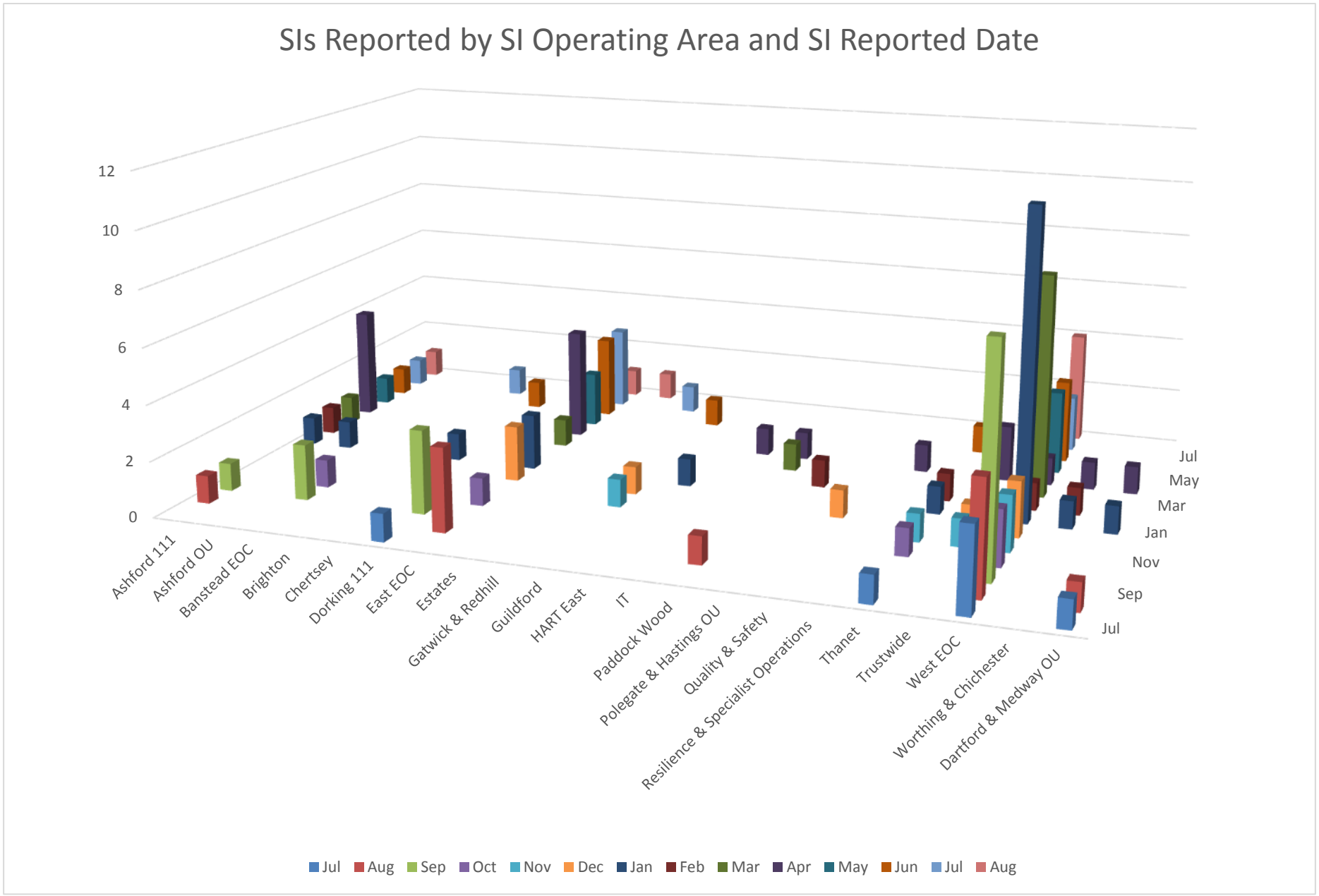
3.2 4 of the 10 treatment/ care serious incidents relate to issues in and around attempted resuscitation in the home environment.

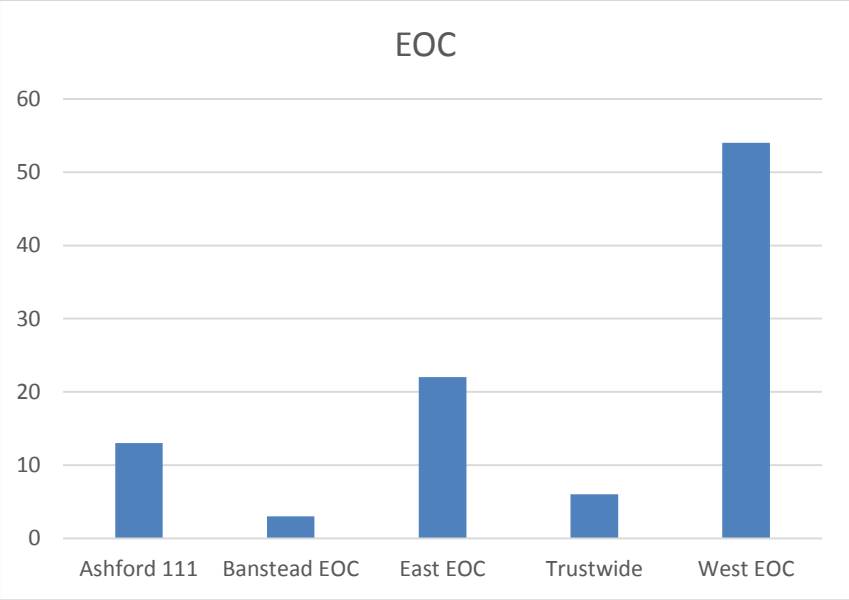


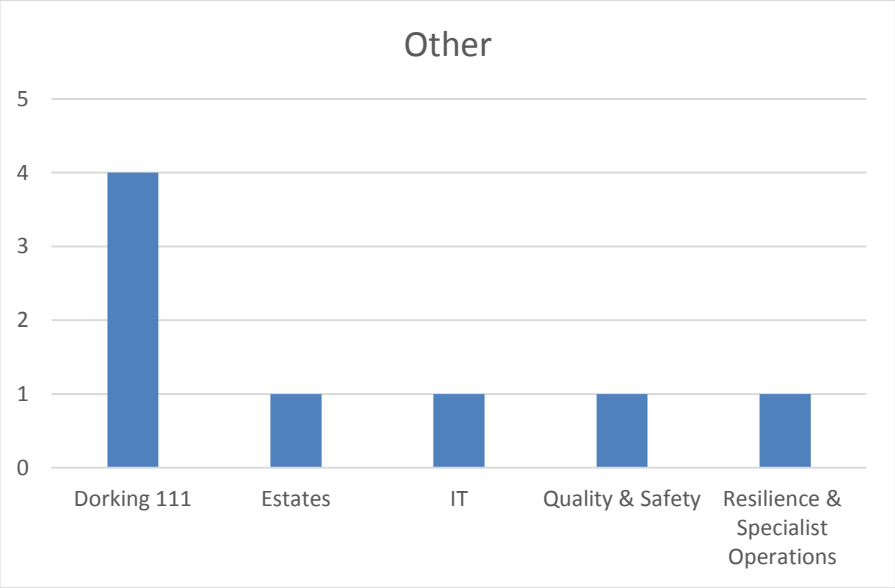
4. SIs by Reporting Operations Area

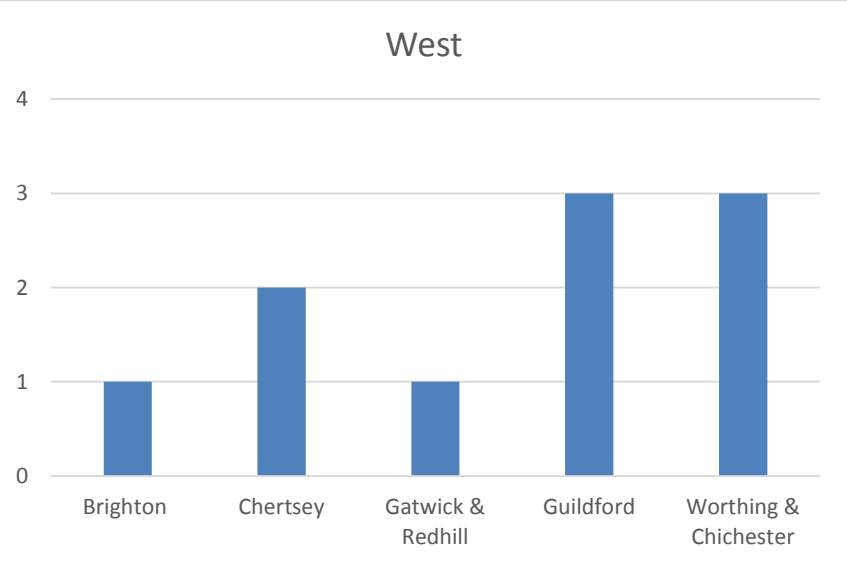
4.1 Data for which Operating Unit the affected Patient falls within has only been captured since December 2017 so analysis for the whole time period covered within this report has not been possible. Future thematic reviews will include this analysis. The graph below shows the data available for reported SIs by reporting Operations Area.

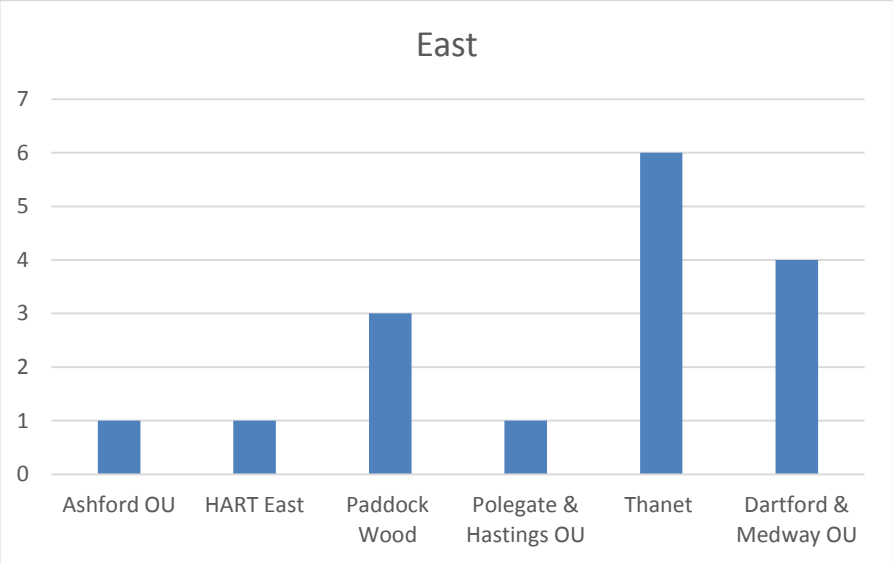
4.2 There will be higher numbers for the Emergency Operation Centres (EOCs) as delayed attendances are attributed to EOC rather than the affected patient's geographical area. A separate graph shows the reporting figures for each of the EOCs


SIs Reported by SI Operating Area and SI Reported Date
12
10
8
6
4
2
0
Ashford 111
Ashford OU
Banstead EOC
Brighton
Chertsey
Dorking 111
East EOC
Estates
Gatwick & Redhill
Guildford
HART East
IT
Paddock Wood
Polegate & Hastings OU
Quality & Safety
Resilience & Specialist Operations
Thanet
Trustwide
West EOC
Worthing & Chichester
Dartford & Medway OU
Jul
May
Mar
Jan
Nov
Sep
Jul
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug


EOC
60
50
40
30
20
10
0
Ashford 111
Banstead EOC
East EOC
Trustwide
West EOC


Other
5
4
3
2
1
0
Dorking 111
Estates
IT
Quality & Safety
Resilience & Specialist Operations


West
4
3
2
1
0
Brighton
Chertsey
Gatwick & Redhill
Guildford
Worthing & Chichester


East
7
6
5
4
3
2
1
0
Ashford OU
HART East
Paddock Wood
Polegate & Hastings OU
Thanet
Dartford & Medway OU

4.3 Worthing, Paddock Wood, and Guildford are the top 3 Operations reporting units.

5. Closed SIs – Root Causes and Learning

5.1 Delayed Dispatch/ Attendance

5.2 Twenty-six of the closed incidents relate to delay in dispatch or attendance. The main theme identified from the root causes related to demand outweighing the resources available.

5.3 The Trust is completing, with the CCGs, an overarching review of demand and capacity. A number of recommendations relate to a review of forecasting and resource planning which will link to this review.

5.4 The Welfare Call Policy and Demand Management Plan feature in recommendations in these types of incidents. Several of these SIs were reported before the Demand Management Plan was replaced by the Surge Management Plan (SMP). There is currently a further review of the SMP and Welfare Call Policy which includes auditing of whether Welfare Calls are being completed.

6. Call Answer Delays

6.1 Of the closed investigations for this category, resourcing in the EOC, due to sickness and vacancies, was the root cause in seven cases.

7. Triage Call Management

7.1 Five closed SIs related to Triage/Call Management in 111. Three recommendations were about the use of the Orange Flag system (raising clinical concerns during a call) this procedure has been re-issued and the message for staff to seek advice if they are unsure about the call they are handling has been reiterated.

7.2 A change request submitted to NHS Pathways around disposition of a call for a patient with breathing difficulties which was to contact GP within 24hrs was made.

8. Child-related / Unexpected Child Death

8.1 Five closed SIs related to Child-related / Unexpected Child Death. Four of these related to a child under 1-year-old. One related to a failure to recognise a deteriorating child, 1 related to non-conveyance and 1 was a hear and treat incident passed to the OOH GP.

One related to an 8-year-old who died following suffering an epileptic fit; no single factor was considered as a root cause leading to any failure by the Trust directly attributable to the death.

8.2 The Trust has introduced a policy of conveying all children under 1 year where an ambulance attendance is made.

9. Treatment / Care

9.1 Four SIs have been closed which relate to Treatment/Care. There were no identified patterns in the root causes found for each of these. One investigation was unable to identify and care or service delivery problems,1 related to a displaced ET tube (possibly due to movement of the patient during resuscitation) that had been reported by the paramedic as an oesophageal intubation.

10. Non-Conveyance

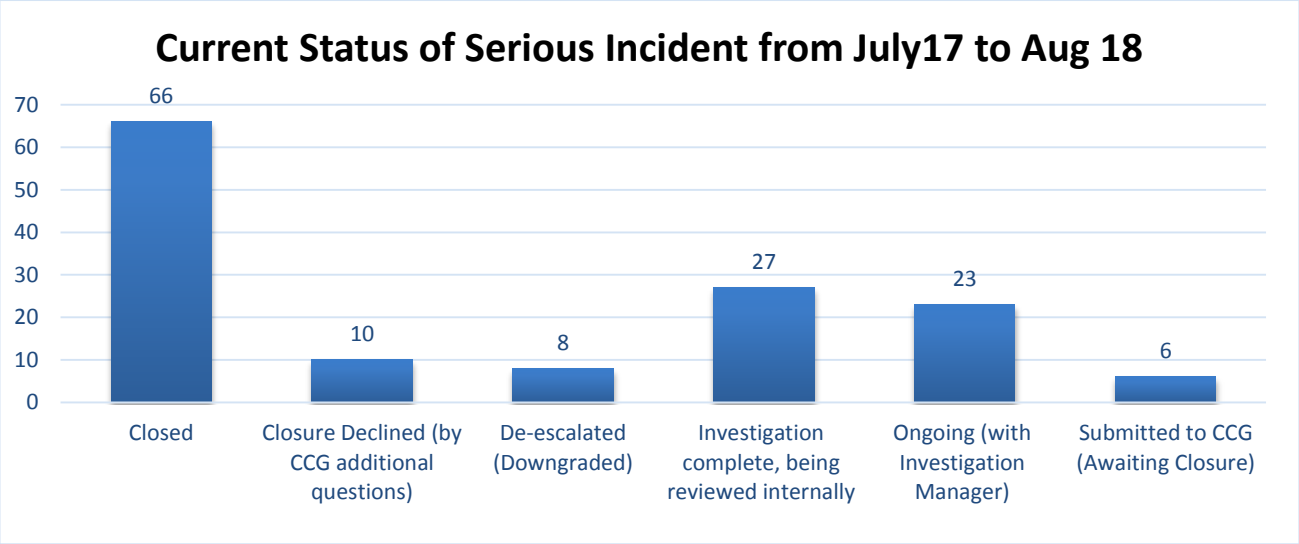
10.1 Four SIs with this reporting reason have been closed. One SI has already been included in the Child-Related section of this report and the root cause/learning was lack of/insufficient process and since the incident a policy of transporting all under 1 year olds has been introduced.

10.2 One investigation found no root cause for the Trust. No error identified with any of the clinicians' actions. A collaborative clinical decision-making process was undertaken with the patient's GP following an expressed wish from the patient to remain at home.

10.3 In one SI there was an initial diagnosis of chest infection – possible misdiagnosis / false impression given by the GP on the initial consultation. Failure of the Paramedic to consider a patient presenting with chest pain and shortness of breath, may be suffering with anything other than a suspected diagnosis by a GP the day before. Confirmation bias.

10.4 In the other SI there was found to be a missed opportunity to convey a patient who was experiencing exacerbation of COPD, influenced by the focus of the patients presenting condition being social conditions.

11. Summary



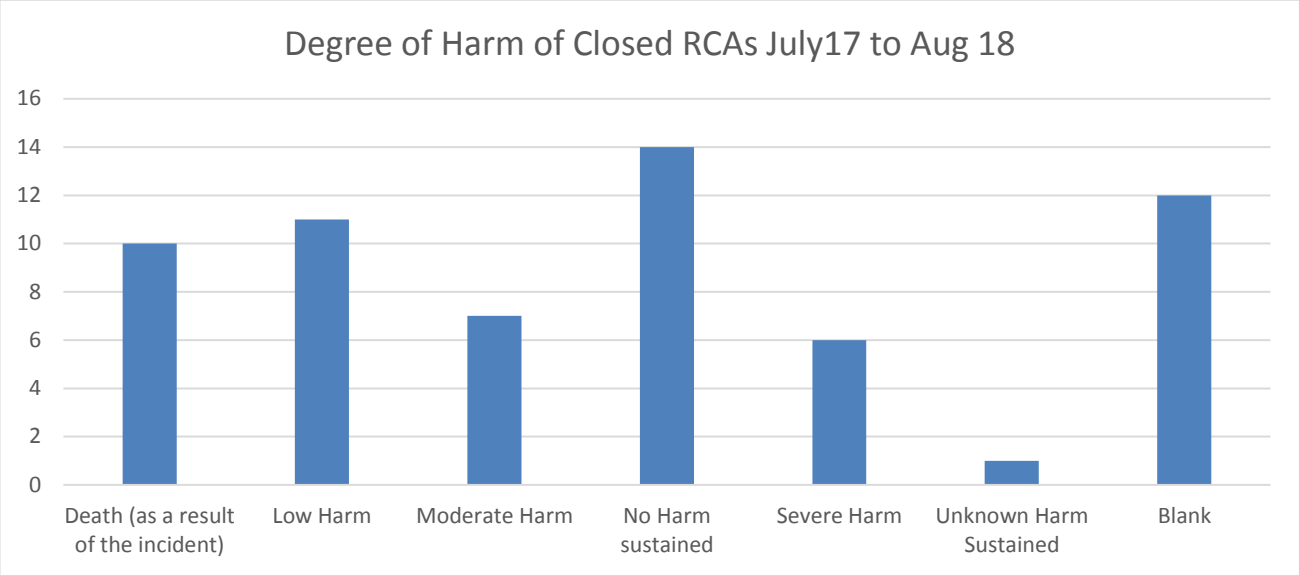
12. Investigation Outcomes

12.1 Each of the 132 Serious Incidents have now been investigated and reports completed. Those reports are being provided to the patients/families and where they are willing to do so, the Trust will meet with each of the recipients to ensure they have received and understood the report and have any questions answered.

12.2 Each of the132 investigations has sought to identify whether or not the patient experienced harm as a direct result of the care received or delay in care. All ambulance services, have to deal with expectant death and dying every day, therefore, the focus of any harm analysis is to understand whether or not the death was expectant or if in these cases, the delayed response caused death or actual harm.

12.3 To complete the 'lessons learned' we need to identify the degree of harm experienced either as a direct result of our care or delay in that care. The table below reflects the outcomes only from the 'closed' SI's and not those awaiting submission and closure.

12.4 This table will be updated as we progress the SI's and transfer the key information onto Datix.



13. Contributory Factors

13.1 The Trust considered three contributory factors to the increase in demand over the past fourteen months:

i. The higher acuity of patients, which saw a higher proportion of callers in Category 1 and 2
ii. The evidence based gap between the Trust's capacity and demand and
iii. The increase in arrival to handover times at many of our regions hospitals.

14. Thematic Review of 132 Serious Incident Investigations

14.1 As part of the Trust's wider learning from serious incidents, this thematic review has been undertaken to ensure that local and regional learning is taking place. This will support the Trust for our winter 2018/19 plan.

14.2 There are four broad themes for the Trust to address:

I. There is a gap between capacity and demand as a result of recruitment and retention difficulties both within the EOC and 'patient facing' exacerbated when demand exceeds forecast.
II. Arrival at Hospital to Handover Delays are still a significant factor affecting available capacity
III. Strengthening our capacity and forecasting processes will help mitigate some of these risks
IV. The need to expedite recruitment of additional Emergency Operations Centre (EOC) staff to reduce human factor issues which lead to human error
V. Increase the number of specialist clinicians within the EOC to support the triage of patients and EMA's.
VI. Lessons learned from this thematic review of serious incidents (SIs) should enable a system-wide collaboration for future periods of high demand. It will also allow the Trust and the wider health system to learn and implement lessons from this winter period and provide patients with reassurance that the Trust is taking the outcomes of the reports very seriously.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	19 October 2018
Overview of issues/areas covered at the meeting:	From the midway point of the meeting, the Committee was not quorate. This meeting considered a number of ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas),* including; **Workforce Planning** **(Partially Assured)** The committee noted the good progress in understanding the issues that need to be addressed to ensure the recruitment targets are met. These challenging targets will require new approaches at every stage of the process, and the committee does not believe there is the capacity in-house to maintain the necessary pace. The vital externally delivered training both for class C1 and blue light driving is not being delivered to plan. We are matching or exceeding our best ever recruitment rate, although retention remains a significant issue. The committee also discussed the importance of staff at all levels taking responsibility for removing barriers to recruitment. For example, by staff not sending back incorrect or incomplete forms to the originator but simply picking-up the phone and asking for the incomplete data. **HR Transformation** **(Partially Assured)** A number of aspects were considered, including the cultural change programme, process improvement, personnel files and the HR operating model. Work on culture was now being developed inhouse and the Committee was hopeful that this would now begin to meet our needs. A good grip was apparent on the work on personnel files and the committee is assured that the issue with incomplete DBS checks did not lead to any inappropriate appointments, or changes in status of existing employees not being addressed. There was concern about capacity in HR and addressing this will be key in implementing the process improvements required. This work was discussed in the context of the implementation of the demand and capacity review and it was agreed that these should be managed together. It was also agreed that a revised set of KPIs should be developed relating to the implementation of the DCR that ties process improvements to meeting the organisational needs of the Trust rather than simply the planned outcomes of the HR transformation work. A proposal is to be brought back to the next committee meeting. **Payroll Discrepancies** **(Partially Assured)** This remains an issue for the Trust but the committee received assurances that we now have a better grip on the provider, and that the provider has agreed to refund some of our costs by way of compensation for its poor service. However, the committee restated

	its view that discrepancies in this area must be minimised. Around 1:8 appeared to be as a result of incorrect actions by managers which need to be addressed. The committee also discussed the very complicated way that the final salary of many of our staff is generated, giving rise to opportunity for error. The committee was assured that a single point of management now exists to lead improvement in this area. **Health and Safety at Work (Partially Assured)** The committee welcomed the much stronger focus on H&SaW and noted the very good work now underway by the new team. The committee also thanked Al Rymer for his support of this work. It was clear that there was a great deal of work to be done but there is good focus on meeting all new RIDDOR timescales. A sound plan is being developed but addressing all aspects of the external review must be achieved as a matter of urgency. The annual staff survey results were discussed in the context of the use of PowerBi. This was welcomed by the Committee but it was stressed that we must focus on what is important to the Trust and our patients and not focusing on improving individual survey scores.
Reports *not* received as per the annual work plan and action required	N/A
Changes to significant risk profile of the trust identified and actions required	None – the committee reviewed the workforce risks on the risk register and was confident that they reflected the current issues. However, it agreed that the focus now must move to measuring the impact of the changes to HR systems and processes to the service transformation delivery. With regard to H&SaW, staff were asked to look at the particular risks being identified and ensure they are related to the right owners (ie not necessarily the H&S team).
Weaknesses in the design or effectiveness of the system of internal control identified and action required	The committee is concerned about capacity issues within HR and was assured that the Executive team is looking at this. The Board should note the significant issue of retention, and specifically within the EOC. It was noted that many EOC staff will progress to roles on the road, and that this is part of the overall recruitment strategy, but of course also means staff move through the EOC at some rate. We need to focus on staff leaving the organisation in terms of exit interviews and understand that better.
Any other matters the Committee	The workforce plan is in progress and the committee will scrutinise the plan to develop the plan at its next meeting. Linking it more to the outputs required for the service transformation delivery should be of benefit to the Trust.

wishes to escalate to the Board	The committee will also prioritise the scrutiny of health and safety during Q1 of 2018/19. Finally, this meeting was one of three committee meetings within the same week and the committee Chair was very aware of the pressure on staff to draft and sign-off papers. Papers were therefore late. The Company Secretary will review the schedule.