South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

29 November 2018
10.00-12.30

Trust HQ, Nexus House

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
Introduction					
121/18	10.01	Apologies for absence	-	-	DA
122/18	10.01	Declarations of interest	-	-	DA
123/18	10.02	Minutes of the previous meeting: 25 October 2018	**Y**	Decision	DA
124/18	10.03	Matters arising (Action log)	**Y**	Decision	DA
125/18	10.05	Board Story	-	Set the tone	DA
126/18	10.10	Chief Executive's report	**Y**	Information	DM
Trust strategy					
127/18	10.15	Delivery Plan Deep Dive: ▪ Culture ▪ Service Transformation	**Y**	Information	SE EG SE
128/18	10.50	CQC Inspection – Findings and Next Steps	**N**	Information	BH
Quality & Performance					
129/18	11.00	Clinical Safety	**Y**	Assurance	JG
130/18	11.20	Falls update	**Y**	Assurance	FM
131/18	11.35	Integrated Performance Report	**Y**	Information	SE
Governance					
132/18	11.55	Brexit		Desision	PL
133/18	12.05	Emergency Preparedness, Resilience & Response – Annual Assurance	**Y**	Assurance	JG
134/18	12.10	Carter Review	**Y**	Information	DH
135/18	12.15	Finance & Investment Committee Escalation Report	**Y**	Information	AS
136/18	12.20	Sussex & East Surrey STP – governance arrangements	**Y**	To note	SE
Closing					
137/18	12.25	Any other business	-	Discussion	DA
138/18	-	Review of meeting effectiveness	-	Discussion	ALL
Close of meeting					

Date of next Board meeting: 20 December 2018
After the close of the meeting, questions will be invited from members of the public

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting,
25 October 2018

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

Present:

David Astley	(DA)	Chair
Daren Mochrie	(DM)	Chief Executive
Alan Rymer	(AR)	Independent Non-Executive Director
Angela Smith	(AS)	Independent Non-Executive Director
Bethan Haskins	(BH)	Executive Director of Nursing & Quality
David Hammond	(DH)	Executive Director of Finance & Corporate Services
Fionna Moore	(FM)	Executive Medical Director
Joe Garcia	(JG)	Executive Director of Operations
Laurie McMahon	(LM)	Independent Non-Executive Director
Lucy Bloem	(LB)	Independent Non-Executive Director
Michael Whitehouse	(MW)	Independent Non-Executive Director
Steve Emerton	(SE)	Executive Director of Strategy & Business Development
Terry Parkin	(TP)	Independent Non-Executive Director
Tricia McGregor	(TM)	Independent Non-Executive Director

In attendance:

Peter Lee	(PL)	Trust Secretary

104/18 Apologies for absence

Adrian Twyning	(AT)	Independent Non-Executive Director
Ed Griffin	(EG)	Executive Director of HR & OD
Janine Compton	(JC)	Head of Communications

105/18 Declarations of conflicts of interest

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

106/18 Minutes of the meeting held in public on 28 September 2018

The minutes were approved as a true and accurate record.

107/18 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.

108/18 Board story [10.05 – 10.18]

This Board story arises from a complaint received relating to how we used the learning from poor care provided to a terminally ill patient, particularly the way the crew communicated to the patient and family. The Board asked about the reflective practice cited in the story seeking assurance that this process was

followed through. The Board reflected that this experience also helped to reinforce the importance of ensuring secondary care support is in place for patients like this who are terminally unwell.

DM added that the service receives increasing 999 calls in absence of the availability of palliative care and so we continue to work to get in place multidisciplinary team decision making, so that the best possible care can be provided to the patient and their family. DM confirmed this is being explored with commissioners and system partners.

The Board was clear that it made no difference that this particular crew were from a private ambulance provider (PAP), and sought assurance that PAPs also ensure learning and reflective practice following issues raised by this story. BH confirmed that we have specific evidence this did happen in this case and explained that our governance for PAPs is much improved.

109/18 Chief Executive's report [10.18 – 10.32]
DM took members through the issues set out in his report, clarifying the role and concept of the Winter Hub, which is led by NHSI, and involving system partners and this year hosted at Nexus House. The Hub is where key system-wide decisions are made during this challenging period.

TM asked about staff survey response rate and uptake on flu, and BH outlined the steps being taken to ensure effective communication to staff in relation to these two important areas.

MW asked about the extent to which we scenario plan, for example in preparation for Winter, and JG responded by setting out the work of the scheduling team and how we forecast based on historic trends and known current factors, such as weather.

110/18 Delivery Plan [10.32 – 11.20]
SE introduced the paper and asked the relevant directors to report issues by exception.

<u>Service Transformation</u>
JG confirmed the approach to service transformation delivery, following the demand and capacity review. He explained that Hospital Handover is rag-rated Red, due to the unlikelihood of meeting the objectives, despite the good progress that has been made.

The NARU inspection was undertaken on 24.10.2018, and this is where they assess the Trust against its self-assessment. JG reminded the Board that we had a challenging report last year and the initial feedback this year has been really positive. A report will come to Board in due course. The improvements include that all HART staff are now paramedic qualified and all leadership posts are covered substantively, save for one. We are now considered the national exemplar for training; and we are training other agencies too. More broadly, other areas of governance were noted to have been strengthened.

TP asked about peer reviews (hospital handover) and our highest performing OUs and what they do. Regarding peer reviews, JG explained they have taken place and had a really positive impact on the most challenged hospitals.

AS raised concern about now always being able to out the target hours out (currently 9000 per day), in the context of some information provided to the finance and investment committee. JG set out the work being undertaken in this area with commissioners, to analyse in great detail the hours we have put out. In recent weeks there have been periods where the hours have fallen below the target-level. Some of this relates to abstraction and the positive decision to complete key skills training, for example, during the summer months to enable more hours during winter. However, there are also other factors such as reduced overtime and

use of BANK, which JG set out, before confirming that there are plans in place to undertake a review of how we approach the BANK, including the provision of better incentives.

AS challenged this response, reinforcing the direct link between hours and performance, and the need for the Board to be very clear in its understanding of when and why there is a shortfall against the target.

SE added here that in last week we have exceeded the target hours, and reminded the Board that the service transformation programme directly tracks this and the impact on performance. The BI tools now available allow retrospective and prospective review of our ability to meet the related objectives, which are linked to the modelling confirmed within the demand and capacity review. Therefore, from November, the Board will have a clear line of sight of this via service transformation delivery.

From the perspective of finance, DH reflected that the level of detailed understanding within operations is really excellent, and much improved from before. He also added that in terms of the workforce challenges which are system-wide, we are involved with STPs at looking on a system-wide basis to combine BANKs as a way to support all provider organisations.

DA summarised – there is clear management attention and scrutiny. We have a positive outcome from the demand and capacity review and now need to support operations to use resources efficiently to deliver the improvement needed.

Sustainability

There were two issues highlighted;

Automated temperate monitoring – FM explained that we will have this across all our sites; the contract is awarded and we are in the process of implementation.

Cyber Security – DH explained this is rag-rated Red following a positive decision not to make IT changes during winter, therefore requiring the timeline to be pushed out.

This led to a discussion about Rag-ratings. The Board felt that the current principles were sound and reinforced that while dates for the delivery of individual objectives could be amended by management, and reflected in the report, any change to the delivery date of the overall project, does require agreement of the Board. There is a robust change management process for both scenarios.

LB asked about the telephony being replaced mid-December and the risk of the timing of this. DH explained the aim is still to do this by mid-November. If this does not prove possible, we will take a decision at the programme board, which will be informed by this very risk.

There was also a discussion about ECPR resulting in the Board asking for a presentation from Cleric.

Action:
The Board to receive a presentation from Cleric on the plans for ECPR.

Compliance

BH explained that incident management is rag-rated Amber due to the issues outlined last month relating to the backlog of serious incidents. Good progress is being made and we are ahead of the trajectory agreed with commissioners. The executive management board is due to approve a new process at the end of October, aimed at addressing some of the issues that have led to the backlog.

The resourcing plan is in Intensive Support. The risk here relates to the delay in C1 licences. The team is working hard on innovative solutions to get this back on track.

Culture is also rated Red and this will be the focus of the deep dive next month, to set out for the Board exactly what we are doing.

LB asked about clinical supervisors/navigators and the apparent gap. JG outlined some of the steps being taken to explore how we get benefit from the HART clinicians, for example providing support to crews. In Tangmere, we are looking at a local support function, to avoid bottle necks.

The Board asked that the quality and patient safety committee scrutinises the plans in place to ensure sufficient clinical capacity and capability within the EOC.

Strategy

SE confirmed that the findings from the strategy refresh is due to come to the Board by December.

LM wondered if we can bring to Board how commissioning colleagues and provider partners are responding to the turbulent environment, e.g. integrated care systems/collaboration of commissioners etc. SE explained this is picked up as part of the strategy refresh.

H&S Deep Dive

BH set out the focus that has been given to health and safety since March. Following the external review, we have a clear improvement plan which has been scrutinised by the workforce and wellbeing committee. The report sets out the areas of weakness identified and the project is monitored by the quality and compliance steering group. Section 2 outlines the steps taken to date, including much more expert leadership capacity and capability. Multidisciplinary training, which includes health and safety has been very well attended with good feedback from participants.

AR (the NED lead for H&S) reinforced the positive impact of the new head of H&S and the systems being put in place to ensure sustainable improvement. AR expressed some concern about the time it has taken to get to this point, but we are now picking up the pace with the infrastructure in place.

TP confirmed that the workforce and wellbeing committee is assured with the plans in place and the leadership to deliver them. In particular, the culture shift to ensure local managers take responsibility for management of the health and safety risks.

TM asked about urgent risks and how they are being addressed. BH confirmed there are some individual risks on the risk register which are being managed. Weekly oversight of the improvement plan is provided by the quality and compliance steering group and business as usual by the central health and safety group. AR added that the workforce and wellbeing committee review some of the risks and mitigations, such as manual handling.

The Board acknowledged the ongoing improvement work and the importance of it.

111/18 Finance Committee Escalation Report [11.20 – 11.29]

AS confirmed the meeting was not quorate. The personal issue kit therefore was approved for recommendation to the Board. The Trust Board approved this business case.

AS outlined the review of business cases as set out in the report, which will be taken in part 2 due to the commercial sensitivities.

With regard to the estates strategy, the committee was supportive, acknowledging it is as much a delivery plan as a strategy.

TP noted the commercial risk of publishing the estates strategy, which the Board acknowledged. Management will therefore consider what can reasonably be put in to the public domain.

SE noted a recurring theme as part of the strategy refresh is the absence of a visible plan to our approach to estate. Therefore, we need to ensure clarity for staff, noting what decisions have been taken and what decision are yet to be approved in terms of expenditure.

[Break at 11.31 – 11.42)

112/18 BAF Risk Report [11.42 – 11.46]
PL outlined the structure of the report, which confirms how the risks are being considered by the executive and the Board and how they are informing the related agendas.

BAF risk 284 and 529 was considered by the executive management board on 24.10.2018 and some actions were agreed. This will include recommending to the Board in November some changes; this current report therefore should be considered against this background.

PL noted that although there is work to do, the executive management board is increasingly assured that the relevant management groups are getting in to the routine of reviewing risks and testing the effectiveness of controls.

As stated earlier under H&S, the multidisciplinary training, which include risk management is really well attended and this is critical to improving the risk management culture within the Trust.

PL concluded by confirming that the relevant BAF risks will continue to be scrutinised by the appropriate board committee.

The Board acknowledged the work and oversight of the BAF risks and following a short discussion, the following actions were agreed;

Action:
The target dates for the BAF risks to be reviewed by the executive.

Specific consideration be given to BAF risk 334 (Culture) – in terms of the controls and actions required.

113/18 QPS Escalation Report [11.46 – 11.53]
TM thanked LB for her stewardship of this committee over the past years. She outlined the areas covered by the committee, as set out in the report, reaffirming that the main area of non-assurance related to the management of serious incidents, as discussed earlier under item 110/18.

Operational resilience was explored in some detail as requested by the Board, and the committee concluded that for some of the reasons set out in the report, including some external factors, it cannot be fully assured. The Board noted this and reinforced the need to be clear where the challenges are so we can ensure we do the best we can to respond to unexpected spikes in demand.

Finally, the clinical audit report is appended as the committee felt this gives really good clarity to where we are with clinical outcomes.

Action:
The Board suggested we provide a presentation to both Trust Board/COG on the work of clinical audit and how it is helping to ensure improvements in clinical outcomes.

114/18 Thematic Review of Sis [11.53– 12.04]
BH introduced this report, which was considered by the quality and patient safety committee on 19 October. She reflected that each of the themes listed in the report have been picked up during this meeting. This was acknowledged by the Board.

Action:
Ensure themes from Sis inform the Board agenda on a rolling basis

LB noted the numbers of EOC incidents and felt that in all likelihood these will not all be truly EOC incidents, but rather delays not connected to the act/omission of the EOC.

TP suggested that the improvements through service transformation delivery will reduce some of the SIs relating to delays. FM added that we need to define what delay will result in an SI; a standard approach is currently being considered by AACE.

JG explained that this is not just about inputs, as we can put more staff on, but if we don't utilise them efficiently we won't get the benefits. This is where service transformation is so critical to how we approach the use of our resources.

115/18 IPR [12.04 – 12.17]
SE introduced the report inviting colleagues to report by exception.

Safety:
Cardiac Arrest survival is below the national average and we have a plan in place to address this. Care Bundles for stroke and STEMI improved.

Quality:
The main issues have been covered earlier in the agenda.

Performance:
The improvement in call answer performance has continued in to October. Cat 2 is a concern and a deep review is being undertaken to understand some of the reasons for this. In terms of 111 the team have been working hard on its improvement plan and call answer has improved significantly.

LB asked about cat 1 and not achieving the 7 min mean. JG explained that we are hovering around 7 min 40 seconds, and the demand and capacity review sets out the actions needed to increase capacity, which is being delivered through service transformation.

FM added that the mean to respond to cardiac arrest is 6min 50 seconds. The Board felt it would be good to include this in the report to give assurance we are responding safely to the most acutely unwell.

Action:
A report to be received by the Board setting out how we respond to Cat 1 patients to ensure safety when there are delays.

There was a discussion about the data not being current enough. The executive agreed to take this away as part of its review of the IPR, and outlined the BI tools now available to ensure robust management of quality and performance.

Overall the Board is assured management has access to real time data and is using this to inform decision making.

Workforce:
EG updated that the number of whole time equivalents is increasing,

Finance:
DH updated that we are on plan at month 6, as referenced in the finance committee report.

116/18 WWC Committee Report [12.17 – 12.27]
TP outlined some of the focus of the committee, as set out in the report. The committee was positive about recruitment rates, and the aim now should be to improve retention, specifically those leaving the Trust, rather than moving to new roles.

In addition, TP outlined the discussion at the committee about capacity within the HR department and the impact of this on the ability to on-board new staff. Management is exploring potentially using external resource to complete, for example, pre-employment checks.

The committee continue to look at pay discrepancies, due to the link to culture and wellbeing of the workforce. An increase in cases has been noted, probably as a consequence of complicated pay structures.

With regards HR capacity, DM assured the Board that the executive management board has good focus on this, to help ensure adequate support in this area to address the issues EG has inherited. Not all the issues are HR-related, as some are down to management practice. The HR role is to ensure systems are clear and easy to follow for managers.

117/18 Staff Retention [12.27 – 12.40]
DM introduced the paper highlighting the work underway to ensure clarity of the issues relating to retention and the approach to developing a strategy to ensure improvement.

There was a discussion about the exit interview feedback and, in particular, one of main reasons relating to morale. DM believed this is about pressure on staff to deliver the day job. With the improvements through service transformation it is expected things will improve, e.g. ensuring staff finish shifts on time as currently 60% of shifts overrun. The Board reinforced the need to do all we can to ensure people are happy in their work. SE added that the first part of retention starts with the recruitment process being efficient and effective.

Action:
Board seminar to be arranged to discuss about we are ensuring staff wellbeing / working lives. Including retention and pay structures.

DA summarised that despite the good work already underway, more is needed with greater clarity on the priorities that will help make a difference.

118/18 Staff Survey Action Plan [12.40 – 12.43]

The plan for staff survey is set out in the paper. DM confirmed that we are ahead of trajectory in terms of survey completion. The Board reflected on some of the good work underway to improve staff experience, including the focus on line management supervision / appraisals and communication through the operational directorate.

119/18 Any other business

AS mentioned CFRs and noted the new head of voluntary services, and asked if the Board could have more regular information about use of CFRs. BH confirmed it is a separate project that will come through the delivery plan. In addition, QPS will receive a detailed update at its December meeting.

120/18 Review of meeting effectiveness

The Board felt there had been good discussion of key issues. Some feedback that we need more time on the BAF risk report to ensure we explore in more detail the specific risks.

There being no further business, the meeting closed at 12.45

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	20.12.2018	Board	IP	The governance and assurance strategy / framework is due to be received by the Audit Committee and then the Board in December
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	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	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	On agenda 29.11.2018
30.08.2018	82/18 b	Fleet Strategy to be considered by FIC in October	JG	TBC	FIC	IP	The committee agreed that further engagement was required prior to it considering it for recommendation to the Board
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	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	
25.10.2018	110/18	The Board to receive a presentation from Cleric on the plans for ECPR.	DH	24.01.2019	Board	IP	aim to schedule for January Board
25.10.2018	112/18	The target dates for the BAF risks to be reviewed by the executive. Specific consideration be given to BAF risk 334 (Culture) – in terms of the controls and actions required.	PL	20.12.2018	Board	IP	
25.10.2018	113/18	The Board suggested we provide a presentation to both Trust Board/COG on the work of clinical audit and how it is helping to ensure improvements in clinical outcomes	FM	TBC	Board/COG	IP	
25.10.2018	114/18	Ensure themes from Sis inform the Board agenda on a rolling basis	PL		Bosrd	C	DA and PL will keep under review the themes from Sis to inform agenda items

25.10.2018	115/18	A report to be received by the Board setting out how we respond to Cat 1 patients to ensure safety when there are delays.	BH	20.12.2018	Board	IP	Aim for Dec Board
25.10.2018	117/18	Board seminar to be arranged to discuss about we are ensuring staff wellbeing / working lives. Including retention and pay structures.	PL	TBC	Board	IP	

Key

	Not yet due
	Due
	Overdue
	Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	126-18

Name of meeting	Trust Board
Date	29.11.2018
Name of paper	Chief Executive's Report
Executive sponsor	Chief Executive
Author name and role	Daren Mochrie
Synopsis	The Chief Executive's Report provides an overview of the key local, regional and national issues involving and impacting on the Trust and the wider ambulance sector.
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.

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

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S REPORT TO THE TRUST BOARD

1. Introduction

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

2. Local issues

2.1 Engagement with local stakeholders & staff

2.1.1 On 23 October 2018, I met with the Chief Fire Officers from East and West Sussex, Surrey and Hampshire. As always, this was a useful opportunity to discuss how we can best work together and identify any areas for improvement.

2.1.2 On 5 November 2018, I joined the operational team supporting the bonfire celebrations in Lewes, which saw thousands of visitors attend the torch-lit procession and firework displays taking place across the town. We had a team of about 50 staff supporting the event, including those working in the dedicated control and worked closely with St John Ambulance who provide medical cover for the event.

2.1.3 I was also very pleased to make a presentation to Glenn Borthwick, who has decided to step down from playing a leading role in the bonfire celebrations after 18 years. Thank you to Glenn for his hard work over the years in keeping our staff, the bonfire societies and the general public who attend the celebrations as safe as possible. I thoroughly enjoyed my evening – thank you to everyone involved for their hard work.

2.1.4 During recent weeks, I have continued my programme of station visits, with visits to Burgess Hill and Haywards Heath. Thank you to all the staff that I have met during these visits – as always, it is enjoyable to meet staff directly and discuss the issues that are important to them.

2.1.5 On 20 and 21 November 2018, the Chair and I attended the Association of Ambulance Chief Executives (AACE) meeting for the Chief Executives and Chairs of all the English Ambulance Trusts. This was a very useful opportunity to spend time with our colleagues nationally, discussing the key issues that are affecting us all and areas where we can work together to drive improvements.

2.2 Latest Care Quality Commission (CQC) report published

2.2.1 On 7 November 2018, the Care Quality Commission (CQC) published their latest report into the Trust, following their planned inspections during July and August 2018.

2.2.2 The report rated SECAmb overall as 'Requires Improvement', a level up from its previous rating. The CQC also recommended to NHS Improvement that the Trust remain in special measures while the improvements made are further embedded throughout the Trust.

2.2.3 Whilst we are obviously disappointed to be remaining in special measures, I was very pleased at the improved overall rating, which reflects the hard work put in by staff across the Trust. I was particularly pleased at the improvements made in the safe and well-led sections of the report and was delighted that staff have, once again, been rated as good for the care they provide to patients.

2.2.4 Areas of good practice and improvements highlighted by the CQC include:

- Staff cared for patients with compassion. All staff inspectors spoke with were motivated to deliver the best care possible and feedback from patients and those close to them was positive.
- The Trust promoted a positive culture that supported and valued staff. Inspectors found an improved culture across the service since the last inspection. Most staff felt the culture had improved and felt able to raise concerns to their managers.
- Medicines management was robust and effective with a marked improvement since the previous inspection. Inspectors found elements of outstanding medicine management, for example the way the trust handled Controlled Drugs.
- A new well-being hub which enables staff to access support in a variety of areas. The service was widely commended by staff during the inspection.

2.2.5 I am aware that there remains work to be done and this has already been taking place since the inspection, prior to the publication of the CQC's report. I know that right across the Trust, staff are committed to further improve the services we provide to our patients.

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:

- Considered the report received from the CQC and how we will continue to make improvements in the quality of our services
- Focussed closely on 999 performance, including response to lower categories of calls, provision of staff hours and call answer times
- Monitored delivery of the Service Transformation & Delivery Programme

2.3.3 As part of the Trust's governance framework, the Resilience Committee also now forms part of the EMB agenda on a regular basis. During the meeting held on 31 October 2018, the Resilience Committee considered a recent review of Emergency Preparedness, Resilience & Response (EPRR) within the Trust, undertaken by the Association of Ambulance Chief Executives (AACE).

2.4 Chief Executive to move to new role

2.4.1 On 12 November 2018 the Trust announced my decision to leave SECAmb in Spring 2019, to take up a new role as Chief Executive of North West Ambulance Service.

2.4.2 I am and will remain immensely proud of the real progress we have made during the past 18 months and have not taken this decision lightly. I know that there is still more to do but as a Trust we have already made significant steps forward and I know I will be leaving the Trust with a strong leadership team who are committed to making this happen.

2.4.3 The process to recruit my successor has already started, led by our Chair David Astley and while this is under way, I remain fully committed to leading SECAmb through the winter and into the New Year.

2.5 Recruitment of clinical advisors

2.5.1 In early November, a team from SECAmb attended a British Nursing Open Day recruitment event in Dubai, organised by Health Sector Jobs, together with Salisbury and Belfast Hospital Trusts.

2.5.2 The event was targeted at clinicians wanting to work in the UK and the team attended with the specific aim of recruiting nurses to work as clinicians in the EOC and in 111. Despite much hard work, we still have a significant number of vacancies for clinical advisors in the EOCs, which in turn has an impact on the safety of patients waiting for an ambulance response, especially those in Categories 3 & 4.

2.5.3 Ahead of the event, the team had received lots of interest and had short-listed dozens of candidates for interview, including a number of British nurses wanting to return to the UK, as well as nurses from a range of other countries.

2.5.4 I was very pleased to hear that we have subsequently made 48 offers following the interviews and I look forward to many of these new colleagues joining SECAmb in the New Year. A lack of clinical staff is one of the main risks to the NHS and I'm pleased that an innovative approach, such as this, has brought such a positive outcome.

2.6 Armed Forces Covenant

2.6.1 During November, the Trust has strengthened its relationship with the armed forces by signing up to the Armed Forces Covenant. The covenant is a commitment to those who serve or who have served in the armed forces and their families and outlines how the Trust will support them, officially, by becoming a military-friendly employer.

2.6.2 Commitments set out in the covenant include:

- Promoting SECAmb as an armed forces-friendly organisation
- Seek to support the employment of veterans young and old and working with the Career Transition Partnership (CTP), in order to establish a tailored employment pathway for service leavers
- Endeavour to offer a degree of flexibility in granting leave for Service spouses and partners before, during and after a partner's deployment

- Seek to support our employees who choose to be members of the Reserve forces, including by accommodating their training and deployment where possible
- Aim to actively participate in Armed Forces Day

2.6.3 SECAmb has a long history of employing former military personnel as well as those who continue to serve in a voluntary capacity and it's important that we maintain and strengthen these ties. I am very pleased that, as a Trust, we have made this official commitment.

3. Regional issues

3.1 Forging an Alliance to improve patient care

3.1.1 On 22 November 2018, the Trust announced that it was working towards forming an alliance with West Midlands and South Western Ambulance Services that will see us working closely together to deliver efficiency savings to invest in front line services.

3.1.2 The alliance expects to deliver savings through initiatives such as the joint procurement of supplies, including equipment and fuel. In addition, we will work collaboratively to share best practice for the benefit of patients and staff and will also work on improving resilience between the organisations for planned events and major incidents.

3.1.3 The work will draw upon existing benchmarking and evidence from the National Audit Office investigation into ambulance services, and more recently, the report from Lord Carter into efficiency and productivity.

3.1.4 It is important to stress that there are no plans to merge services or re-structure existing operations, but the alliance will mean that the three Trusts can make every pound of taxpayers' money work as efficiently as possible.

3.1.5 This is very much the start of the process and further work will follow over coming months through our Board and governance framework. However, by forming this partnership, we will be able to bring together the knowledge and experience of the three Trusts to explore ways to reduce variation and develop new joint initiatives.

4. National issues

4.1 National Health Service Journal (HSJ) Awards

4.1.1 The national Health Service Journal (HSJ) Awards took place on 21 November 2018 and recognise the outstanding contributions of staff and organisations to healthcare in a number of categories.

4.1.2 I was very proud that this year, SECAmb featured in two, short-listed nominations:

- Our work to develop the Intelligence Based Information System (IBIS) to enable frontline clinicians to access patient care plans and complete community referrals on iPADs was shortlisted in the 'Enhancing Care by Sharing Data and Information' category

- And SECAmb, with Surrey Heartlands Health and Care Partnership, was also shortlisted for the work it has done in introducing a new Pregnancy Advice Line, in place in Crawley EOC

4.1.3 Well done to everyone involved and especially to the IBIS team, who were Highly Commended in their category.

5. Recommendation

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

Daren Mochrie QAM, Chief Executive

22 November 2018

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	127-18

Name of meeting	Trust Board
Date	29 November 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 a brief update on the progress made to the Delivery Plan
Recommendations, decisions or actions sought	The board is asked to • review the dashboard to be fully sighted on the current progress of the Delivery Plan • note the developments of the CQC Task and Finish Groups • note the new projects being monitored

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

Executive Summary

The Board should be particularly drawn to the change in terms of reference of the Service Transformation & Delivery Steering Group chaired by Steve Emerton. The focus of this group will be the Service Transformation & Delivery Programme and will oversee the implication of the Demand and Capacity.

The reporting on progress on the four projects that currently sit within the HR Transformation Programme is now contained within the body of this report.

Since the last reporting period, the following projects have now closed; Increased Hear & Treat, NARU and EOC. The PMO are currently working with Project Leads to develop the EOC Clinical Safety which will include some of the findings of the recent CQC report. A Risk Management post project evaluations will be conducted shortly with Safeguarding and Complaints currently in progress.

Incident Management has recently gone through change control to amend the timeline which is now reflected in the Dashboard (Appendix A).

In the next reporting period, action plans will be developed and reported via the Delivery Plan on how the Trust will address the CQC Must and Should Do's with close monitoring via the Compliance & Quality Steering Group

1.0 Introduction

1.1 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
- HR Transformation & Delivery

1.2 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).

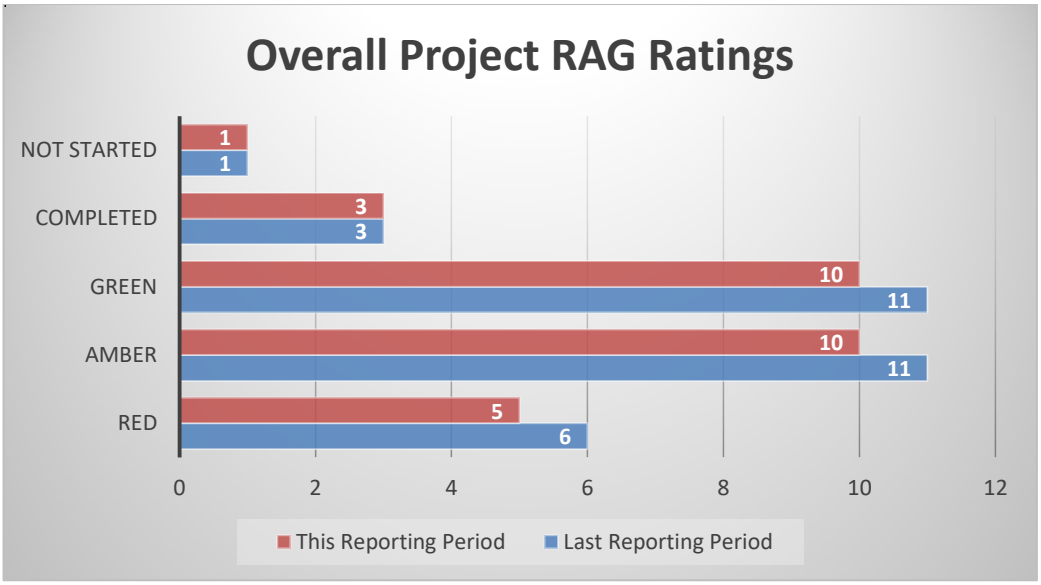
1.3 A summary of overall progress and whether the projects are on track to deliver within the expected completion dates and/or risks of failing can be found in the detail of this report.

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

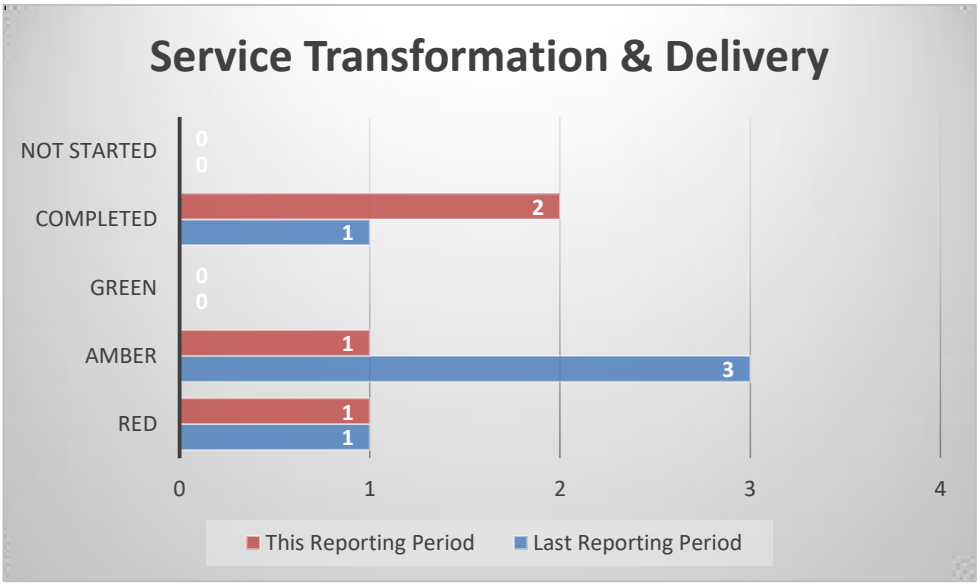
- Red – Serious risk that the project is unlikely to meet business case/ mandate objectives within agreed constraints; requires escalation.
- Amber – Significant risk that project may not deliver to business case/ mandate objectives within agreed constraints, however mitigating actions are in place and close monitoring is required.
- Green – On track and scheduled to deliver business case/ mandate objectives within agreed constraints.
- Blue – For those projects which have completed / formally closed

- White – For those projects not started

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



2.0 Service Transformation & Delivery



2.1 **Service Transformation and Delivery Programme (Previously ARP Demand and Capacity Delivery)** – The project RAG remains Amber. Governance structures are being put in place and coordination of all workstreams is underway. A meeting of Workstream leads has taken place. Risk identification has taken place and supporting Risk Management process are being used across the Programme. Detailed implementation planning has commenced in North Kent and Paddock Wood as OU's to prepare for the local ECSW campaigns commencing on 10/12/18.

There are a large range of activities underway with associated risks and an overall implementation plan based on workstream objectives in support of the overall objective of meeting ARP standards) is being created. There is a risk that SECAmb does not have the capacity or capability to implement the programme. To mitigate this the core project

team is being expanded with staff secondments and recruitment is underway and with certain posts now completed, for example Programme Management support.

2.2 **Hospital Handover –** The project RAG remains Red. There has been significant progress made at several sites to reduce hospital handover delays, mainly in Surrey and Sussex, and an overall improvement has been made across the region compared to the same position last year. There are however some significant outliers who have not made the same level of improvement, and the numbers of hours lost due to handover delays are more at those sites compared to the same period last year. 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.

Live reviews of ambulance conveyances are also being undertaken at identified sites to ensure all available community pathways are being maximised. It is important that all sites are focused on maintaining the improvements made so far. Additional system wide pressures however are expected over the winter months and so there are considerable risks associated with sustainability.

Crew to Clear performance is also varied across hospital sites with some outliers. More focus is being placed on improving crew to clear times at sites where crew to clear times are particularly challenged. This will involve some on site monitoring and analysis.

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 as we move into winter when system wide pressures increase.

2.3 **Increased Hear and Treat** – The project is now closed and RAG rated Blue. Since the introduction of the 111 Interim Service and the Service Transformation programmes, it has been agreed that it would be more efficient to close the Hear and Treat Project and for any incomplete activities to be absorbed into these programmes.

Although the project has not fully achieved its objectives within agreed timescales, Hear and Treat performance did achieve 6.0% and above, most recently from week commencing 25/06/2018 to week commencing 30/07/2018 inclusive. Whilst 6% performance has not always been sustained, the Trust has consistently achieved above the national average for Hear & Treat in comparison with other ambulance trusts.

One of the key outputs from the Hear and Treat Project was the development of the EOC Clinical Framework, with the development of the EOC Clinical Safety Navigator role as a 24/7 clinical leadership function, ensuring clinical oversight, risk mitigation and patient safety improvement. The Clinical Framework also facilitated the implementation of the Operations Manager Clinical into EOCs and 111 to improve and optimise clinical leadership, as well as the introduction of Manchester Triage as an alternative CDSS platform to facilitate clinical recruitment and multi-disciplinary diversification.

The project included the development and implementation of the Surge Management Plan, a structured framework to ensure that in times when the Trust is unable to meet operational demand, or is likely to experience operational challenges, resources are prioritised to address those patients with the greatest clinical need. Further quality assurance measures were also introduced through NHS Pathways Clinical and Operational In-Line Support to meet NHS Pathways licence requirements, Clinical Tail and No Send Audit processes to evaluate the risk mitigation for delayed responses, and no send ambulance dispatches within Surge.

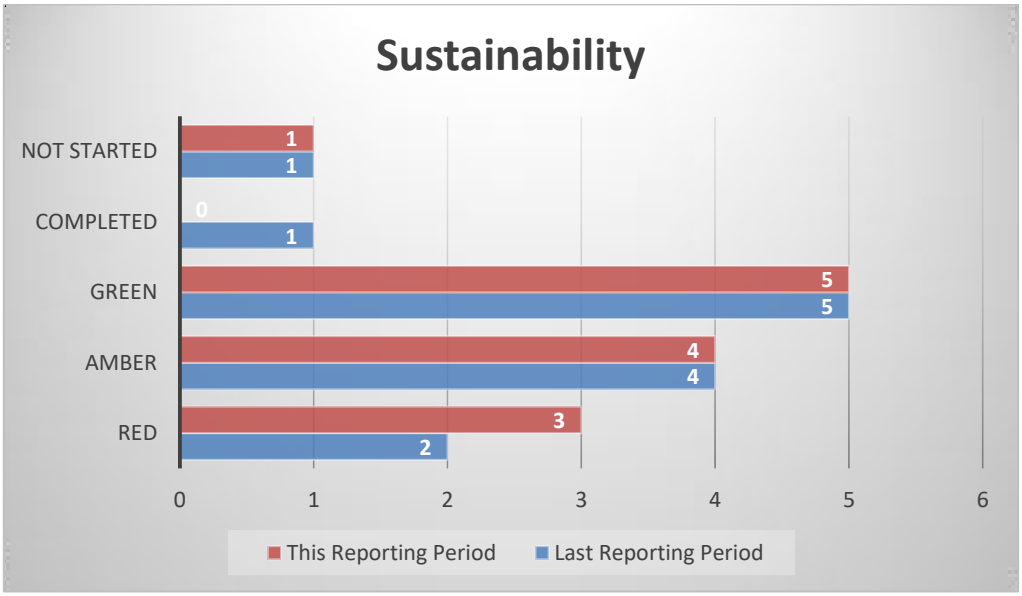
The project also introduced the Surrey Heartlands Maternity Advice line, a collaborative venture between SECAmb, Royal Surrey County Hospital, Epsom & St Helier University Trust, Ashford & St Peters Hospital to provide a single point of access for women across Surrey Heartlands who have booked and are under the care of these hospitals, which was recognised by the CQC during their inspection as an example of outstanding practice.

2.4 **National Ambulance Resilience Unit –** The project is now closed so RAG rated Blue. There are still a small number of actions needing to be completed which have now been transferred to the EPRR 2018/19 Action Plan to monitor and oversee completion of those actions.

- To establish a process for identification, recording and reporting of HART response time standards
- To ensure that there is an agreed training and education procedure for HART (currently out for Trust-wide for consultation)
- To ensure the order for the replacement Gatwick HART fleet is placed on time.
- To determine the level of awareness of HART response time standards from identified staff including: EOC Managers, EOC Dispatchers, and Commanders. (to be completed once awareness training is complete)

The EPRR 2018/19 Action Plan, will be managed via the Trusts Resilience Forum with reporting lines through to the Executive Management Board on a quarterly basis.

3.0 Sustainability



3.1 **111 Clinical Advice Service (Sussex, West Kent & Medway) - 111 Clinical Advice Service (Sussex, West Kent & Medway) -** The project RAG has moved from Amber to Red. Mitigating actions and control mechanisms are being developed, and we now have a signed contract. The workstream governance processes have been agreed, the telephony order has been submitted (critical to successful transition), the recruitment, on boarding and training trajectory has now been drafted – all with high or critical risks associated.

We have a comprehensive programme plan, with 5 workstreams feeding into the Project Board. Workstreams have provided their plans and control documents and risks have been collated on Datix, although we are still finalising the mandates, QIAs, DPIAs, and

EARs. The introduction of new capacity through 2 interim project managers, an internal secondment and the recruitment of further external resources will impact on delivery effectiveness. Many of the milestone dates, as part of the phasing in of the new IUC service developments, have been agreed through the contracting negotiations and form part of the contract schedules. SMEs will need to focus on this project to meet the very tight timescales around key deliverables and be allowed to divert for their BAU activities.

3.2 **111 CAS Contract Exit KMSS –** This is the first reporting period and the project RAG is Red. The purpose of this workstream is to exit the current KMSS 111 contract.

A draft KMSS 111 service exit plan has been developed and shared with our commissioners for their review and comment, which will line up with the contractual terms and conditions and will form the basis the new project mandate

There is a concern that the safe and effective delivery of the KMSS service until 31 March 2019 could be affected by our reliance on Care UK and the risk that they reduce their support for the current service as they mobilise other IUC services nationally. There is an agreed joint delivery service plan overseen by commissioners (on a weekly basis) to ensure that this is mitigated and that Care UK and SECAmb are held to account for ongoing and effective service delivery.

Digital Programme

3.3 **Automated Temperature Monitoring** – The project RAG has moved from Red to Amber. The planned work will be starting on 21 November 2018 and is due for completion by 31 December 2018. The project objectives have been reviewed and now align with the KPI's. A change request is now required to amend the mandate to reflect the change in overall completion date. There is currently an issue with regards to ownership of this project however discussions are being held to address this.

3.4 **Corporate IT systems back up** – The project RAG is White as it has not formally started. The initial potential solution proved too costly, so this will now require further investigation into alternative options. The scoping phase will continue until 31 March 2019 with a view to the project starting in April 2019. A risk has been raised in Datix as there are currently no links to business continuity. Future reporting will cease until the project has commenced.

3.5 **Cyber Security** – The project RAG has moved from Red to Green. The admin firewall migration at Crawley and Coxheath is now complete and work has commenced on the 8 MRC upgrades. Milestones 5 and 6 have been pushed back to February 2019 due to a software update having to be re-written by the supplier. A change request (CR025) was signed off by the Exec Sponsor on 16 October 2018 which reflects the project completion date.

3.6 **ePCR** – The project RAG remains Green. The implementation team have now been formed and workstreams agreed. The Medical Director will be formally writing to all Acute Trusts to inform them about SECAmb's move to electronic handover. This letter will give six months' notice and will be followed up reminder letters at three and one month before go live.

The current risks to successful delivery of this project are internal and external stakeholder engagement and operational staff buy in. There is also a risk in the supplier readiness which could have an impact on the project timeline and the requirement to undertake further system development results. The risks are closely monitored at the ePCR Project Board to ensure there are controls in place to minimise the overall impact.

3.7 **Incident Management Software** – The project RAG remains Green. The date for the final end user training is 3 December 2018, this will be followed by training in administration and training methods for the CP&R and Administration teams. Train the trainer champions will be used to deliver future training to the Trust.

3.8 **Replacement Fleet Management System** – The project RAG remains Amber. The change request to extend the timeline has been approved. A further request is being developed to divide the project into two parts; IT will deliver the system as a complete entity and Fleet will plan for go live. The latter will be achieved by mid-January 2019.

There are concerns around the delivery of the touch screens which may have an impact on the project being able to deliver by its completion date. There is also a risk that Fleet's business processes and training will not be completed by 28 November 2018. Both these risks will continue to be closely monitored via the Digital Programme Board and escalations to Executive Management Board as appropriate.

3.9 **Replacement of Telephony and Voice Recording system** – The project RAG remains Green. All planned activities remain on track to enable a provisional go live date of 12th December 2018.

3.10 **Spine Connect** – The project RAG has moved from Green to Red. The PDS solution has been delivered but is currently not being used in the EOC. A meeting thas been scheduled with Head of EOC to review the plan and timescale for completion.

The use of the SCR in EOC is dependent upon the use of smart cards, a meeting to be scheduled with the Senior Clinical Operations Manager to advise on next steps.

There are currently capacity issues within EOC and to mitigate this, additional staff is currently being sought.

3.11 **GoodSAM** – The project RAG remains Amber. All paperwork and policy development is on track for completion by 23 November 2018. However, there are governance issues that need to be addressed before the system can be implemented. A meeting is scheduled to take place this week with the Medical Directorate to address these issues.

3.12 **Station Upgrades** – This project remains RAG rated Green. The MRC infrastructure and Wi-Fi upgrade commenced 29 October 2018. Site surveys of stations will be planned in over the winter period. A change request will shortly be submitted to add an extra objective which will be to include the identification and replacement of all desktop computers across the Trust utilising the latest Windows 10 operating system. This will allow the Trust to manage our security position and adopt NHS Digital introduced technologies such as Microsoft Advanced Threat Protection (ATP).

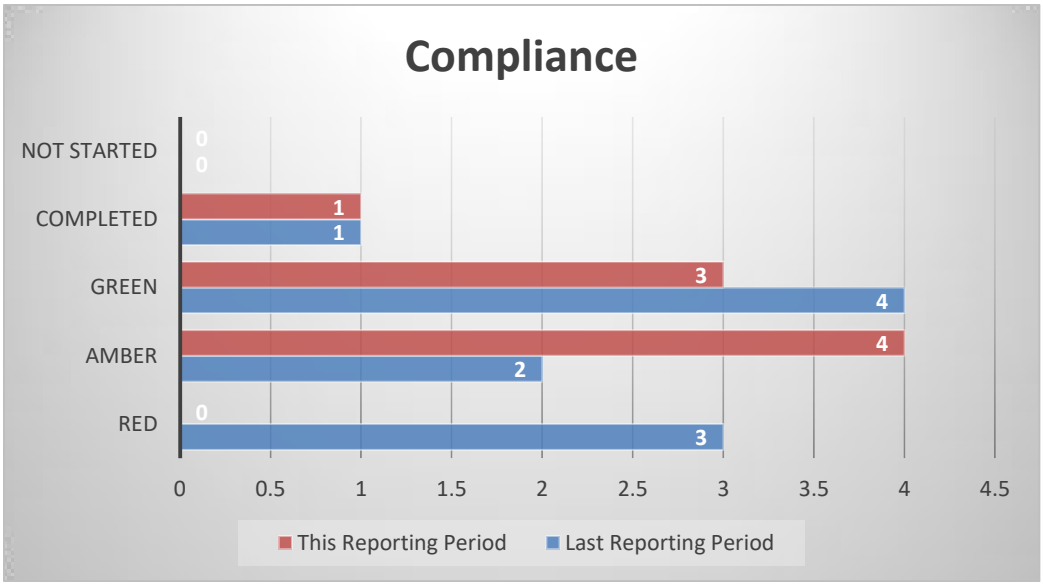
4.0 Financial Sustainability Group

4.1 **CIP –** The RAG remains Amber. The Trust has reported a CIP target of £11.4m to NHSI as part of the 2018/19 Budget and Plan. £8.6m of fully validated savings have been transferred to the Delivery Tracker as at the Month 7 reporting date, of which £5.1m 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.

The RAG rating for the CIPs programme remains at Amber as at month 7, 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 £2.1m for the year covering Operations efficiencies have been developed, of which £0.8m have been achieved at month 7. 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.

5.0 Compliance



5.1 **EOC** *(CQC Must Do)* – The project is now closed so RAG rated Blue. A new EOC Clinical Safety Plan will be developed which will incorporate the findings from the recent CQC Report. Also as part of the Service Transformation & Delivery Programme, an EOC Readiness workstream will also be in place to support the Trust in achieving operational performance.

Although the project did not fully achieve its objectives or fully realise the benefits articulated in the Project Mandate, the project has led to a significant improvement in pathways call audit compliance which was recognised by the CQC as a significant improvement during their most recent inspection.

The project introduced activities which allowed for integrated working between 111 and 999, and the support of AACE to develop efficiencies in EOC practice. Activities to improve call handling processes have included visits to other trust sites, which has promoted closer working with national ambulance trust providers and identified new ideas for improvement.

The project positively impacted on our aim of continuous improvement by ensuring close governance and focus on activities, actions and issues linked to business improvement amongst some of the Trust's key performance indicators. The project's ambitions were not fully realised, but it has set solid foundations on which to build new programmes to ensure that the transfer of outstanding activities and a focus on continuous improvement is maintained.

5.2 **Governance and Risk** – The project RAG remains Green. The Task & Finish Group is assured of the progress being made. As previously reported, there has been a positive engagement with the risk management training, which is central to this specific objective. We have already exceeded the training target. The risk team continue to support colleagues to ensure risks are regularly updated and carefully considered by the relevant management group. A technical solution to help ensure automated reminders is being explored with Datix. In addition, there is a focussed effort to reinforce the principles that underpin the management of policies and procedures. A trajectory to support the updating of all procedures by 1 April 2019 is due to be confirmed during November, and this will help the assessment of risk in relation to this objective.

5.3 **Incident Management** *(CQC Must Do)* – The project RAG remains 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.

The outstanding activity in the plan is the development of the revised SI Procedure following the recent process mapping events to streamline the SI management process to mitigate future backlogs. As a result a Change Control has been undertaken to extend the plan to end January 2019. This is being submitted to the November Trust Board for approval and the revised SI Procedure is now actively under development.

The Head of Patient Safety has been successfully appointed to with the candidate starting 1st February 2019. The two SI Manager posts are currently out to advert with interviews scheduled for 29th November 2018. The SI Coordinator is taking up a secondment into another department from 1st December 2018 and recruitment to backfill that vacancy has now commenced with the post out to advert. The SI Analyst position that was filled on a temporary basis has now been recruited to substantively. To assist mitigate these gaps the SI Lead is being actively supported by a small number of staff on light/alternative duties.

5.4 **Private Ambulance Providers –** The RAG has moved from Green to Amber. Significant work has been undertaken in recent weeks with the majority of the plans now being managed by Subject Matter Experts (SME) to manage and implement directly as part of BAU. It has been noted that some workstreams do not have an identified lead however this is being addressed and monitored at the Task and Finish Group which has recently been set up to monitor progress.

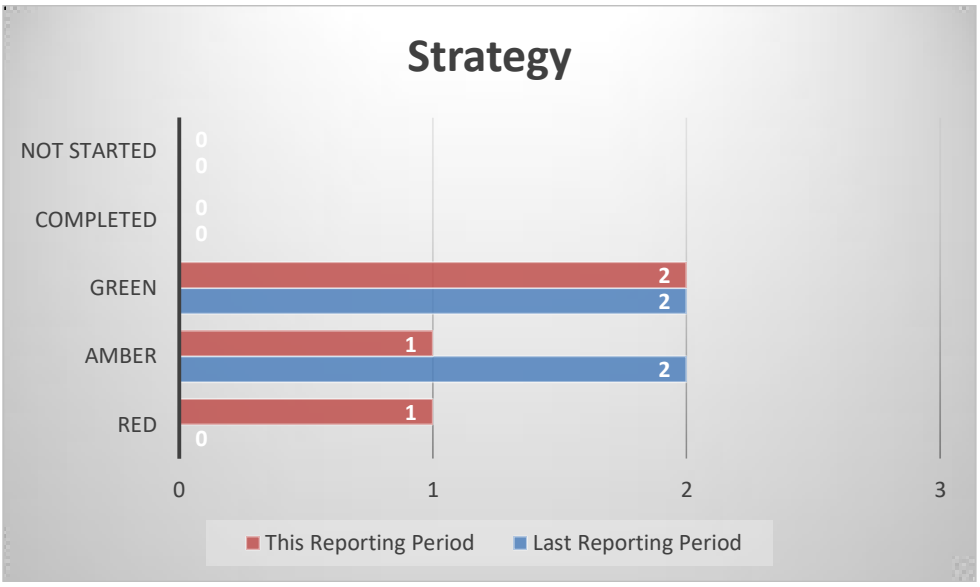
5.5 **Resourcing Plan** – The project RAG remains as Amber as the project has not achieved the trajectory of having 200 Emergency Care Support Workers (ECSW) and 100 Associate Ambulance Practitioner (AAPs) by the project completion date. The Director of Operations has accepted the trajectory and recognises the progress being made with regards to increasing the numbers for the November 2018 and January 2019 ECSW courses. The issue around the C1 Driving Licence are being actively managed. Planning has started to move the recruitment of ECSWs and AAPs to form part of the Service Transformation Delivery Programme and as a result, this project is expected to be formally closed in the next reporting period.

5.6 **Personnel Files** – The project RAG remains Amber. Progress continues to be made with the number of electronic files checked, no initial DBS and DBS renewal. There was a risk around project capacity but this is currently being mitigated with the recent appointment of interim staff.

5.7 **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 6380 audits having taken place this month to date. This will be completed on 12 December 2018 in anticipation for go live of the new telephone system.

5.8 **Health & Safety –** The project RAG remains Green. All activities are currently on track. Health & Safety Management Team are in place and priority policies and procedures are being produced. Initial project plan has been produced and DPIA and EAR are being drafted. Further work is being carried out to refine the plan and teasing out additional steps to complete milestones.

6.0 Strategy



6.1 The Trust continues in its work to review and update our Five Year Strategic Plan 2017-2022. We are now collating and analysing the findings from our extensive internal and external engagement, and our diagnostic work including population needs, policy, development and changes including the Ambulance Response Programme and Demand and Capacity review outcome, and STP and partnerships. The revised strategy will be written up and once consulted upon will come to board for ratification.

6.2 **Annual Planning** – The RAG remains Green. The publication of the NHS Improvement and NHS England Letter on Approach to Planning for 2019/20 was communicated on 16 October 2018 which sets out the key principles and timetable. In late November/early December the NHS will publish its NHS Long Term Plan, followed by publication of the 2019/20 operating planning guidance. An initial plan is due for submission to NHS Improvement by 14th January 2019, and a draft operational plan by 12th February 2019.

We are currently ratifying our approach to this including the engagement needed in this work and alignment of our contracting timetable.

6.3 **Commissioner and Stakeholder Alignment** – The RAG remains Green. Engagement sessions with staff and volunteers have been completed for our strategy refresh, but work will continue to keep pulling in information for the next refresh. In addition, the Trust will continue to gather intelligence from all engagement opportunities for strategic work, for example, quality visits, internal and external meetings, our Council of Governors, and our Strategic Transformation Partnership meetings.

6.4 **Enabling Strategies** – The RAG remains Amber. All activities for Workforce, Fleet, Research and Development, Volunteers, Governance, Patient Experience, and Partnership/ commercial are all underway. The Estates Strategy was approved at the Trust Board last month. Subject to committee approval the Fleet Strategy will be presented to the November Trust Board. It is anticipated that both the Governance and Research and Development Strategies will be presented for approval at the Trust Board in January 2019.

6.5 **Quality Improvement** – The RAG remains Red. The Trust Board has requested in light of the other significant programmes the Trust is implementing, a further review of implementation and benefits is undertaken for this project.

7.0 HR Transformation

7.1 **Process Improvement** – This is the first reporting period and is RAG rated Green. The aims of this project is to improve HR processes which will create an efficient delivery of HR services, combined with having an effective workforce to reduce people risks across the Trust. It will also further support the Trust to become compliant. A current state assessment report has been completed and socialised with senior stakeholders and HR Directorate. The current state process mapping is in progress for the following three areas; Recruitment, Service Centre and Clinical Education.

7.2 **HR Operating Model** - This is the first reporting period and is RAG rated Amber. The aims of this project aim is to design and implement an HR operating model to ensure the structure is aligned to meet current and future organisational needs. The current and future state assessment reports have been completed and socialised with senior stakeholders and HR Directorate. The development of decision criteria for HR operating model is now complete, pending review by HR leadership team and key stakeholders, including Service Transformation and Delivery Programme Lead**.**

7.3 **Culture Change** – The project RAG remains Amber. The review of the existing culture programme has taken place and the project closure has been approved by Quality Compliance Steering Group on the provisio that any incomplete activities from the project plan are tracked to ensure that they are transferred to the new plan should this be appropriate. The post project QIA has been completed and awaiting approval. Some culture initiatives are ongoing and being transitioned to Business As Usual (staff engagement survey, Recognition programme, Behaviours training). It is anticipated in the next reporting period, this project will be closed and a new plan will be in place that addresses the issues around Culture.

7.4 **People Risks –** This is the first reporting period and is RAG rated Green. The aim of the project is to review all people risks across the HR Directorate and to present a plan on how to mitigate major risks that compromise the Trust's ability to operate effectively. The project will also support the Trust in improving its approach to managing risks working in close collaboration with the Risk Team.

Delivery Plan Dashboard

1 October 2018 to 31 October 2018

RAG Key:

Red	Serious risk that the project is unlikely to meet business case/ mandate objectives within agreed time constraints; requires
Amber	Significant risk that project may not deliver to business case/ mandate objectives within agreed constraints, however
Green	On track and scheduled to deliver business case/ mandate objectives within agreed constraints
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)	Service Transformation and Delivery Programme (Previously ARP Demand and Capacity Delivery) – The project RAG remains Amber. Governance structures are being put in place and coordination of all workstreams is underway. A meeting of Workstream leads has taken place. Risk Management process is being implemented. Detailed implementation planning has commenced in North Kent and Paddock Wood as OU's to prepare for the local ECSW campaigns commencing on 10/12/18.	KPIs to be defined	TBC	TBC	TBC	There are a large range of activities underway with associated risks and implementation plans still being formulated. There is a risk that SECAmb do not have the capacity or capability to implement the programme. To mitigate this the core project team is being expanded with staff secondments and recruitment underway.
	Hospital Handover	Red	Red	Gillian Wieck	Joe Garcia	N/A	31/03/2019 (previously 30/04/2018)	There has been significant progress made at several sites to reduce hospital handover delays, mainly in Surrey and Sussex, and an overall improvement has been made across the region compared to the same position last year. There are however some significant outliers who have not made the same level of improvement, and the numbers of hours lost due to handover delays are more at those sites compared to the same period last year. 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. Live reviews of ambulance conveyances are also being undertaken at identified sites to ensure all available community pathways are being maximised. It is important that all sites are focused on maintaining the improvements made so far. Additional system wide pressures however are expected over the winter months and so there are considerable risks associated with sustainability. Crew to Clear performance is also varied across hospital sites with some outliers. More focus is being placed on improving crew to clear times at sites where crew to clear times are particularly challenged. This will involve some on site monitoring and analysis.	Number of handover delay no more than 60mins	432	0	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 as 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	Blue	Amber	Scott Thowney	Joe Garcia	N/A	25/07/2018	The project is now closed and RAG rated Blue. Since the introduction of the 111 Interim Service and the Service Transformation programmes, it has been agreed that it would be more efficient to close the Hear and Treat Project and for any incomplete activities to be absorbed into these programmes. Although the project has not fully achieved its objectives within agreed timescales, Hear and Treat performance did achieve 6.0% and above, most recently from week commencing 25/06/2018 to week commencing 30/07/2018 inclusive. Whilst 6% performance has not always been sustained, the Trust has consistently achieved above the national average for Hear & Treat in comparison with other ambulance trusts. One of the key outputs from the Hear and Treat Project was the development of the EOC Clinical Framework, with the development of the EOC Clinical Safety Navigator role as a 24/7 clinical leadership function, ensuring clinical oversight, risk mitigation and patient safety improvement. The Clinical Framework also facilitated the implementation of the Operations Manager Clinical into EOCs and 111 to improve and optimise clinical leadership, as well as the introduction of Manchester Triage as an alternative CDSS platform to facilitate clinical recruitment and multi-disciplinary diversification. The project included the development and implementation of the Surge Management Plan, a structured framework to ensure that in times when the Trust is unable to meet operational demand, or is likely to experience operational challenges, resources are prioritised to address those patients with the greatest clinical need. Further quality assurance measures were also introduced through NHS Pathways Clinical and Operational In-Line Support to meet NHS Pathways licence requirements, Clinical Tail and No Send Audit processes to evaluate the risk mitigation for delayed responses, and no send ambulance dispatches within Surge. The project also introduced the Surrey Heartlands Maternity Advice line, a collaborative venture between SECAmb, Royal Surrey County Hospital, Epsom & St Helier University Trust, Ashford & St Peters Hospital to provide a single point of access for women across Surrey Heartlands who have booked and are under the care of these hospitals, which was recognised by the CQC during their inspection as an example of outstanding practice.	45 clinical supervisors & clinical safety navigators in post in EOC	25.49	45	45	The KPI's have not been achieved, however, these will be absorbed into the Service Transformation & Delivery Programme.
									Hear and Treat Performance	5.60%	6%	6%	
	National Ambulance Resilience Unit	Blue	Amber	Chris Stamp	Joe Garcia	N/A	30/10/2018 (previously 31/10/2018)	The project is now closed so RAG rated Blue. There are still a small number of actions needing to be completed which have now been transferred to the EPRR 2018/19 Action Plan to monitor and oversee completion of those actions. • To establish a process for identification, recording and reporting of HART response time standards • To ensure that there is an agreed training and education procedure for HART (currently out for Trust-wide for consultation) • To ensure the order for the replacement Gatwick HART fleet is placed on time. • To determine the level of awareness of HART response time standards from identified staff including: EOC Managers, EOC Dispatchers, Commanders. (to be completed once awareness training is complete) The EPRR 2018/19 Action Plan, will be managed via the Trusts Resilience Forum with reporting lines through to the Executive Management Board on a quarterly basis.	Awareness training of HART response time standards for Command Teams	113	361	361	The KPI's have not been achieved, however, these will be absorbed into the EPRR 2018/19 Action Plan. The response times standards for deployment were not a NARU requirement and should not have been used as a benchmark as performance. The KPI was put in place to ensure establishment of a process to measure and track response time for HART incidents.
									Commanders at all levels within Trust are trained and developed.	95.0%	95%	95%	
									IOR Training compliance for frontline staff	2010	1237	2268	
									To meet the Response times standards for deployment	Not Required	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. £8.6m of fully validated savings have been transferred to the Delivery Tracker as at the Month 7 reporting date, of which £5.1m 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.	£8.6m	£11.4m	£11.4m	The RAG rating for the CIPs programme remains at Amber as at month 7, 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 £2.1m for the year covering Operations efficiencies have been developed, of which £0.8m have been achieved at month 7. 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)	Red	Amber	Mark Featherstone	David Hammond	N/A	01/04/2019	Mitigating actions and control mechanisms are being developed, and we now have a signed contract. The workstream governance processes have been agreed, the telephony order has been submitted (critical to successful transition), the recruitment, on boarding and training trajectory has now been drafted – all with high or critical risks associated. We have a comprehensive programme plan, with 5 workstreams feeding into the Project Board. Workstreams have provided their plans and control documents and risks have been collated on Datix, although we are still finalising the mandates, QIAs, DPIAs, EARs. The introduction of new capacity through 2 interim project managers, an internal secondment and the recruitment of further external resources will impact on delivery effectiveness. Many of the milestone dates, as part of the phasing in of the new IUC service developments, have been agreed through the contracting negotiations and form part of the contract schedules. SMEs will need to focus on this project to meet the very tight timescales around key deliverables and be allowed to divert for their BAU activities.	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.	TBC	TBC	TBC	1. There is a risk that if the Operational review of the TEST system is delayed due to resourcing issues then any changes or developments may not be completed in time for go live. 2. There is a risk that the Contract will not be signed off in time to order the new telephony system, which has a long lead time. 3. There is a risk that the workforce planning process will not be completed in time to inform recruiters of the new staff required for the new service and develop a trajectory for on boarding and training of new staff that is achievable.
	111 CAS Contract Exit KMSS	Red	First Reporting Period	John O'Sullivan	John O'Sullivan	John O'Sullivan	John O'Sullivan	This is the first reporting period and the project RAG is Red. The purpose of this workstream is to exit the current KMSS 111 contract. A draft KMSS 111 service exit plan has been developed and shared with our commissioners for their review and comment, which will line up with the contractual terms and conditions and will form the basis the new project mandate	The outcome of this project will be to maintain current services by ensuring the safe, effective delivery of the final 6 months of KMSS NHS 111 in partnership with Care UK.				There is a concern that the safe and effective delivery of the KMSS service until 31 March 2019 could be affected by our reliance on Care UK and the risk that they reduce their support for the current service as they mobilise other IUC services nationally. There is an agreed joint delivery service plan overseen by commissioners (on a weekly basis) to ensure that this is mitigated and that Care UK and SECAmb are held to account for ongoing and effective service delivery.
	Automated Temperature Monitoring	Amber	Red	Jason Tree	David Hammond	N/A	31/12/2018	The planned work will be starting on 21 November 2018 and is due for completion by 31 December 2018. The project objectives have been reviewed and now align with the KPI's. A change request is now required to amend the mandate to reflect the change in overall completion date	To be confirmed once change request has been authorised.	TBC	TBC	TBC	There is currently an issue with regards to ownership of this project however discussions are being held to address this.
	Corporate IT Systems Back-ups	White	White	Jason Tree	David Hammond	N/A	31/03/2019 (anticipated)	The project RAG is White as it has not formally started. The initial potential solution proved too costly, so this will now require further investigation into alternative options. The scoping phase will continue until 31 March 2019 with a view to the project starting in April 2019. A risk has been raised in Datix as there are currently no links to business continuity. Future reporting will cease until the project has commenced.	KPIs to be defined.				No risks or issues highlighted in this reporting period.
	Cyber Security	Green	Red	Phil Smith	David Hammond	N/A	15/02/2019 (previously 31/10/18)	The admin firewall migration at Crawley and Coxheath is now complete and work has commenced on the 8 MRC upgrades. Milestones 5 and 6 have been pushed back to February 2019 due to a software update having to be re-written by the supplier. A change request (CR025) was signed off by the Exec Sponsor on 16 October 2018 which reflects the project completion date.	All software and hardware is deployed and operational.				No risks or issues highlighted in this reporting period.
	Electronic Patient Clinical Records ("EPCR")	Green	Green	Phil Smith	David Hammond	N/A	30/06/2019 (previously 31/03/2019)	The implementation team have now been formed and workstreams agreed. The Medical Director will be formally writing to all Acute Trusts to inform them about SECAmb's move to electronic handover. This letter will give six months' notice and will be followed up reminder letters at three and one month before go live.	The outcome of the project will provide a fully developed and supported system with a minimum up time (system available) of 99.99%				The current risks to successful delivery of this project are internal and external stakeholder engagement and operational staff buy in. There is also a risk in the supplier readiness which could have an impact on the project timeline and the requirement to undertake further system development results. The risks are closely monitored at the ePCR Project Board to ensure there are controls in place to minimise the overall impact.
	GoodSAM	Amber	Amber	Dave Hawkins	David Hammond	N/A	12/12/2018 (previously 01/12/2018)	All paperwork and policy development is on track for completion by 23/11/18 with the 'Go-Live' by the forecast completion date.	GoodSAM system implemented.				There are governance issues that need to be addressed before the system can be implemented. A meeting is scheduled to take place this week with the Medical Directorate to address these issues.
	Incident Management Software	Green	Green	David Wells	David Hammond	N/A	31/12/2018 (previously 30/09/2018)	The date for the final end user training is 3/12/18 this will be followed by training in administration and training methods for the CP&R and Administration teams. Train the trainer champions will be used to deliver future training to the Trust.	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)	The change request to extend the timeline has been approved. A further request is being developed to divide the project into two parts; IT will deliver the system as a complete entity and Fleet will plan for go live. The latter will be achieved by mid-January 2019.	The Fleet Management system will be replaced and implemented.				There are concerns around the delivery of the touch screens which may have an impact on the project being able to deliver by its completion date. There is also a risk that Fleet's business processes and training will not be completed by 28 November 2018. Both these risks will continue to be closely monitored via the Digital Programme Board and escalations to Executive Management Board as appropriate.
	Replacement of Telephony and Voice Recording System	Green	Green	Phil Smith	David Hammond	N/A	12/12/2018 (previously 30/11/2018)	All planned activities remain on track to enable a provisional go live date of 12th December.	New Telephony and Voice Recording system delivered.				No risks or issues highlighted in this reporting period.

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive Lead	CQC Deep Dive Date	Forecast Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
Quality & Compliance Steering Group	Spine Connect	Red	Green	Phil Smith	David Hammond	N/A	31/10/2018 (previously 31/07/2018)	The PDS solution has been delivered but is currently not being used in the EOC. A meeting has been scheduled with Head of EOC to review the plan and timescale for completion. The use of the SCR in EOC is dependent upon the use of smart cards, a meeting to be scheduled with the Senior Clinical Operations Manager to advise on next steps. There are currently capacity issues within EOC and to mitigate this, additional staff is currently being sought.	NHS Number Capture: percentage of C3/C4 calls are matched to an NHS Number.	No data available	No data available	60%	There are currently capacity issues within EOC and to mitigate this, additional staff is currently being sought.
									Summary Care Record: percentage of SCR accessed records where available and appropriate for the type of call.	No data available	No data available	50%	
									Child Protection Information Sharing: percentage of calls where CPIS flag queried	No data available	No data available	80%	
	Station Upgrades	Green	Green	Jason Tree	David Hammond	N/A	31/03/2019	The MRC infrastructure and Wi-Fi upgrade commenced 29 October 2018. Site surveys of stations will be planned in over the winter period. A change request will shortly be submitted to add an extra objective which will be to include the identification and replacement of all desktop computers across the Trust utilising the latest Windows 10 operating system. This will allow the Trust to manage our security position and adopt NHS Digital introduced technologies such as Microsoft Advanced Threat Protection (ATP).	KPIs to be defined				No risks or issues highlighted in this reporting period.
	EOC	Blue	Red	Sue Barlow	Joe Garcia	02/05/2018	31/08/2018	The project is now closed so RAG rated Blue. A new EOC Clinical Safety Plan will be developed which will incorporate the findings from the recent CQC Report. Also as part of the Service Transformation & Delivery Programme, an EOC Readiness workstream will also be in place to support the Trust in achieving operational performance. Although the project did not fully achieve its objectives or fully realise the benefits articulated in the Project Mandate, the project has led to a significant improvement in pathways call audit compliance which was recognised by the CQC as a significant improvement during their most recent inspection. The project introduced activities which allowed for integrated working between 111 and 999, and the support of AACE to develop efficiencies in EOC practice. Activities to improve call handling processes have included visits to other trust sites, which has promoted closer working with national ambulance trust providers and identified new ideas for improvement. The project positively impacted on our aim of continuous improvement by ensuring close governance and focus on activities, actions and issues linked to business improvement amongst some of the Trust's key performance indicators. The project's ambitions were not fully realised, but it has set solid foundations on which to build new programmes to ensure that the transfer of outstanding activities and a focus on continuous improvement is maintained.	Clinical supervisors in post in EOC	25	38	45	The KPI's have not been achieved, however, these will be absorbed into the Service Transformation & Delivery Programme and the EOC Clinical Safety Plan.
									Number of audits per month	59% (October Data)	100.0%	100.0%	
									95% of calls answered within 5 seconds.	85.5%	70.0%	95.0%	
									FTE EMAs in post within EOC	138	171	171	
	Governance and Risk	Green	Green	Peter Lee	Daren Mochrie	N/A	31/03/2019	The Task & Finish Group is assured of the progress being made. As previously reported, there has been a positive engagement with the risk management training, which is central to this specific objective. We have already exceeded the training target. The risk team continue to support colleagues to ensure risks are regularly updated and carefully considered by the relevant management group. A technical solution to help ensure automated reminders is being explored with Datix. In addition, there is a focussed effort to reinforce the principles that underpin the management of policies and procedures. A trajectory to support the updating of all procedures by 1 April 2019 is due to be confirmed during November, and this will help the assessment of risk in relation to this objective.	Organisational Risks reviewed within their Last Review Date	82%	90%	90%	No risks or issues to report in this reporting period
									Project Risks reviewed within their Last Review Date	97%	90%	90%	
									Policies in date	85%	N/A	100%	
									Procedures in date	57%	N/A	100%	
									Multi-Disciplinary Training (including Risk Management) Training Delivered	119	60	120	
	Incident Management	Amber	Amber	Nicola Brooks	Bethan Haskins	08/11/2017	31/01/2019	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. The outstanding activity in the plan is the development of the revised SI Procedure following the recent process mapping events to streamline the SI management process to mitigate future backlogs. As a result a Change Control has been undertaken to extend the plan to end January 2019. This is being submitted to the November Trust Board for approval and the revised SI Procedure is now actively under development. The Head of Patient Safety has been successfully appointed to with the candidate starting 1st February 2019. The two SI Manager posts are currently out to advert with interviews scheduled for 29th November 2018. The SI Coordinator is taking up a secondment into another department from 1st December 2018 and recruitment to backfill that vacancy has now commenced with the post out to advert. The SI Analyst position that was filled on a temporary basis has now been recruited to substantively. To assist mitigate these gaps the SI Lead is being actively supported by a small number of staff on light/alternative duties.	20% increase in overall incident reporting (Monthly)	716	583	583	There is a risk that the current SI backlog and turnaround of Serious Incident investigations will not achieve KPI targets, specifically the target of completing 90% of SI investigations within 60 working days. To mitigate, two SI manager posts are out to advert with interviews scheduled 29 Nov. These will introduce much needed capacity to quality assure Serious Incident investigations before submission to CCG. In addition, an SI coordinator vacancy is out to advert. Serious Incidents are reviewed at the weekly Serious Incident Group (SIG) and performance metrics on the SI backlog SI investigations are monitored at the weekly Task and Finish and QCSG meetings to ensure pace is maintained.
									>75% of incidents closed within time target [SECAmb Target]	84%	75.0%	75.0%	
									90% of Serious Incident investigations will be completed within 60 working days.	8%	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	98%	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%	
	Resourcing Plan	Amber	Red	Alison Littlewood	Ed Griffin	N/A	03/12/2018 (previously 04/12/2018)	The project RAG has moved from Red to Amber as the project has not achieved the trajectory of having 200 Emergency Care Support Workers (ECSW) and 100 Associate Ambulance Practitioner (AAPs) by the project completion date. The Director of Operations has accepted the trajectory and recognises the progress being made with regards to increasing the numbers for the November 2018 and January 2019 ECSW courses. The issue around the C1 Driving Licence are being actively managed. Planning has started to move the recruitment of ECSWs and AAPs to form part of the Service Transformation Delivery Programme and as a result, this project is expected to be formally closed in the next reporting period.	Recruitment of 300 external operational staff (ECSW & AAP) • ECSWs to be operational • AAPs to be in training	144	0	300	The KPI's have not been achieved, however, these will be absorbed into the Service Transformation & Delivery Programme
	Personnel Files	Amber	Amber	Isla MacDonald	Ed Griffin	N/A	30/06/2019	Progress continues to be made with the number of electronic files checked, no initial DBS and DBS renewals. There was a risk around project capacity but this is currently being mitigated with the recent appointment of interim staff.	No. of staff with no initial DBS	89	92	92	There has been an update to Paper vision which has affected performance, and as a consequence the checking of electronic files has slowed down considerably. The supplier and IT have been working to resolve this. The DPIA has not yet been approved, this has now been sent to Caroline Smart in the new template.
									No. staff requiring renewal of DBS	287	402	402	
									No. of electronic files	1303	2282	3723	
	999 Call Recording	Green	Green	Barry Thurston	David Hammond	N/A	12/12/2018 (previously 31/03/2018)	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 6380 audits having taken place this month to date. This will be completed on 12 December 2018 in anticipation for go live of the new telephone system.	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
	Health & Safety	Green	Green	Amjad Nazir	Bethan Haskins	N/A	01/10/2019	All activities are currently on track. Health & Safety Management Team are in place and priority policies and procedures are being produced. Initial project plan has been produced and DPIA and EAR are being drafted. Further work is being carried out to refine the plan and teasing out additional steps to complete milestones.	Implementation of an annual trust wide Health & Safety audit programme.	Available from January 2019	10 per month	100% completion of audits	No risks or issues highlighted in this reporting period.
									Improvements to contractor management. The Health & Safety team will undertake 3 audits per quarter to verify if contractors and staff are following the policy.	Available from January 2019	3 per month	100% completion 3 audits per quarter	
									All identified policies and procedures are up to date.	0	13	100% policies up to date	
	Private Ambulance Providers (PAPs)	Amber	Green	Chris Stamp	Bethan Haskins	10/10/2018	31/03/2019	Significant work has been undertaken in recent weeks with the majority of the plans now being managed by Subject Matter Experts (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.				It has been noted that some workstreams do not have an identified lead however this is being addressed and monitored at the Task and Finish Group which has recently been set up to monitor progress.
Strategy	Annual Planning	Green	Green	Jayne Phoenix Philip Astell	Steve Emerton	N/A	31/03/2019 (previously 01/08/2018)	The publication of the NHS Improvement and NHS England Letter on Approach to Planning for 2019/20 was communicated on 16 October 2018 which sets out the key principles and timetable. In late November/early December the NHS will publish its NHS Long Term Plan, followed by publication of the 2019/20 operating planning guidance. An initial plan is due for submission to NHS Improvement by 14th January 2019, and a draft operational plan by 12th February 2019. We are currently ratifying our approach to this including the engagement needed in this work and alignment of our contracting timetable.	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	Engagement sessions with staff and volunteers have been completed for our strategy refresh, but work will continue to keep pulling in information for the next refresh. In addition, the Trust will continue to gather intelligence from all engagement opportunities for strategic work, for example, quality visits, internal and external meetings, our Council of Governors, and our Strategic Transformation Partnership 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	All activities for Workforce, Fleet, Research and Development, Volunteers, Governance, Patient Experience, and Partnership/ commercial are all underway. The Estates Strategy was approved at the Trust Board last month. Subject to committee approval the Fleet Strategy will be presented to the November Trust Board. It is anticipated that both the Governance and Research and Development Strategies will be presented for approval at the Trust Board in January 2019.	All strategies completed by agreed timescales.				No risks or issues highlighted in this reporting period.
	Quality Improvement	Red	Red	Dean Rigg	Steve Emerton	N/A	Paused (previously 31/03/2018)	The Trust Board has requested in light of the other significant programmes the Trust is implementing, a further review of implementation and benefits is undertaken for this project.	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.
HR Transformation	Process Improvement	Green	First Reporting Period	Lillian Ukety	Ed Griffin	N/A	01/07/2019	This is the first reporting period and is RAG rated Green. The aims of this project is to improve HR processes which will create an efficient delivery of HR services, combined with having an effective workforce to reduce people risks across the Trust. It will also further support the Trust to become compliant. A current state assessment report has been completed and socialised with senior stakeholders and HR Directorate. The current state process mapping is in progress for the following three areas; Recruitment, Service Centre and Clinical Education.	TBC	TBC	TBC	TBC	Tight timeline to complete current process work and challenges in getting staff availability If SME resources cannot be made available for rescheduled workshops, the completion of the resourcing processes is likely to slip further Changes/improvements are being made outside of the transformation which results in the baseline changing.
	HR Operating Model	Amber	First Reporting Period	Julia Lee	Ed Griffin	N/A	01/07/2019	This is the first reporting period and is RAG rated Amber. The aims of this project aim is to design and implement an HR operating model to ensure the structure is aligned to meet current and future organisational needs. The current and future state assessment reports have been completed and socialised with senior stakeholders and HR Directorate. The development of decision criteria for HR operating model is now complete, pending review by HR leadership team and key stakeholders, including Service Transformation and Delivery Programme Lead.	Employee engagement	TBC	TBC	3.6 employment engagement in 2020 survey	Funding is not available for investment needed to improve HR performance (e.g. additional staff, training) Key HR staff leave because of uncertainty over potential HR change and/ or dissatisfaction with direction of future state/operating model, impacting on delivery of core HR services to customers Structural change, new capabilities and ways of working for the operating model are not embedded effectively because of resistance/opposition from staff
									All of Trust vacancy rate	TBC	TBC	3% reduction in all of Trust vacancy rate by February 2020	
									Employment cases managed by HR	TBC	TBC	Less than 20 employment cases on a 12 month rolling average by February 2020	
									Customer satisfaction	TBC	TBC	TBC	
	Culture Change	Amber	Amber	Vivienne Edgecombe	Ed Griffin	N/A	TBC	The review of the existing culture programme has taken place and the project closure has been approved by Quality Compliance Steering Group on the provisio that any incomplete activities from the project plan are tracked to ensure that they are transferred to the new plan should this be appropriate. The post project QIA has been completed and awaiting approval. Some culture initiatives are ongoing and being transitioned to Business As Usual (staff engagement survey, Recognition programme, Behaviours training). It is anticipated in the next reporting period, this project will be closed and a new plan will be in place that addresses the issues around Culture.	To be defined and developed as part of the culture review				A project mandate and plan has yet to be established for the new project, however work is progressing and this is expected in mid-December 2018.
	People Risks	Green	First Reporting Period	Isla MacDonald	Ed Griffin	N/A	01/09/2019	This is the first reporting period and is RAG rated Green. The aim of the project is to review all people risks across the HR Directorate and to present a plan on how to mitigate major risks that compromise the Trust's ability to operate effectively. The project will also support the Trust in improving its approach to managing risks working in close collaboration with the Risk Team.	Identify top people risks which allows for clear mitigation or acceptance of risk	TBC	TBC	TBC	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 7 -October 2018

Programme Summary:

1. Current Pipeline schemes of £12.1m against an internal stretch target of £13.5m.
2. Validated or Scoped schemes of £11.1m 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 £2.1m for the year covering these efficiencies have been developed, of which £0.8m have been achieved. The efficiencies will be monitored on an ongoing monthly basis.
7. The Trust intends to develop CIP schemes for 2018/19 beyond the value of the £11.4m target to provide a buffer against any schemes which do not deliver. At this stage of the financial year, the Cost Improvement Programme is rated Amber.

CIP Opportunity Classification - KEY

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

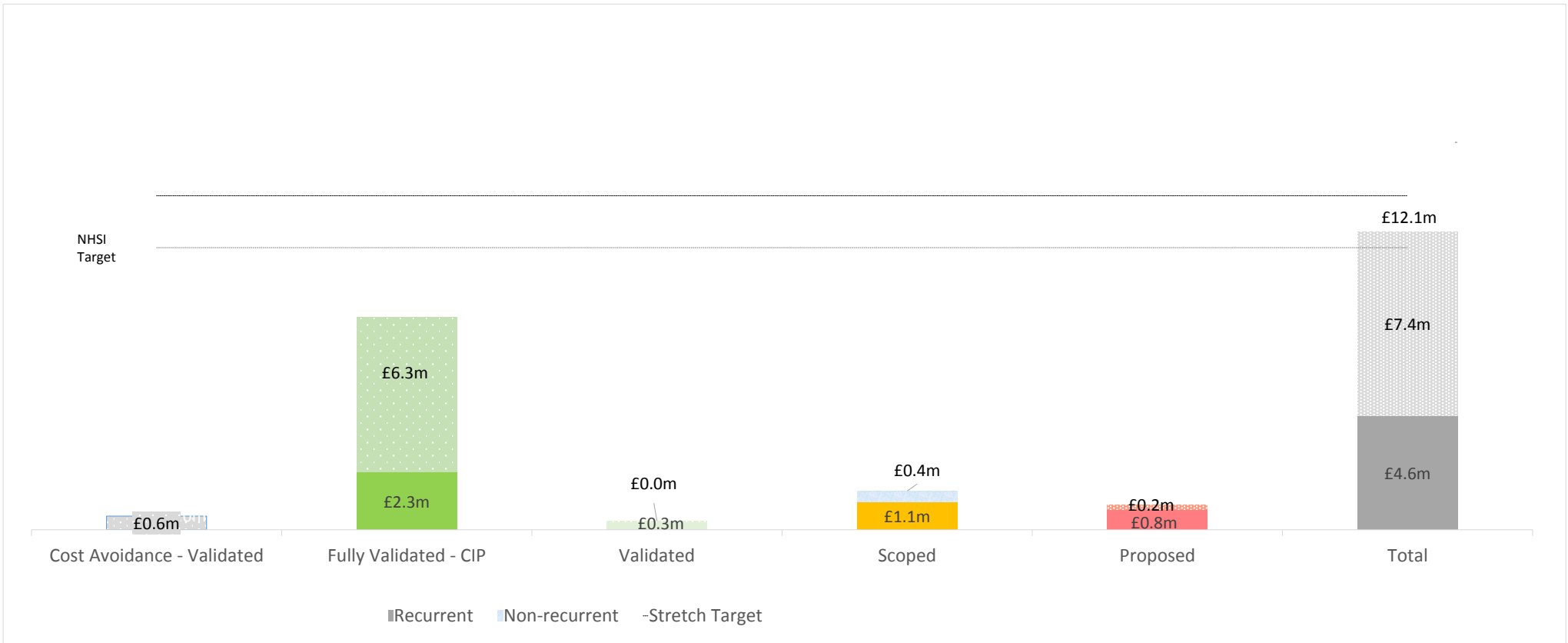
CIP Pipeline and Delivery: Risks and Issues

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

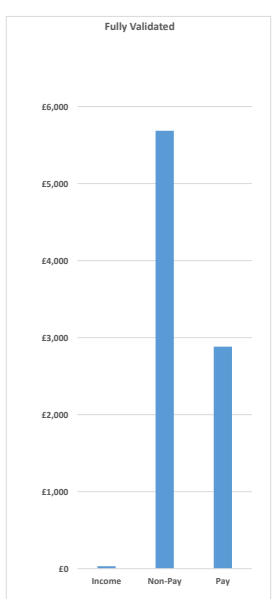
	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	New Lease Cars policy to be agreed.	Awaiting updates from John Griffiths (Response Capable Managers) and Ed Griffin (all other staff)	John Griffiths/ Ed Griffin	Amber	Amber	31-Dec-18
2	Medical Consumables - 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-Dec-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-Dec-18
5	Agency Staff - Potential cost avoidance CIP	PMO/Finance to develop a Project Mandate	Priscilla Ashun-Sarpy/ Kevin Hervey	Amber	Amber	31-Dec-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	31-Dec-18

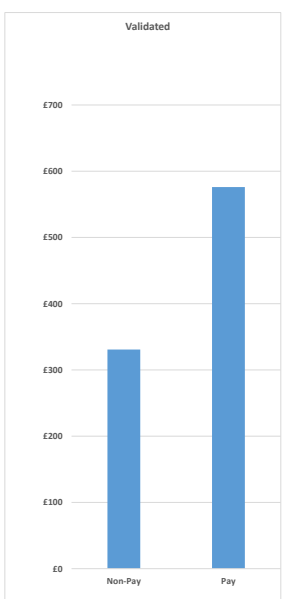
CIP Pipeline Summary

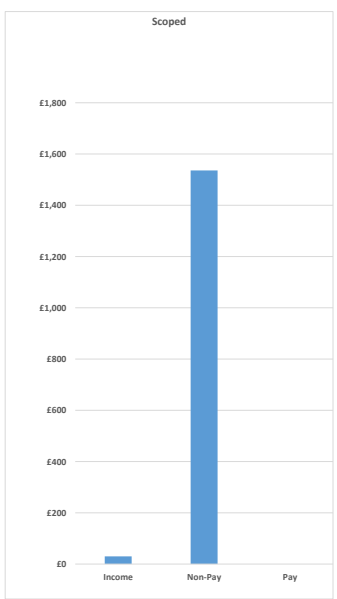
Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£551	£8,601	£356	£1,566	£1,009	£12,083

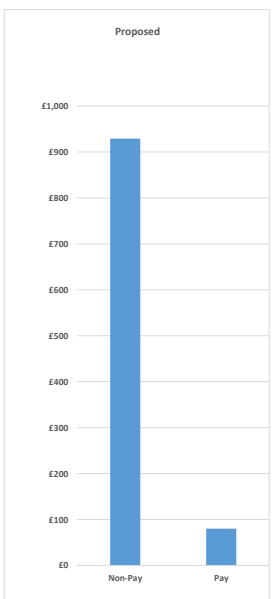


Pay / Non-Pay / Income Breakdown and scheme summary









Scheme Category	Fully Validated	Validated	Scoped	Proposed	Grand Total
Operations efficiencies	2,286	-	-	-	2,286
Recruitment delays & recharges - clinical	978	-	-	80	1,058
Insurance	833	-	-	-	833
External consultancy & contractors	761	-	140	-	901
Training courses & accommodation	683	2	-	-	685
Recruitment delays & recharges - non clinical	419	25	-	-	444
Fleet - Lease costs - ambulances	390	-	400	-	790
Travel & Subsistence	321	38	7	-	366
PDC Dividend	230	-	-	-	230
Fleet - Fuel: Telematics, Bunkered Fuel & Price Differential	200	-	-	-	200
Medicines Management - Consumables	200	94	-	-	294
VAT Rebate	191	-	-	-	191
Single HQ /EOC Benefits realisation	183	-	-	-	183
Medicines Management - Equipment	150	-	17	-	167
IT Productivity and Phones	148	9	140	100	397
Medicines Management - Drugs	132	-	-	-	132
Discretionary Non Pay	108	-	-	-	108
Meeting room hire	99	-	8	-	107
Estates and Facilities management	56	188	624	-	868
Stationery	47	-	-	-	47
111 Efficiency	33	-	-	-	33
Books & Subscriptions	32	-	-	-	32
Printing & Postage	32	-	-	-	32
Furniture & Fittings	30	-	-	-	30
Interest Income	30	-	30	-	60
Legal fees	13	-	-	-	13
Fleet - Uniforms and Contract Refuse	6	-	-	-	6
Contract Photocopier Rentals	5	-	-	-	5
Public relations	4	-	-	-	4
Income including recharges	2	-	-	-	2
Agency Premiums	-	551	-	-	551
Top Slice - all directorates	-	-	-	-	-
Procurement contracts review	-	-	100	-	100
Business Cases Savings 18/19	-	-	-	829	829
Staff Uniforms	-	-	100	-	100
	8,601	907	1,566	1,009	12,082

South East Coast Ambulance Service: CIP Workstream

CIP Delivery Dashboard

Reporting Month Oct-18

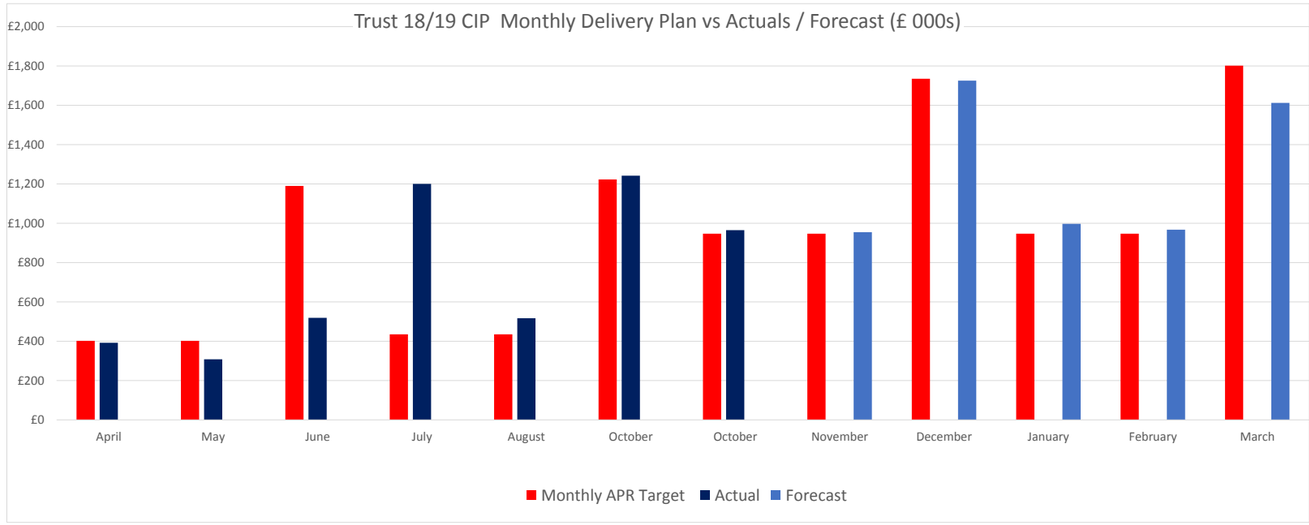
Programme for 2018/19 to deliver a minimum of £11.4m savings to achieve the planned £0.8m control total deficit.

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

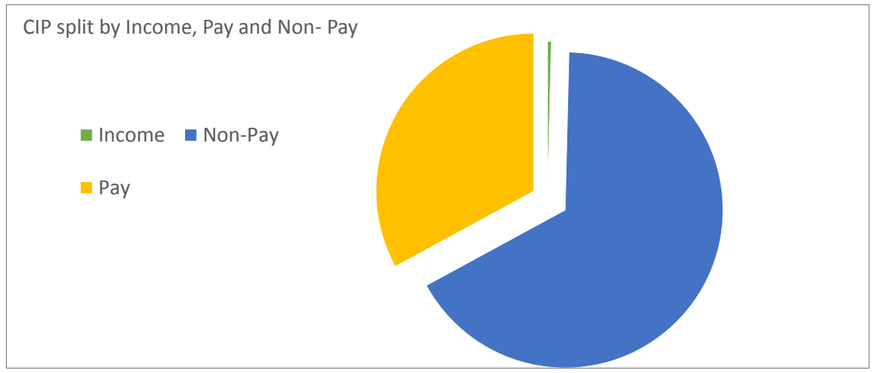
1. The CIPs target remains at £11.4m for the 2018/19 financial year.
2. £8.6m of fully validated savings have been transferred to the Delivery Tracker as at the Month 7 reporting date, of which £5.1m have been delivered against the Plan delivery of £5.0m.
3. The schemes continue to take no account of 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 £2.1m for the year covering these efficiencies have been developed, of which £0.8m 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 31 October 18

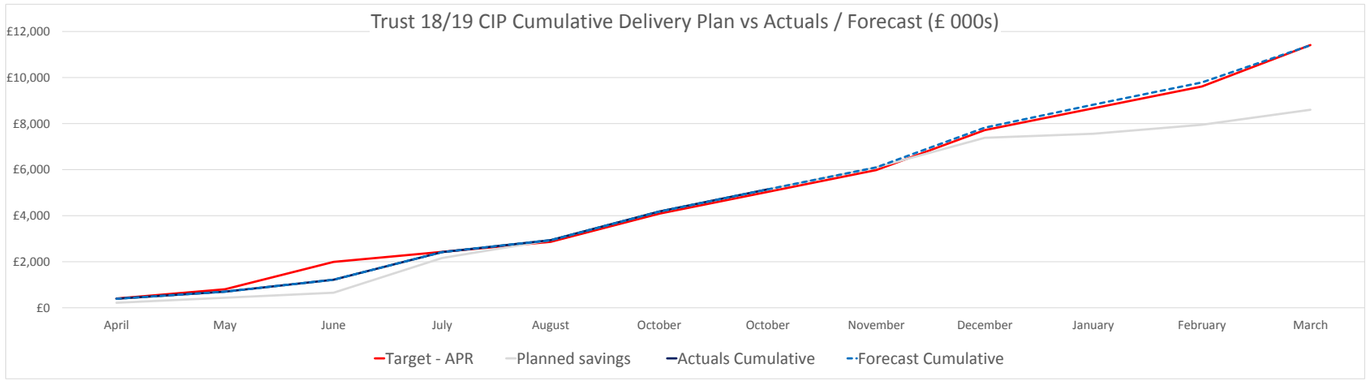
CIP Target for 18/19 £000's	Total planned savings on delivery tracker £000's - as at 31 October 2018	Total forecast savings on delivery tracker £000's - as at 31 October 2018	YTD October 18 - Target Savings £000's	YTD October 18 - Actual Savings £000's	YTD October 18 - variance £000's
11,400	8,600	11,400	5,034	5,143	£109



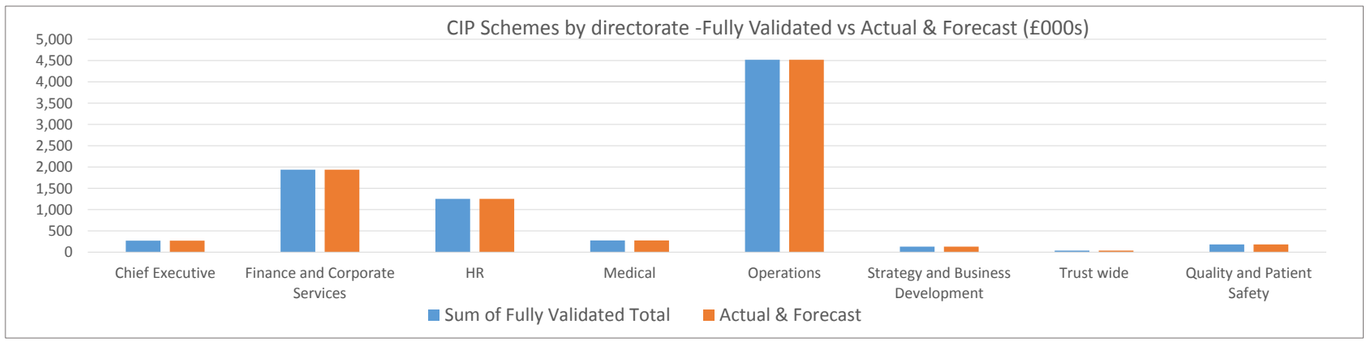
2. CIP - Planned savings split by income, pay and non-pay: as at 31 October



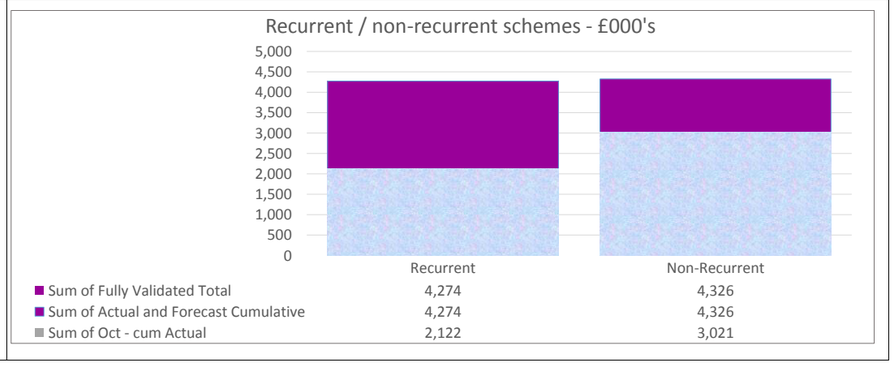
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2018/19



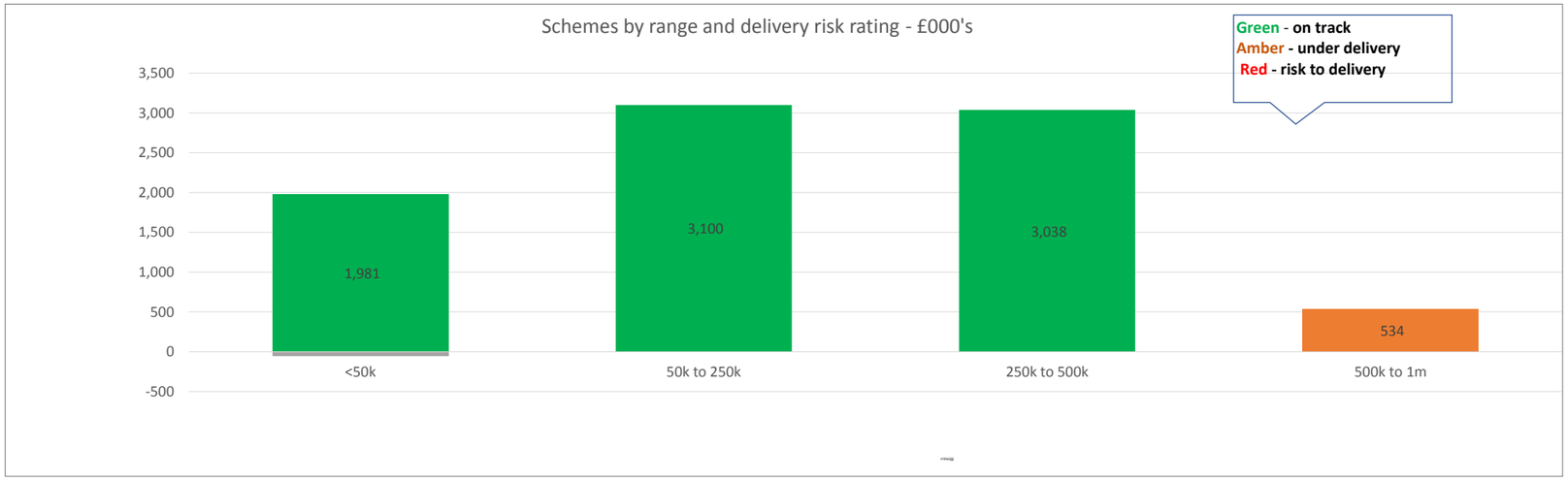
4. CIP schemes by directorate - Fully Validated vs Actual & Forecast 2018/19



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



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



7. YTD Identified CIPs to Date and Savings - October 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 7): £000	YTD Actuals (Month 7): £000	YTD Variance £000	Comments (+/- £20k variance)
External consultancy & contractors	£774	£774	£0	£512	£512	£0	-
Furniture & Fittings	£30	£30	£0	£18	£18	£0	-
Meeting room hire	£101	£101	£0	£62	£62	£0	-
Public relations	£4	£4	£0	£2	£2	£0	-
Stationery	£47	£47	£0	£31	£31	£0	-
Travel & Subsistence	£323	£323	£0	£212	£212	£0	-
Medicines Management - Equipment	£150	£150	£0	£105	£105	£0	-
Medicines Management - Consumables	£200	£200	£0	£117	£117	£0	-
Books & Subscriptions	£32	£32	£0	£25	£25	£0	-
111 Efficiency	£33	£33	£0	£19	£19	£0	-
Fleet - Fuel: Telematics, Bunkered Fuel & Price Differential	£200	£200	£0	£117	£117	£0	-
Estates and Facilities management	£59	£59	£0	£56	£56	£0	-
IT Productivity and Phones	£155	£155	£0	£106	£106	£0	-
Discretionary Non Pay	£113	£113	£0	£60	£60	£0	-
Training courses & accommodation	£683	£684	£1	£499	£499	£1	-
Single HQ /EOC Benefits realisation	£183	£183	£0	£106	£106	£0	-
Medicines Management - Drugs	£132	£132	£0	£77	£77	£0	
Insurance	£833	£833	£0	£558	£558	£0	
Printing & Postage	£32	£32	£0	£19	£19	£0	
Operations Efficiencies	£2,057	£2,057	£0	£810	£810	£0	
Recruitment delays & recharges - clinical	£1,001	£1,001	£0	£621	£621	£0	
Recruitment delays & recharges - non clinical	£599	£599	£0	£382	£382	£0	-
Uniform	£3	£3	£0	£3	£3	£0	-
Fleet - Lease costs	£390	£390	£0	£390	£390	£0	-
Legal Fees	£13	£13	£0	£13	£13	£0	-
VAT Rebate	£191	£191	£0	£191	£191	£0	-
PDC Dividend	£230	£230	£0	£0	£0	£0	-
Income including recharges	£4	£4	£0	£4	£4	£0	-
Total Fully Validated Schemes	£8,600	£8,600	£0	£5,143	£5,143	£0	-
Variance to Year To Date (YTD) Target				(109)		£109	Positive variance between Fully Validated Schemes and YTD Control Total Target
Grand Total	£8,600	£8,600	£0	£5,034	£5,143	£109	

South East Coast Ambulance Service NHS
NHS Foundation Trust

Inclusive, Attractive, Effective, Safe

Culture: the next phase

Supporting and enabling Organisational Health & Performance

Nov 2018

Your service, your call

Background

- Culture initiatives
  - Move to Nexus House
  - Staff recognition (Values, Cards and Cubes)
  - Behaviours training
  - Staff engagement

  - in process of being embedded as BAU
- CQC report specifically indicates positive shift in culture at the Trust, recognising there is still work to be done
- Response rate for annual staff survey 2018 is 7% higher than last year, and in the top group of ambulance trusts
- A shift to local ownership has begun in Operations through behaviours training at all levels of leadership
- A review of the existing culture project and current state has been undertaken

Closure of Current Phase of Culture Change

- Review has found:
  - Need to focus more on desired future culture: Inclusive, Attractive, Effective and Safe
  - Need to concentrate on the fundamental building blocks of organisational health
  - There is a gap in the Trust's proactive support of personal resilience and mental wellbeing
  - Sustained behaviour change requires a mindset shift – without this, unwanted behaviours will re-emerge
  - There is a continued appetite for change
  - 'Culture' has been positioned as an HR responsibility rather than a line manager and individual responsibility
  - Need to create greater local ownership

A new direction

To reflect a focus on organisational health and performance, and devolved responsibility for local culture, the existing phase has been closed and the proposed new model is one of corporate and board support for greater local ownership and action

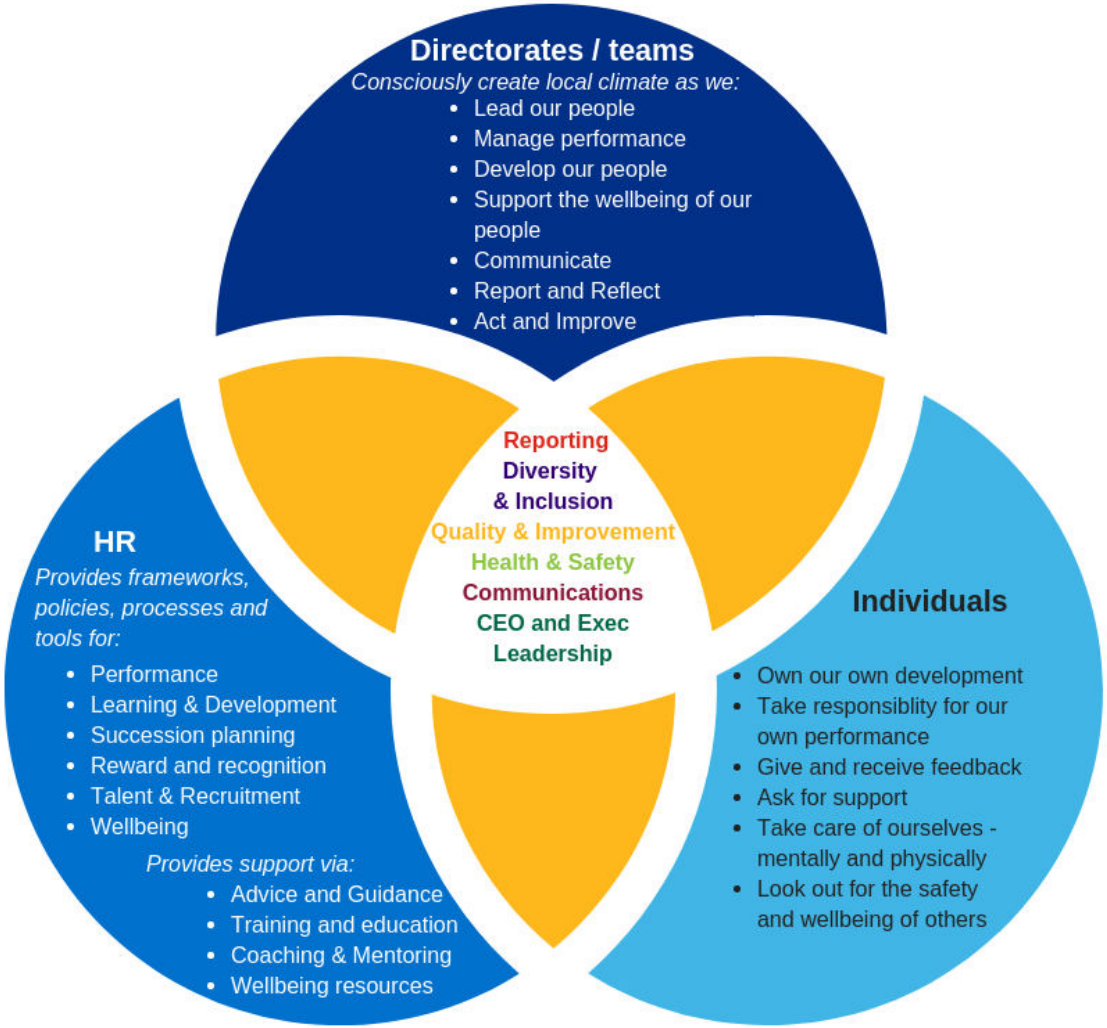
SECAmb's culture vision

Inclusive, Attractive, Effective, Safe

- The core objective of this phase: support SECAmb to get to a point where we can **justifiably and sustainably** claim this culture

What would it look like?

- Systems and processes work for all of us, not against us
- Respect, compassion, integrity and inclusion are our baseline
- The workforce reflects the community we serve
- People feel that they have what they need to meet the challenges of the job
- Collaboration is natural and automatic; decisions are made from a place of clarity, for the good of the Trust
- People are engaged with their work and the organisation, and are productive
- Absenteeism and turnover levels are low
- Safety risks and incidents are minimised
- Stress levels are low and people understand and trust in their own resilience
- Innovation, optimism and creativity abound and are welcomed
- Change seems normal and easy
- Communication is open, respectful, honest and constructive, and received without defensiveness
- People take responsibility for their own performance and development
- People naturally live the Trust values without them being “mandated”



A new approach: We all have a vital part to play

Your service, your call

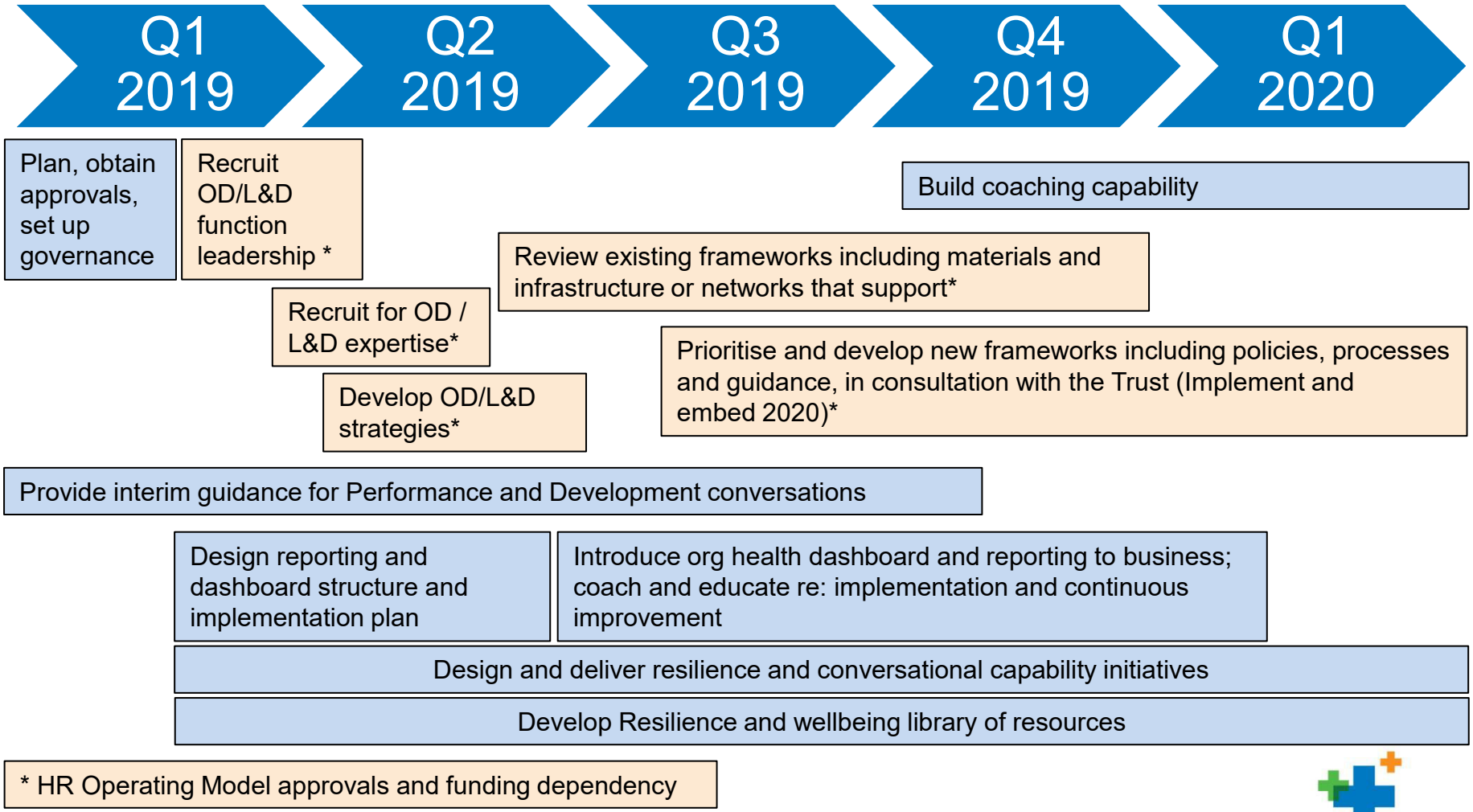
Foundational work

- Build a strategic Organisational Development and Learning & Development function within the HR Directorate, then:
  - In consultation with users, build overarching strategies and frameworks that fit with org strategy for:
    - Performance
    - L&D (clinical and other)
    - Succession and talent management
    - Reward and Recognition
    - Wellbeing
- Build 'conversational capability' within the Trust
- Provide support for Resilience and wellbeing
- Set up Reporting and Dashboard
- Agree and implement a Continuous Improvement methodology
- Communications and change planning
- Continue the good work already underway that is shifting our culture

Plan to Embed and Sustain

- Communication, coaching and education for managers to use the frameworks effectively for their part of the organisation
- Build coaching capability within the Trust (not exclusively managers)
- Support the implementation of Continuous improvement methodology within teams, directorates and leadership (objectives, reporting, corporate and local dashboard, reflection, action, communication)

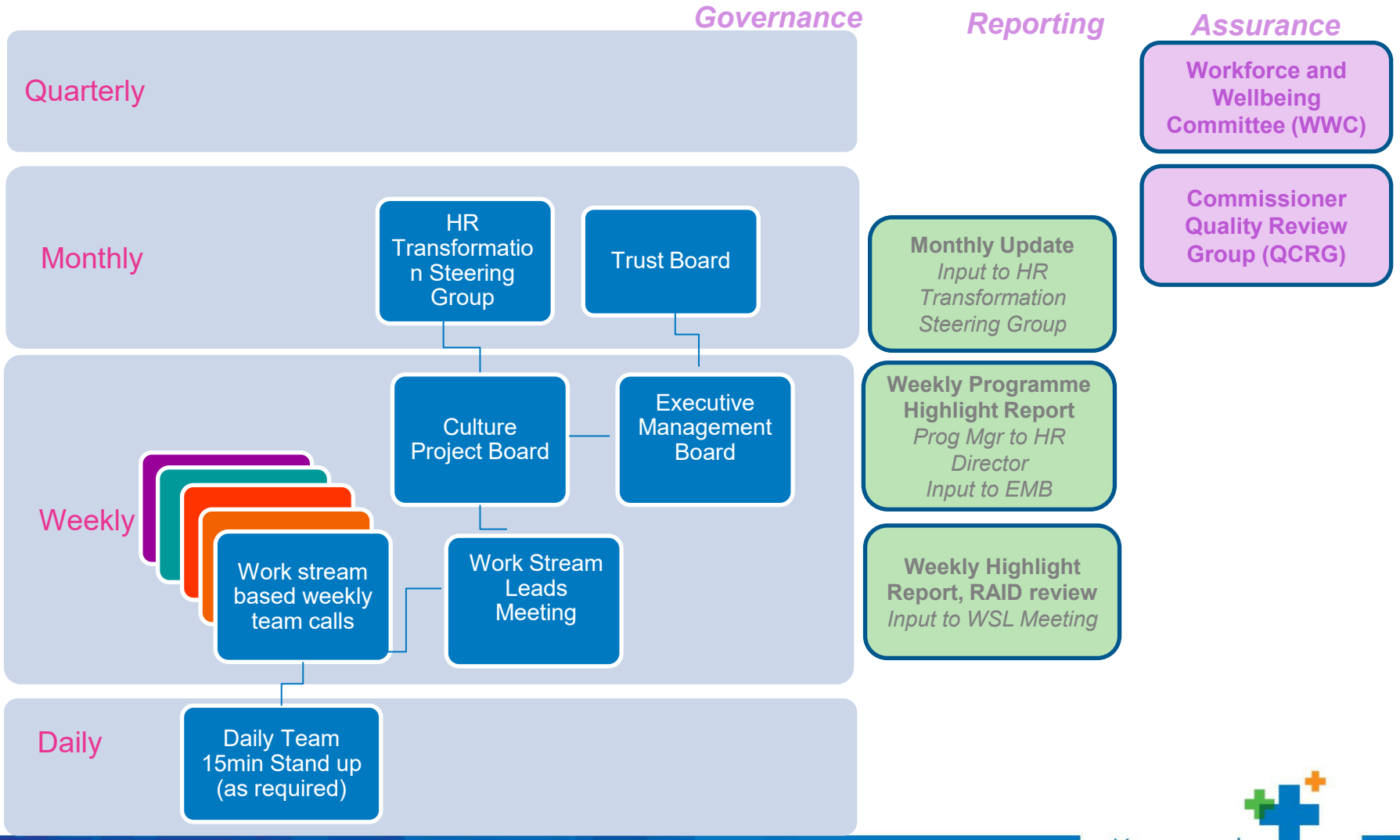
Indicative Timeline



* HR Operating Model approvals and funding dependency

Suggested Metrics (high-level)

- Turnover (voluntary vs involuntary)
- Sickness absence (overall and stress-related, short vs long-term)
- Referrals to the wellbeing hub by type
- Incidence of bullying and harassment
- Issues raised via FTSU
- Diversity and self-reporting
- Issues requiring mediation
- Grievances raised and resolved
- Performance appraisal and development objectives (quality and quantity)
- Success of succession and talent management strategies
- Staff engagement and pulse survey results


Governance
Reporting
Assurance
Quarterly
Monthly
Weekly
Daily
HR Transformation Steering Group
Trust Board
Culture Project Board
Executive Management Board
Work stream based weekly team calls
Work Stream Leads Meeting
Daily Team 15min Stand up (as required)
Monthly Update
Input to HR Transformation Steering Group
Weekly Programme Highlight Report
Prog Mgr to HR Director
Input to EMB
Weekly Highlight Report, RAID review
Input to WSL Meeting
Workforce and Wellbeing Committee (WWC)
Commissioner Quality Review Group (QCRG)

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	130/18

Name of meeting	Trust Board
Date	29th November 2018
Name of paper	Clinical Safety
Responsible Executive	Joe Garcia – Executive Director of Operations
Author	Scott Thowney – Senior Clinical Operations Manager Blair Laird – Operating Unit Manager Dispatch Review
Synopsis	Managing the Tail (from June 2018) and ensuring clinical safety when there are response delays in Category 1 (from October 2018), through EOC Clinical Safety elements & Category 1 Safety Controls. • Patient Welfare Procedure compliance • Systems & Processes (Clinical Safety Navigation & Clinical Prioritisation) • Clinical Tail Audit • Category 1 Safety Delay Controls
Recommendations, decisions or actions sought	The Board is asked to note • EOC Clinical Safety Project to assure tail management proposals • % of Clinical Tail audit and welfare compliance

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**

1. Introduction

1.1. This response paper is to provide an update regarding the Trust's EOC ability in 'Managing the Tail' (from June 2018) and ensuring safety when there are delays in Category 1 (from October 2018).

1.2. Additionally, there is work being undertaken to align the processes of the former CQC EOC Clinical Safety work streams into a PMO supported EOC Clinical Safety Project. Meetings are scheduled for the week commencing 20th November 2018 to finalise the mandate proposal to the Executive Management Board, outlining the key objectives.

2. 'Tail Management' Patient Welfare Procedure

2.1. Due to a variety of issues that may relate to demand, resource or capacity, the Trust will sometimes be delayed in responding to some patients. For the purposes of this paper the 'Tail' is identified as incidents within the Trust "pending dispatch" CAD queue who are experiencing delays in resource arrival.

2.2. Patient welfare calls should be carried out where a response to scene is likely to be delayed beyond the ambulance response time set for the patient during the triage, or if there is a clinical risk identified.

2.3. The revised procedure for Welfare Calling, Patient Welfare Call Procedure, was approved as an independent procedure by the Joint Partnership Policy Forum on 01/11/2018 and identified a change to welfare calls; this change being that the welfare call be carried out in the first instance by a clinical call handler trained in the use of a Clinical Decision Support System (CDSS).

2.4. Each incident subject to welfare calls are stipulated within the Patient Welfare Procedure for review as below.

ARP Response Category	Time of Initial Welfare Call	Time of Subsequent Welfare Call
Category 1	7 minutes	7 minutes
Category 2	19 minutes	30 minutes
Category 3	120 minutes	60 minutes
Category 4	180 minutes	60 minutes
Category 5	180 minutes	60 minutes
HCP 60	180 minutes	60 minutes
HCP 120	180 minutes	60 minutes
HCP 180	180 minutes	60 minutes

2.5. The EOC Clinical Team are submitting a proposal with an associated QIA to the Trust Medical Director in the utilisation of the Clinical Workforce. This will be aligned with the Patient Safety Welfare Procedure where clinicians that do not have Clinical Decision Support (CDSS) accreditation can continue to support the patient welfare call and ensure there is no deterioration of the patient. It also provides an opportunity to gain any clinical information regarding the patient's present condition.

2.6. Patient Welfare compliance is measured by;

Required Welfare Calls in accordance with procedure vs numbers completed.

This is tracked within the Clinical Tail Audit process.

3. 'Tail Management' Processes, Systems and Procedures

3.1. The EOC Clinical Safety project captures plans to ensure Clinical Safety. Navigators and Clinical Supervisors within 999 EOC are working to standardise practices.

3.1.1. Clinical Safety Navigation introduced guidance to the EOC that commenced the quality assurance and approval process that ratifies the Clinical Safety Navigator Procedure. This procedure supports daily/hourly resource and role/activity alignment.

3.1.2. Clinical Supervisor Activity is currently not captured within any core policy or procedure. Work has been initiated to develop and capture current clinical bulletins and instructions within a centralised policy.

3.1.3. Clinical Prioritisation Instruction – released in February 2018 identifies the process to prioritise cases for dispatch by the Clinical Supervisor/ Navigator teams.

3.1.4. Triggers for prioritisation are supported with 'Faller Flowchart' which went live from February 2018. A Clinical Review of case details that is supported by CAD, enables change to facilitating case identification and selection. This went live in November 2018.

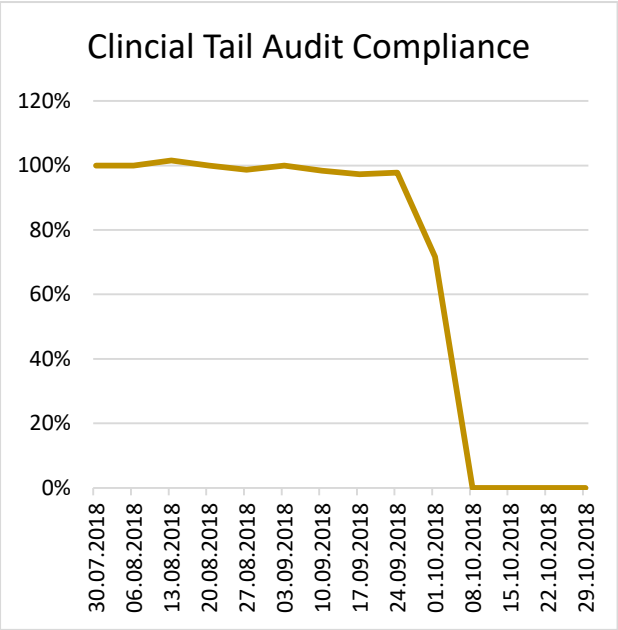
4. 'Tail Management' Clinical Tail Audit

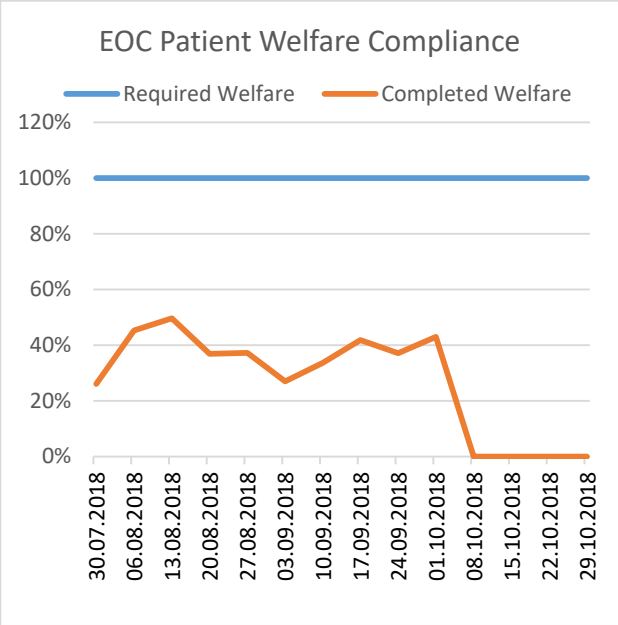
4.1. Clinical Tail audit is an essential tool to evaluate the risk to the Trust of delayed responses and this was recognised by evidential submissions to CQC in how we risk manage our 'long lying patients'.

4.2. The principle of the EOC Clinical Tail Audit procedure is to assure the safety of cases which breach ARP Category Response measures. To achieve this, the Trust identifies cases which require patient safety assurance. These cases are audited against a risk-based 'EOC Clinical Tail Audit Tool'. The Clinical Tail Audit evaluates the risk to patients against a Clinical Risk Matrix, which results in a Final Risk Score for each case assessed. All Clinical Tail Audits scoring a Final Risk Score of 10 require entry into Datix as a DIF1 for further investigation.

4.3. Clinical Tail audit provides the framework to identity required Welfare Calls and Clinical reviews. Weekly reports of Clinical Tail audit are shared with the EOC Clinical workforce, EOC Teams B and the Trust Clinical Governance Group.

4.4. Whilst there was an initial backlog in completing Clinical Tail Audits this is catching up with compliance to completion and Welfare call compliance shown as below (Dated from August 2018).





It should be noted that these are the latest figures available at the time of the report and provides clarity of the work still required to achieve compliance.

5. 'Tail Management' EOC Clinical Establishment

5.1. The previous EOC project has established 24.29 WTEs Clinical Supervisors (required 38 WTE), with 13 Clinical Safety Navigators (required 14 WTE).

5.2. The EOC Clinical Safety Project with the Trust STP programme identifies a series of work streams to increase the clinical establishment and capabilities within EOC, that include increasing the capacity to support clinical activities within EOC utilising dual role Manchester Triage Solution clinicians.

5.3. This project will facilitate an increased capacity by facilitating CAD homeworking and dual role capabilities to effectuate the clinical functions of systematic patient welfare and risk mitigation for patients within pending dispatch queues through approved robust Trust policy frameworks.

5.4. HR Recruitment work streams that include

5.4.1. Overseas Recruitment strategy

5.4.2. Dual Role utilisation with ODA awareness recruitment events

5.4.3. Clinical Advice Service recruitment initiatives to increase recruitment capability (Mental Health Professionals / Pharmacists etc)

6. ‘Category 1 Safety Delays’ Overview

6.1. Under the Ambulance Response Programme (ARP), NHS Ambulance Trusts are committed to achieving the following standards for Category 1 calls:

6.1.1. Clock start at triage or up to 30 seconds from call connect
6.1.2. Mean response of 7 minutes, 90th centile of 15 minutes
6.1.3. Mean transport-capable response of 19 minutes

6.2. An NHS Ambulance Trust also has a standard of answering 95% of 999 calls within 5 seconds.

6.3. Within SECAmb, under Operational Instruction 236, there is an expectation that an Emergency Medical Advisor (EMA) will only remain on the line with a caller for;

- cardiac or peri arrests,
- unconscious / fitting if there is no one on scene that knows how to deal with the patient,
- imminent births
- child callers.

Otherwise, if there are unanswered 999 calls in the waiting queue, an EMA is instructed to clear the line.

Op236 V1 - Staying on Line - 1 May 201

6.4. Resource Dispatchers are instructed to achieve appropriate resourcing for category 1 calls, with the closest responder to be allocated (backed up by a DCA if appropriate).

6.5. For a confirmed cardiac arrest, at least 2 resources are to be assigned to achieve a minimum of “4 pairs of hands” in line with the ‘pitcrew’ model of cardiac arrest management.

6.6. In October 2018, SECAmb achieved:

	C1	Mean
	England	**00:07:13**
1	London	00:06:13
2	North East	00:06:14
3	West Midlands	00:06:51
4	South Central	00:06:53
5	South Western	00:07:02
6	Yorkshire	00:07:10
7	South East Coast	00:07:30
8	East Midlands	00:07:37
9	North West	00:08:01
10	East of England	00:08:09
11	Isle of Wight2	00:12:52

	C1	90th
	England	**00:12:33**
1	London	00:10:14
2	North East	00:10:34
3	West Midlands	00:11:48
4	Yorkshire	00:12:23
5	South Western	00:12:41
6	South Central	00:12:45
7	North West	00:13:21
8	East Midlands	00:13:31
9	South East Coast	00:13:56
10	East of England	00:14:40
11	Isle of Wight2	00:26:20

	C1T	Mean
	England	**00:11:15**
1	West Midlands	00:07:51
2	North East	00:07:53
3	Yorkshire	00:09:57
4	South Central	00:10:08
5	North West	00:10:43
6	South East Coast	00:10:50
7	London	00:11:03
8	South Western	00:11:17
9	East of England	00:12:36
10	Isle of Wight2	00:16:35
11	East Midlands	00:17:17

	C1T	90th
	England	**00:20:54**
1	West Midlands	00:13:43
2	North East	00:13:52
3	Yorkshire	00:17:44
4	North West	00:18:13
5	London	00:18:49
6	South Central	00:18:53
7	South East Coast	00:20:12
8	South Western	00:20:51
9	East of England	00:22:59
10	Isle of Wight2	00:38:41
11	East Midlands	00:40:13

	Call Answer Times	Mean
	England	**7**
1	Yorkshire	2
2	West Midlands	4
3	North East	5
4	South Western	5
5	East Midlands	6
6	East of England	7
7	London	7
8	South Central	8
9	Isle of Wight	9
10	North West	12
11	South East Coast	12

	Call Answer Times	Median
	England	**2**
1	East of England	1
2	Isle of Wight	1
3	North East	1
4	North West	1
5	West Midlands	1
6	Yorkshire	1
7	East Midlands	2
8	South Western	2
9	South Central	3
10	South East Coast	4
11	London	6

	Call Answer Times	95th centile
	England	**42**
1	Yorkshire	1
2	South Western	19
3	North East	20
4	West Midlands	22
5	East Midlands	30
6	South Central	39
7	Isle of Wight	46.15
8	East of England	47
9	London	53
10	South East Coast	71
11	North West	77

	Call Answer Times	99th centile
	England	**94**
1	Yorkshire	41
2	West Midlands	47
3	North East	48
4	South Western	57
5	East Midlands	76
6	South Central	96
7	East of England	102
8	Isle of Wight	113
9	London	119
10	North West	136
11	South East Coast	155

	Proportion of those who had ROSC on arrival at hospital (All Patients)	%
	England	**31.8%**
1	London Ambulance Service NHS Trust	38.3%
2	North West Ambulance Service NHS Trust	37.5%
3	South East Coast Ambulance Service NHS Foundation Trust	36.6%
4	Isle of Wight NHS Trust	33.3%
5	West Midlands Ambulance Service NHS Foundation Trust	32.7%
6	East of England Ambulance Service NHS Trust	32.1%
7	South Western Ambulance Service NHS Foundation Trust	31.0%
8	South Central Ambulance Service NHS Foundation Trust	27.5%
9	East Midlands Ambulance Service NHS Trust	25.0%
10	North East Ambulance Service NHS Foundation Trust	24.4%
11	Yorkshire Ambulance Service NHS Trust	21.7%

	Proportion of those who had ROSC on arrival at hospital (Utstein comparator group**)	%
	England	**56.6%**
1	London Ambulance Service NHS Trust	70.0%
2	South East Coast Ambulance Service NHS Foundation Trust	69.7%
3	West Midlands Ambulance Service NHS Foundation Trust	67.6%
4	North West Ambulance Service NHS Trust	64.9%
5	East of England Ambulance Service NHS Trust	61.5%
6	North East Ambulance Service NHS Foundation Trust	60.0%
7	South Central Ambulance Service NHS Foundation Trust	52.9%
8	Yorkshire Ambulance Service NHS Trust	45.7%
9	South Western Ambulance Service NHS Foundation Trust	41.9%
10	East Midlands Ambulance Service NHS Trust	40.0%
-	-	-

	Proportion discharged from hospital alive (All Patients)	%
	England	**11.3%**
1	South Central Ambulance Service NHS Foundation Trust	25.7%
2	Isle of Wight NHS Trust	20.0%
3	North West Ambulance Service NHS Trust	11.5%
4	South Western Ambulance Service NHS Foundation Trust	11.0%
5	London Ambulance Service NHS Trust	10.9%
6	North East Ambulance Service NHS Foundation Trust	10.5%
7	South East Coast Ambulance Service NHS Foundation Trust	10.2%
8	West Midlands Ambulance Service NHS Foundation Trust	9.9%
9	East of England Ambulance Service NHS Trust	9.4%
10	East Midlands Ambulance Service NHS Trust	8.3%
11	Yorkshire Ambulance Service NHS Trust	6.5%

	Proportion discharged from hospital alive (Utstein comparator group**)	%
	England	**30.9%**
1	North West Ambulance Service NHS Trust	43.2%
2	East of England Ambulance Service NHS Trust	37.5%
3	South Central Ambulance Service NHS Foundation Trust	35.3%
4	London Ambulance Service NHS Trust	34.4%
5	North East Ambulance Service NHS Foundation Trust	33.3%
6	South East Coast Ambulance Service NHS Foundation Trust	33.3%
7	Yorkshire Ambulance Service NHS Trust	30.4%
8	West Midlands Ambulance Service NHS Foundation Trust	26.7%
9	South Western Ambulance Service NHS Foundation Trust	23.0%
10	East Midlands Ambulance Service NHS Trust	20.7%
-	-	-

	Total incidents with cardiac arrest (incl. not resuscitated)	%
	England	**30.9%**
1	North West Ambulance Service NHS Trust	43.2%
2	East of England Ambulance Service NHS Trust	37.5%
3	South Central Ambulance Service NHS Foundation Trust	35.3%
4	London Ambulance Service NHS Trust	34.4%
5	North East Ambulance Service NHS Foundation Trust	33.3%
6	South East Coast Ambulance Service NHS Foundation Trust	33.3%
7	Yorkshire Ambulance Service NHS Trust	30.4%
8	West Midlands Ambulance Service NHS Foundation Trust	26.7%
9	South Western Ambulance Service NHS Foundation Trust	23.0%
10	East Midlands Ambulance Service NHS Trust	20.7%
-	-	-

7. ‘Category 1 Safety Delays’ Controls in place

7.1. Category 1 responses are given a higher level of managerial scrutiny than any other category of response.

7.1.1. Any category 1 call which did not achieve the mean response target is reviewed by a Dispatch Team Leader, verified by an EOC Manager and separately reviewed by an Operational Team Leader.

7.1.2. The slowest category 1 response each day is reviewed by an EOC Manager and discussed at the daily performance / Team E conference call.

7.1.3. Concerns regarding delayed dispositions or incorrect triage that is identified as part of the DTL / EOCM review is tasked to an Emergency Medical Advisor Team Leader to review the call and triage undertaken.

7.1.4. Dispatch audit is solely based on category 1 calls

7.2. Through observation, the Clinical Safety Navigator and Clinical Supervisors focus primarily on waiting calls due to identified risk for this patient group. Unless help is specifically requested by an EMA, or the incident is identified to be of a particularly complex nature (e.g. drowning, traumatic arrest), EOC clinical supervision is often not applied to category 1 calls.

7.3. Worsening care advice is given to all patients as detailed in NHS Pathways. This includes an instruction to the caller to ring 999 again if the patient’s condition worsens, changes or they have any other concerns. This therefore encourages the caller to make contact if the patient deteriorates prior to the ambulance service arriving, if the EMA does not stay on the phone.

7.4. BT have a process of being able to prioritise any calls which they identify to be of a critical nature, in order to present it ahead of other 999 calls and to contact EOC to alert SECAmb to a waiting critical call. This prompts the EMA Team Leader to identify any EMA’s who are able to become clear to receive the call.

7.5. A verbal alert sounds in EOC when calls are waiting over a certain period of time, again, this is to encourage action by the EMA Team Leader and EMA’s to answer callers who have been delayed in being triaged.

7.6. A verbal alert on the CAD sounds to dispatchers when a category 1 call presents in their dispatch desk.

7.7. The CAD auto-allocates the closest available vehicle or diverts a vehicle mobile to a lower priority call, if within a 5 mile area.

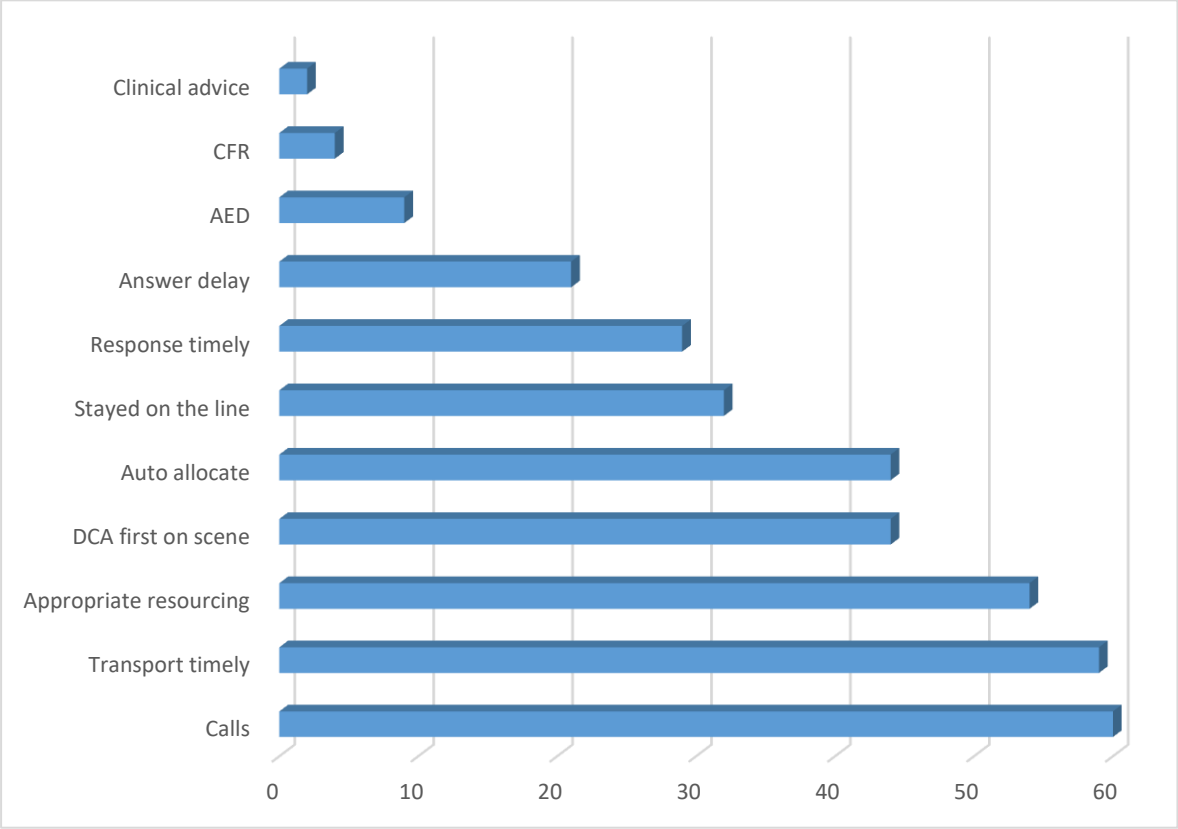
8. ‘Category 1 Safety Delays’ Review of incidents

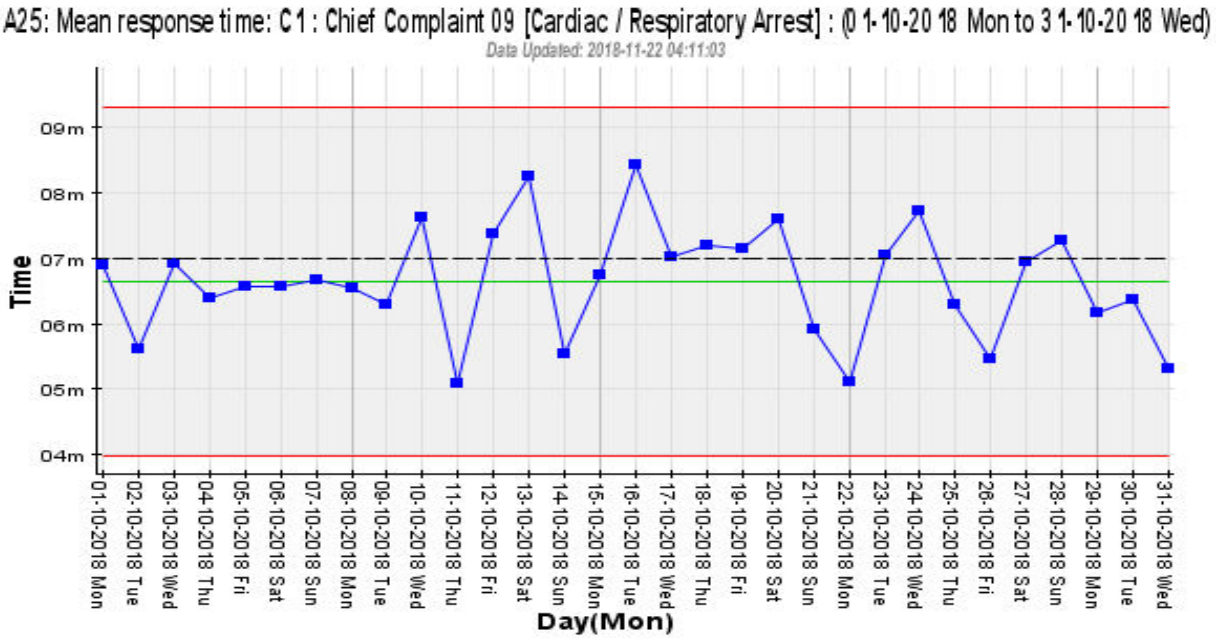
8.1. A total of 3,475 category 1 calls were handled by the Trust in October 2018.

8.2. By far, the largest category was fitting (26.8%), followed by unconscious noisy breathing (21%) and then cardiac arrests (13.4%).

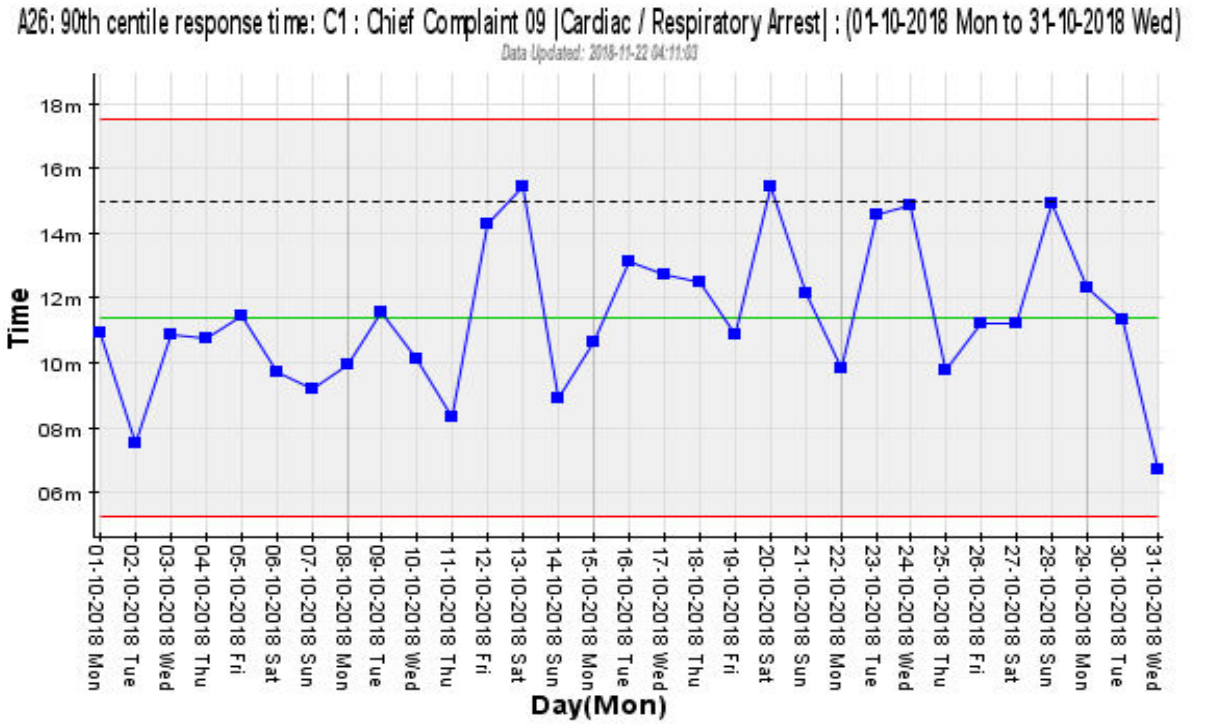
8.3. An in-depth review of 60 category 1 calls was undertaken. This highlighted the following information:

8.3.1. An EMA remained on the line for 53% of calls. All cardiac arrest calls had an EMA remain on the line, however some unconscious patients with noisy breathing had the EMA clear the line before the crew arrived.
8.3.2. Clinical Supervisor assistance was identified in 3% of calls.
8.3.3. No Clinical Navigator review or welfare checks were identified.
8.3.4. 73% of the calls had a vehicle auto allocated.
8.3.5. 15% of the calls had an AED utilised or sent for.
8.3.6. 73% of the calls had a DCA as the first arriving vehicle.
8.3.7. 90% of the calls met the appropriate resourcing criteria.
8.3.8. 7% of these calls had a Community First Responder deployed.
8.3.9. 48% of these calls achieved the response mean average time target.
8.3.10. 98% of these calls achieved the transport mean average target.
8.3.11. 35% of these calls waited over 60 seconds for the call to be answered.





The Trust performed well for response to Cardiac/Respiratory Arrest with a mean response of 6m 50secs – 10 seconds below ARP Target.



Again the Trust performed well against 90th Centile response target with a response below 12 minutes against a target of 14m 30secs.

9. ‘Category 1 Safety Delays’ Improvement

9.1. The EMA establishment has been under intensive review to increase the number of effective staff to the budgeted level. This has been successful of late and the effective establishment is soon to meet the budgeted establishment.

9.2. Process changes are underway to reduce the time taken to process the initial parts of a call and therefore enable a call to be recognised as a category 1 incident more quickly.

10. Conclusion

10.1. The Trust Board is asked to review the contents of this paper and be assured that whilst there are areas of concern, the Operational Leadership Team are fully sighted on these areas and there are plans being drafted to address this gaps in compliance, being managed via the PMO.

South East Coast Ambulance Service
NHS Foundation Trust

Integrated Performance Report

Performance Data for our 999 and 111 Services

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

Board Meeting

November 2018

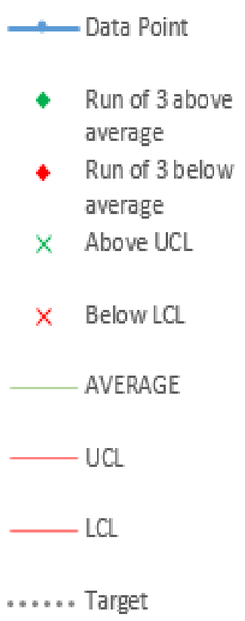
Taking Pride | Striving for Continuous Improvement | Acting With Integrity | Demonstrating Compassion and Respect | Assuming Responsibility

Contents

SECAmb CQC Rating and Oversight Framework

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

Chart Key



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

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

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

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

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

SECAmb Executive Summary

This report sets out data and supporting narrative to provide the Trust Board with assurance that the Executive Directors review historic information and data reflecting performance and service delivery across a number of domains. This is then interpreted and within the body of this report individual Directorates highlight the management response to data where this is applicable. In this way the Board is asked to note the Trust's oversight of performance and management data together with how this data supports decision making and action within the Trust.

With the completion of a CQC inspection the content of page 4 of this integrated report will be reviewed and updated to show feedback from CQC on our progress within year and also where further or new work may be required based on CQC findings. Actions undertaken or newly formed projects will be reported within the Trust's Delivery Plan until such time as they transfer to Business as Usual and are then captured within the scope of this report.

The format and content of this report is continually reviewed to provide greater utility to the Trust Board and clearly communicate the status and actions undertaken by the Trust over time. This will be supported through the transparent 'flow' of project closure to this report and importantly the sharing of prevailing and contemporary performance information and actions where required.

The performance data shared in this report from 999 Operations is as at 20/11/2018

SECAmb Our Enablers

Enabling strategies continue to be reported within the supporting Trust Delivery Plan and narrative.

SECAmb Financial Performance

The Trust achieved its planned deficit of £0.8m for the month of September. The cumulative deficit of £3.6m is marginally better than plan, maintaining operational performance.

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

The Trust achieved cost improvements of £1.2m in the month, which was slightly ahead of plan. The target for the full year is £11.4m.

The Trust's Use of Resources Risk Rating (UoRR) at this point in the year is 3, in line with plan.

Risks to this plan include the delivery of CIP targets, the outcome of the Demand and Capacity review, delivery of performance targets, any financial impact of unfunded cost pressures and recruitment difficulties.

Engagement with the Trust's stakeholders is ongoing in order to mitigate as many of these as possible.

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

Safe

CQC Findings ('Must or Should Do')

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

Caring

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

Effective

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

Responsive

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

Well Led

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

SECAmb Clinical Safety Scorecard

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

	Mar-18	Apr-18	May-18	12 Months
Actual %	56.4%	40.9%	50.0%	
Previous Year %	62.9%	62.1%	56.8%	
National Average %	55.3%	54.4%	55.9%	

Cardiac ROSC - ALL

	Mar-18	Apr-18	May-18	12 Months
Actual %	22.9%	29.7%	25.1%	
Previous Year %	29.7%	28.0%	22.8%	
National Average %	28.3%	31.6%	31.6%	

Cardiac Survival - Utstein

	Mar-18	Apr-18	May-18	12 Months
Actual %	22.2%	21.4%	20.7%	
Previous Year %	16.7%	33.3%	30.3%	
National Average %	27.6%	28.5%	29.4%	

Cardiac Survival - All

	Mar-18	Apr-18	May-18	12 Months
Actual %	5.5%	8.6%	4.5%	
Previous Year %	6.7%	8.1%	6.3%	
National Average %	9.0%	9.8%	10.0%	

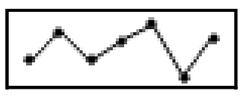
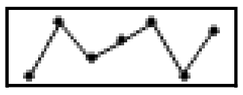
Acute ST-Elevation Myocardial Infarction (STEMI) Care Bundle Outcome

	Mar-18	Apr-18	May-18	12 Months
Actual %	67.8%	69.1%	69.6%	
Previous Year %	65.6%	59.6%	57.5%	
National Average %	tbc	79.5%	tbc	

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

	Mar-18	Apr-18	May-18	12 Months
Mean (hh:mm)	02:22	02:11	02:11	
National Average	02:16	02:11	02:09	
90th Centile (hh:mm)	03:01	02:52	03:06	
National Average	03:01	02:59	02:56	

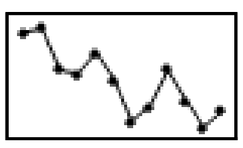
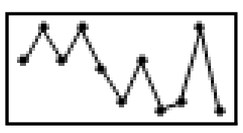
Stroke - call to hospital arrival

	Mar-18	Apr-18	May-18	12 Months
Mean (hh:mm)	01:14	01:05	01:12	
National Average	01:18	01:12	01:18	
50th Centile (hh:mm)	01:06	01:00	01:03	
National Average	01:12	01:05	01:05	
90th Centile (hh:mm)	01:49	01:38	01:47	
National Average	02:00	01:43	01:47	

Stroke - assessed F2F diagnostic bundle

	Mar-18	Apr-18	May-18	12 Months
Actual %	96.5%	97.4%	98.7%	
Previous Year %	94.1%	94.1%	92.3%	
National Average %	tbc	tbc	98.3%	

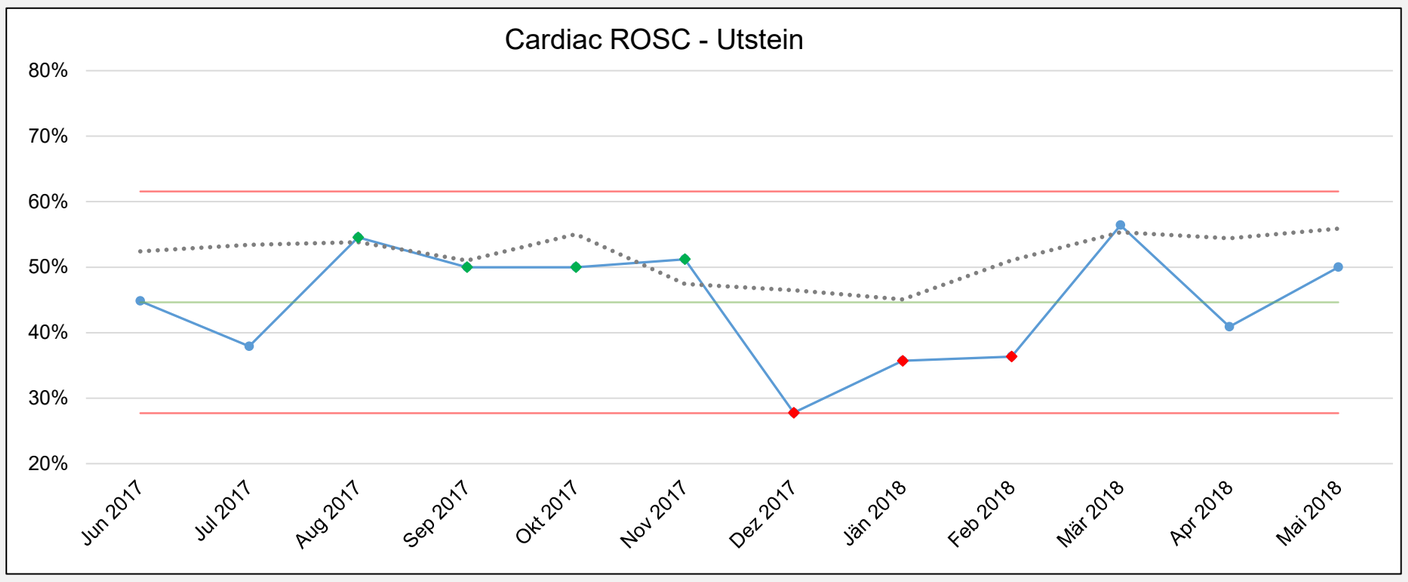
Medicines Governance

	Jul-18	Aug-18	Sep-18	12 Months
Total Number of Medicines Incidents	114	96	80	
Single Witness Sig/Inapt Barcode Use CDs Omnicell	11	6	9	
Single Witness Sig/Inapt Barcode Use CDs Non-Omnicell	1	10	0	
Total Number of CD Breakages	13	13	17	
PGD Mandatory Training	118	24	32	
Key Skills Medicine Governance	430	105	166	

Medicines Management

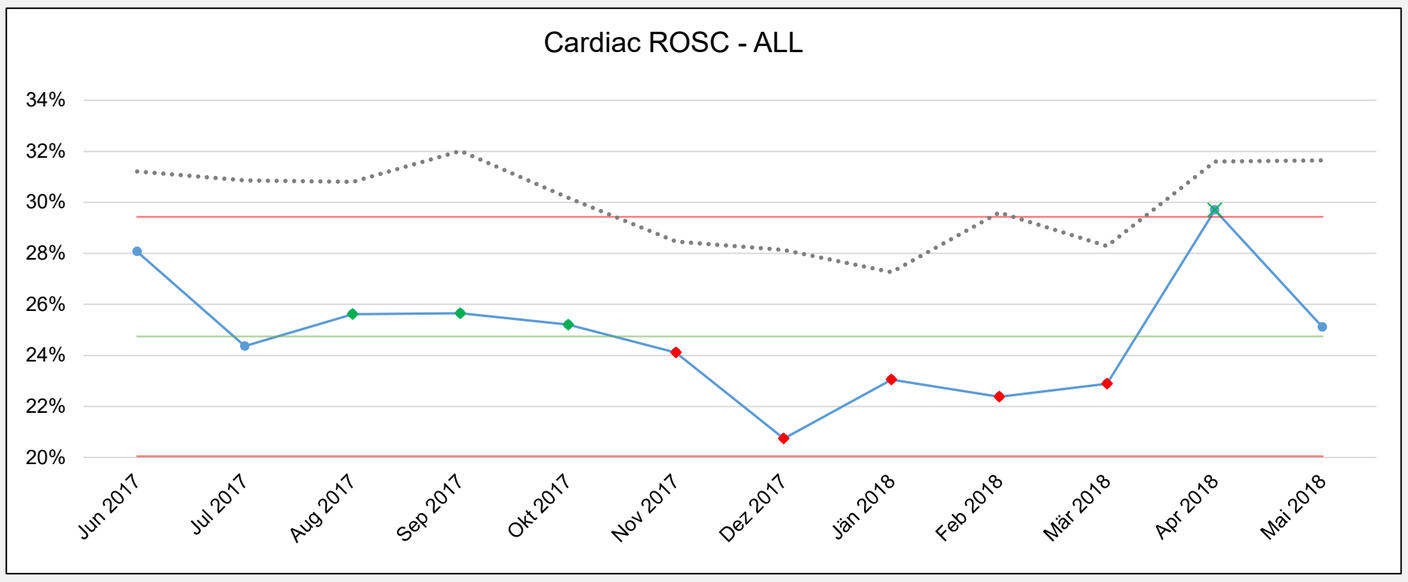
	Jul-18	Aug-18	Sep-18	12 Months
Number of Audits	184	191	187	
Number of audits %	97%	98%	99%	

SECAmb Clinical Safety Charts

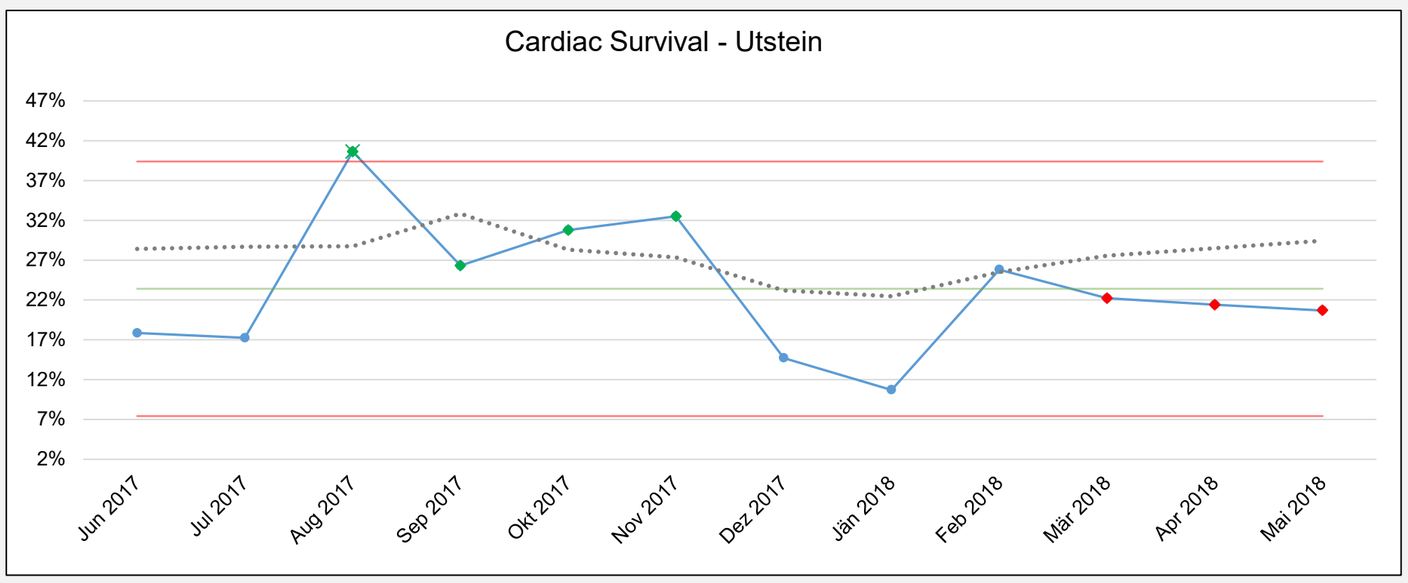


Performance for the cardiac arrest ROSC indicator for the Utstein group for May 2018 is in line with normal patterns of variation.

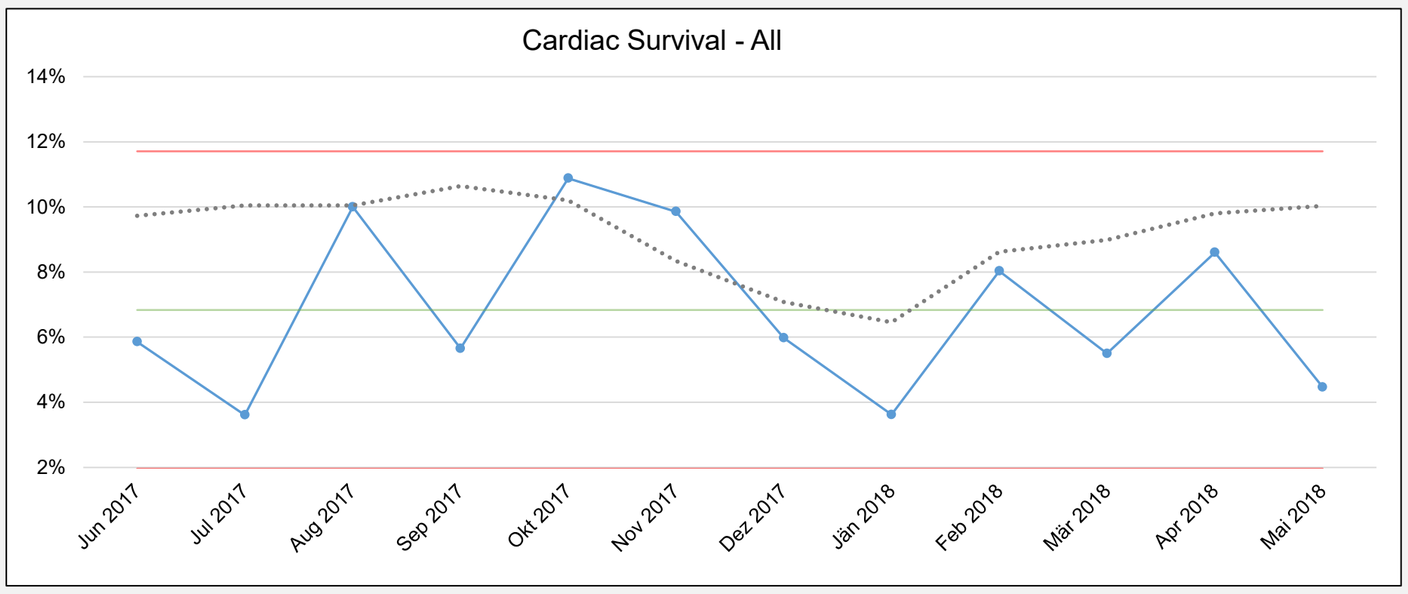
The Medical Directorate has allocated a Senior Clinician to lead on the Trust's Cardiac Arrest Survival Improvement Programme. Areas of focus have included developing a Cardiac Arrest Registry, Trust guidelines for the Management of Cardiac Arrest, developing our database of Public Access Defibrillators,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



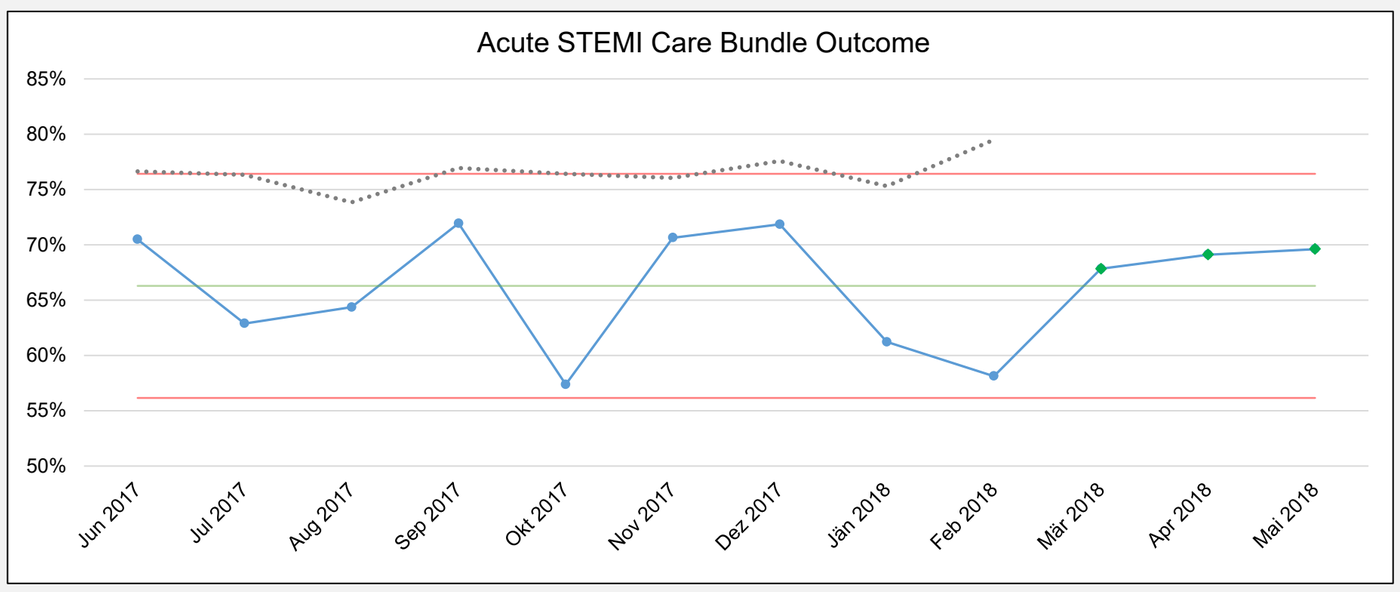
In April 2018 our performance for ROSC in all patient groups is above the SECAmb YTD average and below the national average.



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



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

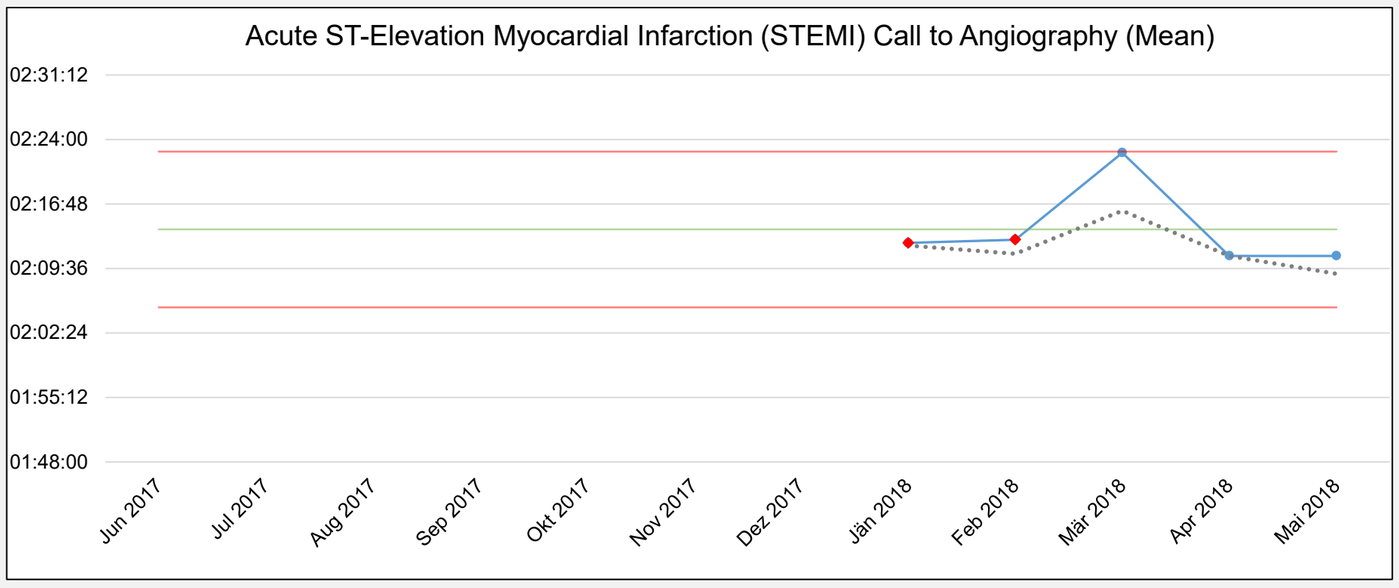


Performance for May 2018 was above the SECAmb average.

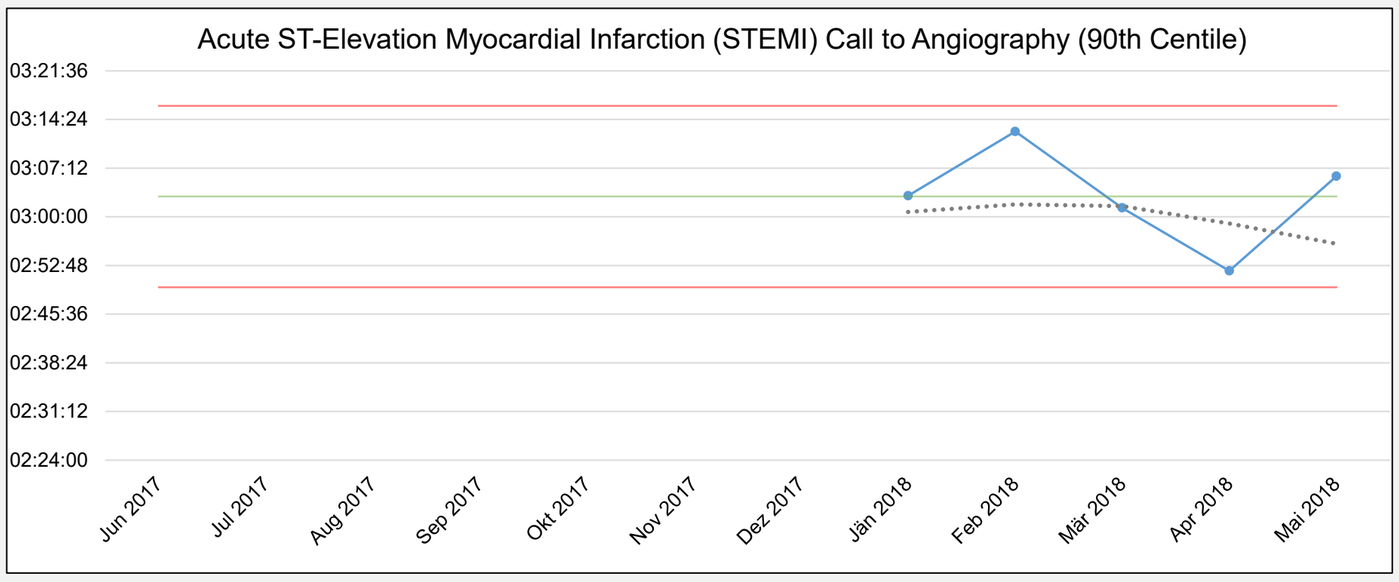
Dashboards and Quality Scorecards showing local performance levels are now routinely being shared with Operating Units (OUs) to facilitate focussed quality improvement. A suite of feedback tools and information sheets has also been developed.

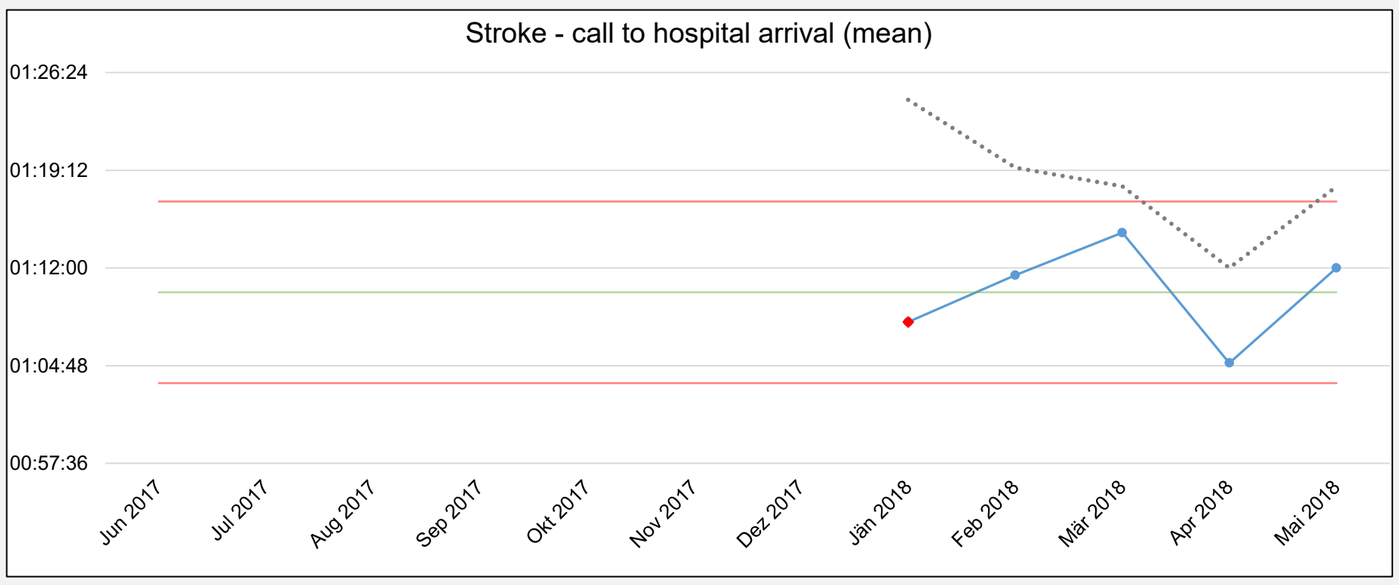
Focussed improvement work is underway for OUs whose average performance is outside of the expected parameters.

SECAmb Clinical Safety Charts

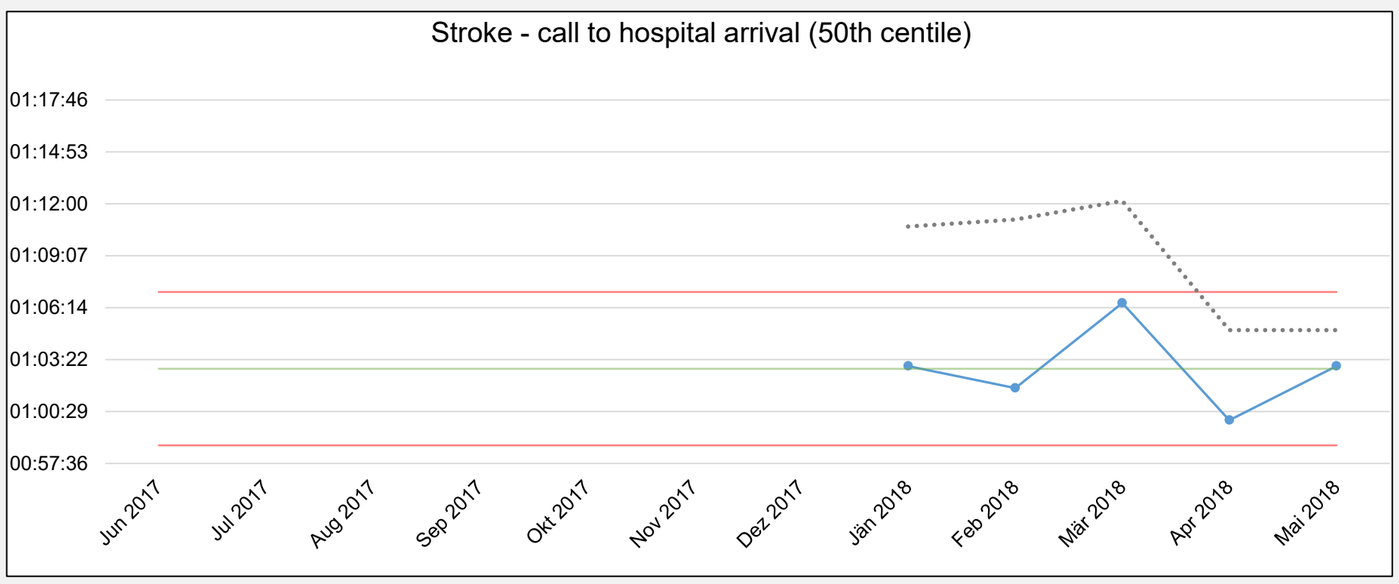


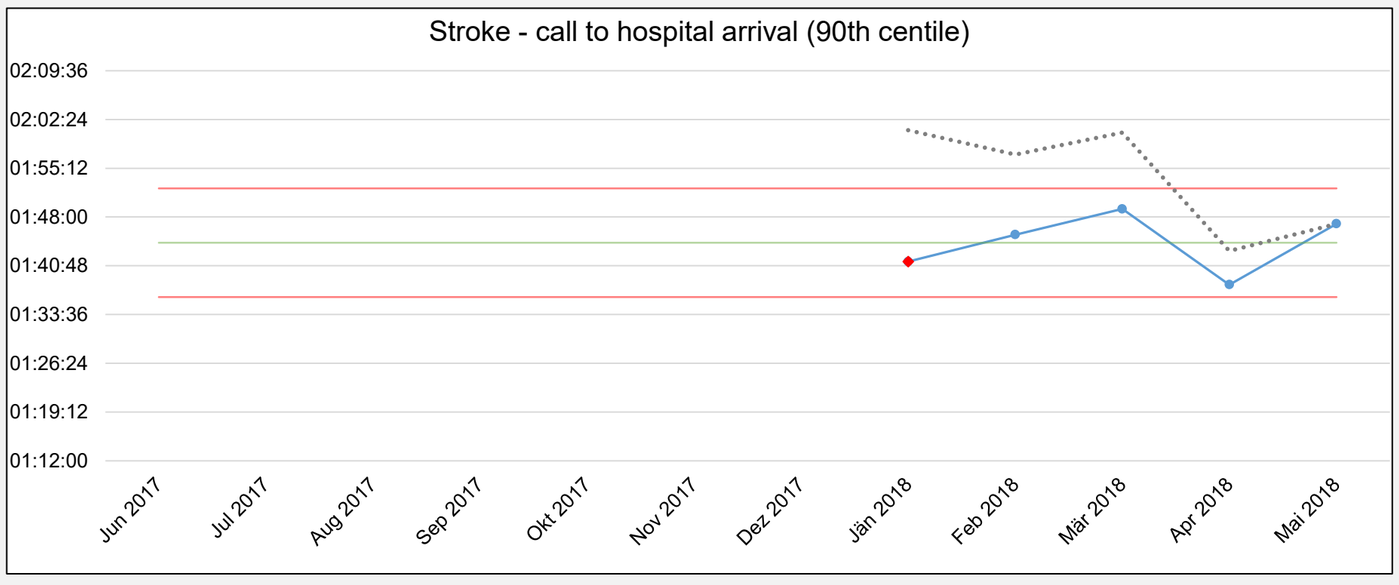
Mean performance is above the National Average. Our 90th centile performance is above the National Average and above the SECAmb average. The data shows normal patterns of variation.



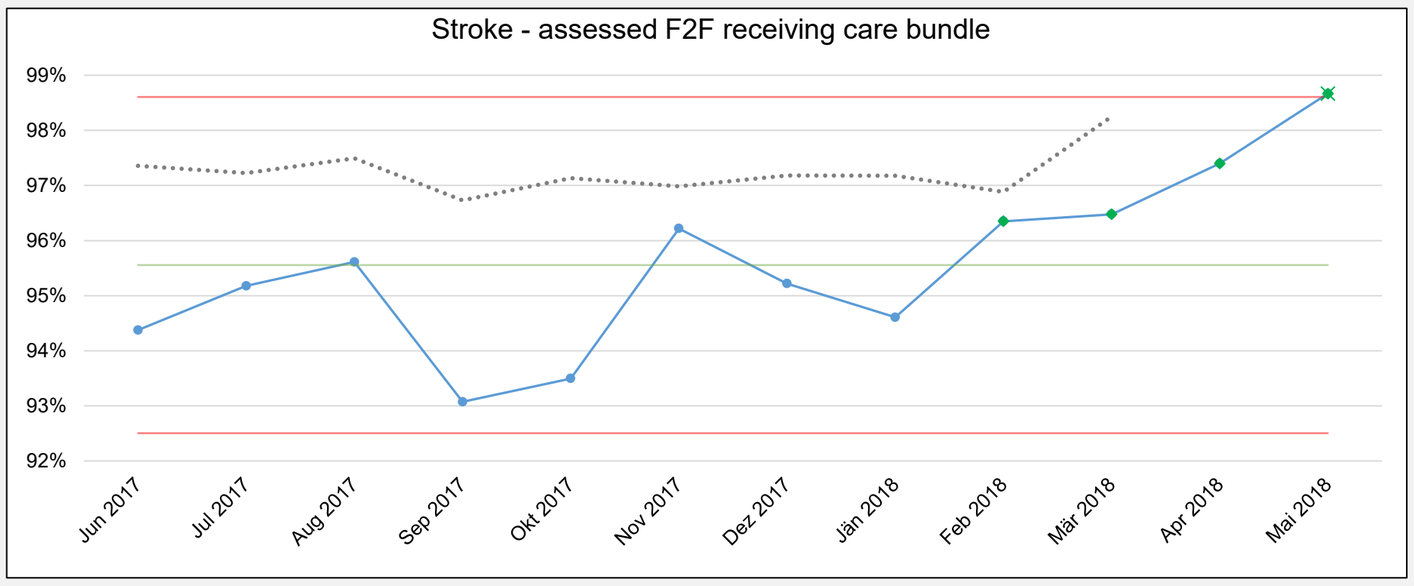


Our mean performance for May 2018 is above the SECAmb average and below the national average. Our median performance was above SECAmb average and below the national average. Our 90th centile time was below the SECAmb average and in line with the national average.





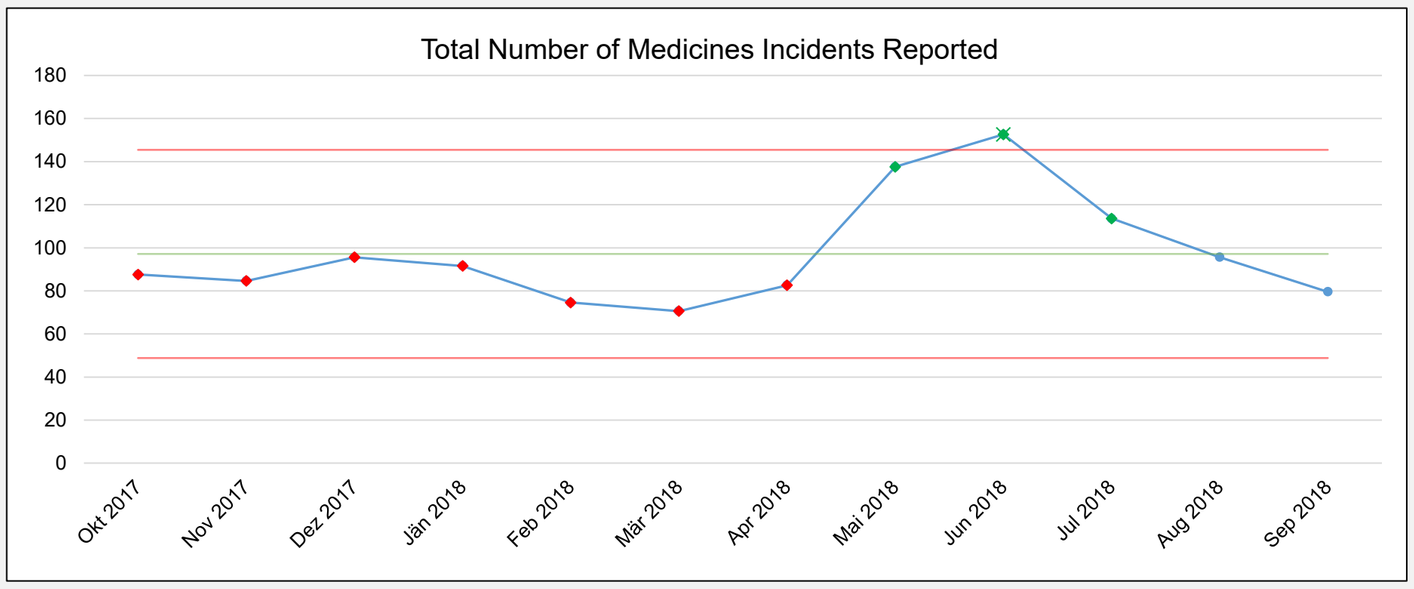
SECAmb Clinical Safety Charts



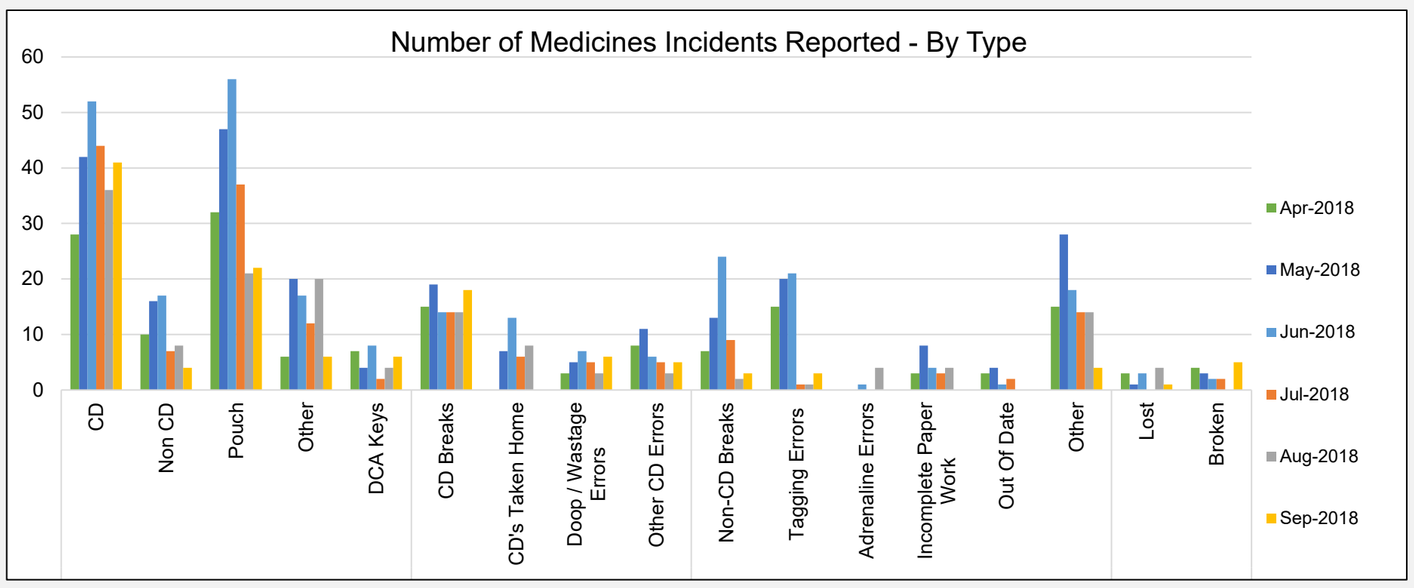
Performance in completing the Stroke Care Bundle is above the SECAmb average and the national average. The sustained improvement seen since February 2018 can be attributed to a change in national data definitions.

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

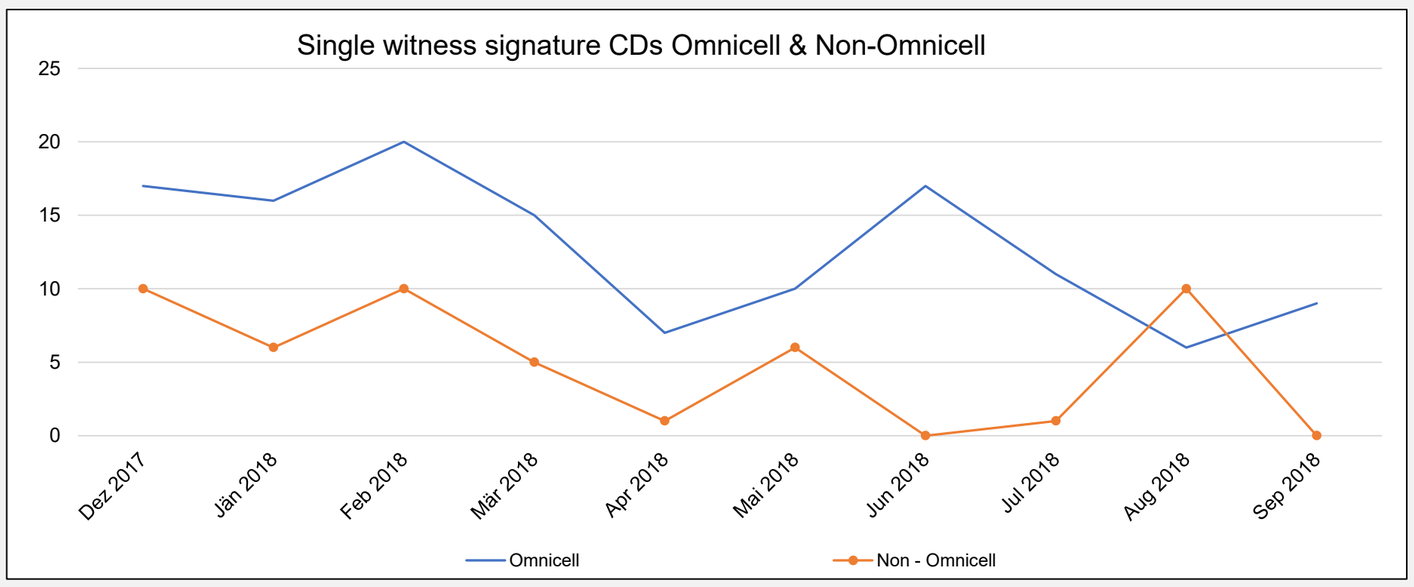
Focussed improvement work is planned for operating units whose average performance is outside of the expected parameters.



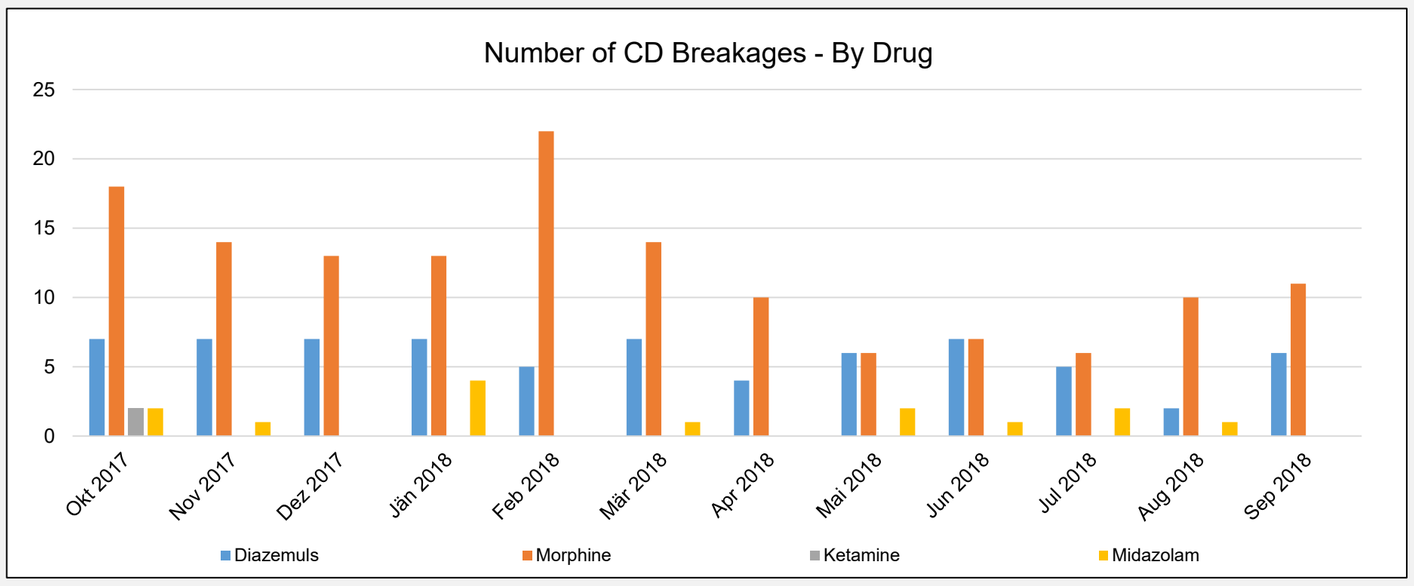
August has seen a further decrease in medicines incidents reported. Change has been made for September 2018 to aid staff with more reporting options for medicines in the Datix system. There are still incidents occurring where staff take Controlled Drugs home at the end of their shifts. Eight incidents were reported in August 2018 around this activity. A process is in place to ensure the drugs are returned without delay, and feedback is provided targeting any staff member who takes CDs home more than once. 22% of errors reported are in relation to medicines pouches and incorrect tagging, missing medicines or incomplete pouch paperwork. There was 5 incidents reported in August 2018 where medicines were not available for our patients due to incorrect tagging of pouches. A pouch review will commence on the whole system at end of October 2018, with a view to work up a project proposal document.



SOP compliance around CDs continues to be reported well. Tagging errors, breakages and incomplete paperwork with medicines pouches continue to be reported by operational staff, however it is under reported.
More work is required around encouraging staff to report more and learning from incidents.

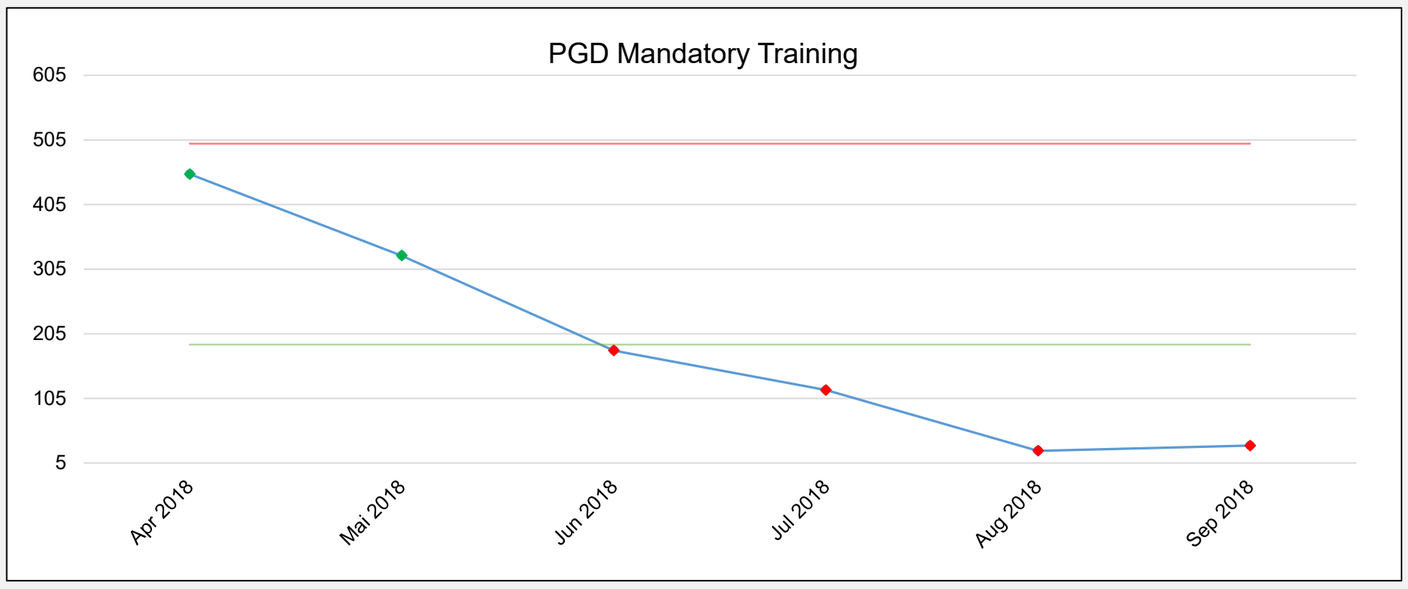


Weekly reports from the medicines governance team are sent to the OTLs on Omnicell sites to confirm the single signature is authorised. Most of the Omnicell sites do not have the emergency barcode in place now, so no single sign out is possible.
Medicines Governance Team rely on the OTLs reporting on this CD activity for non-Omnicell sites. OTLs are encouraged to complete a DIF1 for all unauthorised single CD signatures.



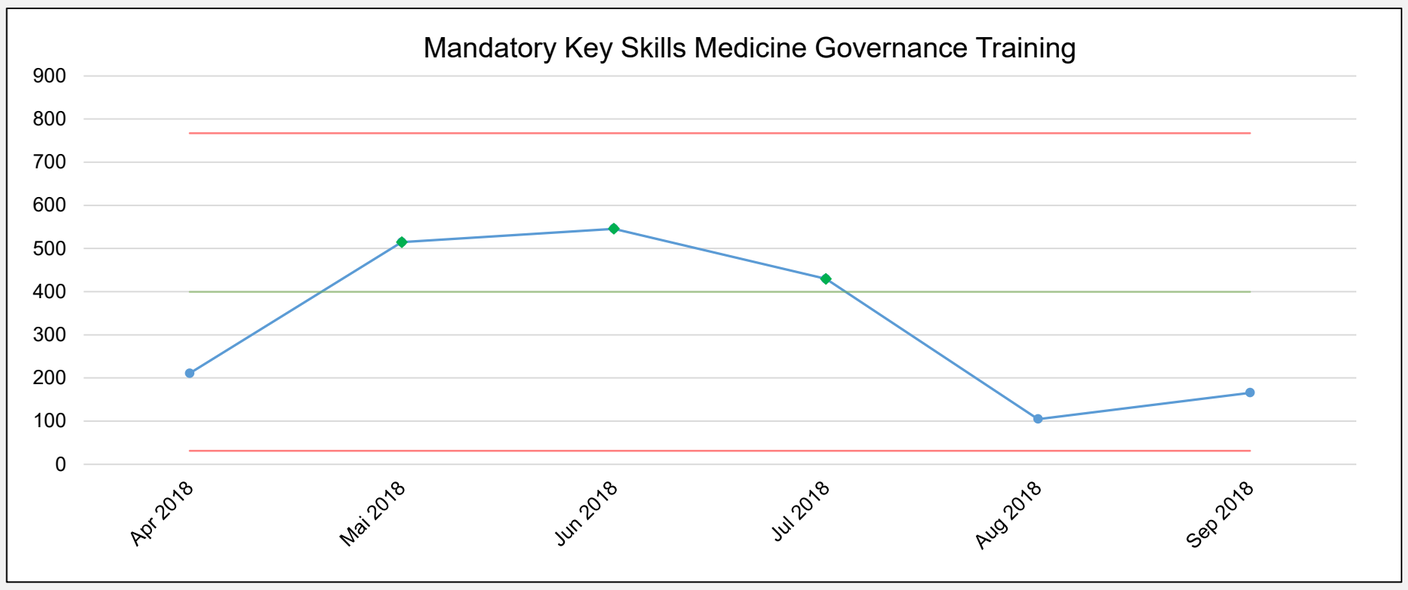
As a Trust we have had significant improvement in CD breakages since the introduction of the CD pouch in October 2017. All CD breaks are reported via DIF1.
Midazolam and ketamine are only available to CCPs whereas morphine and diazemuls are used by all Paramedics.

SECAmb Clinical Safety Charts



1131 Staff have been trained on PGDs in their key skills training to date.

It should be noted that the numbers reflecting mandatory training revert to zero as at 1st April each year.



1973 Members of staff have been trained in their medicines governance key skills to date.

It should be noted that the numbers reflecting mandatory training revert to zero as at 1st April each year.

Analysis of Cardiac Arrest Data – May 2018

Total number of cardiac arrests identified = 536

Number of resuscitation attempts = 228
excluding DNACPR 75 , DOA 223 , No Resus by SECAmb 3 ,
Post arrest 4 , ADRT 3

Utstein definition
Bystander witnessed
Presenting rhythm VF
Cardiac in origin

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

Cardiac Arrests (Utstein incidents) = 30 |rdiac Arrests (All incidents) = 228 (10(

ROSC sustained to hospital (Utstein)
= 15 (50%) + 4 non ROSC

ROSC sustained to hospital (All) = 57
(25%) + 15 non ROSC

Outcomes for ROSC at hospital and non ROSC at hospital patients		
Utstein	Details	Overall
6	Patient survived to discharge	10
12	Patient died in hospital	59
0	Patient still in hospital*	0
1 (no pt data)	Outcome unknown* (Patient identifiable data incomplete)	4 (3 no pt data)

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

Survival to Discharge (Utstein) = 6 (21%)

Survival to Discharge (All) = 10 (4%)

Additional Information – Resuscitation Attempts

Cardiac Rhythm	Overall Totals	ROSC at Hospital	Non ROSC at Hospital
Asystole	108 (47%)	15	5
PEA	63 (28%)	16	4
VF	45 (20%)	22	5
Non-shockable	0 (0%)	0	0
Not recorded	12 (5%)	4	1

CPR Bystander – 144

EMS Witnessed arrest – 31

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

Analysis of Cardiac Arrest Data by area - May 2018

Number of resuscitation attempts = 228

Cardiac Arrests (Utstein) East = 19 (8%)	Cardiac Arrests (All) East = 125 (55%)
Cardiac Arrests (Utstein) West = 11 (5%)	Cardiac Arrests (All) West = 103 (45%)

ROSC sustained to hospital (Utstein) East = 8 (42%) + 1 non ROSC	ROSC sustained to hospital (All) East = 26 (21%) + 7 non ROSC
ROSC sustained to hospital (Utstein) West = 7 (64%) + 3 non ROSC	ROSC sustained to hospital (All) West = 31 (30%) + 8 non ROSC

Outcomes for ROSC at hospital and non ROSC at hospital patients

Area	Utstein	Details	Overall
East	1	Patient survived to discharge	3
West	5		7
East	8	Patient died in hospital	30
West	4		29
East	0	Patient still in hospital*	0
West	0		0
East	0	Outcome unknown* (Patient identifiable data incomplete)	0
West	1	Outcome unknown* (Patient identifiable data incomplete)	4

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

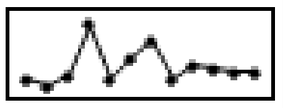
Survival to Discharge (Utstein) East = 1 (5%)	Survival to Discharge (All) East = 3 (2%)
Survival to Discharge (Utstein) West = 5 (50%)	Survival to Discharge (All) West = 7 (7%)

SECAmb Clinical Quality Scorecard

Number of Incidents Reported

	Jul-18	Aug-18	Sep-18	12 Months
Actual	770	806	837	
Previous Year	595	579	585	

Number of Incidents Reported that were SI's

	Jul-18	Aug-18	Sep-18	12 Months
Actual	9	8	8	
Previous Year	8	10	11	

Duty of Candour Compliance (SIs)

	Jul-18	Aug-18	Sep-18	12 Months
Actual %	100%	100%	100%	
Target	100%	100%	100%	

Number of Complaints

	Jul-18	Aug-18	Sep-18	12 Months
Actual	102	91	74	
Previous Year	82	105	132	
Complaints Timeliness (All	98.8%	99.0%	98.8%	
Timeliness Target	95%	95%	95%	

Compliments

	Jul-18	Aug-18	Sep-18	12 Months
Actual	176	189	150	

Hand Hygiene

	Jul-18	Aug-18	Sep-18	12 Months
Actual %	89%	93%	89%	
Target	90%	90%	90%	

Safeguarding Training Completed (Adult) Level 2

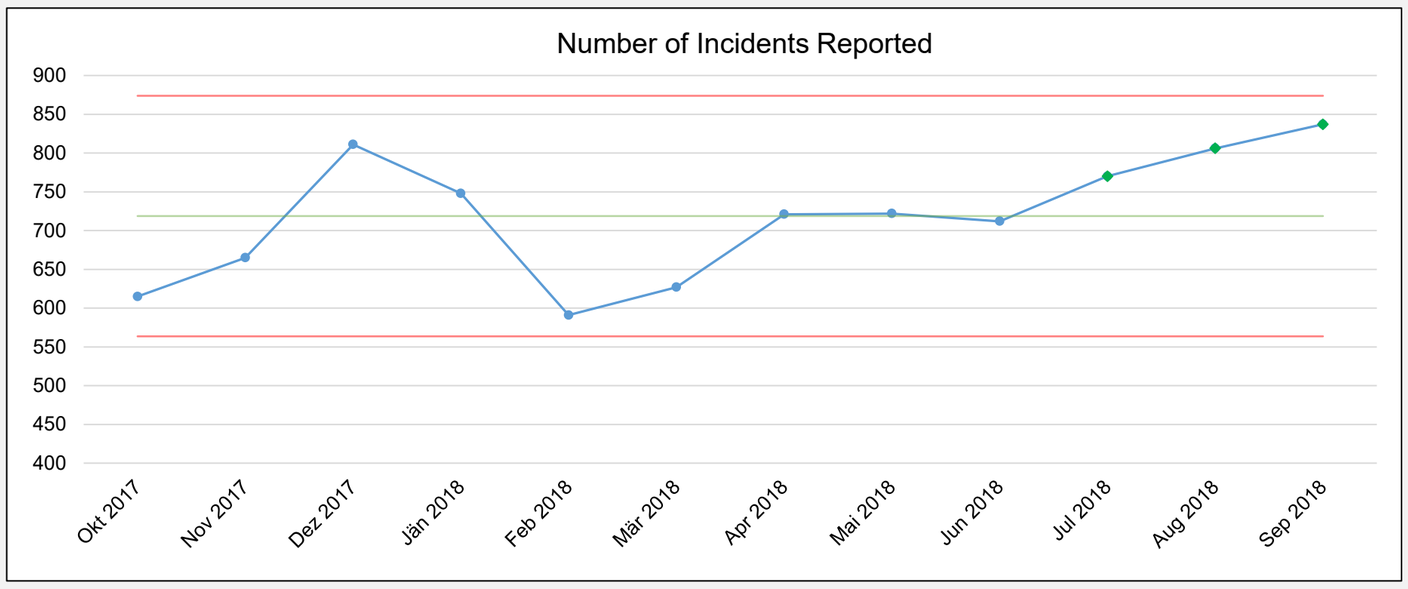
	Jul-18	Aug-18	Sep-18	12 Months
Actual %	58.69%	72.34%	77.07%	
Previous Year %	26.65%	34.06%	45.22%	
Target	85%	85%	85%	

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

Safeguarding Training Completed (Children) Level 2

	Jul-18	Aug-18	Sep-18	12 Months
Actual %	57.62%	71.20%	76.20%	
Previous Year %	20.54%	35.99%	46.62%	
Target	85%	85%	85%	

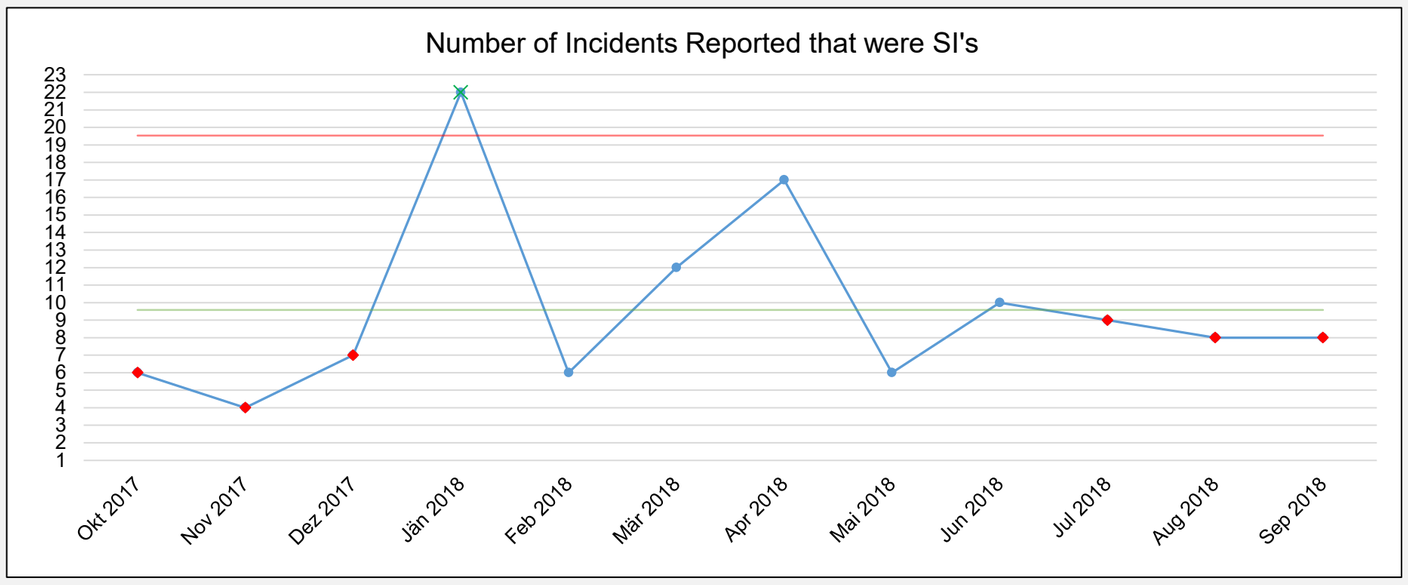
SECAmb Clinical Quality Charts



There has been 837 incidents reported in September 2018. This is an increase from September of 808 incidents. The most common reported incident was around not travelling under blue lights which reported 51 incidents for the month.

We reported 752 no harm incidents over the month and this has meant that we continue to report around 95% of our incidents as no and low harm.

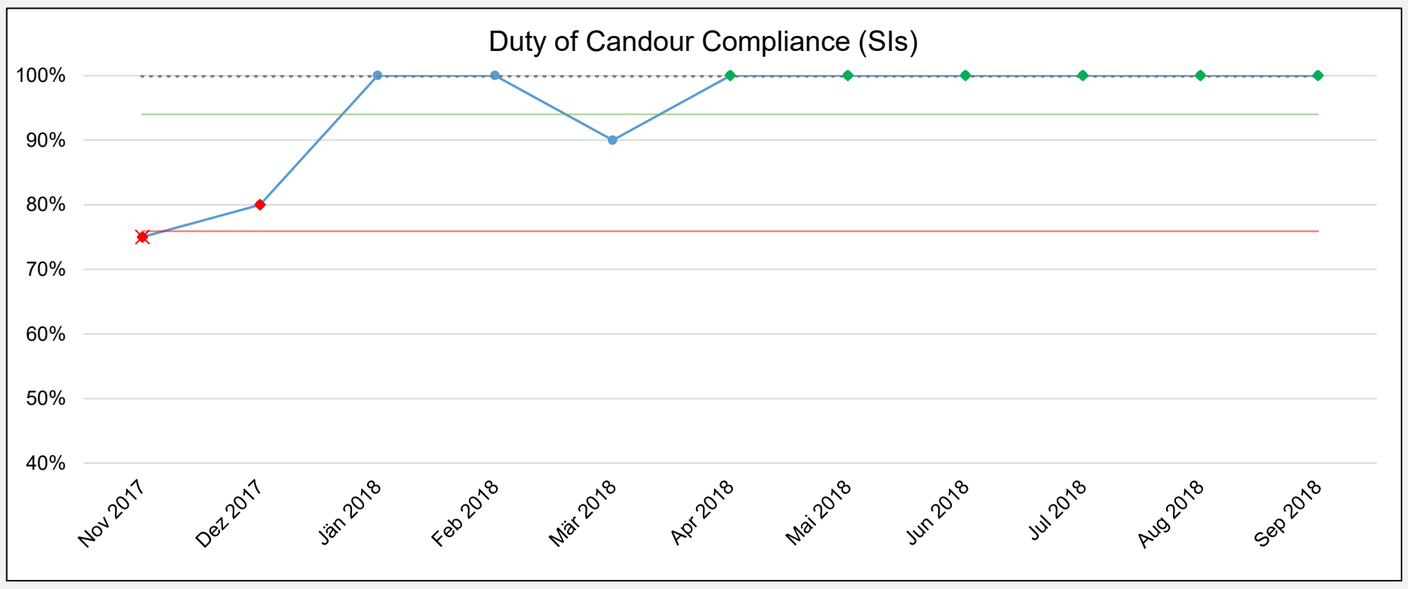
EOC, Polegate & Hastings and Medway & Dartford continue to be high reporters with 151, 86 and 96 respectively.



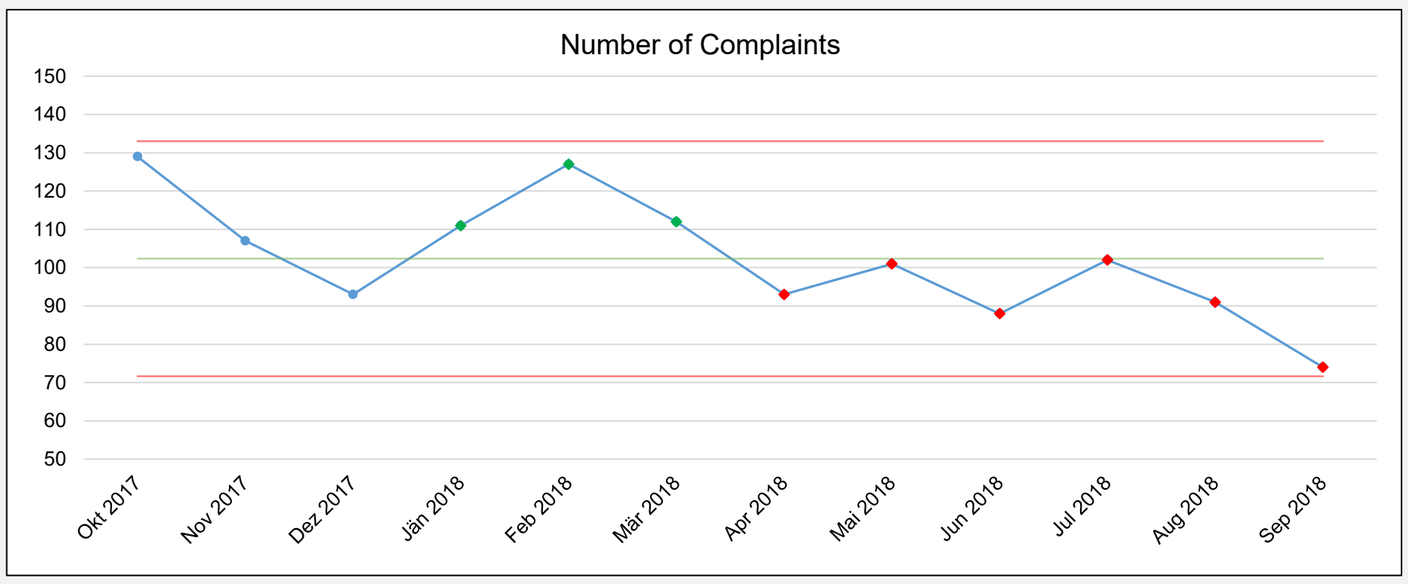
8 Serious Incidents (SIs) were reported in September (8 in August).

73 SIs were open on STEIS at the end of September (72 in August). A decrease of 1 to 27 (from 28 in August) were overdue for first submission to the Clinical Commissioning Group (CCG).

12 SIs were closed in September by the CCG. Overall fifteen SIs had been submitted for the September Commissioner Closure Panel. Twelve were closed and another two were agreed for de-escalation pending submission additional information requested.



The Trust achieved 100% compliance with DoC requirements for SIs with all made/attempted within deadline

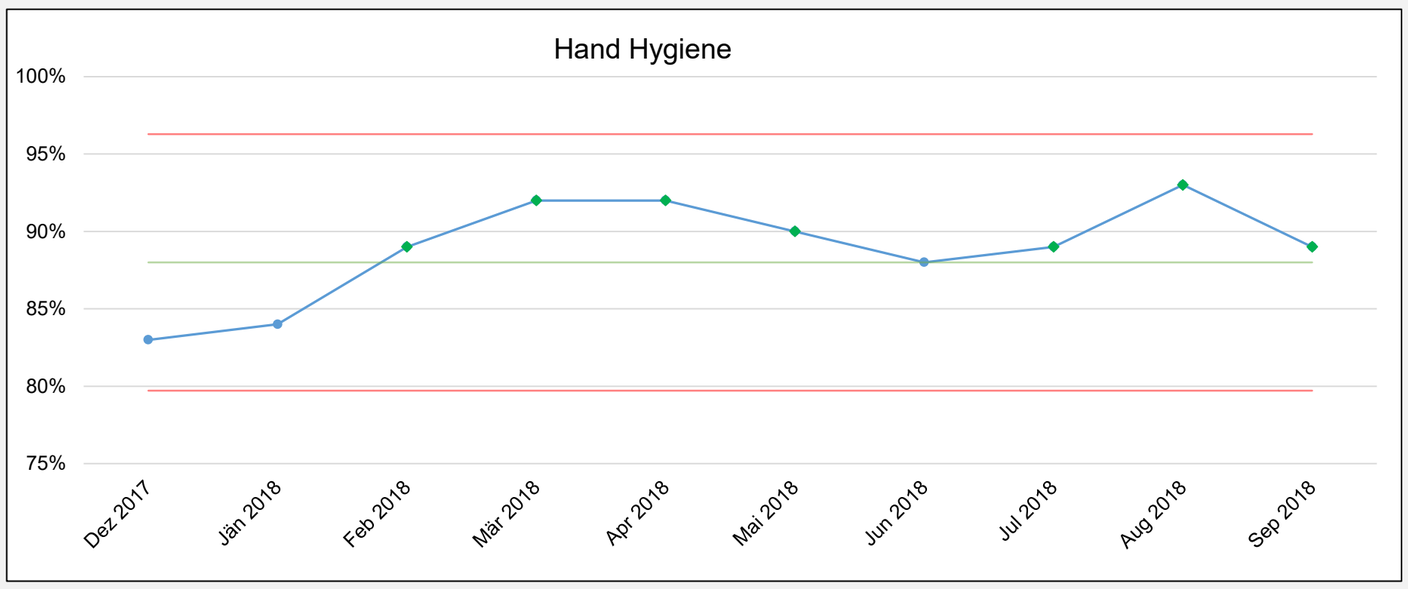


The Trust received and opened 74 complaints in September 2018, compared to 91 in August. The monthly average for 2017/18 was 104.

In September – as for all months – the top three complaints sub-subjects were staff behaviour, NHS Pathways (triage), and timeliness. However, complaints for all three have reduced against August's figures, with 20, 17 and 13 respectively, compared to 21, 27, and 15 in August.

In September 2018 99% of complaints were concluded within timescale, exactly as in August, maintaining the high standard the Trust is now achieving.

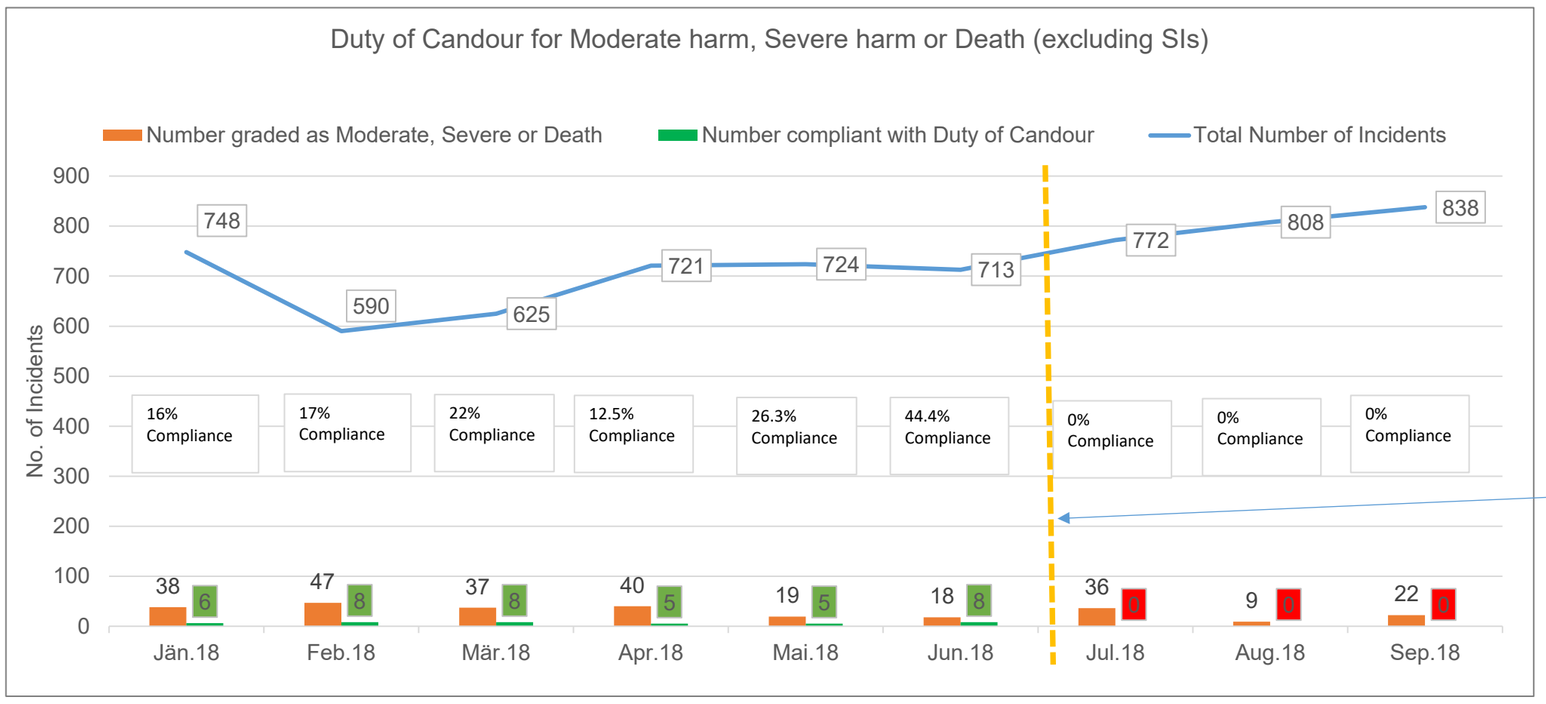
The number of compliments received in September was 151, and although this is a reduction on the 189 in August, this figure is still above average.



247 audits were completed during September using the new audit tools for the Infection Prevention Ready Procedure. This month we were just below the 90% target at 89% for Hand Hygiene and Clinically Ready was showing as 97% compliant.

SECAmb Duty of Candour and Moderate Harm

There has been a change in compliance criteria for this as explained below after an audit in to Duty of Candour in the Summer of 2018. A new process is in place with SIG to put Duty of Candour that does not meet SI reporting criteria. These incidents will go to SIG for review and then if they require DoC will be sent to the patient experience team to make contact with the patient or family member and upload evidence onto Datix to support this.



Prior to July, ticking 'Yes' for Duty of Candour was viewed as compliant. Now, evidence must be attached to the incident to be compliant.

SECAmb Health and Safety Reporting

The Health and Safety improvement plan is now a functional project which is monitored every 2 weeks by the Quality Compliance Steering Group. The improvement objectives will lay the foundations for a robust Health and Safety management system. This will support our longer-term goal to obtain ISO45001 accreditation for Occupational Health and Safety.

The Health and Safety team is now fully functional with 3 new Health and Safety managers and 1 Health & Safety trainer. The team is being led by Amjad Nazir, Head of Health and Safety. Each Health and Safety Manager will be assigned specific sites to support trust wide. This approach will allow unit Managers and Team Leaders to access Health and Safety support via a dedicated H&S Manager. The first part in Health and Safety culture building is developing management commitment and knowledge. The closer working with our H&S managers and site-based management teams will help to foster a positive safety culture within the organisation.

Health and Safety auditing will commence in January 2019. The annual audits will become a permanent monitoring activity to seek continuous improvement.

Violence and Aggression Incidents - See Figure 1 below
Violence and Aggression incidents reported in September were 41 which is the lowest amount reported in 11 months.

Manual handling Incidents - See Figure 2 below
Manual handling incidents reported in September were 17 which is the lowest amount reported in the current financial year.

Health & Safety Incidents - See Figure 3 below
Health and Safety incidents reported in September were 29 this is a small increase from the previous month.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) - See Figure 4 below
RIDDOR incidents reported in September were 4 and all 4 incidents were reported to the Health & Safety Executive on time.
This is the first month within the current financial year that 100% compliance was achieved for RIDDOR reporting.
Over the next few months, the Health and Safety team will improve internal communications to capture any shared learning following a RIDDOR. This activity will aid the culture improvement for Health & Safety.

Figure 1

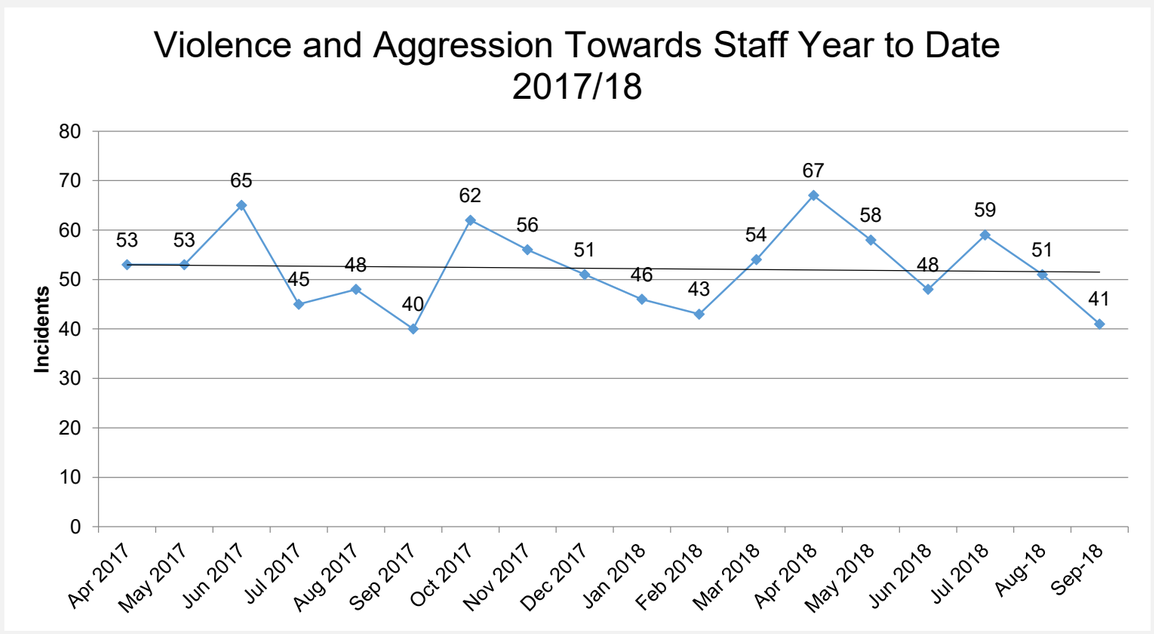


Figure 2

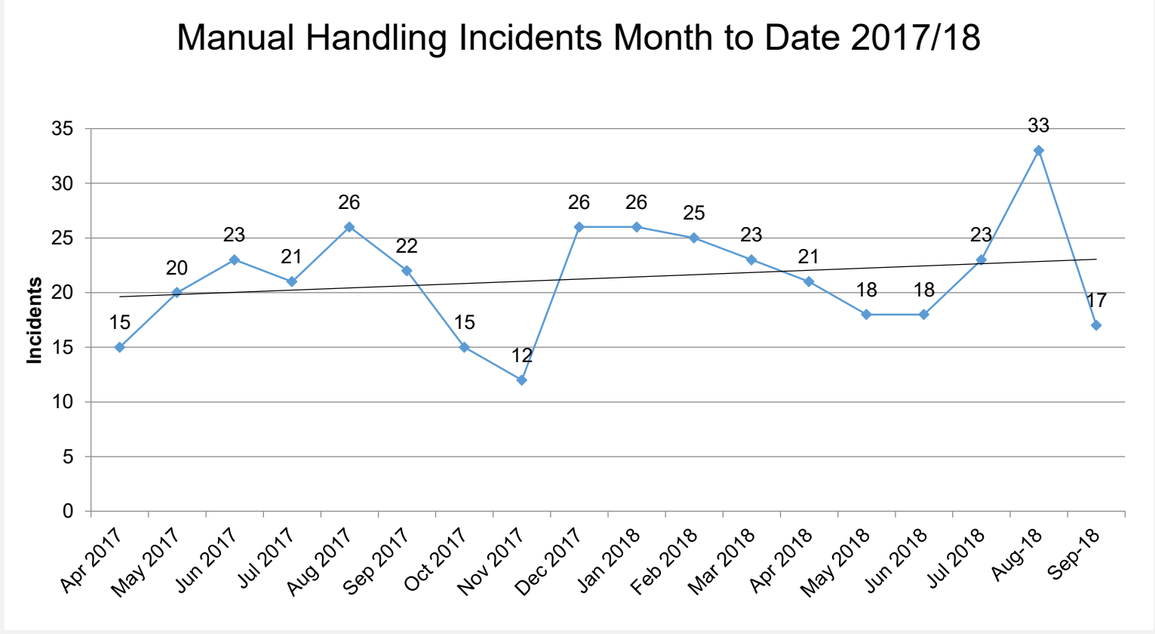


Figure 3

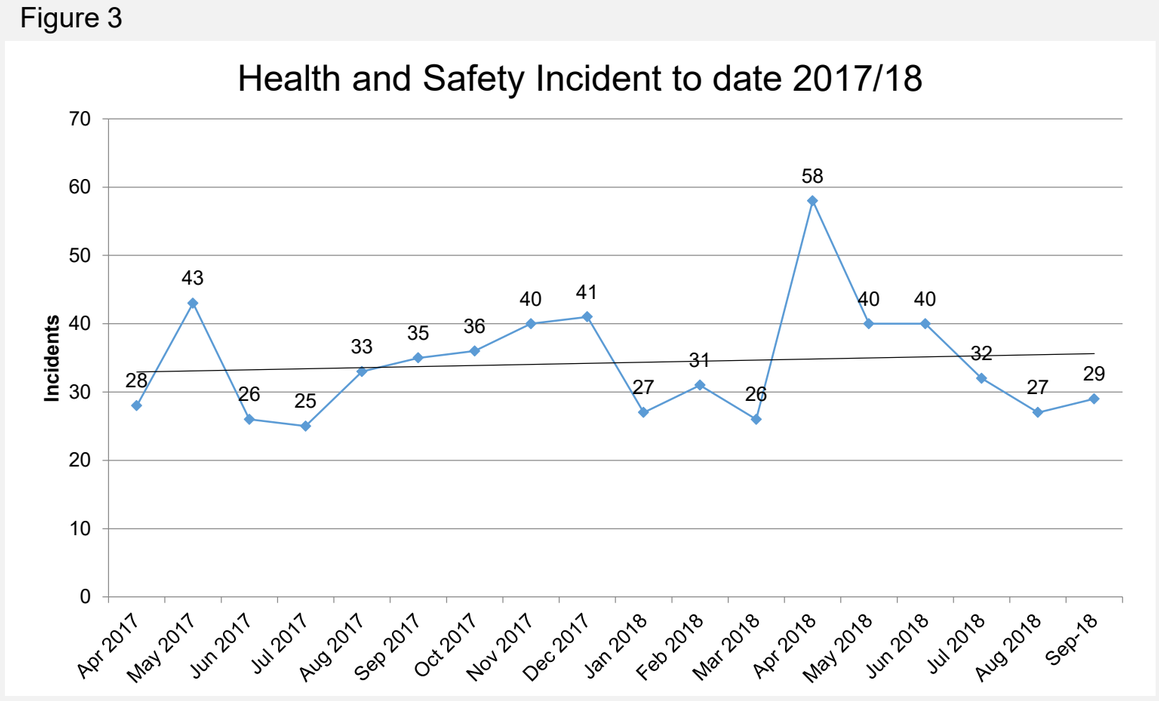
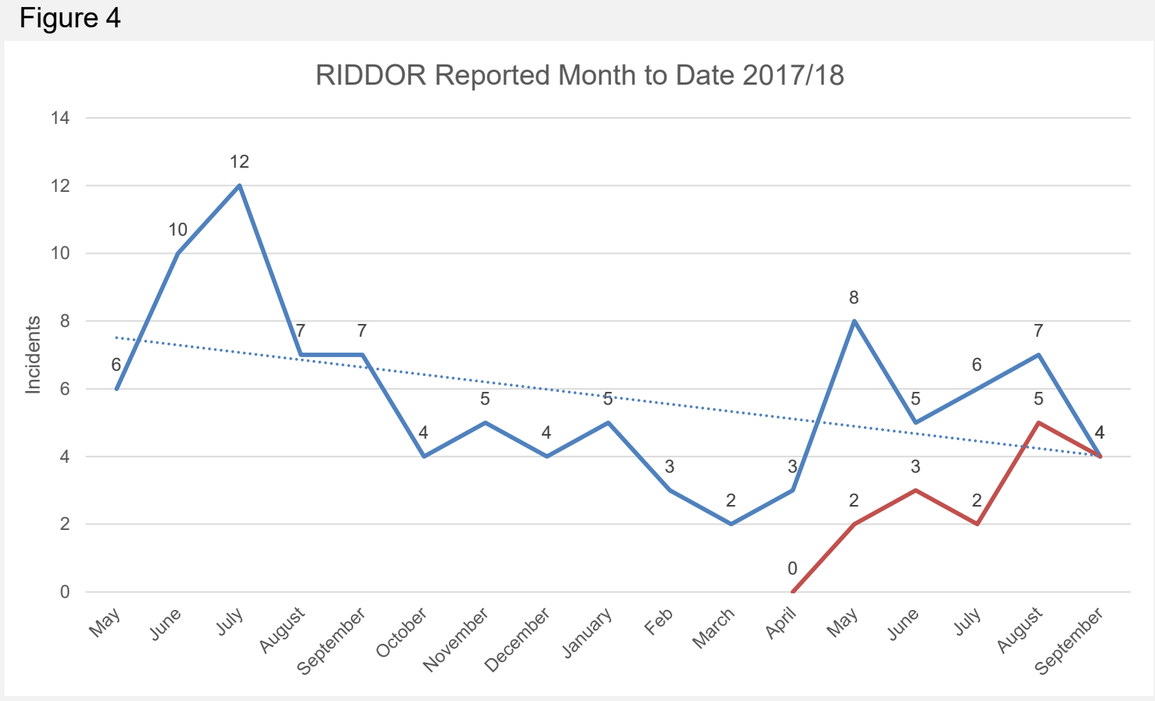


Figure 4

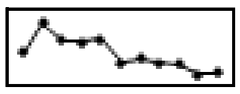


SECAmb 999 Operations Performance Scorecard

Call Handling

	Jul-18	Aug-18	Sep-18	12 Months
5 Sec Performance (95% Target)	72.7%	81.3%	81.8%	
Mean Call Answer Time (secs)	25	16	15	
95th Centile Call Answer (Secs)	143	102	88	
National Mean Call Answer	13	7	8	
National 95th Centile Call Answer	70	41	45	

Cat 1 Performance

	Jul-18	Aug-18	Sep-18	12 Months
Mean (00:07:00)	00:08:19	00:07:32	00:07:41	
90th Percentile (00:15:00)	00:15:12	00:14:17	00:14:12	
Mean Resources Arriving	1.75	1.73	2.37	
Count of Incidents	3590	3326	3369	
National Mean	00:07:37	00:07:17	00:07:20	

Cat 1T Performance

	Jul-18	Aug-18	Sep-18	12 Months
Mean (00:19:00)	00:10:52	00:10:32	00:10:43	
90th Percentile (00:30:00)	00:20:40	00:20:39	00:19:42	
Mean Resources Arriving	2.77	2.71	2.40	
Count of Incidents	2267	2125	2092	
National Mean	00:12:10	00:11:32	00:11:33	

Cat 2 Performance

	Jul-18	Aug-18	Sep-18	12 Months
Mean (00:18:00)	00:19:30	00:18:15	00:19:17	
90th Percentile (00:40:00)	00:37:39	00:35:07	00:36:11	
Mean Resources Arriving	1.13	1.12	1.44	
Count of Incidents	29416	27722	28205	
National Mean	00:22:41	00:20:42	00:21:41	

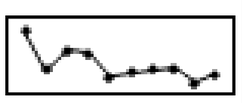
Cat 3 Performance

	Jul-18	Aug-18	Sep-18	12 Months
Mean	01:33:35	01:19:39	01:25:28	
90th Percentile (02:00:00)	03:34:35	03:08:43	03:12:32	
Mean Resources Arriving	1.07	1.06	1.73	
Count of Incidents	20279	20726	19457	
National Mean	01:06:54	00:57:34	01:02:28	

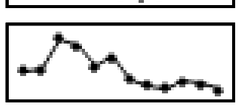
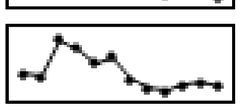
Cat 4 Performance

	Jul-18	Aug-18	Sep-18	12 Months
Mean	01:56:36	01:35:01	01:50:46	
90th Percentile (03:00:00)	04:34:20	03:37:10	04:01:15	
Mean Resources Arriving	1.05	1.05	1.81	
Count of Incidents	1037	958	771	
National Mean	01:32:37	01:19:23	01:22:54	

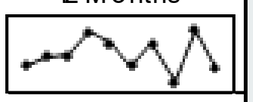
HCP

	Jul-18	Aug-18	Sep-18	12 Months
HCP 60 Mean	01:45:40	01:35:38	01:36:16	
HCP 60 90th Percentile	03:23:15	03:13:06	03:06:22	
HCP 120 Mean	02:22:35	01:58:36	02:13:46	
HCP 120 90th Percentile	05:13:05	04:20:20	04:39:31	
HCP 240 Mean	03:21:52	02:49:47	03:23:00	
HCP 240 90th Percentile	07:19:36	06:11:24	07:08:25	

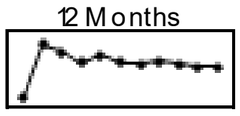
Call Cycle Time

	Jul-18	Aug-18	Sep-18	12 Months
Avg Allocation to Clear at Scene	01:13:25	01:15:11	01:15:22	
Avg Allocation to Clear at Hospital	01:46:36	01:46:13	01:46:07	
Handover Hrs Lost at Hospital (over 30mins)	4764	4496	4135	
Number of Handovers >60mins	399	445	361	

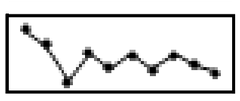
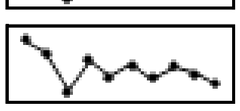
Incident Outcome AQI

	Jul-18	Aug-18	Sep-18	12 Months
Hear & Treat	6.5%	5.9%	5.7%	
See & Treat	33.0%	32.8%	33.5%	
See & Convey	60.5%	61.3%	60.7%	

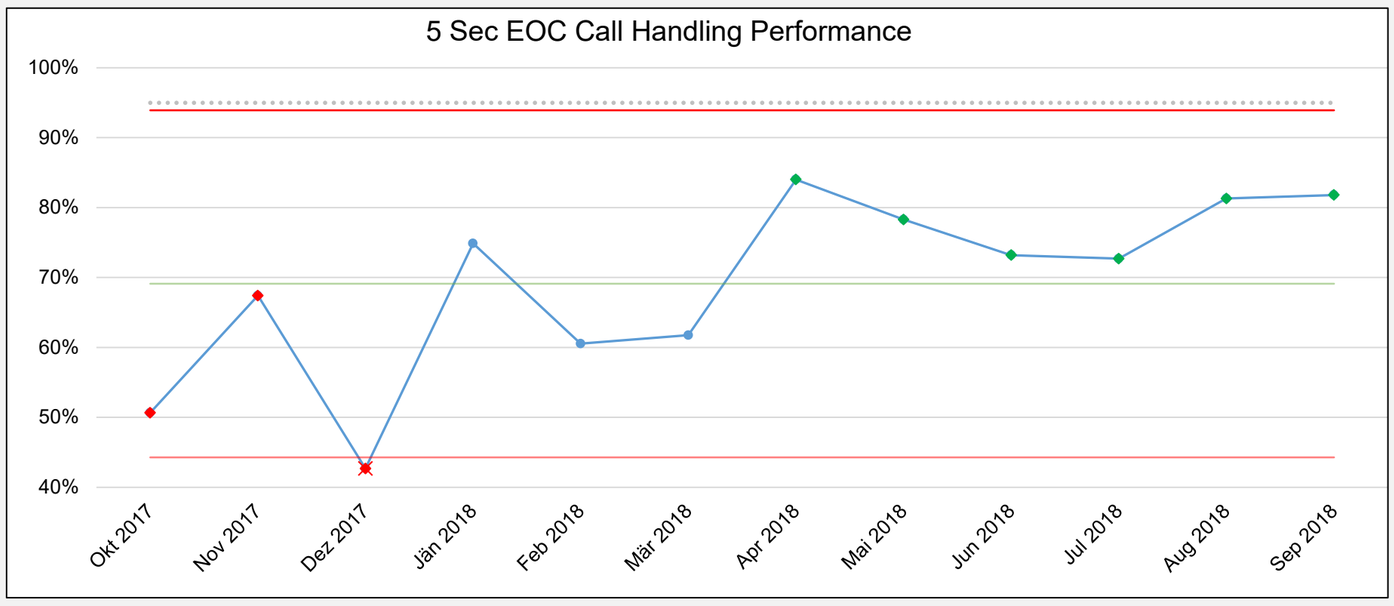
Community First Responders

	Jul-18	Aug-18	Sep-18	12 Months
Volume of Incidents Attended	1555	1452	1450	

Demand/Supply AQI

	Jul-18	Aug-18	Sep-18	12 Months
Calls Answered	69779	63510	63247	
Incidents	60337	58313	56943	
Transports	36531	35763	34589	

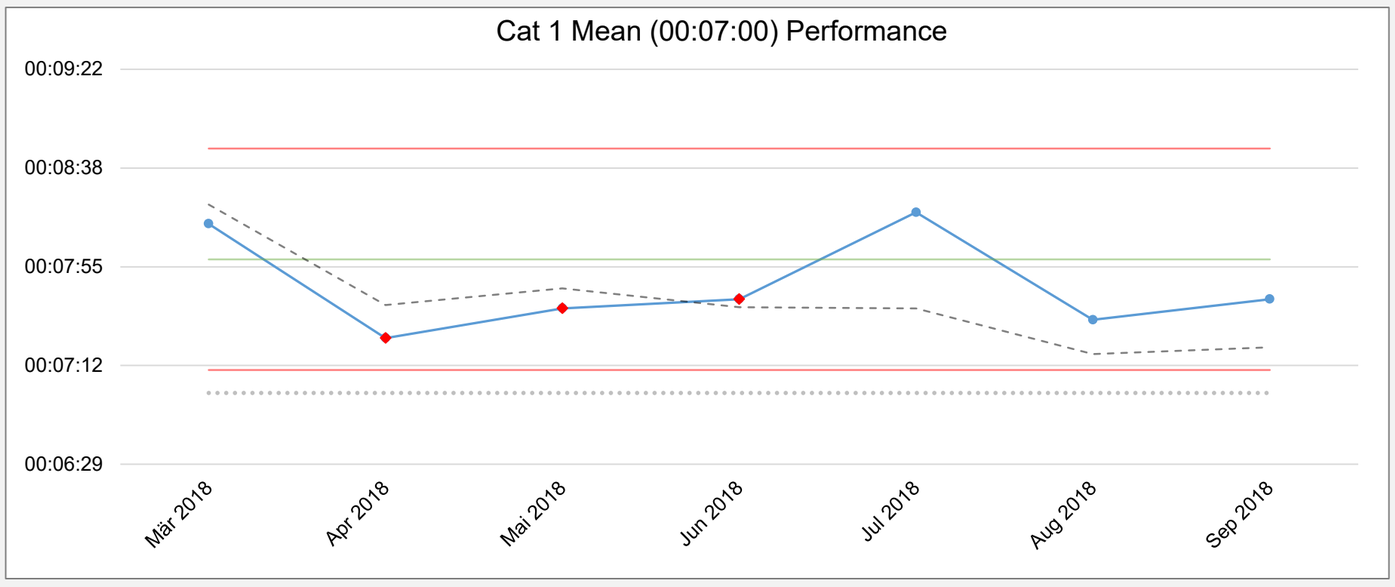
SECAmb 999 Operations Performance Charts



Call answering performance for September has seen a further improvement in performance with an average of 82%. The volume of duplicate calls regarding ETA of responses continues to make a significant contribution to increased call volumes. Management of abstraction rates continue to be scrutinised to deliver maximum unit hours.

Call answer performance is covered in detail in the EOC action plan that is tracking the actions of the EOC task and finish group to address the CQC must do requirement of demonstrating improvement against this key target, along with recruitment and staff retention.

There were 9 new starters for EMA's in September and 18 WTE leavers. It should be noted that 4 leavers, remained within the Trust in alternative roles. 16 EMA's continue in training.

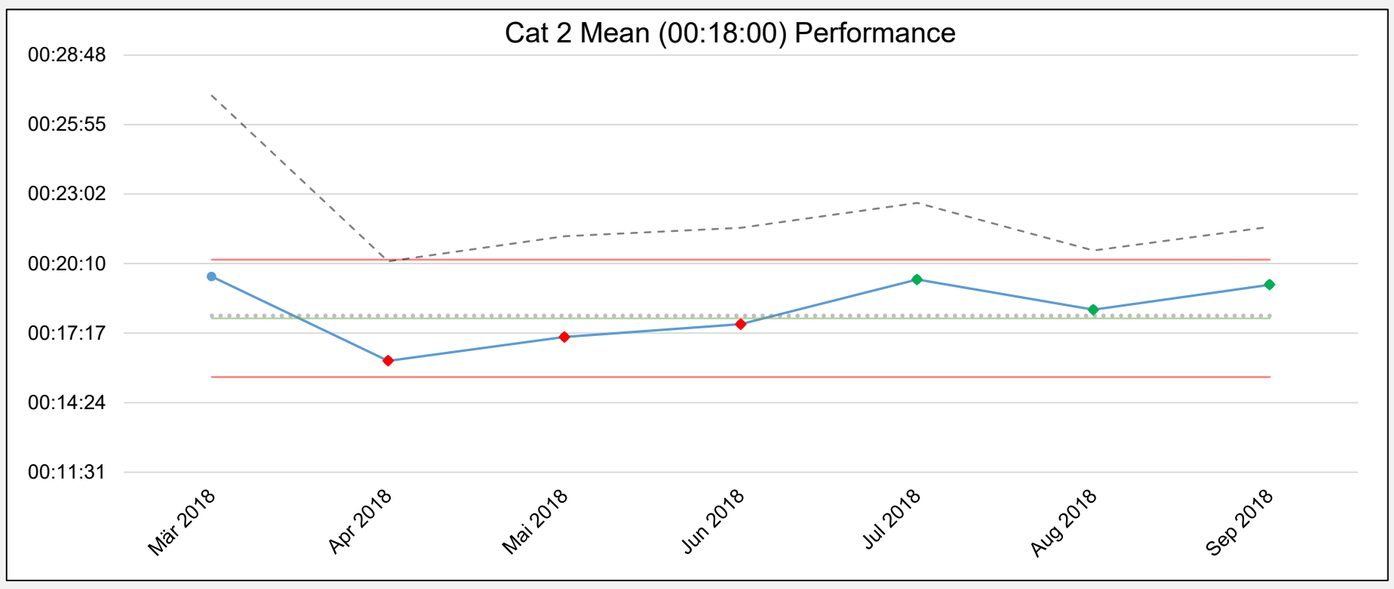


As shown in the graph the Cat 1 mean response performance has declined by 9 secs in September compared to prior month.

Whilst, the Trust are not yet delivering the Ambulance Response Programme (ARP) target of seven minutes, both our mean performance and 90th percentile performance are tracking consistently within the middle of the pack when measured against all other English ambulance services.

This consistency in delivery demonstrates the significant focus given to the high acuity patient groups.

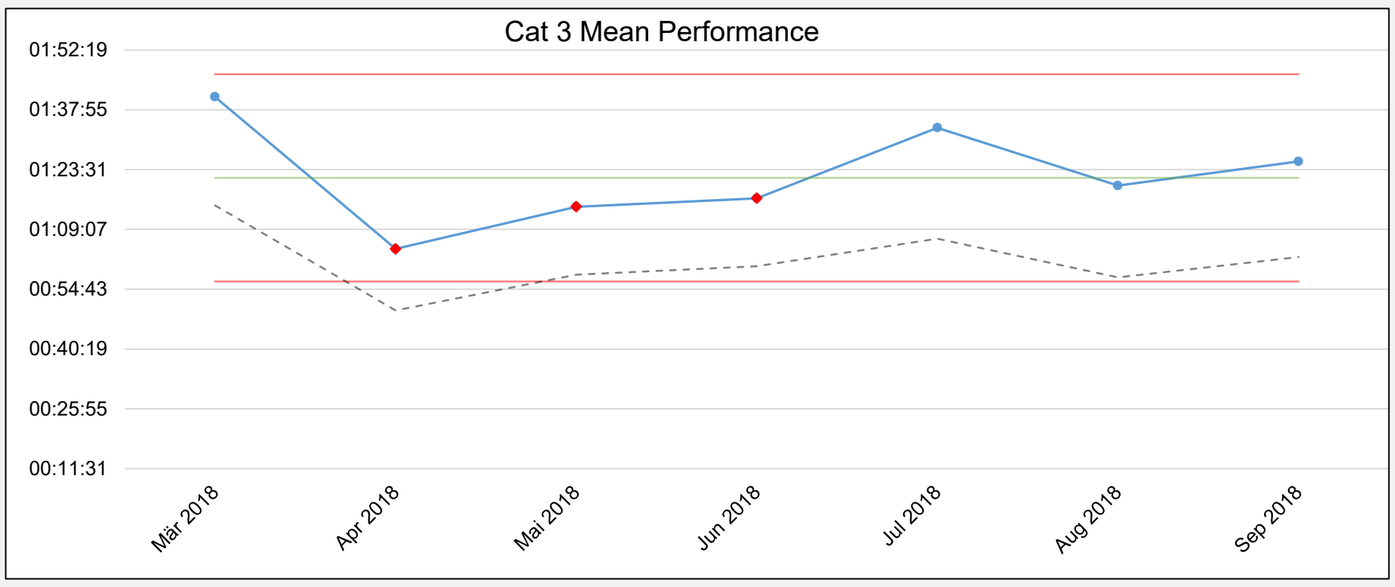
----- National Mean



September Cat 2 Mean Performance fell to 19.17. Despite this performance being 2.21 minutes better when compared with National Performance, we are undertaking significant investigations as to what has generated this particular worsening in recorded performance. One of the immediate observations is a change to NHS Pathways which took place on 05/09/2018 and it is believed that this has contributed to this position. The 90th centile performance has been and remains a particularly successful delivery for SECAmb.

Key skills training is progressing well, with a current completion rate of 88% against a trajectory of 90% completion by end September 2018. This is notably due to 2 outlier Operating Units, Tangmere and Guildford. Both OU's have implemented a recovery plan to address the shortfalls.

----- National Mean

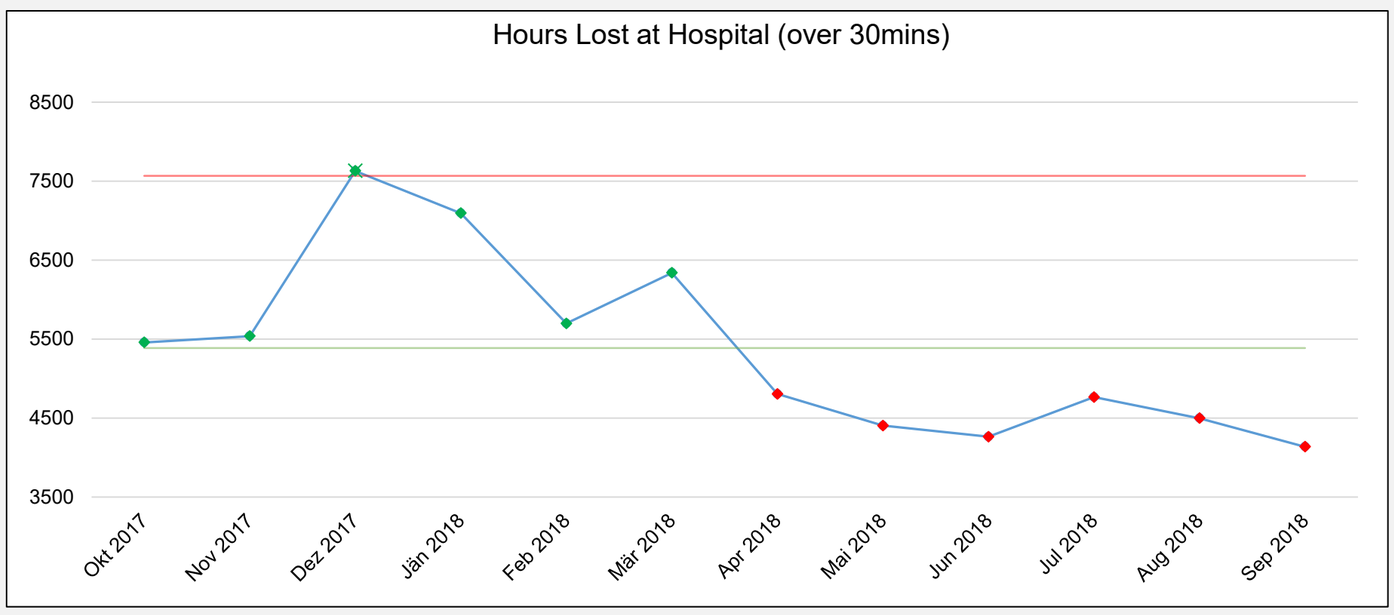


Cat 3 mean has been included to provide the Board with oversight on the significant pressure against the performance requirements for this patient group. Response to this Category of patients is below ARP target.

As highlighted SECAmb have invested heavily in obtaining new fleet that will be deployed to respond better to Cat 3/4 cohort of patients.

The 30 second hand Non-Emergency Transport (NET) vehicles are currently being commissioned and be available for deployment from November, at a rate of 3 vehicles a week to each of the 10 Operating Units.

----- National Mean



Hours lost to operational response capability through hospital delays in September are 4138 compared to 4496 in August . This is an improvement of 358 hours

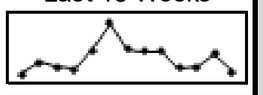
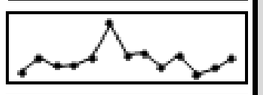
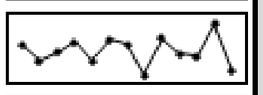
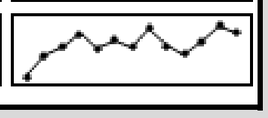
Overall across SECAmb good progress has been made this month with 21% less hours lost in September 2018 compared with September 2017. There are however outliers where there are significant increases in hours lost in September compared to last year, these are Darent Valley, Maidstone and Tunbridge Wells, and Ashford and St Peter's. This is a concern as we move into winter when system pressures increase.

Peer reviews at BSUH and Darent Valley were undertaken in September with best practice shared. To ensure community pathways are being maximised, live joint conveyance reviews (SECAmb, ED staff, community services and primary care) have been undertaken at East Surrey and Ashford and St Peters hospital More reviews are being planned.

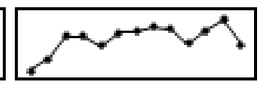
Please find below unvalidated SECAmb weekly performance

SECAmb Weekly Operational Performance - 19th November 2018

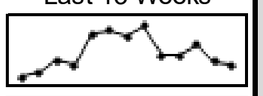
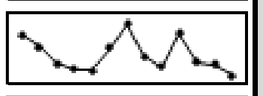
CAT 1

	29/10	05/11	12/11	Last 13 Weeks
Mean	00:07:18	00:07:37	00:07:11	
90th Centile	00:13:13	00:13:32	00:14:01	
RPI	1.77	1.84	1.73	
Count of Incidents	796	842	819	

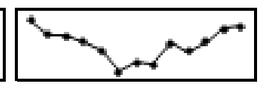
CAT 1T

	29/10	05/11	12/11	Last 13 Weeks
Mean	00:10:24	00:10:13	00:09:45	
90th Centile	00:18:43	00:20:38	00:18:42	
RPI	1.77	1.86	1.75	
Count of Incidents	502	522	479	

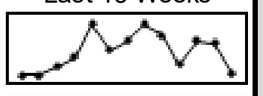
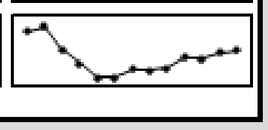
CAT 2

	29/10	05/11	12/11	Last 13 Weeks
Mean	00:19:27	00:18:23	00:18:07	
90th Centile	00:36:25	00:34:19	00:33:55	
RPI	1.12	1.12	1.12	
Count of Incidents	6780	7003	6990	

CAT 3

	29/10	05/11	12/11	Last 13 Weeks
Mean	01:24:34	01:14:28	01:12:27	
90th Centile	03:14:12	02:47:41	02:55:23	
RPI	1.07	1.08	1.07	
Count of Incidents	4647	4839	4866	

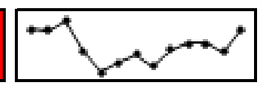
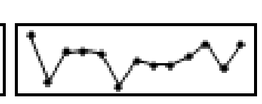
CAT 4

	29/10	05/11	12/11	Last 13 Weeks
Mean	02:00:33	01:57:57	01:29:30	
90th Centile	04:26:18	04:20:09	03:44:21	
RPI	1.06	1.05	1.06	
Count of Incidents	191	201	206	

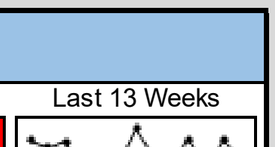
HCP 60

	29/10	05/11	12/11	Last 13 Weeks
Performance	51.4%	42.9%	43.5%	
Count of Incidents	35	28	23	

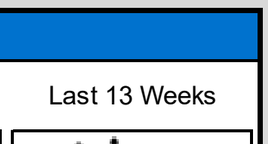
HCP 120

	29/10	05/11	12/11	Last 13 Weeks
Performance	58.3%	55.2%	63.8%	
Count of Incidents	370	330	370	

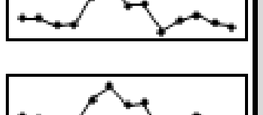
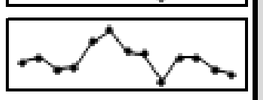
HCP 240

	29/10	05/11	12/11	Last 13 Weeks
Performance	63.5%	77.6%	69.0%	
Count of Incidents	52	67	42	

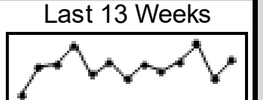
Call Cycle Time

	29/10	05/11	12/11	Last 13 Weeks
Clear at Scene (hh:mm)	01:15	01:13	01:13	
Clear at Hospital (hh:mm)	01:46	01:47	01:46	
Hours Lost at Hospital	888	1090	952	

Call Handling

	29/10	05/11	12/11	Last 13 Weeks
Pickup 5 Second Performance	83.4%	87.7%	90.3%	
Average Call Pickup Time (Seconds)	12	9	7	
Call Pickup Time 95th Percentile (Seconds)	68	51	36	
Call Pickup Time 99th Percentile (Seconds)	155	113	96	
Average Call Length (seconds)	379	376	374	
Abandon Rate	0.70%	0.40%	0.40%	
Staff Hours Provided Against 4865 Hours	88.67%	95.93%	97.45%	

Community First Responders

	29/10	05/11	12/11	Last 13 Weeks
Volume of Incidents Attended	377	290	337	
Hours Provided				

Incident Outcome

	29/10	05/11	12/11	Last 13 Weeks
See and Convey	61.3%	62.1%	61.4%	
See and Treat	33.4%	32.8%	33.3%	
Hear and Treat	5.3%	5.0%	5.2%	

Demand/Supply

	29/10	05/11	12/11	Last 13 Weeks
Call Volume	14420	14468	14161	
Incidents	12920	13393	13409	
Transports	8392	8790	8713	
Staff Hours Provided Against 63000 Hours	100.52%	105.11%	106.04%	

SECAmb 111 Operations Performance Scorecard

Calls Offered

	Jul-18	Aug-18	Sep-18	12 Months
Actual	87586	83359	84650	
Previous Year	86640	80524	80053	

Calls answered in 60 Seconds

	Jul-18	Aug-18	Sep-18	12 Months
Actual %	68.9%	83.7%	70.9%	
Previous Year %	91.5%	93.5%	80.2%	
Target %	95%	95%	95%	

Calls abandoned - (Offered) after 30secs

	Jul-18	Aug-18	Sep-18	12 Months
Actual %	5.7%	2.7%	6.0%	
Previous Year %	1.1%	0.6%	2.0%	
Target %	2%	2%	2%	

Combined Clinical KPI

	Jul-18	Aug-18	Sep-18	12 Months
Actual %	63.3%	61.3%	63.8%	
Previous Year %	71.8%	80.1%	69.5%	
Target %	80%	80%	80%	

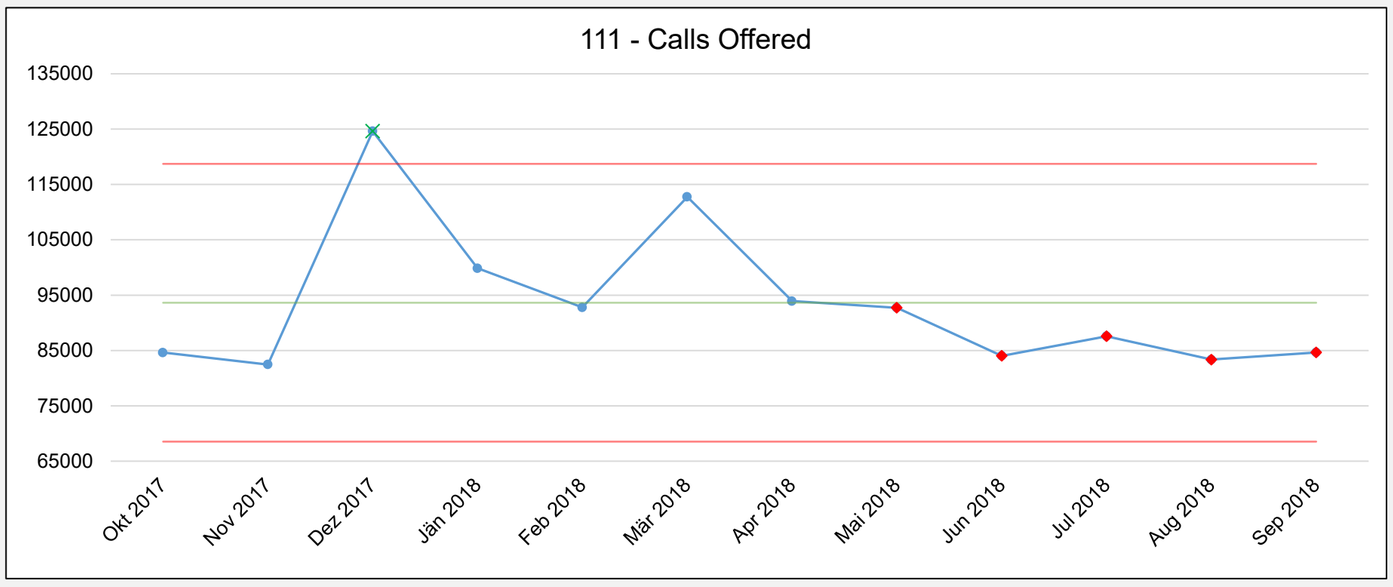
999 Referrals

	Jul-18	Aug-18	Sep-18	12 Months
999 Referrals % (Answered Calls)	11.0%	11.1%	11.3%	
999 Referrals (Actual)	8919	8917	8825	
National	11.5%	11.5%	11.5%	

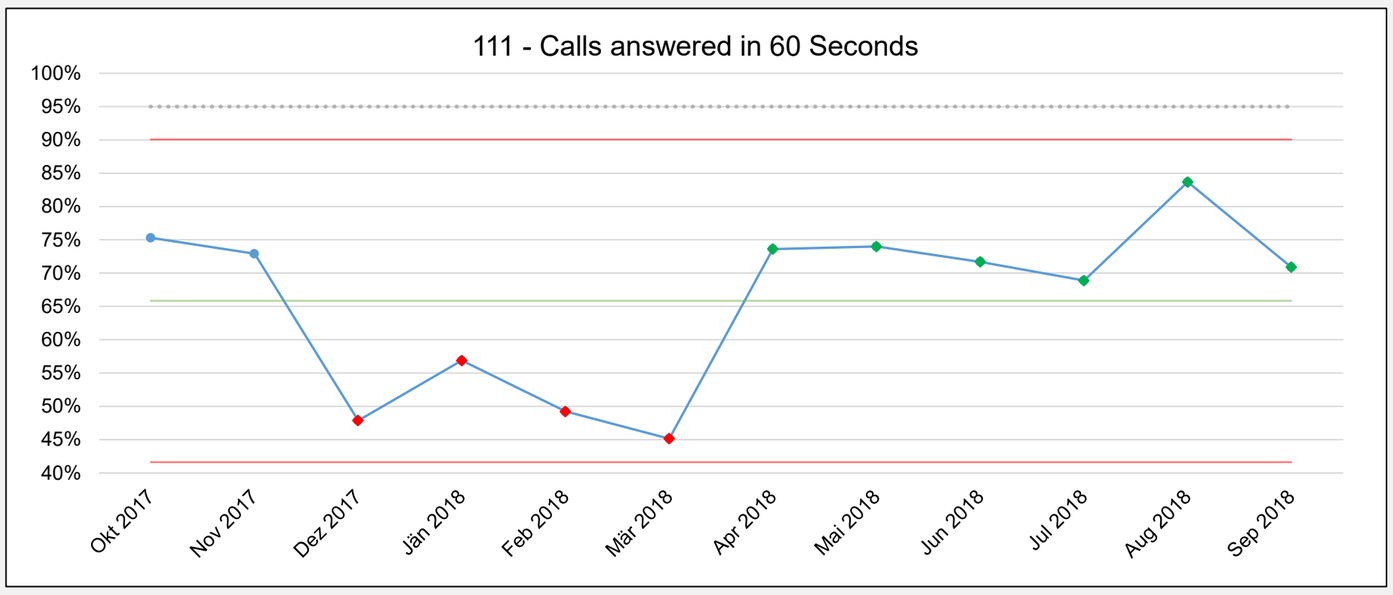
A&E Dispositions

	Jul-18	Aug-18	Sep-18	12 Months
A&E Dispositions % (Answered Calls)	8.8%	8.2%	7.9%	
A&E Dispositions (Actual)	7160	6591	6154	
National	8.8%	8.4%	8.3%	

SECAmb 111 Operations Performance Charts



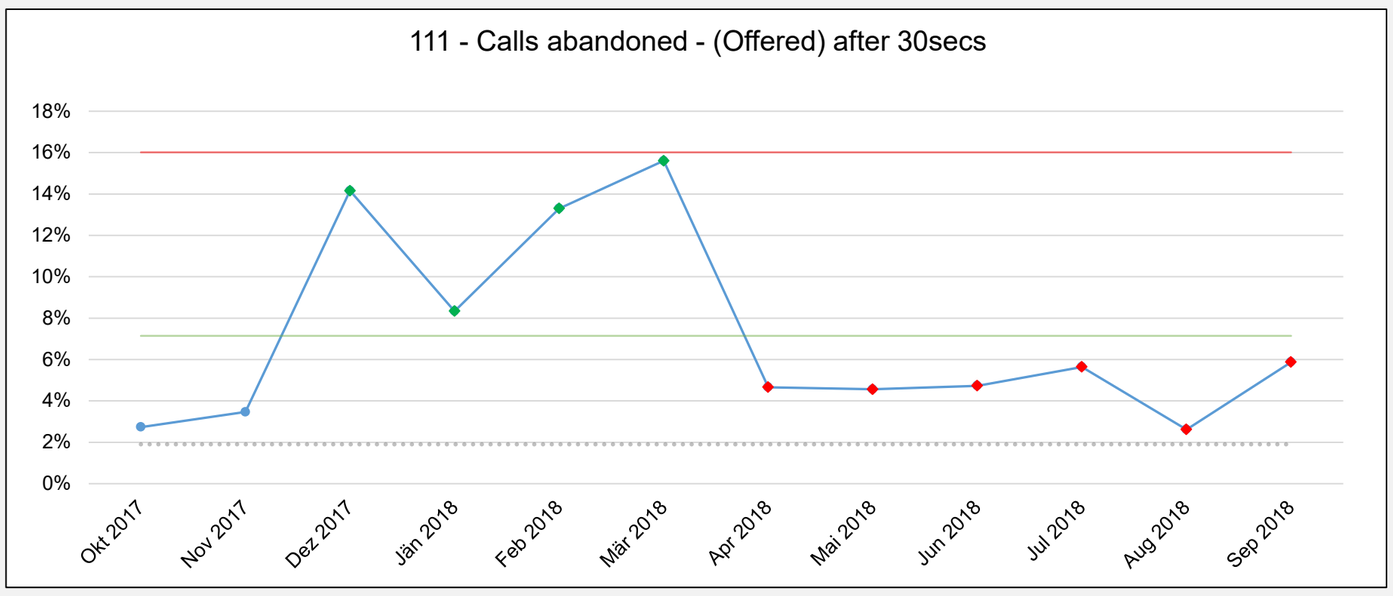
The Calls Offered volume of 84650 for September was broadly in line with seasonal expectations.

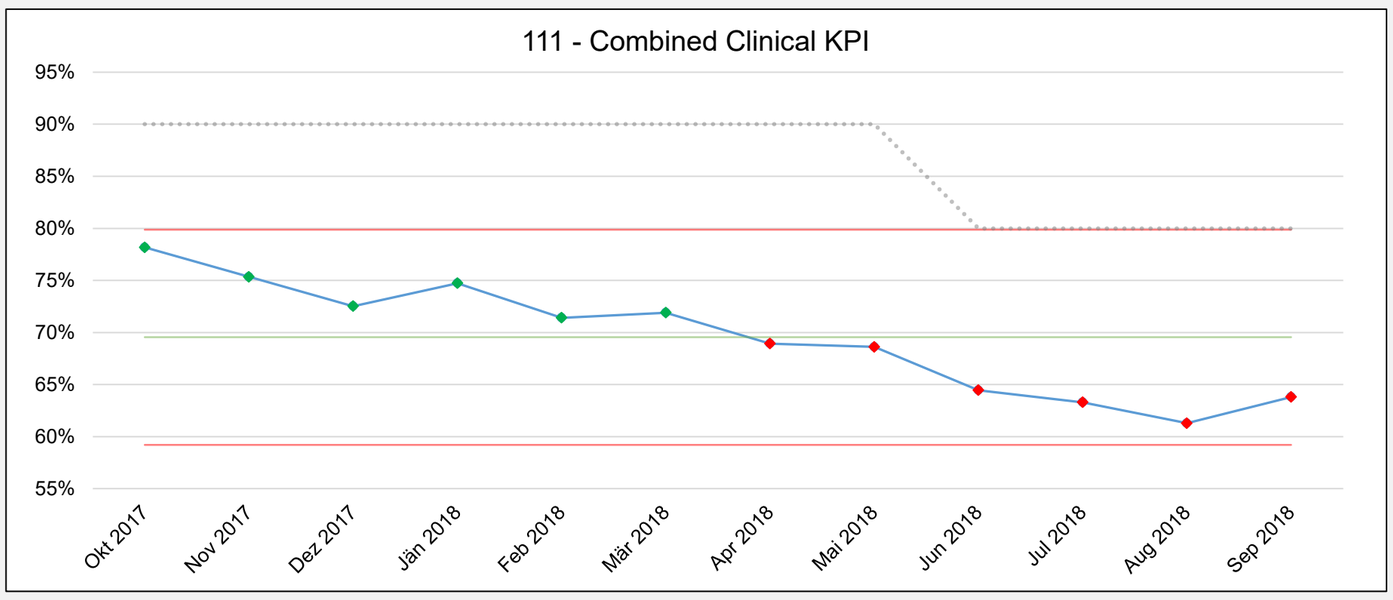


KMSS 111 experienced a decline in performance in September due to rota weaknesses caused by attrition, shrinkage and annual leave across the partner organisations.

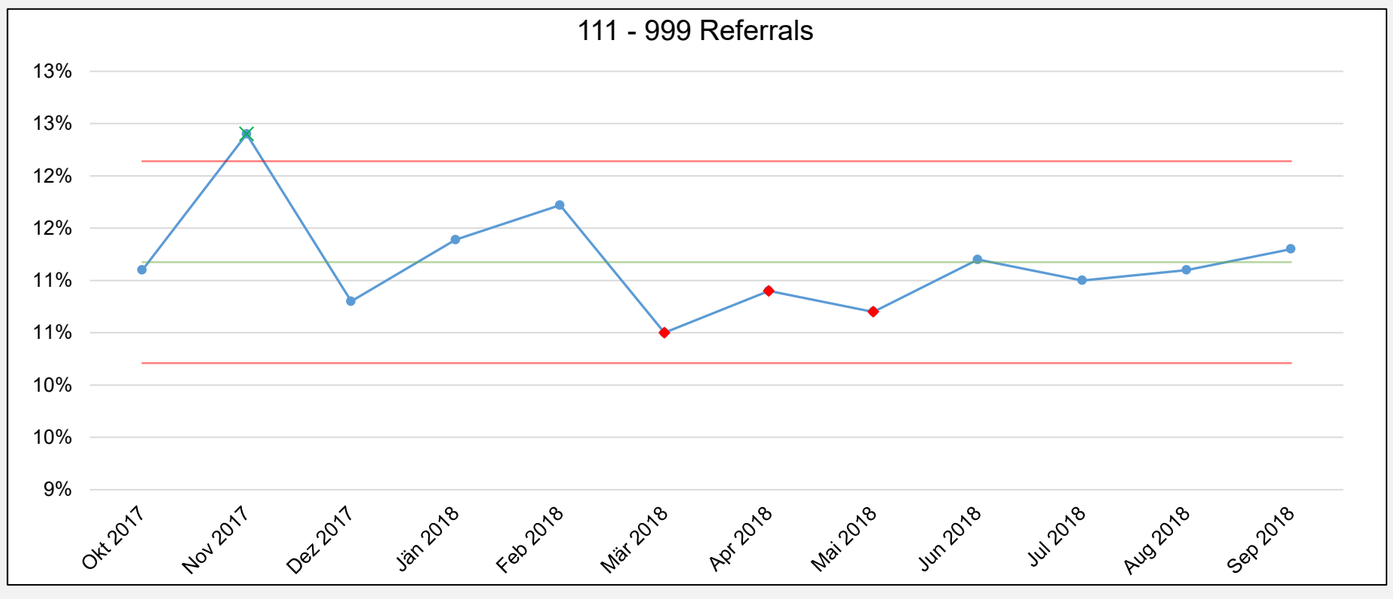
Our “Calls Answered in 60” KPI declined to 70.9%, significantly lower than the National average. The Call Abandonment rate rose to 5.98%. The Average Speed to Answer was 77 seconds.

The KMSS Senior Leadership Team are addressing the contributory factors with a series of actions summarised in the 2018-19 Service Delivery Plan.





Clinical performance continued to outperform the National benchmark in September, and rose to 63.8%. We are seeing the benefits of a substantial programme of clinician recruitment and training in the Ashford centre.

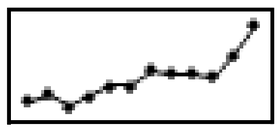
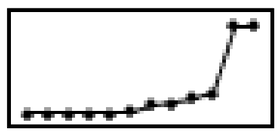
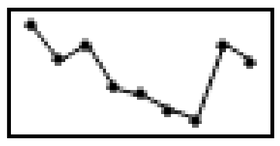


The KMSS 111 Ambulance referral rate was again significantly lower than the NHS E national 999 referral rate in September 2018. This is testament to our focus on mitigating pressure on the Ambulance Service, via Clinical Inline Support, to validate or downgrade C3 / C4 dispositions. This process supported the “No Send” policy during the 23 days of at least Purple SMP escalation by SECAmb during the month.

In addition our A&E referral rate was lower than the national monthly average, confirming our support for the wider health system.

SECAmb Workforce Scorecard

Workforce Capacity

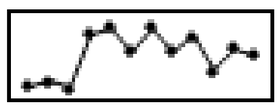
	Jul-18	Aug-18	Sep-18	12 Months
Number of Staff WTE (Excl bank & agency)	3099.0	3150.1	3215.4	
Number of Staff Headcount (Excl bank and agency)	3367	3416	3477	
Finance Establishment (WTE)	3594.89	3837.50	3837.50	
Vacancy Rate	13.78%	17.91%	16.21%	
Vacancy Rate Previous Year	12.60%	13.62%	13.90%	
Adjusted Vacancy Rate + Pipeline recruitment %	6.74%	9.89%	9.12%	

Workforce Compliance

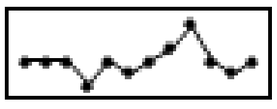
	Jul-18	Aug-18	Sep-18	12 Months
Objectives & Career Conversations %	26.54%	36.73%	38.70%	
Target (Objectives & Career Conversations)	80.00%	80.00%	80.00%	
Statutory & Mandatory Training Compliance %	58.99%	70.83%	75.50%	
Target (Stat & Mand Training)	95.0%	95.0%	95.0%	
Previous Year (Stat & Mand Training) %	47.66%	59.99%	65.46%	

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

Workforce Costs

	Jul-18	Aug-18	Sep-18	12 Months
Annual Rolling Turnover Rate %	15.37%	14.97%	14.88%	
Previous Year %	17.67%	17.51%	17.77%	
Annual Rolling Sickness Absence	5.02%	5.14%	5.10%	
Target (Annual Rolling Sickness)	5.0%	5.0%	5.0%	

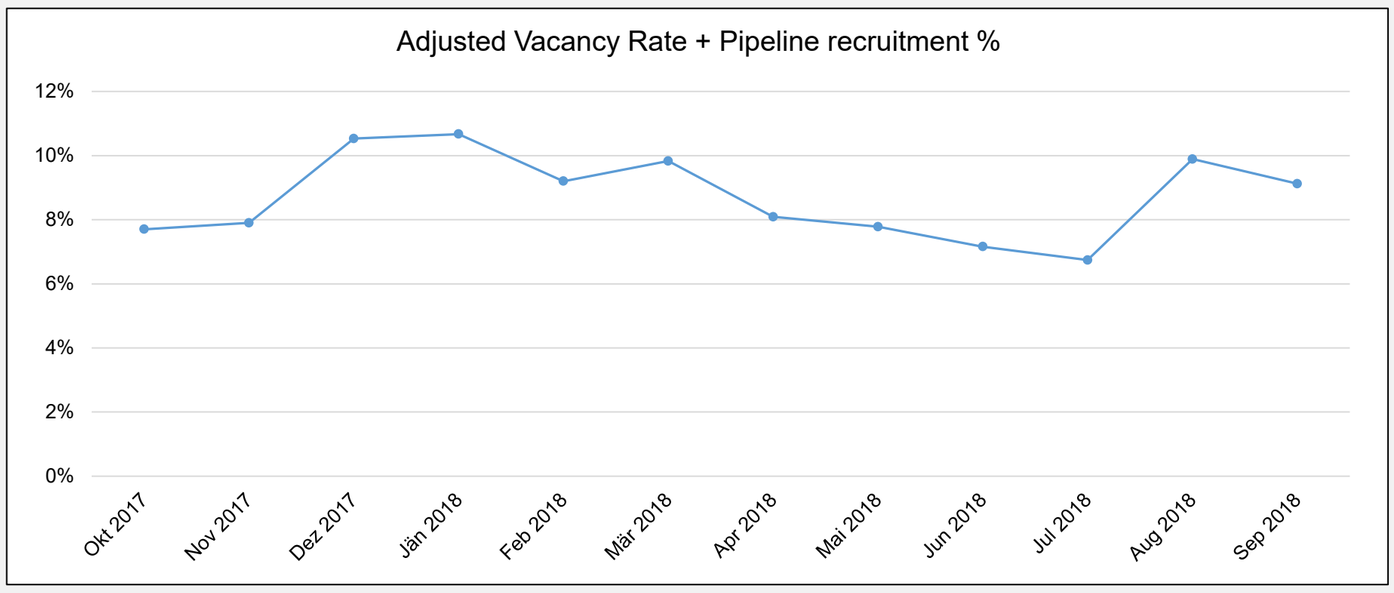
Employee Relations Cases

	Jul-18	Aug-18	Sep-18	12 Months
Disciplinary Cases	4	3	4	
Individual Grievances	2	9	6	
Collective Grievances	2	2	0	
Bullying & Harassment	2	1	2	
Bullying & Harassment Prev Yr	6	0	1	
Whistleblowing	1	0	0	
Whistleblowing Previous Year	0	1	0	

Physical Assaults (Number of victims)

	Jul-18	Aug-18	Sep-18	12 Months
Actual	21	24	9	
Previous Year	21	17	8	
Sanctions	9	3	1	

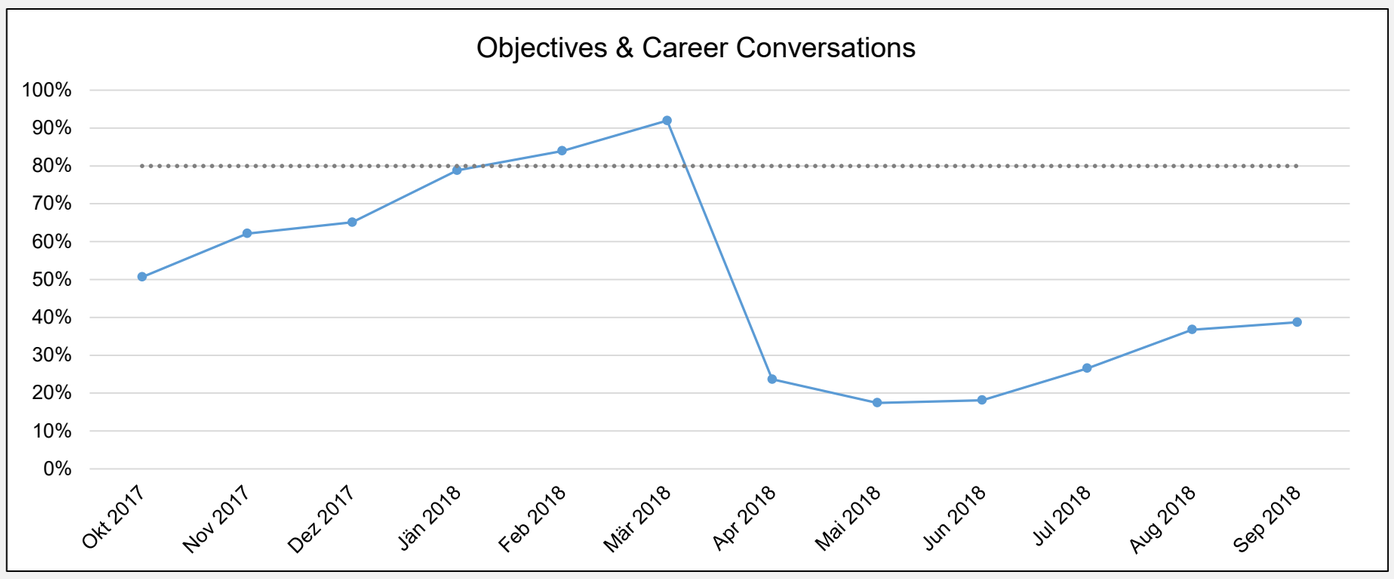
SECAmb Workforce Charts



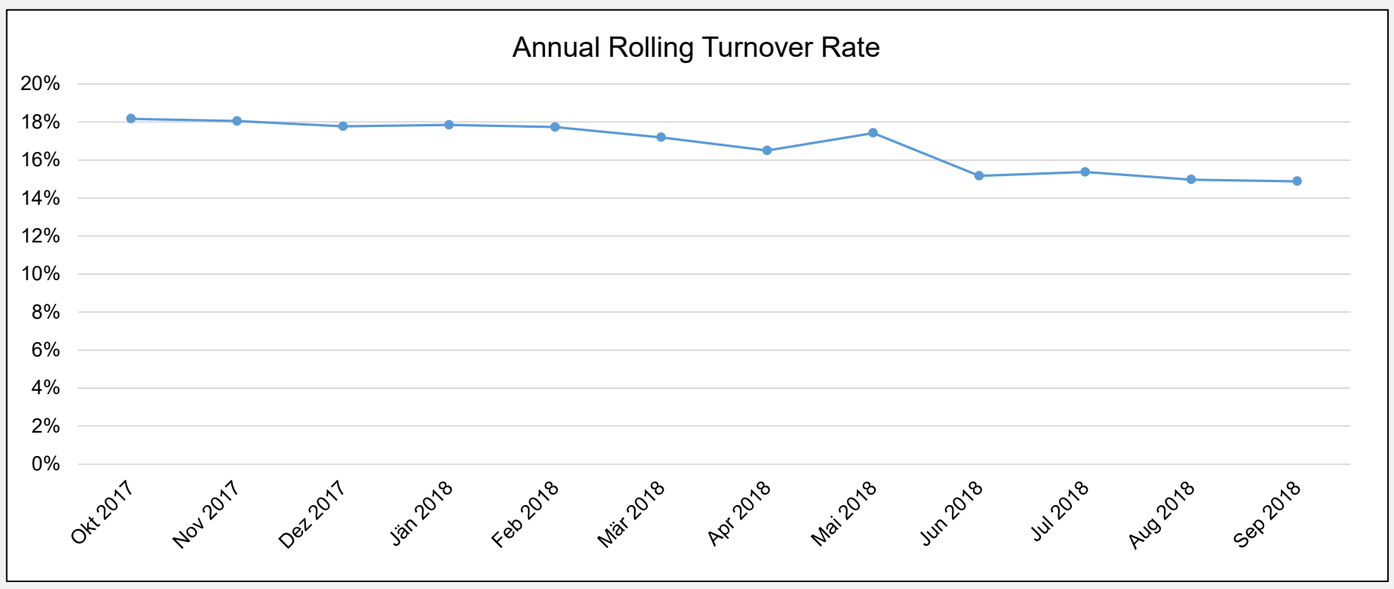
Adjusted vacancy rate & pipeline recruitment of 9.12% in September. As of 8th October we have had 174 Emergency Care Support Worker (ECSW) starters onto programmes and have 34 starters in pipeline for November. This will bring our ECSW starters up to 208.

We have candidates on a waiting list for start dates in early 2019, based on their requirement to pass C1.

We have filled Emergency Medical Advisor (EMA) requirements in the West until February 2019 and are working on the remaining course spaces for the East. Work is underway on the ARP programme to ensure a smooth transition from the 200/100 project and into ARP.



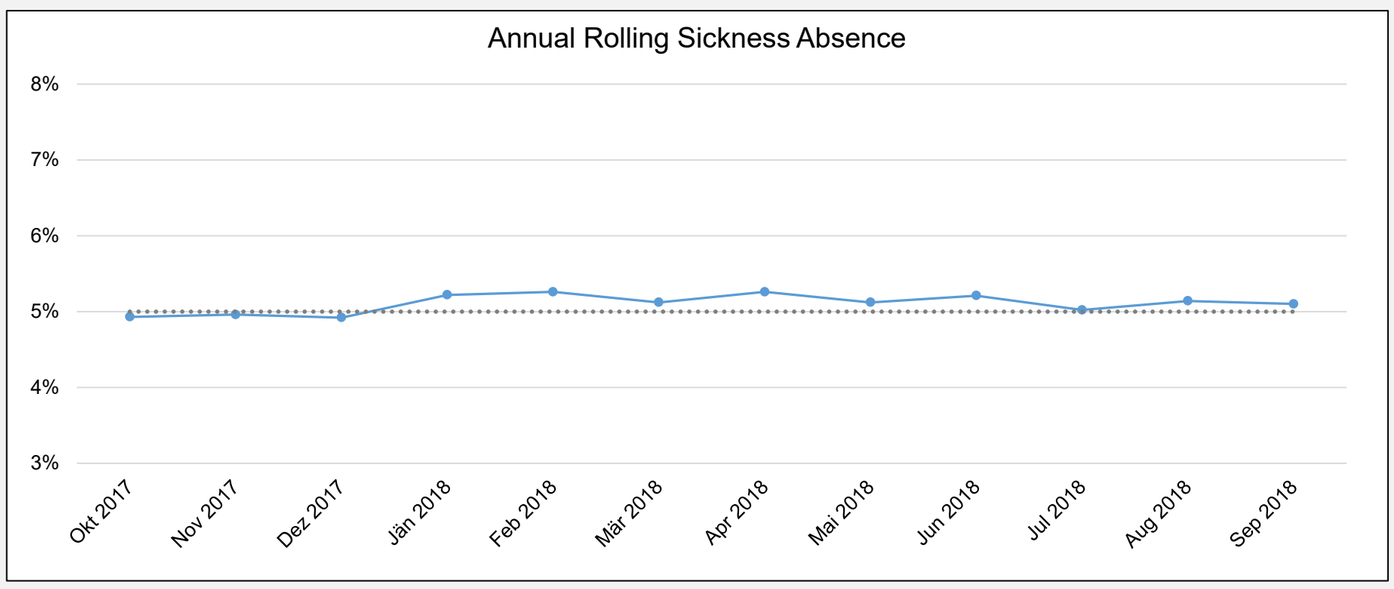
The objectives and career conversations are still steadily increasing with an increase from 26.54% to 36.73%, which is a 10.19% increase.
From September monthly reports incorporated both appraisals in progress as well as those which have been published. This is to reflect a true representation of appraisal being started.
There is a clear uncertainty of when to publish appraisals with some needing to delay publishing until nearer the end of the appraisal period.
It is predicted there will be a spike in figures of those published in the last three months running up to the close of appraisals period



For the fourth consecutive month turnover has decreased which is excellent news. Turnover now stands at 14.88% compared to 18.17% a year ago.

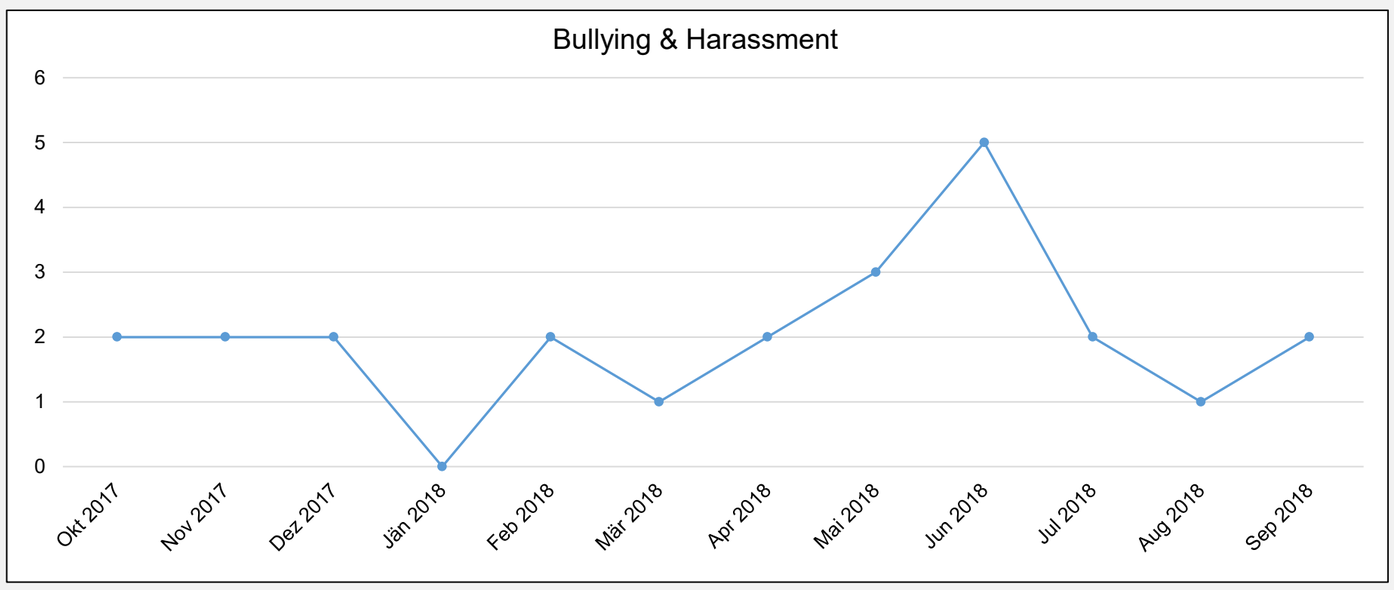
September has seen the lowest turnover of the last 12 months.

A focus on the two Emergency Operations Centres (EOC's) and 111 over the next 3-months should enable a continued downward trend in turnover. EOC East = 26.54%, EOC West = 41.75%, and 111 = 51.87% annual rolling turnover.



Sickness absence remains on or around target with Septembers figures being down slightly on the previous month. 5.10% .v. 5.14%.

Sickness Absence Management continues to be a key focus on the HR Advisors and the Line Managers they support.



There was an increase in Bullying and Harassment (B&H) cases reported in September bringing the rolling total to 24 cases.

There has been a number of very complex cases which has taken a significant amount of time to investigate, complicated by suspensions and sickness.

B&H is notoriously difficult to prove, and in the last 12 months there has been no dismissals as a result of B&H.

SECAmb Finance Performance Scorecard

Income

	Jul-18	Aug-18	Sep-18	12 Months
Actual £	£ 18,211	£18,830	£ 17,589	
Previous Year £	£ 15,778	£ 15,756	£ 16,716	
Plan £	£ 18,011	£ 17,592	£ 17,226	

Expenditure

	Jul-18	Aug-18	Sep-18	12 Months
Actual £	£ 18,122	£ 19,341	£18,402	
Previous Year £	£ 16,185	£ 16,461	£ 17,319	
Plan £	£ 17,930	£ 18,115	£ 18,055	

Capital Expenditure

	Jul-18	Aug-18	Sep-18	12 Months
Actual £	£ 237	£ 795	£ 555	
Previous Year £	£ 69	£ 225	£ 450	
Plan £	£ 661	£ 786	£ 501	
Actual Cumulative £	£ 2,267	£ 3,062	£ 3,617	
Plan Cumulative £	£ 2,633	£ 3,419	£ 3,920	

Cost Improvement Programme (CIP)

	Jul-18	Aug-18	Sep-18	12 Months
Actual £	£ 1,200	£ 517	£ 1,242	
Previous Year £	£ 1,120	£ 1,491	£ 1,330	
Plan £	£ 435	£ 435	£ 1,223	
Actual Cumulative £	£ 2,419	£ 2,936	£ 4,179	
Plan Cumulative £	£ 2,429	£ 2,864	£ 4,087	

CQUIN (Quarterly)

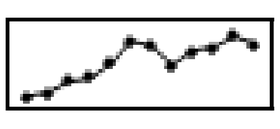
	Q1 18/19	Q2 18/19	Q3 18/19
Actual £	£ 846	£ 847	£ 283
Previous Year £	£ 952	£ 1,019	£ 716
Plan £	£ 848	£ 848	£ 283

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

Surplus/(Deficit)

	Jul-18	Aug-18	Sep-18	12 Months
Actual £	£ 89	-£ 511	-£ 813	
Actual YTD £	-£ 2,286	-£ 2,797	-£ 3,610	
Plan £	£ 81	-£ 523	-£ 829	
Plan YTD £	-£ 2,382	-£ 2,905	-£ 3,734	

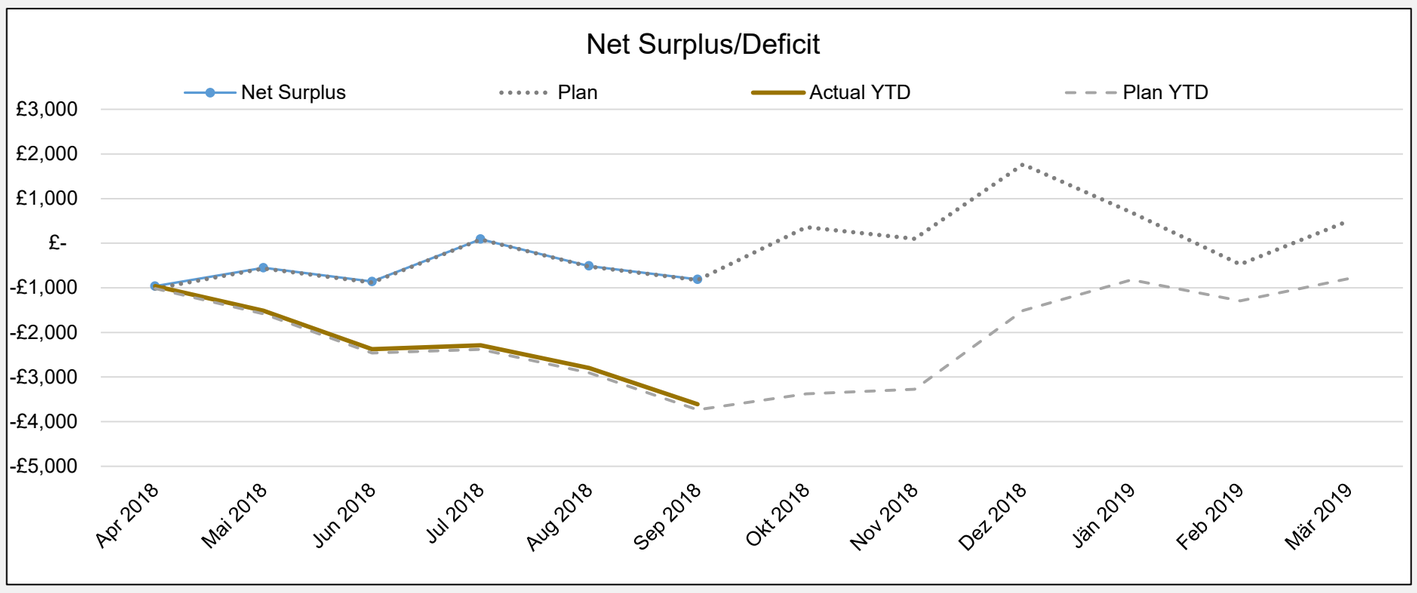
Cash Position

	Jul-18	Aug-18	Sep-18	12 Months
Actual £	£ 24,950	£ 23,042	£ 22,032	
Minimum £	£ 10,000	£ 10,000	£ 10,000	
Plan £	£ 16,893	£ 16,818	£ 14,749	

Agency Spend

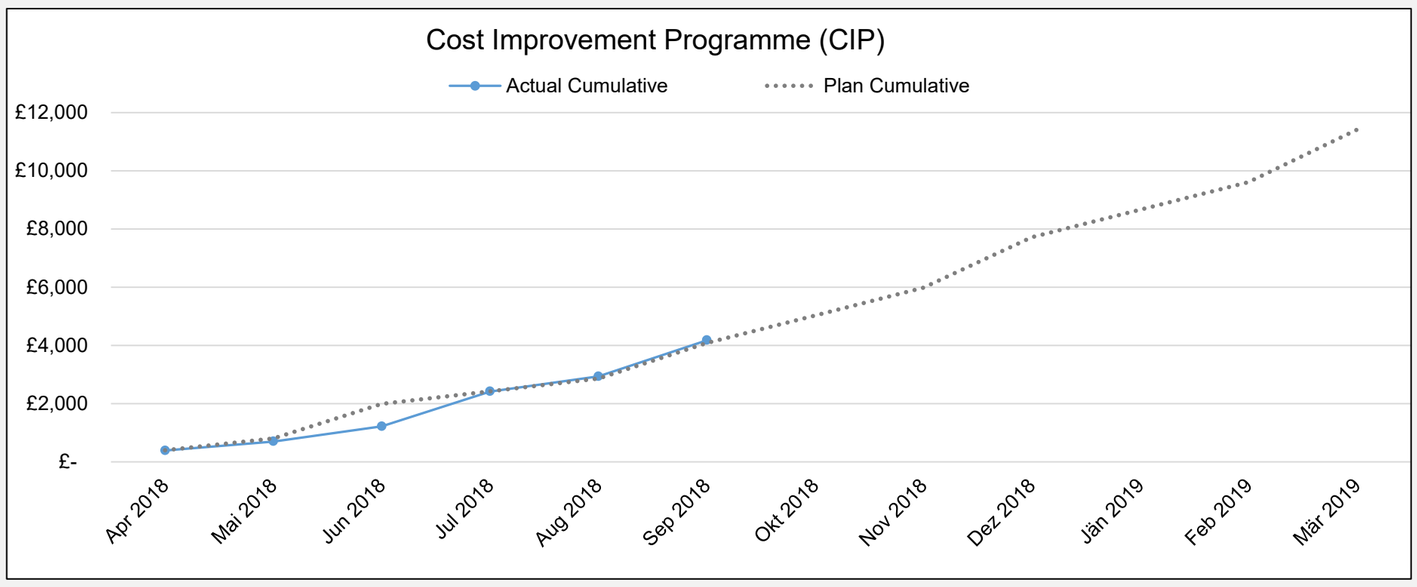
	Jul-18	Aug-18	Sep-18	12 Months
Actual £	£ 258	£ 360	£ 322	
Plan £	£ 229	£ 225	£ 222	

SECAmb Finance Performance Charts



The Trust's I&E position in Month 6 was a deficit of £0.8m, which was as planned.

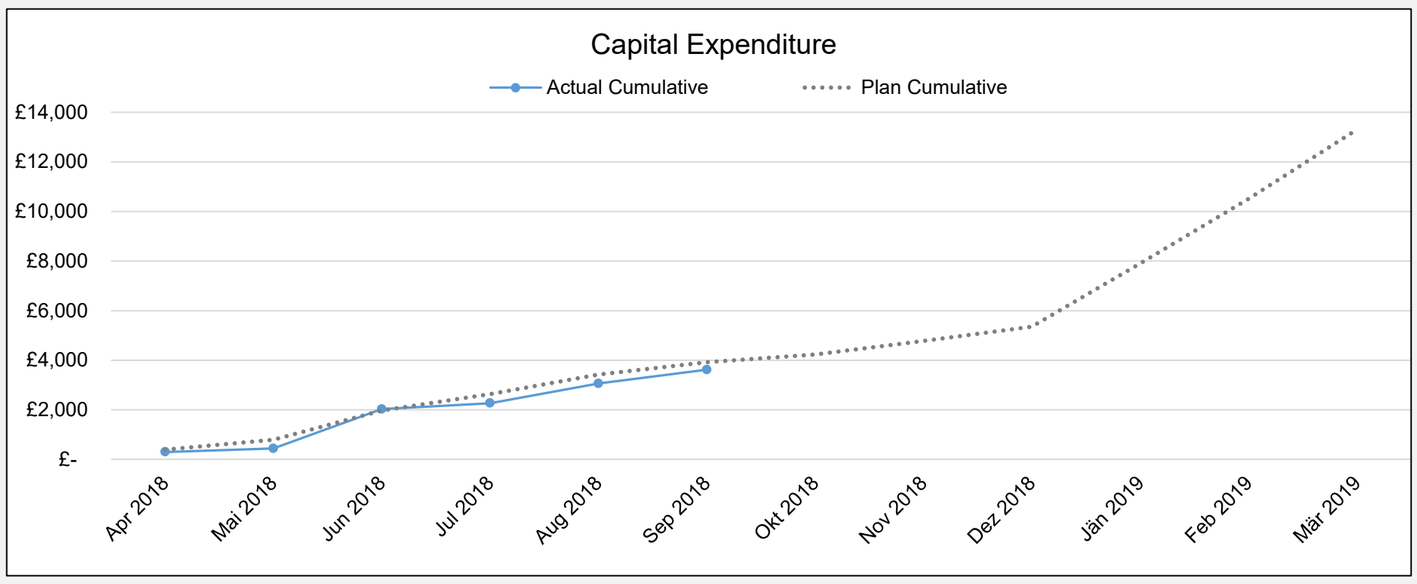
This increased the cumulative deficit to £3.6m, which is £0.1m better than plan.



Cost improvements were £1.2m in the month, as planned.

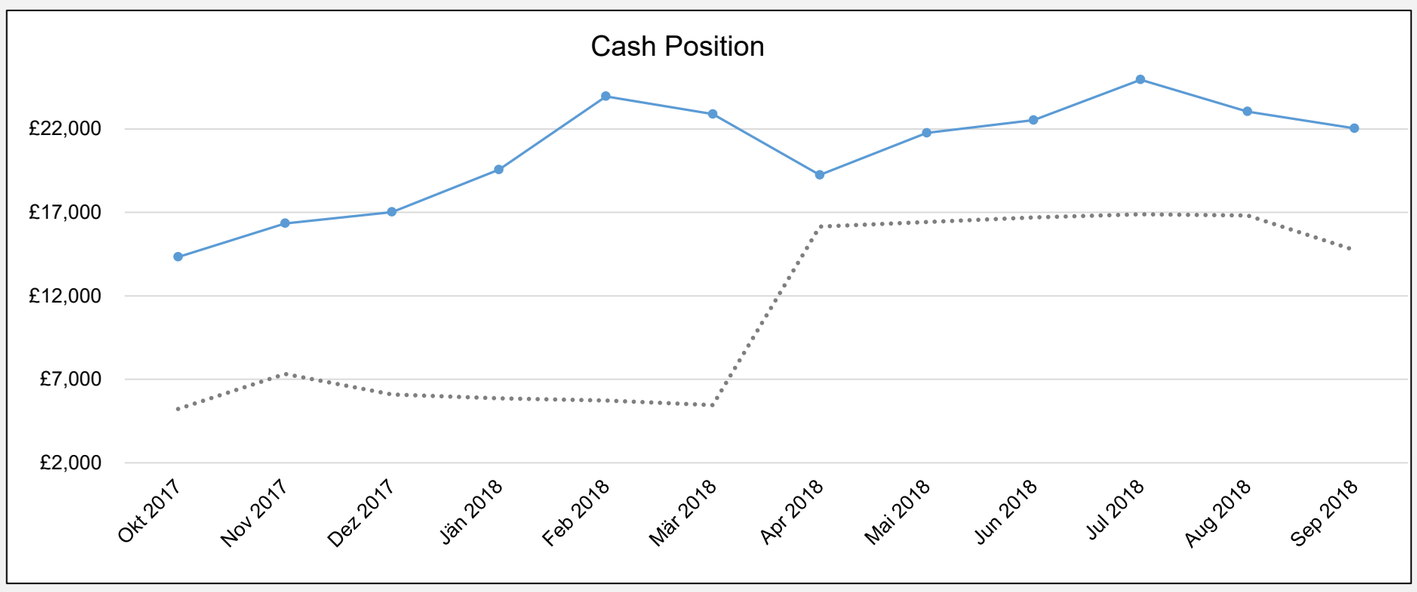
This brought year-to-date achievement to £4.1m.

It is projected that the full year target of £11.4m will be met, notwithstanding the risk associated with the balance of target that has yet to be delivered.



Capital spend in the five months was £3.6m, which is below plan by £0.3m.
The Trust is forecasting capital spend to be £12.8m against the plan of £13.3m, partly due to delays with the delivery of 43 Mercedes box chassis by 31 March, mitigated by additional schemes across estates and information technology.

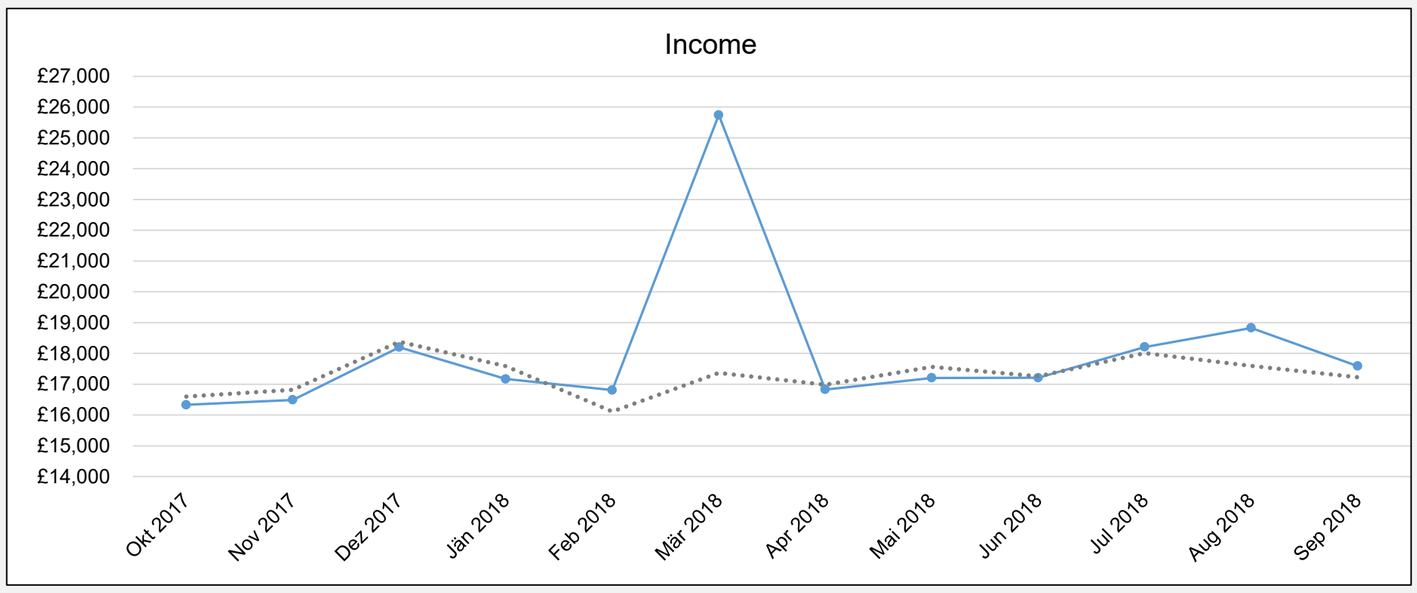
There has been no announcement to date regarding the 'Wave 4' capital bidding process, against which the Trust has submitted bids worth nearly £39.0m. The Trust's bids, comprising new and replacement ambulances, expansion of 'Make Ready' facilities and resilience in EOC, are to support improved efficiency and the delivery of ARP targets.



The cash position at 30 September fell to £22.0m, £1.0m down on the previous month-end. This is still £7.3m better than plan and only slightly below the balance at 31 March. The fall in cash was due to an expected catch up in billing by a small number of the Trust's suppliers.

In line with good practice, the Trust produces cash forecasts for a three-year period. The latest projection indicates, based on forecast capital requirements and I&E performance, that cash could fall to below £15.0m by June 2020 but this is not a cause for concern.

Performance against the 'Better Practice Payment Code' for payment of suppliers improved to 97.3% by value in the month, against a target of 95.0%.



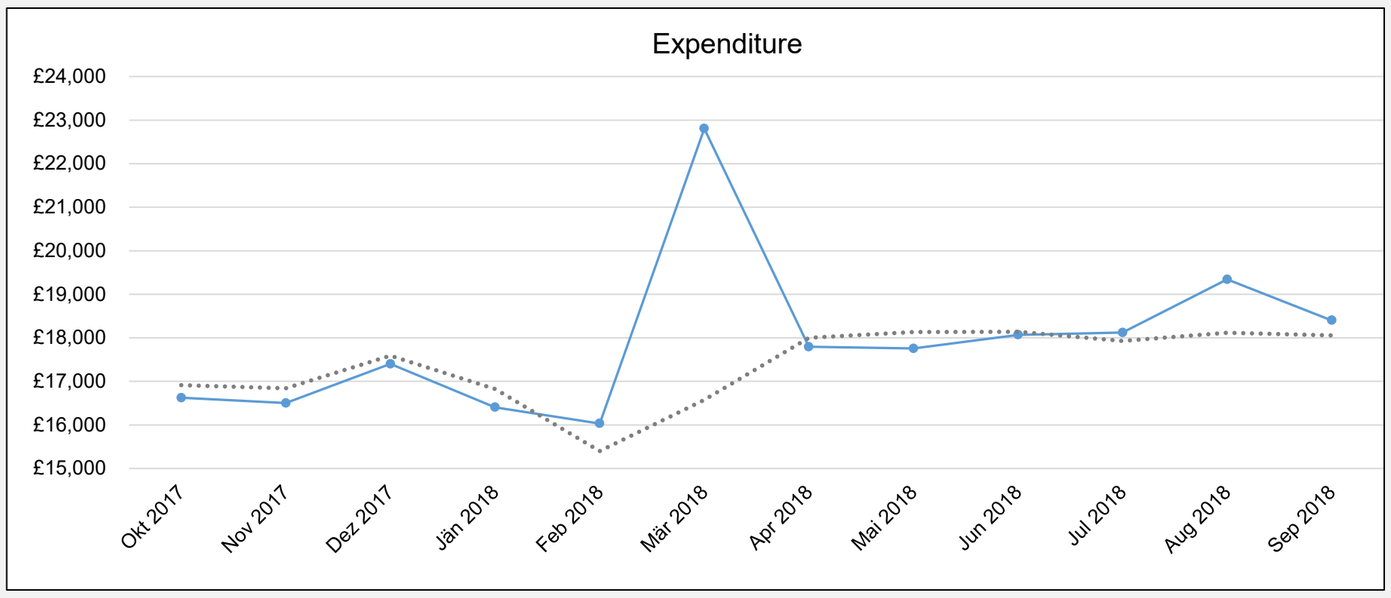
Total Income in the month was £17.6m, which was £0.4m better than plan.

There is now a favourable income variance against plan of £1.2m.

The main reason for the improvement in the month was the impact of the 111 contract variation (£0.3m) and funding for the new pay deal (£0.2m) funding additional pay costs.

The Trust has assumed full achievement of planned Provider Sustainability Fund (PSF) income in the first six months at £0.6m. The full year value is £1.8m and receipt of this funding is contingent on meeting I&E trajectories on a quarterly basis. Funding of £0.3m for quarter one has been confirmed and received.

SECAmb Finance Performance Charts



Total Expenditure exceeded plan by £0.3m in month

Cumulatively expenditure is £1.1m above plan.

Pay costs in the month were above plan by £0.1m, moving the cumulative position to a £0.5m overspend. The main reason for this is the impact of the new pay deal.

Non-pay costs were £0.2m above plan in the month, bringing cumulative costs to £0.2m overspent. The main area of overspend was in providing medical equipment for new vehicles.

Non-operating costs exceeded plan by £0.1m.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	133/18

Name of meeting	Trust Board
Date	29th November 2018
Name of paper	Trust Update on BREXIT
Responsible Executive	David Hammond – Executive Director of Finance & Corporate Services
Author	Justine Buckingham – Business Support Manager
Synopsis	A 'no deal' BREXIT scenario is one where the UK leaves the EU and becomes a third country at 11pm GMT on 29 March 2019 without a Withdrawal Agreement and framework for a future relationship in place between the UK and the EU.
Recommendations, decisions or actions sought	The Board is asked to note the present Trust position around the implications of a 'no deal' BREXIT.

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**

BREXIT SUMMARY REPORT – NOVEMBER 2018
TRUST BOARD

1. BACKGROUND

1.1 The UK triggered Article 50 of the Treaty of the European Union on 29 March 2017.

1.2 As set out under that treaty, the UK has two years to negotiate a withdrawal agreement and framework for a future relationship with the EU before the point of the UK's exit from the EU on 29 March 2019.

1.3 A 'no deal' scenario is one where the UK leaves the EU and becomes a third country at 11pm GMT on 29 March 2019 without a Withdrawal Agreement and framework for a future relationship in place between the UK and the EU.

2. GOVERNMENT PREPARATIONS

2.1 The Department of Health and Social Care (DHSC) has stepped up its planning for a 'no deal' scenario, in order to protect patient safety and general healthcare provision.

2.2 The current planning scenario will ensure that the UK has an additional six weeks supply of medicines in case imports from the EU through certain routes are affected. This remains under constant review in light of evolving developments.

2.3 The DHSC issued an instruction on 23 August 2018, advising all GP's, Hospitals and Pharmacies not to stockpile medicines.

2.4 The DHSC have advised that all Trust Business Continuity Plans should be updated in line with NHS England EPRR Core Standards.

3. RISK REGISTER

3.1 An organisational risk (587) was opened on the Trust Risk Register on 27 September 2018, with an inherent risk rating of 12 (high).

3.2 Chris Stamp, Regional Operations Manager is the Risk Lead, and the risk rests within the Operations Directorate, and is reviewed and monitored by the Workforce and Wellbeing Committee.

3.3 A SECAmb BREXIT planning group will be implemented as and when further information is cascaded by DOSC.

4. TRUST IMPACT

4.1 Directorates were asked to provide an overview of potential issues should a 'no deal' scenario occur.

4.2 ***Medicines***

The volume of medicines used within SECAmb are very small in relation to Acute Trusts, and are sourced from whoelsalers rather than direct from companies. Wholesalers have concerns that medical supplies may be disrupted at the UK Border due to new regulations that may apply to their export. This issue is high on the Government's radar, and is featured in BREXIT negotiations.

The European Medicines Agency are expediting UK licence applications to ensure certain medicines are not disrupted, and have warned their activity will slow due to their imminent relocation from London to Amsterdam.

Carol-Anne Davies-Jones, Chief Pharmacist in SECAmb, is a member of the Ambulance Pharmacist Network, the Royal Pharmaceutical Society and the General Pharmaceutical Council. As a result SECAmb is embedded in these key networks to constantly monitor BREXIT developments, and share information.

4.3 ***Procurement***

SECAmb have been advised not to stock pile consumables to avoid shortages in the current supply chain, ongoing plans are being formulated at a national level via NHS Supply Chain (NHSSC). SECAmb moved all (95%) of its consumables to NHSSC in 2016. Stores have contacted the remaining 5% of products supplied externally to seek assurance.

All SECAmb strategic suppliers for Make Ready, Cleaning, Wastes, Energy and Maintenance are not anticipating disruption to the services they supply the Trust. Most have a labour element and are not reliant on the import of goods.

Energy prices could fluctuate but this would be dependent on the value/ exchange rate of the £, however most international trade is based on the US Dollar.

The DOSC have asked SECAmb to provide a summary of all contracts deemed highly impacted, along with all mitigating activity by 30 November 2018. This exercise is currently being overseen by Paul Ranson, Head of Procurement.

4.4 ***Fleet***

Mercedes do not believe there will be an issue with the provision of vehicle parts, and as they deal in Euros presently this would limit any effect. FIAT have yet to confirm at time of writing, however presently some spares can take up to six weeks as they are shipped by container rather than flown in.

Spares coming from Europe may be subject to delay depending on the customs agreement eventually negotiated.

Wilkers are the current company who convert ambulances for the Trust, and are based in Southern Ireland. There is concern around potential regulatory borders which could impact on import delays and cost increases. Some items are provided to Ireland such as LP brackets, airwave, Terrafix etc, which could potentially be subject to a double delay and custom charges if they were exported and then imported as part of the finished conversion.

4.5 ***Finance***

There could be an increase in charges for EU companies used as a result of custom duties and also maybe subject to exchange rate fluctuations.

In addition to duties there could be import VAT imposed which would not be recoverable on imported goods to the UK.

Should property prices fall, this may have an impact on Estates the Trust may sell.

The government may (to alleviate budget deficits) enforce changes to pension contributions post BREXIT.

4.6 ***Information Technology***

Technology issues are largely dependent on the post BREXIT model.
The biggest issues would be around imports being delayed or new regulations applied. Should a BREXIT deal be reached, there will be minimal impact to IT.

Exchange of information,via the flow of data,may cause issues, as following a ‘no deal’ scenario the UK will be regarded as a third country.

4.7 ***Roads and Transport***

There may be possible pressure on the road networks particualrly if border controls at UK Ports cause commercial vehicles to stack on the motorways. This will impact particularly in Kent, and in turn could affect response times and operational performance.

4.8 ***Recruitment/Retention***

The Home Office have recently launched a toolkit to assist employers in reassuring and supporting EU citizens already resident in the UK, and their dependents, in order to apply for settled status.

The Government have announced that doctors and nurses are now exempt from the cap skilled worker visas, which means there will be no restrictions on the number of doctors and nurses who can be employed trough the Tier 2 visa route.

The Mutual Recognition of Professional Qualifications (MRPQ) is presently a reciprocal arrangement which enables European Economic Area (EEA) nationals to have their professional qualifications recognised in another EEA state other than where the qualification was obtained. In a 'no deal' situation this will no longer apply, and whilst the UK will have a means to seek recognition the arrangements will differ. Current professionals who are UK nationals holding EAA qualifications will not be affected, and their existing recognition decision will remain valid.

In a 'no deal' scenario, there are no expected financial implications or impacts for citizens or businesses operating in the UK (whether UK or EU-based) in regard to workplace rights.

5. NEXT STEPS

5.1 A SECAmb Resilience Forum are meeting monthly to monitor the risks of a 'no deal' BREXIT.

5.2 Arrangements are underway to capture the BREXIT risk assessment within the Trust Strategy.

5.3 County Contingency Meetings are planned, and the Trust is aligned through the SECAmb Business Continuity Team.

5.4 A further update letter from the Secretary of State for Health and Social Care is expected to be released to Trusts imminently.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	134/18

Name of meeting	Trust Board
Date	29th November 2018
Name of paper	Emergency Preparedness Resilience and Response (EPRR) Annual Assurance 2018-19 Report
Responsible Executive	Joe Garcia, Executive Director of Operations
Author	Anne Harvey, Senior Contingency Planning & Resilience Manager
Synopsis	The Emergency Preparedness Resilience and Response (EPRR) Annual Assurance 2018-19 Report provides an overview on the Trust's EPRR requirements, activities and updates on the outcome of the NHS England (NHSE) EPRR Annual Assurance 2018-19 review.
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.

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

Emergency Preparedness Resilience and Response Annual Assurance 2018-19

Introduction

This report provides a briefing on the Trust's Emergency Preparedness, Resilience & Response (EPRR) requirements and capabilities, and updates on the outcome of the NHS England (NHSE) EPRR Annual Assurance 2018-19.

The Civil Contingencies Act 2004 (CCA) requires all NHS organisations and providers of NHS-funded care to demonstrate that they can effectively respond to such incidents whilst maintaining core services.

NHSE maintains an EPRR Framework, which places similar duties to the above on all NHS-funded organisations. Under the EPRR arrangements, the Trust which is also designated a Category 1 Responder under the CCA, is required to undertake an annual self-assessment process in order to determine the level of compliance of resilience arrangements against the NHSE EPRR core standards.

NHSE South (South East) manages this process with assistance from Surrey Heartlands CCG (lead commissioners).

EPRR Core Standards

The NHSE Core Standards for EPRR are split into ten domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Co-operation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN).[1]

Interoperable Capabilities

NHS Ambulance Trusts are required to assure themselves against an additional domain - 'interoperable capabilities' - which include:

- Hazardous Area Response Teams (HART)
- Marauding Terrorist Firearms Attack (MTFA)
- Chemical Biological Radiological Nuclear (CBRN)
- Mass Casualty Vehicles (MCV)
- Command and Control (C2)

[1] For Ambulance Trusts CBRN is reported within the Interoperable Capabilities domain

- Implementation of the Joint Emergency Services Interoperability Principles (JESIP)

In addition to the core standards, a 'deep dive' into Command & Control is included in the assurance process; however, the outcome of the deep dive is not included in the overall compliance ratings.

The Resilience & Specialist Operations Management Team has comprehensively assessed the Trust resilience arrangements against the EPRR core standards and rated the Trust's compliance for each standard against the following criteria.

Compliance level	Definition
Not compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.
Partially compliant	Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.
Fully compliant	Fully compliant with core standard.

The Trust is required to report two assurance ratings and demonstrate compliance to:

1. Core Standards for EPRR
2. Interoperable Capabilities.

The overall assurance rating is based on the percentage of Core Standards that the organisation has assessed itself as being "fully compliant" with.

Core Standards for EPRR

The outcome of this self-assessment demonstrates that against the 49 core standards that are applicable to the Trust, the Trust is;

- Fully compliant with 42 of the core standards
- Partially compliant with five of the core standards
- Non-compliant with one core standard.

This represents a compliance figure of 85.71% and therefore an overall rating of **"Partially Compliant".**

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	13	13	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	5	4	1	0
Warning and informing	3	3	0	0
Cooperation	5	4	0	0
Business Continuity	9	5	3	1
CBRN	0	0	0	0
Total	49	42	5	1

Interoperable Capabilities

The outcome of this self-assessment demonstrates that against the 163 interoperable capabilities standards, the Trust is;

- Fully compliant with 144 of the standards
- Partially compliant with 19 of the standards.

This represents a compliance figure of 88.34% and therefore an overall rating of **"Partially Complaint".**

Interoperable capabilities	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
MTFA	28	26	2	0
HART	33	29	4	0
CBRN	32	31	1	0
MassCas	11	11	0	0
C2	36	27	9	0
JESIP	23	20	3	0
Total	163	144	19	0

Deep Dive Command and Control[2]

The outcome of this self-assessment demonstrates that against the eight command and control standards the Trust is;

- Fully Compliant with these standards.

[2] The outcome of the deep dive is not included in the overall compliance ratings.

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Incident Coordination Centres	4	4	0	0
Command structures	4	4	0	0
Total	8	8	0	0

An EPRR Assurance review meeting took place on 29th August 2018 and, on assessment of the evidence presented, the CCG considers the Trust's overall position to be "**Partially Compliant"** with this year's NHS England EPRR core standards.

NHS England define partial compliance as:

"*The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months."*

An action plan has been generated automatically by the self-assessment spreadsheet to record those standards that are not fully compliant. This will be used by the Commissioners and the NHSE EPRR lead to monitor progress towards full alignment and compliance.

Progress since 2017/18

Since the EPRR Assurance and NARU Inspection in August 2017, a huge amount of work has been undertaken to improve the overall EPRR Compliance against the Core Standards.

- **NARU Project**

In response to the outcome of 2017 EPRR Assurance and Capability Review by NHSE and the National Ambulance Resilience Unit (NARU), the NARU project was established to address areas of partial and non-compliance which was managed by the Programme Management Office (PMO).

Progress against the action plan was reviewed bi-weekly through the NARU project group, which then reported into the Service Transformation and Delivery Steering Group.

Significant progress has been made against the agreed objectives, with the NARU Project being formally closed at the beginning of November 2018.

Any residual outstanding actions have been transferred to the EPRR Action Plan 2018-19 and will be managed through the Trust's Resilience Forum.

- **Training & Exercising**

Over the past year, the Trust has delivered an extensive training programme to bring us in line with EPRR core standards.

Command Training has been prioritised throughout the year with a number of Tactical and Operational Commander courses delivered in-house and through NARU. This has resulted in the Trust having 97% of Operational Commanders and 98% of Tactical Commanders trained to national occupational standards.

Within the key skills programme elements of resilience and emergency planning were included to ensure operational staff continue to develop their understanding of Major Incident and Specialist Operations.

Other areas of EPRR training includes;

- The provision of Loggist training to increase the Trust Loggist capability
- Business Continuity training to a number of staff.

Furthermore, an EPRR training programme will be in place for 2019 to build on this position.

As part of the resilience community, the Trust has continued to participate fully in multi-agency exercises throughout the region. This links into national and local risk assessments where plans and arrangements are tested and exercised.

A small example of exercises we have participated in include;

- Gatwick Airport
- Exercise Comet (Surrey LRF)
- Exercise Shakespeare (Bluewater shopping centre)
- Exercise Dolphin (Newhaven docks)
- and a number of NHSE/Public Health England led exercises.

The Trust is already committed to a number of exercises in the coming months, with an exercise schedule to be in place for 2019 to ensure our continued engagement.

Work Plan following 2018 EPRR Assurance

The EPRR 2018/19 action plan is to be developed to include the outstanding NARU actions and a work plan will be put in place to address the areas of partial and non-compliance.

This will be managed through the Trust Resilience Forum, which reports to the Resilience Executive Committee. In addition, the lead CCG will review progress on a monthly basis at the contract review meeting around the compliance position going forward.

Recommendation

The Board are asked to receive assurance and note the improvements made to raise the Trust's level of compliance against the NHS England 'Core Standards for EPRR', with a view to the Trust working towards full compliance in 2019.

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Agenda No	135/18
Name of meeting	Trust Board		
Date	29th November 2018		
Name of paper	Trust Update on Carter		
Responsible Executive	David Hammond – Executive Director of Finance & Corporate Services		
Author	Justine Buckingham – Business Support Manager		
Synopsis	Following the formal publication of the Lord Carter review into Ambulance Services in September 2018. This report details the progress and activity to date.		
Recommendations, decisions or actions sought	The Board is asked to note progress to date.		
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**	

LORD CARTER - SUMMARY REPORT – NOVEMBER 2018
TRUST BOARD

1. BACKGROUND

1.1 Lord Carter's 2018 review into NHS ambulance trusts identified unwarranted variation in the delivery of ambulance services, as well as the potential savings of £500 million that could be made in efficiencies by 2020/21.

1.2 It identified 9 recommendations that the NHS England and NHS Improvement Joint Ambulance Improvement Programme (JAIP) is responsible for delivering.

2. SUMMARY OF PROGRESS

2.1 A working group has reviewed 9 recommendations detailing 28 separate deliverables and have assigned a BSM (Business Support Manager) for each Directorate.

2.2 A meeting has been arranged to go through work sheet in detail and assign owners and dates for competition of the deliverables. Initial review suggests it is apparent that some of the work has been completed as part of the Service Transformation Delivery which will be updated to the JAIP tracker sheet.

2.3 A separate exercise to link actions and deliverables to the Trust CIP process will monitor and align all financial benefits.

2.4 The governance process is to report through the EMB (first report for EMB on 12/12/18) and then formally to Board.

Justine Buckingham
Business Support Manager
Finance & Corporate Services Directorate

SECAMB Board

Summary of the Extraordinary Finance and Investment Committee (FIC) Meeting of 22nd November 2018

Date of meeting	**22 November 2018**
Overview of issues/areas covered at the meeting:	The key areas covered in this additional meeting related to Financial Performance and Business Cases for approval. Too many Papers were submitted late to this meeting. The executive was asked to review with the Chair the number, timing and format of FIC meetings to ensure that the FIC can best support the Trust whilst providing appropriate scrutiny and challenge on behalf of the full Board. The committee advised the executive that there were significant opportunities to improve the quality of papers in some cases.
Business Cases	Whilst FIC is prepared to consider urgent one-off businesses case on an exceptional basis, the committee re-iterated its expectation that future business cases would normally be expected to consider their impact on post longer term financial projections. Currently FIC has no formal approval powers, so the word "approval" below should be understood to mean "FIC recommends to the full Board that the project be approved" • HART team leader re-banding. This was approved; however, FIC suggested that future proposals of this nature might better considered at WWC • Fleet Strategy. The paper was withdrawn. FIC offered the executive advice on how best to take it forward. The Committee was again grateful to Al Rymer for offering to be the non-executive lead on Fleet matters • HR Transformation. Once assured that the content of the program was supported by WWC, this was approved • IT Re-Structure. This was approved The Executive advised that proposals in respect of Executive and/or Board Committee authorisation powers would be brought forward soon. FIC advised that as part of that review the Executive should consider guidance / rules set for financial analysis to ensure that costs and benefits are included in the analysis with an over-riding principle that financial analysis should be economically robust.

Financial Performance	A brief PowerPoint summary and interpretation of month 7 /year to date financial was included in the papers for this meeting. Whilst the committee ran out of time to discuss performance, the committee re-iterated that meeting dates should be reviewed to ensure that FIC has the opportunity to consider/review/challenge both an interpretative summary and a full finance pack at each ordinary meeting.
Financial Planning	The committee ran out of time to consider this paper but offered guidance that Planning for this year should • Meet NHS standards / guidance • Should extend 3 to 5 years to incorporate the Service Transformation program • Should place less focus on CIPS for the next year in the context of the Efforts that will be required to deliver the Service Transformation program and the substantial efficiency benefits expected therefrom.
Control Total Incentivisation	The committee supported the proposal that SECAMB join the NHSI Control Total Incentivisation scheme for 2018/19.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	137-18

Name of meeting	Trust Board
Date	29 November 2018
Name of paper	Sussex and East Surrey STP
Responsible Executive	Steve Emerton, Director of Strategy and Business Development
Synopsis	This overview is provided by SES STP for partner provider Trust Boards/ CCG Governing Bodies to outline the recent revisions to its governance arrangements and commitment to collaborative system leadership via the newly introduced Compact.
Recommendations, decisions or actions sought	To note and discuss

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**

Sussex and East Surrey STP 2018/19 approach to partnership working and governance support

1. **Background**

   National guidance '*Next Steps on the NHS Five Year Forward View*' published in 2017 highlighted the need to strengthen Sustainability and Transformation Partnerships (STPs), their leadership and infrastructure. The guidance described the formation of 'Sustainability and Transformation Partnerships'. These are not new statutory bodies and hence supplement rather than replace the accountabilities of individual organisations.

   The guidance recognised that growing financial problems in different parts of the NHS cannot be addressed in isolation. Instead providers and commissioners are required to come together to manage the collective resources available for services for their local population.

   National guidance outlined that to succeed all STPs needed a basic governance and implementation 'support chassis' to enable effective partnership working. In 2017/8, the STP commissioned Carnell Farrar to undertake a governance 'review and refresh' exercise which set out the objectives and architecture of the STP governance arrangements. These arrangements, as with all good governance, were evolutionary to ensure optimum support to the progress of the STP.

   Bob Alexander was appointed as the Sussex and East Surrey Sustainability and Transformation Partnership (SES STP) Executive Chair in November 2017; to oversee development and delivery of STP strategic vision and priorities. This provided a timely opportunity to test that the governance arrangements were fit for purpose in line with the STP progression and maturity. The scope focused on SES STP Executive Group, Programme Board and Oversight Group.

2. **The importance of partnership working and good governance**

   Since STPs do not change the statutory responsibilities of individual organisations they raise important questions for how governance and partnership working will be managed and progressed to support collective decision-making.

   Where STPs are beginning to work well, common factors include improved relationships, dedication to system leadership and transparency, commitment at all levels, a focus on place, a clearly articulated story, and evolutionary governance structures.

   Effective governance should drive STP implementation and ensure the best possible decisions are made; working in the best interests of patients and public. Effective partnership working alongside good governance should help to form closer working relationships and identify areas where priorities and incentives can be aligned and duplication avoided. This will mean a cultural shift from maintaining individual power bases to a more collaborative way of working that supports joint decision-making

3. **SES STP Governance requirements**

   Two broad requirements were established for the focus of future SES STP governance arrangements:

i. **Authority and decision making; clear, agreed and accepted** – to achieve consistent collaboration and partnership working from across the SES STP footprint:
   - Accountability
   - Inclusivity
   - Transparency

ii. **Empowered transition from discussion to delivery forum** – to develop a clear line of sight for effective implementation of plans and set the system standard for continued collaboration and expectations:
   - Role and Responsibilities
   - Engagement
   - Leadership and behaviours

Outputs from desk-based research, interviews with SES partners and other STPs, and a governance survey conducted throughout January and February 2018 suggested an overall consensus that:

- Existing governance arrangements were no longer fit for purpose to support effective collaboration and decision making
- Forum inclusivity was not consistent and this was hindering transparency and collaboration
- Authority and accountability lines were not supported by the existing arrangements
- Duplication of information across multiple forums was common place and was not conducive to progress
- Reporting and monitoring mechanism needed to be strengthened
- An agreed system change in culture and behaviours was needed to further the commitment to joint/collaborative working across the STP footprint.

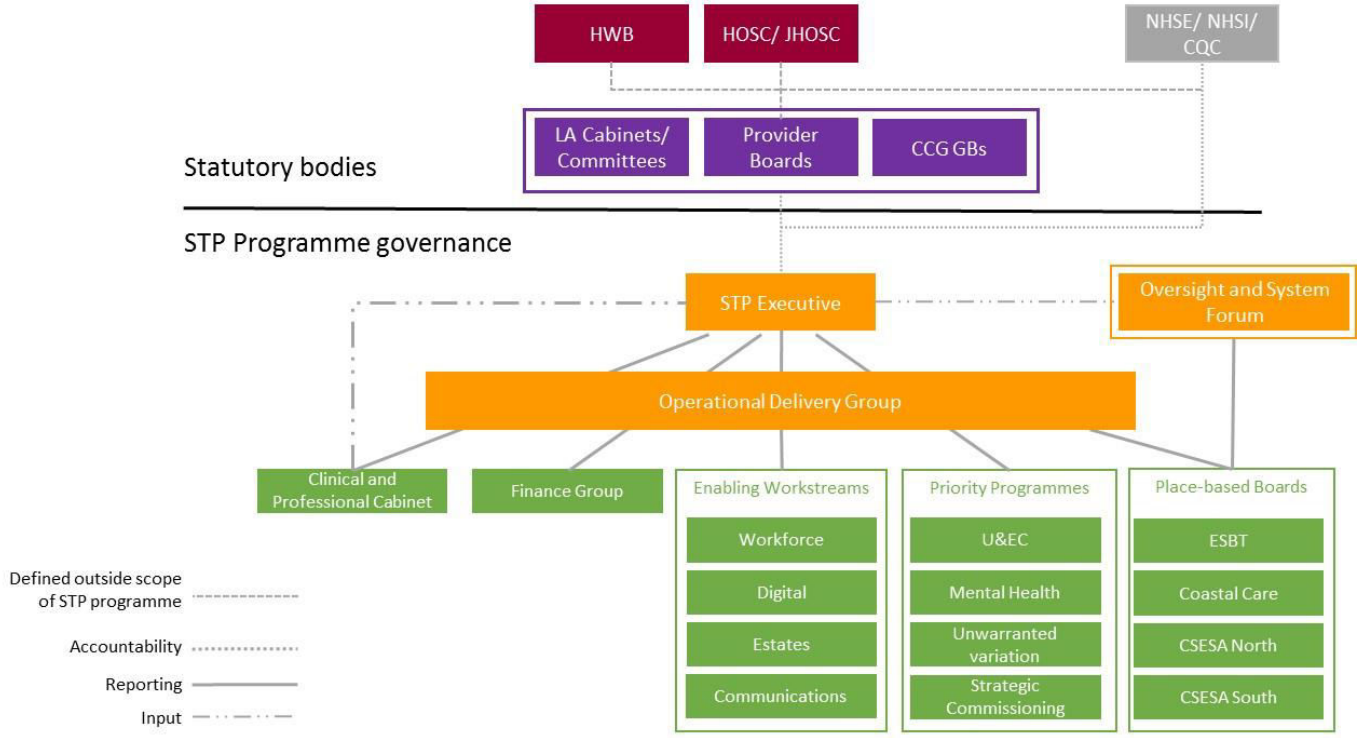
In agreement with the SES STP Executive Group and STP Programme Board and scrutiny from the STP Oversight Group the following were agreed as the principles to guide the next evolution of STP governance:

- Support effective collaboration and trust between SES STP health and social care organisations to work together to deliver the transformation
- Clearly define and embed the roles and responsibilities of the leadership
- Provide a robust yet agile framework that facilitates more effective strategic decision-making, including identification of priorities at system, place or local level
- Clarify decision-making authority and accountability, aligned with individual organisations
- Provide assurance around progress and delivery of both the STP programme and place-based plans
- Clarify the reporting and monitoring mechanisms
- Allow for transparent communication between partners and stakeholders
- Make the most of the scarce and limited resources available

4. Refined governance arrangements

In response, refined governance arrangements have been designed, developed and accepted by the current STP Executive, STP Programme Board and STP Oversight Group as the way forward for governance to support the required onward strategic oversight and delivery of SES STP priorities. It was agreed by all parties and forums that the refined arrangement should take effect immediately to ensure optimal support of STP progression throughout 2018/19.

Figure 4.1 Refined SES STP governance structure



The main revisions to the meeting structures are set out below:

STP Executive	• SES STP strategic decision making forum [previously Programme Board] • Accountability for collective strategy and delivery of SES STP [previously Programme Board] • Inclusive STP partner membership [focused on CEO/AO role across NHS] with Clinical representation secured • Take decisions on behalf of respective organisations and steer recommended decisions through respective statutory boards • Set and manage STP resource • Monthly [previously fortnightly]
Operational Delivery Group	• NEW group • Drives operational delivery and operational decision making [previously intertwined with Executive Group agenda] • Operational/strategic leads from place-based, programmes and enabling workstreams coming together on a regular basis • Monthly
Oversight and System Forum	A meeting of two parts [merging STP Oversight and STP Programme Board]: Oversight: • Focus on place-based plan development and delivery • Utilise existing place-based chairs' forums to inform group discussion • Membership as per existing with inclusion of HWB Chairs [previously Councils Leaders] • Quarterly [previously bi-monthly] System: • Unitary approach to membership: chairs, CEO/AOs and wider system partners/ stakeholders including HWB and Adult and Social Services • Early engagement and involvement in the determination of key elements of the STP – targeted agenda with specific topic/s • Quarterly [previously every six weeks]

5. Principles of the refined governance arrangements

The direction of travel through to final recommendations of the refined governance arrangements has been taken through and accepted by the Executive Group, Oversight Group and Programme Board throughout February to May 2018. SES STP partners have been kept up to date and feedback incorporated.

Subsequently, in July the Local Authorities confirmed the absolute commitment of all four councils to work with the STP to improve health and social care outcomes for our residents and the two core principles this is based on: place based working and effective partnership and good governance and stand ready to participate once the NHS partnership is ready to do so.

The following proposed principles are a direct result of input from SES STP partners as part of the governance review.

System culture and behaviours

- A need for a change in culture and approach to collaborative working
- Some existing behaviours will need to change to allow the governance structure to work effectively
- A common set of commitments identifying the necessary culture and the best ways of working together is required to ensure collective agreement and support for improved delivery of STP priorities throughout 2018/19 and beyond

Inclusivity

- SES STP partner CEOs represented at the STP Executive
- Chairs forum with added value gained from scrutiny of place-based focus and sharing of information
- Wider partners and other stakeholders to support early development/ feedback of STP priorities via the STP Oversight and System Forum

Collective authority

- Organisational leaders take decisions within their delegated powers and bring to bear the authority of their organisational positions
- Inclusivity of meetings facilitates consistent engagement of key leaders with delegation of attendance by exception only

Effective decision-making

- An inclusive STP Executive that is responsible for the strategic development and oversight of the STP
- The relationship with statutory and regulatory bodies, and the associated decision-making processes are clear and consistently applied across all partners
- Formal decision-making rests with statutory organisations, which own and drive the work through their leaders' participation in all elements of the partnership

Clinical leadership

- Clinical and Professional Cabinet is central to the continued development of the programme – securing the right membership and representation is key
- Clinical support and progress to be aligned to a clearly articulated and agreed SES STP Case for Change
- System clinical leaders take on a leadership role via the STP Executive

Efficient processes in place

- Simplified governance structure that reduces duplication and repetition of reporting
- Consistent reporting arrangements introduced to provide routine updates and aid management of the delivery of STP priorities
- Consistent and clear approach to communication and engagement [to come through the revised Communications Workstream]

6. SES STP Compact

In May 2018, the STP Executive agreed a STP Compact to strengthen system leadership and collaborative partnership working. A copy of the Compact is attached at **Appendix A**.

The Compact is designed to clearly articulate the agreed spirit of collaborative partnership working and sets out subscription to a set of commitments to each other as the executive leadership of the STP. This will need to be mirrored throughout the workings of the STP and not just sit at executive level.

The need to safeguard the autonomy of individual organisations is clearly noted alongside the need to commit to effective partnership collaboration and trust; to deliver the aspirations of the STP.

It is acknowledged that much like the evolution of the governance arrangements to remain fit for purpose, so the progress and success of the Compact will be a developmental journey for all STP partners.

7. Conclusion

Following STP Executive, Oversight Group and Programme Board agreement, the refined governance arrangements have been adopted and commenced in May 2018.

The STP Executive has agreed the SES STP Compact. The implementation of the principles and commitments will be work in progress throughout the course of the foreseeable future.

The refined STP governance arrangements and the adoption and implementation of an SES STP Compact are positive developments that aim to compliment the accountability of individual organisations.

Due to the changing nature and dynamics of STP development, however, it is acknowledged these governance arrangements and Compact will be reviewed at appropriate intervals to ensure they remain fit for purpose.

8. Recommendation

The paper seeks SES STP partner statutory Board endorsement of:

- the introduction of a SES STP Compact to support the initiation of a cultural shift in the current approach to system leadership and collaborative working and,
- the refined governance arrangements to support the strategic leadership and operational development of the STP.

APPENDIX A Sussex and East Surrey STP Compact

Ambition

We will radically change the way we work so we successfully address the challenges we face. We will work collectively and collaboratively to transform and integrate services to meet the changing needs of all of the people who live in our area and:

- Offer people better care and better outcomes and make more use of the resources available to us.
- Improve population health and wellbeing by working together as an STP footprint.
- Tangibly progress towards delivering *Next Steps on the Five Year Forward View* especially: redesign of UEC system, better access to primary care, improved mental health and cancer services.
- Where care is more specialised, this care will be provided through acute clinical networks to ensure that we provide the highest quality care that meets the needs of our patients.
- Facilitate the four place-based integrated care systems to go as fast as they can, recognising different starting points; to better meet people's needs within the funding we have available.

Compact commitments

In the spirit of collaborative partnership working, we subscribe to a common set of principles.

We aspire to fulfil these principles through this explicit compact which, sets out our commitments to each other as the executive leadership of the STP.

We pledge to be open to respectful and constructive feedback about how well we do in this regard.

We commit to effective partnership collaboration and trust to work together to deliver the aspirations of the STP, while safeguarding the autonomy of organisations.

We accept that this is a developmental journey for all of us.

STP COMMITTMENT	INDIVIDUAL PARTNER COMMITMENT
As an STP collective we will…..	**As a partner of the STP I will…..**
Create the Right Environment	***Create the Right Environment***
➢ Behaviours should facilitate stronger collective leadership. ➢ Behave in a positive, respectful and consistent way at all levels of interaction with partners. ➢ Be open and transparent, actively contributing at the Executive Group.	➢ Act in a way which is respectful, open and transparent with a *no surprises* approach. ➢ Maintain integrity of positive partnership working. ➢ Show empathy with partner issues. ➢ Work with own statutory board to

➢ Provide a fair and balanced critique of issues raised that are in the interest of the population serviced and do not totally destabilise one partner. ➢ Provide visible leadership to foster consensus and communicate the shared ambition. ➢ Be candid in offering constructive criticism and receptive in receiving it - always assuming good intent	facilitate collaboration and cooperation in the interest of the population served. ➢ Engage with and act as an ambassador to the wider system partners so they have an understanding of the vision and process of the STP.
Foster Excellence & Transformation	***Foster Excellence & Transformation***
➢ Deal with those issues which are best considered on a pan-STP basis. ➢ Ensure clinical leadership and engagement is embedded within the STP. ➢ Make available specialist expertise to support the system. ➢ Share and own risks as a system.	➢ Promote ambition, innovation and continuous improvement, celebrating success and learning from setbacks ➢ Provide the tools and information necessary to support clinical and financial sustainability. ➢ Draw on the talents and expertise of all staff across all grades and disciplines to make improvements.
Listen, Communicate & Influence	***Listen, Communicate & Influence***
➢ Listen and act in a spirit of shared endeavour and mutual learning to support solutions. ➢ Communicate regularly and clearly with partners and advocate for the partnership with stakeholders and the public. ➢ Build coalition of support from the wider system to help the STP to implement the change required and to realise the benefits for people who live in our area.	➢ Maintain two way communications between STP executive and own Governance authority. ➢ Foster effective internal and external relationships built on trust and agreement. ➢ Seek and provide feedback from and to the STP Executive Group. ➢ Provide visible leadership on behalf of the STP Executive Group to stakeholder events.

Open Collaboration	***Open Collaboration***
➢ Consider and agree solutions to close the quality, financial and efficiency gap. ➢ Promote a culture of system sustainability. ➢ Identify and support STP priorities to promote sustainability.	➢ Offer ambitious solutions to improve the system quality, finance and efficiency gap ➢ Be fully committed to place-based plans; to reach maturity and support future system sustainability