South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

24 January 2019
10.00-12.45

Tangmere MRC

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
Introduction					
139/18	10.01	Apologies for absence	-	-	DA
140/18	10.01	Declarations of interest	-	-	DA
141/18	10.02	Minutes of the previous meeting: 29 November 2018	Y	Decision	DA
142/18	10.03	Matters arising (Action log)	Y	Decision	PL
143/18	10.05	Board Story	-	Set the tone	DA
144/18	10.10	Chief Executive's report	Y	Information	DM
Trust strategy					
145/18	10.15	Delivery Plan	Y	Information	SE
146/18	10.35	BAF Risk Report	Y	Decision	PL
147/18	10.45	Research & Development Enabling Strategy	Y	Decision	FM
148/18	11.05	NHS Long Term Plan	Y	Information	SE
149/18	11.15	STP Population Health Check	Y	Information	SE
Quality & Performance					
150/18	11.20	Integrated Performance Report • Cat 1 peformance – maintaining safety during delays • Look back review 24.12.2018 – 06.01.2019	Y Y Y	Information Assurance Information	SE JG JG
151/18	12.00	WWC escalation report	Y	Information	TP
152/18	12.10	QPS Escalation Report	Y	Information	TM
Governance					
153/18	12.20	Audit Committee Escalation Report	Y	Information	AS
154/18	12.30	Finance & Investment Committee Escalation Report	Y	Information	AS
Closing					
155/18	12.40	Any other business	-	Discussion	DA
156/18	-	Review of meeting effectiveness	-	Discussion	ALL
Close of meeting					

Date of next Board meeting: 28 February 2019
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,
29 November 2018

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

Present:

David Astley	(DA)	Chairman
Adrian Twyning	(AT)	Independent Non-Executive Director
Alan Rymer	(AR)	Independent Non-Executive Director
Angela Smith	(AS)	Independent Non-Executive Director
Bethan Haskins	(BH)	Executive Director of Nursing & Quality
David Hammond	(DH)	Executive Director of Finance & Corporate Services
Fionna Moore	(FM)	Executive Medical Director
Joe Garcia	(JG)	Executive Director of Operations
Laurie McMahon	(LM)	Independent Non-Executive Director [from 10.20am]
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:

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

121/18 Apologies for absence

Daren Mochrie	(DM)	Chief Executive

122/18 Declarations of conflicts of interest

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

123/18 Minutes of the meeting held in public on 25 October 2018

The minutes were approved as a true and accurate record.

124/18 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.

125/18 Board story [10.07 – 10.23]

FM introduced this story about an elderly lady that had to wait too long for a response, and the lessons relating to ensuring the right clinical support when delays occur, and understanding the impact on patients.

On behalf of the Board, DA sought assurance from the executive that the right steps are being taken to mitigate the issues highlighted by this patient's experiences. JG outlined the actions to ensure more

clinicians and to develop the clinical navigator role. The Board acknowledged this, reflecting the context of the challenges in demand.

FM added that when a welfare call was made the patient said there was no increase in pain, but this was against the background of her initially being in significant pain, and FM felt that a clinician would be much more likely to pick up the significance of this. In other words, supporting the identified need for more clinicians to undertake welfare calls. The Board noted the recent recruitment campaign in Dubai where 36 offers of employment were accepted, by registered clinicians.

DA summarised that the role of the Board is to ensure that we meet challenges like this, to do everything reasonably possible to ensure patient safety.

126/18 Chief Executive's report [10.23 – 10.35]
In DM's absence, JG highlighted some of the key points as listed in the report.

In terms of the Appliance, DA clarified that at present this is simply a potential direction of travel. Nothing has been agreed/signed, as this first needs to go through the appropriate board governance. The announcement made last week, therefore, was in the context of a national announcement; linked to the need to use resources to best effect to deliver care.

AS referred to previous discussions at Board, about the correlation between performance and available resources available, and reinforced the importance of ensuring clarity on how we are producing the hours.

TM was positive about the recruitment mentioned earlier (from Dubai) and asked for assurance that the right plans are in place to ensure the candidates are settled and provided with robust induction. BH confirmed that management is really focussed on this through the related working group, supported by clinical education, to ensure the new staff from overseas are well supported to settle in to the UK. This includes considering issues such as housing, religious integration etc. EG added that one of things often overlooked is ensuring support to those moving back to UK, as they can be the most neglected; so there is focus on this group too.

LB asked about the AACE peer review referenced in the report.

Action:
Share with the Board the review of Emergency Preparedness, Resilience & Response (EPRR) undertaken by the Association of Ambulance Chief Executives (AACE).

127/18 Delivery Plan [10.35 – 12.03]
SE introduced the report, which was taken as read, asking colleagues to highlight any specific areas, by exception.

<u>Sustainability</u>
DH updated the Board on the 111 project, reinforcing the two distinct aspects; the exit from regional service and the new emergency contract for Kent and Sussex, from 1 April 2019. The main risks to the project include workforce; recruitment and training, which is monitored weekly, and technology and finance.

In terms of the exit from the regional service, CCGs have been asked to facilitate an exit meeting with Care UK to ensure a smooth exit, and awareness of all the exit risks.

DA asked about the pathway for existing staff and sought assurance they have been well engaged. DH confirmed the TUPE arrangements are being worked through now and that staff have been well engaged and supported.

LM expressed concern about reputational risk, seeking assurance that the plans are robust for the exit and handover to Care UK. Assurance was provided by the executive who explained the risk are different between the impact of the new service in Surrey and the service in Kent and Sussex, in relation to the impacts on 999 if they are not well implemented. The Trust is ensuring that CCGs are aware of these risks; there is a joint programme board with CCGs where mitigation of these risks is being picked up.

MW referred to the EPCR project, and asked management to explain why it is 'Green' when the narrative describes a number of issues; he asked whether the rating is appropriate. DH explained the rationale for this, assuring the Board that the risks cited are valid risks but mitigated sufficiently and therefore the expectation is the project will be delivered in line with the milestones. LB who sits on the programme board as the NED-lead, agreed with this.

TM noted that Spine Connect has gone from Green to Red, due to staffing, and asked about impact of delay on patients. DH explained the bottle neck created by staff being required to prioritise other things. In terms of patient risk, FM did not think there is a significant risk on the basis of access to IBIS. 40000 patient records are on IBIS, which is more detailed than summary care records.

Quality & Compliance

BH highlighted three areas:

1. EOC is Blue as we are revising the plan; closing the old plan and introducing a new plan to pick up current issues, some of which have been discussed already and/or will come under the clinical safety item.

2. EOC clinical safety is currently in intensive support. This is due to this being a key priority, not because anything is going wrong with the project.

3. Incident management (specifically the SI backlog) has progressed well. 75 open Sis in October, which is reduced to 52 today; 20 with CCGs for sign-off and only seven out with investigating managers. The new allocation process is working well, significantly reducing delays which has a really positive impact.

On behalf of Board, DA thanked staff for their efforts in improving the position with Sis.

LB sought assurance that there is robust governance in the context of moving from five to eleven private ambulance providers. BH confirmed that she is assured and explained that an assurance paper on this is due to be received by the Quality & Patient Safety Committee next week, the outcome of which will be reported to the Board.

Strategy

SE updated the Board that the findings of the refresh, which is coming to conclusion, is being written up and will come to the Board in Q4. Opportunities are currently being explored with the Academic Health Science Network on collaboration, to ensure a future orientated view for the Trust.

HR Transformation

EG confirmed the good progress with both the process improvement work and current state assessments. These are showing some of the complexity we have in some of our processes and the multiple ways with which some are used. Subject to approval of the business case scheduled for part 2, we will be taking a user

experience design approach, to ensure we create things that are properly useable and useful. Also, we will be looking at how to improve what we do through existing technology and doing benchmarking work with other trusts. For example, a case tracker allows us to manage employee relation cases much more timely.

Deep Dive - Culture

EG introduced this by sharing some research about the impact on staff who experience rudeness, in terms of their subsequent performance and care they provide to patients. This shows that being polite is simple and has no cost, but a great opportunity cost. We therefore need to understand what gets in the way and enables staff to be polite. This will inform our approach to culture being more focussed on how we localise what we do; the sum total of all of our behaviour.

In terms of work to date EG explained that we initially took a central and top down approach, for good reasons. For example, we helped to establish a set of values and behaviours, provided a number of training sessions for the executive and senior managers, and reviewed our approach to performance management. The next phase we seek to take is aimed at a smaller, critical, centre. The more we cascade from the centre the greater the risk of clogging communication. Instead, and learning from what we have started already to introduce through OUs, we are asking OUs to take more responsibility for looking at the local culture and how they can take steps to get to the culture we strive for – as illustrated in the diagram in slide 7, which EG set out.

AS was not convinced by this deep dive as it did not appear to demonstrate a marked difference in approach to what has gone before. She reflected that while over last two years some progress has been made in improving culture, the culture programme hasn't met its stated objectives. Therefore, she was not confident in delivery. EG responded to this challenge by acknowledging that that some things have been missed and some individuals have not been held to account, and so the difference will be ensuring local managers know the local climate and the actions they need to take, with support and tools, to improve that climate.

AT felt that it would be useful to bring back more developed plans to reflect the approach to the different groups of staff with different needs. He did not think the current approach, as set out, demonstrated a multidisciplinary approach across the executive. Agreeing with AS, AT asked for more detail of the progress we are making so that if we miss a milestone, the Board is more acutely aware and can then intervene as necessary. EG agreed that part of the current process will naturally set out the detail requested.

TM said that this was a good further step forward, but the staff voice still seems to be missing, as identified by Prof. Lewis. The paper lacks the focus on staff voice and how we ensure staff feel listened to, such as the metrics that measures staff engagement. She added that, while progress is being made, there are still pockets where cultural problems exist and somehow we have to find a way to deal with these.

EG acknowledged these challenges and agreed to make more explicit link to the staff voice.

JG stated that the paper doesn't capture all the activities underway, for example he and EG have held meeting with all OUs with specific focus on staff voice, listening to them, including when alongside them at A&E and leadership walk rounds etc.

LM agreed with AS, and felt that the paper does not bring out three significant and positive changes;

1. Talking about climate than culture.
2. Localising; shifting to local line management is key.
3. Move away from HR and consultants.

DA summarised this discussion, by firstly reinforcing that this is the Board's responsibility, and each director needs to be clear the role they each have. It is a big organisation with areas that have very distinct cultures

and so a one-size fits all won't work. Overall, there is general support for the direction, with a clear need to speed things up and be clearer about priorities.

Deep Dive - Service Transformation

SE confirmed that this is a programme of work to deliver the outcomes of the demand and capacity review. It is effectively what we do, but the programme is established to ensure focus and drive. The key component links to recruitment and retention and, linking to the previous item, ensuring we ensure an environment where staff can provide excellent services.

SE talked through the slide deck, describing the governance established, main areas of focus, and the progress made to date. In terms of impact, the overall aim is to improve ARP performance, and as we are data-rich the dashboards we are developing will ensure real-time analysis and action. We will demonstrate where we make efficiencies, which was implicit within the demand and capacity review.

In terms of performance, we are showing some good improvement, some of this down to early steps taken, e.g. increasing fleet and staff.

There has been much engagement with OUs and staff have been open about what they think and this continues to inform the programme.

The take home message is that by the end of Q1 next year we will be compliant, in the context of the future being risky.

On governance LB asked if we could confirm which elements come to committees and to Board. In addition, there is no mention in the timeline chart of paramedics, so LB asked whether we are content with the staff mix.

In terms of governance, SE confirmed he would make this explicit. In terms of staff mix, EG added that we have specific planning work on how we translate ECSWs through qualification to paramedic and we have some assumptions on this in the model. Another factor is the rotational paramedic opportunities. We are discussing with STPs how we create more markets to bring for example PPs on rotational roles.

LB clarified that her concern is about patient safety. JG explained that the lack of paramedics is the challenge of the sector. The demand and capacity review changes the model as not every patient needs a paramedic; the non-emergency tier will not include a paramedic. This gets us to the workforce numbers we need to respond to patients we can't currently get to.

AR noted that the slide deck states a target of 6% for hear and treat and asked whether this is right. SE confirmed that it should read 10% by Q1.

MW reflected that transformation programmes can fail when they do not sufficiently take account of optimism bias. We therefore need to be clear we have taken account of this as the figures seem ambitious. Also, we need to ensure through design that improvements are sustained. It would be good to see how over next 3-4 years transformation not only creates value but impacts on the run rate.

SE responded that optimism bias has been taken in to account through what could reasonably be achieved through recruitment.

TM asked whether it would be worth modelling some stress testing. SE confirmed that we met this week with ORH and the intent is to continue to test the model.

There was then a discussion about achievement of ARP performance by the end of Q1, and the need to be clear on the risks.

128/18 CQC Inspection – Next Steps [12.03 – 12.10]
BH confirmed the outcome of the CQC inspection, the report of which has been published since the last Board meeting. BH formally thanked all the staff involved.

It is a positive report in terms of improvement, but more work to do. BH highlighted some of the positive findings, and confirmed that in terms of the negative findings all the issues we had in train which is positive and demonstrated well-led. She then outlined the next steps.

[Comfort break 12.10 – 12.20]

129/18 Clinical Safety [12.20 – 12.31]
JG explained that this paper focusses on clinical supervision within EOC. He outlined the steps taken since the introduction of ARP in November 2017, when it became clear that we needed more clinical support in the EOC, including the development of the clinical navigator role to help manage waiting patients.

TP reflected that a number of the papers at the meeting include the challenges of recruiting clinical staff. He asked whether they could work in different ways, including remotely so that we widen the net and avoid travel. JG confirmed that this has been explored and we are looking at ways to provide home working; there are some challenges about access to the live CAD, which is essential, but it might be possible to work from MRCs. This is very much within our planning cycle to meet peaks in demand.

DA was encouraged that the Executive is looking innovatively in this way.

In the context of the Board Story earlier, TM referred to the graph in 4.4 (welfare checks), which shows we are a long way off delivering what is required. She asked for assurance given that the paper does not set out the action being taken. BH responded by confirming that the delivery plan each month going forward will include progress with welfare checks. JG supported this and explained it is a work in progress.

Action:
EOC welfare checks to be included within the Delivery Plan

DA summarised by acknowledging there are still issues to resolve, and the Board will track progress.

130/18 Falls Update [12.31– 12.44]
FM introduced Vicky who was in audience who has led improvements made over past two years.

FM explained that this update follows the presentation to the Board in the summer, and highlighted the key issues, including the national focus on fractured neck of femur. Going forward, we need to come up with a single offer to commissioners about a model most beneficial to this group of patients. We know training for staff is paramount, and we will be training on the frailty scale.

DA noted that a clear pathway saves lives, and asked whether we are joining up our work with hospital colleagues to ensure timely treatment. FM outlined the work on reducing waits and the steps to ensure patients are fast tracked when they are brought to hospital by ambulance with a fractured neck of femur.

AR referred to the slide about long lies, and explained that one of the things staff raise at the leadership walk rounds is the balance between protocols and allowing clinical judgement. FM explained one significant area of concern is when we miss a neck injury and here the guidance we provide helps staff differentiate between those patients that can be mobilised.

TM supported developing a model of care but expressed concern that we must ensure buy-in from commissioners to ensure investment.

DA commended the work and caring approach we are taking.

131/18 **IPR** [12.44– 13.07]

SE introduced the report inviting colleagues to highlight area by exception. He also confirmed that time will be scheduled shortly to review the format of the report.

Under safety and quality, FM and BH highlighted that cardiac survival is within normal parameters, and stroke and stemi care bundles are improving. We are 100% compliant with RIDDOR reporting.

Performance:

JG explained that this month we have included the most up to date weekly report, which shows the hours; 108% against 63000 hours) At the same time activity is increasing performance is maintained. Incidents are increasing as we are able to get to more patients. The trajectory for PAPs will enable us to deliver additional hours as per the demand and capacity review.

DA asked how we review prospectively to meet demand. JG confirmed that this is reviewed weekly by his operational team. He added that roster changes are due to be delivered by April 2019 and there is much confidence in delivery.

AT asked whether we have the tools to deal with variance in demand. JG expressed confidence that the models going in to the BI tools will accurately forecast demand. The roster changes level out some of the variance. He added that the tools aren't perfect but can forecast and the surge on that forecast comes down to BANK, overtime and PAPs.

AR asked for assurance that we are focussing hours over winter on covering the days where we expect the highest demand. JG set out the incentive schemes in place to ensure cover for the peak days, and explained that in addition to people we are also introducing more vehicles for Cat 3 /4, in order to reduce the tail.

DA was assured that management are using the tools and their experience to manage the best it can.

JG outlined the perfect week and the positive outcome of this demonstrating what can be achieved with the right resource.

Workforce:

EG highlighted the improvement in recruitment activity and the specific success in ECSWs and AAPs. He explained that we can now better analyse how long it takes to recruit following the current state assessment and process mapping. We are aligning business as usual with transformation, introducing quick fixes alongside the longer term improvements. The new system in place now records all employee relation cases to help track better, to improve timeliness and quality.

EG noted that the Wellbeing hub is running at significant levels and is meeting a real organisation need.

TM asked about the bullying and harassment data, as she was unsure what the narrative is describing. EG confirmed that he would review how we express this in future.

Finance:
DH confirmed that month 7 is on plan and the forecast remains on plan too. There were no questions on the financial performance.

132/18 **Brexit** [13.07 – 13.10]
This paper sets out the review by directorate on the potential impact of Brexit. A meeting was held this week focussing on Kent / M20 and we are engaged with various agencies. Differing views are held about likely impact, but the different scenarios are within our awareness and being led by the Head of EPPR.

133/18 **EPRR** [13.10 – 13.14]
This is the EPPR core standards self-assessment, which has been submitted to NHSE. It categorises the standards by core standards and interoperable capabilities and sets out where we have mapped against each. The paper has been reviewed by the quality and patients safety committee. One non-compliant area re business continuity relates to the ability to ensure six staff on each shift, as referred to the Board in October.

JG explained that AACE was asked to undertake a critical friend review of compliance with our actions arising from the NARU inspection last year. The report was quite complimentary of the progress we made. The NARU inspection findings this year are due to report in Q4.

Action:
NARU inspection report to come to Board

134/18 **Carter Review** [13.14 – 13.17]
The Carter team has reported on their findings, following its review of ambulance trusts. DH confirmed that we have set up a carter project and much of the recommendations we have in train already.

Action:
A summary of the progress against the Carter work-streams to come to Board in Q4

135/18 **FIC** [13.18 – 13.18]
The Board noted the report. There were no questions.

136/18 **STP Governance** [13.18 – 13.20]
The Board noted this paper, acknowledging the Trust will play its part in the implementation.

137/18 **Any other business**
The Board acknowledged the good impact of peer reviews, which was mentioned a few times during the meeting. There is not always a need to procure expensive external reviews.

138/18 **Review of meeting effectiveness**
DA apologised for overrunning. The Board felt that the discussion was good, with good participation and constructive challenge.

There being no further business, the meeting closed at 13.21

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	Q4	Board	IP	The governance and assurance framework was considered by the Audit Commtitee in December. A further iteration will be considered prior to it coming to the Trust Board.
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	Q4	Board	IP	Review by management of the IPR is due in early February. Recommendations will then come to the Audit Committee.
25.05.2018	32/18	Learning from External Reviews recommendations to be reviewed in December to confirm how the actions have been implemented.	PL	28.02.2019	Board	IP	Added to February Board agenda
28.06.2018	48/18	FIC to scrutinise the Fleet Man system	DH	TBC	FIC	C	Added to FIC annual plan
30.08.2018	82/18 b	Fleet Strategy to be considered by FIC in October	JG	Q4	FIC	IP	The committee agreed that further engagement was required prior to it considering it for recommendation to the Board
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	C	On agenda (PART 2)
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	C	On agenda
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	C	Received at COG meeting in November
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	C	On agenda
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	Being considered as part of the Board development programme
29.11.2018	126/18	Share with the Board the review of Emergency Preparedness, Resilience & Response (EPRR) undertaken by the Association of Ambulance Chief Executives (AACE).	PL		Board	C	PL circulated by email 21.01.2019
29.11.2018	129/18	Performance against EOC welfare checks to be included within the Delivery Plan	JG	Q4	Board	IP	

29.11.2018	133/18	NARU inspection report to come to Board	JG	ASAP	Board	IP	This will be scheduled for the meeting after the report is received
29.11.2018	134/18	A summary of the progress against the Carter work-streams to come to Board in Q4	DH	Q4	Board	IP	

Key

	Not yet due
	Due
	Overdue
	Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	

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

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

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S REPORT TO THE TRUST BOARD

1. Introduction

1.1 This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional and national issues of note in relation to the Trust during December 2018 and January 2019.

2. Local issues

2.1 Engagement with local stakeholders & staff

2.1.1 On 7 December 2018, I met with the Right Honourable Chris Grayling MP, the Secretary of State for Transport, in his capacity as the local MP for Epsom & Ewell. It was a useful opportunity discuss a number of local issues, including response times and the Trust's most recent CQC report.

2.1.2 On 12 December 2018, I met with Michael Docherty (CEO) and Dr Helen Bowcock (Chair) from the Kent, Surrey & Sussex Air Ambulance. The Air Ambulance are one of our key partners locally and it was extremely useful to meet their new leadership team, to discuss opportunities for future working.

2.1.3 On 10 January 2019 I, and a number of colleagues from across SECAmb, attended the funeral of Brian Rockell, a former Lead Governor for the Trust and a strong supporter of ambulance services in our region over many years. There was fantastic attendance, which is a measure of the high regard in which Brian was held and the multiple organisations he supported.

2.2 999 performance over Christmas and New Year

2.2.1 Learning lessons from previous years, SECAmb worked especially hard this year to ensure the Trust was in the best position possible to respond to the anticipated high levels of demand over the festive period.

2.2.2 A Winter Capacity Plan to cover the period 1 November 2018 to 31 March 2019 was developed, which drew on the experiences of past winters and integrated NHS England recommendations, guidance and criteria for winter capacity planning.

2.2.3 It concentrates on a number of year round processes and key seasonal initiatives that will deliver real resilience during the winter period and ensure engagement with local health systems.

2.2.4 The key areas of the Plan include:

- Maximise resourcing on the road, in the EOCs and in NHS 111, to match anticipated periods of high demand
- Ensuring the availability of key support services, including fleet and logistics
- Identify and utilise appropriate support from all areas of the Trust
- Stand up a Strategic Command Hub to provide additional, on-site strategic support

- Daily up-date calls with the NHS England 'Winter South' Team to provide identification and sharing of challenges in the region

2.2.5 Demand was slightly lower than for the same period last year, in terms of the number of 999 calls received, potentially due to us not experiencing poor weather conditions during this time in our region.

2.2.6 I am pleased that we performed well overall with some particular areas of improved performance including:

- Considerable improved performance in both Category 1 measures for both time periods compared to the previous year
- Improved performance in all call categories for week commencing 24 December including a reduction of almost an hour in our mean response to Category 4 patients
- Significant improvement in 999 call answer times for both time periods

2.2.7 I am extremely proud of the efforts of our staff and volunteers, both ahead of and during this period, which has seen us provide an improved service to our patients. However, I also recognise that there is still more to do to sustain the improvements we have seen and also improve performance in a number of areas, especially in our response to Category 2 and Category 3 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. It also regularly reviews the Trust's top strategic risks. During recent weeks, the EMB has also:

- Closely monitored the Trust's planning and preparation for the Christmas and New Year period, including resourcing and system-wide issues
- Reviewed a number of business cases, as part of the approval process
- Discussed the Trust's on-going work to take forwards the recommendations of the Carter Review

2.3.3 Once a month, the EMB holds a combined meeting with the Trust's Senior Leadership Committee (SLC). This is a valuable opportunity for shared up-dates and discussions around key issues and to agree joint working, between EMB and SLC, as needed.

2.4 Go live of new telephony system

2.4.1 On 11 December 2018 the Trust went live with a new telephony system in our EOCs and 111 centre, to provide all of the Trust's inbound and outbound telephony.

2.4.2 The Avaya telephone system and Nice voice recording system is a combination already used by a number of other ambulance services within their control room environments and has proven to be extremely reliable. As well

improving reliability, the move provides EOC managers with greater access to information to help with planning ahead to ensure the appropriate numbers of call takers are available.

2.4.3 The new system is helping to address concerns previously identified by the Trust and noted in a previous Care Quality Commission report. It also provides us with opportunities to develop the system to better meet its needs, without being reliant on external providers to make changes.

2.4.4 After some initial teething problems, I am pleased that the new system is now working well and is helping us to manage demand more efficiently. Thank you to all of the staff involved in delivering this project.

3. Regional issues

3.1 Deputy Chair of national BME Forum appointed

3.1.1 In December 2018, it was announced that our Deputy Director of Strategy and Business Development, Jayne Phoenix, had been successfully nominated to act as the Deputy Chair of the National Ambulance BME forum.

3.1.2 The National Ambulance Forum was created in 2001 to assist the ambulance service in meeting and complying with the Race Relations (amendment) Act 2000 and subsequently the Equality Act 2010.

3.1.3 The Forum comprises of volunteers from across ambulance trusts in the UK and invited members from represented bodies such as NHS Employers, and others to eradicate discrimination on the grounds of race and to promote equality of opportunity for all ambulance service employees.

3.1.4 I am very proud of this achievement and know that Jayne, who has been actively involved in a range of inclusive and diverse activities across our Trust, will be a great advocate and champion for the good work that has been spearheaded across our Trust on this national platform.

4. National issues

4.1 NHS Long Term Plan published

4.1.1 On 7 January 2019, NHS England published the NHS Long Term Plan. The key headline aims of the Plan are:

- Making sure everyone gets the best start in life
- Delivering world-class care for major health problems
- Supporting people to age well

4.1.2 The Long Term Plan also contains a significant number of specific references for ambulance trusts, including:

- To support patients to navigate the optimal service ‘channel’, a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services from 2019/20 will be embedded. This will provide specialist advice, treatment and referral from a wide array of

healthcare professionals, encompassing both physical and mental health supported by collaboration plans with all secondary care providers.

- Ambulance services are at the heart of the urgent and emergency care system. We will work with commissioners to put in place timely responses so patients can be treated by skilled paramedics at home or in a more appropriate setting outside of hospital. We will implement the recommendations from Lord Carter's recent report on operational productivity and performance in ambulance trusts, ensuring that ambulance services are able to offer the most clinically and operationally effective response. We will continue to work with ambulance services to eliminate hospital handover delays. We will also increase specialist ambulance capability to respond to terrorism. Capital investment will continue to be targeted at fleet upgrades, and NHS England will set out a new national framework to overcome the fragmentation that ambulance services have experienced in how they are locally commissioned.

- Ambulance staff will be trained and equipped to respond effectively to people in a crisis. Ambulance services form a major part of the support people receive in a mental health emergency. We will introduce new mental health transport vehicles to reduce inappropriate ambulance conveyance or by police to A&E. We will also introduce mental health nurses in ambulance control rooms to improve triage and response to mental health calls, and increase the mental health competency of ambulance staff through an education and training programme.

4.1.3 Within SECAmb, we are already taking forward many of these recommendations through the Service Transformation & Delivery Programme and other work-streams and will continue to make sure we align these with the national direction.

4.2 National roles

4.2.1 Within our relatively small ambulance sector, there are a number of important national work-streams in place, where representatives from all Trusts work together to develop initiatives and make improvements in key areas.

4.2.2 Following a review in November, where different portfolios were assigned to ambulance Chief Executives, I am very proud to lead two of these on behalf of SECAmb, NHSI (NHS Improvement) and AACE (the Association of Ambulance Chief Executives):

- The Ambulance Safe Staffing Professional Reference Group – this is a National professional reference group I am chairing on behalf of NHSI looking into developing a tool kit for Ambulance Trusts relating to safe ambulance staffing
- The lead Chief Executive supporting the Chair of the National Ambulance Services Medical Directors' Group (NASMeD) and National Quality Governance and Risk Directors (QGARD) - whose purpose is to improve clinical safety and quality of care by reducing unwarranted variation and sharing best practice across the English ambulance services

4.2.3 Being involved in national groups such as these can be time-consuming. But they also provide valuable opportunities to tackle some of the big issues facing us all

and to use our combined talents and knowledge to try to address them. My aim is to make sure that we benefit within SECAmb as much as possible from these and other work-streams.

4.3 Announcement of capital bids

4.3.1 On 29 November 2018, Matt Hancock MP, the Health & Social Care Secretary announced that SECAmb is to receive almost £13m of government capital funding, during his visit to Medway Maritime Hospital.

4.3.2 The funding, which followed the Trust submitting capital bids to NHS Improvement, includes:

- £6.52 million to create a Make Ready Centre (MRC) at Medway
- £5.52 million for an MRC at Brighton
- £0.24 million to significantly improve our estate at Worthing

4.3.3 Although we still need to work through the business case process, this is fantastic news, which will enable us to significantly improve our facilities in these areas to benefit our staff and patients.

5. Recommendation

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

Daren Mochrie QAM, Chief Executive

17 January 2019

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	145-18

Name of meeting	Trust Board
Date	24 January 2019
Name of paper	Delivery Plan Progress Update
Responsible Executive	Steve Emerton, Director of Strategy and Business Development
Author	Eileen Sanderson, Head of PMO
Synopsis	This paper provides an update on the progress made to the Delivery Plan
Recommendations, decisions or actions sought	The Board is asked to review the progress made in relation to the relevant projects

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 specifically drawn to the following since the last reporting period:

1. A new Project Health Check process has been implemented by the PMO. The purpose of these health checks is to scrutinise and provide a clear picture of a project's state of health. Health checks have been carried out on the following programmes/projects:

    1.1 Service Transformation & Delivery Programme
    2.1 111 (CAS) Interim Service (Sussex, West Kent, North Kent & Medway)
    3.1 Replacement of Telephony and Voice Recording system
    4.1 Replacement Fleet Management System
    5.1 NHS Spine Connect
    6.1 HR Operating Model
    7.1 HR Process Improvement

2. Estates Project Board has now been formally established and from February 2019 the following projects will be reported: Nexus House Capacity, Brighton Make Ready Centre and Worthing Ambulance Station Re-Development

3. A project interdependency framework has been drafted, with particular focus on the Service Transformation & Delivery Programme.

Since the last reporting period both the Replacement of Telephony and Voice Recording system and Incident Management Software (Clio) have gone live operationally. A Post Project Implementation Review has been conducted for Risk Management and the Culture Project closure has been approved and plans are underway to rescope the new Culture Change Programme. The project mandates for the Service Transformation & Delivery Programme, 111 Interim CAS Service and Exit have also now been approved.

The Overall Programme Dashboard has now been reformatted for ease of accessibility. Each Steering Group now has its own separate Dashboard and Timeline which will provide a snapshot of progress (see appendices) with the exception of the HR Transformation Programme which is currently being developed and will be available in the next reporting period along with the Timeline for Service Transformation and Delivery Programme.

This is the first reporting period for CQC Must Do/Should Do Tracker which can be found in appendix A.

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 Programme – see Appendix B
- Sustainability – see Appendix C - F
- Quality and Compliance – see Appendix G
- Strategy
- HR Transformation Programme

1.2 The Steering Group Dashboards provides high level commentary and key points to note for this reporting period. 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) where appropriate.

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 projects are currently RAG using the following definitions:

Red: Serious risk that the project is unlikely to meet business case/mandate objectives within agreed time constraints; requires escalation.
Amber: Significant risk that project may not deliver to business case/mandate objectives within agreed constraints.
Green: On track and scheduled to deliver business case/mandate objectives within agreed constraints.
Blue: The project has been completed.

2.0 Service Transformation & Delivery

2.1 **Service Transformation and Delivery Programme (STAD) –** The RAG remains Amber. A detailed programme plan is being developed to show all workstream activities required to support delivering the programme milestones. The Programme Mandate has been finalised and approved by the Executive Sponsor. Weekly work stream STAD programme planning meetings have now been set up with workstream leads and their teams to ensure that all actions required to deliver the programme benefits remain on track. The STAD workforce dashboard created by the BI team (now Live) was presented to Operating Unit Managers (OUMs) on 4 January 2019. All OUMs will be offered training to use the dashboard functionality.

The first Emergency Care Support Worker (ECSW) recruitment campaign launched in December 2018 to recruit 36 ECSWs across Dartford & Medway & Paddock Wood remains on track. Local ECSW assessment centres and course locations have been booked ahead of schedule. The next ECSW Recruitment Campaign launches on Monday 21 January 2019 and local meetings have been arranged with Chertsey and Ashford Operating Units (OUs) to take this forward.

A STAD Operational engagement workshop took place on Friday 4 January 2019 and received a good level of engagement from Regional Operating Managers (ROMs), OUMs, Operating Team Leaders (OTLs) who articulated what it is they need from the Executive Team to do their jobs (i.e. workforce and on-boarding). There were approximately 30 staff present which contributed to a wider discussion of the emerging Operating Unit (OU) infrastructure limitations and organisational development requirements to be taken forward across OUs.

2.1.1 **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 was a 21% decrease in total hours lost in November 2018 (4354) compared to November 2017 (5540). 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

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 are, however, expected over the winter months 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.

3.0 Sustainability

3.1 **111 (CAS) Interim Service (Sussex, West Kent, North Kent & Medway)** – The RAG remains Red. A project plan is currently being established which will establish the critical path which will then be actively monitored through the Project Board.

3.2 **111 CAS Contract Exit KMSS** – The RAG remains Red however once the exit plan is finalised, the RAG will move to Amber. Several meetings are now arranged with Care UK to discuss the novation of any SLAs, contracts and the transfer of records and data from their systems to the Trust. Commissioners have set up new governance arrangements to split out the exit process from the new service mobilisation and the procurement programme, to ensure effective partnership working and reducing the sharing of sensitive information to potential competitors.

3.3 **Digital Programme**

3.3.1 **Automated Temperature Monitoring** – The RAG remains Amber. The Quality Improvement (QI) Hub have supported with the physical connection of the Monica devices to the Trust's network at identified locations; every site with the exception of Staines and Farnham. All IT activities have now been completed. IT have asked the supplier to provide an update on the data streaming out of the Trust in order to identify if there are issues in any location.

Supplier training is scheduled for 29th January 2019 to be delivered to the medicines team, medicines leads designated by each operating unit and some QI hub team members to enable cascade training to OU's. The Chief Pharmacist has committed to producing the standard operating procedure (SOP) in draft in readiness for the training.

The system is still scheduled to go live by 28 February 2019. However, there is the potential for delay due to sequencing of approvals of Standard Operating Procedures (SOPs) through JPPF. This is being actively monitored.

3.32 **Cyber Security** – The RAG remains Green. Installation of guest Wi-Fi across all Make Ready Centres is now complete. There is no other change since the last reporting period as the Crawley and Coxheath CAD and VOICE network migrations are scheduled to commence in February 2019.

3.3.3 **ePCR** – The RAG rating remains Green. The Project is starting to gather pace. The first working group to review the system has been completed and feedback has been very positive. Whilst there are several system changes being requested, most of these are around 'content' and fall into three key areas:

- Move or Remove (or re-order)
- Rename
- Standardise (search/select)

Feedback is being provided to Cleric. Regular communication and engagement continues via weekly messages and social media channels. Meetings are being arranged with senior hospital managers. Planning has commenced for pre-live testing. A change request for extension of key activities by 6 weeks has been produced; this will not impact the overall project end date.

3.3.4 **Incident Management Software** – The RAG rating has moved to Blue as the project has now completed. CLIO went live operationally on 17 December 2018 and was utilised during the Christmas and New Year period for incident logging; feedback is currently being sought from those who have used the system. A meeting will be arranged with the supplier, Badger Software, to review the feedback and address items requiring attention.

3.3.5 **Replacement Fleet Management System** – The RAG rating remains Amber. There were delays in data transfer as the data provided to Jaama was not in a format that could easily be imported into their tool; this resulted in a requirement for additional supplier support leading to an increase in cost. In turn, this had a knock on effect on operational readiness causing delays in completion of process mapping and training. The project technical go live was 14 December 2018 with operational go live at the end of January 2019. However, after completion of training with the supplier additional training needs were identified warranting an extra training session; this has pushed the project end date out by 2 weeks. A formal change request will be submitted shortly.

3.3.6 **Replacement of Telephony and Voice Recording system** – The RAG rating has moved to Blue as the project has now completed. The system went live on 12 December 2018. The initial migration was successful in terms of minimal disruption to EOC, however, by the evening of go live a BCI event was declared due to significant issues arising. These issues fell into the following categories: calls disconnecting, caller or call handler not being heard, and incorrect call popping, inaccurate reporting (including dashboards). After investigation and implementation of a number of fixes, system stability was attained on 14 December 2018, two days post go live.

There are two outstanding issues, both of which continue to be investigated:

- Inaccurate reporting.
- The phone system deregistering and losing connection to the recording system on one site; there is a potential risk that calls may not be recorded on one site.

Weekly audit reports will continue to be produced to ensure that the system remains stable.

3.3.7 **NHS Spine Connect** – The RAG rating remains Red. The project end date of 31 October 2018 was not achieved and a revised date has not yet been confirmed.

In relation to the Patient Demographic Service (PDS), the Trust's Executive Management Board have requested a risk assessment on the impact of the use of the PDS, a trial to understand the impact of using it, clarification of the benefits and an implementation trajectory. This will need Commissioner involvement as the PDS this month to address the way forward.

In terms of Summary Care Records, the Trust has worked in collaboration with Registration Authority (RA) and NHS Digital which resulted in 3 RA agents and Sponsors appointed to support the Trust in the development of additional smartcards. The EOC Clinical Leadership team are in the process of gathering the required registration documentation and ID verification to enable the issue of smart cards to all EOC Clinicians

by the end of February 2019. Training for smart card use has been developed and will be delivered to the EOC Clinical team from 1 February 2019.

3.3.8 **GoodSAM** – The RAG status has moved from Amber to Red as the project end date of 12 December 2018 has not been achieved. The EOC systems team have yet to test GoodSAM to confirm that the interface is working and suitable for go live. This is due to the Replacement of Telephony and Voice Recording system go live, subsequent Business Continuity Incident (BCI) and winter leave in December 2018. The testing scheduled will be confirmed in the next week or two with a confirmed 'go live' date confirmed.

3.3.9 **Station Upgrades** – The RAG status has moved from Green to Amber. The scope of the project has been amended to replace all PC's below the specification to run Windows 10. Project timescales are currently under review and a revised project plan will be developed in the coming weeks.

4.0 Financial Sustainability

4.1 **CIP –** The Trust has reported a CIP target of £11.4m to NHSI as part of the 2018/19 Budget and Plan. £10.3m of fully validated savings have been transferred to the Delivery Tracker as at the Month 9 reporting date, of which £7.8m 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 E) and Delivery Tracker Dashboard (Appendix F) have been included with this update.

5.0 Quality & Compliance

5.1 **Governance and Risk** (CQC Must Do) – The RAG remains Green. The Task & Finish Group remains assured with the progress being made. As previously reported, the positive engagement with the risk management training is central to this specific objective. Although the target has already been exceeded, the training will continue to be delivered through Q4 of 2019/2020.

A detailed analysis of the trajectories for the review of policies and procedures will be undertaken during January 2019, to establish the risk in relation to all policies and procedures being updated by the end of March 2019.

5.2 **Incident Management** (CQC Must Do) – The RAG has moved from Amber to Red. The significant outstanding activity in the plan is the development of the revised SI Procedure. The consultation on this document is about to commence at the time of this report. There is some delay associated with JPPF which is being addressed. In the interim, dialogue is underway regarding the draft procedure with the Senior Management Team, Executive Team and CCGs. The procedure will be finalised this month, however, it will not have been approved by the JPPF due to the timeframe required for staff consultation. Therefore, the project will not be fully delivered by 31 January 2019. However, there are plans to oversee the ratification of the SI Procedure as part of Business as Usual.

Two SI Manager posts have been offered and are subject to recruitment checks; one is an internal appointment. The SI Coordinator has taken up a secondment into another department and recruitment to backfill that vacancy has been completed.

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.

5.3 **Private Ambulance Providers –** The RAG remains Amber. All plans have an assigned Subject Matter Expert to manage implementation and the aim is to move the project into business as usual at the end of February 2019. There some activities which are currently behind schedule which is being monitored and managed at the Task & Finish Group weekly to monitor progress.

5.4 **Resourcing Plan** – The RAG rating has moved to Blue. The project delivered 144 new Emergency Care Support Worker (ECSW) and Associate Ambulance Practitioner (AAP) starters between April and December 2018. Despite not achieving the anticipated 300 new starters (a stretch target was proactively set by the Director of Operations in early 2018 and has directly facilitated Trust compliance to date with the agreed workforce trajectory within the Demand and Capacity Review) the increased numbers resulted in the Trust to having a successful festive period in comparison to previous years. Further recruitment will be delivered as part of the Service Transformation and Delivery Programme.

5.5 **Personnel Files** – The RAG has moved from Amber to Red. The Disclosure and Barring Service (DBS) checks for staff with no initial DBS up to 31 May 2018 has now been completed, however there is currently no evidence to support that a new backlog from June 2018 onwards has not been created. For DBS renewals, there is also a small cohort of people who have not yet provided their ID. The electronic files are continuing to remain on target and recruitment is underway to bring in a resource to support the team. The DBS Task and Finish Group has met twice with another meeting scheduled in January 2019. Around 300 roles have been reviewed and agreement obtained on the level of DBS required for these.

The issue with the performance of Paper Vision remains, 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 but this has now been sent to the Information Governance Team.

5.6 **999 Call Recording** (CQC Must Do) – The RAG rating has moved to Blue as the project has now completed. Introduction of the new telephony and recording system from 12 December 2018 has replaced the existing arrangements. Monitoring will continue with the new system as part of BAU for the foreseeable future but to date there have not been any issues in relation to lost calls, conjoined calls or part recorded.

5.7 **Health & Safety –** The RAG remains Green. All activities are currently on track. The new Health & Safety Management team are in post. A gap analysis has been undertaken of the Trusts' Health & Safety policies and 10 new Health & Safety related policies have been identified. The Health & Safety team will create these policies and aim to complete by July 2019. The annual Health & Safety audit plan has been implemented with a minimum of 10 audits planned per month. 3 new E-learning modules will be available in April 2019.

All mandatory project documentation has been approved except the DPIA which is work in progress. Further work has been carried out to refine the plan and to establish the additional steps required to complete milestones. A change request has been approved to refine the project's objectives.

5.8 **Audit & Development for 999** – The RAG Remains Green. Audit compliance is recovering well despite loss of staff through sickness. General staff morale has improved although some issues continue on the Coxheath site which require more challenging resolution. Clinical audit compliance remains challenging but this is being actively managed and monitored. Training delivery is meeting the requirements of EOC.

The trialling of the replacement audit tool will begin shortly and meetings are taking place to conclude the business case for amending the structure and numbers within the department (resolving the on-going challenges in the department's ability to meet its requirements).

The main risk to this workstream is around staff sickness and the requirement to enrol and build team buy-in at Coxheath to improve audit compliance with NHS Pathways license requirements. This is being closely managed and monitored. Fortnightly reporting to the Quality & Compliance Steering Group will continue for the foreseeable future.

5.9 **EOC** (CQC Must Do) **-** This is the first reporting period since the Trust Executive Team made the decision to combine the EOC Clinical Safety project and the EOC Readiness projects. Together these plans address the CQC Must Do: 'the Trust must ensure that their processes to asses, monitor and improve the quality and safety of services and also to assess, monitor and improve the assessment of risks relating to the provision of the service are operating effectively'. The Associate Director of Service Transformation will lead the project and will report weekly into the Quality Compliance Steering Group and monthly into Service Transformation and Delivery Steering Group. In the coming weeks the project plans will be reviewed to create an overarching EOC Improvement Action Plan.

The intergration of projects to track delivery from the attraction and on-boarding of personnel and their training/support to ultimately sustained high quality and durable operations within the EOC is a significant step forward.

6.0 Strategy

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

6.1.1 **Annual Planning** – The RAG remains Green. On 16 October 2018 the NHS Improvement and NHS England Letter on Approach to Planning for 2019/20 was published, which sets out the key principles and timetable. Further guidance was published on 24 December 2018 providing more detail and confirming key planning milestones. An initial plan is due for submission to NHS Improvement this month, and a draft operational plan by 12 February 2019. Contracts are expected to be signed by 21 March 2019 with final operating plans submitted by 4 April 2019. The Trust are currently

ratifying our approach to this including the engagement needed in this work and alignment of our contracting timetable. The Trust are on track to deliver to the timescale.

6.1.2 **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 collate 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.

6.1.3 **Enabling Strategies** – The RAG remains Amber. Strategies for Workforce, Fleet, Volunteers, Patient Experience, and Partnership/ commercial are all underway. Work is beginning on Comms and Engagement, and Freedom to Speak Up. Both the Governance and Research and Development Strategies will be presented for approval at the Trust Board this month.

7.0 HR Transformation

7.1 **Process Improvement** – The RAG remains Green. Phase one of the project is now complete. Preparation and scoping of implementation (Phase 2) has started which includes understanding of the key people risks and systematic challenges, system requirements gathering, demand modelling and approach together with a timeline for implementation.

All 124 processes across Service Centre, Recruitment and 9 Clinical Education processes have been mapped, signed off and validated as planned. Improvement and engagement workshops have been held. User stories have been gathered.

Supplier days have been held and further workshops continue to be held with key suppliers of interests. Benchmarking exercise continues to take place against standard data and other comparable Ambulance Trusts.

A Programme Change Control will be submitted to include Phase 2 deliverables and revise the end date on the project mandate.

There is a tight timeline to complete scoping and requirements gathering. The Project Team will define and outline indicative timelines and risks for delivery which can only be confirmed upon agreement of business cases and project plans

The optimal route to market will need to be confirmed such that any implementation delay risk is mitigated whilst being compliant. The Programme Manager and Project Leads will work with the Procurement Team to understand the scope, requirements and options for procurement.

BAU staff within HR and wider teams are keen to implement improvements themselves and will be supported to understand the sequencing of any change. The HR Transformation Lead and Project Lead will liaise with the functional Executive Director and ensure alignment with implementation in a structured manner.

The pace of change and approvals within the Trust is being managed to mitigate any delay to implementation.

7.2 **HR Operating Model** - The RAG has moved from Amber to Green. The aim of this project, which forms part of the HR Transformation Programme, 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 the HR operating model is now complete. The HR Operating Model is being developed in January 2019 and a report will be produced in early February 2019.

A Programme Change Control will be submitted which will impact the deliverables and end date on the project mandate however any implications will be managed accordingly.

If funding is not available for required additional resource it will not be possible to lift HR performance through a new operating model and aligned structure. The Chief Financial Officer and Chief Executive have been briefed by Executive Director Human Resources & Organisational Development.

A risk (which is being managed) is that key HR staff leave because of uncertainty over potential HR change and/ or dissatisfaction with direction of future state / operating model, thus impacting on delivery of core HR services to customers. To mitigate this, collaboration and communication has been built into the project approach. All products are communicated to the HR leadership team first so awareness is raised and all are able to support their staff and our people.

7.3 **Culture Change** – The 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. The post project QIA has been completed and approved.

Some culture initiatives are ongoing and being transitioned to Business As Usual (staff engagement survey, Recognition programme, Behaviours training).

A project mandate has been drafted based on a localised approach to improving culture (responsibility for action sitting with directorates and teams, with central support and CEO/Exec leadership) and draft version presented to QCSG for review.

Revisions are now in progress, with a view to finalising the mandate by the end of January 2019, and project plans drafted by end February 2019.

An approach to making use of the staff survey data and other organisational information has been put to the Executive Team, with templates and exercises for action planning and tracking. These have been created in alignment with the localised culture approach, in the interests of simplicity and not creating additional work for managers and teams. Once agreed, this will be communicated and rolled out during February 2019 and March 2019, after the publication of the detailed results (at team level) in late January 2019.

7.4 **People Risks –** The RAG remains Green. The aim of the project is to review all people risks across the Trust and to present a plan on how to mitigate major risks that compromise the Trust's ability to operate effectively.

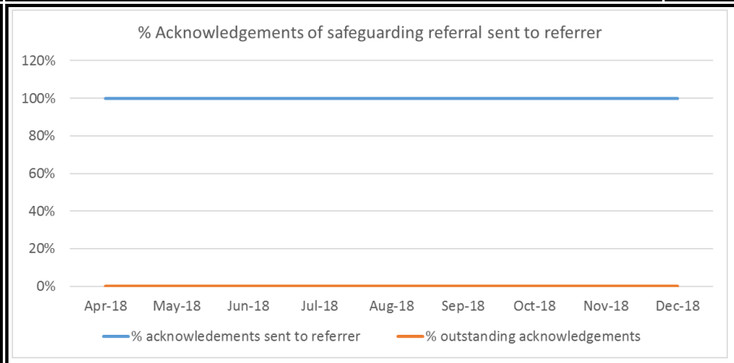
The project will work with the Risk team ensuring that all the HR Directorate risks are correctly managed and mitigated according to the Trust's process.

7.5 **People Strategy & HR Delivery –** The RAG status is Green. This is the first reporting period. There is currently a short term people strategy in place that was produced by the

Director of Human Resources & Organisational Development. As the operating model is built and working with the Service Transformation Programme a long term people strategy will be developed.

South East Coast Ambulance Service NHS Foundation Trust

Domain	CQC Findings ('Must or Should Do')	Metrics	Monitored via
Safe	The Trust **must** ensure that their processes to assess, monitor and improve the quality and safety of services and also to assess, monitor and improve the assessment of risk relating to the provision of the service are operating effectively.	The current EOC Clinical Safety and EOC Readiness plans will be combined to form one overarching EOC plan which will address the Must Do.	EOC (overarching) Project Plan
Safe	The Trust **should** ensure they take action to continue to have effective systems and processes to assess the risk to patients and people using the services and they do all that is reasonably practicable to mitigate those risks, specifically in relation to the risk assessment of patients awaiting the dispatch of an ambulance.	The new overarching EOC plan will include the 6 new Trust procedures identified to ensure effective systems and processes to support risk assessment activities through the EOC Clinical team.	EOC (overarching) Project Plan
Safe	The Trust **should** ensure they continue to monitor the effectiveness of the clinical safety navigator role to ensure continued oversight on the safety of patients waiting for an ambulance.	As part of the overarching EOC plan, the effectiveness of the Clinical Safety Navigator will be monitored through clinical queue management efficacy to meet welfare compliance, SMP No-Send compliance in reviewing no-send cases within specified timeframes. Each of these metrics will be monitored within the weekly reports for both Clinical Tail Audit and No-Send Audit.	EOC (overarching) Project Plan
Safe	The Trust **should** ensure there are a sufficient number of clinicians in each EOC to meet the needs of the service.	The overarching EOC plan will identify a series of activities to monitor staffing levels, as well as HR Recruitment work streams to ensure there are sufficient Clinicians within EOC. Staffing levels are monitored within programme Recruitment trackers. To support EOC Clinical Requirements in meeting welfare compliancy the Clinical Support Worker role is being defined and will facilitate the use of registered clinicians from the Trust.	EOC (overarching) Project Plan

<table>
<tr><th>Domain</th><th>CQC Findings
('Must or Should Do')</th><th>Metric 1</th><th>Metric 2</th><th>Monitored via</th></tr>
<tr><td>Safe</td><td>The Trust should ensure the processes for providing staff with feedback from safeguarding alerts is improved to strengthen and develop learning.</td><td> 

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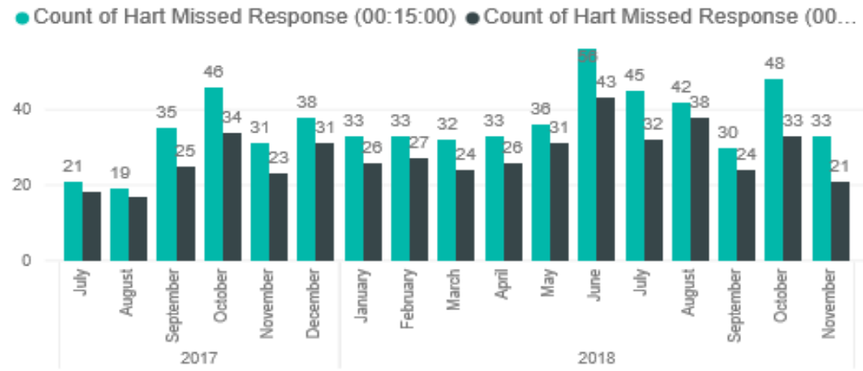
<tr><th></th><th>Apr-18</th><th>May-18</th><th>Jun-18</th><th>Jul-18</th><th>Aug-18</th><th>Sep-18</th><th>Oct-18</th><th>Nov-18</th><th>Dec-18</th></tr>
<tr><td>Total Referrals</td><td>1033</td><td>1109</td><td>1199</td><td>1173</td><td>1170</td><td>1050</td><td>1045</td><td>1275</td><td>1167</td></tr>
<tr><td>No. acknowledgements sent to referrer</td><td>1033</td><td>1109</td><td>1199</td><td>1173</td><td>1170</td><td>1050</td><td>1045</td><td>1275</td><td>1167</td></tr>
<tr><td>No. outstanding acknowledgements</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
</table></td><td></td><td>Safeguarding Action Plan</td></tr>
<tr><td>Effective</td><td>The Trust should ensure that maps in all vehicles are current, up to date and replaced regularly</td><td>A QIA was produced and subsequently approved on 21 December 2018. Further discussions are still to be had on the removal of maps from vehicles, given that there are multiple options available to crew. In the meantime, an alternative option of offline maps has been explored.</td><td></td><td>Not applicable</td></tr>
<tr><td>Safe</td><td>The Trust should ensure that all staff adhere to the trust policy on carrying personal equipment and the regular servicing of such equipment.</td><td>The Personal Issue Assessment Kit (PIAK) policy went out to consultation and there were a few questions relating to the checking of PIAK additional equipment for bank staff use. As this is an operational issue this has been passed to the QI hub who are working on a solution in conjunction with Operations colleagues.

In the meantime, the equipment has been ordered, the bags have been delivered to PWMRC ready to be collated with the equipment when it arrives and allocated to the staff. This will be done a make ready at a time.

N.B. The regular servicing of equipment is not applicable.</td><td></td><td>Not required</td></tr>
<tr><td>Effective</td><td>The Trust should ensure that pain assessments are carried out and recorded in line with best practice guidance</td><td>An action plan has now been developed to ensure systems are in place to identify opportunities to improve assessment of pain and that clinical staff have adequate knowledge to assess pain as well as having systems in place to promote the effective assessment of pain.</td><td></td><td>Pain Assessment Action Plan</td></tr>
</table>

South East Coast Ambulance Service NHS Foundation Trust

Domain	CQC Findings ('Must or Should Do')	Metric 1	Monitored via
Safe	The Trust **should** ensure response times for category three and four calls is improved	In response to the Demand and Capacity Review, the, Service Transformation and Delivery Programme has been established to ensure that by April 2021, the best high quality care and most appropriate response is provided for each patient first time. The Programme Mandate has now been approved with clear objectives on how the Trust will deliver improved response times. A Steering Group has been established led by the Executive Director of Strategy & Business Development to monitor progress.	Service Transformation & Delivery Programme
Safe	The Trust **should** consider producing training data split by staff group and core service area for better oversight of training compliance.	The training data from HR is still being collated as it is formatted differently across the years that we require to measure compliance against. A process to ensure consistent data across the years is taking longer than expected and continues to be undertaken. To ensure that the data is accurate it has been agreed to review the process of moving records from Discover to ESR. It was further agreed that Discover would be compared to ESR each month, with ESR being the definitive source and Discover a cross check.	Training Compliance Action Plan
Responsive	The Trust **should** ensure they collect, analyse, manage and use data on meeting response times for Hazardous Area Response Team (HART) incidents.		EPRR Action Plan

Action Plan

Template v2.0

Action Plan Title	CQC Must Do - Assessment of Quality & Safety of Urgent & Emergency Services	**Accountable Executive Director**	Bethan Haskins (Director of Nursing & Quality)
Last Update (date)	15/01/2019	**Version Number**	4
Nature of the change the Action Plan is addressing	**Assessment of Quality and Safety of Urgent and Emergency Services Action Plan**		

For guidance on completing the template, please see the Project Plan Guidance tab (print friendly) or email pmo@secamb.nhs.uk with any queries

ID	Resource	Action	Owner	Update	Due Date	Date of Completion	Status	Evidence required	Evidence Received
1	**Resourcing**								
1.1	Demand and Capacity review	Increase contracted resource in line with additional funding model	Joe Garcia	This is within the scope of the Service Transformation and Delivery Programme to achieve Ambulance Response Performance targets. A Steering Group has now been set up to meet fortnightly to monitor progress	01/04/2019		In Progress - On Track		
1.2	AFC Bandings	Review relevant role bandings of specific groups to assist with staff retention	Joe Garcia	Technician banding was reviewed in November 2018. PP and CCP banding is currently undergoing evaluation and the AAP scope of practice is under review.	01/04/2019		In Progress - On Track		
1.3	Bank Staffing Model	Revise bank remuneration rates to incentivise greater Bank working as opposed to overtime	Joe Garcia	A briefing relating to bank remuneration to reduce overtime has been drafted and presented to Teams A, now with HR for review.	01/04/2019		In Progress - On Track		
1.4	Nursing career pathway	Develop pilot for nurses working clinically on vehicles as well as nursing career pathway	Bethan Haskins	Pilot site identified and progressing to board approval. Nursing career pathway in development.	01/05/2019		In Progress - On Track		
1.5	Overseas recruitment	Ensure current recruits are inducted well into the trust and explore further recruitment trips	Bethan Haskins	38 nurses recruited from Middle East, induction plan in place for March / April. Further recruitment trip being planned for Q2 19/20	01/07/2019		In Progress - On Track		
1.6	PAPs	Increase provider numbers and hours provided by private providers within a safe governance framework	Joe Garcia	A Task and Finish group has been set up to oversee this. The Project Lead also attends the Service Transformation and Delivery Steering Group to ensure interdependencies are being managed effectively	31/03/2019		In Progress - On Track		
1.7	Staff finishing late LSO	Continue to monitor and reduce the number of staff finishing a shift after the scheduled time, introduce revised end of shift parameters.	Joe Garcia	A pilot is underway (OP268 - Crew Welfare and End of Shift Changes) commenced on 10/12/2018 and is due for review 10/01/2019. **15/1/19** Ops268 has been fully deployed and utilised by the EOCs since its introduction in early December and this is proving to be having a beneficial effect, with a noticeable reduction in shift overruns by crews and evidence supporting the fact that there has been a reduction of some 100 shifts per day finishing late. Whilst this is a sizeable improvement, this still leaves a significant amount of shifts overrunning and we need to monitor progress over the forthcoming months. It would be fair to say that we need to reach a period of more normal activity thresholds to fully understand the potential of the initiative. **Action complete.**	10/01/2019		Complete		
1.8	Mealbreak Compliance	Continue to monitor and reduce the number of staff not being able to take a mealbreak within the break window and during a shift	Joe Garcia	A pilot is underway (OP268 - Crew Welfare and End of Shift Changes) commenced on 10/12/2018 and is due for review 10/01/2019. **15/1/19** Initiatives to improve meal break compliance have been embraced by the EOC Teams and we are now seeing an improvement in allocation of secondary breaks from approximately 1% to over 19% of secondary meal breaks being allocated. This demonstrates a change to Control Room practice and behaviour but is by no means complete. Progress against this initiative continues	28/02/2019		In Progress - On Track		
2	**Fleet & Logistics**								
2.1	Fleet numbers	Increase fleet in line with additional funding model	Joe Garcia	This is within the scope of the Service Transformation and Delivery Programme to achieve Ambulance Response Performance targets. A Steering Group has now been set up to meet fortnightly to monitor progress. The trajectory is as follows; Additional 25 DCAs by November 2019 and a further 25 DCAs by November 2020	30/11/2020		In Progress - On Track		
2.2	Blue light driving	Continue to monitor the use of blue light driving to emergency calls	Joe Garcia	The Trust is intending to capture this data via the MDT. Work is underway to progress this but an end date has not yet been defined.	Ongoing		In Progress - On Track		
2.3	Personal equipment	Ensure staff are issued with personal issue kit as approved by board	Fionna Moore	Equipment will be issued once the PIAK Policy has been approved by JPPF (planned for January meeting).	31/01/2019		In Progress - On Track		

2.4	NET vehicles	Implement and evaluate the NET vehicles	Joe Garcia	NET vehicles are being rolled out across the 10 OU's - 30 NET vehicles will be in place by 07/01/2019. They are undergoing evaluation on a weekly basis. **15.1.19** The proposed NET vehicles have been rolling out at three per week since early December and systems are now in place to monitor activity undertaken specifically by the NET crews. The full roll out will not be completed until end February. At present there are 13 vehicles in the field, six within Trust workshops and five at Eastbourne commissioning centre, leaving the balance to reach us by the end of February as advised above. Due date extended accordingly.	28/02/2019		In Progress - On Track		
3	**ARP Performance**								
3.1	Constitutional Standard Performance	Improved performance against ARP	Joe Garcia	CAT1-4 performance is being reviewed on a daily and weekly basis - the 174 new staff should contribute towards an improvement in performance by the end of Q4.	01/04/2019		In Progress - On Track		
3.2	D&C Operating Model	Define and deliver the Clinical Delivery Model to meet the D&C Review Targeted Dispatch Model	Joe Garcia		01/04/2019				
3.3	CFR strategy	Ensure future strategy in place for CFRs and expand role to responding to careline calls and non injury falls	Joe Garcia	Head of Voluntary Services has been invited to QCSG on 18/12/2018 to provide an update on the strategy for CFRs.	TBC		Not Started		
3.4	Falls pilot	Evaluate trust falls pilot and rollout successful trust model	Fionna Moore	The evaluation of the falls pilot has been completed and was presented to the Trust Board in November 2018. Work is currently underway to finalise the Falls Strategy which will set the direction of travel for all future Falls projects	30/06/2019		In Progress - On Track		
4	**Governance of Performance**								
4.1	Operational Leadership Restructure	Restructure the Senior Operations Leadreship Team and middle management layers	Joe Garcia	The Ops restructure should be in place by April 2019 - the business case will be going to Exec for final approval 09/01/2019 and 24/01/2019 for Board.	01/04/2019		In Progress - On Track		
4.2	Area governance meetings	To continue to ensure that the quality and safety of services are assessed, monitored and improved through discussion / scrutiny	Joe Garcia	Exec will also have oversight of Area Governance Meetings on alternate months, starting 23/01/2018.	Ongoing		In Progress - On Track		
4.3	Teams A-F	To continue to ensure that the quality and safety of services are assessed, monitored and improved through discussion / scrutiny	Joe Garcia	Teams A - F continue to meet on a regular basis	Ongoing		In Progress - On Track		
4.4	Board oversight	To continue to ensure that the quality and safety of services are assessed, monitored and improved through discussion / scrutiny	David Astley	Board meetings continue to take place. Non Executive Directors are also invited to various Steering Groups to provide independent scrutiny	Ongoing		In Progress - On Track		
4.5	Executive oversight	To continue to ensure that the quality and safety of services are assessed, monitored and improved through discussion / scrutiny	Daren Mochrie	Fortnightly Executive meetings continue to take place alongside weekly Exec huddles	Ongoing		In Progress - On Track		
4.6	STAD	To continue to ensure that the quality and safety of services are assessed, monitored and improved through discussion / scrutiny	Steve Emerton	Fortnightly Service Transformation & Delivery Steering Groups in place.	Fortnightly		In Progress - On Track		
4.7	WWC	To continue to ensure that the quality and safety of services are assessed, monitored and improved through discussion / scrutiny	Ed Griffin	Monthly WWC meetings continue to take place.	Monthly		In Progress - On Track		
4.8	HR Transformation SG	To continue to ensure that the quality and safety of services are assessed, monitored and improved through discussion / scrutiny	Ed Griffin	Monthly HR Transformation Steering Groups in place.	Monthly		In Progress - On Track		
4.9	QPS	To continue to ensure that the quality and safety of services are assessed, monitored and improved through discussion / scrutiny	Bethan Haskins/Fionna Moore/Joe Garcia	Monthly QPS meetings continue to take place.	Monthly		In Progress - On Track		
5	**Specific Quality & Safety**								
5.1	SI Process	Embed revised SI process and process for learning from SIs	Bethan Haskins	The SI Procedure has now been drafted and will be going through formal govenance process for ratification.	31/03/2019		In Progress - On Track		
5.2	Mortality and Morbidity	Undertake analysis of current position and develop future strategy regarding learning from deaths	Fionna Moore	An Action Plan has now been developed which addresses the concern that the Trust did not consistently make use of learning from deaths to improve patient safety and care for others.	31/03/2019		In Progress - At Risk		

5.3	Risk Management	Continue training senior operational staff and monitor / audit risk management processes	Bethan Haskins	This is currently been monitored via the Governance and Risk Improvement Action Plans with progress reporting fortnightly to the Quality and Compliance Steering Group	31/03/2019		In Progress - On Track		
5.4	Risk Assessments	Continue training senior operational staff and monitor / audit risk assessment processes	Bethan Haskins	This is currently been monitored via the Governance and Risk Improvement Action Plans with progress reporting fortnightly to the Quality and Compliance Steering Group	31/03/2019		In Progress - On Track		
5.5	Clinical Risk Management	Establish trust wide clinical risk committee following inaugral scoping meeting	Bethan Haskins	Inaugral meeting taken place and TOR agreed. First formal meeting 01/2019	31/01/2019		In Progress - On Track		
5.6	Long wait / harm review	Contibute to system wide review of long waits and embed changes / learning as appropriate	Bethan Haskins	NHS England and CCGs convening system wide approach which we will be contributing to	01/03/2019		Not Started		
5.7	QI methodology	Ensure trust wide QI methodology is agreed upon, resourced and implemented	Steve Emerton	This is currently paused - The Trust Board has asked that the Trust review the timelines for the introduction of QI methodoloy in light of all the other priorities the Trust is currently undertaken e.g Service Transformation and Delivery	TBC		Not Started		
5.8	Patient safety Walkabouts	Continue the revised programme of patient safety walkabouts with executives and NEDs	Daren Mochrie	This is continuing on a regular basis	Ongoing		In Progress - On Track		
5.9	Quality Assurance Visits	Continue the revised programme of QAVs with multi disciplinary teams and subject matter experts	Bethan Haskins	This is continuing on a regular basis	Ongoing		In Progress - On Track		
5.1	A and E Clinician Visits	Continue the quartley A and E trust clinican visits and ensure learning from these is cascaded and embedded	Bethan Haskins	This is continuing on a regular basis	Ongoing		In Progress - On Track		
6	**Education & Development**								
6.1	Leadership Assessment process	Define and Refine the Assessment Centre Process	Ed Griffin	This is in progress and work is underway	01/02/2019		In Progress - On Track		
6.2	Leadership Development programme	Formulate an established leaders, leadership, mentoring and coaching programme	Ed Griffin/Joe Garcia	This is in progress and work is underway	31/03/2019		In Progress - On Track		
6.3	Identify Future Senior Leaders	Establish an aspiring senior leaders development programme	Ed Griffin/Joe Garcia	This is in progress and work is underway	31/05/2019		In Progress - On Track		
6.4	Leadership Appointments Panel	Establish an Inclusive, Effective and Save leadership appointments panel	Ed Griffin/Joe Garcia	This is in progress and work is underway	30/06/2019		In Progress - On Track		

Service Transformation & Delivery (STAD) Steering Group Dashboard

Reporting Period: 01 December 2018 to 11 January 2019

RAG Key:

Red	Serious risk that the project is unlikely to meet business case/ mandate objectives within agreed time constraints; requires escalation.
Amber	Significant risk that project may not deliver to business case/ mandate objectives within agreed constraints,
Green	On track and scheduled to deliver business case/ mandate objectives within agreed constraints
Blue	Completed
White	Not yet started

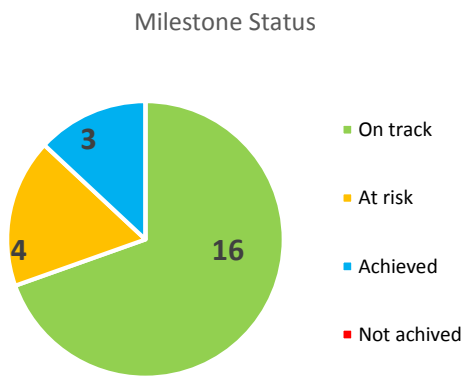
Key points to note for this reporting period

Workstream	Brief Summary
Rota's	Agreeing the Rotas across Operating Units is progressing well, and has received positive feedback from all OUs. A meeting has been planned this month to confirm the details around rotas.
Fleet	A recent meeting with the senior operations team has confirmed that there is a requirement for 92 vehicles to be replaced across Operational Units (OUs) in 2019/2020. 13 Non Emergency Transport (NET) Vehicles have been deployed across 8 OUs with a plan to deploy a further 5 this week. The remaining 12 NET vehicles are still on track to be deployed by 18 February 2019. **To note:** 6 NET vehicles are in the workshop and one of these is at an external contractors for body repairs. Of the 13 NET vehicle's which are operational, 3 are vehicles off the road and 2 are at outside contractors.
Estates	The latest estate infrastructure audit has been completed for Gatwick and Redhill. All estate audit findings are grouped into the emerging OU risks which range from on- boarding, service delivery, estate maintenance and health & safety concerns. All requirements are to be costed and an estate prioritisation meeting will take place on the 31 January 2019.
Operational Units	The Emergency Care Support Worker (ECSW) Recruitment campaign across Dartford & Medway and Paddock Wood is on track. An operational engagement workshop which took place on 4 January 2019 with the Operating Unit Managers had good engagement and the emerging OU infrastructure limitations and organisational development (capacity and capabilities) identified has been updated on Datix.
Hospital Handover	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. Live reviews of ambulance conveyances are also being undertaken at identified sites to ensure all available community pathways are being maximised. Focus is being placed on improving crew to clear times at sites where crew to clear times are particularly challenged

Key Risks and Issues

Workstream	Brief Summary	Score
Programme	There is a risk that that if an agreement isn't reached in the contract to enable resourcing to achieve full and sustainable compliance with all ARP targets. Mitigations include an escalation for EMB to provide guidance.	16
Hospital Handover	The relationships and partnership working between SECAmb and hospitals is at risk as a result of unmatched progress towards achieve standards. Mitigations includes a Paper being presented to EMB including options to improve crew to clear times.	16
Programme	There is a general lack of adequate local car parking facilities across the Trust which is likely to impact on the Programme should they not be addressed. Mitigations includes scoping of infrastructure requirements across OU to establish full impact of Risk and to prioritise local arrangements / agree future opportunities.	16
Hospital Handover	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. (within hospitals and SECAmb). Mitigations includes increasing communications amongst Operational team leads to remind them to follow immediate handover SOP where and when appropriate	15

Workstream	Current Period	Previous Period
Programme	Amber	Amber
Operational Units	Green	Amber
Workforce	Green	Amber
Rotas	Green	Amber
Fleet	Green	Amber
Estates	Green	Amber
Private Ambulance Providers	Green	Amber
Hospital Handover	Red	Red



Achievements this period

- Programme Mandate has been approved.
- The STAD workforce dashboard was launched on 24 December 2018.
- Operational engagement workshop took place 4 January 2019.
- Rotas have been agreed across OU's (excluding Hastings/Redhill)
- Non Emergency Transport vehicles have been deployed across 8 OUs.
- The first Recruitment Campaign received over 100 applicants for the ECSW roles. 54 applicants have been shortlisted for Dartford & Medway and 52 applicants for Paddock wood.
- Weekly workstream project planning meetings have been set up.

111 CAS Interim and Exit Programme Dashboard

Reporting Period: 01 December 2018 – 11 January 2019

RAG Key:

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Green	On track and scheduled to deliver business case/ mandate objectives within agreed constraints
Blue	Completed
White	Not yet started

Key points to note for this reporting period

Workstream	Brief Summary
Programme Governance	Milestone dates as part of the phasing in the IUC service development have been agreed through the contracting negotiations and now form part of the contract schedules.
IM&T, Estates, BI, IG	There are delays with works at Orbital House (Ashford) to ensure robust resilience in the Call Centre. The Cleric deployment remains a significant concern with "application readiness" work only recently commencing. Weekly calls have been put in place with both Cleric and EOC systems to ensure that the system is ready for staff training by end January 2019.
Recruitment & Workforce	Staff estimates identified and modelled towards development of training plan. Development of planned workforce assurance reviews incorporating appropriate actions taken to resolve identified risks.
Finance & Contracting	There still remains a gap between funding and expected costs. This is captured under risk 673.
IUC Service Development	On track with work around joint working with external providers. Further work is required in terms of role mapping to determine if current capacity will be able to support the new clinicians within the CAS.
111 CAS Contract Exit KMSS	Draft Exit plan developed and shared with Commissioners and Exit Planning meetings scheduled. This will be finalised by end January 2019 through collaboration with Care UK and other stakeholders within the mobilisation contract. Once this is complete, the RAG will move to Amber. Commissioners have set up new governance arrangements to split out the exit process from the new service mobilisation and procurement programme.

Project	Current RAG	Previous RAG
111 CAS Interim Service	Red	Red
111 CAS Contract Exit KMSS	Red	Red

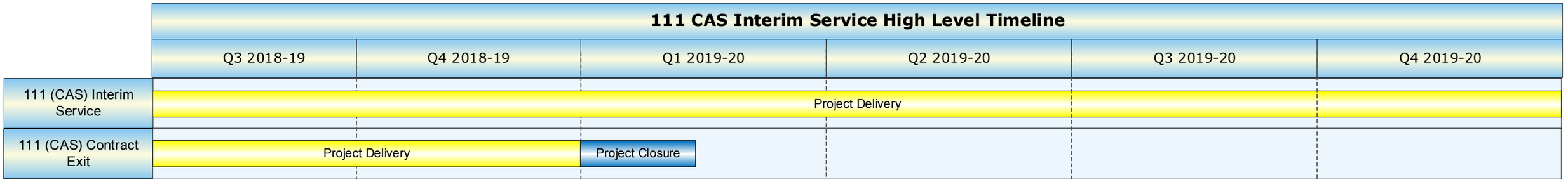
Key risks and issues

Project	Brief Summary	Score
111(CAS) Interim Service	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. To mitigate, the EOC Systems Lead has started reviewing the system and holding weekly calls with Cleric. Detail of functional review (timeline) shared with EOC Systems.	12
111(CAS) Interim Service	There is a risk that if Cleric does not have a functional CAS platform to test before the 1/4/19 go-live, we will not be able to implement the CAS as outlined in the service specification and SDIP. Mitigations includes early testing of the Cleric system to ensure issues are identified and fed back to Cleric.	9
111(CAS) Interim Service ID: 673	There is a risk around the resourcing and funding for the programme from an IM&T, EOC systems perspective, particularly for the critical network orders that have a 90-120 day lead time. Controls in place include a detailed financial model and a contract has been signed. Resources are being identified to support acceptance testing to mitigate further.	8

Achievements this period

- BT Openreach report WAN circuits completed.
- LAN equipment delivered to Switchshop, ready for pre-staging
- Statement of works signed off for Estates workstream
- Handsets delivered to Ashford
- Initial review of 'front end' functionality completed. Gap analysis with required changes shared with Cleric.
- Pathways code set updated (SG/SD/DX skill matrix).
- Review of initial TEST cases complete and feedback / questions provided to Cleric

111 CAS Interim Service High Level Timeline



Last Updated 11 January 2019 v1.0

Digital Programme Board Dashboard

Reporting Period: 01 December 2018 to 11 January 2019

RAG Key:

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Blue	Completed
White	Not yet started

Key points to note for this reporting period

Project	Brief Summary
Stations Upgrades	MRC infrastructure and Wi-Fi upgrade completed. A change request has been approved to include replacement of all PC's below the specification to run Windows 10. Project timescales and activities are currently under review.
ePCR	Feedback on the system has been positive and suggested changes sent to Cleric. A Comms plan has been produced and planning is underway for pre-live testing. Change request for extension of key activities by 6 weeks has been produced; this will not impact the overall project end date of 30/06/2019
NHS 111 (Cleric components)	Cleric deployment remains a significant concern as "application readiness" work has only recently started. Weekly calls have been put in place with both Cleric and EOC systems to ensure that the system is ready for staff training by end January 2019.
Replacement Telephony/VR Recording System	The system went live as planned on 12 December 2018. Initial problems within the system led to a BCI event being declared which was resolved by 14 December 2018. Two outstanding issues remain around reporting and call recording, these continue to be investigated.
Replacement Fleet Management System	The IT element has been completed. A change request is required to extend the operational go live date by 2 weeks to 4 February 2019 due to increased training requirements. The impact of this is minimal.
Spine Connect (PDS/SCR/CPIS)	A revised project end date is yet to be agreed. EMB have asked for a risk assessment, a trial to understand the impact and an implementation trajectory for the PDS element. A plan to address this is under development. For the SCR element 2 additional smart card printers have been ordered. The aim is for all EOC Clinicians to have Smart Cards and received training by 28 February 2019.
Auto-Temperature Monitoring	All IT activities have now been completed. Training for Medicines Team, Medicines Leads and Q.I Hub scheduled for 29th January 2019. There is the potential for delay due to sequencing of approvals of Standard Operating Procedures through JPPF. This is being actively mitigated and monitored.
GoodSam	EOC testing to confirm the interface is working and the plan is that a confirmed 'go live' date will be announced in coming weeks.

Project	Current RAG	Previous RAG
Station Upgrades	Amber	Green
ePCR	Green	Green
NHS 111 (Cleric Components)	Amber	Amber
Replacement of telephony and VR recording system	Blue	Green
Replacement of Fleet Management system	Amber	Amber
Spine Connect	Red	Red
Automated Temperature Monitoring	Amber	Amber
GoodSam	Red	Amber
Cyber Security	Green	Green

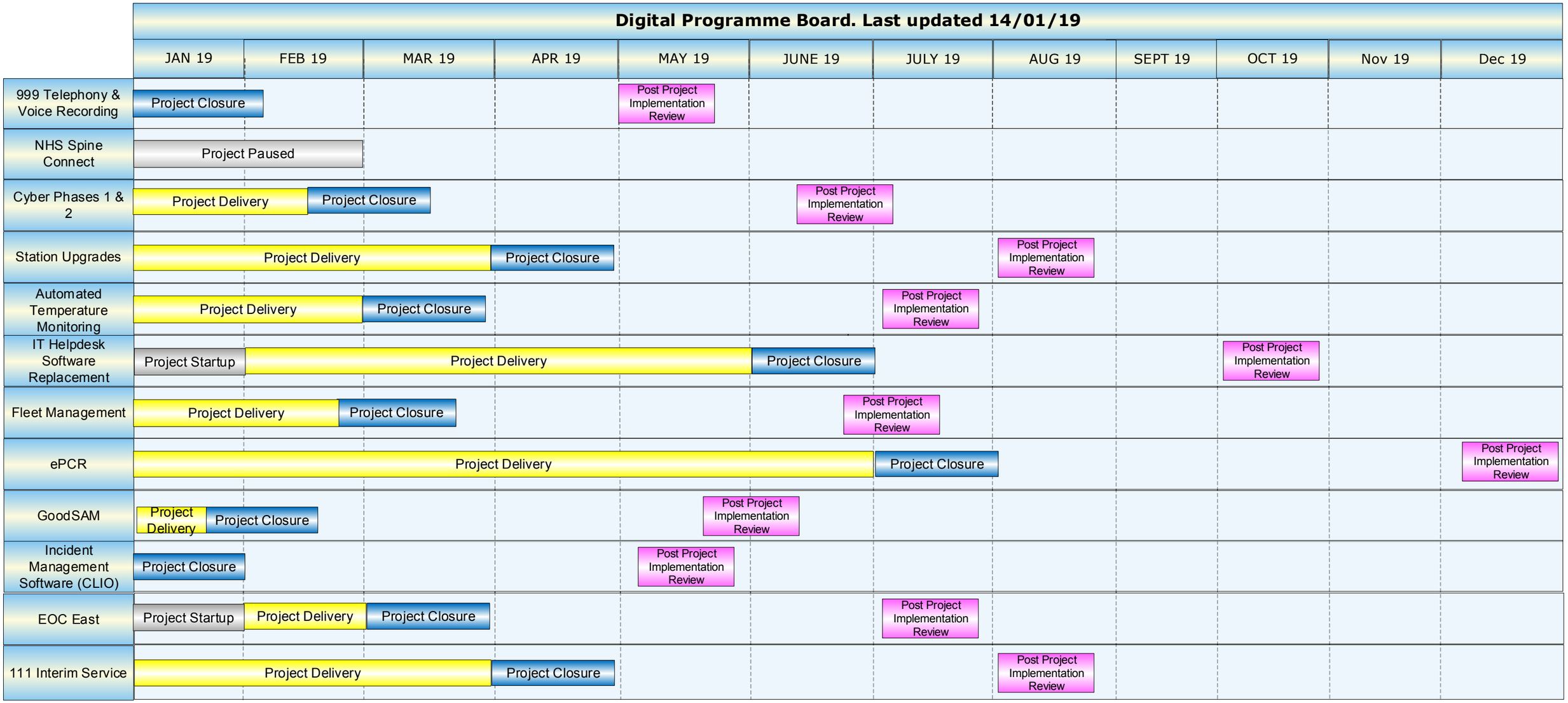
Key Risks and Issues

Project	Brief Summary	Score
ePCR	Current IT Project Manager has been transferred to 111 (CAS) Interim Service project which leaves a gap resource to deliver ePCR. Interim Project Manager interviews scheduled for week beginning 14 January 2019 and Ryan Bird and Julia Hilger-Ellis have increased their project hours to support the project	15
Spine Connect	Current lack of PDS capability will affect delivery of a number of other projects. QIA is currently being completed by EOC Operations to assess impact of delay	9
111(CAS) Interim Service - Resource	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. To mitigate, the EOC Systems Lead has started reviewing the system and holding weekly calls with Cleric. Detail of functional review (timeline) shared with EOC Systems	12

Achievements this period

- Replacement Telephony system go live 12 December 2018.
- CLIO Incident Management System go live 17 December 2018.

Digital Programme Board. Last updated 14/01/19



Last updated 14 January 2019 v1.0

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 9 - December 2018

Programme Summary:

1. Current Pipeline schemes of £12.8m against an internal stretch target of £13.5m.
2. Validated or Scoped schemes of £12.6m 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 a "Substantial Assurance" rating 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 £3.1m for the year covering these efficiencies have been developed, of which £1.7m have been achieved at M9. 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	

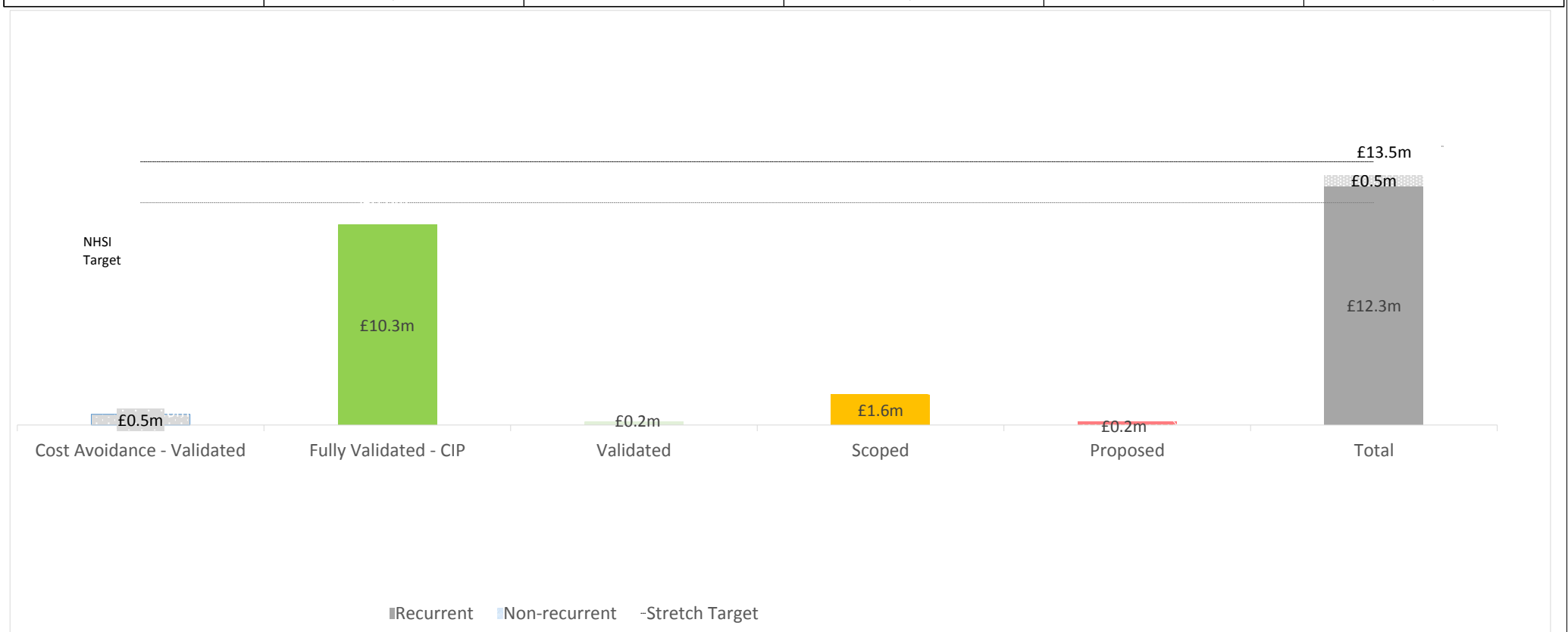
CIP Pipeline and Delivery: Risks and Issues

	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-Mar-19

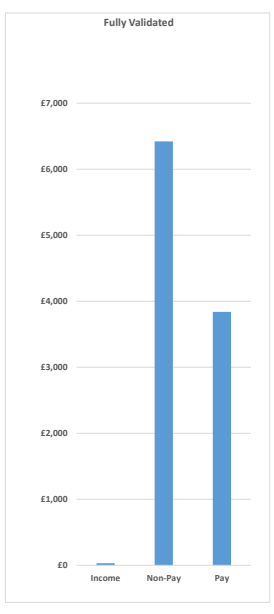
	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	New Lease Cars policy to be agreed.	Awaiting updates from John Griffiths (Response Capable Managers) and Ed Griffin (all other staff). New club car scheme recently announced - to be evaluated in terms of savngs for 2018/19.	John Griffiths/ Ed Griffin	Amber	Amber	31-Jan-19
2	Medical Consumables - procurement cost savings to be considered.	Proposed medical consumables savings to be considered after meeting with NHS Supply Chain	Kirsty Booth/ John Hughes	Amber	Amber	28-Feb-19
3	E-Expenses - potential savings from automation.	E-Expenses system has not yet gone live.	Priscilla Ashun-Sarpy	Amber	Amber	28-Feb-19
4	Agency Staff - Potential cost avoidance CIP	PMO/Finance to develop a Project Mandate	Priscilla Ashun-Sarpy/ Kevin Hervey	Amber	Amber	31-Jan-19
5	Develop Operations CIP schemes.	Project Mandates have been agreed. Savings will be monitored on a monthly basis.	Kevin Hervey/ Graham Petts	Amber	Amber	Ongoing
6	Devise a mechanism for recoveries of old staff overpayments	Ongoing discussions with Payroll Manager/HR Director	Kevin Hervey/ Ed Griffin	Amber	Amber	28-Feb-19

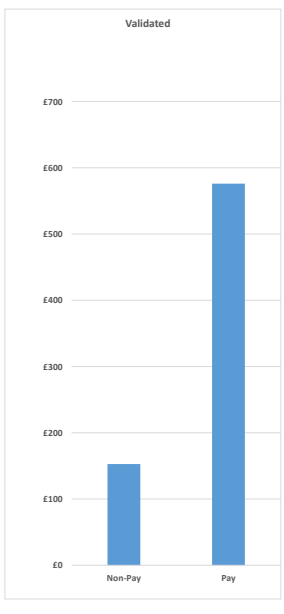
CIP Pipeline Summary

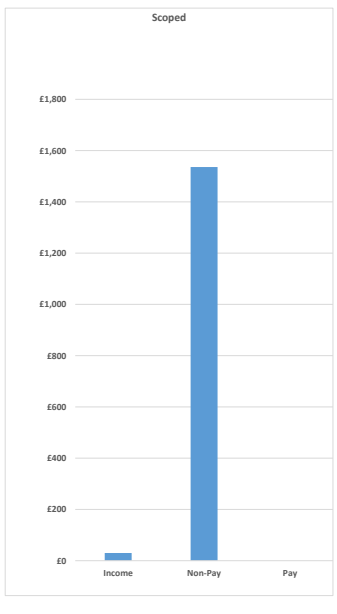
Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£549	£10,289	£178	£1,566	£180	£12,762

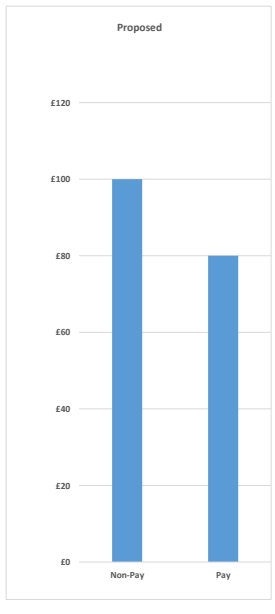


Pay / Non-Pay / Income Breakdown and scheme summary









Scheme Category	Fully Validated	Validated	Scoped	Proposed	Grand Total
Operations efficiencies	3,140	-	-	-	3,141
Accounting efficiencies	1,920	-	-	-	1,921
Recruitment delays & recharges - clinical	1,104	-	-	80	1,184
External consultancy & contractors	632	-	140	-	772
Training courses & accommodation	496	2	-	-	498
Recruitment delays & recharges - non clinical	486	25	-	-	511
IT Productivity and Phones	420	9	140	100	669
Fleet - Lease costs - ambulances	390	-	400	-	790
Travel & Subsistence	364	38	7	-	409
Medicines Management - Consumables	200	94	-	-	294
Fleet - Fuel: Telematics, Bunkered Fuel & Price Differential	200	-	-	-	200
Single HQ /EOC Benefits realisation	183	-	-	-	183
Medicines Management - Drugs	132	-	-	-	132
Medicines Management - Equipment	127	-	17	-	144
Meeting room hire	95	-	8	-	103
Discretionary Non Pay	80	-	-	-	80
Estates and Facilities management	56	10	624	-	690
Stationery	47	-	-	-	47
Printing & Postage	40	-	-	-	40
111 Efficiency	33	-	-	-	33
Furniture & Fittings	30	-	-	-	30
Interest Income	30	-	30	-	60
Income including recharges	23	-	-	-	23
Books & Subscriptions	20	-	-	-	20
Office Equipment	13	-	-	-	13
Legal fees	13	-	-	-	13
Staff Uniforms	7	-	100	-	107
Fleet - Uniforms and Contract Refuse	6	-	-	-	6
Public relations	4	-	-	-	4
Agency Premiums	-	549	-	-	549
Procurement contracts review	-	-	100	-	100
Grand Total	10,289	726	1,566	180	12,762

South East Coast Ambulance Service: CIP Workstream

CIP Delivery Dashboard

Reporting Month Dec-18

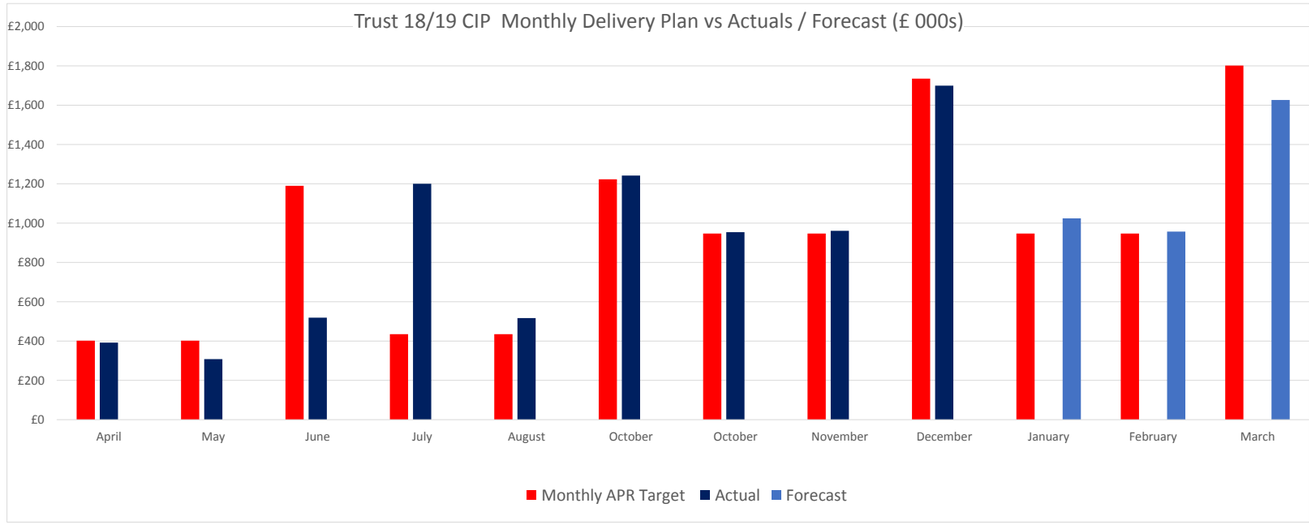
Programme for 2018/19 to deliver a minimum of £11.4m savings to achieve the planned £0.8m control total deficit.

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

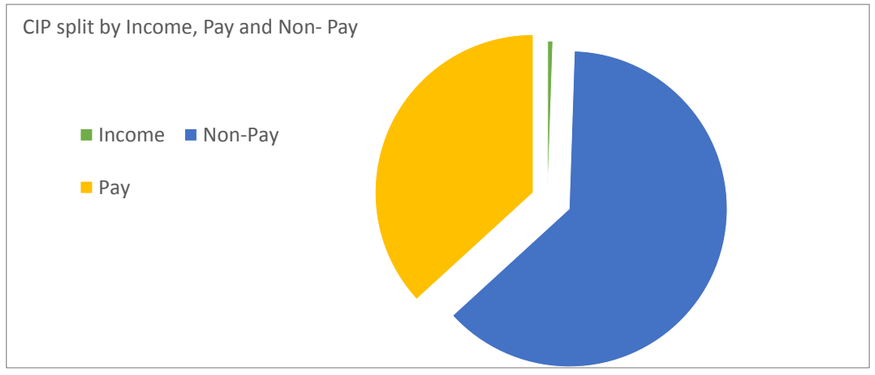
1. The CIPs target remains at £11.4m for the 2018/19 financial year.
2. £10.3m of fully validated savings have been transferred to the Delivery Tracker as at the Month 9 reporting date, of which £7.8m have been delivered against the Plan delivery of £7.7m.
3. The schemes continue to take no account of 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 £3.1m for the year covering these efficiencies have been developed, of which £1.7m have been achieved. The efficiencies will be monitored on an ongoing monthly basis. The Trust intends to develop CIP schemes for 2018/19 beyond the value of the £11.4m target to provide a buffer against any schemes which do not deliver. At this 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 December 18

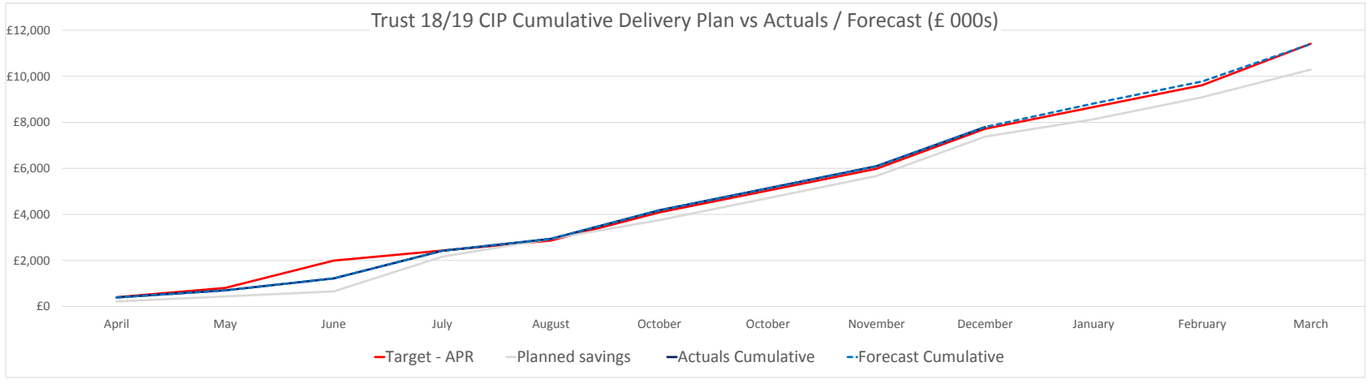
CIP Target for 18/19 £000's	Total planned savings on delivery tracker £000's - as at 31 December 2018	Total forecast savings on delivery tracker £000's - as at 31 December 2018	YTD December 18 - Target Savings £000's	YTD December 18 - Actual Savings £000's	YTD December 18 - variance £000's
11,400	10,289	11,400	7,716	7,793	£77



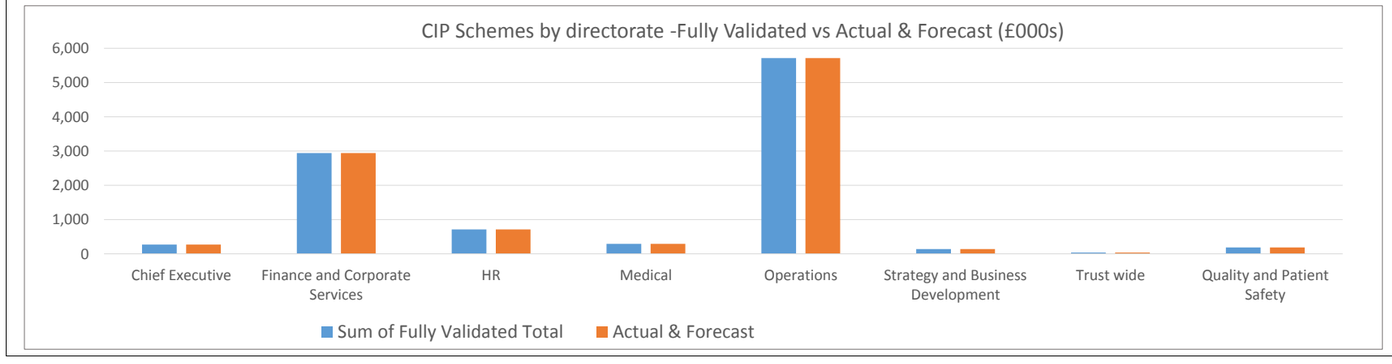
2. CIP - Planned savings split by income, pay and non-pay: as at 31 December



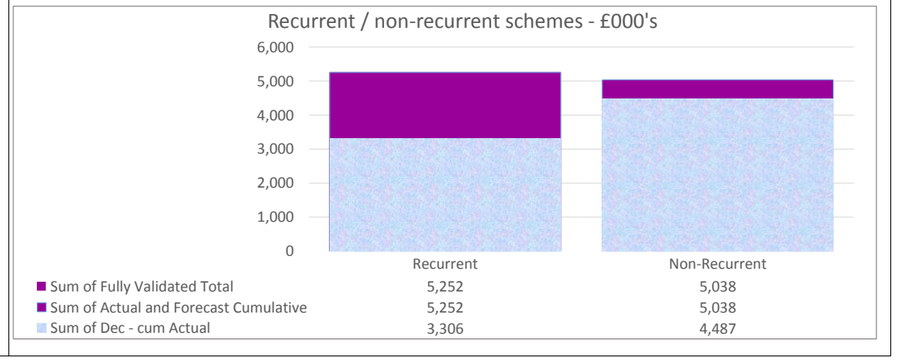
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2018/19



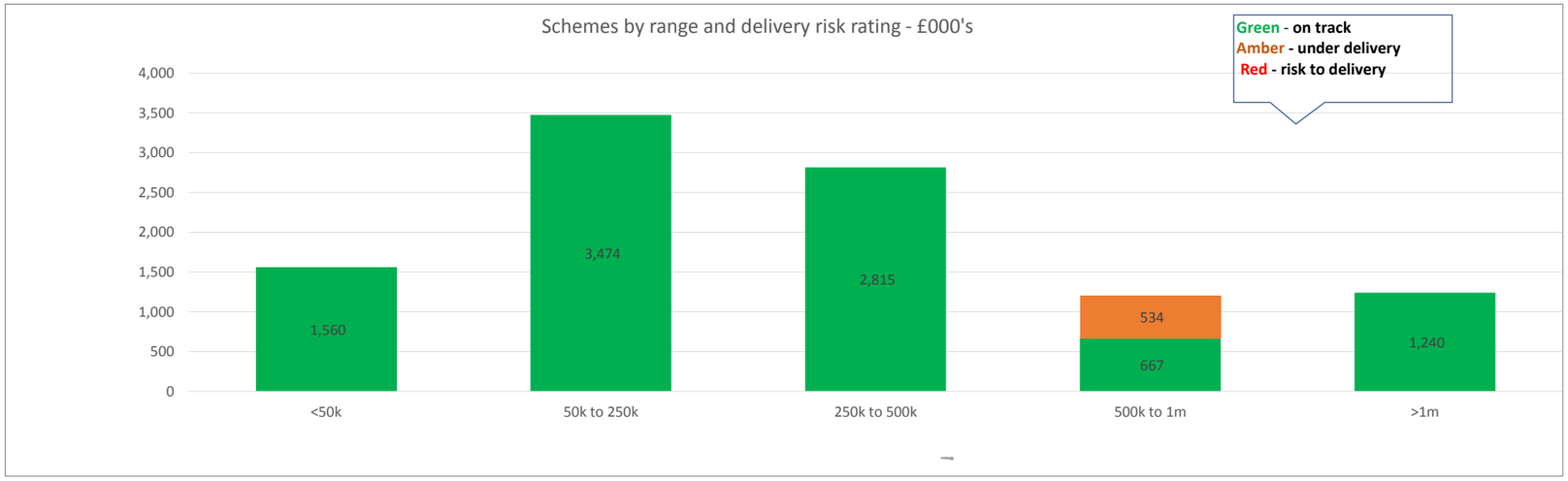
4. CIP schemes by directorate - Fully Validated vs Actual & Forecast 2018/19



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



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



7. YTD Identified CIPs to Date and Savings - December 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	£632	£632	£0	£544	£624	£80	-
Furniture & Fittings	£30	£30	£0	£23	£23	£0	-
Meeting room hire	£97	£97	£0	£74	£78	£4	-
Public relations	£4	£4	£0	£3	£3	£0	-
Stationery	£47	£47	£0	£37	£40	£3	-
Travel & Subsistence	£357	£357	£0	£291	£313	£22	-
Medicines Management - Equipment	£127	£127	£0	£100	£123	£23	-
Medicines Management - Consumables	£200	£200	£0	£167	£167	£0	-
Books & Subscriptions	£20	£20	£0	£16	£31	£15	-
111 Efficiency	£33	£33	£0	£25	£25	£0	-
Fleet - Fuel: Telematics, Bunkered Fuel & Price Differential	£200	£200	£0	£167	£167	£0	-
Estates and Facilities management	£59	£59	£0	£57	£57	£0	-
IT Productivity and Phones	£419	£419	£0	£390	£390	£0	-
Discretionary Non Pay	£91	£91	£0	£83	£88	£5	-
Training courses & accommodation	£496	£497	£1	£385	£612	£228	-
Single HQ /EOC Benefits realisation	£183	£183	£0	£149	£149	£0	-
Medicines Management - Drugs	£132	£132	£0	£99	£99	£0	-
Insurance	£833	£833	£0	£723	£723	£0	-
Printing & Postage	£40	£40	£0	£32	£32	£0	-
Operations Efficiencies	£3,140	£3,140	£0	£1,665	£1,665	£0	-
Recruitment delays & recharges - clinical	£1,031	£1,031	£0	£769	£769	£0	-
Recruitment delays & recharges - non clinical	£564	£564	£0	£548	£585	£37	-
Fleet - Lease costs	£390	£390	£0	£390	£390	£0	-
Legal Fees	£13	£13	£0	£13	£13	£0	-
Interest Income	£30	£30	£0	£30	£30	£0	-
Income including recharges	£25	£25	£0	£25	£25	£0	-
Staff Uniform	£10	£10	£0	£10	£10	£0	-
Total Fully Validated Schemes	£10,289	£10,289	£0	£7,377	£7,793	£416	-
Variance to Year To Date (YTD) Target				339		(£339)	Positive variance between Fully Validated Schemes and YTD Control Total Target
Grand Total	£10,289	£10,289	£0	£7,716	£7,793	£77	

QCSG Dashboard

Reporting Period: 01 December 2018 to 11 January 2019

RAG Key:

Red	Serious risk that the project is unlikely to meet business case/ mandate objectives within agreed time constraints; requires escalation.
Amber	Significant risk that project may not deliver to business case/ mandate objectives within agreed constraints,
Green	On track and scheduled to deliver business case/ mandate objectives within agreed constraints
Blue	Completed
White	Not yet started

Last Updated 15/01/2019 v1.2

Key points to note for this reporting period

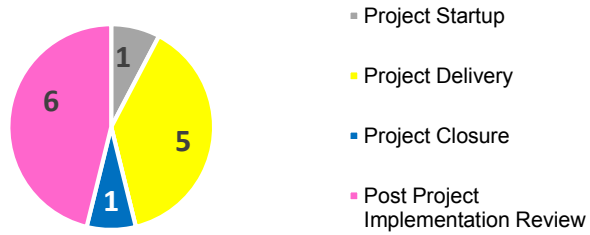
Project	Brief Summary
Personnel Files	Checks for staff with no initial DBS up to 31 May 2018 have now been completed. No evidence has been provided assuring that a backlog has not been built up since. For DBS renewals, there is still a small cohort who have not provided identification.
Culture Change (Previous)	The existing Culture Change project has been reviewed and closed on 27 November 2018.
Culture Change (New)	Project Mandate drafted for new culture project and will be finalised by January 2019, and project plans drafted by February 2019. Project documentation is in development. The Stakeholder meeting to discuss the direction of travel has not yet been scheduled.
Incident Management	It has been agreed that this project will close and transition into BAU at the end of January 2019 on the condition that the SI backlog is cleared. 30 of the 50 backlogged SI incidents are now completed.
EOC	The EOC Clinical Safety and EOC Readiness projects will be combined into a single EOC project to address the CQC Must Do. Mandate and Project Plan are being developed, overseen by Intensive Support until 28 February 2019.
PAPs	All plans have an assigned Subject Matter Expert to manage implementation and the work required to move the project in BAU by the end of February 2019. Some of these activities are behind schedule.
Post Project Implementation Reviews	Safeguarding & Complaints PPIRs completed and shared with Commissioners. Risk Management PPIR completed and approved. Future PPIRs are: IPC, Medicines Governance, Governance & Health Records.

Project	Current RAG	Previous RAG
EOC	Green	None
Governance & Risk	Green	Green
Incident Management	Red	Amber
Resourcing Plan	Blue	Amber
Personnel Files	Red	Amber
999 Call Recording (CQC 2017 Must Do)	Blue	Green
PAPs Action Plan	Amber	Amber
Health & Safety	Green	Green
Culture Change (Previous)	Blue	Amber
Culture Change (New)	Amber	Amber

Key Risks & Issues

Project	Brief Summary	Score
Incident Management	Insufficient resource within the SI team to progress with Serious Incident investigations and the SI procedure. To mitigate, two SI Manager posts have been offered and are subject to recruitment checks. SI procedure is being supported by the Deputy Clinical Director and out for engagement with Senior Managers.	12
Personnel Files ID 662	Risk of slippage due to an issue with PaperVision following a software update. Trust IT department working with DOL IT to explore possible solutions.	6

Projects by Phase



Achievements this period

- 118 ECSWs are operational and 26 AAPs have started training
- New telephony and voice recorder system went live on 12 December 2018.
- Circa 300 roles have been reviewed and agreement obtained on the level of DBS required for these.
- The target to train 120 identified staff on Risk Management has been exceeded and is now at 185.

Quality & Compliance Steering Group High Level Timeline

	JAN 19	FEB 19	MAR 19	APR 19	MAY 19	JUN 19	JUL 19	AUG 19	SEP 19	OCT 19	NOV 19	DEC 19
EOC	Project Startup											
Governance and Risk	Project Delivery			Project Closure								
Incident Management	Project Delivery	Project Closure										
Infection Prevention Control	Post Project Implementation Review											
Medicines Governance	Post Project Implementation Review											
Resourcing Plan			Post Project Implementation Review									
Personnel Files	Project Delivery						Project Closure					
999 Call Recording (2017 CQC Must Do)	Project Closure											
Medical Devices Management		Post Project Implementation Review										
Governance, Health Records and Clinical Audit	Post Project Implementation Review											
PAPs Action Plan	Project Delivery		BAU									
Health and Safety	Project Delivery						Project Closure					
Culture Change (Previous)			Post Project Implementation Review									
Culture Change (New)	Project Startup											

Last Updated 14 January 2019 v1.0

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	146/18

Name of meeting	Trust Board
Date	24.01.2019
Name of paper	Board Assurance Framework Risk Report version 2018 1.4
Responsible Executive	Executive Team
Author	Peter Lee, Company Secretary
Synopsis	The BAF Risk Report includes the principal risks to meeting the Trust's strategic goals, It sets out the controls, assurances, and actions.
Recommendations, decisions or actions sought	The Board is asked to support the progression of the BAF Risk report, and confirm its level of assurance that it is sufficiently focussed on the most relevant high-risk areas.

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

Board Assurance Framework (BAF) Risk Report - version 2018 1.4

1. Introduction

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

Should EMB consider it necessary to add or remove a risk, it will make a recommendation to the Trust Board, for decision. There is a proposal this month to remove one risk, and to replace it with another.

2. Structure of the BAF Risk Report

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

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

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

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

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

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

Low	Moderate	High	Extreme

Figure 1

3. Board Committee Review

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

Based on its most recent meetings, the table below illustrates how the focus of each Board committee reflects the BAF risks.

Committee	Agenda Item	BAF Risk
Finance and Investment	Call Handling Resources	123 / 269
	IT Update	495
	111 Service	284 (602)
Quality and Patient Safety	Safe Recruitment	362
	Clinical Queue	579
Workforce and Wellbeing	Workforce planning	111
	HR transformation	362 & 334
	Wellbeing / Diversity	111

4. Management Review & Recommendation

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

i. To remove risk 284 (which will be closed), to be replaced with risk 602. See Appendix A.
ii. To reduce the risk score for risk 269 given the improvement in call answer performance during the last quarter.
iii. To reduce the risk score for risk 111 in light of the successful delivery of the resourcing plan (100/200) as set out in the Delivery Plan.

5. Conclusion

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

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

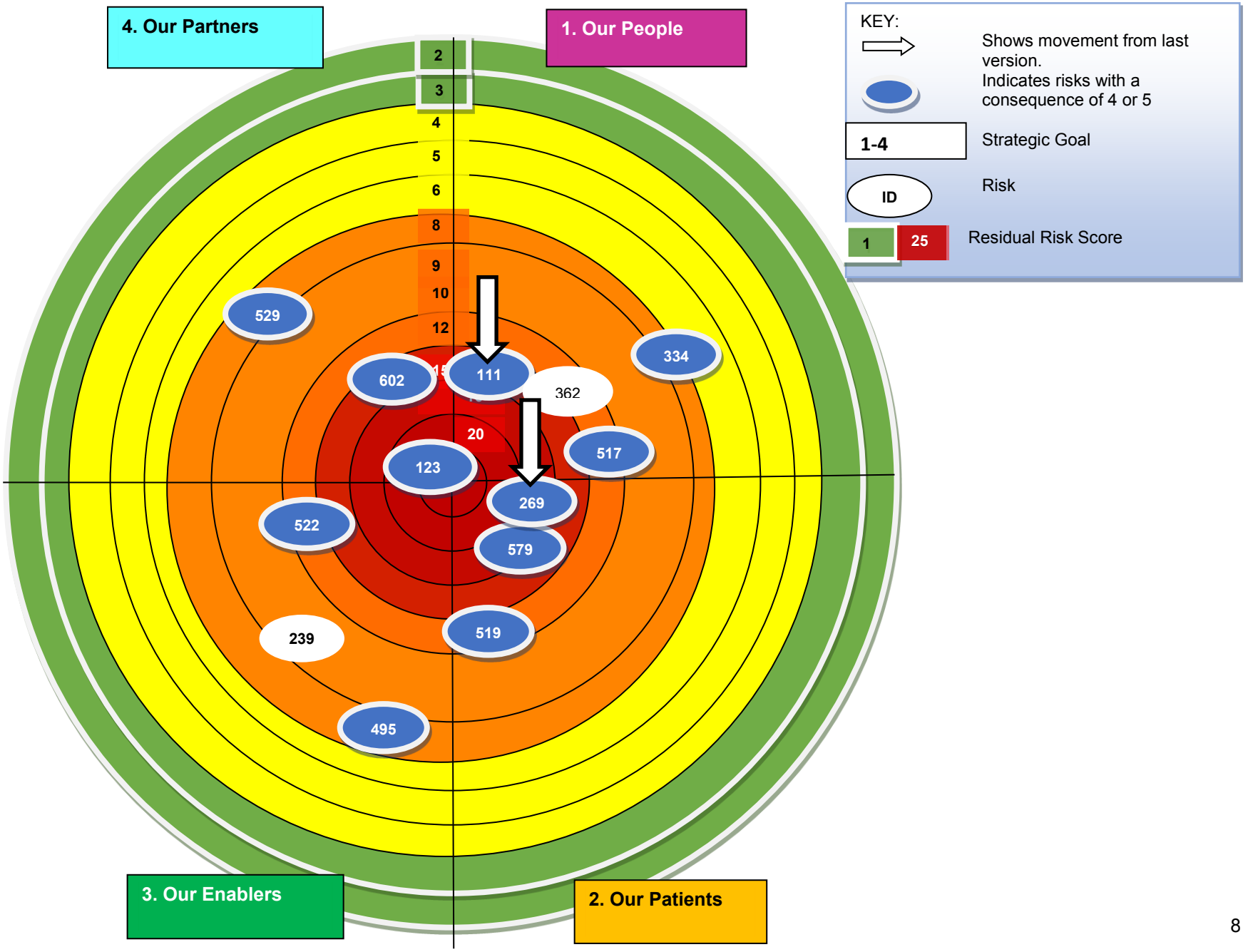
Dashboard

Links to objectives	Link to Delivery Plan (current RAG)	Risk ID / Theme	BAF Dashboard	Inherent Score	Residual Score	Target Score	Target Date	Board Oversight
5,6, 7, 8, 9, 11	Service Transformation Delivery	Risk ID 123 ARP	Risk that the Trust does not consistently achieve ARP standards as a result of insufficient resources, which may lead to patient harm.	25	25	10	01.04.2020	FIC
5, 6, 7, 8	EOC	Risk ID 269 EOC	Risk that we do not consistently answer at least 95% of 999 calls within 5 seconds as a result of; •non-delivery of the planned workforce [see separate workforce risk ID 111] •design of the processes and technology within EOC This may lead to patient harm due to delay in providing care and treatment	25	20 ⇩	5	30.06.2019	QPS
2, 3, 4	Service Transformation Delivery Resourcing Plan	Risk ID 111 Workforce	Risk that we will not deliver the planned workforce as a result of; •inability to recruit to the current gaps •not retaining current staff •inability to recruit to the future needs Due to; •not having optimal HR support functions •not having optimal education and training This may lead to poor patient (and staff) outcomes and experience, and not meeting national performance targets.	25	15 ⇩	10	01.04.2020	WWC
6, 9	**111 (CAS) Interim Service**	Risk ID 602 111 (future)	There is a risk that the short mobilisation timeline and service specification for the transformed 111 service into IUC/CAS could result in clinical care, quality and continuity of 111 service being	20	15	5	01.04.2019	FIC

			compromised during the contract transition process, as a result of a lack of confidence of both organisations delivering the agreed exit strategy. Failure to deliver on time could also result in patient harm and place adverse pressure on 999 and the wider healthcare system.						
6, 9	N/A	Risk ID 284 111 (future)	Risk of not being able to mobilise for / exit from the 111 contract as a result of delay and differential timelines of procurement, which may lead to clinical harm, financial loss, adverse pressure on 999 and the Trust not meeting its strategic aim of integration.		16	16	8	01.04.2019	FIC
2, 7	**Personnel Files**	Risk ID 362 Safer Recruitment	Risk that the Trust is not able to always provide evidence of the relevant employment checks, as a result of inadequate internal controls / record keeping, which may lead to sanctions and reputational damage.		15	12	6	30.06.2019	WWC
7	H&S	Risk ID 517 H&S	Risk that we do not comply with H&S legislation as a result of sub optimal infrastructure and governance, which may lead to harm to staff and related sanctions on the Trust and / or individual directors.		16	12	4	01.09.2019	WWC
5, 6, 7, 8, 9, 10	EOC	Risk ID 579 Care & Treatment	Risk that patients waiting for a response are not appropriately triaged, as a result of lack of clinical resource; suboptimal IT systems; and an inability to respond to demand, which may lead to patient harm.		16	16	4	TBC	QPS
5, 6, 7, 8	N/A	Risk ID 519 111 (current)	Risk that the Trust does not achieve operational standards for 111 as a result of increased pressure on the service, which may lead to patient harm.		16	12	4	30.09.2018	QPS

10	EPCR Cyber Security	Risk ID 495 IT	Risk that IT does not enable delivery of services as a result of; •system development maturity and integration not achieved at right pace •inability to respond to a major cyber crime This may lead to inability or delay to provision of care		16	08	4	31.03.2019	FIC
7, 8	N/A	Risk ID 522 Resilience	Risk that the Trust does not have appropriate business continuity plans, which may result in non-delivery of service(s)		16	12	4	31.03.2019	AuC
7	N/A	Risk ID 239 IG	Risk that the Trust does not adhere to Information Governance requirements and standards as a result of inadequate systems, resourcing and controls, which may lead to sanctions from the ICO and reputational damage.		9	9	3	01.04.2019	AuC
1, 2, 3, 4, 7	Culture Change	Risk ID 334 Culture	Risk of not improving the culture and behaviours within the Trust, as a result of; •not embedding the Trust's values and behaviours •poorly developed leadership and management styles This may lead to low staff morale, issues with retention, adverse impact on patient care and reputational damage.		12	8	4	28.06.2019	WWC
13, 14, 15	N/A	Risk ID 529 Change	Risk that the Trust is unable to influence system change as a result of; •capacity to engage with STPs and system partners •complexity of the environment, e.g. STPs at different stages This may lead to non-delivery of the Trust		12	8	4	31.03.2019	Trust Board

			strategy.						


4. Our Partners
1. Our People
3. Our Enablers
2. Our Patients
2
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529
602
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495
KEY:
Shows movement from last version.
Indicates risks with a consequence of 4 or 5
1-4
Strategic Goal
ID
Risk
1
25
Residual Risk Score

Appendix A
(BAF Risks version 2018 1.4)

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

Underlying Cause / Source of Risk:		
Risk that the Trust will not delivery the planned workforce as a result of; •inability to recruit to the current gaps •not retaining current staff •inability to recruit to the future needs Due to; •not having optimal HR support functions •not having optimal education and training This may lead to poor patient (and staff) outcomes and experience, and not meeting national performance targets.	**Accountable Director**	Director of HR & OD
	Scrutinising Forum	HR Working Group
	Inherent Risk Score	**25** (Consequence 5 x Likelihood 5)
	Residual Risk Score	**15** (Consequence 5 x Likelihood 3)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**10** (Consequence 5 x Likelihood 2)

Controls in place (what are we doing currently to manage the risk)
HR transformation programme – Process improvement and operating model workshop held Resourcing improvement plan (IP) aimed at recruiting 300 Operational external staff by December 2018 has delivered. Improved recruitment in to the EOC Having established the Clinical Framework foundations, Manchester Triage has been finalised and will be the enabler to increase clinical capacity within EOC. Overseas Recruitment
Gaps in Control
HR transformation programme runs to June 2019 Workforce Plan Increased capacity within EOC Business Case

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Internal Audit - sickness absence reporting (2016/17) (-) Internal Audit – training (2015/16) In the 2018/19 Plan (+) improved sickness rates (+) leavers reduced (+) >100% hours for 999 (+) WWC in January assured by the workforce service transformation work-stream approach, plan and evidence of delivery (+) Resourcing Plan delivered 144 new Emergency Care Support Worker (ECSW) and Associate Ambulance Practitioner (AAP) starters between April and December 2018.	Internal Audit – roster planning (in 2018/19 plan) Internal Audit – training (in 2018/19 plan)

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. HR transformation programme > June 2019 2. Resourcing approach development 3. Increased capacity within EOC Business Case to be approved	1. Current state assessment report completed. Process improvement assessment and plan completed. Operating model approved. Programme resources in place. 2. Resourcing Plan has concluded (see Delivery Plan) 3. On the Board agenda for approval 24.01.2019

Last management review	19.12.2018 Executive Management Board	**Last committee review**	17.01.2019 Workforce & Wellbeing Committee

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

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

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

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

Additional resource has been brought in to support this work to ensure an inventory of all paper files across the Trust is set up and all electronic personnel files are reviewed

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

Gaps in Control

Staff requiring DBS checks to be confirmed – scheduled for EMB in January 2019.

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Internal Audit Report – pre-employment checks (2017/18) (+) All staff have an initial DBS check in place (+) Delivery Plan showing project Red	Internal Audit – staff records (in 2018/19 plan) Evidence to support that a new backlog from June 2018 onwards has not developed For DBS renewals, there is also a small cohort of people who have not yet provided their ID

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
A number of actions are underway as set out in the project plan, which forms part of the Delivery Plan.	The DBS checks for staff with no initial DBS up to 31 May 2018 has now been completed. The electronic files are continuing to remain on target and recruitment is underway to bring in a resource to support the team. The DBS Task and Finish Group has met twice with another meeting scheduled in January 2019. Around 300 roles have been reviewed and agreement obtained on the level of DBS required for these.

Last management review	19.12.2018 Executive Management Board	**Last committee review**	17.01.2019 Workforce & Wellbeing Committee

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

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

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

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

Gaps in Control

Core behaviours development programme for all managers
Coaching network

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Roll out of the core behaviours development programme for all managers 2. Development of a coaching network 3. There is a new Culture mandate being developed with a new project plan (see Delivery Plan)	1. Some sessions have been held, others planned. 2. Due to be developed by December.

Last management review	19.12.2018 Executive Management Board	**Last committee review**	17.01.2019 Workforce & Wellbeing Committee

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

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

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

Established an enhanced H&S team
A number of specific H&S risks have been identified (on the risk register) with related mitigating actions, for example in contractor controls assurance; fleet ergonomic assessments; incidents of violence and aggression; MSK and manual handling injuries; fire safety; and working from heights.
A H&S dashboard for the H&S working group has been developed to ensure focus in the right areas, and metrics included in the Integrated Performance Report
>90% of Board members have completed IOSH training
12 month Improvement Plan (in response to the independent H&S review) is being developed
A gap analysis has been undertaken of the Trusts' Health & Safety policies
The annual Health & Safety audit plan has been implemented with a minimum of 10 audits planned per month.

Gaps in Control

Completion of IOSH training for all Board members
Improvement Plan in response to the recommendations from the independent H&S review to be completed
Policies to be established

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Third and final IOSH training session	1. Scheduled for February 2019
2. Delivery of the improvement plan	2. Ongoing
3. 10 new Health & Safety related policies have been identified.	3. Aim to complete by July 2019.
4. E-learning modules to be developed	4. 3 new E-learning modules will be available in April 2019

Last management review	19.12.2018 Executive Management Board	**Last committee review**	17.01.2019 Workforce & Wellbeing Committee

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

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Operations
Risk that the Trust does not consistently answer at least 95% of 999 calls within 5 seconds as a result of; •non-delivery of the planned workforce (see separate workforce risk) •design of the processes and technology within EOC This may lead to patient harm due to delay in providing care and treatment	**Scrutinising Forum**	Teams A/B (EOC)
	Inherent Risk Score	**25** (Consequence 5 x Likelihood 5)
	Residual Risk Score	**20** (Consequence 5 x Likelihood 4)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**05** (Consequence 5 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)	
EMA recruitment Diamond Pod to ensure new EMAs are supported Clinical Safety Navigator in place to provide oversight and management of patients waiting Surge Management Plan ensures resources are prioritised to patients with the greatest clinical need NHS Pathways clinician at each EOC 24/7 Peer support from AACE re call handling processes Introduction of real-time analyst role reviewing non-productive call handling time	Established the Clinical Framework foundations / Manchester Triage Real Time Analyst in place Incentive schemes at period of expected high demand EOC are managing scheduling locally to improve resourcing at evenings and weekends New telephony system
Gaps in Control	
Newly recruited EMAs require training Further EOC clinicians to recruit (see risk 579)	

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) call response still above trajectory – above 95% during Xmas/New Year weeks (+) reduction in ring backs asking for an ETA	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. EMA training in place 2. Recruitment to find additional EOC clinicians 3. Increased call handling capacity Business Case agreed by EMB	1. Training ongoing 2. Recruitment ongoing 3. Business Case on agenda for Board 24.01.2019

Last management review	19.12.2018 Executive Management Board	**Last committee review**	17.01.2019 Quality & Patient Safety Committee

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

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

Controls in place (what are we doing currently to manage the risk)
CAD upgrade provides better visibility of the types of calls requiring triage. Specific improvement plan is in place (see delivery plan) Overseas recruitment fair (aim to make at least 15 clinical appointments) Implementation of Clinical Support Worker to provide assurance in patient welfare calling Focus over Christmas in ensuring clinical cover, including use of non-front line facing clinicians and paramedic practitioners.

Gaps in Control
CSN Procedure

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) CQC - concerns expressed during the recent core services inspection (+) CQC – assured that improvements have been made (-) compliance with welfare calls (+) greater clinical support available over Christmas period, compared to last year	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. CSN Procedure	1. In draft

Last management review	19.12.2018 Executive Management Board	**Last committee review**	17.01.2019 Quality and Patient Safety Committee

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

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

Controls in place (what are we doing currently to manage the risk)	
Operational Recovery Plan (ORP) created in Q4 of 2017/18 to address issues currently affecting performance. This is reviewed fortnightly in meetings with Commissioners (CCG Leads for performance and quality). Contract meetings with Commissioners have moved from bi-monthly to monthly	The deployment of additional Service Advisors and the use of Patient Safety callers have helped call answering and clinical performance respectively Service Delivery Plan in place with agreed milestones for the remainder of this contract with fortnightly Contract Exit meetings with commissioners

Gaps in Control
A lack of resilience within the service to cope with the current elevated seasonal call volumes The current clinical staffing levels in Ashford are lower than planned due to higher than predicted attrition, lower than expected recruitment and rota inequalities Commissioners re-procurement of 111 service

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) (+) clinical performance not meeting national standards but compares well to national average (+) The Ashford Contact Centre is now almost fully staffed (Health Advisors) against its recruitment trajectory (+) Impact of the additional Service Advisors and the use of Patient Safety callers (+) There has been no significant increase in complaints, incidents or SIs in 2018/19 to date (+) Maintenance of full NHS Pathways compliance with regards to audit (+) The HA and CA recruitment trackers for w/c 29.11.2018 show an uplift in staff with continued recruitment planned	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Discussions with the partner provider to explore improved ways of working 2. The interim 111 Operations Manager is now in place and is actively working with the resourcing analysts to improve operational rota fill	1. Ongoing – scheduled to end partnership March 2019 2.

Last management review	19.12.2018 Executive Management Board	**Last committee review**	17.01.2019 Quality & Patient Safety Committee

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

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

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

Over 100 new vehicles, include NET vehicles to ensure focus on Cat 3 / 4
EMA recruitment in the EOC (see BAF Risk ID 269)
Recruitment (see BAF risk 111)
Daily/Weekly monitoring of Cat 1 – 4 performance, including risk mitigation in real time, including weekly progress updates to EMB.
Review of scheduling and make ready processes
External review through AACE of EOC Practice & Process completed
External review of EOC by NHS I Commissioned Project (National work)
Demand and Capacity Review agreed / additional funding agreed for 2018/19

Gaps in Control

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

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Recruitment supported by the resourcing improvement plan 2. Transaction of the D&C review 3. Service Transformation Delivery	1. Recruitment plan in intensive support, led by executive. 2. In discussion with commissioners and NHSI / E. 3. See Delivery Plan

Last management review	19.12.2018 Executive Management Board	**Last committee review**	16.01.2019 Finance & Investment Committee

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

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Finance & Corporate Services
Risk that IT does not enable delivery of services as a result of; •system development maturity and integration not achieved at right pace •inability to respond to a major cyber crime This may lead to inability or delay to provision of care	**Scrutinising Forum**	IT Group
	Inherent Risk Score	**16** (Consequence 4 x Likelihood 4)
	Residual Risk Score	**08** (Consequence 4 x Likelihood 2)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)	
CareCERT monitoring in place and reported monthly Patching carried out as appropriate 2 separate versions of Antivirus software in place (server and desktop) Advisory notices sent to staff Alerts on helpdesk through system monitoring Data is backed up to tape and kept in data safes Servers and key infrastructure items are covered by maintenance/warranty Servers are protected by UPS battery systems Adoption of Cloud First approach for new systems and potential migration of existing systems against IM&T Cloud Services Adoption template. Transfer data to a SAN environment with replication to another site to prevent data loss in the event of a failure. Resilience improvements designed into the arrangements for new HQ. Reviewed at Finance SMT 8 Feb 16. Infrastructure being moved into purpose built data centre in Crawley with high resilience on power and cooling	New WAN links installed to Coxheath and Crawley with diverse routing through different BT exchanges. Testing commenced on resilience at Crawley site. Expected to continue up 8/5/17 when main staff moves commence. Risk is further reduced once staff and EOC transition into the new site with the new resilience in place. Banstead decommissioned and relocated to Crawley and Crawley made primary site. Testing on failover between sites complete December 2017 Network config upgraded and complexity reduced in Coxheath December 2017 Review of power requirements ongoing Coxheath and Crawley Projects overseen by Digital Programme Board and Sustainability Board Application made for adoption of Cyber Essentials Plus standards in partnership with NHS England/Digital New telephone system live 12/12/18

Gaps in Control

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Intended compliance with Cyber Essential Plus through NHS Digital programme of work by April 2019	

Last management review	19.12.2018 Executive Management Board	**Last committee review**	19.09.2018 Audit and Risk Committee 18.10.2018 Finance & Investment Committee

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

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

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

IG Framework in place
IG Working Group established and now meets on a monthly basis
Data Security & Protection Toolkit (IG Toolkit)
IG training, including corporate induction
IG escalation routes (incident / SI), plus internal reporting lines from IG Lead to SIRO and Caldicott Guardian
The GDPR Action plan has been updated and an overarching Dashboard is now in place

Gaps in Control

Create a centralised repository for records management (see link to BAF Risk ID 362)
Create and complete a GDPR compliant Information Asset Register – this is required under Article 30 of the GDPR
Outstanding actions from the GDPR Action Plan
Lack of resource (IG Manager)
Registration Authority process needs to be adequately resourced and an operational business model implemented within the Trust.
New Smartcard printers need to be sourced - IG Lead is currently reviewing with suppliers and is awaiting further information from IT/Suppliers around integration.
Review of resource and processes to manage FOI requests

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) 2017/18 IG Annual Report (-) FOI compliance (+) Internal Audit Report – against the IG Toolkit (+) Over 95% compliance with IG training (+) IG Toolkit Level 2 (+) An independent 'Peer' review was completed in August 2018 with LAS.	ICO Audit – due May 2019

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

into the organisational wide records review and records management repository 3. GDPR Action Plan Delivery 4. IG Manager recruitment 5. FOI process mapping underway 6. Baseline submission of Data Protection & Security Toolkit 7. Independent 'Peer to Peer' review of mandatory IG training within 'Discover' arranged 10/01/2019 with partner organisation			Working Group, which now meets on a monthly basis. 2. There are Information Asset Owners in place and this will remain a standard agenda item for the monthly IGWG meetings. Work is to commence on implementing the new IAR during Quarter 3 2018, meetings have now been scheduled for late November / December 2018 3. PMO engaged. The 'Peer to Peer' review of the revised GDPR Action plan took place with London Ambulance Service on 20 August 2018. A summary report and updated GDPR action plan was presented to the Audit Committee and IGWG in September 2018. 4. Interviews for the IG Manager role have taken place – at this time an unconditional offer has been made subject to suitable references. 5. Due to report to senior leadership committee in November 6. Baseline submission completed. This is currently at an unsatisfactory level as we would expect at this time and further work must commence during Quarter ¾ in order to remain compliant.
Last management review	19.12.2018 Executive Management Board	**Last committee review**	19.09.2018 Audit & Risk Committee

Goal 3 Our Enablers	**BAF Risk ID 522**	**Date risk opened:**

	Resilience – continuity planning	25.05.2018

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Operations
Risk that the Trust does not have appropriate business continuity plans, which may result in non-delivery of service(s). This would include being unable to respond effectively: • at periods of high demand and prolonged escalation • to Winter pressure demands • for bank holidays • for Major Incidents • for significant events e.g. Pride • for CBRN or other Terrorist events • for weather extremes	**Scrutinising Forum**	Resilience Group
	Inherent Risk Score	**16** (Consequence 4 x Likelihood 4)
	Residual Risk Score	**12** (Consequence 4 x Likelihood 3)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

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

Business Continuity Management Policy, Business Continuity Management Plan, Departmental Business Continuity Plans.
The Resilience Forum has been established to take oversight of BC arrangements and planning
Executive resilience committee established
This Contingency Planning and Resilience team are now co-ordinating the review of Departmental BC plans.
The Resilience Forum will have oversight of this piece of work.
BC champions identified and training provided

Gaps in Control

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

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) NARU inspection findings (+) Critical friend review from AACE showing improvement since NARU inspection (+) Delivery Plan - aspects of resilience (+) Executive resilience committee – sighted in all activities / winter plans in place / major incident plan reviewed	2018 NARU inspection findings (due to report in Q4)

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

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

Goal 4 Our Partners	**BAF Risk ID 284** ***THIS RIKS IS PORPOSED FOR CLOSURE*** 111 (future) – 111 service(s) procurement	**Date risk opened: 30.11.2017**

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

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

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

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

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

Last management review	19.09.2018 Executive Management Board	**Last committee review**	19.09.2018 Audit & Risk Committee 19.10.2018 Finance & Investment Committee

Goal 4 Our Partners	**BAF Risk ID 602 – NEW BAF RISK** 111/CAS service (Kent & Sussex)	**Date risk opened:** **09.10.2018**

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Finance
There is a risk that the short mobilisation timeline and service specification for the transformed 111 service into IUC/CAS could result in clinical care, quality and continuity of 111 service being compromised during the contract transition process, as a result of a lack of confidence of both organisations delivering the agreed exit strategy. Failure to deliver on time could also result in patient harm and place adverse pressure on 999 and the wider healthcare system.	**Scrutinising Forum**	Executive Management Board
	Inherent Risk Score	**20** (Consequence 5 x Likelihood 4)
	Residual Risk Score	**15** (Consequence 5 x Likelihood 3)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**05** (Consequence 5 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)
Contract Award Letter in place Collaborative work stream with commissioners and an agreed shared risk profile A six month mobilisation period is built into the process to ensure a safe and effective transition of the NHS 111 service from the existing NHS 111 provided with (Care UK) Programme governance established A Service Delivery Plan agreed with commissioners / Fortnightly meetings with commissioners to review performance and the SDP A service exit plan has been submitted to commissioners to mitigate risk

Gaps in Control

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) SDP milestones for December achieved (-) Delivery Plan showing Red RAG-rating	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
A programme approach will be used to mobilise the new service. This approach will allow for the interdependencies to be picked up between each of the key services to ensure we have a fully functioning call centre in place in January / February for 'testing' until go live (by April 2019) Daily reviews of rotas and cross-organisation conference calls	

Last management review	19.12.2018 Executive Management Board	**Last committee review**	17.01.2019 Finance & Investment Committee

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

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

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

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

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Awaiting invitation from Frimley Health STP	

Last management review	19.12.2018 Executive Management Board	Last committee review	19.09.2018 Audit & Risk Committee

Appendix B
Strategic Goals & Objectives

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

Appendix C

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

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

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

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	147-18

Name of meeting	Trust Board
Date	24 January 2019
Name of paper	Research & Development Optimisation Strategy 2017 - 2022
Responsible Executive	Dr Fionna Moore – Executive Medical Director
Author	Professor Julia Williams – Research Lead
Synopsis	Improving the care we give to our patients is integral in everything we do, this Strategy reinforces previous strategies in ensuring that all research activities are safe and meaningful. The five year plan will support the Trust in the delivery of high quality research to improve patient care. SECAmb is committed to being a research active organisation that is committed to improving its services, clinical outcomes and patient experience through the safe implementation of innovation, service evaluation and research findings. .
Recommendations, decisions or actions sought	The Board is asked to approve the enabling strategy

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**

South East Coast Ambulance Service
NHS Foundation Trust

Caring for you and everyone

Research and Development Strategy 2017-2022

South East Coast Ambulance Service
NHS Foundation Trust

Contents

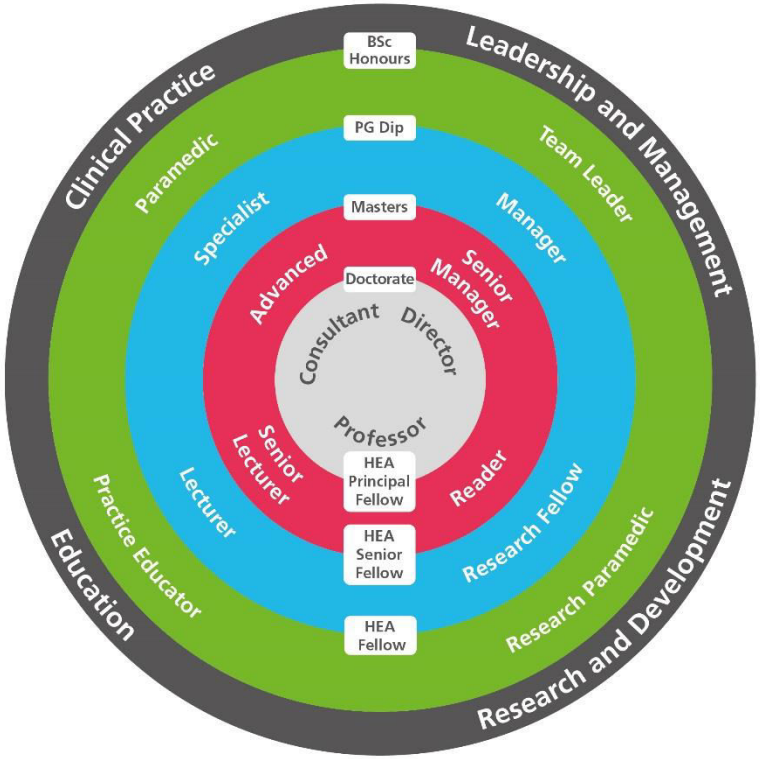
Introduction

This Research strategy will guide the development and expansion of safe, rigorous and meaningful research within our Trust. Research is recognised by the Trust as essential in the delivery and sustainability of high quality care provision. SECAmb is committed to being a research active organisation that is committed to improving its services, clinical outcomes and patient experience through the safe implementation of innovation, service evaluation and research findings. The importance of working closely with other health and social care agencies, academic partners and industry is key to its success when driving forward the safe adoption and spread of innovation and best practices grounded in evidence.

In recent years there have been significant changes in relation to the wider NHS research agenda and research governance. Ambulance services need to be prepared, engaged and responsive to the demands they will encounter in the coming years to define agreed unmet clinical need and sustain developments in clinical provision to improve patient care and the health of their local populations.

Paramedic research has grown rapidly over the last decade in the UK and since 2014 the role of Research Paramedic has been recognised as part of the Paramedic Career Framework developed by the College of Paramedics (Figure 1). It is important that ambulance Trusts capitalise on available opportunities to expand the evidence base underpinning paramedic practice and the provision of out-of-hospital unscheduled, unplanned and urgent healthcare services whilst supporting staff to develop both capability and capacity to undertake and appraise research and utilise the evidence base appropriately, safely and effectively.

Figure 1: College of Paramedics Career Framework (© Copyright 2018 College of Paramedics)



The vision of the National Institute for Health Research (NIHR) remains focused on improving the health and wealth of the nation through research. Their mission is to provide a health research system in which the NHS supports outstanding individuals working in world-class facilities, conducting leading-edge research focused on the needs of patients and the public (https://www.nihr.ac.uk/about-us/our-purpose/vision-mission-and-aims/ accessed June 2018). Government policy indicates a growing pressure on NHS organisations to ensure that research is valued as a core business priority in the development and delivery of healthcare services. SECAmb needs to position itself in the forefront of this changing landscape to realise its aspiration to 'Be better today and even better tomorrow for our people and our patients' and to ensure these developments are grounded in best available evidence and rigorous research.

The Research and Development Department have developed this strategy to be succinct, directive, and accessible. This is a dynamic document that will be reviewed in line with the Trust's overarching strategy as it progresses and in the event of changes in policy and practice.

Our strategic themes and focus

The Trust provides services to a varied catchment of 4.7 million people. The area that we cover is 9,400 square kilometres and includes Kent, Surrey, Sussex and North East Hampshire. The services we provide include responding to 999 and 111 calls and provision of the regional Hazardous Area Response Team (HART) which responds to specialist emergency challenges. To ensure we are able to deliver our services we employ 3,500 staff, of which 85% are directly involved in patient care.

This Research and Development Strategy is a fundamental component to realising our overall vision and mission which is outlined in the Trust's 5-Year Strategic Plan.
The Strategic Plan demonstrates how the Trust will ensure the provision of safe, quality care to its communities and staff. As a Trust, we recognise that there is significant work needed to improve quality for patients, deliver improved performance against targets, meet financial targets and in doing this support and develop our staff. As a Trust, we are determined to continue to learn from feedback from our staff, our volunteers and our patients and embed trust-wide change as a result of this learning. The next five years is focused on delivery of our four strategic themes which are:

Our people – supporting and developing our staff and volunteers
Our patients - ensuring timely quality of care, in the right place by the right people
Our enablers – fit for purpose technology, fleet and estates, underpinned by sustainable financial performance
Our partners – working with health, 'blue lights' and education partners
These strategic themes are translated into our strategic focus over the next five years (see Fig 2 below):

Figure 2 – Our Trust's Strategic Focus

Research and Development relates to a range of objectives across all our four strategic themes but predominantly sits under the themes 'Our Patients' and 'Our Partners' within our Strategic Plan. It therefore relates to a number of our over-arching objectives including those relating to clinically led processes, sharing best practice, improving and embedding governance and quality systems, improving clinical outcomes, care pathways, and effective clinical decision making.

Our Research and Development Strategy's Aims and Objectives

The following four strategic aims are driving our strategic objectives to ensure that our staff, volunteers, patients and public understand what we want to achieve in terms of research and development within the Trust:
SECAmb will become recognised locally, nationally and internationally for:

- The quality of its research
- Its engagement in collaborative research with health and social care partners, academic institutions and industry
- Being able to translate the products of its research into measurable benefits for patient care, health and wellbeing
- Providing an evidence base to underpin developments in paramedic practice.

To achieve these aims it is essential that the Trust develops a culture where research, innovation and service evaluation is prioritized, valued and supported as an integral part of the organisation.

Our strategic objectives

- To involve patients and the public in research at all levels
- To maintain a support and governance function for Trust staff undertaking research
- To develop and build on a research culture that enables established and aspiring researchers to develop capacity and capability
- To contribute to the evidence base that informs paramedic practice and healthcare in urgent and emergency unscheduled/unplanned healthcare
- To generate research income from all sources to ensure research activities become self-funding in the long-term
- To enhance publication and research output from SECAmb staff in both quality and quantity
- To increase research collaboration with other agencies and institutions both nationally and internationally
- To ensure that research, innovation and service evaluation are integral to the Trust's Annual Plan Review (APR)
- To ensure a high quality and sustainable research and development infrastructure with dedicated research staff to facilitate the management and expansion of these activities
- To ensure that research and development is linked with other clinical delivery strategies such as Clinical Audit, Clinical Risk and Clinical Governance
- To ensure that our research profile is recognized both internally throughout the organisation including Executive Board level, as well as externally using methods such as peer reviewed publications and presentations; social media, and representation on national and international research committees/organisations
- To ensure that innovations and all new practices introduced by SECAmb are evidence based where evidence exists and that these are evaluated with regard to measurable benefits for patient care, health and wellbeing

This strategy is informed by various developments both nationally and internationally in relation to the importance and value of health and social care research. The aim of the strategy is to provide strong research leadership and research management to maximise growth of research activities to ultimately improve patient experience and outcomes whilst developing a strong research culture embedded within our Trust.

How we will implement our research and development strategy

Implementation of the Research and Development Strategic Plan will continue over the medium term, with activities in line with the Trust's Five Year plan as identified in Fig 3.

Figure 3: Research and Development strategic focus

Research is essential to the advancement of clinical knowledge and will make a key contribution to the development of our Trust and the NHS more widely. SECAmb has established a discrete, visible Research and Development Department (RDD) staffed by permanent members of the organisation. In order to meet our strategic objectives and to realise our mission "to deliver our aspiration of being better today and even better tomorrow for our people and our patients" research must become core business in our organisation with additional investment in resources and strong research leadership to meet the demands associated with the current growth of research activity within ambulance services.
Establishing the capacity and improving the capability of the Trust to conduct research is essential for the Trust to optimise its contribution to the development and sustainability of the provision of evidence-based health care.

In addition to the RDD, the Research and Development Group (RDG) of the Trust is the strategic group set up to oversee all matters connected with research and development. The RDG's overarching principle within research activities is to ensure patient safety, clinical and cost-effectiveness, high quality and positive patient experiences, and to safeguard the reputation of the Trust by ensuring that any new treatments or other health technologies are only introduced on the basis of high quality evidence where that evidence exists; and where it does not exist that SECAmb will generate new knowledge through robust research to contribute to patient safety.

To achieve this, we will work within the highest standards of research governance to ensure that all research activity is safe and ethical, relevant and feasible, and conducted with integrity and transparency.

In addition, it is key that we work with our partners and networks to enact our strategy as follows:

National Institute of Health Research Clinical Research Network (CRN)

It is essential that SECAmb continues working with the Kent, Surrey and Sussex CRN in order to further develop both research capacity and capability within the Trust.

Academic Health Science Network (AHSN)

Another organisation that is key in funding research and development within the Trust is the AHSN. AHSNs are intended to provide opportunities to align existing networks and join up and spread best practice where it already occurs. AHSNs have the potential to enable collaborative partnerships between local NHS organisations, higher education institutions, industry, private organisations, local government and the third sector. SECAmb is an integral component of the Kent, Surrey and Sussex AHSN and strong research leadership within the Trust is essential to capitalise on the potential opportunities that will emerge from the AHSN and other collaborative structures.

Other partnerships

The Trust will strengthen contacts with partners in health, academia and industry to fully exploit opportunities to participate in clinical research.
SECAmb aspires to develop and affirm existing partnerships and establish new partnerships (especially with universities, local authorities, commercial companies, charities such as Kent Surrey and Sussex Air Ambulance, and industry) with the short-term aim of increasing involvement in research studies and the long-term aim of becoming a centre of excellence for developing and conducting studies in the areas such as: emergency care provision; urgent care provision; critical care; primary care; partnership working; patient experience; health technology; paramedic education; and improved patient outcomes.

Research and Development Annual Plan

The strategy will be enacted through an annual plan produced by the Research Manager. This will reflect on developments in research and development delineating priority areas for research and development activity in order to meet the Trust's strategic objectives. It will identify key deliverables and how these will be implemented.

Patient and public involvement

The involvement of patients and the public in the development of health research priorities and creation of research proposals is increasingly expected as a way to ensure that healthcare research is meaningful and appropriate. Public involvement in all aspects of research, innovation and service evaluation will be expanded.

SECAmb already has an excellent history of engaging the public in our research developments from inception of a research idea through to dissemination of findings and this will continue and be further expanded. Lay people, service users, clinicians and researchers have much to learn from each other and through working together we can ensure that SECAmb's research is relevant and answers key questions effectively.

It has been agreed that there will be two regular lay members on the Research and Development Group to ensure that patient and public involvement is at the forefront of the Trust's developments in research, innovation and service evaluation. In addition, the Trust will hold a bi-annual Public and Patient engagement in research event, where key issues such as patient determined research priorities will be discussed.

As we continue to develop capacity and capability in research, we will also review our research and development strategic objectives to ensure these remain current, reflect our priorities and our overarching guiding Five-Year Strategic Plan, 2017 – 2022. Therefore, each time we update our Five-Year Strategic Plan, 2017-2022 we will also review and refresh our Research and Development Strategy maintaining this as a dynamic document.

References:

Five Year Strategic Plan 2017 - 2022 SECAmb

National Institute for Health Research Vision, Mission and Aims https://www.nihr.ac.uk/about-us/our-purpose/vision-mission-and-aims/ accessed June 2018)

College of Paramedics (2018) Post Registration Paramedic Career Framework (4th Edition) Bristol: CoP page 9

NHS Five-Year Forward View. October 2014. (Link)

Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21, December 2015. (Link)

NHS Constitution for England. Updated 14 October 2015. (Link)

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	148-18

Name of meeting	Trust Board
Date	24th January 2019
Name of paper	The NHS Long Term Plan
Executive sponsor	Steve Emerton, Executive Director of Strategy and Business Development
Author(s) name and role	Jayne Phoenix, Deputy Director of Strategy & Business Development Charlie Adler, Integrated Urgent Care Programme Manager
Synopsis (up to 120 words)	For information. The document has been prepared to highlight those areas of the NHS Long Term plan that relate to SECAmb's service delivery and strategy.
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).	**No**

The NHS Long Term Plan and SECAmb

Introduction

The NHS Long Term Plan was published on the 24th December 2018. This paper provides a summary of the relevant contents of the plan to SECAmb, our current position in relation to the items identified and the next steps planned and required.

Embedded below are the full Long Term Plan and the official summary:

NHS Long Term Plan Summary.pdf

The NHS **Long Term Plan and SECAmb**

This following table provides a summary of the key elements of the NHS Long Term Plan which relate to SECAmb.

Chapter 1: A New Service Model for the 21st Century		
The NHS will Reduce Pressure on Emergency Hospital Services: **Pre Hospital Urgent Care**		
FOCUS	**EXTRACT FROM NHS LONG TERM PLAN**	**RELEVANCE TO SECAmb**
Care Advisory Service (CAS)	1.25. To support patients to navigate the optimal service 'channel', we will embed a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours' services from 2019/20. This will provide specialist advice, treatment and referral from a wide array of healthcare professionals, encompassing both physical and mental health supported by collaboration plans with all secondary care providers. Access to medical records will enable better care. The CAS will also support health professionals working outside hospital settings, staff within care homes, and paramedics at the scene of an incident and other community-based clinicians to make the best possible decision about how to support patients closer to home and potentially avoid unnecessary trips to A&E. This includes using the CAS to simplify the process for GPs, ambulance services, community teams and social care to make referrals via a single point of access for an urgent response from community health services using the new model described at paragraph 1.8 above.	The Trust has embraced NHS England's vision of a multidisciplinary CAS through the pursuit of Integrated Urgent Care (IUC) procurements that are ongoing within our region. These changes are central to a coordinated strategy to improve the experience of patients navigating the urgent care system as well as a mechanism to bring a greater depth of clinical expertise into our 999 contact centres. As providers of both NHS 111 and 999 we understand the synergies that exist in bringing together contact centres, technology and processes to improve the service we provide to all patients and to realise efficiencies that benefit performance and quality. We are also working with partners to ensure that organisational 'ownership' of the collective workforce is not a barrier to good patient care. The Trust already supports multi-professional clinical working by employing and hosting Mental Health professionals, Midwives, Nurses and Pharmacists in our contact centres. Our intention is to increase the quantity and the depth of clinical expertise within our contact centres

		in order to deliver much increased rates of hear and treat and, in time, consult and complete. **The next steps are to:** • Continue to develop our CAS model. • To develop the interim model for Sussex and Kent. • To develop our relationship with the new Surrey provider to ensure we fully participate in the Surrey model. • To consider tender opportunities for the future IUC contract for the Sussex, Kent & Medway System.
Urgent Treatment Centres (UTCs)	1.26. We will fully implement the Urgent Treatment Centre model by autumn 2020 so that all localities have a consistent offer for out-of-hospital urgent care, with the option of appointments booked through a call to NHS 111. UTCs will work alongside other parts of the urgent care network including primary care, community pharmacists, ambulance and other community-based services to provide a locally accessible and convenient alternative to A&E for patients who do not need to attend hospital.	The national roll out of the UTC model will result in standardisation of services that SECAmb interacts with. The effective use of alternative services also relies on an effective Directory of Services and the Trust works closely with commissioners, particularly around our NHS 111 and developing CAS service to ensure that this is up to date. **The next steps are to:** • Ensure that we are aware of all developments and work closely with systems and commissioners where service changes are contemplated that may result in changes in conveyance and travel time. SECAmb will continue to use proven modelling approaches in this regard. • Continue to ensure we add developing and changing models into our response offers. • Work with the UTC providers to ensure appropriate disposition to these to optimise their use.

Urgent and Emergency Care (UEC) and Hospital Handover	1.27. Ambulance services are at the heart of the urgent and emergency care system. We will work with commissioners to put in place timely responses so patients can be treated by skilled paramedics at home or in a more appropriate setting outside of hospital. We will implement the recommendations from Lord Carter's recent report on operational productivity and performance in ambulance trusts, ensuring that ambulance services are able to offer the most clinically and operationally effective response. We will continue to work with ambulance services to eliminate hospital handover delays. We will also increase specialist ambulance capability to respond to terrorism. Capital investment will continue to be targeted at fleet upgrades, and NHS England will set out a new national framework to overcome the fragmentation that ambulance services have experienced in how they are locally commissioned.	We aim to be a key provider and collaborator in our geography's urgent and emergency care systems, working increasingly closely with and across systems to optimise care. The Trust continues to undertake live and retrospective reviews of conveyances to better understand where alternative destinations to A&E such as UTCs may better meet patient need, both as a trust and with our system partners. This work has also been a central feature of the Hospital Hand Over Task/Finish Group which brings together the regional system to share best practice around reducing the hours lost to hand-over delay. These efforts have contributed to a 35% reduction in ambulance hours lost to hand over in December 2018 compared to December 2017. **The next steps are to:** • Enhance SECAmb's participation in this agenda by expanding on developments and successes and partnership working. • Continue to drive handover work to make further reductions and support improving whole system working.
The NHS will Reduce Pressure on Emergency Hospital Services: **Reforms to Hospital Emergency Care, Same Day Emergency Care**		
Data	1.33. Without access to timely and accurate data we cannot maximise the opportunities to improve care for all patients. The new Emergency Care Data Set (ECDS) is enabling us to better understand the needs of patients accessing A&E departments. We will embed this into UTCs and SDEC services from 2020. We will develop an equivalent ambulance data set that will, for the first time, bring together data from all ambulance services nationally in order	SECAmb has invested in updating the suite of systems that shape the data we produce. By implementing Microsoft Power BI we have been able to introduce a step-change to our ability to act on live data and to make better decisions in real time. This improvement also aligns with a series of planned enhancements that collectively will allow us

	to follow and understand patient journeys from the ambulance service into other urgent and emergency healthcare settings.	to more seamlessly support a patient's journey through the system and across multiple providers. Patient Demographic Searching, Summary Care Record Access, enhancements to our Hospital Inbound System and our soon to launch electronic patient record solution will cumulatively allow us to maximise our ability to improve care for all patients. **The next steps are to:** • Develop and refine SECAmb reports to Trust Board, Commissioners and system partners to make the best use of data in a more responsive way. • Develop SECAmb reporting as part of system reporting for Integrated Care Systems (ICS) and Sustainability Transformation Partnerships (STPs).
Chapter 3: Further Progress on Care and Quality Outcomes		

Better Care for Major Health Conditions		
Cardiovascular Disease	3.71. Fast and effective action will help save lives of people suffering a cardiac arrest. The chance of survival from a cardiac arrest that occurs out of hospital doubles if someone receives immediate resuscitation (CPR) or a high energy electric shock to the heart (defibrillation). A national network of community first responders and defibrillators will help save up to 4,000 lives each year by 2028. This will be supported by educating the general public, including young people of school age, about how to recognise and respond to out of hospital cardiac arrest. We also will work with partners such as the British Heart Foundation to harness new technology and ensure the public and emergency services are able to rapidly locate this life saving equipment in an emergency. More effective mapping of data on incidence will help direct community initiatives to areas where they are most needed, with the British Heart Foundation's national Outcomes Registry allowing us to track survival rates and target unwarranted variation. **CASE STUDY:** **CPR and GoodSAM** Apps and mobile technology are increasingly helping people to play a role in their own care and that of others. The GoodSAM app platform allows members of the public who can deliver basic life support (CPR) and use a defibrillator to receive alerts from anyone in their local area who needs urgent assistance. It integrates with ambulance dispatch systems and also features a crowdsourced map of defibrillators – including those in vehicles. The platform now has over 19,000 volunteers and partnerships with 80 organisations, including many NHS ambulance trusts. This is being supported to scale nationwide.	The Trust is developing a cardiac arrest strategy and working to develop and improve our clinical outcomes for this care area. The Trust has added the functionality to embed the GoodSAM platform directly into our Cleric CAD platform, When this goes live later this year the Trust will be able to link into a regional network of first responders and defibrillators to improve early life-saving interventions. The Trust also continues to support the national Restart a Heart initiative and has helped to train thousands of children and adults in Basic Life Support. **The next steps are to:** • Complete and implement the SECAmb Cardiac Arrest strategy including working with partners and the community to improve clinical outcomes. • To optimise further developments in conditions such as hypertension and Atrial Fibrillation that are often encountered during patient interactions with ambulance clinicians. • Work with the developing STPs and Integrated Care Systems to ensure that SECAmb's is contributing to making every contact count around health promotion and primary prevention. • Understand SECAmb's role in the provision

		of recently announced government intentions to add first aid to the national curriculum.
Stroke Care	3.73. Stroke, a preventable disease, is the fourth single leading cause of death in the UK and the single largest cause of complex disability123. Stroke mortality has halved in the last two decades124. However, without further action, due to changing demographics, the number of people having a stroke will increase by almost half, and the number of stroke survivors living with disability will increase by a third by 2035125. 3.74. There is strong evidence that hyper acute interventions such as brain scanning and thrombolysis are best delivered as part of a networked 24/7 service126. Areas that have centralised hyper-acute stroke care into a smaller number of well-equipped and staffed hospitals have seen the greatest improvements127. This means a reduction in the number of stroke-receiving units, and an increase in the number of patients receiving high-quality specialist care. Integrated Stroke Delivery Networks (ISDNs) involving relevant agencies including ambulance services through to early supported discharge will ensure that all stroke units will, over the next five years, meet the NHS seven-day standards for stroke care and the National Clinical Guidelines for Stroke.	The Trust is working internally to continue to improve our clinical outcomes for stroke. This includes prevention as well as the handling of stroke care Externally we are working with partners to refine stroke pathways and systems to optimise patient outcomes with work going on in all parts of our geography at present **The next steps are to:** • Continue to work on the developments above. • Look at the opportunities unlocked by the SECAmb's forthcoming Electronic Patient Notes implementation to better shape the wider system response to health promotion in partnership with our STPs.
Adult Mental Health Services		
Emergency Mental Health (MH) Support	3.95. We will expand services for people experiencing a mental health crisis. Three years ago, only 14% of adults surveyed felt they were provided with the right response when in crisis, and only half of community teams were able to offer an adequate 24-hour, seven-day crisis service150. In 2016, only 12% of hospital A&E departments had an all-age mental health liaison service meeting the 'core 24' service standard151.	Much like our partner ambulance Trusts in Yorkshire and the South West, SECAmb recognises that a significant proportion of our 999 and 111 calls have a mental health nature. We have engaged with partners to develop a range of enhancements to the services we provide. These include:

	3.101. Ambulance staff will be trained and equipped to respond effectively to people in a crisis. Ambulance services form a major part of the support people receive in a mental health emergency. For example, South Western Ambulance Service NHS Foundation Trust reports that at least 10-15% of all calls are related to mental health. By 2023/24 we will introduce new mental health transport vehicles to reduce inappropriate ambulance conveyance or by police to A&E. We will also introduce mental health nurses in ambulance control rooms to improve triage and response to mental health calls, and increase the mental health competency of ambulance staff through an education and training programme. A six-month pilot in the Yorkshire Ambulance Service NHS Trust showed that 48% of mental health calls were usually conveyed to A&E, but only 18% when triaged by a mental health nurse.	• Continuing to refine our responses to those requiring ambulance responses in relation to MH needs, including those sectioned under the mental health act. • Employment of a mental health nurse consultant to oversee our developments in Mental health, partnerships to do so and the education of our staff Joint Response Units with Police in parts of Kent and Surrey. • Piloting of a joint street triage pilot in Crawley which aims to better meet the needs of patients presenting with mental health crisis. • Investing in appropriately trained mental health professionals to work within our emergency operations and contact centres. • Partnership working with our NHS Mental Health partners to redesign the relationship between organisations and integrate services behind fewer access points for patients. • Working with national team and other ambulance services to develop mental health pathways and care options such as differing transport models. **The next steps are to:** • Continue to refine and work on the developments above and initiate new pathways to meet needs. • Study and potentially adopt learnings from national examples through the #ProjectA programme.

Chapter 4: NHS Staff will get the Backing They Need		
Expanding the Number of Nurses, Midwives, AHPs and Other Staff		
Apprenticeships	4.20. 170,000 Allied Health Professionals (AHPs) in 14 professions work independently across the spectrum of care from primary to specialist care provision. AHPs can significantly support the demand profile the NHS faces and we have recently published 15 studies demonstrating how AHPs currently support patient flow across the whole system163. The national workforce group will build on these to make specific recommendations for AHPs, in particular those in short supply – paramedics, podiatrists, radiographers, and speech and language therapists. The Chief Allied Health Professions Officer will further develop the national AHP strategy AHPs into Action to focus on the delivery of the Long Term Plan. North West Ambulance Service NHS Trust offers 145 apprenticeships a year, including level 4 ambulance associate practitioner apprenticeships. This has now been developed for all 10 ambulance trusts.	In SECAmb we are developing our apprenticeship programme as a core part of our Human resources transformation work programme **The next steps are to:** • Refine and implement our programme. • If successful in Integrated Urgent Care procurements, explore the potential to use the apprenticeship programme to further expand the Workforce Blueprint set out by NHS England to develop our NHS 111 workforce.
Supporting our Current NHS Staff		
#ProjectA	4.44. The best solutions come from staff themselves. Talk Health and Care allows staff to post ideas, questions and challenges, and is already providing useful insights into the experiences of our people. NHS England is also backing #ProjectA, a 12-month, staff-led engagement exercise with 2,000 staff across all 10 ambulance	The Trust has engaged proactively with #ProjectA and continues work with all on this especially regarding falls, mental health, health and well-being and hospital hand over **The next steps are to:**

	trusts in England. Teams of ambulance staff and patients identified six priorities to be implemented across the country, including how to reduce stress and isolation for frontline staff.	• Continue to work on the developments above. • Evaluate national exemplars for the relevance and applicability to our developing service delivery model.
Supporting Health and Care Professionals		
Prevention and Support	5.17. Supporting moves towards prevention and support, we will go faster for community-based staff. Over the next three years we want all staff working in the community to have access to mobile digital services, including the patient's care record and plan that will help them to perform their role. This will allow them to increase both the amount of time they can spend with patients and the number of patients they can see. Ambulance services will also have access to the digital tools that they need to reduce avoidable conveyance to A&E.	We will optimise our support to this agenda via 'every contact counts' We recognise this area as a key development for us moving forward over the next period as part of the national #ProjectA work , and also as a component of our system working with other partners **The next steps are to:** • Develop a programme of work specific to this care area. • Work with all providers who deliver a Clinical Assessment Service to ensure that community pathways are embedded and utilised to their maximum extent.
Chapter 6: Taxpayers Investment will be used to Maximum Effect		
Reducing Waste and Increasing Time to Care		
Reducing Variation	iv. The NHS will improve efficiency in community health services, mental health and primary care, which together cost around £27 billion a year. This Long Term Plan sets out the new investment we	Following the recommendations of the Carter Review, the Trust is aware of the need to explore every option to reduce waste. The advanced state of our Make Ready centre

	will make to improve these services. We will also support staff to increase the amount of time they can spend with patients to reduce the unacceptable variation as, for example, documented in Lord Carter's review of community services. To enable this, over the next three years, we want all staff working in the community to have access to mobile devices and digital services as set out in Chapter Five. Ambulance services will be able to reduce avoidable conveyance to A&E by accessing patient records, alternative services and have the right clinical support and training. We will also ensure primary care networks can be most effective by introducing extended roles such as physiotherapists, clinical pharmacists and pharmacy technicians as set out in Chapter One. The GIRFT programme has already started work in mental health and will be extended across to community health services and primary care from April 2019.	model has already delivered significant savings around the management of stock levels and similar gains have been achieved through the comprehensive restructuring of medicines management procedures. The Trust is involved in another of the recommendations around developing and evaluating a national ambulance specification. **The next steps are to:** • Complete the transition to the Make Ready model across the remaining areas of the Trust estate. • Ensure that the Trust fully realises the benefits of Digital in regards to delivering improvements in time to care.
Financial Position	6.3. Putting the NHS back onto a sustainable financial path is a key priority in the Long Term Plan and is essential to allowing the NHS to deliver the service improvements in this Plan. This means: • the NHS (including providers) will return to financial balance; • the NHS will achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care; • the NHS will reduce the growth in demand for care through better integration and prevention; • the NHS will reduce variation across the health system, improving providers' financial and operational performance; • the NHS will make better use of capital investment and its existing assets to drive transformation.	See financial reports. We are also working with our system partners regarding the wider system financial position

Chapter 7: Next Steps		
	We will build on the open and consultative process used to develop this Plan and strengthen the ability of patients, professionals and the public to contribute by establishing the new NHS Assembly in early 2019. 2019/20 will be a transitional year, as the local NHS and its partners have the opportunity to shape local implementation for their populations, taking account of the Clinical Standards Review and the national implementation framework being published in the spring, as well as their differential local starting points in securing the major national improvements set out in this Long Term Plan. These will be brought together in a detailed national implementation programme by the autumn so that we can also properly take account of Government Spending Review decisions on workforce education and training budgets, social care, councils' public health services and NHS capital investment. Within the current legal framework, the NHS and our partners will be moving to create Integrated Care Systems everywhere by April 2021, building on the progress already made. ICSs bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. They will have a key role in working with Local Authorities at 'place' level, and through ICSs, commissioners will make shared decisions with providers on population health, service redesign and Long Term Plan implementation.	We work closely with 2 STPs and 2 ICSs and have good relationships and involvement. We do recognise we need to develop further our work with Frimley Health ICS **The next steps are to:** • Continue to develop and expand SECAmb's relationships with our ICS and STPs. • Continue to be core partners in Surrey Heartlands Integrated Care System as it transitions into a devolved care system from the 1st April 2019. • Become core partners in Frimley Health ICS. • To use our regional perspective to be an 'agent of change' and enhance learning across the multiple systems across the Trust's geography. • To fully utilise our ability to provide the wider perspective to share good practice and avoid unwarranted variation. • To be able to fully articulate and refine our regional offer and our more local offer in line with local needs.

		• To ensure that SECAmb remains a committed system leader in changes that impact across organisational boundaries. • To develop our role as a leader in supply of the paramedic workforce across our region.

Next steps

The Trust continues to improve its services and together with the patients we respond to, is benefiting from recent Commissioner Investment. The Trust programmes of work including our people, digital and ultimately delivering required standards means that we are increasingly better placed to continue our work as a key partner in the region.

SECAmb will be able to be at the heart of moving forward the wider agenda articulated within the NHS Long Term Plan. This will be with our partners in ICS's, STPs, police and fire and rescue and the wider community.

Jayne Phoenix

Deputy Director of Strategy and Business Development

Charlie Adler

Integrated Urgent Care Programme Manager

18/1/19

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	149-18

Name of meeting	Trust Board
Date	24.01.2019
Name of paper	STP Population Health Check
Executive sponsor	Chief Executive
Synopsis (up to 120 words)	The 'Population Health Check' (Appendix 1) for Sussex and East Surrey has been developed by the STP Clinical and Professional Cabinet. Membership of the Cabinet includes the Medical Directors and Clinical Chairs of partner organisations, as well as representation from Chief Nurses, NHS England, Public Health, the Academic Health Science Network and the Clinical Senate. The Population Health Check represents a diagnostic for our system and highlights the priority areas that need focus to allow health and care services to better meet the needs of our populations. It builds on local plans and intelligence and aims to provide a unified picture of the key areas for change across the health and care system. There are five priority areas highlighted in the Health Check: 1. Workforce and capacity strategy 2. Shared decision-making and patient activation 3. Re-framing our cultural norms to make the right lifestyle choices easy to make. 4. Addressing unwarranted clinical variation. 5. Mental and physical health services and social services closer to home with good communication and co-ordination. The Population Health Check has been endorsed by the STP Executive, which is made up of the Chief Executives from all statutory NHS organisations across Sussex and East Surrey. It is going through the NHS Boards / Governing Body meetings of each of these organisations in January and February. The next step is for the STP Clinical and Professional Cabinet to use the information outlined in the Population Health Check to develop a clinical strategy for the population. As the strategy is developed, a sustained period of engagement will take place with patients, staff, public, clinicians and other stakeholders. This engagement process will be called 'Our health and care…Our future' and will provide the opportunity for the strategy to be co-produced and informed by patient, public and staff feedback. The strategy will be aligned to the delivery of the NHS Long-term Plan.
Recommendations, decisions or actions	The Board is asked to reviews and endorse the STP Population Health Check, and note the planned next steps and timeframes, including the

sought	development of a wider clinical strategy for the Sussex and East Surrey STP and need for organisational strategies to be aligned to support delivery.	
Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).		**No**