

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 <ul style="list-style-type: none"> • Cat 1 performance – 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

		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 its 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

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.

3.3.2 ● **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 assess, 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.

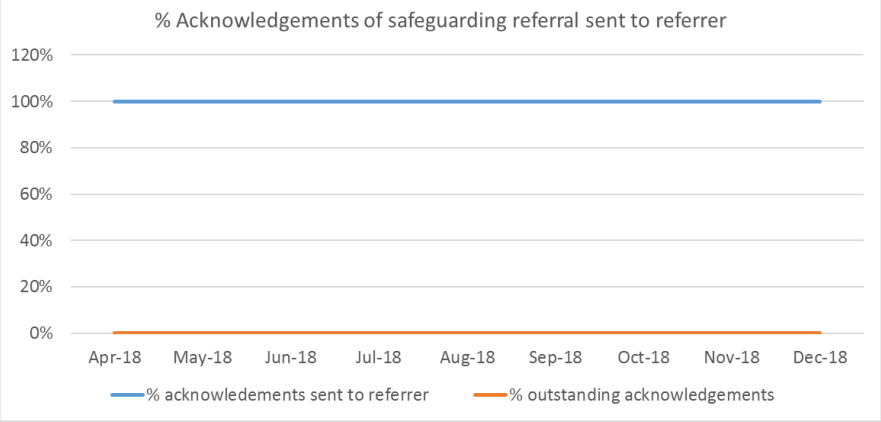
- 7.4** ● **People Risks** – The RAG remains Green. The aim of the project is to review all people risks across the Trust and to present a plan on how to mitigate major risks that compromise the Trust's ability to operate effectively.

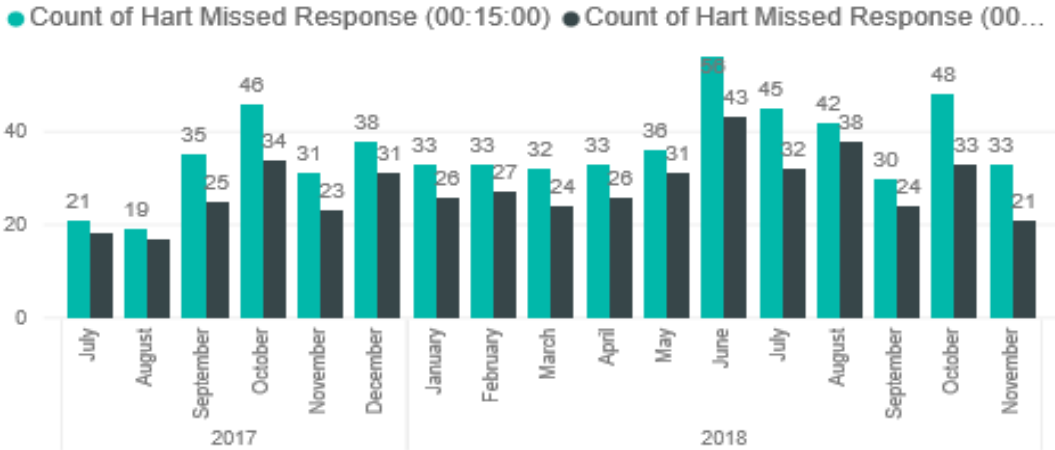
The project will work with the Risk team ensuring that all the HR Directorate risks are correctly managed and mitigated according to the Trust's process.

- 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.

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

Domain	CQC Findings ('Must or Should Do')	Metric 1	Metric 2	Monitored via																																								
Safe	The Trust should ensure the processes for providing staff with feedback from safeguarding alerts is improved to strengthen and develop learning.	 <table border="1" data-bbox="923 766 2368 955"> <thead> <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> </thead> <tbody> <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> </tbody> </table>		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Total Referrals	1033	1109	1199	1173	1170	1050	1045	1275	1167	No. acknowledgements sent to referrer	1033	1109	1199	1173	1170	1050	1045	1275	1167	No. outstanding acknowledgements	0	0	0	0	0	0	0	0	0		Safeguarding Action Plan
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18																																			
Total Referrals	1033	1109	1199	1173	1170	1050	1045	1275	1167																																			
No. acknowledgements sent to referrer	1033	1109	1199	1173	1170	1050	1045	1275	1167																																			
No. outstanding acknowledgements	0	0	0	0	0	0	0	0	0																																			
Effective	The Trust should ensure that maps in all vehicles are current, up to date and replaced regularly	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.		Not applicable																																								
Safe	The Trust should ensure that all staff adhere to the trust policy on carrying personal equipment and the regular servicing of such equipment.	<p>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.</p> <p>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.</p> <p>N.B. The regular servicing of equipment is not applicable.</p>		Not required																																								
Effective	The Trust should ensure that pain assessments are carried out and recorded in line with best practice guidance	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.		Pain Assessment Action Plan																																								

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 governance 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 inaugural 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

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

Reporting Period: 01 December 2018 to 11 January 2019

Key points to note for this reporting period

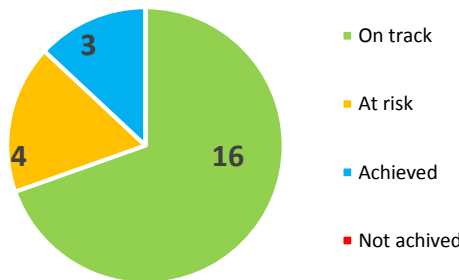
Workstream	Brief Summary
Rota's	Agreeing the Rotas across Operating Units is progressing well, and has received positive feedback from all OUs. A meeting has been planned this month to confirm the details around rotas.
Fleet	A recent meeting with the senior operations team has confirmed that there is 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

Milestone Status



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:

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
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.

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

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

111 CAS Interim Service High Level Timeline

	Q3 2018-19	Q4 2018-19	Q1 2019-20	Q2 2019-20	Q3 2019-20	Q4 2019-20
111 (CAS) Interim Service	Project Delivery					
111 (CAS) Contract Exit	Project Delivery		Project Closure			

Digital Programme Board 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

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 29 th 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

	JAN 19	FEB 19	MAR 19	APR 19	MAY 19	JUNE 19	JULY 19	AUG 19	SEPT 19	OCT 19	Nov 19	Dec 19
999 Telephony & Voice Recording	Project Closure				Post Project Implementation Review							
NHS Spine Connect	Project Paused											
Cyber Phases 1 & 2	Project Delivery	Project Closure				Post Project Implementation Review						
Station Upgrades	Project Delivery			Project Closure				Post Project Implementation Review				
Automated Temperature Monitoring	Project Delivery	Project Closure					Post Project Implementation Review					
IT Helpdesk Software Replacement	Project Startup	Project Delivery				Project Closure				Post Project Implementation Review		
Fleet Management	Project Delivery	Project Closure					Post Project Implementation Review					
ePCR	Project Delivery					Project Closure						Post Project Implementation Review
GoodSAM	Project Delivery	Project Closure				Post Project Implementation Review						
Incident Management Software (CLIO)	Project Closure				Post Project Implementation Review							
EOC East	Project Startup	Project Delivery	Project Closure					Post Project Implementation Review				
111 Interim Service	Project Delivery			Project Closure				Post Project Implementation Review				

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

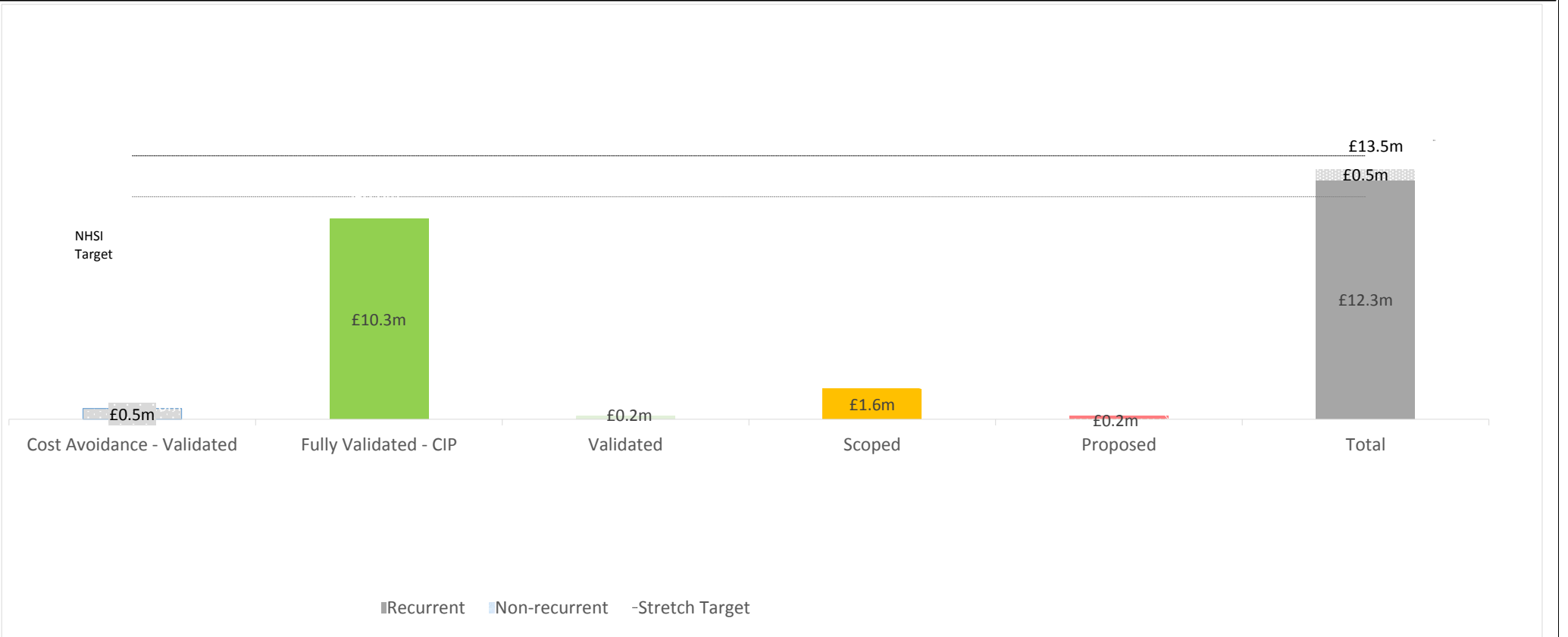
Opportunity Status	Description	Key
Fully Validated	Scheme with confirmed savings calculation prior to delivery tracking	Green
Validated	Scheme with identified benefits under development	Yellow
Scoped	Scheme to be scoped for further development	Orange
Proposed	Proposed CIP idea in analysis	Red

CIP Pipeline and Delivery: Risks and Issues

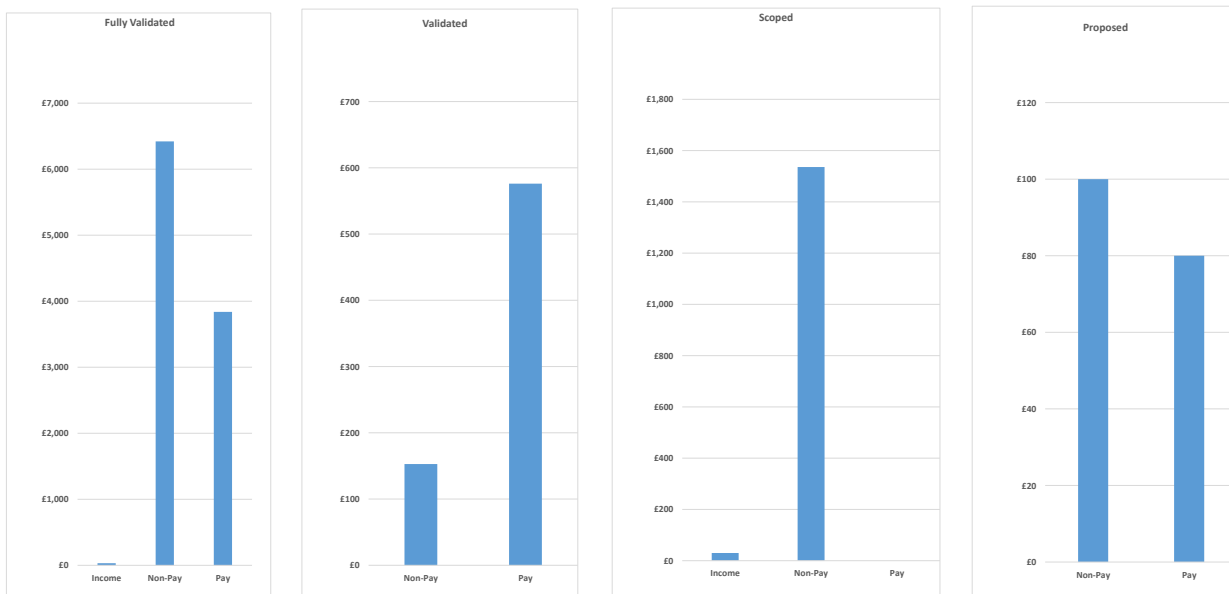
Risk	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1. Risk that the 2018/19 CIPs target of £11.4m will not be fully delivered due to uncertainties within the Operations Directorate.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

Key points to note for this reporting period

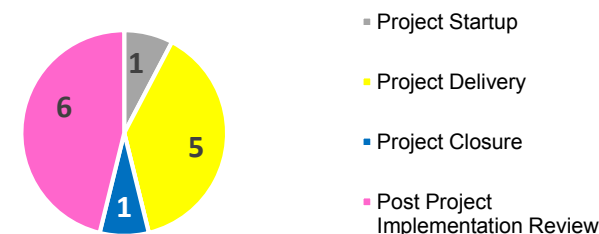
Project	Brief Summary
Personnel Files	Checks for staff with no initial DBS up to 31 May 2018 have now been completed. No evidence has been provided assuring that a backlog has not been built up since. For DBS renewals, there is still a small cohort who have not provided identification.
Culture Change (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											

South East Coast Ambulance Service: CIP Workstream

CIP Delivery Dashboard

Reporting Month: Dec-18

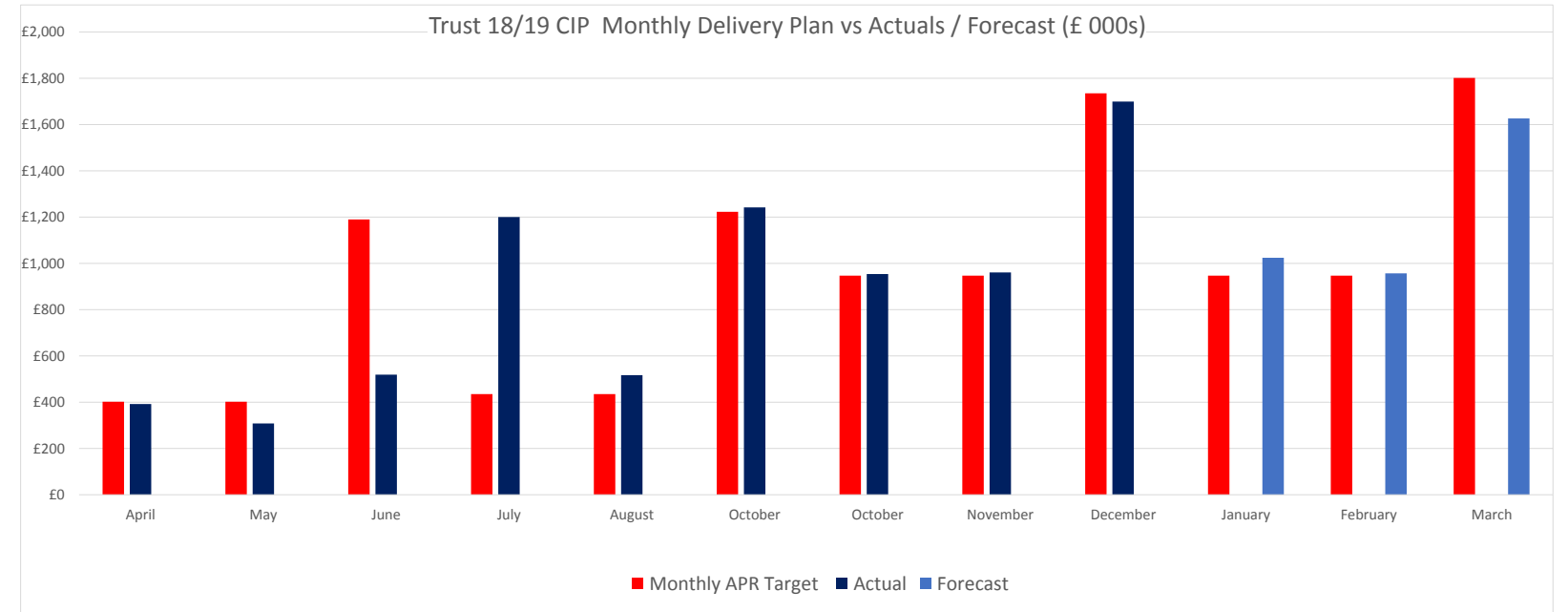
Programme for 2018/19 to deliver a minimum of £11.4m savings to achieve the planned £0.8m control total deficit.

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

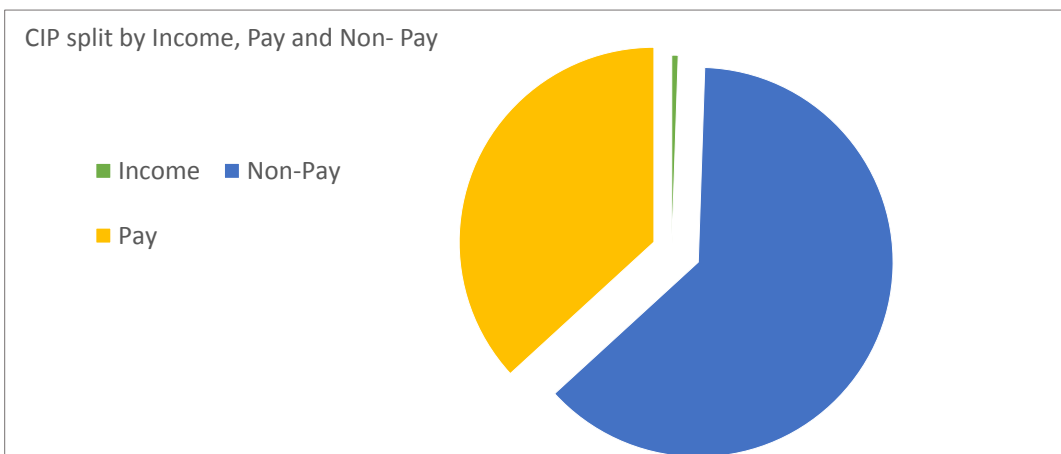
- The CIPs target remains at £11.4m for the 2018/19 financial year.
- £10.3m of fully validated savings have been transferred to the Delivery Tracker as at the Month 9 reporting date, of which £7.8m have been delivered against the Plan delivery of £7.7m.
- The schemes continue to take no account of any 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.
- 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

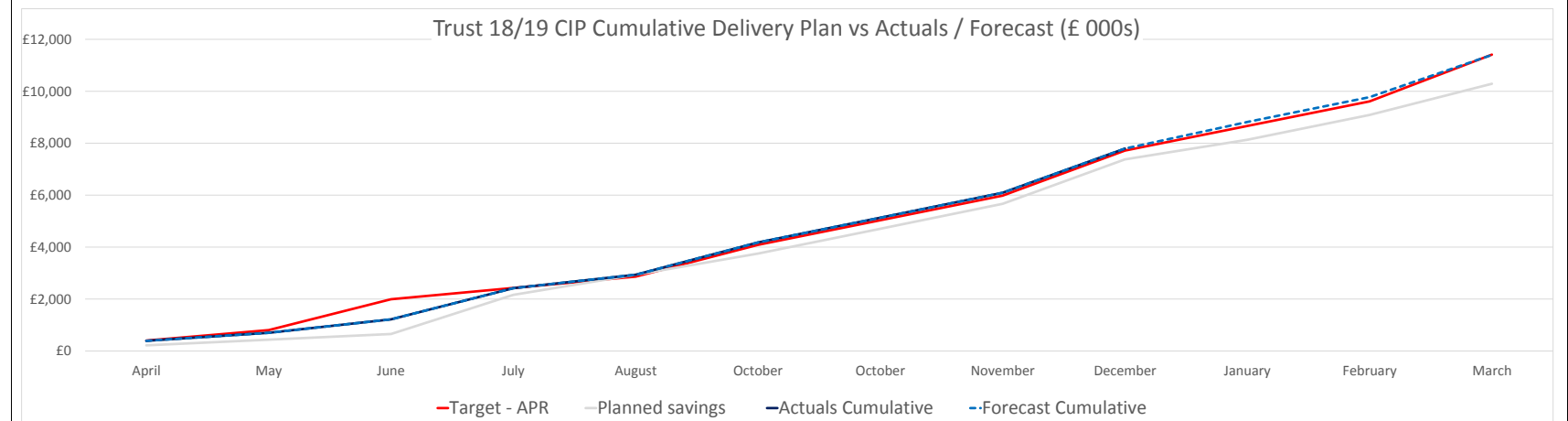
CIP Target for 18/19 £000's	Total planned savings on delivery tracker £000's - as at 31 December 2018	Total forecast savings on delivery tracker £000's - as at 31 December 2018	YTD December 18 - Target Savings £000's	YTD December 18 - Actual Savings £000's	YTD December 18 - variance £000's
11,400	10,289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



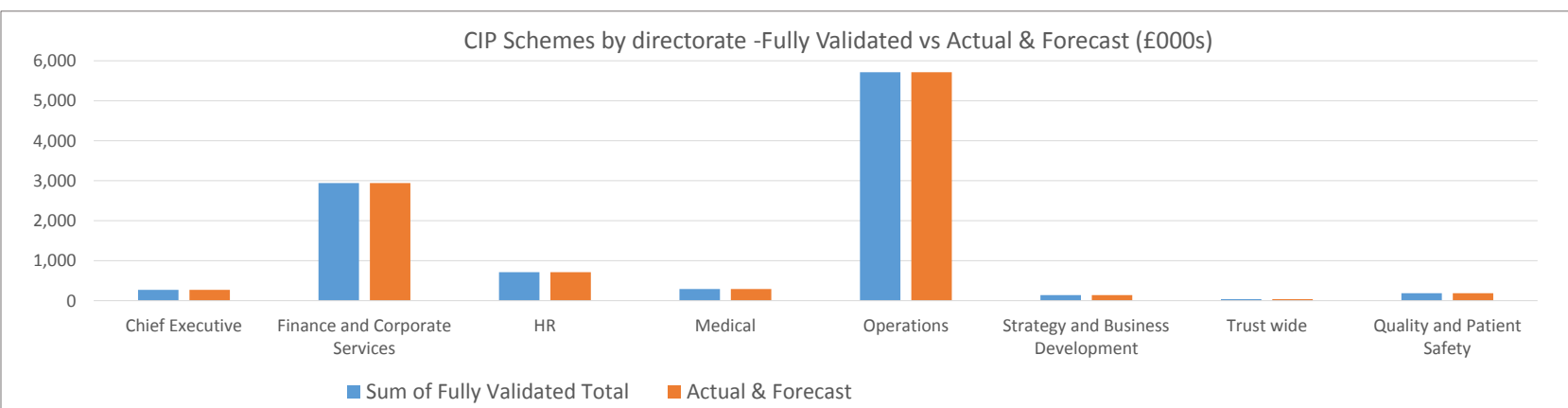
2. CIP - Planned savings split by income, pay and non-pay: as at 31 December



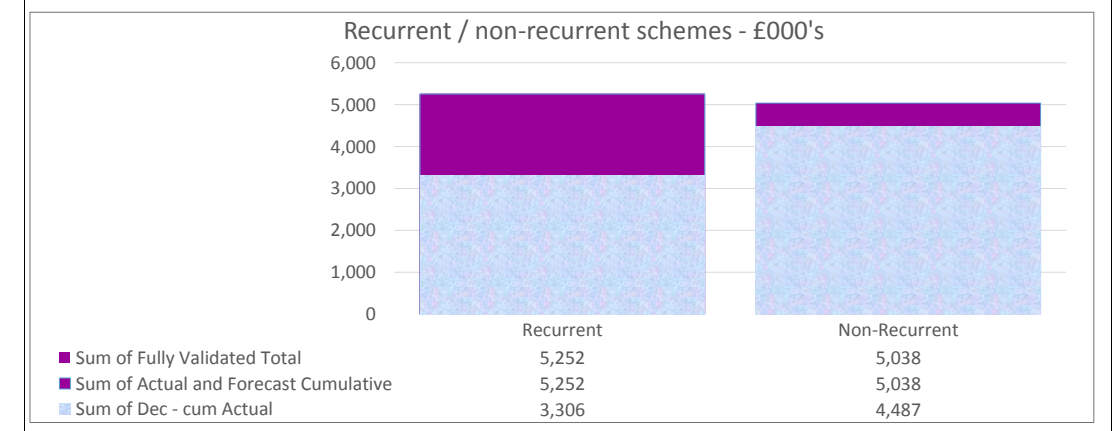
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2018/19



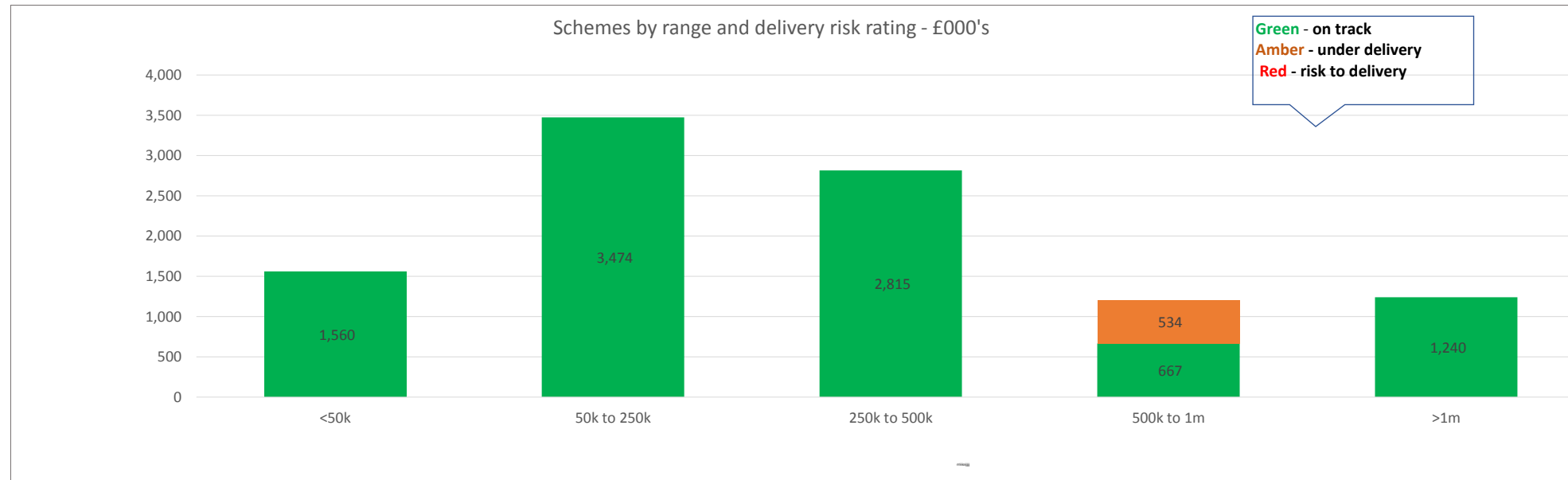
4. CIP schemes by directorate - Fully Validated vs Actual & Forecast 2018/19



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	

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	<p>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.</p> <p>The five year plan will support the Trust in the delivery of high quality research to improve patient care.</p> <p>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. .</p>	
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	



Caring for you and everyone

Research and Development Strategy

2017-2022



Contents

Page

- Introduction 3-4
- Our strategic themes and focus 5
- Our Research and Development Strategy's aims and objectives 6-7
- How we will implement our research and development strategy 8-10
- References 11

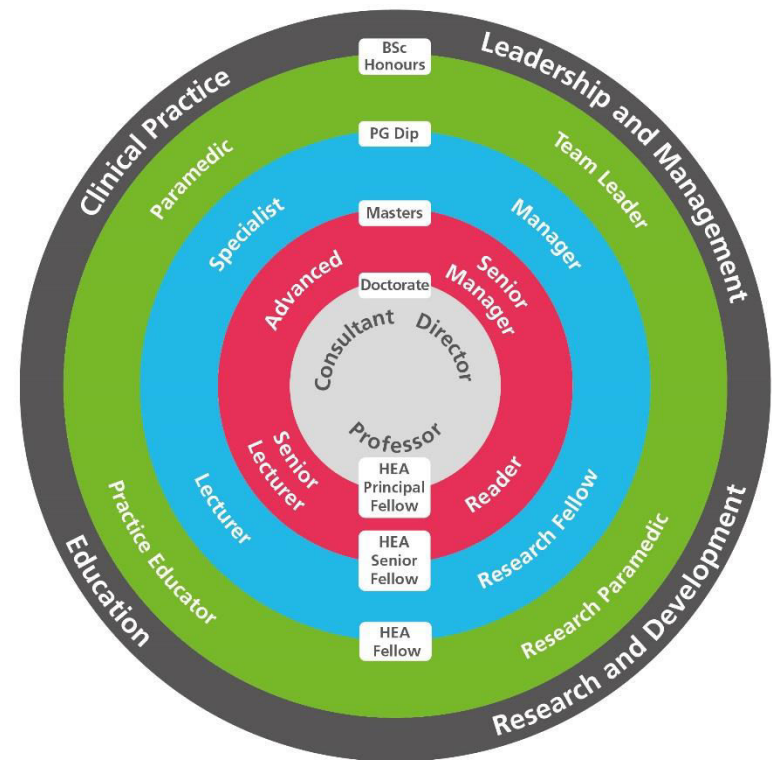
Introduction

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

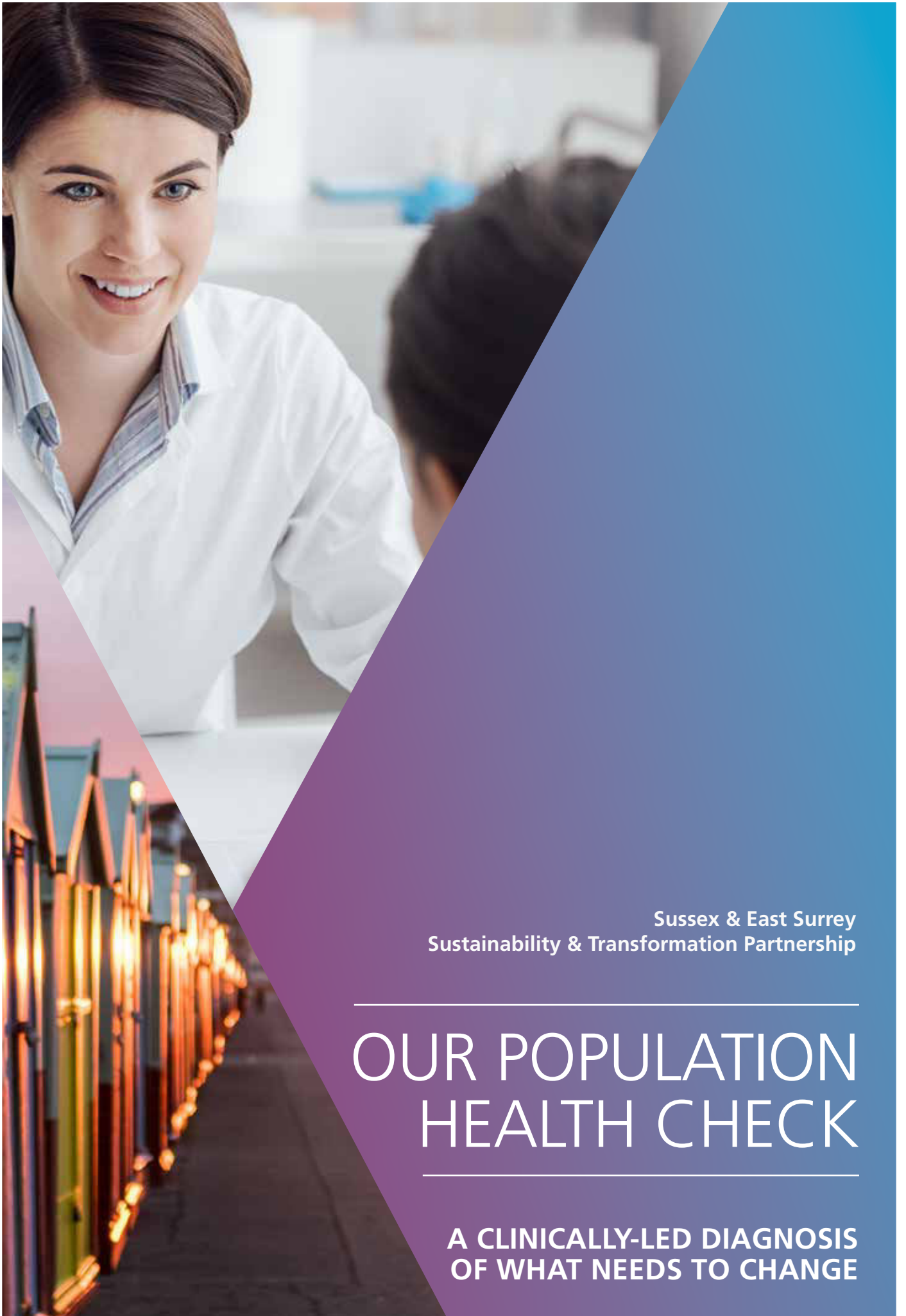
NHS Five-Year Forward View. October 2014. (Link)

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

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

	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)	<p>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.</p> <p>There are five priority areas highlighted in the Health Check:</p> <ol style="list-style-type: none"> 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. <p>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.</p> <p>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.</p>	
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



Sussex & East Surrey
Sustainability & Transformation Partnership

OUR POPULATION HEALTH CHECK

**A CLINICALLY-LED DIAGNOSIS
OF WHAT NEEDS TO CHANGE**

Contents

3	Introduction
4	What is this “population health check”?
6	Why do we need an STP population health check when we already have local plans?
6-7	How do we offer best value?
7-9	What did we find are the key themes?
10-14	What do we need to change to address these key themes?
15-18	Our Population Health Check in context
19	What we found: our evidence base
19-34	Our evidence: Our Population and Demographics
35-39	Our evidence: Our Public and our Patients
40-67	Our evidence: Our Services
68-69	Our evidence: Our Staff
70-73	Our evidence: Our Infrastructure
74-75	Our Priorities
76	Next Steps
76	We need to develop a clinical strategy which delivers “best value” and patient centred care.
76-78	We need to develop a clinical strategy which is future proofed
79-80	We need to develop a clinical strategy which is clear on the optimal population size to lead delivery
81	The process of developing the clinical strategy
82-84	Agreement from core members of the STP Clinical and Professional Cabinet
85-87	Contribution list
88-91	References and bibliography

Introduction

“We have many great services and people, delivering great care. However, there is an urgency to address the gaps in the quality and responsiveness of some of our services. There has been an under-investment in prevention and self-care and not enough emphasis on wellbeing and care. Services are not operationally or financially sustainable in the current set-up, which is based on historic and isolated services, not built around what local people need now. In essence, there is less partnership working than we need between patients and clinicians and between services. Given our demography, we need to rely as much on technology-enabled care as on state funded clinical and domiciliary workforce. There just won’t be as many employees available in future as would be needed to provide current services to a larger population with more retired people and not many more working-age citizens. This Population Health Check represents a case for change and provides the evidence of the key issues and the priorities we will deliver together to ensure we offer sustainable services. Doing nothing is neither affordable nor sustainable”

Dr Minesh Patel and Mr Peter Larsen-Disney, Co- Chairs, Sussex and East Surrey STP Clinical and Professional Cabinet



Population Health Check

This Population Health Check has been developed and agreed by a STP group called the Clinical and Professional Cabinet, which consists of the most senior medical and nursing leaders across our partnership.

WHAT IS THIS "POPULATION HEALTH CHECK"?

This document is a diagnostic analysis of the key issues we are facing in our local health systems today. This analysis provides the strong evidence base we need for the next phase, which will be an STP-wide Clinical Strategy.

The overall goal of the Population Health Check is to identify the challenges facing our population's health and our system's sustainability in order to develop a strategy, which will see people living with better health that is value focussed and patient centred.

WHY DO WE NEED AN STP POPULATION HEALTH CHECK WHEN WE ALREADY HAVE LOCAL PLANS?

Our STP is comprised of four 'places' responsible for locally driven community and integrated care with the aim of improving health outcomes for our communities and reducing avoidable illness and health and care expenditure. Each place is building a model that best responds to both the local health needs and context of the health and care organisations in the region, however many commonalities exist between them. Each place will oversee radical clinical transformation of Long Term Conditions, frailty, mental health, community, social care, general practice and urgent services to transform outcomes and quality.

The STP is not one single separate plan. It is a way of making sure that the plans of all the partners across the area are joined up and working together. It aims to ensure that no part of the health and care system operates in isolation. We know that what happens in GP surgeries, for example, impacts on social care, which also impacts on hospital wards, and so on. With services feeling the strain, working together will give our nurses, doctors and care staff the best chance of success.

The "added value" of an STP Population Health Check, which complements those Place Based Plans and delivers best value is:

The STP is not one single separate plan. It is a way of making sure that the plans of all the partners across the area are joined up and working together.

- We will be consistent with our messages on increasing population health and well-being and the importance of delivering value for money.
- We are able to identify and work together on addressing unwarranted clinical variation to deliver value for money services across the system.
- We will work together to improve communication and collaboration across the system and between clinicians and the public to enable decision based on objective, best value evidence and conversations.
- We will support each other to manage the impact of the 3Ts development at Brighton and Sussex University Hospitals NHS Trust (BSUH), which will reduce bed capacity in the short term through collaborative redesigning our model of services to enable care closer to home (delivering the lowest level of effective care).
- We will provide STP-wide senior clinical support for local plans which may help the pace of change, with consistent messaging on delivering value based services.
- We will develop simpler collaborative commissioning, whilst maintaining local engagement and ownership, to make best use of limited resources and to integrate care for patients,
- We will share best practice and offer support on implementation of local transformation plans to deliver better value care at a faster pace,
- We will further develop the skills of clinical leadership, workforce development and resilience through learning from others outside our neighbouring systems,
- We will support consistent access to supportive mental health services to reduce costly reactive responses to crisis care.
- We will develop system-wide digital technology to support communication across the system,
- We will contribute to the strategic planning for the development of estates to ensure we are able to deliver care closer to home across the system.
- We will provide consistent key message to the public so that A&E is not the option chosen as the urgent care option but that the public understand the benefits of accessing alternative services in the community.

We are able to identify and work together on addressing unwarranted clinical variation to deliver value for money services across the system

THE SYSTEM WILL, THEREFORE, COME TOGETHER ON ISSUES WHICH MAKE SENSE TO DO TOGETHER.

Some of these initiatives, such as the STP Mental Health Strategy, are already underway and demonstrating significant improvements. However, it is crucial that the changes identified throughout are interconnected with the delivery of the STP Mental Health Case for Change, Mental Health Delivery Plan, Mental Health Workforce Plan and the identified Mental Health priority work streams and vice versa. This will then emphasise the importance of parity of esteem where mental health is valued equally with physical health. For example – some of the changes will impact and are interdependent with this overall STP Population Health Check e.g. impact of Improving Access to Psychological Therapies (IAPT) Long-term conditions developments on Diabetes, Musculoskeletal (MSK) and Cardiovascular, the life gap for people with severe mental illness and the high proportion of smokers having a severe mental illness. Also the mental health Crisis & Urgent Care workstream need to work closely with the Urgent and Emergency Care workstream.

HOW DO WE OFFER BEST VALUE?

We need to offer best value care to our patients. In July 2017, the South East Clinical Senate produced a briefing entitled ‘Emphasising Quality, Delivering Value’ (South East Clinical Senate 2017a), which recognises that:

- “The inexorable rise in demand for healthcare and growing pressures and constraints on the workforce and finance threaten the sustainability of the NHS. For clinicians across all disciplines, this means that we need to focus our combined resources on the care that delivers the greatest value.
- Value in healthcare is defined as the achievement of the best outcomes for individual patients and for the public within available resources. It also means doing less of things that add little or no value to patients.
- To achieve best value will require the development and use of standardised outcome measures that are more relevant to patients (such as the impact on their functional status and wellbeing), and their more active involvement through the process of shared decision making with well-informed patients. It also involves recognising unwarranted local variation in the delivery of high value care and addressing it.
- Value is not a financial term. It is a term that integrates high quality, safe and cost effective care that improves patient or population outcomes. It can be represented as follows:”
- Better Conversations’ is a fundamental part of delivering the Five Year

The inexorable rise in demand for healthcare and growing pressures and constraints on the workforce and finance threaten the sustainability of the NHS.



Forward View. The first principle within the ‘New Care Models’ to engage people and communities is that care and support is person-centred: personalised, coordinated, and empowering. Person-centred approaches has recently been published by Skills for Health, Skills for Care and Health Education England as a core skills education and training framework for the health and care workforce.

- We need to begin focusing on assets and “what matters to people” rather than “what’s the matter with” people.

We need to improve communication between services. The way that clinicians work together in providing care to individual patients, and how they communicate with each other, is vital to providing an integrated, coordinated, patient-centred approach, and for delivering the best experience of care and outcomes for patients. Phone calls and conventional letters have been the default means of communication for decades, whilst over time technological changes, increasing specialisation, the need for greater efficiency, changing organisational and professional boundaries, and changing patient expectations, have ceaselessly evolved. (SE Clinical Senate. 2017b)

WHAT DID WE FIND ARE THE KEY THEMES?

We found that:

- There are four main unhealthy behaviours of smoking, alcohol misuse, poor diet and lack of physical activity, as well as poor emotional and mental well-being, which are responsible for at least a third of ill health and are amenable to cost-effective preventative interventions. Focusing on prevention earlier in the life-course will accumulate greater benefits, but even in middle and older age groups, preventative approaches are cost-effective. Prevention requires prioritisation and investment across the system. This includes the need to treat symptoms early in primary



The population is getting older, many more people live with multiple chronic diseases, people are seeing their doctor more often and with more complex problems.

care to stop the development of a long-term condition. To date, across our STP, there has been an under-investment in prevention and self-care and not enough emphasis on wellbeing and care.

- There were 1,314 stillbirths in the South East between 2013-2015, equating to roughly 36 stillbirths per month. A large proportion of stillbirths are attributable to risk factors some of which are fully or partly avoidable, indicating an opportunity for rate reduction. Independent risk factors for stillbirth include: obesity, smoking, acquired medical disorders (diabetes) and disadvantaged populations.
- The STP covers a wide geographical area and many organisations, with a notable amount of variation in financial performance. For 2017/18, the combined net deficit (surpluses and deficits added together) for Clinical Commissioning Groups (CCGs) and Trusts in the footprint was £228.2m.
- There is significant expected growth in the population generally and an enormous growth in the 65+ and 85+ age groups. Significantly, this includes an increase in life expectancy for people in poor health. One in three over-65s and half of those over 80 will suffer a fall each year. In addition to the physical consequences, falls can have a damaging psychological impact, resulting in loss of confidence and independence, and increased isolation and depression. The Department of Health has stated that a falls prevention strategy could reduce the number of falls by 15-30%.
- Pressures on our GP services are critical causing issues with access for patients and staff stress. General Practice across the country is struggling to maintain services, and this situation is mirrored in Sussex and East Surrey. The population is getting older, many more people live with multiple chronic diseases, people are seeing their doctor more often and with more complex problems. General Practice has coped well so far, but we need to address these issues if we are not to face much bigger problems.
- We have significant workforce shortages across the system, in particular in GP surgeries, mental health and social care, with increasing demand.
- There have been many years of under-investment in estates, which has resulted in non-compliance, high backlog maintenance and an inefficient estate with high running costs. This hampers our ability to shift care closer to home.

- Bed capacity is expected to increase by 176 beds by 2023/24 at BSUH as a result of the 3Ts rebuild. However, in the meantime, there will be a detrimental impact on capacity which needs to be supported across the wider system.
- Care is often un-co-ordinated and duplicated leading to poor quality care with multiple hand-offs. The supportive systems are often difficult for the public to navigate, resulting in increased attendance to A&E.
- Communication between clinicians across organisations and between clinicians and patients requires improvement.
- We have a high level of mental illness and dementia, with the need to increase access to supportive services.
- Digital technology needs to better support integrated care, population health management and empower patients in managing their care. We have not been good at establishing systems for self-support which are cheap, cost effective and improve outcomes – (patient held records, patient educational materials /fora via online platforms for example) despite 90% of the population owning a smartphone / tablet or PC.
- We have unmet need at one end of the spectrum and unnecessary and/or non-evidenced treatments at the other with variably informed decision-making in the middle.
- There is variation across the trusts in delivering our constitutional standards (the standards everyone should expect) including Referral to Treatment Times (RTT), emergency admissions, Delayed Transfers of Care, bed occupancy, cancer waits and A&E 4-hour performance.
- Our data shows us we have significant unwarranted variation across the STP that are impacting on quality in many areas but particularly in MSK, Cardiovascular and Falls/Fragility Fractures. There is also evidence that we over treat patients in some specialties.
- Too many people are dying away from their usual place of residence or in a place that is not of their choosing.
- Doing nothing is neither affordable nor sustainable.

Digital technology needs to better support integrated care, population health management and empower patients in managing their care.

WHAT DO WE NEED TO CHANGE TO ADDRESS THESE KEY THEMES?

We concluded that:

We have not focussed enough on promoting the determinants of good health because:

- There remains considerable, and unacceptable, differences in life expectancy between areas across the STP and within local CCG / local authority areas. Service access, take up and outcomes need to be addressed for disadvantaged groups.
- There are four main unhealthy behaviours of smoking, alcohol misuse, poor diet and lack of physical activity, as well as poor emotional and mental well-being, which are responsible for at least a third of ill health and are amenable to cost-effective preventative interventions.
- Focusing on prevention earlier in the life-course will accumulate greater benefits, but even in middle and older age groups, preventative approaches are cost-effective. Prevention requires prioritisation and investment across the system. Prevention includes the reduction of falls in the elderly and healthy living to reduce still births.

In order to keep up with increasing demand, we need to collaboratively redesign our service models to bring care closer to home because:

- There is an imbalance of bed/un-bedded capacity and demand in acute, primary, community and social care.
- BSUH is undergoing a significant re-build programme through 3Ts, which will have an impact on bed capacity until it is completed.
- We want more people to die in their usual place of residence and place of choice.
- Bringing care closer to home, cannot be delivered without addressing the issue that the sustainability of primary care is significantly challenged across the system. Dedicated effort to address primary care challenges is crucial.

Our Urgent and Emergency Care services cannot keep up with demand because:

- Attendances to A&E and handover delays continue to put immense pressure on our services.
- Over a quarter of A&E attendances could be treated at another suitable location e.g. primary care.

- There are several points of contact for access to services, fragmented pathways and gaps in service availability (geographic and time of day), particularly around admissions avoidance and to support hospital discharges.

Our patients with mental health needs are not always able to access support when they need it because:

- There is a lack of a 24/7 crisis support.
- Capacity needs to be built in primary care, closer to home and thereby reduce presentations and referrals to physical and mental health secondary care.
- The prevalence of severe mental illness is 5% higher than nationally, affecting 25,000 individuals
- For dementia, prevalence is 25% higher than nationally, will increase further as the population ages, while the proportion of those with a diagnosis is 5% lower. A quarter of those patients with dementia who are fit to leave acute care wait over 50 days for discharge.
- There is an increasing problem of addiction and its impact on the individual and the system.

We do not have the workforce numbers and skills to meet current and future demands because:

- There is an imbalance in staffing capacity and demand across the whole health and social care system. This includes front line staff providing direct patient/client care, back office staff, and key services e.g. pathology and radiology.
- The average retirement age is 59 and we have 15 % of staff aged 55 years and over.
- The turnover rate for all registered nursing, midwifery and health visiting staff ranges from 13% - 20%.
- In social care there is a significant annual turnover of 26% for registered nurses.
- There are difficulties recruiting and retaining substantive mental health nurses and psychiatrists.
- In June 2017, the Sussex and East Surrey STP had a shortfall of GPs (Full-time equivalents) of 193.

There is an increasing problem of addiction and its impact on the individual and the system.



We need to enable our workforce to have conversations which enable patients to make the right decision about care

Our digital technology does not meet current and future needs because:

- There is a lack of ability and confidence to access shared information to support for Clinicians, professionals, patients and carers in:
 - (a) Direct Care and Self-Management,
 - (b) Population Health Management and Evaluation,
 - (c) Research and Innovation.
- Digital systems do not yet integrate effectively enough to support new models of care or meet expectations.
- There is a lack of health and care services digital maturity, partnerships and agility to take advantage of the opportunities of emerging technologies (e.g. Artificial Intelligence (AI), Precision Medicine, Internet of Things)

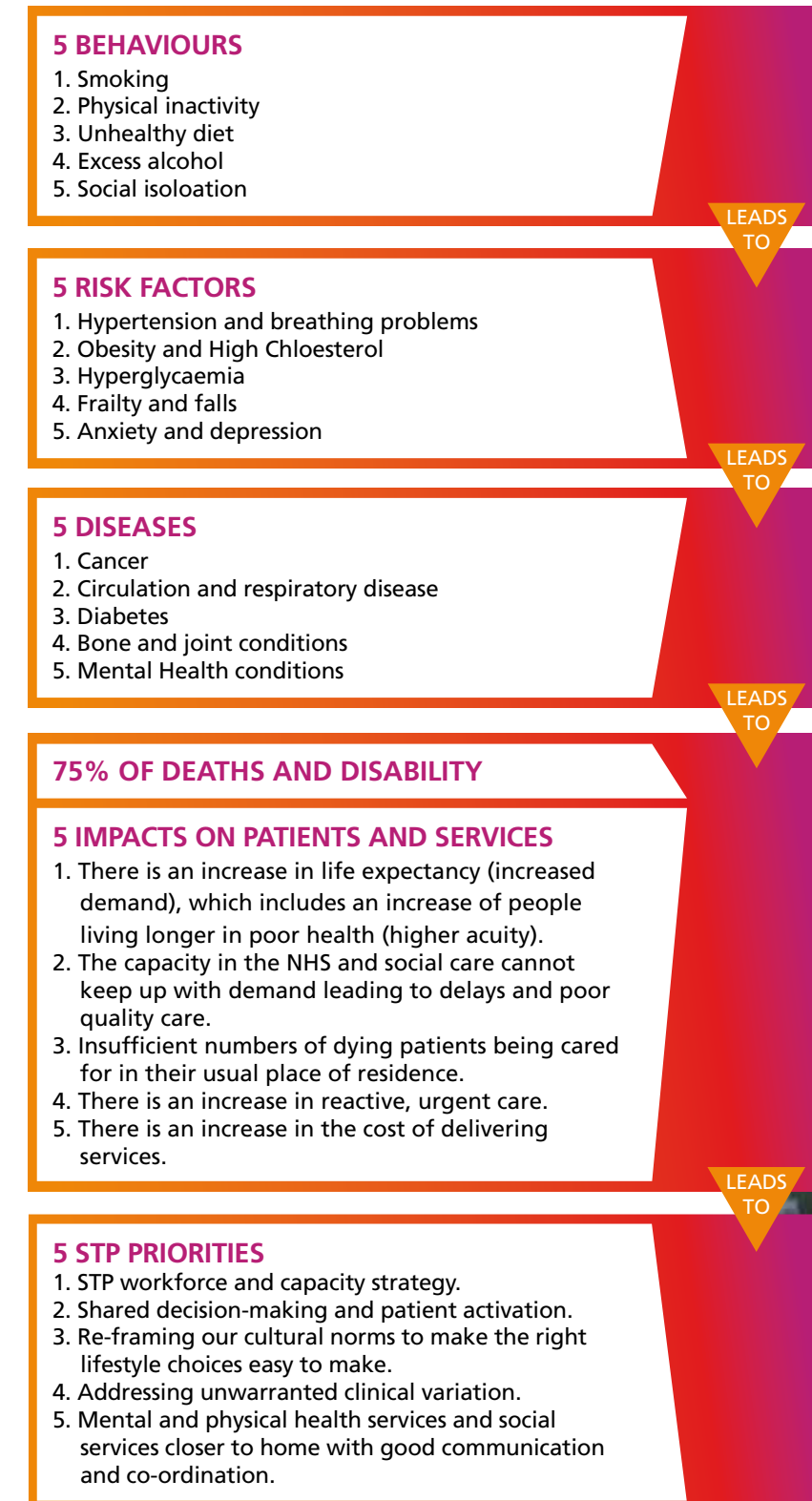
There is a lack of demand management to create the most efficient pathways because:

- There is a lack of working practice changes required to encourage 'channel shift.'
- There is a lack of standardised communication and engagement strategies to reduce demand on the system.
- Communication between clinicians across boundaries needs to be addressed as a priority.

Unwarranted clinical variation exists across the system leading to inequity in access to the good standards of care because

- There is unwarranted variation in referrals guidelines, treatment, medicines and Continuing Healthcare funding when we compare ourselves to our demographic peers.
- There is insufficient shared decision-making between patients and their healthcare professional. We need to enable our workforce to have conversations which enable patients to make the right decision about care, based on objective evidence and dialogue and containing expectations to value based care.

THE FOLLOWING CHART SUMMARISES THE KEY THEMES AND WHAT WE NEED TO CHANGE IN OUR SES STP



OUR POPULATION HEALTH CHECK HAS TRIANGULATED PREVIOUS ANALYSIS INTO A SINGLE CASE

PRIORITY AREA	STP EXECUTIVE	STP CLINICAL AND PROFESSIONAL CABINET	STP PLAN AND REFRESHED PLAN (11 KEY INTERVENTIONS)	EXISTING SYSTEM TARGETS/ MEASURES
Older people + disabilities/ Long-term conditions	11 interventions MSK Get It Right (GIRFT), Continuing Healthcare (CHC), Clinically Effective Commissioning, Medicines, Optimisation	Right: bone and joint, MSK unwarranted variation, Falls and Fragility fractures, end of life care, over treatment, medicalisation	Older people, dementia end of life care, reablement, falls reduction	Delayed transfers of care, dementia indicators (improvement and Assessment Framework (IAF), Urgent and Emergency Care GP access, Learning disabilities
Circulation and Respiratory (cardiovascular disease, coronary heart disease, chronic obstructive pulmonary disease (COPD), diabetes)	Clinically Effective Commissioning (CEC) / Procedures of limited clinical effectiveness (POLCE)	Rightcare 5:5:5 (prevention, detection, management / risk reduction) – Stable angina, Atrial Fibrillation (AF) / Hypertension and breathing problems / High Cholesterol, Hyperglycaemia, obesity, diabetic foot amputations). Shared decision-making and social activation	Adults with physical disability build knowledge and change behaviours	Quality and Outcomes Framework (QOF), RightCare, diabetes. Maternal smoking, obesity (IAF)
Cancer		5:5:5 (cancer risk factors; screening; early detection and treatment, survivorship)	Acute liaison, SEMI	2 week wait, 31 days, 62 days Screening, stage 1 and 2, diagnosed in A&E
Mental health	Mental health strategy	Mental health in relation to 5:5:5 (prevention, wellbeing, early intervention, social isolation, mental health and long-term conditions and dementia)	Acute liaison, SEMI	IAF, IAPT / dementia / acute crisis / CYP
Urgent and Emergency Care	Urgent and emergency care including 111, 3Ts	Capacity across the health and care system	Rapid response in community and acute services	A&E 4 hour waits
Co-ordinated and well communicated care	Digital Strategy Workforce strategy	Improving communication across primary and secondary care. Patient activation	Discharge planning Single point of access Specialist advice Integrated care	Recruitment and retention Agency spend
Maternity	Better Births	Supporting a good start in life		Still birth reduction

Our Population Health Check in context

There are 24 large organisations in our partnership – local authorities, providers and clinical commissioning groups. This STP recognises the very critical part played by so many other smaller but core health, care and wellbeing organisations across the STP.

Our footprint is home to 1.7 million people providing health and social care at a cost of £4bn. It cannot be under-estimated the importance of planning changes to care across the health and social care system so that changes are not made in isolation but in partnership, with the impact of changes being clear and mitigating any negative consequences together.

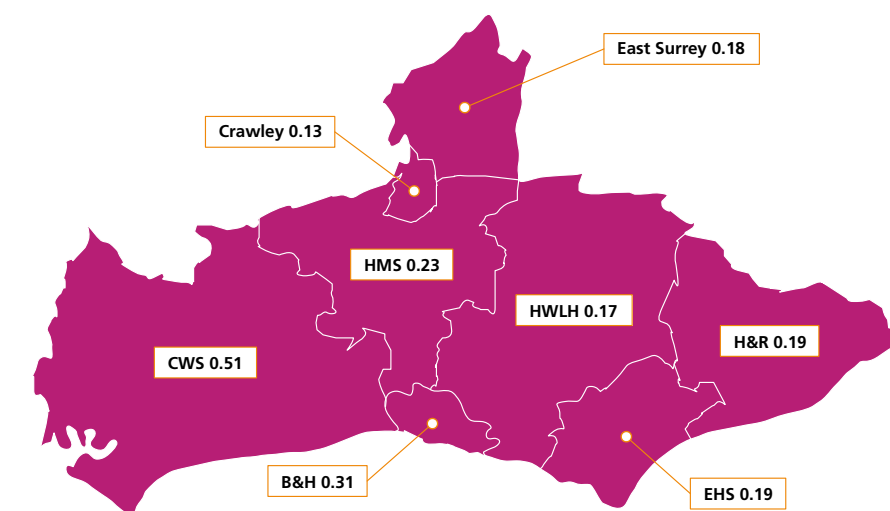
NHS Commissioners
 Brighton & Hove CCG
 Coastal West Sussex CCG
 Crawley CCG
 East Surrey CCG
 Eastbourne Hailsham & Seaford CCG
 Hastings & Rother CCG
 High Weald Lewes Havens CCG
 Horsham & Mid-Sussex CCG
 Specialised Commissioning (NHS E South)
Total = 9

NHS Providers
 Brighton & Sussex University Hospitals
 East Sussex Healthcare
 Queen Victoria Hospital
 South East Coast Ambulance Service
 Surrey & Borders Partnership
 Surrey & Sussex Healthcare
 Sussex Community
 Sussex Partnership
 Western Sussex Hospitals
 GP Providers
Total = 9 (excluding GP Providers)

Non-NHS Providers
 Brighton & Hove City Council
 East Sussex County Council
 Surrey County Council
 West Sussex County Council
 First Community Health and Care
 IC 24
Total = 6

STP Total = 24

POPULATION SIZE BY LOCATION (M)



We must also acknowledge some of the many examples we have of great care across the health and social care services across our STP.

STPs are a way for the NHS to develop its own, locally appropriate proposals to improve health and care for patients. They are working in partnership with democratically elected local councils, drawing on the expertise of frontline NHS staff and on conversations about priorities with the communities they serve. Partnerships will be forums for shared decision making, supplementing the role of individual boards and organisations. Their immediate focus is on refining and implementing their sustainability and transformation plan so that patients can see practical benefits in their local health system. STPs do not replace new care models; instead they will allow the ability to build on their success, by providing a collaborative system of leadership and governance which will allow new care models to evolve and spread. (NHS England, 2018)

Although this document focusses on what we need to change, we must also acknowledge some of the many examples we have of great care across the health and social care services across our STP. For example:

- East Sussex Better Together: Health and Social Care Connect (HSCC) which offers both the public and professionals a single point of access for adult health and social care enquiries, assessments, services and referrals. Streamlining access frees GPs to see other patients rather than having to refer to several different services for a patient. It also supports faster access to the services for patients in their home.
- Central Sussex and East Surrey Commissioning Alliance (CSESCA) North: Integrated, patient-centred teams developing in Primary Care Homes. East Grinstead is a rapid test site for a Primary Care Home model: Key work-streams are addressing urgent 'on the day' primary care capacity with GPs working in the Minor Injury Units (MIUs).
- Central Sussex and East Surrey Commissioning Alliance (CSESCA) South: Dementia Golden Ticket in HWLH. The Golden Ticket delivers a holistic mix of services to address health and wellbeing, supporting people with dementia and their carers in every aspect of their lives. Evaluation of the project shows that it is already reducing GP visits and emergency admissions to hospital. People who said that they had previously felt isolated received support to live more independently.
- Coastal Care: Frailty pathway redesign. The Paramedic and Occupational Therapy team work together on the Falls Response vehicle, provided by Sussex Community NHS Foundation Trust, with the pilot being funded by Coastal West Sussex CCG. So far the conveyance rate for this vehicle in the first four weeks is 9.18% compared to 20.5% for the previous 5 weeks.

- Sussex Partnership NHS Foundation Trust (SPFT): Developing a single access point to ensure that people in crisis can access services 24 hours a day and a no 'wrong front door' approach with access points for other services. They have set up a front door staffed by peer workers, care navigators, carers, voluntary sector staff and mental health clinicians.
- South East Coast Ambulance Service NHS Foundation Trust (SECAmb): 999, Emergency Operations Centre and 111 Rotational Workforce: Working with HEE and commissioners, SECAmb is developing a number of rotational workforce positions. These are focussed on rotating staff out (e.g. Paramedic Practitioners in primary care) and rotating staff in from other organisations (e.g. midwives). This is allowing the Trust to test workforce and governance issues before beginning wider work on rotational workforce approaches such as mental health nurses and rotating SECAmb paramedics into hospice and urgent care centre settings.
- Sussex Community NHS Foundation Trust: Healthy Child Programme, which provides a range of health interventions and support, beginning in pregnancy and continuing through to the end of formal schooling.
- IC24: Developing the multi-professional urgent care workforce and strengthening the role of the GP as a clinical leader.
- Specialist Palliative Care: The adult and children's hospices and Specialist Palliative Care services serving the STP area are all supported by their local communities to provide holistic multi-professional care for those facing death and bereavement. Adults known to hospice services are less likely to die in hospital and have a higher chance of dying in their usual place of residence.
- Academic Health science Network: The Atrial Fibrillation (AF) project identified 580 individuals who were eligible for anticoagulation and would benefit from a change of treatment to reduce their risk of an AF-related stroke. By the end of May 2018, 219 individuals had had their medicines optimised by their GP practice. This has reduced the risk of AF-related strokes to such an extent that the equivalent of six AF-related strokes have been avoided, avoiding debilitating effects on individuals and their families and avoiding costs to state-funded health and social care of over £160,000.

Some residents living within our STP, are treated in Kent and Medway and Surrey and are also affected by their STP Cases for Change. Kent and

Adults known to hospice services are less likely to die in hospital and have a higher chance of dying in their usual place of residence.

People with mental ill health have poor outcomes and may not always be able to access services

Medway STP, Surrey Heartlands STP and Frimley STP have all identified the same issues in their Cases for Change in that:

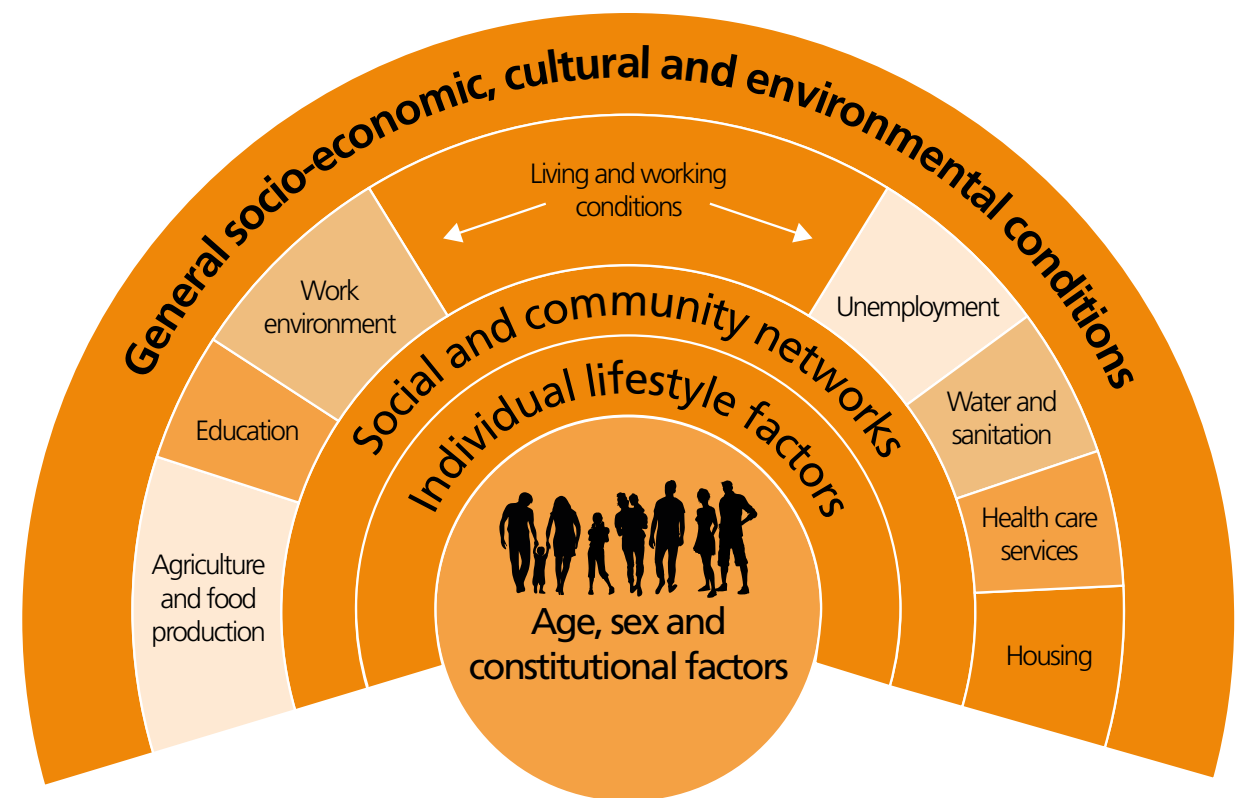
- There is not enough focus on maintaining independence and ill health prevention,
- There are challenges in primary care provision, which is extremely fragile in some areas,
- There are gaps in service and poor outcomes for those with long term health conditions,
- We do not support people with long-term conditions and needs to look after themselves as effectively as we should,
- Many people are in hospital who could be cared for elsewhere,
- There is a growth in demand from older, more complex patients,
- Planned care is not delivered as efficiently and effectively as it could be,
- There are particular challenges in the provision of cancer care,
- People with mental ill health have poor outcomes and may not always be able to access services,
- There are capacity issues,
- There is a lack of Digital integration and innovation,
- They have an unsustainable workforce model,
- They need to reduce clinical variation,
- Urgent and Emergency care needs to reduce.

In addition they have also identified the following which we have not identified in that some local hospitals find it difficult to deliver services for seriously ill people: some services are vulnerable and potentially unsustainable. There is a need to review their specialist acute model including mental health. Existing capacity needs to be redesigned to be used much more productively.

What we found (our evidence)

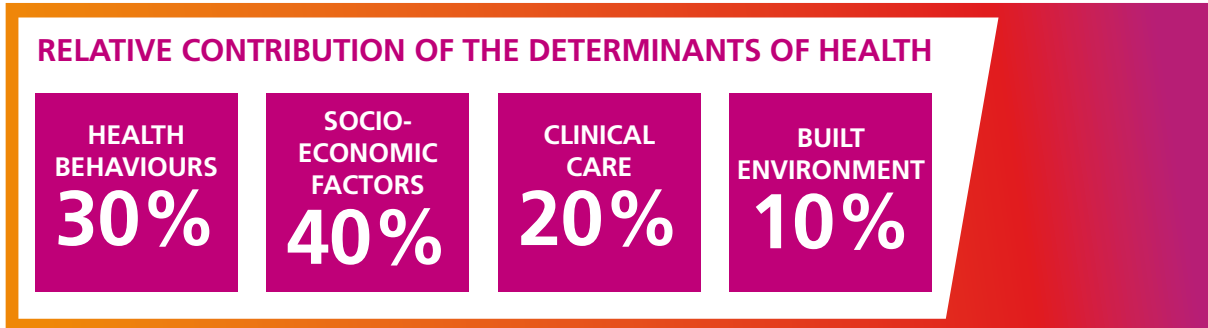
Our evidence: Our Population and Demographics

OUR APPROACH TO HEALTH AND WELLBEING INEQUALITIES



Ref: Determinants of Health, Dahlgren and Whitehead (1991)

Our approach reflects the responsibilities of the whole system in addressing health and well-being – NHS, councils, police, education, voluntary sector, communities and individuals. This well-being approach recognises that health is created by wider factors than health services. This approach requires a strategic commitment to building a culture in which individuals, organisations and communities work together to identify and pool their capacity, skills, knowledge, assets and resources



Ref: Adapted from Gonnering RS and Riley WJ (2018) Robert Wood Johnson and University of Wisconsin Population Health Institute

to improve health and wellbeing outcomes for all our residents. Such an approach requires a shift from a demand management approach to a whole system approach to prevention which addresses “the causes of the causes” as identified in Dahlgren and Whitehead model (1991) above. The “causes of the causes” recognises that if the causes of poor health are social, economic and environmental then the solutions need to be too – from social determinants to those of the built environment, and these solutions require concerted, sustained, partnership working.

CAUSES OF THE CAUSES

Social	Creating opportunities for people to participate in the life of the community: includes education and early childhood development, providing a sense of place, belonging and safety, information, inclusion, informal social support, health and community services, arts and culture, sport and leisure.
Economic	Encouraging sustainable economic development and equitable access to resources includes regeneration, job creation, training, social protection, benefits, occupational health and safety and incentives.
Natural	Looking after natural surroundings and ecosystems: includes clean water, air, soil, natural, land care, waste recycling, energy consumption and climate change adaption.
Built	Altering physical surroundings includes: urban layout, building design and renewal, housing quality, affordability and density, parks and recreatio facilities, roads, paths and transport and the provision of other amenities, such as seating and toilets.

From Health in All Our Policies (Local Government Association 2016)

Our Joint Strategic Needs Assessment (JSNA) show our health priorities are largely the same as elsewhere – good mental health and wellbeing underpins success; poor physical health is linked to lifestyle behaviours, health inequalities result from social and income inequality; healthy futures are built on good employment and decent homes. However, there are extreme variations in terms of socioeconomic status, health outcomes, environment and economic prosperity. These are often masked by averages, meaning health outcomes can seem on a par with the rest of England, when for parts of Sussex and East Surrey the reality is significantly and enduringly worse.

There remain considerable, and unacceptable, differences in life expectancy between areas across Sussex and East Surrey and within local CCG / local authority areas. Service access, take up and outcomes need to be addressed for disadvantaged groups.

Four main unhealthy behaviours of smoking, alcohol misuse, poor diet and lack of physical activity, as well as poor emotional and mental well-being are responsible for at least a third of ill health and are amenable to cost-effective preventative interventions. Substance misuse, in all its forms, continues to present challenges across the STP area, and notably in the Hastings and Brighton and Hove areas.

Unhealthy behaviours of smoking, alcohol misuse, poor diet and lack of physical activity, as well as poor emotional and mental well-being are responsible for at least a third of ill health

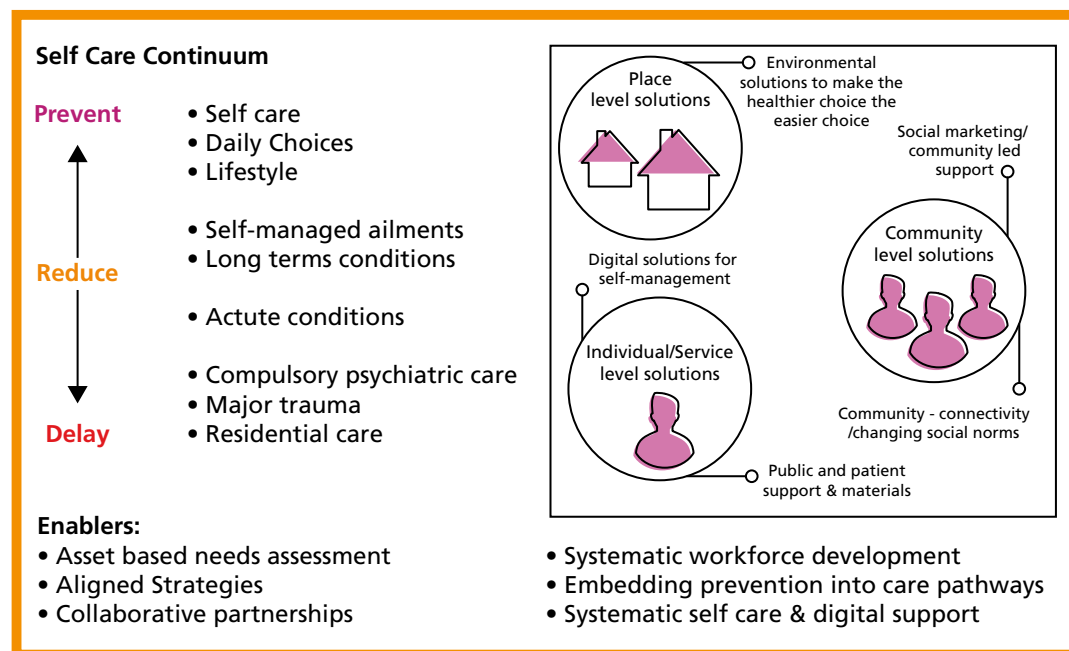
MODIFIABLE RISK FACTORS AND LONG TERM CONDITIONS

MODIFIABLE RISK FACTORS (these can be reduced or controlled by intervention, and by doing so reduce the probability of disease)	METABOLIC CHANGES (the biochemical processes involved in the body's normal functioning)	LONG- TERM CONDITIONS
Tobacco use	Raised blood pressure	Cardiovascular disease
Physical inactivity	Raised total cholesterol	Diabetes
Alcohol use	Elevated glucose	Cancers
Poor diet (increased fat and sodium, with low fruit and vegetable intake).	Overweight and obesity	
Emotional and mental well-being		

LIFE COURSE APPROACH



Starting well in life is important for every child. The first few years of life are critical for readiness to learn, educational achievement, income and economic status - strong predictors of future health and wellbeing. What happens during pregnancy and early years impacts on their risk of long term ill health such as obesity, substance misuse, risk of heart disease, dental decay and poor mental health. These differences are almost entirely explained by deprivation and inequalities. Public health interventions have an important part to play to stem the tide of long-term conditions and increasing costs. Focusing on prevention earlier in the life-course will accumulate greater benefits, but even in middle and older age, preventative approaches are cost-effective. Prevention requires prioritisation and investment across the system.



A WHOLE SYSTEM APPROACH TO PUBLIC HEALTH

As well as individual service interventions, public health interventions to build stronger and more resilient communities and places which support people to maintain independence and manage their own health and wellbeing across the course of their lives, are an important components of a whole system approach to prevention across NHS, local authorities, voluntary sector, community groups and wider stakeholders.

Working together, we can achieve the cultural shift we need to sustain improvements for people wherever they live and create a focus on health rather than the treatment of illness. This is increasingly important if public services are to be sustainable in the future – all parts of the public sector face significant budget pressures and the NHS and local government are by no means exempt. Improving the public's health will help secure the future of these services and deliver longer, healthier lives for all our residents.

Improving the public's health will help secure the future of these services and deliver longer, healthier lives for all our residents.

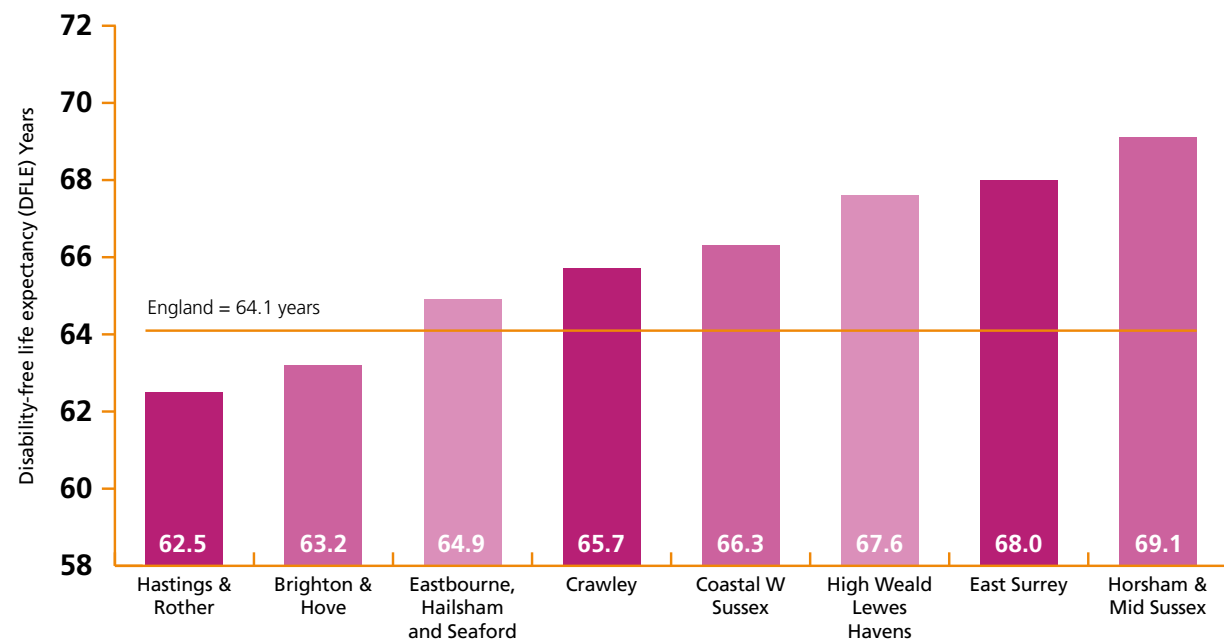
CURRENT RESIDENT POPULATION AND PROJECTED TO 2030 (DATA ROUNDED TO NEAREST 100)

	2016 POPULATION	2030 PROJECTED	% CHANGE
OVERALL RESIDENT POPULATION			
ESBT	375,200	417,900	11.4%
Coastal	498,900	558,800	12.0%
CSESCA North	528,600	578,900	9.5%
CSESCA South	461,800	504,100	9.2%
0-19 YEARS			
ESBT	79,300	83,00	4.7%
Coastal	104,400	111,200	6.5%
CSESCA North	130,100	139,00	6.8%
CSESCA South	99,400	103,900	4.5%
65-84 YEARS			
ESBT	82,400	109,700	33.1%
Coastal	109,200	143,000	31.0%
CSESCA North	79,000	104,900	32.8%
CSESCA South	66,600	86,900	30.5%
85 AND OVER			
ESBT	16,000	22,200	38.8%
Coastal	20,200	28,500	41.1%
CSESCA North	14,500	20,600	42.1%
CSESCA South	11,700	15,500	32.5%

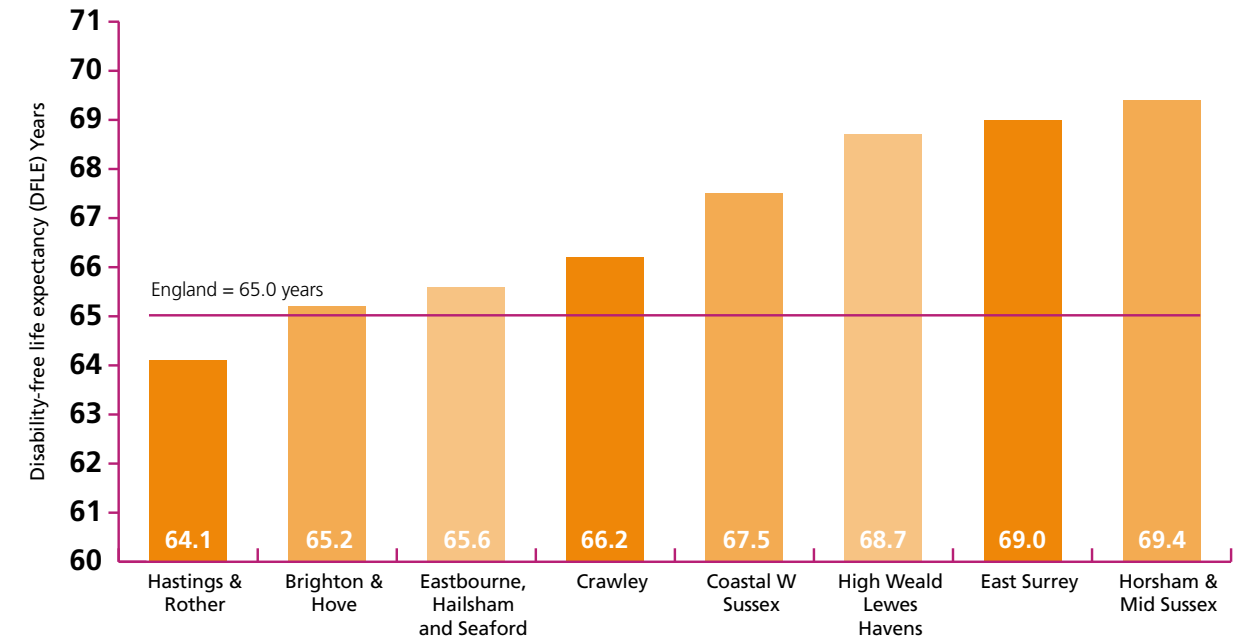
Sources: Aggregated CCG data provided by ONS. 2016 Population - ONS Mid-Year Estimate (Resident Population) 2016. 2030 Projected - ONS Population projections for clinical commissioning groups and NHS regions

The resident population across the overall area is projected to increase between 2016 and 2030, from a projected 9.2% increase in the CSESCA South area to 12% in Coastal. The greatest increases are projected in the older age groups, notably amongst people aged 85 years or over. Growth in the child population is lower than overall change. The overall population increase, and the rise in the older age groups will impact the demand for health and social care services, with frailty and the number of people with one or more long-term health condition rising.

Disability Free Life Expectancy
MEN (2010 - 2012) Source: ONS



WOMEN (2010 - 2012) Source: ONS



Life expectancy varies considerably across the area; this reflects deprivation, with shorter life expectancies in the most deprived local authority areas.

In Hastings male disability-free life expectancy is over five years lower than that in Horsham and Mid Sussex, East Surrey and High Weald, Lewes and the Havens.

Hastings and Rother also has the lowest female disability-free life expectancy at 64.1 years compared with Horsham and Mid Sussex at 69.4 years.

DEPRIVATION - INDEX OF DEPRIVATION 2015

While overall the STP area is relatively affluent, there are some areas, notably along the coastal strip in Hastings, Brighton and Hove and Littlehampton, which rank within the most deprived areas in England; deprivation that has persisted over many years.

In relation to child poverty, rates at a CCG level (2013) range from 7.3% in Horsham and Mid Sussex to 22.7% of children in Hastings and Rother, but again there are neighbourhoods where more than a third of children live in low income households.

The pace of change in older age will increase markedly over the next ten years

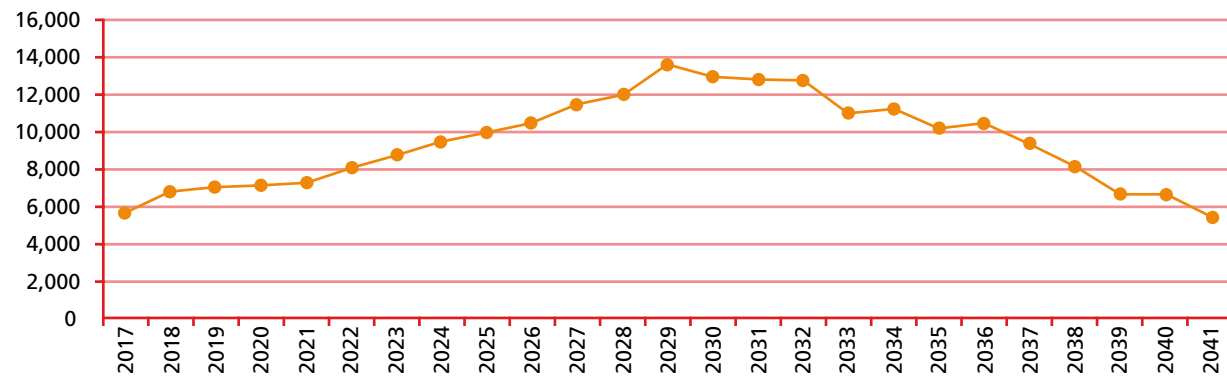
POPULATION – KEY FACTS

The population is increasing, with higher increases in the older age groups. It is also important to note that the pace of change in older age will increase markedly over the next ten years. In the first five years, the annual increase in the 65+ population is projected to be between 6,000 to 8,000 (across the whole STP area) but this then starts to rise, and peaks at around 14,000 in the next 10 years.

YEAR-ON-YEAR CHANGE IN THE POPULATION AGED 65 OR OVER 2017 TO 2041 (COMBINED EIGHT CCGS AREAS)

Given the increase in the old age groups, there will be more people living with a long term health condition. Many people will have multiple long term conditions. There will be considerable challenges in sustaining services and maintaining quality.

Year-on-year change in the population aged 65 or over 2017 to 2041 (Combined eight CCGs areas)

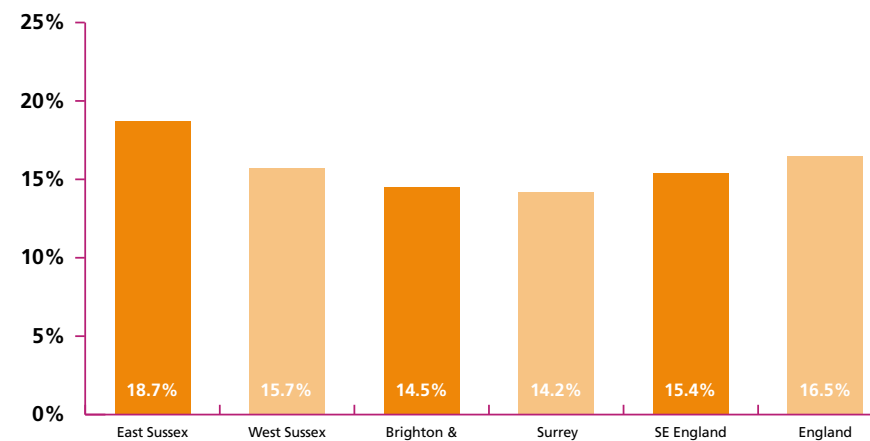


Source: ONS Population Projections (combined CCG areas)

LONG TERM CONDITIONS - DATA FROM QOF REGISTERS OF PATIENTS IDENTIFIED V MODELLED ESTIMATES OF PREVALENCE

Figures rounded to nearest 50. Register data relate to 2016/17	ASTHMA		ATRIAL FIBRILLATION		COPD		DEMENTIA		DIABETES		HYPERTENSION	
	QOF Register	Estimated undiagnosed	QOF Register	Estimated undiagnosed	QOF Register	Estimated undiagnosed	QOF Register	Est diagnosis rate (65+)	QOF Register	Estimated undiagnosed	QOF Register	Estimated undiagnosed
Brighton & Hove	16,750	No recent estimate	4,100	1,850	4,250	No recent estimate	1,700	64%	10,500	7,800	28,900	27,950
Coastal West Sussex	32,750		13,900	3,650	10,050		5,750	63.2%	30,250	9,250	83,400	54,550
Crawley	7,650		1,950	750	2,050		800	64.3%	7,100	1,150	16,250	11,750
East-bourne Hailsham & Seaford	12,900		6,350	700	4,400		2,500	67.3%	10,750	4,900	34,100	22,100
East Surrey	10,600		3,800	750	2,500		1,500	68.2%	7,800	3,300	22,250	17,050
Hastings and Rother	10,250		5,000	950	4,250		1,950	65.0%	10,150	5,450	30,700	17,650
High Weald Lewes Havens	10,150		4,300	950	2,900		1,700	66.0%	7,750	4,300	25,750	17,300
Horsham & Mid Sussex	14,750		5,050	1,650	3,250		2,200	67.9%	10,400	4,400	33,650	22,850

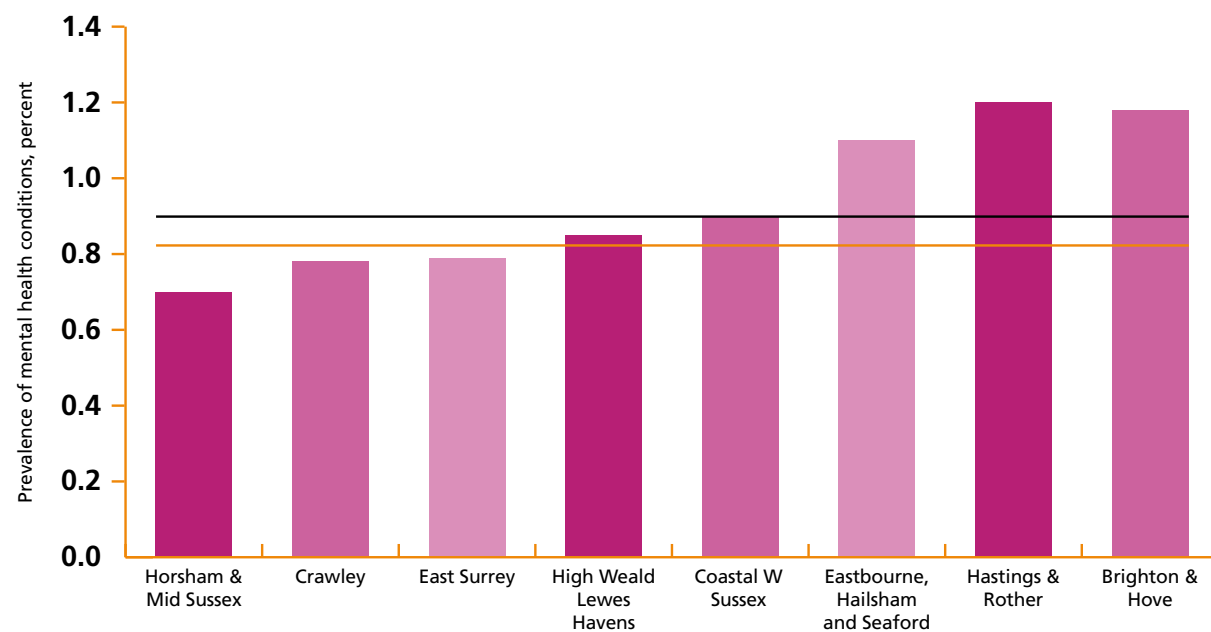
% Of Patients Reporting a Long Term Musculoskeletal Problem (2017 LA Level)



MENTAL HEALTH ESTIMATION OF COMMON MH MENTAL HEALTH PROBLEMS

MENTAL HEALTH	
Estimation of Common Mental Health Problems	MH
2014/15	% of 16-74 years
High Weald Lewes Havens	12.0%
Eastbourne, Hailsham & Sfd	12.4%
Crawley	12.7%
Horsham & Mid Sussex	12.8%
Coastal West Sussex	12.9%
East Surrey	13.3%
Hastings & Rother	13.8%
Brighton & Hove	17.3%

SERIOUS MENTAL ILLNESS



START WELL



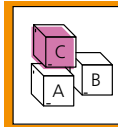
Smoking at the time of delivery

In 2017/18, 1,600 women were known to be smokers at the time of delivery (9.1% of those with recorded status). The percentage in Hastings and Rother was over 15%.



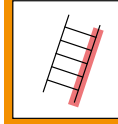
Breastfeeding initiation is high

Over 82% of mothers breastfed their babies in the first 48hrs after delivery in 2016/17. The rate was highest in Brighton & Hove (88.2%), lowest in Hastings and Rother (73.3%)



Readiness for School

In 2017, the percentage of children achieving a good level of development in Brighton & Hove (69.7%) and West Sussex (70.6%) lags behind East Sussex and Surrey, and is lower than England.



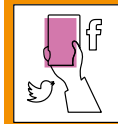
Social mobility rated very good in ...Tendridge (Surrey)

But rated very poor in Arun, Crawley and Hastings



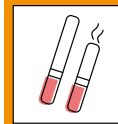
Obesity

7.8 % fo reception pupils and 15% of year 6 pupils were measured as obese in the STP area (2014/15 to 2016/17). Higher percentages of excess and obese children in more deprived areas.



7 hours + of sedentary behaviour

In the 2014/15 "What about Youth" Survey over 60% of 15 years olds surveyed in the STP area reported a mean daily sedentary time (in the last week) over 7 hours per day



Smoking at age 15 years

The percentage of 15 year olds who said they were "current smokers" was high in Brighton & Hove (14.9%), East Sussex (12.8%) and West Sussex (10.6%). Nationally the rate was 8.2%.



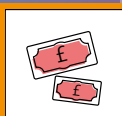
Hospital admissions for self-harm (10-24 years)

In STP areas compared with England, Brighton & Hove, Hastings and Rother and Coastal West Sussex have particularly high rates of admission.

LIVE WELL

**Low Unemployment**

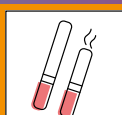
STP area has, overall, a low unemployment rate, but some areas higher such as Hastings

**But low wages in some areas**

Notably full-time wages (2017) are low in Adur, Hastings and Eastbourne.

**Housing Pressures**

Over 40,000 households on council waiting lists, 450-500 households a quarter accepted as homeless and in priority need.

**Over 250,000 smokers on GP registers**

Considerable differences across the patch and between socio-economic groups. High rates in Brighton and Hove and Hastings .

**Falling short of the "5-a-day"**

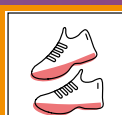
Across the STP area, adults consume only 2.5 to 3 portions of fruit & vegetables a day, and estimates of overweight or obese adults at local authority level range from 48% to 64%.

**250,000+ adults estimated to be "binge" drinkers**

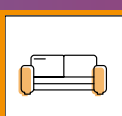
In 2016/17 there were over 1,600 alcohol-specific hospital admissions

**Over 155,000 adults with depression on GP registers**

This represents over 10% of patients. Again there is variation – with 13% of patients in Eastbourne, Hailsham and Seaford identified with depression.

**Physical activity rates vary**

Measured at local authority level, the % of adults undertaking the recommended physical activity level vary from 78% in Brighton & Hove to 62.2% in Crawley.

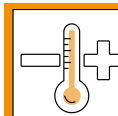
**Rates of physical inactivity vary**

In Eastbourne 27% of adults are estimated to undertake less than 30 minutes of physical activity per week.

AGE WELL

**Over 110,000 older people live alone in the overall STP area**

Of the older people living on their own the vast majority are women (over 70%). Over 83% of older people are owner occupiers

**70,000 households estimated to be in fuel poverty**

Not restricted to older people, but health effects can be greater on the very young and very old.

**Admissions after a fall are high**

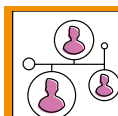
In old age groups a fall can trigger a move into residential care. For people aged 80+ Brighton & Hove, Surrey and West Sussex rates of emergency admissions are far higher than the England rate

**Over 183,000 Carers**

...in the STP area, including over 37,000 people who are caring for 50 hours a week or more, including 15,000 carers aged 65 or overs.

**18,000+ on Dementia Registers**

But we know that many people with dementia are not diagnosed.

**Social isolation and loneliness**

Frequently reported by older people and has an impact on mental and physical wellbeing. Over 60% of carers known to social care say they do not have as much social contact as they would like.



Deaths at home Overall a higher percentage (50.7% in 2016) of people in the STP die in their usual residence (including care homes), compared with England, but this is far lower in Crawley (37.2%)

**Variation in Disability Free Life Expectancy (DFLE)**

Hastings and Rother has the lowest DFLE for both men and women (62.5 years and 64.1 years respectively) and Horsham and Mid Sussex the highest (69.1 years for men and 69.4 years for women)

CASE STUDY - WELLBEING PRESCRIPTION SERVICE – EAST SURREY

The Wellbeing Prescription service allows GPs and other health and social care workers to refer people to local Wellbeing Advisors. The Wellbeing Advisors are trained to identify the clients' needs, provide them with advice and signpost them to relevant local services and activities. The service is delivered in partnership by Tandridge District Council, Reigate & Banstead Borough Council and East Surrey GP practices and is commissioned working closely with NHS East Surrey Clinical Commissioning Group and Surrey County Council through the Better Care Fund.

Quarter 1 18/19 monitoring report shows that 77% of people who have used the Wellbeing Prescription service made a positive change to their lifestyle and 75% have visited their GP less often since using the service. The Wellbeing Advisors can help people with issues such as weight management, getting more active, smoking cessation, social isolation and support with mental and emotional wellbeing. In addition there is Wellbeing Prescription Plus service, which is provided in the homes of patients with multiple, complex needs, as part of an integrated care approach.

CASE STUDY - WEST SUSSEX - SUGAR REDUCTION PROGRAMME

The West Sussex Sugar Reduction Programme was launched in January 2015 (N.B. primary school meals sugar reduction began at the end of 2014). Whilst the overall programme has been successful, sugar reduction in primary school meals has achieved particularly significant results, winning a Public Health England (PHE) award in September 2016 in recognition of this. To date, the following achievements have been made:

- Primary school meals now have over 2 kilos less sugar, per child, per average school year.
- Daily sugar consumption reduced from 18.5g to 6.6g per child
- The total amount of sugar reduced equals 5 double decker London buses per school year!
- That's a 65% sugar reduction in just 3 years!
- 30,000 children per day are benefiting

CASE STUDY - EAST SUSSEX - EMBEDDING PREVENTION ACROSS THE SYSTEM

The Personal and Community Resilience Programme in East Sussex brings together partners across the statutory (CCGs, local authorities, Healthcare Trusts, Police, Fire and Rescue Service, Department for Work and Pensions) and voluntary and community sectors to take action to grow strong communities which improve health; and to co-ordinate activity to embed prevention across the system. The programme includes transformation programmes in key 'settings' (the places where people spend their lives) such as schools, nurseries, and healthcare settings including GPs, pharmacies, hospitals and community health care services, to support them to play a greater role in improving health. As part of this:

- 3,169 frontline staff have been trained to 'Make Every Contact Count'
- 96% of all primary and secondary schools have developed and are delivering whole school health improvement plans
- 81% of all nurseries (private and local authority) have audited and are improving their healthy eating and physical activity offer
- 89% of General Practices are undertaking new health improvement programmes in their practices
- 96% of pharmacies registered as Healthy Living Pharmacies (HLP) Level 1, and 30 targeted pharmacies are being developed as HLP Level 2
- 88,579 people received their NHS Health Check (over the past 5 years)
- A whole systems approach to Social Value is being developed across the county, linked to local priorities and growing strong communities

The programme includes transformation programmes in key 'settings' such as schools, nurseries, and healthcare settings including GPs, pharmacies, hospitals and community health care services

This programme is aiming to reduce the harm caused by substance misuse and unsafe, early sexual behaviour in young people

CASE STUDY – BRIGHTON AND HOVE ADOLESCENT HEALTH OFFER

This programme is aiming to reduce the harm caused by substance misuse and unsafe, early sexual behaviour in young people. The offer is a single, integrated service including:

- Music workshops and mentoring programme for young people use cannabis but do not see it as a problem
- DASH (Drug, Alcohol and Sexual Health) Prevention team which provides a package of resilience building interventions
- Specialist Substance Misuse Treatment Service
- School based health drop-ins staffed by school nurses and youth workers and text messaging support via CHATHEALTH
- PSHE (Personal, Social, Health and Economic) direct support to schools to improve the universal curriculum
- Communication plan, including social media campaign which is aimed at equipping parents to have direct conversations with young people to explain the harms caused by using drugs / drink / tobacco.

Our evidence: Our public and our patients

We always value the views of patients and carers and we have quoted a few examples of patient experience throughout. Some show excellent care and some highlight areas for improvement. For example:

GOOD EXPERIENCES

“Every staff member I have encountered has been brilliant, respectful and knowledgeable.”

“When my husband had a TIA, I could not fault the care of ambulance crew, A&E at hospital, emergency floor”

EXAMPLE

A homeless woman with mental health issues including suicidal thoughts, supported by an outreach team to apply for funding, diary reminders for appointments. The support has dramatically reduced her illicit substance use and she feels more in control.

EXPERIENCES THAT COULD BE BETTER

“Not enough people know about the wide range of services pharmacies can offer.”

EXAMPLE
87 year old discharged post-surgery and told to expect a visit from social care that day. No one came. Only allowed one visit to change her dressing. (ESBT)

EXAMPLE
The importance of continuity of relationships (for young people) with professionals came out in her frustration with the variability and short term nature of those encounters. (Coastal Cares)

IDEAS FOR IMPROVING CARE

“I would like advocates, community navigators and health coaches to have a greater role in supporting people to understand their health conditions and medicine”

“People need to be more aware of healthy lifestyles and to take more responsibility for own health. So more education.”

EXAMPLE
The daughter of a 95 year old woman with dementia raised concerns over her mother's care in a care home. Even though they were funding the care, support to raise concerns would have been welcomed.

Whenever we get into a discussion with patients and the general public there are a number of recurring themes which regularly surface, they are:

- Good access to primary care,
- Keeping care local,
- Care that is well coordinated,
- Having the right information to support self-care and as much focus on wellbeing as on health,
- In addition, local people recommended expansion of the range of local services in local communities so these would be more integrated and accessible both for patients and also for family and carers.

All across the STP, commissioners have been engaging the public to gain their views on current services and/or proposed changes. In the Alliance, CCGs have been conducting a series of discussions called the ‘Big Health and Care Conversation’ and more of these events are planned.

Once we have agreement on the content and strategic direction of the Population Health Check we will engage more widely with our staff, wider partners, Health Overview and Scrutiny Committees etc. and mobilise our communications and engagement resources to widen debate and gain ownership of the plan.

OUR EVIDENCE: WHAT DO PATIENTS EXPERIENCE?

We need to move from how things are now, a fragmented and reactive system, to a future system designed around the individual.

How it looks now:

- A fragmented system with multiple providers, characterised by a lack of coordination,
- A service which is reactive not proactive,
- Pathways of care that are unnecessarily complex.

We need to move from how things are now, a fragmented and reactive system, to a future system designed around the individual.

We need to work with our local communities to help people help themselves. This is what most people tell us they want.

OUR EVIDENCE: WHAT SHOULD OUR PUBLIC AND PATIENTS EXPECT (PRINCIPLES OF CARE)?

We understand the importance of a person centred asset based approach to empowering people to develop the knowledge skills and confidence to self-manage.

The focus needs to be on our population rather than organisational silos, with prevention and self-management at its core. This is enabled through strength based social care, shared decision making, making every contact count, collaborative care and support planning and health coaching.

People have the right to a high-quality health and care service when they really need it.

With rights, however, come responsibilities. We need to work with our local communities to help people help themselves. This is what most people tell us they want. We need to work with people to redesign the system. To do this, we will adopt the following principles of care:

- Make Prevention Everybody's business,
- Maximise Independent Living and Self-Care,
- Target proactive care of people at highest risk of hospitalisation and needing higher intensity care,
- Reduce the time people stay in hospital for and discharge them safely,
- Make patient journeys more joined up, without waste, repetition or duplication,
- Make Sussex and East Surrey STP a great place to work in all our local organisations,
- Prioritise investment areas which bring maximum benefit for patients.

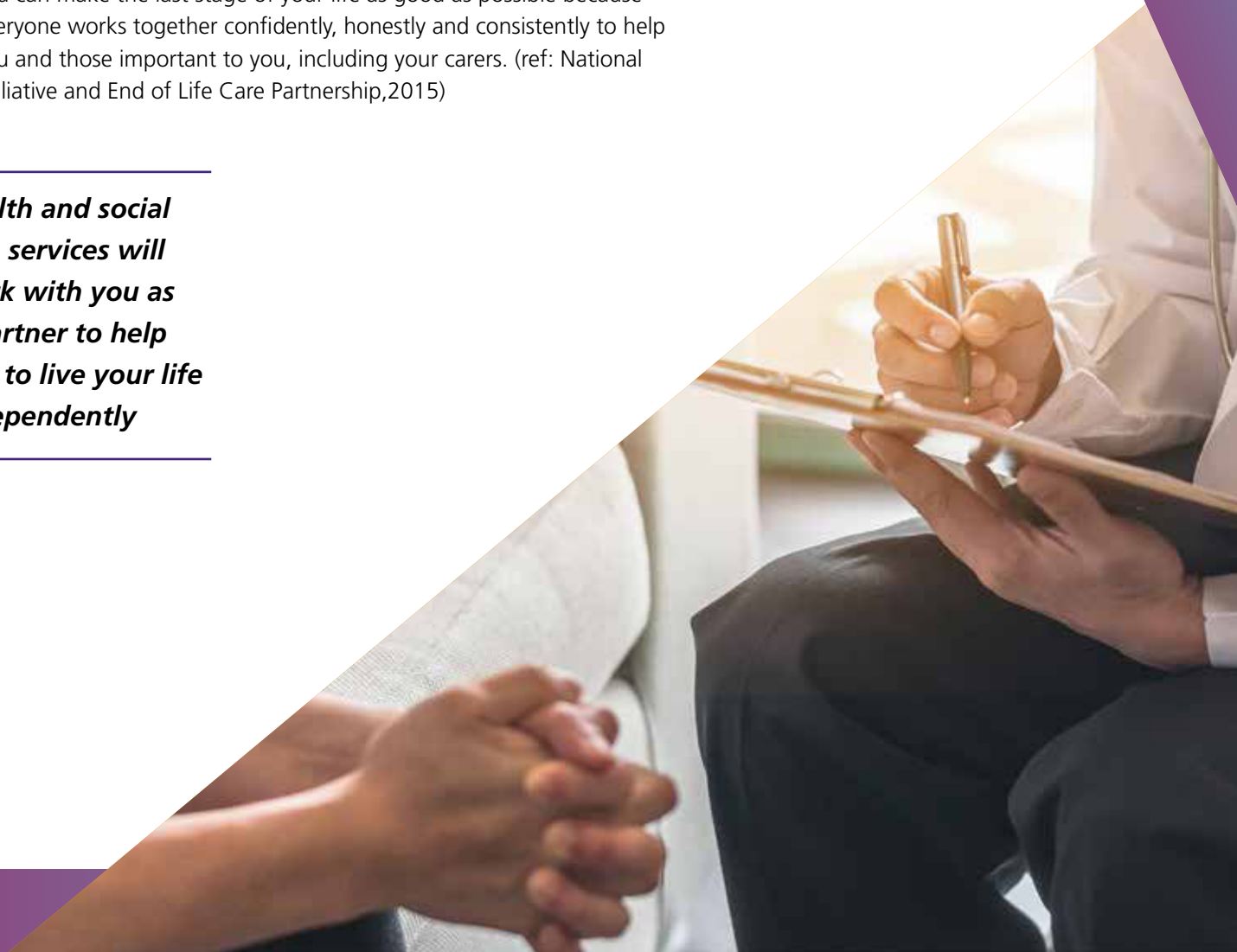
OUR EVIDENCE: WHAT WILL THIS MEAN FOR US ALL?

- You will be empowered and supported to develop the knowledge, skills and confidence to self-manage and stay well.
- We will create environments which make it easier to be healthy. You are also more likely to be offered a personal care or health budget.
- If you become unwell with a long-term condition, you will work

collaboratively with your health and care professionals to develop a care and support plan describing what's important to you.

- There is likely to be a key worker or co-ordinated assigned to you.
- You will have a care record which you will be able to see and add to.
- If you need hospital care, there may be changes to how and where this is offered, with hospitals working as partners to provide more specialised services and with more technology-enabled care.
- If you are frail and elderly and you need to go into hospital, you are more likely to receive support to go straight home to recuperate, rather than having to go somewhere else first.
- Health and social care services will work with you as a partner to help you to live your life independently
- You can make the last stage of your life as good as possible because everyone works together confidently, honestly and consistently to help you and those important to you, including your carers. (ref: National Palliative and End of Life Care Partnership,2015)

Health and social care services will work with you as a partner to help you to live your life independently



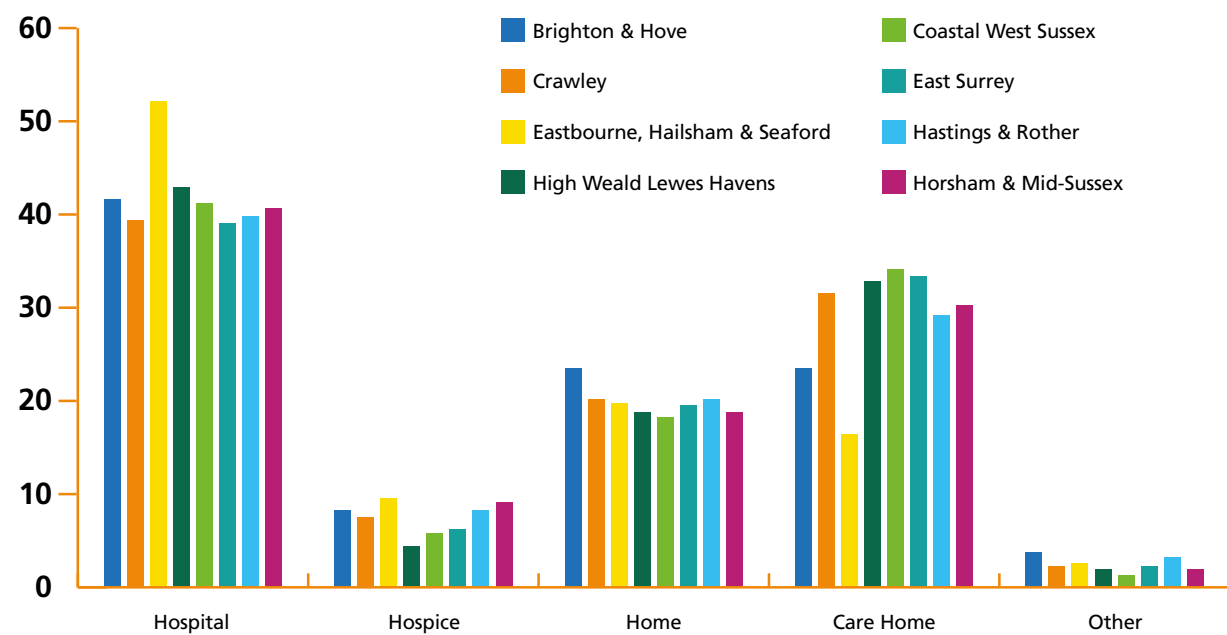
Whilst some people receive excellent care, others experience fragmented and poorly co-ordinated care.

Our evidence: Our services

DYING

- We want more patients to die in their usual place of residence. Across the STP we have a high number of care homes and we should capitalise on this and support more residents to die in these supported and homely environments.
- In the Sussex and East Surrey STP, there were 19,585 deaths in 2015. The percentage of all deaths with dementia as an underlying or contributory cause of death were higher in 50% of the CCGs.
- The percentage of all deaths that are aged 85 years and older were higher than the national average for all CCGs.
- We are poor at identifying people who are at the end of their life.
- There is fragmentation of services and lack of shared records.
- Whilst some people receive excellent care, others experience fragmented and poorly co-ordinated care.

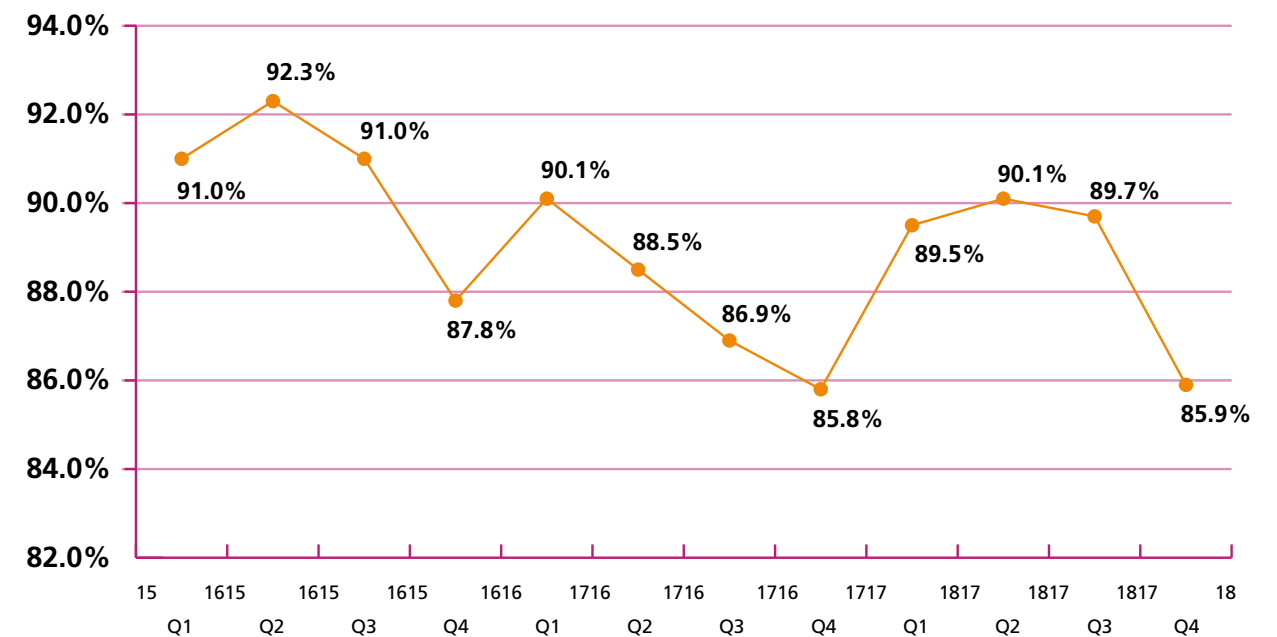
Percentage of death in different locations by CCG



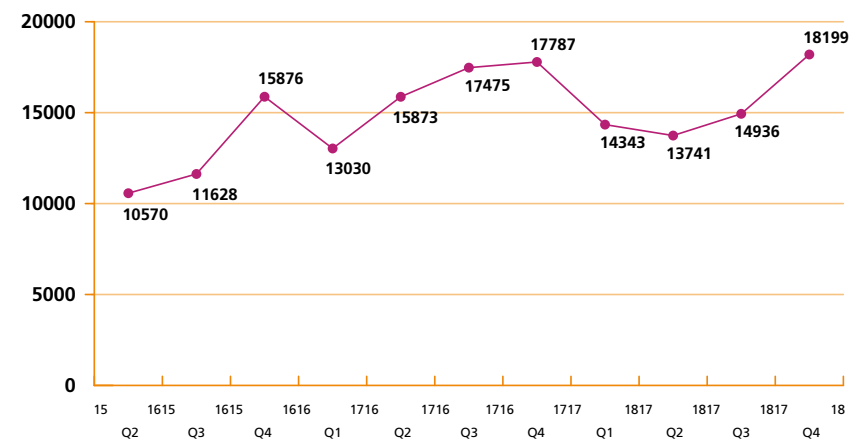
*“Due to the complexity of four parties being involved in our mother’s care ([hospice], [care home], District nurses and the GP) there were times when communication and responsibility were disconnected”
St Catherine’s hospice*

*“I can’t think of anything you can improve on, I am 91 years old and my wife passed away in March of this year at the age of 95. She had Parkinson’s and dementia, she wanted to die at home so I looked after her at home for 3 years or more and the help and care I got from the NHS was so good I can’t say a bad word about it.”
Coastal Care-Primary and Urgent care survey)*

A&E 4HR WAITING TIME PERFORMANCE STP WIDE



A&E BREACHES STP WIDE



Whilst individual Trusts occasionally meet the 95% 4 hour A&E waiting time standard, as a whole, the Sussex and East Surrey STP has not met the standard since it was formed in late 2015.

4/4 acute providers have breached the four hour waiting time target at Q3 16/17. In 2016/17, 2 of the acute trusts were more than 5% below the expected 95% of patients to be seen within 4 hours – for Type 1 A&E attendances. The other 2 trusts were above 90% but below 95% for 3 of the 4 quarters. The NHS Planning Guidance (2018/19) expects 95% to be achieved by month 12.

There are significant hand over delays at our hospitals. Between 24-12-2017 and 02-01-2018 SECAmb lost in excess of 3,200 operational ambulance hours to turnaround delays greater than 30 minutes. This was a 13% increase over the same period last year. This is equivalent to losing 13 ambulances on duty every day of this 10 day period.

Coastal West Sussex and East Sussex areas showing levels of hospitalisation almost four times as high as in other areas of the STP.

ACCESS

ADMISSIONS

There is very large variation in patterns of hospital use for conditions that would not usually require hospitalisation, with Coastal West Sussex and East Sussex areas showing levels of hospitalisation almost four times as high as in other areas of the STP.

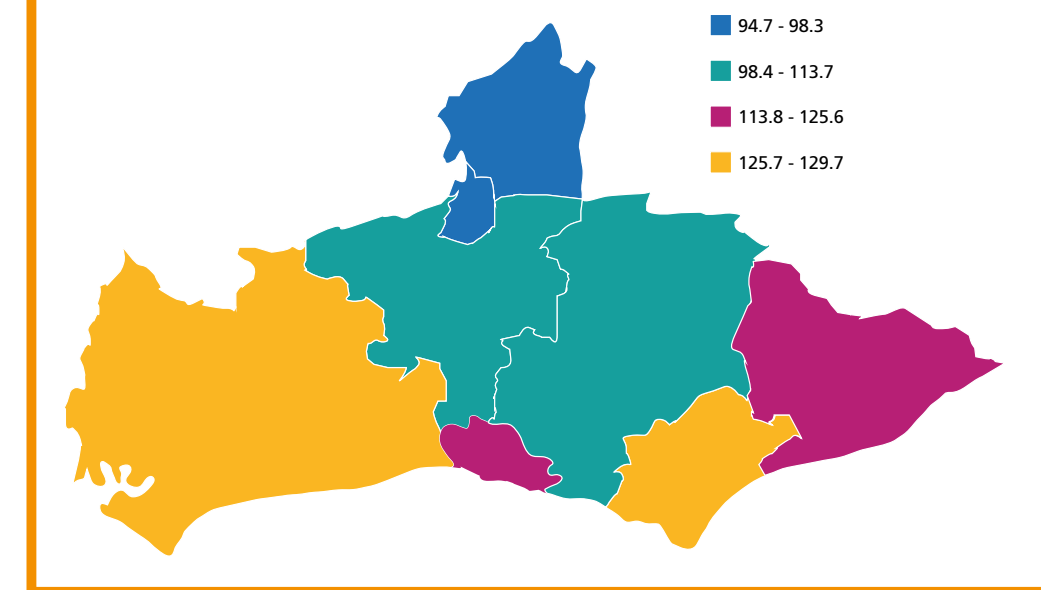
The reasons for this are multi-fold and span patient behaviours but also the availability, accessibility and responsiveness of non-hospital based services.

Although there is no right or wrong formula of what services should be provided in a non-acute setting, it is generally viewed that an over-reliance on acute based care is comparatively more expensive due to the prevailing payment system (Payment by Results).

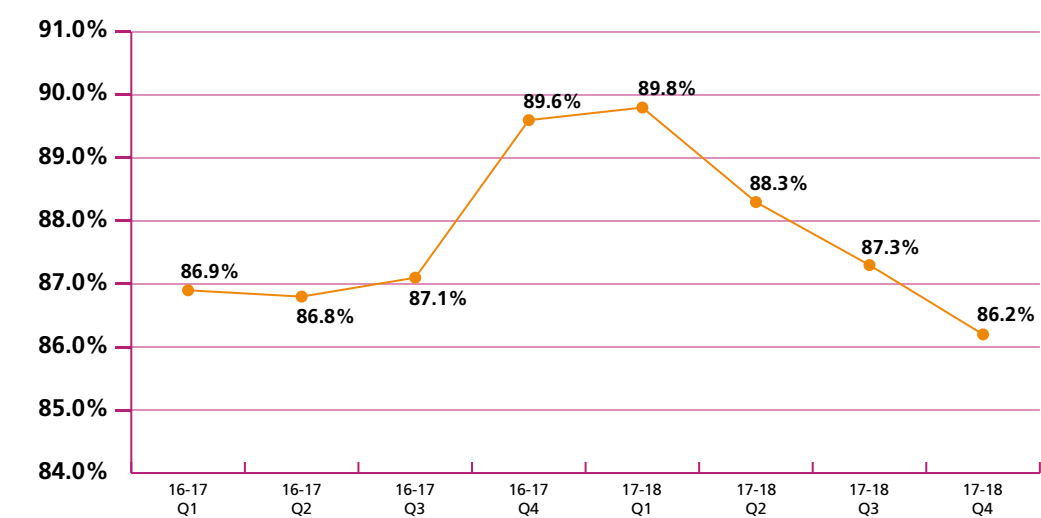
There is variation across the trusts in delivering on Referral to Treatment Times (RTT).

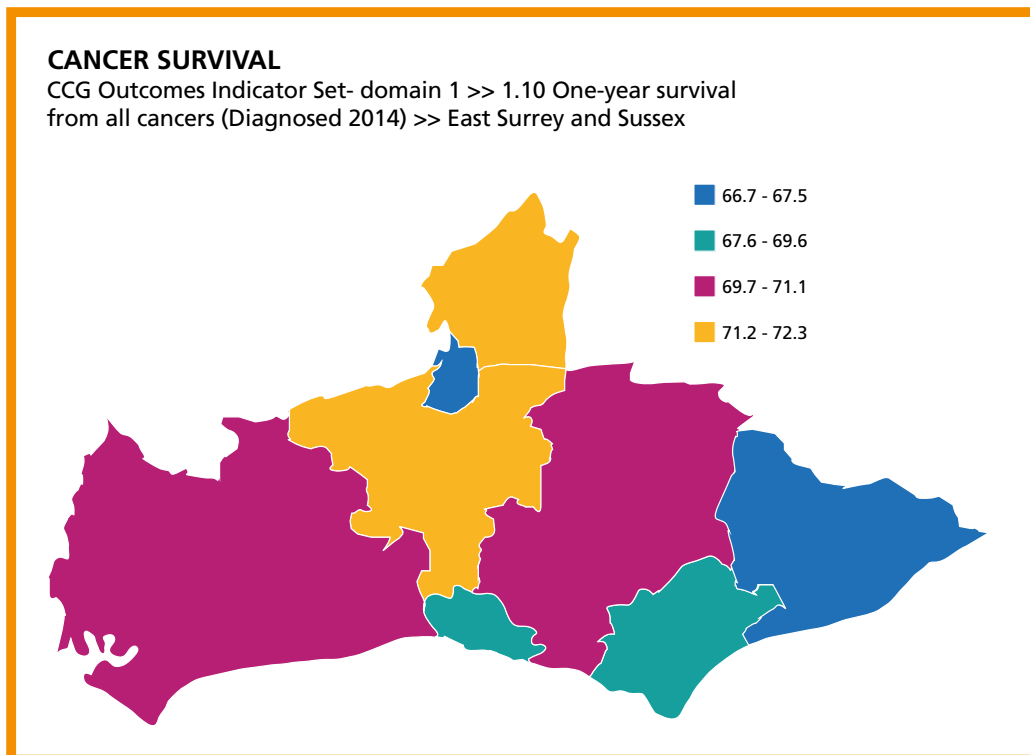
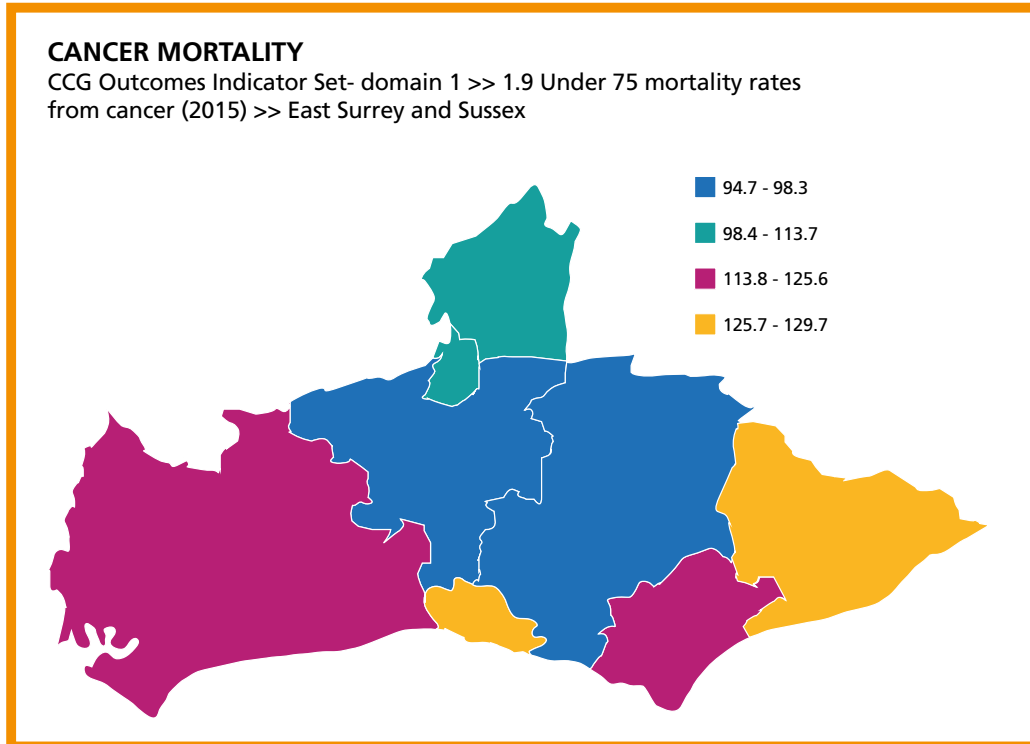
3.3.3.1 Admissions

CCG Outcomes Indicator Set- domain 3 >> 3.1 Emergency admissions for acute conditions that should not usually require hospital admission (2016-2017 (Jul-Jun)) >> East Surrey and Sussex



RTT performance STP wide





"I was recently diagnosed with breast cancer following my first over 50 screening. I have had the surgery and I have just started chemotherapy. I just wanted to let you know how amazing the staff at BSUH have been; The radiographers and nurses in the breast care unit, pre assessment clinic, theatre and Ansty ward at PRH and imaging."

- There is significant variation in mortality rates from cancer, with patients in coastal areas, in particular Brighton and East Sussex being in some instances 20% more likely to die from cancer than patients in Horsham/Mid Sussex.
- In our STP, cancer incidence is high, with low diagnosis at stage 1 and 2. Take up of cervical and breast screening is low.
- We lack of access to modern, high quality and local radiotherapy services.
- There is inadequate introduction and adoption of timed pathways in Lung, Prostate and Colorectal cancer.
- There is variation across the trusts in delivering on cancer waits.
- Diagnostic capacity and workforce shortages continue to be an issue.

(Ref: STP dashboard 2018)

	LATEST PERIOD	LATEST VALUE	RANK WITHIN SOUTH	SPINE CHART
				● = selected STP ■ = middle 50% of South STPs X = England average = STP median
				WORST BEST
Cancer incidence (total tumours)^	2014	11403	13/13	
Cancer incidence (rate)	2014	611.8	9/13	
Breast cancer screening coverage	2015/15	72.4%	12/13	
Cervical cancer screening coverage	2015/16	73.7%	9/13	
Bowel cancer screening coverage	2015/16	60.3%	8/13	
Diagnosis at stage 1 or 2	2015	50.6%	12/13	

UNWARRANTED VARIATION

We know there are areas of healthcare, which demonstrates variation in practice and quality across our STP.

Key areas of variation in our STP are:

- Cardio Vascular Disease (including Stroke care, Atrial Fibrillation, stable angina and diabetes)
- Trauma and Injuries (Falls and Fragility Fractures)
- MSK

"After my stroke, I felt isolated and lost confidence"

"Mum wasn't admitted to the ward for 9 hours"

"The aftercare failed to meet any expectations"

UNWARRANTED VARIATION: CARDIOVASCULAR STROKE

In stroke care there is:

- Inadequate achievement of NICE (National Institute for Health and Care Excellence) Guidelines standards for non-elective stroke care and the South East Clinical Network Stroke standards.
- There continues to be variation across the STP in stroke services, especially in relation to access to allied access to six-month reviews.

Routinely Admitting Teams	Trust	Brighton and Sussex University Hospitals NHS Trust	East Sussex Healthcare NHS Trust	Maidstone and Tunbridge Wells NHS Trust	Maidstone and Tunbridge Wells NHS Trust	Medway NHS Foundation Trust	Surrey and Sussex Healthcare NHS Trust	Western Sussex Hospitals NHS Trust	Western Sussex Hospital NHS Trust
	Team Name	Royal Sussex County Hospital	Eastbourne District General Hospital	Maidstone District General Hospital	Tunbridge Wells Hospital	Medway Maritime Hospital	East Surrey Hospital	St Richards Hospital	Worthing Hospital
Number of patients	Admit	200	149	110	140	89	191	164	189
	Disch	167	175	101	142	84	198	156	186
Patient Centred Data	D1 Scan	A	A	A	A↑	C↓	A	B↓	A
	D2 SU	B	B	C	D↑	E	D	C	C↓
	D3 Throm	B	C↓	C	D↓	D	B↑	B	B
	D4 SpecAsst	A	B↓	B↑	C	D	B↑	C	A↑
	D5 OT	B	C	A	B↓	E	B↓	C	A
	D6 PT	B↑	C	A	A	D	C↓	C	B
	D7 SALT	C↑	E	A	B↑	C	C↓	B	C↑
	D8 MDT	D	D	B	C	D	B↑	C	B↑
	D9 Std Disch	A	A	C	D	A↑	B	B	A
	D10 Disch Proc	B	B↑	B	B	B↓	D	C↑	D↓
PC KI Level	B	C↓	A↑	C	D	B↑	C	B	
Six Month Assessment	Number Applicable	126	109	73	84	85	124	112	106
	% Applicable	98%	100%	100%	100%	98%	99%	99%	100%
	Number assessed	8	14	0	0	3	3	0	0
	% Assessed	6%	13%	0%	0%	4%	2%	0%	0%

PATIENT CENTRED - APRIL TO JULY 2017

SOUTH ENGLAND - SOUTH EAST SCN

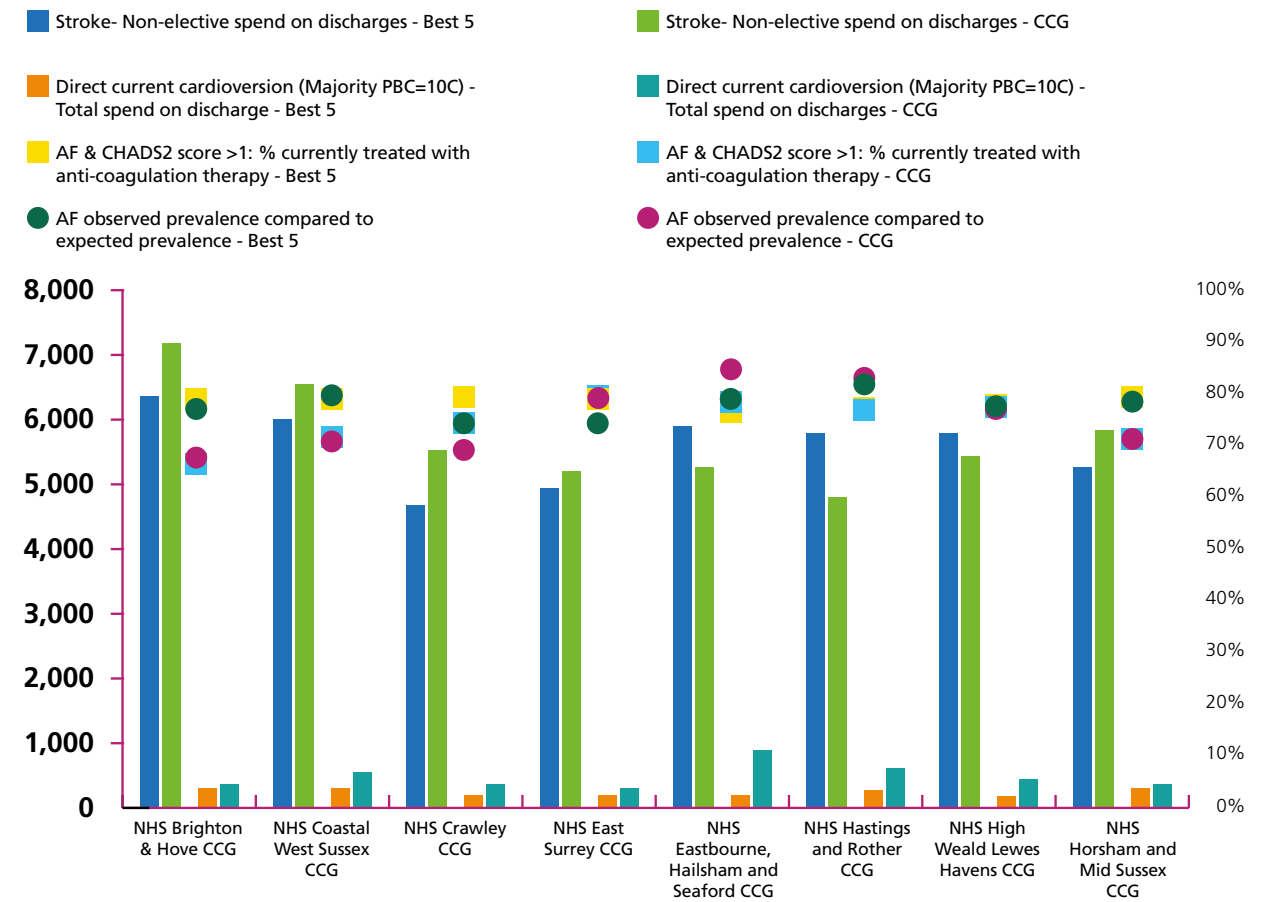
Routinely Admitting Teams	Trust	Brighton and Sussex University Hospitals NHS Trust	East Sussex Healthcare NHS Trust	Maidstone and Tunbridge Wells NHS Trust	Maidstone and Tunbridge Wells NHS Trust	Surrey and Sussex Healthcare NHS Trust	Western Sussex Hospitals NHS Trust	Western Sussex Hospital NHS Trust
	Team Name	Royal Sussex County Hospital	Eastbourne District General Hospital	Maidstone District General Hospital	Tunbridge Wells Hospital	East Surrey Hospital	St Richards Hospital	Worthing Hospital
Number of patients	Admit	210	146	122	148	193	148	164
	Disch	180	188	111	132	177	145	159
Patient Centred Data	D6 PT	A↑	B↑	A	A	B↑	C	B
	D7 SALT	B↑	E	A	B	C	C↓	C
	D8 MDT	B↑↑	D	B	B↑	B	C	B
	D9 Std Disch	B↓	A	D↓	D	A↑	A↑	A
	D10 Disch Proc	B	C↓	B	C↓	D	D↓	C↑
	PC KI Level	A↑	B↑	B↓	C	B	C	A↑
Six Month Assessment	Number Applicable	104	126	75	88	158	114	124
	% Applicable	98%	100%	100%	100%	98%	100%	100%
	Number assessed	2	13	0	0	0	0	0
	% Assessed	2%	10%	0%	0%	0%	0%	0%

PATIENT CENTRED - APRIL TO JULY 2017

SOUTH ENGLAND - SOUTH EAST SCN

UNWARRANTED VARIATION: CARDIOVASCULAR: STROKE PREVENTION AND ATRIAL FIBRILLATION (AF)

For every 25 high risk patients treated for AF, one serious/debilitating stroke is avoided. The chart below shows that, compared with our demographic peers, we often have a gap between our expected prevalence versus our actual prevalence. Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG are identifying more cases than their comparative peers. Where we are finding patients and putting them on blood thinners, our spend on non elective stroke is lower than our demographic peers because we are preventing strokes. Within three years we could stop 660 Strokes if we treated all patients with AF with anti coagulation. This equates to £11.2 million.



EST. AF PREVALENCE	1.97%	3.44%	2.04%	2.51%	3.58%	3.52%	3.11%	2.81%
EST. BEST 5 PREVALENCE	2.06%	3.07%	2.24%	2.42%	3.15%	3.21%	2.97%	2.53%

NHS Brighton & Hove CCG NHS Coastal West Sussex CCG NHS Crawley CCG NHS East Surrey CCG NHS Eastbourne, Hailsham and Seaford CCG NHS Hastings and Rother CCG NHS High Weald Lewes Havens CCG NHS Horsham and Mid Sussex CCG

The NHS reports that people who have diabetes are 15 times more likely to undergo amputations than other people without the condition.

UNWARRANTED VARIATION: CARDIOVASCULAR DISEASE: DIABETES

In diabetes care there is wide variation in:

- The number of major and minor amputations and length of stay.
- The average number of major amputations in England is 8.1 per 10,000 (standardised rate). Across our STP the rate ranges from 5.8 High Weald Lewes Havens CCG to 10.2 Eastbourne, Hailsham and Seaford CCG. The average number of minor amputations in England is 20.7 per 10,000 (standardised rate). Across our STP the rate ranges from 17.7 (Crawley CCG) to 28.9 Eastbourne, Hailsham and Seaford CCG.
- Our current diabetic foot amputation rate will continue to rise. Currently 52% of our diabetic foot ulcers are rated as severe and at least 56% were unhealed at 12 weeks, with 83% of patients waiting more than two days for referral and triage and 38% waiting at least 14 days (NICE recommendation for referral and triage within two days).
- There is still a gap in the actual to expected prevalence rate of diabetes. There is variation across our STP in terms of Primary Care achievement of quality targets such as blood sugar management, blood pressure, cholesterol and the other 8 Care processes.

KEY FACT

The NHS reports that people who have diabetes are 15 times more likely to undergo amputations than other people without the condition. Diabetes is one of the leading causes of amputation of the lower limbs throughout the world. Charity Diabetes UK notes that problems of the foot are the most frequent reasons for hospitalisation amongst patients who have diabetes.

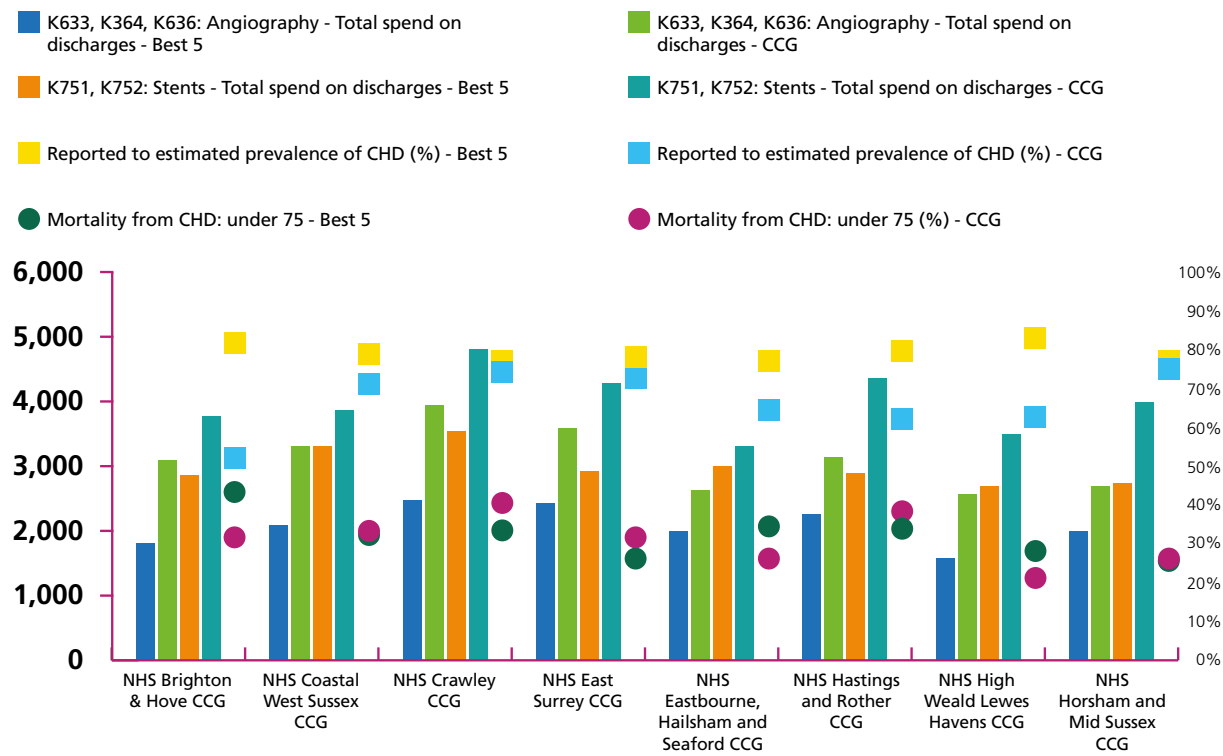
“In the first 5 weeks of attending (the National Diabetes Prevention Programme tailored education) I had lost almost a stone in weight and my cholesterol is falling”

CCG	Major amputations per 1,000 diabetic patients April 2011 - March 2014	Major amputations per 1,000 diabetic patients April 2012-2015	Major amputations per 1,000 diabetic patients 2013-14 2015-16
England	0.8	0.8	0.81
East Surrey CCG	1.0 (19)	0.8 (17)	0.9 (19)
Horsham & Mid Sussex CCG	0.6 (15)	0.8 (21)	0.82 (21)
Crawley CCG	0.5 (9)	0.9 (17)	0.93 (16)
Coastal West Sussex CCG	0.9 (71)	1.0 (79)	0.54 (80)
Brighton & Hove CCG	1.0 (32)	0.9 (29)	0.8 (27)
High Weald, Lewes & Havens CCG	0.6 (12)	0.6 (14)	0.58 (16)
Hastings & Rother CCG	1.0 (27)	0.9 (27)	0.81 (29)
Eastbourne, Hailsham & Seaford CCG	1.7 (47)	1.1 (33)	1.02 (36)
South East Coast Total	578	581	0.82 (613)
CCG	Minor amputations, annual rate per 1,000 adults with diabetes	Minor amputations, annual rate per 1,000 adults with diabetes 2012-2015	Minor amputations, annual rate per 1,000 adults with diabetes 2013-2016
England	1.7	1.8	2.1
East Surrey CCG	2.6 (51)	2.3 (48)	2.42 (57)
Horsham & Mid Sussex CCG	1.5 (39)	2.0 (57)	2.23 (67)
Crawley CCG	1.4 (25)	1.4 (26)	1.77 (30)
Coastal West Sussex CCG	1.9 (143)	2.1 (163)	1.84 (184)
Brighton & Hove CCG	2.1 (66)	1.8 (58)	2.07 (71)
High Weald, Lewes & Havens CCG	2.3 (49)	1.8 (39)	2.15 (59)
Hastings & Rother CCG	2.4 (68)	2.4 (69)	2.05 (74)
Eastbourne, Hailsham & Seaford CCG	2.7 (76)	2.9 (84)	2.89 (98)
South East Coast Total	2.02 (1334) (SEC average)	2.07 (1274)	2.33 (1739)

We have a higher spend on angiography and stents than our demographic peers but not always resulting in better outcomes

UNWARRANTED VARIATION: CARDIOVASCULAR DISEASE: OVER-TREATING PATIENTS WITH STABLE ANGINA

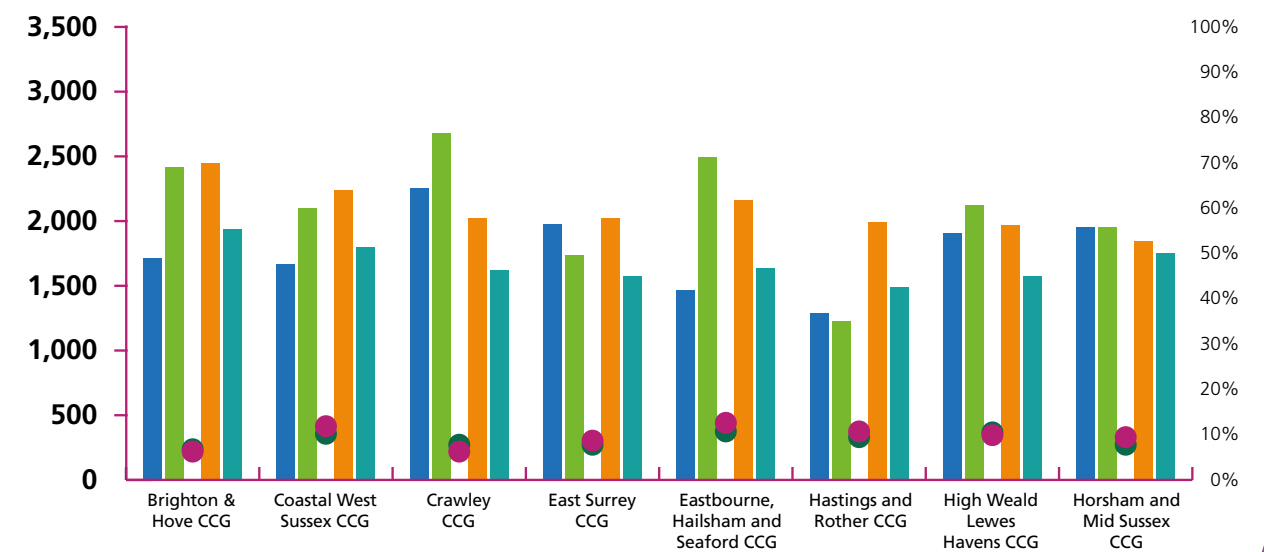
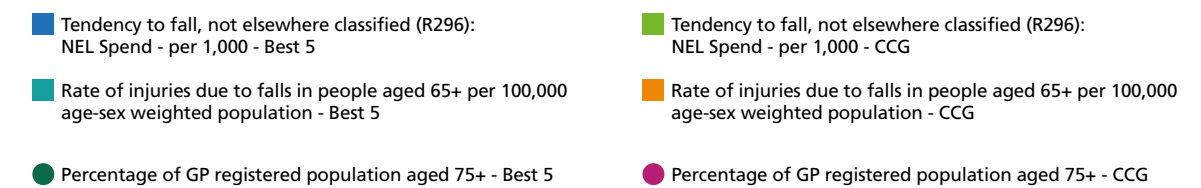
The NICE pathway states that patients with stable angina should have a computerised tomography angiogram first which is non-invasive and cheaper than an invasive angiogram. Only about 20% of patients who have had a CT angiogram would need to go on to have an invasive angiogram. 80% should be given medication to manage their angina. If the medication does not help the pain, a shared decision-making conversation should take place which makes it clear that if the patient has a stent inserted, it will not prolong their life, with the exception of a small defined cohort of our population, but it will help with chest pain. The chart below shows that compared with our demographic peers, we have a lower reported prevalence of CHD than our estimated numbers. Also we have a higher spend on angiography and stents than our demographic peers but not always resulting in better outcomes. There is variation in the implementation of these NICE guidelines across our STP, resulting in too many invasive angiograms and stents.



CCG	CHD Prevalence	Best 5 Prevalence
NHS Brighton & Hove CCG	2.19%	2.86%
NHS Coastal West Sussex CCG	4.11%	3.71%
NHS Crawley CCG	2.77%	2.71%
NHS East Surrey CCG	2.77%	2.69%
NHS Eastbourne, Hailsham and Seaford CCG	4.12%	3.89%
NHS Hastings and Rother CCG	4.20%	3.85%
NHS High Weald Lewes Havens CCG	3.11%	3.33%
NHS Horsham and Mid Sussex CCG	2.96%	2.70%

UNWARRANTED VARIATION: TRAUMA AND INJURIES (FALLS AND FRAGILITY FRACTURES)

The chart below shows that there is wide variation in the number and treatment of falls compared with our demographic peers: One in three over-65s and half of those over 80 will suffer a fall each year. The Department of Health and Social Care has stated that a falls prevention strategy could reduce the number of falls by 15-30%. Admissions relating to fractures where a fall has occurred, notably hip fractures and those people over 65 without significant injury and are not always getting a multifactorial falls assessment and exercises, which we know reduce subsequent falls by 24%. We do not always have effective case-finding and appropriate drug treatment for osteoporosis, particularly after the first fracture has occurred. We know if this treatment is taken then there is a reduction in the risk of the next fracture by 50%.

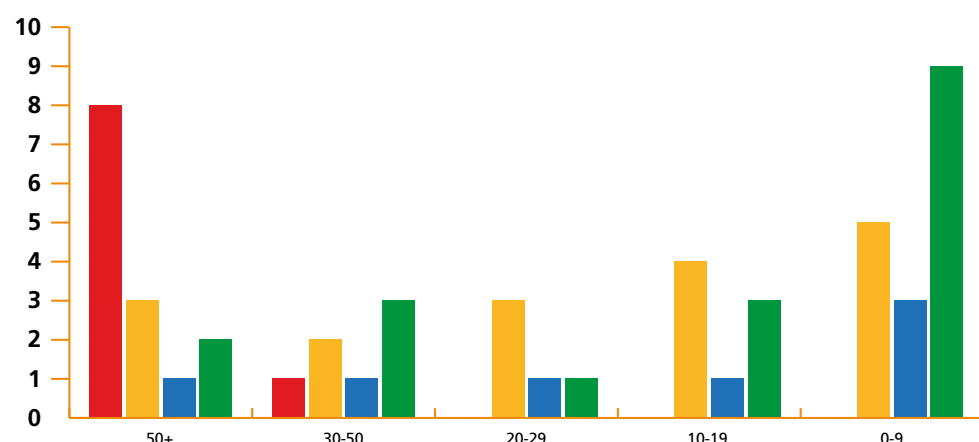


UNWARRANTED VARIATION: MSK

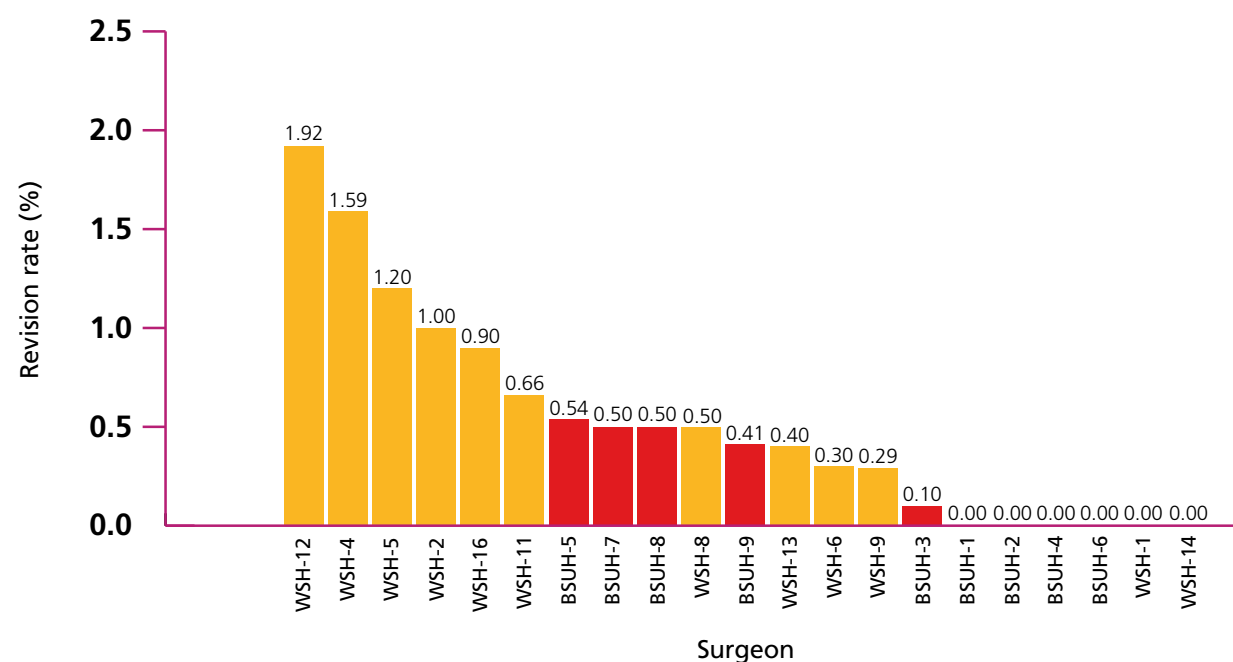
For example, In musculoskeletal surgery there is wide variation in:

- The volume of Total Hip Replacement surgery per surgeon. 34% of surgeons do less than 10 procedures a year, 54% do less than 20 procedures a year and only 30% perform greater or equal to 50
- The number of revisions within a year post joint replacement per surgeon
- The rate of infection post joint replacement per hospital

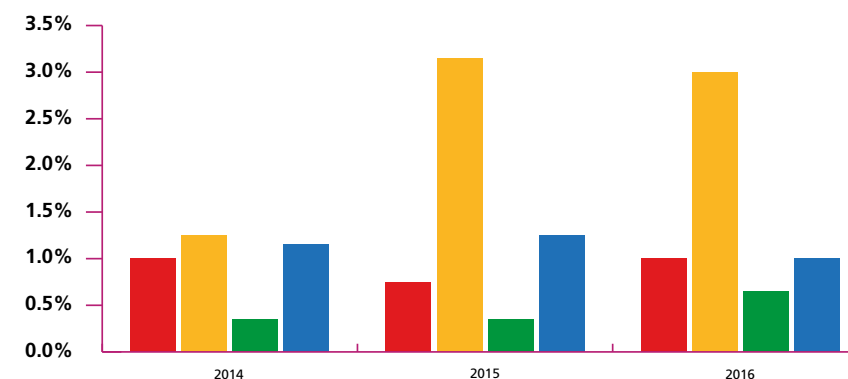
Number of Total Hip Replacement per surgeon



Total Knee Replacement 1 year revision rates

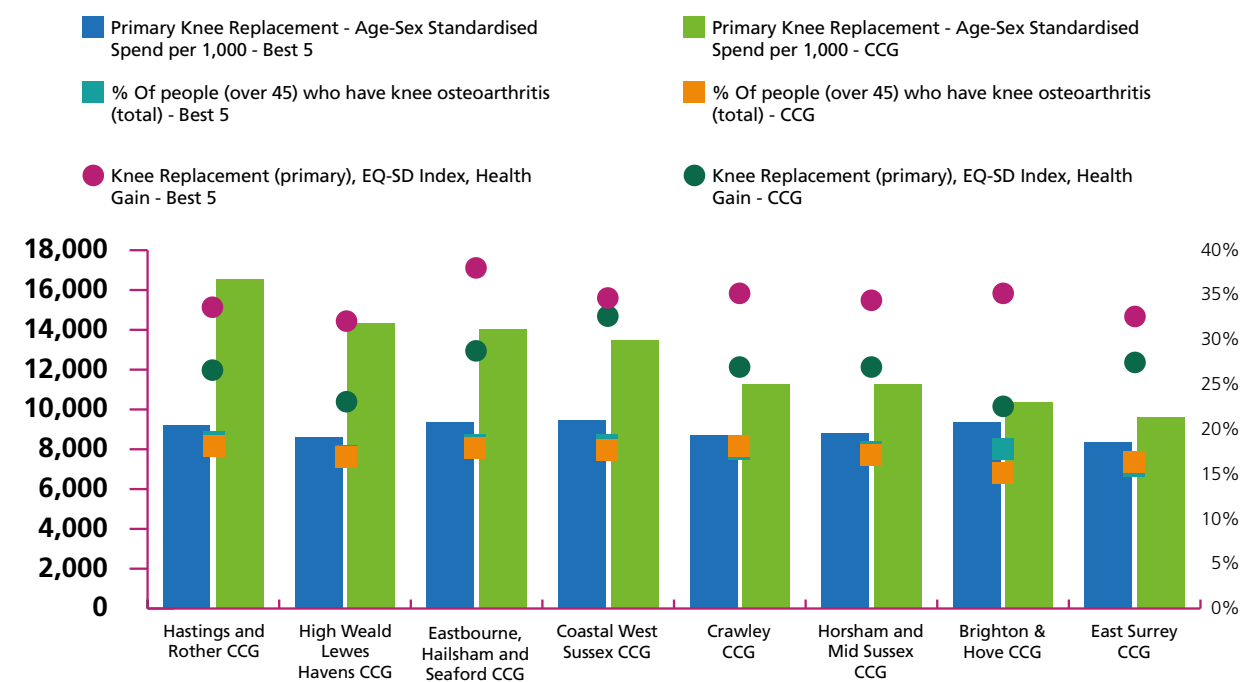


Surgical site infection rates per Trust for Total Hip Replacement



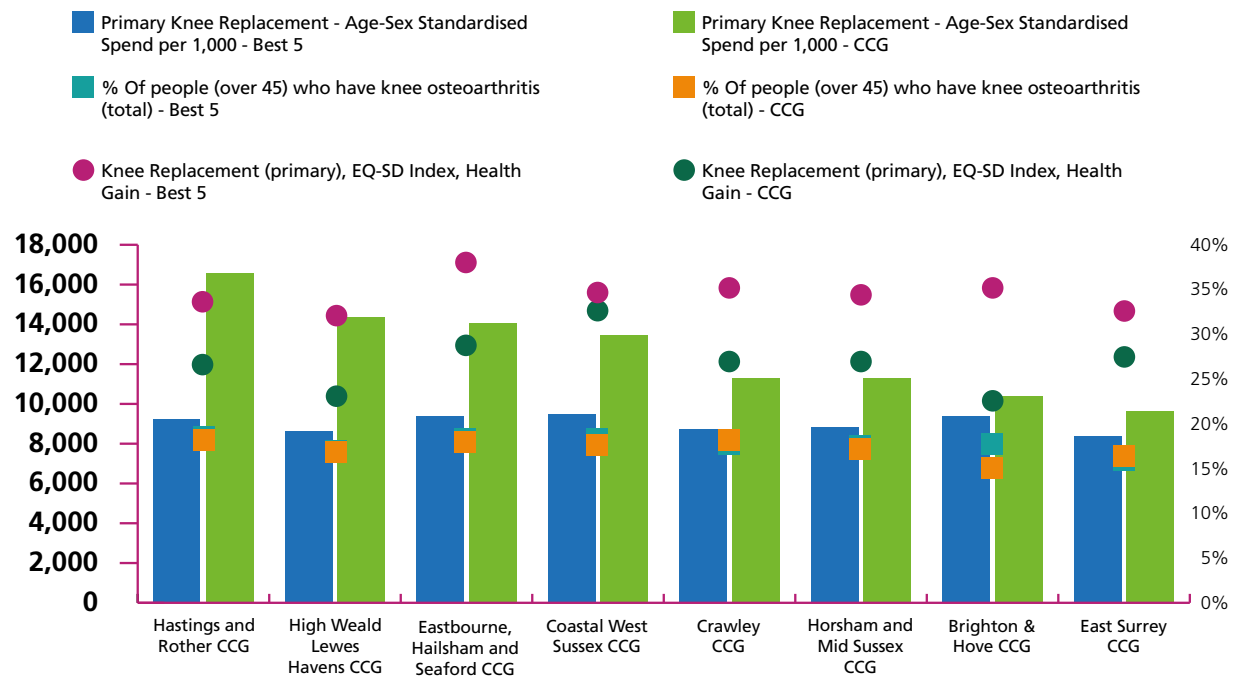
UNWARRANTED VARIATION: MSK - TOTAL KNEE REPLACEMENT

The chart below shows that we are doing more procedures, spending more on elective care and delivering poorer outcomes than our demographic peers. The % of patients 60 and over having same side knee replacement within one year of arthroscopy is declining but is still six times higher than the national average. Nice Guidance recommends conservative management (exercise/weight management/patient education) before consideration for surgery as these approaches can reduce pain, improve function and avoid the need for a Joint replacement as osteoarthritis is not always a progressive condition. Good quality Shared decision making is important to give patients the information they need to make a decision that's right for them.



UNWARRANTED VARIATION: MSK - TOTAL HIP REPLACEMENT

The chart below shows we are spending more than our demographic peers with health gain worse (apart from Eastbourne, Hailsham and Seaford CCG) and prevalence is identical.



AMBULATORY CARE SENSITIVE CONDITIONS

Attendances at our A&E Departments continue to rise with a 4% increase reported over the first 3 quarters of 17-18 compared to 16-17.

Over a quarter of all attendances at A&E could have been treated at another suitable location (e.g. primary care provision) however patient behaviours and the availability of alternative pathways continue to drive this increase in activity.

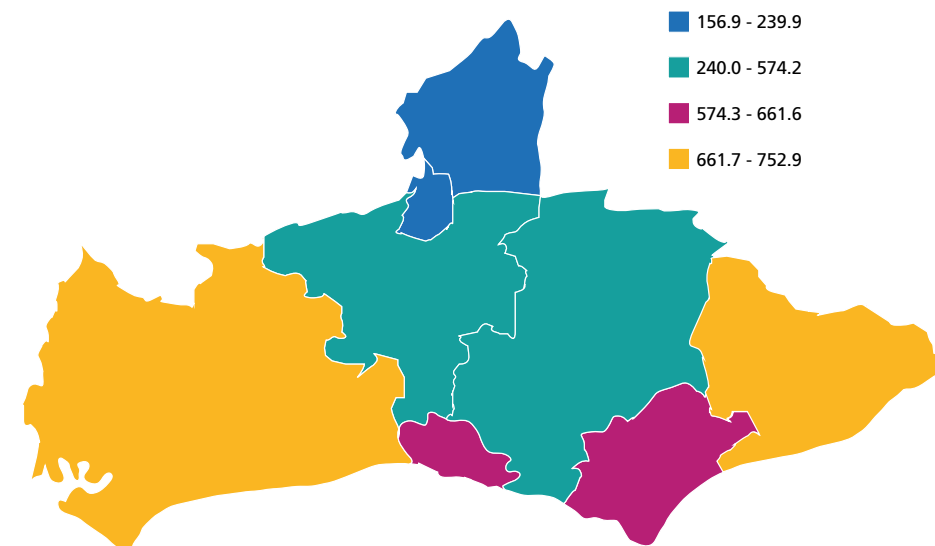
There are several points of contact for access to services, fragmented pathways and gaps in service availability (geographic and time of day), particularly around admissions avoidance and to support hospital discharges. This results in multiple handoffs and confusion over the correct pathways, building in inefficiencies in how services are being delivered, increasing conveyance and admissions and the length of stay in hospitals.

"I would like Community Navigation to be extended in the city. I would like patients to be able to self-refer and to have navigators in communities, like a "go to" person.

"Some people only know to go to A&E for urgent care – there is a lack of awareness about other places people can go. "

"More needs to be done to promote the alternative to A&E and opening times."

Ambulatory care sensitive conditions
CCG Outcomes Indicator Set- domain 2 >> 2.6 Unplanned hospitalisation for chronic ambulatory care sensitive conditions (2016-2017 (Jul-Jun)) >> East Surrey and Sussex



DELAYED TRANSFER OF CARE (DTCOS)

There are many patients in hospital beds who should be cared for at home.

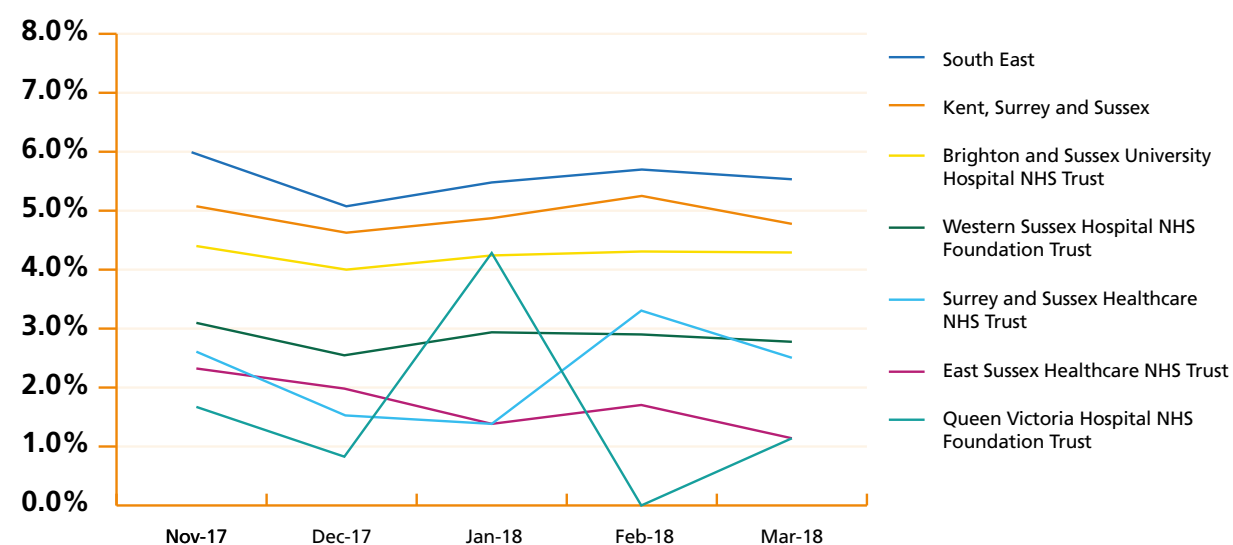
An increasing rate of incomplete to complete pathways has caused a worsening performance against the Referral to Treatment 18 week incomplete standard. At quarter 2 of 2017/18, 5 out of the 6 providers breached the standard. In 2016/17 bed occupancy was at 92.7% (ranked as 35/44 across the STPS) and the percentage of beds attributable to Delayed Transfers of Care (DTCOC) was 8.9% (ranked as 37/44 across the STPS). 1 = best, 44 = worst.

A disproportionate number of those fit to leave their current setting of care have dementia, with over a quarter of patients with dementia or a cognitive impairment fit to leave waiting for over 50 days to leave their settings of care.

KEY FACT

47% of carers in the "Counting the Cost" survey reported that being in hospital had a significant detrimental effect on the general physical health of the person with dementia and 54% reported a negative effect on the symptoms of dementia such as becoming more confused and less independent (Alzheimer's Society 2009)

South East DTOC % (Bed day delays per occupied bed)
Sussex & East Surrey



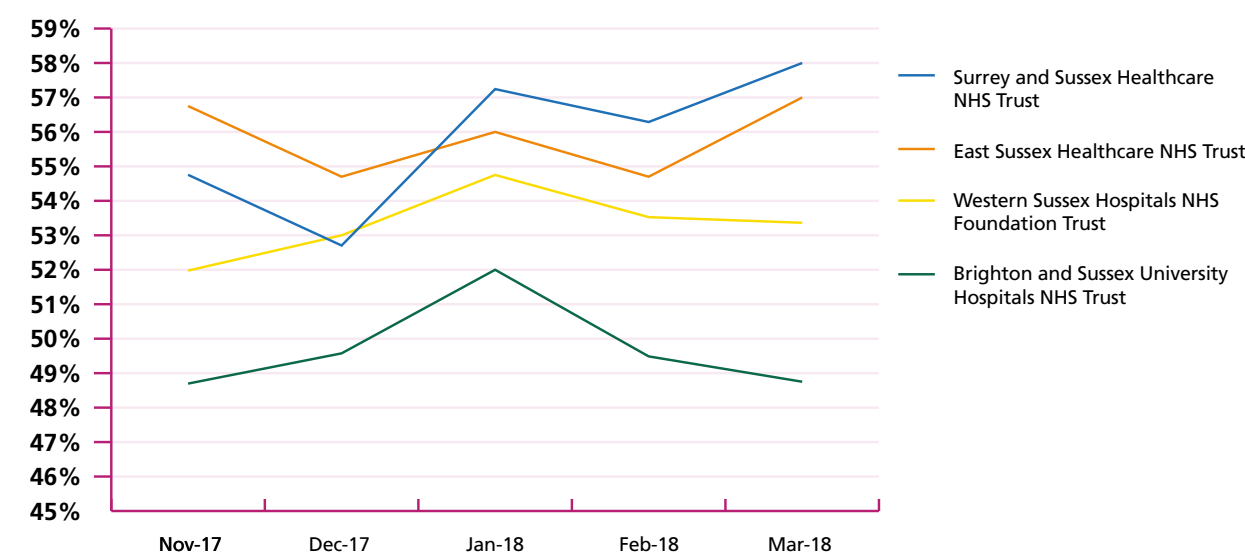
FLOW

A bed audit carried out across the STP identified 22% of patients across Sussex and East Surrey that are "fit to leave" their current setting of care.

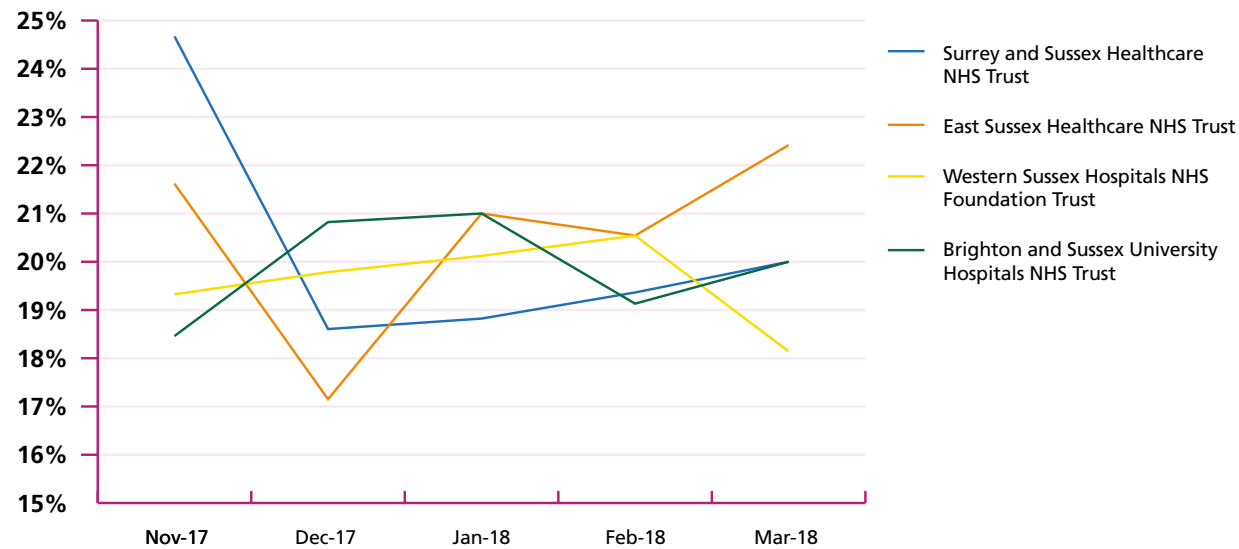
A total of 49% of patients who were classified as fit to leave their current setting of care have remained in hospital for over a week. There were 97% of acute patients fit to leave who were admitted as non-elective patients. A total of 75% of acute patients and 92% of community patients fit to leave their current setting of care are over the age of 70. A majority of delays are attributed to patients awaiting social care, although patient and family choice is a major cause for delay in the community setting. (CF April 2017).

49% of patients who were classified as fit to leave their current setting of care have remained in hospital for over a week.

Beds Occupied by Stranded Patients (7+ days)
Sussex and East Surrey



Beds Occupied by Extended length of stay Patients (21+) Sussex and East Surrey



BED DAY UTILISATION

Across the STP, bed occupancy per provider ranged from 62% (at the specialist provider) to 96% at Quarter 2 2017/18.

Compared with our peers, there is statistically significant variation in the number of bed days across all common conditions. There are currently 3,519 acute inpatient beds across the STP.

- Average length of stay (AoS) increased between 2010/11 – 2016/17.
- Over the last three years, the general and acute bed base has remained relatively constant but bed occupancy has increased over time.
- Bed capacity is expected to increase by 176 beds by 2023/24 at BSUH as a result of the 3Ts rebuild.
- Elective referral rates are increasing across the system and longer lengths of stays are driving a significant elective backlog at all Trusts.
- Demand must be managed to align acute capacity and demand and to prevent shortfalls in available beds to meet the needs of the population.

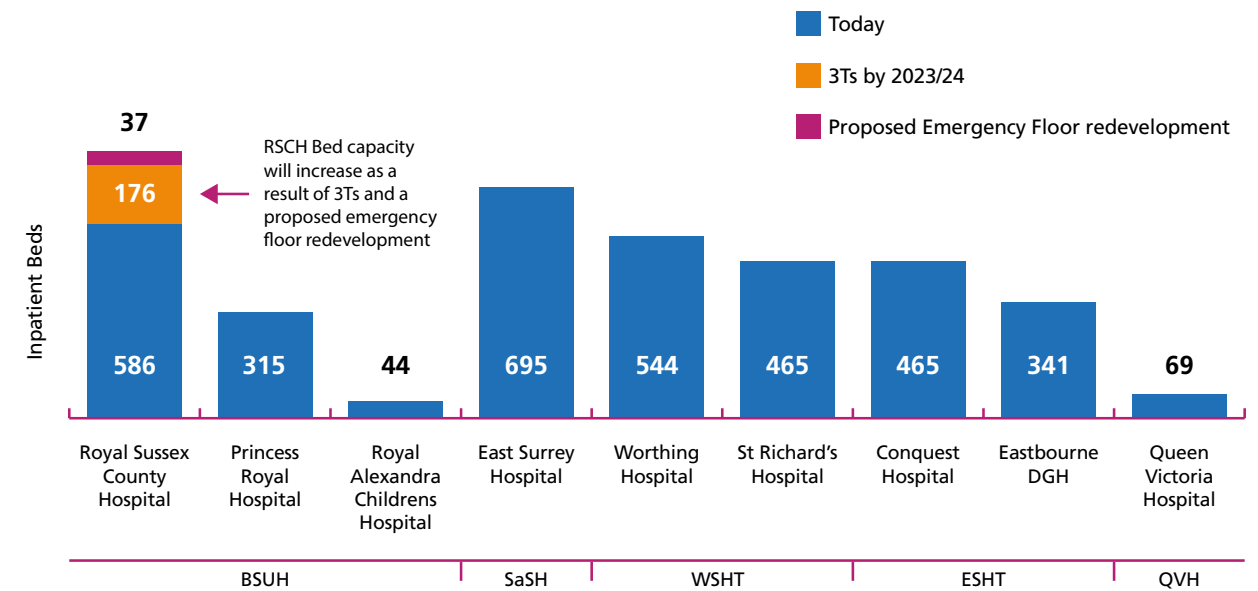
Demand must be managed to align acute capacity and demand and to prevent shortfalls in available beds to meet the needs of the population.

Reduction in beds:

The Royal Sussex County Hospital site in Brighton is delivering a 10-year strategy to improve their estate, which will impact on their ability to deliver care in a timely way. A strategic/system-wide solution is needed to support those pathways affected as all Trusts will be affected.

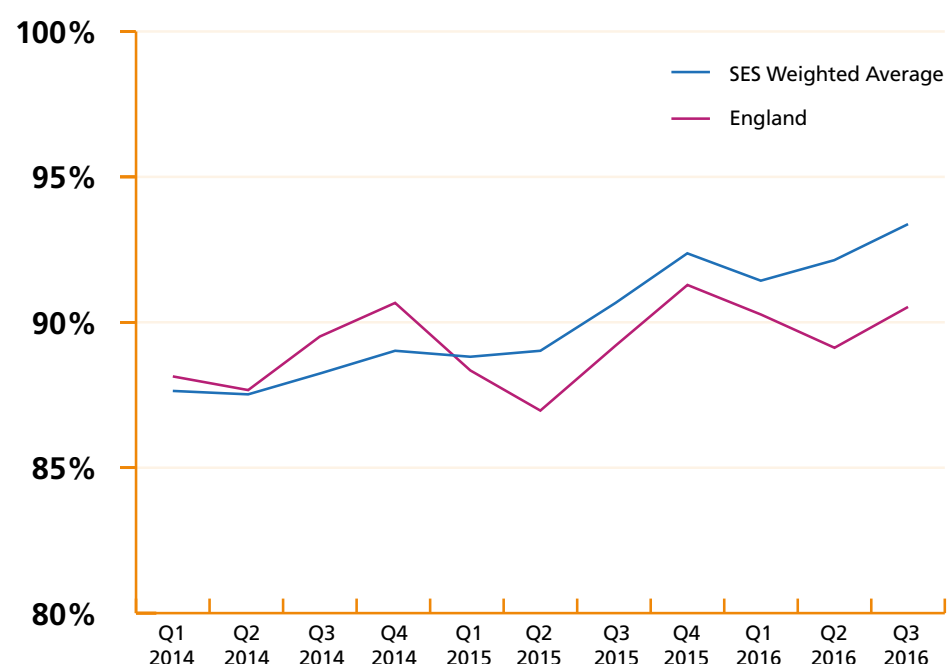
BED DAY UTILISATION

There are currently 3,519 acute inpatient beds across the STP. Bed occupancy across all sites is forecast to increase in 2016/17.

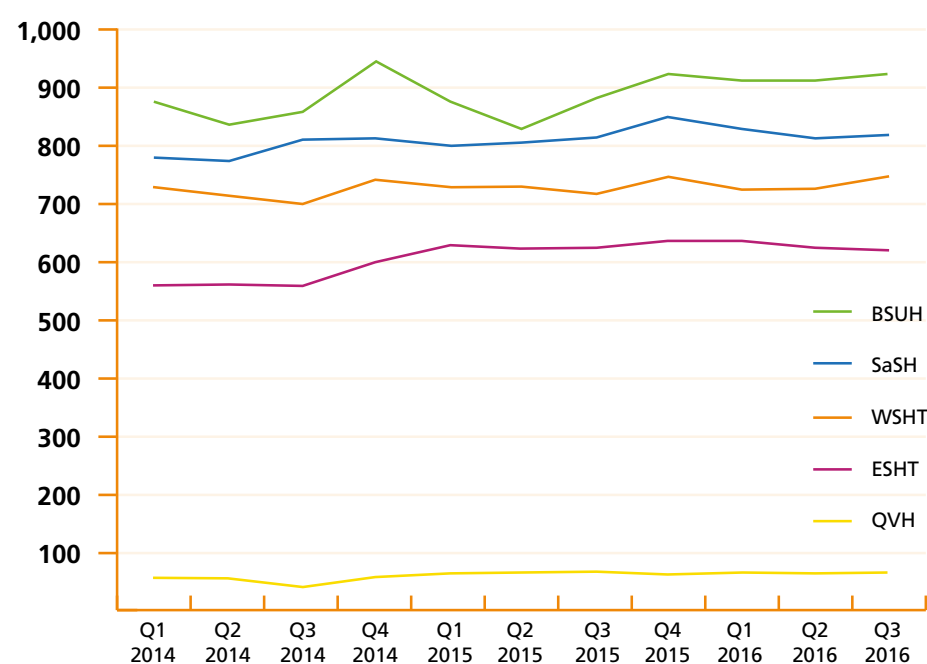


BED OCCUPANCY									
15/16	93%	72%	85%	94%	89%	85%	88%	101%	62%
16/17	96%	74%	88%	96%	91%	87%	90%	103%	64%
	Royal Sussex County Hospital	Princess Royal Hospital	Royal Alexandra Childrens Hospital	East Surrey Hospital	Worthing Hospital	St Richard's Hospital	Conquest Hospital	Eastbourne DGH	Queen Victoria Hospital

Average occupancy by quarter
Q1 2014 - Q3 2016



Total general and acute bed base
Q1 2014 - Q3 2016



CARE QUALITY COMMISSION (CQC) RATINGS

Brighton and Sussex University Hospitals NHS Trust (BSUH): The Trust was last inspected in April 2016 and updated in August 2016. CQC found them to be inadequate in the areas of safety, responsiveness and leadership. The culture of the Trust was viewed as exceptionally challenging. Since the inspection, Western Sussex Hospitals NHS Foundation Trust has taken over the management of the BSUH and improvements have been seen in a number of areas.

East Sussex Healthcare NHS Trust: In June 2018, the CQC noted the Trust has made a marked improvement in the quality of its care, and concludes that the Trust no longer needs to be in special measures for quality. In the areas inspected by the CQC, everything was rated as 'good' or 'outstanding', apart from the Emergency Department at Eastbourne, which was rated as 'requires improvement', but 'good' for well led and caring.

SECamb: Following CQC inspection in 2017 the Trust was rated as Inadequate. This resulted in the Trust remaining in Special Measures and the development of a recovery plan that addresses CQC findings together with work across different areas of the Trust. This includes an overarching Culture and Organisational Development and an extensive programme of work dealing with workforce, recruitment, training and retention. CQC is conducting an inspection of the Trust in July (Core Services and Emergency Operations Centre) and August (Well Led) this year. The results of the inspection will be published in the Autumn. The work across the Trust is also being informed by a jointly commissioned Demand and Capacity review to identify resource requirements to fully meet Ambulance Response Programme standards.

Everything was rated as 'good' or 'outstanding', apart from the Emergency Department at Eastbourne, which was rated as 'requires improvement', but 'good' for well led and caring.

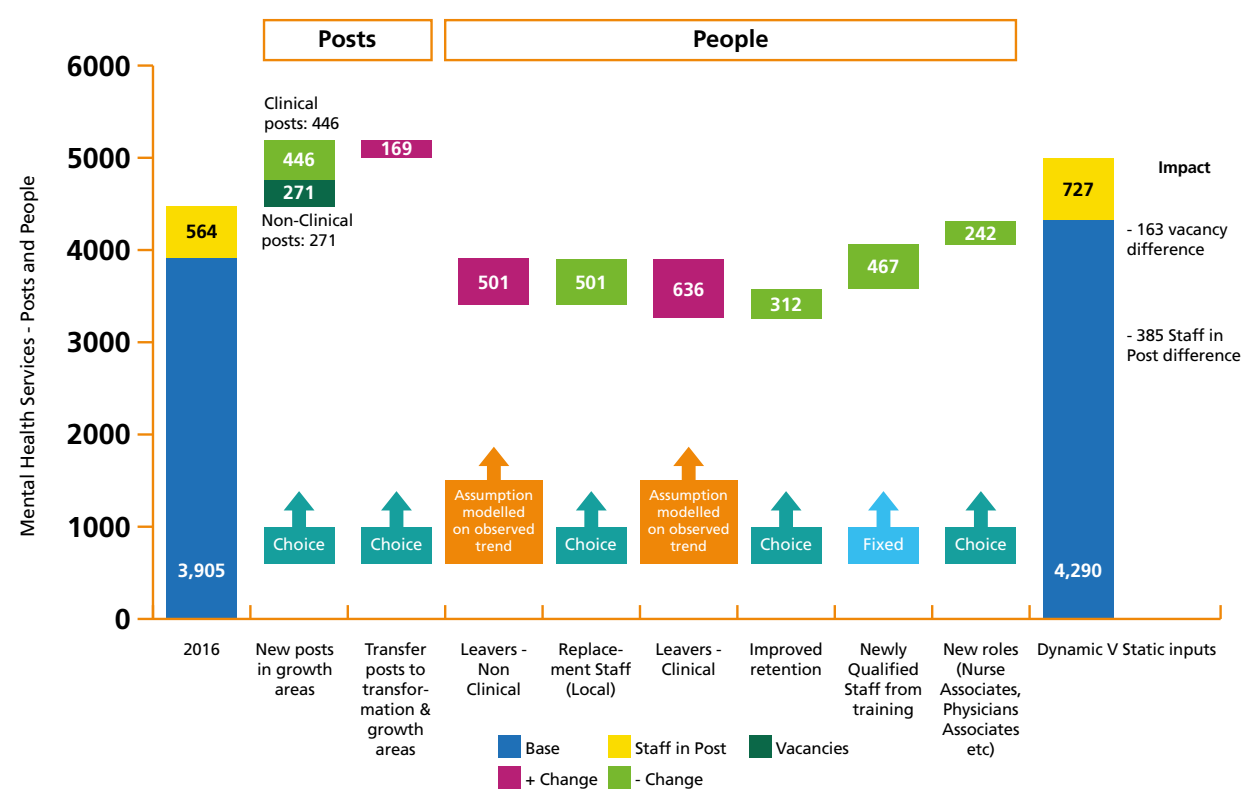
TRUST	CQC RATING
BSUH	Good
ESHT	Requires improvement
WSHT	Outstanding
SASH	Outstanding
QVH	Good
SPFT	Good
SCFT	Good
FCH	Outstanding
SB	Good
SECAMB	Inadequate
IC24	Good

MENTAL HEALTH SERVICES

The health and life outcomes for people experiencing mental health issues in our STP will continue to fall short of those of the general population unless we act to deliver the opportunities aligned with the five year forward view for mental health. To meet the government target of 21,000 new mental health posts by 2021, the STP projected response is set out below

The Sussex and East Surrey STP has an agreed Mental Health Strategy following a detailed Case for Change which identified that:

- Sussex and East Surrey STP need to ensure that 25% of people living with common mental health problems are seen by a local Improved Access to Psychological Therapies service every year.
- Capacity needs to be built in primary care, closer to home and thereby reduce presentations and referrals to physical and mental health secondary care.
- The prevalence of Severe Mental Illness is 5% higher than nationally, affecting 25,000 individuals.



- For dementia, prevalence is 25% higher than nationally, will increase further as the population ages, while the proportion of those with a diagnosis is 5% lower.
- A quarter of those patients with dementia who are fit to leave acute care wait over 50 days for discharge.
- Three quarters of first episodes of mental ill health occur in young people before the age of 25.

KEY FACT

Life expectancy for those with severe mental illness is twenty years' worse than the general population

“My partners mental health and mine wasn't a priority after my stillborn, they took slightly better care but no mention of mental care at any appointments”

GP SERVICES

The National Picture

Workload: Actual GP appointment numbers are not routinely collected by NHS England but the information we have would suggest significant rises, for instance 15.4% between 2010/11 and 2014/15. The Kings Fund (2016) estimated that there had been a 15 per cent overall increase in contacts, 13 per cent increase in face-to-face contacts and a 63 per cent increase in telephone contacts.

Workforce numbers: Nearly a quarter (23%) of the GP workforce is over 55. Less than a quarter (22%) of GP trainees plan to practise full-time one year after qualifying, according to a recent study by the King's Fund, falling to 5% who expect to be working full time after 10 years. 'The intensity of the working day' was cited as the most common reason.

Morale: A 2017 survey conducted by Exeter University in the South West indicated that over half of the GP workforce reported low or very low morale, and 40% of all GPs intended to retire within five years.

Practice Closures: Increasing numbers of practices are either closing their lists to new patients (a medium term approach) or capping their list (a shorter term approach), in order to maintain the quality of the service to existing patients within the resources they have.

Estates Issues: A 2018 BMA Survey revealed that four out of 10 GPs feel their premises are not adequate for patient care, describing how they are struggling to provide essential services in buildings that are cramped and

Less than a quarter (22%) of GP trainees plan to practise full-time one year after qualifying

Pressure through retirement of partners and salaried GPs has been a contributing factor to 16 practices closing and 10 mergers since 2013

outdated. It also reported that six out of 10 GPs in England are forced to share consulting rooms or 'hot-desk' around their surgeries.

STP examples

- **Increasing elderly:** The West Sussex Joint Services Needs Assessment (JSNA) estimates that the local population aged 70+ will grow at the fastest rate of any demographic; and that by 2039 more than 30% of the CCG resident population will be aged 65 or over. They also project that this means that the number of adults in this age group admitted to hospital with falls will nearly double over the same period. There are already some small areas of West Sussex where more than 50% of the resident population are aged 65 or above. Between 2018 and 2030 the JSNA predicts that the number of cases of dementia will rise by 45%.
- **Workforce:** According to NHS England figures, in 2015 there were 960 full time equivalent (FTE) GPs across East Surrey and Sussex. In order to deliver the growth required to deliver our proportion of the 5,000 extra GPs promised in the GP Forward View we would need to boost that to 1106 FTE GPs (so an increase of 146) . However the GP FTE across the patch as of Sept 2017 number 936 – a fall of 24 FTE, or 170 short of the target 1106. Figures for nurses seem to be broadly stable, GP Nurses FTE as of Sept 2015 numbering 502, and as of June 2018, 522. Large percentage of both practice nurses and GPs in our area that are over 55 and coming up to retirement. It is anticipated that there will be a loss of a third of GPs over next 10 years as they reach 55+. The retirement risk in ESBT is 46% of practice nurses in Hastings and Rother and 31% in Eastbourne, Hailsham and Seaford age 55+ with GPs 55+ at 24% in Hastings and Rother and 17% in Eastbourne, Hailsham and Seaford. Currently 210 GPs (18.5% of the workforce) are over 55 years.
- The STP has 203 practices. There are 12 single-handed GP practices and 189 partnerships, with the smallest registered list of 1,379 and the largest being 25,054. Pressure through retirement of partners and salaried GPs has been a contributing factor to 16 practices closing and 10 mergers since 2013. The GP workforce across the STP is in decline, of between 3% in the Coastal West Sussex area to 15% in Hastings and Rother CCG. In Brighton, nine surgeries (out of an initial total of 44) have closed in the last four years, displacing more than 33,000 patients, and putting extra pressure on already-struggling practices nearby. Brighton has been described in the press as possibly 'the hardest hit town in the whole of the UK?' In Hastings and St Leonards, at one point in the last 12 months 10 out of 14 practices had either closed or capped their patient lists, putting enormous pressure on the remaining practices. In Arun in Coastal West Sussex, three out of six practices have had to cap their lists due to the

closure of a practice of 8,000 patients. The retirement of partners and salaried GPs has been a contribution factor to 16 practice closures and 10 mergers.

- Utilising the GP international recruitment scheme has not delivered the volume of new GPs anticipated. A target of 25 was set for 2018 but only five have been recruited.

OUR SERVICES – KEY FACTS

- Our pathways are often fragmented and there are frequent breakdowns in handoffs between agencies.
- There are delays in people accessing services and therefore may be missing out on timely treatment.
- There is a lack of timely access to effective primary and community services driven by insufficient capacity in primary care and community services.
- Discharge arrangements from acute care is variable, which means patients spend longer than necessary in hospital.
- We are often not meeting our constitutional standards for A&E, Referral – to-Treatment.
- There are gaps in reaching minimum standards of care in such areas as stroke, diabetes and cancer.
- General practice is facing significant issues in workforce with a backdrop of increasing demand

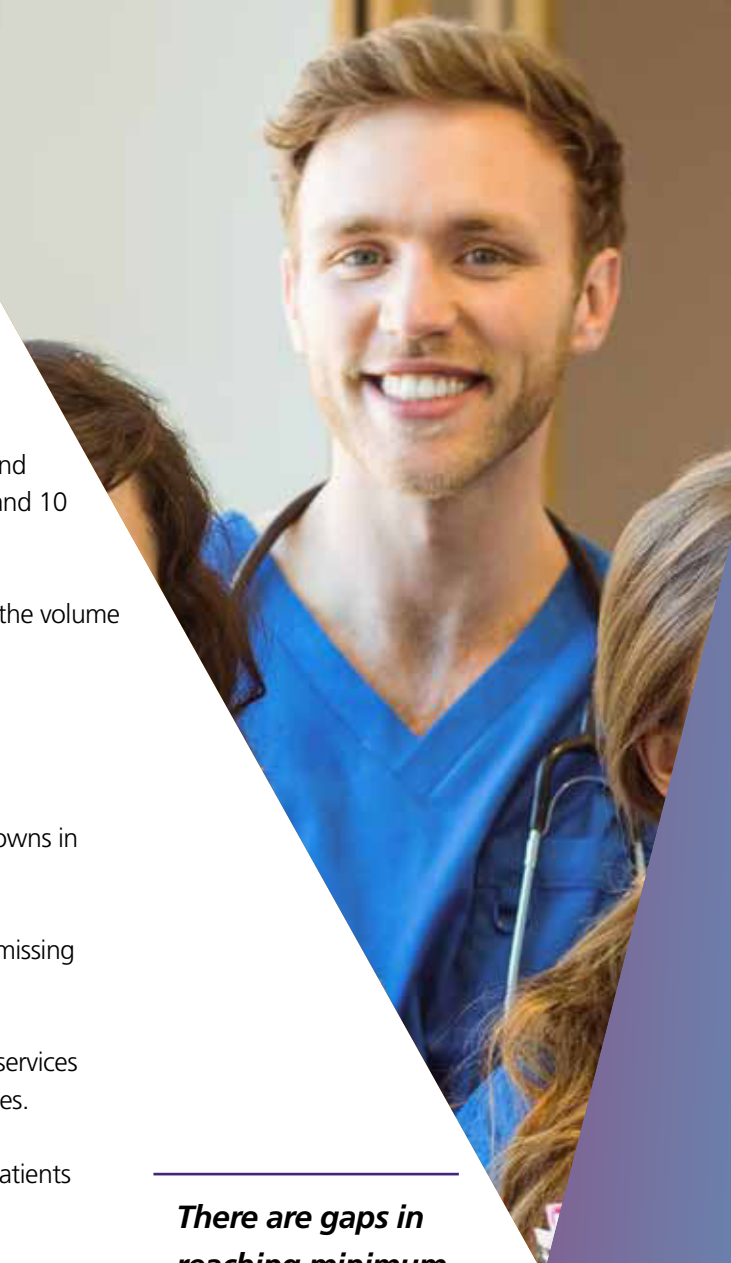
MAIN CHALLENGES:

- Addressing the significant un-warranted variation in MSK, Cardiovascular and falls/ fragility fractures.
- Making a step change in managing flow, stranded and super stranded patients.
- Improving shared decision making.

THE CONSEQUENCE WE OBSERVE:

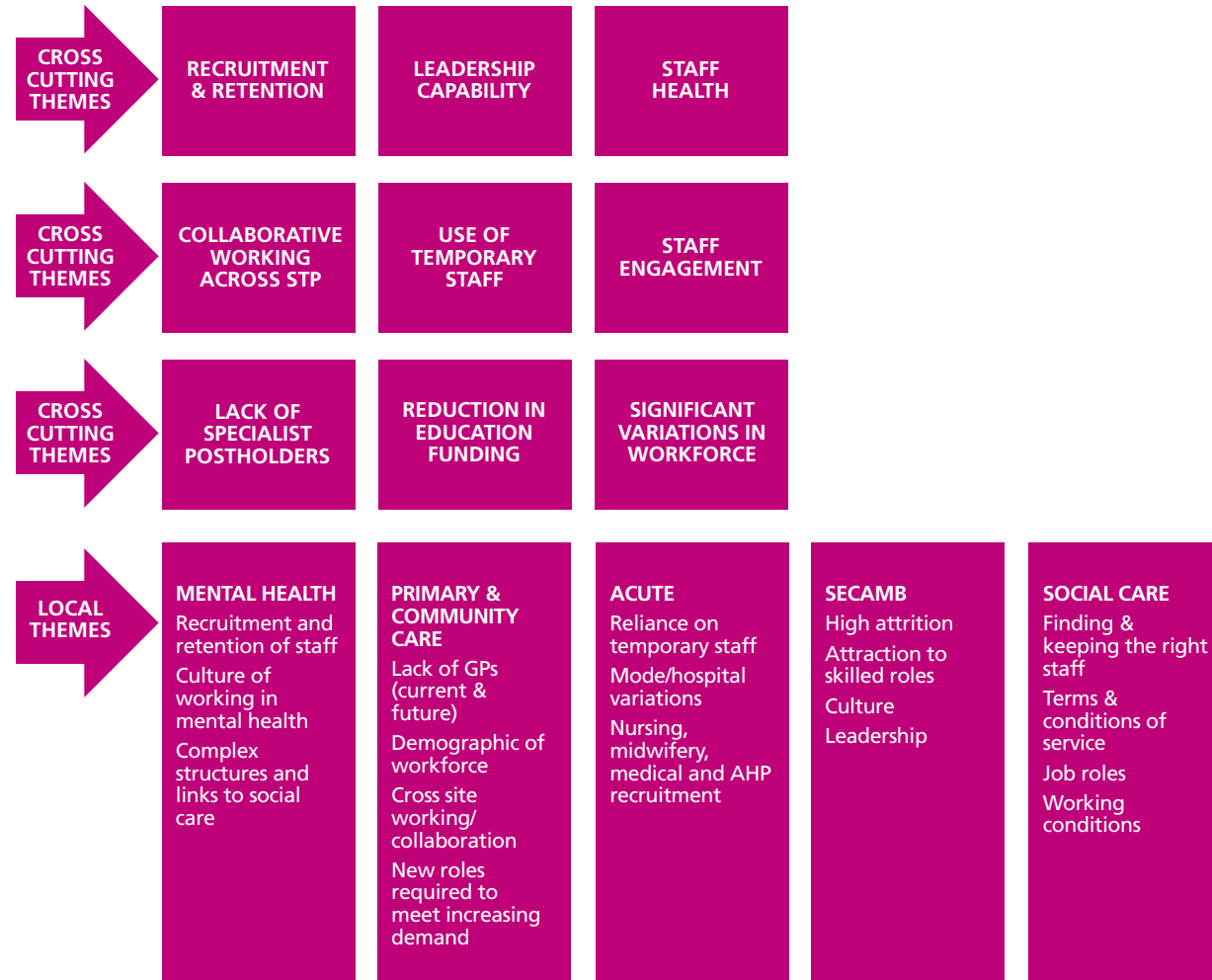
- Frequent, unnecessary admissions to hospital when patients could be cared for in a different setting.
- Challenge in meeting and maintaining A&E and elective care targets.

There are gaps in reaching minimum standards of care in such areas as stroke, diabetes and cancer.



Our evidence: Our staff

OUR PEOPLE - OUR CHALLENGES



KEY FACTS

- There are 10,926 headcount staff and 9,375.90 FTE Registered Nursing, Midwifery and Health Visiting Staff across Sussex and East Surrey STP.
- The average retirement age is 59, with 15.38% of staff aged 55 years and over. The staff groups with over 20% of staff aged 55 and over that may be approaching retirement ranges from Registered School Nurses at 31% to Community Services (excl. Health Visitors and District Nurses) at 20.68%.
- The Turnover Rate for all Registered Nursing, Midwifery and Health Visiting Staff ranges from 12.84% in Maternity Services (excl. Registered Midwives) to 20.29% in district nursing.

- In social care there is a significant annual turnover of 26% for registered nurses, which rises to 32% turnover amongst support workers providing direct care in East Sussex.
- Skills for care estimates that in Brighton & Hove, 8.6% of roles in adult social care were vacant, this equates to around 700 vacancies at any one time. This vacancy rate was similar to the region average, at 6.8% and similar to England at 6.6%.
- Difficulty recruiting and retaining substantive mental health nurses and psychiatrists, has led to a sustained and increasing agency spend (in Sussex agency spend in mental health services was £2.6m in 2012/13 rising to £9.8m in 2015/16).
- In June 2017, the SES STP had a shortfall of GPs (FTE) of 193.
- The average level of sickness absence across acute trusts for 2014-15 was just over 4%. Just a 1% improvement in sickness absence equates to £280m in staff costs – without accounting for lower dependence on agency staff and reduced cancellations.
- Spend on temporary staffing continues to increase.

KEY ISSUES:

- We have significant issues relating to workforce and need to ensure we have the right people in the right place at the right time to deliver care.
- Given our demography, we need to rely as much on technology-enabled care as on state funded clinical and domiciliary workforce. There just won't be as many employees available in future as would be needed to provide current services to a larger population with more retired people and not many more working-age citizens.
- We have an inadequate number of mental health posts to meet the needs of our population.
- We need to increase the workforce within Primary Care to support changes to the way we deliver care across the system.

THE CONSEQUENCES WE OBSERVE:

- There is a real risk that we are failing to attract and retain the best talent.
- There is a significant risk to the resilience of services and the sustainability of a workforce.

Difficulty recruiting and retaining substantive mental health nurses and psychiatrists, has led to a sustained and increasing agency spend

Significant elements of the estate are either functionally unsuitable or compromised in the current configuration

Our evidence: Our infrastructure

ESTATES

There is a diverse legacy of primary, community and acute provider estate across the STP.

Historically there have been many years of under-investment in estate, which has resulted in non-compliance, high backlog maintenance and inefficient estate with high running costs.

Significant elements of the estate are either functionally unsuitable or compromised in the current configuration.

There is multiple ownership of the estate, which ranges from NHS acute and community provider organisations, GP partners, NHS Property Services, third party commercial landlords, public/private partnerships to local authority partners.

There is a lack of formal lease/licence agreements in place resulting in ambiguity over estates running costs, occupation and utilisation information.

Estates running costs are higher than the national “Carter” benchmark indicators. Key high cost acute sites include the Royal Sussex County Hospital, St Richards Hospital, Worthing Hospital, East Surrey Hospital and Eastbourne District General Hospital. There is also a substantial backlog maintenance requirement across the acute and community estate, with high and significant risk elements exceeding £81million (excluding primary care and NHS Property Services community estate).

DIGITALISATION

Individual Digital Maturity of secondary care providers is broadly in line with national average with evidence of improvement over the past year. However the maturity levels between providers vary significantly.

There is significant variation in technology usage across the STP with limited consolidation of suppliers except for PACS (Picture and Communication System) for Radiology, which represents a significant opportunity.

There is a lack of effective information sharing which presents a significant barrier to implementing new models of care.

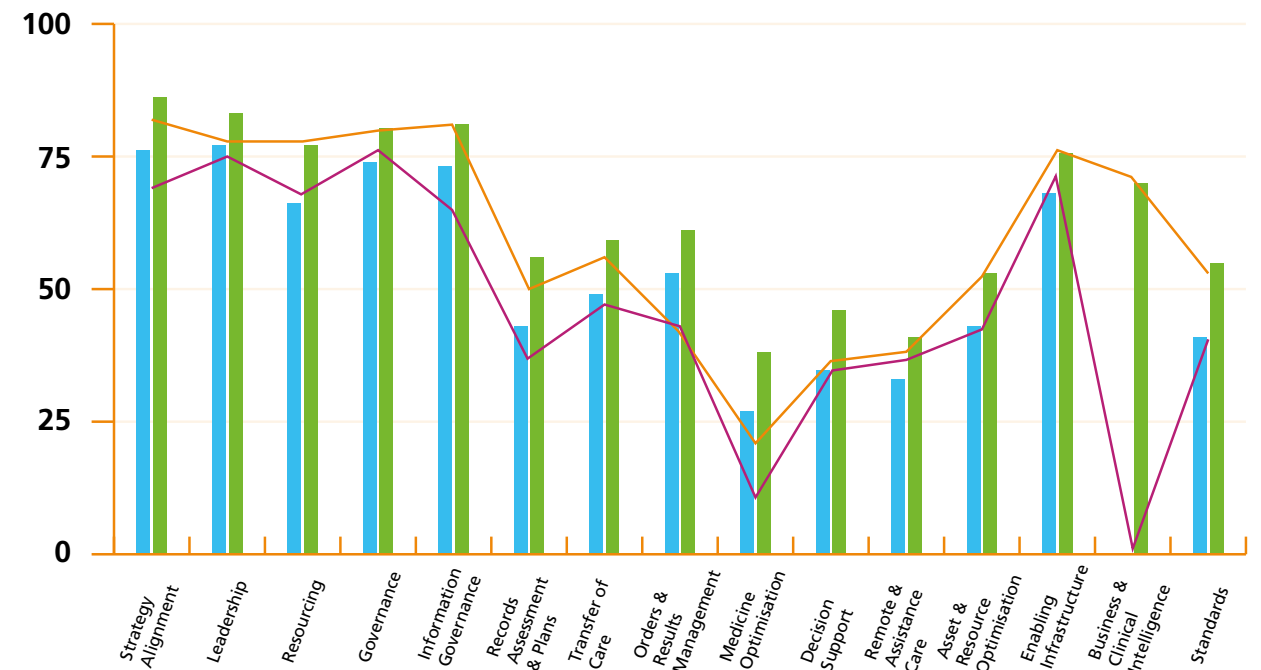
Population Health Management and Risk Stratification are fragmented and vary in use and sophistication.

The information governance community is capable and enthusiastic, but capacity is variable and is a limited resource overall.

Clinicians and professionals lack clarity and confidence to support information sharing.

Digital Maturity - Secondary Care

Sussex and East Surrey 2016
Sussex and East Surrey 2017



FINANCE

Current situation: The STP covers a wide geographical area and many organisations, with a notable amount of variation in financial performance. In 2017/18, seven out of nine Trusts ended the year in surplus. The two trusts in deficit - East Sussex Healthcare NHS Trust and Brighton and Sussex University Hospitals NHS Trust - are in Financial Special Measures. Of eight CCGs in the footprint, one ended the year in surplus. Overall the combined net deficit (surpluses and deficits added together) for CCGs and trusts was £228.2m. It should also be noted that this figure includes significant amounts of one-off funding, including Sustainability and Transformation Funding, which was released at the end of the year.

2018/19 planning: Control totals (the required surplus/deficit set by regulators) for 2018/19 add up to a total net deficit of £185.8m for CCGs and Trusts, including one-off sustainability funding for providers. An additional £111.6m of commissioner sustainability funding is available to those CCGs that meet their deficit control totals.

Strategic Financial Framework: The STP has a Strategic Financial Framework that sets out the approach to system-wide financial sustainability over a 5-year time horizon. It is comprised of four elements:

- Improving productivity and efficiency
- Delivering the right care to improve value
- Transforming and investing for change
- Improving system contracting/admin

These elements are progressed through 11 STP programme priority areas and supported by four enabling work streams.

The STP five-year financial model brings these aspects together and calculates their combined medium to long-term financial impact, taking account of risk, to allow financial sustainability to be assessed. This is updated iteratively to reflect the progress and evolution of ongoing transformation work, and to allow reassessment of its financial impact.

OUR INFRASTRUCTURE – KEY FACTS

There is a multiplicity of IT system many of which do not communicate to each other.

- We have Information Governance issues.
- There is a significant mismatch between revenue and expenditure.
- We have higher use of acute services that are proportionally more expensive.
- Our community and primary care assets are not optimised or necessarily fit for purpose.

Main challenges:

- The provision of a balanced estate portfolio that is fit for purpose in a constrained capital environment and meets the needs of the population.
- Achieving a sizable reduction in the current deficit position of the STP.
- Rising to the Digital requirements as a priority.

The consequence we observe:

- Duplication in processes.
- Inability to maximise use of technology for patient benefits.

Our community and primary care assets are not optimised or necessarily fit for purpose.



Our priorities

The evidence presented in the Population Health Check naturally leads to the following priorities.

- Addressing capacity and demand
- Tackling unwarranted clinical variation
- Focussing on workforce
- Moving to a people centred value based system
- Reducing the financial deficit

We need to deliver value across our STP i.e. the best outcomes for the individual and for our population within the available resources. This includes doing less of things that add little or no value to patients. This includes reducing the over – medicalisation of care.

This requires:

1. The development and implementation of a clear workforce and capacity strategy, which will address the short-term and long term (future-proofing) crisis in relation to the number of staff and skills.
2. Improving shared decision making i.e. more active involvement with well-informed patients and developing and using standardised outcome measures that are more relevant to patients (such as the impact on their functional status and wellbeing).
3. Leading the reframing our cultural norms, so that making the right choice in relation to lifestyle changes, is the easy choice. This includes putting initiatives, such as “Making Every Contact Count” and healthy eating, into relevant contracts to deliver the highest standards of work-based health.
4. Recognising unwarranted clinical variation and addressing it. We can achieve this through the combination of Right Care, Clinically Effective Commissioning and Getting it Right First Time (GIRFT) all of which describe key clinical areas where Quality Improvement is required.

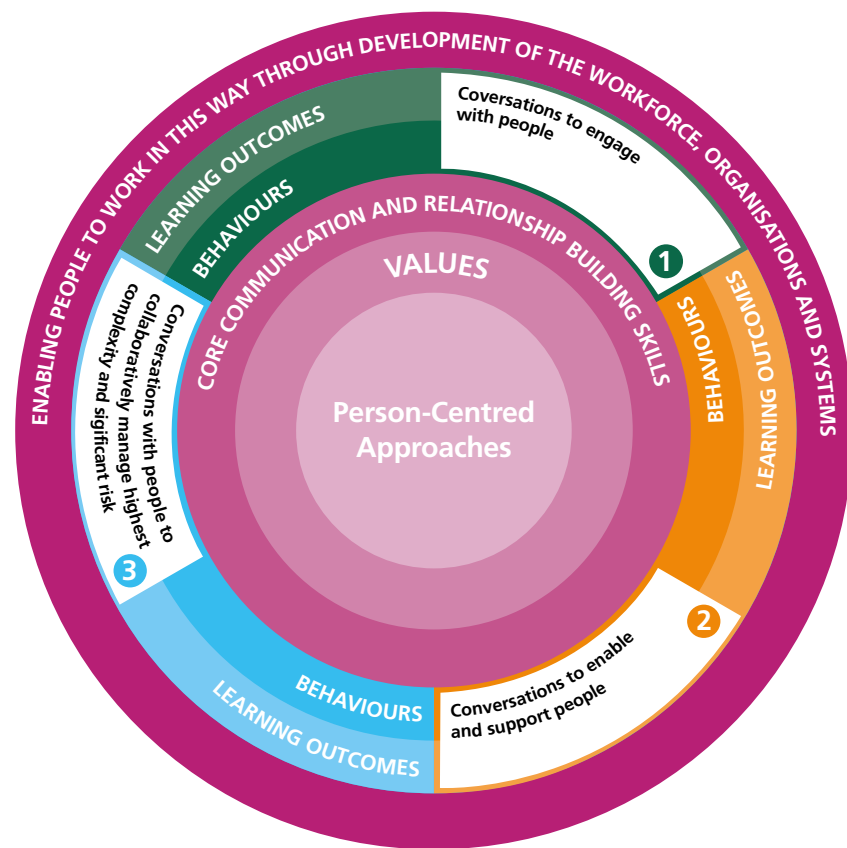
- Reduced productivity.
 - We cannot afford to continue to pay for services at the current rate.
5. Reducing A&E attendances through ensuring the resources are available to support patients nearer home, including addressing fragmented pathways, gaps in service availability, communication across services, mental health support and digital shortfalls which block shared access to information. Make navigating the system easy for the public and encourage the development of advance and anticipatory care plans which are accessible to all who need to see them.



Next steps

We need to develop a clinical strategy which delivers “best value” and patient centred care.

PERSON CENTRED APPROACHES FRAMEWORK (SKILLS FOR HEALTH/SKILLS FOR CARE/HEALTH EDUCATION ENGLAND)



WE NEED TO DEVELOP A CLINICAL STRATEGY WHICH IS FUTURE PROOFED

On a local level Sussex and East Surrey is facing significant challenges in providing sustainable care for its population. These challenges include financial pressures as well as workforce recruitment and retention shortfalls. Much of this Population Health Check describes variation in consumption of healthcare, through variation in referral from primary care, through to differences locally to peers in secondary care intervention,

length of stay and bed occupancy (note the Carnell Farrar data and information provided by Rightcare), and the consequent opportunity this affords the STP. This provides both the immediate case for change and the initial targets.

Eric Topol is conducting his review with Health Education England for the Secretary of State on how technology will impact care and the training of carers. This review builds on Facing the Facts, Shaping the future (Health Education England, December 2017) and starts with acknowledging that the pace of development of genomics, digitisation and data analytics, machine learning and AI, biotech, nanotech and robotics is game changing.

An empowered and more digitally aware and competent population will demand at the least that the medical information known about them is recorded in a way that promotes their care. We already see both the success and acceptability of care records that can be read by paramedics, primary care and the emergency department. Advanced care decisions that are not paper based and don't need to be sought and transferred with the patient from the nursing home out of hours with a high chance of loss is acceptable to the public and to staff. In fact it is probably already more acceptable than the unreliable paper based norm. We already see the common theme of complaint of people being asked repeatedly, by a succession of carers for the same information. This is probably a basic and the advantage in reducing conveyance, reducing harm and reducing length of stay has been demonstrated.

Beyond this people will increasingly expect a better offering, more tailored to them as an individual, responsive when they need it not batched for provider convenience. Again, within this STP, there are models of care that are not face to face and are IT-enabled. These have reduced out-patient attendance, crowding in waiting rooms, and cost (e.g. Digital virtual clinics for people living with inflammatory bowel disease and Virtual Fracture Clinics in BSUH). Importantly they have left patients feeling better supported and better able to manage their long term conditions and stay motivated in their recovery. They provide a digital relationship and connection to clinicians and healthcare professionals more suited to the always on expectations of our digital selves.

The importance of the digital agenda has been underlined by the Prime minister in her Macclesfield speech. The Office for Life sciences (OLS) has issued a variety of challenges and at the present time there are open calls for a second wave of digital and Internet of Things (IOT) test beds, industrial strategy challenge funding, ageing grand challenges, an active

An empowered and more digitally aware and competent population will demand at the least that the medical information known about them is recorded in a way that promotes their care.

Brighton ranked particularly strongly in its innovation for data, virtual reality, health and artificial intelligence despite being relatively smaller than its competitors

call for new Collaborations of Leadership in Applied Health Research and Care (this time badged as Applied Research Collaborations). All of these calls have tens of millions of pounds available to demonstrate new ways of working, drawing on modern and forward-facing technology, that deliver improved outcomes with a different kind of workforce. All require scalability and all require a legacy to be left locally.

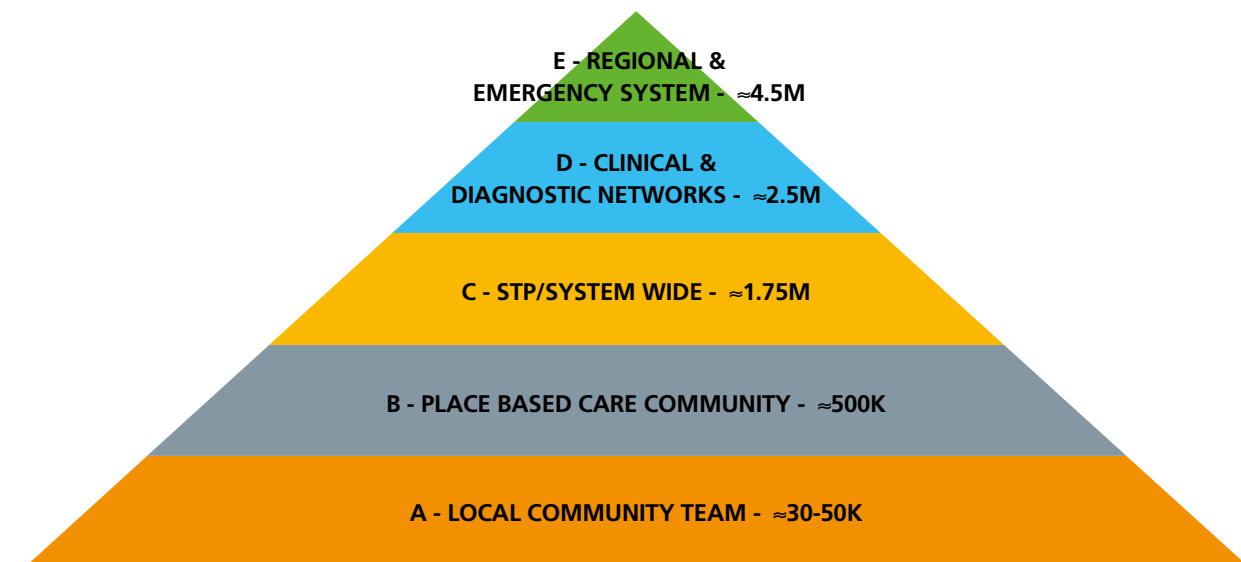
Our STP contains a medical school, two universities, thoughtful and effective collaborations between health and social care, between academia and industry and care. It has an abundance of small and medium enterprises with Brighton & Hove ranked fourth in a new index highlighting the size and success of digital industries around the country and their potential for growth. Brighton ranked particularly strongly in its innovation for data, virtual reality, health and artificial intelligence despite being relatively smaller than its competitors. It has a strong record of research and of education. It is bracketed by two STPs with similarly strong records of new models of care (Kent vanguard, Surrey wave one Internet of Things test bed). Its hospitals already connect digitally around imaging and diagnostics.

We also should not miss the link that investment in the local economy improves job prospects, affluence and helps mitigate the impact that poverty has on the health and wellbeing of our local population. There are strong digital and IT economic sectors already in our local economies with around 25% of Brighton & Hove's economy is in the Creative Digital and IT sector which has seen 40% growth over the past 5 years, with strong academic relationships through the Digital Catapult and one of the first 5G testbeds in the country.

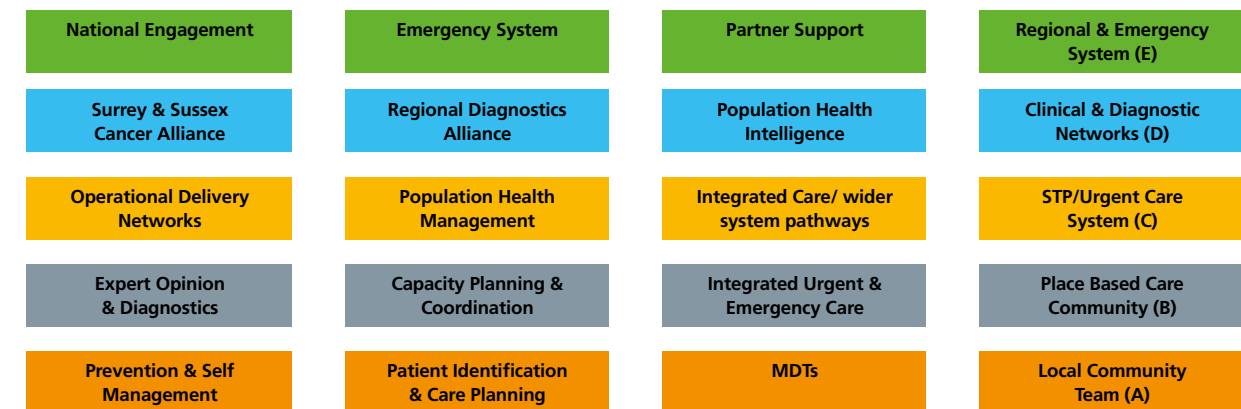
In our quest to drive out waste and address historic financial over spend, which is urgent, we will take the opportunity to work on models of care that put our people at the heart of new pathways. We must not lose sight of this.

WE NEED TO DEVELOP A CLINICAL STRATEGY WHICH IS CLEAR ON THE OPTIMAL POPULATION SIZE TO LEAD DELIVERY

Some of the changes needed will be led and delivered locally, supported by the STP as the direction of travel. A few will be led by the STP organisations together, providing that adds value and does not duplicate local work.



BUSINESS LANDSCAPE



LOCAL COMMUNITY TEAM 30-50K

<p>Prevention & Self Management</p> <ul style="list-style-type: none"> ● Falls prevention ● Social prescribing ● Health coaching ● Building knowledge & changing behaviours ● Support for people to manage their long term condition 	<p>Patient identification & care planning</p> <ul style="list-style-type: none"> ● Identifying frail & vulnerable patients ● Developing and implementing care plans 	<p>Multi-disciplinary Teams</p> <ul style="list-style-type: none"> ● Care coordination ● Reablement ● Bringing integrated Health and Social Care into the home
--	--	--

PLACE BASED CARE COMMUNITY ≈500K

<p>Expert Opinion & Diagnostics</p> <ul style="list-style-type: none"> ● Timely diagnostics ● Access to expert opinion ● Timely assessment 	<p>Capacity Planning & Coordination</p> <ul style="list-style-type: none"> ● Demand & Capacity Planning ● Transitions of care & patient flow ● Mental health liaison ● Social care coordination ● Community & capacity development 	<p>Integrated Urgent & Emergency Care</p> <ul style="list-style-type: none"> ● A&E coordination ● See and Treat ● Rapid response ● Single Point of Access ● Telecare/health
--	--	---

STP/WIDER SYSTEM ≈1.7M

<p>Operational Delivery Networks and clinical networks</p> <ul style="list-style-type: none"> ● Trauma ● Maternity ● Vascular ● Burns ● Clinical networks: specialist cardiology, cardiac surgery, renal dialysis, and paediatric surgery 	<p>Population Health Management</p> <ul style="list-style-type: none"> ● Population health planning ● research and Evaluation ● Provider and collaboration 	<p>Integrated Care/wider system pathways</p> <ul style="list-style-type: none"> ● 111 Service ● UEC ● Mental Health ● Capacity (3Ts) ● Clinical variation ● Maternity
---	--	--

CLINICAL & DIAGNOSTIC NETWORKS ≈12.5

<p>Clinical & Diagnostic Networks</p> <ul style="list-style-type: none"> ● Surrey & Sussex Cancer Alliance ● Radiology Network ● Pathology ● South East Clinical Networks 	<p>Population Health analytics</p> <ul style="list-style-type: none"> ● Sussex & Surrey Integrated Dataset ● Research and Evaluation
--	---

REGIONAL & ≈1.7M

<p>National Engagement</p> <ul style="list-style-type: none"> ● NHS England ● NHS Improvement ● NHS Digital ● Specialist Commissioning 	<p>Emergency System</p> <ul style="list-style-type: none"> ● 999 & Ambulance Service ● care Plan Sharing service 	<p>Partner Support</p> <ul style="list-style-type: none"> ● HEE KSS ● KSS AHSN ● NIHR Clinical Research Network KSS ● South East Coast Clinical Senate
---	---	---

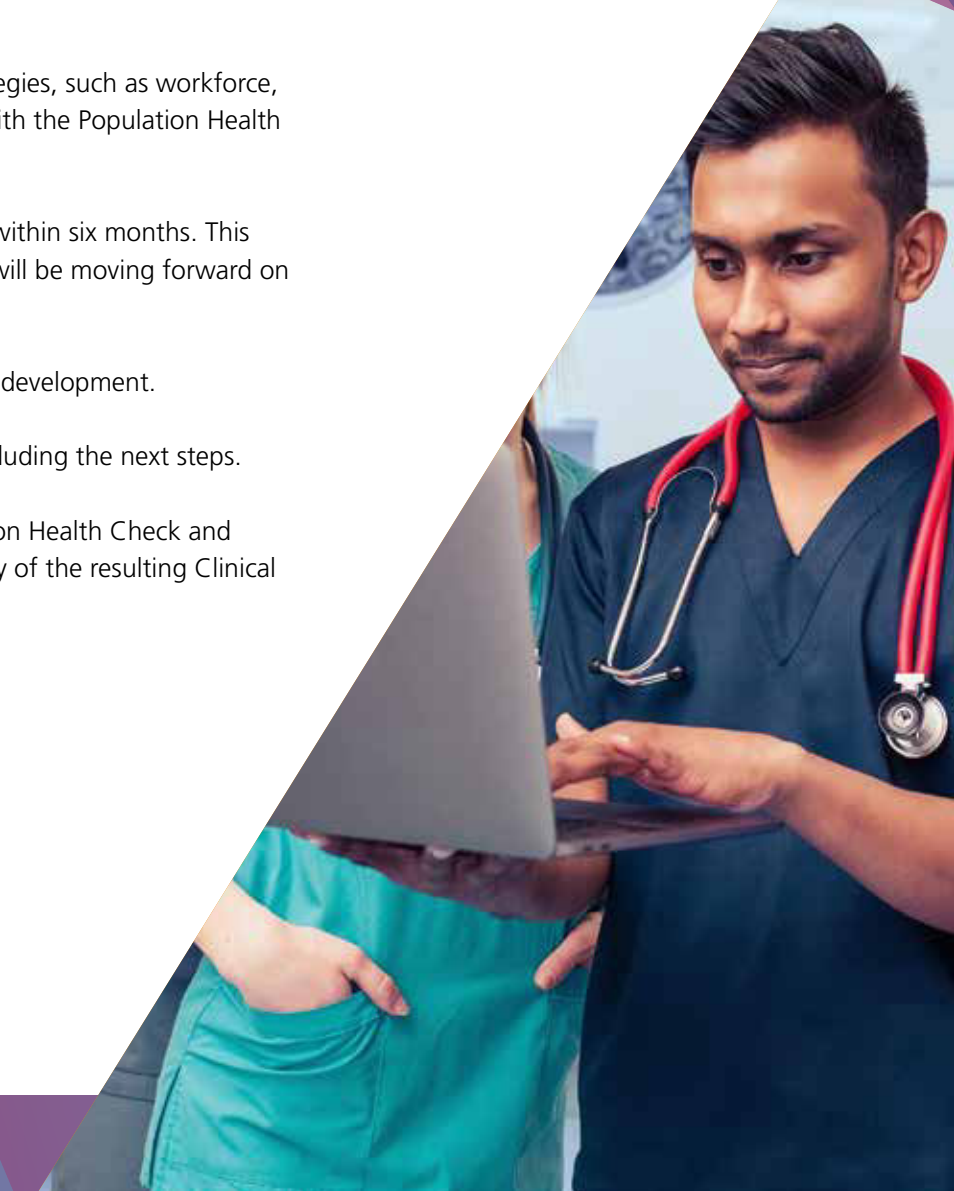
THE PROCESS OF DEVELOPING THE CLINICAL STRATEGY (ADDED POST SIGN OFF. STP EXEC GROUP AGREEMENT)

The Population Health Check provides the rationale for addressing certain themes as priorities; it does not attempt to offer solutions.

In order to achieve that, we will now:

- Develop a public-facing version of the report, which will include graphics and a visual explanation of the report for the open section of Boards and Governing Bodies.
- Draft an engagement and communication strategy in order to ensure we are engaging at the earliest opportunity on how to address the themes identified.
- Our Medical Directors and Chief Nurses will be discussing the report more widely internally with their clinical colleagues and with their Executive leads.
- We will be ensuring that co-dependent strategies, such as workforce, digital technology, estates etc. are aligned with the Population Health Check and the developing Clinical Strategy.
- Develop a plan to deliver a Clinical Strategy within six months. This Clinically-led Strategy will describe how we will be moving forward on delivery of the priorities at pace.
- Have had an opportunity to contribute to its development.
- Agree with the Population Health Check, including the next steps.
- Are committed to championing the Population Health Check and contributing to the development and delivery of the resulting Clinical Strategy.

This Clinically-led Strategy will describe how we will be moving forward on delivery of the priorities at pace.



Agreement from the Core members of the STP Clinical and Professional Cabinet

We would like to formally confirm our support for this Population Health Check. We confirm that we:

- Have had an opportunity to contribute to its' development
- Agree with the Population Health Check, including the next steps
- Are committed to championing the Population Health Check and contributing to the development and delivery of the resulting Clinical Strategy

Name	Title	Organisation	Date agreed
Minesh Patel	Clinical Chair (Co-chairperson)	NHS Horsham and Mid Sussex CCG	25/09/2018
Peter Larsen-Disney	Clinical Director of 3Ts (Co-chairperson)	Brighton and Sussex University Hospital NHS FT	20/08/2018
Rob Haigh	Medical Director	Brighton and Sussex University Hospitals NHS Trust	14/09/2018
George Findlay	Chief Medical Officer/ Deputy CEO	Brighton and Sussex University NHS Trust and Western Sussex Hospitals NHS FT	02/10/2018
David Supple	Clinical Chair	NHS Brighton and Hove CCG	05/09/2018
Gill Galliano	Acting Lay Chair	NHS Coastal West Sussex CCG	02/10/2018
Laura Hill	Clinical Chair	NHS Crawley CCG	05/09/2018
Elango Vijaykumar	Clinical Chair	NHS East Surrey CCG	25/09/2018
Martin Writer	Clinical Chair	NHS Eastbourne, Hailsham and Seaford CCG	02/10/2018
David Warden	Clinical Chair	NHS Hastings and Rother CCG	13/09/2018
Elizabeth Gill	Clinical Chair	NHS High Weald Lewes Havens CCG	25/09/2018

David Walker	Medical Director	East Sussex Healthcare NHS Trust	22/08/2018
Ed Pickles	Medical Director	Queen Victoria Hospital NHS FT	17/09/2018
Karen Eastman	Clinical Lead for Unwarranted Clinical Variation	SES STP	12/09/2018
Fionna Moore	Medical Director	South East Coast Ambulance Services NHS FT	29/08/2018
Des Holden	Medical Director	Surrey and Sussex Healthcare NHS Trust	02/10/2018
Richard Quirk	Medical Director	Sussex Community NHS FT	13/09/2018
Rick Fraser	Consultant Psychiatrist and Chief Medical Officer	Sussex Partnership NHS FT	30/08/2018
Justin Wilson	Chief Medical Officer	Surrey and Borders Partnership NHS Trust	09/10/2018
Sue Marshall	Executive Chief Nurse	Sussex Community NHS FT	13/09/2018
Jonathon Warren	Chief Nurse	Surrey and Borders Partnership Trust	22/08/2018
Liz Moulard	Chief Nurse and Director of Clinical Standards	First Community Health and Care	21/08/2018
Patricia Brayden	Medical Director	St Catherine's Hospice, Crawley	31/08/2018
Andrew Catto	Medical Director	IC24	31/08/2018
Alison Taylor	Deputy Medical Director	NHSE	29/08/2018
Allison Cannon	Chief Nurse	STP Commissioners	28/08/2018
Karen Devanny	Chief Nurse and Director of Quality	CSESCA	12/09/2018
Guy Boersma	Managing Director	KSS AHSN	17/09/2018
Michael Bosch	RCGP STP Ambassador and Alliance for Better Care GP Federation	Alliance for Better Care GP Federation	20/08/2018
Anna Raleigh	Director of Public Health	WS CC-Evidence: Our Population and Demographics	18/09/2018
Richard Brown	Medical Director	S&SLMCs	20/09/2018

Agreement from the Core members of the STP Clinical and Professional Cabinet

We would like to formally confirm our support for this Population Health Check. We confirm that we:

- Have had an opportunity to contribute to its development
- Agree with the Population Health Check, including the next steps

Name	Title	Organisation	Date agreed
Lawrence Goldberg	Chair	South East Clinical Senate	20/08/2018

Contribution list

List of colleagues who have received and have been given the opportunity to contribute to the Population Health Check so far

Bob Alexander	STP Executive Chair	SES STP
Bruce Allan	GP	Worthing Medical Group
Sam Allan	Chief Executive	SPFT
Helen Atkinson	Executive Director of Public Health and Head of Adult services	Surrey County Council
Michael Bailey	STP workforce Project lead	SES STP
Gaynor Baker	STP Estates Lead	SES STP
Paul Bennett	Delivery and Improvement Director	NHSI (SE)
Sarah Billiard	Chief Executive	First Community Health and Care
Michael Bosch	RCGP STP Ambassador and Alliance for Better Care GP Federation	Alliance for Better Care GP Federation
Guy Boersma	Managing Director	KSS AHSN
Patricia Brayden	Medical Director	St Catherine's Hospice, Crawley
Karen Breen	TP Programme Director	SES STP
Richard Brown	Medical Director	Surrey and Sussex LMC
Jessica Britten	Chief Operating Officer	ESBT
Adrian Bull	Chief Executive	ESHT
Allison Cannon	Chief Nurse	STP Commissioners
Andrew Catto	Medical Director	IC24
Jacqueline Clay	Principal Manager	West Sussex Public Health and Social Research Unit
Karen Devanny	Chief Nurse and Director of Quality	CSESCA
Sarah Doffman	Chief of Medicine	Brighton and Sussex University Hospital NHS FT
Adam Doyle	Accountable Officer	CSESA and CWS CCG
Karen Eastman	Lead for Unwarranted Clinical Variation	SES STP

CONTRIBUTORS

Fiona Edwards	Chief Executive	Surrey and Borders NHS Trust
Amanda Fadero	Director	Coastal Care
George Findlay	Chief Medical Officer/ Deputy CEO	Brighton and Sussex University Hospitals NHS Trust Western Sussex Hospitals NHS FT
Pennie Ford	Director of Assurance and Delivery	NHSE (SE)
Rick Fraser	Consultant Psychiatrist and Chief Medical Officer	Sussex Partnership NHS FT
Darrell Gale	Director of Public Health	East Sussex County Council
Elizabeth Gill	Clinical Chair	NHS High Weald Lewes Havens CCG
Rachel Gill	Consultant in Public Health	Surrey County Council
Lawrence Goldberg	Chair	South East Clinical Senate
Marianne Griffiths	Chief Executive	WSHT and BSUH
Tom Gurney	Communications Lead	SES STP
Rob Haigh	Medical Director	Brighton and Sussex University Hospitals NHS Trust
Des Holden	Medical Director	Surrey and Sussex Healthcare NHS Trust
Laura Hill	Clinical Chair	NHS Crawley CCG
Jackie Huddleston	NHS England – South East (Kent, Surrey, Sussex)	NHS England – South East (Kent, Surrey, Sussex)
Caroline Huff	Clinical Programme Director	SES STP
Steve Jenkin	Chief Executive	QVH
Maggie Keating	STP UECN Senior Programme Manager	SES STP
Peter Kottlar	Chief Operating Officer	East Surrey CCG (CSESA)
Peter Larsen-Disney	Clinical Director of BSUH 3Ts and Co-chairperson of the SES STP Clinical and Professional Cabinet	Brighton and Sussex University Hospital NHS FT
David Lipscomb	Chair Diabetes Oversight Group Sussex and Surrey STP	SCFT
Hugo Luck	Associate Director of Operations	HWLH CCG and CSESA (S)
Nick Lake	Deputy Medical Director	SPFT
Vaughan Lewis	Medical Director Specialised Commissioning NHS South	NHSE
Susan Marshall	Chief Nurse	Sussex Community NHS FT
Siobhan Melia	Chief Executive	SCFT
Alistair Hill	Director of Public Health	BH City Council
Fionna Moore	Medical director South East Coast Ambulance Services	NHS FT

CONTRIBUTORS

Ralph McCormack	Programme Director – Commissioning Programmes	STP
Liz Moulard	Chief Nurse and Director of Clinical Standards	First Community Health and Care
Minesh Patel	CCG Clinical Chair and Co-chairperson of the SES STP Clinical and Professional Cabinet	NHS Horsham and Mid Sussex CCG
Maggie Patching	Workforce Transformation Lead	HEKSS
Amanda Philpott	Accountable Officer	HR CCG and EHS CCG
Ed Pickles	Medical Director	Queen Victoria Hospital NHS FT
Mark Preston	Director of Organisational Development & People	SASH
Richard Quirk	Medical Director	Sussex Community NHS FT
Anna Raleigh	Director of Public Health and co-ordinating lead for SES STP DsPH input	West Sussex CC
Rosalind Ranson	Primary Care Lead	IC24
Nicola Rosenberg	Public Health Consultant	BH CC
Paul Simpson	Chair	SES STP Finance Group
Ashley Scarff	Director of Commissioning & Deputy Chief Officer	HWLH CCG
Sam Stanbridge	Director of Commissioning	East Surrey CCG (CSESA)
Su Stone Clinical chair	NHS Coastal West Sussex	CCG
David Supple	Clinical Chair	NHS Brighton and Hove CCG
Alison Taylor	Deputy Medical Director	NHSE
Tim Taylor	Medical Director	Western Sussex Hospitals NHS FT
Sarah Valentine	Strategic Director of Contracting & Performance	Sussex & East Surrey CCGs
David Walker	Medical Director	East Sussex Healthcare NHS Trust
David Warden	Clinical Chair	NHS Hastings and Rother CCG
Jonathan Warren	Chief Nurse	Surrey and Borders Partnership Trust
Mark Watson	Digital Programme Manager	SES STP
Justin Wilson	Chief Medical Director	Surrey and Borders Partnership NHS FT
Michael Wilson	Chief Executive	SASH
Martin Writer	Clinical Chair	NHS Eastbourne, Hailsham and Seaford CCG
Elango Vijaykuma	Clinical Chair	NHS East Surrey CCG

References/bibliography

Alzheimer's Society (2009) Counting the cost: Caring for people with dementia on hospital wards.

https://www.alzheimers.org.uk/sites/default/files/2018-05/Counting_the_cost_report.pdf

BMA (2018) GP premises not fit for patients.

<https://www.bma.org.uk/news/2014/july/gp-premises-not-fit-for-patients>

Carnell Farrer (CF) (March 2017) Acute services work stream: demand and capacity review. (On application STP Office)

Carnell Farrer (CF) (April 2017) Sussex and East Surrey STP review and refresh. Summary report. (On application STP Office)

Carnell Farrer (April 2017b) Capped expenditure process information for benchmarking and opportunities. Available on application

Carter, (2016) (DoH) Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. An independent report for the Department of Health by Lord Carter of Coles

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

Central Sussex and East Surrey Alliance (2016) Place Based Delivery Plan

<http://www.brightonandhoveccg.nhs.uk/sites/btnccg/files/files/CSESA%20Place%20Based%20Plan%20FINAL.pdf>

CSESA Primary Care Cornerstone of the PBP, (2016) Available on application

Coastal Care (2016): Inspiring healthy communities together

<https://www.coastalwestsussexccg.nhs.uk/building-first-class-health-and-care-system-for-sussex-and-east-surrey>

Coastal Care (2017) Coastal Care Delivery Plan (2017) on application

Dahlgren and Whitehead (1991) Determinants of Health, Dahlgren, G., & Whitehead, M. (1991). Policies and strategies to promote social equity in health. Stockholm: Institute for Future Studies.

Google Scholar

DoH (2016) (Professor Tim Briggs: The Future of Commissioning for Planned Surgery Getting it right for orthopaedics Learning from the first round of 'Getting it Right First time'

ESBT (East Sussex Better Together) (2014): Commissioning a sustainable, integrated health and social care system that best meets population need

<http://www.eastbournehailshamandseafordccg.nhs.uk/intranet/resources/east-sussex-better-together/>

ESBT (East Sussex Better Together) (Nov 2016) The Case for Change in East Sussex (Accountable Care)

<http://news.eastsussex.gov.uk/east-sussex-better-together/wp-content/uploads/sites/10/2016/11/The-Case-for-Change-in-East-Sussex-Accountable-Care.pdf>

Eastman, K (2017) Presentation to the SES STP Clinical Board. Available on request.

Gonnering RS and Riley WJ (2018) Robert Wood Johnson and University of Wisconsin Population Health Institute: Health Outcomes and Health Factors.

https://link.springer.com/chapter/10.1007/978-3-319-73636-5_13

Hunt, Jeremy (2015) 'New Deal for General Practice'.

<https://www.gov.uk/government/speeches/new-deal-for-general-practice>

House of Commons Library (2015)

<https://publications.parliament.uk/pa/cm201516/cmselect/cmhealth/408/40807.htm>

Kings Fund (2009) General Practice in England.

<https://www.kingsfund.org.uk/sites/default/files/General-practice-in-England-an-overview-Sarah-Gregory-The-Kings-Fund-September-2009.pdf>

Kings Fund (2015) Place-based systems of care: A way forward for the NHS in England.

www.kingsfund.org.uk

Kings Fund (2016) Understanding pressures in General Practice.

https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf

Kings Fund (2018) Through the eyes of GP trainees: workforce of the future

<https://www.kingsfund.org.uk/blog/2018/08/gp-trainees-workforce-future>

National Palliative and End of Life Care Partnership (2015) Ambitions for Palliative and End of Life Care.

<http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf>

Nuffield (2017) Shifting the Balance of Care.

<https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf>

NHSE (2018)

<https://www.england.nhs.uk/integratedcare/stps/faqs/>

NHS Rightcare (2016) Commissioning for Value Focus pack: cardiovascular disease.

<https://www.england.nhs.uk/rightcare/intel/cfv/data-packs/south/#21>

NHS Rightcare (2016b) Commissioning for Value pack: Long Term Conditions

<https://www.england.nhs.uk/rightcare/products/ccg-data-packs/long-term-conditions-packs/#south>

NHS Rightcare (2017) Tools and Techniques.

http://www.futurefocusedfinance.nhs.uk/sites/default/files/media-posts/163299_Tools%20%26%20Techniques.pdf

NHS Rightcare (2017b) Mental Health conditions packs

<https://www.england.nhs.uk/publication/mental-health-conditions-packs-2017-south/>

NHSE (2016) Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for maternity care.

<https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

PHE-Public Health England (2017a) Public Health outcomes framework.

<http://fingertipsreports.phe.org.uk/public-health-outcomes-framework/e10000011.pdf>

PHE-Public Health England (2017b) Public Health outcomes framework.

<http://fingertipsreports.phe.org.uk/public-health-outcomes-framework/e10000011.pdf>

PHE-Public Health England (2017c) Public Health outcomes framework.

<http://fingertipsreports.phe.org.uk/public-health-outcomes-framework/e10000011.pdf>

PHE-Public Health England (2017d) Public Health outcomes framework.

<http://fingertipsreports.phe.org.uk/public-health-outcomes-framework/e10000011.pdf>

Public Health (2017) Local Alcohol profile.

<http://www.eastsussexjsna.org.uk/profiles>

PHE Public Health England (2016a) Health profile.

<http://www.eastsussexjsna.org.uk/profiles>

PHE Public Health England (2016b) Health Profile

<http://fingertipsreports.phe.org.uk/health-profiles/2016/e06000043.pdf>

PHE Public Health England (2016c) Health Profile<http://fingertipsreports.phe.org.uk/health-profiles/2016/e06000043.pdf>

PHE Public Health England (2016d) Health Profile

<http://fingertipsreports.phe.org.uk/health-profiles/2016/e06000043.pdf>

PHE, CQC, NHSE (2017) End of Life Care: STP Support tool.

PULSE (2018) Revealed: 450 GP surgeries have closed in the last 5 years.

<http://www.pulsetoday.co.uk/news/hot-topics/stop-practice-closures/revealed-450-gp-surgeries-have-closed-in-the-last-five-years/20036793.article>

PULSE (2018) Brighton: the hardest hit town in the whole of the UK.

<http://www.pulsetoday.co.uk/news/hot-topics/postcards-from-the-edge/brighton-the-hardest-hit-town-in-the-whole-of-the-uk/20036786.article>

Simpson, P. and Holden, D (Jan 2017) Getting it right first time: orthopaedics – Model Hospital Data (available on application)

SES STP (Sussex and East Surrey Sustainability and Transformation Plan).

<http://www.brightonandhoveccg.nhs.uk/search/site/Central%20Sussex%20and%20East%20Surrey%20Alliance%20%282016%29%20Place%20Based%20Delivery%20Plan>

SES STP Finance Group (2017) Capped Expenditure Process: Sussex & East Surrey STP: response stage #2. Available on application.

SES STP (July 2017) Mental health in Sussex and East Surrey: the case for change (v0.5) available on application

SE Clinical Senate (2016) Reducing avoidable hospital based care: re-thinking out of hospital clinical pathways.

england.clinicalsenatesec@nhs.net, www.secsenate.nhs.uk

SE Clinical Senate (2017a) Emphasising Quality, delivering value.

england.clinicalsenatesec@nhs.net, www.secsenate.nhs.uk

SE Clinical Senate (2017b) Improving Clinical Communications Between Primary and Secondary Care Clinicians: A review and recommendations for the Sussex and East Surrey STP.

england.clinicalsenatesec@nhs.net, www.secsenate.nhs.uk

SE Clinical Network (2017) Sussex and East Surrey Local Maternity System (LMS): 10/05/2017: Laura Ansboro presentation. Available on application.

Skills for Health/Skills for Care/Health Education England (2017) Person-Centred Approaches. Empowering people in their lives and communities to enable an upgrade in prevention, wellbeing, health, care and support.

<http://www.skillsforhealth.org.uk/images/pdf/Person-Centred-Approaches-Framework.pdf?s=form>

SPFT (April 2017) Clinical Strategy: The next steps in our journey 2017-2010.

<http://www.sussexpartnership.nhs.uk/our-clinical-strategy>

Stevens, Simon (June 2016) speech to NHS Confederation.

<https://www.england.nhs.uk/2016/06/simon-stevens-confed-speech/>

STN (Sussex Trauma Network) (2017) Operational Policy. Available on application.

Surrey and Sussex Cancer Alliance (March, 2017) – Delivery Plan: A high-level Cancer Transformation plan to ensure the sustainable development and delivery of cancer services. Available on request.



**Sussex & East Surrey
Sustainability & Transformation Partnership**

Copyright © 2019 Sussex and East Surrey
Sustainability & Transformation Partnership
Produced by Creative@sussexpartnership.nhs.uk
Published February 2019
All information correct at time of printing



Integrated Performance Report

Performance
Data for our
999 and 111
Services



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

Board Meeting

January 2019



Taking
Pride



Striving for
Continuous
Improvement



Acting With
Integrity



Demonstrating
Compassion
and Respect



Assuming
Responsibility










Contents Summary

Content	Page
Executive Summary	3
CQC Must Do's / Should Do's	4
Clinical Safety	5
Clinical Quality	14
Operations 999	18
Operations 111	21
Workforce	23
Finance	25

SECamb CQC Rating and Oversight Framework

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

Chart Key

 Data Point	This represents the value being measured on the chart
 Run of 3 above average	These points will show on a chart when the value is above or below the average for 3 consecutive points. This is seen as statistically significant and an area that should be reviewed.
 Run of 3 below average	
 Above UCL	When a value point falls above or below the control limits, it is seen as a point of statistical significance and should be investigated for a root cause.
 Below LCL	
 AVERAGE	This line represents the average of all values within the chart.
 UCL	These lines are set two standard deviations above and below the average.
 LCL	
 Target	The target is either an Internal or National target to be met, with the values ideally falling above or below this point.

SECamb Executive Summary

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

The performance data shared in this report from Operations 999 is as at 7/1/19

The format and content of this report is continually reviewed to provide greater utility to the Trust Board and clearly communicate the status and actions undertaken by the Trust over time. During February and March 2019 this report and our quality reporting will be reviewed in order to further develop and refine our reporting going forward into 2019/20.

SECamb Our Enablers

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

SECamb Financial Performance

The Trust achieved its planned surplus of £0.1m for the month of November. The cumulative deficit of £3.1m is marginally better than plan, maintaining operational performance.

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

The Trust achieved cost improvements of £1.0m in the month, which was slightly ahead of plan. The target for the full year is £11.4m.

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

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

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

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

CQC Findings ('Must or Should Do's')

Safe

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

Caring

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

Effective

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

Responsive

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

Well Led

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

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

	May-18	Jun-18	Jul-18	12 Months
Actual %	50.0%	69.7%	46.7%	
Previous Year %	56.8%	44.8%	37.9%	
National Average %	55.9%	56.6%	55.9%	

Cardiac ROSC - ALL

	May-18	Jun-18	Jul-18	12 Months
Actual %	25.1%	36.6%	28.8%	
Previous Year %	22.8%	28.1%	24.4%	
National Average %	31.6%	31.8%	31.9%	

Cardiac Survival - Utstein

	May-18	Jun-18	Jul-18	12 Months
Actual %	20.7%	33.3%	28.6%	
Previous Year %	30.3%	17.9%	17.2%	
National Average %	29.4%	30.9%	33.9%	

Cardiac Survival - All

	May-18	Jun-18	Jul-18	12 Months
Actual %	4.5%	10.2%	8.4%	
Previous Year %	6.3%	5.9%	3.6%	
National Average %	10.0%	11.3%	11.8%	

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

	May-18	Jun-18	Jul-18	12 Months
Actual %	69.6%	75.0%	69.4%	
Previous Year %	57.5%	70.5%	62.9%	
National Average %	79.5%	79.5%	81.2%	

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

	May-18	Jun-18	Jul-18	12 Months
Mean (hh:mm)	02:11	02:19	02:14	
National Average	02:09	02:11	02:07	
90th Centile (hh:mm)	03:06	03:15	03:09	
National Average	02:56	03:05	02:51	

Stroke - call to hospital arrival

	May-18	Jun-18	Jul-18	12 Months
Mean (hh:mm)	01:12	01:10	01:14	
National Average	01:18	01:13	01:15	
Median (hh:mm)	01:03	01:01	01:04	
National Average	01:05	01:05	01:06	
90th Centile (hh:mm)	01:47	01:45	01:52	
National Average	01:47	01:49	01:52	

Stroke - assessed F2F diagnostic bundle

	May-18	Jun-18	Jul-18	12 Months
Actual %	98.7%	97.5%	97.8%	
Previous Year %	92.3%	94.4%	95.2%	
National Average %	98.3%	98.3%		

Post ROSC Care Bundle

	May-18	Jun-18	Jul-18	12 Months
Actual %	77.6%	75.2%	93.3%	
National Average %			57.3%	

Medicines Governance

	Sep-18	Oct-18	Nov-18	12 Months
Total Number of Medicines Incidents	80	93	74	
Single Witness Sig/Inapt Barcode Use CDs Omnicell	9	17	24	
Single Witness Sig/Inapt Barcode Use CDs Non-Omnicell	0	1	0	
Total Number of CD Breakages	17	16	15	
PGD Mandatory Training	44	20	17	
Key Skills Medicine Governance	166	180	82	

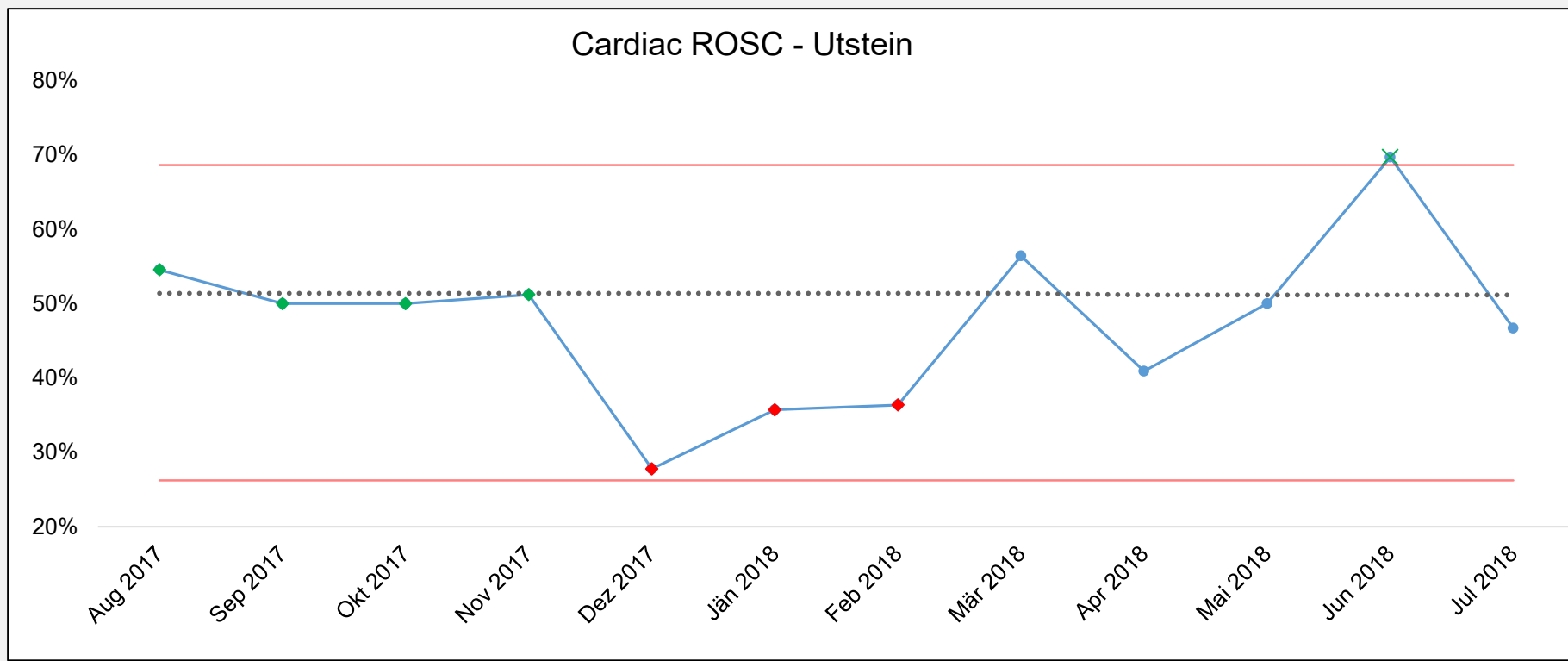
Sepsis Care Bundle Compliance

	May-18	Jun-18	Jul-18	12 Months
Actual %	84.7%	83.0%	82.2%	

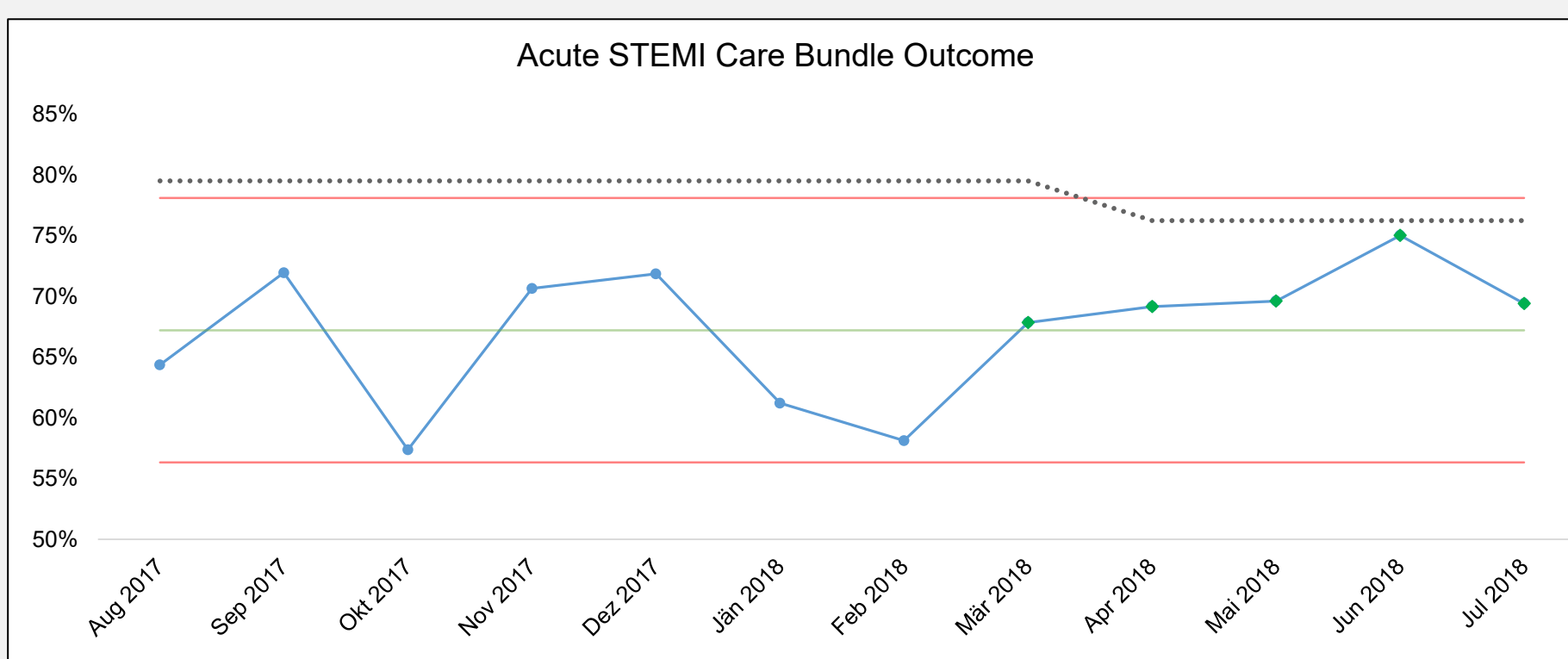
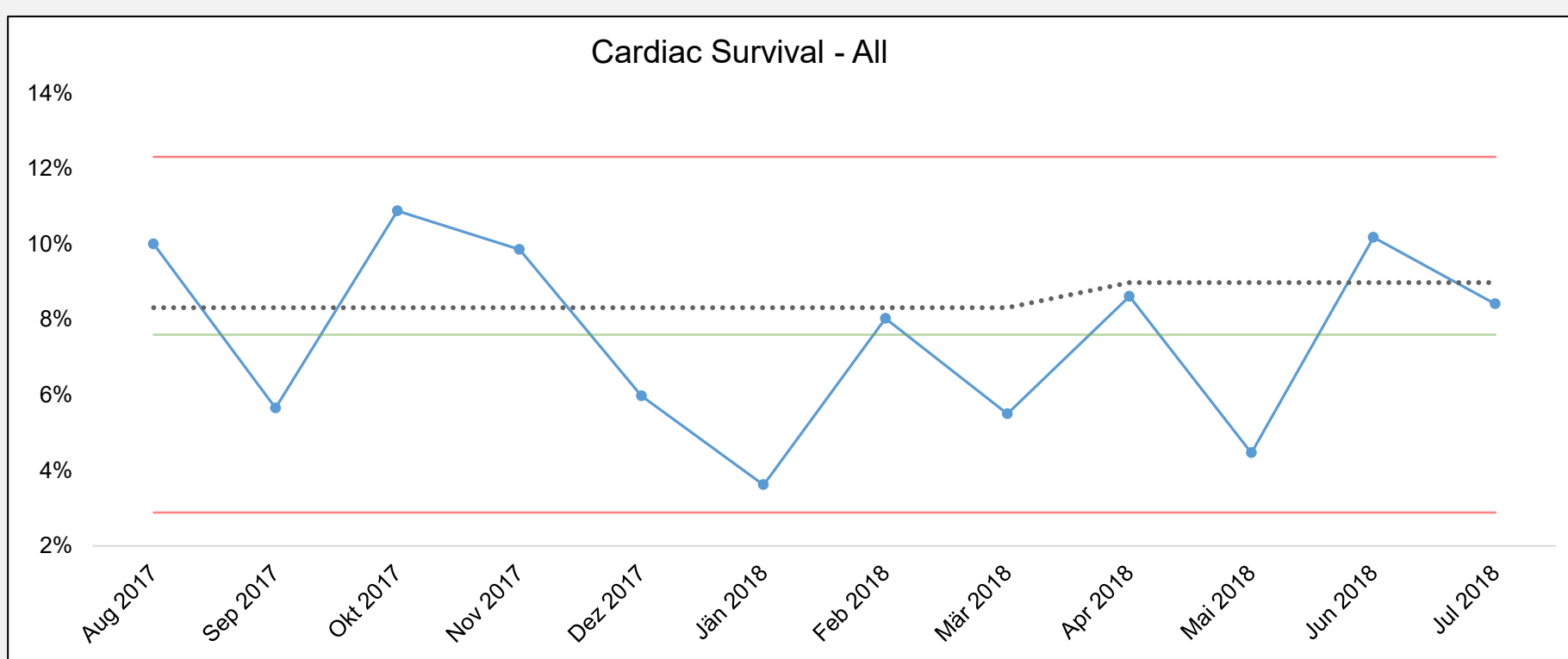
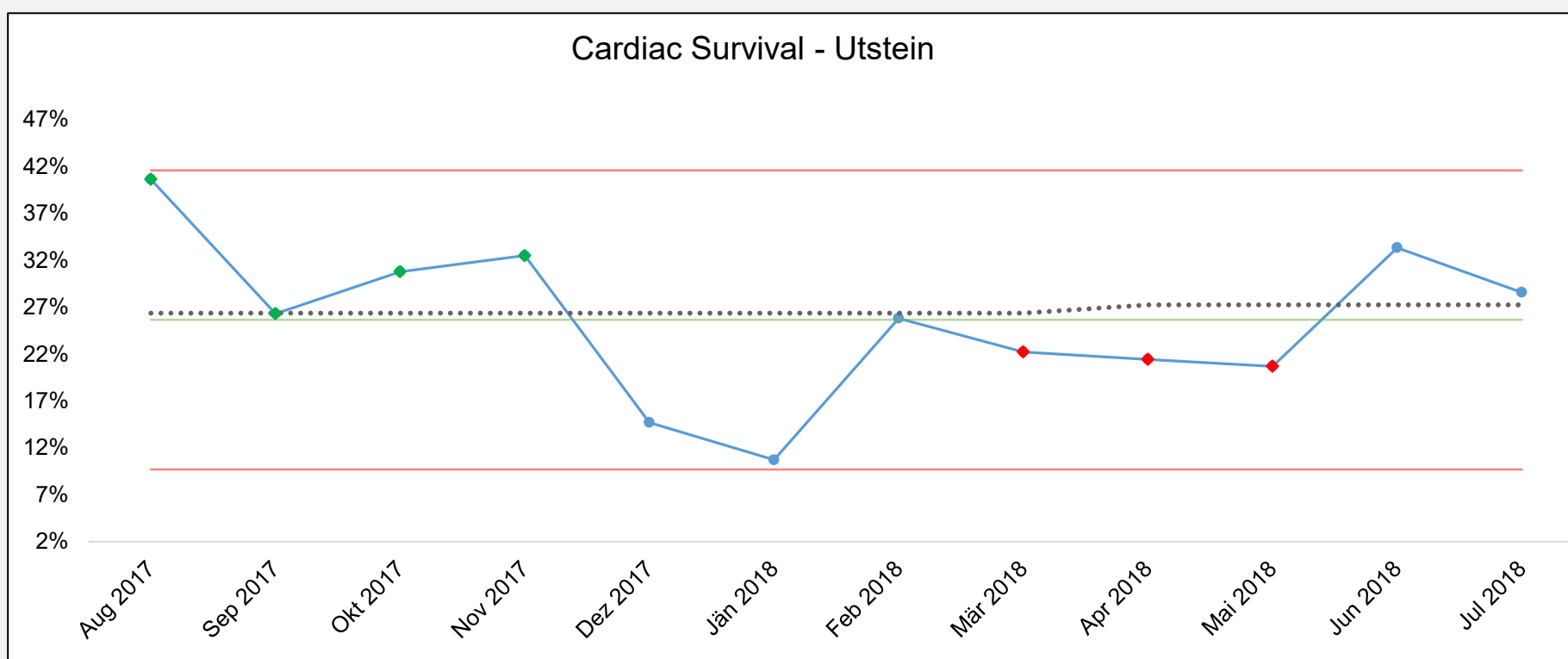
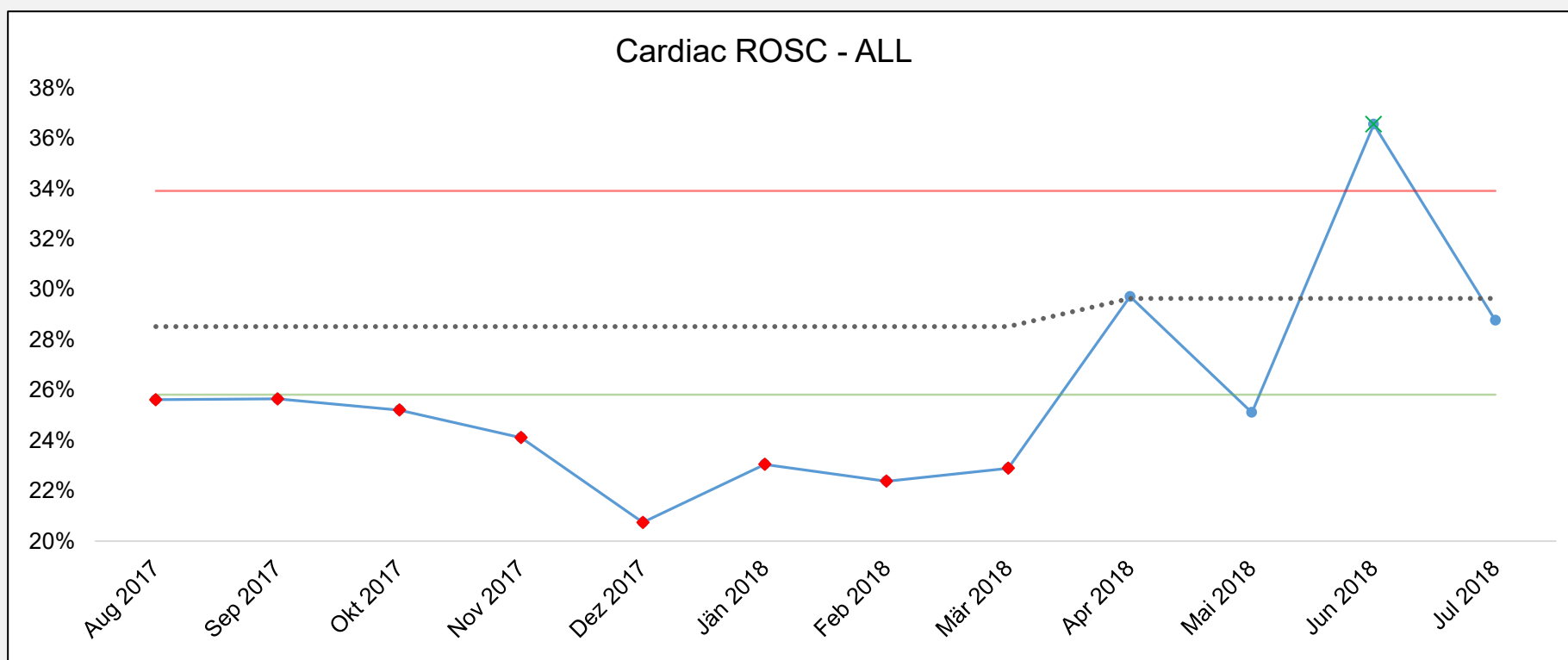
Medicines Management

	Sep-18	Oct-18	Nov-18	12 Months
Number of Audits	187	169	178	
Percentage of Audits	99.0%	99.4%	99.0%	

SECamb Clinical Safety Charts

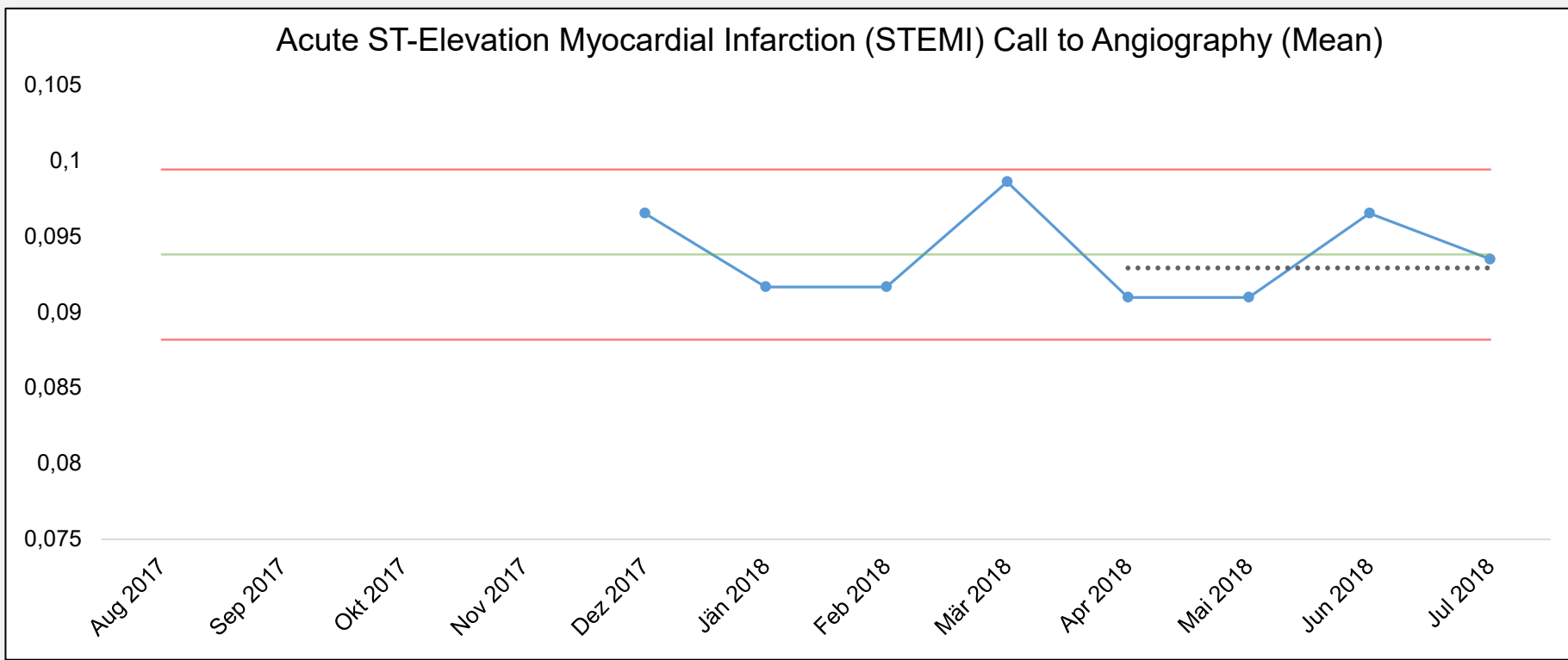


This data continues to show normal patterns of variation. Upcoming programmes of work to improve outcomes from cardiac arrest include; the introduction of the GoodSam App, a full day of resuscitation training in Key Skills 19/20, the relaunch of the cardiac arrest downloads programme, a new resuscitation procedure and the STAD programme that will improve our response time to all incidents.

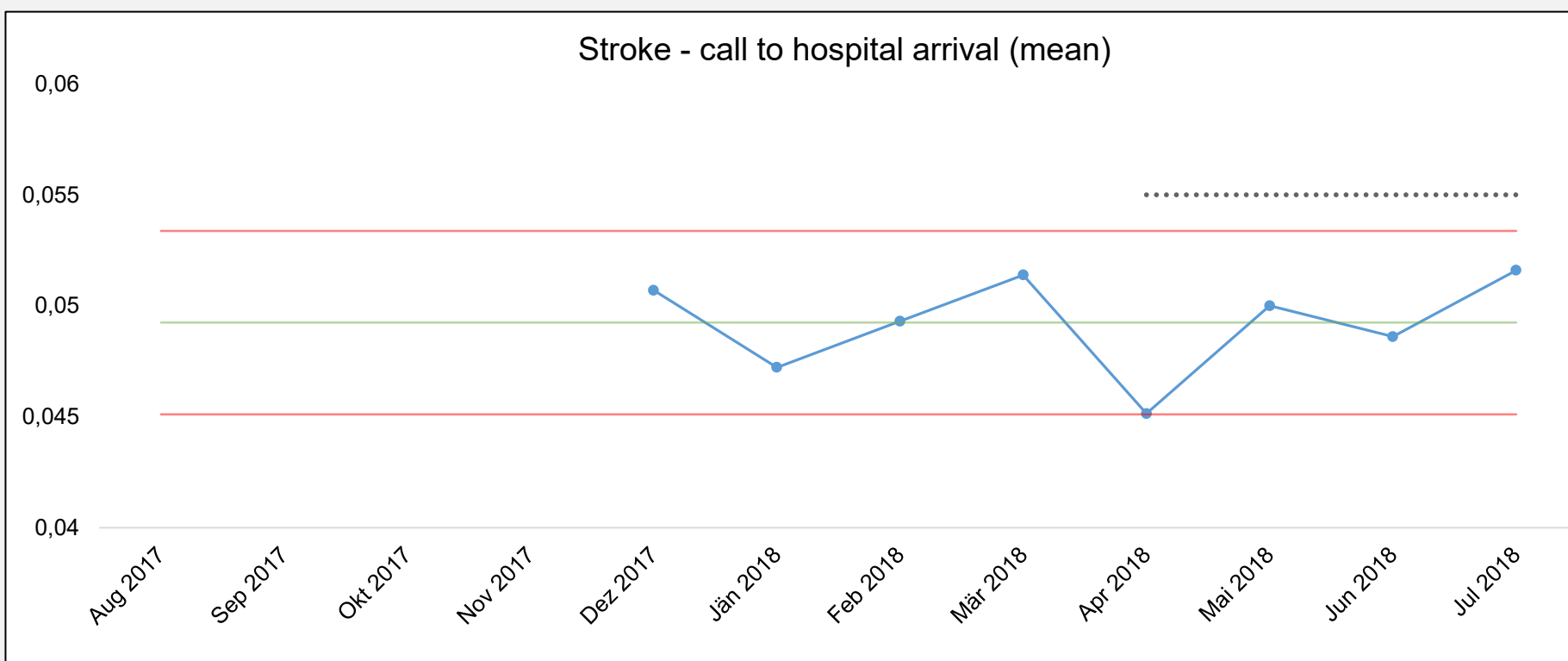
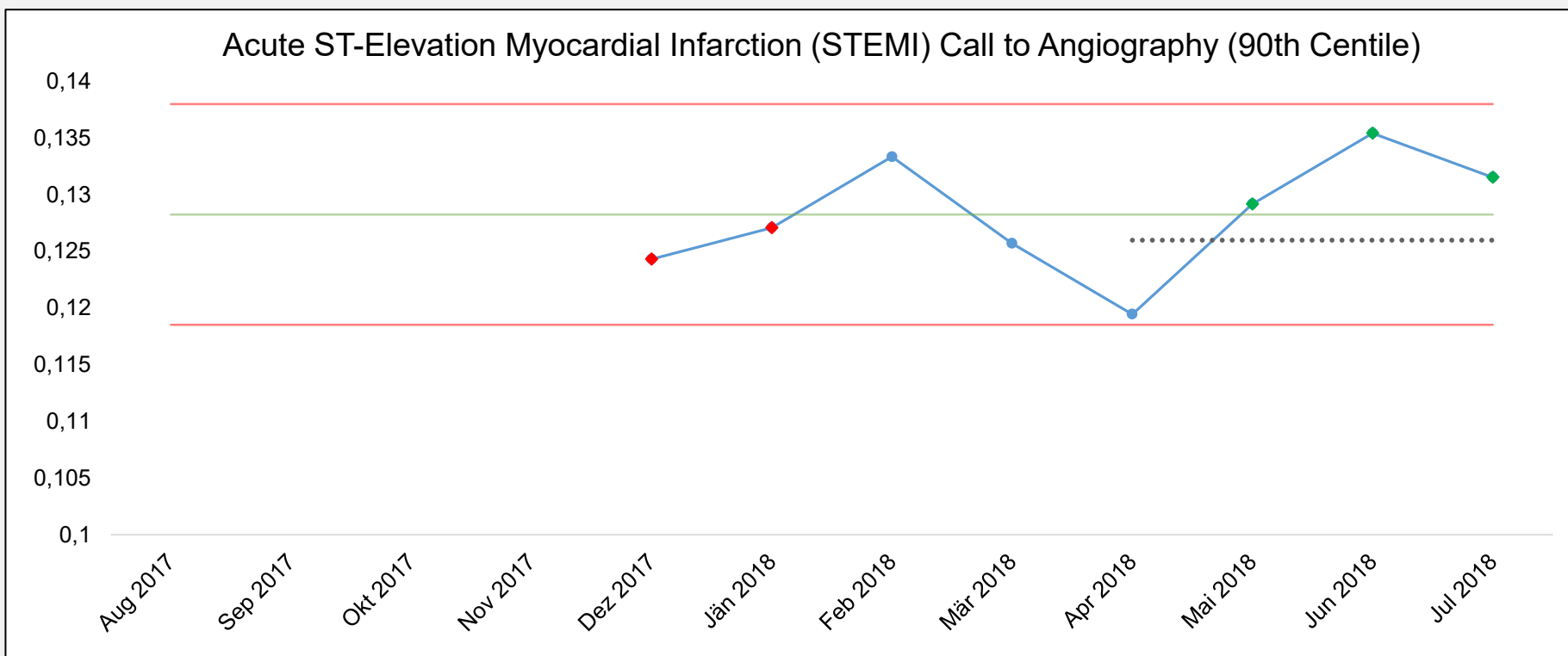


The acute STEMI care bundle shows sustained improvement. Plans to improve this further include a refresher training in the Key Skills programme, the procurement of an electronic Clinical Audit system that will give individual clinicians and their managers access to performance data and changes to our paper and electronic patient records to discourage documentation omissions.

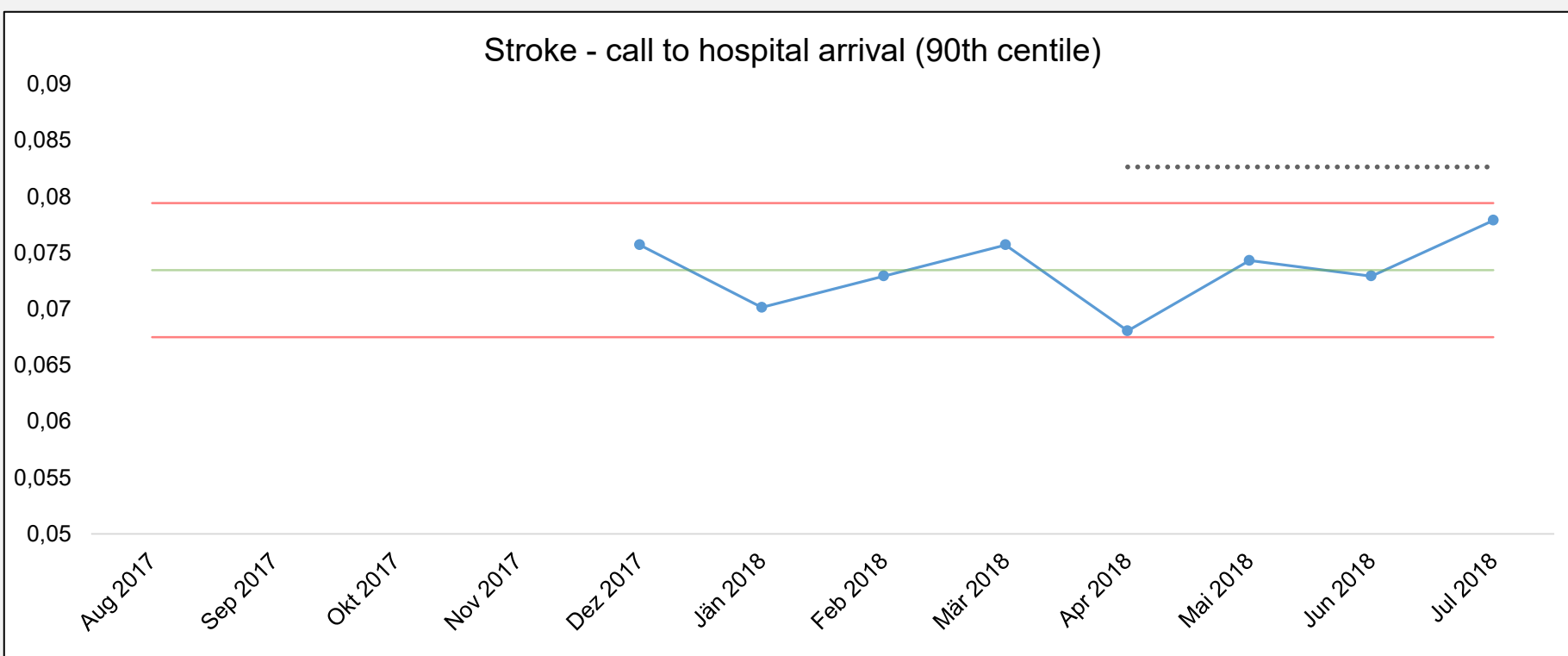
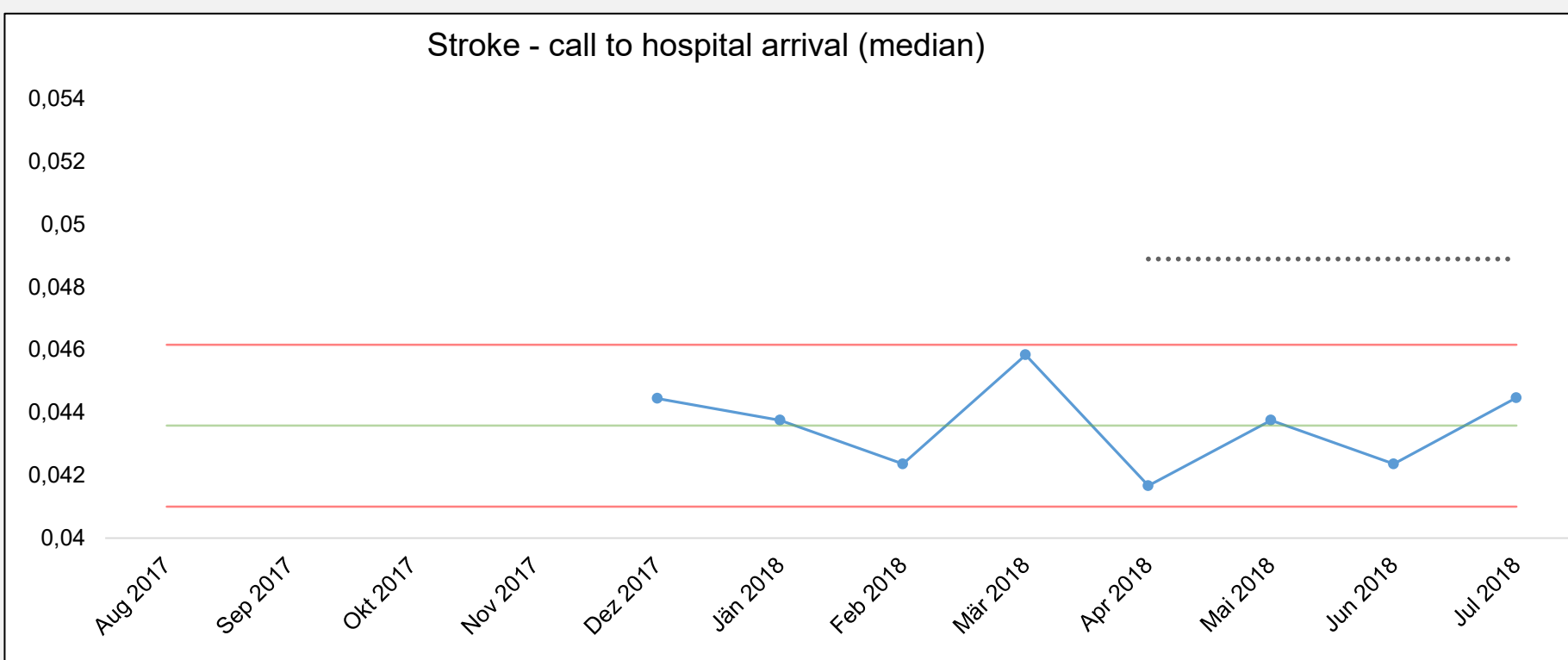
SECamb Clinical Safety Charts



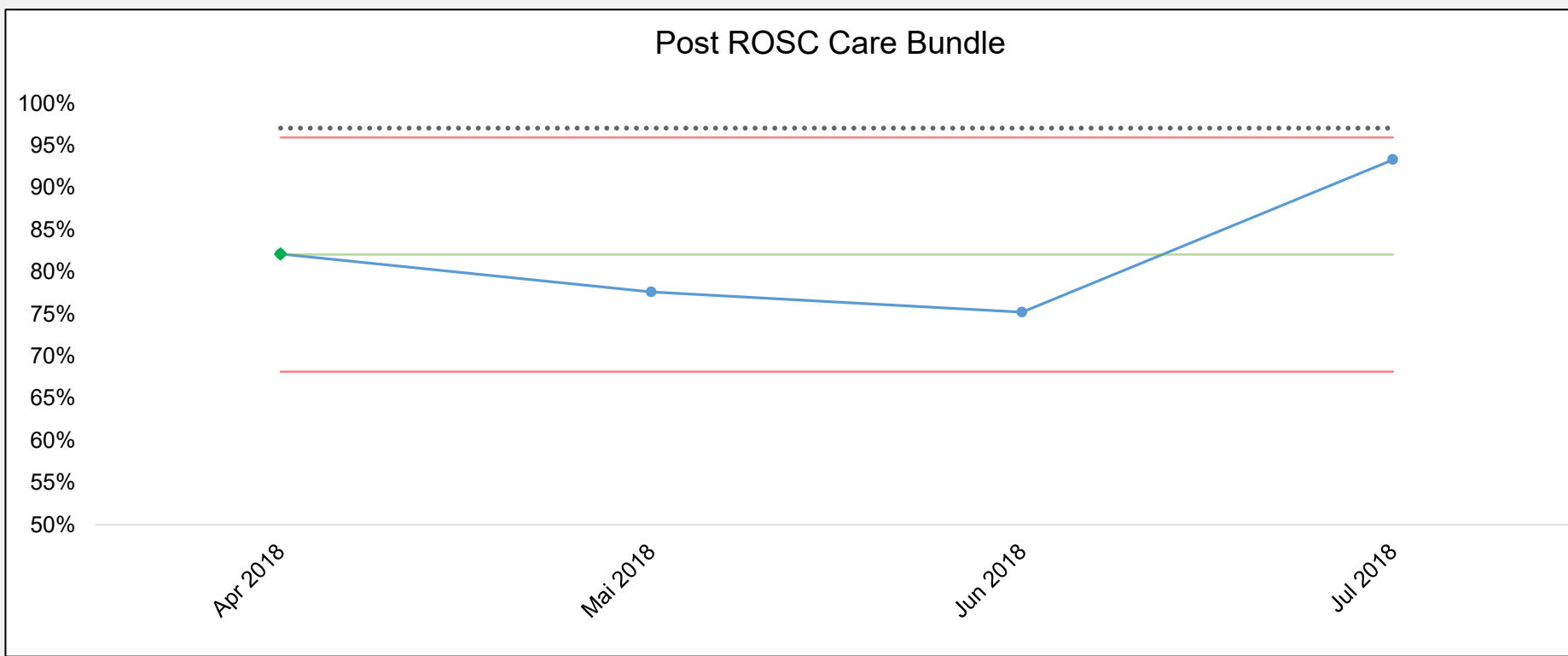
Our call to angiography timeliness measures continue to show normal patterns of variation. We continue to perform in line with the national average. The Trust plans to improve performance against this measure by increasing our focus on reducing on scene times. A focus on the 10:10:10 approach will be made in Key Skills 19/20. This approach gives clinicians 10 minutes to assess the patient and decide the management plan. 10 minutes to remove the patient to the vehicle and 10 minutes to depart from scene.



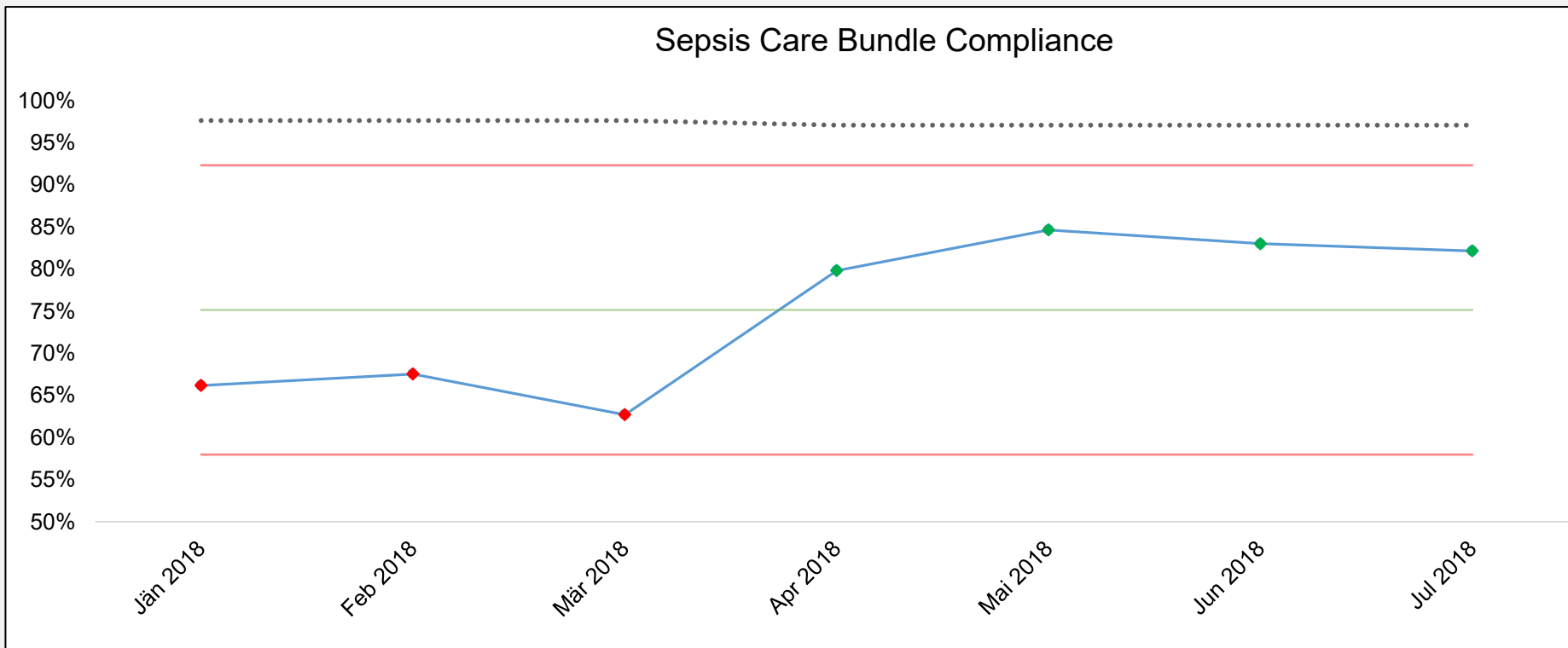
Our stroke timeliness data continues to show normal patterns of variation. Our average call to hospital time is still more timely than the national average. A focus on the 10:10:10 approach will be taken in Key Skills 19/20.



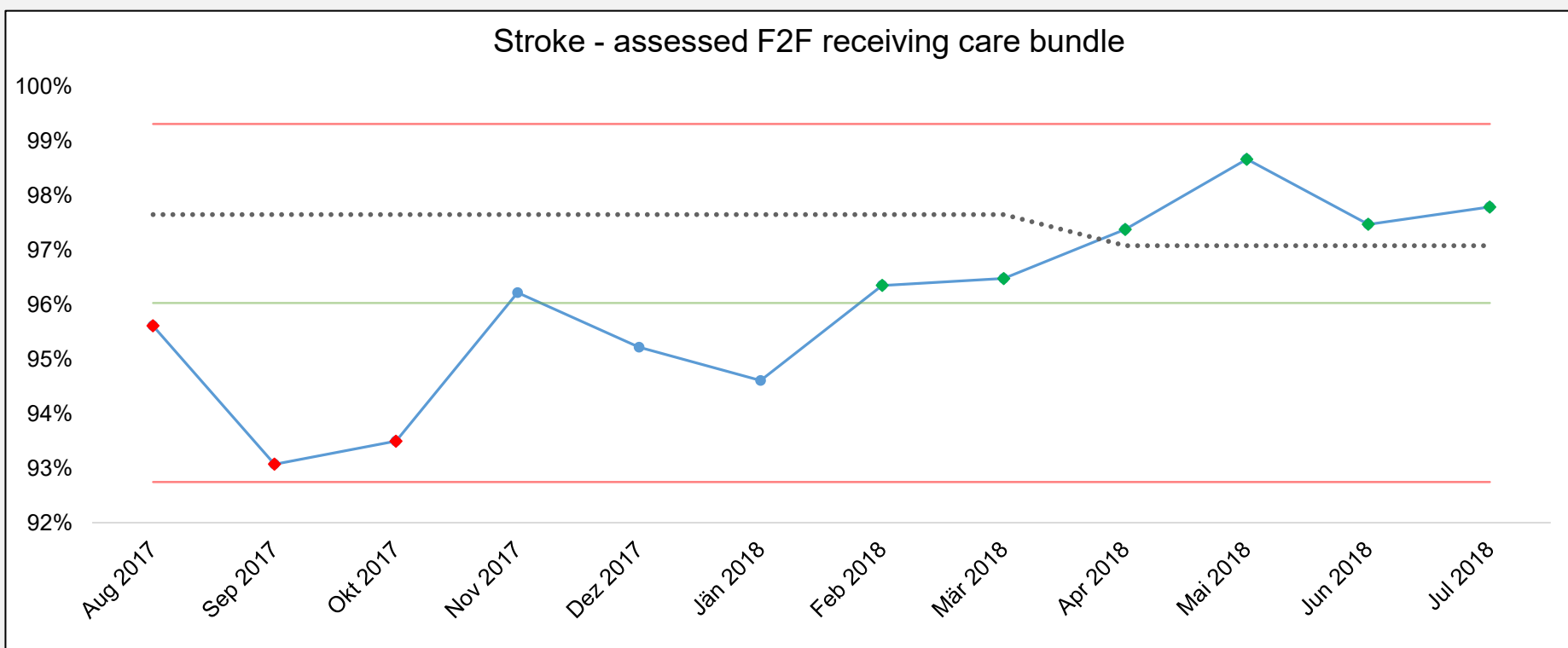
SECamb Clinical Safety Charts



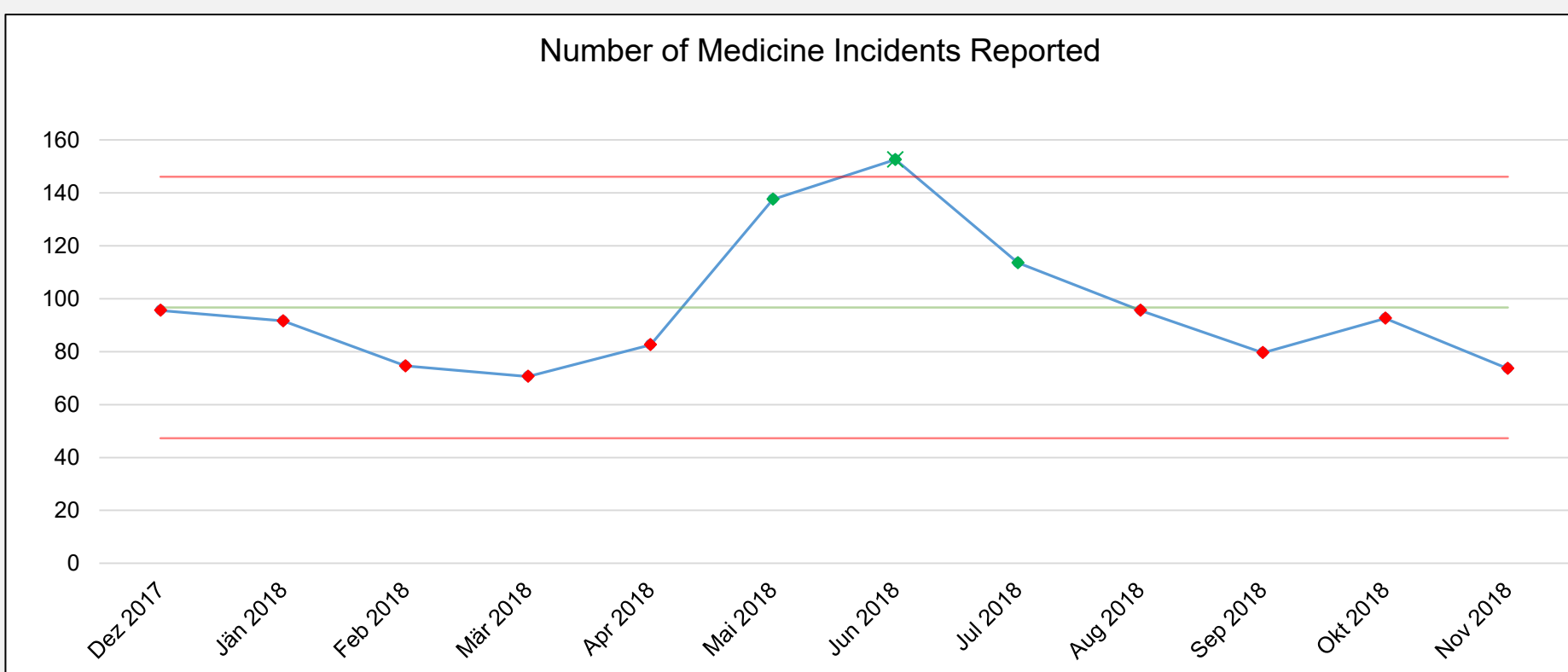
The post-ROSC care bundle continues to show normal patterns of variation. The Trust continues to be one of the highest performing Trusts nationally against this measure.



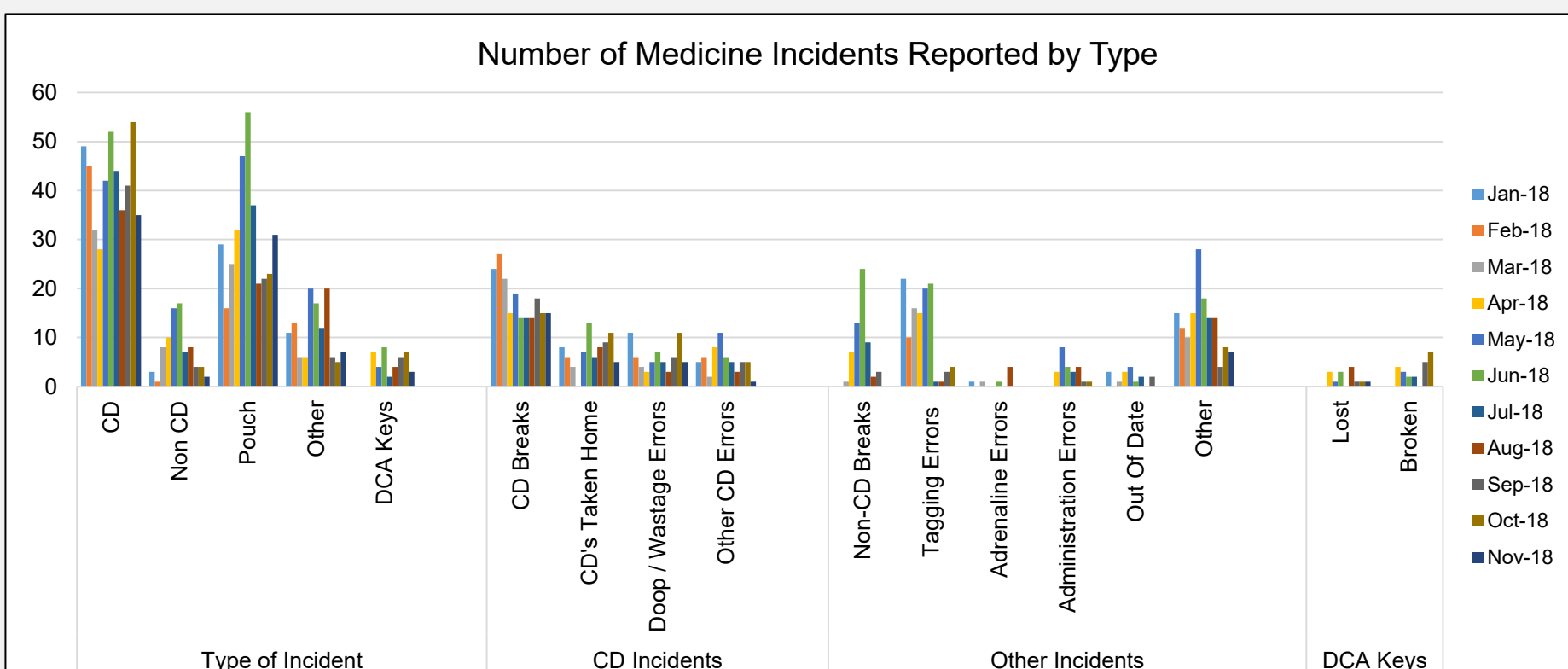
The sepsis care bundle continues to show normal patterns of variation. The Trust continues to be one of the highest performing Trusts nationally against this measure. Performance against this measure would be improved with consistent documentation of pre-alert calls. An improvement is expected following forthcoming changes to our vehicle's mobile data terminals which will soon prompt crews to select whether a pre-alert call was provided, every time they clear from hospital.



The Stroke Diagnostic Bundle shows sustained improvement and continued performance above the national average. Plans to improve this further include a refresher training in the Key Skills programme, the procurement of an electronic Clinical Audit system that will give individual clinicians and their managers access to performance data and changes to our paper and electronic patient records to discourage documentation omissions.

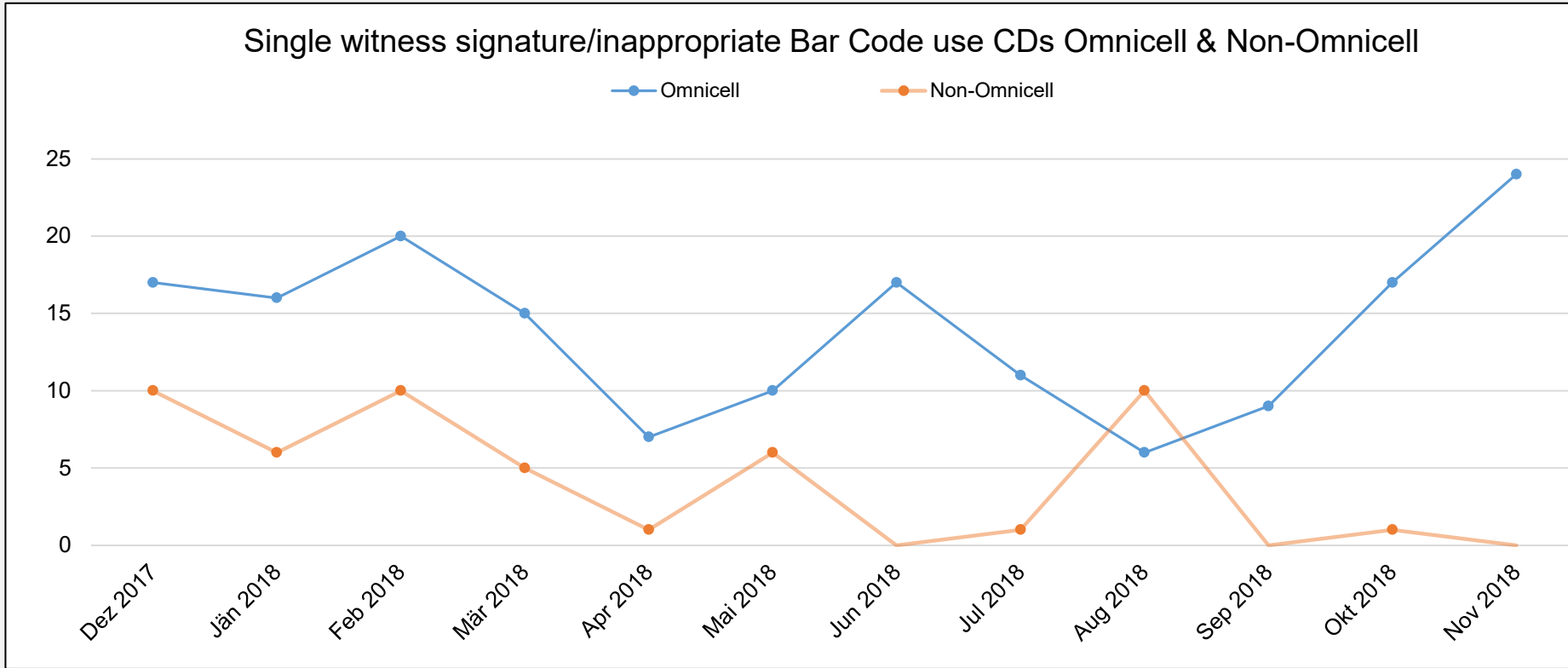


79 medicines incidents recorded in November 2018. This is a reduction on previous months. Staff are encouraged to report medicines incidents. There are still incidents occurring where staff take Controlled Drugs home at the end of their shifts. Eight incidents were reported in November 2018 around this activity. A process is in place to ensure the drugs are returned without delay, and medicines team are monitoring trends in this area. There was 15 CD breakages recorded for the month of November. 31 of the incidents reported were in relation to medicines pouches and incorrect tagging, missing medicines or incomplete pouch paperwork. This is currently under reported by staff. There was 2 incidents reported in November where medicines were not available for our patients due to incorrect tagging of pouches.

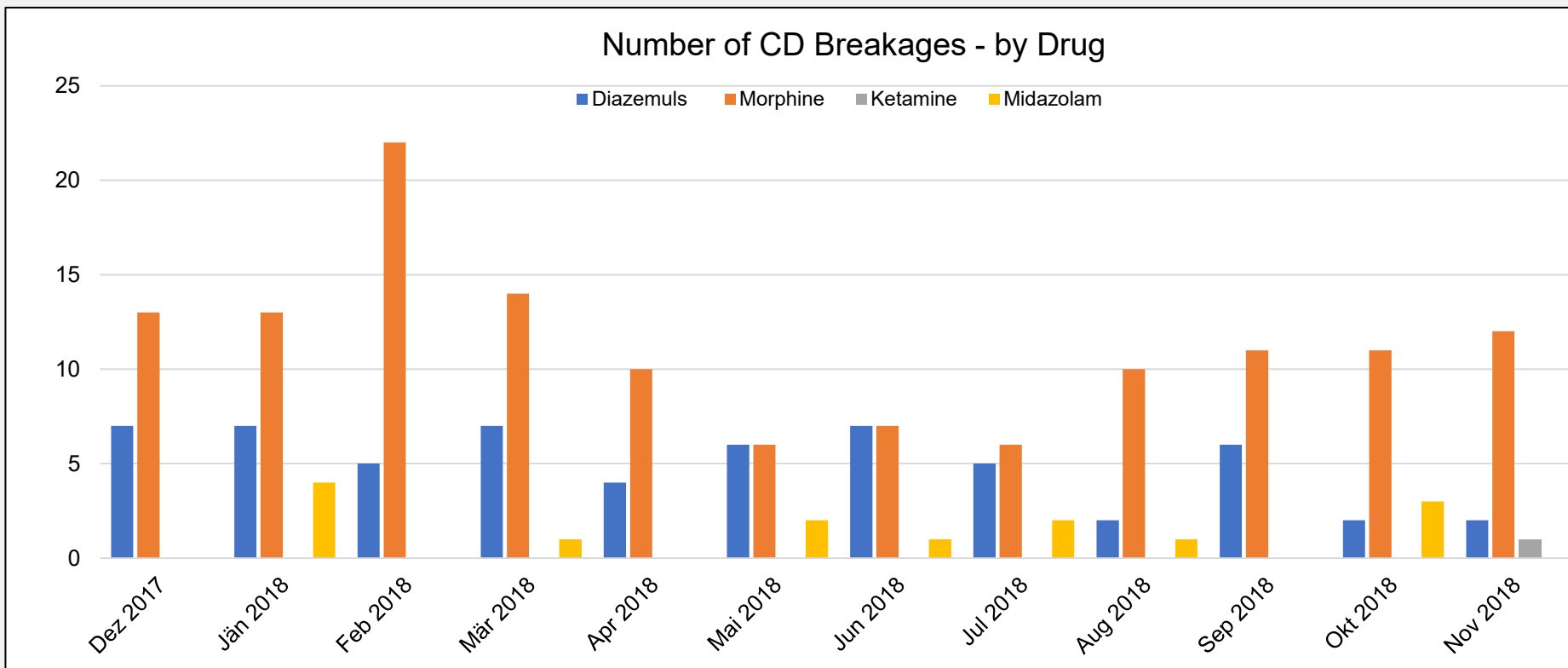


This relates to graph above. SOP compliance around CDs continues to be reported well. Tagging errors, breakages and incomplete paperwork with medicines pouches continue to be reported by operational staff, however it is under reported. More work is required around encouraging staff to report more and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

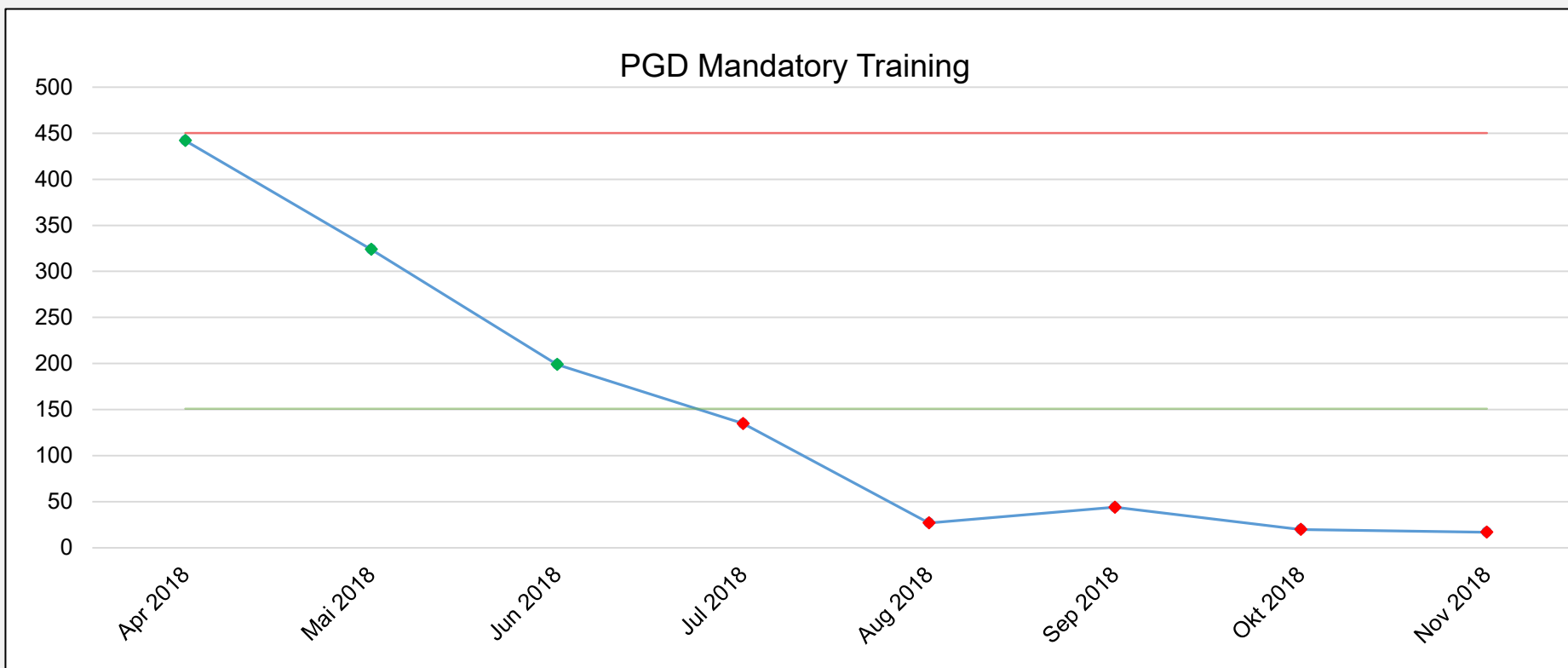
SECamb Clinical Safety Charts



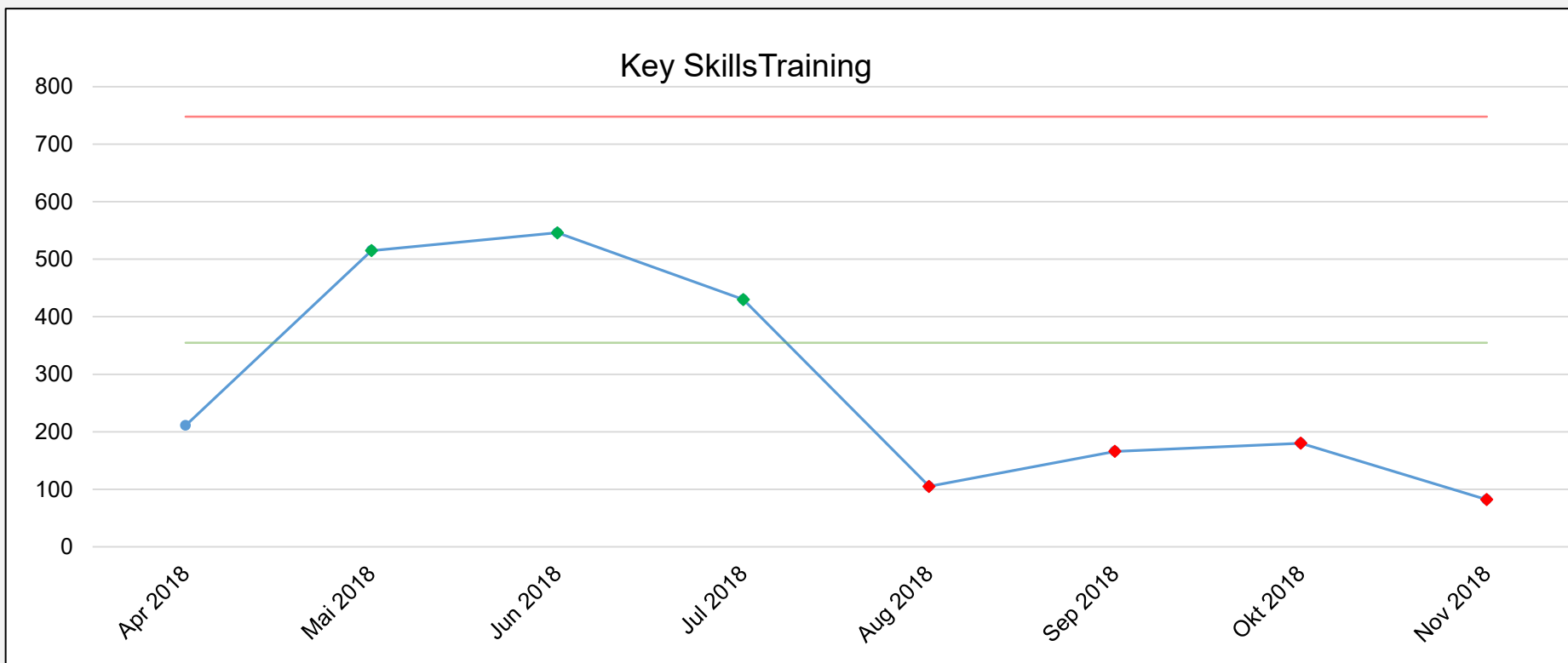
Weekly reports from the medicines governance team are sent to the OTLs on Omnicell sites to confirm the single signature is authorised. Medicines Governance Team rely on the OTLs reporting on this CD activity for non-Omnicell sites. OTLs are encouraged to complete a DIF1 for all unauthorised single CD signatures. The Trust is seeing improvement in the use of single signatures as operational sites look to reduce this activity



As a Trust we have seen significant improvement in CD breakages. All CD breaks are reported via DIF1 and CD registers updated. Midazolam and ketamine are only available to CCPs whereas morphine and diazemuls are used by all Paramedics. November 2018 saw 15 CD breakages. Breakages occurred in the following areas. 8 broken during issue/return, 4 dropped accidentally and 3 shattered whilst opening



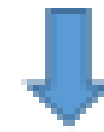
Total headcount PGD Mandatory Training completed to date (1208) 85.13%



Total headcount Key Skills Training completed to date (2235) 70.71%

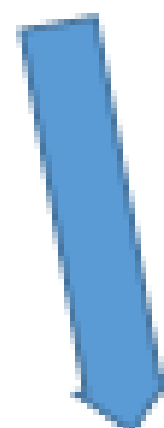
Analysis of Cardiac Arrest Data – July 2018

Total number of cardiac arrests identified = 560



Number of resuscitation attempts = 219
excluding DNACPR 81, DOA 251, No Resus by SECamb 5,
 Post arrest 1, ADRT 3

Utstein definition
 Bystander witnessed
 Presenting rhythm VF
 Cardiac in origin



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

Cardiac Arrests (Utstein incidents) = 31 (14%) Cardiac Arrests (All incidents) = 219 (100%)

Utstein
 = 14 (46.7%) + 1 non ROSC

ROSC sustained to hospital (All) = 63
 (28.8%) + 8 non ROSC

Outcomes for ROSC at hospital and non ROSC at hospital patients		
Utstein	Details	Overall
8	Patient survived to discharge	18
5	Patient died in hospital	48
0	Patient still in hospital*	0
2	Outcome unknown (Patient identifiable data incomplete)	5

Survival to discharge is calculated as a percentage of the Overall or Utstein figures

minus any incident missing patient outcomes (as detailed * above)

Survival to Discharge (Utstein) = 8 (28.6%)

Survival to Discharge (All) = 18 (8.4%)

Additional Information – Resuscitation Attempts

Cardiac Rhythm	Overall Totals	ROSC at Hospital	Non ROSC at Hospital
Asystole	113 (52%)	19	5
PEA	48 (22%)	11	1
VF	50 (23%)	28	1
Non-shockable	0 (0%)	0	0
Not recorded	8 (3%)	5	1

CPR Bystander - 131

EMS Witnessed arrest - 27

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

Analysis of Cardiac Arrest Data by area - July 2018

Number of resuscitation attempts = 219

Cardiac Arrests (Utstein) East = 20 (9%)
Cardiac Arrests (Utstein) West = 10 (5%)

Cardiac Arrests (All) East = 123 (56%)
Cardiac Arrests (All) West = 96 (44%)

ROSC sustained to hospital (Utstein) East = 9 (45%) + 0 non ROSC
ROSC sustained to hospital (Utstein) West = 5 (50%) + 1 non ROSC

ROSC sustained to hospital (All) East = 35 (28%) + 4 non ROSC
ROSC sustained to hospital (All) West = 27 (28%) + 4 non ROSC

Outcomes for ROSC at hospital and non ROSC at hospital patients

Area	Utstein	Details	Overall
East	6	Patient survived to discharge	13
West	2		5
East	2	Patient died in hospital	23
West	3		25
East	0	Patient still in hospital*	0
West	0		0
East	1	Outcome unknown* (Patient identifiable data incomplete)	3
West	1	Outcome unknown* (Patient identifiable data incomplete)	2

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

Survival to Discharge (Utstein) East = 6 (32%)
Survival to Discharge (Utstein) West = 2 (22%)

Survival to Discharge (All) East = 13 (11%)
Survival to Discharge (All) West = 5 (5%)

Mental Health Care (November 2018 data)

Rag Ratings:

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

Overall RAG Rating = 

The mental health indicator has been rated **GREEN** as the mean response measures are **on balance** within Cat 2 standard.
 Cat 2 = 00:18:50
 90th Centile= 00:39:31

Mental Health Response Times (Section 136 MHA)

During November 2018 there were 120 Section 136 related calls to the service. 110 (91.6%) of these calls received a response (compared to 86.3% in October) resulting in a conveyance to a place of safety by an ambulance of 104 calls (86.6%) (compared to 82.5% in October) on these occasions.

The overall performance mean shows a response time across the service as 00:18:55 for November (October 00:18:50). Against the 90th centile measure, the response was 00:38:27 (October was 00:39:31).

There were 3 transports of under 18's in November (7 during October).

There were 10 occasions when SECAmb did not provide a response. This is down from 18 in October. This report RAG rates against **both** mean ARP standards within Cat 2; these being 18 minutes and the 90th percentile within 40 minutes. The report also details conveyances measured under Cat 3, Cat 4, C60 HCP, C120 HCP and C240 HCP (these are likely to be secondary conveyances and are not RAG rated) and these are as follows:

Cat 3:	Total calls 3	Total responses 3	Total transports 2
	Performance Mean 00:00:24.41	90 th centile 00:36.12	
Cat 4:	Total calls 0	Total responses 0	Total transports 0
C60 HCP:	Total calls 6	Total responses 2	Total transports 1
	Performance Mean 00:31:29	90 th centile 00:42:43	
C120 HCP:	Total calls 0	Total responses 0	Total transports 0
C240 HCP:	Total calls 0	Total responses 0	Total transports 0

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

Quality and Patient Safety Report :

Unreconciled Clinical Records: Improvements made in the number of unreconciled incidents have been sustained, but has plateaued at circa 11% unreconciled each month. Procurement for an IT solution that will improve this figure has commenced.

Medicines compliance to safe and secure handling weekly audits by Operational Team Leaders (OTLs) for ranged between 79% and 100% on station sites for November 2018. The Trust average for compliance was 94.04%. Eleven stations achieved 100% each week for November. 5 sites missed a weekly report in November. The monthly audits have remained at 100% for those submitted by the OUMs. Compliance for the monthly checks was 93%.

Infection Prevention Control: Hand Hygiene (HH) compliance was above the compliance target this month at 94%, which is due to the new 3R's for hand hygiene procedure and staff understanding of it compared to the Five Moments for Hand Hygiene previously used. Clinically Ready was also above target again for the month at 97%. A total of 302 audits were carried during the month compared to 235 last month. Make Ready Centre (MRC) and Vehicle Preparation programme (VPP) Deep Clean rates were both fell below the 99% target for the month and VPP was only 88% with Surrey West only achieving 73% completion. Polegate MRC was very low at 53% due to staffing issues. Infection Prevention and Control (IPC) Level 2 training showing as below the monthly target of 91% this month and currently stands at 82%. Environmental Cleanliness audit completion was 80% for the month, so we still need to improve on the monthly completion rates. The IPC Lead will email all areas and ask that these audits are completed for November. Compliance was 77% against the 85% target. The IPC and Estates Team continue to hold a monthly meeting with the contractors to discuss any concerns raised locally in regard to cleaning standards.

Safeguarding referral rates continue to increase (currently a 8% increase compared to December 2017). Training on Level 2 child safeguarding for all operational staff is 79.19% and for Level 2 adult safeguarding (both e-learning) is 80.14% (increased from 58% in July).

Incidents: There have been 31 more incidents in this reporting period. The additional reporting being undertaken to track tail audit data in relation to not sending ambulance resources has generated a number of incidents which have increased reporting in the past month. Reporting is reaching levels similar to those reported under the winter pressures of 2017-2018. Incident reporting remains above the 20% increase in incidents that the Trust has set itself under the improvement plan. Backlogs associated with allocation to an investigator continue to increase with 177 now over due. The Datix department is working with the Quality Improvement Hub to reduce the number of overdue incidents in this area which has mainly been effected by the high number of tail audit incidents not being moved to being investigated. The deadline for completion of investigations is 20 working days. The figure has stabilised at around 216 in November 2018.

Serious Incidents (SIs) and Duty of Candour (DoC): 12 SIs were reported in November (2 in October). 52 SIs were open on STEIS at the end of November (56 in October). A decrease to 23 (from 27 in October) were overdue for first submission to the CCG. 13 incidents were submitted for review at the monthly closure panel, 6 incidents were closed overall in November. The Trust achieved 100% compliance with DoC requirements for SI's. 100% compliance was also achieved for DoC made/attempted within deadline.

Patient Experience: The Trust received and opened 79 complaints in November, a substantial drop from the 94 received in October and against a monthly average for the year of 95 (01/12/17 to 30/11/18). There were 93 complaints closed, with 59% upheld in some way. The top three complaint subjects were staff behaviours where complaints increased to 38 from 21 in October; timeliness where there was also an increase from 18 to 21; however, patient care decreased from 35 to 29. Falls continues to be the top theme with 16 complaints reported, a slight decrease from October when 17 were reported. Complaints response timeliness performance since the end of January continues, with 97% responded to within the Trust's 25 working day timescale this month. November saw an increase in compliments received 159 against 133 in October, this is above the usual monthly trend of circa 130-140.

STEMI Care Bundle performance for July is at 69.4% (from 75%), which continues below the national YTD average of 76.4%. Stroke Diagnostic Bundle performance is now above the national average (97.1%) at 97.9%.

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

Number of Incidents Reported

	Sep-18	Oct-18	Nov-18	12 Months
Actual	837	716	762	
Previous Year	585	615	665	

Number of Incidents Reported that were SI's

	Sep-18	Oct-18	Nov-18	12 Months
Actual	8	2	12	
Previous Year	11	6	4	

Duty of Candour Compliance (SIs)

	Sep-18	Oct-18	Nov-18	12 Months
Actual %	100%	100%	100%	
Target	100%	100%	100%	

Number of Complaints

	Sep-18	Oct-18	Nov-18	12 Months
Actual	74	96	79	
Previous Year	132	129	107	
Complaints Timeliness (All)	98.8%	92.9%	97.0%	
Timeliness Target	95%	95%	95%	

Compliments

	Sep-18	Oct-18	Nov-18	12 Months
Actual	150	133	159	

Hand Hygiene

	Sep-18	Oct-18	Nov-18	12 Months
Actual %	89%	94%	97%	
Target	90%	90%	90%	

Safeguarding Training Completed (Adult) Level 2

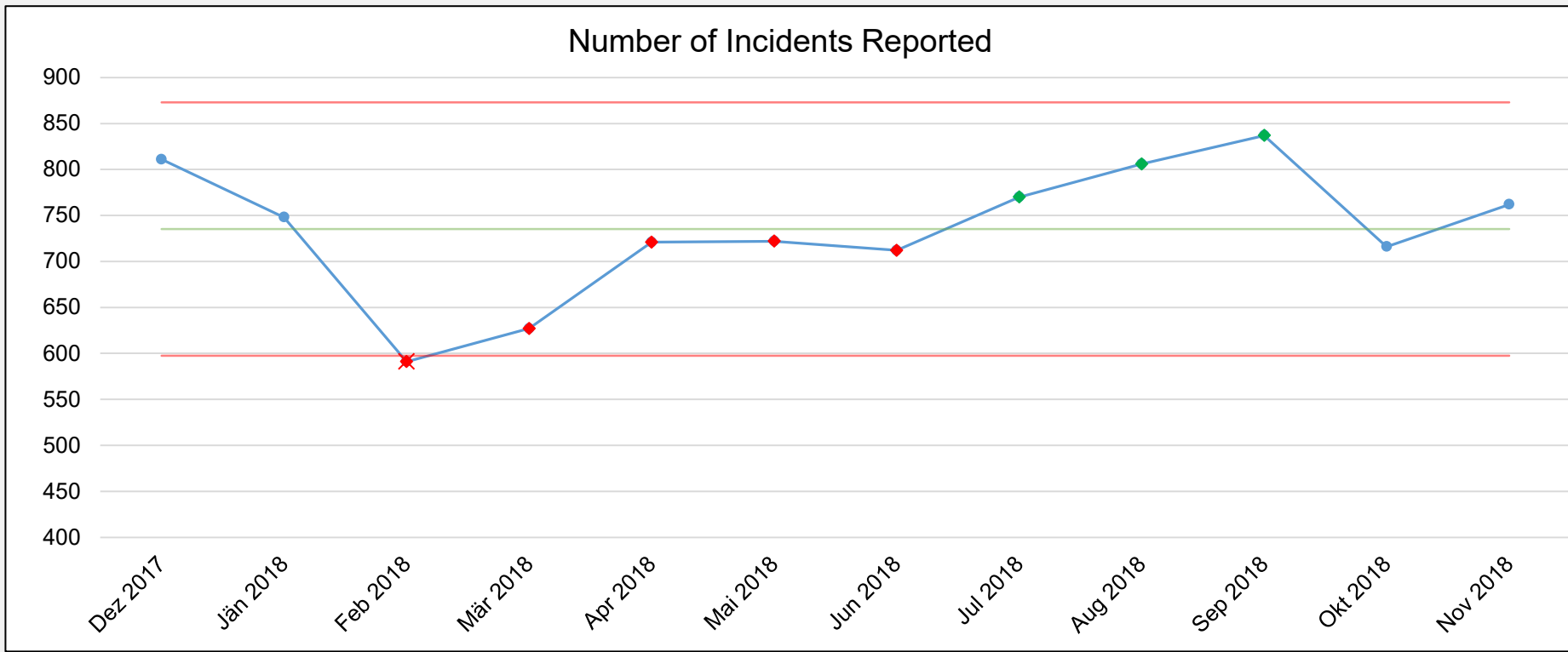
	Sep-18	Oct-18	Nov-18	12 Months
Actual %	77.07%	80.52%	80.14%	
Previous Year %	45.22%	50.82%	55.55%	
Target	85%	85%	85%	

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

Safeguarding Training Completed (Children) Level 2

	Sep-18	Oct-18	Nov-18	12 Months
Actual %	76.20%	79.30%	79.19%	
Previous Year %	46.62%	50.00%	54.70%	
Target	85%	85%	85%	

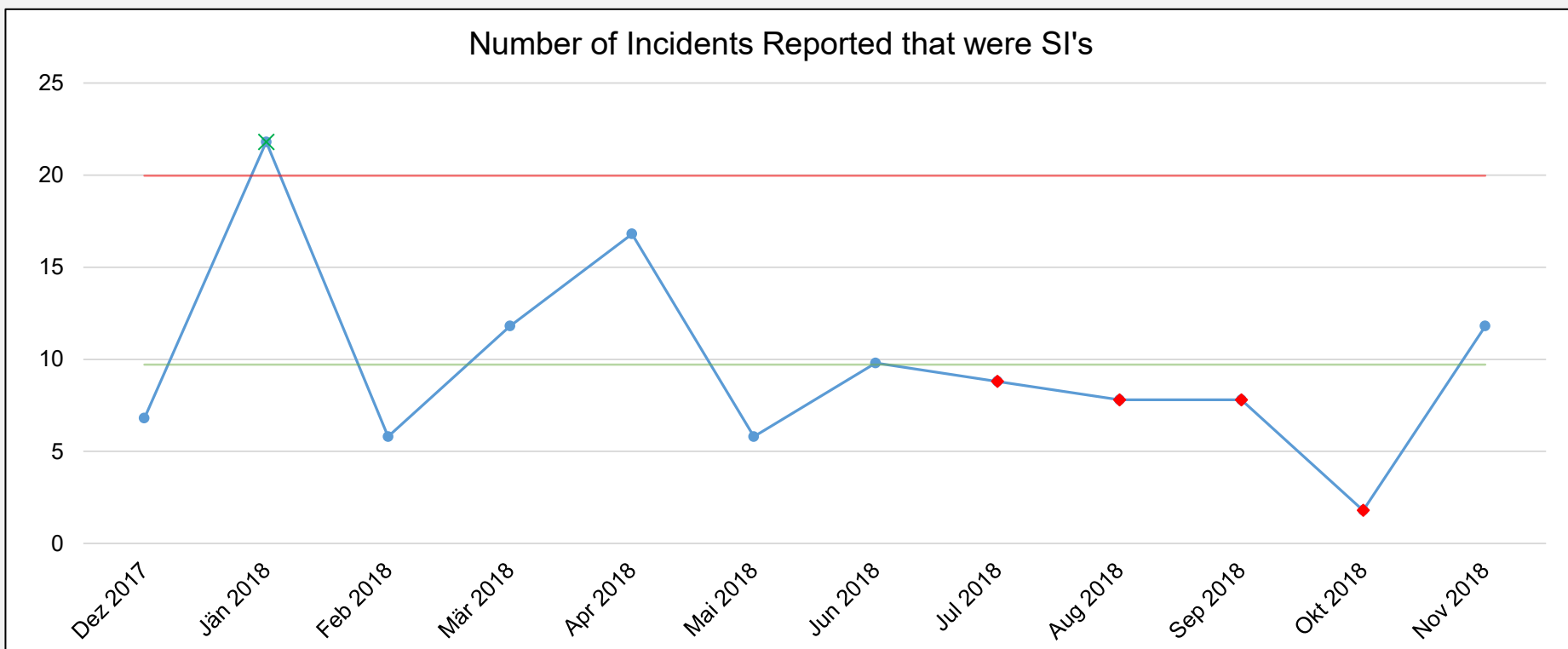
SECAmb Clinical Quality Charts



762 incidents were reported in November. 69 incidents were reported by EOC Clinical with the majority of these being around SMP no send audits. These are compiled for any audit that scores 10 or above.

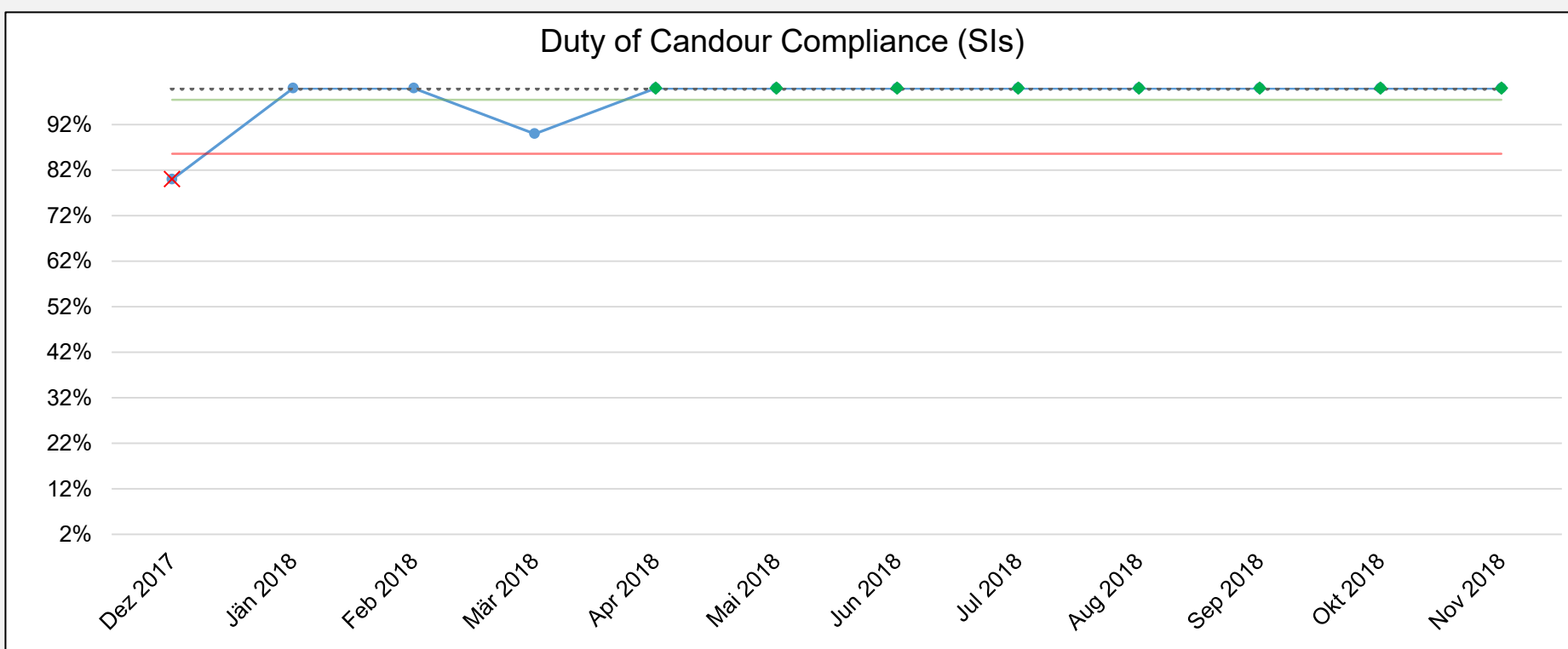
Other notable incidents are around meals breaks and delayed initial resources. In previous months, blue light audits have made up a good proportion of the reports. These were discontinued in November, due to ineffective reporting.

The organisation met the target of 96% of incidents being reported as no/low harm.



12 Serious Incident were reported in November.

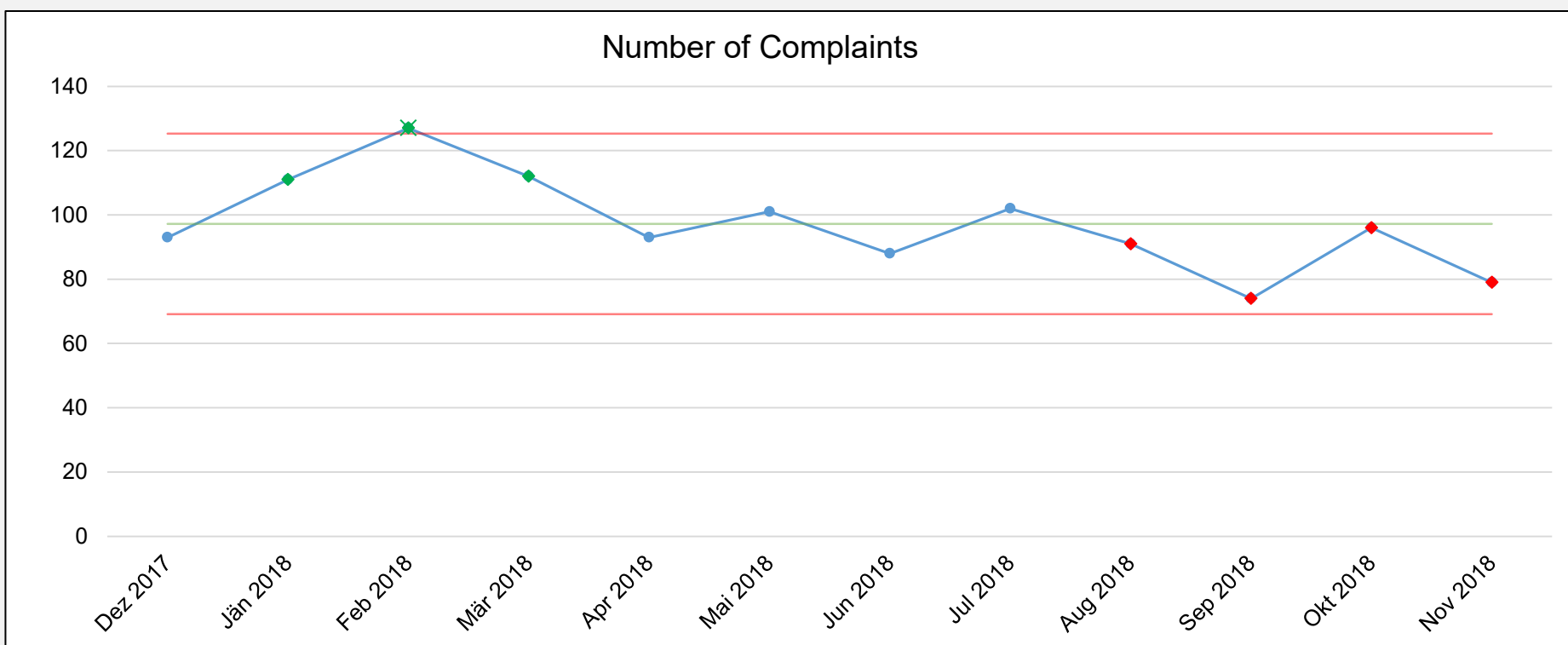
- 5 x Patient Care
- 3 x Timeliness / Delay
- 1 x Attendance Delay
- 1 x EOC Systems
- 1 x Incident affecting Trust
- 1 x Incident affecting Patient/Service User



Compliance with Duty of Candour (DoC) for SIs where DoC was required in November 2018 is: (due in the month)

- SI's reported (where DoC due in November) - 5
- Number where DoC required - 5
- DoC made/attempted within deadline - 5 (100%).

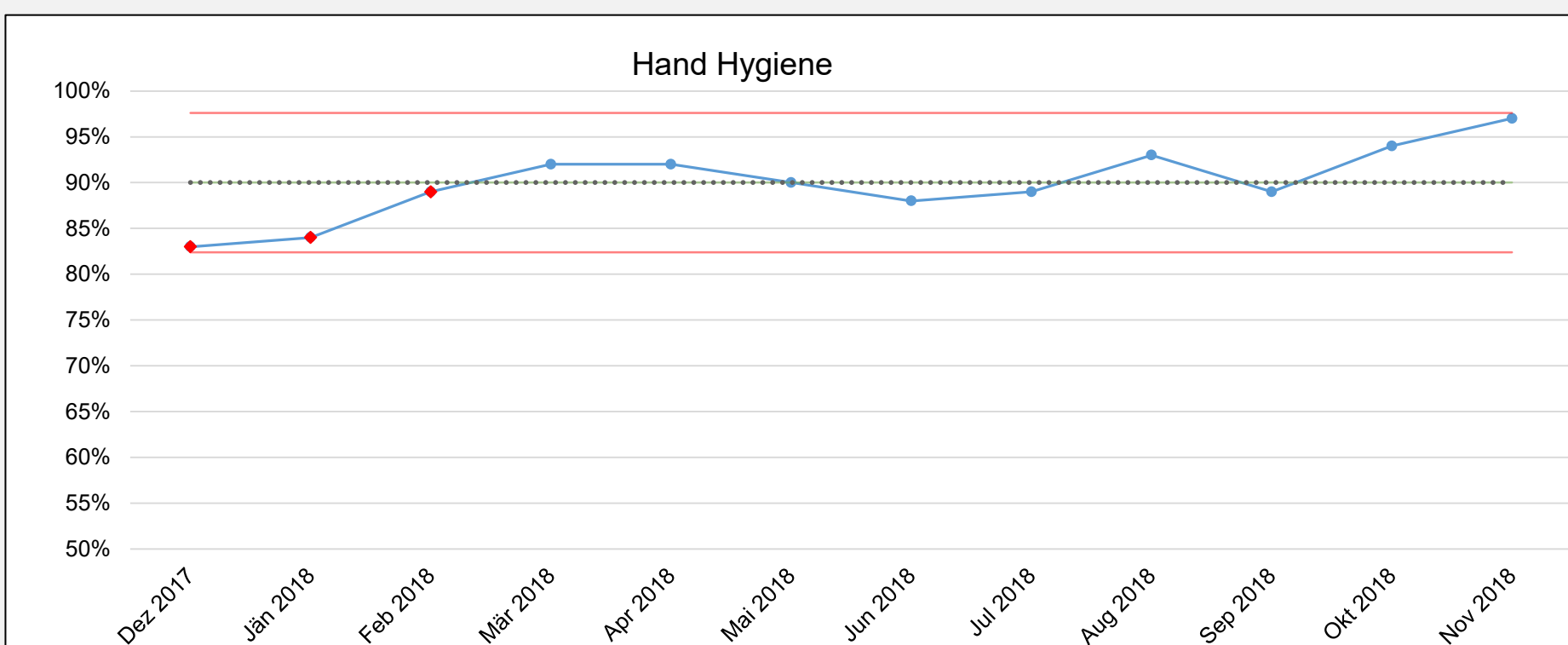
The organisation met the target of 100% of DoC being completed within the 10 working day time scale.



The Trust received and opened 79 complaints in November, a substantial drop from the 94 received in October and against a monthly average for the year of 95 (01/12/17 to 30/11/18).

There were 93 complaints closed, with 59% upheld in some way. The top three complaint subjects were staff behaviours where complaints increased to 38 from 21 in October; timeliness where there was also an increase from 18 to 21; however, patient care decreased to 35 from 29. Falls continues to be the top theme with 16 complaints reported, a slight decrease from October when 17 were reported.

Complaints response timeliness performance since the end of January continues, with 97% responded to within the Trust's 25 working day timescale this month.



November has seen a rise in the number of Hand Hygiene audits completed as well as our best compliance % for the year. The Infection Prevention Team are now able to schedule in more local visits to speak to frontline staff about all IP related issues.

The verified data is not available for this report; it will be included in the next report.

The Health and Safety improvement plan is progressing well. Progress of the improvement plan is monitored every 2 weeks at our Quality Compliance Steering group. In addition to this a Task and Finish group meet every 2 weeks to review progress. The task and finish group consist of key internal stakeholders that contribute to the overall plan.

The Health & Safety team are preparing three new E-learning modules which will be available in April 2019.

Module 1 is a revised version of standard Health & Safety training for all employees.

Module 2 is a Risk Assessment training package which will further assist our Managers.

Module 3 is a specific training package for our fleet staff and is tailored around key hazards which are present in workshop environments.

The annual Health & Safety audit programme has been implemented. The Health & Safety team will undertake a minimum of 10 audits per month. The audit data will become an agenda item for discussion at our Central Health & Safety group meetings.

Violence and Aggression Incidents - See Figure 1 below

Violence and Aggression incidents reported in November were 54 this is an increase of 17 incidents from the previous month. November 2018 Violence and Aggression incidents are a similar amount when comparing to November 2017 V&A incidents.

Manual handling Incidents - See Figure 2 below

Manual handling incidents reported in November were 20 which is a decrease of 2 incidents from the previous month.

Health & Safety Incidents - See Figure 3 below

Health and Safety incidents reported in November were 32 which is a decrease of 7 incidents from the previous month.

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

RIDDOR incidents reported in November were 10 with 5 incidents reported late to the Health & Safety Executive. The internal incident forms were completed late at local level which resulted in the late reports to the HSE. Further improvement work is required to educate our workforce in the requirements to comply with the RIDDOR regulations.

Figure 1

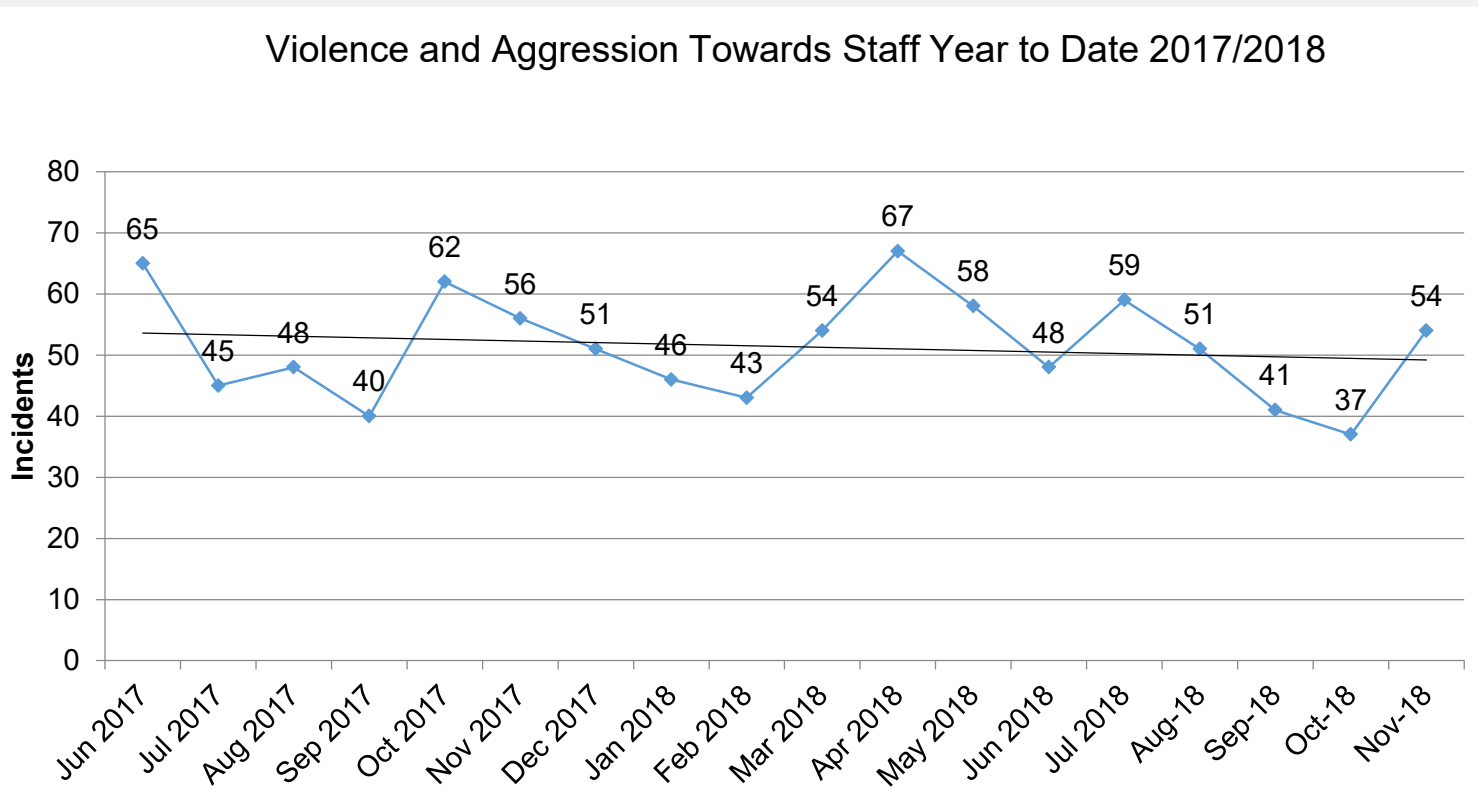


Figure 2

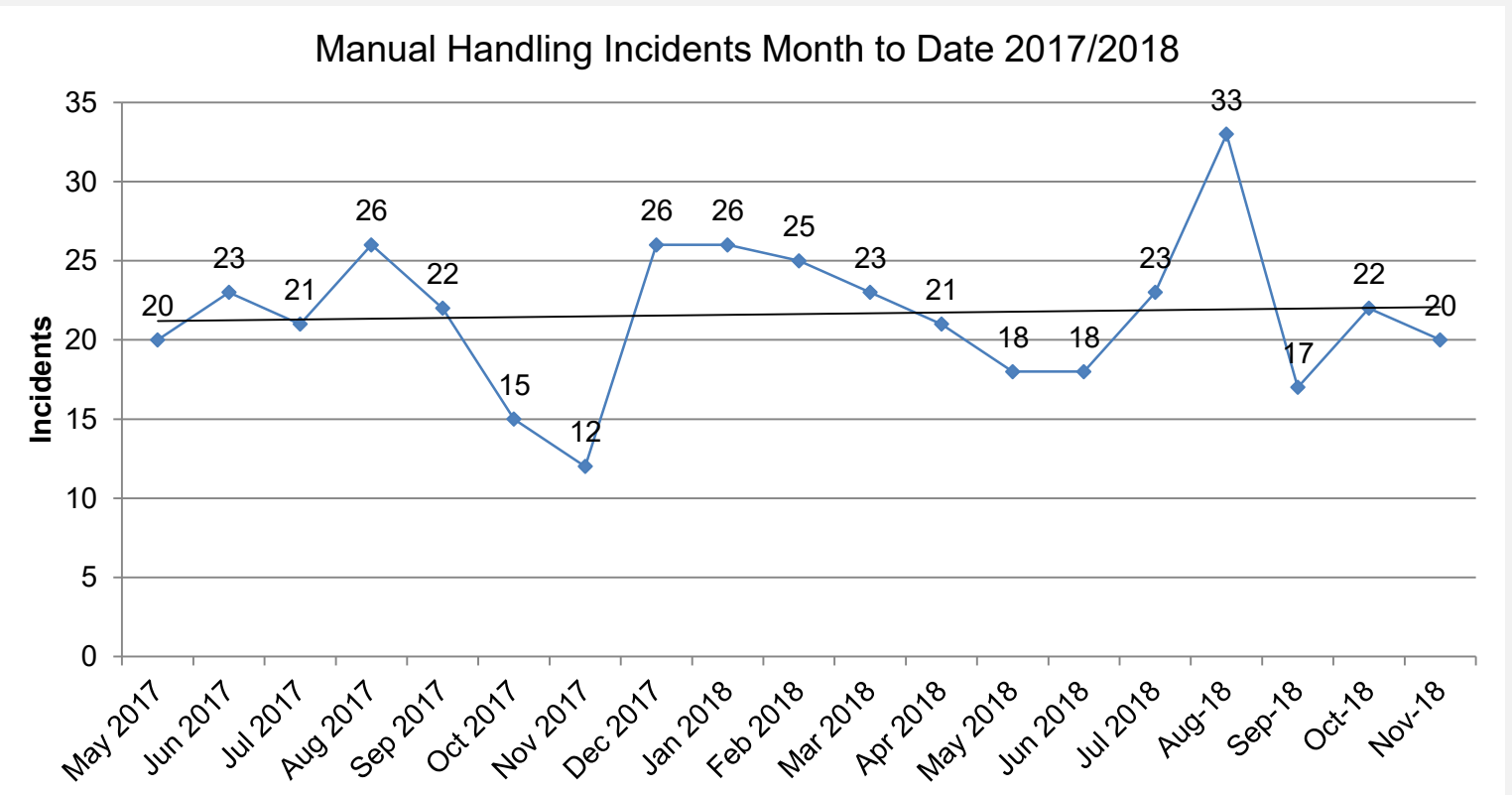


Figure 3

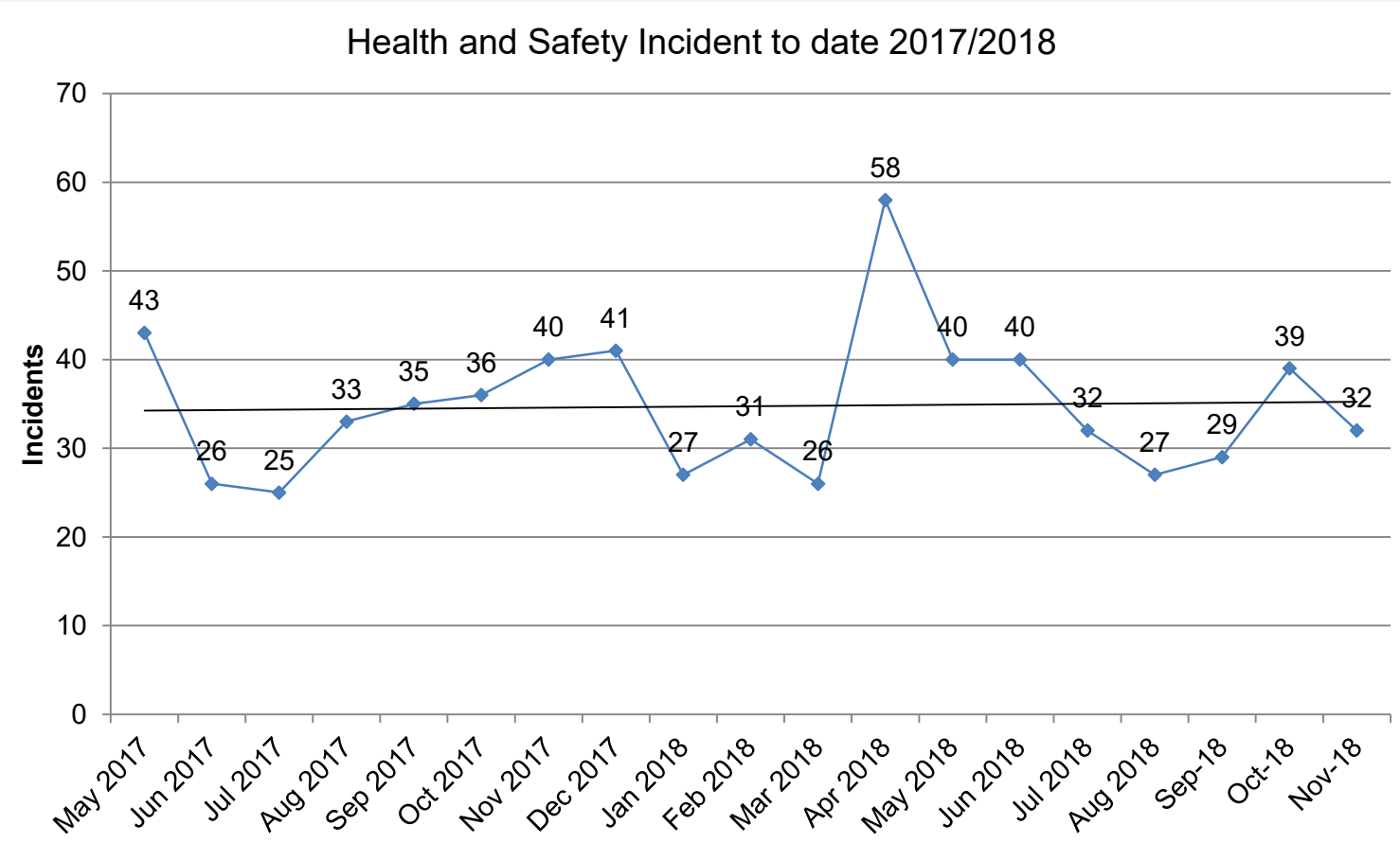
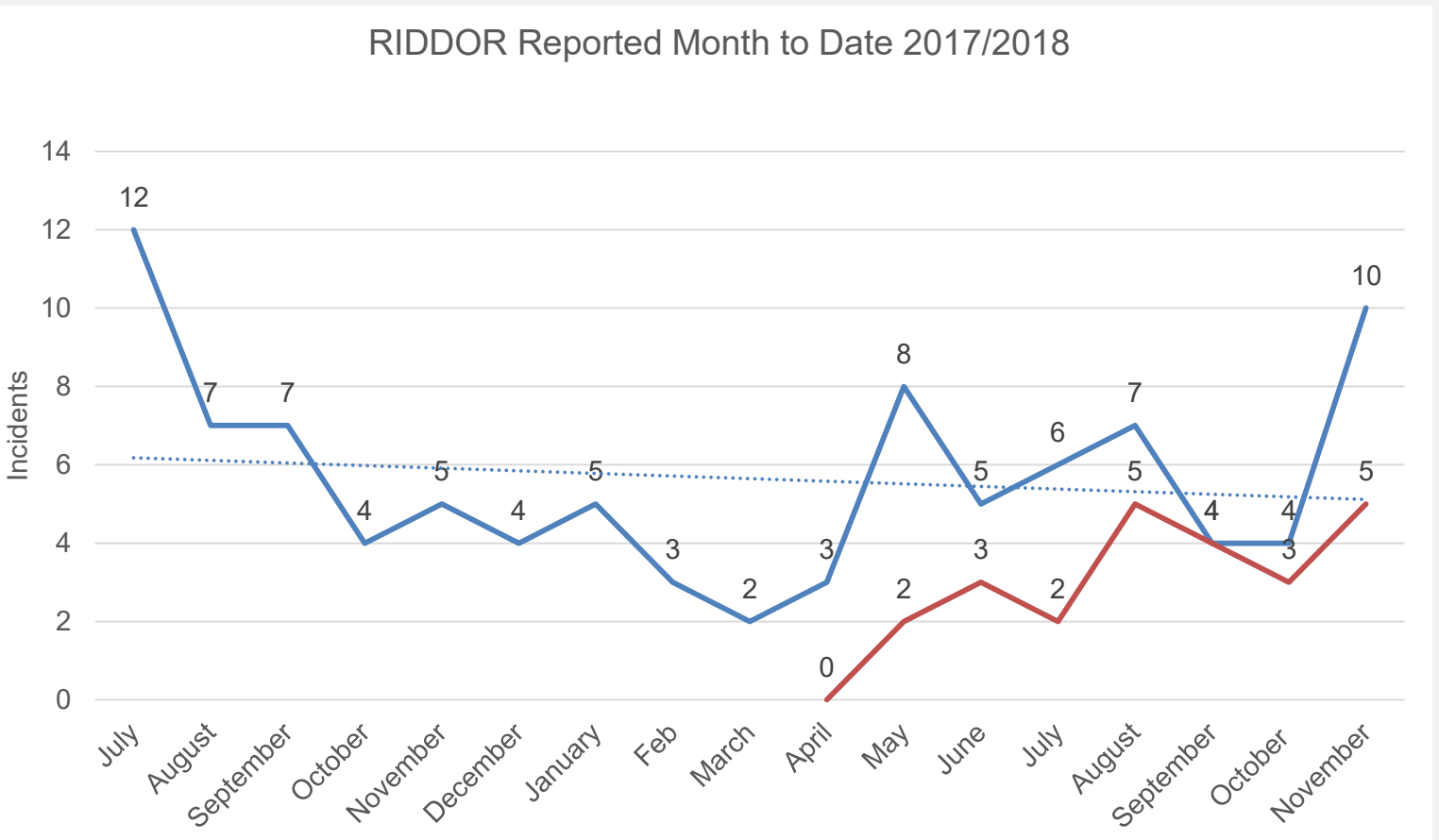


Figure 4



Call Handling

	Sep-18	Oct-18	Nov-18	12 Months
5 Sec Performance (95% Target)	81.8%	85.5%	89.4%	
Mean Call Answer Time (secs)	15	12	8	
95th Centile Call Answer (Secs)	88	71	43	
National Mean Call Answer	8	7	6	
National 95th Centile Call Answer	45	42	36	

Category 1 Performance

	Sep-18	Oct-18	Nov-18	12 Months
Mean (00:07:00)	00:07:41	00:07:30	00:07:31	
90th Percentile (00:15:00)	00:14:13	00:13:56	00:13:59	
Mean Resources Arriving	1.71	1.71	1.73	
Count of Incidents	3385	3458	3536	
National Mean	00:07:20	00:07:13	00:07:11	

Category 1T Performance

	Sep-18	Oct-18	Nov-18	12 Months
Mean (00:19:00)	00:10:12	00:10:23	00:09:50	
90th Percentile (00:30:00)	00:18:54	00:19:40	00:18:35	
Mean Resources Arriving	1.77	1.74	1.73	
Count of Incidents	2101	2201	2183	
National Mean	00:11:31	00:11:15	00:11:11	

Category 2 Performance

	Sep-18	Oct-18	Nov-18	12 Months
Mean (00:18:00)	00:19:15	00:19:24	00:19:24	
90th Percentile (00:40:00)	00:36:01	00:36:36	00:36:44	
Mean Resources Arriving	1.12	1.12	1.11	
Count of Incidents	28425	29905	31036	
National Mean	00:21:41	00:21:17	00:21:56	

Category 3 Performance

	Sep-18	Oct-18	Nov-18	12 Months
Mean	01:25:30	01:21:35	01:23:05	
90th Percentile (02:00:00)	03:12:40	03:10:21	03:13:49	
Mean Resources Arriving	1.06	1.07	1.07	
Count of Incidents	19521	19964	20242	
National Mean	01:02:28	01:00:30	01:03:16	

Category 4 Performance

	Sep-18	Oct-18	Nov-18	12 Months
Mean	01:51:08	01:59:04	01:50:32	
90th Percentile (03:00:00)	04:06:21	04:38:29	04:12:29	
Mean Resources Arriving	1.05	1.05	1.01	
Count of Incidents	774	781	813	
National Mean	01:24:15	01:23:41	01:25:38	

Health Care Professional

	Sep-18	Oct-18	Nov-18	12 Months
HCP 60 Mean	01:31:07	01:46:00	01:37:18	
HCP 60 90th Percentile	03:01:22	04:02:54	03:43:06	
HCP 120 Mean	02:10:59	02:12:48	02:09:16	
HCP 120 90th Percentile	04:35:17	04:42:46	04:39:12	
HCP 240 Mean	03:19:34	02:46:04	03:10:25	
HCP 240 90th Percentile	07:03:18	06:00:05	06:14:14	

Call Cycle Time

	Sep-18	Oct-18	Nov-18	12 Months
Avg Allocation to Clear at Scene	01:15:22	01:14:59	01:15:54	
Avg Allocation to Clear at Hospital	01:46:07	01:46:10	01:46:56	
Handover Hrs Lost at Hospital (over 30mins)	4138	4413	4312	
Number of Handovers >60mins	361	430	427	

Incident Outcome AQI

	Sep-18	Oct-18	Nov-18	12 Months
Hear & Treat	5.7%	5.6%	5.4%	
See & Treat	33.5%	32.4%	32.8%	
See & Convey	60.8%	62.0%	61.6%	

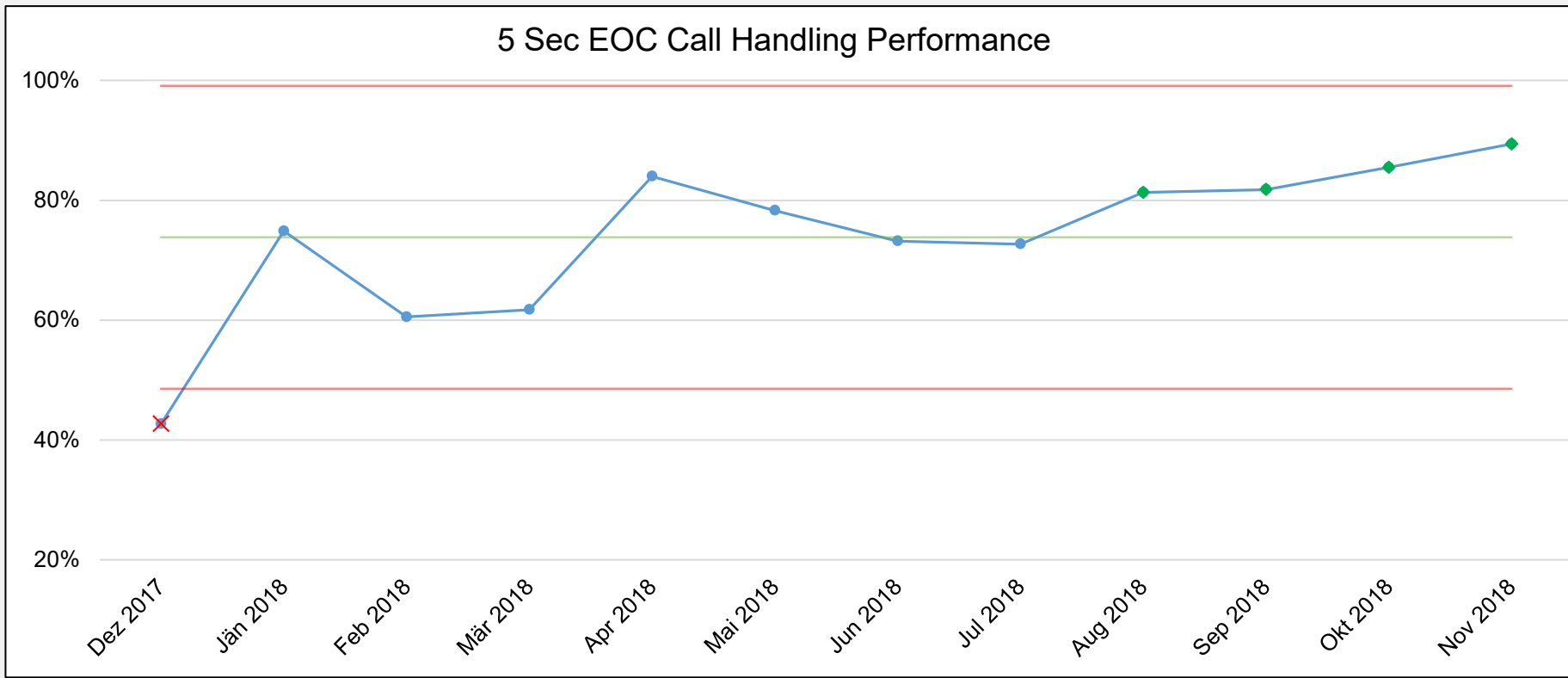
Community First Responders

	Sep-18	Oct-18	Nov-18	12 Months
Volume of Incidents Attended	1450	1385	1418	

Demand/Supply AQI

	Sep-18	Oct-18	Nov-18	12 Months
Calls Answered	63200	63761	63111	
Incidents	57222	59471	60863	
Transports	34788	36870	37595	

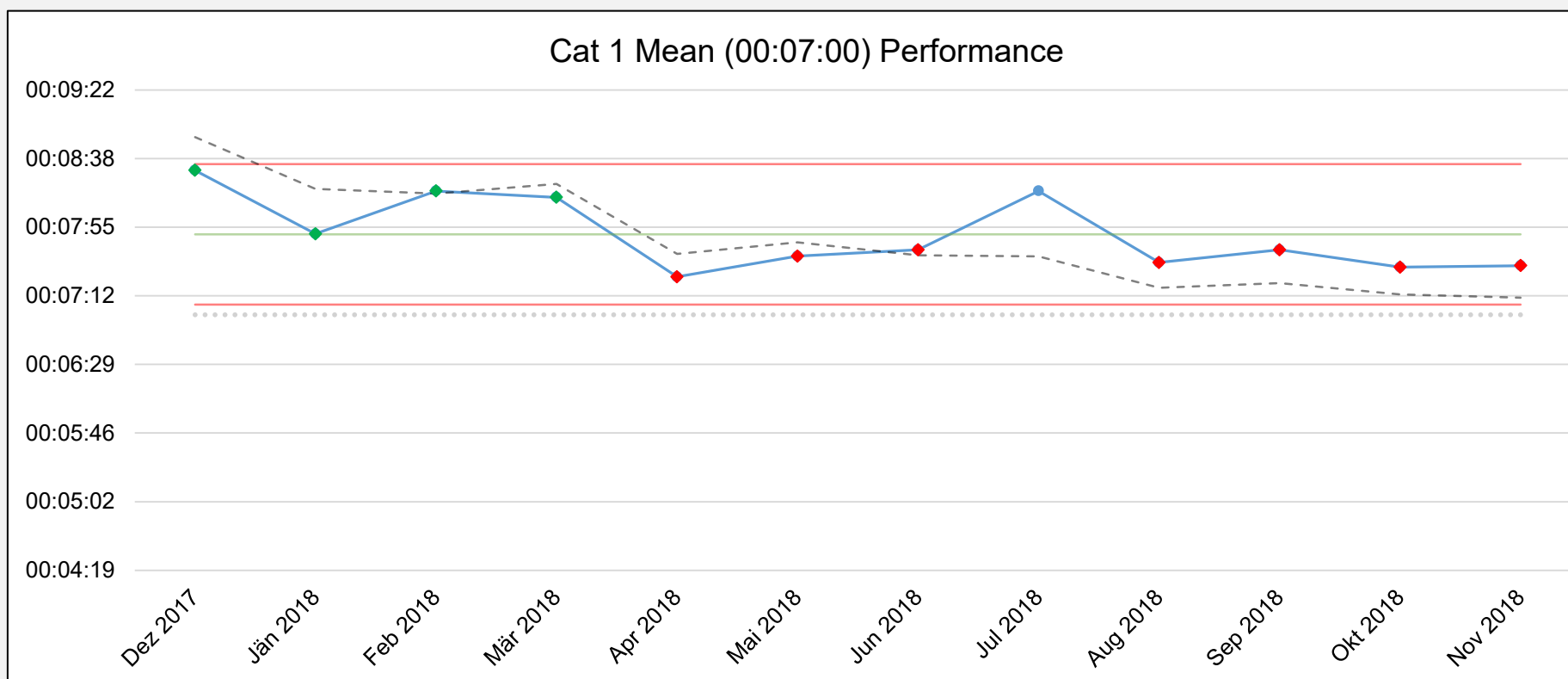
SECAmb 999 Operations Response Time Performance Charts



Call answering performance for November continues on an upward trajectory in performance with an average of 89% and the highest average since the introduction of ARP. This is the fourth consecutive month of improved performance.

The volume of duplicate calls regarding ETA of responses continues to make a significant contribution to increased call volumes. Abstraction rates continue to be scrutinised to deliver maximum unit hours, with the planned reduction in annual leave being commenced.

Call answer performance is covered in detail in the EOC action plan that is tracking the actions of the EOC task and finish group.

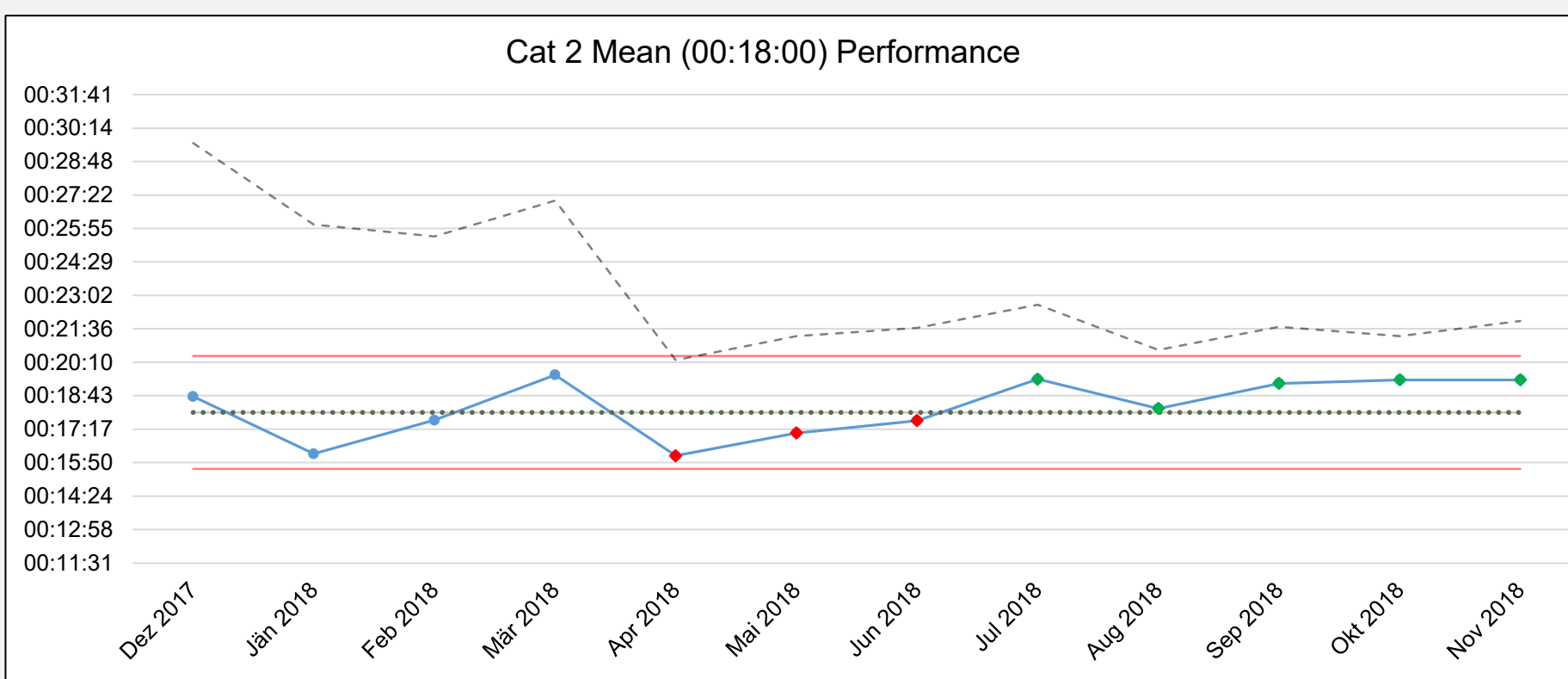


As shown in the graph the Cat 1 mean response performance remained static during October and November.

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

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

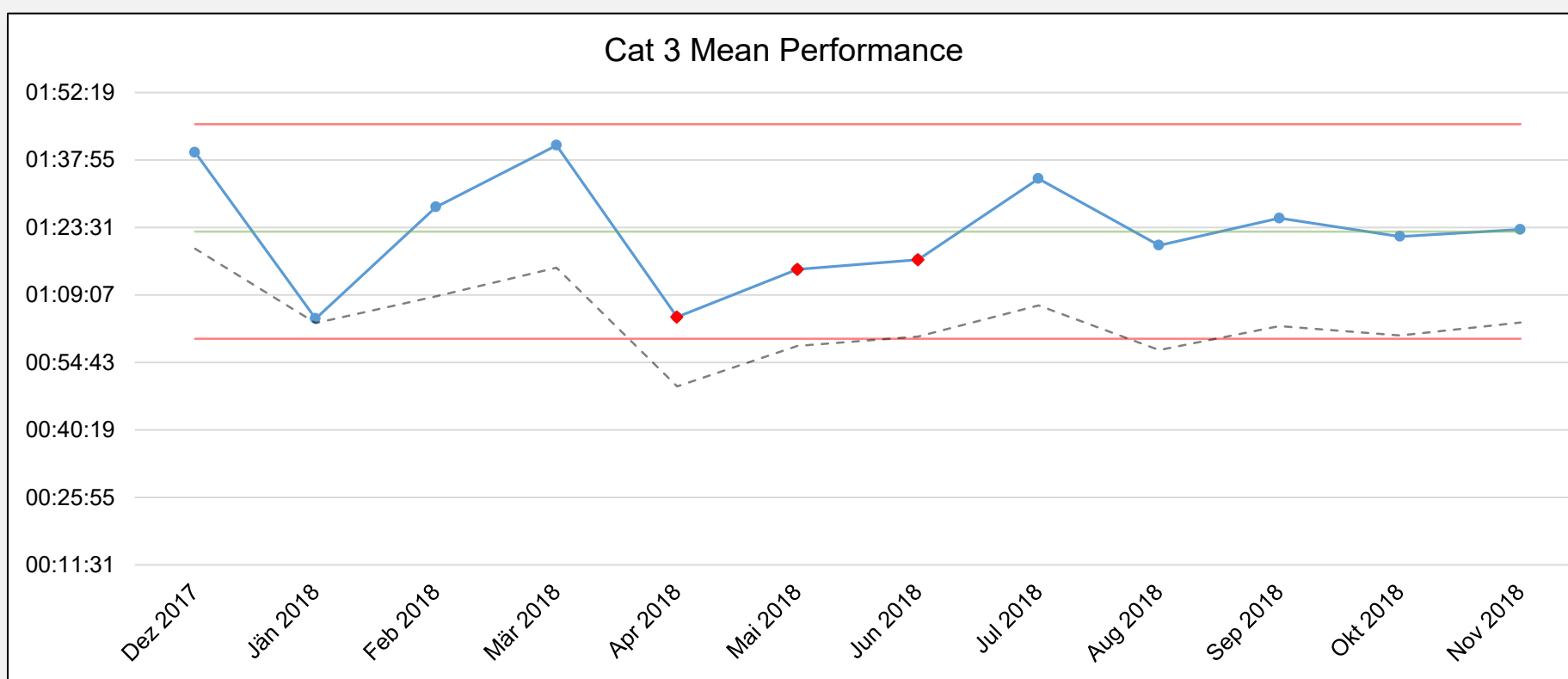
----- National Mean



November Cat 2 Mean Performance was 19.24, (the same as October) with a further increase of over 1400 incidents over the month. Performance remains significantly above mean National Performance by 2.32 minutes.

The improvement in performance can be in part attributed to the increase in the number of new front line staff joining the trust and a direct improvement in operational hours.

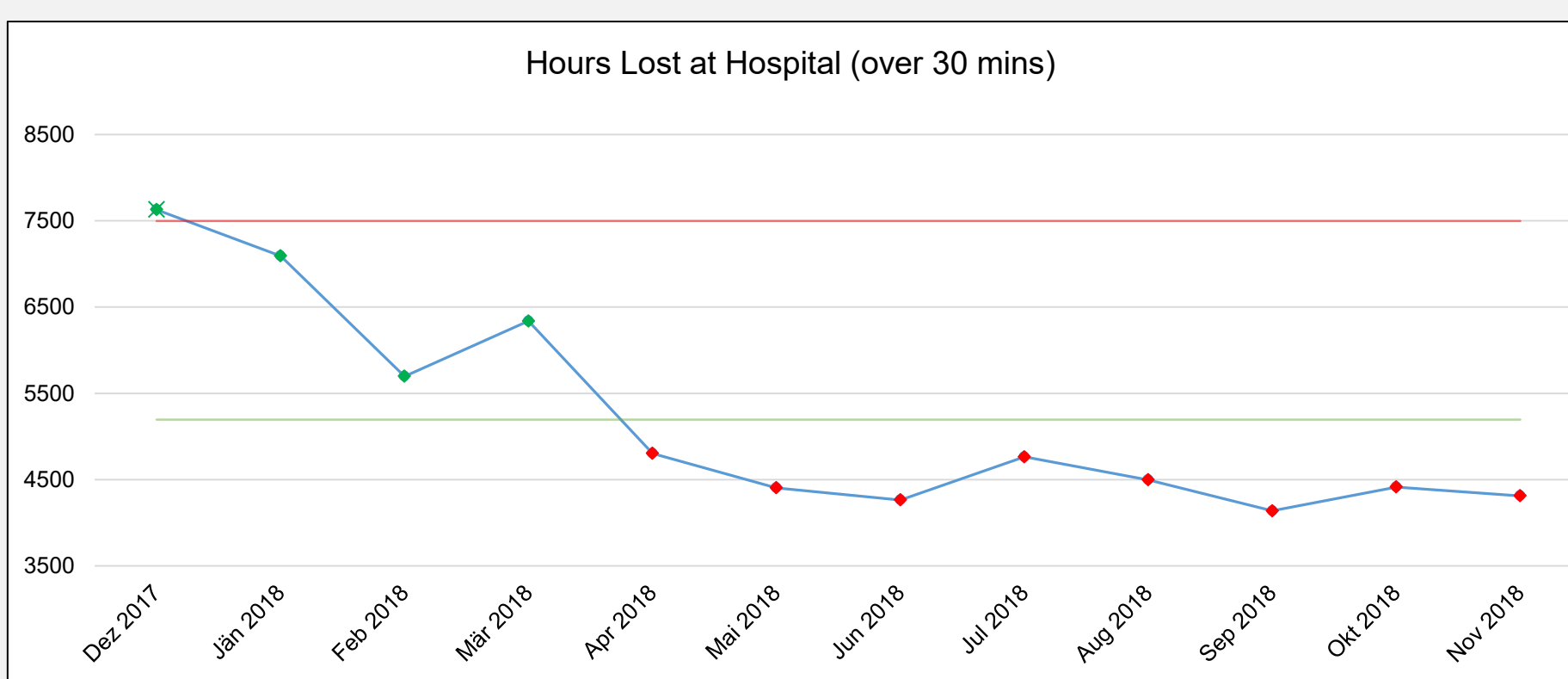
----- National Mean



Cat 3 mean has been included to provide the Board with oversight on the significant pressure against the performance requirements for this patient group. Response to this Category of patients is below ARP target. The average performance remains approximately 20 minutes above the national average, which all ambulance trusts are challenged to achieving.

The 30 second-hand Non-Emergency Transport (NET) vehicles are currently being commissioned with the roll out starting in December 2018 with a planned roll out of 3 vehicles a week.

----- National Mean



Hours lost to operational response capability through hospital delays in November are 4354 hours compared to October at 4434. This is a decrease of 80 hours. Overall good progress has been made this month with 21% less hours lost in November 2018 compared with November 2017. There are however outliers where there are increases in hours lost in November compared to last year, they are: Darent Valley Hospital, Maidstone and Tunbridge Wells Hospitals and Royal Sussex County Hospital. Additional support is being provided at these sites. The two (East and West) operational groups have now been stood down over the winter period and the chairs will join the steering group. Local site based joint operational groups will however continue. The focus on the winter months will be to maintain improvements that have already been made, with an aim of achieving as many hospital handovers <15 minutes and crew to clear >15 minutes. In order to address the additional winter pressures, the individual hospital sites will also be focusing on having clear triggers and actions (both in internal, and system wide escalation plans) to prevent ambulance handover delays, and actions needed if ambulances start to queue.

SECamb Weekly Operational Performance - 7th January 2019

CAT 1				
	17/12	24/12	31/12	Last 13 Weeks
Mean	00:07:43	00:06:50	00:07:15	
90th Centile	00:14:47	00:12:50	00:12:51	
RPI	1.73	1.80	1.78	
Count of Incidents	875	956	906	

CAT 1T				
	17/12	24/12	31/12	Last 13 Weeks
Mean	00:09:55	00:09:27	00:09:20	
90th Centile	00:18:46	00:18:17	00:18:38	
RPI	1.75	1.84	1.81	
Count of Incidents	552	580	570	

CAT 2				
	17/12	24/12	31/12	Last 13 Weeks
Mean	00:20:37	00:20:08	00:18:13	
90th Centile	00:39:35	00:38:35	00:34:43	
RPI	1.11	1.10	1.10	
Count of Incidents	7610	7554	7859	

CAT 3				
	17/12	24/12	31/12	Last 13 Weeks
Mean	01:46:04	01:38:12	01:20:41	
90th Centile	04:05:02	03:56:22	03:03:27	
RPI	1.07	1.06	1.06	
Count of Incidents	4350	4383	4833	

CAT 4				
	17/12	24/12	31/12	Last 13 Weeks
Mean	02:17:21	02:01:59	01:53:47	
90th Centile	04:46:13	04:23:05	04:18:33	
RPI	1.03	1.06	1.07	
Count of Incidents	173	176	211	

HCP 60				
	17/12	24/12	31/12	Last 13 Weeks
Performance	26.3%	30.0%	40.0%	
Count of Incidents	19	20	15	

Call Cycle Time				
	17/12	24/12	31/12	Last 13 Weeks
Clear at Scene (hh:mm)	01:14	01:12	01:13	
Clear at Hospital (hh:mm)	01:48	01:46	01:47	
Hours Lost at Hospital	1165	1185	1344	

HCP 120				
	17/12	24/12	31/12	Last 13 Weeks
Performance	56.8%	62.8%	62.5%	
Count of Incidents	333	288	360	

Call Handling				
	17/12	24/12	31/12	Last 13 Weeks
Pickup 5 Second Performance	82.7%	93.6%	95.9%	
Average Call Pickup Time (Seconds)	10	5	3	
Call Pickup Time 95th Percentile (Seconds)	73	19	3	
Call Pickup Time 99th Percentile (Seconds)	128	95	72	
Average Call Length (seconds)	366	374	373	
Abandon Rate	0.80%	0.60%	0.60%	
Staff Hours Provided Against 4865 Hours	108.09%	106.25%	110.07%	

HCP 240				
	17/12	24/12	31/12	Last 13 Weeks
Performance	64.5%	68.3%	73.4%	
Count of Incidents	62	60	64	

Community First Responders				
	17/12	24/12	31/12	Last 13 Weeks
Volume of Incidents Attended	209	294	316	
Hours Provided				

Incident Outcome				
	17/12	24/12	31/12	Last 13 Weeks
See and Convey	61.3%	60.3%	60.8%	
See and Treat	33.0%	33.8%	34.2%	
Hear and Treat	5.7%	5.8%	5.0%	

Demand/Supply				
	17/12	24/12	31/12	Last 13 Weeks
Call Volume	15969	14664	14974	
Incidents	13531	13555	14385	
Transports	8787	8690	9205	
Staff Hours Provided Against 63000 Hours	105.08%	102.05%	111.46%	

SECAmb 111 Operations Performance Scorecard

Calls Offered

	Sep-18	Oct-18	Nov-18	12 Months
Actual	84650	87344	90785	
Previous Year	80053	84639	82468	

Calls answered in 60 Seconds

	Sep-18	Oct-18	Nov-18	12 Months
Actual %	70.9%	72.5%	73.5%	
Previous Year %	80.2%	75.3%	72.9%	
Target %	95%	95%	95%	

Calls abandoned - (Offered) after 30secs

	Sep-18	Oct-18	Nov-18	12 Months
Actual %	6.0%	5.4%	5.1%	
Previous Year %	2.0%	2.8%	3.6%	
Target %	2%	2%	2%	

Combined Clinical KPI

	Sep-18	Oct-18	Nov-18	12 Months
Actual %	63.8%	69.3%	73.1%	
Previous Year %	69.5%	78.2%	75.3%	
Target %	90%	90%	90%	

999 Referrals

	Sep-18	Oct-18	Nov-18	12 Months
999 Referrals % (Answered Calls)	11.3%	11.7%	12.6%	
999 Referrals (Actual)	8825	9457	10645	
National	11.5%	12.0%	12.6%	

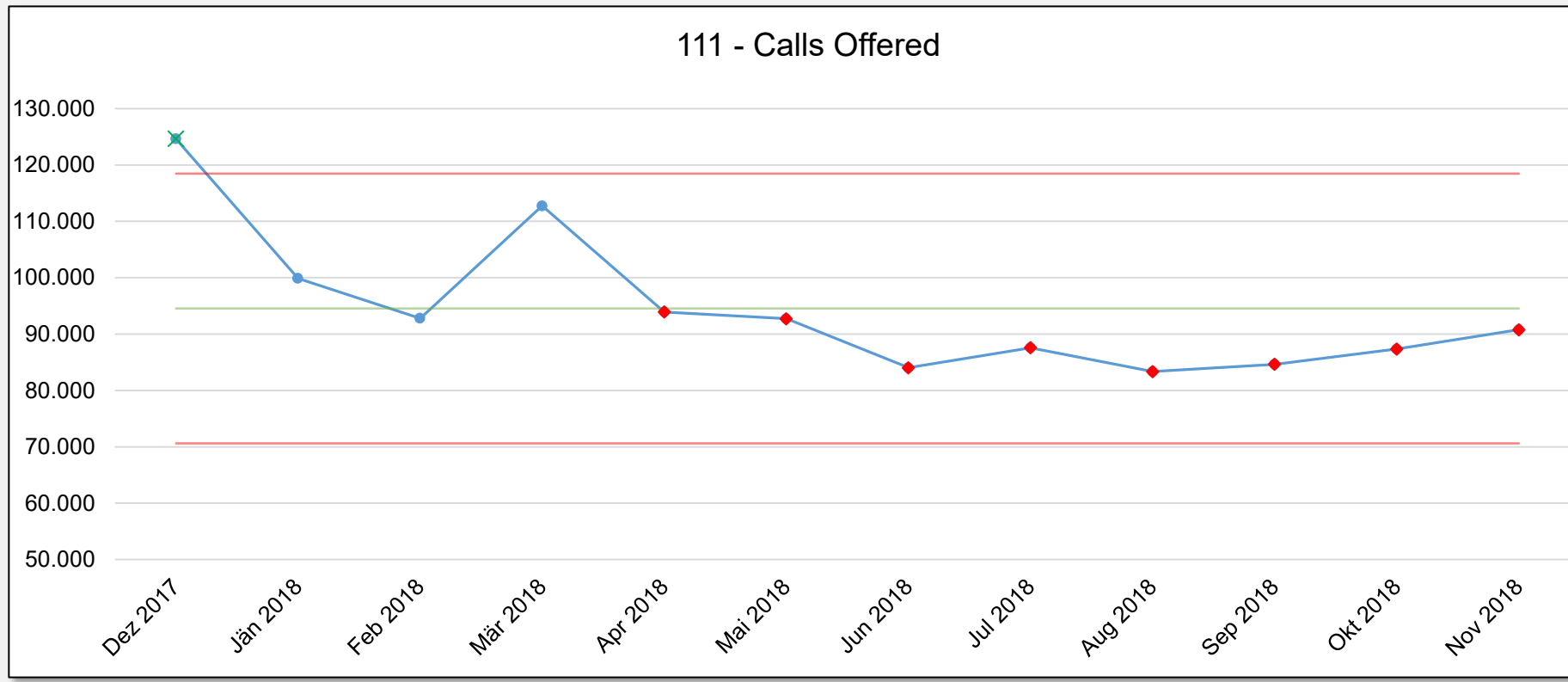
A&E Dispositions

	Sep-18	Oct-18	Nov-18	12 Months
A&E Dispositions % (Answered Calls)	7.9%	8.2%	8.3%	
A&E Dispositions (Actual)	6154	6666	7003	
National	8.3%	8.1%	8.3%	

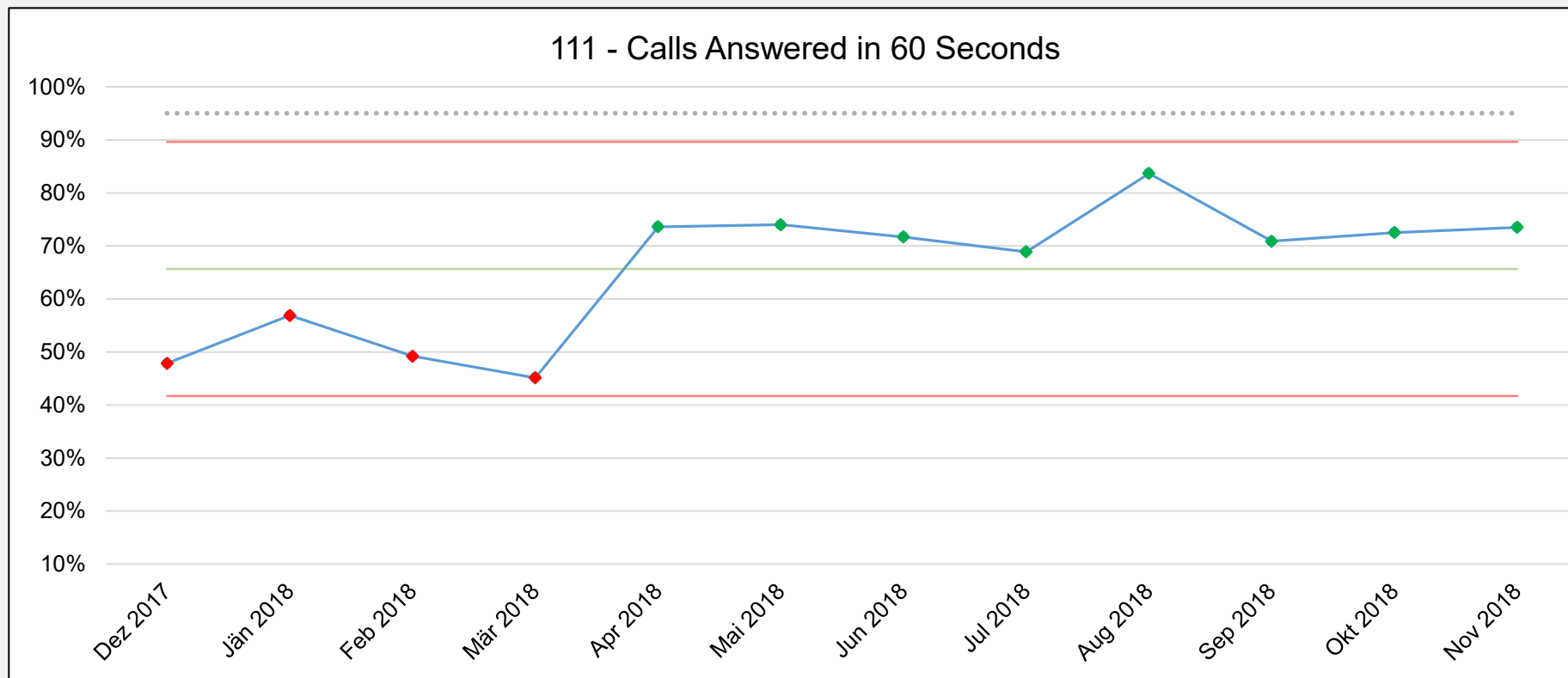
Home Management

	Sep-18	Oct-18	Nov-18	12 Months
Actual %	5.7%	6.2%	7.5%	

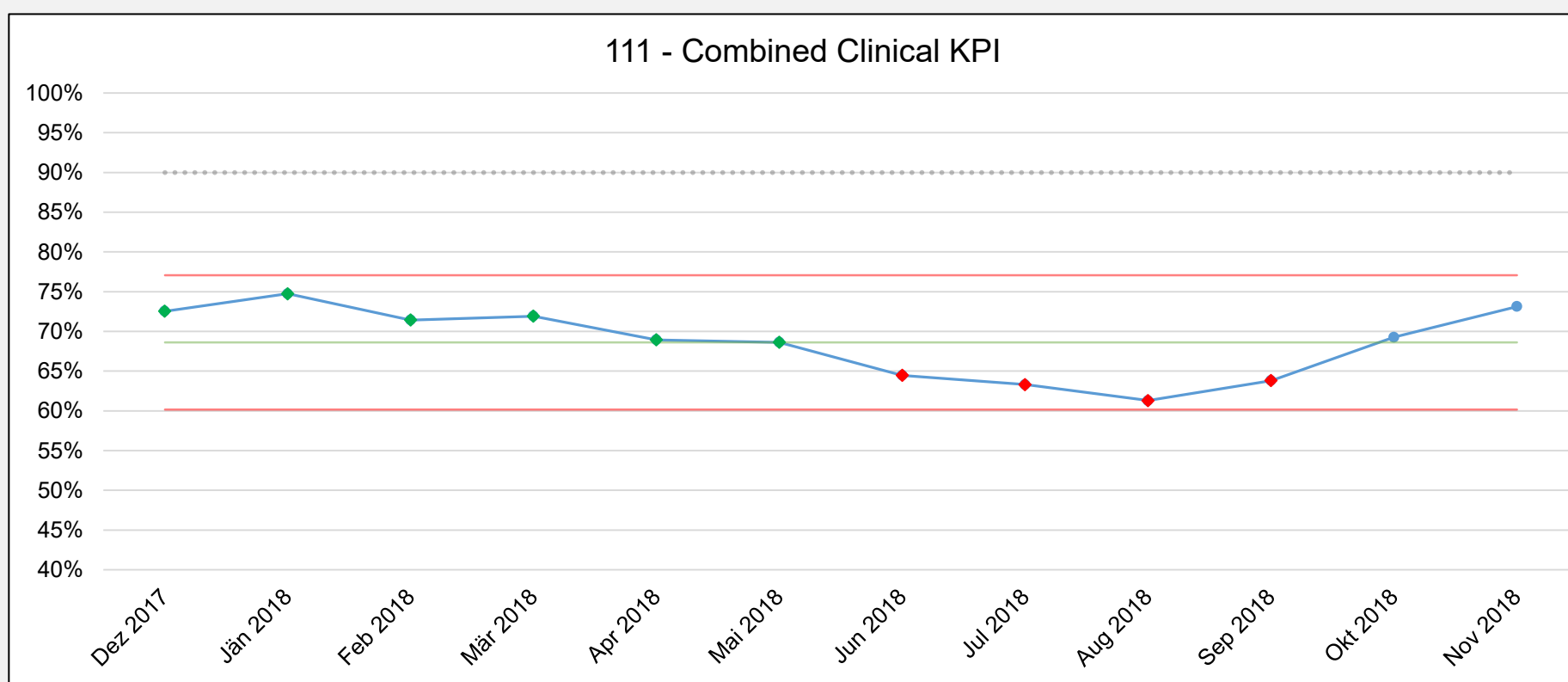
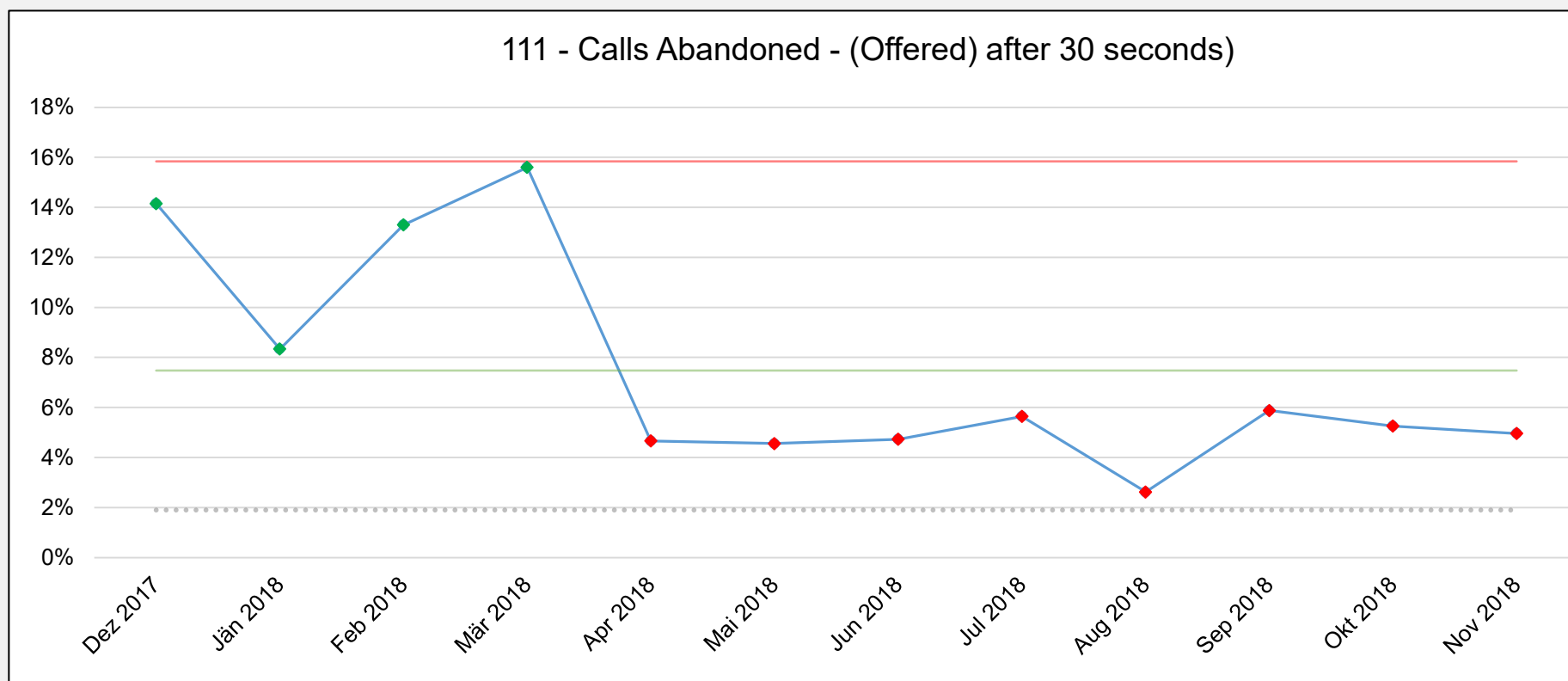
SECAmb 111 Operations Performance Charts



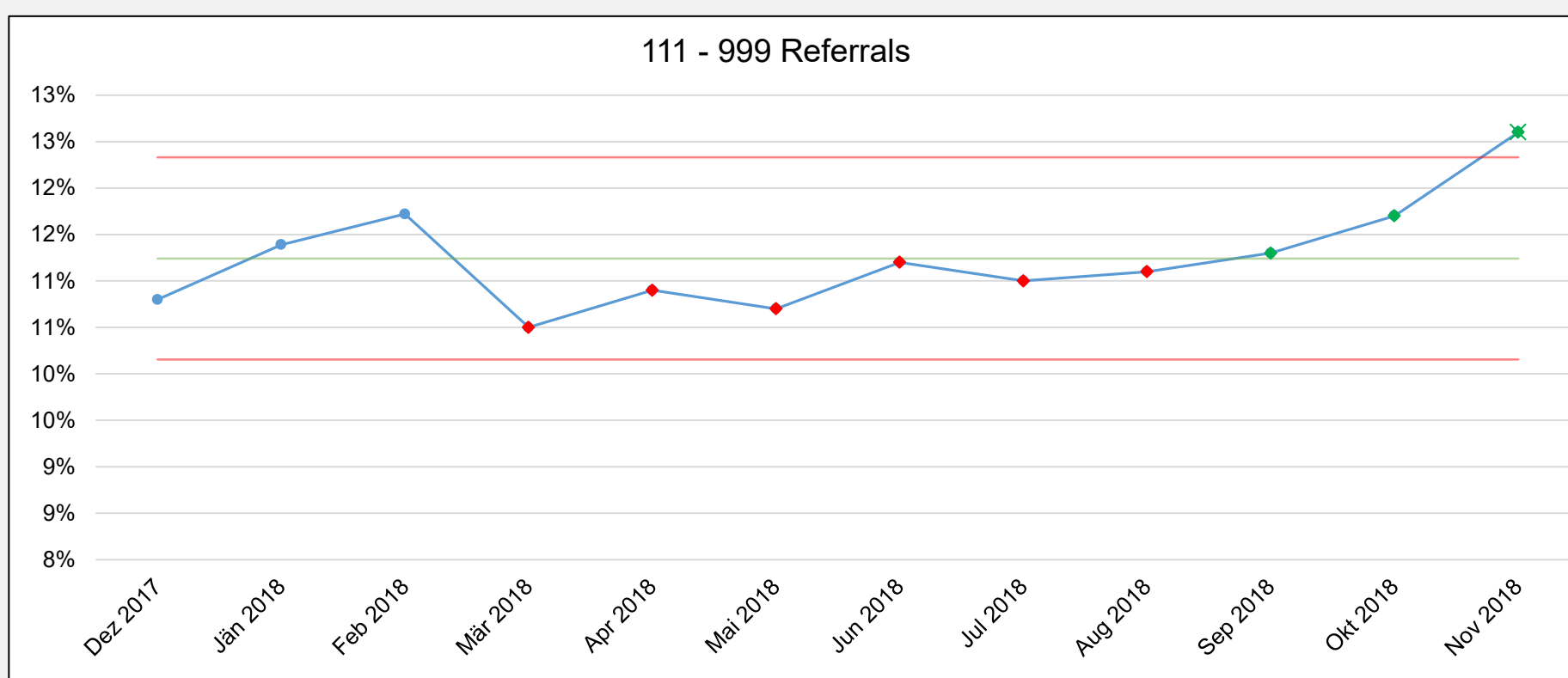
The Calls Offered volume of 90785 represented a 10% increase against the same month last year.



Despite this increase in activity, our Service Level fell only slightly to 73.5%. The Call Abandonment rate was stable at 5.1%, as was the Average Speed to Answer (72 seconds).



The service's best performance coincided with days when SECAmb did not declare SMP Level 3 or 4.



Our Clinical performance climbed to over 73%, considerably above the national benchmark for November.

Workforce Capacity				
	Sep-18	Oct-18	Nov-18	12 Months
Number of Staff WTE (Excl bank & agency)	3215.4	3300.9	3387.4	
Number of Staff Headcount (Excl bank and agency)	3477	3575	3665	
Finance Establishment (WTE)	3837.50	3837.50	3837.50	
Vacancy Rate	16.21%	13.70%	11.73%	
Vacancy Rate Previous Year	13.90%	13.51%	13.09%	
Adjusted Vacancy Rate + Pipeline recruitment %	9.12%	6.50%	7.30%	

Workforce Compliance				
	Sep-18	Oct-18	Nov-18	12 Months
Objectives & Career Conversations %	48.09%	48.44%	50.47%	
Target (Objectives & Career Conversations)	80%	80%	80%	
Statutory & Mandatory Training Compliance %	75.50%	79.10%	79.08%	
Target (Stat & M and Training)	95%	95%	95%	
Previous Year (Stat & M and Training) %	65.46%	76.06%	71.06%	

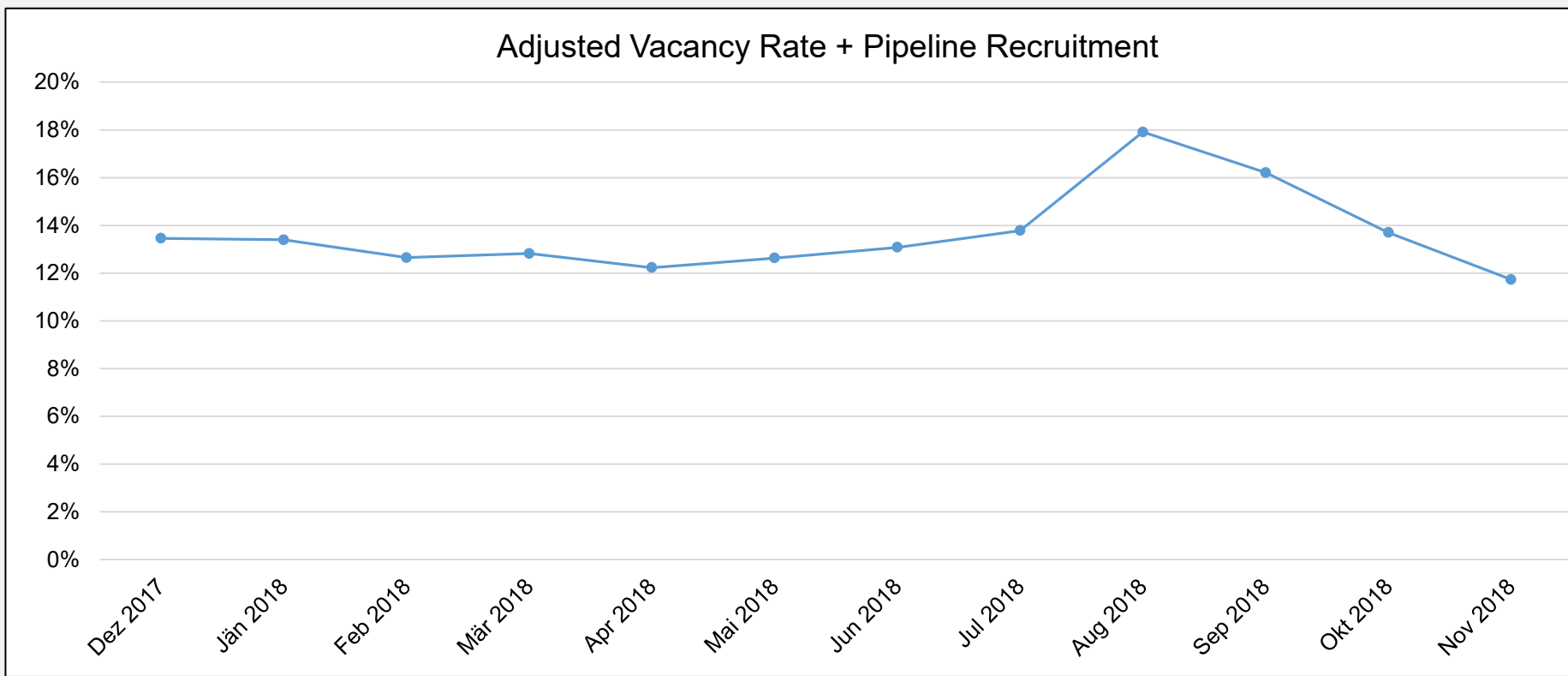
* Objectives & Career Conversations and Statutory & Mandatory training has been measured by financial year. The completion rate is reset to zero on 01/04/2018

Workforce Costs				
	Sep-18	Oct-18	Nov-18	12 Months
Annual Rolling Turnover Rate %	14.88%	14.62%	14.57%	
Previous Year %	17.77%	18.17%	18.05%	
Annual Rolling Sickness Absence	5.10%	5.08%	5.04%	
Target (Annual Rolling Sickness)	5%	5%	5%	

Employee Relations Cases				
	Sep-18	Oct-18	Nov-18	12 Months
Disciplinary Cases	4	10	4	
Individual Grievances	6	1	4	
Collective Grievances	0	1	2	
Bullying & Harassment	2	1	0	
Bullying & Harassment Prev Yr	1	2	2	
Whistleblowing	0	0	0	
Whistleblowing Previous Year	0	0	0	

Physical Assaults (Number of victims)				
	Sep-18	Oct-18	Nov-18	12 Months
Actual	9	25	30	
Previous Year	8	17	20	
Sanctions	1	1	18	

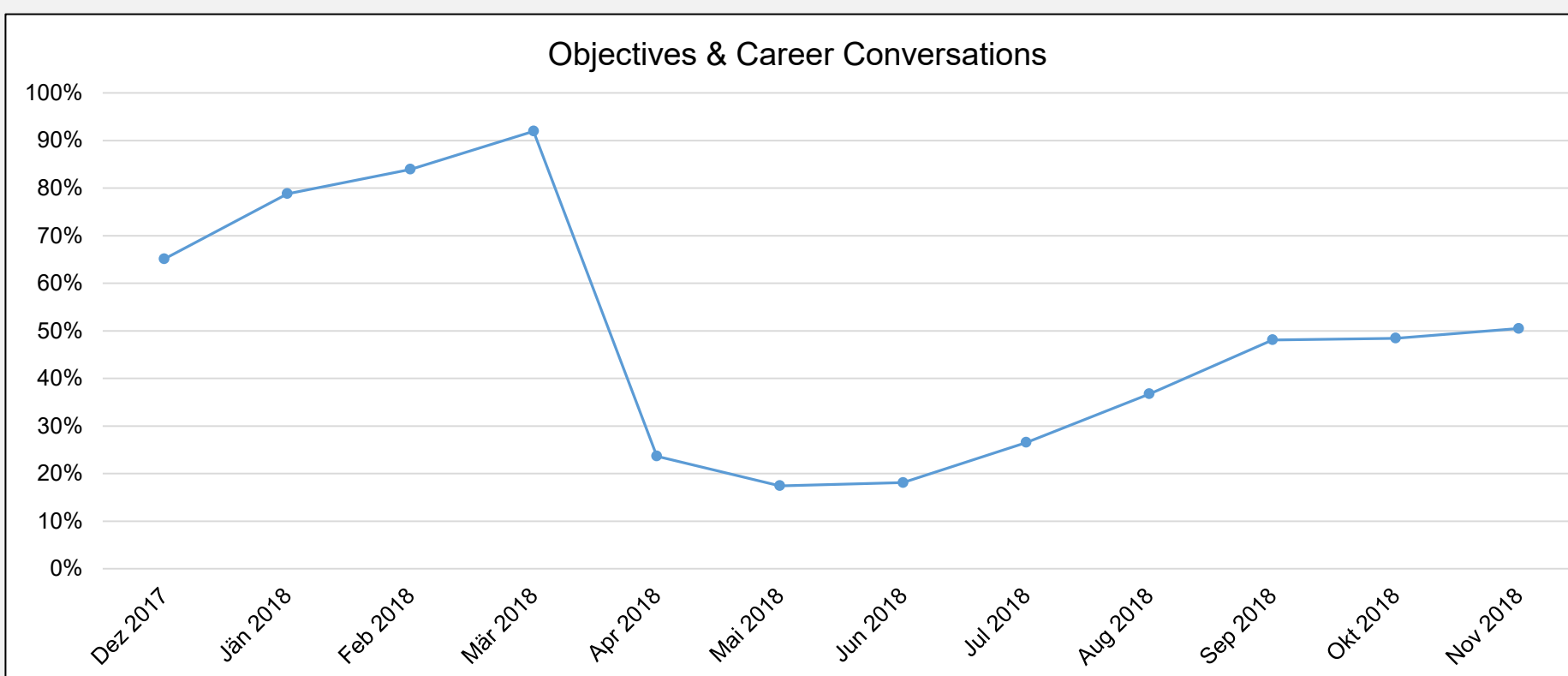
SECamb Workforce Charts



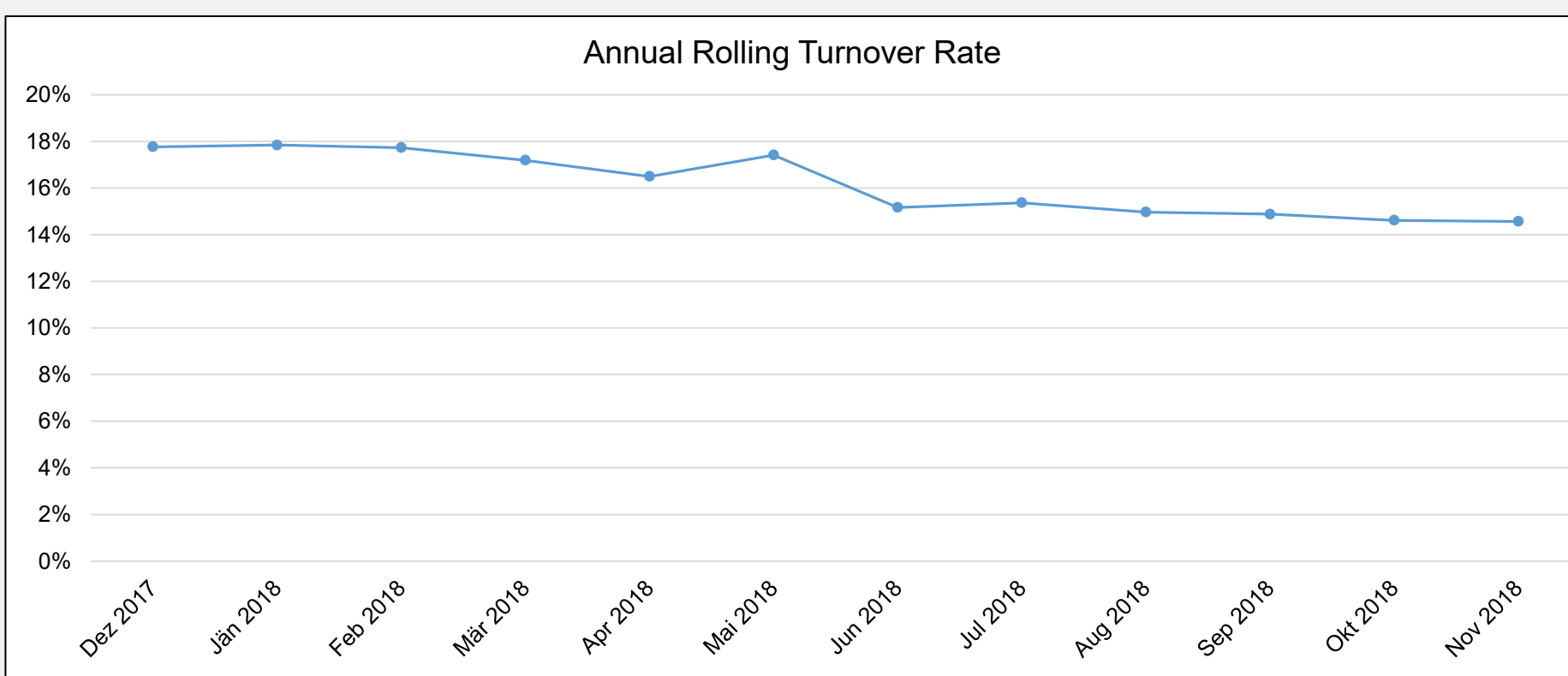
In November we recruited 102 new staff into the Trust. Our adjusted vacancy rate increased slightly to 7.3%

We have 21 EMAs due to start in December and have filled the pipeline of EMAs for West up until February 2019. We have a talent pool of candidates for West. Our focus is on East EOC recruitment.

We had 34 new ECSW start in November. Our pipeline for ECSW is currently 38 new joiners for January



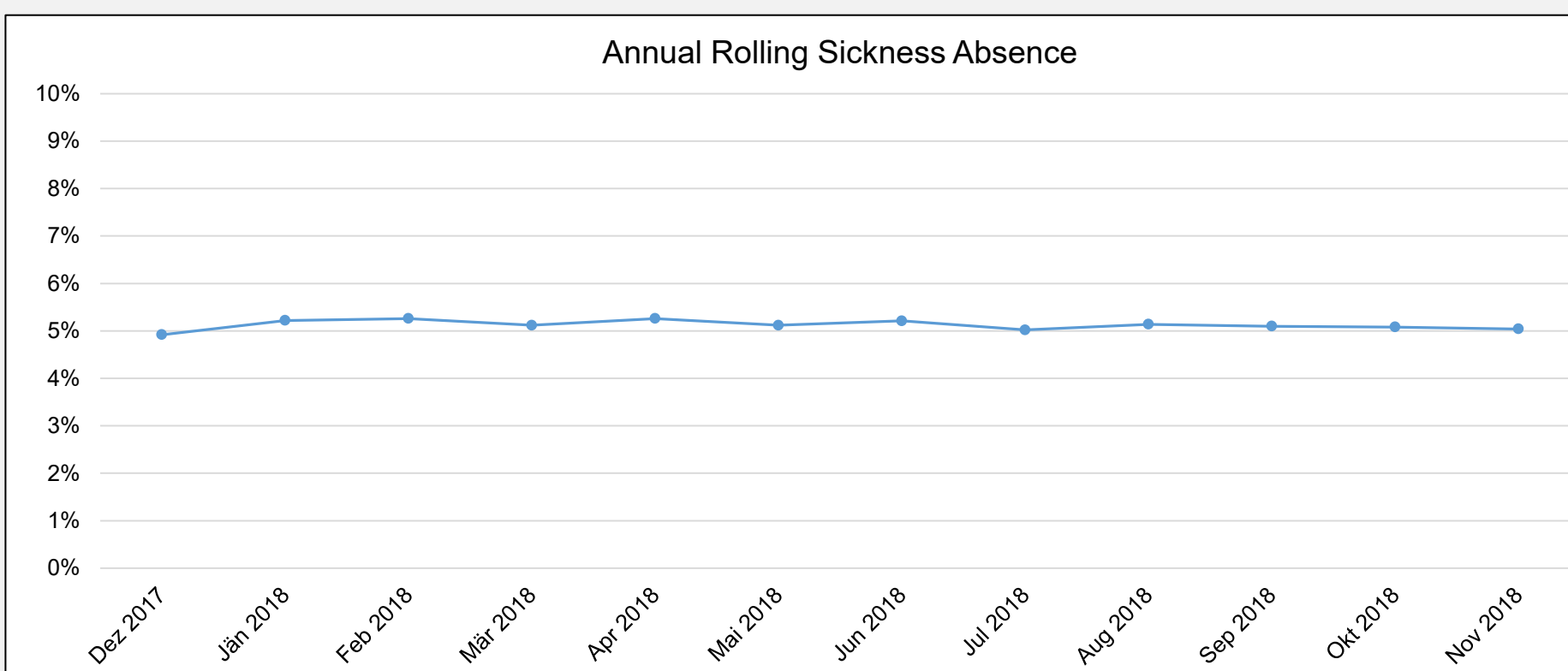
There is a continued increase in appraisals being published which shows activity in some areas of the organisation. The appraisal percentage has increased to 48.09% from 36.73%, from the previous month. However this representation is only for published appraisals on the performance management system and we need to view the combined activity of appraisals which are in-progress as well. This reflects an actual figure of 63.74%, which at this time last year we are on target to achieve our target, at the projected rate of 10% each month.



We can now report a clear downward trend in our annual rolling turnover rate, which is excellent news. Turnover now stands at 14.6% compared to 18.05% a year ago.

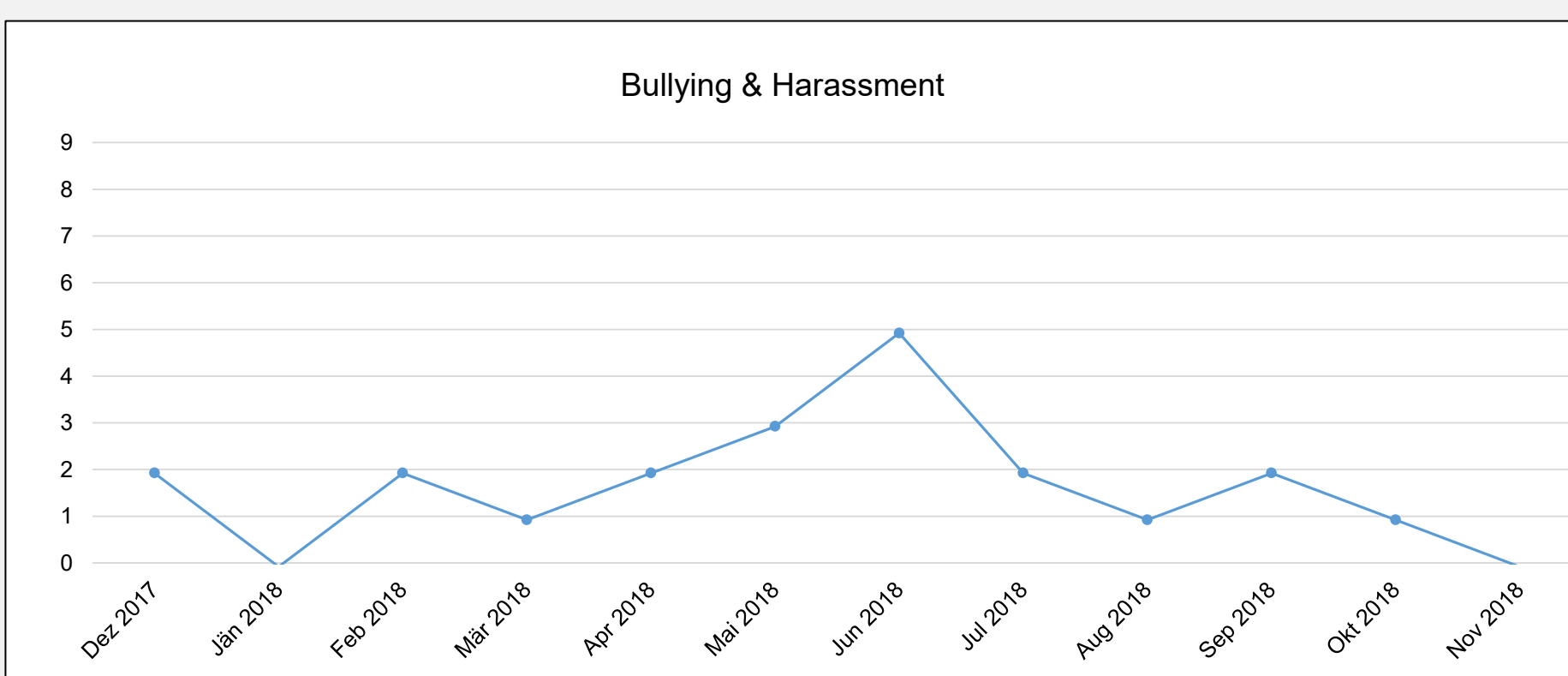
November has seen the lowest turnover of the last 12 months.

We continue to focus on the two Emergency Operations Centres (EOC's) and 111 over the next 3-months should enable a continued downward trend in turnover.



Sickness absence hit target (5.0%) for the first time in 11 months which is excellent news.

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



There was no reported cases of Bullying and Harassment (B&H) in November bringing the rolling total to 25 cases.


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

HR Advisors and HR Business Partners spent a significant amount of time bringing our ER Tracker System up to date and we have now introduced a rolling monthly review meeting with the Director of HR and OD

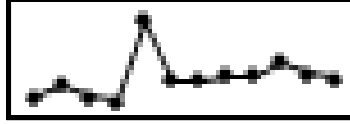
We are in the next stages of our plan to eradicate Bullying and Harassment in SECamb which we hope to have completed for a New Year launch

On January 9th 2019 we held a workshop for Senior Leaders and Executives with our employment lawyers.

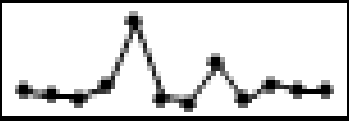
Income

	Sep-18	Oct-18	Nov-18	12 Months
Actual £	£ 17,589	£ 18,398	£ 20,453	
Previous Year £	£ 16,716	£ 16,329	£ 16,493	
Plan £	£ 17,226	£ 18,034	£ 18,051	

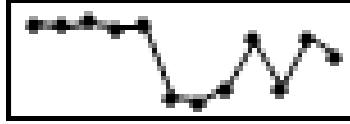
Expenditure

	Sep-18	Oct-18	Nov-18	12 Months
Actual £	£ 18,402	£ 18,029	£ 20,344	
Previous Year £	£ 17,319	£ 16,623	£ 16,501	
Plan £	£ 18,055	£ 17,674	£ 17,951	

Capital Expenditure

	Sep-18	Oct-18	Nov-18	12 Months
Actual £	£ 555	£ 598	£ 405	
Previous Year £	£ 450	£ 375	£ 554	
Plan £	£ 501	£ 308	£ 551	
Actual Cumulative £	£ 3,617	£ 4,215	£ 4,215	
Plan Cumulative £	£ 3,920	£ 4,228	£ 4,779	

Cost Improvement Programme (CIP)


	Sep-18	Oct-18	Nov-18	12 Months
Actual £	£ 1,242	£ 965	£ 961	
Previous Year £	£ 1,330	£ 1,304	£ 1,459	
Plan £	£ 1,223	£ 947	£ 947	
Actual Cumulative £	£ 4,179	£ 5,144	£ 6,105	
Plan Cumulative £	£ 4,087	£ 5,034	£ 5,981	

CQUIN (Quarterly)


	Q1 18/19	Q2 18/19	Q3 18/19
Actual £	£ 871	£ 870	£ 1,161
Previous Year £	£ 850	£ 846	£ 855
Plan £	£ 870	£ 870	£ 870

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

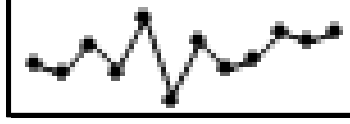
Surplus/(Deficit)

	Sep-18	Oct-18	Nov-18	12 Months
Actual £	-£ 813	£ 369	£ 109	
Actual YTD £	-£ 3,610	-£ 3,241	-£ 3,241	
Plan £	-£ 829	£ 360	£ 100	
Plan YTD £	-£ 3,734	-£ 3,374	-£ 3,274	

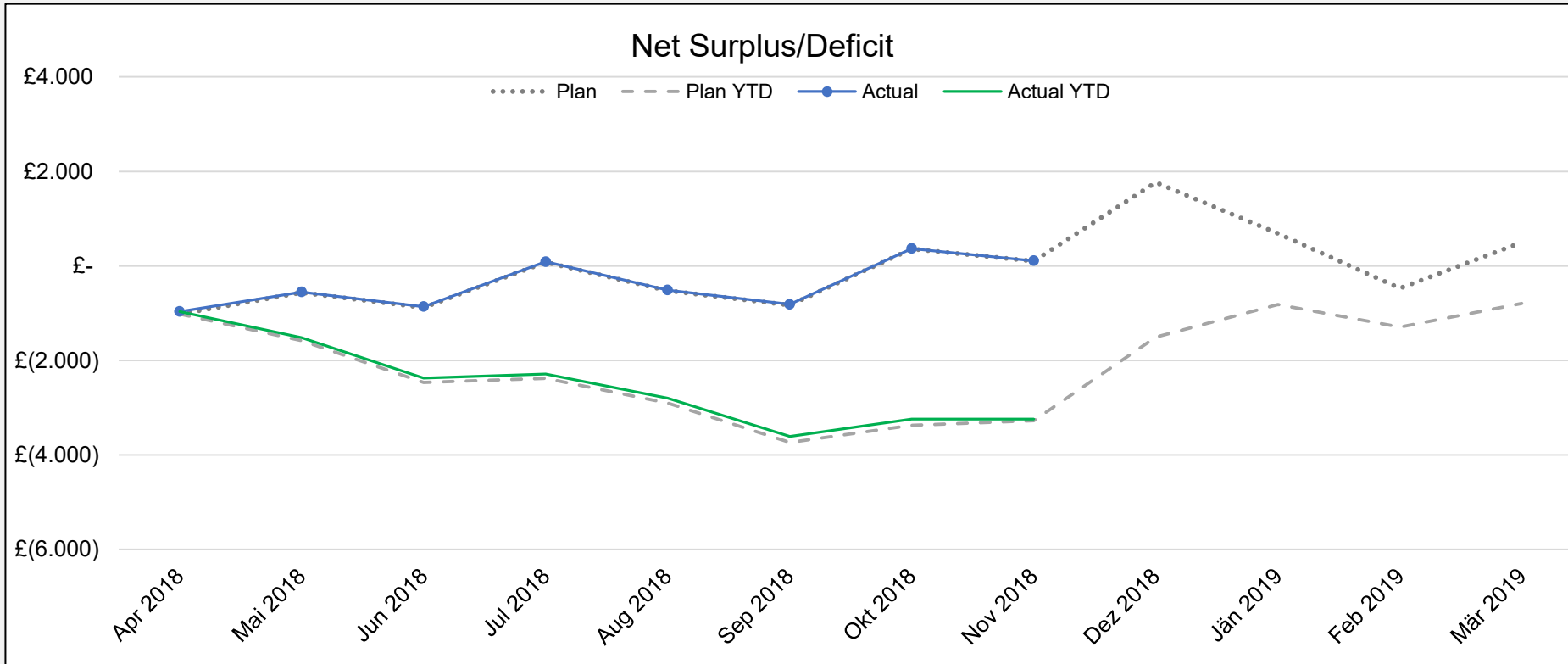
Cash Position

	Sep-18	Oct-18	Nov-18	12 Months
Actual £	£ 22,032	£ 21,971	£ 26,656	
Minimum £	£ 10,000	£ 10,000	£ 10,000	
Plan £	£ 14,749	£ 14,693	£ 14,402	

Agency Spend

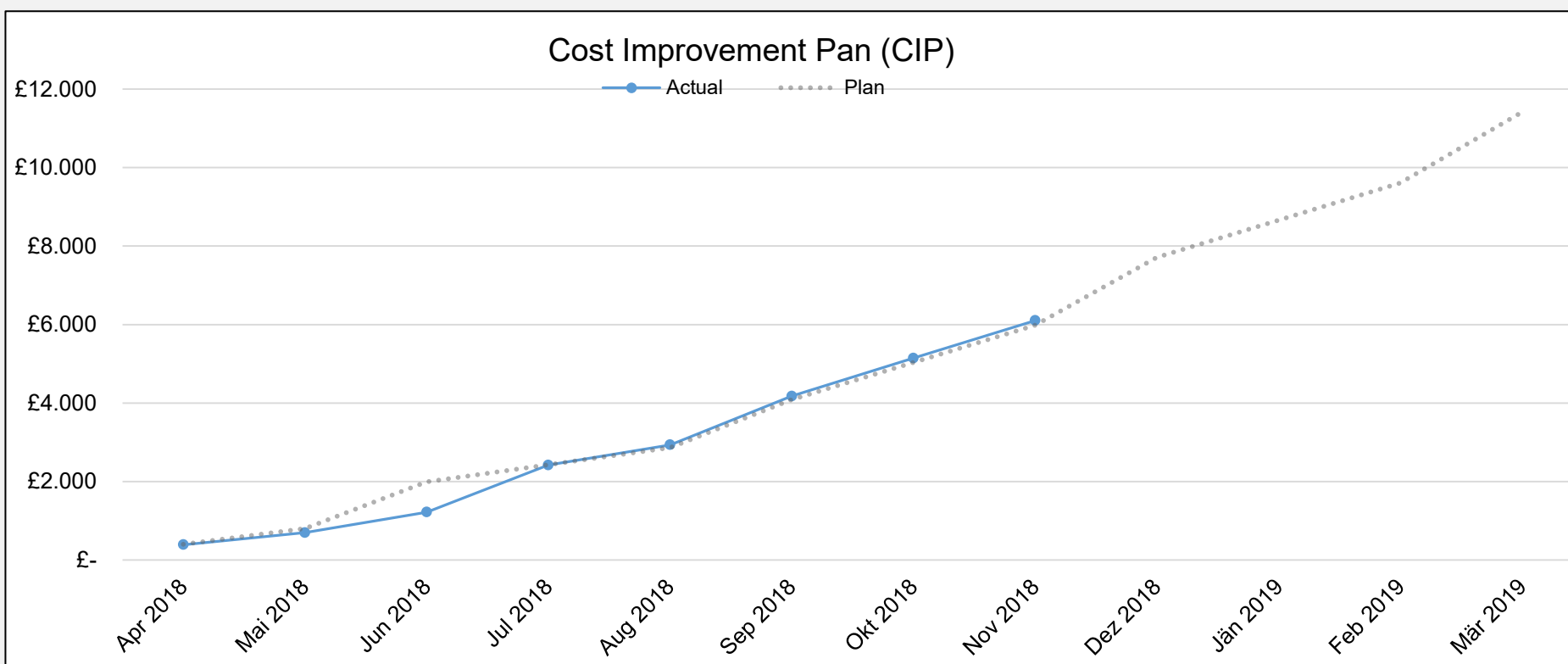
	Sep-18	Oct-18	Nov-18	12 Months
Actual £	£ 322	£ 357	£ 430	
Plan £	£ 222	£ 218	£ 215	

SECamb Finance Performance Charts



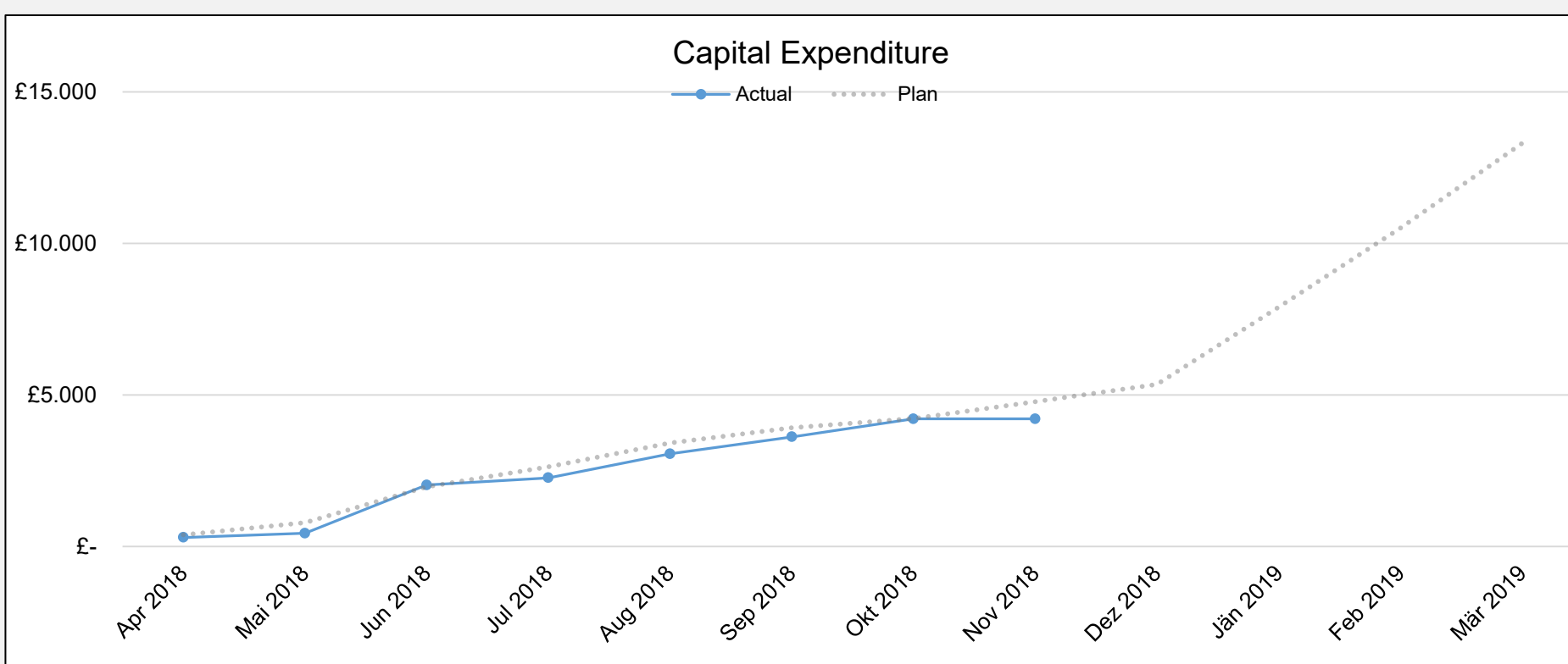
The Trust's I&E position in Month 8 was a surplus of £0.1m, in line with plan.

This reduced the cumulative deficit to £3.1m, which is a £0.1m improvement above plan



CIPs to the value of £1.0m were achieved in the month, as planned. Achievement to date is £6.1m, which is slightly ahead of plan.

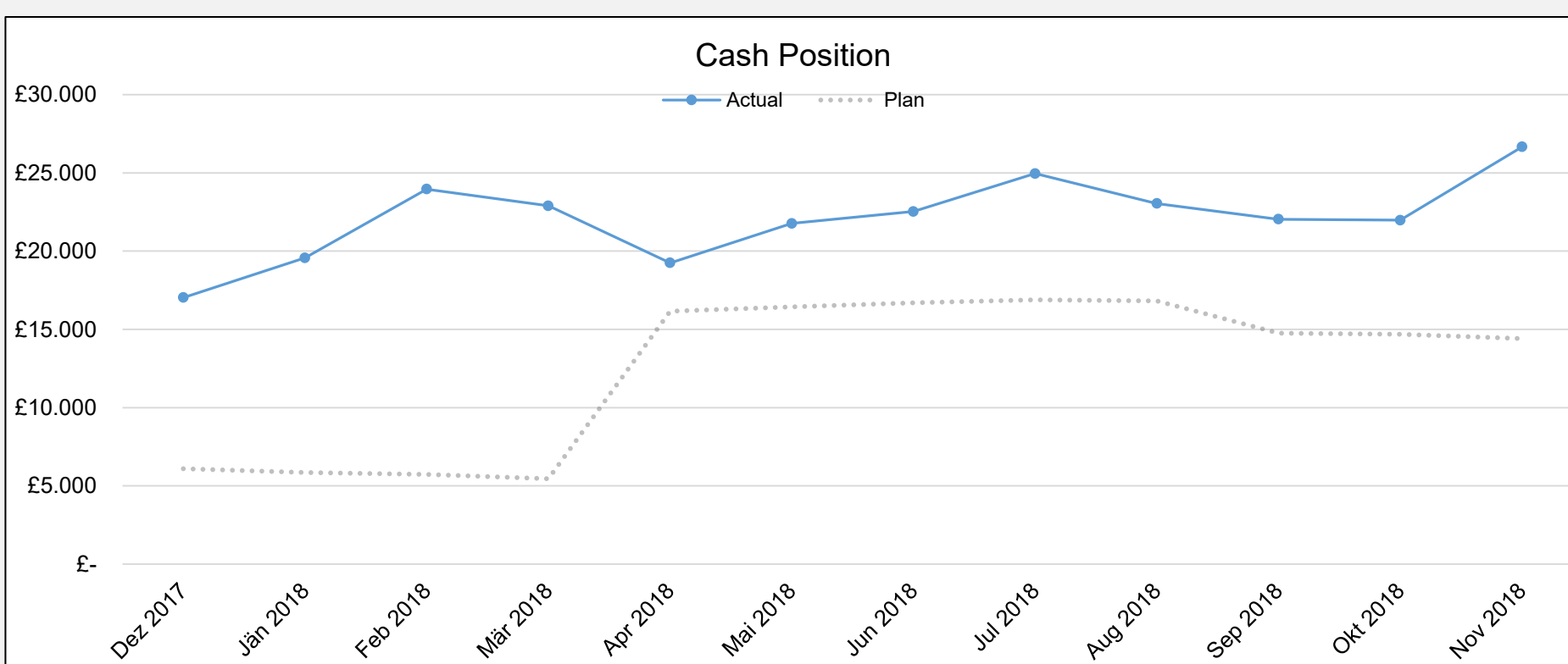
It is projected that the full year target of £11.4m will be met, but there remain challenges to achieving this. £10.3m of schemes were fully validated, with a total of £13.9m identified schemes on the pipeline tracker as at month 8



Capital expenditure in the month was £0.4m and cumulative spend is just £0.2m behind plan. The forecast for the year is a spend of £12.9m against a plan of £13.3m, the shortfall is due to the delay in the delivery of some of the 43 Mercedes box chassis beyond 31 March and spend on the new ePCR, partly offset by the substitution of 111 implementation.

In November it was announced that £12.3m of capital funding has been awarded to the Trust for 3 make ready centres in Brighton, Medway and Worthing. A further £6.7m has also been recently awarded for developments at the Nexus House Headquarters. The Trust has been unsuccessful with a bid for new ambulances.

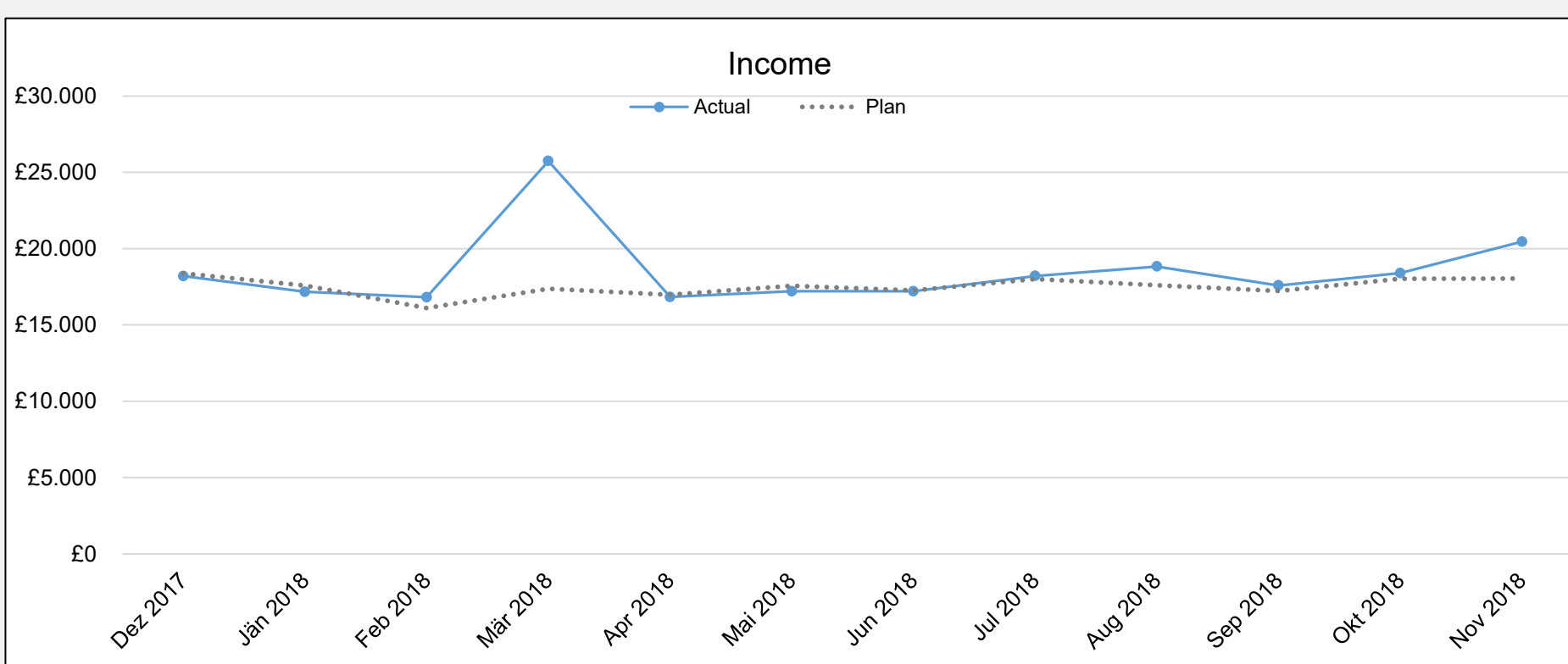
The above funding is subject to formal approval of a business case and recommendation to DHSC (Department of Health and Social Care) by NHSI.



The cash position at 30 November increased to £26.7m. This is £12.3m better than plan and £3.8m above the balance at 31 March. The main cause for the increase in month is receipt of funds following the 999 contract variation.

In line with good practice, the Trust produces cash forecasts for a three-year period. The latest projection shows, based on forecast capital requirements and I&E performance, cash could fall to below £15.0m by June 2020. This reflects the Trust's investment plans for the estate and frontline vehicles, any impact from the capital bids will be included once business cases have been fully approved.

Performance against the 'Better Payment Practice Code' for payment of suppliers declined slightly this month, falling year to date to 93.3% by value, against a target of 95.0%.



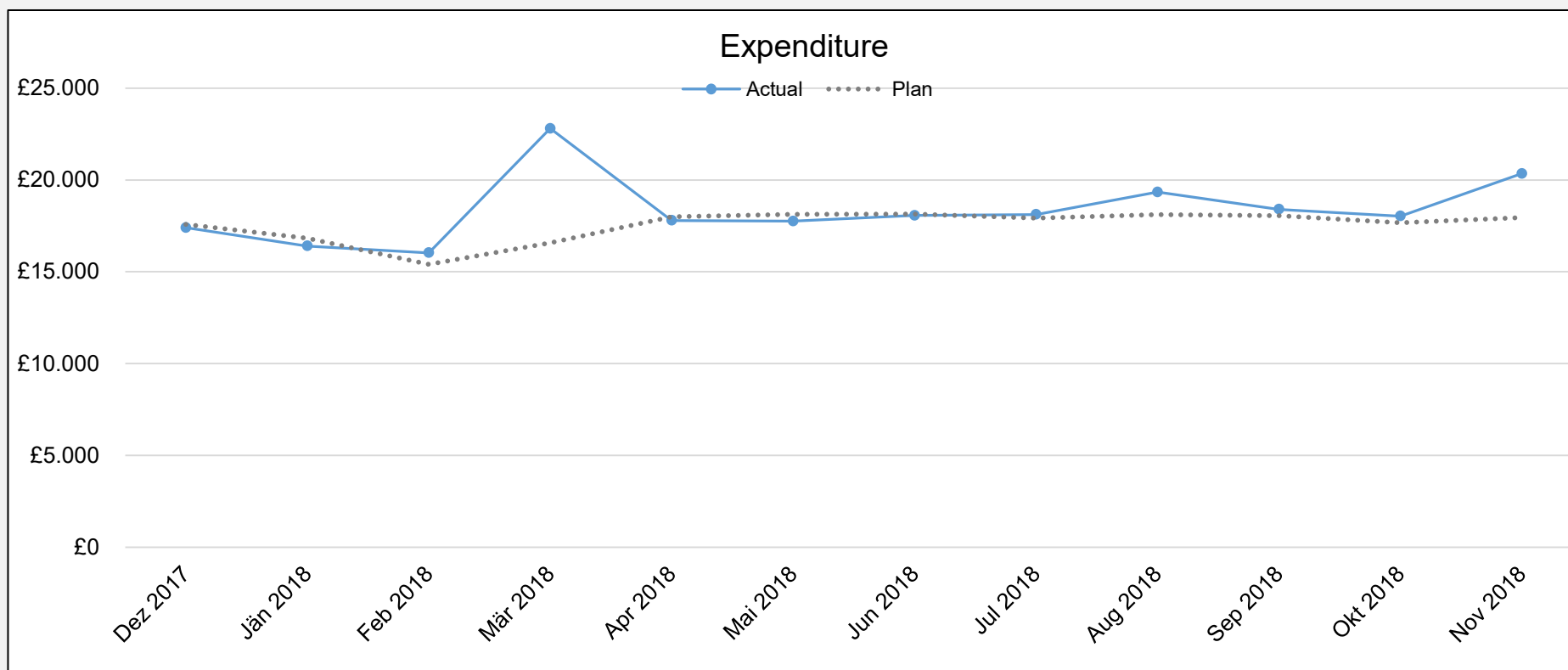
Total Income in the month was £20.4m, which was £2.4m better than plan.

This resulted in a cumulative favourable variance against plan of £4.0m.

The main reason for the improvement in the month was the recognition of £2.0m from the 999 contract variation arising from the successful conclusion of the demand and capacity agreement with commissioners. This includes an additional £0.4m for the Helicopter Emergency Medical Service (HEMS). A further £0.1m represents the impact of the new contract variation for 111 and £0.5m funding for the new pay deal.

The Trust has assumed full achievement of planned core PSF income in the first eight months at £1.0m. The full year value is £1.8m, funding being weighted towards the latter part of the year. Receipt of this funding is contingent on meeting I&E trajectories on a quarterly basis. Funding of £0.6m for quarters one and two has been confirmed

SECamb Finance Performance Charts



Total Expenditure exceeded plan by £2.4m in month

Cumulatively expenditure is £3.9 above plan.

Pay costs in the month were above plan by £1.3m, moving the cumulative position to a £2.1 overspend. The main reason for this is the £0.5m impact of the new pay deal, £0.2m in Operations due to the respective recognition of the approved re-banding uplift for Technicians and increasing hours over plan, £0.5m transfer from reserves to support approved business cases.

Non-pay costs were £1.1m above plan in the month, bringing cumulative costs to £1.3m overspent. The main area of overspend was for £0.4m HEMS support (reflecting the additional income reported above), £0.2m uniforms and £0.2m for estates improvements.

Non-operating costs were £0.1m greater than plan in month.

	Agenda No	145/18
Name of meeting	Trust Board	
Date	24 th January 2019	
Name of paper	Responding to Category 1 patients ensuring patient safety when there are delays.	
Responsible Executive	Joe Garcia – Executive Director of Operations	
Author	Mark Bailey – EOC Operations Unit Manager Hilary Parsons – Business Support Manager	
Synopsis	This paper provides confirmation on the management of Category 1 calls.	
Recommendations, decisions or actions sought	The Board is asked to note the contents of this paper.	
Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	No	

1. Introduction

- 1.1. This response paper is to provide confirmation on how Category 1 calls are managed when there is a delay in response.

2. Incident Resourcing, Deployment & Management Standard Operating Procedure

- 2.1. The embedded document below provides the full procedure for the process for the deployment of resources to all categories of 999, Urgent and appropriate routine calls during normal working arrangements.
- 2.2. The overriding consideration of these procedures and protocols is to promote patient safety and clinical excellence, and to ensure that best practise is delivered at all times.



Incident
Resourcing Deployn

3. The 10 Principles of Dispatch

- 3.1. There are 10 Emergency Dispatch Principles which the Dispatchers must follow at all times and these are the core dispatching rules of engagement. These are listed below;
 1. Ensure that all resources are booked on and set up correctly in the CAD including confirmation and set up of appropriate staff, shift and meal break times. Late sign-ons escalate to the Dispatch Team Leader.
 2. Check that all First Responders (including all types of Community Responders) are booked on correctly on the CAD if they are available and are showing their dispatch point positions accurately.
 3. Allocate the nearest available resource/s to all Category 1 Incidents.
 4. Monitor all other emergency calls on the dispatch stack and assign a suitable resource when;
 - The time exceeds 240 seconds and the incident remains uncategorised.
 - The incident has been coded (the incident line will change colour to reflect the response level).
 5. Divert resources from other lower priority calls as necessary.
 6. Ensure the most appropriate and nearest CFR is assigned to the emergency if applicable (in accordance with the incident type and/or location) and confirm they are mobile.

7. Consider and respond other suitable additional resources to the emergency if appropriate and in accordance with incident type and/or location e.g. Helicopter Emergency Medical Service (HEMS), Hazardous Area Response Team (HART), Critical Care Paramedic (CCP), Paramedic Practitioner (PP), Operational Manager etc.
8. DCA must respond to SRV back up requests.
9. **Guidance On Running Calls:** If a crew are flagged down or come across a running call whilst transporting a patient to hospital, they should be expected to contact control to advise a running call and request back up whilst rendering aid to the patient/s.
10. If appropriate contact a solo responder who is on scene with a DCA crew to check if they can respond to another incident as the nearest and quickest response.

3.2. General Broadcasts via Airwave group call should be undertaken by dispatchers in the following circumstances:

- All Category 1 incidents irrespective of ETA for assigned
- All grade one back up requests from SRVs

4. Responding and Resourcing to Incidents

- 4.1. On receiving an incident, the personnel crewing the vehicle, will proceed to the vehicle without delay. Mobilisation will be measured by the time it takes a vehicle to physically move once allocated.
- 4.2. Crews are expected to proceed to any incident under emergency conditions until the exact nature of the call is established.
- 4.3. Resourcing to category of incidents 1 – 4 should be based on the clinical needs of the patient ensuring that response time standards are also adhered to.
- 4.4. Calls will be responded to as follows:

Category	Default Response	Ideal Resource Type	Response Time Standards
Category 1	Full Emergency Conditions	Nearest Resource Including Closet DCA, If not initial assigned.	Initial Response & Transport 7 Minutes
Category 2	Full Emergency Conditions	DCA (Consider SRV)	Initial Response & Transport 18 Minutes
Category 3	Full Emergency Conditions	SRV/DCA (Consider Specialist Resource)	Transport Must Arrive In 120 Minutes

5. Responding to Category 1 Calls

- 5.1. Cardiac Arrest Calls require significant attention to detail. Every effort will be made to ensure the timeliest response possible is achieved. For every minute the patient remains in cardiac arrest, the chance of survival reduces by 10%.
- 5.2. Due to the nature of cardiac arrest calls, careful resourcing is required. Too few resources will compromise care (due to rescuer fatigue etc.), however, it is possible to over-resource these calls which may cause scene management issues, which also compromises care.
- 5.3. The Trust operates the “pit stop” model in its approach to delivering advanced life support and as such staffing levels should be as a guide four pairs of hands.
- 5.4. An Airwave general broadcast will be carried out for every category 1 call.
- 5.5. The nearest resource, regardless of grade, will be sent to every category 1 via automated dispatch function via CAD.
- 5.6. The Dispatcher will also check to see which resource/s are being sent to the incident and review other resources that could be deployed, for example any managers, community first responders (CFRs), Co-Responders or HART resources nearer to the incident.
- 5.7. A Double Crewed Ambulance (DCA) must be deployed to each category 1 incident.
- 5.8. The Incident Command Hub will review all Cardiac Arrest calls to ensure optimum ratio and skill mix has been deployed. Consideration for CCP to attend will also be considered.
- 5.9. Following cardiac arrest, crews should be offered a welfare check after the event and if required offered support from the duty operational commander.

6. Emergency Operations Centre (EOC) Call Handling Procedure

- 6.1. This procedure provides a full process to ensure that the Trust’s EOCs manage calls received appropriately and that the patient’s safety and welfare needs are met.
- 6.2. This procedure will ensure all calls handled by the EOC are matched to a disposition which will provide recommendation for the most appropriate clinical care, dependant on the needs of the individual patient in line with national and local performance standards. The full copy of the procedure is embedded below.



EOC Call Handling
Procedure V1.00.pdf

7. Staying on the Line

7.1. The Emergency Medical Advisor (EMA) should only remain on the line under the following criteria, as any time spent on the phone unnecessarily impacts on the EOCs ability to answer other waiting 999 calls. Under the Trust’s Operational Instruction 236, there is an expectation that the EMA will Stay on the Line for;

- Cardiac or peri arrests
- Unconscious / fitting if there is no-one on scene who knows how to deal with the patient
- Imminent births
- Child callers

7.2. The EMA should stay on the line where in line care advice is being provided, or where there is a concern on the management of the patient’s airway in an unconscious patient.

8. “Tail Management” Patient Welfare Procedure

8.1. A paper was submitted at the Trust Board Meeting on 29 November 2018, which provided an update on the progress and management of the “tail” to ensure patient safety. A copy of this paper is embedded below as a reference;



130.18 Clinical
Safety - EOC Tail Ma

8.2. This report provides full detail on how the “tail” is managed and the controls in place to ensure that patient safety and welfare is maintained. For the purposes of this paper the ‘tail’ is identified as incidents within the Trust pending dispatch CAD queue who are experiencing delays in resource arrival.

8.3. Under the Trust’s Welfare Call Procedure, any incident subject to welfare calls are specified as below;

ARP Response Category	Time of Initial Welfare Call	Time of Subsequent Welfare Call
Category 1	7 minutes	7 minutes
Category 2	18 minutes	30 minutes
Category 3	120 minutes	60 minutes
Category 4	180 minutes	60 minutes
Category 5	180 minutes	60 minutes
HCP 60	180 minutes	60 minutes
HCP 120	180 minutes	60 minutes
HCP 180	180 minutes	60 minutes

8.4. Latest performance figures for Category 1 Response calls for December 2018 are;

C1		Mean
England		00:07:06
1	London	00:06:17
2	North East	00:06:29
3	West Midlands	00:06:48
4	South Western	00:06:49
5	South Central	00:06:55
6	Yorkshire	00:07:03
7	East of England	00:07:31
8	North West	00:07:41
9	South East Coast	00:07:44
10	East Midlands	00:07:45
11	Isle of Wight	00:09:40

C1		90th
England		00:12:24
1	London	00:10:29
2	North East	00:11:17
3	West Midlands	00:11:49
4	Yorkshire	00:12:15
5	South Western	00:12:18
6	South Central	00:12:26
7	North West	00:12:55
8	East of England	00:13:42
9	East Midlands	00:13:50
10	South East Coast	00:14:13
11	Isle of Wight	00:18:34

C1T		Mean
England		00:10:56
1	North East	00:07:43
2	West Midlands	00:07:45
3	Yorkshire	00:09:02
4	South Central	00:09:58
5	South East Coast	00:10:01
6	North West	00:10:29
7	Isle of Wight	00:10:42
8	London	00:11:02
9	South Western	00:11:02
10	East of England	00:11:33
11	East Midlands	00:17:32

C1T		90th
England		00:20:28
1	West Midlands	00:13:33
2	North East	00:13:56
3	Yorkshire	00:16:33
4	North West	00:17:52
5	South East Coast	00:18:44
6	South Central	00:18:46
7	London	00:19:05
8	Isle of Wight	00:20:34
9	South Western	00:20:41
10	East of England	00:20:53
11	East Midlands	00:41:10

9. Managing Category 1 Delays

- 9.1. The nature of each incident will vary depending on the call, however the concept for managing C1 calls remains dynamic and will follow the procedures as highlighted above.
- 9.2. Any delays to C1 responses that exceed the 7-minute target time are recorded on the CAD and the EOCMs must review and sign off these responses ensuring reasons are documented.
- 9.3. The longest C1 response each day is explained by the EOCM on the daily Teams E conference call. This allows any risks to be discussed and the Strategic Commander to be fully sighted on issues.
- 9.4. It should be noted that many of the longest delays recorded are not actually delays but rather upgrades from lower acuity calls C2, C3, C4 and HCP. This is due to the fact that on upgrade the clock does not restart.
- 9.5. The EOC Clinical Team, review the C1 incidents as part of the Tail Audits, as detailed in the earlier embedded document and previously presented to the Trust Board in November 2018.

10. Conclusion

- 10.1. This paper has sought to set out the fundamental requirements for the management of Category 1 calls and the priority that these calls are given from both the EOC and Field Operations.
- 10.2. The Trust is asked to note the contents of this paper as further supporting information to the paper 130.18 Clinical Safety – EOC Tail Management and CAT 1 Assurance.

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Operational review of Christmas and New Year period – 2018/19

1. Introduction

1.1 The aim of this document is to provide a brief summary of the performance of South East Coast Ambulance Service's (SECAmb's) 999 service during the Christmas 2018 and New Year 2019 period. For clarity, this paper will focus on the period 24 December 2018 to 6 January 2019.

1.2 Separate papers provide a detailed operational look-back for the NHS 111 service in our region during the same period, as well as a detailed review of the Emergency Operations Centres (EOCs).

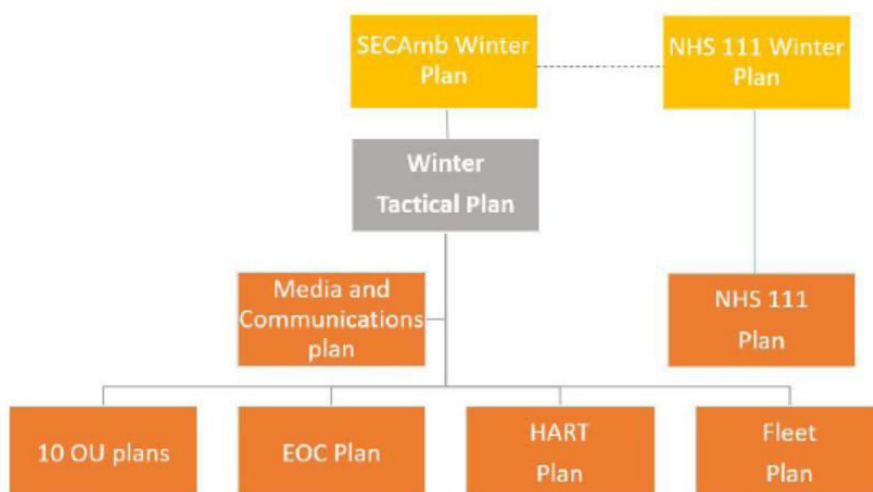
2. Planning and preparation for the Christmas and New Year period

2.1 Learning lessons from previous years, SECAmb worked 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 A **Winter Capacity Plan** to cover the period 1 November 2018 to 31 March 2019 was developed by the Trust and can be found at Appendix A.

2.3 This Plan draws on the experiences of past winters and integrates NHS England recommendations, guidance and criteria for winter capacity planning. 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.

2.4 It also serves as an overarching plan to bring together the arrangements detailed in the individual Operating Unit, Emergency Operations Centre winter plans and the NHS111 Winter Plan, as shown below:



2.5 The Winter Capacity Plan was developed to deliver the following:

Strategic Intentions:

- Maintain a clinically safe service to all our patients
- Mitigate and minimise the impact to the wider NHS
- Inform the public and maintain public confidence
- Ensure sufficient assets are available to manage the event to maintain service delivery to national standards
- Ensure a swift return to normality in the event of an incident

Tactical Intentions:

- To ensure patient safety is at the centre of our actions
- To have a pre-defined Command and Control Structure in place to ensure the operational demand is managed effectively
- To maintain core services through the effective use of escalatory framework
- To ensure that staff welfare is considered by providing refreshments and adequate breaks within the constraints of the demands being placed on the service
- To work with partners to mitigate demands and limit the impact on the wider NHS

2.6 Underpinning our planning assumptions to deliver the above intentions were the following key drivers:

- Maximising staffing on the road and in the control rooms by:
 - Closely managing staff abstraction
 - Incentivising key operational shifts between 24 December 2018 and 6 January 2019
 - Developing individual operational plans for each local Operational Unit, including detailed local staffing plans
 - Maximising support from volunteer CFRs and Co-Responder schemes
 - Utilising operationally-capable managers to provide additional resources
 - Working closely, in advance, with our Private Ambulance Providers (PAPs) to ensure maximum availability of resources
 - Identification of clinically-trained staff, not working in patient-facing roles, who were able to provide additional support at peak times
 - Close, on-going monitoring of resource levels, including conference calls three times per week (in addition to the business as usual, daily 'Teams E' call)
- High-level on-site support from senior managers and Executive Directors on key dates during this period, including Christmas Day, Boxing Day, New Year's Eve and New Year's Day
- Maximising availability of key support functions, including Fleet, Logistics and Make Ready
- Establishment of the Strategic Command Hub at EOC West:
 - Stood up from 26 December 2018 to 3 January 2019

- To provide additional strategic oversight, on-site from 0700 to 2300 hours and on-call overnight, utilising the same methodology as for a Major Incident
- Close working as part of the broader NHS & Social Care system:
 - Ensuring our plans took full account of the guidance circulated in July 2017 by NHS England and NHS Improvement regarding planning for winter 2017/18
 - In line with this guidance and the operational priorities set out by the NHS England Board on 30 November 2017 for 2018/19, the Trust continued to engage with the wider NHS through the CCGs and A&E Delivery Boards to deliver local initiatives
 - Hosting of the NHS England 'Winter South' Team on a number of days across the period
 - Daily up-date calls with the NHS England 'Winter South' Team to identify and share challenges in the region
- Detailed analysis of activity data from preceding years, to identify potential 'hot spots'

2.7 This year, as part of the delivery of the early phases of the Service Transformation and Delivery Programme (STAD), the Trust also benefited from the extensive recruitment of front-line staff, which had taken place during Quarter Three. Including internal transferees, by January 2019 we saw a total of 389 extra staff working operationally to support patients.

2.8 Ahead of the winter period, the Trust had also revised its Surge Management Plan (SMP), to ensure it was as responsive and effective as possible and the revised version went live on 3 December 2018, following in-put from a range of internal and external stakeholders.

2.9 The SMP is utilised by the EOC in situations of surges in call volume, which result in the supply of ambulance service resources being insufficient to meet the clinical demand of patients. The more flexible and immediate nature of this plan will often mean that it provides an effective and expedient response to surges in demand that are likely to be for short durations.

2.10 The SMP is subject to an on-going cycle of review and improvement. Following feedback from its use during the festive period, it is currently under review, with a further revised version likely to go live in February 2019.

3. 999 Performance

3.1 As anticipated, SECAMB experienced sustained and significant pressure across the festive period, although we did not experience poor weather conditions during this time in our region.

3.2 As the information below shows, we performed well overall with some particular areas of improved performance. However, there remain a number of areas where we need to see improvement and on which we continue to focus.

3.3 The tables below show activity levels and performance for the individual periods week commencing 24 December and week commencing 1 January and compared to the same periods last year:

999 Activity levels

w/c 24 December	2017/18	2018/19	Difference
Number of 999 calls answered	17,246	14,664	Decrease of 15%
Number of incidents with a response	14,358	13,542	Decrease of 6%
Number of transports	9,346	8,947	Decrease of 4%

w/c 31 December	2017/18	2018/19	Difference
Number of 999 calls answered	15,011	14,974	Decrease of 0.25%
Number of incidents with a response	13,956	14,413	Increase of 3%
Number of transports	8,923	9,436	Increase of 6%

999 call answer performance

w/c 24 December	2017/18	2018/19
Number of 999 calls answered	17,246	14,664
Average answer time (seconds)	64	5
95 th centile (seconds)	236	19

w/c 31 December	2017/18	2018/19
Number of 999 calls answered	15,011	14,974
Average answer time (seconds)	80	3
95 th centile (seconds)	362	3

Performance against ARP standards

w/c 24 December	2017/18		2018/19	
	Mean Response Time	90 th centile	Mean Response Time	90 th centile
Category 1 - these will be responded to in a mean average time of seven minutes and at least 9 out of 10 times before 15 minutes	00:08:32	00:15:17	00:06:57	00:12:45
Category 2 - these will be responded to in a mean average time of 18 minutes	00:20:03	00:38:38	00:20:05	00:38:11

and at least 9 out of 10 times before 40 minutes				
Category 3 - these types of calls will be responded to at least 9 out of 10 times before 120 minutes	01:52:08	04:17:42	01:38:32	03:56:24
Category 4 - these less urgent calls will be responded to at least 9 out of 10 times before 180 minutes	03:01:11	06:35:55	02:02:35	04:20:57

w/c 31 December	2017/18		2018/19	
	Mean Response Time	90 th centile	Mean Response Time	90 th centile
Category 1 - these will be responded to in a mean average time of seven minutes and at least 9 out of 10 times before 15 minutes	00:08:09	00:14:15		
Category 2 - these will be responded to in a mean average time of 18 minutes and at least 9 out of 10 times before 40 minutes	00:17:08	00:32:17		
Category 3 - these types of calls will be responded to at least 9 out of 10 times before 120 minutes	01:07:55	02:36:23		
Category 4 - these less urgent calls will be responded to at least 9 out of 10 times before 180 minutes	01:41:14	04:15:38		

3.4 As can be seen from the tables above, activity levels for both periods were down compared to last year, which is likely to be explained by the reasonably mild weather conditions experienced during this period.

3.5 A decrease overall in the number of 999 calls can also potentially be explained by the Trust providing an improved service to waiting patients i.e. with the increased number of resources we have available, patients are waiting less time overall for a response, meaning they do not have to make repeat 999 calls.

3.6 It is also interesting to note that, despite a small decrease in the number of 999 calls received for the week commencing 31 December compared to the previous year, the number of incidents that received an ambulance response increased by 3% and the number of patients transported by 6%. Although specific

analytical comparison is difficult, these increases were potentially caused by an increase in the acuity of patients phoning 999.

3.7 As the figures also show, a number of performance areas saw improvement compared to the same period last year:

- 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

3.8 I am pleased to see sustained improvements such as this during a busy and pressurised period and am extremely proud of the efforts of staff and volunteers, both ahead of and during this period, which has seen us provide an improved service to our patients.

3.9 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.

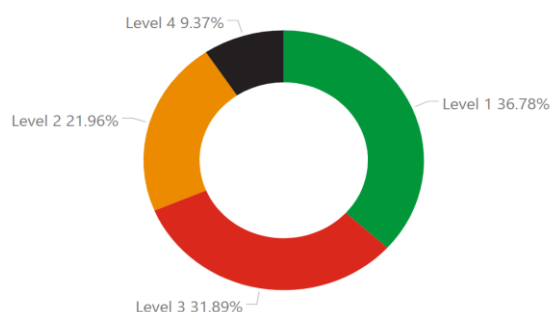
4. Escalation levels

4.1 As explained in 2.9 above, the Trust's Surge Management Plan (SMP) provides a framework for managing escalation. It contains levels of surge linked to specific triggers, from Level 1 (business as usual) to Level 4 (major pressure which prevents the Trust from delivering a comprehensive service to patients).

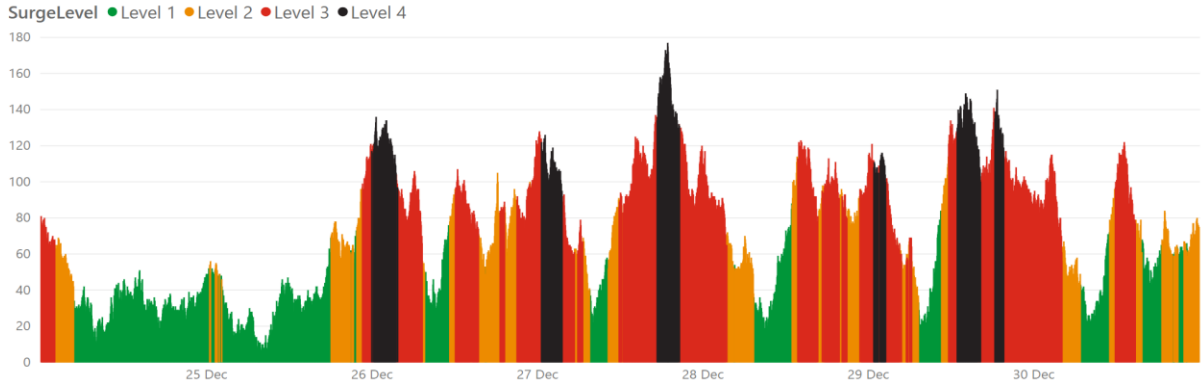
4.2 Analysis of the percentage of time spent at the different levels of surge during this period provides a good indication of the level of pressure experienced by the Trust, taken alongside performance indicators. (Comparison with the previous year is not possible, as surge levels have only been constantly recorded and available to run as a report since July 2018).

Surge Profile – w/c 24 December 2018

Proportion of Triggered Surge

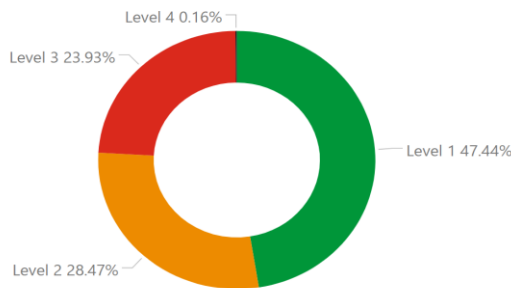


Total Calls Outstanding by Triggered Surge Level

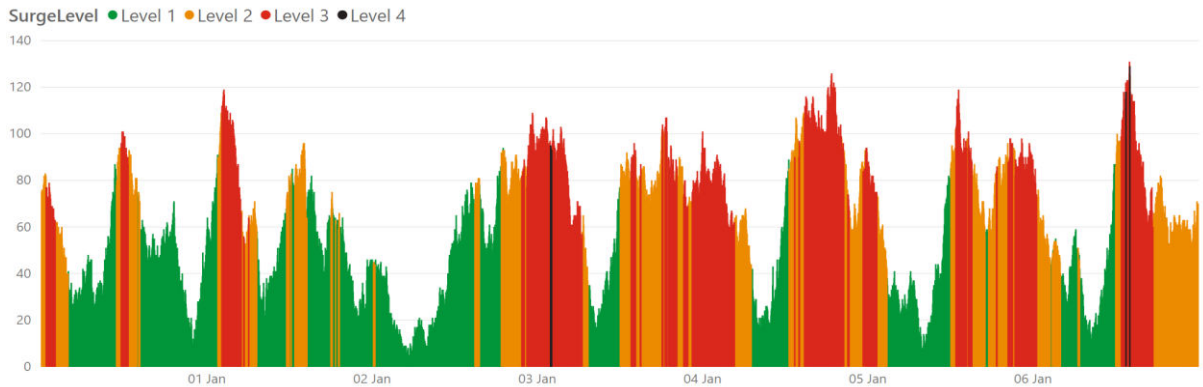


Surge Profile - w/c 31 December 2018

Proportion of Triggered Surge



Total Calls Outstanding by Triggered Surge Level




5. Communications

5.1 As shown in 2.4 above, the Trust developed and delivered a Winter Media & Communications Plan during this period, to ensure that key stakeholders were kept up-dated on challenges and key issues and, importantly, that public messages were delivered as needed to support operational delivery during periods of escalation.

5.2 A key strand of this year’s Plan was the in-house development of a range of bespoke infographics to support the communication of key messages on-line and on various social media platforms:

**HELP US
HELP YOU**
KNOW WHAT TO DO



	Grazed knee. Sore throat. Hungover. Cough.	Self-care
	Diarrhoea. Runny nose. Painful cough. Headache.	Pharmacy
	Unwell? Unsure? GP surgery closed? Need help?	NHS 111
	Vomiting. Ear pain. Stomach ache. Back ache.	GP Surgery
	Choking. Chest pain. Blacking out. Blood loss.	A&E or 999 Emergencies only



NHS
South East Coast
Ambulance Service
NHS Foundation Trust

**HELP US
HELP YOU**
STAY WELL THIS WINTER



**We're currently
facing very
high demand**

Please help us, help you
and only call 999 if you're
facing a life-threatening
or serious emergency

**HELP US
HELP YOU**
STAY WELL THIS WINTER

5.3 Whilst the objectives contained in the Plan will continue into Q1 of 2019, a significant number of winter and demand-specific proactive media releases were

issued during December and into early January, utilising a range of communication mechanisms.

5.4 Following evaluation, key achievements so far include:

- A significant reduction in the number of reactive media statements issued in relation to long response times. This could be down to overall improved response times and a greater understanding of the public of the new response standards, thanks to, in part, communications messaging
- Positive broadcast media coverage, including coverage on ITV including interviews with EOC staff and coverage by BBC South East on the Trust's Hazardous Area Response Team (HART) alongside figures for number of calls handled by the Trust on New Year's Eve
- Significant coverage of Trust messages on social media including:
 - Figure 1 as shown above at 5.2 was estimated by Facebook to have reached more than 400,000 people and was shared more than 5,000 times after it was posted on 4 December 2018
 - Other posts, including Figure 3 above, regularly reached in excess of 50,000 people on Facebook

5.5 While these are estimates and should only be used as a guide, it is worth noting that these figures are far in excess of the reach of many regional newspapers weekly sales. While regional newspapers remain an extremely worthwhile medium in which to achieve coverage of the Trust's key messages, especially given their own online presence and reach, the Trust's own reach via social media, linking to its own website and utilising bespoke media, should not be under estimated.

6. Patient experience, staff & safety indicators

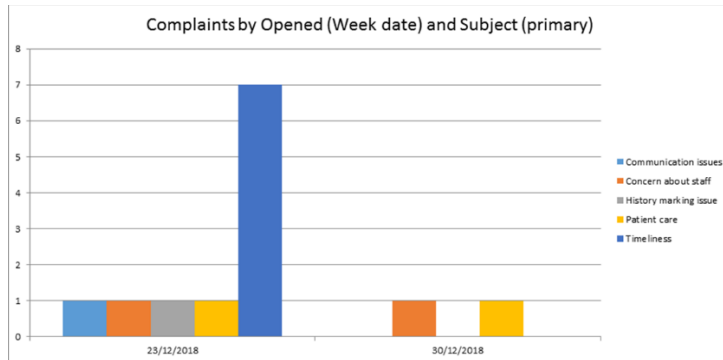
6.1 Alongside 999 performance measures, it is useful to consider a range of other indicators when assessing the Trust's performance during Q3. However, due to the long lag on performance reporting, we will be unable to consider performance against our clinical indicators for a number of months.

6.2 To date, two Serious Incidents (SIs) have been reported, relating to incidents occurring during this period. This compares to ten SIs reported during the same period last year:

- 28.12.18 - (999) call received from Police about a patient who was not breathing. Delay in locating incident as Police unable to provide an accurate location and EMA struggled to find anything with the information given. EMA finished call but did not make a call back to scene to give CPR advice
- 03.01.19 - received a call from care line, regarding an elderly female with slurred speech. After initial care line contact, no further response from patient. This was categorized as Cat 3 (respond within 2 hours). At 12:00 3 x welfare calls were attempted with no answer. Crew arrived on scene to find patient deceased

6.3 These are currently being investigated as part of the SI process.

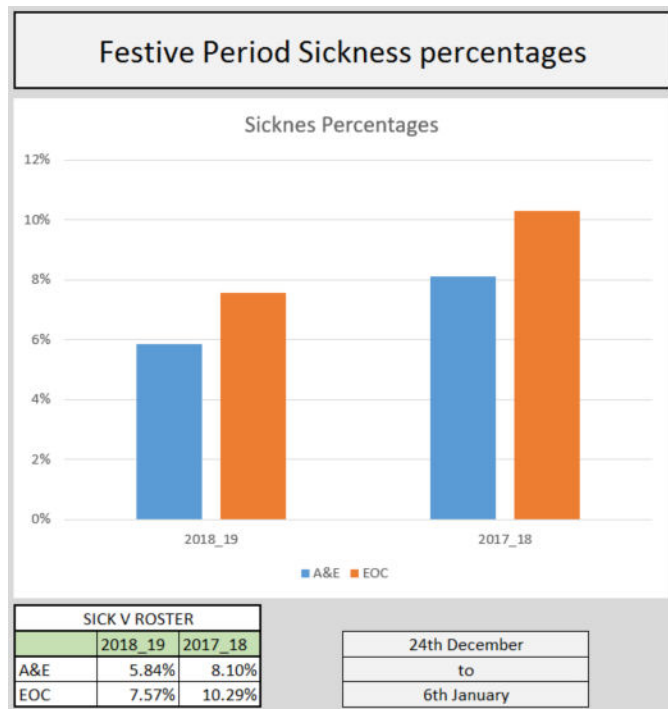
6.4 A review of the number and themes of complaints received relating to incidents during this period is as below:



6.5 When compared to the numbers of complaints received for these periods last year, we saw a reduction in overall numbers for both periods:

w/c 24 December	2017/18	2018/19	Difference
Number of complaints received	22	11	Decrease of 50%
w/c 31 December	2017/18	2018/19	Difference
Number of complaints received	14	2	Decrease of 79%

6.6 Another key indicator to consider for this period is staff sickness levels and, as the table below shows, sickness levels for both A&E and EOC staff were down compared to the previous year for this period.



7. Issues

7.1 The only key issue that the Trust experienced during this period, which impacted on our ability to respond to patients, was hospital handover delays.

7.2 During the past year, the Trust has been working as part of a system-wide programme to reduce hospital handover delay experienced by ambulance crews when handing over patients at acute hospital sites.

7.3 Good progress has been made in many areas and as the tables below show, the total number of hours lost to delays during this period was considerably lower than last year.

w/c 24 December	2017/18	2018/19	Difference
Number of handovers	7,790	7,646	Decrease of 2%
Hours lost over 30 minutes	710	325	Decrease of 54%
Number of handovers over 60 minutes	430	205	Decrease of 52%
Proportion of handovers over 60 minutes	5.5%	2.7%	Decrease of 2.8%

w/c 31 December	2017/18	2018/19	Difference
Number of handovers	7,383	8,079	Increase of 9%
Hours lost over 30 minutes	894	411	Decrease of 54%
Number of handovers over 60 minutes	580	233	Decrease of 60%
Proportion of handovers over 60 minutes	7.9%	2.9%	Decrease of 5%

7.4 It is worth noting however that, despite the improvement in figures for the region at a whole, delays were experienced at individual sites during this period, which in turn had a considerable impact on our local response to patients.

8. Conclusion

8.1 As part of our on-going improvement methodology, we are continuing to review performance in all areas for this period and to identify lessons learned for future years.

8.2 I am also conscious that, we may still experience low temperatures and bad weather across our region, which would increase demand for our services and create a number of logistical challenges. We are continuing to plan for this scenario and monitoring the medium range weather forecasts carefully.

8.3 Finally, I would like to thank all of our staff and volunteers for everything they did to help our patients during this period and throughout the year.

Notwithstanding the improvements we need to make, I am immensely proud of the dedication of every colleague within the Trust and the achievements we have made.

Joe Garcia, Executive Director of Operations
16 January 2019