South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

23 May 2019
11.30-15.15

Crawley HQ

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
Introduction					
01/19	11.30	Apologies for absence	-	-	Chair
02/19	11.31	Declarations of interest	-	-	Chair
03/19	11.32	Minutes of the previous meeting: 28 March 2019	**Y**	Decision	Chair
04/19	11.33	Matters arising (Action log)	**Y**	Decision	PL
05/19	11.35	Board Story	-	Set the tone	Chair
06/19	11.45	Chief Executive's report	**Y**	Information	FM
Trust strategy					
07/19	11.55	Delivery Plan • Deep Dive on 999 Transformation & Performance	**Y**	Information	SE JG
08/19	12.35	Finance & Investment Committee Escalation Report		Information	MW
09/19	12.45	Fleet Strategy	**Y**	Decision	DH
Quality & Performance					
10/19	12.55	Integrated Performance Report	**Y**	Information	SE
Lunch 13.20-13.50					
11/19	13.50	Quality & Patient Safety Committee Escalation Report	**Y**	Information	TM
12/19	14.00	Complaints Annual Report	**Y**	Information	BH
13/19	14.10	Infection Prevention and Control Annual Report	**Y**	Information	BH
Governance					
14/19	14.20	CFR Governance – use of salbutamol	**Y**	Decision	MN
15/19	14.30	Audit Committee Escalation Report	**Y**	Information	AS
16/19	14.40	Information Governance Annual Report	**Y**	Information	BH
17/19	14.50	Workforce and Wellbeing Escalation Report	**Y**	Information	TP
18/19	15.00	Board Meeting Schedule 2019/20	**Y**	Decision	PL
19/19	15.05	Annual Review of Committee Plans / TORs	**Y**	Decision	PL
20/19	15.10	Modern Slavery Statement	**Y**	Decision	BH
Closing					
21/19	15.15	Any other business	-	Discussion	Chair
22/19	-	Review of meeting effectiveness	-	Discussion	ALL

Close of meeting

Date of next Board meeting: 25 July 2019
After the close of the meeting, questions will be invited from members of the public

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting,
28 March 2019

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

Present:

David Astley	(DA)	Chairman
Fionna Moore	(FM)	Executive Medical Director
Angela Smith	(AS)	Independent Non-Executive Director
Adrian Twyning	(AT)	Independent Non-Executive Director
Alan Rymer	(AR)	Independent Non-Executive Director
Bethan Haskins	(BH)	Executive Director of Nursing & Quality
Joe Garcia	(JG)	Executive Director of Operations
Laurie McMahon	(LM)	Independent Non-Executive Director
Lucy Bloem	(LB)	Independent Non-Executive Director
Steve Emerton	(SE)	Executive Director of Strategy & Business Development
Terry Parkin	(TP)	Independent Non-Executive Director
Tricia McGregor	(TM)	Independent Non-Executive Director

In attendance:

Peter Lee	(PL)	Company Secretary
Kim Blakeburn	(KB)	FTSU Guardian [for item 184/18 only]

174/18 Apologies for absence

Daren Mochrie	(DM)	Chief Executive
David Hammond	(DH)	Executive Director of Finance & Corporate Services
Michael Whitehouse	(MW)	Independent Non-Executive Director
Janine Compton	(JC)	Head of Communications

DA welcomed members and those observing, which included a number of governors.

DA confirmed that FM will be acting CEO from 1 April and that Magnus Nelson will cover as Acting Medical Director. This is in advance of Philp Astle arriving as the Trust's new Chief Executive from 1 September 2019.

Finally, DA acknowledged that this will be EG's final Board meeting and on behalf of the Board offered his best wishes and thanks for EG's commitment since he arrived in early 2018.

17518 Declarations of conflicts of interest

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

176/18 Minutes of the meeting held in public on 28 February 2019

The minutes were approved as a true and accurate record.

177/18 Matters arising (action log)

The progress made with outstanding actions was noted as confirmed in the Action Log and completed actions will now be removed.

178/18 Board story [10.07 – 10.15]
This Board story related to an off duty staff member helping to ensure a positive outcome for a member of the public in cardiac arrest. The member of won a staff award and this video was also shown at the recent award ceremony.

JG reflected on the training provided to staff and how for many, working for an ambulance service is more a vocation than a job. He also reinforced from the story the importance of the chain of survival, specifically bystander life support.

179/18 Chief Executive's report [10.15 – 10.20]
FM added her thanks to EG and then updated on the issues set out in the report. She highlighted the staff survey results and felt it was important to recognise the improvement, while at the same time acknowledging the work still to do.

There were no questions.

180/18 Delivery Plan [10.20 – 11.02]
SE introduced the report, explaining how it is structured and monitored, including the supporting appendices. Directors were then invited to update by exception.

<u>Service Transformation and Delivery (STAD)</u>
SE acknowledged the hard work put in to this by whole programme team and wider Trust, to move forward the related work-streams. This includes managing the contract with commissioners and SE confirmed the review being undertaken jointly with commissioners as part of a contract performance notice, to understand the issues in Q3 relating specifically to Cat 2 performance. This is nearly complete and part of the emerging findings point to an unexpected shift in case mix. In other words, the number of patients requiring a response under Cat 2 was much higher than modelled. The related actions will seek to address this.

DA asked whether we are able to provide adequate assurance to commissioners that we are doing all the things we should be. SE confirmed that we are and it is helpful that the review is being undertaken jointly as this helps commissioners better understand the issues. For example, they know that we are ensuring the hours as modelled by the demand and capacity review, and this in addition to ensuring improved staff welfare, e.g. meal breaks and fewer shift overruns.

JG added that we have moved from 53% to above 63% in Cat 2 and this is a trend being seen in other parts of the country. The shift in acuity is a significant factor in why we did not meet the target trajectory. He went on to explain for context that despite the need to do all we can to improve this position, many other Trust are struggling to meet Cat 2 targets; SECamb is middle of pack compared nationally and two minutes better than the national mean.

AS asked whether we can project where we will be in Q1 against the trajectory. JG explained that we do forecast through the programme in terms of the recruitment pipeline, where we have consistently met or exceeded the hours required, but forecasting then the impact on performance targets is difficult given the many variables.

SE emphasised that we are now data-led and have asked ORH to review some of the identified changes so that they can re-run the model to understand how best to meet the changing profile and revalidate performance for the coming year.

DA summarised the discussion noting that this is a live issue and being worked through with commissioners.

LM asked whether we are adequately utilising the provision of private providers. SE confirmed that in Q3 we did not achieve the expected hours, but since then there has been positive progress. However, despite this, we did make up the hours from overtime and Bank, to ensure we met the projected hours.

The Board agreed to take a closer look at how this programme is impacting performance at the meeting in May.

Sustainability

JG confirmed that the interim 111 service has gone live and as yet there are no identified problems. All appears to be working well; up to 10am we were reliant on third party technology but now we are fully integrated with the 999 platform, which helps to demonstrate the benefits of remaining a provider of 111.

In terms of ECPR this has moved Red due to a software issue that we expect to be resolved within 7-10 days.

Quality and Compliance

BH highlighted the following:

Personnel files – the previous project covered staff files and DBS checks. This was then closed this and we now have two separate plans. Regarding DBS checks, BH confirmed that zero staff are without an initial check and there are 15 outstanding for the 3-year renewal; each one is in the renewal process.

TP reflected that this is best we have known it (re DBS checks) and if management is confident in the data then this should be brought in to business as usual, rather than a specific project. BH agreed and confirmed that the project will support a much more robust process.

Audit and Development for 999 – BH outlined the challenges with clinical capacity and the audit tool itself. There are clear actions in place but requires investment, which will come through the business case that has been developed. TM expressed concern that the business case is taking too long to get through and JG provided assurance that it is developed and currently with the Executive as part of the broader cost pressure / priority review.

EOC Clinical Safety – this is RAG-rated Red mainly related to the issue of clinical capacity. We are below the recruitment trajectory and despite the multiple actions and having more clinicians than this time last year, there is still a significant risk. The main challenge is making it an attractive area to work.

DA summarised that we have set ambitious plans we aren't yet meeting but are clear about what needs to happen. There is clear oversight by the Workforce and Wellbeing and Quality and Patient Safety Committees and we should plan a deep dive at Board on clinical support in the EOC.

Action:
Board Deep Dive on EOC clinical support to be scheduled.

Strategy

SE confirmed that the work is progressing and will pick up in more detail in part 2.

HR Transformation

EG updated that there is a meeting planned with FM to review the programme and agree a way forward. In the meantime, work continues to improve processes within clinical education. A revised culture mandate is scheduled to come to QCSG next week and we are in discussion with Health Education England for additional

funding to support our approach to culture, through a pilot; 'Better Place to Work' which targets retention specifically.

TP expressed concern that some areas are RAG-rated Red due to EG leaving, as this points to a lack of organisational resilience. With regards culture, TP reflected that we have had the best ever outcome from the staff survey yet this is RAG-rated Red. He challenged whether we have the right balance between process and outcome, when rating progress. EG responded that it is currently more about process than outcome as we have a mandate yet to be approved. So, although work is ongoing the governance has fallen behind. TP therefore challenged the use of the RAG-rating system. The executive agreed to consider this in its ongoing development of the Delivery Plan report.

The Board then discussed the structure of the culture mandate and agreed to pick this up as part of the planned board development session in April or June.

In relation to enabling strategies, LB noted that many are scheduled over the next few months, and so asked that there is careful planning to get them through the Board.

LB then asked about the cost improvement plan, in the context of this years plan including many non-recurrent schemes. The Board acknowledged this and agreed there is a need for a different approach in 2019/20. A more detailed review of this would be overseen by the Finance & Investment Committee.

181/18 Finance Plan [11.02 – 11.37]

PA started with the slide deck, which summarises the key components of the final plan to be submitted on 4 April, as currently drafted. It is based on the expected income. He took the Board through each slide expanding in some areas to provide clarity and context. In conclusion, he noted the significant risks to the plan, and asked the Board to approve it for submission.

AS confirmed that the Finance & Investment Committee met recently to review the plan, and supported it recognising the huge amount of work by management. However, the committee noted the following;

- It is significant that we have yet to agree income
- The plan only covers one year, as required for NHS FTs.
- As the Board is aware, there has been several areas of under investment in recent years and so to catch up will be a challenge; this is incorporated to an extent in the plan.
- The way the plan is devised, it works back from the control total and demand and capacity review, with the balancing item being the cost improvement programme (CIP); therefore the CIP this year is real.
- The Board will be required to take difficult decisions to manage within its resources and so will need to agree priorities.

DA felt this was a summary and reinforced the need to be open about risks.

TP asked about the confidence in delivery of the capital programme. PA responded that risk is in the planning process; we are on schedule with the main schemes in that they are already approved. Other areas are contracted out, so in terms of capacity there is less burden on employed staff. In other words, PA felt that subject to delays from centre, we are confident we can deliver. DA asked that any slippage is clearly communicated, not just to the Board but to the staff.

SE added that with regards income, we are in dialogue with commissioners and if we end with less than expected income then there will be a direct consequence on the numbers of people we can recruit and therefore level of performance.

There were then some detailed questions from the Board about some of the numbers, assumptions and cost pressures, which were addressed.

DA summarised as follows: we have had a realistic examination of the financial plan and it is important we now go forward with this direction of travel with a sense of realism. The plan has to include a number of assumptions. We need to continue to ensure we manage the Trust effectively; sighted on the significant risks of CIP /cost pressures and ability to meet performance targets. Overall the message is one of flexibility.

Decision
The Board is content to put forward the plan acknowledging the risks and how they are managed, subject to some revisions, including strengthening the section on Carter.

182/18 **IPR** [11.37 – 12.10]
Directors updated by exception:

Clinical Safety: FM highlighted the post ROSC care bundle where we are performing really well, mostly due to input of CCPs.

Quality: BH drew the Board's attention to duty of candour and the dip in performance to 70%. She explained that there were 10 cases and we only completed within timeframe in 7 cases. The target should be 100% (the report states 70% in error). BH went on to reassure the Board that we have fixed the issue, which related to a process problem, and is confident that we will be back to 100% from next month.

Operations: JG confirmed that Cat 2 performance remains a challenge, but is relatively steady. Call handling is improving and we now have much more granular data to understand what is happening. In the paper is the last 13 week data showing progress in this period, which included the highest number of calls ever. Although we are coming out of winter there is a new norm being established as a consequence of meeting previously unmet demand, i.e. calls previously cancelled.

The Board explored whether there are distinct reasons to plan differently for winter, in the context of the reasons for growth/demand; is it for example related to other gaps in the system and where in the system do we have systemic view of demand. SE explained that we have such conversations with commissioners and share some data, e.g. data on unmet demand and the link to self-presenters at A&E.

DA summarised that we need to continue to understand the changing demand on our services and, with commissioners, work through the clinical context and different seasonal variation, continuing to provide the evidence.

Workforce: EG reflected that he is struck by the consistency of care provided by our staff and their desire to improve the quality of care. He heard recently of the work of staff in Brighton on improving care for the homeless.

In terms of the scorecard; firstly EG confirmed that we continue to develop and manage workforce and clinical education to ensure alignment with STAD and 111; sharing openly with commissioners and Health Education England each month. Work to investigate employee relations cases continues and we have halved the open cases; 64 are currently open, most of which are grievances.

TP asked about the variation in stat/man figures and EG explained some of this relates to new staff coming in.

AR asked about trainee paramedics and an issue raised recently at the Council of Governors. EG explained there are two things; firstly the placements that trainee paramedics require, we are working with St. Georges on this. Secondly, regarding supervision for new paramedics, we are ensuring that we meet requirements through the workforce trajectory planning. Overall however there is more work to improve relations. The Board noted that this is an area being reviewed by the Workforce and Wellbeing Committee.

Finance: PA confirmed we are on track to meet the control total. Cash and capital is also on track. AS added that while we have good financial control, we need more transparency on the way we make decisions.

[Break 12.10 – 12.23]

183/18 Telephony BCI [12.23– 12.26]
JG updated that the look back review is due to conclude shortly. The issue is not related to the new platform, but a technology issue identified after 14 hours. It was addressed promptly and the business continuity plans were activated and were effective.

184/18 FTSU Guardian [12.26– 12.45]
KB confirmed that this is her first report since joining as FTSU Guardian. She thanked BH and TM for their support and outlined some of the themes emerging, which include bullying and harassment and lack of leadership training.

With KB, the Board reflected on the Prof Lewis recommendations and link to leadership training and staff voice, specifically the ability locally to raise concerns safely. There was also discussion about the worrying trend about how staff jump initially to a grievance and the urgent need to address this so there is more informal, but effective, resolution. The Board tested the appetite for outsourcing some investigations and other some of the other interventions that might be needed.

Action
Executive to bring through WWC a target number of grievances to be expected, and a plan to achieve that number and ensure more timely resolution of formal investigations.

JG set out the plans in place for leadership training and development within operations, which aims to achieve in the first instance a minimum level. EG also updated the work to develop HR Business Partners to build line management capability.

LB reflected that FTSU is one avenue to obtain staff feedback and so the Board needs to understand what other routes exist and how effective they are.

Action
Paper for the Board setting out the routes available for staff to raise concerns / be heard and an assessment of their effectiveness.

DA summarised that the FTSU Guardian is effectively the backstop, but is currently overwhelmed as we haven't refined our systems to ensure staff can speak up. The executive has been asked to think through what can be done to improve this.

DA then thanked KB for her efforts.

185/18 **AUC** [12.45 – 12.52]
AS expressed concern that papers continue to arrive late and the adverse impact this has on the effectiveness of the committee. She then took the Board through the outcome of the meeting as set out in the report.

There were no questions.

186/18 **FIC**
Verbal update to be provided in part 2 related to the items on the agenda.

187/18 **CFC** [12.52– 12.58]
AS described the work to review the governance framework for charitable funds, using the meeting as a workshop. AR added that we are exploring interesting questions about use of charitable funds.

DA reflected that this is an opportunity to capitalise on the standing in the community of an ambulance service.

188/18 **Carter Update** [12.58 - 13.06]
JG outlined some of the progress made against the aspects from the review, as set out in the paper. The model ambulance portal is due to come online in May and will allow us to measure our metrics against others almost instantly. The level of detail is way above what we would share today as national benchmark data; so will allow us to drill down in to processes and link to costs.

Action
FIC to use Carter as a reference point to check progress against CIP.

189/18 **Any other business**
TP raised that we are in Purdah from next week and agreed to share some guidance published recently.

190/18 **Review of meeting effectiveness**
The Board felt that it was a good meeting, with constructive challenge. However, the meeting over ran.

There being no further business, the meeting closed at 13.07

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

Date _____

South East Coast Ambulance Service NHS FT Trust Board Action Log

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
25.01.2018	162/17	Board to receive a paper in the summer, setting out the totality of the Trust's governance structure. An outline plan of what is to be prepared to be agreed by the Audit Committee.	PL	25.07.2019	Board	IP	The latest interation of the governance and assurance framework was considered by the Audit Commtitee in March (see escalation report on the agenda). The aim is to agree the final version in May, ahead of the Board meeting on 23 May 2019. **This item is deferred to the July AUC meeting.**
27.03.2018	197/17	Data on employee relations cases – numbers outstanding; time taken to resolve; benchmark against others Trusts – to be included in the IPR as part of its review.	SE/EG	Q1	Board	IP	Review of the IPR will come to the Audit Committee in July.
30.08.2018	82/18 b	Fleet Strategy to be considered by FIC in October	JG	23.05.2019	FIC	C	The committee agreed that further engagement was required prior to it considering it for recommendation to the Board. An engagement session has been organised and the aim is to have a final version for Board approval in May - On agenda
25.09.2018	98/18 a	A Board seminar to be arranged to understand the broad generality of the Major Incident Plan and Board's responsibilities relating to other agencies.	PL	TBC	Board	IP	To be added to the board development schedule for 2019/20
25.10.2018	117/18	Board seminar to be arranged to discuss about we are ensuring staff wellbeing / working lives. Including retention and pay structures.	PL	TBC	Board	IP	To be added to the board development schedule for 2019/20
24.01.2019	145/18a	The executive to review the structure of the Delivery Plan report, including how to reflect the dependencies on the Trust's strategic aims, to help the Board focus on the key areas.	SE	Q1 2019/20	Board	IP	
24.01.2019	145/18c	The executive to assure the Board that HR is appropriately funded – via workforce and wellbeing committee.	Exec	Q1	WWC	IP	
24.01.2019	145/18d	Confirm to the Board the timeline and approach to developing the CFR / Volunteer strategy.	JG	25.07.2019	Board	IP	Aim is to bring to Board via QPS in July

24.01.2019	147/18	Board seminar during 2019/20 on R&D progress and how it is impacting on improving patient care.	PL	tbc	Board	IP	To be added to the board development schedule for 2019/20
24.01.2019	150/18	WWC to explore how best to get the right level of detail at Board with regards to ensuring the right staffing levels.	EG	Q1	WWC	IP	
24.01.2019	151/18	Board's approach to diversity and inclusion and the aims is was to achieve to be considered as part of the board development programme.	PL	TBC	Board	IP	To be added to the board development schedule for 2019/20
28.02.2019	161/18	Paper to the Board during Q2 updating on the work of the Trust in terms of public awareness / training, e.g. CPR.	JG	Q2	Board	IP	
28.02.2019	162/18a	WWC to review whether any link can be established between take up of flu vaccinations and sickness rates.	PL	TBC	WWC	IP	
28.02.2019	162/18b	Details of the (hospital handover) system wide learning programme to be brought to the Board in due course.	BH	TBC	Board	IP	
28.02.2019	163/18a	Outcome of the - CPN- Q3/Q4 review to come to the Board.	SE	Q1	Board	C	On agenda - Deep Dive 999 Transformation & Performance
28.02.2019	163/18b	A more forward view which predicts the level of performance to be included in either the Delivery Plan / IPR.	SE	Q1	Board	IP	
28.02.2019	163/18c	WWC to scrutinise the system for ensuring support and recruitment of student paramedics	PL	TBC	WWC	IP	
28.02.2019	167/18	Paper to the Board in due course setting out the implications of the new national guidance on learning from deaths.	FM	Q2	Board	IP	
28.03.2019	180 18	Board Deep Dive on EOC clinical support to be scheduled.	JG	27.07.2019	Board	IP	
28.03.2019	184 18a	Executive to bring through WWC a target number of grievances to be expected, and a plan to achieve that number and ensure more timely resolution of formal investigations.	PR	11.07.2019	WWC	IP	
28.03.2019	184 18b	Paper for the Board setting out the routes available for staff to raise concerns / be heard and an assessment of their effectiveness.	PR	27.07.2019	Board	IP	
28.03.2019	188 18	FIC to use Carter as a reference point to check progress against CIP.	DH	TBC	FIC	IP	

Key

	Not yet due
	Due
	Overdue
	Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	06-19

Name of meeting	Trust Board
Date	23.05.2019
Name of paper	Chief Executive's Report
Author name and role	Dr Fionna Moore Interim Chief Executive
Synopsis	The Chief Executive's Report provides an overview of the key local, regional and national issues involving and impacting on the Trust and the wider ambulance sector.
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.

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

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S REPORT TO THE TRUST BOARD

1. Introduction

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

2. Local issues

2.1 Changes at Board level

2.1.1 On 1 April 2019, I took on the role of Interim Chief Executive following Daren's departure from the Trust and ahead of Philip Astle joining SECAmb as our new substantive Chief Executive in September 2019.

2.1.2 I am very proud to be undertaking this role and grateful for the support received so far from my Board colleagues and from the wider organisation as a whole during what has been a busy period.

2.1.3 In March 2019, Paul Renshaw joined us following our announcement that Ed Griffin, Director of HR & OD would be leaving SECAmb at the end of April 2019. Paul was able to have a short, hand-over period ahead of Ed leaving and will be with the Trust until the end of December 2019.

2.1.4 The Trust has now started the process for the substantive recruitment and we will provide up-dates in due course.

2.1.5 I am very pleased that in June 2019, Dr Richard Quirk will be joining the Trust as Deputy Medical Director. Richard, a GP, is currently Medical Director at Sussex Partnership Trust but also worked with SECAmb recently as NHS I's Improvement Director.

2.1.6 I am also pleased to welcome both Dr Robin Warshafsky and Dr Magnus Nelson to the Trust as Assistant Medical Directors. Robin is a GP and has a wealth of experience in urgent care, whilst Magnus is an experienced A&E Consultant, already well-known within SECAmb through his work with the Air Ambulance.

2.1.7 Magnus is currently taking on the role of Interim Medical Director, ahead of Richard Quirk joining SECAmb, at which point Richard will take on that role until September 2019.

2.2 Executive Management Board (EMB)

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

2.2.2 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 reviewed and discussed the Trust's contractual position
- Been actively involved in the preparation for and submission of the NHS 111 bid
- Paid close attention to the Trust's response time performance, especially Category 3 performance

2.2.3 In April 2019, the EMB also held one of the quarterly Executive Resilience Committee meetings. This Committee is responsible for all matters relating to Emergency Prevention, Preparedness & Resilience and during this meeting, received a report of the Trust's preparations for the UK's exit from the EU.

2.3 NHS Staff Survey results

2.3.1 Following publication on 26 February 2019, of the 2018 NHS Staff Survey results, we have committed to taking a two-strand approach to addressing the issues highlighted in the results – at a corporate and at a local level.

2.3.2 At a corporate level, the three areas that the Board has agreed to focus on are:

- Leadership communications
- Improving the quality of appraisals
- Looking after our staff better

2.3.3 Work is already underway in each of these areas and progress will be monitored through the Executive Management Board (EMB) and through the Workforce and Wellbeing Committee.

2.3.4 At a local level, managers have been supplied with results for their own area, which will enable them to focus on developing local plans, with their teams, to address the issues which are relevant to their staff. Progress in delivering these plans will be monitored through the Area Governance structure for operational teams and by Directors through their departmental meetings with support teams.

2.4 Management training/induction

2.4.1 At its meeting in April 2019, the Workforce and Wellbeing Committee identified an emerging theme relating to management induction / training, which links to some of the internal control issues currently being experienced. The committee escalated this to the Executive Management Board (EMB), and a gap analysis was undertaken relating to both management induction and training.

2.4.2 The initial findings were received by EMB on 15 May 2019 and the next steps will be agreed over the coming weeks. An update will be provided to the Workforce and Wellbeing Committee on 13 June 2019.

2.5 Engagement with local stakeholders & staff

2.5.1 During April and May, I have met with a number of our key external stakeholders including the Chief Executive and senior teams of a number of our

acute hospital partners, including Medway, East Sussex Health and Maidstone & Tunbridge Wells Trusts.

2.5.2 These meetings are obviously beneficial in an operational sense but are also vital if we want to build strong relationships and play an important role in the evolving regional STPs as they develop into ICSs (Integrated Care Systems.

2.5.3 On 29 April 2019, I also met with Assistant Chief Constable Nev Kemp from Surrey Police, who is one of our appointed Governors. This was a great opportunity to meet Nev and have time to discuss how our organisations can continue to work well together, as evidenced by the recent success of the Joint Response Unit **3**

2.6 Care Quality Commission (CQC) inspection

2.6.1 Last week, the CQC confirmed that they will be carrying out their next inspection of the Trust during this coming summer. The Core Services element will take place in early June, followed by the Well Led inspection in July.

2.6.2 I am looking forward to the opportunity to show the CQC that, although we have more to do, we have made real progress since their last visit and that we have fantastic staff, providing excellent care to our patients, every day across our region.

3. Regional issues

3.1 Visit by the Information Commissioner's Office (ICO)

3.1.1 During May 2019, the ICO visited SECAmb and undertook a mini-audit of the Trust, as part of their regular programme of visits. The ICO are an independent body, responsible for upholding information rights in the public interest and national regulators regarding information and Information Governance.

3.1.2 Whilst there was an agreed programme for their visit, the ICO also took the opportunity to talk to operational staff and visit the Quality Improvement Hub.

3.1.3 We have not yet received the draft audit report from the ICO, however feedback received to date has been largely positive.

3.2 Go live of interim NHS 111 service

3.2.1 On 28 March 2019, the Trust went live with a new interim NHS 111/Integrated Urgent Care Service for Sussex, North and West Kent and Medway for 2019/20. This followed a considerable amount of additional work for the staff involved and was an extremely busy period. Thank you to the staff involved for their efforts.

3.2.2 Shortly after go-live, an issue was identified whereby a number of 111 calls, which had reached an ambulance disposition, had been closed in error. Immediate action was taken to prevent further occurrences and an investigation started and I am pleased that our systems enabled us to identify this so quickly.

3.2.3 A thorough review has been undertaken and this is currently going through our governance processes together with our Commissioners. However, initial findings

indicate a very small number of calls were affected. Each of these have been looked into in detail and two have been identified, that were triaged as Category 2 999 calls, where there was a potential risk of the patient involved suffering harm due to a delay in our response.

3.2.4 As a consequence of the immediate action taken, the issue was resolved and there has been no reoccurrence.

3.2.4 On 18 April 2019, the Trust submitted a bid to run the NHS 111 & Clinical Advice (CAS) service in Kent, Medway and Sussex from April 2020 onwards, following. At time of writing, the outcome of this submission is not known.

4. National issues

4.1 European Emergency Medical Services (EMS) Congress 2019

4.4.1 Between 26 and 28 April 2019, I was very proud to have been asked, once again, to speak at the EMS 2019 Congress, held this year in Madrid. More importantly, I was delighted that, for the first time, SECAmb sent a multi-disciplinary team to attend the Congress, which provided an invaluable opportunity to learn from best practice from across the sector and from across Europe.

4.4.2 As part of the Congress, our SECAmb team also took part in the European EMS Championship - a fun, challenging and educational experience for emergency medical personnel, who compete in scenario-based events that test each team's ability to manage patients in various circumstances. Well done to our team who worked really hard in preparation, competed strongly against dozens of other teams from across Europe and put in a fantastic performance.

4.4.3 During my visit, I also had the opportunity to visit the Madrid state-of-the-art, multi-disciplinary emergency control room in Madrid and to witness the preparations for the Madrid Marathon, which coincided with the Congress.

4.4.4 The Congress was an extremely useful event and I was extremely proud of the contribution of our whole team and how they all embraced the opportunity to learn from the best practice being shared.

4.2 National vehicle specification published

4.2.1. In early April 2019, the national ambulance vehicle specification for English NHS ambulance trusts was published by NHS Improvement.

4.2.2 This follows Lord Carter's review last year into efficiency and productivity within English ambulance trusts, which found 'unwarranted variation' in the national ambulance fleet and which recommended a rapid move to a single vehicle specification for all Trusts to follow.

4.2.3 We have already been working hard to take account of Lord Carter's recommendations, which have been incorporated into our new Fleet Strategy.

5. Recommendation

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

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	07-19

Name of meeting	Trust Board
Date	23 May 2019
Name of paper	PMO Delivery Progress Update
Responsible Executive	Steve Emerton, Director of Strategy and Business Development
Author	Eileen Sanderson, Head of PMO
Synopsis	This paper provides a brief update on the progress made to the Delivery Plan
Recommendations, decisions or actions sought	What is the board/committee being asked to consider and/or decide? • To note the continued progress made in relation to the PMO governed projects • To note the new and emerging projects • To review the dashboard on the current progress of the Delivery Plan • To note the progress made on the CQC Must and Should Do's

Does this paper, or the subject of this paper, require an equality analysis record ('EAR')? (EARs 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. CQC Should Do Action Plans for 999 Audit & Development, Pain Assessments and Training Compliance are no longer reporting into the Quality & Compliance Steering Group:

    - 999 Audit & Development plan is reporting into the EOC Governance Group.
    - Pain Assessment plan is complete.
    - Training Compliance plan is now complete.
    - Safeguarding plan is now complete.

2. Following a workshop with Senior Managers, it has been agreed that the EOC Clinical Safety & Performance improvement plan will be refreshed to re-focus on clinical safety and drive ownership of the activities required to achieve results.

3. The Trust successfully launched the new 111 IUC interim service on Thursday 28 March 2019 at 10.00am. The launch of this service sees the Trust continuing to provide NHS 111 services for North and West Kent, Medway and Sussex. SECAmb will be the sole provider of the interim service for the duration of the 12-month contract, whilst the Trust awaits the outcome of the procurement bid which will allow the Trust to deliver integrated urgent and emergency care for patients across its footprint.

4. Additional documentation e.g. Project RACI, Stakeholder Plan, Dependencies log and Communication plan have recently been introduced within the PMO Project Lifecycle to improve and enhance consistency in standards and processes at each stage throughout the project lifecycle.

5. Strategy Steering Group will no longer be reporting to the Trust Board via the PMO as this is part of Business as Usual. The Steering Group will continue to meet monthly, chaired by the Executive Director of Strategy and Business Development.

Since the last reporting period the Incident Management and Personnel Files projects have been closed and 2 change requests have been approved; NHS Spine Connect project end date extended to 30 June 2019 and the STAD mandate revised to provide more clarity on objectives and KPI measures. Three Post Project Implementations have also been carried out and approved; Complaints, Safeguarding and Infection Prevention Control.

The CQC Must Do/Should Do Tracker has been updated and can be found in appendix A.

The Steering Group/Programme Dashboards are included as appendices (see appendices B-E) to provide a snapshot of progress except for the HR Transformation Programme.

1.0 Introduction

1.1 This paper provides a summary of the progress for the Trust's Delivery Plan. The plan includes an update on the following Steering Groups:

- CQC Must Do/Should Do Tracker - see appendix A
- Service Transformation and Delivery Programme – see Appendix B
- Sustainability – see Appendix C & D
- Quality and Compliance – see Appendix E

1.2 The Steering Group Dashboards provide 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 programme RAG remains Amber. The recent CPN notice issued by Commissioners (NWS CCG) regarding non-compliance of Category 2 performance for Q3(18/19) has an impact on STAD which has resulted in the creation of an improvement action plan. There remains a risk that performance is not achieved by the end of Q1(19/20) and this is being actively managed via actions within our remedial action plan.

The PAP contracts award is 32 days behind schedule. The new contract terms have been well received by providers, but documentation is still to be finalised. However, PAP Providers are now working the contracted hours. Discussions continue with providers, and SECAmb staff, in a bid to close the gap in filling the required number of hours for Q1 (19-20), in particular weekend working.

The Ambulance Handover workstream is still at risk of delivery, principally due to system and Acute pressures. SECAmb staff working with system partners, and supported by CCGs, have developed a shared approach to reducing delays and established good working relationships at most sites. Peer review visits have been undertaken with support from the Emergency Care Intensive Support Team (ECIS) and best practice is being shared. Live joint conveyance review at individual sites is taking place.

The New Rota implementation across operating units has been a success with the implementation taking just over 7 months as opposed to the usual 3 years. 80% of new rotas are now live. This leaves the final 3 dispatch desks; Paddock Wood, Polegate and Hastings are on schedule to go live by 31 July 2019. Engagement with staff and mobilisation across Operating Units has been good. New Rotas are tailored to meet demand in individual areas based on the jointly developed Demand & Capacity review. All submitted rotas are accompanied by a rota demand tool to monitor that the presented rota meets the required demand profile.

The Fleet workstream is progressing well. The Business case for the additional 50 DCA's is scheduled to go to the Executive Management Board for approval. The Fleet Strategy has been developed and scheduled to go to the Finance & Investment

Committee on the 13 May 2019 for approval. From April 2019, DCA's have been moved across the patch to align vehicles with operating units staffing requirements.

Recruitment campaigns across the region continue to attract candidates to address the current Emergency Care Support Workers (ECSW) vacancies.

3.0 Sustainability

3.1 **111 (CAS) Interim Service (Sussex, West Kent, North Kent & Medway)** – The RAG has moved from Amber to Green following the successful launch on 111 IUC and the following stable performance over the key Easter period. A significant number of activities for the CAS remain open and these will be picked up under phase 2. The project team are now closely working with NHSE / CCG's as part of the formal closure process. It is anticipated that this project will be formally closed in the next reporting period.

3.2 **111 CAS Contract Exit KMSS** – The RAG rating has moved from Amber to Green. The Trust successfully launched the new 111 IUC interim Service on 28th March 2019 at 10.00am exiting KMSS 111 contract. There are a couple of outstanding activities which need to be completed to ensure the outcome has been successful. The expectation is that the project will be formally closed during the next reporting period.

3.3 **Worthing Ambulance Make Ready Conversion –** This is the first reporting period and the project RAG is Amber. The aim of this project is to improve the infrastructure of the SECAmb estate in the Worthing area. Up until recently, SECAmb was responding from 3 ambulance stations based at Littlehampton, Worthing and Shoreham which was impacting on our ability to maintain a high standard of, medicines management compliance, vehicle cleanliness, rotation of consumables. Hours were also being lost due to the location of stations and their distance from local hospitals and also at shift start and finish times. With all staff reporting to one location, the vehicles will be prepared which will help to improve operational capacity and the capability of SECAmb to deploy clinical resources.

A further business case has been drafted to reflect unavoidable and necessary works to make the site secure, alleviate Health & Safety concerns and provide a duty of care to staff welfare. Contractors have been on site since March 2019 and are due to complete on 23rd June 2019.

3.4 **Digital Programme**

3.4.1 **Automated Temperature Monitoring** – The project RAG remains Green. Go live went ahead as scheduled on 28 February 2019, however, there are a couple of outstanding activities which need to be completed to ensure the outcome has been successful. The expectation is that the project will be formally closed in the next reporting period.

3.4.2 **Cyber Security** – The project RAG has moved from Green to Amber. The original April migration dates for East and West EOC's had to be rescheduled as insufficient preparatory work had been completed. West EOC is now complete and East EOC scheduled for 25/26 June 2019. Change request drafted to extend end date of project to 31st July 2019. The Trust have taken on-board the lessons learned from the Crawley migration and are working with EOC Systems and a number of external vendors to minimise the impact of the Coxheath work. Co-ordinating availability from multiple vendors and liaising with EOC for a suitable slot has meant delaying until late June 2019 as above.

3.4.3 **ePCR** – The Project RAG remains Red due to delays in starting the 'Pre-live' testing. The impact this has is that the system will be 'live' on the platform but full roll out is not expected as planned in July 2019. A change request is currently in development to extend the project end date to 30th November 2019.

The familiarisation training to all staff will commence from the 1 June 2019 and this will run concurrently with the Key Skills Programme. For those who have already undertaken the Key Skills Programme, discussions are taking place with Operating Unit Managers to ensure that this cohort of staff undertake the ePCR familiarisation training at a future date.

It is expected the RAG status will move to Green in the next reporting period once the system has gone live and training has commenced.

3.4.4 **Replacement Fleet Management System** – The project RAG remains Green as the system is live, however, there are two outstanding activities which need to be completed by the end of May 2019 to ensure a successful outcome. It is anticipated that the project will formally be closed during the next reporting period.

3.4.5 **NHS Spine Connect** – The project RAG remains Green. A Change request was recently agreed to extend the project end date to 30 June 2019. The final element (Summary Care Records) is waiting on NHS Digital accreditation before it can be implemented at SECAmb.

3.4.6 **GoodSAM** – The Project RAG status remains Red. The Trust is waiting for an updated code drop from Cleric for the final fixes which will enable the system to go live by end of May 2019. The system is currently being tested by EOC Systems Team and would require an extra day of testing after the issue being resolved before rolling out.

3.4.7 **Station Upgrades** – The project RAG remains Green. Deployment of new PCs and screens has been extensively communicated and is now more than 50% complete. Installation and cutover to new managed network circuits is 55% complete. Some ACRPs have lost connectivity for longer than expected during this process which has been managed with EOC operations. Cabling of multiple Wi-Fi Access Points required at larger sites is 40% complete. On track to deliver within the agreed timescales.

3.4.8 **IT Helpdesk Replacement –** The project RAG remains Green. The new Helpdesk System successfully went live on 8 May 2019 with EOC Systems and IT Support Teams now using the system to manage IT requests. The self-help portal went live for all staff and weekly bulletins were disseminated to promote the system throughout the Trust. There are a few post go live activities to be completed but it is expected that this project will be formerly closed in the next reporting period.

3.4.9 **East EOC –** The project RAG has moved from Green to Amber as the project is unlikely to be completed by the agreed timescales. Server room air conditioning was successfully replaced and is now fit for purpose. Commissioning of the replacement UPS requires power to be shut down in the ground floor server room which will affect CAD and EOC telephony at Coxheath during the works therefore IT, EOC and third parties are working toward agreeing a site shutdown at the end of June 2019 to support. Visual alerting cannot be commissioned until the UPS has been installed. A project change will be requested to extend completion date to end of July 2019. This will mean that the power vulnerability, due to their only being one power between the UPS and generator, will remain for an additional month.

4.0 Financial Sustainability

4.1 **CIP –** The RAG rating for the Cost Improvement Programme has been assessed at Amber at this early stage of the new financial year. The savings target of £8.6m has been allocated to Directorates based on their individual pro rata share of operating expenses to total Trust operating expenses. Directorate targets have been further allocated against business areas/cost centres in the same way.

The Pipeline Tracker reflects these allocations as "Proposed" schemes and they will be reduced during the course of the year and replaced by definitive CIP schemes when constructed by Budget Holders. The Finance Team within the PMO will assist Budget Leads with the development of definitive savings schemes. Fully validated CIP schemes will be moved to the Delivery Tracker after QIA approval. There has been positive engagement with Execs and Budget Leads in agreeing the CIP targets. The CIP Programme governance framework and processes will be continued into 2019/20. It is fully functioning in the business and was given a "Substantial Assurance" rating by Internal Audit in April 2018.

The CIPs schemes to be developed will include any savings that might arise from i) the actions of the four Sustainability Transformation Programmes (STP) with which the Trust is engaged ii) the Carter Recommendation for Ambulance Trusts ii) operations efficiencies relating to improved sickness rates, reduced handover delays, reductions in task cycle time and increases in key skills training to the extent that these can be realised. £1.0m of savings have been transferred to the Delivery Tracker as at the Month 1 reporting date, of which £0.1m has been delivered to date in line with the Plan. The Pipeline Tracker and Delivery Tracker (Appendices F & G) provide more detail on the construction of the CIP Programme.

5.0 Quality & Compliance

5.1 **Governance and Risk** (CQC Must Do) – The project RAG has moved from Amber to Red due to some policies and procedures which will not be updated prior to 30 June 2019. There is a plan in place that will ensure the majority meet the trajectory for 9 July 2019 (the JPPF meeting where policies are approved), but to date nine do not meet this trajectory and there is some risk to a small number that do have trajectory; for these, works continues to support the various leads. Despite the project not achieving one of the objectives (to ensure 100% of policies and procedures are reviewed and up-to-date by 30 June 2019), the plan is still to move this in to business as usual from July 2019, by which time the expectation is that less than 10% will be outstanding. All other aspects of the project have either been completed or are on track.

5.2 **Personnel Files** – The RAG rating has moved to Blue as the project was closed on 28 March 2019 following a decision at QCSG to separate out the DBS and Personnel Files Solution elements into 2 new projects. The scope and objectives for these projects are currently being revised. Both Projects will continue to report to QCSG.

5.3 **Health & Safety –** The project RAG rating remains Green. All remaining objectives are on track for completion on the dates specified within the improvement plan.

Health & Safety audits are progressing well, and so far, 40 audits have been completed trust wide. All sites audited are provided with a detailed action plan to improve on any non-compliant categories identified during the audit.

Currently the organisation has an established (CHSWG) Central Health & Safety Working group which meets on a quarterly basis. Due to the Health & Safety improvements being

made we shall be introducing 5 new sub groups which will meet on a bi-monthly basis. The new sub groups are listed below and will report into the CHSWG.

- East Region Health & Safety Group
- Central Region Health & Safety Group
- West Region Health & Safety Group
- Fire Safety Group
- Water Safety Group

5.4 **Audit & Development for 999** – The project RAG remains Red due to the Trust not being able to deliver the required levels of audit to remain compliant with NHS Pathways and Manchester Triage licences. A Business Case has been put forward to seek approval to increase capacity within the EOC Audit and Training team to facilitate the basic delivery of audit and training requirements to enable the effective assessment, monitoring and subsequent improvement to the quality of services that EOCs provide to our patients. On the basis that the business case is approved, the implementation of the structure will be overseen by the EOC Governance Group and will no longer be required to report into the Quality & Compliance Steering Group and therefore will not be included in this report from the next reporting period.

5.5 **EOC Clinical Safety & Performance –** The project RAG remains Red however there has been progress in key areas such as EMA recruitment and retention, audit proposal and dispatch. Effective non-clinical staffing levels are on target to meet new establishment levels by June 2019, supported by a reduction in EMA turnover against forecast. Resignations from EMAs leaving the trust improvement having dropped from an average of 14 a month Q4 2017/18 to 6 a month in Q4 18/19.

Overall, the recruitment non-clinical pipeline is strong with September 2019 courses currently being populated. Focus is shifting to attracting part time workers over the next few months, to support the retention strategy to employ 50% of call handling establishment as part time workers. Key learning will be to be collated to identify early trends in part-time staff turnover.

A strategic and full clinical resource plan, broken down by roles and numbers is being developed. This will be complimented by a recruitment tracker and aligned KPI's supported by documented communications. A clinical candidate attraction strategy will be developed and costed, seeking approval for additional spend required. The use of agencies is being investigated to support interim arrangements. Exploration, pilot and implementation elements have been identified and are progressing for example using GP's in the EOC.

A full retention and development plan will be produced by the EOC with their HR Business Partner to outline the steps that will be taken to retain and re-engage existing staff. Feedback will be sought from existing clinical staff as to what is good about the jobs they do and what they would change. This will be fed into the candidate strategy, retention & development plans. A key focus being the attraction retention and efficiencies of staffing.

For the international recruitment, the initial plan for staff to come on board was ambitious. This has led to a revised plan for a reduced number of candidates to have commenced by August 2019. The revision has been driven by the slow progress to obtain the English qualification prior to visa application.

Recruitment of UK clinicians on the whole is more positive, with 3 Clinical Supervisors in training. 6 candidates were offered an interview on the 8 May 2019 but only 1 attended with a successful outcome. 4 more have been shortlisted and will be invited to interview within the next couple of weeks. We have the first of our Mental Health Clinicians joining us for training on the 10 June 2019.

Abstractions for key skills and NHS Pathways V17 training is proving challenging and may impact capacity in May 2019 and June 2019; this is being reviewed weekly as part of weekly planning meeting with scheduling.

The proposal for the agreed dispatch model is to adopt a phased, governed approach to ensure all learning is captured and best practice implemented. This is partly due to the recruitment lag of 20 WTE identified in the improvement plan. The dispatch rules will be written based around the targeted response model being trialled in May 2019.

Opportunities for efficiencies in workforce and IT are being investigated such as, Green Car Nurse, NHSP support tool for non-clinician and NQP for discharge at scene. These fall out of scope of the existing plan but need to be identified and assigned as drivers for improvement and change.

Domain	CQC Findings ('Must or Should Do')	Metrics	Monitored via	RAG Rating
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 EOC Clinical Safety Project addresses this CQC Must Do. Within this, metrics and trajectories have been set for key targeted measures to ensure effective monitoring and compliance for the provision of our service operating safely and effectively. Included within these measures are the following which will be identified within weekly updated trackers available to the EMB, PMO and Project Management teams: 1. Clinical staffing required to fulfil EOC Clinical Activities – Target: 100% (Current Performance 35.9%) 2. Identification of completed / Required Clinical Welfare calls for delayed dispatch – Target: 100% (Current Performance 35.9%) 3. Surge Management No Send Audit compliancy – Target: 100% (Current Performance 35.9%) 4. Tracking of all risks and issues through Datix, the Trust's Risk Management System. These are monitored via the EOC Teams B Meeting. Operational application, monitoring and escalation of these key deliverables is through a series of clinical project led working groups integrated with our HR, Recruitment and Clinical and Medical directorates. This team is supported through the robust operational team structure, daily through Teams E strategic led meetings, weekly within the Teams B, EOC meetings alongside the Operational strategic leadership Teams A meetings. These measures are reported through the EOC Clinical Safety Project Group to the Trust Quality and Compliance Steering Group on a fortnightly basis, with monitoring and escalations also through the Trust Clinical Governance Group and Executive Management Board	EOC Clinical Safety & Performance project plan • Hours Filled Weekly against Hours required to carry out EOC Clinical Safety Assurance activities • Clinical Welfare Call Compliancy • Surge Management 'No-Send' Compliancy • Tracking of reported Risks and incidents / SIs/ Complaints	
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 EOC Clinical Safety Project is facilitating the review of current EOC clinical working practices, policies and procedures to ensure the efficacy of our systems and processes to assess and mitigate patient risk within our EOC. Included within this review, is the creation of new Trust Quality Assured Procedures, adhering to our robust policy on policies and the review and implementation of key Clinical bulletins to align and optimise EOC Clinical working practices, which include: 1. Clinical Safety Navigator Procedure (56% complete) 2. Clinical Supervisor Procedure (19% complete) 3. Clinical & Operational In-Line Support Procedure (19% complete) 4. Crew Call Back Procedure (51% complete) 5. Clinical Tail Audit Procedure (19% complete) 6. No-Send Audit Procedure (19% complete) 7. CAT 3 and CAT 4 CSD Procedure (35% complete) 8. Clinical Review Bulletin (86% complete) 9. Care Line / Life line Bulletin (16% complete)	EOC Clinical Safety & Performance project plan • Policies Completion % • Bulletin Completion %	
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.	The ability to monitor the efficacy of the Clinical Safety Navigator (CSN) is a key enabler of the EOC Clinical Safety Project. The CSN Procedure captures and specifies the key roles of the CSN to support the oversight of patients awaiting ambulance dispatch. Through the EOC Clinical Safety Project, monitoring of key indicators is captured to identify efficacy of the role, development and support framework opportunities . Measures include the below which will be identified within weekly updated trackers available to the EMB, PMO and Project Management teams:	EOC Clinical Safety & Performance project plan • CSN Staffing WTE • CSN Cover Report • Clinical Welfare Call	

		1. Clinical Safety Navigator Substantive staffing levels – Target: 100% (Current Performance 50%) 2. Clinical Safety Navigator Cover 24/7 – Target: 100% (Current Performance 94%) 3. Identification of completed / Required Clinical Welfare calls for delayed dispatch – Target: 100% (Current Performance 35.9% - W/E 04/02/2019) 4. Trust Faller Flowchart application compliancy – Target: 100% . Development of a report to monitor this forms part of the project plan with an anticipated completion date of 31 May 2019. Reporting will therefore be available from June 2019 onwards. 5. Utilisation and tracking of all risks and issues through Trust Risk and Incident Datix System. These are monitored via the EOC Teams B Meeting. These measures are monitored and reported through the EOC Clinical Safety Project board to the Trust Quality and Compliance Steering Group on a fortnightly basis, with monitoring and escalations also through the Trust Clinical Governance Group and Executive Management Board.	Compliancy • Faller Flowchart Compliancy	
Safe	The Trust **should** ensure there are a sufficient number of clinicians in each EOC to meet the needs of the service.	The EOC Clinical Safety Project identifies a series of activities and Trust strategies to monitor staffing levels, as well as HR External and Internal Recruitment work streams to ensure there are sufficient Clinicians within EOC. Staffing levels are monitored within programme Recruitment trackers. These metrics have been finalised to show weekly staffing Clinical hours within the EOC against the targetted required and include the below, which will be identified within weekly updated trackers available to the EMB, PMO and Project Management teams: 1. EOC Clinical Staffing Weekly Hours Actual Vs Required (%) – Target: 100% (Current Performance: 35.9%) 2. Internal Staff Optimisation rota fill (Utilisation of Trust EOC Support Clinicians to meet required Hours - Target: 100% (Current Performance: 2%) 3. EOC Clinical Supervisor WTE Substantive – Target: 100% (Current Perfomance: 50%) 4. EOC Cinical ICAS WTE Substantive – Target: 100% (Current Performance: 14.1%) 5. EOC Clinical Safety Navigator WTE Substantive – Target: 100% (Current Performance: 50%) Operational application, monitoring and escalation of these key deliverables is through a series of clinical project led working groups integrated with our HR, Recruitment, Scheduling and Clinical and Medical directorates. This team is supported through the robust operational team structure, daily through Teams E strategic led meetings, weekly within the Teams B, EOC meetings alongside the Operational strategic leadership Teams A meetings. Within the Clinical Safety Project all known Clinician opportunities are in the process of exploration and implementation. These measures are monitored and reported through the EOC Clinical Safety Project board to the Trust Quality and Compliance Steering Group on a fortnightly basis, with monitoring and escalations also through the Trust Clinical Governance Group and Executive Management Board.	EOC Clinical Safety & Performance Project Plan • Clinical EOC Staffing % Requirement • Internal Staff Optimisation % Requirement • EOC CS WTE Establishment • EOC ICAS WTE Establishment • EOC CSN WTE Establishment	

Safe	The Trust **should** ensure the processes for providing staff with feedback from safeguarding alerts is improved to strengthen and develop learning.	A Safeguarding Feedback Action Plan has been developed to address the CQC Should Do – all of the activities within this plan are now complete. The action plan consisted of three over-arching themes: • Setting staff expectations when receiving feedback • Promoting system wide learning from safeguarding concerns • Establish the consistency of local authority feedback to staff The standard email response to alerters has been updated to ensure staff expectations on the level of feedback to be received are clear. Learning is discussed and highlighted at the Trust's Safeguarding Sub-Group and feedback agreed. This is cascaded via the Trust's monthly internal bulletins/ quality posters. Safeguarding information is also shared through the weekly bulletin as and when required. This overlaps with wider organisational learning including incidents, SIs and complaints. There were approximately 200 cases which have feedback to return to the referrer (in addition to the original automated feedback response) – capacity within the safeguarding team has been limited to complete all of these, therefore it has been agreed at the Quality & Compliance Steering Group that the learning feedback will be incorporated in next month's QI Hub poster – this will demonstrate what action has taken place following feedback. The Action Plan is now complete and the 'should do' has been addressed.	Safeguarding Feedback Action Plan	
Effective	The Trust should ensure that maps in all vehicles are current, up to date and replaced regularly	In consultation with Staff side colleagues the considered most effective approach was to retain the map books in a standardised form, generating the opportunity to link the books to a standard format across the Trust and facilitate the ability to provide a map page number and grid square to responding crews where necessary. The next steps are to identify and confirm the best provider that covers the regional area with the addition of London and the ability for this product to be converted into the Cleric CAD platform. Once the best product has been identified, replacement books will be procured for each vehicle and any out of date books replaced through the routine vehicle service cycle as necessary.	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.	Personal Issue Assessment Kits are due to roll out during Q1, the intention is to roll out 50% of the Trust in May, weeks commencing 13 & 20th. This is reliant on Logistics moving the kits from Paddock Wood throughout the Trust. A roll out plan is being developed to ensure that we meet our expected numbers. Once the stock has been delivered to stations/MRCs it is envisaged this could take up to three weeks for the roll out to be completed for larger stations and allowing for annual leave, smaller stations should be completed quicker. The delivery delay is due to the manufacturer of the blood glucose machine (Nipro) being unable to fulfil the order. I was notified last week of the delay and spoke with our account manager to understand what the delay is and why and what the expected date of delivery is. The remaining 900 machines will be delivered by the end of June, the intention is that we will roll out the remaining numbers in July once we have received the order.	Not required	

		A Standard Operating Procedure has been developed and is in the final stages of review by Operational managers, prior to being presented to the JPPF in May. This procedure embeds the importance of staff checking their equipment. A monthly testing sheet will be completed by all staff, this will be in the OU and will be sent to the Consultant Clinicians Administrator. A digital solution will be explored using our iPad platform once work on rolling out the ePCR has been completed. This work has not yet started. N.B. The regular servicing of equipment is not applicable.		
Effective	The Trust **should** ensure that pain assessments are carried out and recorded in line with best practice guidance	Systems are now in place to identify opportunities to improve the assessment of pain – pain scoring has now been added to the Trust's monthly documentation audit, which is reported to Clinical Audit & Quality Sub Group. The 2018/19 Assessment & Management of Pain Audit document has been published and the re-audit has been added to the 2019/20 Clinical Audit Plan. Furthermore, pain scoring has now been added to the minimum data set as a mandatory field, with a bulletin issued to state that every patient in pain should have at least 2 pain scores recorded (with the exception of child patients, who will only require one pain score to be recorded). The mandatory fields have also been shared with the ePCR team for review during the pre -live testing period. Work is in progress to ensure clinical staff have adequate knowledge to assess pain – this will be disseminated via a best practice guide and key skills training. The Action Plan is now complete and the 'should do' has been fully addressed.	Pain Assessment Action Plan	
Safe	The Trust **should** ensure response times for category three and four calls is improved	The intention is to proactively drive the targeted dispatch model to enhance clinicians and paramedics answering Category 3 call earlier on in the day. System integration and the ability to forecast increasing call volumes is required. Work is in place, coordinated with clinicians, to target the dispatch model and the use of SRVs as a model trial to answer low acuity patients releasing the DCAs to target category 2 patients with a mean time of 18 minutes. This will take place as part of Perfect Week commencing 20 May 2019. The first 42 Mercedes DCAs and their predicted delivery locations have been provided. The deployment will on a 2 per week rolling process, as new vehicles come on stream during April 2019 and May 2019 they will be prioritised across the operating units to support staff having the right vehicles to respond to calls. Staff using NET vehicles will be identified at the earliest opportunity to answer Category 3 and Category 4 especially when there is a delay in the clinical stacks. The opportunity to bring in resources into the EOCs is a benefit to help solve the problem. A recruitment process is in place to recruit international staff to work in EOC to manage the stack of calls but there has been a delay in getting the new recruits started. There is a much-improved picture for monitoring of PAP Governance and Assurance against Service provided and Contract Performance. PAPs are aligned to our strategy and will support Category 1 and 2 and Category 3 and 4 where demand is required.	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.	This Should Do has now been addressed as a Dashboard is now available to monitor statutory and mandatory training on rolling basis. At this time, the report is available to HR and the Business Intelligence team. Best practice for sharing of the dashboard more widely is currently being investigated with the Information Governance team. Action Plan is now complete and the 'should do' has been fully addressed.	Training Compliance Plan	
Responsive	The Trust **should** ensure they collect, analyse, manage and use data on meeting response times for Hazardous Area Response Team (HART) incidents.	Work on the Power BI system to collect and analyse the HART Response Time Standards is underway with the aim of producing an interactive form which allows the HART leadership team to validate these standards against the incidents that HART attend. This work has been slightly delayed due to the Power BI App software not initially being supported by the Trust which has had a slight impact on timescales. It is envisaged that the development of the interactive form will allow the HART leadership team to analyse the data to ensure that only those incidents that required a HART team or if a 'safe system of work' is required, is included as part of the data analysis. This is a key component as the HART response time standards differ from other time base standards as there is a degree of subjectivity involved. Currently, HART response time data from the CAD is now being reviewed by the HART leadership team and sent back to the Power BI team who are working with this information to produce some usable data that we will be able to analyse against the standards. It is anticipated that this will be available mid-May 2019. Based on this information, the 'should do' is being addressed, however, not fully as the quality of the data needs to be improved and the team are working on addressing this via the interactive form.	EPRR Action Plan	

Service Transformation & Delivery (STAD) Steering Group Dashboard

Reporting Period from: 15 March 2019 – 13 May 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

Last Updated 14/05/2019 v1.0

Key Points

Workstream	Brief Summary
Rotas	80% of new rotas are now live. This leaves the final 3 dispatch desks; Paddock Wood, Polegate and Hastings are scheduled to go live by 31 July 2019. Unlike previous rota provision all OUs are now working to a consistent model of rota design in line with new rota parameters and the Demand & Capacity guidance. The new model reflects local working and local owners. Rotas will continue to be reviewed locally to take into account local events and activity changes. This will ensure the best possible provision and timely rota changes to continue to meet the increasing and changing demand.
Fleet	The 2 remaining NETS vehicles have now transferred to BAU and will be managed in line with local operational/fleet management priority. The Business Case for the uplift of 50 Fiats DCAs is dependent upon the Fleet Strategy which is due for completion June 2019; in the interim the 25 of the Fiats have been ordered at risk. The first 42 Mercedes DCAs and their predicted delivery locations have been provided. These will be deployed on a rolling 2 per week basis. As new vehicles come on stream during April 2019 and May 2019 the planned decommissioned vehicles will be retained.
Estates	Workshops have been carried out at Guildford, Chertsey, Gatwick, Redhill, Dartford, Medway and Thameside. Workshops will take place with the remaining OUs (ROMs and OUMs) to understand the Units ability to accommodate STAD requirements (more staff, vehicles and training room capacity).
Workforce	Recruitment Campaigns are progressing well. Candidate attraction and response to adverts across Kent, Surrey and Sussex remains positive. Trust operational STAD plan ensures clarity on the exact numbers required and when. Local candidate attraction & increased recruitment team are resulting in green shoot positive outcomes.
PAP	The PAP contracts award is 32 days behind schedule. The new contract terms have been well received by providers, but documentation is still to be finalised. However, PAP Providers are now working the contracted hours. Discussions continue with providers, and SECAmb staff, in a bid to close the gap in filling the required number of hours for Q1 (19-20), in particular weekend working. The work to monitor PAP's performance will commence at the end of April 2019 when a KPI performance report will be formulated and sent to each provider working under the contract. The expected reduction in PAP usage over the next 3 years still needs to be planned and expedited.
Hospital Handover	The Hospital Handover Steering Group has agreed to meet for a further year to focus on further improvement particularly at the most challenged sites. A stock take system wide event is planned for 21 May 2019 to share good practice and lessons learnt across all hospital sites and associated systems. Invites have been sent to hospitals, community and primary care services, NHSI, NHSE and CCG. This event will also include an overview of the STAD programme and the system wide benefits expected.

Workstream	Current RAG	Previous RAG
Programme		
Workforce		
Rotas		
Fleet		
Estates		
Private Ambulance Providers		
Hospital Handover		

Key Risks

Workstream	Brief Summary	Score
Risk (826) Failure to achieve ARP targets - Q1 2019-20 (STAD)	Influencing Factors: a: 111 Service 'go live' 28/3 and Frequency of FEM b: Associated Risks with EU Exit (Road Networks) c: Handover Delays d: Misaligned Rotas e: PAP Hours Shortfall f: Usual spike in activity over Easter g. Lack of clinical support within EOC **Mitigation:** All elements of risks and influencing factors managed through associated risks. Each element has a principal risk lead to oversee/manage	6
Risk (758) Estate Infrastructure / Operational Readiness	There is a risk that our existing Estate Infrastructure and proposed Strategy for development in certain areas to underpin delivery of the corporate objectives (STAD) is not 'fit for purpose'. Local OU audit meeting scheduled for 19/03. **Mitigation**: Audit of each OU taking place, to be completed by end of May 2019. Subsequent strategy will identify both strategic and Tactical needs to deliver STAD and build in resilience	12
Risk (909) Hospital handover delays	There is a risk that our ability to meet our response times within the ARP targets will be compromised as a result of the number of diverts that are being requested leading to crews being out of their normal working area This risk is increased during winter when system is under increased pressure. **Mitigation:** A system wide divert process is currently being drafted to ensure that a robust process for requesting a divert is in place and all risks are considered before a divert agreed . Process will include collecting numbers of diverts requested and number of patients that have been diverted so requests can be monitored . The process will also include quarterly reporting to lead commissioner and associate CCGs so that the impact of diverts is understood.	9
Risk (757) Workforce - Recruitment Front Line Staff	There is a risk that the Trust may not be able to recruit sufficient core front line staff to meet workforce profile requirements to deliver the activity projected in the Service Transformation & Delivery Programme for 19/20 & 20/21 **Mitigation:** HR Risk Lead identified. Weekly reviews taking place with monthly scrutiny by STAD Committee. STAD Recruitment trajectories currently under review to ensure all elements on track.	12
Risk (819) High Attrition Rate within Clinical Teams	There is a risk that if staff attrition does not reduce in line with the workforce model we will need to recruit more staff than originally projected. This ultimately will have a negative impact on finances and current HR support. Unmanaged this is likely to impact on the delivery of patient care and the STAD Programme **Mitigation:** HR Risk Lead to be identified. STAD Group working to align recruitment trajectories by position (ECSW, NQP, Paramedic) with actual/projected attrition rates. This will act as an 'early warning' system should we move away from plan.	12

Achievements this period

- The Communication Plan has been finalised.
- Chertsey, Gatwick, Redhill, Dartford, Medway and Thameside estates workshops completed.
- Gatwick went live with new rota on 15 April 2019
- Brighton went live with new rota on 6 May 2019.
- Recruitment campaign for Polegate, Ashford & Dartford & Medway commenced.
- New PAP supplier on NHS Contract.

Service Transformation & Delivery High Level Milestone Plan

	Q4 2018/19			Q1 2019/20			Q2 2019/20			Q3 2019/20			Q4 2019/20			Q1 2020/21			Q2 2020/21			Q3 2020/21			Q4 2020/21		
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
Workforce	Target: 2029 WTE Actual: 2051 WTE			Target: 2051 WTE			Target: 2139 WTE			Target: 2241 WTE			Target: 2252 WTE			Target: 2286 WTE			Target: 2339 WTE			Target: 2444 WTE			Target: 2413 WTE		
Fleet Target				Target Double Crewed Ambulance (operational) x12			Target Double Crewed Ambulance (operational) x10			Target Double Crewed Ambulance (operational) x5			Target Double Crewed Ambulance (operational) x6			Target Double Crewed Ambulance (operational) x6			Target Double Crewed Ambulance (operational) x6			Target Double Crewed Ambulance (operational) x5			Final Target Fleet Operational: 382		
Estates				List of works created Estates workshops completed						Business Case for OU STAD Estates work approved																		
Private Ambulance Providers (PAP)	Target usage: 16% Actual usage: 10% Contract approval sign-off			Target usage: 16%			Target usage: 12%			Target usage: 9%			Target usage: 9%			Target usage: 6%			Target usage: 3%			Target usage: 0%			Target usage: 0%		
Rotas				01/04 - Go-live: Ashford, Dartford, Medway, Tangmere, Thanet, Chertsey, Redhill, Worthing, Guildford 15/04 - Go-live: Gatwick 06/05 - Go-live: Brighton TBC - Go-live: Hastings, Polgate 31/07 - Go-live: Paddock Wood												Intranet STAD update											
Comms & Engagement				Initial Comms for all Stakeholders Stakeholder matrix Key messages and comms channels Comms plan finalised			STAD Intranet update			STAD Intranet update			STAD Intranet update			STAD Intranet update			STAD Intranet update			STAD Intranet update			STAD Intranet update		
Performance Management (BI)		STAD BI Resource in place		EOC Reports live on BI STAD Programme Reports live on BI												STAD Historic Reports live on Power BI Operational Mgt Reports live on Power BI											
System Working (Hospital Handover)																Agreed processes at each hospital sight Best practice embedded in SECamb and Acute Alternative pathways identified											

◇ Completed ◇ On track ◇ At risk ◇ Overdue

Last updated: 10/05/2019

Digital Programme Board Dashboard

Reporting Period: 15 March 2019 – 13 May 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

Last Updated 14/05/2019 v1.0

Key Points

Project	Brief Summary
Station Upgrades	The project RAG remains Green. Deployment of new PCs and screens has been extensively communicated and is now more than 50% complete. Installation and cutover to new managed network circuits is 55% complete
ePCR	The Project RAG remains Red due to delays in starting the 'Pre-live' testing pilot. Training options paper is awaiting review and approval by the ePCR Project Board. A change request is currently in development to extend the project end date to 30 Nov 19.
Replacement Fleet Mgmt System	The project RAG remains Green. The system is being used, however, there are two activities to be completed by the end of May 2019 to ensure a successful outcome. It is anticipated that the project will close during the next reporting period.
NHS Spine Connect	The project RAG remains Green. A Change request was recently agreed to extend the project end date to 30 June 2019. The final element (Summary Care Records) is waiting on NHS Digital accreditation before it can be implemented.
Automated Temp Monitoring	The project RAG remains Green. Go live went ahead as scheduled on 28 February 2019. The expectation is that the project will be closed during the next reporting period once the last remaining activities have been completed.
GoodSam	The Project RAG remains Red as the technical issue is due to be fixed imminently which will enable the System to go live by end of May 2019. The system is currently being tested by EOC Systems Team and would require an extra day of testing before rolling out.
Cyber Security	The project RAG has moved from Green to Amber. The original April migration dates for East and West EOC's had to be rescheduled as insufficient preparatory work had been completed. West EOC is now complete and East EOC scheduled for end of June 2019. Change request drafted to extend end date of project to 31st July 2019. Lessons learned from the Crawley migration have been incorporated and EOC Systems, jointly with IT, are working with a number of external vendors to minimise the impact of the Coxheath work.
IT Helpdesk System	The project RAG remains Green. The new Helpdesk System successfully went live on 8 May 2019 with EOC Systems and IT Support Teams now using the system to manage IT requests. The self-help portal went live for all staff and weekly bulletins went out to promote the system throughout the organisation. Closure is expected in the next reporting period.
East EOC	The project RAG has moved from Green to Amber. Server room air conditioning was successfully replaced and is now fit for purpose. Commissioning of the replacement UPS requires a site shutdown which requires agreement on a date from IT, EOC and Third Parties. Visual alerting cannot be commissioned until the UPS has been installed. A project change will be requested to extend completion date to end of July 2019. This will mean that the power vulnerability, due to their only being one power between the UPS and generator, will remain for an additional month.

Project	Current RAG	Previous RAG
Station Upgrades		
ePCR		
Replacement Fleet Management system		
NHS Spine Connect		
Automated Temperature Monitoring		
GoodSam		
Cyber Security		
IT Helpdesk System		
East EOC		

Key Risks

Project	Brief Summary	Score
Risk (451) Spine Connect	For SCR, Clinician in EOC will require Smartcards. The Trust does not currently have a process or resources in place to issue / manage Smartcards outside of NHS 111. **Mitigation:** SmartCard printer is installed in Crawley HQ in addition to 111 and awaiting final confirmation of printing and issue of cards by end May 2019.	6
Risk (903) ePCR	As a Trust we use a number of providers, PAPs, CFR and Co-responders to attend our emergency calls. As a result, we need to consider how providers will be made familiar with our ePCR as well as policy and procedures for mobile device management. We have an increasing risk due to demand and PAP utilisation from April with the Trust new rota scheme. This may lead to our providers continuing to use paper PCRs until a robust solution is put in place. **Mitigation:** The Trust is seeking a technical solution to enable CFRs and PAPs access to the Trust's ePCR platform.	6

Achievements this period

- IT Helpdesk System go-live
- West EOC successfully migrated to new network infrastructure
- Server room air conditioning successfully replaced at East EOC

Digital Programme Board Delivery Timeline

	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 Delivery					Project Closure				Post Project Implementation Review	
Cyber Security		Project Paused			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		
EOC East		Project Startup		Project Delivery		Project Closure		Post Project Implementation Review				

Last updated: 13/03/2019

111 CAS Interim and Exit Programme Dashboard

Reporting Period: 15 March 2019 – 13 May 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

Last Updated 14/05/19 v1.0

Key Points

Workstream	Brief Summary
Programme Governance	Following the successful launch on 111 IUC and the following stable performance over the key Easter period, the Project RAG is being reported as Green. A significant number of activities for the CAS remain open and these will be picked up under phase 2. The project team are now working closely with NHSE / CCG's as part of the formal closure process and transitioning to BAU.
IM&T, Estates, BI, IG	Management of IT Systems issues have been moved across to BAU. All the issues raised post launch have been moved across the EOC Systems BAU Action Log. Updates to system configuration documentation are underway and staff training updates being planned.
Recruitment & Workforce	Candidate attraction and recruitment activities for Health Advisor (HA) and Clinical Advisors (CA) continues with training courses for 18 candidates running every three weeks. Interest from HA candidates remains high. CAs remain a challenge but the calibre of the applications we are receiving is positive and following interview are appointable. The focused attention recruitment has been given has made an difference to the success of the campaigns.
Finance & Contracting	Finances finalised and business case is now signed off.
IUC Service Development	Now the mobilisation has taken place, focus will now shift to the development of the CAS. The Clinical mapping paper / proposal is complete and has been reviewed by different leads and now awaiting for medical director sign off.
111 CAS Contract Exit KMSS	The Trust has successfully completed the 111 KMSS contract exit process. This project will formally close in the next reporting period.

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

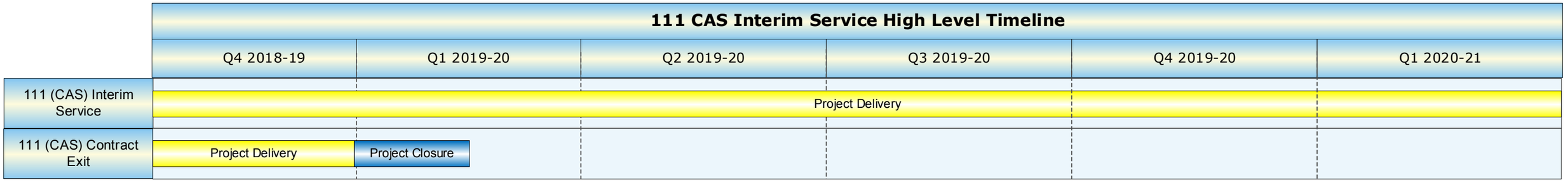
Key Risks

Project	Brief Summary	Score
Risk (667) 111 CAS Interim Service	There is a risk that the inability of commissioners to provide the GP's to work within the clinical Assessment (CAS), will result in a lack of GP oversight to support the development of the CAS. **Mitigation:** The service will run as per the existing GP model and include all functionality currently provided i.e. linking to GP out of hours (OOH) service and sign posting to in hours GP practices.	8
Risk (725) 111 CAS Interim Service	There is a risk of lack of capacity to clinical leads within the Trust (Pharmacist, Mental Health, GP) to provide the required oversight and supervision for the new clinical roles which are planned to be introduced to the service as part of the developing CAS. **Mitigation:** A CAS Mapping paper will identify the requirement for clinical supervision.	9
Risk (832) 111 CAS Interim Service	There is a risk that if the Trust does not assign the appropriate Project Management arrangements in place to oversee the delivery of the CAS, progress of achieving the CAS deliverables could be hampered. **Mitigation:** To be discussed at 111 Project Board on 16 May.	9

Achievements this period

- Successful launch of the 12 month interim service
- Stable platform / safe service over Easter weekend
- Recognition of the Trust achievement from NHS England and Commissioners

111 CAS Interim Service High Level Timeline



Last Updated 09 May 2019 v0.1

QCSG Dashboard

Reporting Period: 15 March 2019 – 13 May 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

Last Updated 14/05/2019 v1.0

Key Points

Project	Brief Summary
EOC Clinical Safety & Performance	The project RAG remains Red. EMA recruitment is on track. Clinical recruitment in month is improving but remains a challenge. All options are being explored to attract staff. The 999 Audit Business Case is currently part way through the approval process. Once approved the challenge will be recruiting and embedding the structure whilst supporting existing staff. A new, phased, approach has been proposed for implementing the dispatch model; partly due to the recruitment lag.
Governance & Risk	The project RAG has moved from Amber to Red. This is due to some policies and procedures which will not be updated by the project end date of 30 June 2019. A plan is in place to ensure that the majority are tabled at the July JPPF meeting. Despite the project not achieving the objective of updating 100% of policies and procedures, the plan is to continue this work as business as usual from July 2019.
Personnel Files	The RAG rating has moved to Blue as the project was closed on 28 March 2019. The outstanding activities relating to DBS and Employee Records will form 2 new projects. The scope and objectives for these projects are currently under review.
Health & Safety	The project RAG remains Green. All objectives are on track for completion on the dates specified within the improvement plan. Health & Safety audits are progressing well, and so far, 40 audits have been completed trust wide. All sites audited are provided with a detailed action plan to improve on any non-compliant categories identified during the audit.
999 Audit & Development	The project RAG remains Red due to the Trust not being able to deliver the required levels of audit to remain compliant with NHS Pathways and Manchester Triage licences. A Business Case has been put forward to seek approval to increase capacity within the EOC Audit and Training team to facilitate the basic delivery of audit and training requirements to enable the effective assessment, monitoring and subsequent improvement to the quality of services that EOCs provide to our patients. On the basis that the business case is approved, the implementation of the structure will be overseen the EOC Governance Group.

Project	Current RAG	Previous RAG
EOC Clinical Safety & Performance		
Governance & Risk		
Personnel Files		
Health & Safety		
999 Audit & Development		

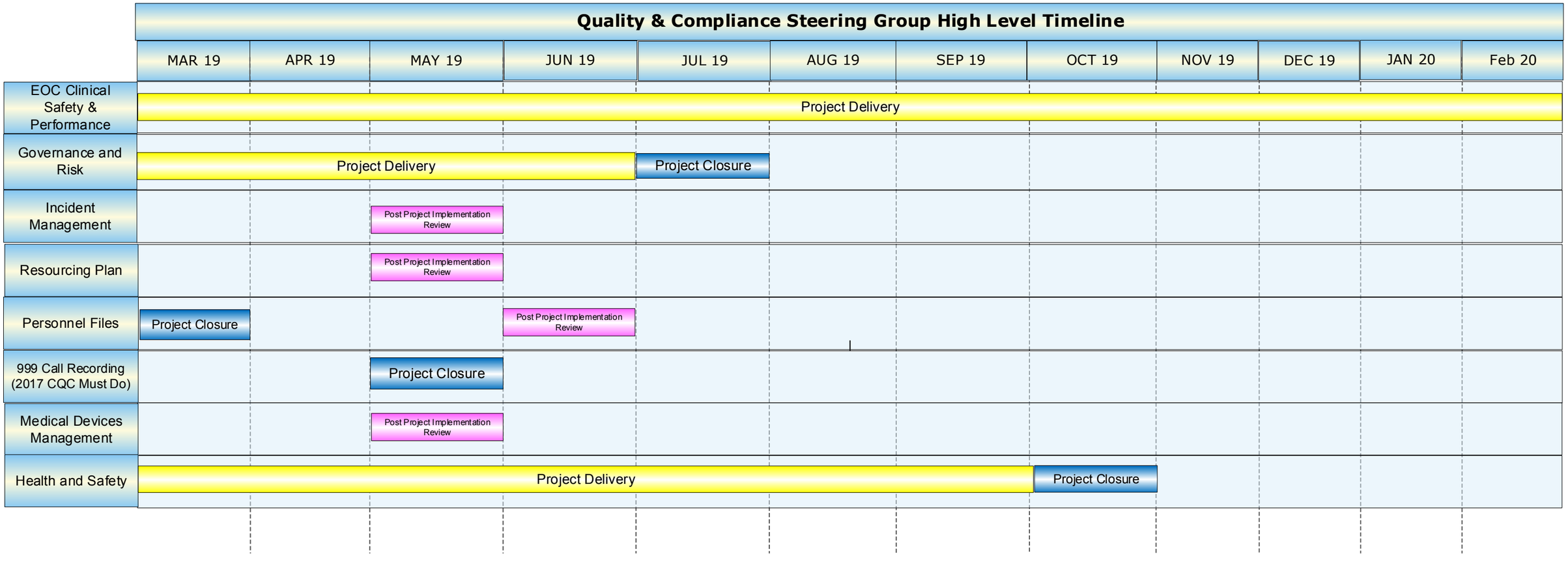
Key Risks

Project	Brief Summary	Score
Risk (922) Clinical Safety & Performance	There is a risk that future CQC reports will be adversely impacted as a result of the Clinical Safety & Performance project not being delivered, which may lead to a downgraded report. **Mitigation**: The improvement plan is undergoing a refresh with workstream leads to re-focus on clinical safety and drive ownership.	10
Risk (701) Governance & Risk	There is a risk that the overdue policies and procedures in the Governance & Risk Project Plan will not be updated by the 30 June 2019. This is due to the authors not having sufficient capacity to update their policies and procedures. **Mitigation**: Policy authors are being supported in the process of updating their policies and procedures and an escalation is in place to ensure senior management / executive is aware of delays so that corrective action can be taken.	9
Risk (905) 999 Audit & Development	There is a risk that the trajectory to meet Clinical Tail and No-Send audit compliance as part of the EOC CS&P plan will not be achieved, including the welfare call compliance. This is because there is insufficient capacity to complete the audits in a timely manner. **Mitigation:** A business case has been written and is currently going through the approval process.	15

Achievements this period

- The EOC Audit & Training Uplift business case has passed the first and second stages of the approval process.
- CQC Should Do Action plans for Pain Assessment, Training Compliance and Safeguarding are now complete.
- 3 Post Project Implementation Reviews undertaken: Complaints, Safeguarding and Infection Prevention Control.
- 2 project closures approved: Incident Management and Personnel Files.

Quality & Compliance Steering Group High Level Timeline



Last Updated 09 May 2019 v0.1

Programme for 2019/20 to deliver a minimum of £8.6m savings to achieve the planned £0.1m control total deficit.

Financial Reporting Period: Month 1 - April 2019

Programme Summary:

1. The savings target of £8.6m has been allocated to Directorates based on their individual pro rata share of operating expenses to total Trust operating expenses. Directorate targets have been further allocated against business areas/cost centres in the same way. The Pipeline Tracker reflects these allocations as "Proposed" schemes and they will be reduced during the course of the year and replaced by definitive CIP schemes when constructed by Budget Holders.
2. The current target remains at £8.6m. The Finance Team within the PMO will assist Budget Leads with the development of definitive savings schemes.
3. Fully validated CIP schemes will be moved to the Delivery Tracker after QIA approval.
4. There has been positive engagement with Execs and Budget Leads in agreeing the CIP targets. The CIP Programme governance framework and processes will be continued into 2019/20. It is fully functioning in the business and was given a "Substantial Assurance" rating by Internal Audit in April 2018.
5. The CIPs schemes to be developed will include any savings that might arise from i) the actions of the four Sustainability Transformation Programmes (STP) with which the Trust is engaged ii) the Carter Recommendation for Ambulance Trusts ii) operations efficiencies relating to improved sickness rates, reduced handover delays, reductions in task cycle time and increases in key skills training to the extent that these can be realised.
6. The Cost Improvement Programme is rated Amber at this early stage of the new financial year.

CIP Opportunity Classification - KEY

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

CIP Pipeline and Delivery: Risks and Issues

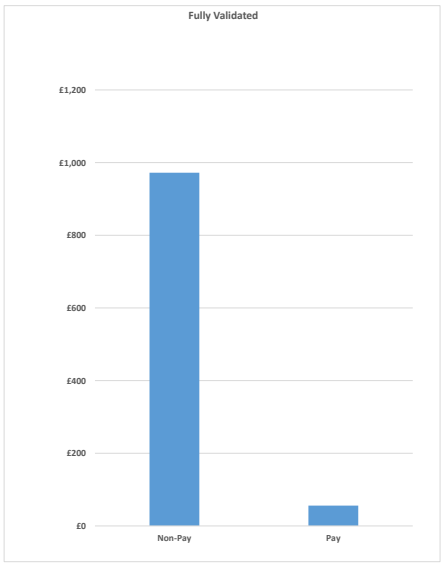
	Risk	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Risk that the 2019/20 CIPs target of £8.6m will not be fully delivered due to uncertainties within the Operations Directorate.	The savings target of £8.6m has been allocated to Directorates based on their individual pro rata share of operating expenses to total Trust operating expenses. Monthly meetings with Budget Holders and the Senior Operations Team	Kevin Hervey	Amber	Amber	31-Mar-20

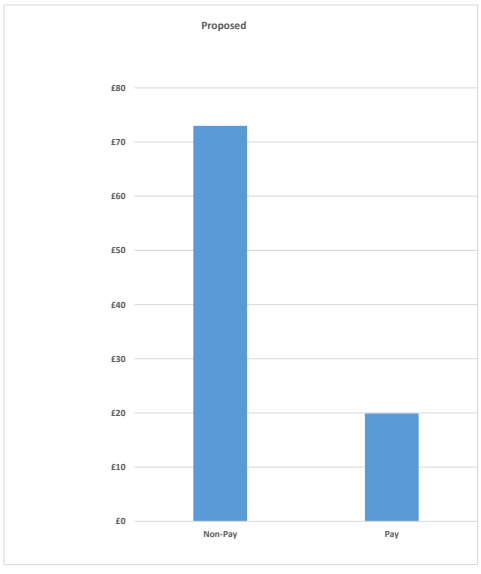
	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	New Lease Cars policy to be agreed.	A Business Case is being finalised based on fit for purpose cars for operational managers aligned to roles. New club car scheme was launched in January - to be evaluated in June following collection of	John Griffiths/ Paul Renshaw	Amber	Amber	30-Jun-19
2	Medical Consumables - procurement cost savings to be considered.	Savings on alternative products through using non NHS Supply Chain suppliers identified. This is currently being discussed with	Kirsty Booth/ John Hughes	Amber	Amber	30-Jun-19
3	E-Expenses - potential savings from automation.	E-Expenses system has been paused due to non-ratification of the Expenses policy. HR are also waiting for the outcome of the HR	Paul Renshaw	Amber	Amber	31-Jul-19
4	Agency Staff - Potential cost avoidance CIP	Savings plan to be developed for 2019/20.	Priscilla Ashun-Sharpy/ Kevin Hervey	Amber	Amber	30-Jun-19
5	Develop Operations CIP schemes.	Savings to be identified based on data supplied by Informatics and Clinical Scheduling.	Kevin Hervey/ Graham Petts	Amber	Amber	31-Mar-20
6	Devise a mechanism for recoveries of historic salary overpayments	Ongoing discussions with Payroll Manager/HR Director	Kevin Hervey/ Paul Renshaw	Amber	Amber	30-Jun-19

CIP Pipeline Summary

Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£0	£1,028	£7,604	£0	£0	£8,632

Pay / Non-Pay / Income Breakdown and scheme summary





Scheme Category	Fully Validated	Proposed	Total
Accounting efficiencies	861	-	861
Budget Allocation	-	7,584	7,583
External Consultancy	24	-	24
IT Productivity and Phones	48	-	48
Legal/Professional Fees	29	-	29
Public Relations Expenses	12	-	12
Recruitment delays & recharges - non clinical	56	20	76
Grand Total	1,028	7,604	8,632

South East Coast Ambulance Service: CIP Workstream

CIP Delivery Dashboard

Reporting Month Apr-19

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

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

1. The CIPs target for the 2019/20 financial year has been set at £8.6m.

2. £1.0m of savings have been transferred to the Delivery Tracker as at the Month 1 reporting date, of which £0.1m has been delivered to date in line with the Plan.

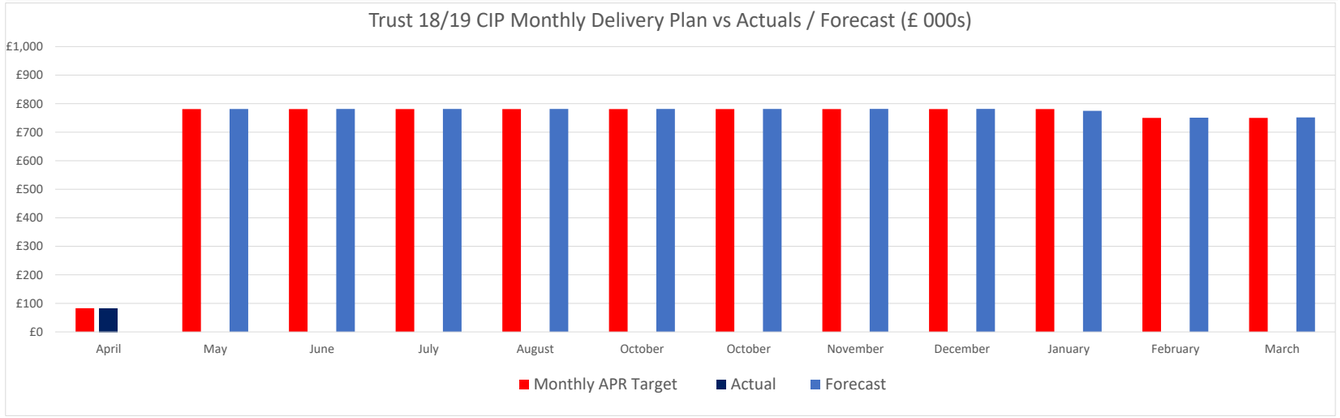
3. Regular review meetings with Budget Leads and Finance Business Partners will again take place and will focus on identifying new schemes to build a sustainable pipeline of recurrent schemes for 2019/20.

5. The CIPs schemes to be developed will include any savings that might arise from i) the actions of the four Sustainability Transformation Programmes (STP) with which the Trust is engaged ii) the Carter Recommendations for Ambulance Trusts ii) operations efficiencies relating to improved sickness rates, reduced handover delays, reductions in task cycle time and increases in key skills training to the extent that these can be realised.

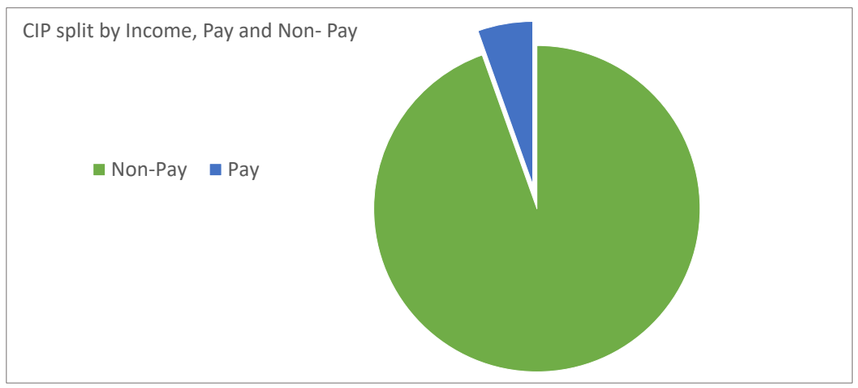
6. The Cost Improvement Programme is rated Amber at this early stage of the new financial year.

1. Monthly CIP Trust Profile - as at 30 April 2019

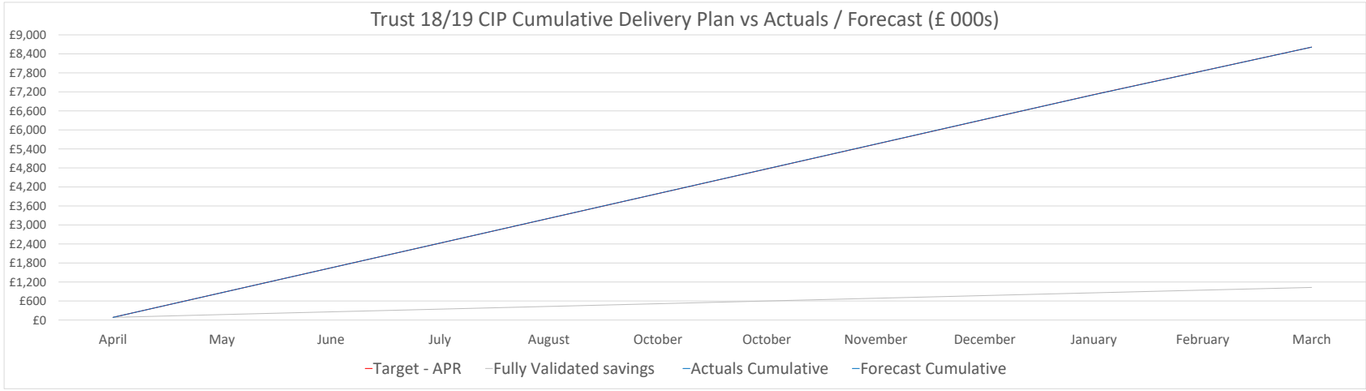
CIP Target for 19/20 £000's	Total planned savings on delivery tracker £000's - as at 30 April 2019	Total forecast savings on delivery tracker £000's - as at 30 April 2019	YTD April 2019 - Target Savings £000's	YTD April 2019 - Actual Savings £000's	YTD April 2019 - variance £000's
8,612	1,028	8,612	83	83	£0



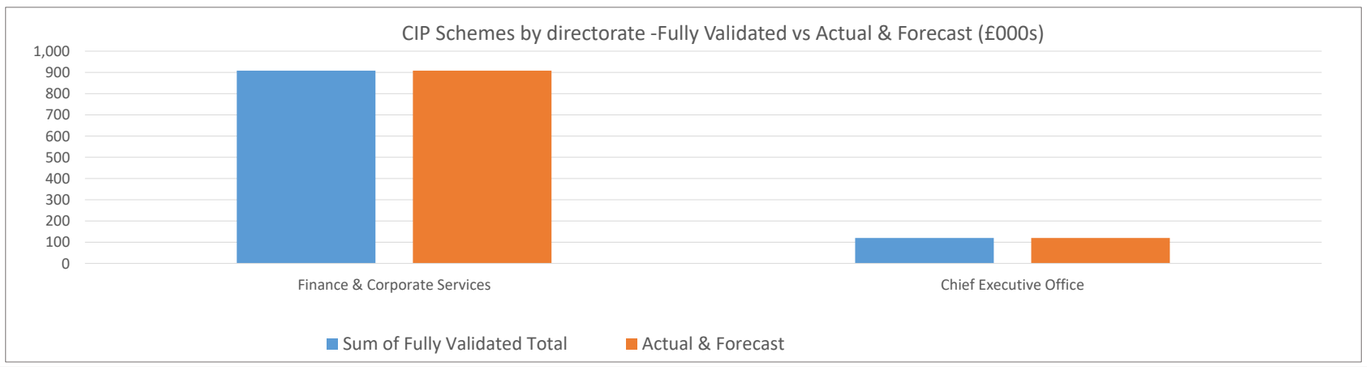
2. CIP - Planned savings split by income, pay and non-pay: as at 30 April



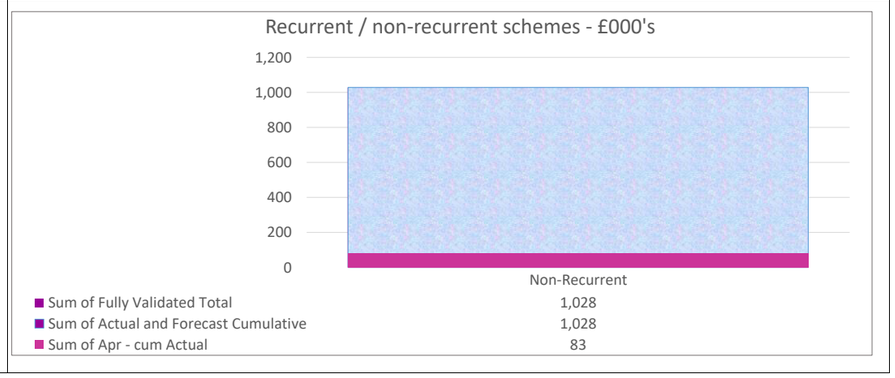
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2019/20



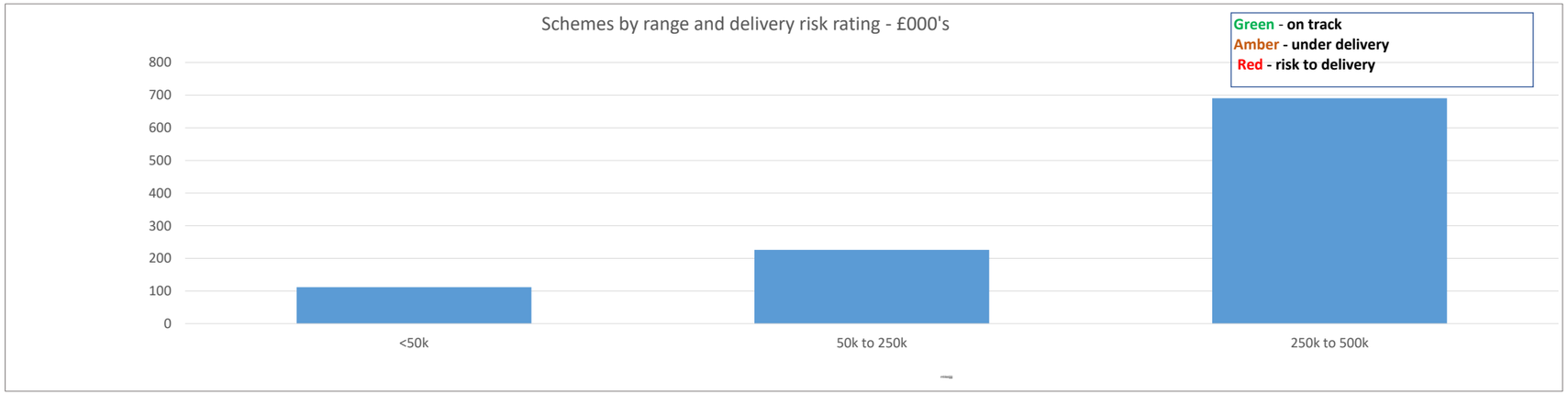
4. CIP schemes by directorate - Fully Validated vs Actual & Forecast 2019/20



5. Value of forecast recurrent and non-recurrent savings - 30 April 2019



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



7. YTD Identified CIPs to Date and Savings - March Reporting Period

Scheme Category	2019/20 Value of Fully Validated Schemes - £000	2019/20 Forecast Value £000	Full Year Variance £000	YTD Planned / Fully Validated Schemes Savings (Month 1): £000	YTD Actuals (Month 1): £000	YTD Variance £000	Comments (+/- £20k variance)
IT Productivity and Phones	48	48	0	1	1	0	-
Recruitment delays & recharges - non clinical	56	56	0	5	5	0	-
Accounting efficiencies	861	861	0	72	72	0	-
External Consultancy	24	24	0	2	2	0	-
Legal/Professional Fees	29	29	0	2	2	0	-
Public Relations Expenses	12	12	0	1	1	0	-
Total Fully Validated Schemes	1,028	1,028	0	83	83	0	

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999 Service Transformation & Delivery (Programme of work)

Deep Dive

May 2019

Aspiring to be ***better today*** and even ***better tomorrow***

Aim of 999 STAD Deep Dive

South East Coast Ambulance Service NHS Foundation Trust

Scope

- To provide CQC with assurances around the SECAmb service transformation and delivery plan.
- To share the workstream progress made since the programme started.
- To outline the workstreams' next steps.

999 STAD Deep Dive

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Out of Scope

- A detailed analysis of all programme risks.
- Reviewing all operational processes.
- EOC.

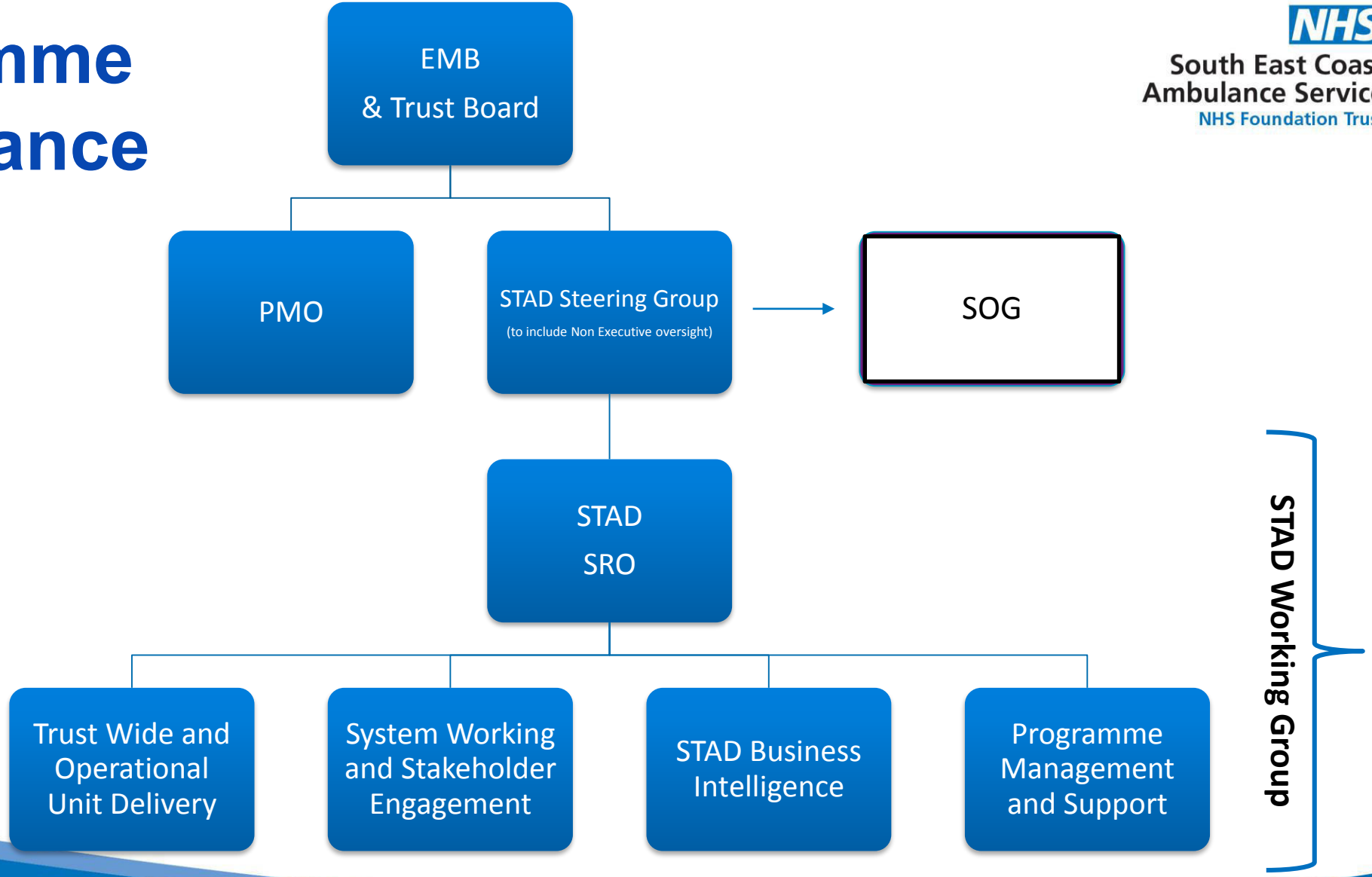
Background - Our Mandate

South East Coast Ambulance Service NHS Foundation Trust

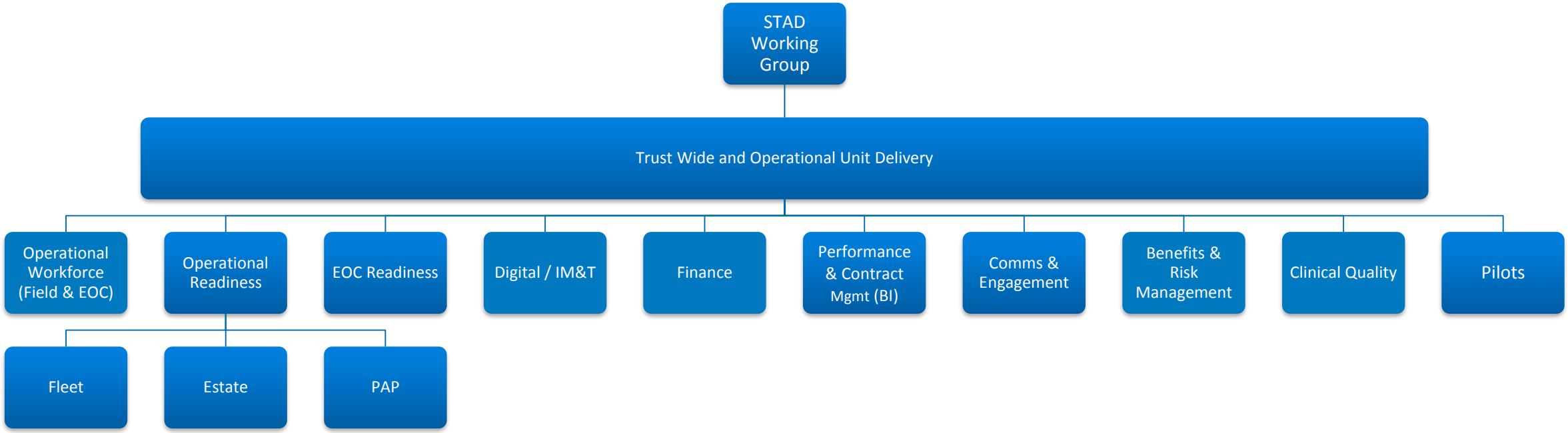
Objective 1 - By 31st March 2021, SECAmb to increase the establishment of front line staff by 605 WTE from 1808 to 2413, split by OU.
Objective 2 - By 31st March 2021, to ensure that the modelled split of registered (46%) and non-registered (54%) personnel (paramedic) trajectory is met.
Objective 3 - By 31st March 2021, to ensure that all 382 (consists of 356 DCAs and 26 NETs to match with rosters) are used efficiently in the delivery of targets.
Objective 4 - By 31st March 2021, to commission 50 extra DCAs to support the delivery of the targets.
Objective 5 - By 31st March 2021, to commission below modelled levels of PAP resources (<5%) to support the delivery of the targets.
Objective 6 – By 31st March 2021, to ensure that handovers are effectively managed and delays are minimised across 18 hospital sites.

It should be noted that objectives are subject to the stated assumptions and levers within the Demand and Capacity Review. Detailed trajectories for key inputs are available and being refined to show planning expectations for Personnel, Fleet and Private Ambulance Provision…

Programme Governance



Programme Approach (continued)



PMO Governance

The STAD Programme is being managed through the PMO

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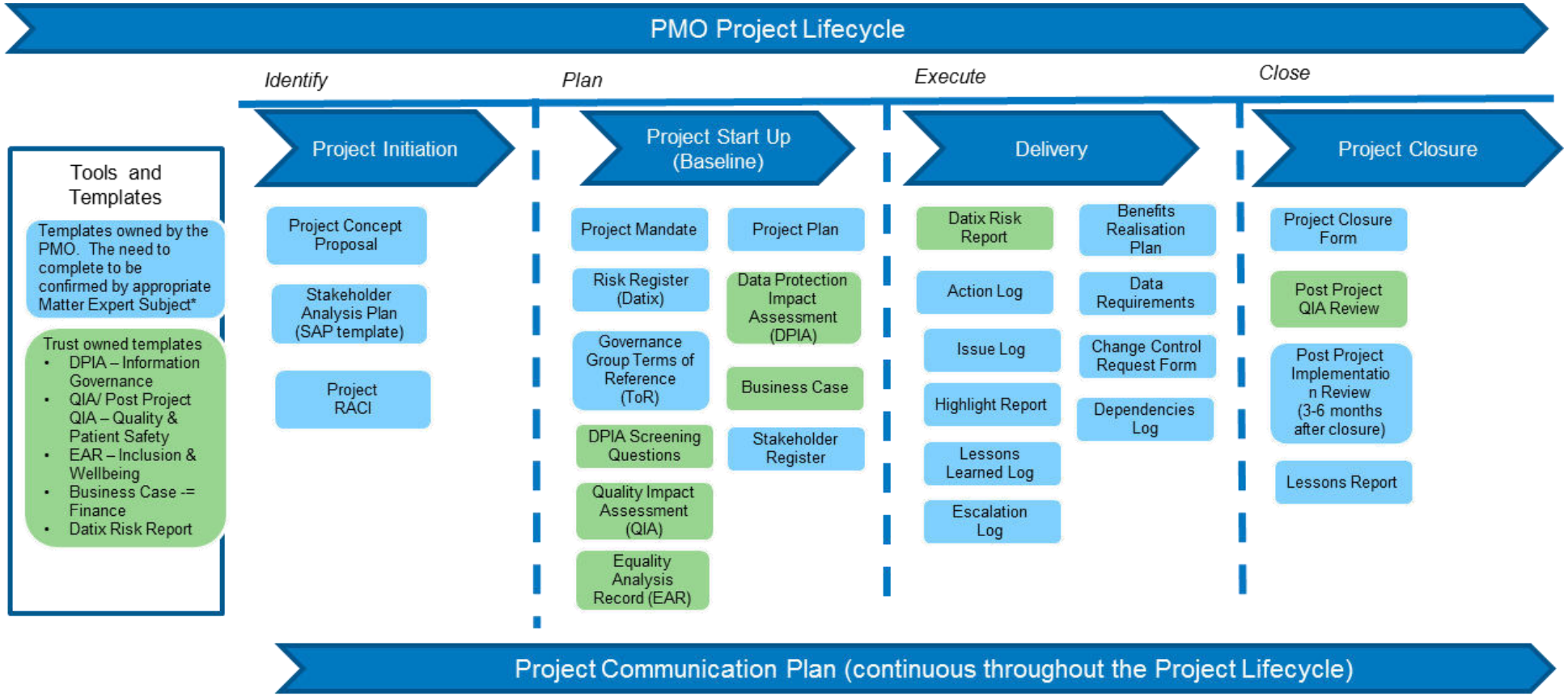

Our Model - Targeted Dispatch

South East Coast Ambulance Service
NHS Foundation Trust

Healthcare Professional

Patient

Public

Integrated Emergency and Urgent Call Triage

Telephony: Single point of access for 999 and 111 contact

24/7 Multi Disciplinary Team

Service Function

- Clinical assessment
- Remote monitoring
- Telemedicine
- Paramedic pathfinder
- Capacity management
- MiDoS application
- Integrated care records
- Direct booking
- IBIS

Care Pathways

- Hear and treat
- Hear and refer
- Hear and book
- Care plan followed
- See and treat
- See and refer
- See, treat, and convey
- Interfacility transfer
- GP urgent

Dispatch

SRV

Ambulance

Acute Visiting Service

Specialist Response

(e.g. PP, Falls, Mental health triage etc.)

Intermediate Tier Vehicle

Community First Responder

Transfer of care to core services

Primary Care Services

(e.g. UCC, OOH etc.)

Community Services

Social Care

Secondary Care

Mental Health Services

Overview of Current Position – Ambulance Response Targets

South East Coast Ambulance Service NHS Foundation Trust

- As well as providing the 999 emergency ambulance service, the additional investment provided an opportunity cost to allow the delivery of a fit for purpose service, including the provision of non-emergency patient transport services and value for money, embedding quality at the heart of improvement.

- Clear areas of progress have been made, including building SECAmb's capability as the direction of travel. SECAmb came under the spotlight of lead commissioners (NWS CCG) recently when a CPN was issued (GC9.4, 12/02/2019) concerning Category 2 (C2) performance not being met for quarter 3 of 2018/19.

- A joint Investigation (SECAmb and NWS CCG) took place and summarised that action was needed in the following areas: Utilising hours / Producing Hours/ Continuous Improvements and recruitment.

- In response to the investigation, an action plan was created – this is owned by Operations.

Overview of Current Position – Ambulance Response Targets (continued)

NHS South East Coast Ambulance Service NHS Foundation Trust

- The challenges impacting on delivery are known and confidence remains high to achieve ARP compliance by end of Q1 (19-20). Our efforts are interlocked with commissioners to ensure that the action plan is a success, embedding quality improvement plans every step of the way.

- SECAmb has, and continues to supply, the modelled/required hours. Demand is aligned with the Demand and Capacity review taking into account calls cancelled by caller (proxy measure for unmet need).

- Efficiency and utilisation analysis shows opportunities for improvements across segments of the pre-hospital pathway. Plans to improve clinicians' availability within call centres will enhance operations and better target the patients, and make better use of clinicians for responding to Category 3 patients.

- The private ambulance market is actively managed. There is also a willingness to pro-actively drive the targeted dispatch model to aid clinicians and paramedics in answering Category 3 calls.

Overview of Current Position – Ambulance Response Targets (continued)

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NHS Foundation Trust

- Funding from commissioners provided.
- Deloitte report analysis and findings reviewed.
- Service Transformation and Delivery Team (STAD) in place.
- Programme management approach.
- Workstream Monitoring – weekly meetings.
- STAD Steering group and STAD SOG monitoring.
- Communication and engagement plan.
- Risk management.
- Benefits realisation to the health economy (being developed).

Overview of Improvements and Impact

NHS South East Coast Ambulance Service NHS Foundation Trust

To manage service transformation, programme milestones are in place to monitor performance

Indicators that are better than expected

1. Rota implementation and alignment has been quicker than expected.

2. The additional vehicle allocation to support the extra activity.

3. A clear understanding of 999 STAD risks and impact of associated organisational risks.

Indicators showing improvement

1. ECSWs recruitment is ahead of trajectory.

2. Staff engagement has been positive showing good level of participation.

3. Alert to the skill mix and detailed planning and apprenticeship work is in place, with HEE fully embedded.

Indicators that are worse than expected

1. PAP contract - moving PAP providers on to the traditional NHS contract has taken longer than anticipated.

2. National shortage of driving instructors impacting on 999 service.

3. The time frame for achieving the ARP is challenging.

4. Not on the curve for NQP and paramedics in the East.

Indicators showing decline

1. Awareness of the STAD challenges are known and action plans are being developed to address the challenges.

Benefits Realisation - ARP

The additional investment provided is not new money but an opportunity cost to allow the delivery of a fit for purpose service, and value for money, embedding quality at the heart of improvement.

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Benefits			
Benefit	**Description**	**Delivery Date**	**Deliverables**
Improving Flow	Improving patient flow - aims to enhance patient outcomes, improve patient experience and reduce mortality by prioritising those with the greatest need.	31/03/20	• Ensuring patients get access to the right care, first time • Saving lives and improving patient outcomes • Supporting more patients in their own home
Collaborative	We are committed to removing duplication and doing things once where possible.	31/03/20	• Ensuring crews with the correct skill set and vehicle/equipment dispatched first time in a timely manner and advanced and specialist paramedic roles -expanded clinical decision making and assessment,
Practical	We engage with the broader healthcare system to ensure our approaches work for those delivering care to patients	31/03/20	• Working with Commissioners, wider acute NHS colleagues and other Ambulance Trusts to improve care delivery and processes and share our capability with our partners.
Aligned	We engage with the broader healthcare system to ensure our approaches work for those delivering care to patients	31/03/20	• Increase in the number of patients 'see, treat and discharge' on scene • Increased working alongside community, primary care, social care, mental health
Adaptive	We actively seek input and feedback from each other and from our stakeholders on our policies and activities	31/03/20	• Sharing analysis of demand trends, patient flow, service gaps, processes and local variations
Efficient	Our structures and processes are designed to adapt to changing circumstances We build learning into all our major processes	31/03/20	• Less on scene time, • Less multi-vehicle deployments • Less Diverts • Reduce the number of patients transported to hospital

STAD Workstream Achievements Q4 (18-19)

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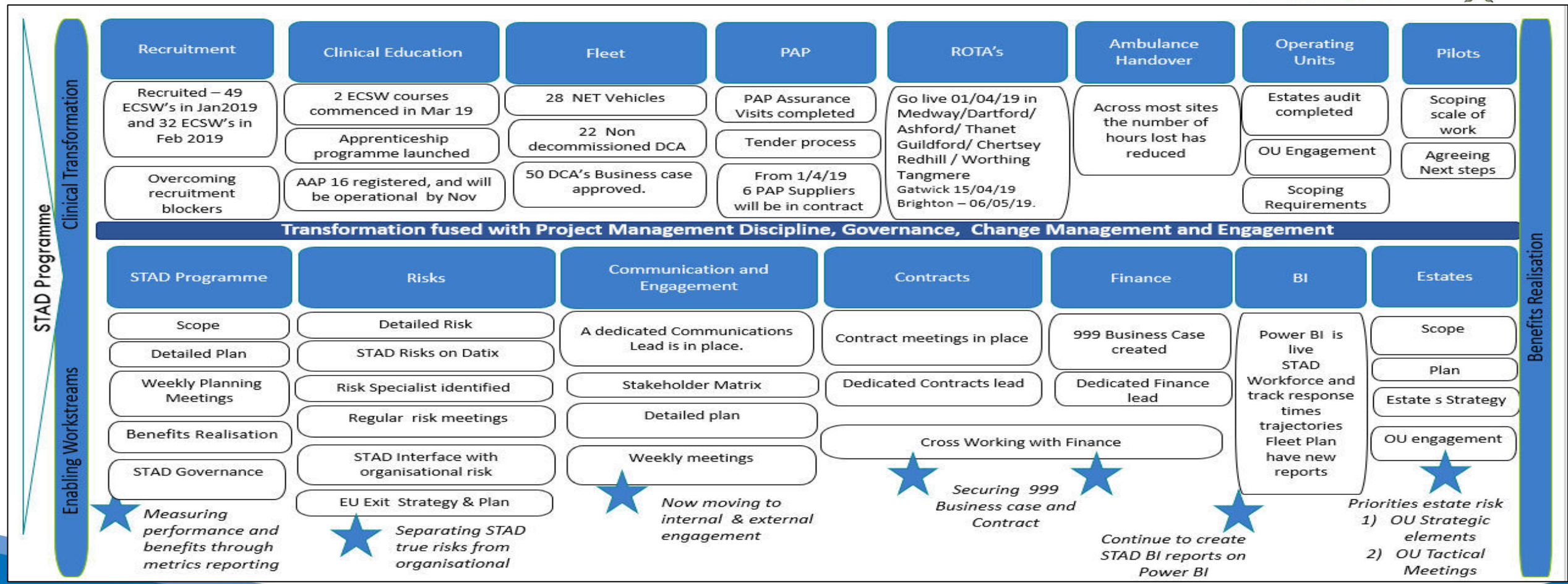

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Workstream Progress

Recruitment

South East Coast Ambulance Service NHS Foundation Trust

Current Performance

- **2018/19 - recruited 726 FTE Frontline Staff**
- 328 ECSW & AAPs: 256 ECSW, 72 AAP (200:100)
- 97 NQPs and 196 EOC EMAs
- 177 111 Advisors (162 Health Advisors & 15 Clinical Advisors)

Strengths

- Candidate attraction & response to adverts across Kent, Surrey & Sussex remains positive. Trust operational STAD plan ensures clarity on the exact numbers required & when. Local candidate attraction & increased recruitment team are resulting in green shoot positive outcomes. Time to hire has reduced from 27 weeks in June 2018 to 13 weeks in March 2019.

Issues

- Delays to candidates obtaining C1 licenses.
- Recruitment trajectory staying on track with candidate numbers – current course drop out rate is 12%
- Low conversion rate for some roles from application to offer – 23% for 111, 10% EOC, 40% NQP, 21% ECSW.

Recruitment Metrics

NHS South East Coast Ambulance Service NHS Foundation Trust

Objectives - By 31st March 2021, SECAmb to employ 25% (605) more front line staff, split by OU.

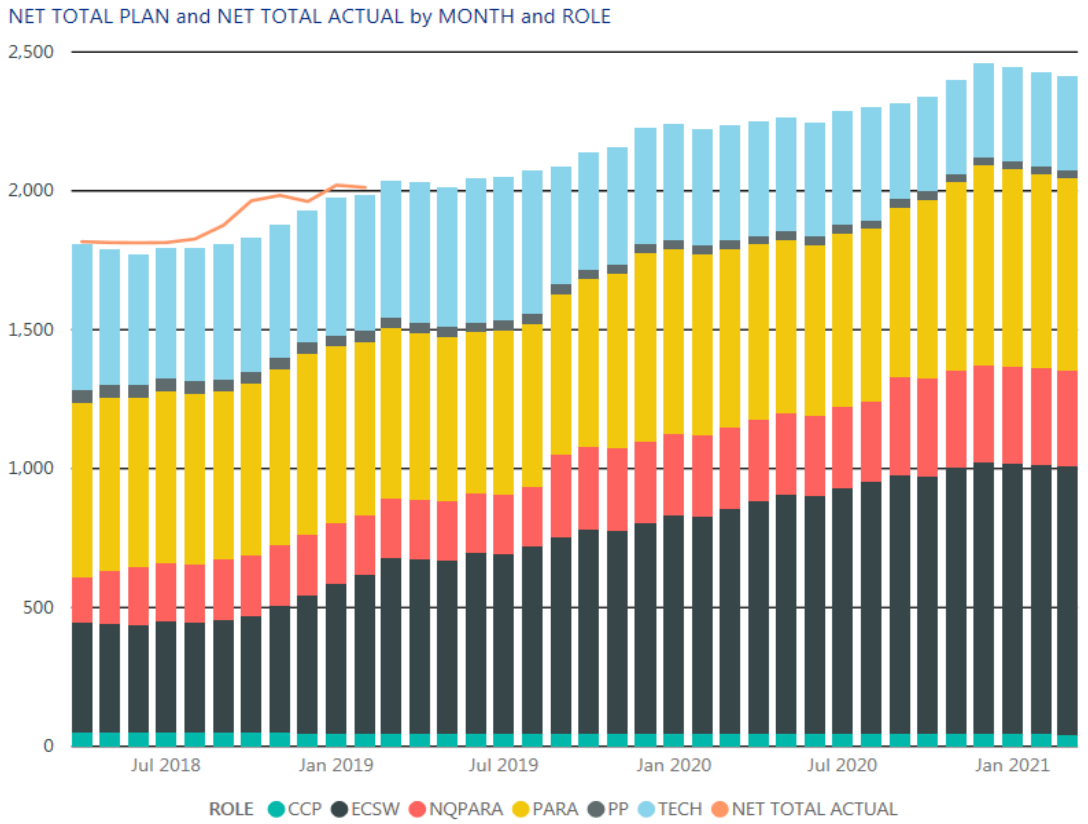
The planned workforce trajectory remains on track.

2019/20 targets are as follows:

- **Front Line** (FTE) is 413 - ECSW – 264, NQP – 132, Technician - 17
- **EOC** (FTE) – 97 (EMA - 42, Clinicians – 55)
- **111** (FTE) – 95 (HA, SA – 54, Clinicians – 41)

Current Annual Rolling Turnover Rate (March 2019)

- 14% Trust wide, 13.5% Operations – EOC - 32% East, 38% West, 111 46%.



Recruitment Challenges

- On-going Trust turnover and attrition rate.
- Continued delays to candidates obtaining C1.
- Manual pre-employment checking compliance processes.
- Impact of HR Transformation.
- National shortage of experienced paramedics and clinical staff for Contact Centres.

Clinical Education

South East Coast Ambulance Service NHS Foundation Trust

Current Performance

- 16 registered on the (external) Associate Ambulance Practitioner Apprenticeship and will be operational by Nov 19. 12 completers have achieved their qualification with either a Distinction or Merit. 324 ECSWs and 100 AAP course places available and working towards accredited Future Qual qualification. Over 450 Driver training spaces available to meet STAD workforce demands.

Strengths

- Introduction of Apprenticeships and Career Pathways
- Full utilisation of Apprenticeship Levy and collaboration with other Trusts to utilise their underspend. Departmental flexibility and positive adaptation to change and growth in workforce numbers and skills

Issues

- National shortage of driving instructors
- Clinical education vacancies and newness of staff to the teaching profession
- Training facilities to deliver localised requirements

Clinical Education metrics

South East Coast Ambulance Service NHS Foundation Trust

Objectives - By 31st March 2021, to ensure that the modelled split of registered (46%) and non-registered (54%) personnel (paramedic) trajectory is met.

- Staffing trajectory table shows year by year requirement from a base of 1808 WTE
- Plans are progressing to balance the number of non-registered and registered paramedics
- Increasing paramedic numbers will be achieved by targeting our partner universities, offering early engagement with those on placement with SECAmb.

Workstream		Apr-18	Mar-19	Mar-20	Mar-21
Workforce numbers front line	ECSW	395	614	762	942
Workforce numbers front line	TECH	524	483	409	331
Workforce numbers front line	NQPARA	163	222	309	373
Workforce numbers front line	PARA	630	604	640	697
Workforce numbers front line	CCP	50	47	44	43
Workforce numbers front line	PP	47	39	33	29
Workforce numbers front line	TOTAL	1808	2009	2197	2415

Clinical Education Challenges

NHS
South East Coast Ambulance Service
NHS Foundation Trust

- Attraction rate.
- Planning and delivery of BSc Apprenticeship to fill gap in HEE funding.
- Filling vacancies within the department and ensuring staff are educationally qualified to deliver programmes.
- Lack of suitable training facilities to meet workforce requirements (planning for the future).

Fleet

South East Coast Ambulance Service NHS Foundation Trust

Current Performance

- **Achieved:** 50 double-crewed ambulances (Mercedes, DCA) have been ordered and will be operational from August 2019.
- 30 new non-emergency transport (NET) vehicles introduced to help achieve a better response to Category 3 and 4 targets. On target to achieve the Fleet trajectory

Strengths

- An additional 50 DCAs (FIAT) is proposed, which will increase the Fleet numbers and enable the replacement of older vehicles.
- An additional 22 vehicles due to be decommissioned will be available to support achieving ARP targets (short term basis).

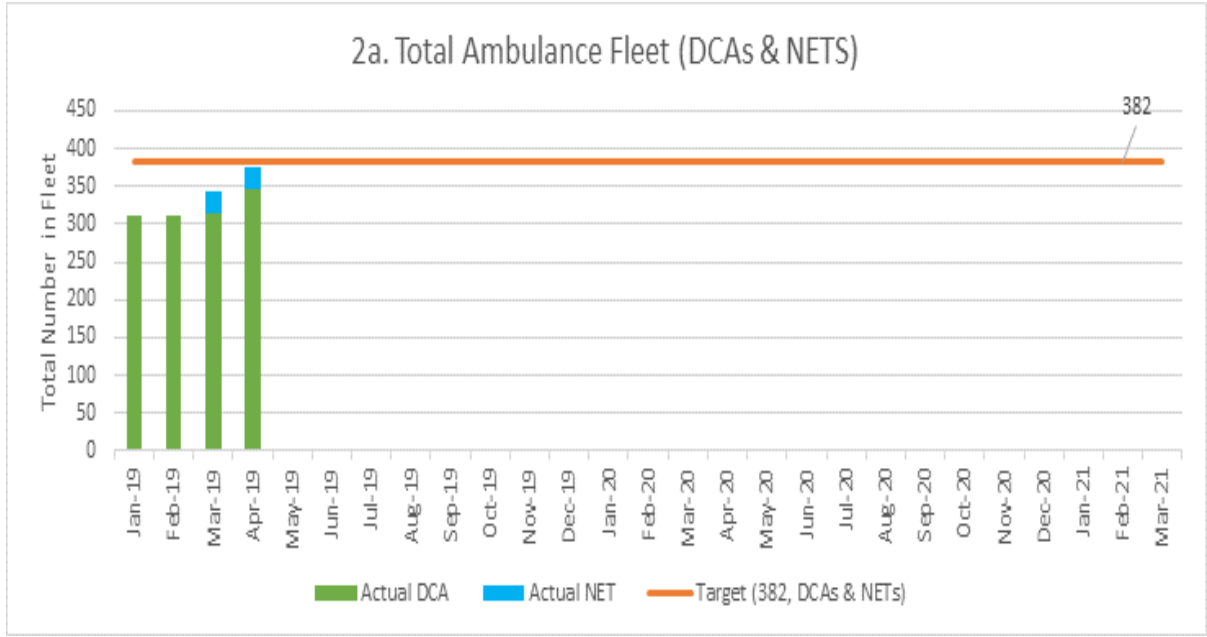
Issues

- The business case for the additional FIATs above has been ratified at EMB is being presented to Finance Investment Committee (FIC).
- Realignment of the Fleet Strategy is required before the business case can be approved for the additional 50 vehicles and this is also going to FIC.

Fleet Metrics

South East Coast Ambulance Service NHS Foundation Trust

- **Objective - By 31st March 2021, to commission 50 extra DCAs to support the delivery of the targets.**
  - Following publication of the Carter Report, the updated business case supported by the Fleet Strategy is due to be completed by June 2019.
  - From April 2019 onwards, DCA's have been moved around the Trust aligning vehicles with operating unit staffing requirements.



Fleet Challenges

South East Coast Ambulance Service NHS Foundation Trust

- Update Fleet strategy and obtain Board approval.
- Submit business case for additional 50 DCAs (Fiat) in line with Carter Report.
- Aligning Fleet strategy with Human Resource Recruitment Strategy.
- Unknown impact of EU exit (Transport infrastructure).

Private Ambulance Providers (PAP)

South East Coast Ambulance Service NHS Foundation Trust

Current Performance

- **Achieved:** Moved to new NHS standardised contract for private ambulance providers, due to be completed end of April 2019.
- Governance and Assurance inspections moved to Compliance Team.

Strengths

- Much improved picture for monitoring of PAP Governance and Assurance against service provided and contract performance.
- KPIs are in place to monitor the performance of each PAP supplier.
- PAP hours provision is in an improving position.

Issues

- Shortage of PAP contracted hours in Q1 (19/20)
- National shortage of PAP providers

PAPs metrics

- **Objective - By 31st March 2021, to commission below modelled levels of PAP resources (<5%) to support the delivery of the targets**.

  - From 1st April, 6 PAP providers are under the NHS contract. Current PAP utilisation in April was at 8%. Allowing for the reduction to less than 5% by 2021 is dependent on having the right number of staff and vehicles available to allow for this reduction in PAP provision.

  - There exists a shortfall in contracted hours for both SECAmb and PAP hours/shifts in Q1, 19-20. A review of the hours provided by PAP/staff overtime is being looked at to close the gap.

PAP Challenges

- Continue to develop and review plans to reduce PAP utilisation to the minimum over the next two years.
- PAP market has the possibility to reduce if the work is not made available.
- Realignment of the PAP strategy to meet increased volume of calls.

Operational Rotas

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Current Performance

- **Achieved:** Rota implementation over 7 months, which usually takes 3 years.
- Engaged workforce and staff mobilised and focused.
- 60% of SECAmb rotas went live as predicted 1st April. Two more dispatch desks go live at the beginning of May with the final 3 dispatch desks projected to go live July 2019.

Strengths

- New rotas are tailored to met individual area demand, based on the jointly developed Demand & Capacity review.
- All submitted rotas are accompanied by a rota demand tool to monitor that the presented rota meets the required demand profile.

Issues

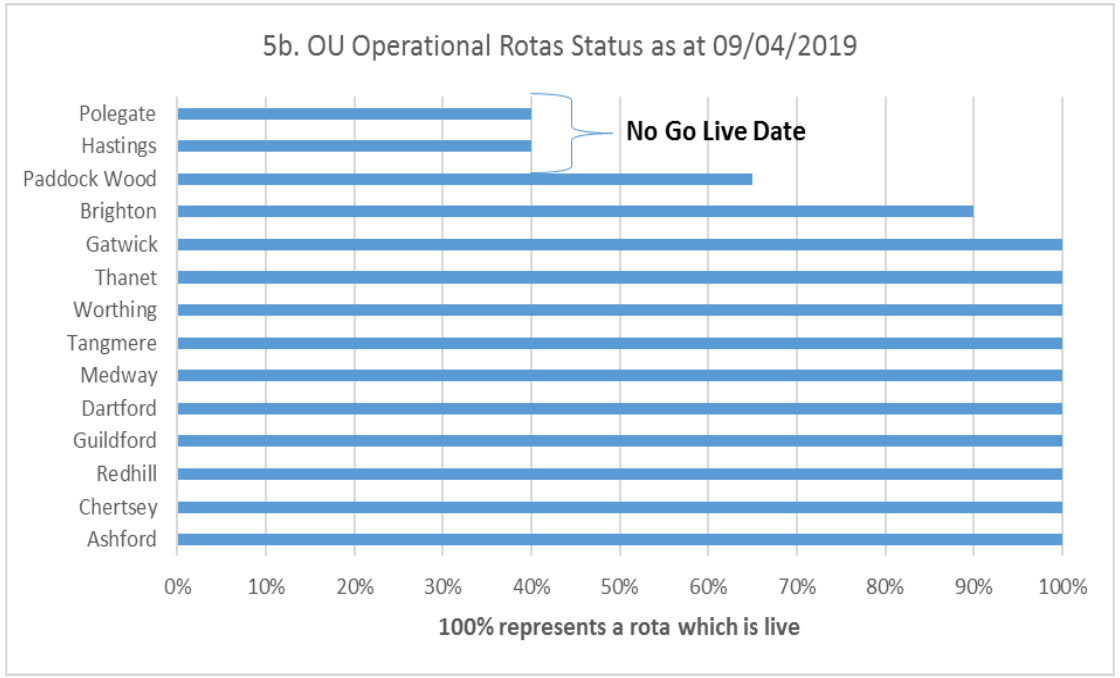
- Resource cover for weekend gaps in rota shift hours.
- Staff shortage across operating units impacting on effectiveness.

Operational Rotas metrics

South East Coast Ambulance Service NHS Foundation Trust

Objective - To implement new rotas by April 2019 to meet ORH rota keys

- An analysis of the ORH report has taken place to identify and implement rotas that meet the jointly agreed demand for 11 out of 14 dispatch desks in 6 months.
- All sites can maintain compliance to the demand profile via the developed demand tools at a local level.
- Rotas continue to be reviewed at a local level, including local events and activity changes to ensure the best possible provision and timely rota changes.



Rota Challenges

- Continue to monitor effectiveness to ensure that adequate cover is provided 24/7 across all areas (inc. weekend and night shifts).
- Impact of staff shortages across specific operating units.

System Wide – Ambulance Handovers

South East Coast Ambulance Service NHS Foundation Trust

Current Performance

- **Achieved:** Overall there was a 17% decrease in ambulance hours lost (11,998) >30 minute turnaround comparing 2018/19 financial year to 2017/2018 financial year (68822 hrs to 56824 hrs).

Strengths

- SECAmb staff working with system partners - with support from CCGs - have developed a shared approach to reducing delays and established good working relationships at most sites. Peer review visits have also been undertaken with support from ECIST, and best practice is being shared, which will increase benefits. Live joint conveyance reviews at individual sites to optimise community pathways are being undertaken.

Issues

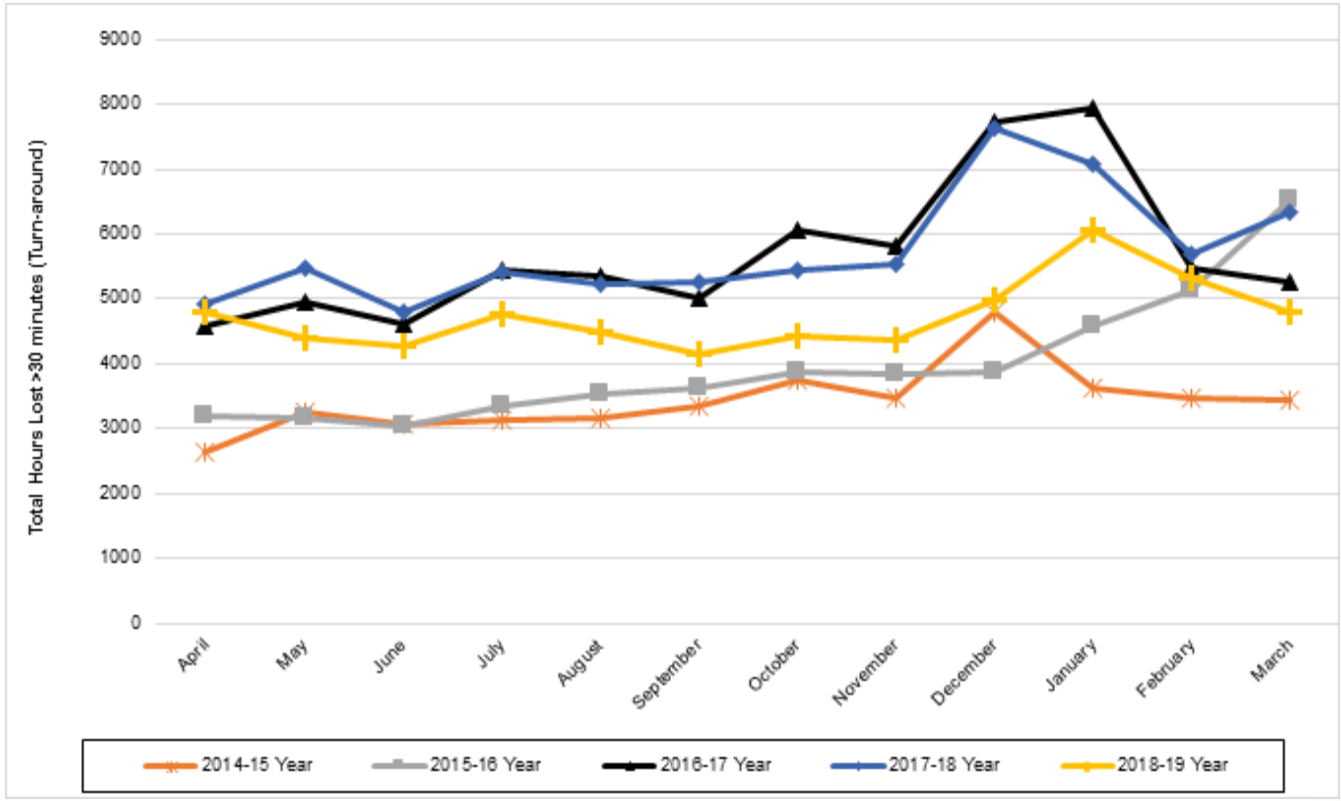
- Handover delays increase over the winter period caused by increased system-wide winter pressures
- There has been an increase in the number of requests for diverts (mainly between sites belonging to the same Trust) to manage patient flow.

Ambulance Handovers metrics

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Objective - By 31st March 2021, to ensure that there are agreed robust handover processes across 18 hospital sites.

- 17% reduction in the number of patients who waited between 30 and 60 minutes for a hospital handover.
- 34% reduction in the number who waited over 60 minutes.



System Wide Handover Challenges

South East Coast Ambulance Service NHS Foundation Trust

- Improvements not consistent at all sites (key outliers)
- Establishing good communication between SECAmb and Hospitals; to ensure responsive escalation with associated actions, to avoid queues occurring, and to effectively manage surges.

Operational Readiness (Estates)

South East Coast Ambulance Service NHS Foundation Trust

Current Performance

- **Achieved:** Outline Operating Units' estates scoping requirements for STAD.
- Estates workshops are underway to understand the operating units' ability to accommodate the STAD requirements and to determine the improvements required now to deliver the programmes priorities (will be completed May 2019).

Strengths

- Regular support and engagement with Operational Unit Managers (ROMs, OUMs) with regards to the STAD programme.
- Delivery leads in place attending operating units meetings (Team A, B).

Issues

- Variation in STAD OU estates readiness.
- Revisit Estate strategy to align with Fleet/Recruitment strategies.

Operational Units Readiness

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	1	2	3	45	6 7	8	9	10 11	12 13	14
	Ashford OU	**Brighton OU**	**Chertsey OU**	**Dartford & Medwa**	**Gatwick & Redhill**	**Guildford OU**	**Paddock Wood (**	**Polegate & Hastin**	**Tangmere & Worthi**	**Thanet OU**
•Status summary	Ashford Make Ready Centre is in good order, with minor STAD related issues.	Brighton OU is largely in good order, with minor STAD related issues which will be resolved once the Falmer site is built.	Chertsey location means access is difficult during peak traffic. Staff accommodation and parking are causing issues.	Busiest OU in the East, support needed from other OUs daily. Sheppey is due for refurb by end 2019.	OU has a MRC and several Ambulance Stations. Leatherhead is currently struggling due to lack of space for management.	Issues related to OU ability to physically take more staff and parking remains an issue.	Paddock Wood covers the largest geographical area in SECamb. Struggles with acute lack of parking. Rural location can meet OU misses ARP.	MRC in good working order. Hastings has issues with meeting ARP Cat. 1 due to rural location. Staff travelling to Polegate for training exacerbates parking	Overall the OU is in a good state for the STAD programme. Current refurbishment work at Worthing due to finish in June.	Thanet OU covers a large area. Current staffing numbers are satisfactory, but an increase in registered clinicians required to balance skill mix.
•Estates summary	Main issues to do with staff and vehicle parking.	Main issues to do with staff and vehicle parking which will be resolved once parking is sorted.	Main issues to do with staff and vehicle parking. Staines lease due for renewal. A strategic OU and Estates workshop has been planned to deal with Chertsey location and	All sites have parking issues. No training facilities exist until Sheppey is built. Key Skills can be held at Medway.	Parking is an issue across the OU. Training spaces at Gatwick.	Strategic workshop planned to discuss OU. Tongham site incomplete impacting training venue availability.	Acute parking issues affecting operational staff resulting in a loss of hours worked. Can host ECSW courses unless Key Skills is planned.	Hastings struggle to host more staff in current state.	Midhurst standby point to be located to fire station and become an ACRP.	Training rooms required.
•Recruitment summa	ECSWs have been assessed and trained and due to be operational in July and	No ECSW recruitment planned.	ECSWs have been assessed and trained and due to be operational in July 2019 and January 2020.	Heaviest recruitment with 8 ECSW campaigns between 2019-2020.	4 ECSW campaigns planned, first one live 15/04/19 due to be operational October 2019.	3 ECSW courses planned between ow and 2020. First cohort to be operational by August 2019.	6 ECSW courses are planned between now and 2021. First cohort to go operational in June 2019.	No ECSW recruitment planned.	No ECSW recruitment planned.	No ECSW recruitment planned.
•Priorities	Extension of local parking arrangements.	None.	Extension of local parking arrangements. Arranging a new Staines lease.	Secure new location for Dartford to enable planning beyond the ned of the lease. Car parking.	Parking can impact delivery.	Space to take more staff.	Parking.	Hastings site improvement for training and potentially more staff.	approve Midhurst ACRP with West Sussex Council.	Additional 4 training rooms required.

Operational Readiness Challenges

South East Coast Ambulance Service NHS Foundation Trust

- Realigning the estates strategy following detailed analysis of the OU audits and scoping exercise.
- Making the required changes to the estates to ensure readiness for STAD.
- Realigning the estates strategy with the Fleet and HR Recruitment strategies.

Pilots

South East Coast Ambulance Service NHS Foundation Trust

Current Performance

- 20 projects working collaboratively with commissioners or other providers and on varied timelines.
- Trials focused on fallers, joint response with other blue light providers, paramedic practitioners in the community and primary care, mental health, maternity line and more.

Strengths

- Collaborative and integrated working has supported strong system relationships and improved patient care.
- Projects are very patient focused
- Focus on shared workforce e.g. maternity service, PP trails and the mental health street triage.
- Can have big wins for SECAmb
- Locally based, pilots developed with associate commissioners and local providers for localized improvements.
- Steers care closer to home.

Issues

- Need to develop better roadmaps to BAU.
- Set the strategic direction and scope of innovations for 19/20 in line with NHS long term plan, SECAmb 19/20 plan and 5 year strategy.

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STAD Enabling Workstreams

Risk Management Process

South East Coast Ambulance Service NHS Foundation Trust

Current Performance

- **Achieved:** STAD risks identified and STAD risks aligned with organisational risk.
- Review of all STAD risks has taken place.
- Risks monitored and reported via monthly Dashboard.

Strengths

- STAD risks aligned with programme.
- Organisational risks that may impact on STAD are aligned.
- Individual risks monitored by relevant committees.
- All risks with a Residual Score (high/extreme) are escalated to EMB monthly.

Issues

- OU strategy to be aligned with Fleet and Recruitment strategy.
- Recruitment trajectory to be reviewed and aligned by Grade to Attrition Rates

STAD Risk Review 1

NHS
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NHS Foundation Trust

Risk Reference: 826	Name Risk: Failure to achieve ARP targets – Q1 2019-20 (STAD)
Risk Analysis:	There is a risk that the Trust will not achieve its ARP standards for quarter 1 2019-20
Underlying Causes	This is as a result of insufficient resources and the collective impact of other associated risks (project and organisational)
Risk Management:	
Current Actions	• Recruitment supported by the resourcing improvement plan and interim specialist • External PAPs' available hours for Q1 less than identified operation need. Under review but hours still fall short of requirements • High Attrition rates under review - still around 11%
Current Risk Score	**Extreme (20)**

STAD Risk Review 2

NHS South East Coast Ambulance Service NHS Foundation Trust

Risk Reference: 852	Name Risk: EOC - Clinical Safety and Performance
Risk Analysis:	There is a risk that patient care could be compromised unless the Trust takes immediate action to deliver improvements and optimise patient safety, whilst meeting performance targets within our EOCs
Underlying Causes	• Shortfall in clinical support within the EOC • Delay in processing overseas recruits/High Attrition Rate
Risk Management:	
Current Actions	• EOC Project Group established supported by PMO • Strategy being developed for Recruitment of Emergency Medical Advisors (EMAs), Clinical Supervisors and Resource Dispatchers
Current Risk Score	**Extreme (20)**

STAD Risk Review 3

Risk Reference : 758	Name Risk: Estate Infrastructure / Operational Readiness
Risk Analysis:	There is a risk that our existing estate infrastructure and proposed strategy for development in certain areas, to underpin delivery of the corporate objectives (STAD), is not 'fit for purpose'
Underlying Causes	Estate strategy developed and approved (pre Demand & Capacity).
Risk Management:	
Current Actions	• Estates workshops taking place across all operating units and are due to be completed by May 2019 • Future state (for all OUs) to be aligned to existing technical estates expertise/knowledge of OU estates.
Current Risk Score	**High (12)**

STAD Risk Review 4

NHS
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Risk Reference: 757	Name Risk: Workforce - Recruitment Front Line Staff
Risk Analysis:	There is a risk that the Trust may not be able to recruit sufficient core frontline staff to meet workforce profile requirements and to deliver the activity projected in the Service Transformation & Delivery Programme for 19/20 & 20/21
Underlying Causes	The transferrable skills of paramedics and current national shortage of approx. 12%
Risk Management:	
Current Actions	• Increased Recruitment activity and engagement with Universities/graduates • Review recruitment plan and capacity against revised requirement.
Current Risk Score	**High (12)**

STAD Risk Review 5

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Risk Reference: 819	Name Risk: High Attrition Rate within Clinical Teams
Risk Analysis:	There is a risk that if staff attrition does not reduce in line with the workforce model, more staff will need to be recruited than projected.
Underlying Causes (Sector Wide)	• Pay and reward/Demand placed on 999 services • Workload on individuals and working practices • Increase in working hours and work related stress • Bullying and harassment and physical violence
Risk Management:	
Current Actions	• Staff attrition reasons identified and retention approaches developed • HR resource to be identified and Attrition Workstream set up
Current Risk Score	High (12)

Business Intelligence

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Current Performance

- **Achieved:** STAD BI report created for Workforce, PAP, Fleet and ARP Targets.
- Job Cycle time report created.

Strengths

- Integration with Operations and regular discussions in place.
- Central repository of information, aligned to performance reporting, contracts, and Commissioning.

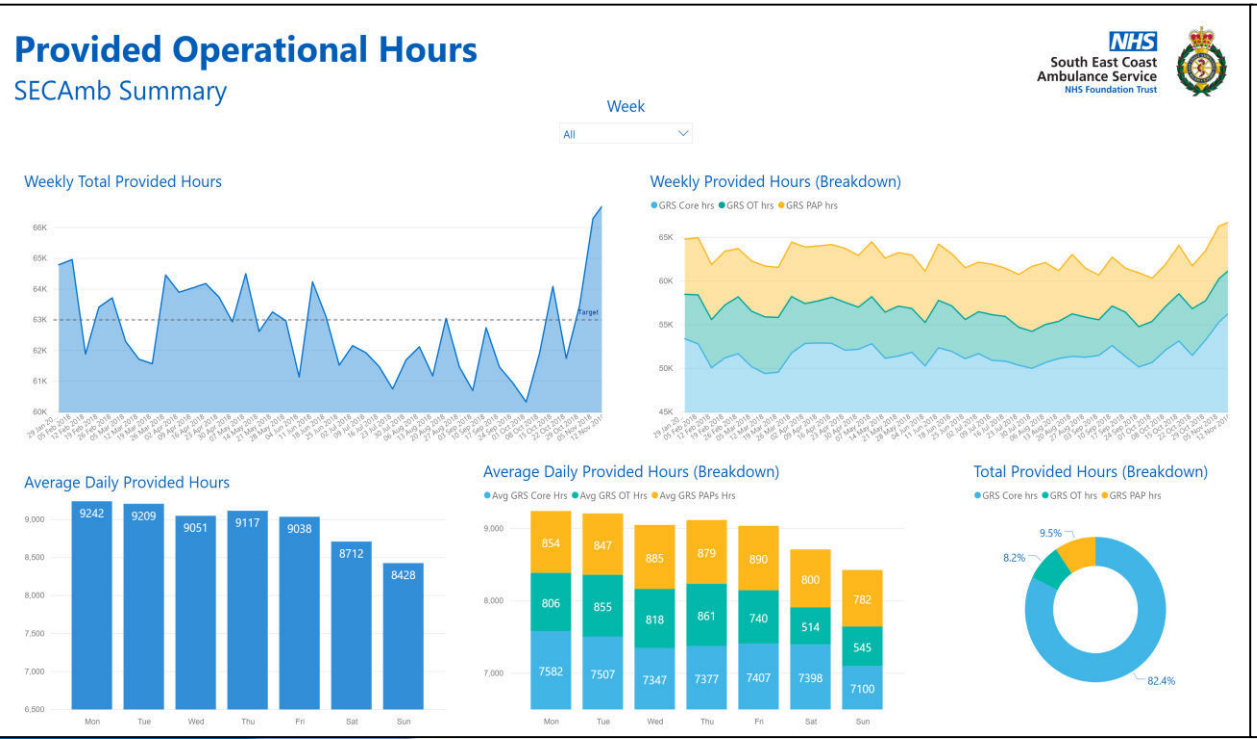
Issues

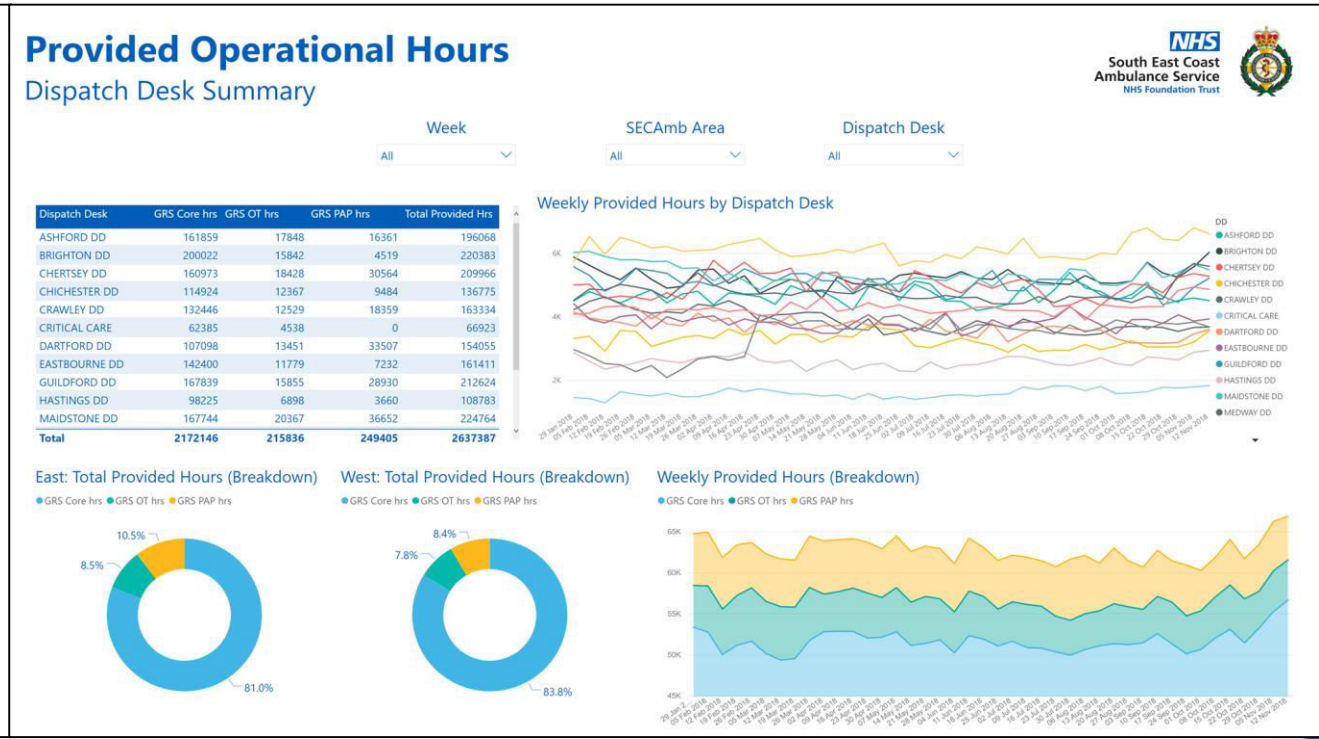
- Difficulty recruiting additional staff for the programme given the length of time required to familiarise with ambulance datasets.

Power BI - Forecasting capability and reporting platforms

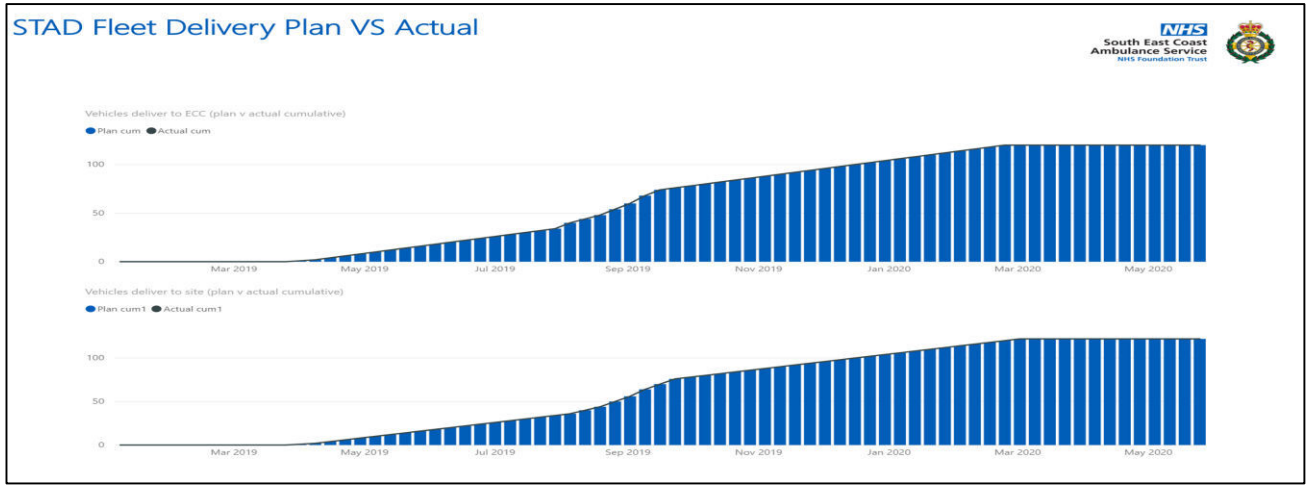
NHS South East Coast Ambulance Service NHS Foundation Trust

Robust look back reporting on operational hours provided, enabling operational managers to identify areas of concern





Power BI - Workforce capacity



Aspiring to be ***better today*** and even ***better tomorrow***

Communication and Engagement

South East Coast Ambulance Service NHS Foundation Trust

Current Performance

- **Achieved:** Dedicated STAD Communications lead recruited to programme
- Communications Plan and stakeholder map written and in operation.

Strengths

- Broad range of established communications and engagement channels through which to relay programme progress, milestones and benefits to staff & stakeholders.
- Lots of positive outcomes to share already.

Issues

- Patchy inter-directorate comms and internal cascade of key messages.
- Low awareness of STAD among frontline staff – poor engagement with existing comms channels.

999 STAD Communications

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South East Coast Ambulance Service
NHS Foundation Trust

The goal of the communications plan is to ensure that the programme's key stakeholder audiences:

- Are aware of and understand the goals and benefits of STAD and the progress and deliverables that have been achieved.
- Feel invested in the programme and its successful delivery.
- And, where appropriate, actively feedback and input into the delivery of the programme's improvements.

This will be achieved by:

- Engaging stakeholders throughout the journey (giving timely progress-against-goals updates) and supporting a two-way dialogue wherever possible/relevant.
- Focusing on the programme's tangible deliverables and relevance to different stakeholders.
- Being transparent on the nature of changes and the role of stakeholders in its success.

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Appendix

- CPN Action Plan – hard copy provided
- You Said We Did – hard copy provided

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Questions

SECAMB Board

Finance and Investment Committee Escalation report to the Board

Date of meetings	13 May 2019
Overview of key issues/areas covered at the meeting:	***Business Cases*** All Business Cases are initially considered by the Business Case Review Group and those requiring Board approval are reviewed by the Executive Management Board prior to submission to the Finance and Investment Committee. At the meeting in May, two Business Cases were brought for review both of which are recommended to the Board for approval: 1. 50 Double-Crewed Ambulance Business Case The committee was assured that the van conversions would comply with the minimum national standard set by Carter and that funds were available, through the capital plan. 2. EOC Audit and Training Business Case The committee strongly supported this given the requirements of the NHS Pathways Licence and need within the EOC to ensure quality. However, there was a detailed discussion about reviewing investment decisions in isolation and the associated risks. The committee noted the work underway by management to ensure greater clarity of the known investments, so that more informed decisions can be made relating to both priority and affordability. This was discussed more specifically under financial performance below. Both Business Cases are in Part 2 due to commercial sensitivities, and the decisions made will be reflected in the next Chief Executive's report to the Board, in July. ***Financial Performance*** The committee acknowledged and thanked the finance team for all the work they had put in to help achieve the year-end financial position, which was set out in the Month 12 month report. Despite meeting all the financial performance targets for the year, overall the Trust is operating with an underlying £2 million deficit. Therefore, over the coming year the Trust will face further challenges with balancing the need for a demanding Cost Improvement Programme (CIP) and further investment. The committee explored the importance of having a longer term strategic financial plan to address the underlying deficit and to guide future investments in terms of affordability and to ensure that planned efficiencies are sustainable. The committee asked that a longer term strategic financial plan be available for its August meeting for subsequent discussion and review by the Board as part of the development session on 29 August. The committee also asked that a draft plan for delivering the 2019/20 CIP be available for its June meeting. This is to provide assurance that the plan is deliverable and not adversely impact on quality / safety. The Quality and Patient Safety Committee will in

	more detail seek assurance on the latter, as part of its review of the related quality impact assessment process. The committee noted that the Trust and Commissioners had yet to reach final agreement on funding for 2019/20. The hope was that this would be resolved by the time the Board meets and a verbal update will be provided then. ***999 Service Transformation / Operational Performance*** The committee carried out a deep dive into 999 Service Transformation Delivery (STAD) Programme and supporting governance. It was impressed by the considerable efforts undertaken to align the various enablers (fleet, recruitment, rotas, and training) to ensure sustained improvement in meeting national Ambulance Response Programme (ARP) standards. There are however a number of internal and external factors including not securing sufficiently qualified paramedics, which means that the Trust will not meet planned performance for the first quarter of 2019/2020, particularly for Category 3 and 4 call response times. In light of these risks, the committee was only partially assured by the remedial plan, set out by the executive team, to ensure compliance with ARP by 1 July 2019. The committee noted that the Trust Board is scheduled to consider this as part of the next Delivery Plan deep dive. ***Fleet Strategy*** The revised draft of the fleet strategy was considered by the committee to be a major improvement. It acknowledged the considerable work that had gone into achieving this. Further suggestions were made for strengthening the rationale for the size and type of fleet needed to support the targeted dispatch model, particularly in achieving sustained improvements in patient care and potential for further efficiencies in the target combined vehicle operating model beyond the proposed 138% (from the current 141%) through the move to Make Ready Centers. The underlying financial projections needed further refinement and the committee agreed that these could be detached from the strategy, which should be principles based, and instead included in an implementation plan. Progress with developing this plan will be reported to the committee at its next meeting on 18 June. Subject to the strategy being amended along the lines suggested, which includes the need to outline the timetable for agreeing the implementation plan, the committee agreed that it should be considered by the Board at its May meeting. Subject to Board approval, the Committee recommends that future decisions on the best procurement approach (outright purchase or leasing) should be agreed by the Director of Finance in conjunction with the committee chair. ***111/CAS*** The Committee welcomed the further work undertaken to prepare for the delivery of the 111 service should the Trust be appointed. It asked that further assurance be provided to the Trust Board in May, on the stated timetable for resolving the outstanding issues, prior to the scenario assessments run by the commissioning body in the week of 17 June. This will be discussed in Part 2.

	The committee also asked for further assurance about the scope and timing of work to secure a solution to ensure interoperability between the various systems. ***Estate Maintenance*** A report was received updating on the work of estates. The committee asked for further analysis for its June meeting to provide assurance that planned expenditure on maintenance and remedial work in 2019/20 is consistent with the approved estates strategy and in complying with appropriate health and safety standards and the wellbeing of staff. ***IT / Digital*** The committee was not convinced that the paper reflected the full extent of planned or essential digital projects in 2019/20. It therefore asked for a more comprehensive assessment to be provided at the June meeting together with assurance about the Trust's capability and capacity to deliver this.
Any other matters the Committee wishes to escalate to the Board	As reflected above, the committee felt that the board development programme should include as a matter of some priority, time to reflect on the developing longer term strategic financial plan. It suggested using the session scheduled in August, by which time the initial proposals should be starting to emerge. The Board will then need some further time to refine and develop this, possibly in October-December 2019. The papers for the committee arrived in good time, and the committee noted the ongoing work to ensure the quality of papers continues to improve.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	09-19

Name of meeting	Trust Board Meeting
Date	23rd May 2019
Details of paper	**Fleet Strategy**
Responsible Executive	Joe Garcia, Director of Operations
Report Author	John Griffiths – Head of Fleet and Logistics Hilary Parsons – Business Support Manager for Operations
Synopsis	This paper provides the Fleet Strategy for the Trust for the years 2018-2023. It has been reviewed by the Finance and Investment Committee as reflected it its Board escalation report.
Recommendations, decisions or actions sought	The Board is asked to approve this Fleet Strategy.

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

South East Coast Ambulance Service NHS Foundation Trust

Fleet Strategy 2018-2023

Contents

About us

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) was formed in 2006 following the merger of Kent, Surrey and Sussex Ambulance Services and in 2011 achieved Foundation Trust status.

We receive and respond to over 1 million 999 calls from the public each year, urgent calls from healthcare professionals and receive and respond to calls from NHS 111 as well as providing the regional Hazardous Area Response Team (HART).

We meet this need by deploying our operational colleagues in Emergency Ambulances as a Dual Crewed resource and Single Response Vehicles. We deploy Specialist Clinicians and Managers in support of our Operational Teams in dedicated All Wheel Drive vehicles and we meet the needs of less acute patients through the use of appropriate Non-Emergency transport.

We are led by a Unitary Trust Board composed of Chair, Non-Executive Directors, Chief Executive and Executive Directors. We are held to account by our Council of Governors comprised of publicly-elected, staff elected and appointed governors.

Our 3,499 staff, 85% of whom are patient facing, provide services to 4.7 million people over the 9,400 square kilometres of Kent, Medway, Surrey, Sussex and North East Hampshire.

Trust Vision

The Trust recognises 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.

We must ensure that we deliver a Future Fleet that is fit for purpose, balanced to support our developing operating model, and sufficient to meet the projected future demand.

Trust Strategic Themes and Focus

This Fleet Strategy contributes, and is aligned, to the Trust's Five-Year Strategic Plan from 2017-2022. The Strategic Plan demonstrates how the Trust will ensure the provision of safe, quality care to its communities and staff.

The plan also acknowledges that the Trust is in the process of delivering a holistic improvement plan with the aim of returning to a position of providing consistently high-quality care for all. 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 are 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.

Figure 1 – Our Trust's Strategic Focus

The Fleet Strategy, and nature of vehicles used, is central to our operations and means that this relates to a range of objectives across all four strategic themes, but mainly sits under the theme 'Our Enablers' within our Strategic Delivery Plan, and under the two-year objective: -

"Ensure that our fleet is fit for purpose and supports the clinical model"

Our Fleet Strategic Goals and Principles

This Fleet Strategy will contribute to the delivery of the Trust's Five-Year Strategic Plan and the implementation of changes in clinical and operational models.

The aim of this Fleet Strategy is to provide a fleet that is;

- **Fit for purpose**
- **Safe**
- **Reliable**
- **Cost-effective fleet of standardised vehicles**
- **Will enable the Trust to deliver optimum patient care and services in the communities it serves**

- **Support clinicians to improve outcomes for our patients and enable the effective use of clinical time and resources**
- **A "greener" fleet that meets the profile and needs of the patients that we serve.**

Our priority will be to ensure that there are sufficient vehicles to meet operational demand and this will be balanced against the requirement to update the Trust's ageing fleet.

It will consider key external influences including the Ambulance Response Programme (ARP), the Carter Report and the recent ORH Demand and Capacity review.

We will support the delivery of the Targeted Dispatch Model, drive efficiencies in vehicle provision assumption aligned to the Carter report, minimise our environmental impact whilst fitting this within our affordability envelope.

Our goals are clear.

We will deliver a Trust Fleet that meets the needs of our patients and our staff, with their safety at the forefront of any decisions, whilst ensuring that we get the best value for money for the Trust.

Targeted Dispatch Model

Following consultation with our partners in the Demand and Capacity Review we will adopt a Targeted Dispatch Model which focuses on getting a clinically appropriate resource to patients to support them in the community, increasing the use of specialist paramedics and Non-Emergency Transport Vehicles (NETs).

To deliver this to a consistent standard that maintains patient safety and delivers value for money our current aim is to have a responsive vehicle fleet of approximately 650 operational vehicles plus a reduced lease car fleet.

This targeted operating fleet model means that with our current efficiencies, our total combined on the road, and reserve fleet for DCAs is 140% of our peak load highest value. This is the greatest number of Ambulances that we deploy at the busiest part of any period within the week. We are confident that as we increase our make ready capacity, we will continue to make further efficiencies to achieve a reduction to 138% by 2021. This will be reviewed on an annual basis and reduced due to the reduced need for spare vehicles as we pool vehicles in Make Ready Centres as opposed to smaller stations.. Due to the smaller numbers of SRVs and specialist vehicles this number will be lower and variable.

Where are we now?

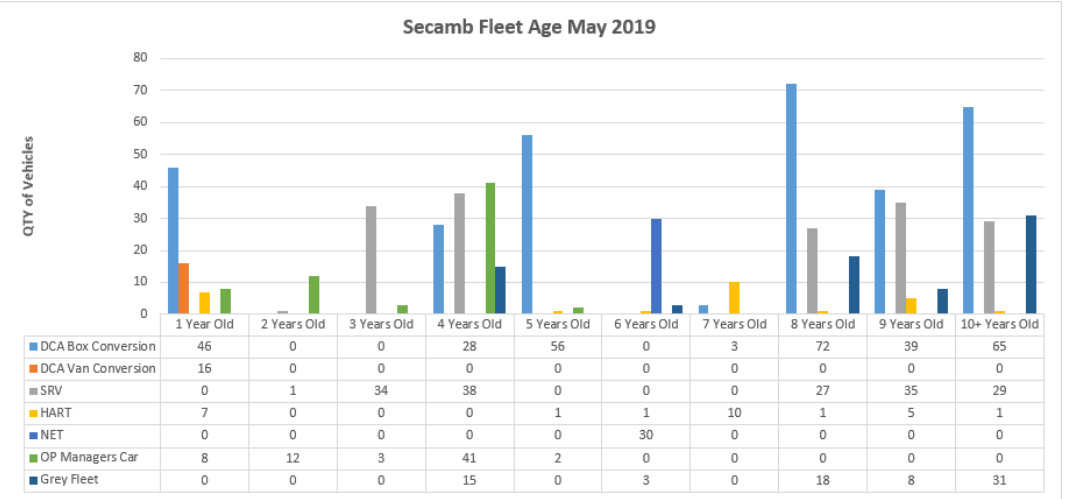
We receive and respond to 999 calls from the public, urgent calls from healthcare professionals and receive and respond to calls to NHS 111 as well as providing the two HART teams.

The demographics of our catchment area and of our staff is varied. There is an increase in acute demand, and delivery of care at home or close to home.

The Trust currently manages a fleet of vehicles, of which over 584 are used in direct support of operations made up of:

- 315 Dual Crewed Ambulances (DCA) plus a small Neonatal and Bariatric fleet.
- 30 Non-Emergency Ambulances (NETs).
- 164 Single Response Vehicles (SRV).
- 26 Hazardous Area Response Team (HART) vehicles.
- 69 other specialist units (grey fleet), made up of contingency planning, estates, IT, Logistics and other departments.
- 35 Operational Managers' vehicles dedicated to that role.
- Approximately 120 lease cars, of which circa 31 are in use by operational and clinical managers.

The Trust drives approximately 16 million miles per year and spends around £6m on fuel.



	1 Year Old	2 Years Old	3 Years Old	4 Years Old	5 Years Old	6 Years Old	7 Years Old	8 Years Old	9 Years Old	10+ Years Old
DCA Box Conversion	46	0	0	28	56	0	3	72	39	65
DCA Van Conversion	16	0	0	0	0	0	0	0	0	0
SRV	0	1	34	38	0	0	0	27	35	29
HART	7	0	0	0	1	1	10	1	5	1
NET	0	0	0	0	0	30	0	0	0	0
OP Managers Car	8	12	3	41	2	0	0	0	0	0
Grey Fleet	0	0	0	15	0	3	0	18	8	31

We currently have:

- Too few Dual Crewed Ambulances (DCA) and a high proportion of Single Response Vehicles (SRV). We currently have a ratio of DCA:SRV 66:34.
- Too many DCAs which are old and unreliable, as the result of little investment in the last 2-4 years.
- Old and unreliable NETs – a recently procured batch is helping to relieve pressure on DCAs and SRVs but require high levels of maintenance.
- A high proportion of (older) vehicles which are retained to cope with periods of high demand and cope with

current levels of maintenance, defects and un-programmed off-road time.

Following the recently commissioned Demand and Capacity Review (D&C) we have agreed the additional financial resources we require to achieve an improved trajectory of performance. The review has helped re-define our operating model and the numbers of front-line staff and vehicles we require to deliver good patient care and operational performance.

This recognises that we must initially focus on building up a front-line workforce with the right mixture of skills and training who deliver a standard and quality product.

We aim to match this build up by progressively addressing the imbalances in our Fleet and increasing the numbers of vehicles of the right types to support our changing front-line workforce.

We will need to match the number, capacity, and working practices of our in-house workshops to the size of the Future Fleet.

The Carter Report – How Do We Compare?

The recent study by Lord Carter revealed unwarranted variation in the management of Ambulance Services, including the design, procurement and support of vehicles.

In April 2019, the NHS released the National Ambulance Vehicle Specification which is now mandated through the NHS Standard Contract for Ambulance Services 2019/2020.

All ambulance services will be committed to developing standard designs for ambulance service vehicles and to co-ordinating procurement to improve Value for Money.

Nationally, there is limited industrial capacity for the build and conversion of ambulance service vehicles. Our supply chain will continue to be dependent on suppliers in the UK and Europe, notably Ireland, Germany and Italy.

The introduction of large numbers of vehicles of different manufacture and design is likely to lead to additional requirements for new support facilities, tooling, training and documentation, adding cost. These additional requirements will require an anticipated investment of circa £220,000 if this materialises, however this will ensure that the equipment and staff skill set are fit for purpose.

The Carter Report and the new "National Ambulance Vehicle Specification for English NHS Ambulance Trusts" indicates some changes to our current Dual Crewed Ambulance Specification, this is minimal and is not beyond the capabilities of our current suppliers who either build, supply components or working systems for our Double Crewed Ambulances. We will meet the specification in full this year with the new van conversion fleet.

In summary, the Trust are well placed to meet the new requirements, with minimum disruption or investment required. The Trust are exceeding the requirements of telematics for its fleet.

Our Future Fleet

We have already begun to address Fleet imbalance and future capacity requirements by placing significant orders for new vehicles. Our current orders will provide the following vehicle numbers as a minimum within our fleet within the next five years; this will be subject to a continuous review under the Service Transformation and Delivery programme.

- 365 Dual Crewed Ambulances (DCA).
- 28 Non-Emergency Ambulances (NETs).
- 166 Single Response Vehicles (SRV), including operational and clinical managers, SORT, CCP and PP specialist vehicles.
- 22 HART vehicles.
- 64 other specialist units (made up of contingency planning, estates, IT, Logistics and other departments).
- A reduced number of lease cars as operational managers are transferred into SRV type vehicles and non-operational managers are encouraged to maximise the use of hire and pool cars managed by a chosen provider.

We therefore aim to achieve a Future Fleet with the following characteristics:

Vehicle Design and Manufacture/Conversion

Our future fleet will comprise a mixture of vehicle manufacturers and designs for the foreseeable future. These will include those commissioned in 2019/20 to a SECAmb specification, and vehicles, which in future, will be commissioned to national standard specifications.

Medical equipment carried in vehicles will be standardised and based on the direction and guidance arising from the Carter Report recommendations. We will continue to involve our Vehicle User Group, Clinical Equipment Group and other

stakeholders in planning, contribution to national specifications and decision making on future vehicle and equipment design and procurement.

It should be noted that the Carter Report specifies van conversions. At this time Fiat are the only manufacturer who can meet the minimum specification. However, we are aware that Vauxhall, Volkswagen and Mercedes are currently in the process of designing alternative models. There is no roll out date yet confirmed.

Dual Crewed Ambulances (DCA)

We will require a high proportion of DCA vehicles to meet the core demand for responding to, and conveying, emergency and urgent cases.

The ratio of DCAs to SRVs will be driven by demand and operational requirements rather than a fixed ratio and will need regular reviewing and flexibility to meet evolving operational strategy and clinical demands.

Single Response Vehicles

We will require sufficient SRVs to meet the demand for fast response/back up to DCAs for our most seriously ill patients and the targeted dispatch of single responders where conveyance is unlikely. Vehicles will be designed to support specialists such as OTLs, CCPs, PPs and SORT and will be based on 4x4/AWD capability where possible and practicable.

Non-Emergency Transport Vehicles (NET)

We will need sufficient NET vehicles to reduce the pressure on DCAs and SRVs for targeted responses to, and conveyance of, less seriously ill patients; typically, the C3, C4 and HCP categories of need.

Specialist Vehicles

We will also require a range of specialist vehicles to support SECAmb operations, guided by national experience and specifications. This includes vehicles, yet to be fully specified, that are suitably equipped to convey any patients that require a section 136 conveyance under the Mental Health Act and HART vehicles to meet the requirement set by the National Ambulance Resilience Unit (NARU) financed centrally through the provision of an annual depreciation tariff.

Lease Cars Allocated to Individuals

We will minimise the requirement for lease cars allocated to individuals. We will do this by focusing on the requirement to support managers who are expected to respond regularly to

either emergency calls or for command responsibilities. These cars will be standardised, fit for purpose and tied to specific operational and clinical roles; again, providing a 4x4/AWD capability for resilience purposes.

Other requirements will be met from standard fleet vehicles, hire/car club cars and supplied in partnership with an approved provider.

Lease cars will still be available for the higher mileage non-operational users.

Normal Maximum Age of DCA vehicles

We aim to maximise the availability and use of vehicles in our Future Fleet. Based on the experience and accepted "best practice" of other ambulance services there is close correlation between vehicle age, usage and increasing unplanned vehicle breakdowns.

We will initially assume a normal maximum vehicle age of:

- 7 years – Box based Coach Built DCAs
- 5 years – Van Conversion DCAs
- 5 years - SRVs

Our HART vehicles are subject to a regular replacement cycle, currently five years, as dictated by NARU expectations.

We will progressively procure new vehicles and dispose of our oldest and least reliable vehicles. However, it will take time to achieve the target fleet vehicle ages unless additional investment is prioritised.

We anticipate that it will take until March 2024 on the current vehicle replacement plan to reach a point where all the fleet will be within normal age parameters.

We will gather and analyse reliability data in our Fleet IT system which will be used to review the planning of vehicle replacements.

We will make a clear distinction between the requirements for additional vehicles that are indicated by the peak demand and the requirement driven by maintenance, defects and un-programmed off-road time.

Both these requirements are currently covered by an historic assumption of 141% vehicle provision. We anticipate that this will reduce to 138% and be regularly reviewed and reduced as we achieve the targeted operating fleet and the Trust's Strategic Estates Programme delivers a complete Make Ready Model. These figures are similar to other Trusts and apply to DCAs only.

How we will deliver our Future Fleet

We have already begun the major investment required to deliver our Future Fleet and we are already seeing significant benefits. These include:

- Improved vehicle availability.
- Improved vehicle reliability.
- Better alignment of vehicle types to our targeted operating model.
- Front line staff recognition of our investment in their vehicles and equipment.
- Improved patient care and satisfaction with vehicles and equipment.

We must ensure that we deliver a Future Fleet that is fit for purpose, balanced to support our developing operating model and sufficient to meet the projected future demand. This will take time.

The management of the fleet will be data led to ensure both our capacity to meet ambulance response times and promote value for money. All vehicles will be fitted, in line with Carter recommendations, with a full telematics fit to provide reliable data on utilisation and fuel usage. The system will also provide useful data and security to staff and patients through a full CCTV fit. Future use of this system will allow for driver identification and the roll out of telemedicine projects. This will ensure that our fleet deployment is optimised.

SECAmb is currently only one of three Trusts utilising telematics within its current Fleet Technology approach.

The Five-Year Fleet Plan

The five-year Fleet Implementation Plan predicts the anticipated vehicle procurements and disposals to meet our operational performance improvement trajectory as detailed within Annex A. It considers;

- projected future demand
- the changing operational model (as we currently understand it) and our ability to optimise the use of vehicles as we increase the numbers, and develop the right skills balance, of our front-line workforce.
- projected vehicle type balance
- approved performance improvement trajectories
- realistic future funding availability
- the capacity of vehicle manufacturers and converters to support our requirements and the competing demands of other ambulance services.

It forecasts the expected numbers of vehicle procurements and disposals to achieve the Future Fleet. The Fleet Plan will be formally reviewed annually.

The Fleet Implementation Plan will be presented to the Finance and Investment Committee (FIC) and to the Board annually, and funds will be identified in the Trust's financial plan. This will ensure the Trust has full oversight of its mid-term financial management.

Fleet Procurement and Disposal Approvals Process

All future procurement orders will be preceded by a robust Business Case. This will meet the requirement of a demanding "Initial Gate" FIC/Board approval. This will be required before we enter into any financial commitments associated pre-orders. Final approval to place an order ("Main Gate") will require an updated Business Case and FIC/Board approval.

Funding

We will need to select the best funding model to support the acquisition of new vehicles and this will be completed, in partnership with the Finance Directorate, and will be based on the most suitable model at the time based on current market rates, trends and the Trust's financial position.

The decision to buy or lease, whilst relevant, will be dependent upon the Trust's current balance sheet, so these decisions will be devolved to the Trust's financial experts for the most appropriate use of Trust funds.

We recognise that there are competing demands for the funding made available to the Trust, which may include estates, people, maintenance facilities, so this may mean that we will not be able to deliver as quickly as we would like.

Future Fleet Support and Administration

It is essential that the Future Fleet is supported and administered to meet our legal responsibilities for the safety and compliance of vehicles, and to ensure the availability of vehicles whilst achieving value for money. This must integrate effectively with the management of driving standards, and the investigation and subsequent action on driving incidents (e.g. RTC) and defects.

We will progressively review all aspects of Fleet support and administration, taking full consideration of NHS guidance and direction arising from the Carter Report and other advice from the centre.

Our priority will be to ensure that we have the capacity and facilities to cope with the increased size of the Fleet.

Maintenance and Repair

Our planning assumption (supported by the Carter Report recommendations) is that we will continue to conduct most routine maintenance and repair at our Make Ready Centres and that breakdown recovery and major repairs (e.g. to chassis, bodywork and paintwork) will continue to be contracted out.

We must ensure that Business Cases accurately reflect the investment required in facilities, tooling, training and documentation to support new vehicle types, and that these are introduced in time for the commissioning of new vehicles.

Fleet IT

We have recently completed the procurement of a modern Fleet IT system. We will use this system to support the maintenance of the Future Fleet, improve the analysis of reliability, availability and maintenance information and improve decision making on when to replace batches of vehicles or individual vehicles showing poor reliability.

Fuel Efficiency

We currently spend about £6M per annum on fuel. We will continue to embrace technologies (e.g. telematics – a Carter recommendation) to help improve driving efficiency and support the introduction of operating procedures to reduce fuel consumption and costs.

It should be noted that only about 5% of all SECAmb operating mileage is incurred whilst on blue lights – appropriate operating instructions therefore have the potential to achieve large economies in fuel consumption.

Estates

As new fleet is added to the Trust inventory, it will require changes to current maintenance facilities. These changes will be aligned to the Trust's current Estates Strategy in terms of vision, property/development restrictions and cost.

Bulk Fuel Storage

We will continue to maximise, provide and safely maintain and operate bulk fuel storage facilities at key sites (in line with Carter Report recommendations). This will not only help reduce fuel procurement costs but will also enhance operational resilience.

Vehicle Allocation to Operating Units and Make Ready Centres

We will centralise the allocation of all vehicles at a Trust wide level. Our priority will be to meet operational demand by understanding Operating Units' demand and rostering requirements, and by optimising the provision of sufficient, reliable vehicles at Make Ready Centres.

The fleet will be rotated to equalise mileage and patterns of use to ensure maximum longevity of use.

Safety and Compliance

We will continually review of all relevant vehicle design, operating and maintenance standards and regulations to ensure that the Trust operates a safe and compliant fleet of vehicles.

We will review our organisation and procedures of internal regulation and audit of vehicle operation and maintenance, for example:

- the separation of responsibility for maintenance and MOT testing,
- the investigation of equipment failures,
- continued membership and compliance with approved bodies such as Van Excellence who will ensure an appropriate and nationally acceptable standard of fleet management.

Environmental Sustainability

SECAmb is very aware of its responsibilities with respect to the environment and will be expecting to maximise the use of Ultra Low Emission Vehicles such as hybrid, fully electric and the use of Hydrogen powered vehicles as technology develops, as well as trialling the deployment of other efficiencies such as solar panels on vehicles to maximise battery life. To date there is no publicised timeline of when these new environmentally friendly vehicles will be available in a cost effective form.

The Trust identifies the requirement to reduce its impact on the environment as part of its duty of care. The Trust will continue to recycle all renewable waste where possible and monitor all workshop waste including special waste.

We will be open to testing and trialling new green vehicles and fuel technology will also assist the Trust in strengthening its resilience in the face of climate change impacts.

Air quality restrictions may also expand outside London to become standard requirements in smaller cities and towns. Fleet and Operations will work together to be able to identify useful technological innovation and to invest in the best of it to support greener cleaner service delivery.

Decommissioning and Disposal

The decommissioning of all vehicles is completed through approved contractors ensuring that the disposal, especially of marked vehicles, is completed appropriately and that maximum financial return is achieved.

Operational Resilience

As a category 1 emergency provider we must demonstrate resilience and fleet will support this area fully.

The Contingency, Planning and Resilience (CP&R) Department have identified the requirement for a small dedicated fleet to support their activities. These will include a need for Command and Control assets as well as other specialist vehicles which may attract external funding. The fleet department will work with CP&R as required to satisfy those needs and this will develop across years one and two of this plan.

There has always been be a requirement to provide a 4x4 fleet to be used in times of inclement weather and to aid in off road patient recovery and transport.

Currently, this fleet is made up of:

- 13 Land Rover Discoveries,
- 15 Hybrid Mitsubishi Outlanders,
- 35 all-wheel drive (AWD) Skoda SRVs and AWD managers' cars.

We will aim to review the overall SRV fleet and the 4x4 component with a view to replacing vehicles in years two and three, all future SRVs will be procured in an All-Wheel Drive variant where possible or accessible to the UK market, the proposed purchase of AWD cars for operational managers will assist in the reduction of a need to hire expensive vehicles during inclement weather.

We will have key business partnerships with lease car companies to ensure that the Trust can access 4x4/AWD resource in a timely manner when needed, e.g. extremely demanding weather conditions.

Options for cost effective All-Wheel Drive DCA vehicles are not practical within the UK market at present but we will continue to watch the sector for developments in this area.

Our Fleet Replacement Plan for 2019-2023 (Annex A)

Fleet Planned Replacement Plan 2019 - 2023							
		Replacement Year	2019	2020	2021	2022	2023
Vehicle Type	Vehicle life Years	Average Replacement Cost	2019-20	2020-21	2021-22	2022-23	2023-24
DCA Box Conversion	7	£ 169,000.00	93	0	0	0	0
DCA Van Conversion	5	£ 140,000.00	0	83	57	57	57
SRV	5	£ 50,000.00	59	50	55	23	40
HART	5	£ 40,000.00	14	0	0	0	0
NET	5	£ 90,000.00	0	0	28	0	0
OP Managers Car	5	£ 63,000.00	46	10	10	0	0
Grey Fleet	5	£ 80,000.00	30	22	4	12	0

South East Coast Ambulance Service
NHS Foundation Trust

Integrated Performance Report

Performance Data for our 999 and 111 Services

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

Board Meeting

May 2019

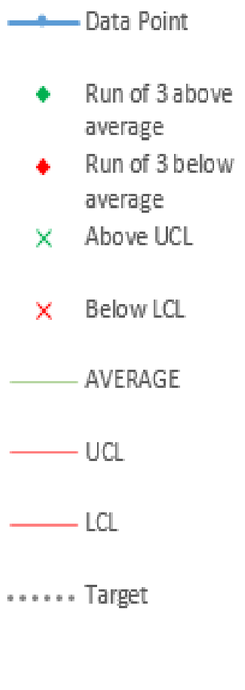
Taking Pride | Striving for Continuous Improvement | Acting With Integrity | Demonstrating Compassion and Respect | Assuming Responsibility

Contents Summary

SECAmb CQC Rating and Oversight Framework

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

Chart Key



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

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

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

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

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

SECAmb Executive Summary

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

The performance data shared in this report from Operations 999 is as from 13/05/2019

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 March and April 2019 this report and our quality reporting was reviewed in order to further develop and refine our reporting going forward into 2019/20.

A requirement from a recent review of trust performance recommended that, 'The Trust should ensure response times for category three and four calls are improved'.

Response times are monitored in a monthly national report to NHSE, provided by the Business Intelligence (BI) service and internally on our preferred reporting system (Power BI) in the ARP Performance Dashboard.

In addition to the official reporting, BI circulate a weekly performance dashboard to organisation leads and this is discussed in weekly operational team meetings as part of a routine In Depth Analysis (IDA). Operational actions to improve response times are discussed as part of a weekly call with commissioners.

SECAmb Our Enablers

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

SECAmb Financial Performance

The Trust exceeded its planned surplus for the month of March and year to date by £1.7m due to additional, unplanned Provider Sustainability Funding (PSF).

Cost improvements of £1.8m were delivered in the month, which was as planned, and the full year target of £11.4m was achieved.

The Trust's Use of Resources Risk Rating (UoRR) for the year is 1, in line with plan.

The Trust faced substantial financial risks in 2018/19 and these have been managed effectively.

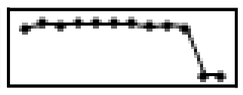
The results for the year remain subject to audit at this point.

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.

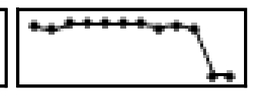
Our Patients

SECAmb Clinical Safety Scorecard

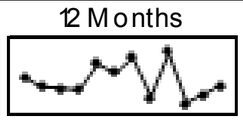
Cardiac Return of Spontaneous Circulation (ROSC) - Utstein (a set of guidelines for uniform reporting of cardiac arrest)

	Nov-18	Dec-18	Jan-19	12 Months
Actual %	45.2%	41.5%	52.9%	
Previous Year %	51.2%	27.8%	35.7%	
National Average %	51.3%			

Cardiac ROSC - ALL

	Nov-18	Dec-18	Jan-19	12 Months
Actual %	19.1%	25.9%	29.5%	
Previous Year %	24.1%	20.7%	23.1%	
National Average %	28.5%			

Cardiac Survival - Utstein

	Nov-18	Dec-18	Jan-19	12 Months
Actual %	14.3%	18.4%	22.6%	
Previous Year %	32.5%	14.7%	10.7%	
National Average %	26.6%			

Cardiac Survival - All

	Nov-18	Dec-18	Jan-19	12 Months
Actual %	6.6%	7.2%	9.7%	
Previous Year %	9.9%	6.0%	3.6%	
National Average %	9.2%			

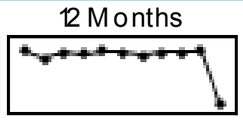
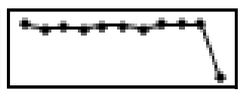
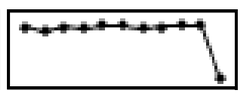
Acute ST-Elevation Myocardial Infarction (STEMI) Care Bundle Outcome

	Nov-18	Dec-18	Jan-19	12 Months
Actual %	58.7%	65.0%	53.6%	
Previous Year %	70.6%	71.8%	61.2%	
National Average %				

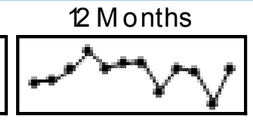
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography

	Nov-18	Dec-18	Jan-19	12 Months
Mean (hh:mm)	02:18			
National Average	02:13			
90th Centile (hh:mm)	03:24			
National Average	03:00			

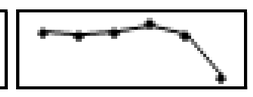
Stroke - call to hospital arrival

	Nov-18	Dec-18	Jan-19	12 Months
Mean (hh:mm)	01:13	01:16		
National Average	01:14			
Median (hh:mm)	01:06	01:07		
National Average	01:08			
90th Centile (hh:mm)	01:53	01:53		
National Average	01:50			

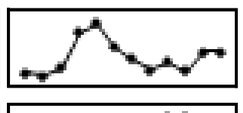
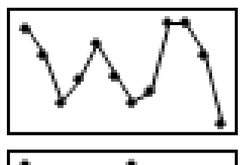
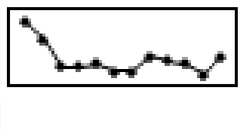
Stroke - assessed F2F diagnostic bundle

	Nov-18	Dec-18	Jan-19	12 Months
Actual %	97.1%	94.9%	97.4%	
Previous Year %	96.2%	95.2%	94.6%	
National Average %	98.4%			

Post ROSC Care Bundle

	Nov-18	Dec-18	Jan-19	12 Months
Actual %	94.7%	91.2%	77.7%	
National Average %				

Medicines Governance

	Jan-19	Feb-19	Mar-19	12 Months
Total Number of Medicines Incidents	109	116	122	
Single Witness Sig/Inapt Barcode Use CDs Omnicell	2	5	6	
Single Witness Sig/Inapt Barcode Use CDs Non-Omnicell	1	0	0	
Total Number of CD Breakages	17	19	17	
PGD Mandatory Training	14	8	65	
Key Skills Medicine Governance	344	0	29	

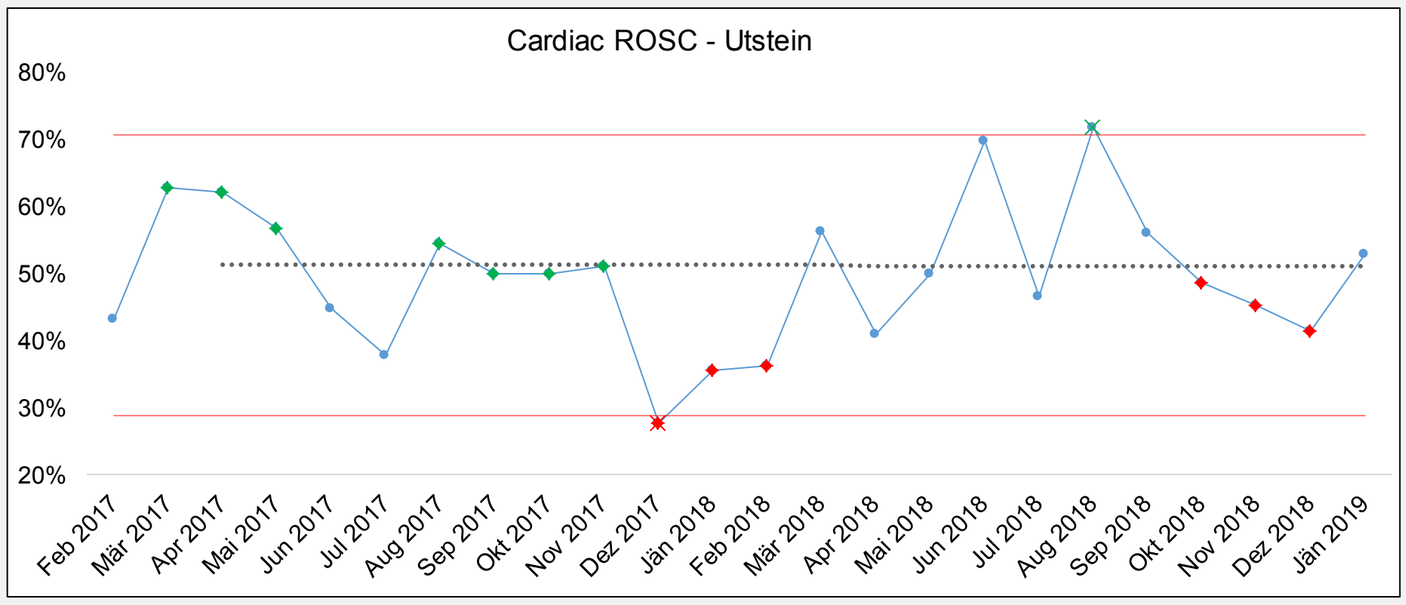
Sepsis Care Bundle Compliance

	Nov-18	Dec-18	Jan-19	12 Months
Actual %	81.5%	82.1%	84.5%	

Medicines Management

	Jan-19	Feb-19	Mar-19	12 Months
Number of Audits	191	166	184	
Percentage of Audits	98.5%	98.5%	99.7%	

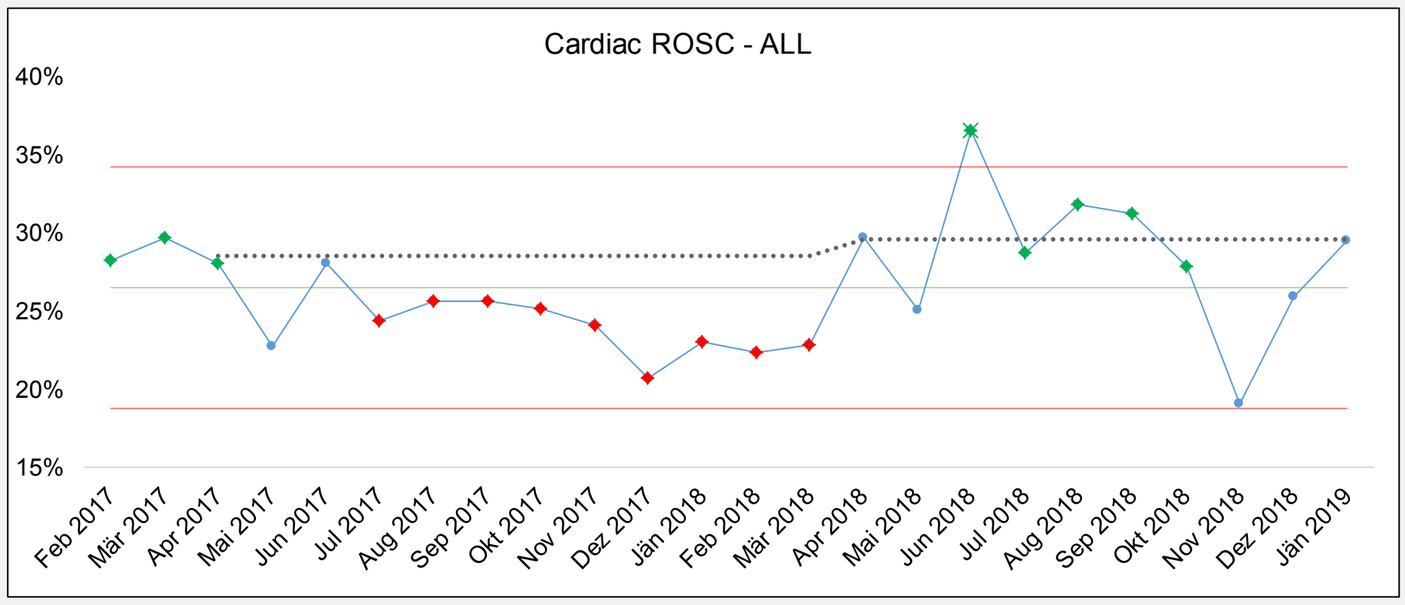
SECAmb Clinical Safety Charts

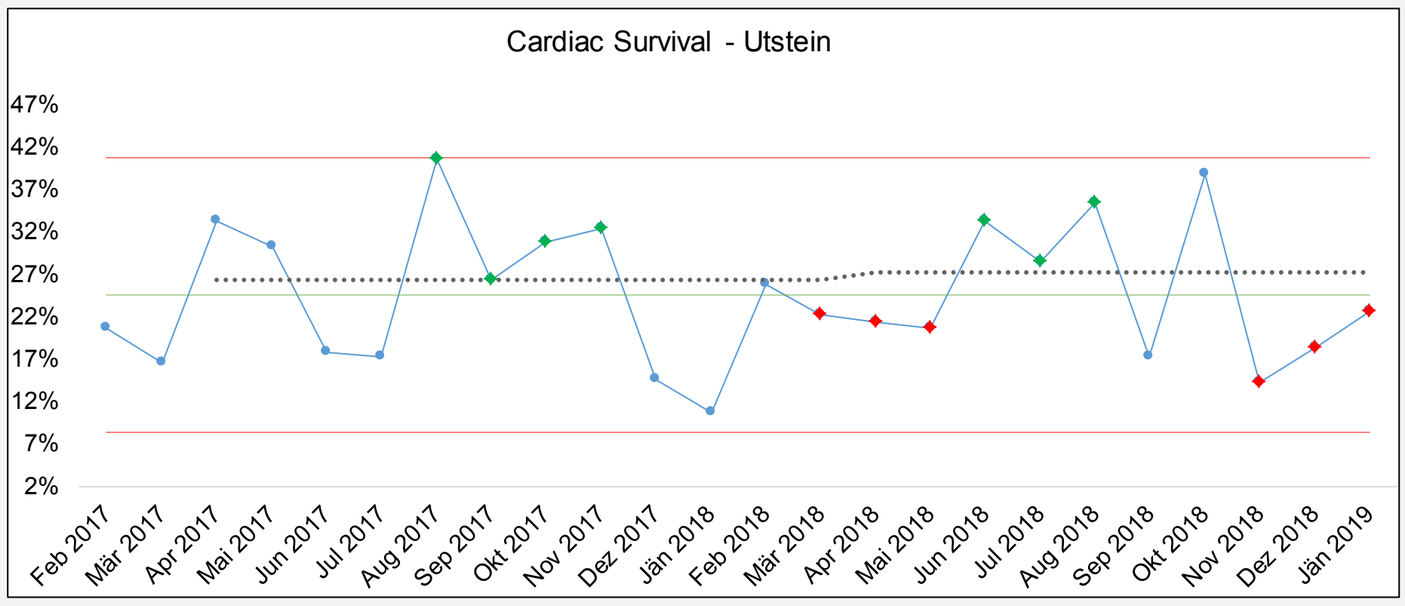


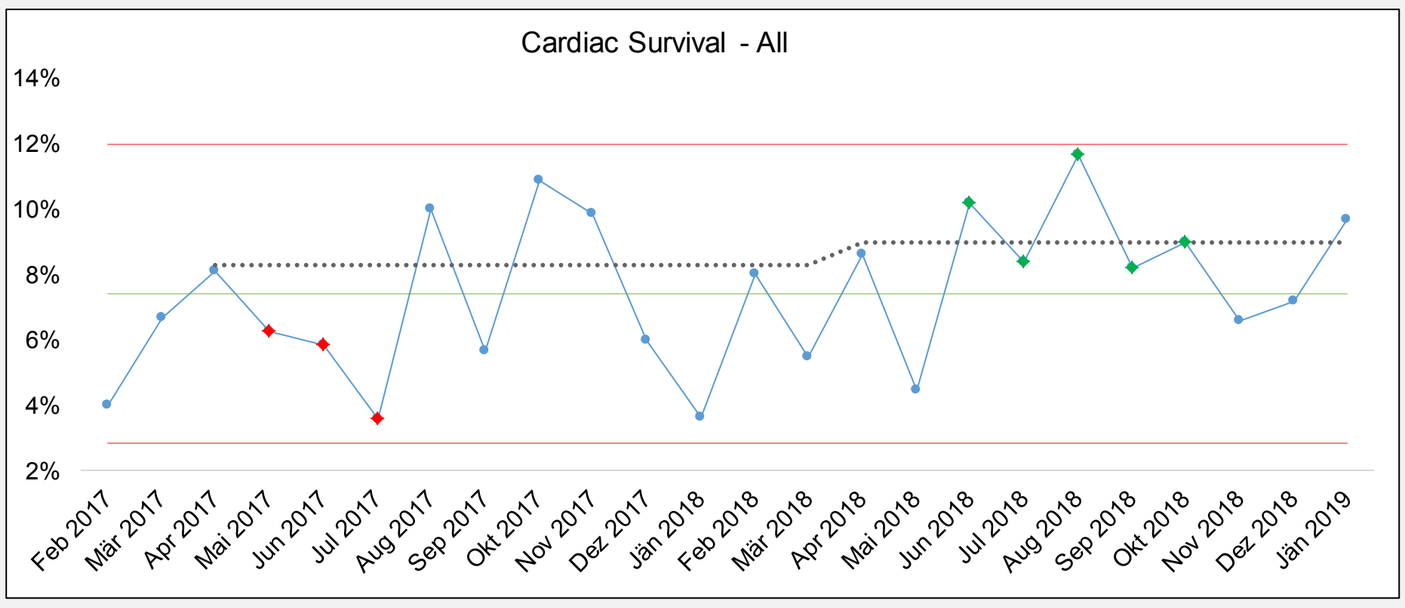
The cardiac arrest charts show the proportion of patients who had a ROSC at hospital and the proportion who survived to be discharged from hospital after resuscitation was attempted.

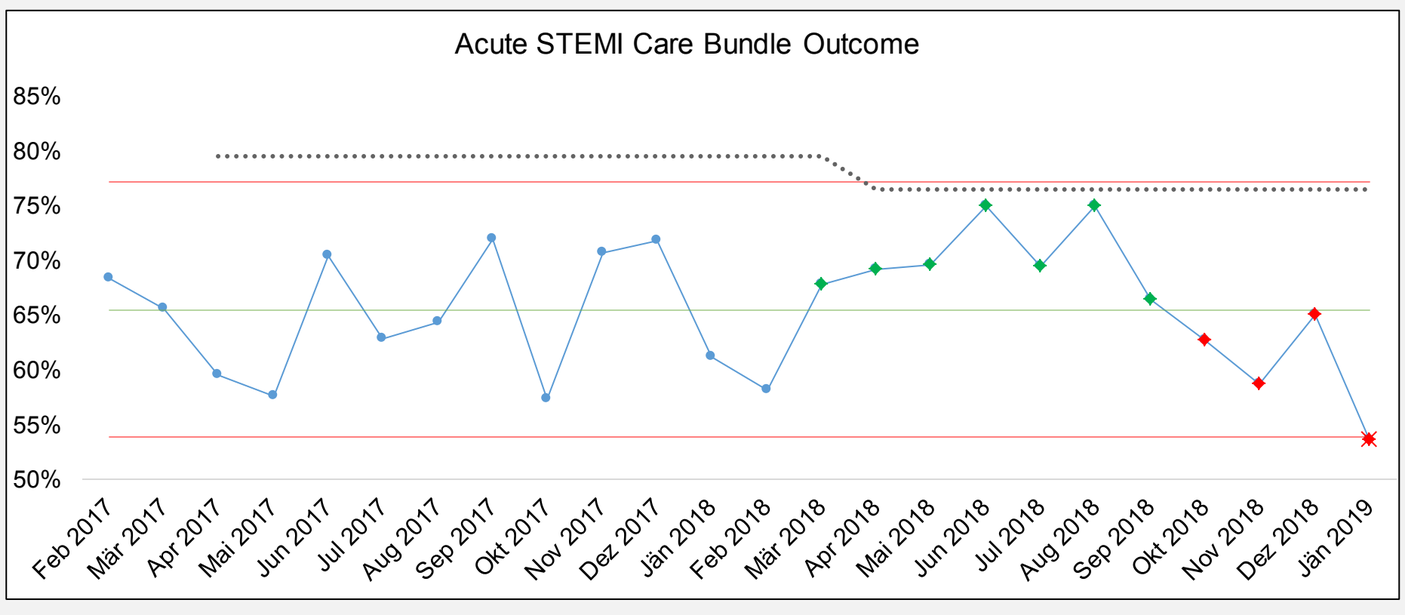
The charts continue to show normal patterns of variation.

A full day of resuscitation training is planned for all staff in 2019/20 Key Skills training. The Trust has also restarted the cardiac arrest download programme that provides information on the effectiveness of a resuscitation for clinicians to reflect upon. This is being positively received by clinicians.









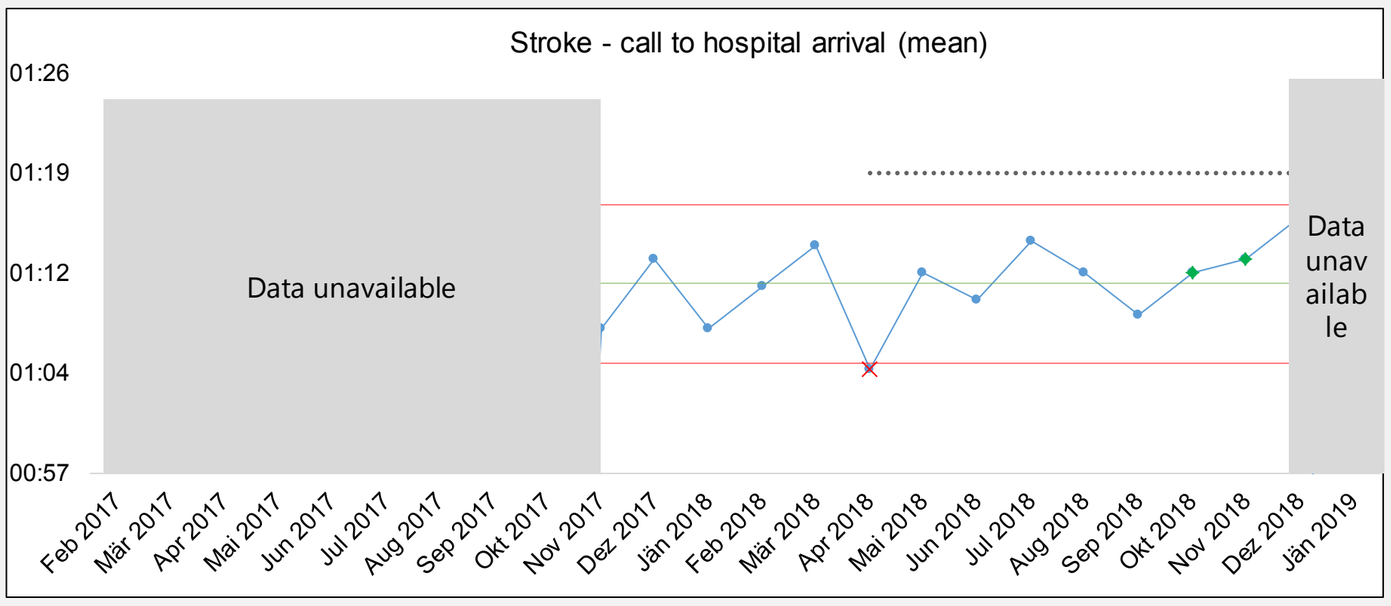
This chart shows the proportion of patients who were suffering a suspected STEMI and received a full care bundle.

There has been a reduction in performance against this measure. This is in line with a change in AQI guidelines, which mandates that paracetamol administration is no longer acceptable for management of STEMI.

The Trust expects to see further improvements with the introduction of ePCR. This system will prompt users to document a full bundle of care where an omission might have been made through error.

The Trust has also procured an electronic clinical audit system that will allow clinicians to log into the system and review their own care bundle compliance, as part of a reflective process.

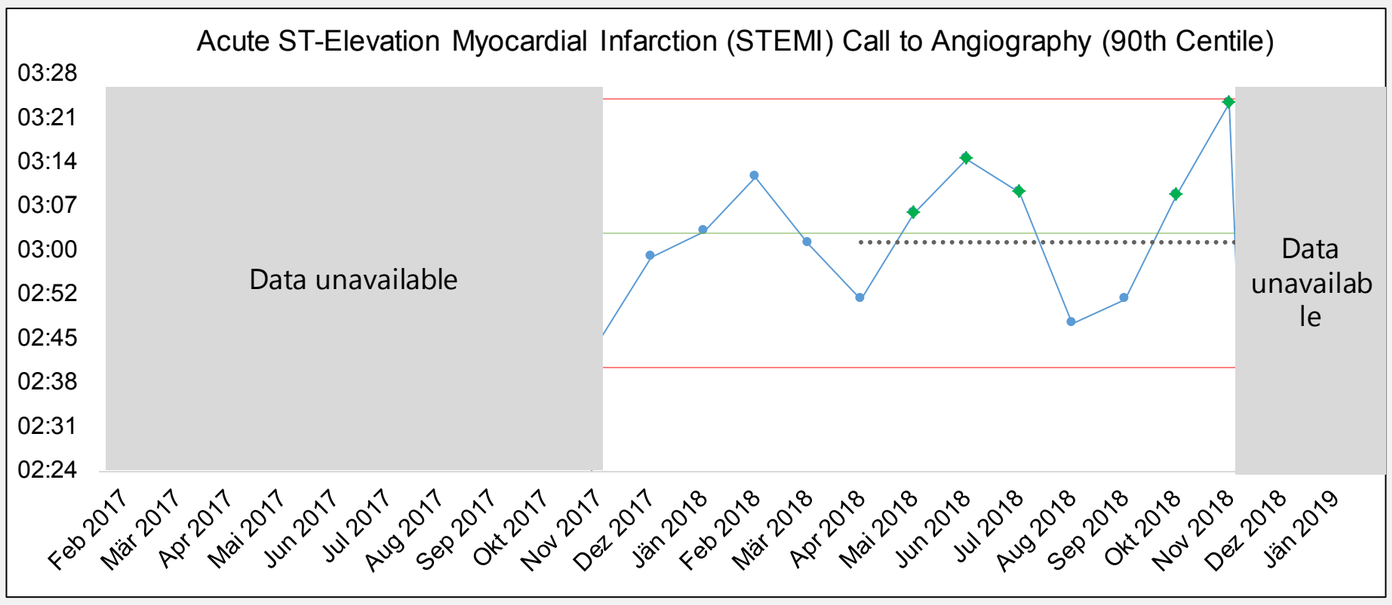
SECAmb Clinical Safety Charts

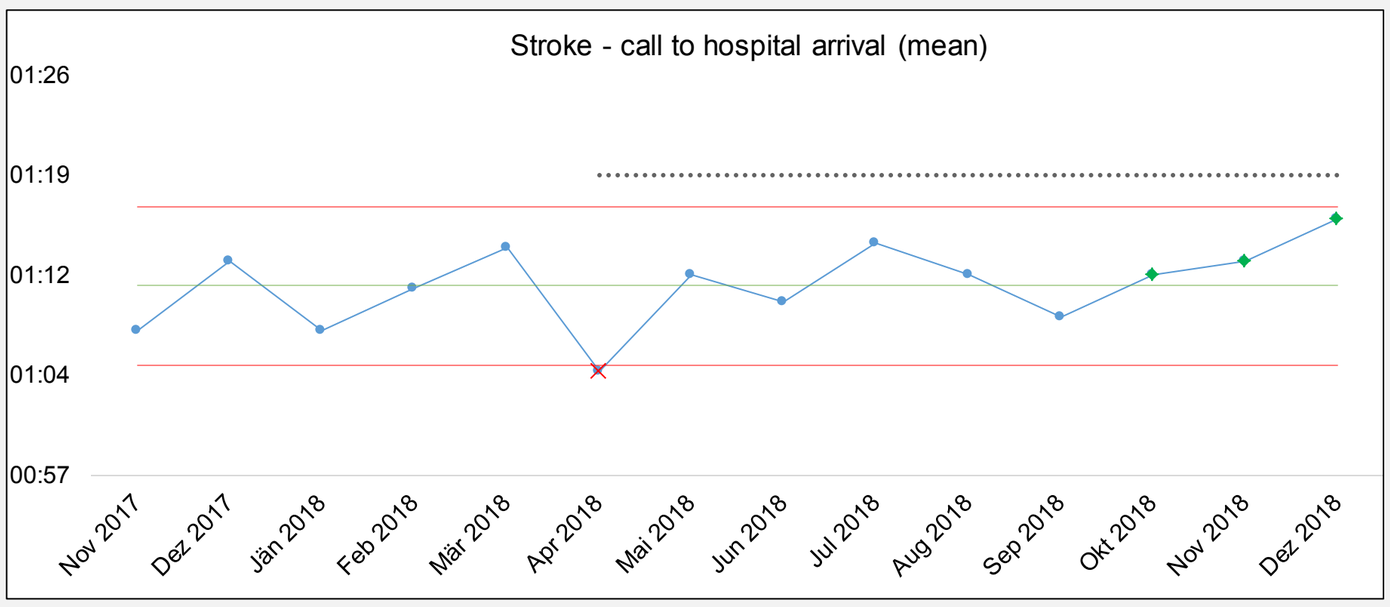


STEMI timeliness charts show the mean and 90th centile call to angiography time for patients who are suffering STEMI.

These measures continue to show normal patterns of variation. Trust performance is broadly in line with national averages.

Key Skills training for 2019/20 will give clinicians strategies for reducing on-scene times for patients in this cohort. It is hoped that this will reduce the overall call to angiography time.

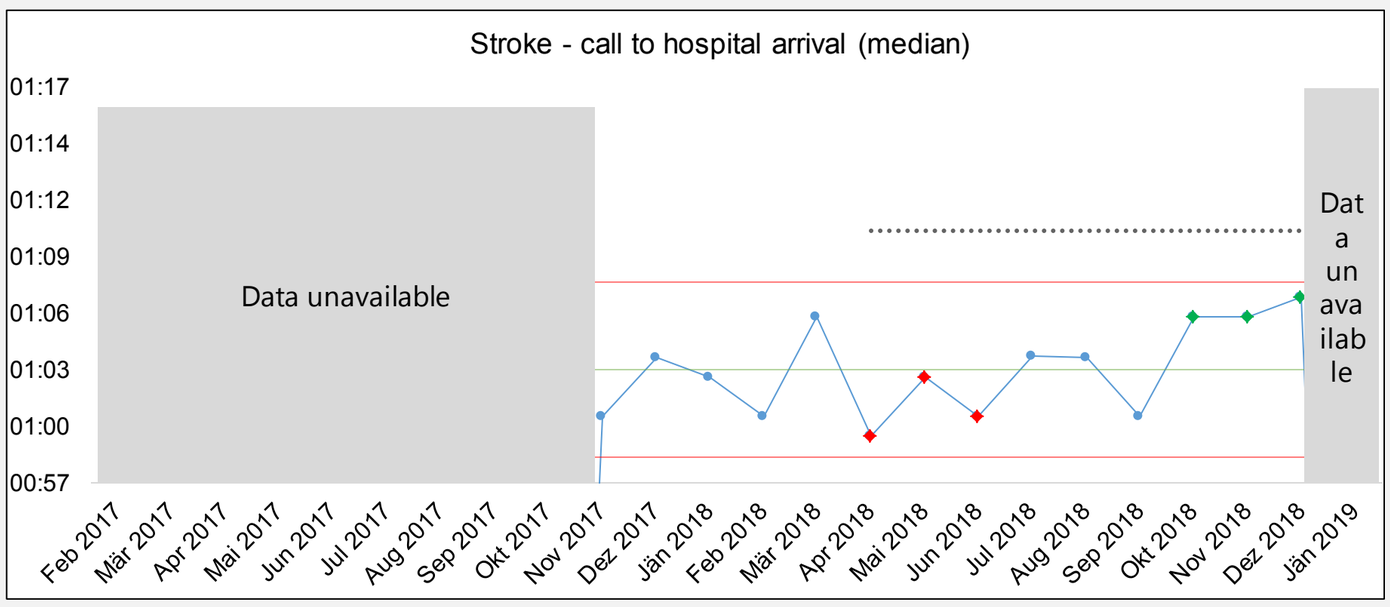


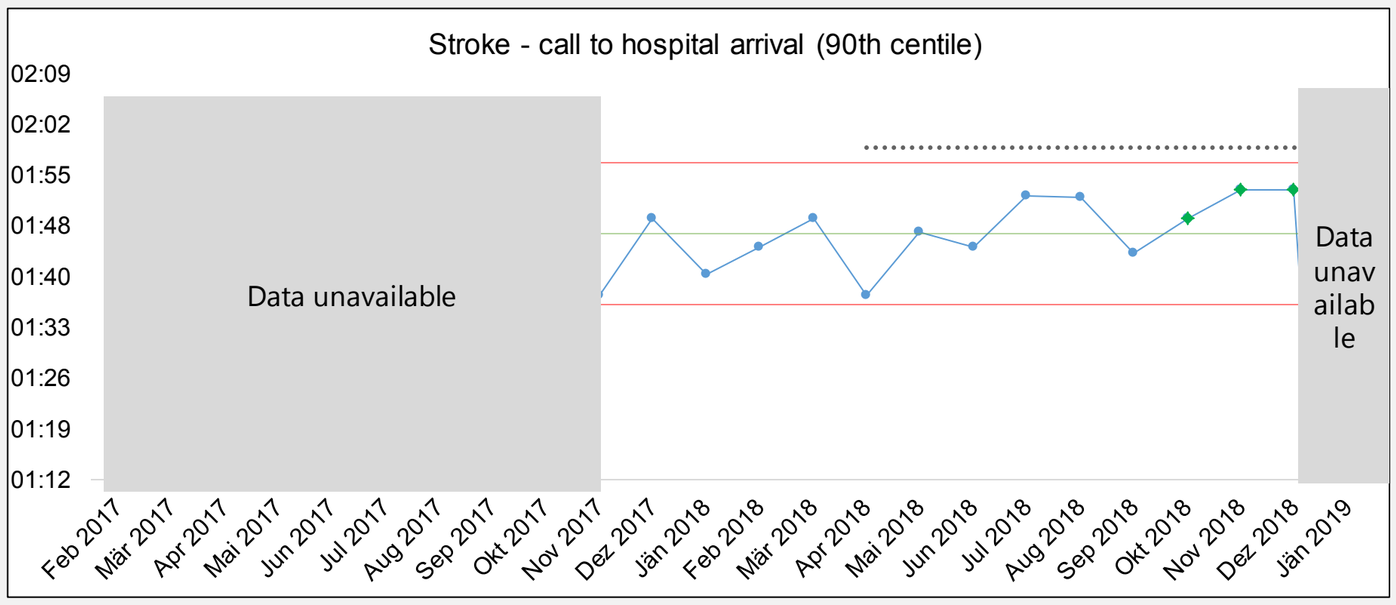


Stroke timeliness charts show the mean, median and 90th centile call to angiography time for patients who are suffering stroke.

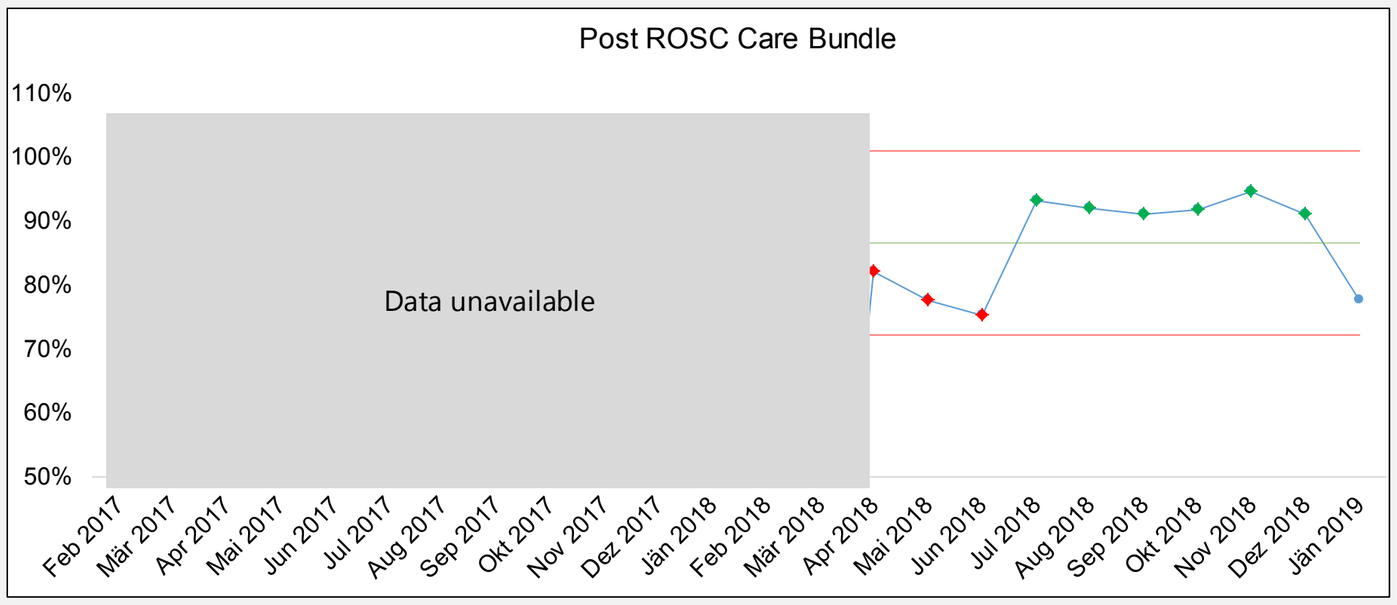
These measures continue to show normal patterns of variation. SECAmb continues to deliver stroke care that is more timely than the national average.

Key Skills training for 2019/20 will give clinicians strategies for reducing on-scene times for patients in this cohort. It is hoped that this will reduce the overall call to hospital time.





SECAmb Clinical Safety Charts

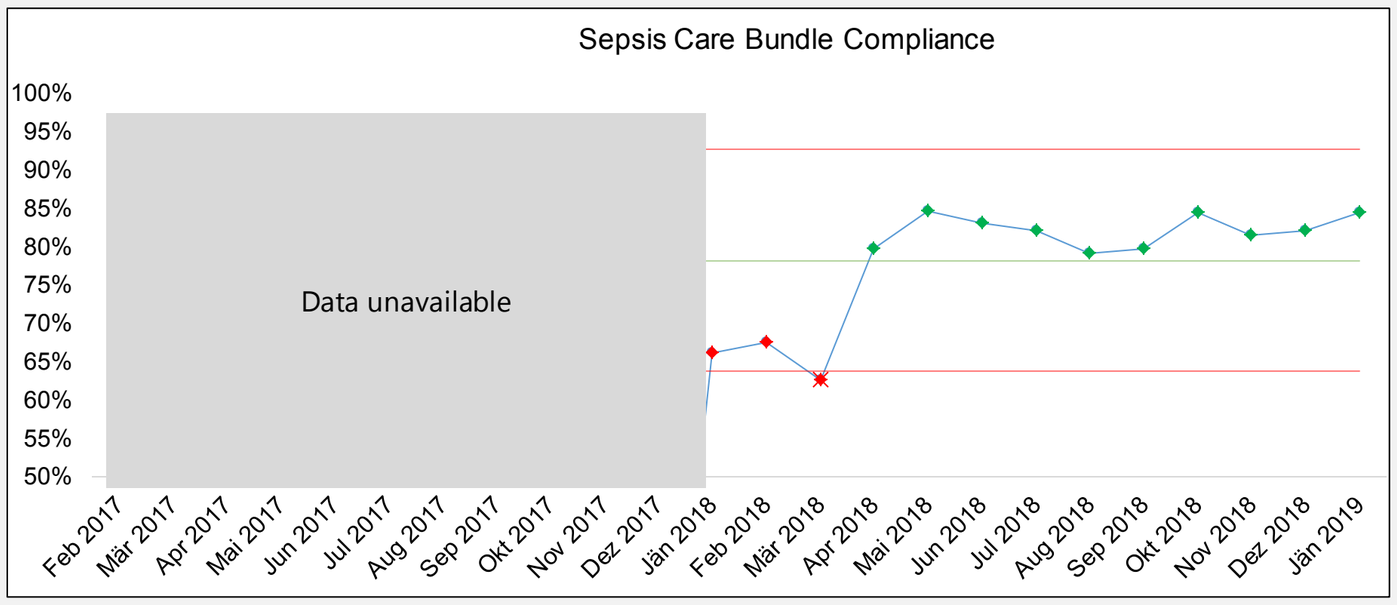


This chart shows the proportion of patients who received a full bundle of care after ROSC was achieved.

The data continue to show normal levels of variation. SECAmb continues to perform above the national average.

The Trust expects to see further improvements with the introduction of ePCR. This system will prompt users to document a full bundle of care where an omission might have been made through error.

The Trust has also procured an electronic clinical audit system that will allow clinicians to log into the system and review their own care bundle compliance, as part of a reflective process.

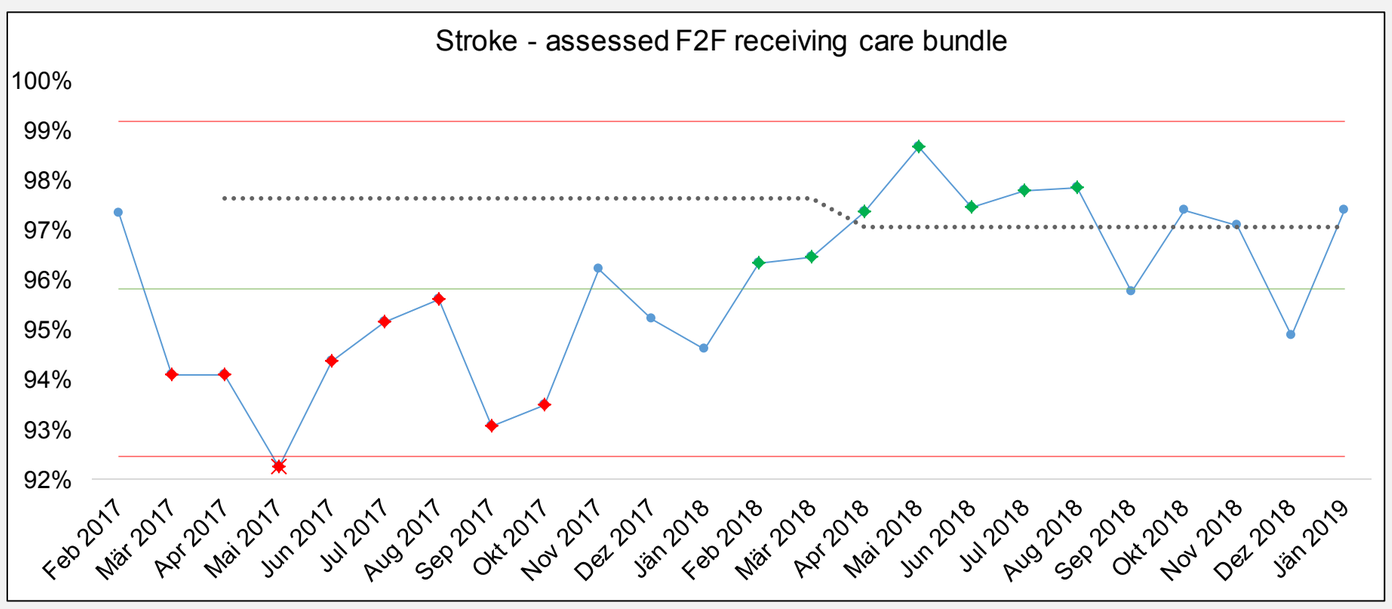


This chart shows the proportion of patients who were suffering suspected sepsis and received a full bundle of care.

The data continue to show normal levels of variation. SECAmb continues to perform above the national average.

The Trust expects to see further improvements with the introduction of ePCR. This system will prompt users to document a full bundle of care where an omission might have been made through error.

The Trust has also procured an electronic clinical audit system that will allow clinicians to log into the system and review their own care bundle compliance, as part of a reflective process.

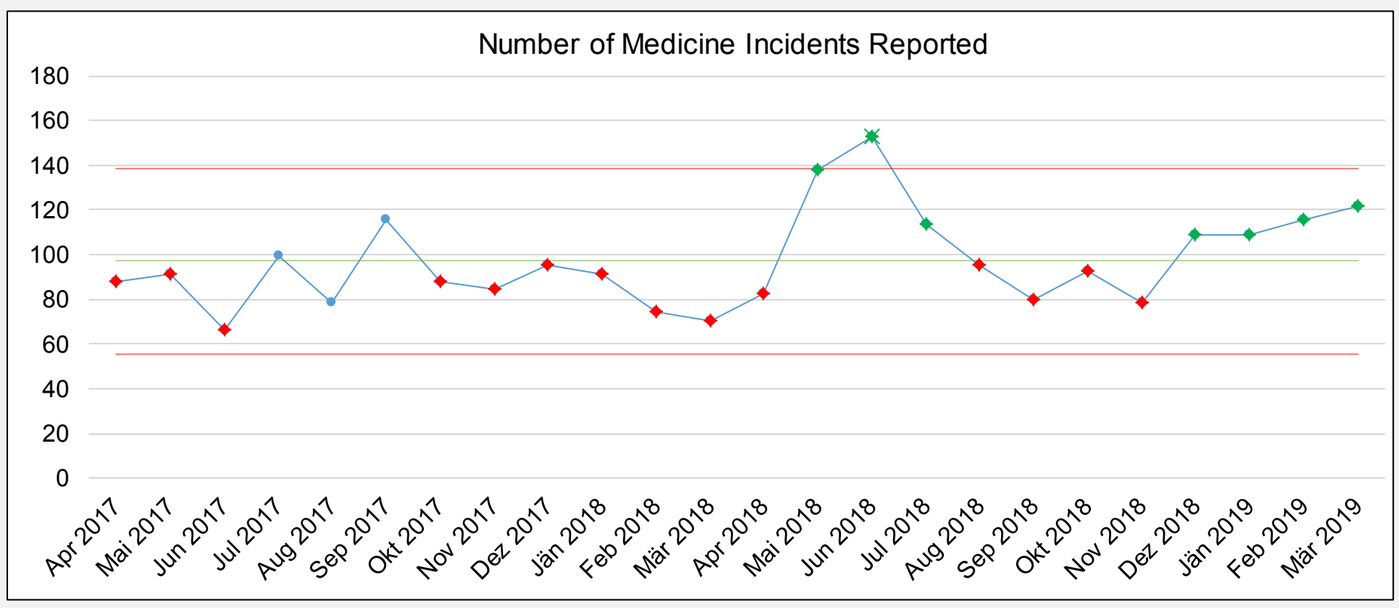


This chart shows the proportion of patients with a suspected stroke who received a full bundle of care.

The data continue to show normal levels of variation.

The Trust expects to see further improvements with the introduction of ePCR. This system will prompt users to document a full bundle of care where an omission might have been made through error.

The Trust has also procured an electronic clinical audit system that will allow clinicians to log into the system and review their own care bundle compliance, as part of a reflective process.



122 medicines incidents were recorded for March 2019.

Medicines Governance Team and QI hub are encouraging staff to submit bulk Datix around medicines pouches due to under reporting of these incidents. Due to this change 37 of the pouch incidents actually relate to 81 incidents due to bulk submissions.

The Medicines Governance Team continue to encourage operational staff to report around medicines governance across the Trust.

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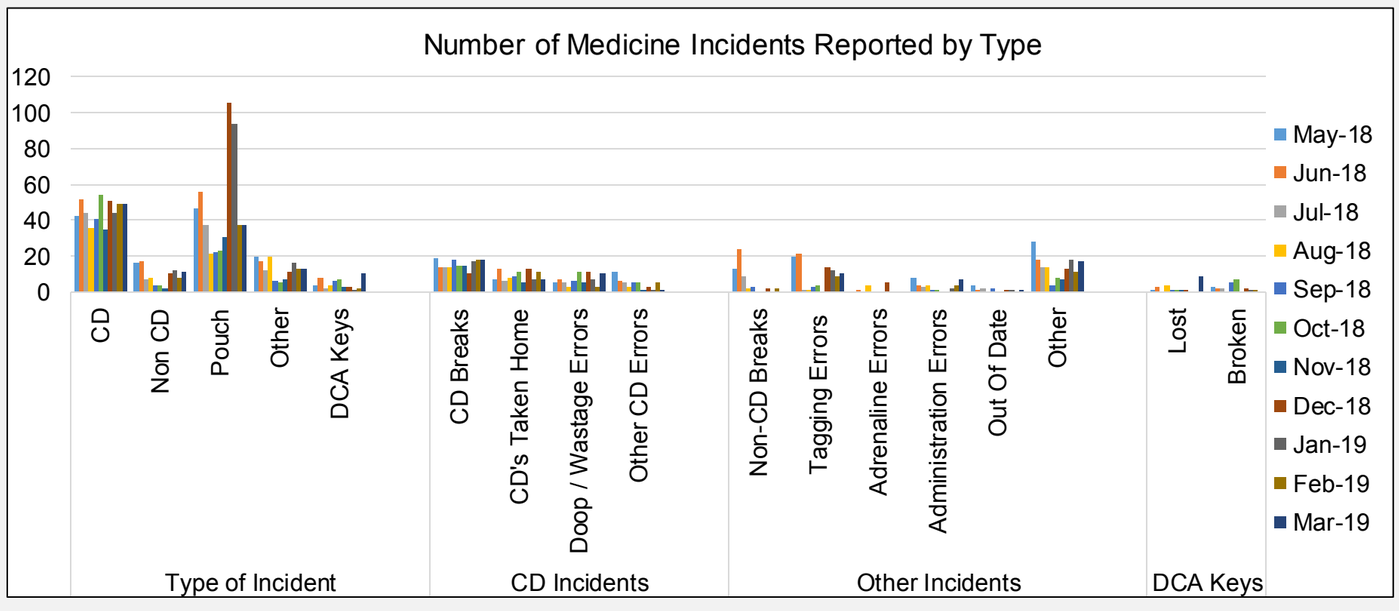
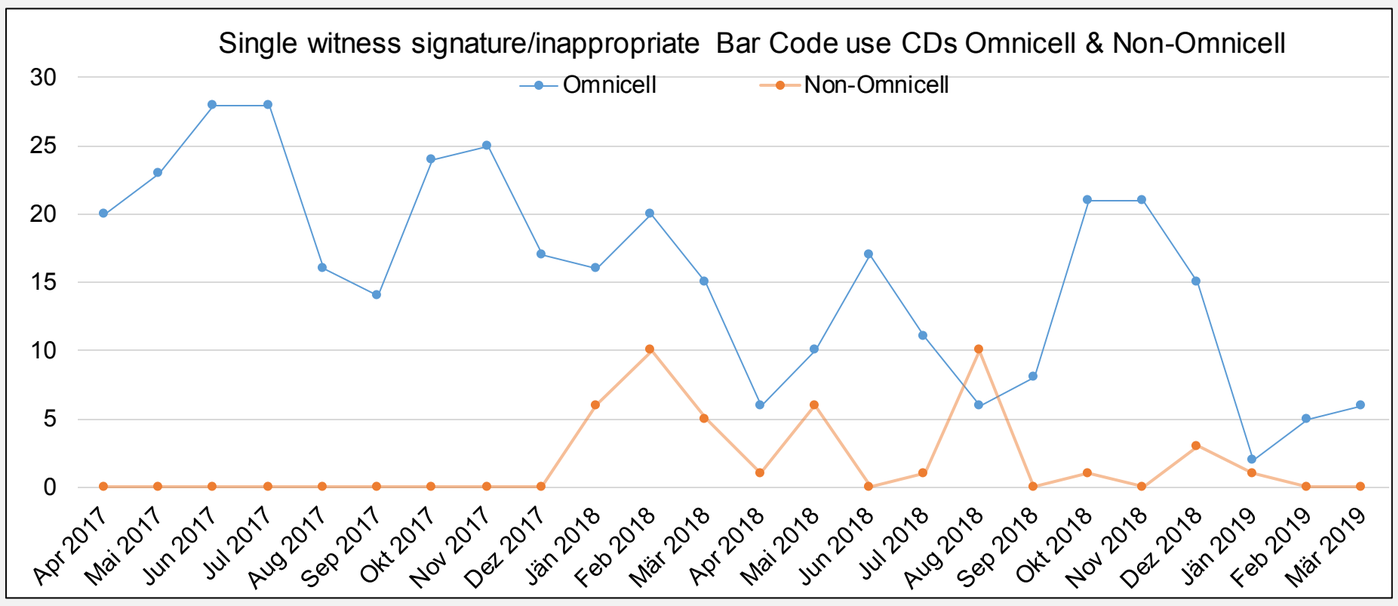


49 of the 122 incidents reported for March 2019 were in relation to controlled drugs (CD) governance, breakages and non-adherence to SOPs.

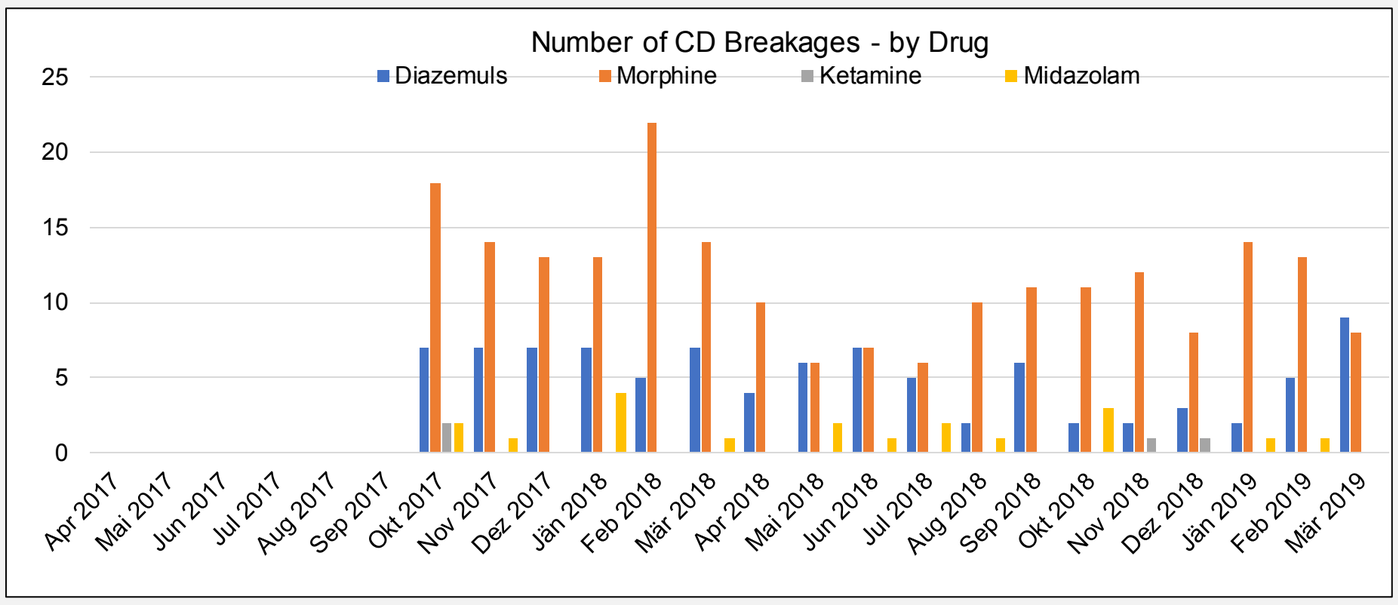
There were 37 incidents reported around medicine pouches, however due to bulk Datix this equates to 81 pouch incidents in total. There was 25 incidents were medicines were missing from pouches. Crews reported 2 incidents were medicines were not available for patients due to incorrect tagging (non-compliance to SOP) by operational crews. There were 7 medication administration errors reported during March 2019.

Clinical bulletins were sent to staff to address a trend seen in Metoclopramide administration errors.

SECAmb Clinical Safety Charts

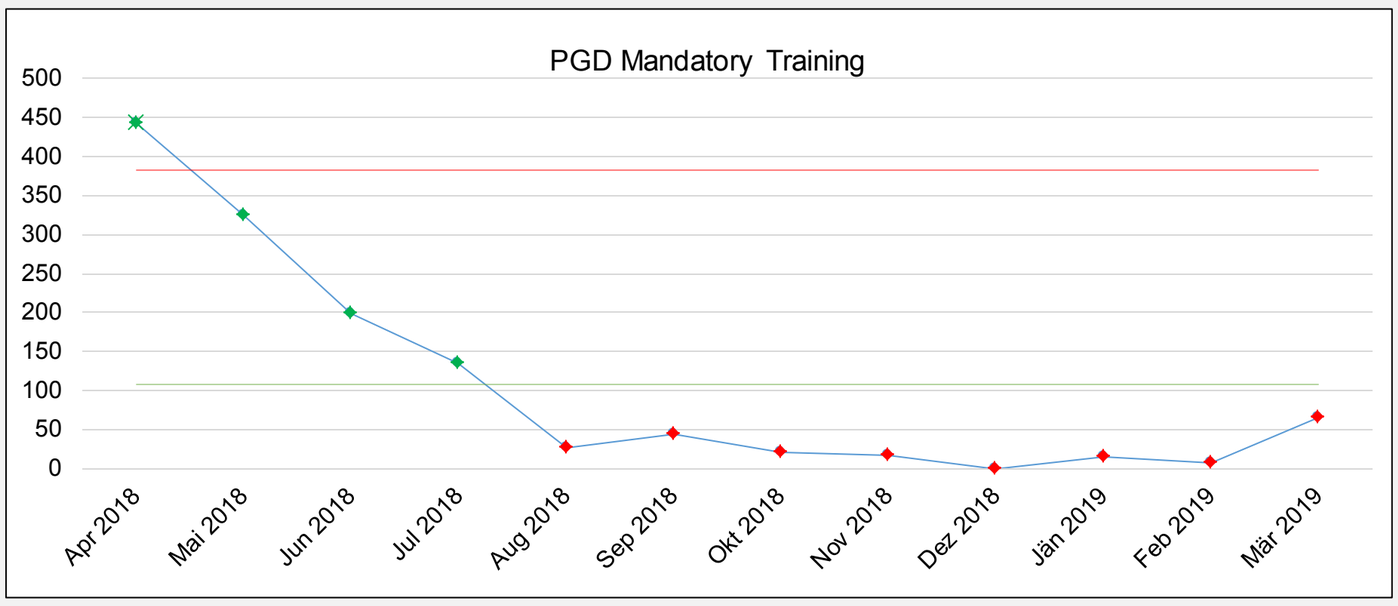


Work continues across the Trust on reducing CD single witness signatures. There were 8 incidents reported during March 2019 of unauthorised single signatures.

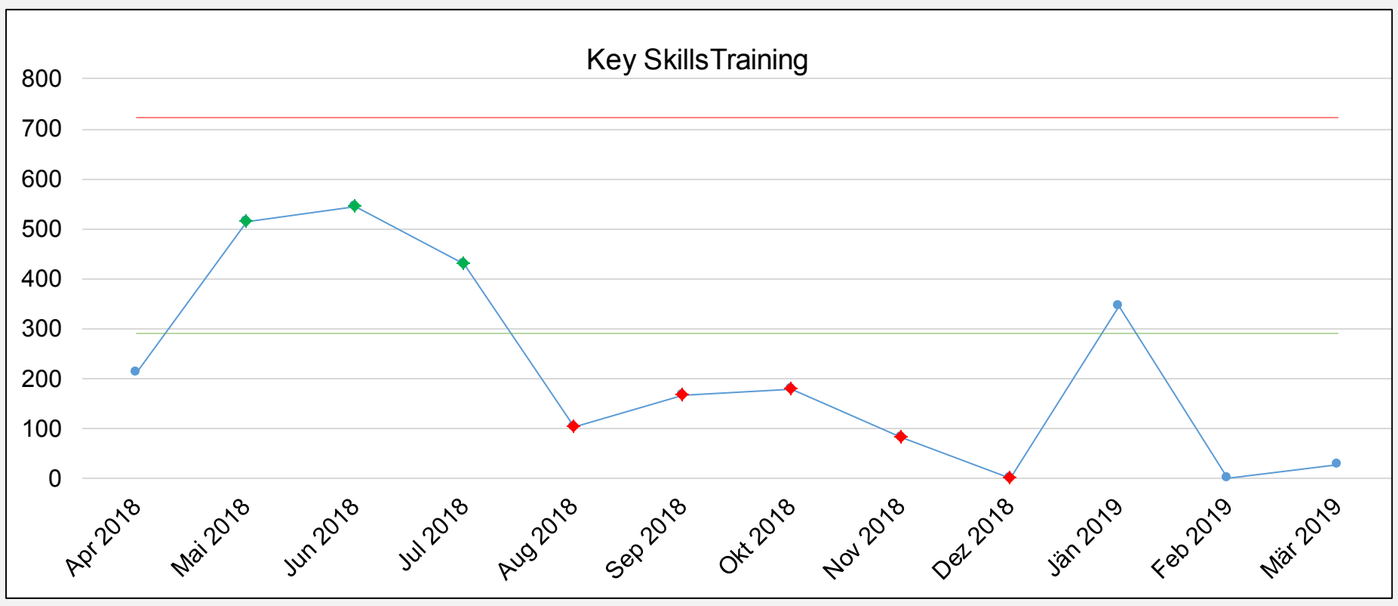


March 2019 reported 17 CD breakages.
8 Morphine
9 Diazemuls

Breakages occurred in the following areas: eight shattered whilst opening, four broken during issue/return, five dropped accidentally.



Most staff have now completed their mandatory key skills training and PGD e-learning package.



Most staff have now completed their mandatory key skills training and PGD e-learning package.

Analysis of Cardiac Arrest Data – February 2019

Total number of cardiac arrests identified = 593

Number of resuscitation attempts = 217
excluding DNACPR 94, DOA 245, No Resus by SECAmb 2,
In hospital arrest 2, Post arrest 5, ADRT 27

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) = 32 (15%) rdiac Arrests (All incidents) = 217 (100;

ROSC sustained to hospital (Utstein)
= 15 (47%) + 3 non ROSC

ROSC sustained to hospital (All)
= 59 (27%) + 13 non ROSC

Outcomes for ROSC at hospital and non ROSC at hospital patients		
Utstein	Details	Overall
9	Patient survived to discharge	14
8	Patient died in hospital	50
0	Patient still in hospital*	0
1	Outcome unknown* (Patient identifiable data incomplete)	8

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) = 9 (29%)

Survival to Discharge (All) = 14 (7%)

Additional Information – Resuscitation Attempts

Cardiac Rhythm	Overall Totals	ROSC at Hospital	Non ROSC at Hospital
Asystole	101 (47%)	19	2
PEA	60 (28%)	15	4
VF	48 (22%)	24	5
Non-shockable	1 (0%)	0	0
Not recorded	7 (3%)	1	2

CPR Bystander – 130

EMS Witnessed arrest – 26

Cardiac Arrest downloads received for Feb 18	213
Cardiac Arrest download reports sent to crews	89

Analysis of Cardiac Arrest Data by area - 2019

Number of resuscitation attempts = 216
this figures excludes incidents as PAS & VAS crew (of which attained ROSC at Hospital)

Cardiac Arrests (Utstein) East = 18 (56%)	Cardiac Arrests (All) East = 115 (53%)
Cardiac Arrests (Utstein) West = 14 (44%)	Cardiac Arrests (All) West = 101 (47%)
ROSC sustained to hospital (Utstein) East = 8 (44%) + 1 non ROSC	ROSC sustained to hospital (All) East = 30 (26%) + 6 non ROSC
ROSC sustained to hospital (Utstein) West = 7 (50%) + 2 non ROSC	ROSC sustained to hospital (All) West = 29 (29%) + 7 non ROSC

Outcomes for ROSC at hospital and non ROSC at hospital patients

Area	Utstein	Details	Overall
East	5	Patient survived to discharge	6
West	4		8
East	4	Patient died in hospital	26
West	4		24
East	0	Patient still in hospital*	0
West	0		0
East	0	Outcome unknown* (Patient identifiable data incomplete)	4
West	1	Outcome unknown* (Patient identifiable data incomplete)	4

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

Survival to Discharge (Utstein) East = 5 (28%)	Survival to Discharge (All) East = 6 (5%)
Survival to Discharge (Utstein) West = 4 (29%)	Survival to Discharge (All) West = 8 (8%)

Mental Health Response Times (Section 136 MHA)

During March 2019 there were 171 Section 136 related calls to the service.149 of these calls received a response (87.13%) (81.8% in February) resulting in a conveyance to a place of safety by an ambulance on 136 (79.5% of total calls; in February this was 78.8.% of total calls) on these occasions.

The overall performance mean shows a Cat 2 response time across the service as 00.19.50 (February was 00.19.25). Against the 90th centile measure, the response was 00.44.57 (February was 00.36.50).

There were 3 transports of under 18's (6 during February).

There were 22 occasions when SECAmb did not provide a response. This is down from 30 in February. 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 4	Total responses 2	Total transports 1
Performance	Mean 00:18.12	90th centile 00:25.02	
Cat 4:	Total calls 0	Total responses 0	Total transports 0
C60 HCP:	Total calls 17	Total responses 9	Total transports 8
Performance	Mean 01:48:16	90th centile 01:27:55	
C120 HCP:	Total calls 2	Total responses 1	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 :

The following exceptions are reported:

Compliance with Duty of Candour has decreased. This is due to capacity issues within the serious incident team. A robust plan is in place to rectify this and appears to be on track but is not reflected in the March data.

The revised procedure for serious incidents is in the process of being ratified by JPPF. There remains a challenge meeting national timescale due to some capacity issues within the serious incident team which are being addressed and the need to increase the number of investigators. Serious incident investigation training is being rolled out. Never the less there are signs of improvement in terms of management of the overall process and there is positive feedback from the Clinical Commissioning Group in relation to the improving quality of reports.

Complaints
A rise in the number of complaints in January, mainly attributable to system pressures, and some capacity issues within the complaints team have impacted on compliance with response times. A plan has been in place and improvements are being demonstrating although not demonstrable for May IPR report.

IPC
The IPC team continue to monitor audit compliance for deep cleaning of vehicles and are working closely with the third-party contractors. There has been some impact due to system pressures and ‘hot loading’.

Our People

SECAmb Clinical Quality Scorecard

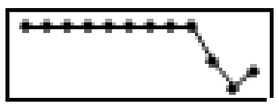
Number of Incidents Reported

	Jan-19	Feb-19	Mar-19	12 Months
Actual	838	761	810	
Previous Year	748	591	627	

Number of Incidents Reported that were SI's

	Jan-19	Feb-19	Mar-19	12 Months
Actual	18	12	14	
Previous Year	22	6	12	

Duty of Candour Compliance (SIs)

	Jan-19	Feb-19	Mar-19	12 Months
Actual %	70%	47%	62%	
Target	70%	47%	62%	

Number of Complaints

	Jan-19	Feb-19	Mar-19	12 Months
Actual	81	96	63	
Previous Year	111	127	112	
Complaints Timeliness (All	89.7%	87.0%	88%%	
Timeliness Target	95%	95%	95%	

Compliments

	Jan-19	Feb-19	Mar-19	12 Months
Actual	180	145	145	

Hand Hygiene

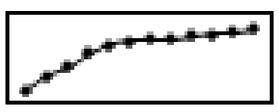
	Jan-19	Feb-19	Mar-19	12 Months
Actual %	91%	92%	91%	
Upper Target	90%	95%	95%	

Safeguarding Training Completed (Adult) Level 2

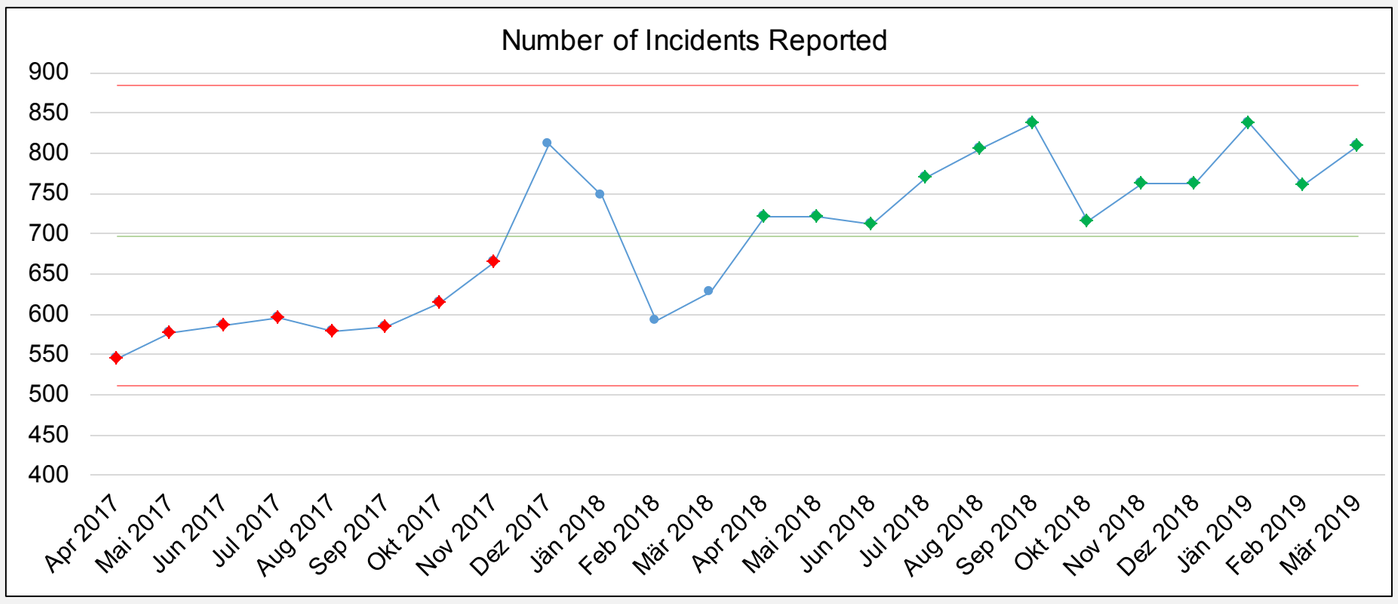
	Jan-19	Feb-19	Mar-19	12 Months
Actual %	86.81%	89.04%	94.30%	
Previous Year %	69.33%	85.66%	94.62%	
Target	85%	85%	85%	

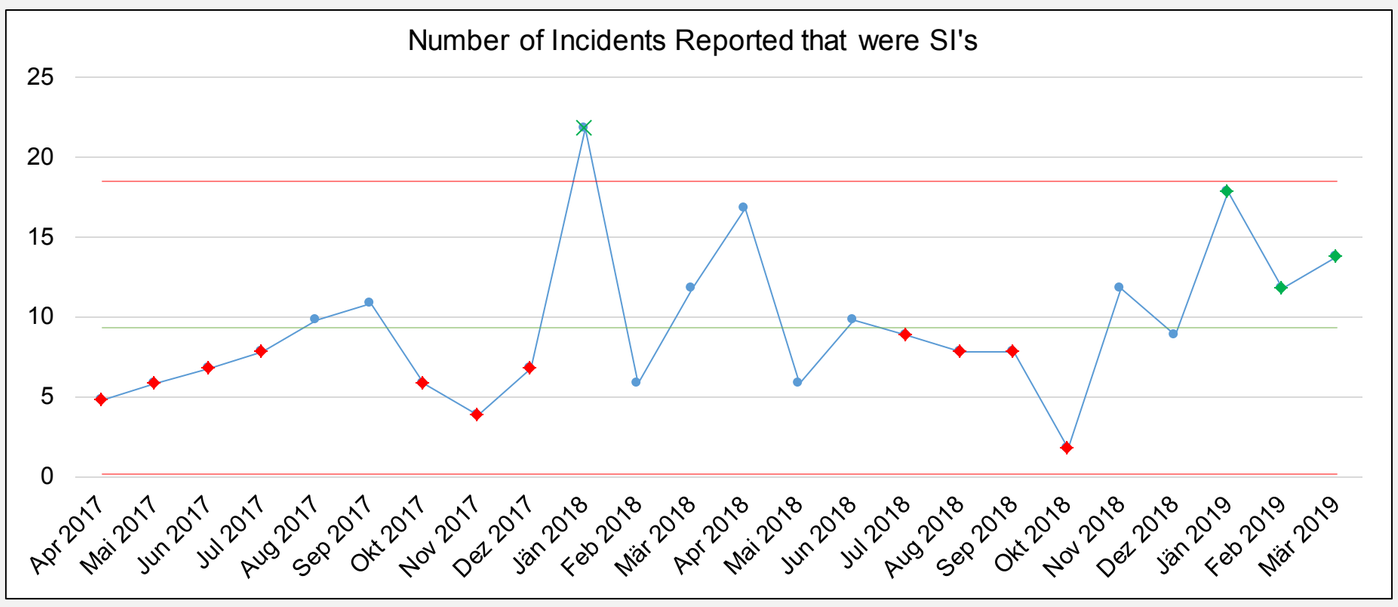
* Safeguarding training is completed each financial year, which explains the significant drop for April 2018

Safeguarding Training Completed (Children) Level 2

	Jan-19	Feb-19	Mar-19	12 Months
Actual %	86.50%	88.62%	94.08%	
Previous Year %	69.63%	84.36%	93.99%	
Target	85%	85%	85%	

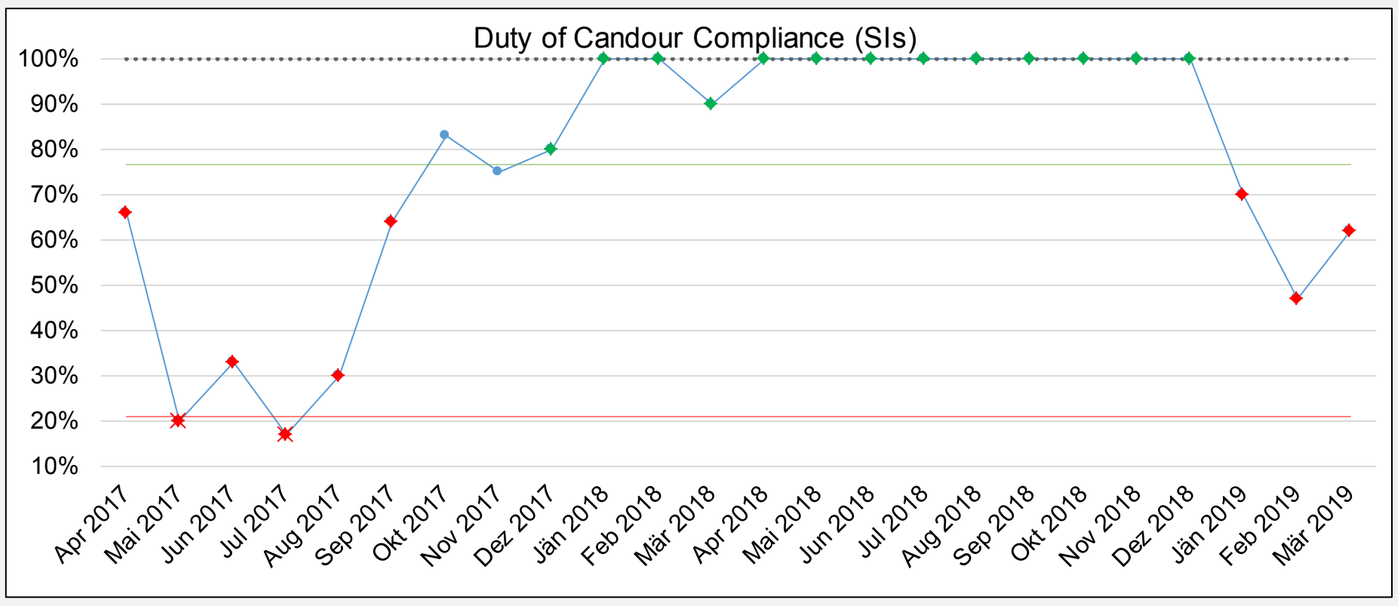
SECAmb Clinical Quality Charts





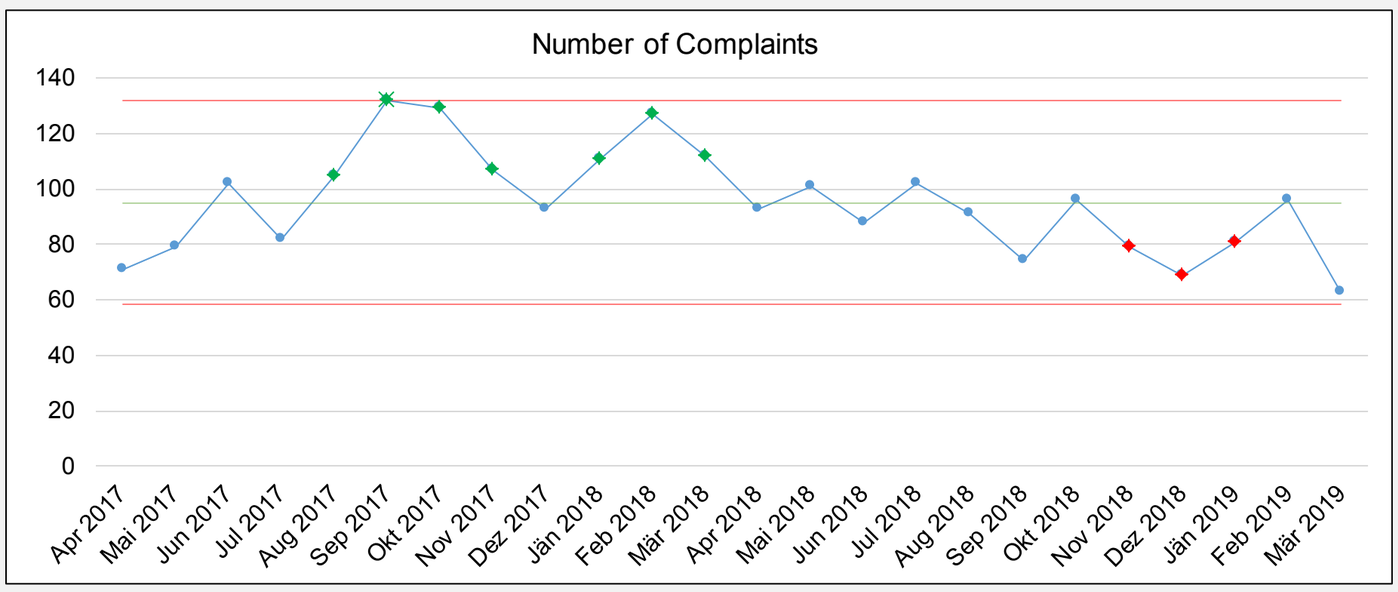
14 Serious Incident (SI) were reported in March.

6 x Delayed Dispatch / Attendance
1 x Call Answer Delay
2 x Non-Conveyance / Condition deteriorated
1 x Staff Conduct
4 x Triage/Call Management



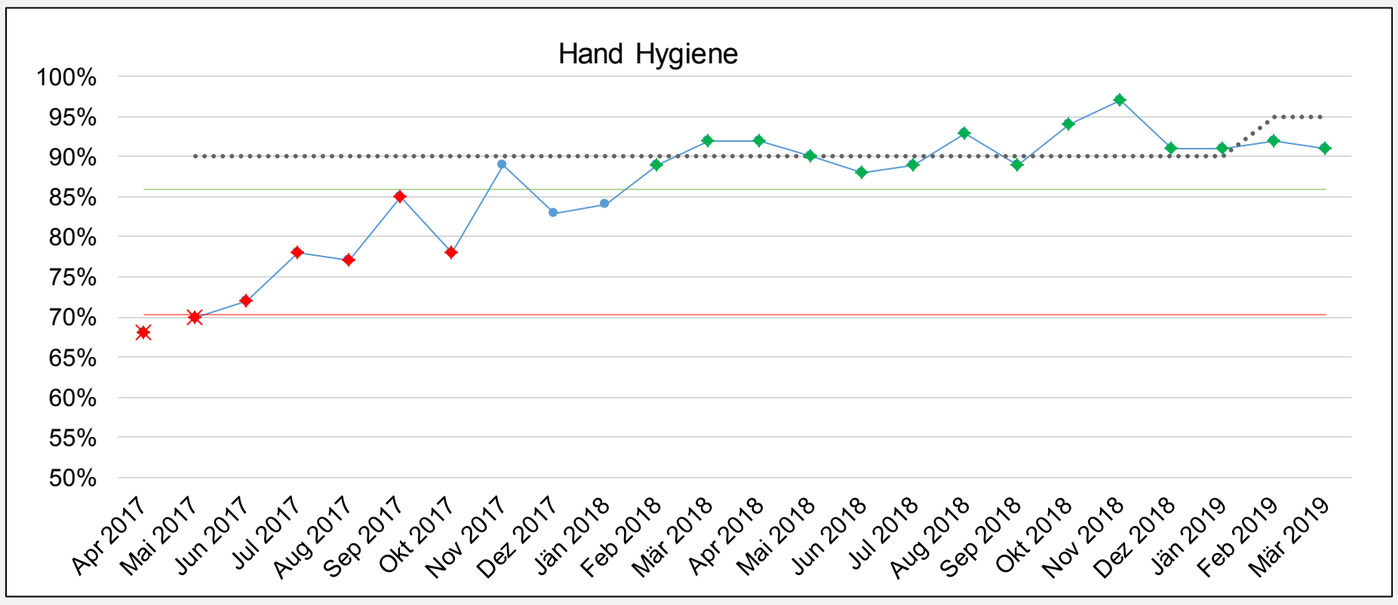
Compliance with Duty of Candour (DoC) for Serious Incidents (Sis) where DoC was required in March 2019 is: (due in the month)

SIs reported (where DoC due in March) - 8
Number where DoC required - 8
DoC made/attempted within 10 working day deadline - 5 (62%)



The Trust received and opened 63 complaints in March.

The Trust responded to 88% complaints within timescales. Delays were mainly due to capacity issues within the patient experience team and OUs in relation to investigations, in part due to the increase in complaints in previous months. These issues are now resolved.



We have changed the level of compliance for hand hygiene to reflect the improvements we have seen since the 3R's was introduced back in July 2018. The Upper Compliance Level is now 95% and the Lower Compliance Limit is 90%.

Compliance has been just above the lower limit for both February and March 92% and 91% respectively and the IPC Team are working with the local IPC Champions to further improve the compliance with some awareness materials being produced.

Clinically Ready compliance will now be 100% with no lower limit as adherence to the procedure forms part of the Trust Uniform Policy and should therefore be followed at all times. Compliance in February was at 95% and 97% for March.

Upper Target
Lower Target

SECAmb Health and Safety Reporting

The Health & Safety team are making good progress with the implementation of a robust safety management system.

Since the implementation of the annual Health & Safety Audit programme 40 audits have been completed. The audits were undertaken in different working environments across the organisation.

Currently the organisation has a well established (CHSWG) Central Health & Safety Working group which meets on a quarterly basis. With the Health & Safety improvements being made we shall be introducing **5** new sub groups which will meet on a bi-monthly basis. The new sub groups are listed below and will report into the CHSWG.

- East Region Health & Safety Group
- Central Region Health & Safety Group
- West Region Health & Safety Group
- Fire Safety Group
- Water Safety Group

Violence and Aggression Incidents - See Figure 1 below
Violence and Aggression incidents reported in March were 50 which is a decrease of 2 incidents from the previous month.

Manual handling Incidents - See Figure 2 below
Manual handling incidents reported in March were 22 which is identical to the previous month.

Health & Safety Incidents - See Figure 3 below
Health and Safety incidents reported in March were 25 which is identical to the previous month.
When comparing the same period last year March 2018 incidents were almost identical with 26 reported incidents.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) - See Figure 4 below
RIDDOR incidents reported in March were 4 and 2 incidents were 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. In 2018/2019 the organisation reported **69** RIDDOR incidents and **52%** of these incidents were reported on-time to the Health & Safety Executive.

Figure 1

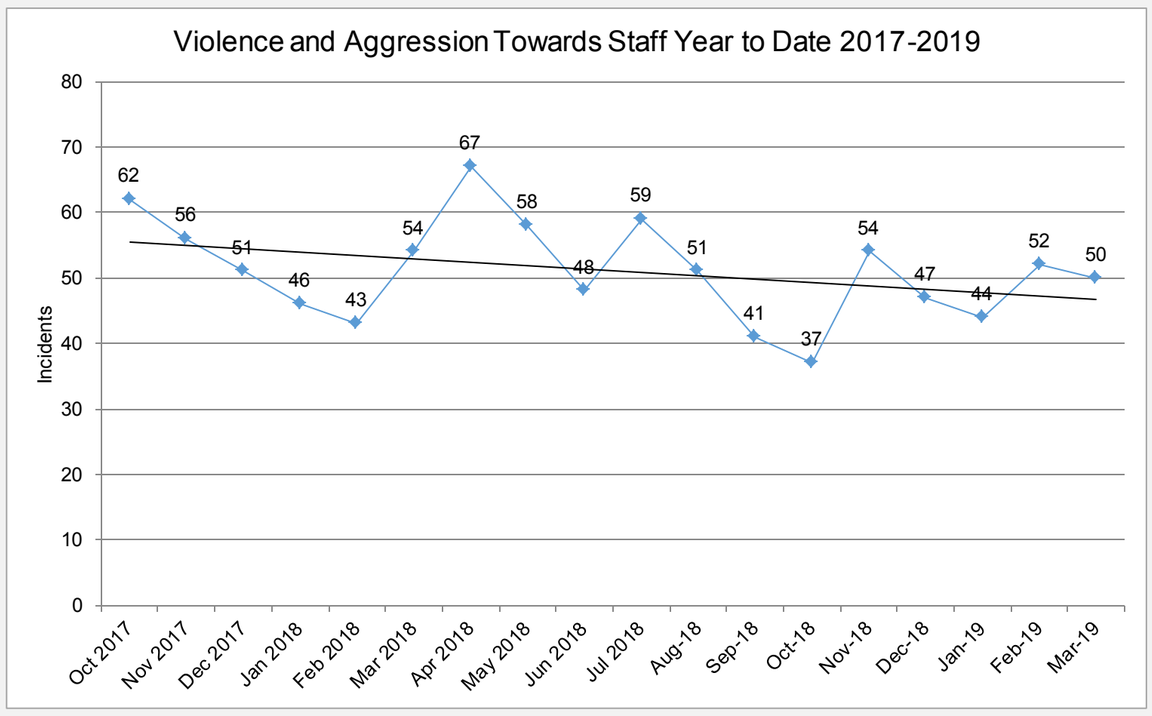


Figure 2

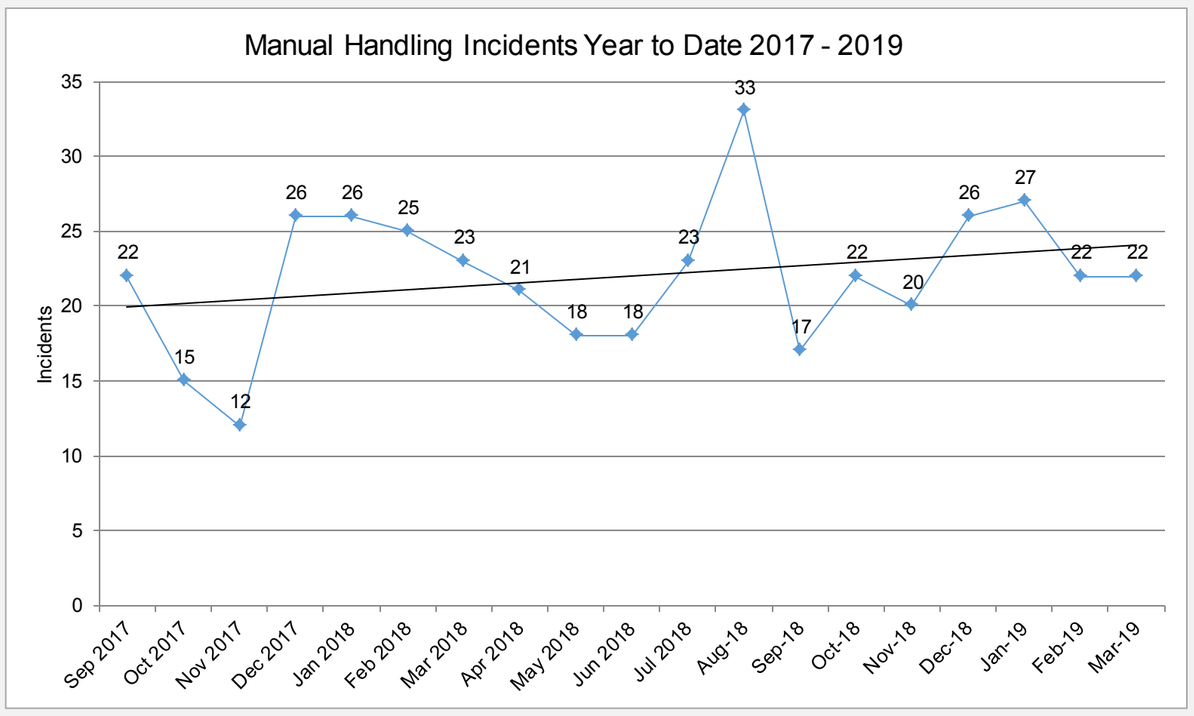


Figure 3

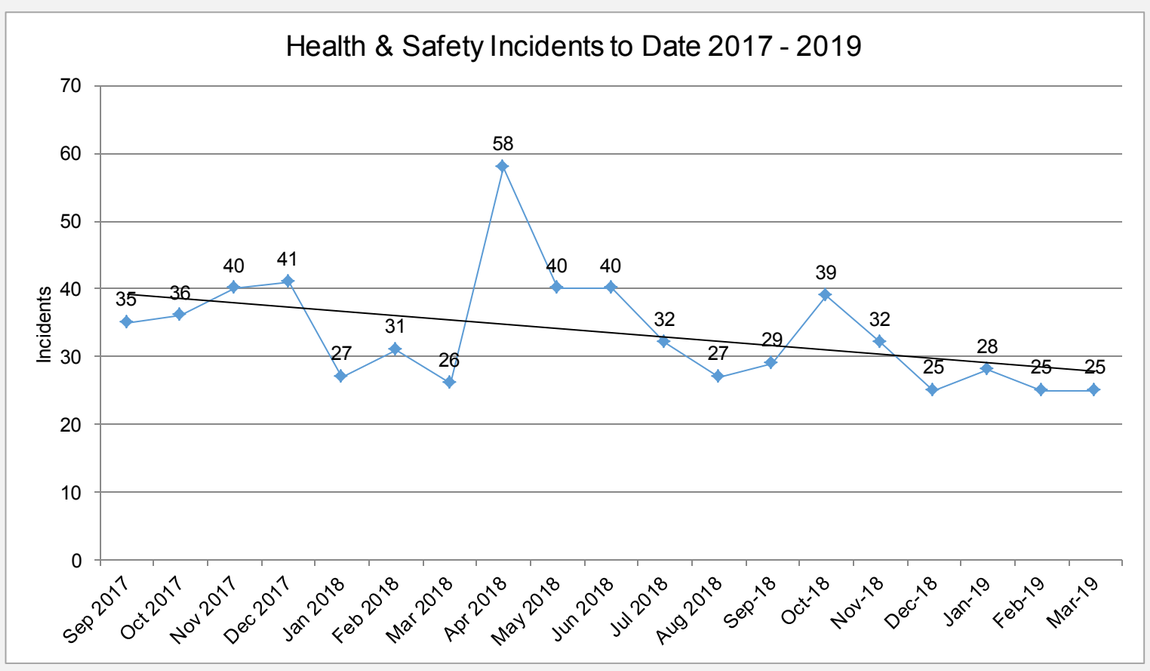
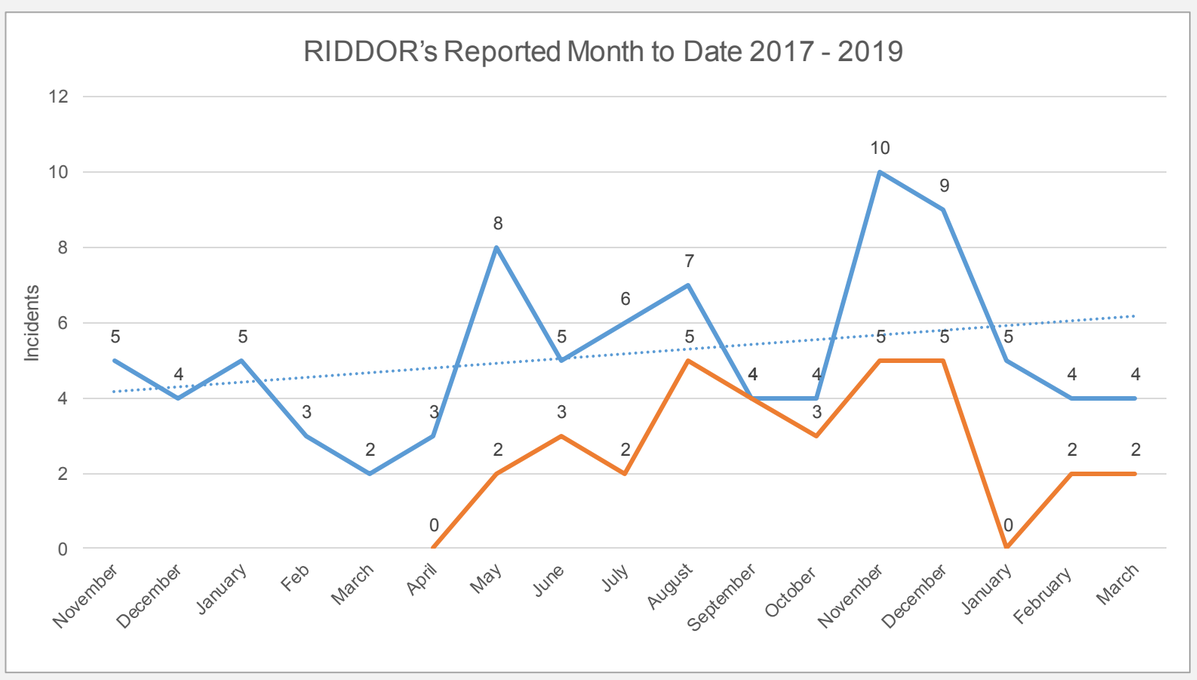


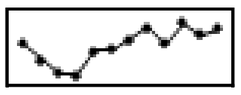
Figure 4



Our Enablers

SECAmb 999 Operations Response Time Performance Scorecard

Call Handling

	Jan-19	Feb-19	Mar-19	12 Months
5 Sec Performance (95% Target)	91.5%	87.0%	89.4%	
Mean Call Answer Time (secs)	5	7	6	
95th Centile Call Answer (Secs)	30	50	37	
National Mean Call Answer	5	7	5	
National 95th Centile Call Answer	27	41	31	

Category 1 Performance

	Jan-19	Feb-19	Mar-19	12 Months
Mean (00:07:00)	00:07:58	00:07:50	00:07:31	
90th Percentile (00:15:00)	00:14:15	01:14:24	00:13:50	
Mean Resources Arriving	1.69	1.68	1.67	
Count of Incidents	3796	3399	3708	
National Mean	00:07:08	00:07:17	00:07:00	

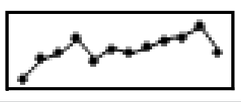
Category 1T Performance

	Jan-19	Feb-19	Mar-19	12 Months
Mean (00:19:00)	00:09:58	00:10:21	00:09:47	
90th Percentile (00:30:00)	00:18:31	00:19:25	00:18:13	
Mean Resources Arriving	1.72	1.68	1.69	
Count of Incidents	2401	2156	2376	
National Mean	00:11:16	00:11:23	00:10:46	

Category 2 Performance

	Jan-19	Feb-19	Mar-19	12 Months
Mean (00:18:00)	00:20:59	00:22:31	00:20:12	
90th Percentile (00:40:00)	00:39:57	00:43:19	00:38:10	
Mean Resources Arriving	1.09	1.08	1.08	
Count of Incidents	34842	31361	32586	
National Mean	00:22:58	00:23:37	00:21:15	

Category 3 Performance

	Jan-19	Feb-19	Mar-19	12 Months
Mean	01:42:14	02:04:28	01:46:30	
90th Percentile (02:00:00)	03:55:06	04:46:01	04:09:41	
Mean Resources Arriving	1.06	1.06	1.06	
Count of Incidents	19142	15745	18478	
National Mean	01:07:42	01:12:19	01:01:24	

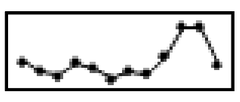
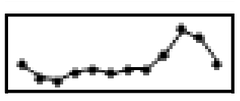
Category 4 Performance

	Jan-19	Feb-19	Mar-19	12 Months
Mean	02:08:41	02:31:53	02:15:17	
90th Percentile (03:00:00)	04:27:24	05:15:02	05:06:19	
Mean Resources Arriving	1.05	1.05	1.05	
Count of Incidents	761	584	745	
National Mean	01:25:43	01:29:45	01:20:29	

Health Care Professional

	Jan-19	Feb-19	Mar-19	12 Months
HCP 60 Mean	01:50:19	01:39:08	01:46:22	
HCP 60 90th Percentile	03:50:21	04:14:50	03:53:10	
HCP 120 Mean	02:21:37	02:09:42	01:53:29	
HCP 120 90th Percentile	04:52:36	04:58:06	04:07:43	
HCP 240 Mean	03:23:22	03:13:17	02:39:51	
HCP 240 90th Percentile	07:46:55	06:58:51	06:06:01	

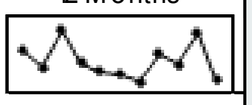
Call Cycle Time

	Jan-19	Feb-19	Mar-19	12 Months
Avg Allocation to Clear at Scene	01:16:24	01:17:15	01:16:00	
Avg Allocation to Clear at Hospital	01:49:23	01:50:12	01:47:13	
Turnaround Hrs Lost at Hospital (> 30mins)	6059	6043	4673	
Number of Handovers >60mins	1066	926	525	

Community First Responders

	Jan-19	Feb-19	Mar-19	12 Months
Volume of Incidents Attended	1208	1067	1484	

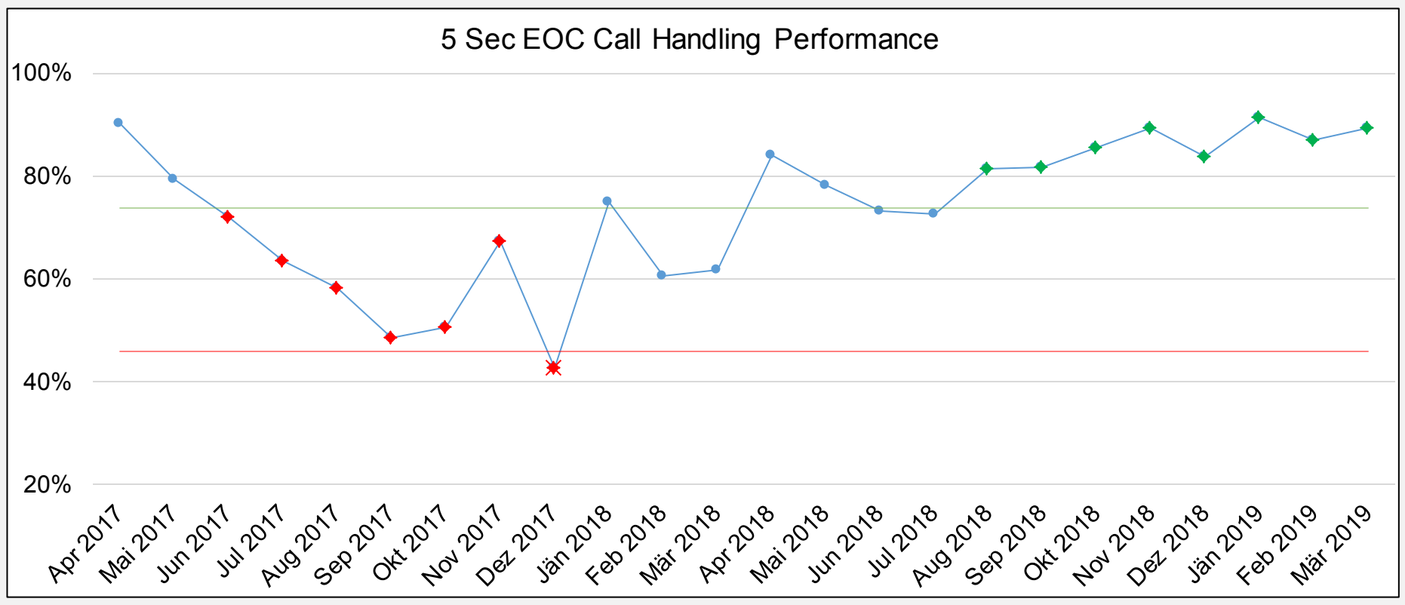
Incident Outcome AQI

	Jan-19	Feb-19	Mar-19	12 Months
Hear & Treat	5.8%	6.5%	5.5%	
See & Treat	32.1%	31.6%	31.8%	
See & Convey	62.0%	61.9%	62.7%	

Demand/Supply AQI

	Jan-19	Feb-19	Mar-19	12 Months
Calls Answered	68681	64478	66945	
Incidents	64309	56575	60991	
Transports	39912	35001	38229	

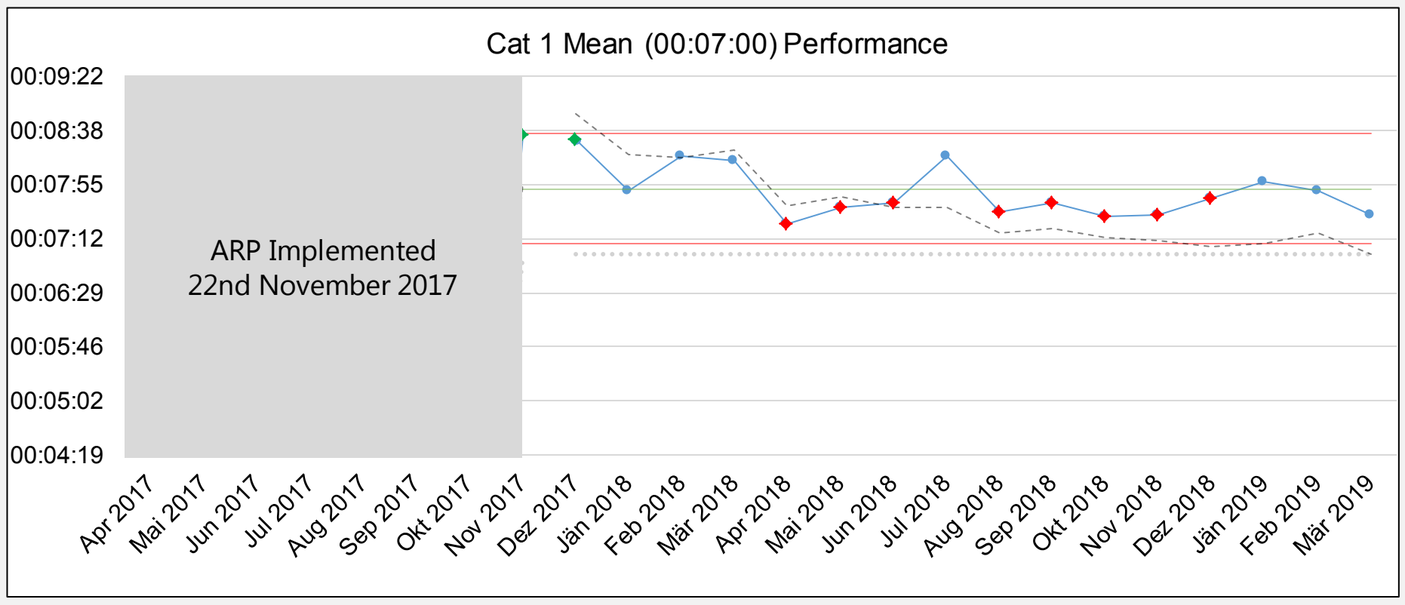
SECAmb 999 Operations Response Time Performance Charts



Call answering performance for March improved to 89.4% on average and the Trust continues to exceed the revised trajectory set with the commissioners in September 2018. National Call Answer performance showed that the Trust's performance remained at a mid table position 7/8 compared to other ambulance services.

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.

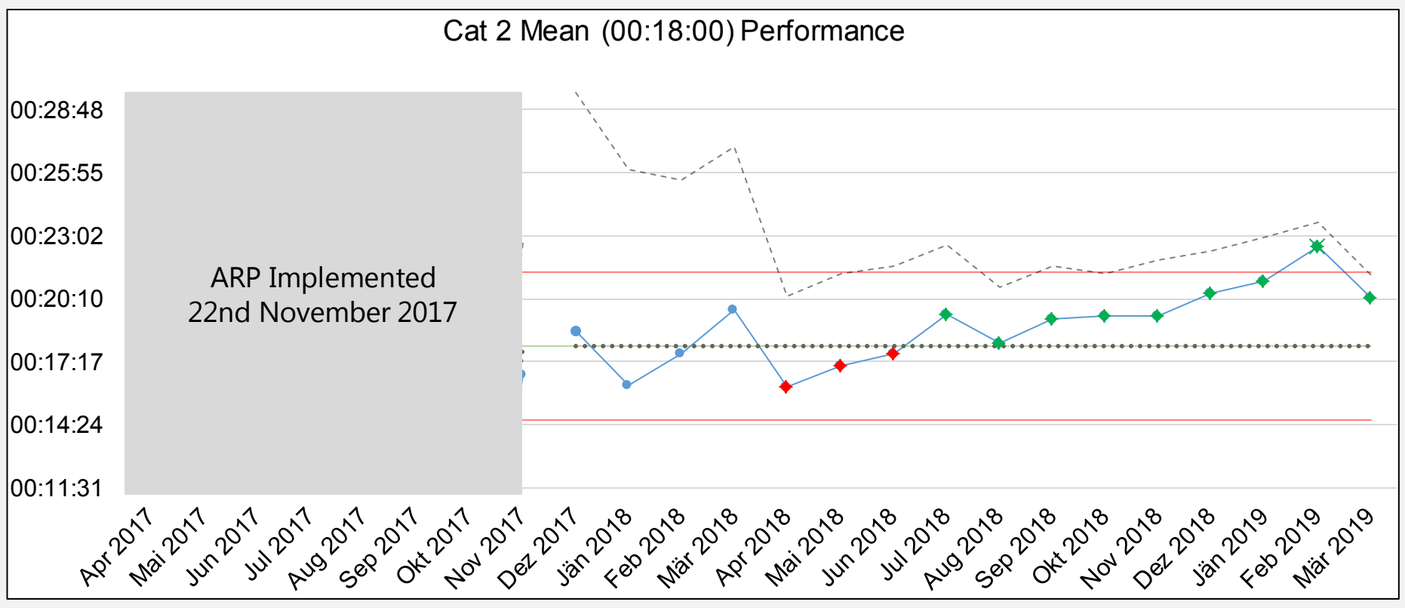


March Category1 (C1) mean response saw an improvement of 21secs to achieve an average of 7.31. The number of incidents increased by 300 on prior month, however this can be directly attributed to the number of days in March versus February.

Whilst the Trust are not yet delivering the Ambulance Response Programme (ARP) target of seven minutes for C1 Mean, the Trust has met C1T Mean and C1 90th Centile against ARP standards and are sitting near the upper end of the pack for C1 Transport, when measured against all other English ambulance services.

There remains significant focus given to this high acuity patient group.

----- National Mean

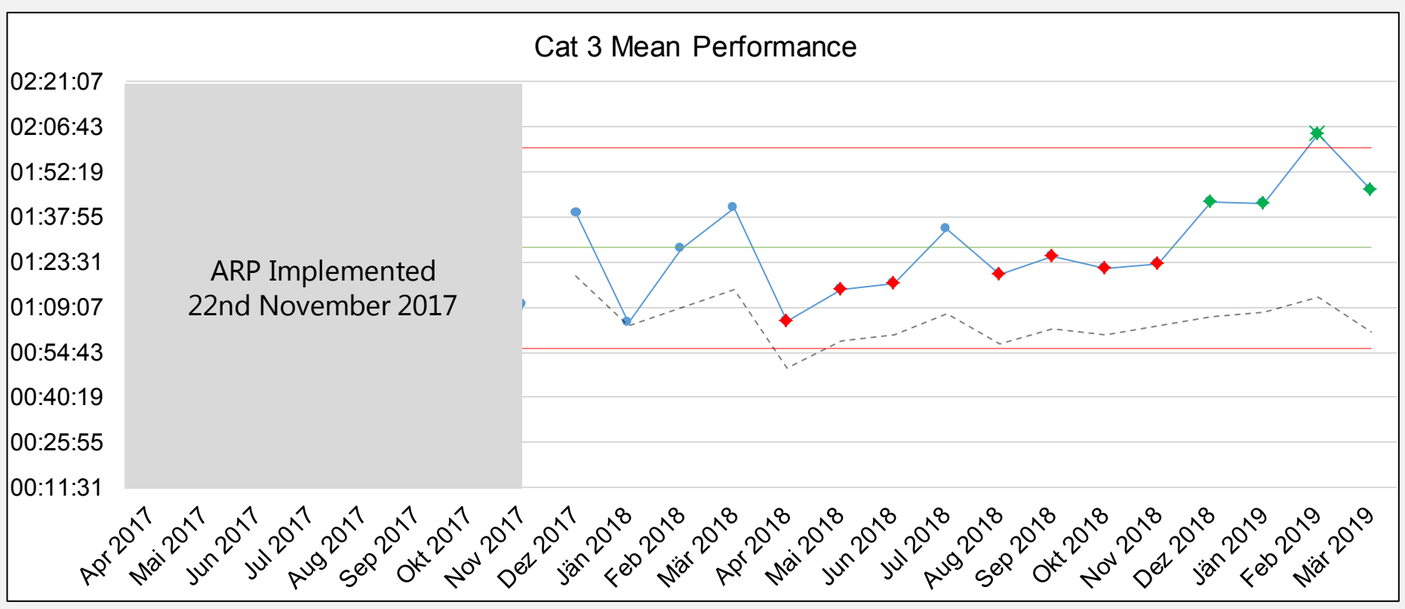


March Category 2 (C2) Mean Performance improved by 2 minutes 21 seconds on the prior month, to an average mean performance of 20.12. The Trust responded to 1225 more C2 incidents compared to the prior month. Whilst performance is not achieving the ARP standard the Trust continues to hold its position in the National Performance tables in the middle of the table.

The Trust continued to perform nationally for C2 Mean and 90th Centile, achieving a position of 5th compared to our peers.

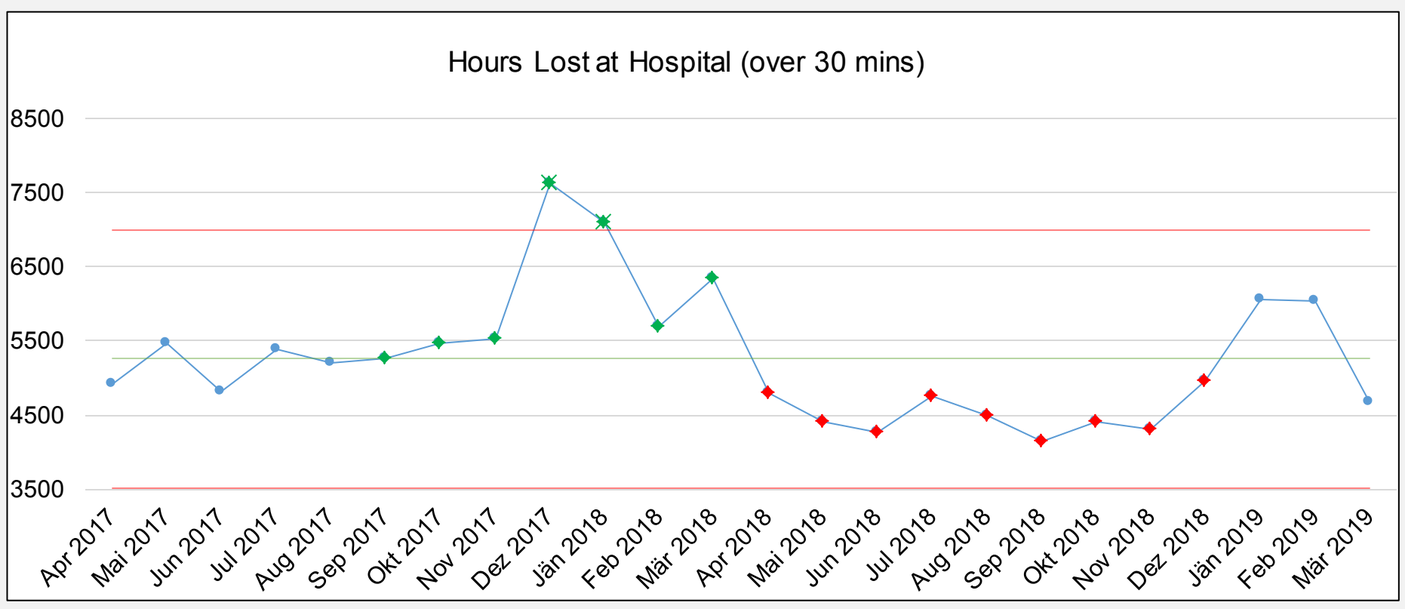
The Trust is identifying several initiatives to address C2 performance including a trial using SRV's to attend C3 incidents, freeing some additional DCA capacity to attend C2 calls. If approved this trial will commence in May 2019 for one week.

----- National Mean



Responses to Category 3 (C3) incidents continues to be below the ARP target and remains a significant challenge to the Trust. The average mean response is 1:46:30, which is an improving position by over 17 minutes on the prior month. The Trust's performance nationally is poor and for both C3 Mean and 90th Centile remain at the bottom of the leader board. The average national performance is approximately 3 hours better than SECAmb. March saw an increase of 2733 C3 incidents on the prior month. The 30 second-hand Non-Emergency Transport (NET) vehicles are now rolled out across the Trust. Further development of the NET Deployment policy is required to ensure the NET vehicles are being used effectively and providing a prompt response to C3 incidents and that this is aligned to the Trust Surge Management Plan. As detailed above there are several initiatives being considered to further address the current performance.

----- National Mean



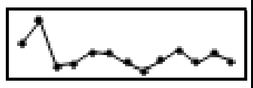
In March there was a decrease of 1554 hours lost >30 minute turnaround compared to February. Comparing overall hours lost >30 minute turnaround in March 2019 with March 2018, there was a 24% decrease (1554 hours).
In March 12.5% of patients waited between 30 and 60 minutes for a hospital handover and 1.6% of patients waited over 60 minutes. Whilst the overall improvement is positive there are some sites who are key outliers.

The ambulance handover steering group continues to meet and local joint hospital and SECAmb meetings are also continuing. Work is focusing on maintaining improvements made so far, and supporting on sites where there are particular challenges.

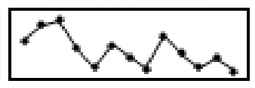
SECAmb unvalidated weekly Response Time Performance

SECAmb Weekly Operational Performance - 13th May 2019

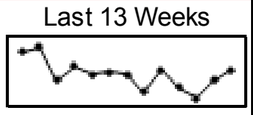
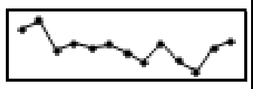
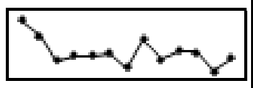
CAT 1

	22/04	29/04	06/05	Last 13 Weeks
Mean	00:07:15	00:07:22	00:07:11	
90th Centile	00:13:39	00:14:00	00:13:42	
RPI	1.74	1.74	1.80	
Count of Incidents	825	809	818	

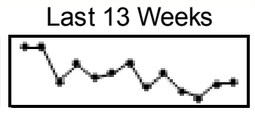
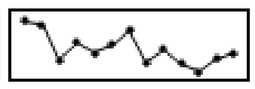
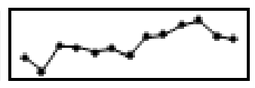
CAT 1T

	22/04	29/04	06/05	Last 13 Weeks
Mean	00:09:20	00:09:40	00:09:13	
90th Centile	00:18:51	00:17:17	00:17:20	
RPI	1.76	1.81	1.81	
Count of Incidents	488	503	533	

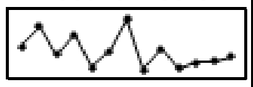
CAT 2

	22/04	29/04	06/05	Last 13 Weeks
Mean	00:18:15	00:19:33	00:20:23	
90th Centile	00:33:51	00:37:57	00:39:16	
RPI	1.10	1.10	1.10	
Count of Incidents	7358	7118	7279	

CAT 3

	22/04	29/04	06/05	Last 13 Weeks
Mean	01:24:42	01:34:26	01:35:30	
90th Centile	03:17:29	03:39:16	03:49:39	
RPI	1.07	1.07	1.08	
Count of Incidents	4802	4500	4432	

CAT 4

	22/04	29/04	06/05	Last 13 Weeks
Mean	01:58:20	01:58:55	02:02:06	
90th Centile	04:43:24	04:25:34	05:08:03	
RPI	1.07	1.03	1.09	
Count of Incidents	124	101	114	

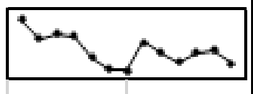
HCP 60

	22/04	29/04	06/05	Last 13 Weeks
Performance	55.6%	44.7%	63.0%	
Count of Incidents	36	38	27	

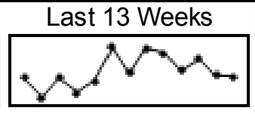
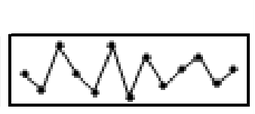
HCP 120

	22/04	29/04	06/05	Last 13 Weeks
Performance	69.6%	67.1%	63.6%	
Count of Incidents	408	410	387	

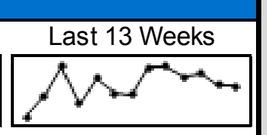
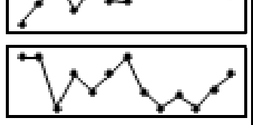
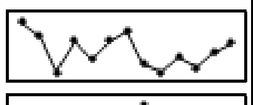
Call Cycle Time

	22/04	29/04	06/05	Last 13 Weeks
Clear at Scene (hh:mm)	01:15	01:14	01:14	
Clear at Hospital (hh:mm)	01:47	01:47	01:46	
Hours Lost at Hospital	1188	1160	1099	

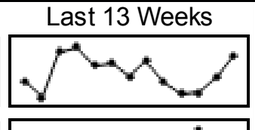
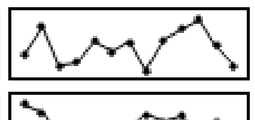
HCP 240

	22/04	29/04	06/05	Last 13 Weeks
Performance	84.0%	76.2%	75.4%	
Count of Incidents	75	63	69	

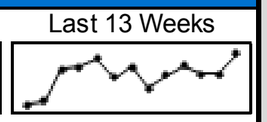
Call Handling

	22/04	29/04	06/05	Last 13 Weeks
Pickup 5 Second Performance	92.1%	90.6%	90.5%	
Average Call Pickup Time (Seconds)	4	5	6	
Call Pickup Time 95th Percentile (Seconds)	22	31	37	
Call Pickup Time 99th Percentile (Seconds)	79	93	101	
Average Call Length (seconds)	366	373	390	
Abandon Rate	0.40%	0.50%	0.41%	
Staff Hours Provided Vs 5030 Hours 2018/19 Q3/4 6413 Hours 2019/20 Q1	86.46%	84.31%	82.43%	

Incident Outcome

	22/04	29/04	06/05	Last 13 Weeks
See and Convey	61.7%	62.2%	63.0%	
See and Treat	33.1%	32.4%	31.8%	
Hear and Treat	5.2%	5.4%	5.2%	

Community First Responders

	22/04	29/04	06/05	Last 13 Weeks
Volume of Incidents Attended	315	315	371	
Hours Provided	2963.3	2799.3	2841.6	

Demand/Supply

	22/04	29/04	06/05	Last 13 Weeks
Call Volume	14854	14877	15044	
Incidents	13731	13151	13262	
Transports	8950	8651	8827	
Staff Hours Provided Vs 65500 Hours 2018/19 Q3/4	109.76%	102.86%	104.27%	

Our Partners

SECAmb 111 Operations Performance Scorecard

Calls Offered

	Jan-19	Feb-19	Mar-19	12 Months
Actual	98477	92883	78251	
Previous Year	99868	92798	112748	

Calls answered in 60 Seconds

	Jan-19	Feb-19	Mar-19	12 Months
Actual %	78.1%	68.0%	83.8%	
Previous Year %	56.9%	49.2%	45.1%	
Target %	95%	95%	95%	

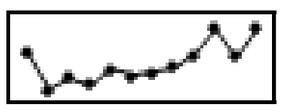
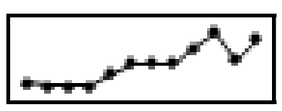
Calls abandoned - (Offered) after 30secs

	Jan-19	Feb-19	Mar-19	12 Months
Actual %	4.1%	6.1%	2.6%	
Previous Year %	8.4%	13.4%	15.7%	
Target %	2%	2%	2%	

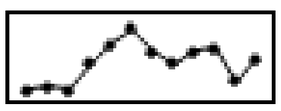
Combined Clinical KPI

	Jan-19	Feb-19	Mar-19	12 Months
Actual %	72.1%	60.6%	64.0%	
Previous Year %	74.7%	71.4%	71.9%	
Target %	90%	90%	90%	

999 Referrals

	Jan-19	Feb-19	Mar-19	12 Months
999 Referrals % (Answered Calls)	12.6%	11.9%	11.6%	
999 Referrals (Actual)	11733	10173	8779	
National	12.3%	11.9%	11.7%	

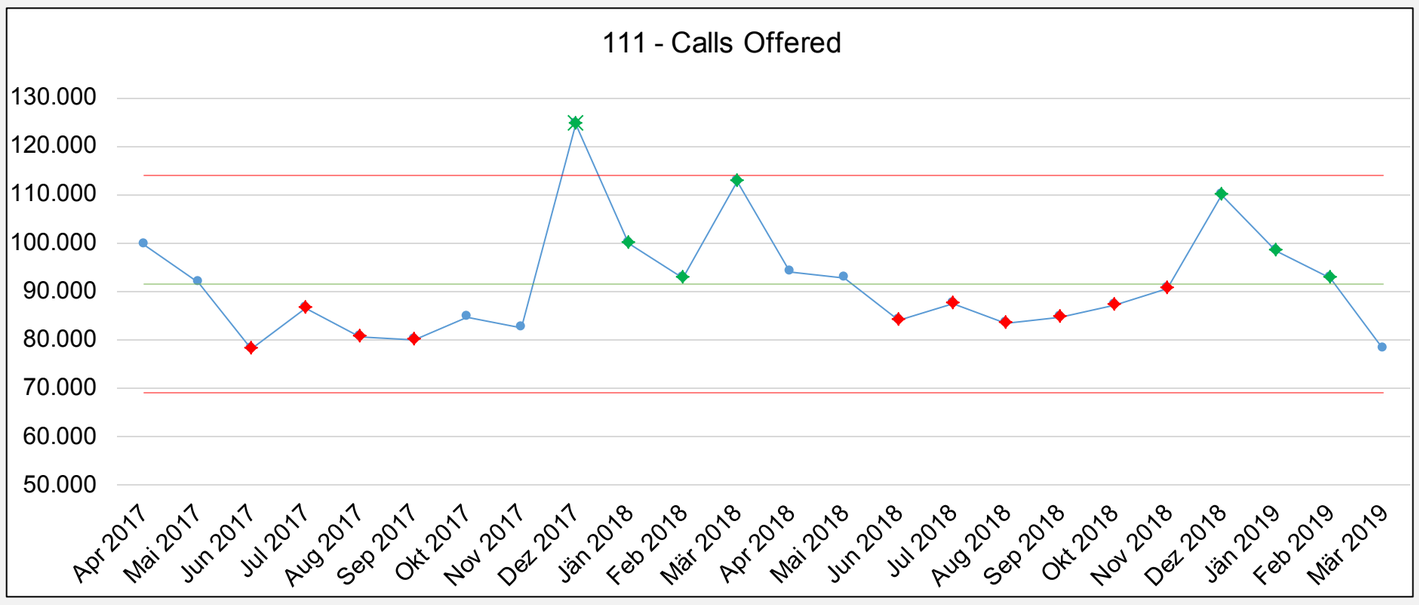
A&E Dispositions

	Jan-19	Feb-19	Mar-19	12 Months
A&E Dispositions % (Answered Calls)	8.0%	8.1%	8.2%	
A&E Dispositions (Actual)	7475	6984	6202	
National	7.6%	7.6%	7.7%	

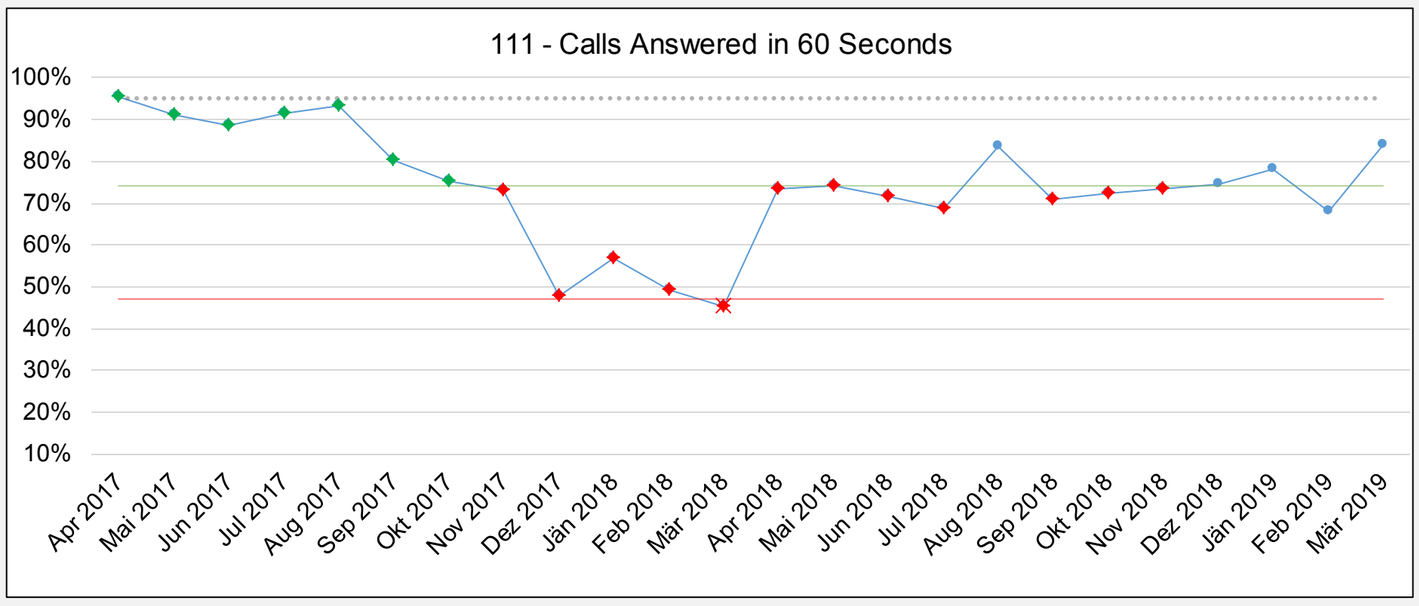
Home Management

	Jan-19	Feb-19	Mar-19	12 Months
Actual %				

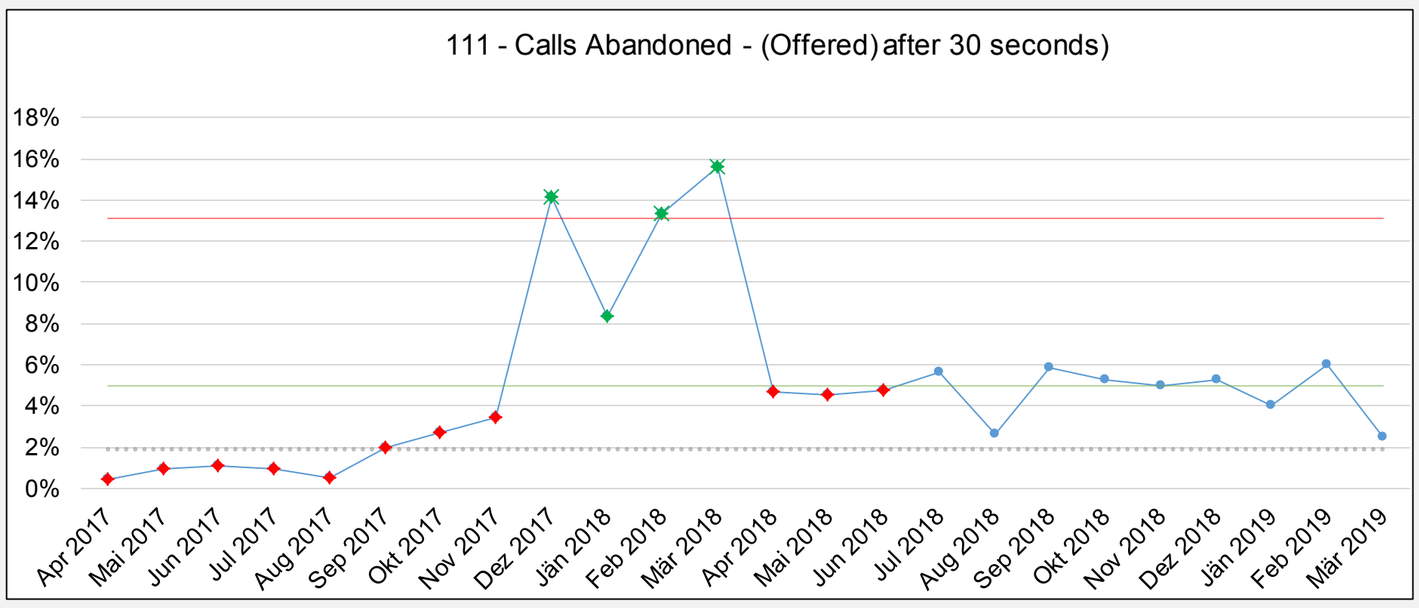
SECAmb 111 Operations Performance Charts



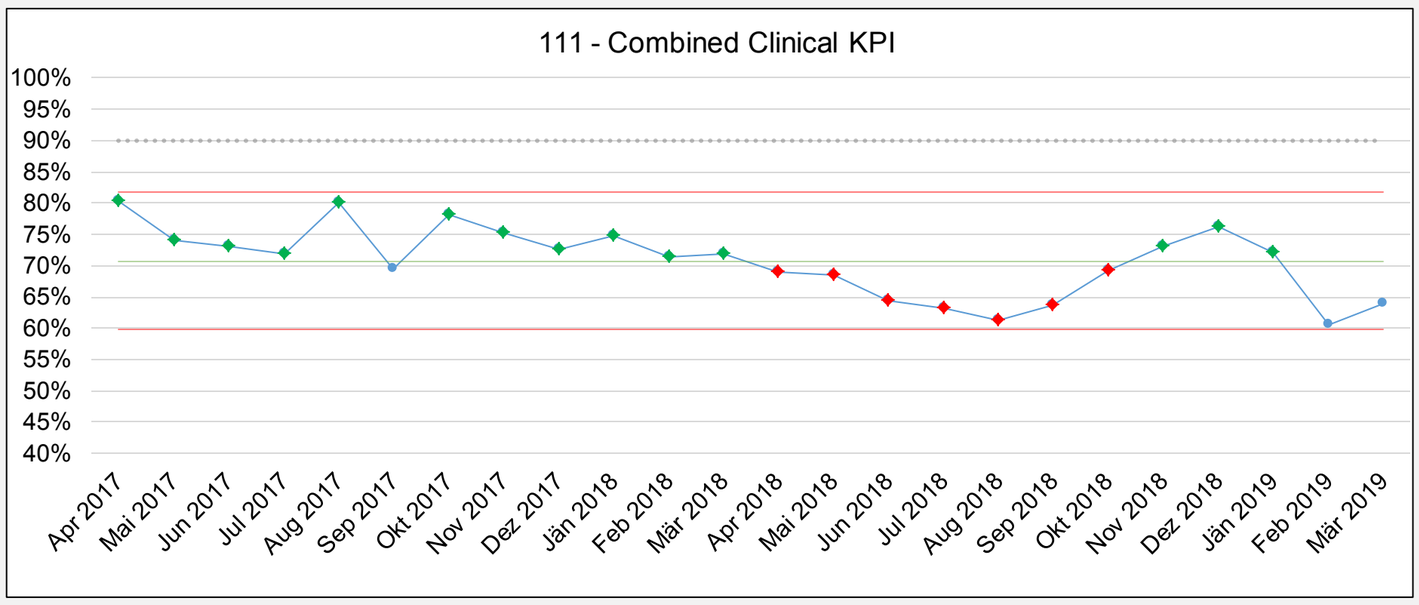
The contract for SECAmb to deliver the KMSS 111 service in collaboration with Care UK ceased on the 28th March 2019. From this point onwards, SECAmb has delivered the new interim SEC 111 IUC service for the Sussex, North and West Kent and Medway CCG's.
For the last financial year, KMSS 111 received 1,086,831 calls which was broadly in line with the contractual planned activity.
It is also important to note that not only will the population that SECAmb services for 111 change from March 28th onwards (11 CCG's and not 17), but also the contractual metrics and KPI's will also change as the Trust migrates towards the reporting against the NHS E IUC Minimum Data Set (MDS) which has a far greater scope than the traditional 111 metrics.



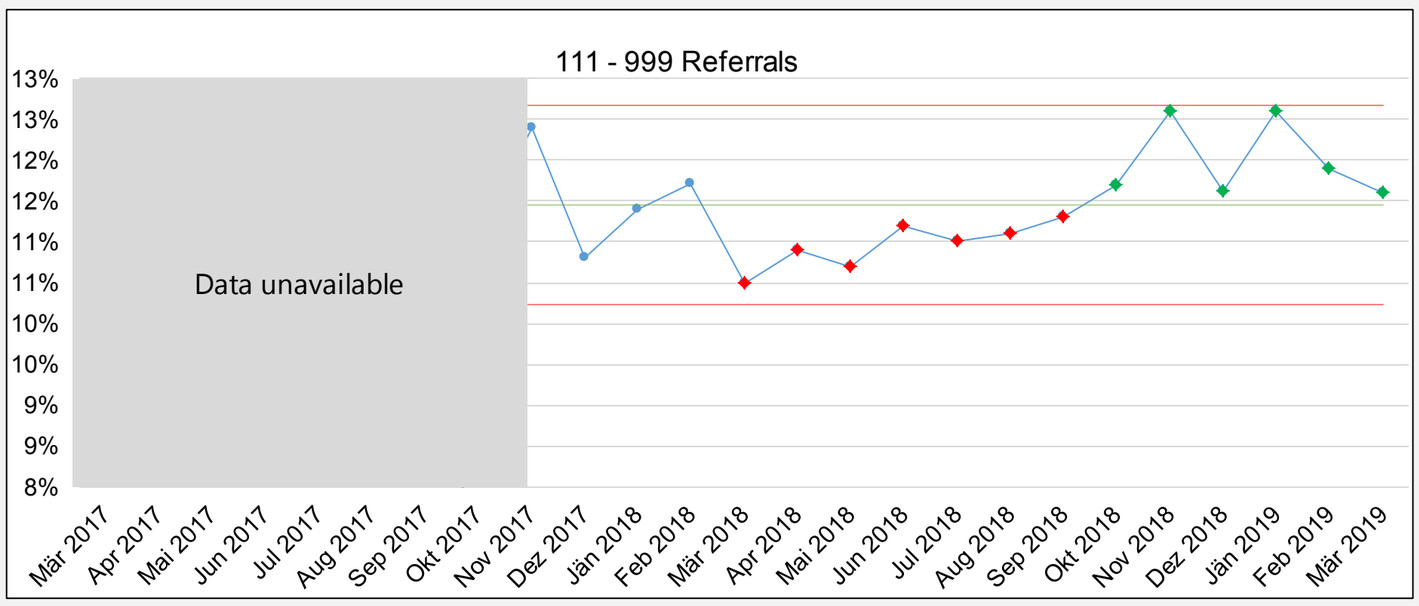
Despite the challenges of exiting the KMSS 111 contract and mobilising the new SEC 111 IUC contract, along with the introduction of a new telephony and host IT system, the service demonstrated a solid performance across the winter period (outperforming the NHS E national average for the intensely busy two festive weeks at Xmas) and recorded a marked increase in performance towards the end of the contract in March 2019. This performance for March of 83.6% was marginally behind the national average of 85%.



The service's call abandonment rate (a good indicator of risk) for March was 2.6% and this was significantly within the NHS E IUC national target of 5%. Despite the operational challenges in the first half of 2018/19, it is pleasing that in the second half of the financial year (when the service was under most pressure with winter pressures), KMSS 111 was able to demonstrate a good grip on call handling with an improving trajectory for the call abandonment rate.



The combined clinical KPI is a combination of immediate "warm transfer" to a clinician in-house or, a call back from a 111 NHS Pathways clinician within ten minutes. Over the last three years, KMSS 111 has consistently outperformed the NHS E national average and has on a monthly basis been in the top decile for national performance. This measure of clinical responsiveness is a widely acknowledged indicator of how a 111 service performs clinically. To provide context, the 64% achieved for March was 10% better than the NHS E 111 average.

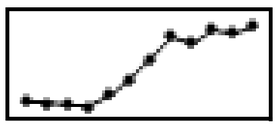
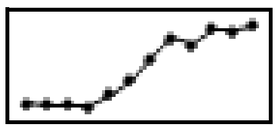
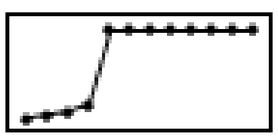
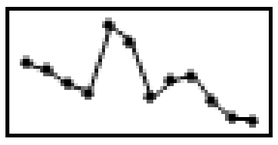


For the past three years, KMSS 111 has used its Clinical Inline Support (CIS) to target the validation of non emergency Cat 3 and 4 ambulances to protect SECAmb's 999 service and the wider emergency care system. Again in March (as with the majority of 2018/19), KMSS 111 achieved an ambulance referral rate of less than 12%, which was lower than the NHS E national average.
However, it is important to note that for the new SEC 111 IUC contract, the service will be measured on ambulance referrals with a different denominator and this will subsequently increase the % (but not overall number) of ambulance referrals.

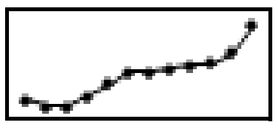
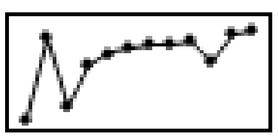
Our People

SECAmb Workforce Scorecard

Workforce Capacity

	Jan-19	Feb-19	Mar-19	12 Months
Number of Staff WTE (Excl bank & agency)	3415.9	3406.3	3436.0	
Number of Staff Headcount (Excl bank and agency)	3703	3695	3724	
Finance Establishment (WTE)	3837.50	3837.50	3837.50	
Vacancy Rate	10.99%	11.29%	11.29%	
Vacancy Rate Previous Year	13.40%	12.65%	12.82%	
Adjusted Vacancy Rate + Pipeline recruitment %	6.30%	5.56%	5.46%	

Workforce Compliance

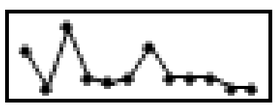
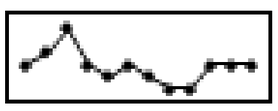
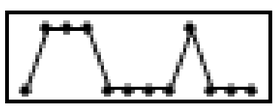
	Jan-19	Feb-19	Mar-19	12 Months
Objectives & Career Conversations %	55.19%	64.46%	89.57%	
Target (Objectives & Career Conversations)	80%	80%	80%	
Statutory & Mandatory Training Compliance %	61.63%	88.62%	93.58%	
Target (Stat & Mand Training)	95%	95%	95%	
Previous Year (Stat & Mand Training) %	79.12%	86.32%	93.24%	

* 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

	Jan-19	Feb-19	Mar-19	12 Months
Annual Rolling Turnover Rate %	14.06%	14.12%	14.07%	
Previous Year %	17.85%	17.74%	17.19%	
Annual Rolling Sickness Absence	4.92%	5.49%	5.00%	
Target (Annual Rolling Sickness)	5%	5%	5%	

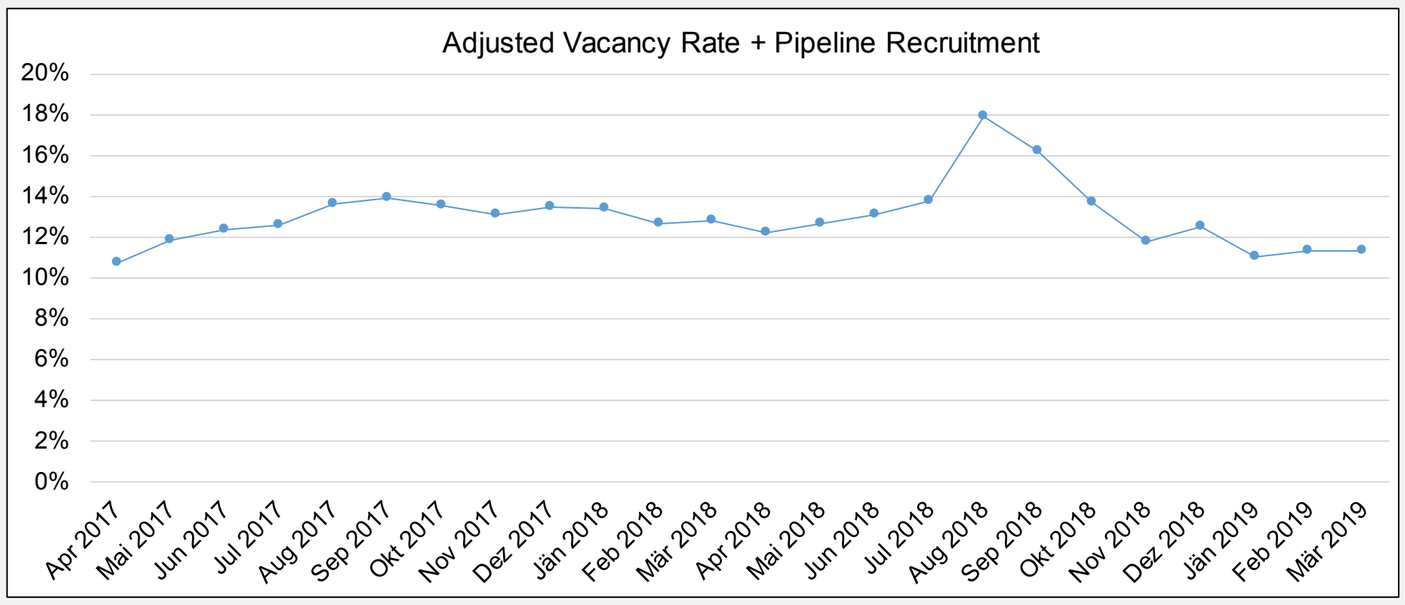
Employee Relations Cases

	Jan-19	Feb-19	Mar-19	12 Months
Disciplinary Cases	4	2	2	
Individual Grievances	9	9	9	
Collective Grievances	0	1	1	
Bullying & Harassment	2	2	2	
Bullying & Harassment Prev Yr	0	2	1	
Whistleblowing	0	0	0	
Whistleblowing Previous Year	0	1	0	

Physical Assaults (Number of victims)

	Jan-19	Feb-19	Mar-19	12 Months
Actual	18	22	18	
Previous Year	16	15	17	
Sanctions	3	4	3	

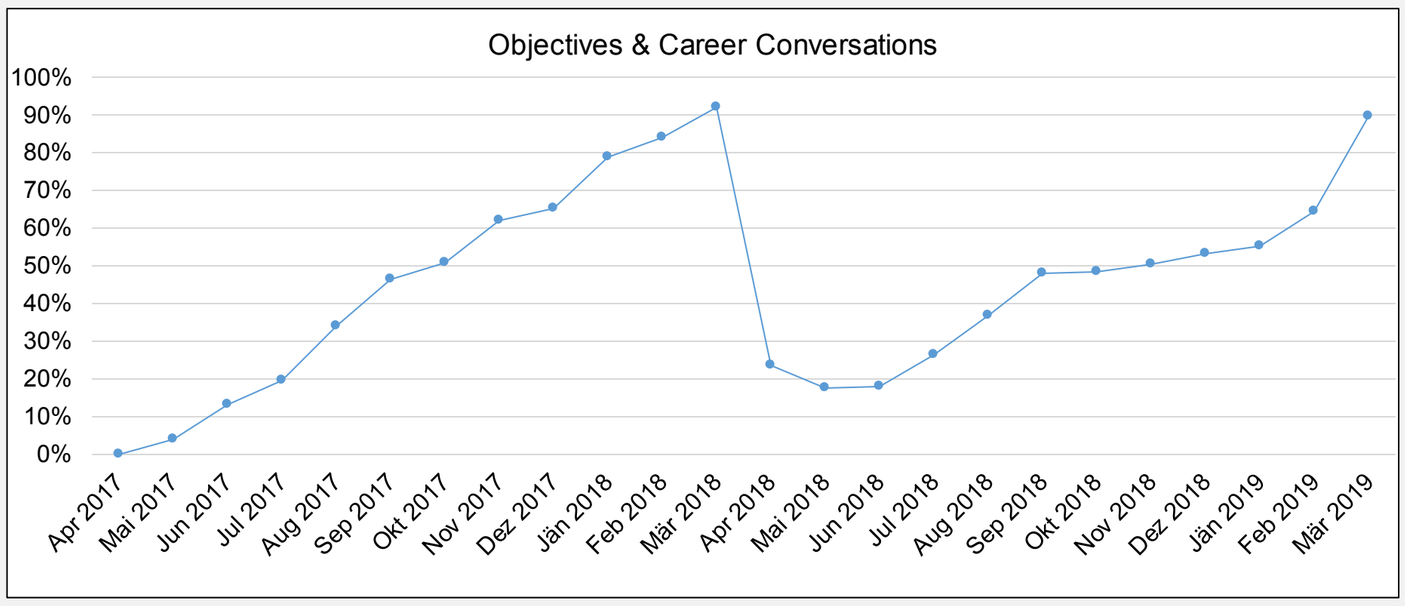
SECAmb Workforce Charts



In March we recruited 33 new staff into the Trust, this will increase in coming months based on ARP programme. Our adjusted vacancy rate decreased to 5.46%

Our pipeline for ECSW is on track with the STAD plan.

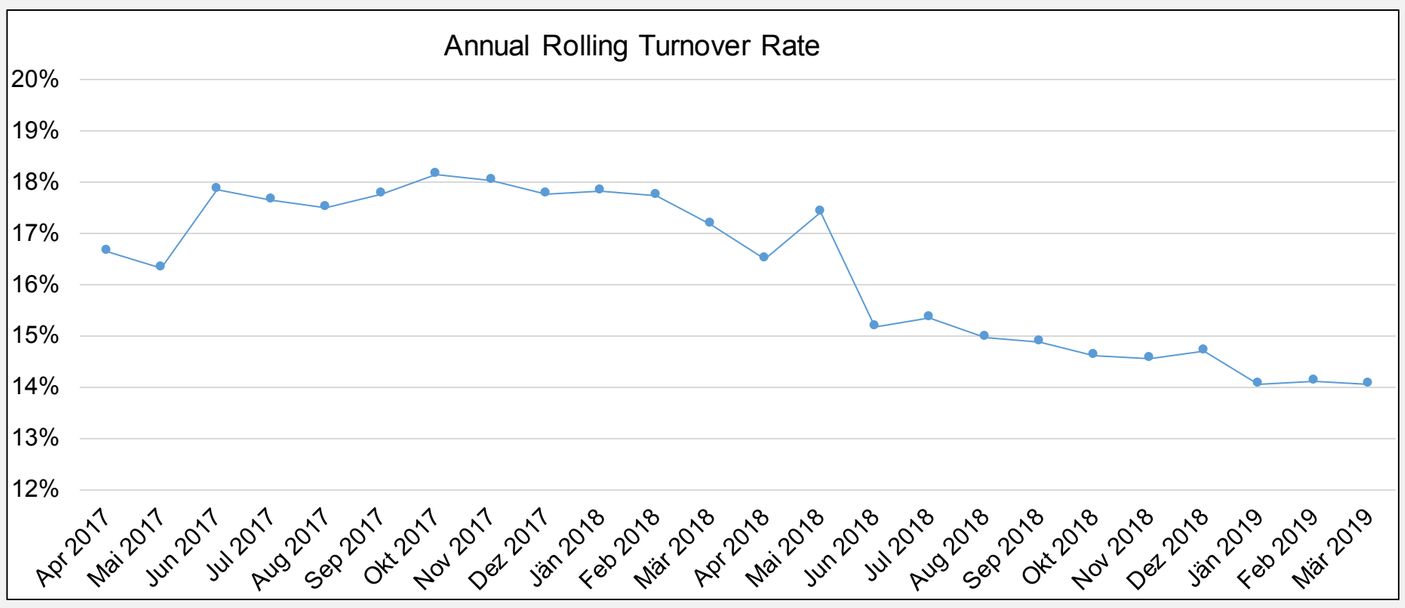
Our focus remains on 111 and EOC recruitment in order to meet the establishment requirements. We are also focusing our efforts on the international clinicians who are likely to join from July onwards in order to reduce the risk to Clinical governance in EOC.



The target for the appraisal year 2018-2019 was set at 80%. At the end of the appraisal period, March 2019 the final total reached was 90.21%.

The final calculations includes all published and in progress appraisal conversations.

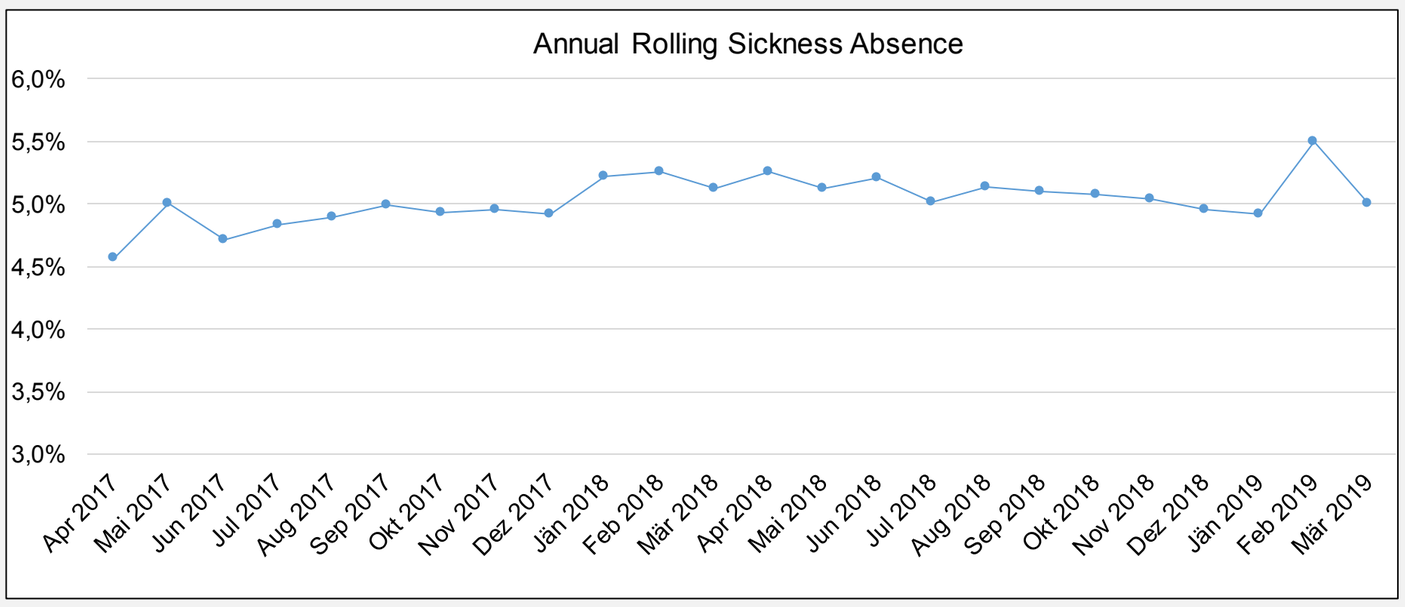
Exclusions were made from the final figures of bank staff, maternity staff, career breaks and all new starters after December 2017.



Following a period of continued downward trend on turnover we have reached a plateau for February, March and April at 14.1%. A paper has now been reviewed at WWC on Retention and Trends in the EOC with tangible actions to improve turnover.

EOC East Turnover for March 19 - 31.97% (By comparison EOC East for the same period last year was 26.12%)
EOC West Turnover for March 19 - 37.78% (By comparison EOC West for the same period last year was 43.86%)
111 Turnover for March 19 - 46.38% (By comparison 111 for the same period last year was 45.46%)

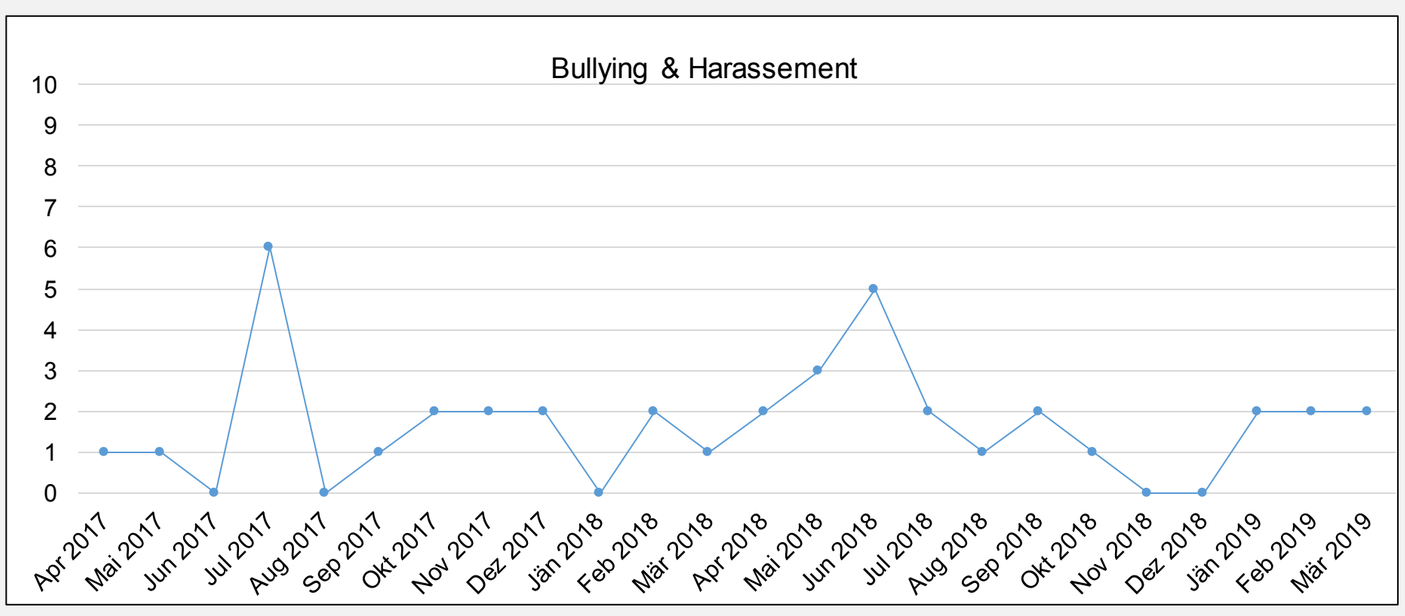
An updated paper on Exit Interview Data has been written for the HRD, and we are also looking specifically at Paramedic Exit Interview Data.



Sickness absence hit target again at 5.0% for April 2019

Across SECAMB the areas where we have more HR focus include Operations Directorate (5.23%), Ashford (5.96%), Guildford (5.72%), Polegate & Hastings (7.92%), EOC East (6.54%), EOC West (6.05%) and 111 (9.2%).

HR Advisors continue to focus heavily on Sickness Absence Management. Maybe now would be a good time to add a new stretch target of 4.0%.



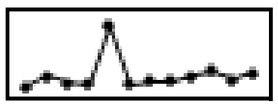
There were 2 reported cases of Bullying and Harassment (B&H) in April 19 with the rolling total no at 31 cases.

We are currently developing an overarching programme of work to ensure all our processes (to include areas such as induction and appraisal) and development for all our people is focussed on improving culture and specifically to reduce Bullying and Harassment.

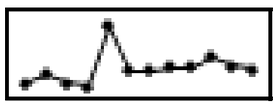
Our Enablers

SECAmb Finance Performance Scorecard

Income

	Jan-19	Feb-19	Mar-19	12 Months
Actual £	£ 20,428	£ 19,491	£ 22,057	
Previous Year £	£ 17,171	£ 16,810	£ 25,743	
Plan £	£ 18,741	£ 17,435	£ 18,583	

Expenditure

	Jan-19	Feb-19	Mar-19	12 Months
Actual £	£ 19,580	£ 19,762	£ 19,683	
Previous Year £	£ 16,404	£ 16,032	£ 22,806	
Plan £	£ 17,853	£ 17,709	£ 17,882	

Capital Expenditure

	Jan-19	Feb-19	Mar-19	12 Months
Actual £	£ 2,578	£ 2,663	£ 2,660	
Previous Year £	£ 285	£ 780	£ 3,190	
Plan £	£ 2,550	£ 2,600	£ 2,800	
Actual Cumulative £	£ 7,714	£ 10,377	£ 13,037	
Plan Cumulative £	£ 7,904	£ 10,504	£ 13,304	

Cost Improvement Programme (CIP)

	Jan-19	Feb-19	Mar-19	12 Months
Actual £	£ 872	£ 949	£ 1,786	
Previous Year £	£ 1,496	£ 1,380	£ 1,406	
Plan £	£ 947	£ 947	£ 1,801	
Actual Cumulative £	£ 8,665	£ 9,614	£ 11,401	
Plan Cumulative £	£ 8,663	£ 9,610	£ 11,411	

CQUIN (Quarterly)

	Q1 18/19	Q2 18/19	Q3 18/19
Actual £	£ 871	£ 870	£ 1,524
Previous Year £	£ 850	£ 846	£ 855
Plan £	£ 870	£ 870	£ 870

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

Surplus/(Deficit)

	Jan-19	Feb-19	Mar-19	12 Months
Actual £	£ 848	-£ 271	£ 2,374	
Actual YTD £	£ 284	£ 14	£ 2,388	
Plan £	£ 888	-£ 274	£ 701	
Plan YTD £	£ 280	£ 6	£ 707	

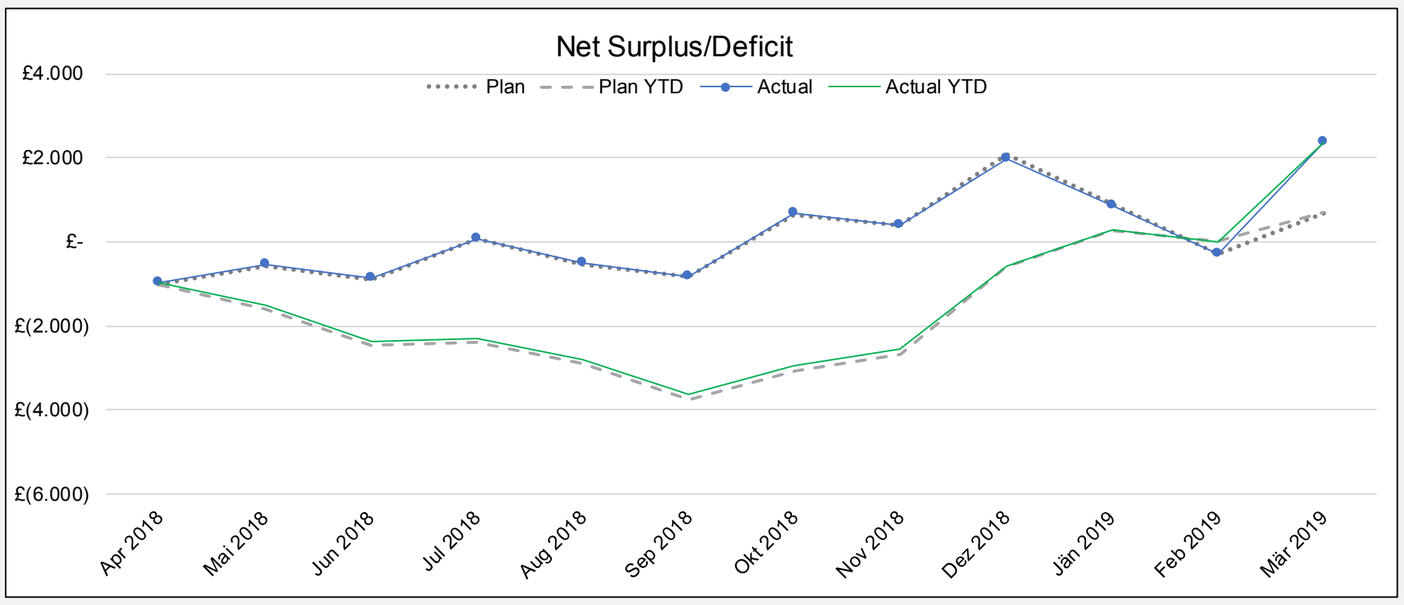
Cash Position

	Jan-19	Feb-19	Mar-19	12 Months
Actual £	£ 27,841	£ 27,481	£ 24,154	
Minimum £	£ 10,000	£ 10,000	£ 10,000	
Plan £	£ 16,019	£ 16,397	£ 17,794	

Agency Spend

	Jan-19	Feb-19	Mar-19	12 Months
Actual £	£ 363	£ 312	£ 457	
Plan £	£ 207	£ 204	£ 200	

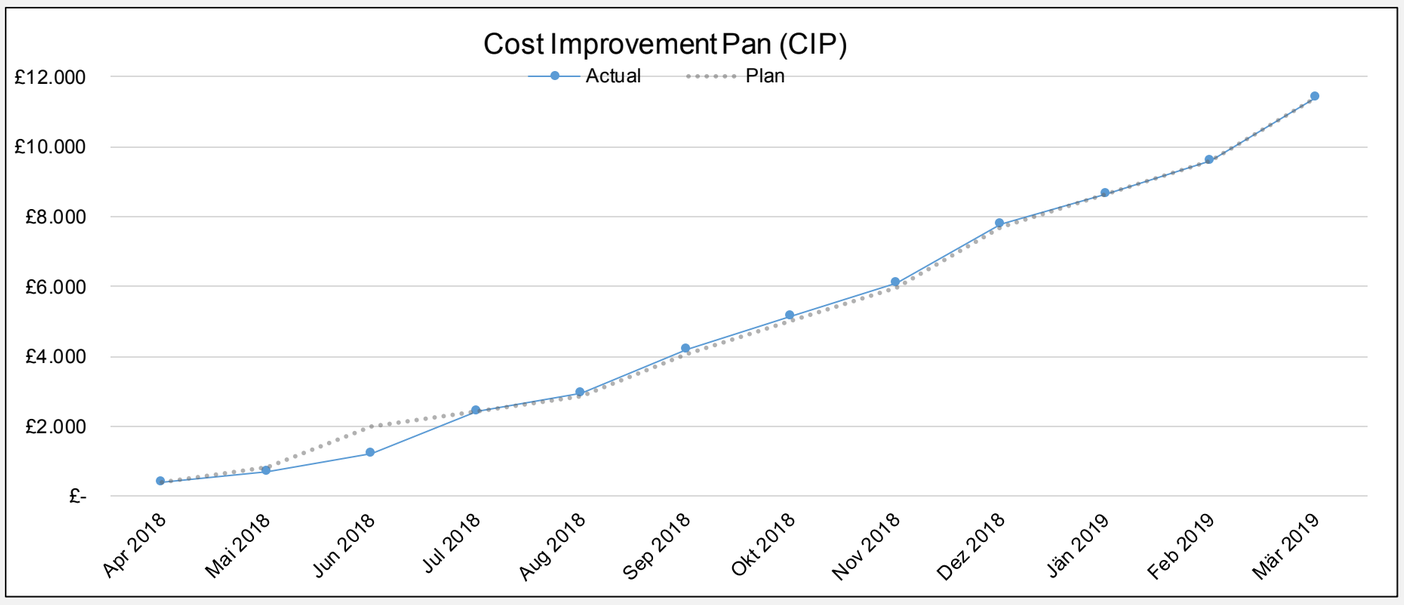
SECAmb Finance Performance Charts



The Trust's I&E position in Month 12 was a surplus of £2.4m, this is £1.7m better than plan.

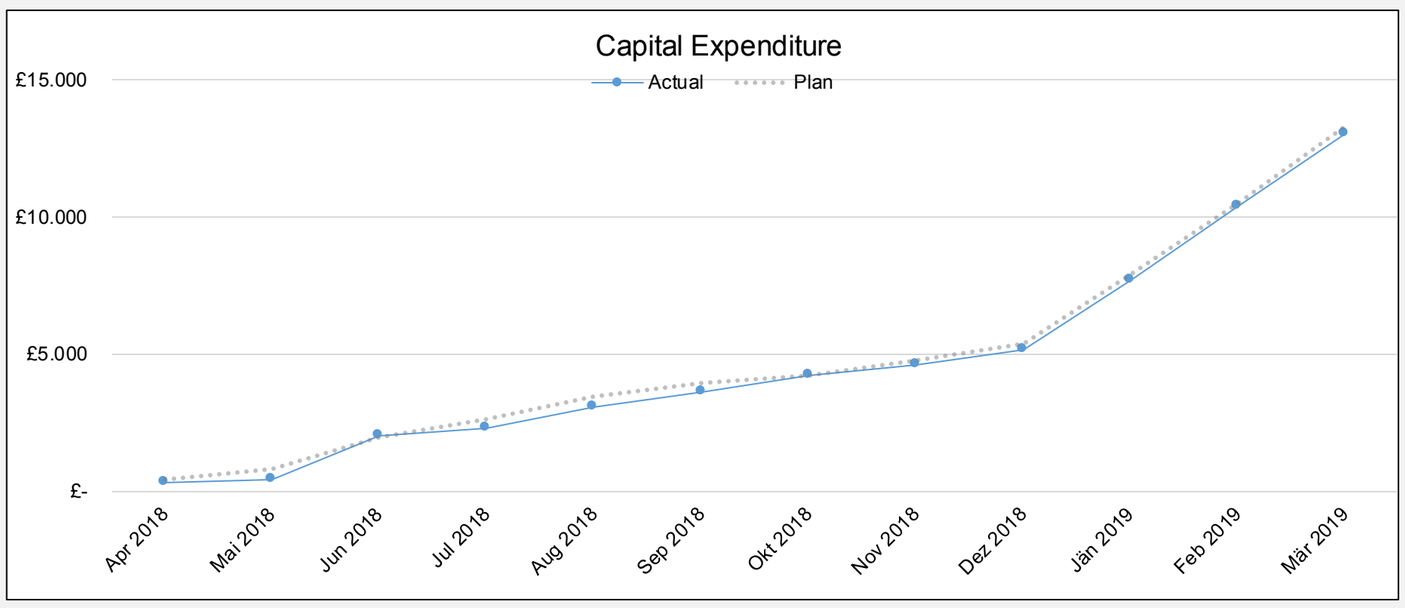
This includes the benefit of £1.7m of unplanned Provider Sustainability Funding (PSF).

This improved the cumulative position to a £2.4m surplus, which is £1.7m better than plan.



CIPs to the value of £1.8m were achieved in the month, as planned.

The full year CIP plan of £11.4m was achieved.

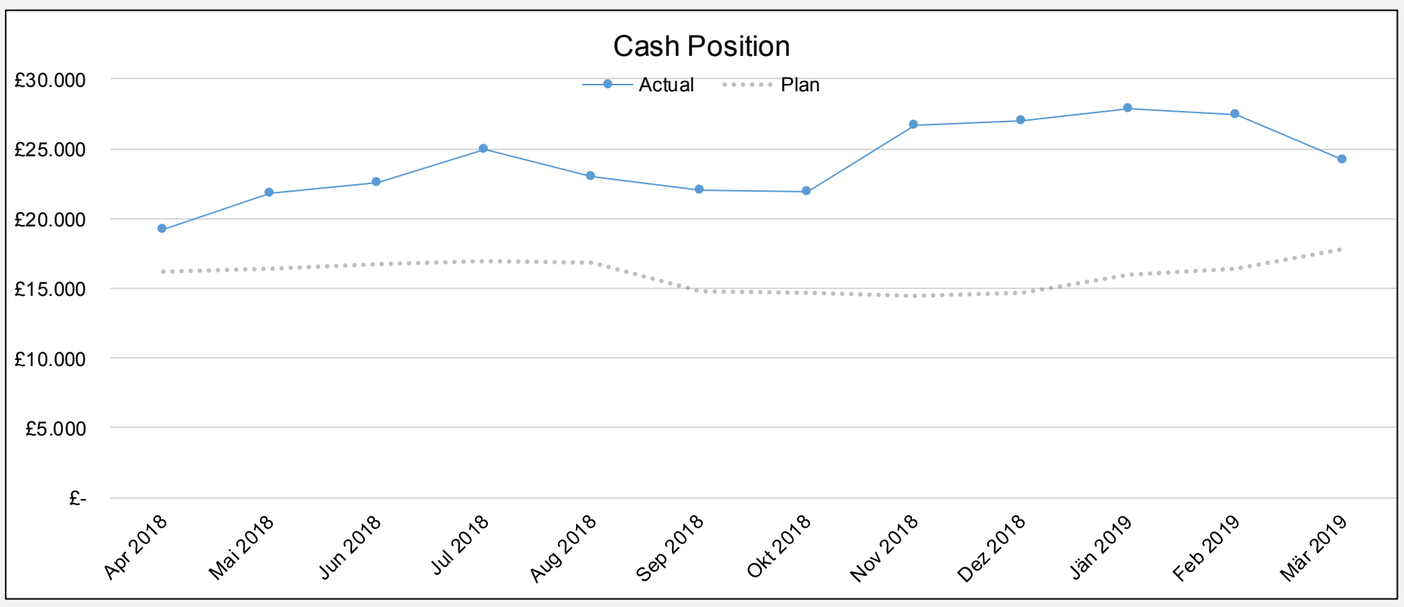


Capital expenditure in the month was £2.7m and full year spend was £13.0m, which was £0.3m below plan.

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 awarded for developments at the Crawley Headquarters. The Trust has been unsuccessful with a bid for new ambulances.

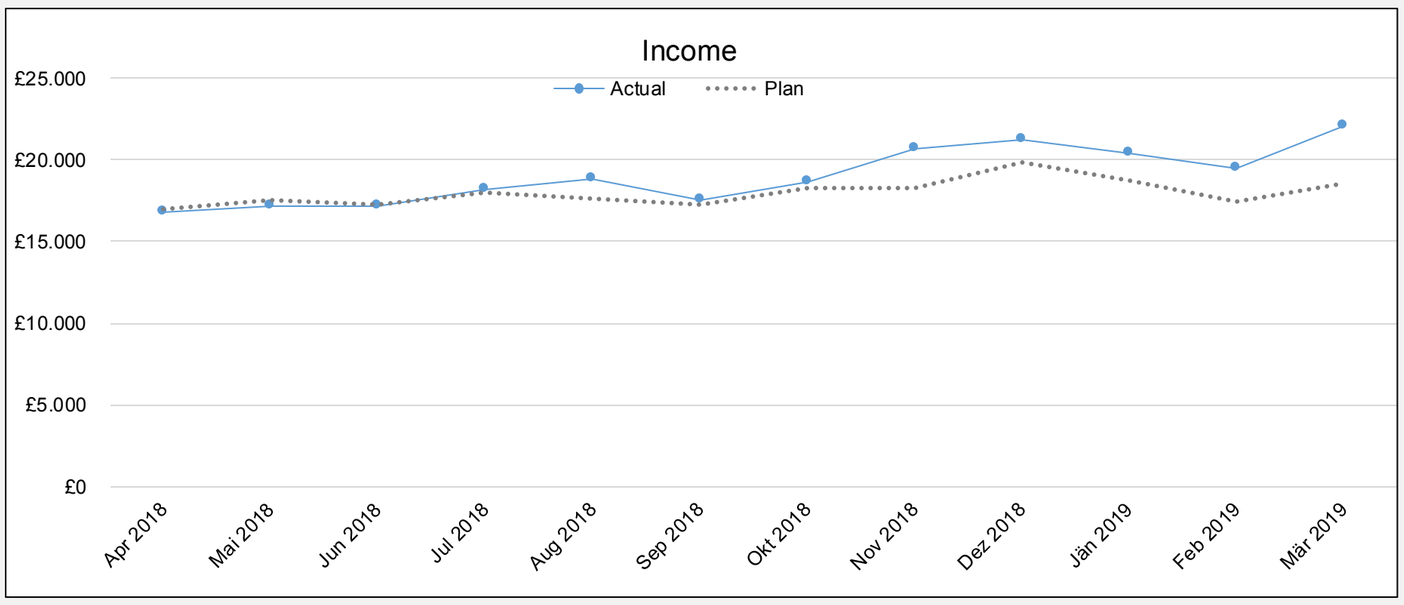
The above funding is subject to formal approval of a business case and recommendation to DHSC (Department of Health and Social Care) by NHSI.



The cash position at 31 March 2019 was £24.2m, which is £6.4m better than plan and £1.3m above the balance at 31 March 2018.

The Trust produces cash forecasts for a rolling three-year period. As an adjunct to planning for 2019/20 the Trust is will be developing a medium term financial projection, including a revised 5-year capital programme, which will inform cash requirements over that period. This will reflect the Trust's investment plans for the estate and frontline vehicles. The impact of the capital bids will be included once business cases have been fully approved.

Performance against the 'Better Payment Practice Code' for payment of suppliers improved in the month, to 97.8% by value, against a target of 95.0%.

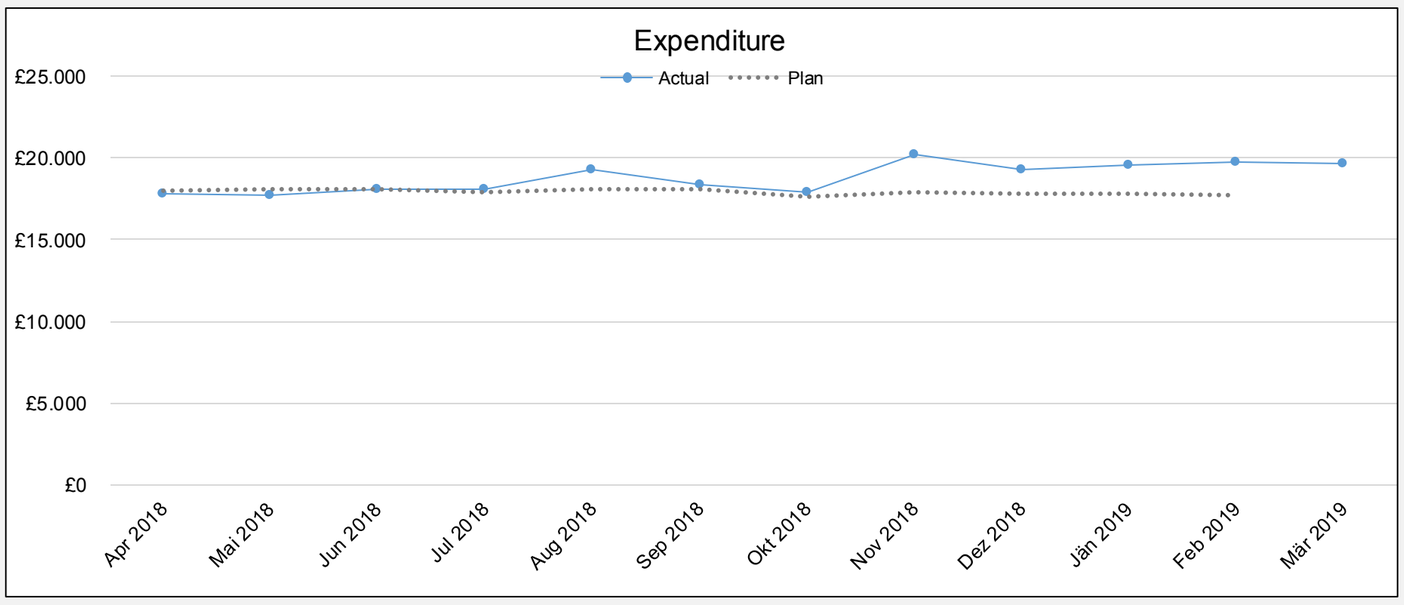


Total Income in the month was £22.1m, which was £3.5m better than plan. This resulted in a favourable variance against plan of £12.6m for the financial year.

The main reasons for the improvement in the month were the additional £1.7m of unplanned PSF and the recognition in the month of £0.8m from the £10.0m 999 contract variation following the successful conclusion of the Demand and Capacity Review with commissioners. This includes an additional £0.1m for the Helicopter Emergency Medical Service (HEMS). Also included in the income variance is central funding of £0.4m for the NHS pay deal.

The Trust has assumed full achievement of planned core PSF income in the year at £1.8m. 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 received.

SECAmb Finance Performance Charts



Total Expenditure exceeded plan by £1.8m in month and £10.8m for the year. This included costs funded from unplanned income referred to above.

Pay costs in the month were above plan by £1.1m, moving the cumulative position to a £5.6m overspend. The main reason for this is £0.5m of costs in respect of unsocial hours on annual leave, £0.4m impact of the new pay deal and £0.2m of additional costs for the 111 service.

Non-pay costs were £2.2m above plan in the month, bringing full year costs to £6.8m over plan. The main area of overspend in month was for additional provisions for holiday pay on overtime and accruals for estates minor works and fleet costs to support frontline resources.

Non-operating costs were £1.5m better than planned, mainly due to the profit on sale of Epsom Ambulance Station.

SECAMB Board

QPS Committee Escalation report to the Board

Date of meetings	04 April 2019
Overview of key issues/areas covered at the meeting:	This meeting considered a number of ***Management Responses*** (*response to previous items scrutinised by the committee)*, including: **Non-Register Clinicians Scope of Practice Assured** This management response clarified the scope of practice governance for non-registered clinicians. It is assured about the work completed to improve the clarity of the scope of practice for the various roles, including the career structure. The Committee requested that this is now communicated and shared so that the model and roles are well understood. As part of the item the committee explored the balance of workforce to deliver quality and safety. It noted the gap in paramedic numbers and the trajectory to deliver the appropriate registered/non-registered balance as part of STAD. This is directly linked to the 999 transformation programme and the committee is aware that recruitment is being closely scrutinised on behalf of the Board, by the Workforce and Wellbeing Committee. In the meantime the mitigation is the use of the targeted dispatch model utilising senior clinical staff in decision making. **999 NHS Pathways License – themes from SIs Partially Assured** This response arose from the committee seeking further assurance on how we follow up actions to ensure the necessary improvements are delivered. It noted the identified themes from SIs, including Sepsis which was the subject of a deep dive at the Morbidity and Mortality Group and will come to the committee in May. Overall the committee was assured by the process underpinning SI investigations, but only partially assured that actions are always properly followed up to deliver the desired impact. It has asked for further assurance on this for its meeting in June. **CFRs Assured** The paper provided a progress update on the developing CFR strategy, outlining the approach and timeframes. The committee noted that 150 new CFRs were appointed following the recent recruitment campaign, but 200 CFRs have not maintained compliance with certification (training requirements etc.) which is being followed up with the individuals concerned. The committee supported the steps to ensure CFRs undertake the necessary training, and asked management to take extra care to ensure there is clear messaging about this. The committee explored the spread of CFRs across the region, which is relatively even although there are some gaps such as in Ashford. The team will be using this data going forward as part of workforce planning. The committee was assured that there is now clarity about numbers of CFRs; ability to communicate with them; plot them by postcode; and ensure training is in place. The strategy aims to establish how best to use CFRs in future, e.g. Cat 3.

The committee asked that the scope of strategy should include the wider CFR support team. Also, that it has a section on how to establish a forum for CFRs to raise issues; at the moment this is a gap and as a consequence many issues come through the Council of Governors.

The CFR strategy is expected to come to the Board in July.

Kent & Sussex 111 Mobilisation **Partially Assured**
A verbal update was provided on the mobilisation of the emergency contract in Sussex and Kent. The committee acknowledged all the good work to ensure this was successful, especially given the short period of time the Trust had to mobilise. The committee explored some of the initial glitches with particular focus on one significant issue that had only just started to emerge at the time of the meeting relating to the closure of some calls. The Committee was confident that a full and thorough investigation was being urgently completed. It was in light of this issue that only partial assurance could be obtained.

More detail on this is provided in the Chief Executive's Board report.

The meeting also considered a number of ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas),* including;

EOC Clinical Safety **Partially Assured**
The committee undertook a very detailed review of the measures being taken to ensure clinical safety in the EOC, as part of the overarching programme of work. The EOC management team attended to present against their specific areas, including; clinical staffing, call handling, dispatch, and audit and training.

The presentations provided a good overview of the progress being made with the EOC improvement plan. The committee continued the discussion here on the issue of clinical capacity and the challenges in attracting clinicians in to the EOC. Despite the significant risk to achieving the target for clinical staffing, the committee noted that we continue to increase the provision of clinical hours. This linked to the discussion about clinical audit compliance, which is a challenge due to the lack of clinicians to undertake audits. This is being addressed through the related business case which is scheduled to come to the Board in May. In meantime, the committee challenged the executive to ensure there is at a minimum one audit per clinician per month, to ensure at least some review.

EOC was also subject to a recent Internal Audit, which the committee received and the actions arising from this are being integrated in to the existing improvement plan.

This area will remain a focus of the committee at every meeting, as reflected in the annual cycle of business.

Data Quality **Assured**
The Internal Audit report on data quality provided 'substantial assurance', and the committee reflected on how positive this is given where the Trust has been in recent

	years with data quality. **DBS Checks Not Assured** The committee received the Internal Audit report, which was an additional audit requested by management and helped to provide assurance that the audit data matched what management had understood. There is now a plan in place with a clear timeframe and the improvement plan is in 'intensive support'. Despite the specific internal control issues, the committee was assured with the mitigation to ensure patient safety, such as ensuring no staff are left unsupervised until a DBS check is in place. It has therefore referred this to the Workforce and Wellbeing Committee to oversee until the weaknesses in controls are rectified. The committee also received an update on the **Quality Account** which is progressing in line with the plan, and reviewed its **terms of reference** and the **committee annual plan**.
Any other matters the Committee wishes to escalate to the Board	None

SECAMB Board

QPS Committee Escalation report to the Board

Date of meetings	20 May 2019
Overview of key issues/areas covered at the meeting:	Ahead of the next meeting, when the committee will be receiving a detailed overview on the mobilisation of the interim 111 service in Kent and Sussex, a verbal update was provided on the system issue that occurred during the initial mobilisation period. An issue was discovered relating to the transfer of some calls to 999 being erroneously cancelled. The reason was quickly established and the corrective action resulted in there being no further recurrence. There has been a look back review of the calls potentially affected and two incidents have been assessed as possibly resulting in moderate harm. These are currently under investigation in line with the Trust's SI policy. The committee was assured by the speed with which this issue was identified and fixed as well as the openness with which it was declared and managed. Details are also included in the Chief Executive's Board report. This meeting considered a number of ***Management Responses*** (*response to previous items scrutinised by the committee)*, including: **Medical Equipment Assured** The committee asked for assurance at its meeting in February on the system in place to ensure the timely servicing of medical equipment. It explored then the reassurance that the committee had from manufacturers on extending the service dates. Management was asked to check with the manufacturers the servicing schedule/timelines. The paper received provided assurance. The committee also explored items that are not classed medical equipment, such as spinal boards, and the extent to which these are checked and recorded in a systematic way. Management will confirm next time what items should be included in an assurance schedule, what level of assurance is currently available and how these will be recorded as part of the new fleet management system. **Co-Responders Assured** At its meeting in February the committee was assured by the arrangements in place for Co-Responders. However, it sought further clarification on how management assured itself that the required DBS and vaccination requirements in the MOU were completed. The response set out the process which assured the committee. The meeting also considered a number of ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas),* including; **EOC Clinical Safety Partially Assured** The committee undertook a review of two specific aspects of the overarching EOC improvement plan;

1. Audit and Training – the committee noted that the solution to ensuring sustained compliance with both NHS Pathways and Manchester Triage audits required additional capacity. It noted that the related business case is on the Board agenda, having been recommended by the Finance & Investment Committee. In the meantime, the mitigation is ensuring cover by overtime and using clinicians on alternativee duties. The committee is really supportive of the business case (having previously escalated its concern to the Board), which will resolve this long-standing issue.
2. Clinical Capacity – as the Board is aware, ensuring optimal clinical capacity in the EOC remains a significant challenge and the committee explored the main schemes aimed at addressing this challenge. It heard about the EOC workshop held recently to review all (new) ideas to unblock some of the issues. The ideas being considered for trialling include:

    - GPs working within the EOC
    - Expanding the role of Midwives & mental health clinicians
    - Expanding the use of agency staff for certain functions, e.g. welfare calls.
    - Recruitment and retention premium, subject to business case

The committee also explored one of the impacts of sub-optimal clinical capacity on the ability to task ECSW crews; who cannot attend patients without a clinical assessment. The targeted dispatch model running w/c 20 May seeks to review how to utilise such resources more efficiently.

This will be a standing item for the committee in the context of patient impact and it will look to the Workforce & Wellbeing Committee to scrutinise the recruitment trajectory.

In summary, it is a complex set of challenges and so there is a good degree of comfort that management are exploring a number of initiatives, recognising there is no one single answer.

The committee acknowledged the great work of the staff in EOC and wanted to reinforce that these challenges are not a reflection on them; but ensuring there is sufficient resources to provide timely, safe and effective care.

Clinical Outcomes Assured

This item focussed on Sepsis care following a recommendation in a previous QPS paper on SIs that sepsis should be a topic for a 'deep dive'.. The paper set out the steps to identify sepsis patients at the earliest stage, and the outputs of a recent deep dive by the Morbidity & Mortality Group , which identified the following themes that are emerging:

- Recognition of 'red flags' for sepsis/immediately life-threatening concerns by Emergency Medical Advisors (EMA)
- Adherence to the manual upgrade of incident priority process
- Missed opportunities to re-triage
- Surge levels affecting response times
- Clinical staff using NEWS2 scoring and following sepsis guidelines

A recent audit shows that the Trust is consistently above the national average in

	recognition and management of sepsis (care bundle). The committee welcomed the very informative paper, which demonstrated a large number of comprehensive actions that have been taken to address issues identified. The Committee also welcomed the good links with other providers to ensure the whole care pathway is considered. **CFRs Partially Assured** A paper was received which addresses concerns about how we are approaching CFRs who are not compliant with specific requirements, such as training. The committee acknowledged that this has caused some confusion and ill-feeling, but was assured that a proper process has been followed. The committee tested the mechanisms in place now to ensure timely and effective communication with CFRs, for example, how we got important messages through if an urgent issue arose. Management confirmed some of the things in place, which includes having a database for every CFR; email addresses; and meetings led by the new head of community engagement. The Chief Pharmacist also confirmed that with regards medicines, we can now link pouches to individuals. The committee was assured with the progress being made and supported the need to ensure CFRs are up to date and that the governance is strong. It wasn't completely convinced on some aspects of communication and so following the strategy due in July, it asked for confirmation that we can communicate urgent messages quickly enough and that there is in place an effective communication and engagement approach for CFRs. This important area of further work resulted in the overall partial assurance. The committee also received a number of reports under its section on *Monitoring Performance*: **Infection Prevention & Control Annual Report** This is a positive report, which reflects the improving picture in line with the strategy. However, the committee did challenge on the area of vehicle cleanliness, as it felt the report could include more detail on actions given some of the current gaps identified. The committee was acutely aware of this given the scrutiny provided earlier in the year. The Committee will continue to review progress on vehicle cleanliness. Overall, however, the committee is really pleased with progress and reflected how far we've come in the past three years when this area was led by just one person. Now there is a team of five supported by a number of IPC champions. The committee commends this report to the Board. **Complaints Annual Report** This report highlights the great improvement in response times, and how we learn from complaints. Although there is still work to do, the journey this year in how the complaints team triangulates with other areas was noted. The committee discussed whether we approached the allocation of complaints fairly,

	as potentially a disproportionate number relating to delays are allocated to the EOC. The committee challenged whether all these complaints actually relate to an EOC issue. The committee also thought the report could include more on the range of actions that have been undertaken in response to complaints; to better reflect the positive impact. The committee commends this report to the Board. **Clinical Audit Annual Report** The clinical audit report was well received; it set out the completion of the full plan which despite some risks during the year was completed in full with the addition of some extra audits. The focus next year will be on how actions can improve survival rates. The Committee was delighted to see the amount of progress made in the area of clinical audit and suggested that more could be done to share the results and celebrate success. The committee explored the opportunity to do joint audits with other providers, e.g. in Stroke and STEMI. **Quality Account** A full review of the Quality Report & Account was undertaken and there was some relatively minor suggested additions / amendments, which will be confirmed at the Board meeting, as part of a 'change sheet'. Overall, there are no surprises and the committee felt it was consistent with the work of the committee during the year, reflecting an open and honest summary.
Any other matters the Committee wishes to escalate to the Board	The committee undertook a detailed review of the issues arising from the paper on the Board agenda, relating to **non-parenteral prescription only medicines** (POMs) by clinicians (registered healthcare professionals, non-registered clinicians) and volunteers. The paper is quite technical, but in summary, it asks the Board to make a decision on whether to allow non-registered clinicians and CFRs to administer non-parenteral prescription only medicines – specifically salbutamol and ipratropium. The Medical Director confirmed that the view of clinical leaders within the ambulance service is that these medicines should be provided given the clear clinical need, and in the context of the governance arrangements being in place, as set out. In the meantime, there is a call for a decision to be made centrally at some point to clarify the discrepancy. The Director of Nursing and Quality supported this, but agreed to approach the CQC, NHSI and the CCG to first seek their views.

	In consideration of the recommendation from the Medical Director and Chief Pharmacist, the committee concluded the following: • These are low-risk medicines and the risk to patients of not being able to use them outweighs the risk of using them in a way that might contravene the law, as it could be interpreted. Therefore, • Registered healthcare professionals and non-registered clinicians should be able to continue to administer Ipratropium bromide and Salbutamol in accordance with national JRCALC guidelines, despite being a prescription only medicine. The Chief Pharmacist confirms that this is the position adopted by every other trust in the England. • However, in relation to CFRs and Immediate Emergency Care Responders, we do not have confirmation, but it appears that if we would allow these groups to administer Salbutamol as per clinical protocol in Appendix B (despite being a prescription only medicine and no legal framework to administer this medication) then we would certainly be in the minority. Those Trusts that do allow this are in the process of reviewing the position. Therefore, • The committee suggests that if the Board decided to approve this aspect, then it should be introduced in a phased way, using the learning from the planned audits of registered and non-registered clinicians, and review of asthma presentations over the intervening period. In other words, to proceed with some caution until further clarity emerges nationally.

South East Coast Ambulance Service NHS Foundation Trust

		Agenda No	12-19
Name of meeting	Board		
Date	23 May 2019		
Name of paper	Complaints and Compliments Annual Report 2018/19		
Responsible Executive	Bethan Haskins Executive Director of Nursing		
Report Author	Judith Ward Deputy Director of Nursing		

The report sets out key achievements and compliance with legislation throughout 2018/19.

- 95% of complaints were responded to within the Trust's agreed timescale of 25 working days.
- Robust internal monitoring process which includes a weekly open complaints report providing a clear position of current complaints under investigation to directors, senior managers and investigating managers.

Key points:

- During 2018-19 the Trust received 1,846 compliments, slightly more than the 1,688 received in 2017/18, thanking our staff for the treatment and care that they provided.
- During 2018/19 the Trust received one complaint for every 2,604 patient interactions, meaning that 0.099% of all calls / journeys attracted a complaint.
- In the year 2018/2019 the PHSO contacted the Trust and asked for copies of 14 complaint files, four cases have been investigated so far, none of which have been upheld. The other 10 cases are still with the PHSO being reviewed.

Future areas of development are outlined in the report

Action Required	For information

Compliments and complaints Annual Report 2018/19

Contents

Introduction

South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to ensuring that our patients receive an excellent standard of care whenever they use its services, and that when our patients or their representatives wish to compliment, complain or provide other feedback to us about their experience, they have every opportunity to do so. Compliments and complaints help the Trust to identify what we are doing well and areas where improvements to quality and services can be made.

The Trust uses its website to promote our feedback / complaint process and contacts. We also monitor NHS Choices and Care Opinion as additional sources of feedback.

There have been some significant improvements during the last year following the recruitment of a full Patient Experience Team and changes in various in-house processes and these are reflected in the vast improvement of the response time for our complaints.

The number of compliments received by the Trust in 2018/2019 has increased by just under 10% and the number of complaints has also decreased by just over 15%. Within the overall drop in received complaints is a fall in the number of complaints received about ambulance delays 2018/2019 252 against 350 in 2017/2018 a fall of 28%.

Key Achievements

- 95% of complaints were responded to within the Trust's agreed timescale of 25 working days.
- Robust internal monitoring process which includes a weekly open complaints report providing a clear position of current complaints under investigation to directors, senior managers and investigating managers.

Compliments

Each year the compliments received by the Trust, thanking our staff for the work that they do, far outnumber complaints. Compliments are recorded on the Trust Datix database, alongside complaints, so that both the positive and negative feedback is captured and reported back to operational staff. The staff concerned receive a letter from the Chief Executive, in recognition of the dedication and care that they provide to our patients.

During 2018-19 the Trust received 1,846 compliments, slightly more than the 1,688 received in 2017/18, thanking our staff for the treatment and care that they provided.

Table 1 Compliments by service/operating (OU) area and month:

	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Total
Ashford OU	6	15	4	10	9	17	11	19	11	13	11	3	129
Brighton and Mid Sussex OU	11	7	9	14	22	16	11	15	13	16	15	13	162
Chertsey OU	9	8	9	16	8	9	9	13	10	4	11	6	112
Gatwick and Redhill OU	22	17	17	26	23	28	18	15	26	24	15	23	254
Guildford OU	9	9	8	9	15	14	12	12	13	20	10	19	150
HART	0	0	0	1	0	0	1	0	0	0	0	0	2
Medway and Dartford OU	24	23	14	26	28	11	26	22	15	27	26	22	264
Paddock Wood OU	11	13	13	14	13	9	5	12	12	14	10	10	136
Polegate and Hastings OU	14	11	13	9	12	6	14	14	19	14	15	21	162
Tangmere and Worthing OU	16	19	24	29	32	18	19	13	15	25	15	14	239
Thanet OU	12	12	21	19	23	23	10	19	18	20	16	13	206
East EOC	1	0	0	0	0	0	0	1	0	0	0	0	2
West EOC	2	0	0	1	1	0	0	1	2	0	1	1	9
Ashford 111 Centre	2	0	2	4	2	0	3	0	1	1	0	0	15
Dorking 111 Centre	0	1	0	0	0	0	0	0	1	2	0	0	4
Total	139	135	134	178	188	151	139	156	156	180	145	145	1846

Compliments provide a welcome boost for our staff, in previous years there have been no guidelines regarding the time taken for the Trust to process compliments. This has led to crews not receiving their much-deserved recognition in a timely manner. Although there is no statutory requirement for compliments to be processed within a defined period the importance of processing these has been recognised and an internal restructure is now taking place to ensure that compliments are dealt with within five working days of receipt.

The 1,846 compliments received during 2018/2019 represent one compliment for every 1,423 interactions.

Some examples of the compliments that the Trust received are below:

"The Patients Neighbour wants to thank the crews who attended for being extremely professional and for doing everything they could to the Patient. They also wanted to thank the EMA, who took

his 999 call, for talking him through CPR. He went on to say he knew what he was doing but it was great to have a voice on the end of the phone talking them through it."

"A GP called to compliment on a patient's behalf and to commend the paramedic that attended the patient, who by assessing with an ECG was able to diagnose Postural Orthostatic Tachycardia syndrome. On arrival at hospital this was found to be clinically diagnosed accurately and patient has now has beta blockers."

"Please pass my thanks to the ambulance crew that attended my mother after a fall. They were courteous efficient, friendly & extremely helpful. My mother felt relaxed with them, they spent a long time with her. Thankfully there were no injuries, and she was ok the following morning. Once again very many thanks for very professional and efficient operation."

"Head teacher had taken some pupils on a field trip, one of the pupils required an ambulance. The head teacher would like to thank the ambulance crew for their caring, professionalism and go the extra mile to ensure not only the patient and his father were okay but also the other pupils were not upset or distressed by the incident."

Complaints

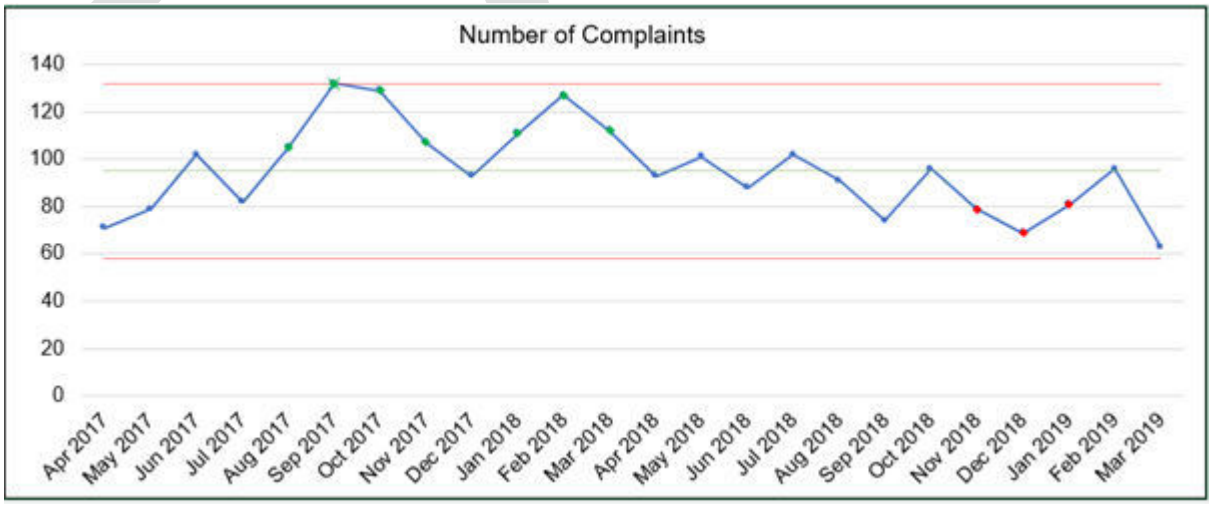
Statistics:

During 2018/19:

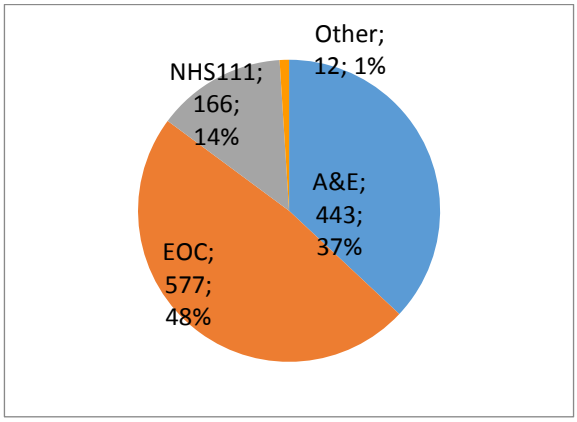
- Our Emergency Operations Centre staff took 853,067 calls.
- Our A&E road staff made 677,237 responses to patients.
- Our NHS 111 staff took 1,097,530 calls.
- SECAmb received 1,009 complaints.

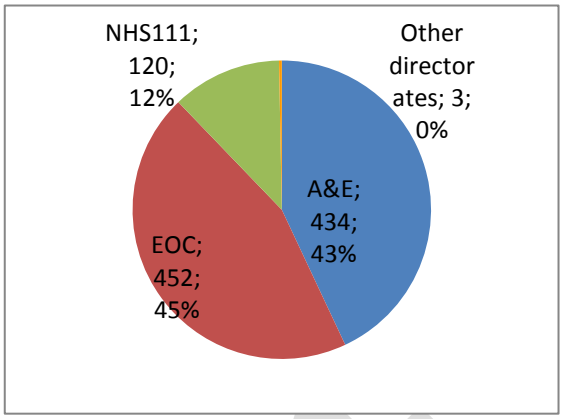
This equates to one complaint for every 2,604 patient interactions, meaning that 0.099% of all calls / journeys attracted a complaint. Detailed below is a comparison between the complaints received in the past two years which shows a slight reduction in 2018/19 against 2017/18.

SECAmb complaints over the past two years:



17/18: 1,198 **18/19: 1,009**





Complaints by service/operating (OU) area and month:

	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Total
Ashford OU	5	9	6	3	2	5	7	5	5	6	5	4	62
Brighton and Mid Sussex OU	6	8	7	3	8	0	4	4	7	5	3	1	56
Chertsey OU	7	4	4	5	3	4	7	1	3	3	6	5	52
Gatwick and Redhill OU	8	1	11	8	9	5	7	9	9	5	8	6	86
Guildford OU	2	5	5	7	1	4	6	5	3	3	6	7	54
Medway and Dartford OU	9	9	9	7	5	6	3	4	9	13	4	4	82
Paddock Wood OU	5	7	4	5	1	4	8	7	4	4	5	3	57
Polegate and Hastings OU	10	7	8	10	7	5	6	5	3	5	12	4	82
Tangmere and Worthing OU	5	10	5	7	5	5	8	9	3	7	2	6	72
Thanet OU	2	4	5	12	8	7	7	5	8	6	7	9	80
HART	0	1	0	0	0	0	0	0	0	0	0	0	1
East EOC	4	8	5	4	10	5	10	7	5	12	9	4	83
West EOC	5	6	7	19	14	8	14	5	3	13	12	9	115
EOC Clinical	1	0	0	0	0	0	0	0	0	1	0	0	2
Ashford 111 Centre	12	9	4	5	6	10	5	8	7	7	15	3	91
Dorking 111 Centre	5	5	3	7	5	0	3	0	0	2	0	0	30
Private Ambulance Provider	0	0	0	0	0	0	0	0	1	0	0	0	1
Other directorates	0	0	0	1	0	1	0	0	1	0	0	0	3
Total	86	93	83	103	84	69	95	74	71	92	94	65	1009

Complaints are reviewed and graded according to their apparent seriousness, this ensures that they are investigated proportionately. These are:

- Level 1 - complaints that can be dealt with by the Patient Experience Team as they already hold the information necessary to respond to the complaint or can easily obtain it without sending the complaint to anyone else for investigation. These are normally registered as concerns, what would be considered as PALS issues in other Trust's.
- Level 2 – a complaint that appears to be straightforward, with no serious consequences for the patient / complainant, but which needs to be sent to a manager for the service area concerned to investigate.
- Level 3 – a complaint which is considered to be serious, having had clinical implications or a physical or distressing impact on the patient / complainant, or to be of a very complex nature.
- Level 4 - any complaint which is later classified as a Serious Incident (SI). T Once a decision has been taken by the Serious Incident Group to declare a serious incident the complaint is then passed to the SI Team for an investigation to be carried out. Once this has been completed a copy of their report is passed back to PET to send under a covering letter from the Chief Executive and the complaint is closed in the normal way.

The majority of complaints of complaints received in 2018/19 were graded as level 2, 869 (86%), with the remaining 140 (14%) as level 3.

Complaints are categorised into subjects and can be further distinguished by sub-subject if required.

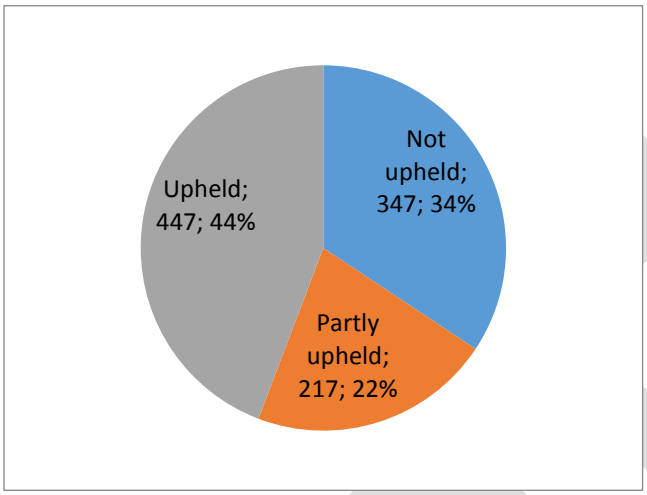
Complaints received during 2018-19 by subject and service area

	A&E	EOC	NHS111	Other directorates	Total
Administration	4	8	15	1	28
Communication issues	3	14	2	0	19
Concern about staff	275	19	22	0	316
History marking issue	2	0	0	1	3
Miscellaneous	3	1	0	1	5
Patient care	144	158	71	0	373
Timeliness	3	252	10	0	265
Total	434	452	120	3	1009

When a complaint is concluded, the investigating manager, with input from the Patient Experience Team where necessary, assesses whether the complaint should be upheld, partly upheld or not upheld based on the findings of their investigation. During 2018/19 there were 1009 responded to.

Of these complaints, 66% were found to be upheld or partly upheld. If a complaint is received which relates to one specific issue, and substantive evidence is found to support the allegation made, the complaint is recorded as 'upheld'. If a complaint is made regarding more than one issue, and one or more of these issues are upheld, the complaint is recorded as 'partially upheld'. The outcome from complaints is shown in the figure below:

Complaints by outcome, 2018/19



During 2018/19 95% of complaints were responded to within the Trust's timescale, compared to 65% in 2017/18. The agreed timescale within the procedure is for 90% of complaints to be responded to within 25 working days.

Complaints by service area: A&E field ops

The table below shows the A&E field ops complaints by subject. The two main themes of complaints about emergency field ops are, as in previous years, "Concern about staff" (which includes complaints about the standard of driving), 275 (63%), and "Patient care", 144 (33%).

	Administration	Communication issues	Concern about staff	History marking issue	Miscellaneous	Patient care	Timeliness	Total
Ashford OU	1	0	22	0	0	14	0	37
Brighton and Mid Sussex OU	1	1	22	0	1	15	0	40
Chertsey OU	0	0	20	0	0	11	0	31
Gatwick and Redhill OU	0	1	36	2	2	10	0	51
Guildford OU	1	0	19	0	0	13	1	34
HART	0	0	1	0	0	0	0	1
Medway and Dartford OU	0	0	31	0	0	17	0	48
Paddock Wood OU	0	0	27	0	0	12	0	39
Polegate and Hastings OU	0	1	29	0	0	23	0	53

	Administration	Communication issues	Concern about staff	History marking issue	Miscellaneous	Patient care	Timeliness	Total
Tangmere and Worthing OU	0	0	35	0	0	12	2	49
Thanet OU	1	0	33	0	0	17	0	51
Total	4	3	275	2	3	144	3	434

Concern about staff:

Concerns regarding staff feature as one of the top five themes of complaints within the NHS. (For the Trust this includes the standard of driving for which there were 39 complaints included in the theme).

The overall 275 complaints the Trust received regarding concerns about A&E road staff in 2018/19 shows an overall increase over 2017/18 when we received 226. Of those received in 2018/19, 54% (149) were upheld or partly upheld, compared to 50% in 2017/18.

Patient Care:

Complaints about patient care are divided into sub-subjects, which include:

- Crew diagnosis
- Equipment issues
- Inappropriate treatment
- Patient injury
- Patient made to walk
- Patient not conveyed to hospital
- Privacy and dignity
- Skill mix of crew

In 2018/19 we received 144 complaints specifically about the care provided by our road staff and an additional 43 complaints where “Patient care” was a secondary concern i.e. initial complaint regarding timeliness and concerns raised regarding care provided by the crew once on scene, a total of 187 complaints. Of which 108 (58%) were upheld or partly upheld, compared to 170 in 2017/18 of which 51% were upheld or partly upheld.

69 complaints were received in relation to inappropriate treatment 48%, with 33 (44%) of those upheld or partly upheld.

Forty-nine complaints were received about patients not having been conveyed to hospital, of these 35 (72%) were upheld / partly upheld.

Crew diagnosis, which is sometimes used interchangeably with non-conveyance, though not all misdiagnoses resulted in non-conveyance accounted for 35 complaints of which 20 (57%) were either upheld / partly upheld.

Complaints by service area: Emergency Operations Centres (EOCs)

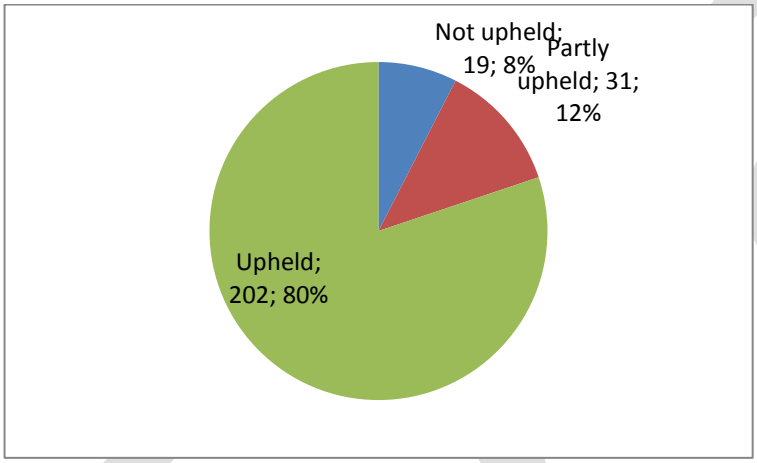
Complaints received regarding the Trust EOC’s have reduced from 577 in 2017/18 to 452 in 2018/19, a reduction of 125 (21%).

The figure below shows the EOC complaints by subject. The two main themes of complaints about the Trust EOC's are, as in previous years, "Timeliness" 252 (56%) and "Patient care" 158 (35%).

	Administration	Communication issues	Concern about staff	Miscellaneous	Call triage	Timeliness	Total
East EOC	1	6	11	0	68	108	194
West EOC	7	8	8	1	90	144	258
Total	8	14	19	1	158	252	452

Timeliness:

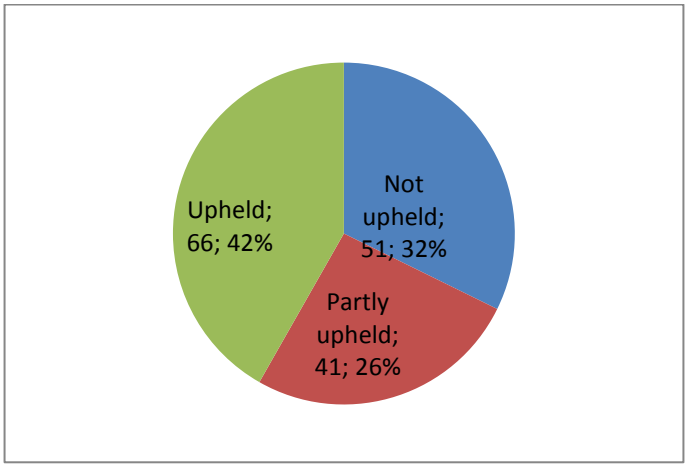
By far the highest number of complaints that were received regarding the EOC's were timeliness, 252, with 233 (92%) found to be upheld or partly upheld. Timeliness complaints are when the Trust does not achieve its target response times, when this is confirmed the complaint is always found to be upheld.



Call triage:

Call triage formed the next highest number of complaints with 158 complaints received with 107 (68%) being upheld in some part. These complaints were in the main the result of human error, with staff not correctly following the triage process:

- selecting the wrong pathway
- insufficient probing
- insufficient explanation
- EMA not deferring to clinician
- clinical supervisor not using NHS Pathways to reinforce their clinical decision
- not following policy correctly
- issue with NHS Pathways itself.

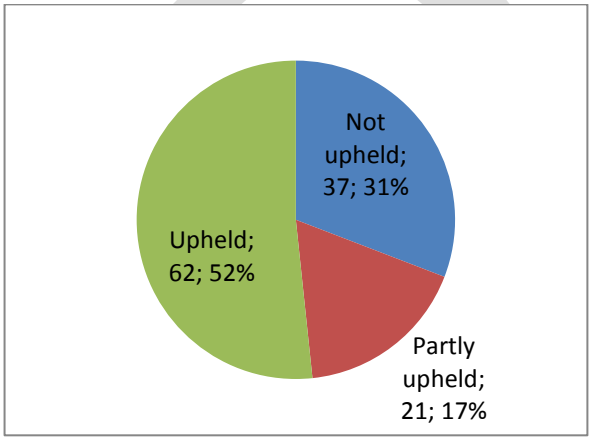


Complaints by service area: NHS111

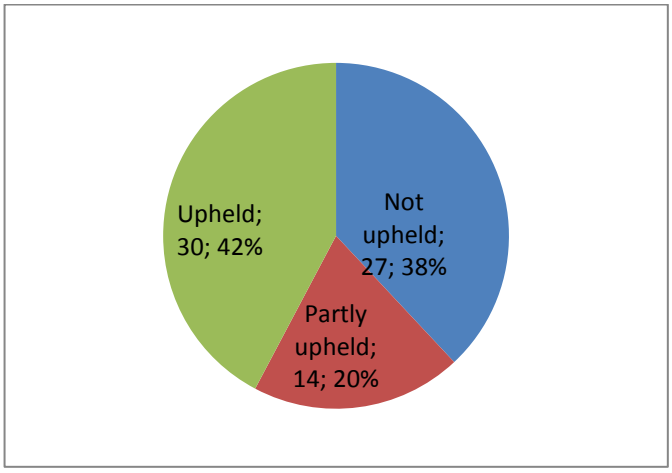
During 2018/2019 the Trust received 120 complaints about its NHS111 service, compared to 166 in 2017/2018; a decrease of 28%.

	Administration	Communication issues	Concern about staff	Call triage	Timeliness	Total
Ashford 111 Centre	14	2	13	53	8	90
Dorking 111 Centre	1	0	9	18	2	30
Total	15	2	22	71	10	120

Of the complaints received 83, (69%) were found to be upheld in some way.



As with the Trust EOC's, the highest number of complaints relate to call triage; 71 (59%). Of those 56, (62%) were upheld in some way.



Learning from complaints

Lessons from complaints throughout 2018/19 have been wide ranging.

226 of the 434 complaints received for A and E were found to be upheld or partly upheld. As a result, there were 343 actions identified. Actions from complaints are wide ranging and include feedback provided to the crew both formally and informally, reflective practice, additional training and "ride outs", when an Operational Team Leader spends the day with a crew reviewing their working practice.

349 of the 452 complaints received for the Emergency Operations Centre were found to be upheld or partly upheld. As a result, there were 408 actions identified. Actions from complaints are again wide ranging and include feedback provided to the EOC staff both formally and informally, additional training or mentoring, clinical instruction and policy / procedural reviews.

Below are set out some examples of more common themes and lessons learnt:

A&E complaints:

Example 1:

A Paramedic Practitioner raised concerns regarding a patient's conveyance to hospital against the express advice of their anticipatory care plan.

It transpired that the patient had two IBIS records: one the Advanced Care Plan (ACP) shared by the GP practice, along with a second IBIS record containing a DNACPR for the patient. At the time of the 999 call, the DNACPR marker was sent to the responding ambulance crew, however the IBIS data assistant failed to realise that the patient also had an ACP record on IBIS and therefore neglected to notify our clinicians of its presence.

A reminder was issued to all IBIS Data Assistant staff to refresh them on the need to check for alternative IBIS records, second to ones which have an associated "at-risk" marker, to ensure crews are notified.

Staff development plan was put in place to start regular audits for IBIS Data Assistants, to highlight similar issues and identify any additional training needs.

Current IT developments being made to capture NHS numbers within Cleric CAD during 999 calls. Once complete this will allow potential developments within IBIS for 'auto matching' of some patient records, which will reduce the risk of human errors.

Example 2:

A patient's wife raised concerns following an incident involving one of our paramedics (patient was accidently given too much medication). Complainant stated that she was never contacted by our Trust regarding this matter and would also like to know if the paramedic is ok.

The investigation found that the member of staff disclosed her mistake to the patient's wife and apologised; however, this should have been followed up with a written letter by the investigating manager who carried out the internal investigation.

Discussion held with Operational Team Leader (OTL) who carried out the investigation. understood that written response would also be required as well as the verbal contact that took place.

EOC complaints:

Example 1:

The parent of a 10-year-old child complained about the information that was provided by a Clinician and then confirmed by the Emergency Medical Advisor (EMA). The parents were advised to take the child to a walk-in-centre which resulted in a delay in the child receiving the correct care and causing considerable additional upset to the child and their parents.

The complaint was investigated, and it was found that whilst the call passed the audit the clinician had provided incorrect advice. The clinician should have followed the Directory of Service (DoS) which would have provided the correct advice. The EMA also failed to provide worsening advice.

The Clinician and the EMA were provided with feedback from the investigation and the Clinician was given further instruction on the use of the DoS.

Example 2:

A patient suffering severe abdominal pain, dizziness, fainting, raised temperature and shivering, on her own with no one to help her or drive her to the hospital, called 999. The patient was told that as their symptoms were not considered to be life-threatening, no one would come. The patient called back after five hours as their symptoms continued, they could not walk, and they were fainting and vomiting. They were again informed that no one was coming, and they should make their own way to hospital, despite fainting upon standing up. Husband arrived home and called to complain, he was told an ambulance would be there in 4-5 hours, then was called later to say no would come, only if she stopped breathing. Upon surgery, had burst appendix, pus in abdomen and hole in her bowel.

The complaint was upheld due to concerns identified during telephone interactions and the ability of the service to dispatch a timely response.

Call review:

The investigation identified concerns with two of the EMA's and their handling of the calls received. In both cases the calls were sent to audit and were found to be non-compliant.

- One EMA did not probe or record the information supplied by the patient regarding fainting. Had they notified a clinician there is a possibility the outcome of 'No send' may have been changed.
- The second EMA closed and cancelled the Category 3 response on the request of the patient's husband. However, the cancelation of the ambulance should have been validated by a Clinician. Without the case having clinical intervention at this point it was not possible to determine if the ambulance would have been agreed to stand down.

Contributory Factor – Communication. The patient spoke / appeared very calm during the telephone assessments. It is therefore a consideration that there was a likelihood of "Wellness Bias" during assessments and direct patient interaction.

Service delivery:

The investigation also reviewed the delay to the response. It was clear the service was experiencing extremely high levels of demand, that was also felt across the emergency care network into A&E departments. The demand during most of the day was above available resources. Contributory to the pressures on the service, were notable delays in the handover of patients within the A&E departments.

Feedback to the EMA's regarding note recording, probing and seeking clinician involvement. Also, following the process for standing down responses and seeking clinician involvement.

NHS111 complaints:

Example 1:

A patient's son raised concerns following his contact with the NHS111 service. He stated that the Health Advisor (HA) refused to carry on the assessment because he was not in the same room as the patient. He was also advised he could not speak to a supervisor to discuss his issue and was given an incorrect contact number when he stated he wished to complain.

On investigation it was found that the call was not compliant with our call taking procedures. The HA failed to pass on the call to the manager on duty and an incorrect number was also given when the caller requested the telephone number for the team who deals with complaints.

Individual feedback regarding delaying patient care, passing calls to the on duty manager when necessary and providing correct contact numbers when a caller wishes to complain.

Example 2:

South Central Ambulance Service NHS Foundation Trust (SCAS) raised concerns following a patient's contact with our NHS111 service. Initial contact with NHS111 was made at 10.00am but no referral was made, and case was closed. Patient's family contacted NHS111 at 5.00pm and a referral was made to SCAS. Patient was admitted to hospital as he was very unwell with sepsis.

It was found that the Health Advisor (HA) failed to provide the number for the district nursing team to the caller. The patient's phone number was also recorded incorrectly which caused delay in the patient being contacted by the Out of Hours (OOH) service.

HA received feedback regarding reading the referral instructions presented and documenting the correct telephone number within the case.

Parliamentary and Health Service Ombudsman

Any complainant who is not satisfied with the outcome of a formal investigation into their complaint may take their concerns to the Parliamentary and Health Service Ombudsman (PHSO) for review. When the Ombudsman's office receives a complaint, they contact the Patient Experience Team to establish whether there is anything further the Trust feels it could do to resolve the issues. If we believe there is, the PHSO will pass the complaint back to the Trust for further work. If the Trust believes that local resolution has been exhausted the PHSO will ask for copies of the complaint file correspondence to review and investigate.

In the year 2018/2019 the PHSO contacted the Trust and asked for copies of 14 complaint files, four cases have been investigated so far, none of which have been upheld. The other 10 cases are still with the PHSO being reviewed.

Patient Advice and Liaison Service (PALS)

PALS is a confidential service to offer information or support and to answer questions or concerns about the services provided by SECAmb which do not require a formal investigation.

The chart below details the number of PALS enquires received by the Trust during 2017/2018 against 2018/19:

Type	2017	2018	Percentage difference
Concern	63	52	-17%
Enquiry	48	40	-17%
Information request	230	348	51%
Total	341	440	29%

Most requests for information are Subject Access Requests, where patients or their relatives require copies of the Patient Clinical Record completed by our crews when they attended them, or recordings of 999 or NHS111 calls, for a range of reasons. These requests have increased by 51% over the year 2017/2018. The requests received have all been dealt with within the one calendar month timescale.

Other contacts are requests for advice and information as to what to expect from the ambulance service, people wanting to know how they can provide us with information about their specific conditions to keep on file should they need an ambulance, calls about lost property, and on occasion, families wanting to know about their late relatives' last moments.

Monitoring Systems

The Trust has continued to improve the incorporation of the electronic reporting System (Datix) into the complaints process which has improved the ability to produce accurate reports and streamline the audit process.

The Trust has embedded protocols for regular weekly follow up of all complaints A weekly open complaints report is sent each Monday to all investigating managers and copied to directors and senior managers which sets out all open cases under investigation within their areas, this includes a reminder of the due dates for reports to be returned to the Patient Experience Team.

Reporting Arrangements

Monthly reporting on compliance with internal complaints timescales is to Board within the Integrated performance report. Additional management assurance has also been provided to the Quality and Patient Safety Committee. Patient stories are provided to each board meeting and available through the Trust website.

The national return for complaints with the NHS is the KO41a return. This data is submitted on a quarterly basis to the Health & Social Care Information Centre (HSCIC) via their online portal.

The Patient Experience Team

The overarching responsibility for complaints, PALS and compliments sits with the Patient Experience Team. The work is diverse and brings the team into contact with many patients and their families, some of whom are struggling with mental illness or disorder; and bereavement. Whilst the majority of these contacts are constructive there have been occasions when team members have had to deal with highly complex and stressful or distressing situations. Supportive work has begun with the team in terms of resilience. Additional work is planned to support the team with Mental Health First Aid knowledge and skills.

Conclusion and future areas of development

Some work has been undertaken to correlate trends from incidents, complaints and serious incidents. This can be demonstrated in the deep dives undertaken by the Trust as part of the work of the mortality and morbidity meetings. Further work is planned to continue to triangulate these trends. This will require review of the Datix system throughout the coming year. The Trust are also currently reviewing the potential benefits of Datix Cloud to improve data analysis.

A key priority for the quality account for 2018/19 was to share learning from complaints incidents and serious incidents. This work was partially achieved. It can be evidence by The Trust electronic database (Datix); patient stories presented to the board; Content of key skills training 2018/19; Clinical and operational bulletins; monthly case studies and posters displayed in operating units; shared learning posters in our EOCs. Further work is required to ensure that lessons are learned more widely across the organisation.

The trust continues to develop the rigour of complaints investigations. The new training for Trust investigators will ensure that all complaints, incidents and serious incidents are investigated to the same high standard and lead to more tailored and appropriate learning outcomes.

Further work is required in the coming year to develop audit processes to ensure that all complaints responses meet an agreed standard and are worded in a helpful way for our patients. Collaborative work with CCG and external stakeholders is currently in the early planning stages.

Ongoing work is planned with the patient experience team to develop skills and knowledge to support them during complex challenging patient / relative interactions.

The patient experience strategy will be consulted on in the next couple of months. This will go to Board in September. It is likely that there will be significant learning from consultation events on how we manage our complaints, compliments and Pals processes.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

		Agenda No	13-19
Name of meeting	Board		
Date	23 May 2019		
Name of paper	IPC Annual Report 2018/19		
Responsible Executive	Magnus Nelson, Acting Medical Director		
Report Author	Aide Hogan, Head of IPC		

The report sets out key achievements and compliance with legislation throughout 2018/19.

- 95% of complaints were responded to within the Trust's agreed timescale of 25 working days.
- Robust internal monitoring process which includes a weekly open complaints report providing a clear position of current complaints under investigation to directors, senior managers and investigating managers.

Key points:

- During 2018-19 the Trust received 1,846 compliments, slightly more than the 1,688 received in 2017/18, thanking our staff for the treatment and care that they provided.
- During 2018/19 the Trust received one complaint for every 2,604 patient interactions, meaning that 0.099% of all calls / journeys attracted a complaint.
- In the year 2018/2019 the PHSO contacted the Trust and asked for copies of 14 complaint files, four cases have been investigated so far, none of which have been upheld. The other 10 cases are still with the PHSO being reviewed.

Future areas of development are outlined in the report

Action Required	For information

Infection Prevention and Control Annual Report 2018/19

Contents

Executive Summary

The purpose of this report is to inform the Board, staff, patients and members of the public of the progress made against the Care Quality Commissions standards (Outcome 8, Regulation 12) and the Department of Health 'Health and Social Care Act' 2008 during the last 12 months. The Infection Prevention and Control (IPC) Annual Work Programme for 2019/2020 has been developed and will be reviewed at every Infection Prevention and Control Sub Group meeting on a quarterly basis. The report provides information and evidence of the ongoing commitment of the Trust to embed IPC principles and practices throughout the organisation.

As a result of learning and improvement, South East Coast Ambulance Service NHS Foundation Trust (SECAmb) has a workforce that has the knowledge, skills and experience to appropriately minimise infection risk for patients and staff, thereby improving patient safety and staff well-being. The organisation is able to demonstrate compliance with IPC standards and delivery of key strategic objectives including: 'Delivering high quality, patient focused services' and 'Ensuring a highly skilled, motivated and engaged workforce'.

Key Achievements

- Implementation of the IPC Improvement Plan which was developed with teams / staff across the Trust
- Introduction of Infection Prevention Ready Procedure in July 2018
- The Care Quality Commission report for 2018 stated *"There were good standards of cleanliness and hygiene were maintained throughout the vehicle fleet and we found reliable systems in place to prevent and protect people from infection. The trust had implemented an infection prevention improvement plan since the last inspection and staff demonstrated good infection control practices".*
- Additional IPC Practitioner introduced to the team as a secondment
- IPC Administrator post filled in September 2018
- Two IPC Champion development days delivered which included outside speakers from Public Health England and a Consultant Microbiologist
- Further development of IPC audit / review tools and dashboards all now available on staff iPad
- Continued and improved access to joint working streams with healthcare providers throughout Kent, Sussex and Surrey
- Further development of the preliminary IPC training sessions for all levels of staff
- Successful IPC Level 2 training for staff via the DISCOVER platform achieving 95.4% uptake
- New system for review of all IPC DATIX incidents by the IPC Team introduced
- Introduction of ATP Swab testing during Quarter 4 to monitor vehicle cleanliness standards
- Continued IPC involvement at internal meetings across the Trust to support IPC awareness
- Introduction of a monthly meeting for environmental cleaning standards by the Estates Team and the contractor
- Head of IPC now Chairs the National Ambulance Service IPC Group
- Delivered information provided to all staff for the World Health Organisation Hand Hygiene Day, Glove Awareness Week and Antimicrobial Awareness Week
- All of the good work carried out during the year culminated in the trusts best ever flu vaccination uptake figures and for the first time we exceeded the target of 75% for both reporting lines –

IMMFORM (Frontline Healthcare Staff) = 78.7%
CQUIN (All Trust Staff) = 76.3%

The final seasonal flu programme report for 2018 / 2019 is shown in Appendix A.

Introduction

This is the second IPC Annual Report from the Executive Director of Nursing and Quality / Director of IPC (DIPC). The report is to inform the Board, staff, patients and members of the public of the progress made against the Care Quality Commissions standards (Outcome 8, Regulation 12) and the Department Health 'Health and Social Care Act' 2008 during the last 12 months. An outline of the IPC Annual Work Programme for 2019/20 is appended to the report (Appendix 1) to illustrate the priorities for the forthcoming year.

The report provides information and evidence of the ongoing commitment of the Trust to embed IPC principles and practices throughout the organisation and shows the significant improvement the Trust has made in this respect.

Background

Effective infection prevention and control practice requires ownership at every level – from Board to Frontline. Success depends on creating a managed environment that minimises the risk of infection to patients, staff and the public and ensures compliance with relevant national and local standards, guidance and policies. A sustained approach to IPC can be achieved through personal accountability, skilled and competent staff, transparent and integrated working practices and clear management processes.

The Health and Social Care Act 2008: Code of Practice for Health and Social Care on the Prevention and Control of Infections and related guidance (Department Health).

Section 21 of the Health and Social Care Act (2008) enables the Secretary of State for Health to issue a revised Code of Practice. The Code contains statutory guidance about compliance with the registration requirement for cleanliness and infection control. The Act states that the Code must be taken into account by the Care Quality Commission (CQC) when decisions are made regarding the cleanliness and infection control standards required to achieve registration. The Code, revised in July 2015, focuses on 10 areas. The table below is the 'Code of Practice' for all providers of healthcare and adult social care on the prevention of infections under The Health and Social Care Act 2008. This sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirements related to infection prevention. Not all criteria will apply to every regulated activity.

	Criteria Requirement	Compliance	RAG
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	Compliant following the introduction of a new system for water testing which was introduced during Q1 of 2018 / 2019.	
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Compliant – Environmental cleanliness audits are now being completed at each site and monitored by the IPC Team on a monthly basis.	
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial	Compliant – PGD's have been reviewed and an audit carried out with learning outcomes actioned	

	resistance.	by the Consultant Paramedics.	
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	Compliant - As described in the Trusts Scope of Practice and Clinical Standards Policy.	
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Compliant - As described in the Trusts Scope of Practice and Clinical Standards Policy.	
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Compliant – As described in the Trusts Scope of Practice and Clinical Standards Policy.	
7	Provide or secure adequate isolation facilities.	Not applicable to ambulance Trusts	
8	Secure adequate access to laboratory support as appropriate.	Not applicable to ambulance Trusts	
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	Compliant – As described in section 6.4 Policy Review and Development.	
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Compliant – As described in section 6.9.	

Board Assurance

Corporate Responsibility

In December 2003 the Department of Health published 'Winning Ways: Working Together to Reduce Healthcare Associated Infections' which highlighted the requirement for a Director of Infection Prevention and Control (DIPC). The Executive Director of Nursing and Quality has been designated as the DIPC with lead responsibility within the Trust for IPC. This post reports directly to the Chief Executive Officer and the Trust Board. The Trust Board holds overall responsibility for ensuring that the Trust is compliant with IPC national guidance. The IPC Lead has been designated as the Deputy DIPC.

Performance Monitoring

Oversight

Oversight of Infection Prevention and Control is via the Quality and Patent Safety Committee. Management responses have been provided throughout the year, in particular in relation to vehicle cleanliness. The Board receives exception reports and monitors hand hygiene via the Integrated Performance and Quality Report (IPR)

The Infection Prevention and Control Sub Group (IPCSG)

The aim of the IPCSG is to provide assurance to the Trust Board that all services are provided in a clean and safe environment through the effective performance monitoring of key performance indicators (KPIs). It provides a forum for the co-ordination of any IPC related projects ensuring a consistent approach to IPC throughout the Trust. During 2017 - 2018 the group met quarterly for the first three quarters of the year and then monthly for the last quarter to help support the work with the IPC Improvement Plan.

The IPCSG is responsible for providing assurance to the Clinical Practice Group (CPG) and upwards to the Quality and Patient Safety Committee (a sub-committee of the Board). It monitors compliance with the Health and Social Care Act 2008 via updates from all areas within SECAmb relating to the IPC audits for vehicles, premises and observed practice, and IPC training compliance is provided at each meeting.

The Infection Prevention and Control Team (IPC Team)

The Trust has a proactive IPC Team (which has been enhanced since the recruitment of the IPCP) that is very clear on the requirements necessary to support the Trust in maintaining its commitment to patient safety and quality of care. Equally, it is recognised that IPC is the responsibility of every member of staff and must remain a high priority for all to ensure the best outcome for patients.

Director of Infection Prevention and Control (DIPC) and Deputy Director of Infection Prevention and Control (DDIPC)

The responsibilities of the DIPC are outlined in 'Winning Ways' (DoH, 2003) and include:

- To be the responsible Executive Lead for IPC within the Trust reporting directly to the Chief Executive
- To ensure that pre-determined targets are met by overseeing the IPC work programme and Annual IPC Audit Programme
- Present regular reports to the Trust Board
- Approve and contribute to the Director of Infection Prevention and Control Annual Report
- The Deputy Director of Infection Prevention and Control manages and oversees the performance of the IPC team

Head of Infection Prevention and Control (HIPC) / Deputy DIPC

The responsibilities include:

- Performing a self-assessment of the Trust against the Health and Social Care Act 2008 and ensuring plans are appraised by the IPCSG and are implemented to sustain compliance
- Ensuring the Trust policies, procedures and manual reflect the national and local IPC requirements
- Developing and overseeing the delivery of an annual inspection programme and monitor through the IPCSG
- Developing and overseeing the delivery of an annual work programme focusing on improving and sustaining compliance with the Health and Social Care Act 2008
- Producing an Annual IPC report
- Developing and updating integrated inspection tools to ensure these are fit for purpose
- Managing the Trusts seasonal flu vaccination programme

Infection Prevention and Control Practitioner (IPCP)

- Challenges unsafe practice in all levels of staff in order to reduce the risk of health care related infections
- Offer infection prevention advice on patient care in relation to preventing cross infection

- Carry out risk assessments in relation to infection prevention and control including clinical practices to reduce the risk of healthcare related infection
- Assists where appropriate in the management and the control of meningitis, tuberculosis, hepatitis B, hepatitis C, HIV, and major outbreaks of gastrointestinal infection in association with existing personnel.
- Day to day monitoring of infection control incidents within the Trust.
- To assist the HIPC with the development of an infection control annual plan, to include audit planning against key performance indicators.
- Provide effective communication of the Trust's infection prevention and control
- Investigates incidents of infection control and produces reports to the relevant groups. Report the lessons learnt and actions via the IPCSG, in order to prevent and control further incidents within the Trust.
- To assist the HIPC with specialist training as appropriate such as induction programmes, service specific training and as required in response to risk assessments and incidents.
- Act as, or co-ordinates, mentorship and clinical supervision for Infection Prevention and Control Champions.

Infection Prevention and Control Champions (IPCC)

- To liaise between the IPC Team and their local staff and managers
- To facilitate the introduction & implementation of new & existing IPC practices
- In conjunction with the IPC Team to act as a resource for staff concerning IPC related problems in the clinical area
- To assist in the education of staff in their service area in the principles of IPC as it relates to their speciality
- To participate in IPC activities as appropriate
- To assist the IPC Team with accurate surveillance/audit as appropriate

Infection Prevention and Control Annual Work Programme

The IPC Annual Work Programme for 2018/19 has been completed. The aim of the annual programme is to provide a framework with which to clearly demonstrate improvements in IPC from Board to Frontline. The IPC Team have produced the 2019-2020 Annual Work Programme (Appendix A) and it will tabled at the April 2019 IPCSG for approval. The plan focuses on embedding and sustaining good IPC practice across the organisation, thereby maintaining compliance with the Health and Social Care Act 2008.

Infection Prevention and Control Improvement Plan

The Trusts IPC Team were tasked with developing an Improvement Plan for 2018 / 2019 that would review all IPC related practices across the Trust to ensure that we met the objective of 'Keeping patients and staff safe by breaking the chain of infection.

The year began with a workshop that involved a diverse range of staff from across the Trust and was focused on producing a new procedure for IPC related practices that translated into practice for the ambulance setting and environment. The new procedure would follow Best Practice guidance for IPC, but would be adapted to specifically allow ambulance staff to relate to terminology that was more suitable for them to comply with on a day-to-day basis.

The new procedure was developed and introduced into the Trust in July 2018 and is known as 'Infection Prevention Ready' (IP Ready). The procedure is made up of the following elements -

- Process Ready (Policy/Champions)
- Make Ready (Environment)
- Person Ready (Health & Immunisation)
- Protection Ready (Uniform & PPE)

- Hands Ready (Hand Hygiene)
- Competence Ready (Knowledge)
- Effectiveness Ready (How do we know we did not cause harm)

During the development stage, the IPC Team produced a new set of audit / review tools that would be accessible to staff carrying out the audits / reviews on their individually issued IPad and would capture live results and compliance levels. The staff carrying out the audit / reviews are a mixture of IPC Champions and Operational Team Leaders, which allowed the IPC team to focus on embedding the new procedure into practice at a local level and discussing non-compliance issues with staff at the time of the audit / review being carried out. The IPC Team also carryout regular visits to Trust and hospital locations to provide some consistency checks on the results being generated. The Quality Assurance Visit teams complete a Post Patient Care Review tool at hospitals during their visits, which provides the organisation with further evidence of either compliance or non-compliance of staff to the procedures.

The entire development plan and IPR Procedure has been shared with colleagues from Public Health England, the NHS Improvement Team and Care Quality Commission staff, along with local healthcare providers across the region. The feedback from all parties has been positive and the IPC Team have been asked to present the new procedure at several IPC Forums and Infection Prevention Society workshops since its introduction.

Policy Review and Development

As part of the Improvement Plan the IP Ready Procedure was introduced into the Trust, which will mean that both the IPC Policy and IPC Manual will require a review. The review for both has been scheduled for Q1 of 2019 / 2020 in agreement with the IPCSG.

National Ambulance Service IPC Group (NASIPCG)

The Trusts Head of IPC Chairs the national group, which meets on a quarterly basis throughout the year. The role of the group is to provide expert advice on IPC in Ambulance Services to the National Ambulance Quality Governance & Risk Directors (QGARD).

During 2018 / 2019 some of the key achievements of the group were:

- Agreement nationally that the principles of Bare Below the Elbow should be adhered to in all Ambulance trusts
- Working with the Department of Health in the development of national guidance for hand hygiene and environmental cleanliness standards
- Work has started on developing a National Ambulance Services IPC Policy
- Involvement in the new guidance for ‘Post Blood and Body Fluid Exposure’ with Public Health England, which is due for publication in September 2019
- Continued support to all IPC Ambulance Leads throughout the UK

South East Regional IPC Forums

Reporting to the Lead Commissioners: As part of the agreed Quality and Information reporting requirements defined in the Trusts contract for 2018/19, frequent update reports pertaining to IPC within the Trust are also reported to the Lead Commissioners Clinical Quality Review Group meetings. The HIPC also represents SECAmb at IPC Forums in Kent, Sussex and Surrey where Infection Control Practitioners from various healthcare settings meet to promote standardisation and consistency of practice related to infection prevention and control. The purpose and objectives of these meeting are as follows;

- Facilitate partnership working between NHS organisations
- Promote shared learning and expertise within the specialist field of infection prevention and control
- Standardise approach to infection prevention and control practice

- Provide valuable resources to infection prevention and control teams and associated organisations
- Implement latest guidelines and initiatives related to infection prevention and control
- Improve the patient experience.

IPC Reported Incidents

The IPC Team review every IPC related incident and where required offer support to both the Investigating Manager and the staff member involved in the incident. During the year the team has also reviewed the investigation of each incident and provided feedback to the investigator in relation to the completion of the investigation being either satisfactory / unsatisfactory.

Appendix B provides a full breakdown of the types of incidents and the review of the investigation.

Themes and learning outcomes from incidents are discussed at every IPCSG meeting and added to the Trust Risk Register when deemed a significant risk for the Trust. Any recurring categories of incidents are added to the IPC annual training programme for the following year.

Corporate Risk Register

Risks relating to IPC throughout the year are monitored by the IPC Team and each risk is then reviewed at the quarterly IPCSG meetings.

Appendix C provides detail of these risks and their current status as of the 31st March 2019.

Learning and Development

As a consequence of our large geographical spread, the Trust has utilised a mix of delivery mechanisms to educate and train our staff. This has included 'face to face' training, IPC workbooks, Content Locker on iPads and communication briefings delivered via email, weekly bulletin articles and IPC alert notices.

The IPC Team are responsible for ensuring that all IPC educational material is up to date and reflects current best practice and national guidance. Hand hygiene is a core theme throughout all training packages and compliance is monitored through the Observed Practice Audit Tool.

The Trust's IPC Training Presentations have been further developed throughout the year following feedback from students and members of the Clinical Education Team as well as changes in national guidance. Ensuring the training meets the necessary competencies set by the awarding organisation, FutureQuals, for each of the different qualifications.

- Emergency Care Support Workers
- Associate Ambulance Practitioner
- Transition to Practice Staff

This year Level 2 IPC training for all clinical staff was delivered on the DISCOVER platform. The main themes for this year's training were;

1) Hand hygiene compliance
2) Aseptic non touch technique procedure
3) Sharps awareness

All training modules were adapted following the introduction of the IPC Ready Procedure in September 2018.

A risk in reporting uptake of the training was hi-lighted via the IPC Improvement Plan. This being that the DICSOVER platform and ERS do not connect to one another and the Trust still has to rely on a manual

input of training completion totals. This was added to the Risk Register and has been escalated to the Exec Team.

In addition to the annual training programme the IPC Team have created the following sessions for specific groups;

- Medicines Packing Team (sharps awareness)
- The role of the EOC IPC Champions

Third Party Contractors

Third party providers are required to provide evidence that they are fully compliant with the Care Quality Commission's Essential Standards related to the quality and safety of care. These are set out in the Health and Social Care Act 2008. Contract meetings with third party providers include membership from the IPC team to monitor IPC compliance. During 2018/19 The IPC team have worked closely with third party contractors used to support the deep clean programme and that their staff have received appropriate training and adhere to IPC standards. The Occupational Health contract monitoring mechanism also includes representation from the IPC team. Third party sub-contractors of A&E work are also monitored for compliance with IPC standards as part of a wider monitoring mechanism. This has involved close working with those organisations, which, currently contract or seek to contract with SECAmb. In August 2018 the Trust commenced a gap analysis was undertaken which helped to identify some gaps in our governance / compliance processes for services delivered by our Private Ambulance Providers (PAPs).A set of requirements that all PAP's will have to provide assurances on have been agreed and which will be managed and monitored by the Contracts Team

Delivery of IPC workstream including;

1) Up to date policy and procedures for IPC, evidence of IPC advisory support

2) Up to date staff training records for level 2 IPC annual training

3) Vehicle cleaning schedules and the evidence behind these being completed

4) IPC kit for each vehicle including, PPE, detergent wipes, spill kits and hand gel dispensers

5) Evidence for post management of incidents involving needlestick / contamination from blood or body fluids (including Occupational Health records for staff)

The plan to measure their compliance is as follows;

1) Check all providers Policies and Procedures

2) Review their annual audit plan

3) Review any audits they may carryout

4) Include the PAP crews in the Trusts observational audits / reviews

5) IPC Team to form part of the random inspection team for PAP's

Annual IPC Audit / Review Programme 2018 / 2019

The Infection Prevention and Control (IPC) Team have the task with providing assurances regarding the following areas:

- Hand Hygiene (HH)

- Clinically Ready (CR) – (formerly known as Bare Below the Elbows)
- Aseptic Non Touch Technique (ANTT)
- Vehicles Cleanliness
- Environmental Cleanliness
- IPC Environmental Standards
- Post Patient Care Reviews

At the start of the year The Trust was still using the previously developed audit tools from 2017, but these were changed following the introduction of the new Infection Prevention Ready Procedure in July 2018. The graphs below show Quarter 1 as the previous audit / review tools and the rest of the year shows the new IP Ready audits and reviews.

All of the audit / review tools are available on the iPad platform to make it possible for member of staff to potentially be able to complete them, eliminate the use of paper completely and provide even better data for analysis.

This system will allow identification of common non-compliance themes are and where OUs may need further support with advising and education staff. This will be managed with support from the local IPC Champion and the IPC Team.

The HIPC provides regular updates on any non-compliance issues to both the CGG and the Quality Patient Safety Committee and the IPC Team provide graphs and dashboards to the OU's showing their previous months results for all audits and reviews carried out.

The audit / review results are shown in Appendix D.

Introduction of Adenosine Triphosphate (ATP) Swab Testing

There was a slight delay in the introduction of ATP Swab testing due to the transfer of the budget, but the initial trials commenced at the start of Quarter 4.

During this period the IPC Team tested the reporting system and the number of individual swab tests and locations of the tests that should be carried out for each vehicle. This enabled the team to agree a monthly programme for swab testing which commenced at the start of Quarter 1 2019 / 2020.

Monthly reports on the cleanliness standards of the vehicles will be provided. This will enable the Trust to consider any changes required to ensure compliance at both a local and Trust wide level.

Summary and Conclusion

Patient safety remains a top priority for the Trust and IPC is integral to maintaining this. The Trust has shown its commitment to IPC by the systems and processes implemented during 2018/2019. The key achievements over the year continue to be associated with embedding IPC standards firmly from Board to Frontline staff as demonstrated by means of a comprehensive communication plan, continued IPC education for all staff and joint working between IPC and Operational staff.

Appendix A

Seasonal Flu Programme Report 2017 / 2018

Introduction and Background

This year SECAmb identified a team from relevant areas of the Trust who all contributed to running the flu vaccination programme. This included the introduction of weekly updates via the Quality Improvement (QI) Hub during their weekly conference calls, which provided a more focused approach to areas of low uptake and the sharing of good practice from those with high uptake figures.

The principles developed from previous year's programmes were once again applied and a more locally focused programme using local staff to perform and promote the vaccinations enabled staff to have the vaccine at a more convenient time and venue for them. The QI Hub were also very pro-active in vaccinating staff at Nexus House.

As in previous years' posters, leaflets, stickers and educational materials were sent out to all areas of the Trust as well as weekly bulletin, Intranet articles and Twitter posts which were regularly sent out to inform staff that the flu vaccination programme had commenced and how they could access a vaccine. We also provided a live streaming question and answer session on Facebook, which was the first time the Trust had ever tried this method of communication with staff. Dr Fionna Moore (Medical Director) and Aide Hogan (Head of Infection Prevention and Control) spent over half an hour briefing staff on this year's programme, providing some myth busting details, as well as answering questions that came in during the live stream.

Those receiving the flu vaccine this year were also given a choice for gifting one or more individuals from one of the world's poorest communities, as part of the UNICEF incentive, with one of the following options:

Provide a Measles vaccination for a child

Provide three children with Polio vaccination

Provide protection for six children against Tetanus

Oral antibiotic to protect 14 people against river blindness

Oral antibiotic to protect from three people against Trachoma

Results

The Head of Infection Prevention and Control called into the weekly QI Hub conference call to provide uptake figures throughout the Trust and produced a league table for individual Operating Units, separate EOC / 111 and Directorate tables. There was also a Trust overall uptake table, benchmarking against previous year's figures and a trajectory graph for the programme.

The DoH percentage target for frontline healthcare workers to be vaccinated for flu is 75% and this year SECAmb achieved its best total to date of **78.7%** in comparison to last year's total of 69.6%

an increase of 9.4%. The national average for flu vaccination uptake for frontline healthcare staff was % this year, so once again the Trust were above this final total.

The target for CQUIN this year was 75% and this figure showed all Trust staff that had the flu vaccination, with the exception of 111 staff. The final total for this year was **76.3%** in comparison to last year's total of 69% an increase of 7.3%.

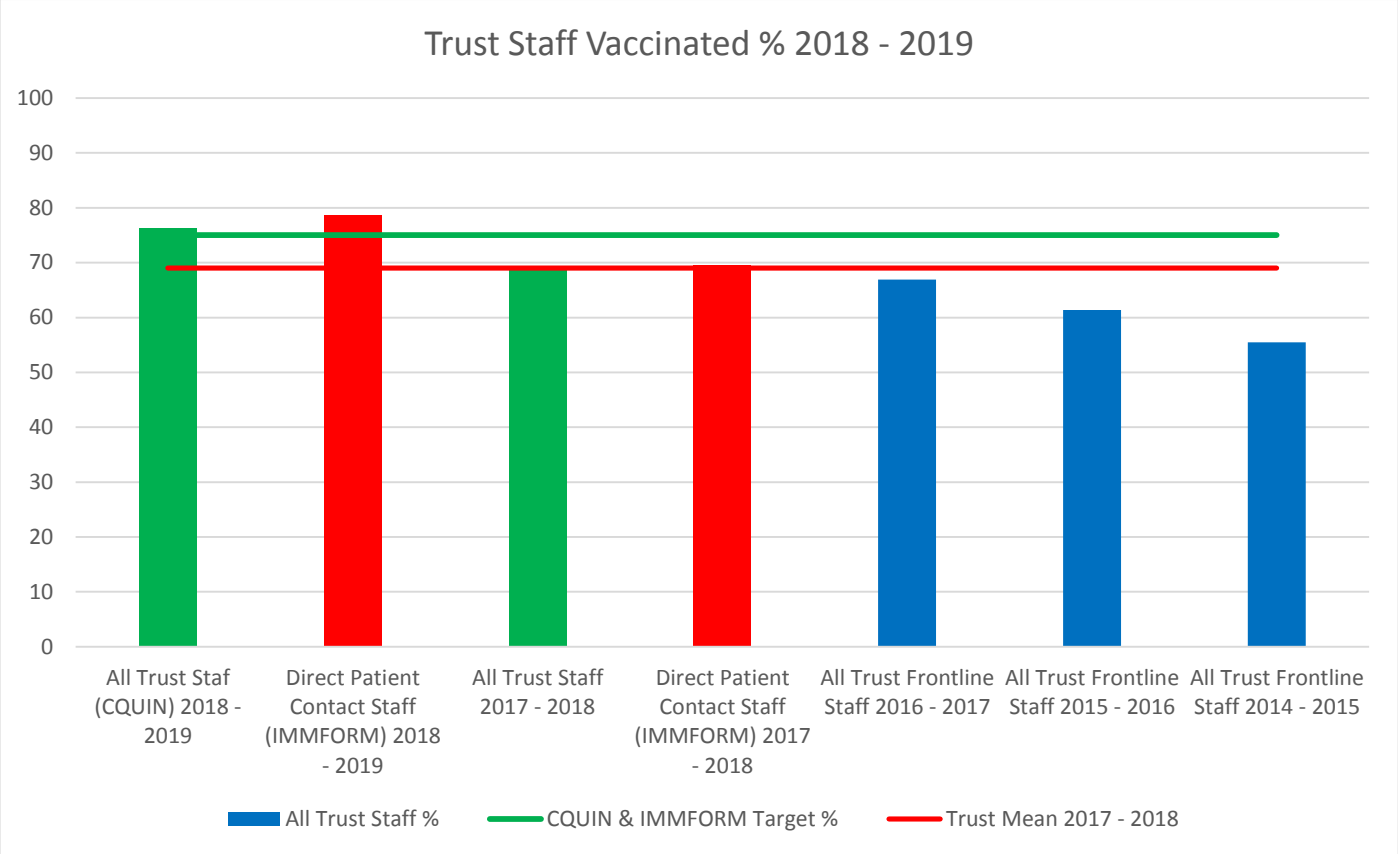
The flu vaccination programme team would like to pass on their thanks and appreciation to all of the Local Flu Vaccinators who were the real driving force behind this year's programme.

Next Steps

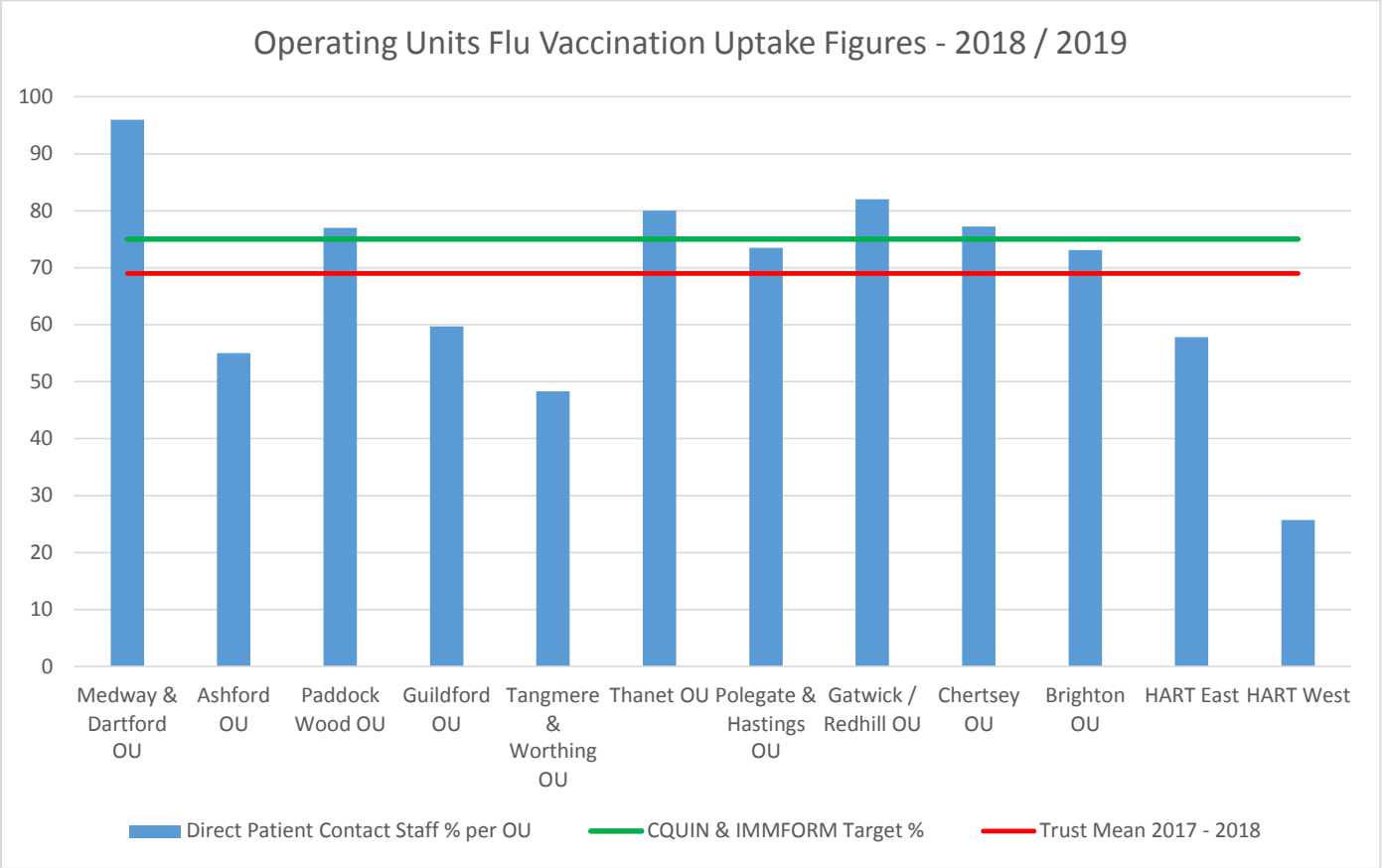
With lessons learnt and some modifying of this year's programme, we hope to once again improve on uptake for the 2019 / 2020. The main issues to be reviewed are:

- The reporting tool used for recording uptake figure in line with staff numbers for each area.
- A planned focus on low uptake areas from last year and providing them with educational / awareness sessions of the importance of having a vaccine.
- Review of the training package for administering the vaccine and PGD compliance.
- Review of myth busting materials.
- Budget requirements for the flu programme.

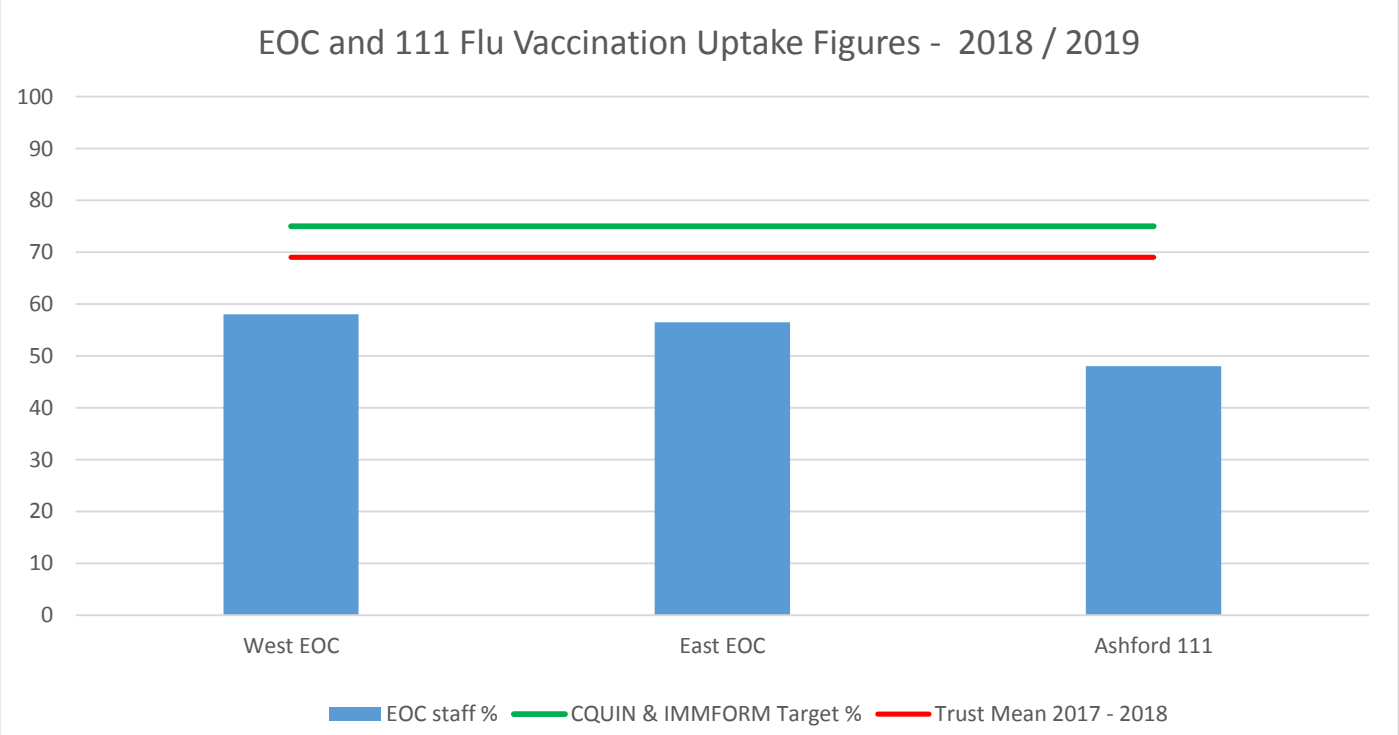
Overall Trust Figures for 2018 / 2019 (with the last four years figures):



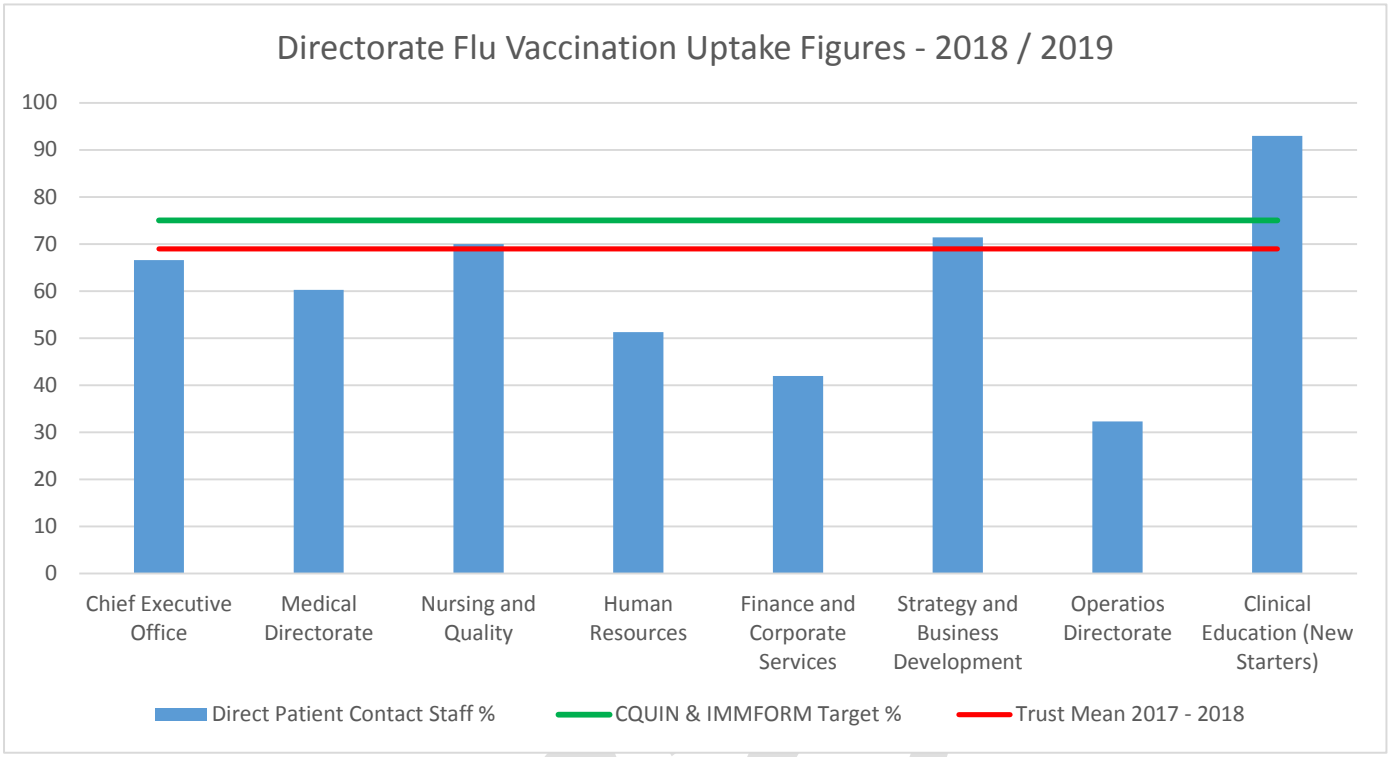
Area Breakdown Figures for Operating Units including HART 2018 / 2019:



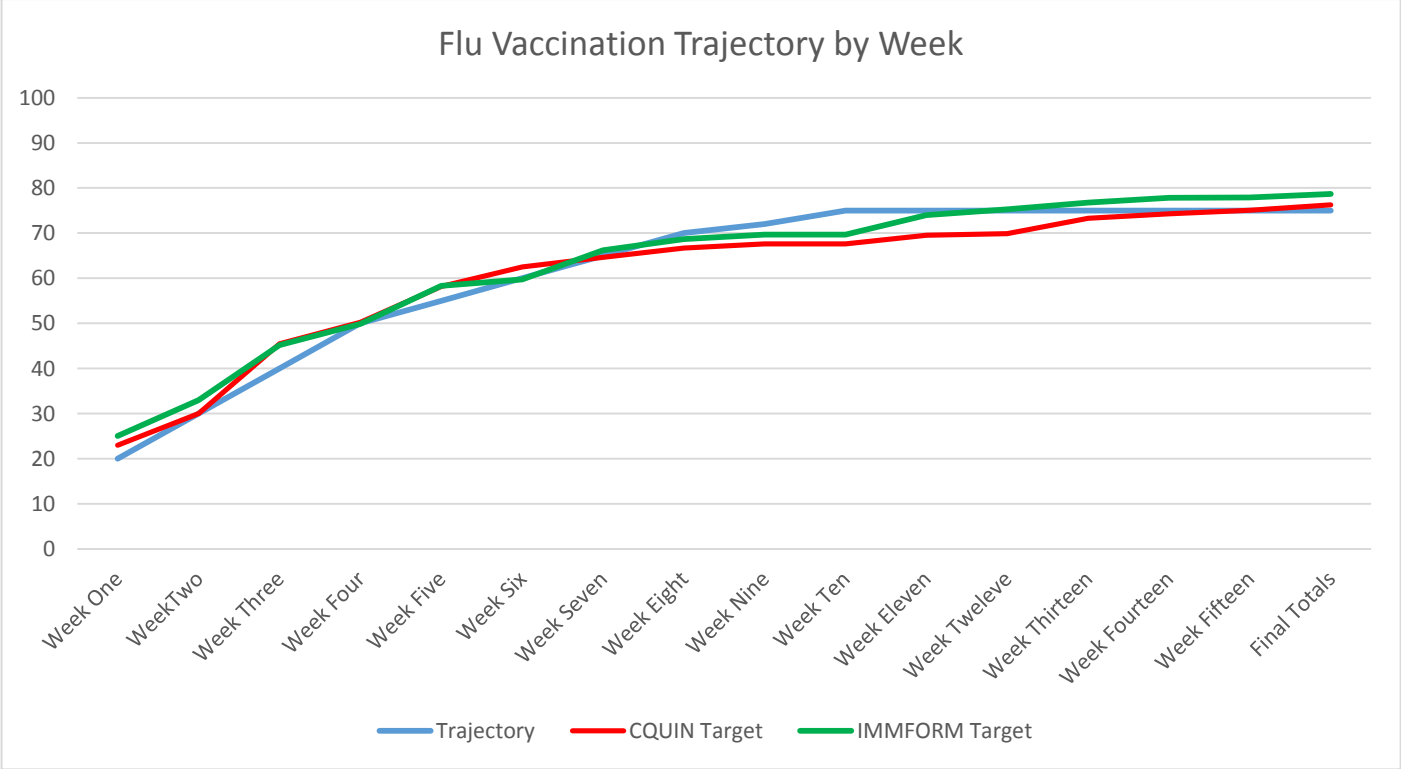
EOC and 111 Figures 2018 / 2019:



Directorate Figures including clinical staff (new starters) 2018 / 2019:



Flu Vaccination Trajectory 2018 / 2019:



Appendix B

IPC Datix Summary					
2018-2019	Q1	Q2	Q3	Q4	End of Year
Incident by type					
Needlestick / Sharp	12	16	18	13	59
Blood / Body fluid exposure	2	11	6	12	31
Exposure to Disease (including when not informed by HCP)	10	8	7	6	31
Equipment Contamination	1	1	4	0	6
Vehicle Contamination	0	0	1	1	2
Disposal of Clinical Waste	4	2	4	2	12
Totals	**29**	**38**	**40**	**34**	**141**
Unsatisfactory Investigations	17	28	30	28	103
	58%	74%	75%	82%	73%

Appendix C

As of the 31st March 2019 there were only three risks on the corporate Risk Register that are being managed by the IPCSG. Two of these are to be closed following the April meeting of the IPCSG.

Datix Risk Register Ref.	Adequacy of Controls: E (Effective) N (Non-Effective)	Risk Grade(s) Reviewed Y (Yes) N (No)	Review Date Met Y (Yes) N (No)	Status Review O (Open) P (Proposed for Closure)	Narrative Reviewed Y (yes) N (no)
322 – Hand Hygiene and Clinically Ready Compliance	Effective	Yes	Yes	Open	Yes
407 – IPC Mandatory Training	Effective	Yes	Yes	Proposed for Closure	Yes
717 – Cleaning of allocated Occupational Health Rooms	Effective	Yes	Yes	Proposed for Closure	Yes

Appendix D

Infection Prevention and Control Audit / Review results for 2018 / 2019

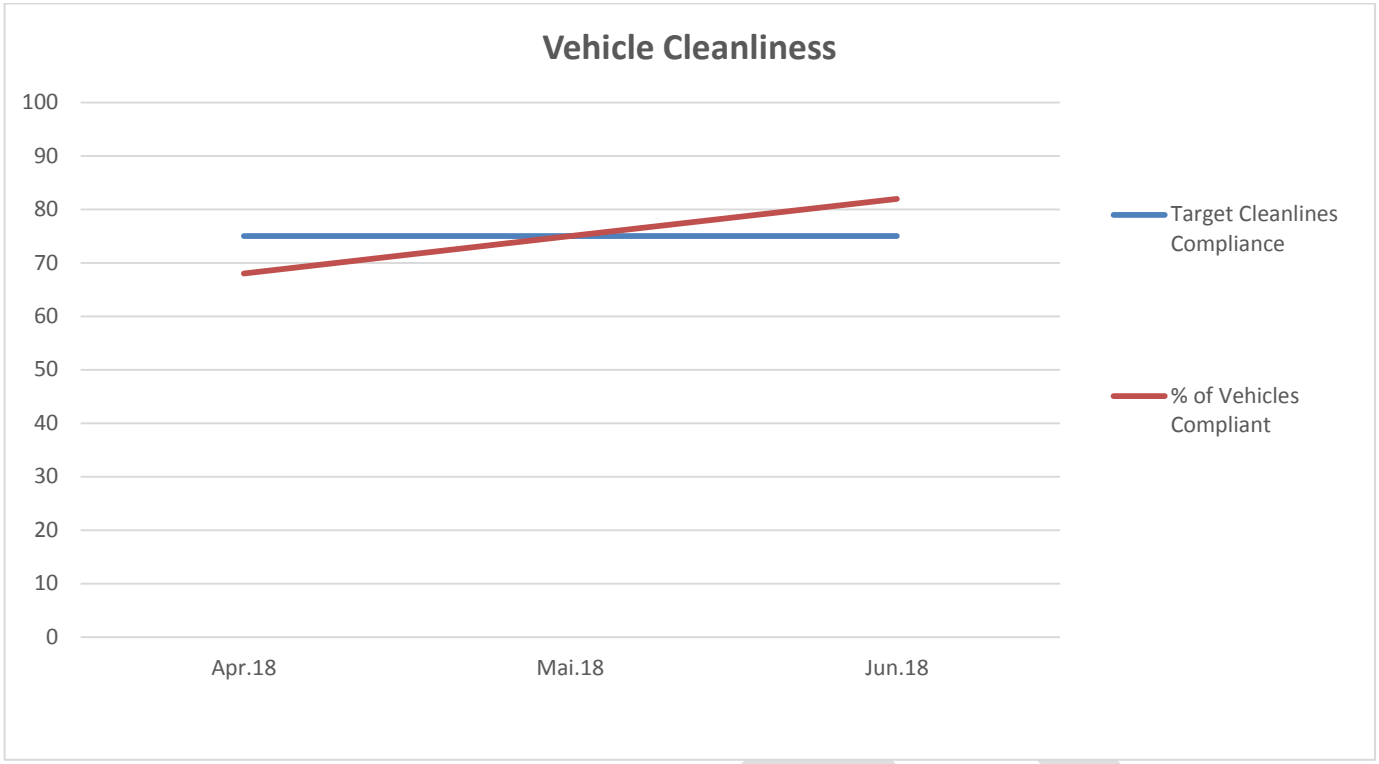
Following the introduction of IP Ready in July 2018 the audit / review tools were changed to reflect the changes to new procedure and terminology used. The changes were as follows –

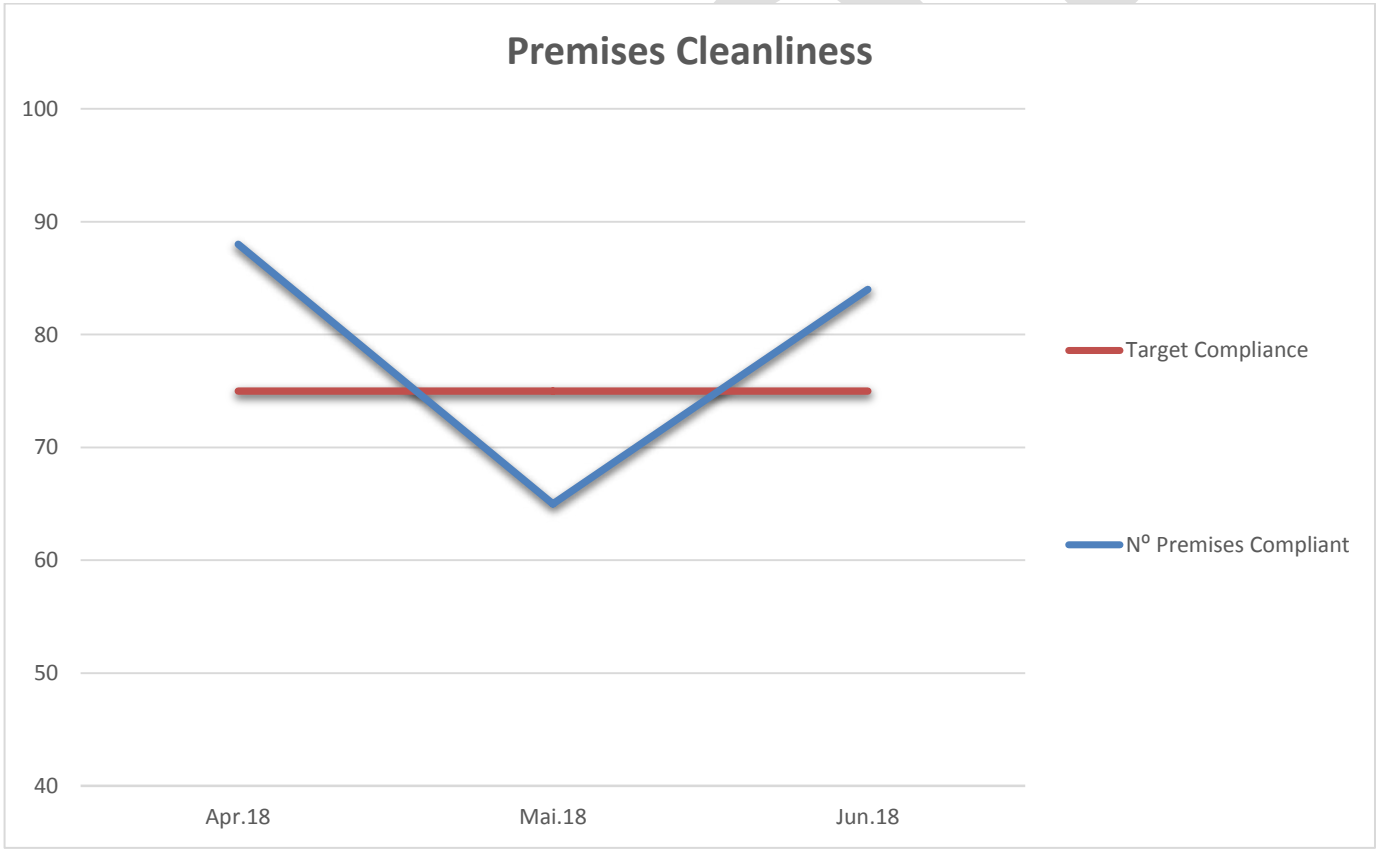
Hand Hygiene - from the Five Moments to the 3R's for hand hygiene

Bare Below the Elbows to Clinically Ready

Quarter One 2018 / 2019:

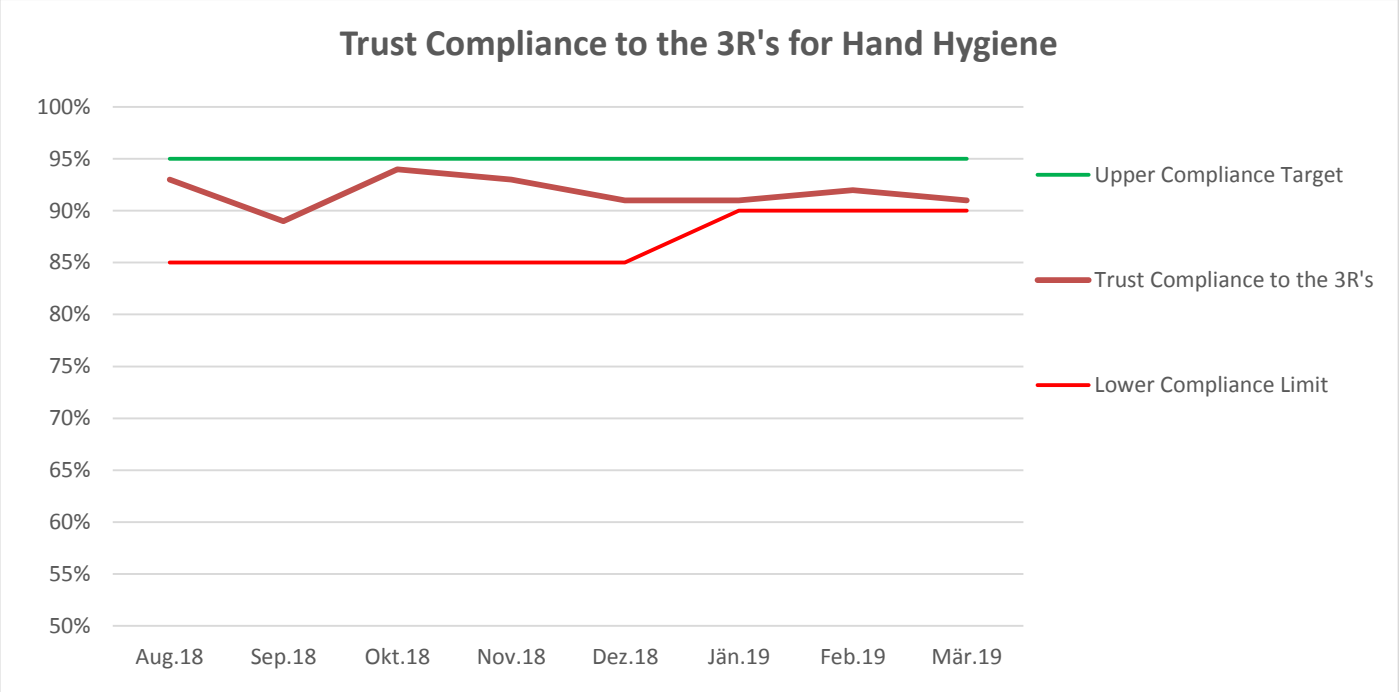
	Hand Hygiene	**Bare Below the Elbows**
Ashford	81%	91%
Brighton	90%	89%
Chertsey	96%	94%
Tangmere / Worthing	92%	87%
Polegate / Hastings	84%	97%
Guildford	94%	92%
HART Ashford	100%	94%
HART Gatwick	96%	97%
Medway / Dartford	93%	98%
Paddock Wood	78%	94%
Gatwick / Redhill	88%	97%
Thanet	90%	92%
SECAmb Total	**90%**	**93%**

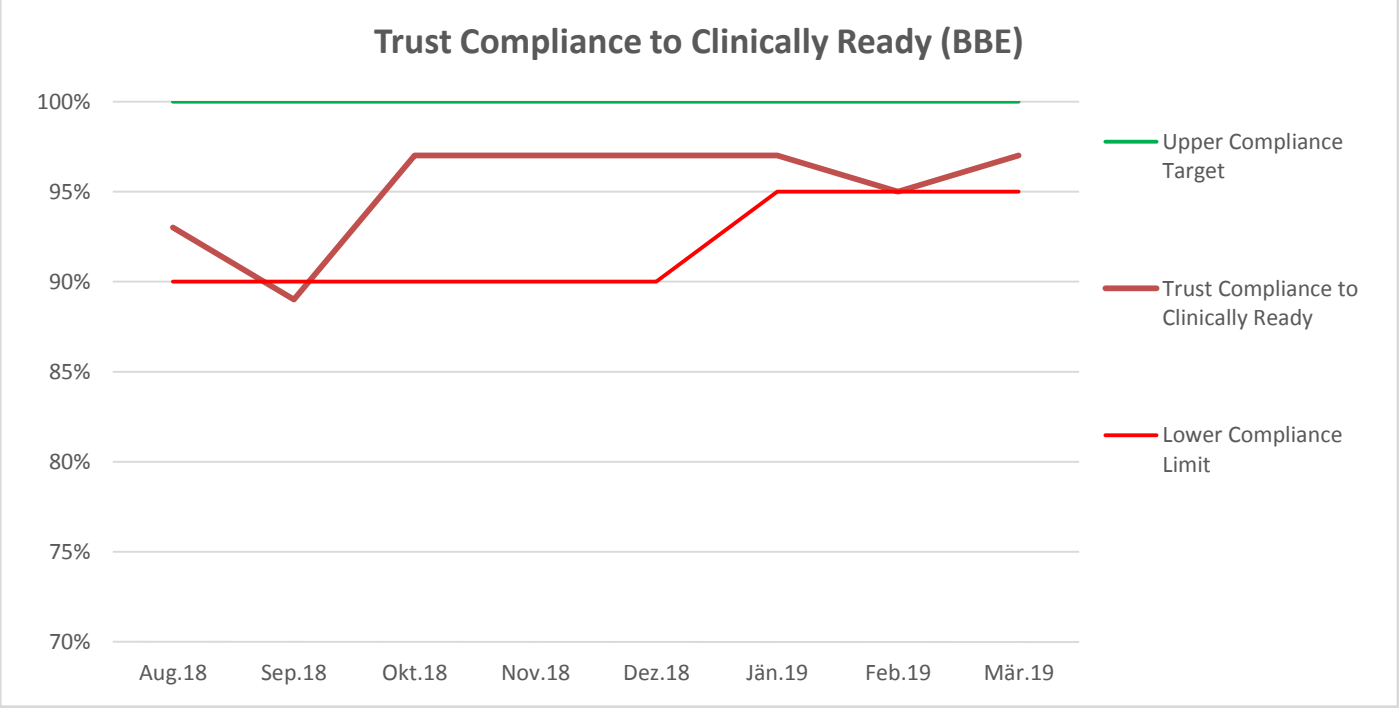

Vehicle Cleanliness
100
90
80
70
60
50
40
30
20
10
0
Apr.18
Mai.18
Jun.18
Target Cleanlines Compliance
% of Vehicles Compliant

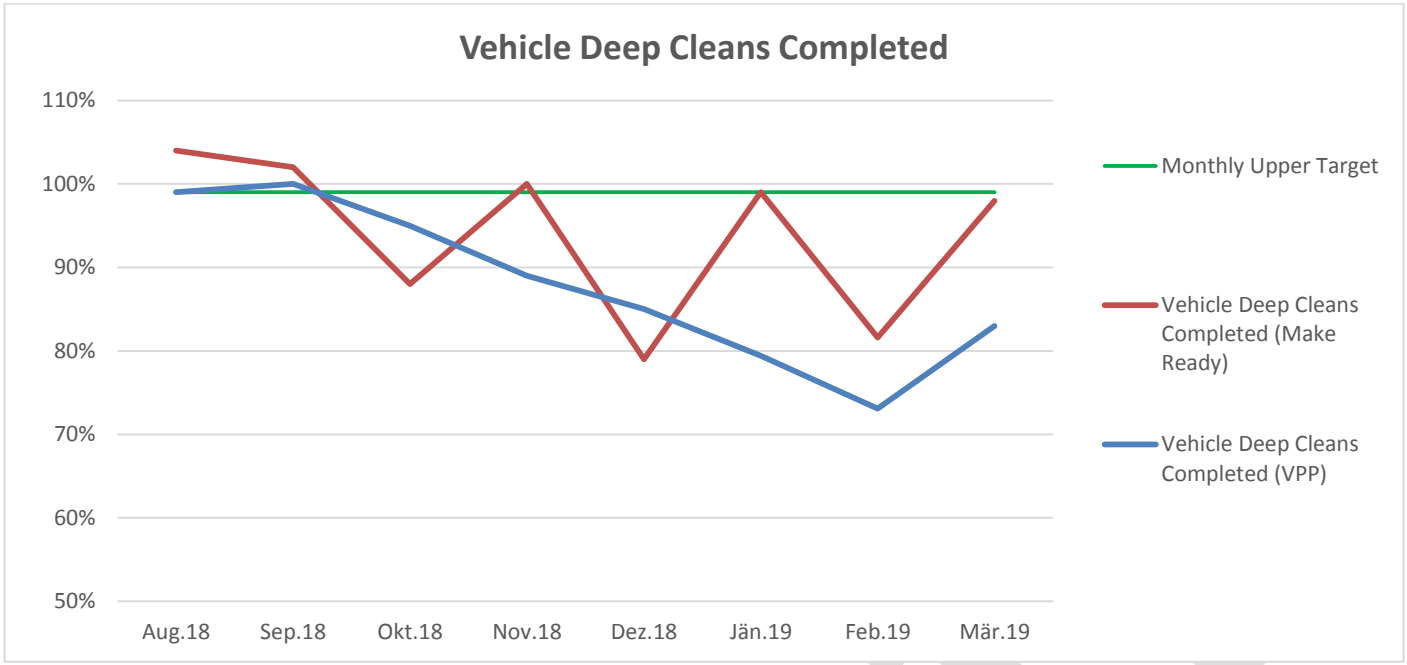

Premises Cleanliness
100
90
80
70
60
50
40
Apr.18
Mai.18
Jun.18
Target Compliance
Nº Premises Compliant

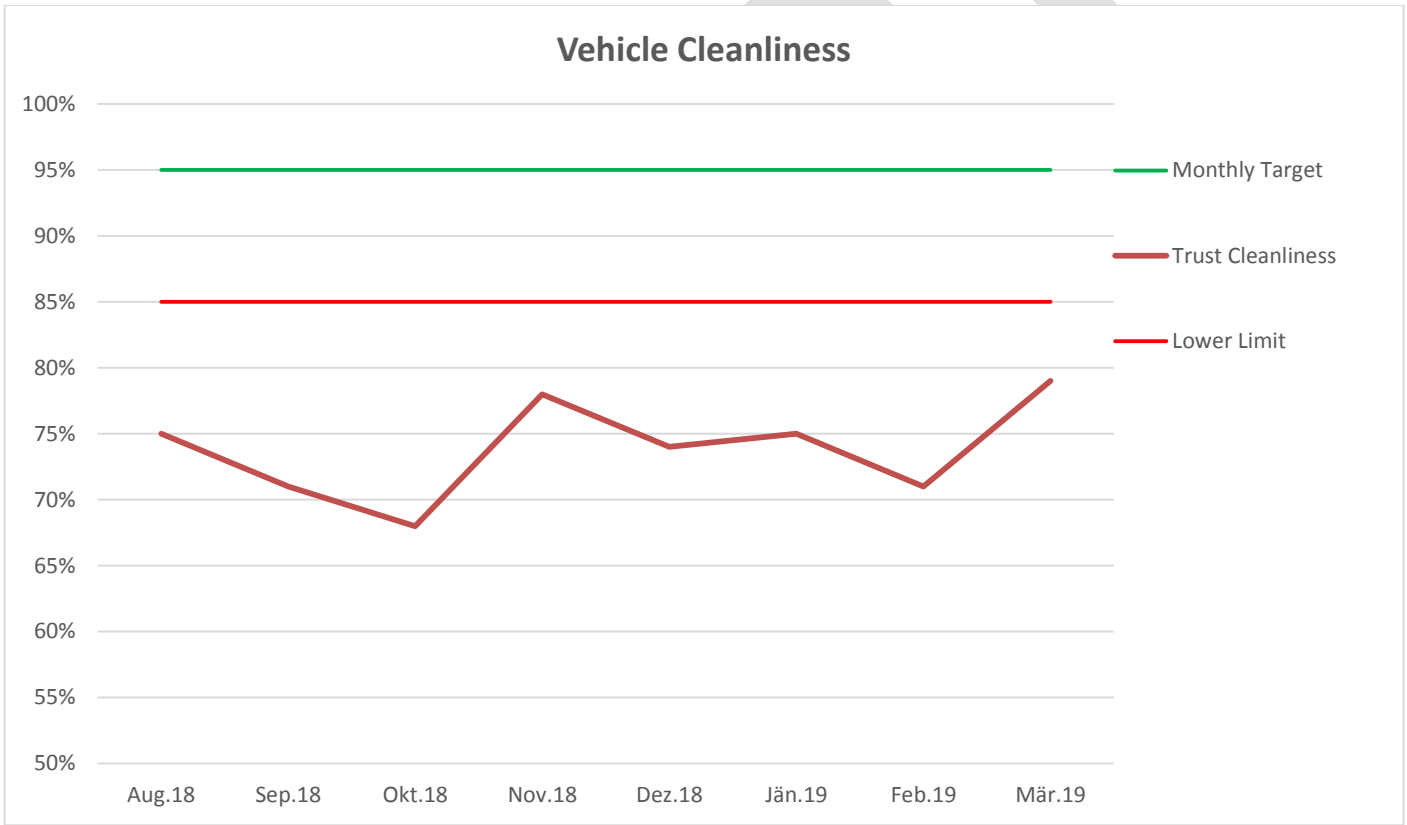
Post Introduction of IP Ready Graphs:

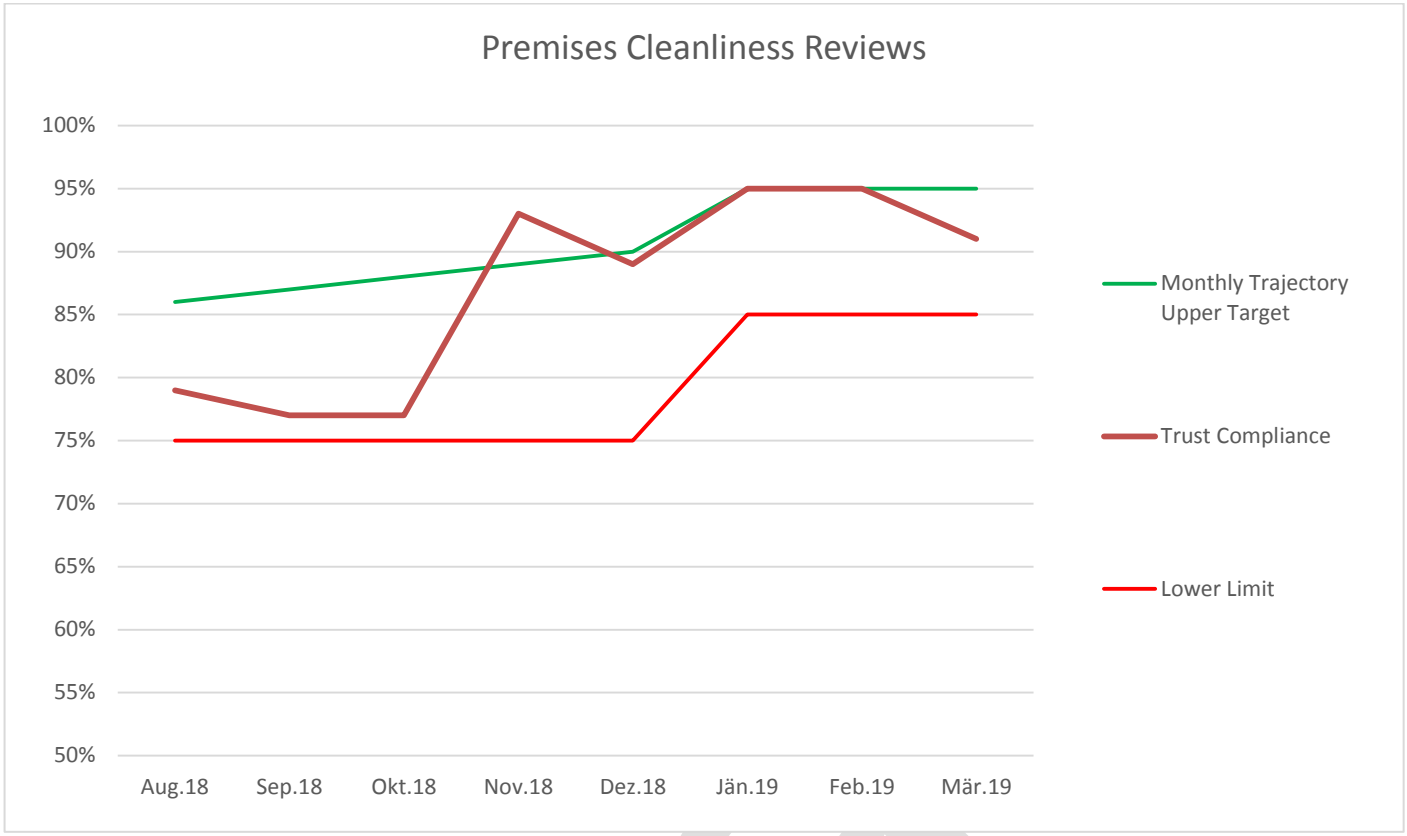
Following a review of all of the IPC audit / review tools as part of the Improvement Plan the graphs below were developed and introduced in August 2018 to show compliance to all IPC elements of the plan. This included monthly Deep Cleans for vehicles and monthly IPC Level 2 trajectory compliance.

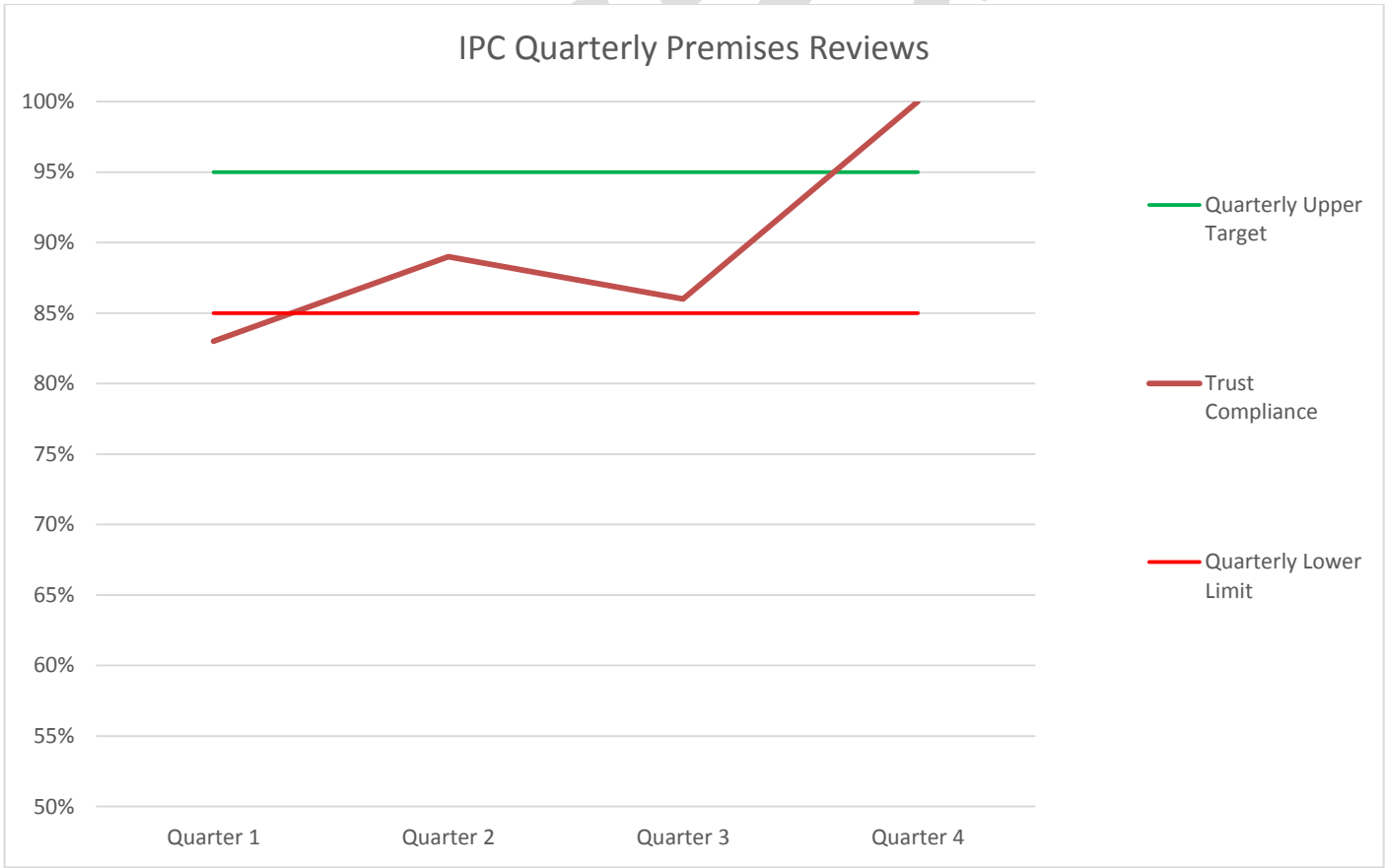


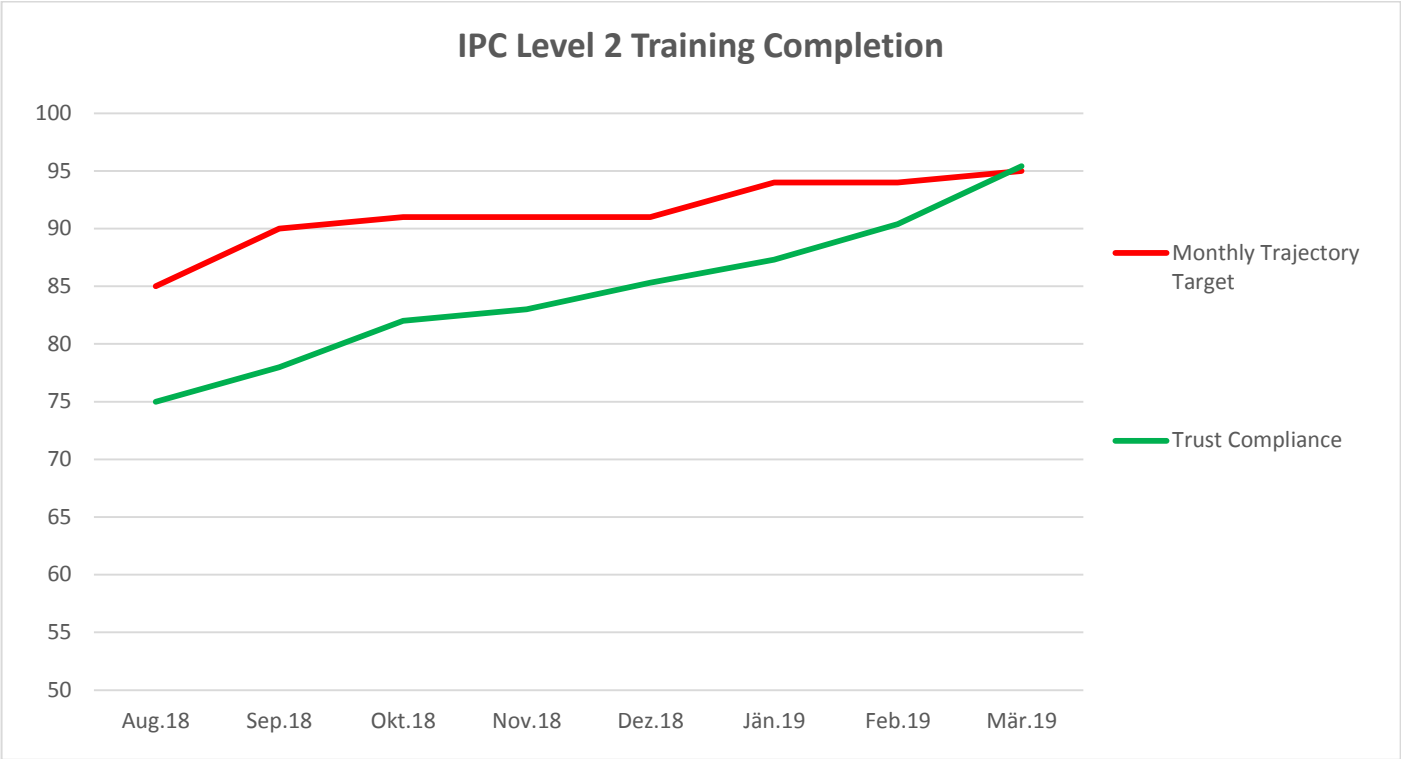



Vehicle Deep Cleans Completed
110%
100%
90%
80%
70%
60%
50%
Aug.18
Sep.18
Okt.18
Nov.18
Dez.18
Jän.19
Feb.19
Mär.19
Monthly Upper Target
Vehicle Deep Cleans Completed (Make Ready)
Vehicle Deep Cleans Completed (VPP)


Vehicle Cleanliness
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Aug.18
Sep.18
Okt.18
Nov.18
Dez.18
Jän.19
Feb.19
Mär.19
Monthly Target
Trust Cleanliness
Lower Limit


Premises Cleanliness Reviews
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Aug.18
Sep.18
Okt.18
Nov.18
Dez.18
Jän.19
Feb.19
Mär.19
Monthly Trajectory Upper Target
Trust Compliance
Lower Limit


IPC Quarterly Premises Reviews
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Quarter 1
Quarter 2
Quarter 3
Quarter 4
Quarterly Upper Target
Trust Compliance
Quarterly Lower Limit


IPC Level 2 Training Completion
100
95
90
85
80
75
70
65
60
55
50
Aug.18
Sep.18
Okt.18
Nov.18
Dez.18
Jän.19
Feb.19
Mär.19
Monthly Trajectory Target
Trust Compliance

Specialist Pharmacy Service

NHS

When Patient Group Directions (PGDs) are not required:

Guidance on when PGDs should not be used and advice on alternative mechanisms for supply and administration of medicines

The first stop for professional medicines advice

When PGDs are not required:
Guidance on when PGDs should not be used and advice on alternative mechanisms for supply and administration of medicines

Contents

1. Introduction

This guidance is designed to assist organisations in identifying when a Patient Group Direction (PGD) should not be used. The aims of this guidance are to:

- Sign post users to alternative mechanisms for supply and administration.
- Reduce the operational workload of developing, authorising, reviewing and updating unnecessary PGDs where simpler mechanisms for administration and supply are available.

Further guidance when considering the need for a PGD can be found in a separate SPS resource 'To PGD or not to PGD'[1] and 'Medicines Matters: A guide to mechanisms for the prescribing, supply and administration of medicines (in England)'[2]. These resources provide additional details on all the potential mechanisms for supply and administration of medications.

2. Background

In May 2018 Lord Carter identified the duplication of effort across NHS organisations in producing PGDs and medicines policies[3]. The report recommended that NHS England's Specialist Pharmacy Service (SPS), overseen by the Regional Medicines Optimisation Committees (RMOCs), develop a national 'Do Once' system for organisational medicines governance, including national standardised medicines policies, PGDs and other essential organisational governance documents.

PGDs enable the supply and/or administration of medicines in the absence of a Patient Specific Direction[4], prescription or a legal exemption in Human Medicines Regulations 2012[5].

PGDs should only be developed after careful consideration of the legal classification of the medication and all the potential methods of supply and/or administration of medicines, including prescribing by doctors, dentists or independent or supplementary prescribers and consideration of the legal exemptions that may be applicable.

NICE Medicines Practice Guideline Patient Group Directions (2017)[6] states:

- Provide the majority of clinical care involving supplying and/or administering medicines on an individual, patient-specific basis (i.e. using a prescription or a Patient Specific Direction (PSD)). Reserve patient group directions (PGDs) for limited situations in which this offers an advantage for patient care, without compromising patient safety, and where there are clear governance arrangements and accountability.
- Explore all the available options for supplying and/or administering medicines in a specific clinical situation.
- Do not use PGDs for medicines when exemptions in legislation allow their supply and/or administration without the need for a PGD.

Medicines that are classified as Pharmacy (P) or General Sales List (GSL) medicines[7] can be **administered** without the need for a PGD, and pre-packed GSL medicines can be **supplied** without a PGD. The **supply** of a P medicine requires a PGD unless an exemption applies or the supply is made from a registered pharmacy premises under the supervision of a pharmacist.

Legal Category	Is a PGD necessary to administer?	Is a PGD necessary to supply?
GSL	No	No
P	No	Yes (unless you are a pharmacist supplying from a registered pharmacy premises)
POM	Yes	Yes

3. Situations where a PGD should not be used

3.1 Where there is an opportunity for the medicines to be prescribed

A PGD is not necessary and should not be used when there is an opportunity in the care pathway for the medicine to be safely prescribed on an individual basis by a qualified prescriber. The majority of clinical care involving supplying and/or administering medicines should be undertaken on an individual, patient-specific basis where this does not compromise patients' timely access to care.

This would include:

- the writing of a PSD
- the issuing of a prescription by a prescriber during the patient's treatment pathway
- the completion of a pre-printed part of a drug chart
- completed entry on an electronic prescribing and medicines administration system*.

3.2 Where there is an exemption under the Human Medicines Regulations 2012

A PGD is not necessary and should not be used when there is an exemption under the Human Medicines Regulations 2012[5]. These are:

- exemptions for paramedics, orthoptists, midwives and podiatrists/chiropodists. These exemptions allow these registered health professionals to administer or supply certain specified medicines within their scope of practice and competency without a PSD or prescription.
- exemptions for administration of certain parenteral medicines for the purpose of saving life in an emergency.
- exemptions for administration and supply of medicines within Occupational Health Schemes.

See Appendix 1 for further information.

3.3 Where the medicines to be supplied or administered are GSL medicines

A PGD is not necessary and should not be used where the medicines to be **supplied or administered** are General Sales List (GSL) medicines.

A locally approved protocol could be used to support administration and supply of GSL medicines – this may be a stand-alone policy, or incorporated within a broader medicines policy. Such policies are often referred to as Homely Remedy or Discretionary Medicines policies. Examples are given in Appendices 2 & 3. The Regional Medicines Optimisation Committee has issued guidance on homely remedies in care homes and this can be adapted for different care settings[8].

In organisations with inpatient units where GSL medicines may be frequently or commonly administered under such a policy it may be preferable to have a pre-printed section on the drug chart or a standard entry within an e-prescribing system* which the healthcare professional administering the medication completes. These usually have a maximum number of doses that can be administered without a prescriber review.

In summary:

Legal Category	Is a PGD necessary to administer?	Is a PGD necessary to supply?
GSL	No	No

See Appendix 1 for further information.

3.4 Where the medicines to be administered are P medicines

A PGD is not necessary and should not be used where the medicines to be **administered** are Pharmacy (P) medicines.

A PGD or PSD is needed for **supply** of P medicines unless the supply is made from a registered pharmacy premises under the supervision of a pharmacist or an exemption exists.

A locally approved protocol could be used to support administration of P medicines – this may be a standalone policy, or incorporated within a broader medicines policy. Such policies are often referred to as Homely Remedy or Discretionary Medicines policies. Examples are given in Appendices 2 & 3. The Regional Medicines Optimisation Committee has issued guidance on homely remedies in care homes and this can be adapted for different care settings[8].

In organisations with inpatient units where P medicines may be frequently or commonly administered under such a policy it may be preferable to have a pre-printed section on the drug chart or a standard entry within an e-prescribing system* which the healthcare professional administering the medication completes. These usually have a maximum number of doses that can be administered without a prescriber review.

In summary:

Legal Category	Is a PGD necessary to administer?	Is a PGD necessary to supply?
P	No	Yes (unless being supplied from a registered pharmacy premises under the supervision of a pharmacist)

See Appendix 1 for further information.

3.5 Where a medical gas is to be administered

A PGD is not necessary and should not be used for the administration of medical gases as these are not commonly Prescription Only Medicines (POMs) and advice for GSL/P medicines should be followed or the medical gas be prescribed. Organisations should clarify the legal classification of the gases they use in practice.

It is acknowledged that, in line with local policy, organisations may only allow emergency medical gases to be given if prescribed by a medical or independent prescriber or administered under a PGD. In these cases a pre-printed section of the drug chart or a standard entry within an e-prescribing system* may be more appropriate than having an unnecessary PGD in place. This is in line with the British Thoracic Society guideline for oxygen use in adults, which suggests that oxygen should be prescribed or a PSD used. A PGD should only be used if other mechanisms have not worked in clinical practice[9].

See Appendix 1 for further information.

4. Removing unnecessary PGDs from practice

Where an organisation has PGDs in place where other mechanisms for supply/administration are available the PGDs can be superseded by the suitable alterative mechanism as detailed in this guidance. Organisations need to ensure that any PGDs removed from practice and the alterative mechanisms identified are reviewed and agreed in accordance with local governance or other relevant processes. Organisations need to ensure that changes to practice are robustly communicated to all relevant personnel.

Safety is paramount and organisations should ensure appropriate governance when transferring administration/ supply mechanisms and consideration should be given to service continuity and the training needs of staff.

*ePMA (electronic Prescribing and Medicines Administration) systems can be used to support administration/supply records. How systems are configured to meet the need should be determined locally based on available functionality, local configuration and experience.

5. References:

1 - 'To PGD or not to PGD' https://www.sps.nhs.uk/articles/to-pgd-or-not-to-pgd-that-is-the-question/ (accessed 10.8.18)
2 - Medicines Matters A guide to mechanisms for the prescribing, supply and administration of medicines (in England) https://www.sps.nhs.uk/articles/medicines-mattersa-guide-to-mechanisms-for-the-prescribing-supply-and-administration-of-medicines-in-england/ (accessed 29.10.18)
3 - Operational productivity unwarranted variations in mental health and community health services (2018). Lord Carter's review into unwarranted variations in mental health and community health services | NHS Improvement (accessed 8.8.18)
4 - SPS Q&A Questions about Patient Specific Directions (PSD) https://www.sps.nhs.uk/articles/patient-specific-directions-qa/ (accessed 12/12/18)
5 - The Human Medicines Regulations 2012 http://www.legislation.gov.uk/uksi/2012/1916/contents/made (accessed 10.8.18)
6 - NICE Medicines Practice Guideline Patient Group Directions (2017) https://www.nice.org.uk/Guidance/MPG2 (accessed 10.8.18)
7 – What is the law on the sale of medicines? https://www.nhs.uk/common-health-questions/medicines/what-is-the-law-on-the-sale-of-medicines/
8 - RMOC Guidance: Homely Remedies https://www.sps.nhs.uk/articles/rmoc-guidance-homely-remedies/ (accessed 26.11.18)
9 - BTS guideline for oxygen use in adults in healthcare and emergency settings https://www.brit-thoracic.org.uk/document-library/clinical-information/oxygen/2017-emergency-oxygen-guideline/bts-guideline-for-oxygen-use-in-adults-in-healthcare-and-emergency-settings/ (accessed 5.11.18)
10 - The Human Medicines Regulations 2012 Schedule 19 http://www.legislation.gov.uk/uksi/2012/1916/schedule/19/made (accessed10.8.18)
11 -The Human Medicines Regulations 2012 Schedule 17 http://www.legislation.gov.uk/uksi/2012/1916/schedule/17/made (accessed10.8.18)
12 - PGDs and Occupational Health Schemes https://www.sps.nhs.uk/articles/pgds-and-occupational-health-schemes/ (accessed10.8.18)
13 – Personal correspondence with MHRA 11/12/2018
14 - NHS England guidance on over the counter medicines which should not be prescribed in primary care.https://www.england.nhs.uk/wp-content/uploads/2018/03/otc-guidance-for-ccgs.pdf (accessed10.8.18)
15 - The National Health Service (Charges for Drugs and Appliances) Regulations 2015 https://www.legislation.gov.uk/uksi/2015/570/contents/made (accessed 13.8.18)
16 - SPS Q&A Do patients receiving medicines under a PGD pay NHS prescription charges? https://www.sps.nhs.uk/articles/do-patients-receiving-medicines-under-a-pgd-pay-nhs-prescription-charges/ (accessed 12/12/18)

Appendix 1 Situations were PGDs should not be used

Situation	Explanation
Exemptions for administration of certain parenteral medicines for the purpose of saving life in an emergency (HMR 2012 Schedule 19)[10]	Schedule 19 of the Human Medicines Regulation 2012[10] allows administration of certain parenteral medicine without a prescription for the purpose of saving life in an emergency. PGDs should not be used for the administration of these medicines but administration should follow national guidance such as the Resuscitation Council guidance on the management of anaphylaxis or a local organisation guideline/protocol. Currently listed in Schedule 19 are: • Adrenaline 1:1000 up to 1mg for intramuscular use in anaphylaxis • Atropine sulphate and obidoxime chloride injection • Atropine sulphate and pralidoxime chloride injection • Atropine sulphate injection • Atropine sulphate and obidoxime chloride injection • Atropine sulphate, pralidoxime mesilate and avizafone injection • Chlorphenamine injection • Dicobalt edetate injection • Glucagon injection • Glucose injection • Hydrocortisone injection • Naloxone hydrochloride • Pralidoxime chloride injection • Pralidoxime mesilate injection • Promethazine hydrochloride injection • Snake venom antiserum • Sodium nitrate injection • Sodium thiosulphate injection
Exemptions from the restriction on sale, supply and administration of prescription only medicines (HMR 2012 Schedule 17)[11]	There are exemptions within the Human Medicines Regulations 2012[11] which allow certain registered professionals to sell, supply and administer the listed medications without a prescription. Where such exemptions exist a PGD should not be used. Local protocols may be developed to support the use of these medicines. Exemptions are in place for the following professions: • Paramedics • Podiatrists/Chiropodists • Midwives • Orthoptists Refer to the full regulations for the medications exempted for further detail.
Occupational Health Schemes (OHS)	An Occupational Health Scheme (OHS) is a multidisciplinary service that aims to protect and promote workers' physical, mental and social health and well-being through actions related both to the work environment and to the workers themselves[12]. Under the Human Medicines Regulations 2012[11] OHS are exempt from the restrictions that apply to prescription only medicines, where medicinal products are supplied or administered in the course of the OHS by a doctor, or by a registered

Situation	Explanation
	nurse acting in accordance with the written (and signed) directions of a doctor. This instruction is commonly documented in a written operating protocol. More information can be found in 'PGDs and Occupational Health Schemes.'[12]
GSL medicines for administration or supply	PGDs are not required and should not be used for a GSL medicine to be **administered or supplied** to a patient. Medicines legislation states that a PGD is not necessary to supply a GSL medicine, provided the supply takes place from lockable premises and the medicines are pre-packed and fully labelled (see below for further detail). In the case of the administration or supply of a GSL medicine a protocol can be used to support these tasks – this may be a standalone policy, or incorporated within a broader medicines policy. Such policies are often referred to as Homely Remedy or Discretionary Medicines policies. Such protocols can be used in all healthcare settings including for the management of minor aliments in an inpatient setting within acute, community and mental health services and also in minor injury or urgent care departments, care homes and a patient's own home. In organisations with inpatient units where GSL medicines may be frequently or commonly administered under such a policy it may be preferable to have a pre-printed section on the drug chart or a standard entry within an e-prescribing system which the healthcare professional administering the medication completes. These usually have a maximum number of doses that can be administered without a prescriber review. The SPS Medicines Governance Do Once Secretariat has produced a sample protocol template (see Appendix 3) which can be adapted for local use. Locally adapted templates must be ratified in line with local governance procedures. An example of a discretionary medicines policy which is part of the organisation's overarching medicine's policy is given in Appendix 2. When a GSL medication is **administered** without a prescription or PGD being in place and where the legal classification of the medicine is based on the pack size (for example paracetamol) we have been advised by the MHRA that administration of single doses can be made from a POM, P or GSL pack which has been legally obtained by the organisation[13]. When a GSL medication is **supplied** without a prescription or PGD being in place the medication supplied must be in a pre-packed GSL labelled pack only. When a GSL medicine is supplied to a patient if the dosage instructions on the GSL pack reflect the dose required to be administered under the protocol then over-labelling is not required. It would be good practice to add the patient's name/date supplied and address of the supplying unit to any medicine supplied. This information can be

Situation	Explanation
	as a pre-printed label to which the patient's name and date of supply is added at the time of supply. Any additional label should be added in such a way that it does not obscure manufacturer's information on the pack. When considering if a GSL medicine should be supplied please refer to the 2018 NHS England guidance on over the counter medicines which should not be prescribed in primary care[14]. Whilst this guidance was written for primary care services all NHS services should be mindful of this guidance and practitioners should advise patients to buy over the counter medicines for self-care wherever practicable to do so. Where a medicine is supplied under an NHS commissioned service then the regulations require that a prescription charge is made unless the patient is exempt from such charges[15]. In most cases it would not be cost effective for a patient to pay a prescription charge for a GSL medicine to be supplied which they can purchase. If any GSL medicines are supplied and a prescription charge levied the organisation should have a mechanism in place for collecting these charges[16]. Local processes for record keeping, staff training and competency assessments, audit, incident reporting and medicines storage, labelling and requisition must all be considered when operating under protocols.
P medicines for administration	PGDs are not required and should not be used for a P medicine to be **administered** to a patient. In the case of the **administration** of a P medicine a protocol can be used to support these tasks – this may be a standalone policy, or incorporated within a broader medicines policy. Such policies are often referred to as Homely Remedy or Discretionary Medicines policies. Such protocols can be used in all healthcare settings including for the management of minor aliments in an inpatient setting within acute, community and mental health services and also in minor injury or urgent care departments, care homes and a patient's own home. In organisations with inpatient units where P medicines may be frequently or commonly administered under such a policy it may be preferable to have a pre-printed section on the drug chart or a standard entry within an e-prescribing system which the healthcare professional administering the medication completes. These usually have a maximum number of doses that can be administered without a prescriber review. The SPS Medicines Governance Do Once Secretariat has produced a sample protocol template (see Appendix 3) which can be adapted for local use. Locally adapted templates must be ratified in line with local governance procedures. An example of a discretionary medicines policy which is part of the organisation's overarching medicine's policy is given in Appendix 2.

Situation	Explanation
	When a P medication is **administered** without a prescription or PGD being in place and where the legal classification of the medicine is based on the pack size (for example fluconazole) we have been advised by the MHRA that administration of single doses can be made from a POM or P pack which has been legally obtained by the organisation. A registered pharmacy can legally **supply** a P medication without a PGD or prescription. Local processes for record keeping, staff training and competency assessments, audit, incident reporting and medicines storage and requisition must all be considered when operating under protocols.
Medical Gases	A PGD is not necessary and should not be used for the administration of medical gases as these are not commonly Prescription Only Medicines (POMs) and advice for GSL/P medicines should be followed or the medical gas be prescribed. Organisations should clarify the legal classification of the gases they use in practice. It is acknowledged that, in line with local policy, organisations may only allow emergency medical gases to be given if prescribed by a medical or independent prescriber or administered under a PGD. In these cases a pre-printed section of the drug chart or a standard entry within an e-prescribing system* may be more appropriate than having an unnecessary PGD in place. This is in line with the British Thoracic Society guideline for oxygen use in adults, which suggests that oxygen should be prescribed or a PSD used. A PGD should only be used if other mechanisms have not worked in clinical practice[9].

Appendix 2 Example of Acute Trust Discretionary Medicines Policy (Appendix of Organisational Medicines Policy)

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Note SPS are not responsible for nor endorsing any of the medication choices/doses etc included in this guideline – it is provided as an example only.

Medicines administered at the discretion of nurses

Treatment with certain specified medicines (not classified as prescription only medicines) may be initiated by nurses/midwives without the authorisation of a prescriber, provided:

a) The medicine is listed on Trust approved lists below
b) The treatment is recorded on the appropriate section of the Trust prescription card.
c) An appropriate note of the medicines used is made in the nursing record.

1. Oral medicines that may be administered to adult patients at the discretion of a Registered Nurse

Medicine	Approved Use
Dioralyte Sachets/Oral Rehydration Salts	Diarrhoea/Vomiting
Glycerin Thymol Pastilles (1-3 pastilles)	Sore Mouth
Gaviscon advance	Heartburn/indigestion
Magnesium Hydroxide Mixture (25-50ml)	Constipation
Magnesium Trisilicate Mixture (10ml)	Indigestion
Paracetamol Tablets (1-2 tablets)	Analgesic/Antipyretic
Senna Preparations (2-4 tablets or 10-20ml syrup)	Constipation
Simple Linctus (5ml)	Cough

Medication initiated by a registered nurse shall be restricted to ***one*** dose and must be reported to the prescriber when he/she next visits the ward or earlier if indicated by the condition of the patient. If the patient's condition does not respond to this treatment the prescriber must be notified immediately. All such medication must be recorded in the nursing notes and on the patient's prescription sheet either in the *stat* section for a one-off administration or in the *prn* section if it is intended that further doses may be administered following countersignature by a doctor. The record of administration must be signed and dated by the nurse.

2. Topical applications administered at the discretion of a Registered Nurse

The Trust Prescribing, Acquisition, Storage and Administration of Medicines Policy permits nurses to administer certain topical applications without a prescription written by a registered practitioner. The following may be administered by a registered nurse at his/her discretion for the approved use specified against each product. An appropriate entry of all topical applications marked with an asterisk must be made in the nursing records after use.

Topical Application	Approved Use
Acetone	Removal of nail polish
Alcohol swabs (Sterets, Medi-swabs)	Skin cleaning
Anusol cream*	Local pain relief from haemorrhoids

Topical Application	Approved Use
Aqueous cream	Dry skin
Benzoin compound tincture	Skin protection (undiluted) steam inhalation (in hot water)*
Benzydamine 0.15% (Difflam) oral rinse	Sore mouth/throat
Calamine lotion	Skin rashes/itching skin
Chlorhexidine 0.2% (Corsodyl) mouthwash	Mouth ulcers
Chlorhexidine (Aqueous) Solution	Hand washing for staff and skin decolonisation/bioburden reduction for patients
Chlorhexidine (Alcoholic) Solution	Skin disinfectant
Chlorhexidine 2% (Alcoholic) Solution	Skin disinfectant
Choline salicylate paste (Teejel, Bonjela)*	**Adults only.** Minor oral ulceration
Clotrimazole 1% cream	Candida infection of skin or genitalia
Dermalo bath emollient	Dry skin conditions
Dermol 500	Skin decolonisation/bioburden reduction
Emulsifying ointment	Emollient for dry skin/ soap substitute
Ethyl chloride spray	Local anaesthesia prior to venesection or injections
Flexible collodion, methylated BP	Sealing skin following drain removal, lumbar puncture etc
Glycerin & Icthammol*	Thrombosed veins following intravenous therapy
Glycerol suppositories*	**Adults only.** Constipation
Hypromellose 0.3% eye drops	Dry eyes
Lubricating Jelly (KY Jelly)	Lubrication for rectal catheters etc
Lignocaine Gel 1% with Chlorhexidine *	Local anaesthetic prior to catheterisation
Metanium Ointment	Urinary rashes and related disorders (third line)
Methylated spirit, Industrial (70%)	Cleaning skin after iodine/cord care
Micro-enema*	**Adults only**. Constipation
Mouthwash tablets (Tellodont)	Oral hygiene
Octenidine 0.3& (Octenisan)	Handwashing, skin disinfectant/decolonisation/bioburden reduction
Olive oil*	Emollient for dry skin/cradle cap
Plaster remover	Removal of adhesive tape marks
Polyhexanide (Prontoderm) solution/foam/gel	Skin disinfectant/decolonisation/bioburden reduction
Povidone-iodine solution* (Betadine)	Skin disinfectant/superficial wound dressing
Povidone-iodine spray*	Skin disinfectant/superficial wound dressing
Sodium Bicarbonate	Oral hygiene
Sodium Chloride 0.9%	Mouth care
Sudocrem cream	Urinary rashes and related disorders (second line)
White or Yellow soft paraffin	Sore/cracked lips
Zinc and castor oil	Urinary rashes and related disorders (first line)

3. Wound Care that may be administered to adult patients at the discretion of a Registered Nurse

For general principles in the treatment of wounds and further information about specific conditions and treatments refer to the Wound Care Guidelines Booklet and poster.

Topical Application	Approved Use
Calcium Alginate dressing/packing/ribbon (Sorbsan)	See wound care guidelines
Foam dressings (Allevyn, Lyofoam)	Moderate to heavy exudating wounds
Hydrocolloid paste/dressings (Duoderm Comfeel, Aquacel)	See wound care guidelines
Hydrogel dressing/gel (Purilon, Intrasite Conformable)	See wound care guidelines
Paraffin gauze dressings (Jelonet)	Radiotherapy wounds
Plastic film faced dressing (Skintact)	See wound care guidelines
Proflavine cream	Wound care (as ward protocol)
Sodium Chloride 0.9% (Normasol)	Cleaning wounds/eye care
Spray adhesive film dressing (OpSite spray)	Secondary dressing for sutured wounds
Vapour-permeable adhesive film dressing BP (OpSite)	Clean wounds

4. Medicines Administered to Children at the Discretion of a Registered Nurse

The following medicines may be administered by a registered nurse to children without a written instruction by a registered practitioner. The medicine must be administered by a registered nurse authorised to administer medicines at his/her own discretion.

Medicine	Approved Use
Amethocaine Gel 4%	Local anaesthetic
Dioralyte Sachets	Diarrhoea/vomiting
Ibuprofen Liquid /Tablets	Analgesic/antipyretic
Nystatin Oral Solution	Oral thrush
Paracetamol Suspension/Tablets/ Suppositories	Analgesic/antipyretic

Medication should be restricted to ***one*** dose given in accordance with BNFC standard text/manufacturers/pharmacy guidelines and ward/unit protocols. It must be reported to the relevant doctor when he/she next visits the ward or earlier if indicated by the condition of the patient. If the patient's condition does not respond to this treatment the prescriber must be notified immediately. All such medication must be recorded in the nursing notes and on the patient's prescription sheet either in the *stat* section for a one-off administration or in the *prn* section if it is intended that further doses may be administered following countersignature by a doctor. The record of administration must be signed and dated by the nurse.

Appendix 3 Protocol Template

Template protocol for the administration or supply of a GSL or administration of a P medicine

Note packs supplied to a patient under a protocol must be GSL packs. Single doses of a medicine from P or GSL packs (or a POM pack if legal classification is based on pack size) can be administered under a protocol.

1. Staff competencies	
Authorised staff	*Insert detail of healthcare professionals who can operate under this protocol as per local agreement*
Additional requirements	*Insert detail as per local agreement to include: staff grade levels as appropriate; requirements of training to be undertaken before accessed as competent; any on-going training/CPD requirements.*
2. Clinical condition or situation	
Clinical situation	
Patients included	
Patients excluded	
Action for patients excluded	
Action if patient declines	
3. Description of treatment	
Medicine to be administered/supplied	
Dose schedule including maximum dosage	
Maximum time medicine can be administered under protocol for before review by a prescriber	
Quantity of medicine to be made if supplied (GSL only)	Supply in original GSL pack only This must have full dosage instructions on the packaging
Follow up/Patient advice	• Inform patient of medicine being administered and rationale. • Patient Information Leaflet offered (must be supplied if medicine is being supplied to patient). • If administered monitor patient and use clinical judgement to decide when to seek medical advice. • Inform patient how/when to seek further medical advice.
Record keeping	The following must be recorded on the *drug chart/EPS or clinical notes as per local protocol*: • Date and time of administration/supply. • Patient details such as name, date of birth, hospital or NHS number, allergies, previous adverse events and the criteria under which the patent fits the protocol. • Details of medicines including name, strength, form, dose, route. • If supply made then quantity supplied. • A statement that administration/supply is under a protocol. • Name and signature (which may be electronic) of healthcare professional acting under the protocol to administer/supply the medicine. • Relevant information that was given to the patient/carer. • Record that consent gained (or refused) – if consent refused record actions taken.

For an alternative template see RMOC Homely Remedies in Care Homes.[8]

NHS Specialist Pharmacy Service

www.sps.nhs.uk

Protocol Reference:	**001**
Version Number:	**0.4**
Review:	**10/06/2021**
Expiry:	**10/09/2021**
Issue:	**10/09/2018**

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Medicines Protocol

For the administration of:

Salbutamol 2.5mg in 2.5ml Nebuliser Solution

Name of Product:	**Salbutamol (Ventolin)**
Legal Category:	**Prescription Only Medicine (POM)**
Relevant Legislation:	**POM administered on Trust Board Authority**
Route of Administration:	**Nebulised**
Authorised Clinical Grades:	**Community First Responders (CFRs) and Immediate Emergency Care Responders (IECRs)**

Authors' Name(s):	**Jay Fenimore Sanders, Greg Smith**
Approval: **Medical Director**	**Name:** Fionna Moore **Position:** Executive Medical Director **Signature:** **Date:**
Approval: **Senior Pharmacist**	**Name:** Carol-Anne Davies-Jones **Position:** Chief Pharmacist **Signature:** **Date:**
Approval: **Senior Paramedic**	**Name:** Julie Ormrod **Position:** Consultant Paramedic **Signature:** **Date:**

Approval: **Trustboard**	**Name:** **David Astley** **Position:** **Chairman** **Signature:** **Date:**

PROTOCOL

Overview	This document describes the requirements and processes for Community First Responders (CFRs) to safely administer Salbutamol to patients in the community prior to the arrival, and handover of care of the patient, to a SECAmb Clinician. This protocol applies to all volunteers undertaking the role of the Community First Responder for South East Coast Ambulance Service NHS Foundation Trust (SECAmb). The purpose of this protocol is to: ▪ Support the delivery of safe, effective care to patients; ▪ Minimise the risk to patients associated with receiving a prescription only medication (POM); ▪ Ensure consistency of medicine administration.
Presentation	Nebules containing 2.5 milligrams/2.5ml
Indications	Patients with a diagnosis of asthma/COPD who are experiencing an: ▪ Acute asthma attack where normal inhaler therapy has failed to relieve symptoms. ▪ Exacerbation of chronic obstructive pulmonary disease (COPD) with increased difficulty in breathing not relieved by normal inhaler therapy.
Contraindications	Not for administration in children less than 18 months old.
Actions	Salbutamol is a selective beta2-adrenoreceptor stimulant drug. This has a relaxant effect on the smooth muscle in the medium and smaller airways, which are in spasm in acute asthma attacks. If given by nebuliser its smooth-muscle relaxing action, combined with the airway moistening effect of nebulisation, can relieve the attack rapidly.
Side Effects	**Common or Very Common:** ▪ **Tremor** ▪ **Tachycardia**

	▪ **Palpitations** ▪ **Headache** ▪ **Nausea** ▪ **Arrhythmia**

PROTOCOL

Route of Administration	Nebulised via Oxygen driven nebuliser with a flow rate of 6-8 L/Min.
Product for Administration	Single use mask for nebulisation.
Dosage and Administration	**Aged under 18 months and under:** ▪ Not indicated **Aged 18 months to 5 years:** ▪ Single dose: 2.5mg (1 x 2.5mg Nebules) **Aged 6 years and above:** ▪ Single dose: 5mg (2 x 2.5mg Nebules) **A second dose of the same quantity may be given following consultation with an EOC clinician.** **Before administration, check:** ▪ Correct Drug ▪ Correct Dosage ▪ Expiry Date ▪ Nebule Sealed & Intact ▪ Colour and Composition – clear, no 'cloudiness' or floating 'bits' ▪ If unsure seek advice from EOC Clinician
Actions if patient declines treatment	▪ Explain the risks of non-administration ▪ Offer all other reasonable treatment patient consents to ▪ Obtain advice from EOC Clinician ▪ Record treatment and advice given on PCR ▪ Handover to the SECAmb Clinician
Ongoing treatment and Monitoring	▪ Monitor patient and record vital signs at minimum every 10 minutes. ▪ Report any deterioration to EOC.

In case of adverse reaction	▪ Notify EOC or SECAmb Clinician as appropriate.
Additional Information	CFRs must adhere to the standard operating procedure (SOP) on Supply and Distribution of medicines for CFRs. CFRs must ensure that their medicines are kept within manufacturing temperature guidelines and are secure at all times.

PROTOCOL

References & Resources	1. Joint Formulary Committee. *British National Formulary* London: BMJ Group and Pharmaceutical Press. https://bnf.nice.org.uk/drug/salbutamol.html 2. EMC. Salbutamol 2.5mg/2.5ml Nebuliser Solution https://www.medicines.org.uk/emc/product/3209/smpc [Accessed on 15/10/2018] 3. National Institute for Health and Care Excellence (2018) Clinical Knowledge Summaries: Asthma https://cks.nice.org.uk/asthma#!scenario:2 4. Joint Royal Colleges Ambulance Liaison Committee, Association of Ambulance Chief Executives. (2016). JRCALC *Clinical Practice Guidelines*. Cited from: *iCPG* (2018) (Version 1.3.3). Bridgewater: Class Publishing Ltd.

Appendix 1 - Nebuliser Assembly

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Step 1

Remove a strip of Salbutamol ampoules from the foil packaging.

Step 2

Check the expiry date. Never use an ampoule that has been opened already or if the solution is discoloured.

Step 3

Unscrew the nebuliser. Hold the ampoule upright and open it by twisting off the top. Squeeze all of the liquid from the plastic ampoule into the nebuliser chamber.

Step 4

Connect the nebuliser to the oxygen tubing.

Step 5

Set the flow regulator on the oxygen cylinder to 6–8 lpm, to produce a fine mist from the mask.

Step 6

Place the mask on the patient's face and tighten the elastic strap to ensure a tight seal. Encourage the patient to breath slowly and deeply.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	

Name of meeting	Trust Board
Date	May 2019
Name of paper	**Update on the use of Non-Parenteral Prescription Only Medicines (POMs) by SECAmb clinicians (registered healthcare professionals, non-registered clinicians) and volunteers**
Executive sponsor	Magnus Nelson, Acting Executive Medical Director
Author name and role	Carol-Anne Davies-Jones, Chief Pharmacist Michael Bradfield, Consultant Paramedic
Synopsis (up to 120 words)	This technical paper provides an update of the Trust's legal position regarding the use of non-parenteral prescription only medicines (POMs) by clinical staff and volunteers. This paper also highlights our current position and the proposed changes for approval by the Board to continue to allow non-registered clinical staff access to non-parenteral POMs for the purpose of administration to our patients. The Board are also asked to approve the use of the medicine salbutamol by the Community First Responders and co-responders by way of a new clinical protocol with limited indications for use. Safety is paramount and our Trust needs to ensure appropriate governance around the administration of these medicines as laid out in this paper.
Recommendations, decisions or actions sought	Trust Board to approve the use of non-parenteral POMs by our clinical staff and volunteers for administration to our patients where specific legislation does not exist.

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** If yes and approval or ratification is required, a completed EA Record must be attached.

South East Coast Ambulance Service NHS Foundation Trust

Trust Board

Update on the use of Non-Parenteral Prescription Only Medicines (POMs) by SECAmb clinicians and volunteers (registered healthcare professionals, non-registered clinicians, Community First Responders (CFRs) and Immediate Emergency Care Responders (IECRs)

1. Introduction

1.1. The effective treatment of patients using medicines is an integral and well-established part of pre-hospital emergency care within the ambulance service.

1.2. Medicines are grouped into classifications, based on their legal status and/or product characteristics (including safety record, side effects, etc.), as follows:

1.2.1. General Sales List (GSL)

1.2.2. Pharmacy item (P)

1.2.3. Prescription Only Medicines (POM) – A medicinal product which may only be sold or supplied against the signed prescription from an appropriate prescriber or given under an alternative legal mechanism, such as a PGD, or an exemption (for example, Schedule 19 of the Human Medicines Regulations 2012).

1.3. The legal mechanisms that cover the use of medicines are complex, and the two schedules within the Human Medicines Regulations 2012 (17 and 19) only cover parenteral medicines for administration, and do not include non-parenteral medicines.

1.4. Registered Healthcare professionals may also follow prescriptions, patient group directions (PGD), and patient specific directions (PSD).

1.5. Medicines legislation is very clear regarding who can possess and administer most medicines, and specific exemptions and other mechanisms exist to facilitate the administration of medicines to patients by both our registered healthcare professional staff and non-registrants.

1.6. Non-parenteral routes discussed in this document refer to the nebulised, inhaled route delivered via an oxygen mask (salbutamol and ipratropium) or via the rectal route (diazepam).

1.7. Historically, within the Ambulance Service a selection of non-parenteral prescription only medicines have been administered to

patients by trained but not registered staff, including nebulised ipratropium bromide and salbutamol.

1.8. The Legislation which governs the administration of POM is the Human Medicines Regulations 2012. The specific Regulation is 214 (2)

1.9. Regulation 214(2) provides for the administration of a parenteral POM but is silent regarding their administration by any other route. Ambulance trusts have utilised this gap in the legislation to facilitate care by trained but non-registered staff such as Ambulance Technicians who administer the medicines in accordance with the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guideline. However, the gap in the Legislation means that there is no formal legal framework to support this practice.

1.10. NHS England's Specialist Pharmacist Service (SPS) have recently issued guidance (March 2019) on when Patient Group Directions (PGDs) should be used (see appendix A). The SPS have been tasked to coordinate the national PGDs for Ambulance Trusts. The new SPS guidance state that a PGD is required to administer a POM (parenteral or otherwise).

1.11. Many trusts are currently experiencing a migration of the paramedic workforce into primary care. To maintain operational efficiency it is likely that increasing numbers of vehicles will be staffed by non-Paramedic crews. In this situation trusts may find that they require trained but not registered staff to continue to administer non parenteral POMs e.g. salbutamol and ipratropium and utilise the emergency drugs list on Schedule 19 of the Human Medicines Regulations 2012 to deliver timely care to patients. If non-parenteral POMs are to be administered under PGD then non-registered staff will be unable to administer these medications under this legal framework and this will put our patients at risk. It is important to note that non-registered staff in the ambulance sector have been administering salbutamol and ipratropium safely for years.

1.12. A search of the SECAmb incident reporting system showed no report of any incident that affected patient care due to the administration of these non-parenteral POMs by any staff grade or skill mix. There have also been no serious incidents reported, complaints or Coroners' recommendations relating to poor administration of these non-parenteral POMs.

1.13. This paper provides a briefing on the specific legal, practical, and patient safety challenges relating to administration of non-parenteral medicines, and provides recommendations for Trust Board approval.

2. **Responders who administer non-parenteral POMs**

2.1. Trust frontline staff and volunteers fall into the following groups:

2.1.1. Registered healthcare professionals (Doctors, Paramedics, etc.)

2.1.2. Non-registered clinicians (Associate Ambulance Practitioners, Associate Practitioners, Technicians/Advanced Technicians)

2.1.3. Healthcare support workers (Emergency Care Support Workers)

2.1.4. Volunteers (Community First Responders)

2.1.5. Immediate Emergency Care Responders (Fire and Rescue services).

3. **Non-parenteral POMs in the Trust currently administered outside of clear legal framework, and recommendation for Trust Board**

3.1. The current position in the Trust is that we have **three** medicines which are non-parenteral POMs, for which there is no specific legal basis for clinical staff or volunteers to administer.

3.1.1. **Diazepam (rectal, as Stesolid)**

3.1.2. Currently only used by paramedics within their scope of practice, but is not subject to a clear legal mechanism

3.1.3. An anomaly exists here because registered Paramedics are exempt from the Regulations and authorised to administer parenteral versions of this medicine i.e. Diazepam emulsion for injection 10mg in 2ml, yet there is no legal framework for the non-parenteral and safer form of the medicine as rectal Diazepam preparation.

3.1.4. **Recommendations**

3.1.5. Develop a PGD for Paramedics to align with new JRCALC 2019 guidelines (due for publication later this year)

3.1.6. **Ipratropium Bromide**

3.1.7. Currently used under Trust Authority for registered healthcare professionals (Paramedics) and Non-registered clinicians (Associate Ambulance Practitioners, Associate Practitioners, and Technicians/Advanced Technicians).

3.1.8. All of the above non-registered clinicians have received education and assessment on the use of this medicine as part of their basic training, which includes pharmacology, indications, contra-indications, mechanism of action and side effects. These are based on the national JRCALC Drug Guidelines and all staff

have access to this and are encouraged to refer to it before administering any medication. This has been in place since the original IHCD Basic Ambulance Aid course for Ambulance Technicians and a more detailed version of this is included in the current Associate Ambulance Practitioner course.

3.1.9. All clinical staff have access to Clinical Support via EOC if they have questions in relation to the administration of any medication.

3.1.10. **Recommendations**

3.1.11. Request Board approval that registered healthcare professionals and non-registered clinicians may continue to administer Ipratropium bromide in accordance with national JRCALC guidelines, despite being a prescription only medicine.

3.1.12. Add to the 2019/20 Clinical Audit Plan, the safe and effective administration of Ipratropium bromide by SECAmb staff.

3.1.13. **Salbutamol**

3.1.14. Currently used under Trust Authority for registered healthcare professionals (Paramedics), Non-registered clinicians (Associate Ambulance Practitioners, Associate Practitioners, Technicians/Advanced Technicians) and Healthcare support workers (Emergency Care Support Workers).

3.1.15. All of the above non-registered clinicians and emergency care support workers have received education and assessment on the use of this medicine as part of their basic training, which includes pharmacology, indications, contra-indications, mechanism of action and side effects. These are based on the national JRCALC Drug Guidelines and all staff have access to this and are encouraged to refer to it before administering any medication.

3.1.16. All clinical staff have access to Clinical Support via EOC if they have questions in relation to the administration of any medication.

3.1.17. Salbutamol was withdrawn from CFRs and Immediate Emergency Care Responders (IECRs) in February 2018. Since this time an e-learning package has been developed and new face to face training for our volunteers. A new SOP was approved in April 2019 for medicines pouch processes and governance. A new clinical protocol has also been developed for the administration of salbutamol for restricted indications less than that of JRCALC, so that only those patients who are confirmed as already using this medicine and have attempted to

use their own prescribed inhaler may be given this by CFRs (see Appendix B).

3.1.18. **Recommendations**

3.1.19. Request Board approval that registered healthcare professionals and non-registered clinicians employed by SECAmb may continue to administer Salbutamol in accordance with national JRCALC guidelines, despite being a prescription only medicine.

3.1.20. In relation to CFRs and IECRs request Trust Board approval that these volunteers administer Salbutamol as per clinical protocol in Appendix B, despite being a prescription only medicine and no legal framework to administer this medication.

3.1.21. Add the safe use of Salbutamol to the 2019/20 Clinical Audit Plan for all staff and volunteers.

4. Risks and Benefits (Clinical and Corporate)

4.1. Risks

4.2. For the most part, the risks of continuing authorisation for non-parenteral POMs use by our staff are reputational and legal in origin.

4.2.1. The current state means that we are outside of published legislation for three medicines currently in use in the Trust.

4.2.2. Currently there has not been a formal audit of the use of these medicines (although there have been no incidents resulting in patient harm or complaints relating to inappropriate use that have been identified)

4.2.3. Not allowing non-registered clinicians (and emergency care support workers) to use non-parenteral POMS, salbutamol in particular, poses a significant risk to patient safety by denying them access to medicines that are shown to be safe, effective and potentially life-saving in the emergency setting and which is time-critical in some cases and should not be delayed.

4.3. Benefits

4.4. The legal basis for the use of non-parenteral POMs outside of a clear legal framework is an immovable object, and requires the Trust to take a decision to operate otherwise than in accordance with the law on the basis of patient benefit outweighing the legal issues.

4.4.1. The non-parenteral POMS used by the Trust are potentially life-saving medications which are generally thought to be safe, with a low incidence of complications.

4.4.2. In particular, Salbutamol is recommended as first-line treatment for severe / life-threatening asthma by the British Thoracic Society and forms part of the initial management of bronchospasm in the Resuscitation Council (UK) Advanced Life Support guidelines and is a key part of pre-hospital emergency care guidelines nationally.

5. Summary

5.1. SECAmb is currently in line with all other ambulance trusts regarding the use of non-parenteral POMs, with regard to its directly employed staff of registered healthcare professionals and non-registered clinicians

5.2. Where we would differ, should the Trust Board approve, is allowing access to non-parenteral POMs for our volunteers. Training and standard operating procedures and new clinical protocol have all been developed for our volunteers.

5.3. The Board is asked to consider the recommendations above and when followed these will preserve the quality of patient care and promote patient safety.

Carol-Anne Davies-Jones
Chief Pharmacist

Michael Bradfield
Consultant Paramedic

Appendix A

SPS-When-PGDs-should-not-be-used-final

Appendix B

Medicines%20Protocol%20Reference%20\

SECAMB Board

WWC Committee Escalation report to the Board

Date of meetings	18 April 2019
Overview of issues/areas covered at the meeting:	This was the first committee meeting since the departure of Ed Griffin. Paul Renshaw, Interim HR Director attended and general attendance by non-members was, as always, good. The committee considered a number of ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas),* including; **HR Transformation Not Assured** Good progress has been made in understanding the breadth and depth of issues within the HR support processes. In spite of much good work by individuals, the committee was clear that many systems are not adequate. The business case to take forward phase 2 of the transformation programme is being revised by the new interim HRD. The committee supported this, acknowledging the criticality of ensuring we get it right first time. However, it reinforced to the executive that progress on implementing new systems and processes is becoming increasingly urgent. The committee expects to review the business case at its meeting in June. With regards some of the specific aspects, the committee is confident that the DBS issues are now under control and that the new systems around personnel files meant there was better grip on this issue. Management was confident this would be resolved shortly with no more than 1% (and probably a far lower percentage) needing further resolution. The Committee welcomed this assurance and recognised the great deal of good work that had gone into first exposing this then understanding and fixing it. While the committee has some comfort that there is good clarity of the issues which will inform the corrective action via the business case, overall the committee is not assured given the work still to do, and the continuing internal control process issues still need to be fixed. **Resourcing Partial Assurance** Data was provided regarding recruitment suggesting the pipeline is working well for most grades, in both 111 and 999 services but it became clear that there is a very significant risk with regard to the recruitment and retention of EOC clinicians. 17/42 posts are vacant. The team is aware that it needs to look at new ways of recruiting to these posts, given these are difficult positions to attract. Retention remains a concern and the committee heard of issues with the induction systems and the expectations of new starters. Data showed that turnover rates vary considerably between role and sites. The committee was therefore assured that the recruitment practice for 111 and EMAs was on target and that the processes in place were effective. However, it was not

assured about the recruitment of EOC clinicians given the considerable challenges in this area. Unless this improves, we lack the capacity to ensure clinical safety, which the committee notes is a primary focus of the Quality and Patient Safety Committee.

Payroll Discrepancy Policy **Partial Assurance**
A new policy has been developed, but the committee felt that unless managers ensured submissions of payroll returns happened in a timely manner, errors would continue. The need to move to an online system remains paramount. The committee was assured that this is being taken seriously but no more than partially assured that it was resolved. The committee will review this at each meeting, so that progress can be monitored. A clear training need was identified for new and existing managers.

Health & Safety **Partial Assurance**
The committee received an update on the improvement plan (in place now for six months), which is informed by the independent review undertaken in 2018. The objectives are either delivered or on track, and this is overseen by the Quality and Compliance Steering Group.

The committee felt this is an area that has been transformed. There is far greater understanding of responsibilities and a culture shift that ensures staff understand that it is not just the responsibility of the central H&S team; instead they are there to advise and support.

However, the committee felt that that although Estates and Fleet had responded well to the increased degree of challenge, the programme has yet to impact fully. Further training needs for staff have been identified and are being implemented via specific improvement plans. Overall, there is confidence in the grip on this aspect of our work but will require particular assurances from Fleet and Estates at the meeting in June.

New Paramedic Training **Partial Assurance**
The committee thanks the Council of Governors for bringing this issue to its attention. Two particular issues were noted. The first of those in training not getting the elective experiences that are necessary for a rounded training experience, typically in acute hospital settings. In part, this is caused by increasing numbers of students in a number of disciplines competing for the same placements, such as paediatrics. This is ultimately for the HE providers to resolve and SECamb has only limited powers to intervene. The second concerned placements within the Trust: this was in our control. Around a third of the 700 or so students studying at any one time are our staff undertaking the paramedic degree programme. The committee is clear that we must ensure that these have the best possible experience. Issues of rostering were discussed, and the insistence that such staff, even though coming from typically an EMA background, should always be seen as supernumerary. This is a challenge to operations and the committee is assured that this is taken seriously.

The issue of other students (i.e. those on undergraduate courses but not sponsored by the Trust) was less reassuring. Being based at St George's means that many may not be seeking a career in the south east (with London and South Central just as accessible) but this group is clearly vital in terms of recruitment. The Committee felt it important that they should have the best possible experience in SECAmb but, primarily for operational reasons, this was not always the case. This would appear a

	significant risk to the organisation and forms part of the wider picture of recruitment challenges. WWC agreed to look again at this issue but was confident that there is good understanding and grip. **EOC Retention** This paper updated on the actions to improve retention. It was discussed in part under 'Resourcing' above, and the committee remain concerned that in spite of the various actions in place, this remains a significant issue for the Trust and so only partial assurance could be obtained that this is being addressed effectively. A robust programme of interventions has been identified and the committee will monitor closely their implementation. The committee also reviewed the steps being taken in response to the **staff survey** results. A planning toolkit has been developed to establish local priorities. The committee is content with this approach. The usual **HR dashboard** was not received due to ongoing work with power BI to develop an updated dashboard for the committee.
Any other matters the Committee wishes to escalate to the Board	The committee's annual plan and refreshed terms of reference were considered and the updated versions are before the Board. The committee is refreshing how it considers the risks related to its purview, and is planning to hold a workshop to review the risk register so that members better understand the overarching risks/themes. Papers remain of a variable quality and it is clear that there needs to be better support to paper authors. The executive is aware of this. From the scrutiny items considered at this meeting, a clear theme started to emerge related to an unmet training need for staff in leadership and management positions. In particular, the induction programmes for those newly promoted to management roles seemed ineffective in many cases, or simply missing, and led directly to issues such as poor pay returns, DBS failures, grievances, and so on. It was suggested that a new training needs analysis should be undertaken for those entering management roles and programmes addressing that TNA put in place, for example as online packages. The committee formally escalated this to the Executive. The Board may wish to be further assured that the levels of clinicians, and the plans to ensure full staffing levels in the EOCs are sufficient to maintain both safety and to support continuous improvement of services through audit.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	18-19

Name of meeting	Board Meeting
Date	23 May 2019
Name of paper	Board Meeting Schedule
Author name and role	Peter Lee, Company Secretary
Synopsis	The Trust Board has agreed to meet formally in public every other month. The schedule (Appendix A) confirms the meeting dates for 2019/20. In the alternate months where there is no formal meeting, the time will be used for Board development. Appendix B lists to dates for the Board development sessions. A sub-group of the Board is in the process of developing a proposal for the development programme to build on the two sessions already held and the one planned for June, which will focus on strategy. The rationale for moving from monthly Board meetings includes the need to provide more dedicated time for development and focus on strategic planning. In addition to this schedule there will be two joint Board/COG meetings. The first was held on 2 May and the second is scheduled for 7 November 2019.
Recommendations, decisions or actions sought	The Trust Board is asked to approve the meeting schedule.

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**

Appendix A
Formal Board Meeting Schedule

Date of Meeting	Time	Venue
Thursday 23 May 2019	10.00-15.00	Crawley HQ McIndoe 1, 2, 3
Thursday 25 July 2019	10.00-15.00	Crawley HQ McIndoe 1, 2, 3
Thursday 26 September 2019	10.00-15.00	Crawley HQ McIndoe 1, 2, 3
Thursday 28 November 2019	10.00-15.00	Crawley HQ McIndoe 1, 2, 3
Thursday 30 January 2019	10.00-15.00	Crawley HQ McIndoe 1, 2, 3
Thursday 26 March 2019	10.00-15.00	Crawley HQ McIndoe 1, 2, 3

Appendix B
Board Development Schedule

Date of Meeting	Time	Venue / Focus
~~Thursday 25 April 2019~~	~~10.00-17.00~~	~~Banstead / Culture~~
~~Thursday 2 May 2019~~	~~13.00-17.00~~	~~Crawley HQ McIndoe 1, 2, 3 / Culture and Priorities~~
Thursday 27 June 2019	10.00-17.00	Crawley HQ McIndoe 1, 2, 3 / Strategy

Thursday 29 August 2019	10.00-17.00	Crawley HQ McIndoe 1, 2, 3 / TBC
Thursday 31 October 2019	10.00-17.00	Crawley HQ McIndoe 1, 2, 3 / TBC
Thursday 19 December 2019	10.00-17.00	Crawley HQ McIndoe 1, 2, 3 / TBC
Thursday 27 February 2019	10.00-17.00	Crawley HQ McIndoe 1, 2, 3 / TBC

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	19-19

Name of meeting	Board of Directors
Date	23 May 2018
Name of paper	Board Committee Annual Review / TOR
Author	Peter Lee, Company Secretary
Synopsis	This is the annual review of four main Board Committees plans for 2019/20, and their Terms of Reference (Appendices 1-8). The plans have been considered jointly by each of the committee Chairs and will be appropriately dynamic, to reflect any need to change focus. On behalf of the Board, the Audit & Risk Committee will undertake a formal review of the plans mid-year. The amendments to the terms of reference are indicated in the version control schedules at the end of each document. The assurance purview map (Appendix 9) is included for information. This has not changed since it was last approved by the Board in May 2018.It has been used to guide the annual plans for each committee.
Recommendations, decisions or actions sought	The Board is asked to confirm that it is satisfied with the plans for each of the four main committees and to agree the revised terms of reference / membership. The Board will note the proposal to include each Independent Non-Executive Director as an ex-officio member of each committee. **Membership of Board Committees**

	Appointments and Remuneration	Audit	Quality & Patient Safety	Finance & Investment	Workforce & Wellbeing	Charitable Funds
David Astley Chairman	√		√			
Michael Whitehouse Non-Executive Director	√	√		Chair		√
Lucy Bloem Non-Executive Director	√		√	√		
Terry Parkin Non-Executive Director	√	√			Chair	
Angela Smith Non-Executive Director	√	Chair		√		Chair
Al Rymer Non-Executive Director	Chair	√			√	√
Tricia McGregor Non-Executive Director	√	√	Chair			√
Laurie McMahon Non-Executive Director	√		√		√	
Adrian Twyning Non-Executive Director	√			√	√	
Chief Executive	√	A	A			
Executive Director of Nursing & Quality		A	√*		√	
Executive Medical Director			√	√		
Executive Director of Operations			√	√	√	√
Executive Director of Finance & Corp. Services		A*		√*		√*
Executive Director of Strategy				√	√	
Executive Director of HR			√		√*	

*denotes committee Executive-Lead

A – Attends

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

South East Coast Ambulance Service NHS Foundation Trust

Workforce and Wellbeing Committee (WWC)

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Workforce and Wellbeing Committee (WWC) referred to in this document as 'the committee'.

2. Purpose

The purpose of the committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to the workforce (encompassing resourcing, staff wellbeing and HR processes) are designed appropriately and operating effectively.

3. Membership

Appointed by the Board, the membership of the committee shall constitute at least three independent Non-Executive Directors and at least two Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:
Terry Parkin, Independent Non-Executive Director (Chair)
Al Rymer, Independent Non-Executive Director
Laurie McMahon, Independent Non-Executive Director
Adrian Twyning, Independent Non-Executive Director
Executive Director of Operations
Executive Director of Strategy
Executive Director of Nursing & Quality
Interim Director of HR

In addition, each Independent Non-Executive Director will be an ex-officio member of the committee.

4. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance

5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Company Secretary
- HR Business Support Manager

5.2. At the request of a committee member, other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are to be scrutinised.

5.3. Members unable to attend should identify, with the committee chair's agreement, an appropriately informed deputy to attend the meeting.

5.4. With the agreement of the committee chair, members of the committee or other Trust managers and officers may participate in a meeting of the committee by means of a tele/video conference. In such instances, it is a requirement that all persons participating in the meeting can hear each other. Participation in the meeting in this manner shall be deemed to constitute the presence in person at such a meeting. A member of the committee joining the meeting in this way shall count towards the quorum.

6. Frequency
The committee shall meet at least six times a year and extraordinary meetings may be called by the committee chair in addition to discuss and resolve any critical issues arising.

7. Authority
The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively. The committee will seek assurance (i.e. the elimination of reasonable doubt) from sources and systems including the front line operations, corporate services and from external independent sources such as peer review; internal audit, local counter fraud service, external audit and others, including legal or other professional advice when required.

8. Purview
The purview of the committee is set out in the accompanying purview document and annual cycle of business, which is approved by the Board along with these Terms of Reference**.** The committee will prioritise the acquisition and scrutiny of assurances according to the Board's requirements, using a risk based approach to prioritisation. The committee will not necessarily review all aspects of the system of internal control identified in the purview in every year.

9. Support
Under the guidance of the Company Secretary, and in conjunction with the committee chair, the HR Business Support Manager will provide secretarial support to the committee, including planning meetings twelve months in advance, setting agendas, collating and circulating papers five working days before meetings; taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting
The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure

11. Review
The committee shall reflect upon the effectiveness of its meeting at the end of each meeting. The committee shall review its Terms of Reference at least once a year to

ensure that they fit with the Board's overall review of the system of internal control. Any proposed changes shall be submitted to the Board for ratification.

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0	12 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. WDC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16 Board.
1.1	20 Sept 16		Minor amendment proposed at para 5.3 see italicised changes.
2.0	04 October 2017		Change in Chair and Membership Additional regular attendees Administrative support provided by the HR Business Support Manager; from the corporate governance dept.
2.1		25 May 2018	Updated membership Reduced frequency to minimum 4 times a year (from 6)
2.2			Updated membership Increased frequency to minimum 6 time a year (from 4)

	Lead	18 April 2019	13 June 2019	11 July 2019	12 Sept 2019	21 November 2019	23 January 2020	12 March 2020	
ADMINISTRATION									
Apologies	Chair	√	√	√	√	√	√	√	
Declarations of Interests	Chair	√	√	√	√	√	√	√	
Minutes	Chair	√	√	√	√	√	√	√	
Action Log	Chair	√	√	√	√	√	√	√	
Next Meeting Agenda / Forward Look	Chair	√	√	√	√	√	√	√	
Meeting Effectiveness	Chair	√	√	√	√	√	√	√	
SCRUTINY									
HR Transformation Programme									
Programme Milestones		√							
HR Operating Model			√						
Process Improvement									
People Risk									
Culture									
HR Funding - is it sufficient? (action from Board Jan 145/18c)			√	√					
HR Service Centre									
Payroll Discrepancy - effectiveness of policy		√							
Payroll Contract for April 2020									
Workforce Planning									
Resourcing 999, EOC, 111 - incl. skill mix		√							
Student Paramedics - recruitment and support (action from Feb Board 163/18c)		√							
Safe Staffing (action from Board Jan 150/18)				√					
Staff Retention									
Workforce Governance									
Personnel Files			√						
Pre-Employment Checks									
Staff Registration									
Volunteers - governance/support									
DBS Checks - Internal Audit actions (from QPS in April)			√						
Clinical Education									
Apprenticeships				√					
Attraction, Recruitment, Retention and Development of Clinical Education Staff				√					
Estates and Clinical Education Facilities			√		√				
Career Pathways						√			
Employee Relations									
Bullying & Harassment									
Grievances									
Equality, Diversity, Inclusion & Wellbeing									
Flu Vaccination - link to staff sickness (action from Feb Board 162/18a) - whos responsible - Aide Hogan									
Staff Engagement (Voice)									
Equality Delivery System - EDS2 Goals, Delivery on the WRES, DES, Equality Objectives, Gender Pay gap.									
Learning & OD									
Management Training - ongoing requirements				√					

	Lead	18 April 2019	13 June 2019	11 July 2019	12 Sept 2019	21 November 2019	23 January 2020	12 March 2020	
Role of L&OD				√					
NHS Streamlining (New Starter Pathway, L&OD, Recruitment and ESR)					√				
Induction Programme					√				
Statutory & Mandatory Training - Planning & Delivery						√			
Appraisal - completion / quality									
Health & Safety									
H&S Improvement Plan		√	√	√					
Health & Safety Management systems						√			
MONITORING PERFORMANCE & QUALITY									
Staff Survey Results Next Steps / Update on focus areas		√			√				
HR Dashboard - Power BI		√	√	√	√	√	√	√	
H&S Dashboard				√		√	√		
Annual H&S Audits				√					
Annual Inclusion report / mid year review of objectives									
Annual Wellbeing report / mid year review of objectives									
MANAGEMENT RESPONSES (delete once received)									
STRATEGIES									
People Strategy						√			
Clinical Education Strategy				√					
Inclusion Strategy								√	
Retention Strategy				√					
GOVERNANCE & RISK MANAGEMENT									
Board Assurance Framework / Strategic Risks relating to committee purview	Company Secretary	√							
Annual Review of Risks	Company Secretary			√					
Committee Annual Self-Assessment: Cycle of Business Terms of Reference	Company Secretary	√							
Mid-Year Review of Cycle of Business	Company Secretary					√			

South East Coast Ambulance Service NHS Foundation Trust

Finance and Investment Committee ('FIC')

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Finance and Investment Committee ('FIC') referred to in this document as 'the committee'.

2. Purpose

The purpose of the committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to finance, corporate services and investments in future operational capability, are designed appropriately and operating effectively.

3. Membership

Appointed by the Board, the membership of the committee shall constitute three independent Non-Executive Directors and three Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:
Michael Whitehouse, Independent Non-Executive Director (Chair)
Angela Smith, Independent Non-Executive Director
Adrian Twinning, Independent Non-Executive Director
Lucy Bloem, Independent Non-Executive Director
Executive Director of Finance & Corp. Services (Executive Lead)
Executive Director of Strategy & Business Development
Executive Medical Director
Executive Director of Operations

In addition, each Independent Non-Executive Director will be an ex-officio member of the committee.

4. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance

5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Company Secretary
- Deputy Director of Finance
- A senior manager from operations

5.2. At the request of a committee member, other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are to be scrutinised.

5.3. With the agreement of the chair, members of the committee or other Trust managers and officers may participate in a meeting of the committee by means of a tele/video conference. In such instances, it is a requirement that all persons participating in the meeting can hear each other. Participation in the meeting in this manner shall be deemed to constitute the presence in person at such a meeting. A member of the committee joining the meeting in this way shall count towards the quorum.

6. Frequency

The committee shall meet at least six times a year and extraordinary meetings may be called by the committee chair in addition to discuss and resolve any critical issues arising.

7. Authority

The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively.

8. Purview

The purview of the committee is set out in the accompanying purview document, which is approved by the Board along with these Terms of Reference**.** The committee will prioritise the acquisition and scrutiny of assurances according to the Board's requirements, using a risk based approach to prioritisation. The committee will not review all aspects of the system of internal control identified in the purview in every year.

9. Support

Under the guidance of the Company Secretary and, in conjunction with the committee chair and executive lead, the Business Support Manager will provide secretarial support to the committee, including planning meetings twelve months in advance, setting agendas, collating and circulating papers five working days before meetings; taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting

The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Review

The committee shall reflect upon the effectiveness of its meeting at the end of each meeting. The committee shall review its Terms of Reference at least once a year to ensure that they fit with the Board's overall review of the system of internal control. Any proposed changes shall be submitted to the Board for ratification.

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0	21 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. FBDC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16.
1.1	19 October 17	23 October 17	Update to membership Inclusion of additional regular attendees Administrative support provided by the HR Business Support Manager; from the corporate governance dept.
1.2		25 May 2018	Update to membership
2.1	13 May 2019, subject to the stated revisions		Update to membership Increased frequency from 4 to 6 meetings Revised section 7 leaving the detail of areas covered by the committee to the purview/annual plan.

	Lead	13 May 2019	18 June 2019	8 August 2019	17 October 2019	14 November 2019	16 January 2020	TBC March 2020
ADMINISTRATION								
Apologies	Chair	√	√	√	√	√	√	√
Declarations of Interests	Chair	√	√	√	√	√	√	√
Minutes	Chair	√	√	√	√	√	√	√
Action Log	Chair	√	√	√	√	√	√	√
Meeting Effectiveness	Chair	√	√	√	√	√	√	√
SCRUTINY								
999 Transformation & Delivery / Operational Performance*	Exec Director of Operations	√	√	√	√	√	√	√
Financial Results / Forecast	Exec Director of Finance	√**Q4**		√**Q1**	√**Q2**		√**Q3**	
Financial Planning 2020/21	Exec Director of Finance						√	√
Capital Programme 19/20	Exec Director of Finance	√			√			
Reference Costs	Exec Director of Finance							
ERIC Return (Estates)	Exec Director of Finance							
Financial Viabilty of SSG (PAP) - from QPS Feb 185/19	Exec Director of Operations	√						
Cost Improvement Programme / Overview of Schemes	Exec Director of Finance		√		√			
Projects Deep Dive TBC	TBC		√	√	√	√	√	√
Procurment (compliance with legislation)	Executive Director of Finance			√				
Management of Sub Contractors TBC	TBC					√		√
Fleet Servicing	Executive Director of Operations				√			
IT - staffing resilience	Executive Director of Finance					√		
Monitoring Performance								
IT Dashboard/KPIs	Exec Director of Finance	√			√			√
Estates Dashboard/KPIs	Exec Director of Finance	√			√			√
Business Cases								
Business Case Schedule / Tracker	Exec Director of Finance		√		√			√
Business Cases TBC	TBC							
Return on Investment / Benefits Realisation	TBC							
Strategies								
Fleet Strategy	Exec Director of Operations	√						
Estates Strategy	Exec Director of Finance							√
Digital / ICT Strategy	Exec Director of Finance				√			
Partnership and Commercial Strategy	Exec Director of Strategy							
Governance & Risk								
BAF Risks	Company Secretary		√	√		√	√	
Annual Review of Risk Register (linked to purview)	company Secretary			√				
Committee Annual Self-Assessment	Company Secretary		√					
Cycle of Business	Company Secretary	√						
Terms of Reference	Company Secretary	√						

*This standing item focusses on use of resources (investment) and assurance that the Trust's delivers the expectations set out in the demand and capacity review

South East Coast Ambulance Service NHS Foundation Trust

Quality and Patient Safety Committee

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Quality and Patient Safety Committee ('QPS') referred to in this document as 'the committee'.

2. Purpose

The purpose of the committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to quality governance (encompassing patient safety, clinical effectiveness and patient experience) are designed appropriately and operating effectively.

3. Membership

Appointed by the Board, the membership of the committee shall constitute at least three independent Non-Executive Directors and at least three Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:
Tricia McGregor, Independent Non-Executive Director (Chair)
Lucy Bloem, Independent Non-Executive Director
Laurie McMahon, Independent Non-Executive Director
David Astley, Chairman
Executive Director of Nursing & Quality (Executive Lead)
Executive Medical Director
Executive Director of Operations
Executive Director of HR & OD

4. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance

5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Chief Executive
- Company Secretary
- Deputy Medical Director
- Chief Pharmacist
- Consultant Nurse / Paramedic
- Regional Operating Manager
- Head of IT
- 111 Lead

5.2. Other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are to be scrutinised.

5.3. With the agreement of the chair, members of the committee or other Trust managers and officers may participate in a meeting of the committee by means of a tele/video conference. In such instances, it is a requirement that all persons participating in the meeting can hear each other. Participation in the meeting in this manner shall be deemed to constitute the presence in person at such a meeting. A member of the committee joining the meeting in this way shall count towards the quorum.

6. Frequency

The frequency of meetings will be agreed at the start of each financial year, ensuring the committee meets at least six times a year. Extraordinary meetings may be called by the committee chair in addition to those agreed, to discuss and resolve any critical issues arising.

7. Authority

The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that the Trust's system of governance internal control in relation to the areas with its purview are designed well and operating effectively.

8. Purview

The purview of the committee is set out in the accompanying purview document, which is approved by the Board along with these Terms of Reference. The committee will prioritise the acquisition and scrutiny of assurances according to the Board's requirements, using a risk based approach to prioritisation. The committee will not review all aspects of the system of internal control identified in the purview in every year.

9. Support

Under the guidance of the Company Secretary and, in conjunction with the committee chair and executive lead, the Business Support Manager will provide secretarial support to the committee, including planning meetings twelve months in advance, setting agendas, collating and circulating papers five working days before meetings; taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting

The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Review

The committee shall reflect upon the effectiveness of its meeting at the end of each meeting. The committee shall review its Terms of Reference at least once a year to ensure that they fit with the Board's overall review of the system of internal control. Any proposed changes shall be submitted to the Board for ratification.

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0	5 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. RMCGC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16.
1.1		23 October 2017	Update to membership Inclusion of additional regular attendees Administrative support provided by the HR Business Support Manager; from the corporate governance dept.
1.2		25 May 2018	Updated membership
2.1			Updated membership Clarified that frequency of meetings is to be agreed at the start of each year

	Lead	4 April 2019	20 May 2019	20 June 2019	18 July 2019	9 September 2019	24 October 2019	5 December 2019	17 January 2020	17 February 2020	*QPS 30/19*
ADMINISTRATION											
Apologies	Chair	√	√	√	√	√	√	√	√	√	
Declarations of Interests	Chair	√	√	√	√	√	√	√	√	√	
Minutes	Chair	√	√	√	√	√	√	√	√	√	
Action Log	Chair	√	√	√	√	√	√	√	√	√	
Next Meeting Agenda / Forward Look	Chair	√	√	√	√	√	√	√	√	√	
Meeting Effectiveness	Chair	√	√	√	√	√	√	√	√	√	
SCRUTINY											
111											
111 Clinical effectiveness (performance & patient outcomes inc clinical indicators, pathways call audits, key risk and concerns)	Director of Operations										
111 transition of new service from 1 April 2019	Director of Operations				√						
EOC											
EOC clinical safety - Deep Dive of aspects of the Project	Director of Operations	√	√	√	√	√	√	√	√	√	
999 NHS Pathways License compliance	Director of Operations										
999											
Consent to Treatment (is it being sought in line with legislation and guidance?)	Medical Director			√							
Surge (application of the SMP / Clinical Harm Review)	Medical Director /Director of Operations				√						
Bariatric Care (vehicle equipment and response) Are they located correctly, Policy, equipment, analysis of performance, tasking, training,	Director of Operations									√	
Private Ambulance Providers: to be reviewed twice yearly to include governance, policies and porcedures in place, system for planning, compliance data to include complaints, risks, issues, serious incidents. Plus clinical effectivness	Director of Operations					√					
Job cycle time for Stroke/STEMI and major trauma (Sept 106/18)			√								
Clinical Outcomes - deep dive in to specific areas, e.g. cardiac survival	Medical Director		√		√		√		√		
Medical Equipment: Full review of Medical Devices IAP including all equipment, pre implementation checks	Director of Operations					√					
Obstretics: Assurance can deliver effective care and treatment (Policy/Procedures, Training, Incidents,Risk)	Medical Director							√			
RTC's - Emergency, non-emergency, Collisions not involving public, and safety. Assurance of learning from incidents	Director of Operations									√	
Co-Responders: Organisation and reporting lines, governance, assurance on skills, knowledge and experience to deliver effective care and treatment. Thematic incident analysis and learning.To include recruitment & retention. To include tasking	Director of Operations									√	
Paediatrics: Assurance can deliver effective care and treatment (Policy/Procedures, Training, Incidents,Risk)	Medical Director							√			
Frequent Callers							√				
Specialist											
HART: Organisation and reporting lines, governance, assurance on skills, knowledge and experience to deliver effective care and treatment. Thematic incident analysis and learning.To include recruitment & retention. To include tasking. NARU Audit readiness assessment	Director of Operations										
Specialist Paramedics (PP & CCP) Scope of Practice - Organisation and reporting lines, governance, assurance on skills, knowleedge and experience to deliver effective care and treatment. Thematic incident analysis and learning . To include recruitment & retention.	Medical Director										
Clinical Governance / Standards											
Non Registered Clinicians - Scope of Practice - Organisation and reporting lines, governance, assurance on skills, knowleedge and experience to deliver effective care and treatment. Thematic incident analysis and learning . To include recruitment & retention.	Medical Director	√									
Medicines Governance Incl. QAVs	Medical Director			√							
Infection Prevention and Control - internal controls / effectivness / progress against strategy and objectives	Director of Nursing & Quality										

	Lead	4 April 2019	20 May 2019	20 June 2019	18 July 2019	9 September 2019	24 October 2019	5 December 2019	17 January 2020	17 February 2020	*QPS 30/19*
Learning. Are lessons learned and improvements made when things go wrong. Thematic Analysis of Serious Incidents, complaints, incidents. Include examples of change	Director of Nursing & Quality										
Serious Incident Q Thematic Review	Director of Nursing & Quality			√	√		√		√		
Duty of Candor - compliance with legislation and staff impact, (internal audit report due Sept)	Director of Nursing & Quality				√						
P**atient Records / ECPR**	Medical Director /Director of Operations			√							
Complaints To consider assurance to the deisgn and effectiveness of the System of controls re Complaints	Director of Nursing & Quality					√					
Internal Safeguarding (including an analysis of activity and outcomes and any lessons learnt)	Director of Nursing & Quality	√									
Key Skills planning	Medical Director							√			
CIP QIAs: A paper detailing the content and process followed in developing this years CIP QIAs	Director of Nursing & Quality		√								
QIA mid year review	Director of Nursing & Quality						√				
CFR Governance & Effectiveness	Director of Operations				√						
Clinical Supervision	Medical Director				√						
MONITORING PERFORMANCE & QUALITY											
Quality & Safety Report	Director of Nursing & Quality		√		√		√		√		
Clinical Audit Review	Medical Director			√			√			√	
Mortality & Morbidity / Learning from Deaths Bi-Annual Review	Medical Director										
Safeguarding Mid-Year Review	Director of Nursing & Quality					√					
Quality Account Development*/Sign Off**/Mid Year Review***	Director of Nursing & Quality	√	√				√				
Incident / SI Annual Report	Director of Nursing & Quality			√							
Infection Prevention and Control Annual Report	Director of Nursing & Quality		√								
Clinical Audit Annual Report 2017/18	Medical Director		√								
Clinical Audit Annual Plan	Medical Director		√								
Annual Safeguarding Report	Director of Nursing & Quality			√							
Accountable Officer for Controlled Drugs Annual Report (Medicines Governance)	Medical Director			√							
Annual NARU Audit Findings	Director of Operations								√		
Annual Review of Quality IPR Dashboard	Director of Nursing & Quality		√								
Freedom to Speak Themes / *Annual Report	Director of Nursing & Quality		*√		√			√			
Quality Assurance Visits / Patient Safety Leadership Visit	Director of Nursing & Quality				√		√		√		
STRATEGIES											
Volunteeers	Director of Operations				√						
Freedom to Speak Up	Director of Nursing					√					
Safeguarding	Director of Nursing								√		
Patient Experience	Director of Nursing					√					
Infection Prevention & Control	Director of Nursing				√						
MANAGEMENT RESPONSES (delete once received)											
Medical Equipment (from Feb 186/19)	Director of Operations		√								
Co-Responders (from Feb)	Director of Operations		√								
NHS Pathways License - Sis (from April 06/19)	Director of Nursing			√							
GOVERNANCE & RISK MANAGEMENT											
Board Assurance Framework / Strategic Risks relating to committee purview	Company Secretary	√		√		√			√		
Bi-Annual Review of High/Extreme Risks	Director of Nursing			√					√		

	Lead	4 April 2019	20 May 2019	20 June 2019	18 July 2019	9 September 2019	24 October 2019	5 December 2019	17 January 2020	17 February 2020	*QPS 30/19*
Committee Annual Self-Assessment: Cycle of Business Terms of Reference	Company Secretary		√								
Mid-Year Review of Cycle of Business	Company Secretary						√				

South East Coast Ambulance Service NHS Foundation Trust

Audit & Risk Committee (AuC)

Terms of Reference

1. Constitution

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Audit & Risk Committee (AuC), referred to in this document as 'The Committee'.

2. Purpose

2.1. The purpose of the Committee is to provide the Trust with a means of independent and objective review of internal control over the following key areas:

- Financial systems
- The information used by the Trust
- Assurance Framework systems
- Performance and Risk Management systems
- Compliance with law, guidance and codes of conduct

2.2. In undertaking such review, the Committee provides assurance to the Chief Executive and to the Board about fulfilment of the responsibility of the Trust's Accounting Officer, who under the terms of the National Health Service Act 2006 is held responsible to Parliament by the Public Accounts Committee for the overall stewardship of the organisation and the use of its resources.

3. Membership

3.1. The Committee shall have not less than three members, appointed by the Board from amongst the independent Non-Executive Directors of the Trust. The Chairman of the Trust shall not be a member. One of the members having recent and relevant financial experience shall be appointed Chair of the Committee by the Board.

3.2. **Current members:**

- Angela Smith, Independent Non-Executive Director (Chair)
- Michael Whitehouse, Independent Non-Executive Director
- Al Rymer, Independent Non-Executive Director
- Tricia McGregor, Independent Non-Executive Director
- Terry Parkin, Independent Non-Executive Director

In addition, each Independent Non-Executive Director will be an ex-officio member of the committee.

4. Quorum

4.1. The quorum necessary for formal transaction of business by the Committee shall be two Independent Non-Executive Directors.

5. Attendance

5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Chief Executive
- Executive Director of Finance & Corporate Services
- Executive Director of Nursing & Quality
- Company Secretary
- Internal Auditor
- External Auditor
- Counter Fraud

5.2. The Chairman and organisational managers and officers may be invited to attend meetings for specific agenda items or when issues relevant to their area of responsibility are to be discussed.

5.3. Officers unable to attend a meeting are required to send a fully briefed deputy or provide a written update to the Committee members at least two working days beforehand.

5.4. The Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should non-attendance jeopardise the functioning of the Committee the Chair will discuss the matter with the members and if necessary seek a substitute or replacement.

5.5. Attendance at Committee meetings will be disclosed in the Trust's Annual Report and Accounts.

6. Frequency

6.1. The frequency of meetings will be agreed at the start of each financial year, ensuring the committee meets at least four times a year. Extraordinary meetings may be called by the committee chair in addition to those agreed, to discuss and resolve any critical issues arising.

6.2. At least once a year the Committee shall meet privately with the External and Internal Auditors. The External Auditor or the Internal Auditor may request a private meeting if they consider this to be necessary.

6.3. Meeting dates will be diarised on a yearly basis.

7. Telephone Conference

7.1. With leave of the Chair of the Committee, any member or attendee of the Committee may participate in a meeting of the Committee by means of a teleconference/videoconference where circumstances require it or similar communications equipment whereby all persons participating in the meeting can hear each other and participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.

8. Authority

8.1. The Committee has no executive powers. It is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively. The committee will seek assurance from sources and systems including the front line operations, corporate services and from external independent sources such as peer review; internal audit, local counter fraud service, external audit and others, including legal or other professional advice when required.

8.2. The Committee is authorised by the Board to investigate any action within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

8.3. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers necessary. It may challenge the reports and duties of other Committees to ensure due and robust business processes are in place.

9. Duties

9.1. The subject matter for meetings will be wide-ranging and varied but in particular it will cover the following:

9.2. Governance, Risk Management and Internal Control

9.2.1. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives.

9.2.2. In carrying out this work, the Committee shall primarily utilise the work of Internal Audit, External Audit and other assurance functions, but shall not be limited to these audit functions. It may seek reports and assurances from directors and managers as appropriate. The Committee may also take assurances from work undertaken by other established committees of the Trust Board.

9.2.3. Reviews by the Committee shall concentrate on the overarching systems of integrated governance, risk management and internal control, together with

indicators of their effectiveness. This shall be evidenced through the Committee's use of an effective Assurance Framework to guide its work and the work of the audit and assurance functions that report to it. In particular, the Committee shall review the adequacy of:

i. All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, External Auditor's opinion or other appropriate independent assurances, prior to endorsement by the Board;

ii. The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks (including through review of the Risk Register and Board Assurance Framework) and the appropriateness of the above disclosure statements;

iii. The processes for ensuring compliance with relevant regulatory, legal and code of conduct requirements;

iv. The policies and procedures for all work related to fraud, corruption and security management as set out in the NHS Standard Contract which requires providers to put in place appropriate arrangements for counter fraud and as required by NHS Protect;

v. The Trust's whistleblowing policy(s) so test that arrangements are in place for proportionate and appropriate investigation;

vi. The Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

9.3. Internal Audit

9.3.1. The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit standards and provides appropriate independent assurance to the Committee, Chief Executive and Board. This shall be achieved by:

vii. Consideration of the provision of the Internal Audit service, the cost of the service and any questions of resignation and dismissal;

viii. Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework;

ix. Consideration of the major findings of Internal Audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources;

x. Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

xi. Annual review of the effectiveness of Internal Audit.

9.4. External Audit

9.4.1. The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This shall be achieved by:

xii. Consideration of the appointment and performance of the External Auditor in so far as compliance with governance codes permits;

xiii. Making a recommendation to the Council of Governors on the appointment, reappointment or removal of the External Auditor; and if the Council of Governors does not accept the Committee's recommendation, ensuring that the Board includes in the annual report a statement from the Committee explaining its recommendation and setting out reasons why the position of the Council of Governors was different;

xiv. Discussion and agreement with the External Auditor, before audits commence, about the nature and scope of the audit ensuring coordination, as appropriate, with other External Auditors in the local health economy;

xv. Discussion with the External Auditor concerning assessment of the Trust with regard to locally evaluated risks, and the associated impact on the audit fee;

xvi. Reviewing all External Audit reports, including agreement of the ISA 260 before submission to the Trust Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

9.5. Financial Reporting

9.5.1. The Committee shall ensure that systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

9.5.2. The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

xvii. The wording of the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

xviii. Changes in, and compliance with, accounting policies and practices;

xix. Unadjusted mis-statements in the Financial Statements;

xx. Major judgemental areas;

xxi. Significant adjustments resulting from audit.

9.6. Other Assurance Functions

9.6.1. The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider any implications for the governance of the organisation.

9.6.2. These shall include, but shall not be limited to, consideration of any reviews by Department of Health arms length bodies, regulators or inspectors (e.g. NHSI, Care Quality Commission, NHS Resolution etc.), or professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

9.6.3. In addition, the Committee shall review the output of other committees established by the Board, whose work can provide relevant assurance to the Committee's own scope of work.

10. Reporting

10.1. The Committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Support

11.1. Under the guidance of the Company Secretary and, in conjunction with the committee chair and executive lead, the Business Support Manager will provide secretarial support to the committee, including planning meetings twelve months in advance, setting agendas, collating and circulating papers five working days before meetings; taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

12. Review

12.1. The Committee will undertake a self-assessment at the end of each meeting to review its effectiveness in discharging its responsibilities as set out in these Terms of Reference.

12.2. The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. Any proposed changes shall be submitted to the Board for approval.

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0		March 2016	
1.1		May 2018	1. Amend to Audit and Risk 2. Included members 3. Amended attendees 4. Quorum from 3 to 2 NEDs to reflect other committees. 5. Authority section to be consistent with other committees 6. Amended the admin support arrangements 7. Included review from every 2 years to annually to be consistent with other committees
2.1			Updated membership and revised wording on frequency.

AUC	Lead	20 May 2019	11 July 2019	19 Sep 2019	12 Dec 2019	12 March 2020	Private Meeting with External Auditor
ADMINISTRATION							
Apologies	Chair	√	√	√	√	√	
Declarations of Interests	Chair	√	√	√	√	√	
Minutes	Chair	√	√	√	√	√	
Action Log	Chair	√	√	√	√	√	
Next Meeting Agenda / Forward Look	Chair	√	√	√	√	√	
Meeting Effectiveness	Chair	√	√	√	√	√	
FINANCIAL STATEMENTS & THE ANNUAL REPORT							
Annual Report & Accounts -External Audit Report -ISA260 Report (Audit Hilights Memo) -Management Representations Letter on the financial statements -Management Representations Letter on the quality report	Exec Director of Finance KPMG	√					
Annual Governance Statement	Company Secretary	√				√Draft	
Accounting Policies	Exec Director of Finance			√			
Accounting and Reporting Systems	Exec Director of Finance						
Financial statements - integrity / judgments	Exec Director of Finance				√		
Losses and Special Payments	Exec Director of Finance		√	√	√	√	
INTERNAL AUDIT							
Counter Fraud Progress Report	RSM		√	√	√	√	
Counter Fraud Work Plan	RSM					√	
Counter Fraud Annual Report incl. SRT	RSM					√	
Internal Audit Progress Report	RSM		√	√	√	√	
Internal Audit Annual Plan	RSM	√				√	
Annual Report to include Internal Audit Opinion	RSM	√				√Draft	
Private meeting of committee to review annual report with IA	RSM	√					
EXTERNAL AUDIT							
External Audit Finding Report	KPMG	√					
Report to Governors on Quality Report	KPMG	√					
Limited Assutance opinion on Qualiry Report Indicators	KPMG	√					
Progress Report / Technical Update	KPMG					√	
Audit Plan	KPMG				√		
GOVERNANCE & RISK MANAGEMENT							
Business Continiuty	Exec Director of Operations		√				
Data Quality	Exec Director of Strategy				√		
Whistleblowing	Exec Director of Nursing			√			
Decl. of Interests	Company Secretary						
Policy Review	TBC		√	√	√	√	
Board Assurance Framework Review	Company Secretary		√			√	
Risk Review, incl. BAF Risk Report	Executive Director of Nursing / Company Secretary		√	√	√	√	
Risk Management System / effectivess of the policy and procedure	Exec Director of Nursing			√		√	
Annual Review of SO's/SFI's	Exec Director of Finance		√			√	

Annual Self Certification GC6/COS 7	Company Secretary	√					
Corporate Governance Statement	Company Secretary	√				√Draft	
Integrated Performance Report Annual Review	Exec Director of Strategy		√				
Information Governance (incl. *Annual Report)	Exec Director of Nursing	√*			√		
Annual Review of Cycle of Business	Company Secretary	√					
Annual Self-Assessment	Company Secretary		√				
Review of Terms of Reference	Company Secretary						
Review Purview / TOR of other Board Committees	Company Secretary				√		

APPENDIX 1 - SECAmb Board draft assurance purview / map for 2019-20

This chart sets out the purview of each committee.
Topics are selectively picked according to the risk around each area.
Not every topic is scrutinised every year.

			Board	QPS	WWC	FIC	Audit	ARC	CFC
		Have we a well designed and effectively operating system of internal control to deliver the strategic goals?							
G1		Our People							
G2		Our Patients							
G3		Our Enablers							
G4		Our Partners							
1		Significant risks threatening achievement of objectives, as set out in BAF							
2		Have we enabling sub-strategies to deliver the objectives ? *Quality; clinical leadership; people (resourcing and leadership), estates, long term financial model; health, wellbeing and safety; fleet, commications; informatics.*							
		Have we established controls to deliver regulatory and legal compliance?							
3		NHSI Licence conditions compliance							
4		NHSI single oversight framework compliance							
5		NHSI regulatory ratings							
6		NHSI Code of governance compliance							
7		Annual report and accounts							
8		NICE							
9		Other regulatory disclosure statements							
10		CQC registration requirements compliance							
11		Equalities legislation							
12		Health & safety legislation							
13		Anti-fraud and anti-bribery legislation							
14		Employment legislation (bullying, harrassment, discipline, grievance, raising concerns, whistleblowing)							
	CQC key lines of enquiry	**By safe, we mean that people are protected from abuse and avoidable harm.**							
S1		How do systems, processes and practices keep people safe and safeguarded from abuse?							
S2		How are risks to people assessed, and their safety monitored and managed so they are supported to stay safe?							
S3		Do staff have all the information they need to deliver safe care and treatment to people?							
S4		How do we ensure the proper and safe use of medicines, where the service is responsible?							
S5		What is the track record on safety?							
S6		Are lessons learned and improvements made when things go wrong?							
		By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.							
E1		Are people's needs assessed and care and treatment delivered in line with legislation, standards (eg JRCALC, NHS Pathways licence) and evidence-based guidance to achieve effective outcomes?							
E2		How are people's care and treatment outcomes monitored and how do they compare with other similar services?							
E3		Do staff have the skills, knowledge and experience to deliver effective care and treatment? *(appraisals, mandatory training)*							
E4		How well do staff, teams and services work together to deliver effective care and treatment?							
E5		How are people supported to live healthier lives and, where the service is responsible, how does it improve the health of its population?							
E6		Is consent to care and treatment always sought in line with legislation and guidance?							
		By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.							
C1		How does the service ensure that people are treated with kindness, respect and compassion, and that they are given emotional support when needed?							
C2		How does the service support people to express their views and be actively involved in making decisions about their care, treatment and support as far as possible?							
C3		How are people's privacy and dignity respected and promoted?							
		By responsive, we mean that services are organised so that they meet people's needs.							
R1		How do people receive personalised care that is responsive to their needs?							
R2		Do services take account of the particular needs and choices of different people?							
R3		Can people access care and treatment in a timely way?							
R4		How are people's concerns and complaints listened and responded to and used to improve the quality of care?							
		By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.							
W1		**Kloe 1 Is there the leadership capacity and capability to deliver high quality, sustainable care?**							
1.2		Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?							
1.2		Do leaders understand the challenges to quality and sustainability and can they identify the actions needed to address them?							
1.3		Are leaders visible and approachable?							
1.4		Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?							
W2		**KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?**							
2.1		Is there a clear vision and a set of values, with quality and sustainability as the top priorities?							
2.2		Is there a robust realistic strategy for achieving the priorities and delivering good quality, sustainable care?							
2.4		Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?							
2.4		Do staff know and understand what the vision, values and strategy are, and their role in achieving them?							
2.5		Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?							
2.6		Is progress against delivery of the strategy and local plans monitored and reviewed and is there evidence to show this?							
W3		**KLOE 3 Is there a culture of high quality, sustainable care?**							
3.1		Do staff feel supported, respected and valued?							
3.3		Is the culture centred on the needs and experience of people who use services?							
3,3		Do staff feel positive and proud to work in the organisation?							
3.4		Is action taken to address behaviour and performance that is inconsistent with the vison and values, regardless of seniority?							
3.5		Does the culture encourage, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?							
3.6		Are there mechanisms for providing all staff at every level with the development they need, including high quality appraisal and career development conversations?							
3.7		Is there a strong emphasis on safety and well-being of staff?							
3.8		Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?							
3.9		Are there co-operative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?							
W4		**KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?**							
4.1		Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?							
4.2		Do all levels of governance and management function effectively and interact with each other appropriately?							
4.3		Are staff at all levels clear about their roles and do they understand what they are accountable for and to whom?							
4.4		Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care							
W5	*Well-led KLOEs.*	**KLOE 5. Are there clear and effective processes for managing risks, issues and performance?**							
5.1		Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?							
5.2		Are there processes to manage current and future performance? Are these regularly reviewed and improved?							
5.3		Is there a systematic programme of clinical and internal audit to monitor quality, operational, and financial processes, and systems to identify where action should be taken?							
5.4		Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'?							
5.5		Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities?							
5.6		When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?							
W6		**KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?**							

APPENDIX 1 - SECAmb Board draft assurance purview / map for 2019-20

This chart sets out the purview of each committee.
Topics are selectively picked according to the risk around each area.
Not every topic is scrutinised every year.

		Board	QPS	WWC	FIC	Audit	ARC	CFC
6.1	Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?							
6.2	Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and challenge it appropriately?							
6.3	Are there clear and robust service performance measures, which are reported and monitored?							
6.4	Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?							
6.5	Are information technology systems used effectively to monitor and improve the quality of care?							
6.6	Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required?							
6.7	Are there robust arrangements (including appropriate internal and external validation), to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?							
W7	**KLOE 7 Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?**							
7.1	Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?							
7.2	Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups?							
7.3	Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected equality characteristic?							
7.4	Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?							
7.5	Is there transparency and openness with all stakeholders about performance?							
W8	**KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?**							
8.1	In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?							
8.2	Are there standardised improvement tools and methods, and do staff have the skills to use them?							
8.3	How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?							
8.4	Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation?							
8.5	Are there systems in place to support improvement and innovation work including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?							
	Other aspects of governance							
15	Policy governance							
16	Defib strategy							
17	Long term financial model							
18	Procurement							
19	Disposals and acquisitions							
20	Standing financial instructions; standing orders; scheme of reservation & delegation							
21	Employee relations							
22	Corporate trustee responsibilities re Charity No 1059933							
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South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	20-19

Name of meeting	Trust Board
Date	23rd May 2019
Name of paper	Modern Slavery Act Statement
Responsible Executive	Bethan Haskins, Executive Director of Nursing & Quality
Author	Philip Tremewan, Nurse Consultant for Safeguarding
Synopsis	To comply with the expectations of the Modern Slavery Act 2015 all publicly funded organisations need to ensure they have a statement of compliance regarding modern slavery on their public facing webpages. Much of the focus of the statement needs to provide assurance that procurement processes and supply chains have no elements of modern slavery within them. The Head of Procurement & Acting Head of Strategic Estates has reviewed the draft and his happy with the content. Included in red is the wording from Sec 54 of the Modern Slavery Act – this won't be included in the final statement but does provide the legal expectations of the statement.
Recommendations, decisions or actions sought	For approval

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

Modern Slavery Act Statement

South East Coast Ambulance Service NHS Foundation Trust is part of the National Health Service (NHS). We respond to 999 calls from the public, urgent calls from healthcare professionals and provide NHS 111 services across the region.

South East Coast Ambulance service:

- Covers a geographical area of 3,600 square miles (Brighton & Hove, East Sussex, West Sussex, Kent, Surrey, and North East Hampshire)

- We work across a diverse geographical area of 3,600 square miles which includes densely populated urban areas, sparsely populated rural areas and some of the busiest stretches of motorway in the country.

- We have over 3,300 staff working across 110 sites in Kent, Surrey and Sussex. Almost 90 per cent of our workforce is made up of operational staff – those caring for patients either face to face, or over the phone at our emergency dispatch centre where we receive 999 calls.
- Our patients range from the critically ill and injured who need specialist treatment, to those with minor healthcare needs who can be treated at home or in the community.
- As well as a 999 service, we also provide NHS 111 services across the region.

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting.

The Modern Slavery Act 2015 introduced changes in UK law focused on increasing transparency in supply chains, to ensure our supply chains are free from modern slavery (that is, slavery, servitude, forced and compulsory labour and human trafficking). SECAmb is committed to working with local partners to improve our practice in combatting slavery and human trafficking and to raise awareness, disrupt and respond to Modern Slavery.

Arrangements to prevent slavery and human trafficking

We are committed to ensuring there is no modern slavery or human trafficking in our supply chains or any part of our business activity.

Our commitment to social and environmental responsibility is covered by our approach to modern slavery and human trafficking, which is part of our safeguarding strategy and arrangements.

Our arrangements

Safeguarding

Our commitment is to ensure no modern slavery is reflected in a number of our policies and procedures. These include our Safeguarding Policy and Procedures for Children, Young People and Adults.

Training and promotion

Our enhanced safeguarding training includes role relevant modern slavery awareness. The Trust promotes awareness of modern slavery e-learning via the relevant on-line platform and SECAmb's intranet pages for staff provides further support and resources on modern slavery and human trafficking.

Suppliers/tenders

The trust complies with the Public Contracts Regulations 2015 and uses the mandatory Crown Commercial Services (CCS) Pre-Qualification Questionnaire on procurements, which exceed the prescribed threshold. Bidders are required to confirm their compliance with the Modern Slavery Act.

Sub-contracts

Our procurement and contracting team is qualified and experienced in managing healthcare contracts, which includes:

- using our routine contract management meetings with our providers, to address any issues around modern slavery
- implementing any relevant clauses contained within the Standard NHS Contract.

This statement is made pursuant to section 54 of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for 2019/20.

http://www.legislation.gov.uk/ukpga/2015/30/section/54/enacted

Section 54 Transparency in supply chains etc

(1)A commercial organisation within subsection (2) must prepare a slavery and human trafficking statement for each financial year of the organisation.

(2)A commercial organisation is within this subsection if it—

(a)supplies goods or services, and

(b)has a total turnover of not less than an amount prescribed by regulations made by the Secretary of State.

(3)For the purposes of subsection (2)(b), an organisation's total turnover is to be determined in accordance with regulations made by the Secretary of State.

(4)A slavery and human trafficking statement for a financial year is—

(a)a statement of the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place—

(i)in any of its supply chains, and

(ii)in any part of its own business, or

(b)a statement that the organisation has taken no such steps.

(5)An organisation's slavery and human trafficking statement may include information about—

(a)the organisation's structure, its business and its supply chains;

(b)its policies in relation to slavery and human trafficking;

(c)its due diligence processes in relation to slavery and human trafficking in its business and supply chains;

(d)the parts of its business and supply chains where there is a risk of slavery and human trafficking taking place, and the steps it has taken to assess and manage that risk;

(e)its effectiveness in ensuring that slavery and human trafficking is not taking place in its business or supply chains, measured against such performance indicators as it considers appropriate;

(f)the training about slavery and human trafficking available to its staff.

(6)A slavery and human trafficking statement—

(a)if the organisation is a body corporate other than a limited liability partnership, must be approved by the board of directors (or equivalent management body) and signed by a director (or equivalent);

(b)if the organisation is a limited liability partnership, must be approved by the members and signed by a designated member;

(c)if the organisation is a limited partnership registered under the Limited Partnerships Act 1907, must be signed by a general partner;

(d)if the organisation is any other kind of partnership, must be signed by a partner.

(7)If the organisation has a website, it must—

(a)publish the slavery and human trafficking statement on that website, and

(b)include a link to the slavery and human trafficking statement in a prominent place on that website's homepage.

(8)If the organisation does not have a website, it must provide a copy of the slavery and human trafficking statement to anyone who makes a written request for one, and must do so before the end of the period of 30 days beginning with the day on which the request is received.

(9)The Secretary of State—

(a)may issue guidance about the duties imposed on commercial organisations by this section;

(b)must publish any such guidance in a way the Secretary of State considers appropriate.

(10)The guidance may in particular include further provision about the kind of information which may be included in a slavery and human trafficking statement.

(11)The duties imposed on commercial organisations by this section are enforceable by the Secretary of State bringing civil proceedings in the High Court for an injunction or, in Scotland, for specific performance of a statutory duty under section 45 of the Court of Session Act 1988.

(12)For the purposes of this section—

- "commercial organisation" means—

(a)
a body corporate (wherever incorporated) which carries on a business, or part of a business, in any part of the United Kingdom, or

(b)
a partnership (wherever formed) which carries on a business, or part of a business, in any part of the United Kingdom,

and for this purpose "business" includes a trade or profession;

- "partnership" means—

(a)
a partnership within the Partnership Act 1890,

(b)
a limited partnership registered under the Limited Partnerships Act 1907, or

(c)
a firm, or an entity of a similar character, formed under the law of a country outside the United Kingdom;

- “slavery and human trafficking” means—

(a)
conduct which constitutes an offence under any of the following—

(i)
section 1, 2 or 4 of this Act,

(ii)
section 1, 2 or 4 of the Human Trafficking and Exploitation (Criminal Justice and Support for Victims) Act (Northern Ireland) 2015 (c. 2 (N.I.)) (equivalent offences in Northern Ireland),

(iii)
section 22 of the Criminal Justice (Scotland) Act 2003 (asp 7) (traffic in prostitution etc),

(iv)
section 4 of the Asylum and Immigration (Treatment of Claimants, etc.) Act 2004 (trafficking for exploitation),

(v)
section 47 of the Criminal Justice and Licensing (Scotland) Act 2010 (asp 13) (slavery, servitude and forced or compulsory labour), or

(b)
conduct which would constitute an offence in a part of the United Kingdom under any of those provisions if the conduct took place in that part of the United Kingdom.