South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

25 July 2019
10.00-13.00

Crawley HQ

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
Introduction					
23/19	10.00	Apologies for absence	-	-	Chair
24/19	10.01	Declarations of interest	-	-	Chair
25/19	10.02	Minutes of the previous meeting: 20 May 2019	**Y**	Decision	Chair
26/19	10.03	Matters arising (Action log)	**Y**	Decision	PL
27/19	10.05	Board Story	-	Set the tone	Chair
28/19	10.15	Chief Executive's report incl. CQC initial feedback letter	**Y**	Information	FM
Trust strategy					
29/19	10.35	Delivery Plan Deep Dive on EOC Clinical Support	**Y**	Information	SE BH
30/19	11.05	BAF Risk Report	**Y**	Information	PL
Quality & Performance					
31/19	11.15	Integrated Performance Report	**Y**	Information	SE
32/19	11.45	Quality & Patient Safety Committee Escalation Report	**Y**	Information	TM
33/19	11.55	Incident and SI report Annual Report	**Y**	Information	BH
34/19	12.05	Use of Salbutamol	**Y**	Decision	RQ
Workforce					
35/19	12.15	Workforce and Wellbeing Escalation Report	**Y**	Information	TP
36/19	12.25	Diversity and Inclusion Annual Report	**Y**	Information	TP
Governance					
37/19	12.35	Audit Committee Escalation Report	**Y**	Information	AS
38/19	12.40	Finance & Investment Committee Escalation Report	**Y**	Information	MW
39/19	12.45	Charitable Funds Committee Escalation Report	**Y**	Information	AS
Closing					
40/19	12.50	Any other business	-	Discussion	Chair
41/19	-	Review of meeting effectiveness	-	Discussion	ALL
Close of meeting					

Date of next Board meeting: 26 September 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,
20 May 2019

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

Present:

David Astley	(DA)	Chairman [left after item 07/19]
Fionna Moore	(FM)	Acting Chief Executive
Angela Smith	(AS)	Independent Non-Executive Director
Alan Rymer	(AR)	Independent Non-Executive Director
Bethan Haskins	(BH)	Executive Director of Nursing & Quality
David Hammond	(DH)	Executive Director of Finance & Corporate Services
Joe Garcia	(JG)	Executive Director of Operations
Laurie McMahon	(LM)	Independent Non-Executive Director
Lucy Bloem	(LB)	Senior Independent Director / Deputy Chair [Chair from item 08/19]
Michael Whitehouse	(MW)	Independent Non-Executive Director
Tricia McGregor	(TM)	Independent Non-Executive Director

In attendance:

Paul Renshaw	(PR)	Director of HR
Peter Lee	(PL)	Company Secretary
Janine Compton	(JC)	Head of Communications
Sara Songhurst	(SS)	Deputy Clinical Director

01/19 Apologies for absence

Adrian Twyning	(AT)	Independent Non-Executive Director
Steve Emerton	(SE)	Executive Director of Strategy & Business Development
Terry Parkin	(TP)	Independent Non-Executive Director
Magnus Nelson	(MN)	Acting Medical Director

DA welcomed members to the meeting, and welcome PR to his first meeting. DA also confirmed the news that AT will be stepping down from the end of May and on behalf of the Board thanked him for his contribution.

DA then acknowledged the sad passing of Bruce, a long serving paramedic who recently passed away and who was honoured at the staff awards. DA expressed condolences to Bruce's family and the SECamb team who knew him.

02/19 Declarations of conflicts of interest

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

03/19 Minutes of the meeting held in public on 28 March 2019

The minutes were approved as a true and accurate record.

04/19 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.

05/19 **Board story** [11.37 – 11.53]
The Board was shown a film reviewing progress with hospital handover delays. It highlighted the impact on patients waiting in the community and the specific initiatives being taken at different hospitals to ensure more timely handovers at A&E.

The Board reflected on the really good collaborative work, acknowledging that this is still a significant issue and one that will require the whole system to help resolve. JG reinforced this by confirming that the Trust loses 1100 hours each week, over and above the 15 minute threshold, which equates to 95 shifts. This issues therefore requires constant focus.

Following some questions about the reasons why there is variance across hospitals, the Board noted that much relies on the leadership and focus given.

06/19 **Chief Executive's report** [11.53 – 12.06]
FM took the Board through her report, specifically highlighting the issue escalated to EMB by the Workforce and Wellbeing Committee, relating to themes around induction and management training, and the investigation being carried out following the issues arising from the 111 service going live.

Questions then followed, including from TM who asked for assurance that local teams have the results from the staff survey. PR confirmed that each team has been tasked with developing their priorities which will be collated; a summary will come to the workforce and wellbeing committee.

The issue of management training was also explored by the Board and it noted that operations restructure focusses on management development.

Finally, the Board expressed its gratitude for the openness with which management has addressed the issues from the 111 service going live, focussing on learning. It also received assurance that the Trust has discharged its duties under duty of candour.

07/19 **Delivery Plan** [12.06 – 12.56]
FM asked directors to update by exception.

<u>Sustainability</u>
DH formally acknowledged the work of staff involved in the Worthing ambulance station re-fit, phase 1 of which is due to complete as planned by the end of June. Phase 2 addresses some of the environmental issues and the related business case will be developed in due course.

In terms of cyber security, the Board received an update on the hardware and software updates in the Crawley EOC. Lessons from this will be used when Coxheath is updated.

The Board asked for some assurance relating to the EPCR project, following the delay in pre live testing and the knock on consequences. It confirmed that roll out is scheduled to be completed by the end of October, when all staff will be using EPCR on their I-pads. As the NED member of the project board, LB confirmed that there are 75 staff using EPCR pre live and, to-date, there have been no significant issues, including with hospitals being able to download the PDF.

DH concluded by reinforcing the challenges with the cost improvement programme that aims to ensure we become increasingly more efficient.

Quality and Compliance

BH explained that the Red RAG-rating of the Governance & Risk Project is slightly misleading, because this relates to it not achieving one of its objectives; to ensure all 100% of policies and procedures where up-to-date. This was always an ambitious target and despite not achieving this level, significant inroads have been made with more than 90% of policies now in-date and a plan for those outstanding.

The Board noted the significant concerns relating to audit in line with NHS pathways, the mitigation of which will be helped by the additional investment the Board approved in the earlier part 2 meeting.

The Board received some assurance that the issues linked to EOC clinical safety has significant oversight of both the workforce and quality committees, as set out in the related escalation reports. It explored the approach to using GPs and the very careful review of the governance protocols that will support this, and also how the Trust can better attract clinicians to the EOC.

Although RAG-rated Green, the Board took time to acknowledge the really good progress with health and safety, and the hard work of staff to ensure the improvements in this area.

The Board then reviewed the CQC dashboard, specifically the three areas still RAG-rated Red. Some assurances were provided, but the Board remained concerned especially about welfare calls.

999 Service Transformation and Performance – Deep Dive

JG took the Board through the presentation, reinforcing the six objectives of the programme and how each is governed. The slide on the targeted dispatch model slide illustrates the aim of delivering in an integrated way, the standards within the ambulance response programme (ARP). A pilot of this model is being run this week to ensure better utilisation of the resources we have available to respond to patients, specifically ECSW crews and how we can respond more timey to Cat 3 and 4 calls.

DA summarised that the presentation simplifies what we are doing and shows a well-governed process that aims to ensure improvement. He then opened up for questions.

MW is on the programme board and felt the presentation was helpful. He asked two questions, the first about recruitment and how we can use our people more effectively, and the second about how the Board can see progress by area, rather than always looking globally.

On recruitment, JG explained that as the Trust wasn't initially in a position to deliver the number of staff required, the agreed approach was to develop a local recruitment and education campaign to change the dynamics of attraction and retention. The Trust also changed the way it assesses newly qualified paramedics (NQPs) as there was a need to appoint more; there is a 90% target for NQPs from universities in the region and the plan is to change this to 100%. This creates the challenge of preceptorship, and JG shared his view that the key is through localising recruitment, retention and education as this will better ensure improved staff experience.

Board also explored some of the detail behind the recruitment metrics, and the difference in pipeline between the different groups of staff.

LM asked about competition for paramedics from other parts of the healthcare system. This led to a discussion about making the Trust more attractive and thinking more innovatively, e.g. rotational models, as this will create an environment to attract paramedics back to the service. The Board also acknowledged that the Trust needs to be more flexible than it has been in the past, recognising that not everyone wants to work full time.

There was then a discussion about the challenges in meeting ARP and despite some of the differences in operating models, how the Trust could seek to learn from others ambulance services.

DA summarised that while the most seriously ill patients receive a quicker response, the Trust needs to think more creatively to ensure improvements across all areas, especially Cat 3.

08/19 Finance & Investment Committee Escalation Report [12.56 – 13.13]
09/19 Fleet Strategy

These two items were taken together. MW started with the escalation report and outlined the context in which the committee scrutinises investments. It is moving to taking a more medium to long term view so investments deliver sustainable change, is affordable in the context of long-term financing and delivers the stated benefits. MW confirmed that the committee is supporting the executive to deliver a medium to long term plan over the next few months, which will then inform the decisions the Trust takes.

MW then set out the way in which the committee scrutinised the fleet strategy, which it supported subject to it be followed by a detailed implementation plan. The committee challenged some aspects, including being clearer on what the Trust is actually aiming for; is it the optimum fleet as per the demand and capacity review, or what the Trust believes is affordable.

JG reinforced that the optimum fleet is as it is set out in the demand and capacity review and so it is not constrained by finances. However, efficient vehicle utilisation is improved by make ready centres.

LM asked whether this takes account of future demand. JG confirmed this is taken into account by the demand capacity review, as has the skill mix via the targeted dispatch model. The demand and capacity review projects to 2021, based on what is currently in place.

Decision
Noting that the fleet strategy is recommended by the finance and investment committee (FIC), the Board approved the strategy. It asked that it be reviewed annually, to take account of any changes, and that FIC has oversight of the implementation plan.

10/19 IPR [13.13 – 14.09]
Directors updated by exception.

<u>Clinical Safety</u>
SS highlighted the following;

- Cardiac ROSC is within reasonable variation. Staff can now download ECGs to ensure reflective practice.
- Acute STEMI care bundle – the main point here is we are not achieving in pain management. A deep dive is planned to follow the pain audit. FM added that at the area governance meeting on 19 May helped to confirm that local managers are not getting the breakdown and so we need to resolve this.
- Sepsis Care Bundle – a new tool has been developed that clarifies when staff need to pre-alert hospitals and we continue to do well; EPCR will further improve outcomes for patients.
- PGD is a good news story; it is now on JRCALC through I-pads.
- Breakages of controlled drugs is not reducing at the rate we would like to see; the next weekly CEO message will reinforce the importance of this.

Questions then followed, firstly from TM who asked the level of confidence that crews know and understand the data. JG confirmed that we know through the area governance reviews that OUs receive, understand

and use the clinical outcome data. The gap identified by FM above demonstrates this. TM then asked about mandatory training and assurance was provided that OUs have detail by individual, and the steps taken to ensure abstraction.

The Board then clarified that the issue relating to the acute STEMI care bundle is both the documenting and administering.

Action
QPS committee to explore the corrective action being taken to ensure pain scores are taken and recorded, relating to the acute STEMI care bundle.

Quality
BH explained that there has been in dip in Q1 in compliance with duty of candour. This is now been corrected and April and May has gone back to 100%.

There has also been a dip in response times for complaints for the first time in a long time; the main reason for this is the significant increase in numbers, largely related to delays in responding to patients. Additional capacity is being arranged and there is a 4 week trajectory to clear the backlog.

[Break 13.26 – 13.50]

Operations
JG outlined the information within the first scorecard which reflects Q4 of 2018/19; call handling is on an improving trajectory, and this has continued through a difficult period, as reflected in the second scorecard which includes the current data.

In terms of 111, JG explained that the scorecard sets out the final positon of the KMSS contract; going forward there will be data for the new emergency contract. LB asked whether there been any impact on 999 dispositions from Surrey, following Care UK taking over this service. JG explained that it is difficult to assess currently due to the way the measurement has changed. However, this is picked up through contract meetings and any adverse variance will be reported through the IPR.

Workforce
PR highlighted the vacancy rate holding around the 11% mark, which is better than the same period last year. In terms of recruitment, PR expressed good confidence that the targets will be me, but felt that more work is needed to improve retention, despite some recent improvement. One of the themes from exit interviews relates to being more flexible with part-time hours.

There are 31 outstanding cases relating to bullying and harassment, which is lower than previous years. Although the staff survey shows improvement the Trust is still bottom when compared to other ambulance trusts; there is therefore some work to clarify the definition of bullying and harassment and the HR team is reviewing what is in place to ensure this message is landed and to give skills to managers to resolve issues before they escalate. The fundamental point is about how we act with each other.

The Board reflected that the Trust is beginning to see good grip of these issues.

Finance
DH confirmed that all financial targets were met for the year just ended. The Board reflected on this achievement, and acknowledged the huge financial challenge this year, including the link between better patient care and income.

11/19 Quality and Patient Safety Committee Escalation Report [14.09 - 14.12]
TM took the reports as read and highlighted some of the key issues identified from the meetings in April and May. There were no questions.

12/19 Complaints Annual Report [14.28 – 14.32]
BH confirmed that some of the challenges at the Quality and Patient Safety Committee has been reflected in current version before Board.

The Board explored whether it was a fair reflection on the EOCs, to link complaints about delays as these are a broader system issue. It therefore asked management to look in to how this might be changed in future.

The Board supported this annual report and noted how much progress has been made with the management of complaints.

13/19 IPC Report [14.32 – 14.34]
BH introduced what the Board agreed was an extremely positive report. This was reviewed by the Quality and Patient Safety Committee and one specific challenge was made that the report was not clear enough about the issue with vehicle cleanliness; there are not insignificant compliance issues, which the committee is picking up.

14/19 Non-Parenteral Prescription Only Medicines [14.12 – 14.28]
LB asked that the Board considers this under the following three headings:

Paramedic PGDs
SS confirmed here that PGD is a standing procedure for paramedics, and so there is no issue.

Use of medicines for non-registered clinicians
SS explained that this can't be used under a PGD as it relates to non-registered clinicians, but it is usual practice for ambulance staff. The issue is that legislation isn't very clear, as set out in the paper. BH confirmed that the approach recommended is supported by the CQC and CCGs, but requires a Board decision as it is not covered by a PGD.

TM confirmed that this was considered carefully at the Quality and Patient Safety Committee, which concluded that it should continue.

The Board agreed that non-registered clinicians may continue to administer Ipratropium bromide in accordance with national JRCALC guidelines, despite being a prescription only medicine

CFRs and Co Responders
The Board noted the review by the Quality and Patient Safety Committee, which established that the Trust would be in the minority and asked for more clinical data to inform the decision. It therefore agreed in principle, but felt that it would be prudent to defer implementation until a clearer clinical case for change could be made.

FM added this is a patient safety issue; use of Salbutamol would be restricted to known asthmatic patients, and the data will almost certainly demonstrate the patient benefit. JG agreed, and with the controls now in place supported this. This led to a discussion by the Board about the risks and benefits. It concluded that while it supported the use of Salbutamol for CFRs and Co Responders, it would prefer to first have more data, which wouldn't take long to collate, to ensure the decision was fully informed.

15/19 **AUC Report** [14.34– 14.44]
AS thanked all members of the committee for their time in going through the annual report and accounts, on a page by page basis, and the finance team for the quality of the accounts; the external auditors were very complimentary. AS then outlined the areas covered by the committee, as set out in the report.

With regards the head of internal opinion, the committee agreed it was balanced, but overall was disappointed. There have been too many partial assurance audits and so management need to be more pro-active to put controls in place, so that when internal audit undertake a review they can be more confident that they are well designed and operating effectively.

DH added his thanks to the committee and KPMG who were very robust and worked well together to get everything approved.

16/19 **IG Annual Report**
This item was deferred for reasons set out in the AUC report.

17/19 **WWC Report** [14.44 - 14.49]
AR covered this report in TP's absence, picking out some of the highlights identified by the committee. There were no follow up questions.

18/19 **Board Meeting Schedule** [14.49 - 14.51]
PL confirmed the plan for the Board schedule this year, which the Board approved.

19/19 **Annual Review of Committees** [14.51 - 14.52]
PL set out the work that has been undertaken to agree a framework for each board committee, which included good liaison between the chairs. The Board approved the committee annual plans.

20/19 **Modern Slavery Statement** [14.52 - 14.55]
The Board noted the requirement of all NHS Trusts to have statement to comply with modern slavery act; this statement is based on review of others and after taking advice. The Board then explored how it seeks assurance we are compliant.

Action
QPS committee to add it is purview, compliance with the modern slavery act.

21/19 **Any other business**
None

22/19 **Review of meeting effectiveness**

There being no further business, the meeting closed at 14.56

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	C	This action is deferred to AUC and is currently on hold pending a review of the performance and accountability framework.
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	C	Action is closed as the Audit Committee is overseeing a review of the IPR which refreshes the KPIs.
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	C	To be closed and considered in the context of the board development programme TBC
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	C	To be closed and considered in the context of the board development programme TBC
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	Q2 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	C	HRT Business Case approved in June
24.01.2019	145/18d	Confirm to the Board the timeline and approach to developing the CFR / Volunteer strategy.	JG	26.09.2019	Board	IP	Aim is to bring to Board via QPS in Sept
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	C	To be closed and considered in the context of the board development programme TBC
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	Board	C	This is to be picked up as part of the discussion about rotas and skill mix - see FIC escalation report
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	C	To be closed and considered in the context of the board development programme TBC

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	26.09.2019	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	C	Add to WWC cycle of business
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	163/18b	A more forward view which predicts the level of performance to be included in either the Delivery Plan / IPR.	SE	Q1	Board	C	This is being considered as part of the IPR review overseen by AUC. It also relates to the discussion at FIC in July - see escalation report
28.02.2019	163/18c	WWC to scrutinise the system for ensuring support and recruitment of student paramedics	PL	TBC	WWC	C	Added to WWC cycle of business
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	26.09.2019	Board	IP	Updated scheduled
28.03.2019	180 18	Board Deep Dive on EOC clinical support to be scheduled.	JG	27.07.2019	Board	C	On agenda
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	Q2	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	26.09.2019	Board	IP	
28.03.2019	188 18	FIC to use Carter as a reference point to check progress against CIP.	DH	TBC	FIC	C	Considered in June and will be kept under review - see escalation report
20.05.2019	12 19	QPS committee to explore the corrective action being taken to ensure pain scores are taken and recorded, relating to the acute STEMI care bundle.	PL	25.07.2019	QPS	C	Added to QPS cycle of business
20.05.2019	20 19	QPS committee to add it is purview, compliance with the modern slavery act.	PL	25.07.2019	QPS	C	Added to QPS cycle of business
20.05.2019							

Key

	Not yet due
	Due
	Overdue
	Closed

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Dr Fionna P Moore
South East Coast Ambulance NHS Foundation Trust
Nexus House
4 Gatwick Road,
Crawley
RH10 9BG

12 July 2019

Care Quality Commission
Health and Social Care Act 2008
Re: CQC Inspection

Our Reference: INS2-6805312311
Account number: RYD

Dear Fionna

Following the feedback meeting with Catherine Campbell, Louise Thatcher and Cheryl Howarth on 10 July 2019, I thought it would be helpful to give you written feedback of our preliminary findings as highlighted at the inspection and given to David Astley, Bethan Eaton-Haskins and Richard Quirk at the feedback meeting.

This letter does not replace the draft report we will send to you, but simply confirms feedback given 10 July 2019 and provides you with a basis to start considering what action is needed rather than waiting for the draft inspection report.

An overview of our preliminary findings

The preliminary findings that we fed back to you were:

- Thank you to you and your staff for being welcoming, positive and engaged in the process.
- The inspection team commented on the remarkable, positive progress made within the organisation.
- We commented on exceptional individuals in the organisation, who were the company secretary and the head of the project management office.

- It was important to note that the departure of the last chief executive officer from the organisation had not impacted on the positive change in the organisation, which is a credit to the executive team.
- We commented on the responsiveness of the trust to any requests for information and additional interviews and are very thankful for that.

Areas for development:

- Consider implementing quality improvement tools to further support trust improvement.
- To consider how learning lessons can become intrinsic in all aspects of every services.
- In relation to the workforce race equality standard, consider how this can be more articulated and more evident at the most senior level.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and all your staff.

If you have any questions about this letter, you can contact me through our National Customer Service Centre using the details below:

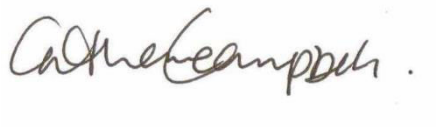
Telephone: **03000 616161**

Email: **enquiries@CQC.org.uk**

Write to: **Care Quality Commission**
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely



Catherin Campbell
Head of Hospital Inspection

Louise Thatcher
Inspection Manager

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	28-19

Name of meeting	Trust Board
Date	25.07.2019
Name of paper	Chief Executive's Report
Executive sponsor	Acting Chief Executive
Author name and role	Dr Fionna Moore
Synopsis (up to 120 words)	The Chief Executive's Report provides an overview of the key local, regional and national issues involving and impacting on the Trust and the wider ambulance sector.
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.

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 June and July 2019.

2. Local issues

2.1 Changes at Board level

2.1.1 On 10 June 2019, we were pleased to welcome Dr Richard Quirk to SECAmb in the substantive role of Deputy Medical Director. Richard, a GP and previously Medical Director at Sussex Community Trust, is also very familiar with the Trust, as he previously provided support as an NHS Improvement Performance Director.

2.1.2 Until September 2019, Richard will be undertaking the role of Acting Medical Director, whilst I continue as Acting Chief Executive ahead of our new Chief Executive, Philip Astle, joining SECAmb in September.

2.1.3 Adrian Twining, Independent Non-Executive Director stood down on 31 May due to conflicting work pressures. On behalf of the Board, I would like to thank Adrian for the contribution he made during his time with the Trust.

2.2 Executive Management Board (EMB)

2.2.1 The 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.

2.2.3 During recent weeks, the focus has been largely on monitoring the Trust's response time performance and delivery of the Performance Improvement Plan (see below), as well as spending time discussing workforce planning and skill-mix for our operational staff and the Trust as a whole and the recent CQC inspection.

2.3 Care Quality Commission (CQC) Inspection

2.3.1 During June and July 2019, the CQC carried out their Core Services and Well Led inspections of the Trust. They also carried out a full inspection of the Trust's NHS 111 service during July.

2.3.2 I would like to thank everyone who took part in the inspections and particularly to those who were interviewed by the inspectors. After each phase of the inspection, the CQC team commented that all the staff they had encountered had been professional, energetic and welcoming.

2.3.3 Shortly after the Well Led phase of the inspection, we received a feedback letter from the CQC, which you can read in full in Appendix A to this report, ahead of the Trust receiving their full report.

2.3.4 As you will see in the letter, the CQC are extremely complimentary about the progress that we've made in the last year, despite the changes at executive level and reference a number of areas of outstanding practice. As we know, there are a few areas where we still need to make progress but it's great to see the progress we know we've made being acknowledged in this way.

2.3.5 I understand that the CQC are looking to publish their full report into the Trust during August 2019, following the factual accuracy and sign-off processes taking place.

2.4 Engagement with local stakeholders & staff

2.4.1 During June and July, I have been extremely busy meeting with a number of our key external stakeholders, as below. 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).

2.4.2 During June and July 2019, I have attended a number of system-wide meetings with many of our regional acute Trusts including East Kent Hospitals, Maidstone & Tunbridge Wells, Darent Valley, Surrey & Sussex Healthcare and Ashford & St Peter's Hospitals. These are extremely useful meetings in terms of ensuring a shared understanding of both the opportunities facing us, as well as the challenges.

2.4.3 On 10th July 2019, I attended a national NHS EU Exit meeting, accompanied by a number of our senior operational team. This meeting was opened by the Rt Hon Stephen Hammond, Minister of State for Health and chaired by Professor Keith Willett, the NHS national lead for the EU Exit and as well as NHS colleagues, also included representation from other key partners including Highways England and the Border Force. This was a useful opportunity to work through some of the challenges that will face our region following the UK's exit from the EU, as well as some of the particular challenges that will face SECAmb.

2.4.4 I was also particularly pleased to see that the other nine English ambulance services, present at the meeting, committed to providing SECAmb with mutual aid, should the need arise.

2.4.5 On 2nd July 2019, I had the pleasure of meeting with Bo Escritt from the National Ambulance Diversity Forum, an important national group who work hard to promote and extend diversity across ambulance services. This was an enjoyable meeting and a good opportunity to discuss the steps we are taking within SECAmb in this key area.

2.4.6 I have also spent time with our 'blue light' partners recently, including at the Eastbourne Emergency Services Day on 6th July 2019, along with a variety of local

dignitaries and the local MP, Stephen Lloyd and at the Surrey Fire & Rescue Service Open Day on 20th July, together with the Chief Fire Officer and Chief Constable.

2.5 Improving operational performance/patient safety

2.5.1 As reported to the Board previously, we have been focussing hard in recent weeks to improve the safety of the 999 service we provide to our patients across all categories of call, especially our lower acuity patients, where we have seen some unacceptable waiting times previously.

2.5.2 As well as support from our local commissioners to make improvements, we are also receiving strategic and tactical support from NHS Improvement, as well as from the national strategic advisor to ambulance services, Professor Anthony Marsh.

2.5.3 Supported by myself and the whole Executive Team, the senior operational leadership team have developed a detailed Performance Improvement Plan. To support the delivery of this and ensure clear grip and focus, we have also 'stood up' the Strategic Hub, based in our West EOC, during recent weeks.

2.5.4 We still have some way to go but I am very pleased that we have seen some real areas of improvement in recent weeks. This translates into improved patient safety with reductions in the time it takes us to reach our C3 patients. Our focus now is to continue to drive further improvement, as well as ensuring that this is sustainable.

3. Regional Issues

3.1 NHS 111 service

3.1.1 On 18th 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.

3.1.2 At time of writing, the outcome of this submission is not known, however we are expecting an announcement to be made by the commissioners responsible for this service shortly.

4. National issues

4.1 Employers Network for Equality and Inclusion (enei) Award

4.1.1 On 2nd July 2019, I was very proud to hear that the Trust had been awarded a silver in the enei Talent, Inclusion and Diversity Benchmark for the second year running. Fellow shortlisted organisations at the awards included the BBC, the Environment Agency and the Ministry of Defence

4.1.2 The Trust was also represented in two further categories at the annual enei awards, hosted by the Law Society in London - SECAmb's Wellbeing Team celebrated success winning in the public sector wellbeing category while the Trust's LGBT Pride in SECAmb network was shortlisted in the employee network group category.

4.1.3 It is fantastic to see our approach to Equality and Diversity receiving national recognition in this way. I know that Angela Rayner and her team will now use the outputs of the report to make further improvements in this area.

4.1.4 I'm also delighted that the work of our newly-established Wellbeing Hub was recognised and won in what was a very strong category and that our Pride in SECAmb, LGBT network was shortlisted. Everyone involved in each team should be very proud of everything they have done to support our staff and patients.

5. Recommendation

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

Dr Fionna Moore, Interim Chief Executive

22 July 2019

APPENDIX A – Letter received from Care Quality Commission (CQC)

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	29/19

Name of meeting	Trust Board
Date	25 July 2019
Name of paper	Delivery Plan Progress Update
Responsible Executive	Steve Emerton, Director of Strategy and Business Development
Author	Eileen Sanderson, Head of PMO
Synopsis	This paper provides an update on the progress made with the projects within the Delivery Plan
Recommendations, decisions or actions sought	The Board is asked to review the progress made in relation to the relevant projects.

Does this paper, or the subject of this paper, require an equality 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. Portfolio timelines have been developed by the PMO which includes project milestones for the HR Transformation Programme (see Appendix A). The purpose of these timelines is to provide a clear snapshot of all the projects governed by PMO.

2. A prioritisation matrix has been developed by the PMO to ensure all concept proposals submitted to the Innovation and Service Change group are prioritised using set criteria. This will also support the Trust to prioritise key initiatives and projects.

3. The Service Transformation and Delivery Programme is transitioning into Business as Usual as part of the 999 Delivery Programme. The PMO are currently working with the Operational Lead to formally close down the programme by 31 July 2019.

4. The EOC Clinical Safety & Performance Improvement Plan refresh has been undertaken to align objectives with the CQC Must and Should Do's and key enablers. The Project Mandate has been revised with the initial draft scheduled for review by the Quality & Compliance Steering Group on 16 July 2019.

5. A new process has been introduced to ensure benefits, dependency tracking and lessons learnt reviews are embedded in all projects to improve and enhance consistency in standards and processes at each stage throughout the project lifecycle and increase the likelihood of projects being delivered on time, within budget and to quality.

Since the last reporting period 5 projects have been formally closed; further detail is captured in the body of this report. These are:

- 111 Interim Service
- IT Helpdesk System
- Automated Temperature Monitoring
- Health & Safety Improvement
- Governance & Risk

A post project implementation review has been undertaken on the Resourcing Plan project which has been subsequently approved at the Quality Compliance Steering Group. The review highlighted that the Trust continued to increase the ECSW's and AAP's recruitment by 110 roles since January 2019.

Three change requests have been approved: ePCR project end date extended to 30 November 2019, East EOC project end date extended to 2 August 2019 and Cyber security project end date extended to 31 July 2019. The impact of any of the change in timelines is explained in the relevant sections of this report.

The CQC Must & Should Do Tracker has been updated and can be found in Appendix B.

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:

- Service Transformation and Delivery Programme
- Sustainability (see Appendix C)
- Quality and Compliance (see Appendix D)

- HR Transformation (see Appendix E)

1.2 In this reporting period, there is a Dashboard for Quality and Compliance and Sustainability Steering Group with a high-level timeline for HR Transformation Programme. Service Transformation and Delivery Programme is now in project closure phase, so a Dashboard has not been produced for this reporting period.

1.3 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.

1.4 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 the project is unlikely to meet business case/ mandate objectives within agreed time 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 rating remains Amber. It is expected to report as completed in the next reporting period as preparations are under way for transitioning into BAU.

Since the last reporting period, the Operating Unit Manager for Ashford has recently taken over as the Operational Lead to transition the STAD programme into business as usual by 31 July 2019 with the support of local management teams. The Operational Lead is currently working with Operating Unit Managers to take responsibility over the existing programme elements, for example, local recruitment, rotas and private ambulance provider management. A formal reporting governance structure is in the process of being established to monitor progress in the Business as Usual environment.

The PMO are currently working with the Operational Lead to formally close down the programme. As part of project closure, all risks and issues, benefits, lessons learned and KPI's will be reviewed with any outstanding activities actively monitored by the PMO. A Post Project Implementation Review will be conducted 3 to 6 months after project closure to assess if all the desired benefits have been realised and to identify any additional lessons which can be applied to the planning and management of future projects. It is anticipated that the full closure documentation will be presented to the STAD Steering Group on 24 July 2019 for ratification prior to formal sign off by the Executive Sponsor.

3.0 Sustainability

3.1 **111 (CAS) Interim Service (Sussex, West Kent, North Kent & Medway) –** The project RAG rating has moved from Green to Blue following the successful launch of the interim service on 28 March 2019. The technical transition was seamless, and the Trust has seen a steady improvement in the overall performance since launch. As the mobilisation element of the project (phase 1) was achieved, the Project Board agreed for the project to move into closure phase and the CAS Development elements form a new project plan (phase 2).

The project was formally closed on 24 June 2019 following a robust closure process completed in collaboration with NHSE/CCGs and a new 111 CAS Development project initiated.

3.2 **111 CAS Contract Exit KMSS –** The project RAG rating has moved from Green to Blue following the Trust's successful exit from the KMSS 111 contract on 28 March 2019 and the transition to the new 111 (CAS) interim service. In the post transition period, all outstanding activities were completed, and no issues emerged. The project was formally closed on 24 June 2019 following a robust closure process completed in collaboration with NHSE/CCGs.

3.3 **Worthing Ambulance Make Ready Conversion –** The project RAG has moved from Amber to Red due to the continued delays with the project. The project was initially due to be completed by 23 June 2019 with the initial delay of the contractor being unable to complete the electrics and redecoration, a further extension is required to complete the snagging before the works are formally signed off and handed back to Operations. It is anticipated that next month, the PMO will be working with operation colleagues to formally close the project and ensure that the intended benefits continue to be tracked to ensure they have been fully realised.

4.0 Digital Programme

4.1 **Automated Temperature Monitoring** – The RAG project rating has moved from Green to Blue as the project has now been completed. Temperature sensors have been installed in 37 locations reducing the amount of medicines wastage due to temperature fluctuations. This has now enabled SECAmb to provide 100% temperature compliance records for all medicine's storage facilities 24 hours 7 days a week.

4.2 **Cyber Security** – The project RAG rating has moved from Amber to Green as the migration of all Coxheath servers onto Fortinet networking has been completed with all EOC desktops now on the Fortinet networking, bypassing Cisco equipment.

As reported in the last Delivery Plan report, a change request has now been approved to move the end date of the project to the end of July 2019 to factor in the insufficient preparatory work. The project is on track to complete by the revised end date with only the decommissioning of Telehouse Cisco equipment and the migration of all staff VPN connections from Telehouse onto Fortinet still outstanding. The expectation is that the project will be formally closed in the next reporting period.

4.3 **ePCR** – The Project RAG remains Red and has not moved to Green, as stated in the last reporting period. This is due to the connectivity issues being experienced which has led to a delay in starting the 'Pre-live' testing. However significant progress has been made with the stability of the platform following the removal of the VPN solution with no issues been reported by the pre-live users.

As reported in the last Delivery Plan report, a change control has been approved to extend the end date of the project from end of July 2019 to November 2019 to factor in the issues the Trust has experienced with the pre live testing.

The project plan has now been re-baselined and the systems testing is due to conclude shortly and the formal decision to go/no go on 5th August 2019 will be made at the next ePCR project Board on 26th July 2019.

It is anticipated that there will be a phased approach to sites going live, as below:

- Chertsey, Medway and Brighton from 5th August 2019
- Guildford, Gatwick and Redhill from 19th August 2019
- Dartford and Paddock Wood from 2nd September 2019
- Ashford and Thanet from 16th September 2019
- Tangmere and Worthing from 30th September 2019
- Polegate and Hastings from 14th October 2019

4.4 **Replacement Fleet Management System** – The project RAG rating has moved from Green to Amber as there is still an outstanding activity to transfer all historic Data into the new system. All IT work is completed, and new scanners have been installed. The expectation is that the project will be formally closed in the next reporting period.

4.5 **NHS Spine Connect** – The project RAG rating has moved from Green to Amber as the project is unlikely to be completed by the agreed timescales due to a delay in the accreditation which was due to occur at the beginning of June 2019 with an anticipated go live date of 30 June 2019. NHS Digital has now recently accredited Summary Care Records and testing can now commence by the EOC Systems team with a target 'go live' date of 5 August 2019. A change control will be enacted to ensure that any impact with this delay has been considered. SECAmb systems testing can now commence by EOC Systems Team with a target go-live date of 5 August 2019.

4.6 **GoodSAM App** – The Project RAG status has moved from Red to Green as the Clinical Bulletin has now been signed off. The application is due to be launched on 22 July 2019. No further update expected for this project in the next reporting period.

4.7 **Station Upgrades** – The project RAG rating has moved from Green to Amber as significant delays have impacted 4 sites being upgraded with new network circuits by 31 July 2019. This is due to the excess work at Polegate no longer feasible and Sky is trying to work out a new route into the site. Worthing upgrades have been delayed due to the redevelopment work. A site survey is scheduled for w/c 15 July 2019. Work has been halted at Battle ACRP due to the discovery of asbestos. A full site survey, yet to be scheduled is required at Banstead to confirm network requirements to support current site usage. This is being closely monitored by the Digital Programme Board.

4.8 **IT Helpdesk Replacement –** The project RAG rating has moved from Green to Blue as the project has now completed. The new Service Desk went live on 8 May 2019 and all staff are now using the new helpdesk to manage all IT requests.

4.9 **East EOC –** The project RAG rating has moved from Amber to Green as the installation and migration of services to the replacement UPS and associated electrical cabling was successful completed overnight on 25 June 2019.

As reported in the last Delivery Plan report, a change request has now been approved to move the end date of the project to early August 2019 to factor the complexity and challenges experienced with the Crawley migration. The project is on track to complete by the revised end date with only the installation of a monitoring solution and EOC warning panel still outstanding. The expectation is that the project will be formally closed in the next reporting period.

4.10 **Electronic Clinical Audit System (ECAS) -** This is the first reporting period for this project. The aim of this project is to implement Doc-Works system to help move forward our strategy towards a more effective quality assurance and quality system. The project is currently RAG rated Amber due to the dependency with ePCR go live. As a result, the project plan will need to be re-baselined. Server structure has been built and the Doc-Works system installed. The focus this month will include installation on Health record staff's machines and local configuration of system settings.

5.0 Financial Sustainability

5.1 **CIP -** The RAG rating for the Cost Improvement Programme remains Amber at the end of the first quarter ending June 2019. The current pipeline schemes reflect the annual savings target of £8.6m. £4.2m of schemes have been fully validated and transferred to the CIP Delivery Tracker. The validated and scoped schemes of £1.4m are awaiting Executive Sponsor and QIA approval prior to moving to delivery. Finance is working collaboratively with budget leads on the development and validation of schemes to achieve the remaining £2.9m "proposed" value on the Pipeline tracker.

The First quarter CIP achievement of £1.4m is £0.2m below plan. This is partly due to the difficulties in delivering the anticipated improvements in handover delays. The full year target of £8.6m is expected to be met, although this remains challenging. The CIP Pipeline and Delivery Tracker (Appendices F & G) provide more detail on the construction of the Programme

6.0 Quality & Compliance

6.1 **Governance and Risk** (CQC Must Do) – The project RAG has moved from Red to Blue as the project has now been formally closed and has transitioned into business as usual. At project closure, 91% of policies and 81% of procedures are now in date. Organisational and project risks are currently being reviewed and there is a process in place to actively monitor progress in the business as usual environment. The reports and metrics developed from this project will continue to be used at monthly review meetings to maintain oversight and enable escalation where issues are identified. The project has led to greater awareness within the Trust of the management of risk, and ensuring policies and procedures are kept up to date.

6.2 **Health & Safety** – The project RAG has moved from Green to Blue as the project has delivered its objectives set out in the project mandate and was completed to timescale. Significant improvements have been made in terms of the culture and governance around Health & Safety within the organisation. There is an improved Health & Safety management system and networking sessions are now in place with Trade Union colleagues. As a result of this project, a bespoke audit programme is now in place, with 10 audits conducted per month. The Trust has made significant progress with the development and updating of Health & Safety policies. Health & Safety will continue to be overseen by the Health & Safety Committee as part of business as usual.

6.3 **EOC Clinical Safety & Performance** – The project RAG rating remains Red. The key risk to the delivery of the whole plan is the audit element. Whilst the business case has

been approved the implementation will be reliant on the completion of a staff consultation and will result in significant delay to deliver the full staffing model. Mitigations are in place to provide temporary cover for audit but compliance for clinician audit remains poor. This is monitored through the EOC Clinical Governance meeting as a standing agenda item.

However, good progress is being made in key areas such as EMA recruitment and retention, dispatch recruitment. Clinical Supervisor recruitment is on track to be established by September 2019. Policies and procedures on track and approved.

In terms of recruitment, the EMA pipeline is strong with October 2019 courses currently being populated. Focus has shifted to attracting part time workers and this has now reached the projected target allowing the advertising to be reduced to one part time advert. The dispatch team are on track to be fully recruited by October 2019

In respect of registered clinicians, the trajectory indicates full recruitment by September 2019. The pipeline is fragile and requires focus at all times to keep the candidates engaged. The international recruitment has progressed with a more focused approach. Currently there are 8 candidates ready with start dates from August 2019 through to October 2019.

In the interim the Trust has worked with external agencies to provide pathways trained Clinical Supervisors, 10 in total with 4 currently being assigned 1-2 shifts per week. The recruitment strategy for EOC remains incomplete; to address these adverts are posted and interviews undertaken on a rolling monthly basis with a weekly recruitment meeting to escalate concerns and challenges. This strategy is a key enabler to not only provide guidance and support to maintain safe staffing but also will be key in addressing the staff turnover experienced in the EMA cohort to support resilience within this group.

Key areas such as policies and procedures remain on track for completion. All NHS Pathways staff are required to be NHS Pathways v17 compliant by 4 September 2019; a staggered training plan has been agreed to manage abstraction and ensure all staff have been trained by 1 September 2019.

During the next reporting period further work will be progressed to ensure the Trust focus in on the key deliverables to achieve clinical safety, e.g. clinical recruitment, rotas and pathways audit for 999.

7.0 HR Transformation

7.1 **HR Transformation Programme -** This is the first reporting period of the rescoped programme and the RAG status is Green. The HR Transformation Business Case was recently approved at Trust Board and over the coming weeks, the project team will be defining the scope of the works to produce project plans that will transform the systems and processes that are required to ensure an effective and efficient HR operation. In essence, the Programme will consist of 4 projects;

- Applicant Management System (TRAC) to improve the candidate and hiring manager experience
- Implementation of e-expenses
- Implementation of e-timesheet
- Implementation of ESR Manager Self Service

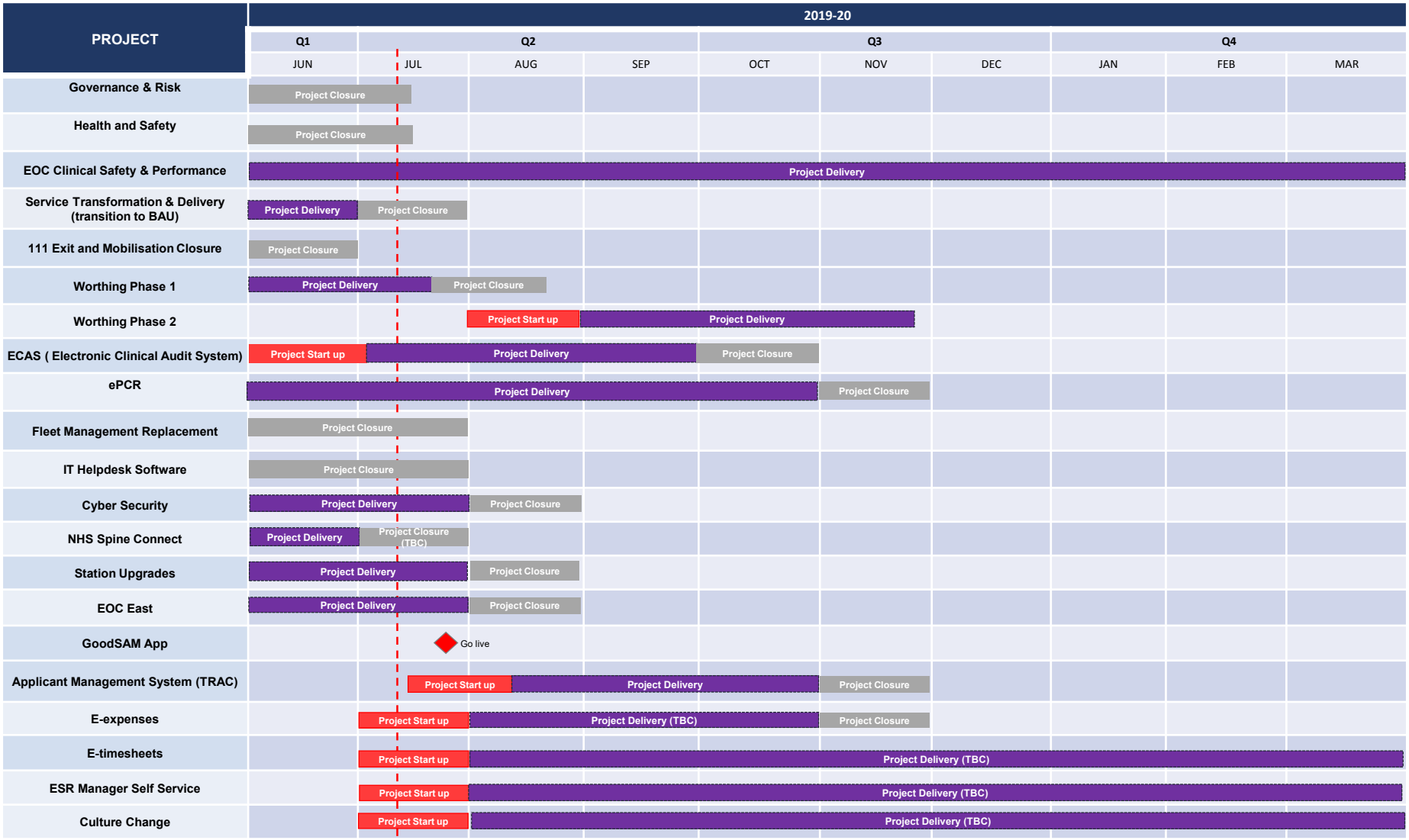
All the above projects will go through the full project lifecycle and progress will be monitored via the HR Transformation Steering Group. An action plan will be developed to monitor the structure changes required within the HR team and this will also be monitored via the Steering Group to ensure the intended benefits are realised.

7.2 **Culture Change** (please note this programme is not currently overseen by PMO)

The aim of the Culture Change work to be proposed to this month's Trust Board as 'our patients and all our people feel listened to, respected and well supported'. In terms of the agreed priorities, work continues to embed interventions at all levels of the employee life cycle in relation to reducing bullying and harassment and this will be completed by October. Work is also underway to simplify the current appraisal system (hosted on the Actus system) by September 2019 and then develop a plan to have this hosted on the ESR system by April 2020. More detail of this work can be found in the July Board update on all current HR initiatives.

It is anticipated that this project will report into this HR Transformation Steering Group from next month.

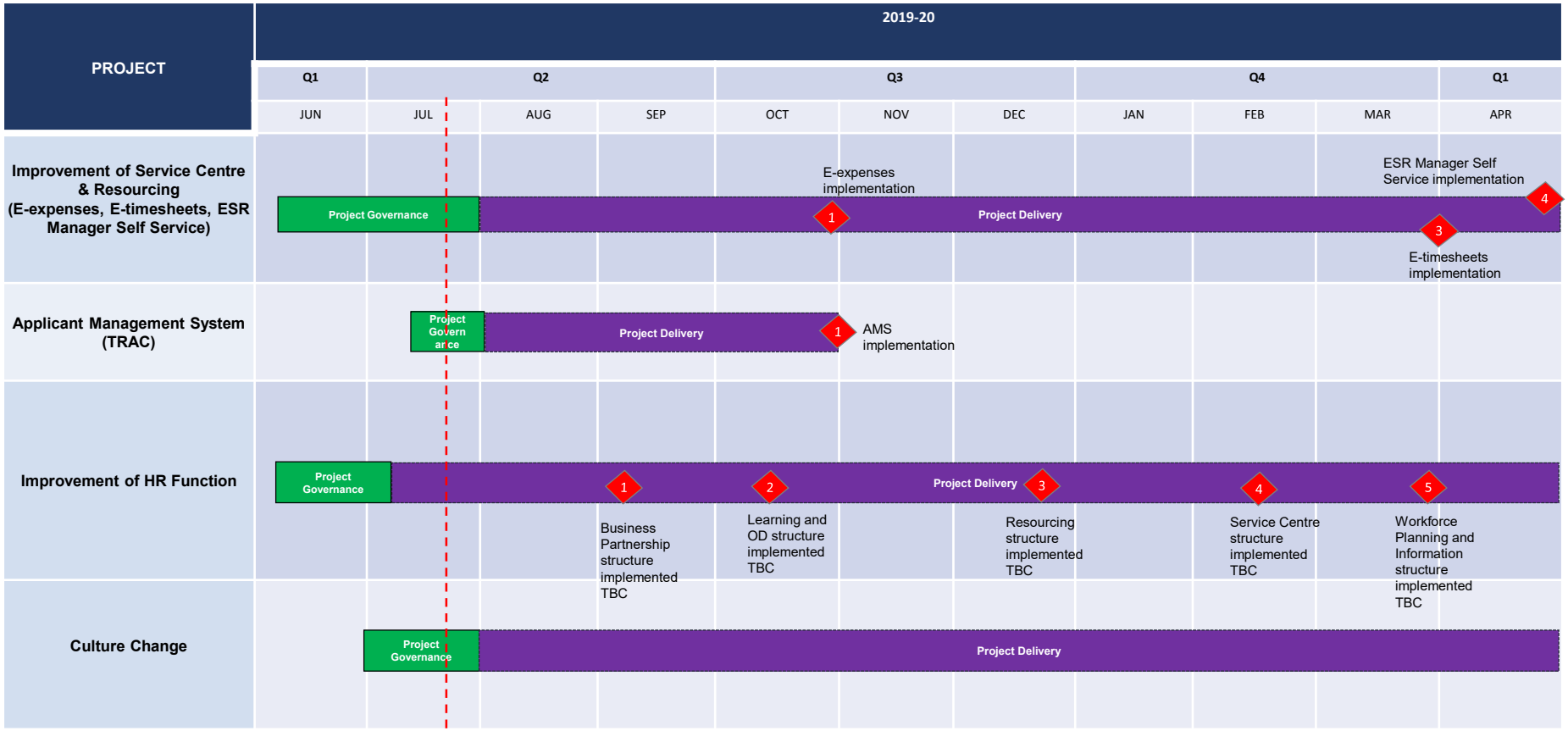
PMO Portfolio Timeline (Last updated: 15 July 2019)



HR Transformation Programme Timeline

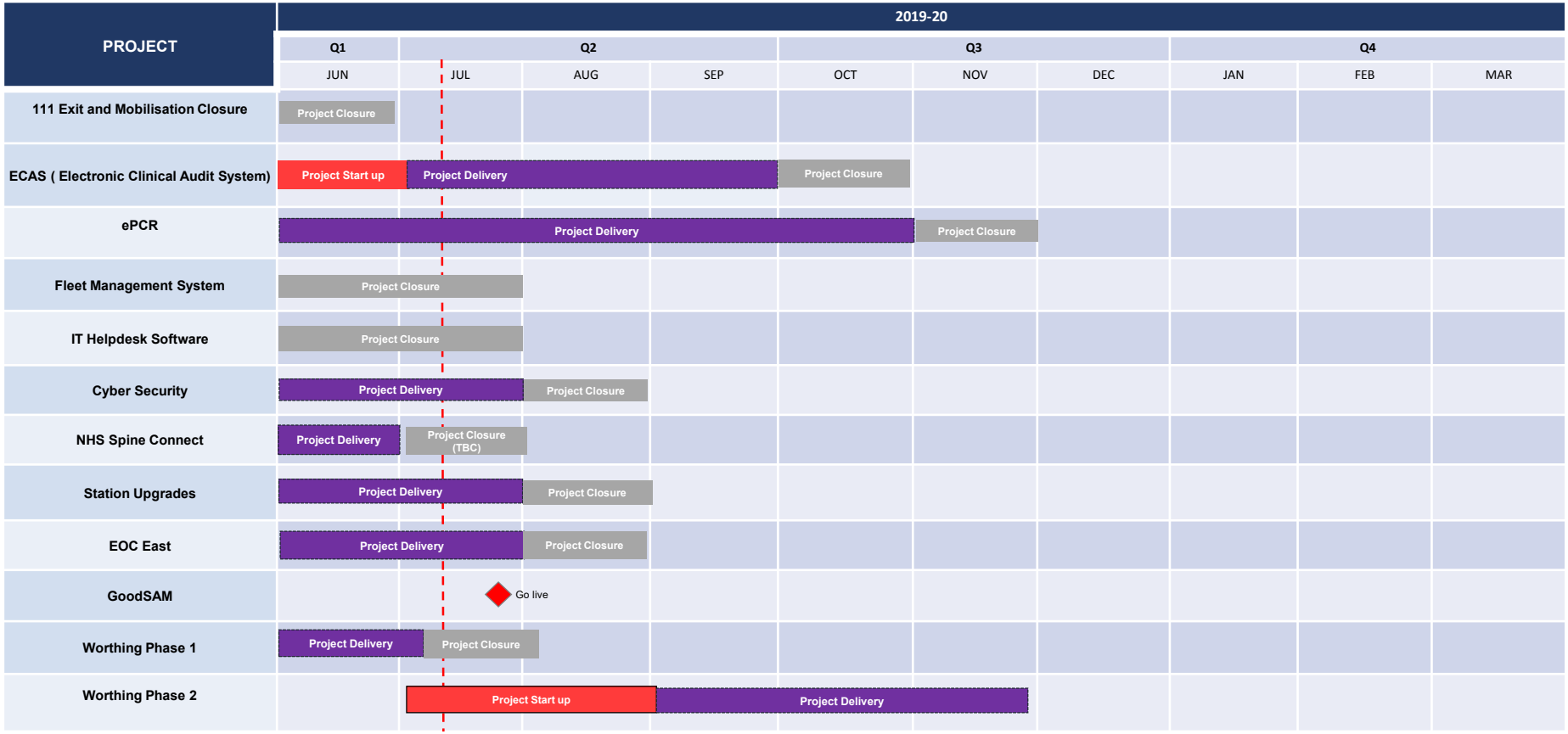
Last Updated: 17/07/2019

(please note that dates are subject to change)



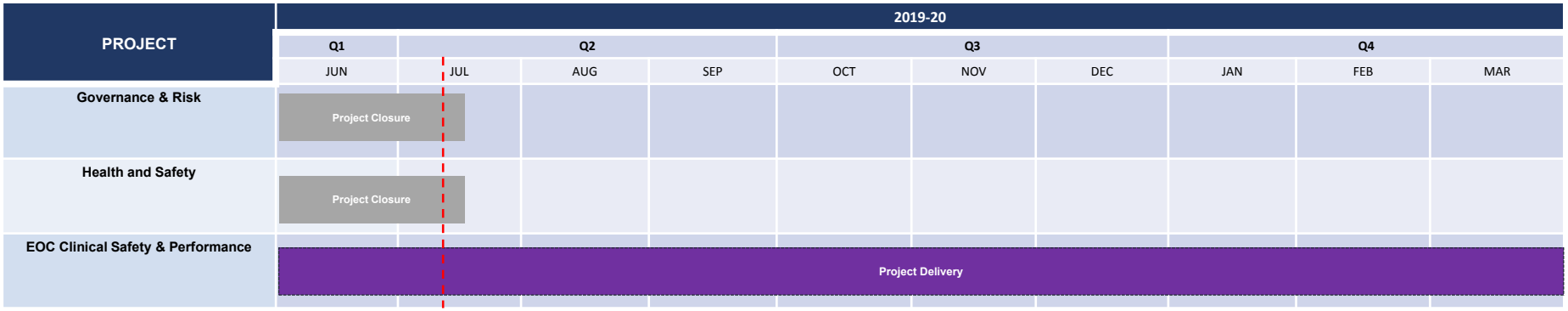
Sustainability Steering Group Projects Timeline

(Last updated: 15 July 2019)



Quality & Compliance Steering Group Projects Timeline

(Last updated: 15 July 2019)



South East Coast Ambulance Service NHS Foundation Trust

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 60%). However, 1 WTE Clinical Supervisor for the East is undergoing mentoring this week with 3 having started training in the West. 2. Identification of completed / Required Clinical Welfare calls for delayed dispatch – Target: 100% (Current Performance 15%) 3. Surge Management No Send Audit compliancy – Target: 100% (Current Performance 95.7%) 4. Tracking of all risks and issues through Datix, the Trust's Risk Management System. These are monitored via the EOC Teams B Meeting. Ongoing work is occurring to look at the historic auditing of no send and clinical welfare calls and the weekly publication of the look back reports is ongoing. There is a current dependency on alternative and light duties staff to support in the completion of the no send and tail audit. Several staff are moving back to their substantive duties as they are now fit to work, therefore, work is continuing with the Wellbeing Hub to replace them.	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 (100% complete) – published and live 2. Clinical Supervisor Procedure (40% complete) 3. Clinical & Operational In-Line Support Procedure (40% complete) 4. Crew Call Back Procedure (90% complete) – to be tabled at JPPF on 13/09/19 5. Clinical Tail Audit Procedure (35% complete) 6. No-Send Audit Procedure (25% complete) 7. CAT 3 and CAT 4 CSD Procedure (40% complete) 8. Clinical Review Bulletin (100% complete) – published and live 9. Care Line / Life line Bulletin (40% 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 Compliancy	

		1. Clinical Safety Navigator Substantive staffing levels – Target: 100% (Current Performance 50%). Currently advertising for part time CSN and seconded CSN role via NHS jobs. 2. Clinical Safety Navigator Cover 24/7 – Target: 100% (Current Performance: 100%) 3. Identification of completed / Required Clinical Welfare calls for delayed dispatch – Target: 100% (Current Performance 15%) 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. However, reporting has been delayed due to focus on operations and will therefore not be available before August 2019. Currently 0% of March 2019. 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 Task & Finish 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. Working with HR to alter the advertising of the CSN role has been positive with further application and interest shown. Use of the agency band 5 nurses in the role of patient safety callers and paramedic staff from the wellbeing hub should help to improve the compliancy of welfare calls as well as the support of fallers presenting to the trust.	• 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 Performancefor: 43%) 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: 60%) a. Target: 41 WTE – 18 in post with 13 new starters due to join by October 2019. 8 international are currently in the recruitment pipeline, 3 of which have start dates. b. The recruitment pipeline although steady is fragile. Courses scheduled up to September 2019 are full. c. During the interim there are currently 5 B6 clinical agency staff with pathways licence v17 working 1-3 shifts per week. The plan is to offer them a 6 month commitment. B5 Agency Patient Safety Clinicians are being employed to handle calls, however, the recruitment pipeline is very slow. 4. EOC Cinical ICAS WTE Substantive – Target: 100% (Current Performance: 14.1%). a. Mental Health Clinicians – Target 12 WTE (Max 15 head count). 5 in post and 3 pending start dates. Recruitment pipeline is stead. b. Pharmacy – Scope of practice has now been agreed. c. GP – The pilot is progressing through the Trust's governance route; start date to be agreed. 5. EOC Clinical Safety Navigator WTE Substantive – Target: 100% (Current Performance: 50%) a. The recruitment pipeline is slow with only 2 interviews schedule. b. A mix of job types are being advertised, eg, secondment, part-time, agency.	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	

		Ongoing work with HR sees courses at West EOC fully booked with at least one clinician on every course between now and November. Targeted campaigns for East EOC to address concerns over recruitment into the role of CS are ongoing. The first group of Mental Health clinicians are now working within the 999/111 environment, with a further course in a couple of weeks – this is the first group of ICAS clinicians in working. Recent completion of training with 5 agency NHS Pathways trained clinicians, along with an ongoing drive with the agency to source fully trained NHSP clinicians will improve operational hours covered.		
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	Complete – no further update from previous submission expected
Effective	The Trust should ensure that maps in all vehicles are current, up to date and replaced regularly	The previous proposal to retain map books in a standardised form and link to the Cleric CAD platform to provide map page numbers and grid squares to crews is unfortunately not viable as the organisation has not been able to source a single provider who is able to supply map books for all of the regions covered by SECAmb. An options paper has been drafted for presentation at Executive Management Board: • 'Do nothing' and migrate over to digital services but with the potential of GPS outage. • Have bespoke map books printed to cover the missing counties as they become unavailable (use of a mix of map book publishers). • Move over to A-Z as the sole supplier of Trust map books. • Use of the 'Tom Tom Go' app which has the functionality to operate offline on devices.	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.	The rollout of Personal Issue Assessment Kits had previously been planned for Q1 of this year, however had been delayed due to the manufacturer of the blood glucose machines being unable to fulfill the order for the Trust. However, the Trust has since taken delivery of 600 blood glucose machines this week, with the remaining 300 due for delivery this month. In the meantime, it is anticipated that the roll out of the current stock will start by the end of July. The Standard Operating Procedure was approved at the May JPPF – this includes the importance of staff checking their equipment. N.B. The regular servicing of equipment is not applicable.	Not required	
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	Complete – no further update from previous submission expected
Safe	The Trust **should** ensure response times for category three and four calls is improved	The Trust has issued an operational instruction to OTLs to ensure that existing policies and procedures are robustly followed and implemented regarding hospital handovers. This will assist with the efficacy of available hours on day. The Trust has also agreed to suspend Delayed Handover at Hospital, where applicable, to allow crews to clear the scene and to get to the longer waits in the community in a more timely way. A July Performance Improvement Plan has been produced which includes standing up the Strategic Command Hub to provide focus and manage responses on an hour by hour basis each day. Within the plan, clinical and operational resource will be reviewed to assist in improving on day operational hours. The Trust have offered incentivised shifts to staff to ensure the provision of cover meets our demand profile. Weekly calls with all PAP providers has also been instigated to review performance and rectify any operational hour short falls. In order to reduce lost hours on day due to equipment restock, the Trust has given the responsibility of those staff on light and alternative duties to attend hospitals or incident locations to restock crews on site. The Trust will not grant abstraction unless essential.	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	Complete – no further update from previous submission expected
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	Complete – no further update from previous submission expected

Digital Programme Board Dashboard

Reporting Period: 13 May 2019 – 15 July 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 16/07/2019 v1.0

Key Points

Project	Brief Summary
EPCR	Significant progress has been made with the stability of the platform over the last couple of weeks and following the removal of the VPN solution, no issues with connectivity have been reported by the pre-live users. Following this period of stability, the effort to support the users has been much reduced compared to previous periods. Target go live date is 5 August 2019 for OU area 1 (pending Project Board approval 29 July 2019).
GoodSAM	The Clinical Bulletin has been approved and the app is scheduled to go live 22 July 2019.
Electronic Clinical Audit System	This is the first reporting period. The aim of this project is to implement Doc-Works system to help move forward our strategy towards a more effective quality assurance and quality system. Work is underway to define the agreed timescales and project plan.
Station Upgrades	On track to complete 104 sites out of 108 by end of July 2019. 4 sites (Polegate, Worthing, Banstead and Battle) are at risk of delivery where local issues mean installation of new network circuits is being delayed. This is being closely monitored by the Digital Programme Board.
NHS Spine Connect	NHS Digital Accreditation Certificate now issued so final systems testing can be completed by EOC Systems Team. Target go live date is 5 August 2019 (subject to testing).
Replacement Fleet Mgmt. System	All IT work is complete and new scanners have been installed. Closing actions remain with Fleet Workshop Manager to transfer all the data from old system to new system before this project can formally close.
Cyber Security	All migrations now completed and 2 outstanding activities are on track to be completed by the end of July 2019. The expectation is that the project will be closed during the next reporting period.
East EOC	The installation and migration of all services to replace UPS and associated electrical cabling was successful. The installation of a monitoring solution and EOC warning panel are currently scheduled to complete early August 2019. The expectation is that the project will be closed during the next reporting period.
Automated Temperature Monitoring	Temperature sensors have been installed in medicines fridges in 37 locations reducing the amount of medicines wastage. The project is now formally closed.
IT Helpdesk Replacement	The new system went live on 8 May 2019.The outstanding activities around the reporting training have now been completed. This project is now formally closed.

Key Issues

Project	Brief Summary	Score
EPCR Issue	Issues with the system connectivity has delayed the completion of pre-live testing. Re-run of pre-live testing with new connectivity commenced 8th July. System now appears stable. Pre-live systems will be migrated to LIVE systems w/c 15 July 2019. Final systems testing will then be completed before 26 July 2019.	N/A
EPCR Risk	Risk that there will be insufficient resources to provide ongoing Clinical ePCR support. **Mitigations**: EOC systems team will receive ePCR infrastructure and app usage and will support live system in the same way they do the existing Cleric platform OTLs being trained on ePCR usage and will, over time be able to assist with support queries amongst their teams ePCR Champions being identified to assist with training and support	9

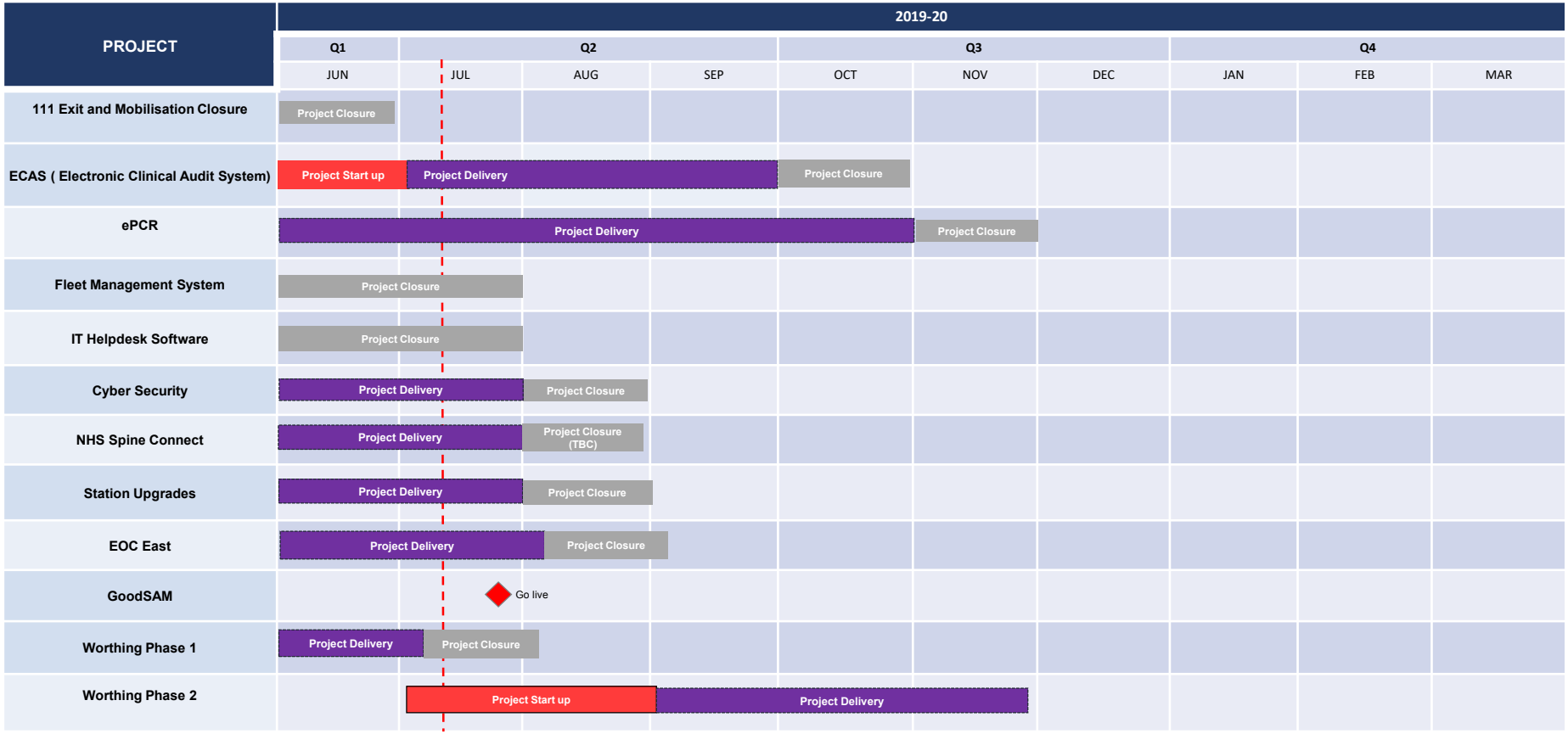
Project	Current RAG	Previous RAG
ePCR		
GoodSAM		
Electronic Clinical Audit System (ECAS)		First Reporting Period
Station Upgrades		
NHS Spine Connect		
Replacement Fleet Management System		
Cyber Security		
East EOC		
Automated Temperature Monitoring		
IT Helpdesk Replacement		

Achievements this period

- ePCR connectivity now stabilised following removal of the VPN solution.
- East EOC successfully migrated to new network infrastructure
- Successful change to network routing overnight 25th June
- Station upgrades : 100 sites of 108 completed (93%)
- Server structure has been built and the Docworks system installed on these servers.

Sustainability Steering Group Projects Timeline

(Last updated: 15 July 2019)



QCSG Dashboard

Reporting Period: 13 May 2019 – 15 July 2019

RAG Key:

Last Updated 16/07/2019 v1.0

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

Key Points

Project	Brief Summary
EOC Clinical Safety & Performance	The project RAG rating remains Red, due to the audit element of the plan being at risk – whilst the business case has been approved, implementation of the new structure has been delayed by staff consultation. EMA recruitment is progressing well with a strong pipeline in place. The Clinician trajectory indicates that full recruitment will be reached by September 2019, however this is fragile. In the interim, external agencies have provided 10 pathways trained Clinical Supervisors to support. Policies and procedures remain on track. During the next reporting period further work will be progressed to ensure the Trust focus in on the key deliverables to achieve clinical safety, eg, clinical recruitment, rotas and pathways audit for 999.
Governance & Risk	The project RAG rating has moved from Red to Blue as the project has been formally closed and transitioned to business as usual. At project closure, 91% of policies and 81% of procedures are now in date. Organisational and project risks are actively being reviewed and there is a process in place for monitoring in the business as usual environment. The project has led to greater awareness within the Trust of the management of risk and ensuring policies and procedures are kept up to date.
Health & Safety	The Health & Safety Improvement Plan is now RAG rated Blue as this project has delivered the objectives set out in the project mandate. Significant improvements have been made in terms of the culture and governance around Health & Safety within the organisation. There is now an improved Health & Safety management system and networking sessions with Trade union colleagues are in place. A bespoke audit programme is now in place, with 10 audits conducted per month. Health & Safety will continue to be overseen by the Health & Safety Committee as part of business as usual.

Project	Current RAG	Previous RAG
EOC Clinical Safety & Performance		
Governance & Risk		
Health & Safety		

Key Risks

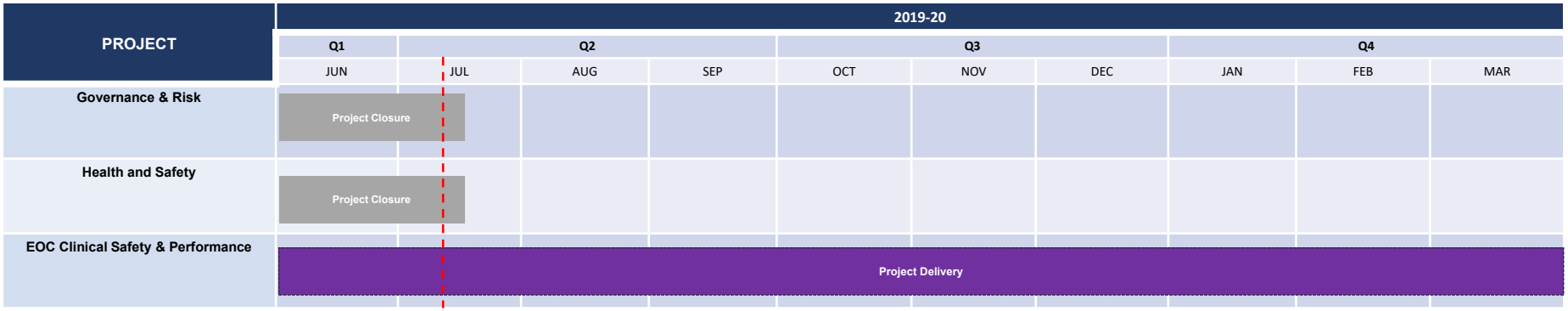
Project	Brief Summary	Score
Risk (922) EOC Clinical Safety & Performance	There is a risk that future CQC reports will be adversely impacted as a result of the Clinical Safety & Performance project not being delivered, which may lead to a downgraded report. **Mitigation**: The improvement plan is undergoing a refresh with workstream leads to re-focus on clinical safety and drive ownership.	12
Risk (905) EOC Clinical Safety & Performance	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:** Business case approved. Implementation of structure not yet started; this is dependent upon the settlement of an outstanding grievance. Continued use of alternative duties to complete Clinical Tail Audit and No Send audits as an interim measure.	15

Achievements this period

- In terms of the EOC Clinical Safety & Performance project, EMA recruitment has reached the projected target, allowing advertising to be reduced to one part time advert. The EMA pipeline is strong with courses populated up to October 2019.
- **1** Post Project Implementation Review undertaken: Resourcing Plan. This project resulted in the HR Resourcing Team reviewing and improving candidate attrition and engagement. Further clarity has also been gained on the responsibilities of both the Resourcing and Clinical Education team.
- **2** project closures approved: Governance & Risk (11 July 2019) , Health & Safety (08 July 2019).

Quality & Compliance Steering Group Projects Timeline

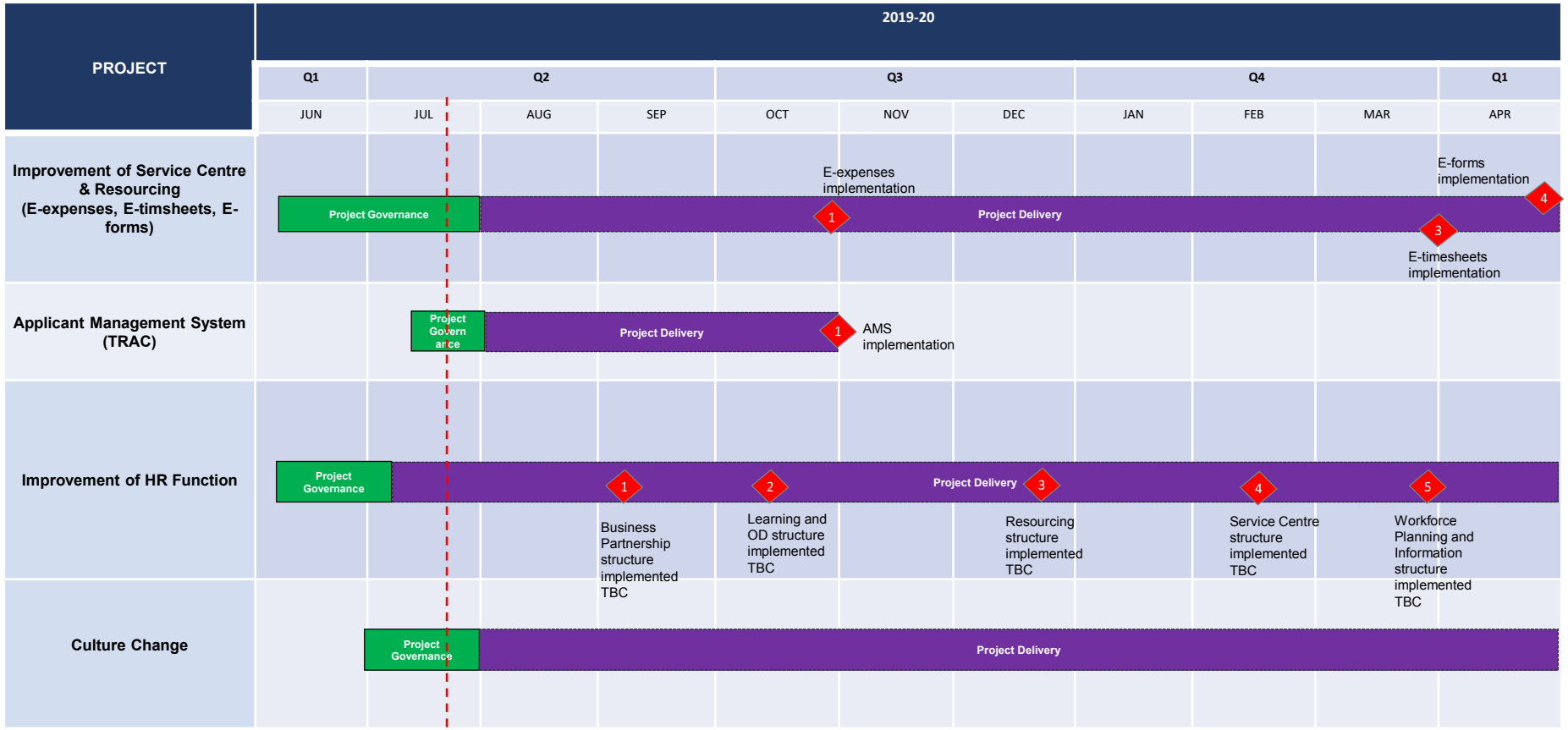
(Last updated: 15 July 2019)



HR Transformation Programme Timeline

Last Updated: 15/07/2019

(please note that dates are subject to change)



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 3 - June 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 are expected to be reduced during the course of the year and replaced by definitive CIP schemes when constructed by Budget Holders.

2. Fully validated CIP schemes of £4.2 have been moved to the Delivery Tracker after QIA approval.

3. Current Pipeline schemes of £8.6m include Validated and Scoped schemes of £1.4m.

4. Positive engagement with Executives Directors and CIP Project Leads remains. The CIP Programme governance framework and processes continue to be functional in the Trust in 2019/20.

5. The CIP schemes anticipated 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

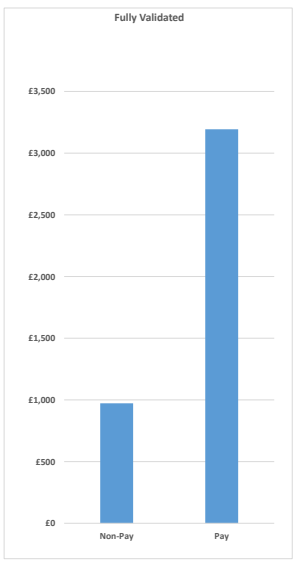
	Risk	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Risk that the 2019/20 CIPs target of £8.6m will not be fully delivered due to uncertainties within the Operations Directorate.	The savings target of £8.6m has been allocated to Directorates based on their individual pro rata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

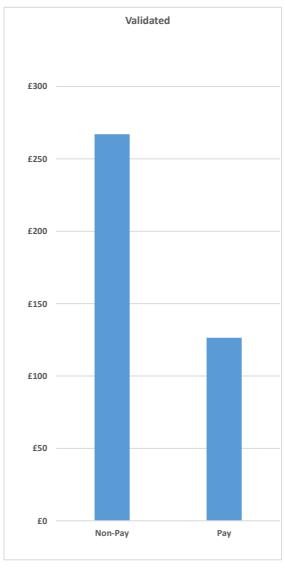
	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	New Lease Cars policy to be agreed.	A Business Case is being finalised based on fit for purpose cars for operational managers aligned to roles. New club car scheme was launched in January - to be evaluated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

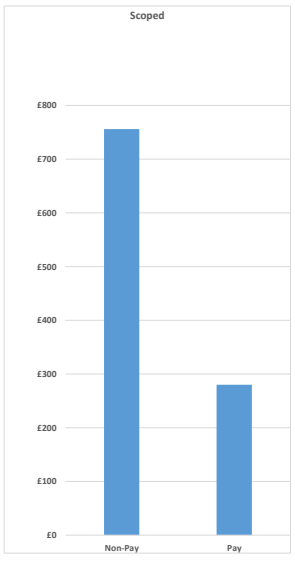
CIP Pipeline Summary

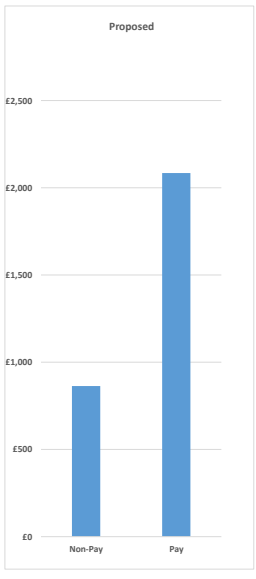
Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£0	£4,236	£393	£1,036	£2,947	£8,612

Pay / Non-Pay / Income Breakdown and scheme summary









Scheme Category	Fully Validated	Validated	Scoped	Proposed	Total
Accounting efficiencies	861	-	-	-	861
Budget Allocation	-	-	-	2,947	2,947
Discretionary Non Pay	14	77	33	-	124
Estates and Facilities management	-	-	100	-	100
External Consultancy	24	-	-	-	24
External consultancy & contractors	-	190	-	-	190
Fleet Veh Run Costs - Fuel	-	-	200	-	200
IT Productivity and Phones	48	-	-	-	48
Lease costs - ambulances	-	-	185	-	185
Legal/Professional Fees	29	-	-	-	29
Meal Break Costs	-	-	30	-	30
Medicines Management - Consumables	-	-	98	-	98
Office Equipment	-	-	15	-	15
Operations efficiencies	2,714	-	-	-	2,714
Public Relations Expenses	12	-	-	-	12
Recruitment delays & recharges - clinical	-	-	240	-	240
Recruitment delays & recharges - non clinical	316	126	40	-	483
Training courses & accommodation	219	-	-	-	219
Travel & Subsistence	-	-	95	-	95
Grand Total	4,236	393	1,036	2,947	8,612

South East Coast Ambulance Service: CIP Workstream

CIP Delivery Dashboard

Reporting Month Jun-19

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

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

1. Achieved CIP savings of £1.4m in the first quarter ending June 2019. This is £0.2m below the NHSI plan. The recurrent schemes represent 29% of the total.

2. £4.2m of fully validated savings have been transferred to the Delivery Tracker as at year to date, June 2019 reporting date. This is almost half of the annual target of £8.6m.

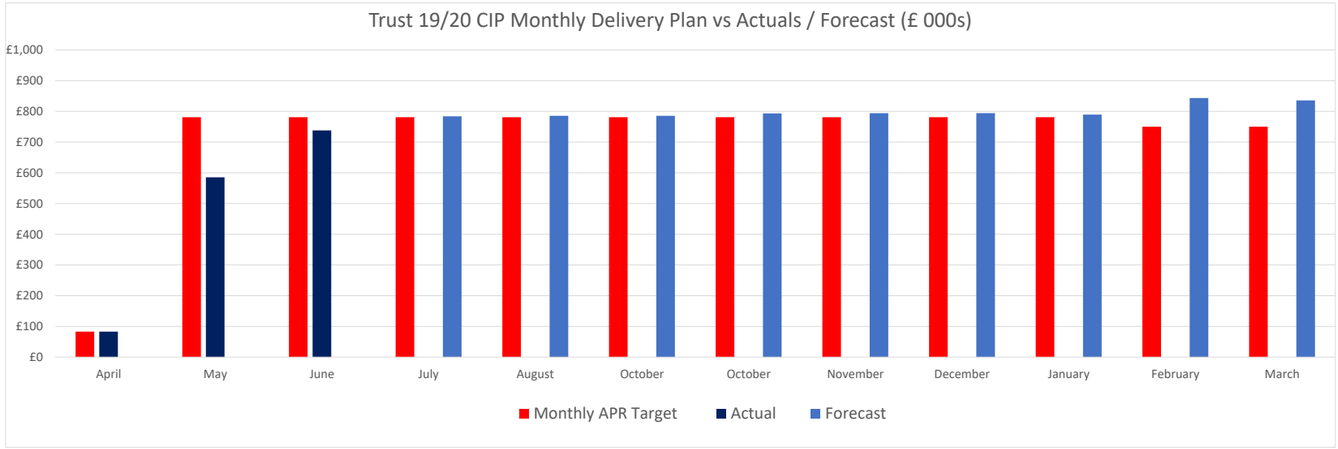
3. Regular review meetings with Budget Leads and Finance Business Partners is in progress focusing on identifying new schemes to build a sustainable pipeline of recurrent schemes for 2019/20.

4. The CIPs schemes under development include savings arising 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 - the anticipated reduction in handover delays and sickness remain challenging.

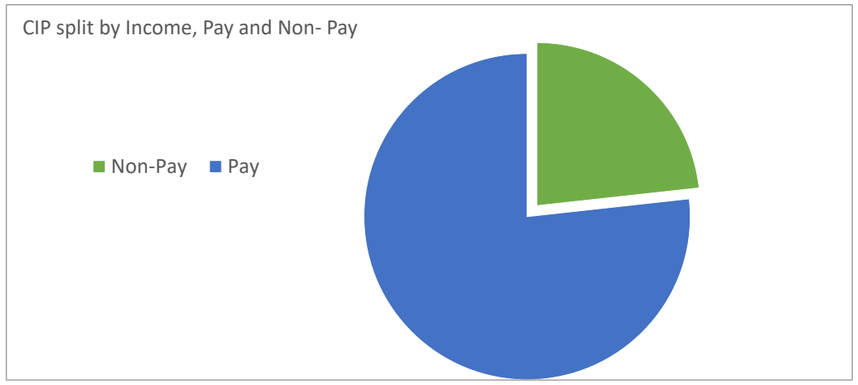
5. The Cost Improvement Programme is rated Amber at this early stage of the financial year.

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

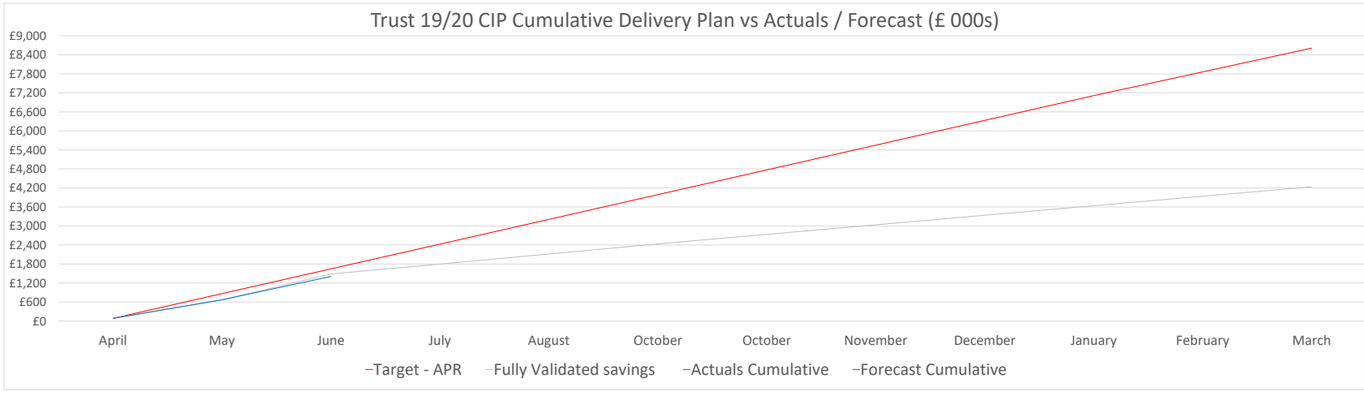
CIP Target for 19/20 £000's	Total planned savings on delivery tracker £000's - as at 30 June 2019	Total forecast savings on delivery tracker £000's - as at 30 June 2019	YTD June 2019 - Target Savings £000's	YTD June 2019 - Actual Savings £000's	YTD June 2019 - variance £000's
8,612	4,236	8,612	1,645	1,407	(£238)



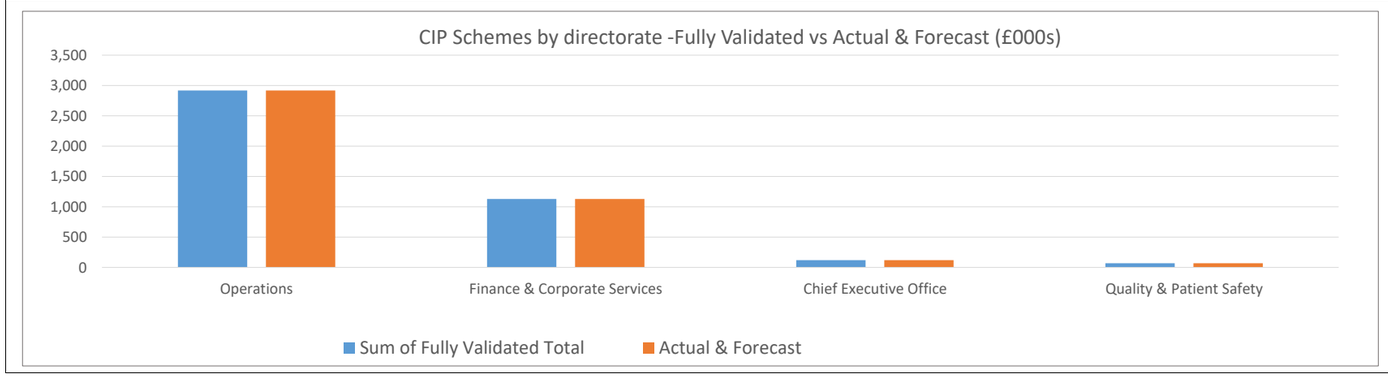
2. CIP - Planned savings split by income, pay and non-pay: as at 30 June



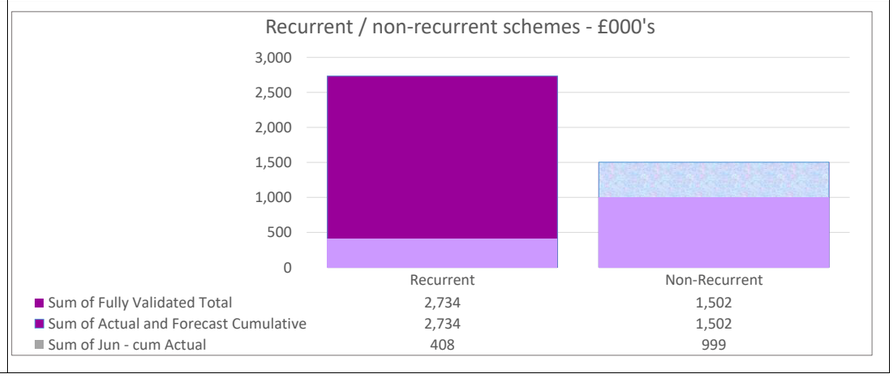
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2019/20



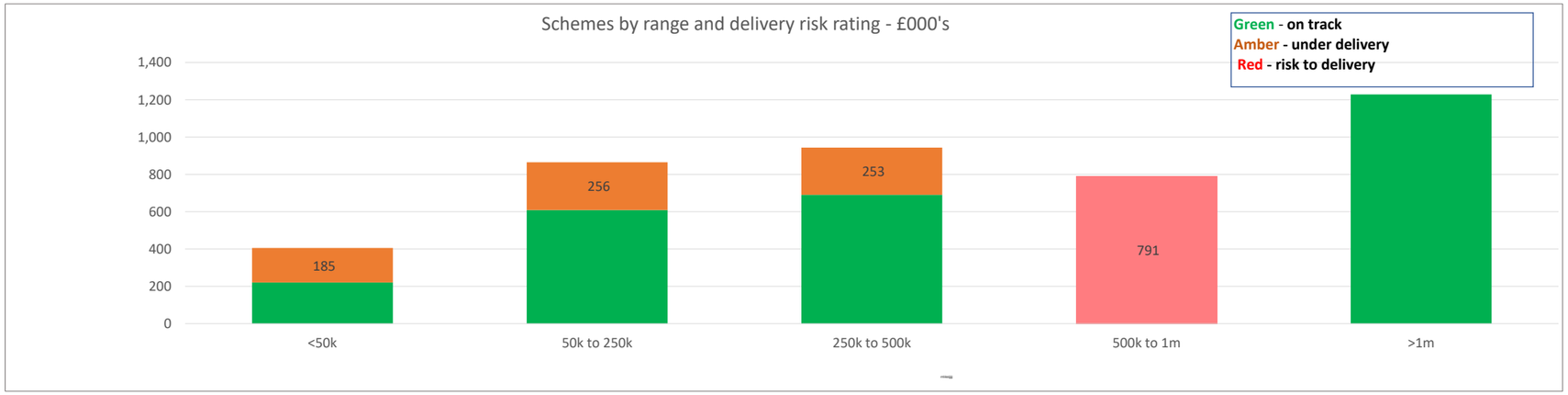
4. CIP schemes by directorate - Fully Validated vs Actual & Forecast 2019/20



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



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



7. YTD Identified CIPs to Date and Savings - May 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 3): £000	YTD Actuals (Month 3): £000	YTD Variance £000	Comments (+/- £20k variance)
IT Productivity and Phones	48	48	0	12	12	0	-
Discretionary Non Pay	13	13	0	3	3	0	-
Training courses & accommodation	219	219	0	99	99	0	
Operations Efficiencies	2,714	2,714	0	475	396	(79)	YTD underachievement in handover delays - improvement anticipated
Recruitment delays & recharges - non clinical	316	316	0	185	185	0	-
Accounting efficiencies	862	862	0	695	695	0	-
External Consultancy	24	24	0	6	6	0	-
Legal/Professional Fees	29	29	0	7	7	0	-
Public Relations Expenses	12	12	0	3	3	0	-
Total Fully Validated Schemes	4,236	4,236	0	1,486	1,407	(79)	
Variance to Year To Date (YTD) Target				159		(£159)	Variance between Fully Validated Schemes and YTD Control Total Target
Total Fully Validated Schemes	4,236	4,236	0	1,645	1,407	(238)	

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	30-19

Name of meeting	Trust Board
Date	25.07.2019
Name of paper	Board Assurance Framework Risk Report
Author	Peter Lee, Company Secretary
Synopsis	The BAF Risk Report includes the principal risks to meeting the Trust's strategic goals, It sets out the controls, assurances, and actions.
Recommendations, decisions or actions sought	The Board is asked to review the BAF risks, and confirm its level of assurance that it is sufficiently focussed on the most relevant high-risk areas. It is also asked to support the changes proposed as recommended by the executive / board committees.

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

Board Assurance Framework (BAF) Risk Report

1. Introduction

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

Should EMB consider it necessary to add or remove a risk, it will make a recommendation to the Trust Board, for decision. The recommendations are listed in section 4.

2. Structure of the BAF Risk Report

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

Each risks aligns to one of the four strategic goals and linked to the 16 corporate objectives, as illustrated in the **Dashboard** below. Where applicable, the Dashboard confirms the link between the risk and the Strategic Delivery Plan.

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

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

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

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

Low	Moderate	High	Extreme

Figure 1

3. Board Committee Review

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

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

Committee	Agenda Item	BAF Risk
Finance and Investment	111 emergency contract mobilisation	602
	EPCR	495
	999 transformation	123

The committee noted / agreed the following:

- To remove BAF risk 602 (mobilisation for 111 emergency contract) – on the basis that the target score is achieved and the service is now mobilised.
- To recommend to the Board a new BAF risk (178) – risk of failure to achieve the planned financial target / control total for 2019/20.

Quality and Patient Safety	EOC clinical safety	269
	Dispatch Safety Model	269 & 579
	111 Clinical Effectiveness	966

The committee noted / agreed the following:

- The description of BAF Risk 269 would be updated to reflect the ARP target for call answer performance which is no longer 95% within 5 seconds, as this risk previously stated.
- The score for Risk 579 should be increased to 20.
- Although risk 123 (ARP) is under the purview of the finance and investment committee a view was expressed that this risk should more clearly distinguish that the greatest risk currently relates specifically to responding to Cat 3 patients.

Workforce and Wellbeing	Personnel Files	362
	DBS Checks	362
	H&S Plans	517
	Leadership Development	334
	EOC retention	111

The committee noted / agreed the following:

- In review of BAF risk 111 (Workforce) the committee acknowledged that the Trust is on a better position than last year, and asked QPS to explore the links to patient safety. It also asked management to update the mitigating actions.

- BAF risk 362 (safer recruitment) – the committee was more assured with regards DBS checks than with the personnel files.

- The committee suggested that the residual risk for BAF risk 334 (Culture) should be increased from 8 to 12.

4. Management Review & Recommendation

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

i. Remove BAF Risk 602 ((mobilisation for 111 emergency contract) – on the basis that the target score is achieved and the service is now mobilised.
ii. Add BAF Risk 178 (risk of failure to achieve the planned financial target / control total).- details will be provided in the next version of the report.
iii. Note the increase in residual risk score for Risk 334
iv. Consider whether to remove risk 522 as the risk score is now considered to be met
v. Note that risk 529 will be updated in August following the mapping exercise being undertaken with commissioners to ensure arrangements for system assurance involving SECamb is more manageable.
vi. In light of the feedback from the most recent QPS committee meeting, BAF Risk 123 will be reviewed to better reflect the specific risk relating to Cat 3 performance.

5. Conclusion

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

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

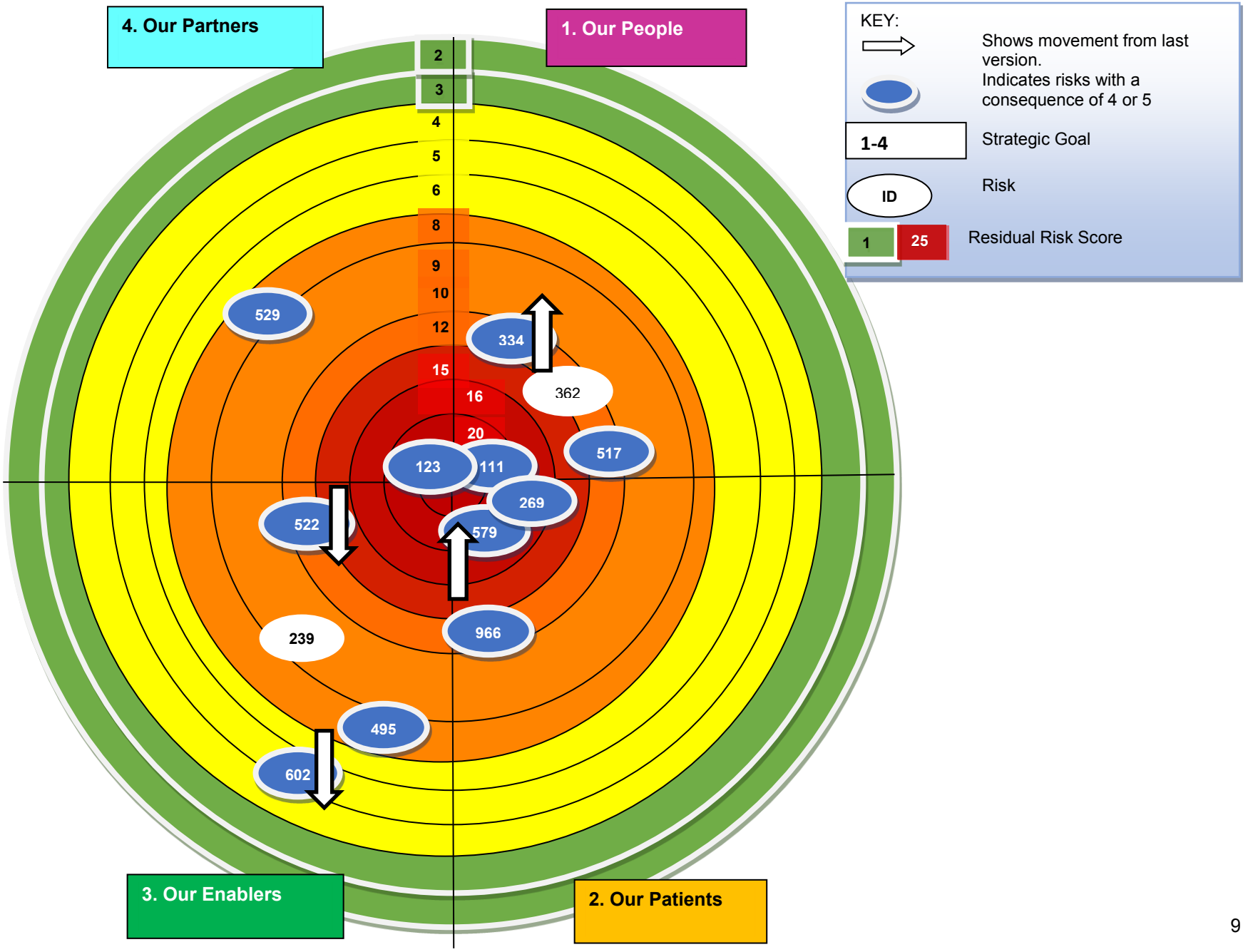
Dashboard

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

6, 9	**111 (CAS) Interim Service**	Risk ID 602 111 (future)	There is a risk that the short mobilisation timeline and service specification for the transformed 111 service into IUC/CAS could result in clinical care, quality and continuity of 111 service being compromised during the contract transition process, as a result of a lack of confidence of both organisations delivering the agreed exit strategy. Failure to deliver on time could also result in patient harm and place adverse pressure on 999 and the wider healthcare system.		20	5 ↓	5	01.04.2019	FIC *Recommends closing this risk*
2, 7	**Personnel Files**	Risk ID 362 Safer Recruitment	Risk that the Trust is not able to always provide evidence of the relevant employment checks, as a result of inadequate internal controls / record keeping, which may lead to sanctions and reputational damage.		15	12	6	30.06.2019	WWC
7	H&S	Risk ID 517 H&S	Risk that we do not comply with H&S legislation as a result of sub optimal infrastructure and governance, which may lead to harm to staff and related sanctions on the Trust and / or individual directors.		16	12	4	01.09.2019	WWC
5, 6, 7, 8, 9, 10	EOC	Risk ID 579 Care & Treatment	Risk that patients waiting for a response are not appropriately triaged, as a result of lack of clinical resource; suboptimal IT systems; and an inability to respond to demand, which may lead to patient harm.		20 ↑	20 ↑	4	01.09.2019	QPS
5, 6, 7, 8	N/A	Risk ID 966 111 Service	Risk that the Trust does not achieve operational standards for 111 as a		16	12	4	30.09.2019	QPS

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

		Change	influence system change as a result of; •capacity to engage with STPs and system partners •complexity of the environment, e.g. STPs at different stages This may lead to non-delivery of the Trust strategy.						


4. Our Partners
1. Our People
3. Our Enablers
2. Our Patients
2
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12
15
16
20
529
334
362
517
123
111
269
522
579
966
239
495
602
KEY:
Shows movement from last version.
Indicates risks with a consequence of 4 or 5
1-4
Strategic Goal
ID
Risk
1
25
Residual Risk Score

Appendix A

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

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

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

Resourcing improvement plan (IP) delivered 227 new ECSWs and 44 new AAPs.
Improved EMA recruitment in to the EOC
Manchester Triage (enabler to increase clinical capacity within EOC)
HR transformation programme (Phase 1 – diagnostic)
Improving working conditions, e.g. meal breaks / shift overruns
Rotational paramedic roles aimed and better attraction and retention

Gaps in Control

Workforce Plan
Overseas Recruitment
HR transformation programme (Phase 2 – improving functions)

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) WWC not assured with HRT Plan (-) under-utilisation of NET/ECSW crews (-) IA sickness absence reporting (2016/17) / sickness rates above the 5.2% target. (+) leavers reduced (+) >100% hours for 999 (+) Resourcing Plan delivered.	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. 10-year front line workforce plan 2. Clinicians to be appointed from overseas 3. HR transformation programme developed Review 999 transformation plan, with renewed focus on skill mix	1. Working Group tasked with agreeing an options paper for EMB in August. 2. Offers have been made and the aim is to have the new clinicians in post from July 2019. 3. HRT business case approved by the Trust Board in June 2019.

Last management review	Executive Management Board	**Last committee review**	13.06.2019 Workforce & Wellbeing Committee

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

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

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

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

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

Gaps in Control

New projects for both DBS and Personnel Files to be established
Policy to be reviewed relating to renewal of DBS checks
HRT Plan (Phase 2) – aimed at improving basic controls

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Internal Audit Reports – pre-employment checks (2017/18); DBS Checks (2018/19); Staff Records (2018/19) (-) Head of Internal Audit Opinion (+) All staff have an initial DBS check in place	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. QCSG overseeing the development of two projects for both DBS and Personnel files 2. Review of the policy is underway to confirm which groups of staff require the different level of DBS, and whether a 3-year renewal is necessary. 3. Deliver Phase two of the HRT Plan	1. Projects to be established by the end of June 2019 and will report through the Delivery Plan 2. Policy to come to Board in Q2 3. HRT Business Case approved by the Trust Board in June 2019.

Last management review	Executive Management Board	**Last committee review**	13.06.2019 Workforce & Wellbeing Committee

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

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

Controls in place (what are we doing currently to manage the risk)
Established a values and behaviours framework Staff recognition programme / staff awards Leadership development programme Modules completed for senior managers (>Band 8B) Exec and Senior Managers individual and team coaching Wellbeing Hub Honest Mistakes Policy implemented Staff engagement champions in place Staff Appraisals
Gaps in Control
Defined programme of work relating to Culture

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) High number of grievances (+) feedback from staff following the launch of the values and behaviours (+) Wellbeing Hub (-) LCFS Annual Report – on the question of an open culture (+) 2018/19 Staff Survey	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Programme of work to be developed	1. Plan presented to the Board in May, and we will established in line with the HR Transformation Plan.

Last management review	Executive Management Board	**Last committee review**	13.06.2019 Workforce & Wellbeing Committee

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

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

Controls in place (what are we doing currently to manage the risk)
A number of specific H&S risks have been identified (on the risk register) with related mitigating actions. A H&S dashboard for the H&S working group has been developed to ensure focus in the right areas, and metrics included in the Integrated Performance Report >90% of Board members have completed IOSH training 12 month Improvement Plan (in response to the independent H&S review) A gap analysis has been undertaken of the Trusts' Health & Safety policies The annual Health & Safety audit plan has been implemented and 40 audits have been completed
Gaps in Control
Improvement Plan in response to the recommendations from the independent H&S review to be completed Policies to be established

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) HSE inspection visit in February 2018 focussing on Muscular Skeletal Disorders (+) violence and aggression to staff showing a slow downward trend. (-) manual handling incidents high (+) increase in H&S reporting – showing greater awareness (+) Delivery Plan showing H&S as Green (+) WWC April	
Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Delivery of the improvement plan 2. 10 new Health & Safety related policies have been identified. 3. MDT training	1. Ongoing 2. Aim to complete by Q2 2019. 3. Over 200 operational managers have received classroom based H&S training

Last management review	Executive Management Board	**Last committee review**	13.06.2019 Workforce & Wellbeing Committee

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

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

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

Assurance: Positive (+) or Negative (-)		**Gaps in assurance**
(-) NHS Pathways / MT audit compliance (-) Call Answer performance around 90% against the 95% target (-) EOC clinical capacity (-) QPS meeting May 2019 / Project RAG Red	(+) reduction in ring backs asking for an ETA (+) reduction on EMA turnover against trajectory	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
A range of actions are set out in the EOC clinical safety and performance project plan / Delivery Plan	A range of actions are set out in the EOC clinical safety and performance project plan / Delivery Plan

Last management review	Executive Management Board	**Last committee review**	18.07.2019 Quality & Patient Safety Committee

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

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Nursing & Quality
Risk that patients waiting for a response are not appropriately triaged, as a result of lack of clinical resource; suboptimal IT systems; and an inability to respond to demand, which may lead to patient harm.	**Scrutinising Forum**	Executive Management Board
	Inherent Risk Score	**20** (Consequence 4 x Likelihood 5)
	Residual Risk Score	**20** (Consequence 4 x Likelihood 5)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)
CAD upgrade provides better visibility of the types of calls requiring triage. Specific improvement plan is in place (see delivery plan) Overseas recruitment fair (aim to make at least 15 clinical appointments) Implementation of Clinical Support Worker to provide assurance in patient welfare calling Clinical recruitment

Gaps in Control

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
A range of actions are set out in the EOC clinical safety and performance project plan / Delivery Plan	A range of actions are set out in the EOC clinical safety and performance project plan / Delivery Plan

Last management review	Executive Management Board	**Last committee review**	18.07.2019 Quality and Patient Safety Committee

Goal 2 Our Patients	BAF Risk ID 966 111 (current) –operational standards	Date risk opened: 25.05.2018

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

Controls in place (what are we doing currently to manage the risk)	
Enhanced recruitment of Health Advisors Regular review of performance data to monitor service improvement Review of training / mentoring process to ensure optimum performance of new staff Reduce overall call handling time by increasing coaching Learn best practice from other cleric users Effectively manage unplanned absence	Improve adherence through use of Real Time Annalyst tools Strengthen the role of Senior Health Advisor through migration to HATL role Increase numbers of HATLs from 10 to 12 Explore closer working with EOC colleagues to implement satellite working Blend 999 and 111 calls to a larger workforce gaining benefits of economies of scale

Gaps in Control

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) (+) clinical performance not meeting national standards but compares well to national average (-) 2% above national average for referrals to 999 (+) Impact of the additional Service Advisors and the use of Patient Safety callers (+) Maintenance of full NHS Pathways compliance with regards to audit	

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
Service Development Improvement Plan aims to ensure performance improvement to contractual standards by the end of August; and reduce by 2% the referrals to 999 to bring in line with the national average/	

Last management review	Executive Management Board	Last committee review	18.07.2019 Quality & Patient Safety Committee

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

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

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

Over 100 new vehicles, include NET vehicles to ensure focus on Cat 3 / 4
EMA recruitment in the EOC (see BAF Risk 111 & 269)
Recruitment (see BAF risk 111)
External review through AACE of EOC Practice & Process completed
External review of EOC by NHS I Commissioned Project (National work)
Demand and Capacity Review agreed / additional funding provided for 2019/20
Support from NHS England Performance Team, NHSI and the Ambulance Advisor to the Department of Health

Gaps in Control

Skill Mix / utilisation of NET/ECSW crews (see BAF risk 111)
Clinical Support in the EOC (see BAF risk 111 & 269)
Hospital Handover delays – lost hours
999 transformation and delivery plan – requires revision.

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Performance under trajectory (-) CPN with commissioners (-) Lost hours from handover delays (+) Call answer performance	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Handover Programme 2. 999 Transformation Delivery Plan revision	1. On-going 2. In progress – aimed to be completed by July 2019

Last management review	Executive Management Board	**Last committee review**	18.06.2019 Finance & Investment Committee

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

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

Controls in place (what are we doing currently to manage the risk)	
CareCERT monitoring in place and reported monthly Patching carried out as appropriate 2 separate versions of Antivirus software in place (server and desktop) Alerts on helpdesk through system monitoring Data is backed up to tape and kept in data safes Servers and key infrastructure items are covered by maintenance/warranty Servers are protected by UPS battery systems Adoption of Cloud First approach for new systems and potential migration of existing systems against IM&T Cloud Services Adoption template. Resilience improvements designed into the arrangements for new HQ. Infrastructure being moved into purpose built data centre in Crawley with high resilience on power and cooling	New WAN links installed to Coxheath and Crawley with diverse routing through different BT exchanges. Banstead decommissioned and relocated to Crawley and Crawley made primary site. Testing on failover between sites complete Network config upgraded and complexity reduced in Coxheath Review of power requirements ongoing Coxheath and Crawley Projects overseen by Digital Programme Board and Sustainability Board Application made for adoption of Cyber Essentials Plus standards in partnership with NHS England/Digital New telephone system live

Gaps in Control

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Trust wide Cyber programme underway 2. Intended compliance with Cyber Essential Plus through NHS Digital programme of work by April 2020 3. Continued work on removing redundant systems - Banstead closure 4. Removal of vulnerable systems - website, info.secamb, ibis	

Last management review	Executive Management Board	**Last committee review**	18.06.2019 Finance & Investment Committee

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

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

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

IG Framework in place
IG Working Group established and now meets on a monthly basis
Data Security & Protection Toolkit (IG Toolkit)
IG training, including corporate induction
IG escalation routes (incident / SI), plus internal reporting lines from IG Lead to SIRO and Caldicott Guardian
The GDPR Action plan has been updated and an overarching Dashboard is now in place
New IG Manager in post from January 2019.
New Smartcard printers in place
HR Subject Access Requests now have an appointed HR lead with agreed SOP in place.
Independent 'Peer to Peer' review of mandatory IG training within 'Discover' completed in January 2019
IG training reviewed and updated and published April 2019.

Gaps in Control

Create a centralised repository for records management (see link to BAF Risk ID 362)
Create and complete a GDPR compliant Information Asset Register – this is required under Article 30 of the GDPR
Outstanding actions from the GDPR Action Plan

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) IG Annual Report (-) FOI compliance (+) Internal Audit Report – against the IG Toolkit (+) Compliance with IG training (+) IG Toolkit Level 2 (- / +) ICO Audit	

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

repository 3. GDPR Action Plan Delivery 4. IG Manager recruitment 5. FOI process mapping underway 6. Baseline submission of Data Protection & Security Toolkit			2. There are Information Asset Owners in place and this will remain a standard agenda item for the monthly IGWG meetings. 3. Ongoing. 4. Complete 5. Complete 6. Complete
Last management review	Executive Management Board	**Last committee review**	Audit and Risk Committee 11.07.2019

Goal 3 Our Enablers	**BAF Risk ID 522** Resilience – continuity planning	**Date risk opened: 25.05.2018**

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

Controls in place (what are we doing currently to manage the risk)
Business Continuity Management Policy, Business Continuity Management Plan, Departmental Business Continuity Plans. The Resilience Forum has been established to take oversight of BC arrangements and planning & Executive resilience committee established All service areas now have a Business Continuity plan in place and reviewed within the past 12 months. BC champions identified and training provided

Gaps in Control

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Business Continuity Impact Analysis. 2. See report to 11 July audit committee for details of further work planned	1. Further sessions planned.

Last management review	Executive Management Board	**Last committee review**	11.07.2019 Audit & Risk Committee

Goal 4 Our Partners	**BAF Risk ID 602**	**Date risk opened:**

	111/CAS service (Kent & Sussex)	**09.10.2018**

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

Controls in place (what are we doing currently to manage the risk)
Contract Award Letter in place Collaborative work stream with commissioners and an agreed shared risk profile Service Delivery Plan agreed with commissioners A service exit plan has been submitted to commissioners to mitigate risk Service has now been mobilised

Gaps in Control

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) Service in place	

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

Last management review	Executive Management Board	**Last committee review**	18.06.2019 Finance & Investment Committee

Goal 4 Our Partners	**BAF Risk ID 529**	**Date risk opened:**

	Change – influencing the healthcare system	**25.05.2018**

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

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

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
Review being undertaken of this risk to reflect the different arrangements across the region – a mapping exercise with commissioners is underway and due to report in early August.	

Last management review	Executive Management Board	**Last committee review**	11.07.2019 Audit & Risk Committee

Appendix B

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

Appendix C

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

				Critical report	

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

South East Coast Ambulance Service
NHS 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

July 2019

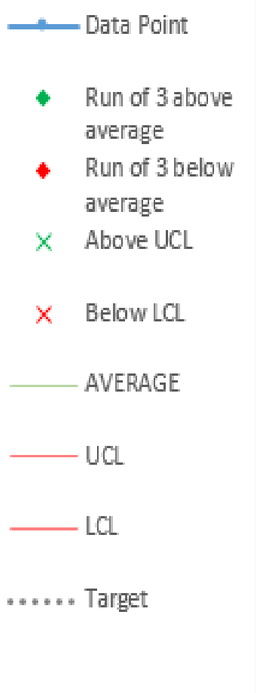
Taking Pride | Striving for Continuous Improvement | Acting With Integrity | Demonstrating Compassion and Respect | Assuming Responsibility

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 08/07/2019.

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, with a new version to be provided in summer 2019.

SECAmb Our Enablers

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

SECAmb Financial Performance

The Trust did not achieve its planned deficit for the month of May, mainly due to 999 activity being less than planned.

Cost improvements of £0.6m were delivered in the month, which was behind plan, the full year target is £8.6m.

The Trust's Use of Resources Risk Rating (UoRR) for April is 3, in line with plan.

The Trust faces significant financial risks in 2019/20, the main ones are:

- Achievement of contractual income if it is unable to met its activity demand and performance trajectories.
- Ability to meet its demanding resourcing plan for both 999 and 111 that could incur premium costs to ensure delivery of its performance trajectories.
- Delivery of cost improvements that are essential to ensure financial balance.

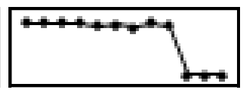
The finance team continue to work with budget holders and service leads to mitigate as many of these risks as possible.

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

	Feb-19	Mar-19	Apr-19	12 Months
Actual %	46.9%	50.0%	34.6%	
Previous Year %	36.4%	56.4%	40.9%	
National Average %				

Cardiac ROSC - ALL

	Feb-19	Mar-19	Apr-19	12 Months
Actual %	27.2%	33.0%	19.2%	
Previous Year %	22.4%	22.9%	29.7%	
National Average %				

Cardiac Survival - Utstein

	Feb-19	Mar-19	Apr-19	12 Months
Actual %	29.0%	28.1%	8.0%	
Previous Year %	25.8%	22.2%	21.4%	
National Average %				

Cardiac Survival - All

	Feb-19	Mar-19	Apr-19	12 Months
Actual %	6.7%	9.8%	6.0%	
Previous Year %	8.0%	5.5%	8.6%	
National Average %				

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

	Feb-19	Mar-19	Apr-19	12 Months
Actual %	52.2%	61.9%	57.5%	
Previous Year %	58.1%	67.8%	69.1%	
National Average %				

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

	Feb-19	Mar-19	Apr-19	12 Months
Mean (hh:mm)				
National Average				
90th Centile (hh:mm)				
National Average				

Stroke - call to hospital arrival

	Feb-19	Mar-19	Apr-19	12 Months
Mean (hh:mm)	01:16	01:15	01:11	
National Average				
Median (hh:mm)	01:08	01:06	01:04	
National Average				
90th Centile (hh:mm)	01:51	01:55	01:44	
National Average				

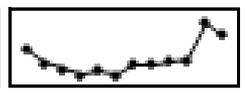
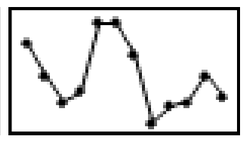
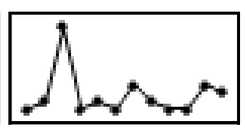
Stroke - assessed F2F diagnostic bundle

	Feb-19	Mar-19	Apr-19	12 Months
Actual %	96.6%	97.5%	97.8%	
Previous Year %	96.4%	96.5%	97.4%	
National Average %				

Post ROSC Care Bundle

	Feb-19	Mar-19	Apr-19	12 Months
Actual %	76.3%	80.4%	87.5%	
National Average %				

Medicines Governance

	Mar-19	Apr-19	May-19	12 Months
Total Number of Medicines Incidents	122	229	192	
Single Witness Sig/Inapt Barcode Use CDs Omnicell	6	11	7	
Single Witness Sig/Inapt Barcode Use CDs Non-Omnicell	0	3	2	
Total Number of CD Breakages	17	30	19	
PGD Mandatory Training	65	N/A	N/A	
Key Skills Medicine Governance	29	32	218	

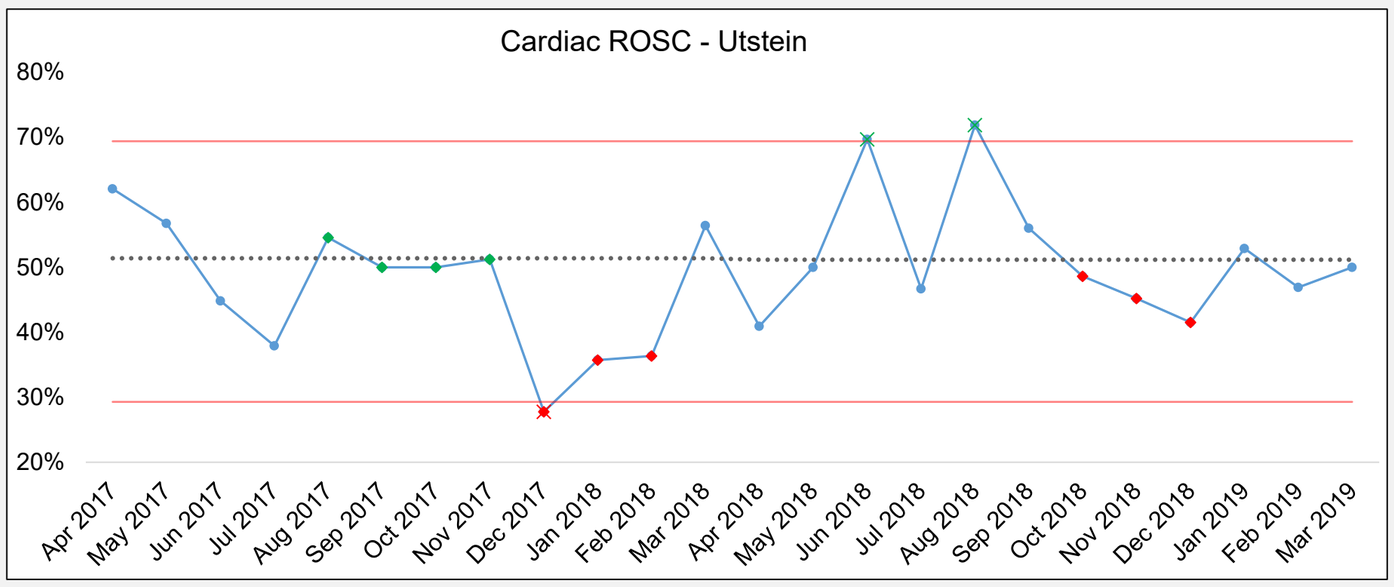
Sepsis Care Bundle Compliance

	Feb-19	Mar-19	Apr-19	12 Months
Actual %	77.3%	74.9%	78.9%	

Medicines Management

	Mar-19	Apr-19	May-19	12 Months
Number of Audits	184	168	192	
Percentage of Audits	99.7%	99.5%	99.6%	

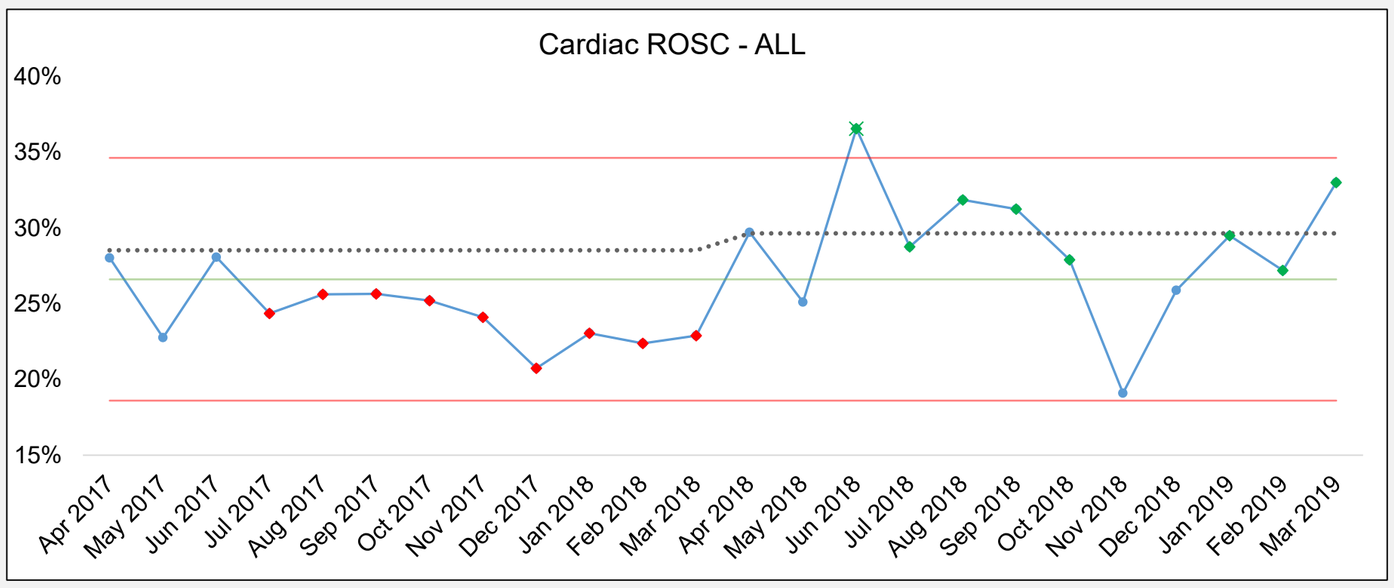
SECAmb Clinical Safety Charts

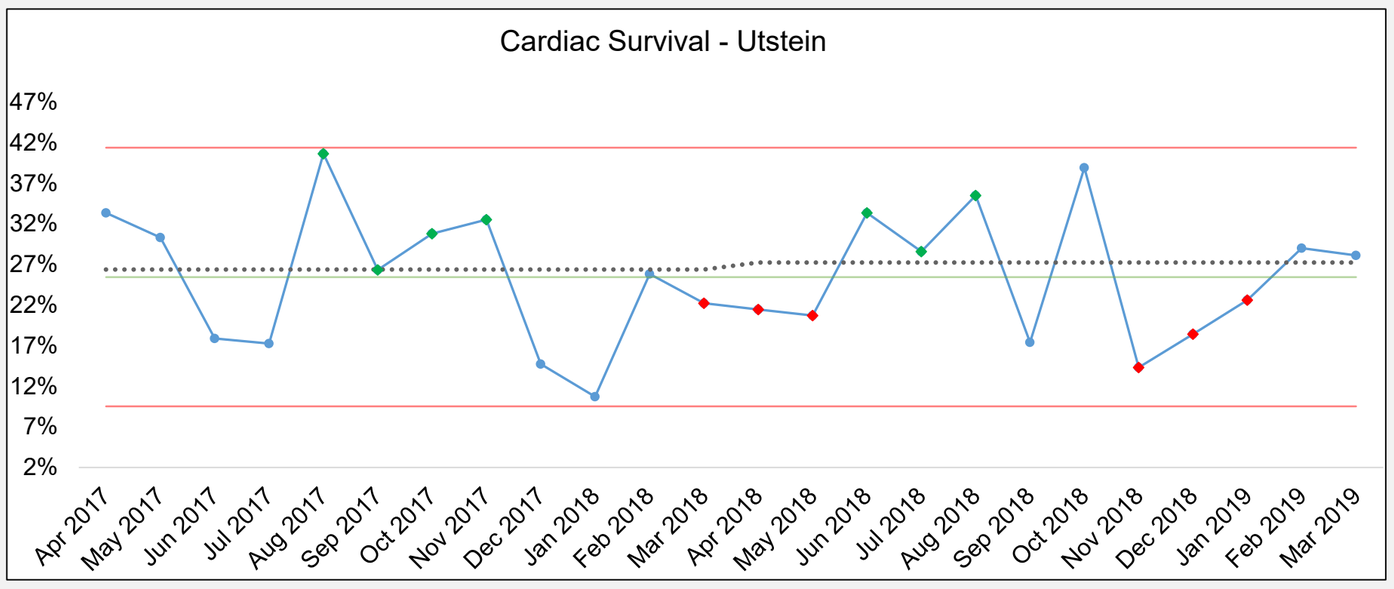


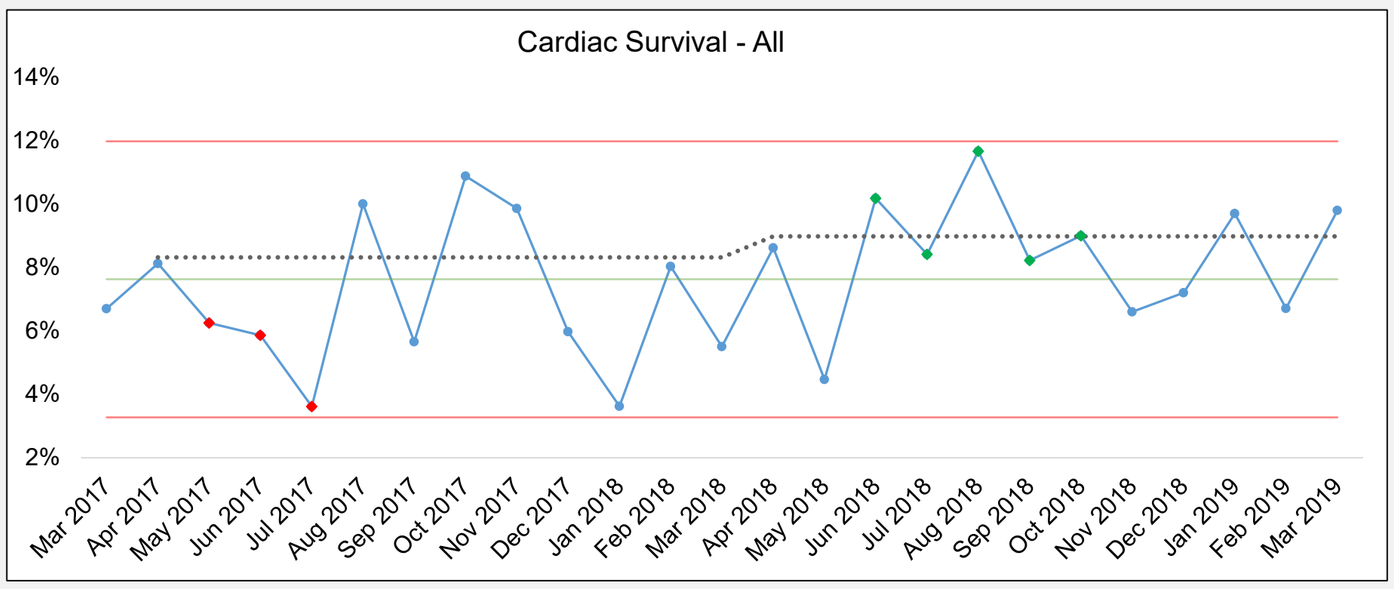
The cardiac arrest charts show the proportion of patients who had a ROSC at hospital and the proportion who survived to be discharged from hospital after resuscitation was attempted.

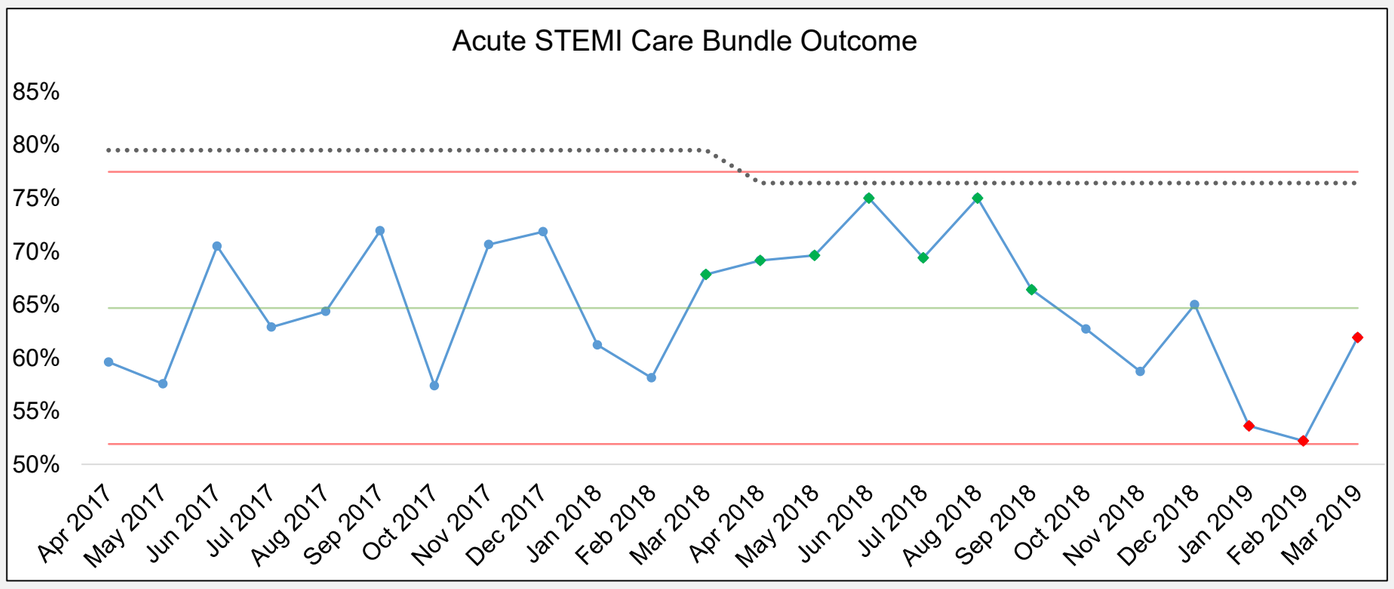
The charts continue to show normal patterns of variation.

A full day of resuscitation training is currently being delivered to staff through the 2019/20 Key Skills training programme. In Q2 of 2019/20 the Trust will evaluate the effectiveness of the Cardiac Arrest Download programme to ensure that the process leads to improved clinical care and improved patient outcomes.







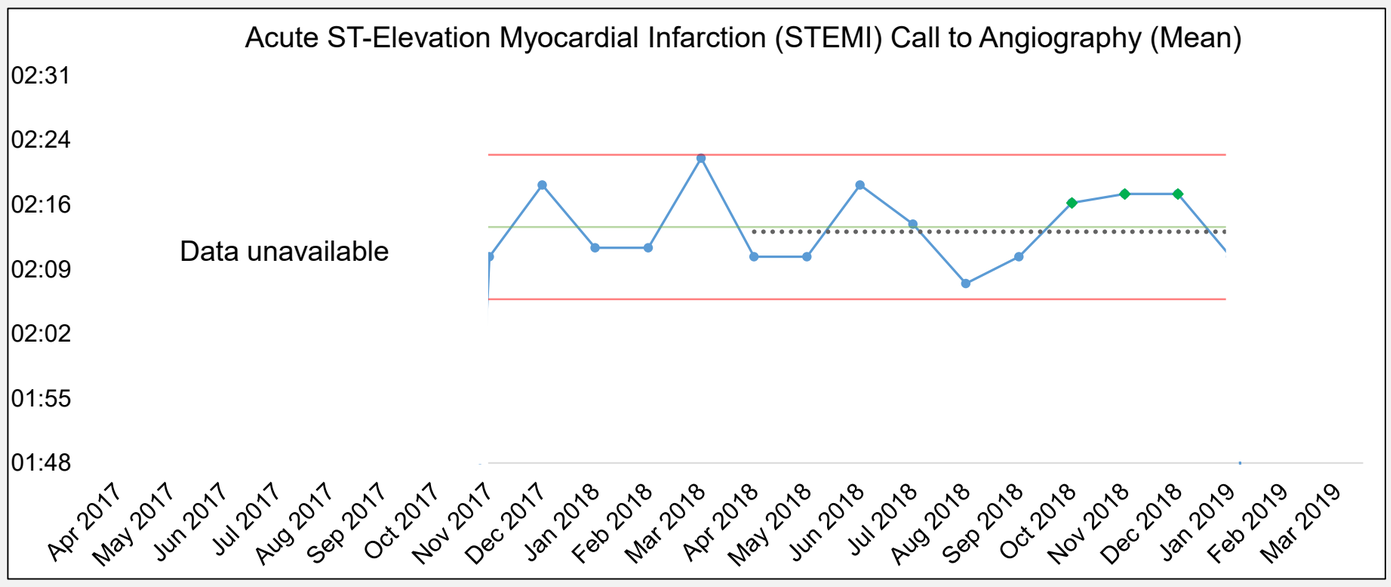


This chart shows the proportion of patients who were suffering a suspected STEMI and received a full care bundle.

There has been a sustained reduction in performance against this measure. A task and finish group has been established in the Medical Directorate to address this. The Doc-Works system is expected to be available to clinicians and team leaders in Q2 of 19/20 to enable feedback and reflection on care bundle incidents.

In the short term, the clinical audit team are manually sending STEMI incidents to OTLs to enable direct feedback. A 'STEMI Care Month' is planned for August 2019 to increase organisational focus on this topic.

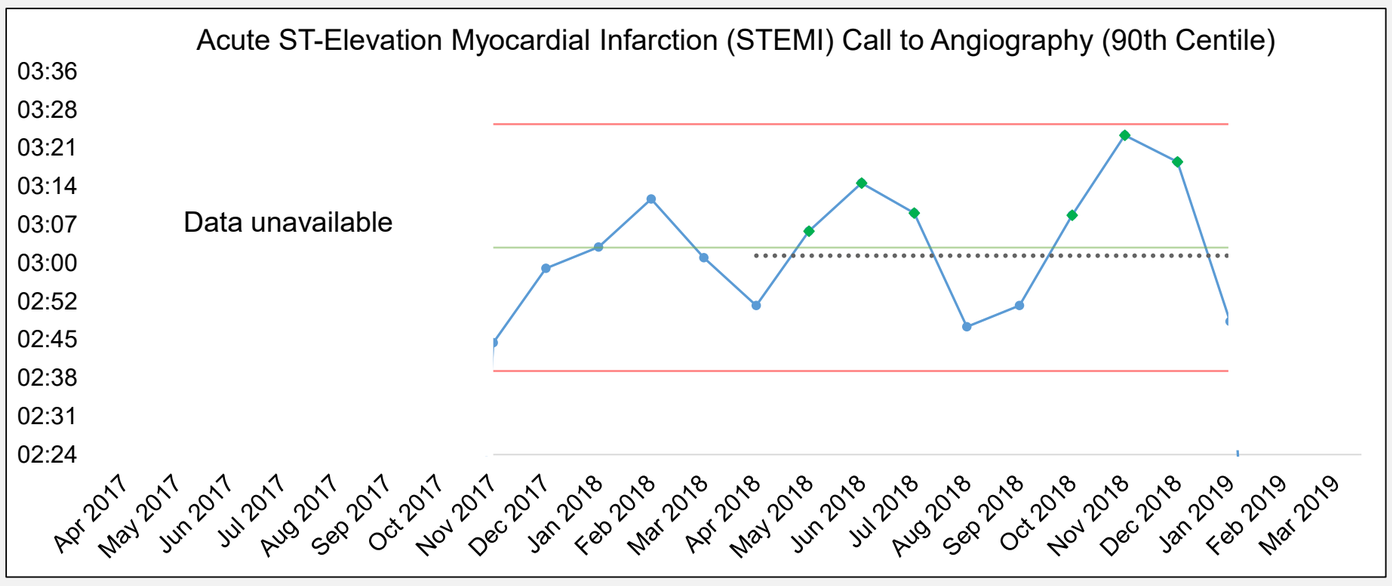
SECAmb Clinical Safety Charts

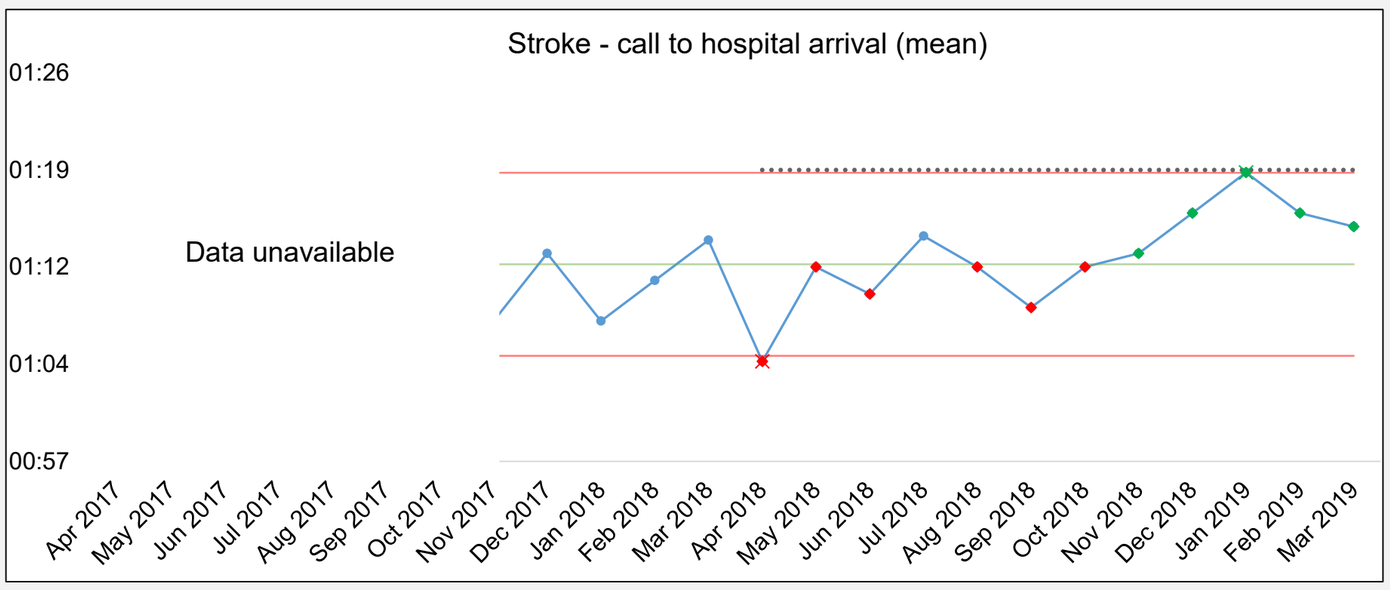


STEMI timeliness charts show the mean and 90th centile call to angiography time for patients who are suffering STEMI.

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

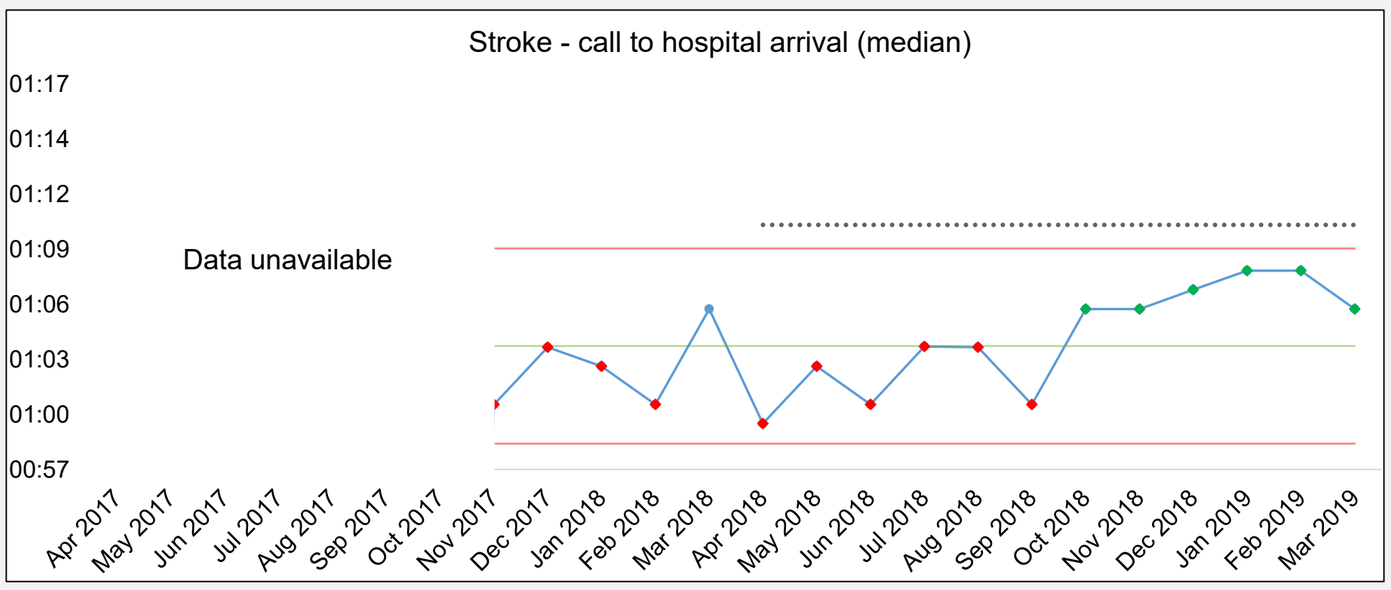
'STEMI Care Month' in August 2019 will include promoting strategies for reducing on scene times for STEMI patients.

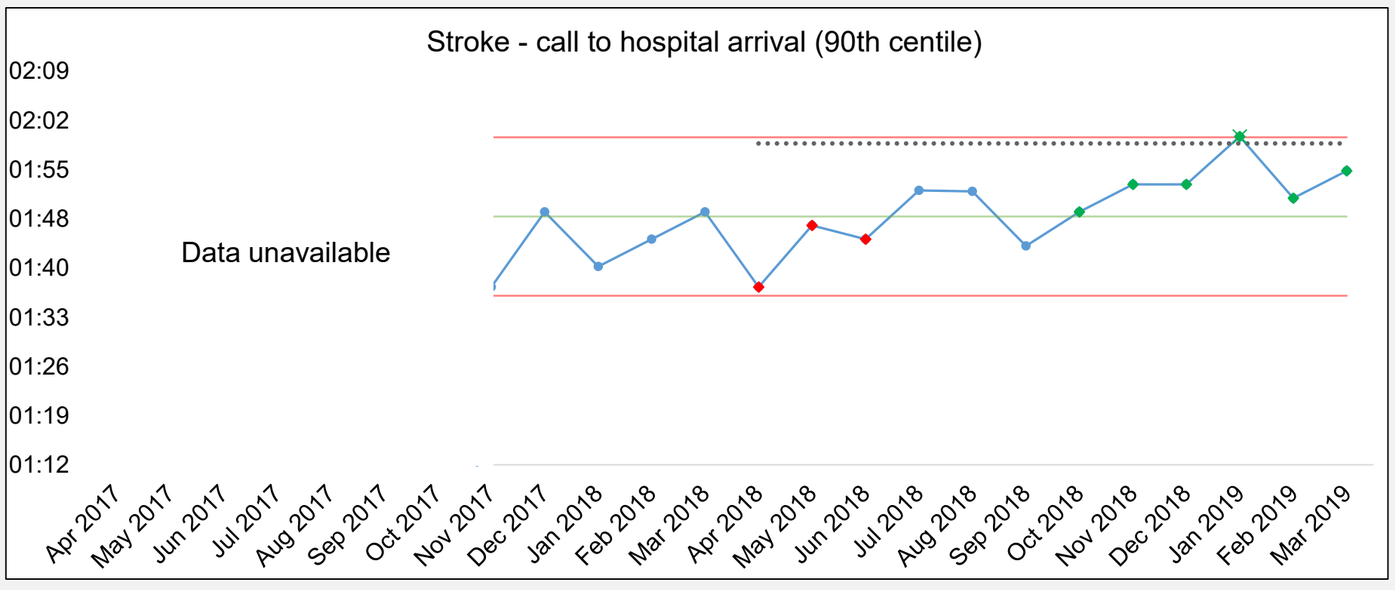




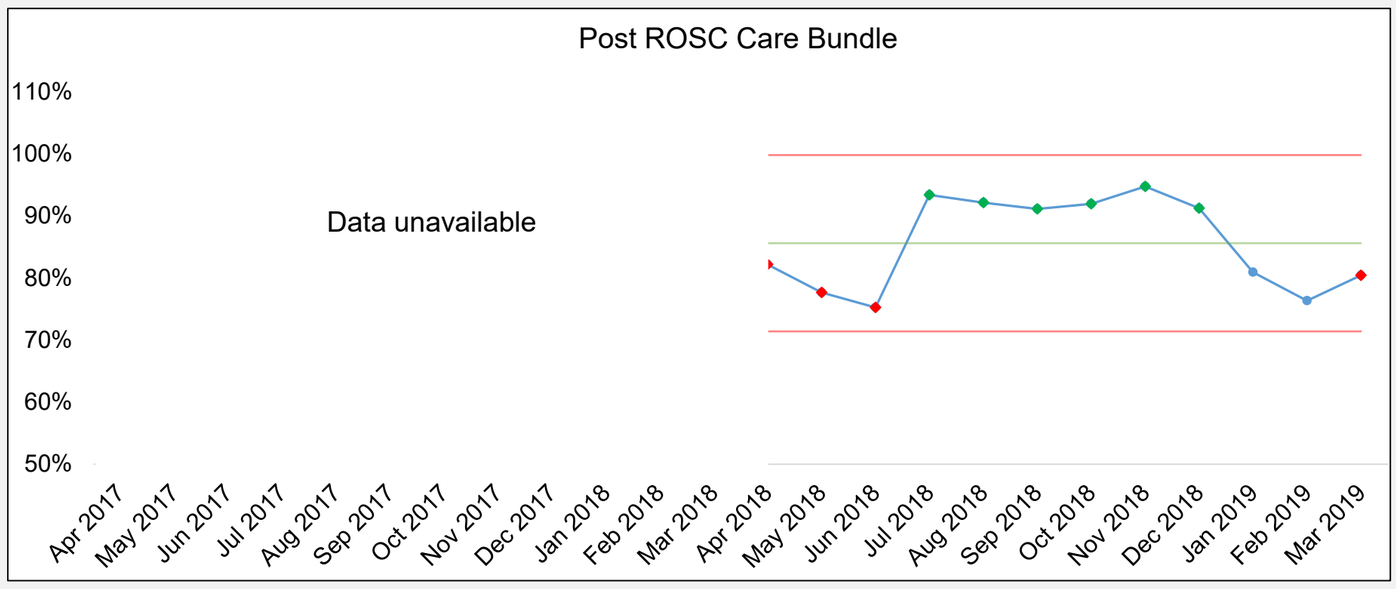
Stroke timeliness charts show the mean, median and 90th centile call to angiography time for patients who are suffering stroke.

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





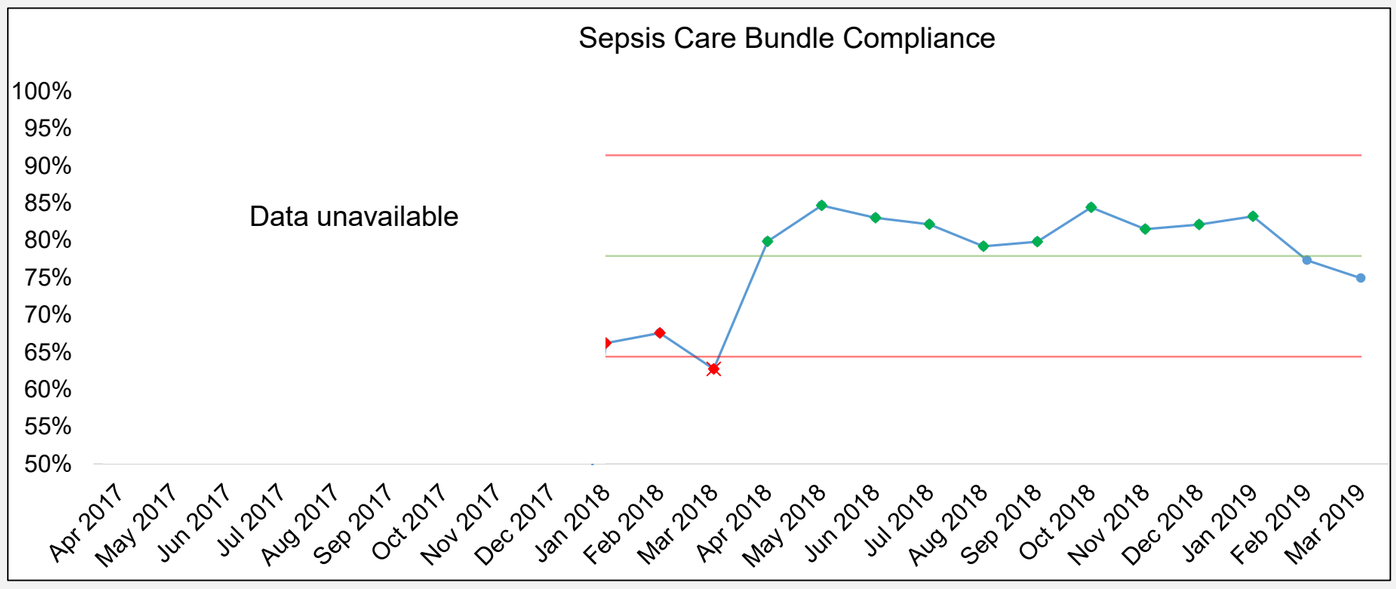
SECAmb Clinical Safety Charts



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.

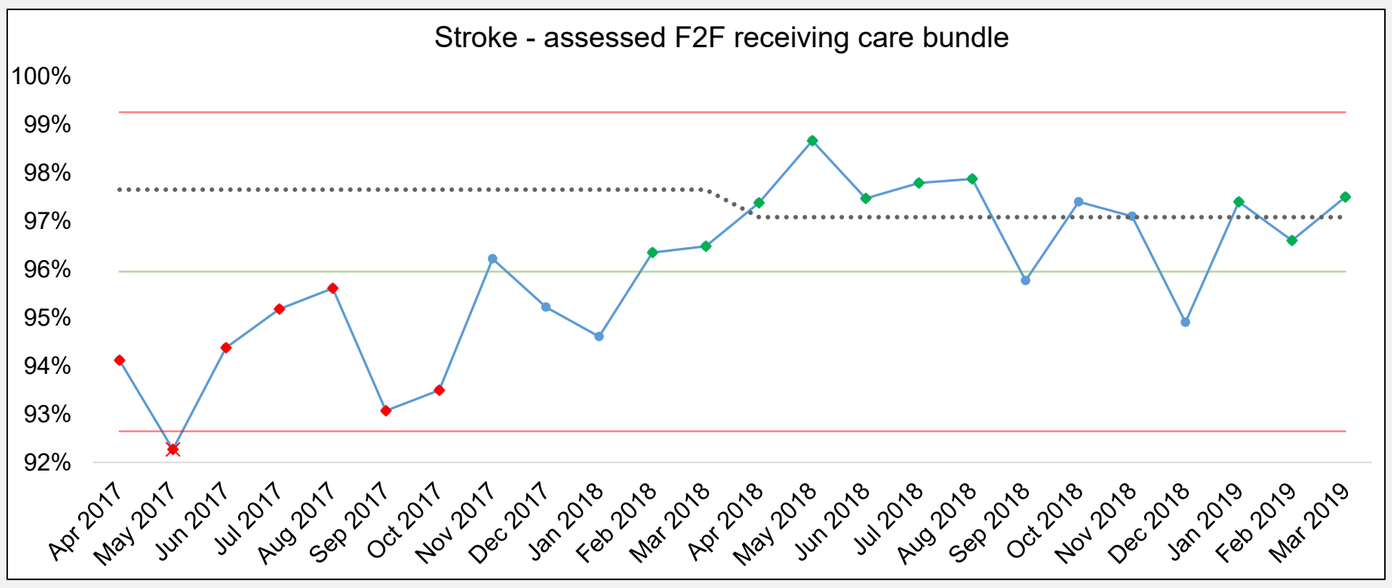
The Doc-Works system is expected to be available to clinicians and team leaders in Q2 of 19/20 to enable feedback and reflection on care bundle incidents.



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

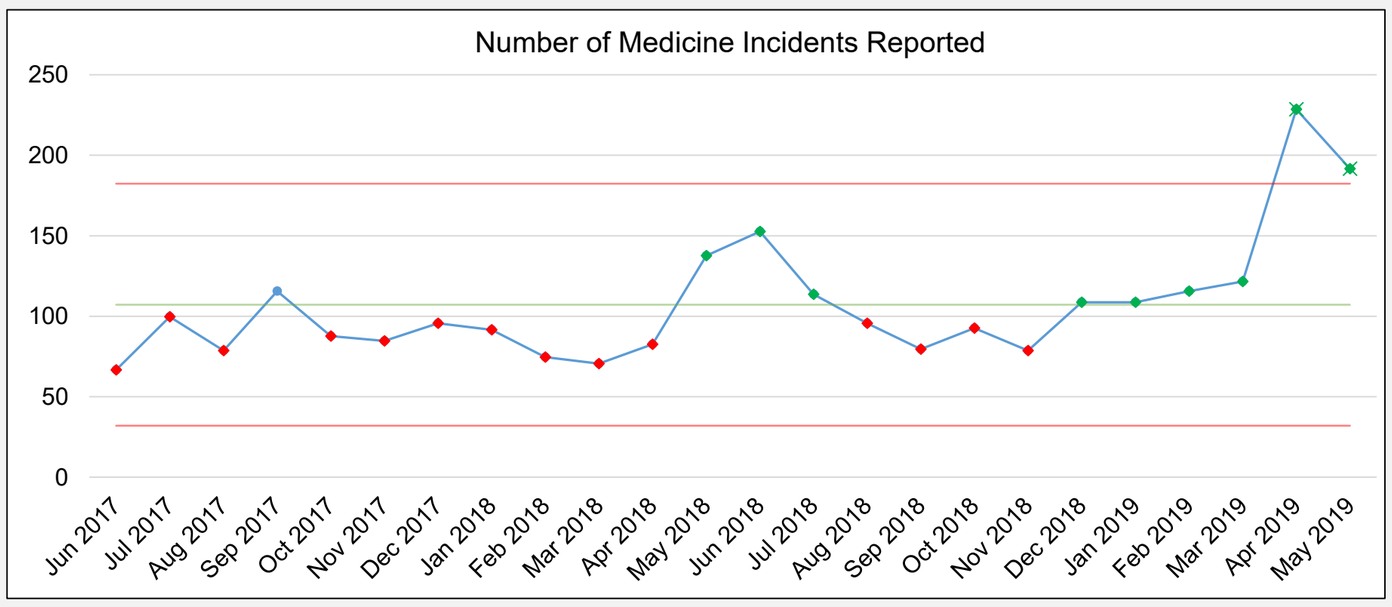
The data continues to show normal levels of variation. SECAmb continues to perform above the national average.

The Trust recently went live with its updated 'Red Flag Sepsis' guidance, this is expected to improve detection and management of sepsis.

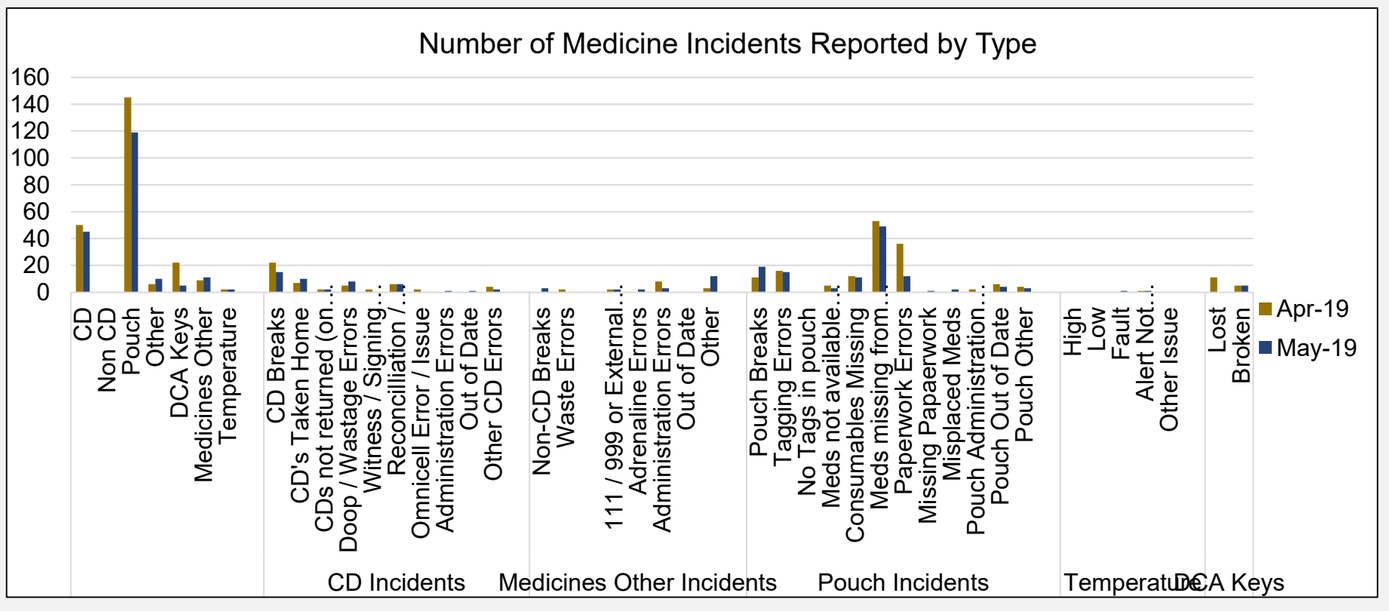


This chart shows the proportion of patients with a suspected stroke who received a full bundle of care.

The data continues to show normal levels of variation. This measure is being monitored to ensure that this level of performance is maintained.



192 medicine incidents were reported via Datix during May 2019. This demonstrates a continuing upward trend following encouragement by Medicines Governance and QI teams to encourage reporting.

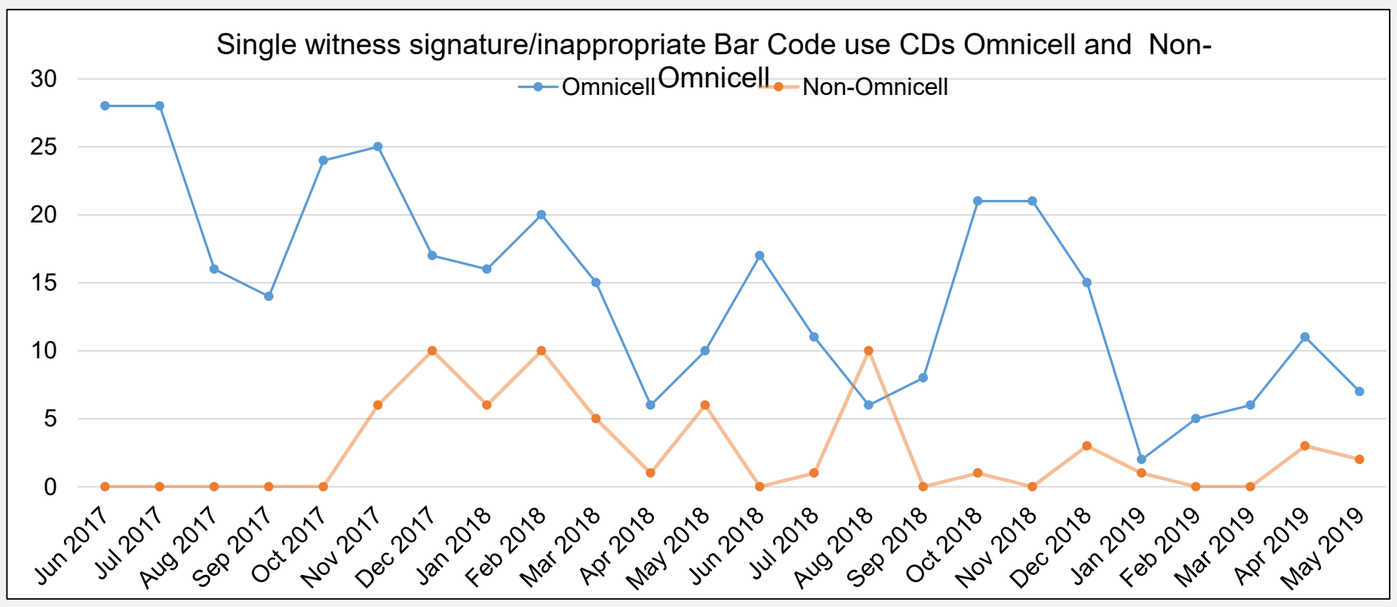


45 of the 191 incidents reported for May 2019 were in relation to controlled drugs (CD). 25 of these related to either CD breakages or CDs being inadvertently taken home by front-line staff.

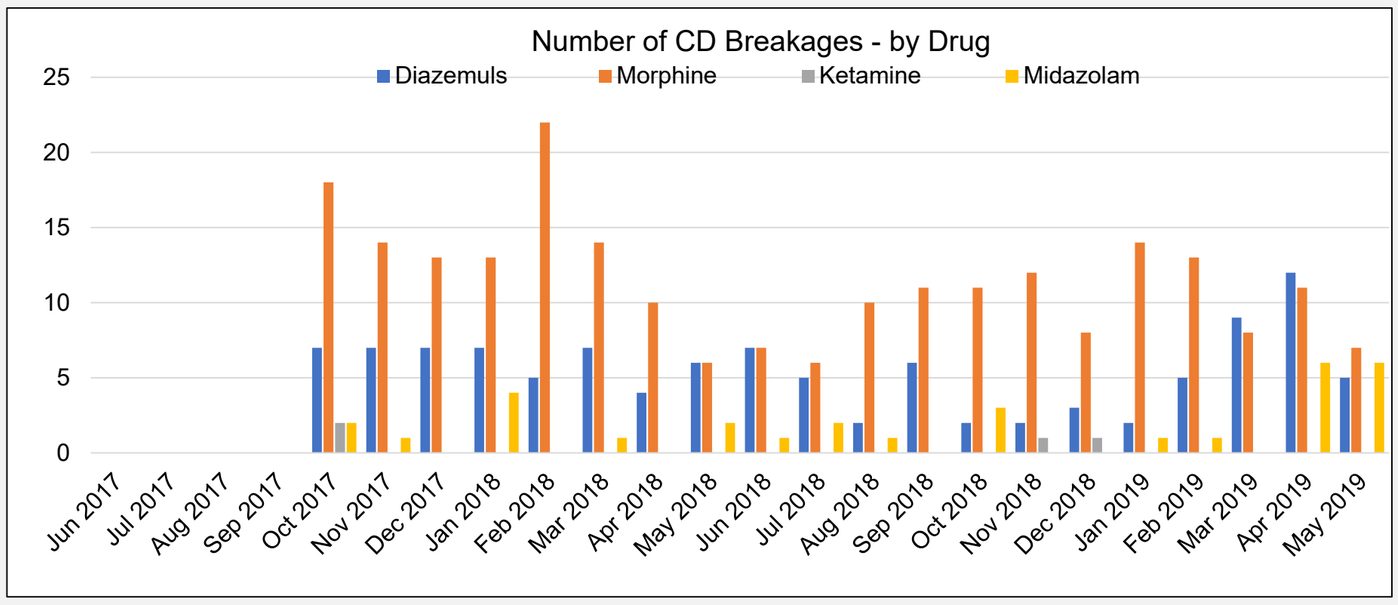
There were 41 incidents reported around medicine pouches, equating to 119 pouch incidents in total.

There were 3 medication administration errors reported during May 2019 the medicines involved were adrenaline, diazepam and ticagrelor / clopidogrel.

SECAmb Clinical Safety Charts



Work continues across the Trust on reducing CD single witness signatures. There were 9 incidents reported during May 2019 of unauthorised single signatures, a slight decrease on the previous month. Continue to encourage staff to report incidences via DIF1. Medicines Governance Team continue to monitor trends regularly and report unauthorised activity.

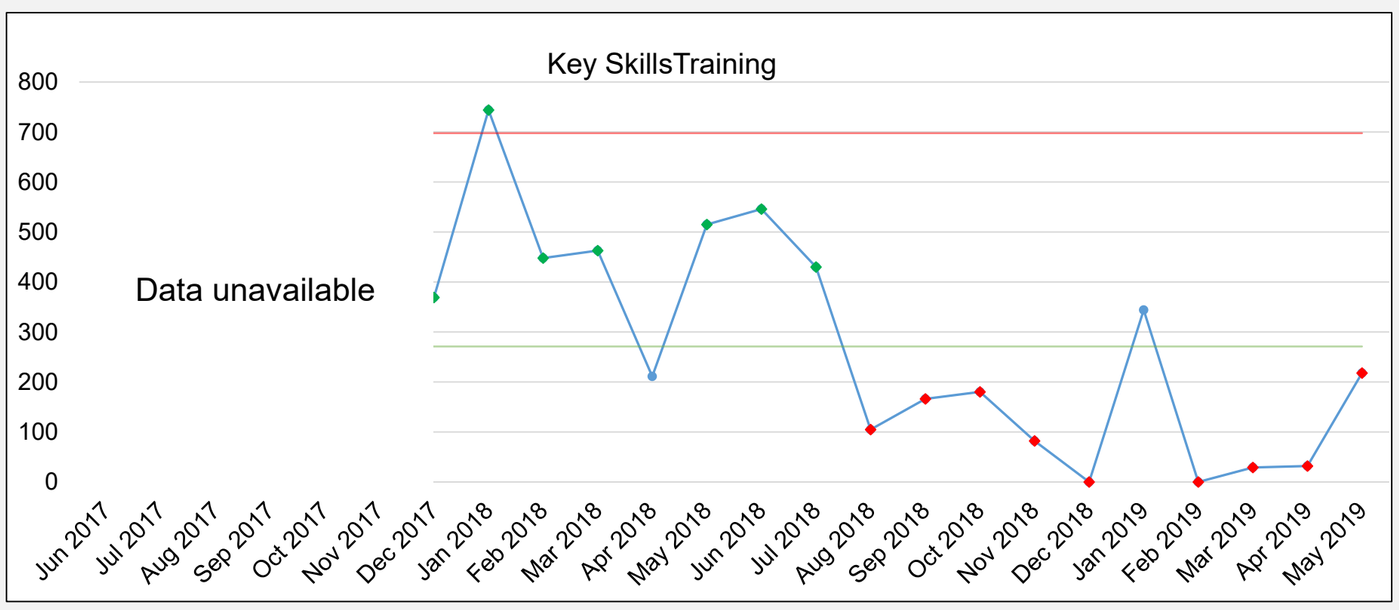


May 2019 reported 19 CD breakages.

5 Diazemuls
7 Morphine
6 Midazolam

- Logistics staff found 5 broken ampoules (midazolam) during delivery to site

Overall breakages are low, morphine remains the highest break, but this is most frequently used CD within ambulance sector



Analysis of Cardiac Arrest Data – February 2019

Total number of cardiac arrests identified = 614

Number of resuscitation attempts = 227
excluding DNACPR 86, DOA 259, No Resus by SECAmb 2,
In hospital arrest 1, Post arrest 7, ADRT 32

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 (1

Cardiac Arrests (All incidents) = 217 (100%)

ROSC sustained to hospital (Utstein)
= 18 (50%) + 5 non ROSC

ROSC sustained to hospital (All)
= 75 (33%) + 13 non ROSC

Outcomes for ROSC at hospital and non ROSC at hospital patients

Utstein	Details	Overall
9	Patient survived to discharge	19
10	Patient died in hospital	55
0	Patient still in hospital*	3
4	Outcome unknown* (Patient identifiable data incomplete)	11

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 (28%)

Survival to Discharge (All) = 19 (9%)

Additional Information – Resuscitation Attempts

Cardiac Rhythm	Overall Totals	ROSC at Hospital	Non ROSC at Hospital
Asystole	106 (47%)	20	3
PEA	55 (24%)	18	2
VF	55 (24%)	32	5
Non-shockable	2 (1%)	1	0
Not recorded	9 (4%)	4	3

CPR Bystander - 147

EMS Witnessed arrest - 28

Cardiac Arrest downloads received for Mar 18	201
Cardiac Arrest download reports sent to crews	106

Analysis of Cardiac Arrest Data by area - 2019

Number of resuscitation attempts = 227
this figures excludes incidents as PAS & VAS crew (of which attained ROSC at Hospital)

Cardiac Arrests (Utstein) East = 17 (47%)	Cardiac Arrests (All) East = 117 (52%)
Cardiac Arrests (Utstein) West = 19 (53%)	Cardiac Arrests (All) West = 110 (48%)

ROSC sustained to hospital (Utstein) East = 10 (9%) + 1 non ROSC	ROSC sustained to hospital (All) East = 42 (36%) + 4 non ROSC
ROSC sustained to hospital (Utstein) West = 8 (42%) + 4 non ROSC	ROSC sustained to hospital (All) West = 33 (30%) + 9 non ROSC

Outcomes for ROSC at hospital and non ROSC at hospital patients

Area	Utstein	Details	Overall
East	6	Patient survived to discharge	12
West	3		7
East	4	Patient died in hospital	29
West	6		26
East	0	Patient still in hospital*	0
West	0		0
East	1	Outcome unknown* (Patient identifiable data incomplete)	5
West	3	Outcome unknown* (Patient identifiable data incomplete)	9

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

Survival to Discharge (Utstein) East = 6 (35%)	Survival to Discharge (All) East = 12 (10%)
Survival to Discharge (Utstein) West = 3 (16%)	Survival to Discharge (All) West = 7 (6%)

MENTAL HEALTH CARE APRIL (May 2019 data)

Rag Ratings:

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

Overall RAG Rating = 

The mental health indicator has been rated **GREEN** as the mean response measures are within cat 2 standard on the 18 minute and 90th centile response.
Cat 2 = 00: 17:12
90th Centile= 00:35:54

Mental Health Response Times (Section 136 MHA)

During May 2019 there were 154 Section 136 related calls to the service.138 (89.6%) of these calls received a response (90.7% in April) resulting in a conveyance to a place of safety by an ambulance on 124 (80.5% of total calls; in April this was 87.8% of total calls) on these occasions.

The overall performance mean shows a Cat 2 response time across the service as 00:16.17 (April was 00.17:12). Against the 90th centile measure, the response was 00.32.40 (April was 00.35:54).

There were 6 transports of under 18's (4 during April).

There were 16 occasions when SECAmb did not provide a response. This is up from 13 in April. 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 2 Total responses 1 Total transports 0

Cat 4: Total calls 0 Total responses 0 Total transports 0

C60 HCP: Total calls 17 Total responses 12 Total transports 7

Performance Mean 01:44:07 90th centile 04:03:42

C120 HCP: Total calls 1 Total responses 1 Total transports 0

Performance Mean 00:48.05 90th centile 00:48.05

C240 HCP Total calls 0 Total responses 0 Total transports 0

Quality and Patient Safety Report :

Infection prevention and control (IPC): Hand Hygiene (HH) compliance was below target this month at 83%, but staff compliance to 'Clinically Ready' was well above target at 95%. Make Ready Centre (MRC) and Vehicle Preparation Programme (VPP) Deep Clean rates were both very low, which was due to operational demand throughout the month and staffing resources at some of the sites, this is expected to improve within the coming months. The IPC Team have developed two workbooks this year which are now available on the DISCOVER platform for staff to complete. Level One - is for all non-clinical staff and Level Two - is for all clinical staff to complete. There are no figures for completion of the workbooks for April at this time, but we will report monthly from May 2019 onwards and reflect the Trusts trajectory as the compliance level. Training is reviewed on an annual basis to ensure it is up to date. Therefore, all mandatory training compliance drops to zero on 1st April to ensure we capture data on staff who have been trained with the current year's programme. Progress in compliance will be noted as training is rolled out. The IPC and Estates Team continue to hold a monthly meeting with the contractors to discuss any concerns raised locally concerning cleaning standards.

Safeguarding referral rates continue to increase. During May the Trust made 1065 safeguarding referrals regarding adults and 206 referrals regarding children. Given the Trust's significant commitment to delivering safeguarding training during 2017/18, it is likely that the increase in overall referral activity is a direct response to this improved safeguarding profile across the Trust.

Incidents: Incident reporting remains GREEN due to the incident reporting rate remaining above the 20% target and a reduction in the backlog for Serious Incidents. The Trust has reported 858 incidents during May 2019. The highest reporting categories remain relatively consistent, and are: clinical tail audits; meal breaks; call closed in error; injury whilst lifting or moving a patient or other person and incorrect disposition reached. The OUs reporting the highest number of incidents are EOC Clinical; Medway and Dartford; Ashford 111; Gatwick and Redhill and West EOC. Although the overall back log of incidents not investigated within timescales has started to reduce it remains an area of concern, and continues to be discussed and escalated; the clinical tail audits significantly add to the backlog. The Datix team are working closely with the areas of concern to aid them where possible.

Serious Incidents (SIs) and Duty of Candour (DoC): 10 SIs were reported during May 2019, whilst 87 SIs were open on STEIS at May's close. The Trust achieved 100% compliance with DoC requirements for SI's; this reflects the amount that were undertaken within timescale. This much improved compliance with DoC reflects the success with embedding the new process of DoC responsibility once again sitting with the central SI Team. DoC compliance continues to be monitored weekly by the Serious Incident Group.

Patient Experience: The Trust received and opened 64 complaints during May 2019. Timeliness in response to the patient was the most notable trend. Two other trends were also noted: patient care and concerns about staff. The Trust responded to 55% of complaints within the Trust's 25 working day timescale this month; whilst this is an improvement on last month's figure it still remains significantly lower that the target of 95%; the challenge in responding within timescale predominantly relates to EOC complaints where only 22% were completed on time, whereas NHS111 reflected 100% and Operations Aand E reflected 85%. Work is underway to review how the EOC complaints can be returned in a more timely way. The Trust recorded 47 compliments during May.

STEMI Care Bundle: In November 2017, the method for measuring the timeliness of care delivered to STEMI patients changed to a measure of mean and 90th centile call to angiography (the procedure used to visualise the blood vessels that supply the heart). This measure is no longer collated internally and is taken directly from the national MINAP database of confirmed STEMIs. The latest available measure is from July 2018. Performance for July is at 69.4% (from 75%), which continues below the national YTD average of 76.4%. Stroke Diagnostic Bundle performance is now above the national average (97.1%) at 97.9%.

Clinical Audit: The 2019/20 Clinical Audit annual plan continues to be on track and national requirements for the collection and submission of data are being met.

Learning from Deaths: The Trusts Learning from Deaths Policy had been approved and published in January 2018, but had not been fully implemented. This was noted in the late 2018 CQC review and subsequent reports to the Trust regarding Learning from Deaths. An organisational risk regarding this has been added to the Trusts Risk Register (no 723). In October/November 2018 NHS Improvement announced that Learning from Deaths was likely to be mandated for Ambulance Trusts from April 2019 and further guidance applicable to the sector was under development, expected to be published during Q4 2018/19. This guidance is awaited at the time of writing. Further to which the Trust policy will be revised as necessary. A Learning from Deaths Action Plan has been developed and approved at the Quality Compliance Steering Group in early January 2019. Reporting is via the Clinical Governance Group and Quality and Patient Safety Committee to the Board. To support the development of the Action Plan, a Task and Finish Group has also been established (first meeting 23 January 2019).

Our People

SECAmb Clinical Quality Scorecard

Number of Incidents Reported

	Mar-19	Apr-19	May-19	12 Months
Actual	810	843	858	
Previous Year	627	721	722	

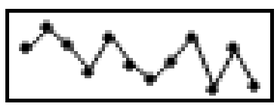
Number of Incidents Reported that were SI's

	Mar-19	Apr-19	May-19	12 Months
Actual	14	14	10	
Previous Year	12	17	6	

Duty of Candour Compliance (SIs)

	Mar-19	Apr-19	May-19	12 Months
Actual %	62%	46%	100%	
Target	62%	46%	100%	

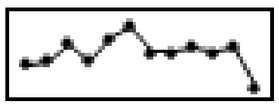
Number of Complaints

	Mar-19	Apr-19	May-19	12 Months
Actual	63	88	64	
Previous Year	112	93	101	
Complaints Timeliness (All	88.0%	36.4%	55.0%	
Timeliness Target	95%	95%	95%	

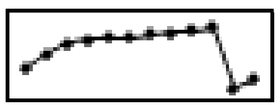
Compliments

	Mar-19	Apr-19	May-19	12 Months
Actual	145	86	47	

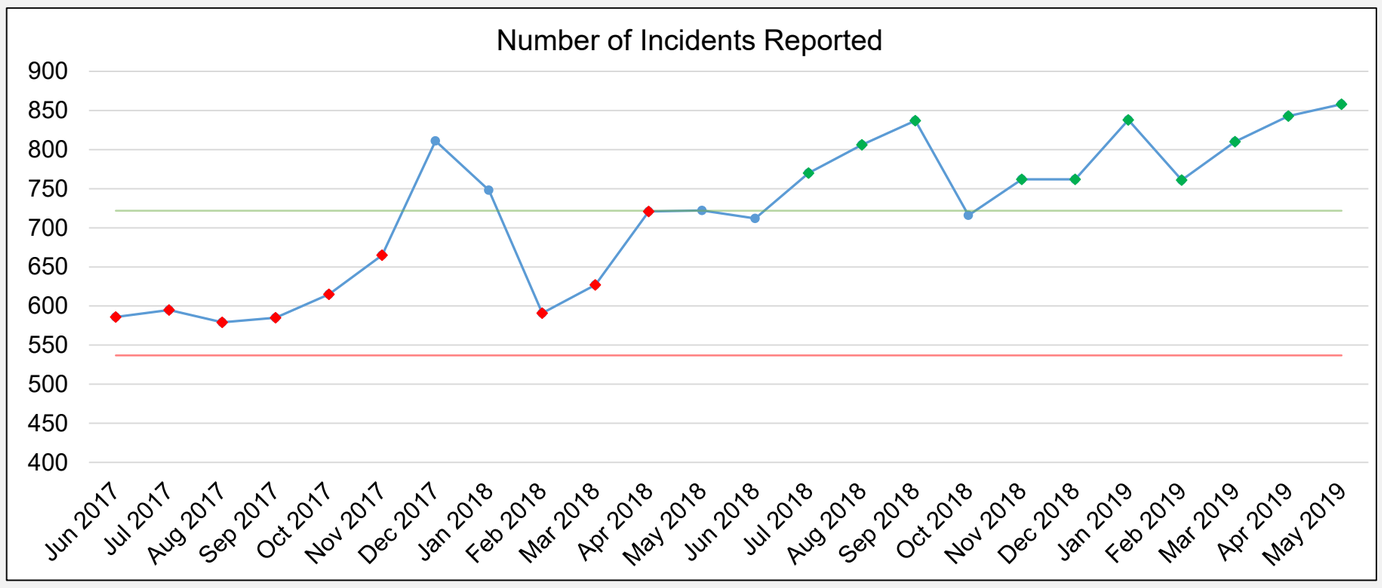
Hand Hygiene

	Mar-19	Apr-19	May-19	12 Months
Actual %	91%	92%	83%	
Upper Target	95%	95%	95%	

Safeguarding Training Completed (Children) Level 2

	Mar-19	Apr-19	May-19	12 Months
Actual %	94.08%	8.33%	21.46%	
Previous Year %	93.99%	6.51%	25.88%	
Target	85%	85%	85%	

SECAmb Clinical Quality Charts

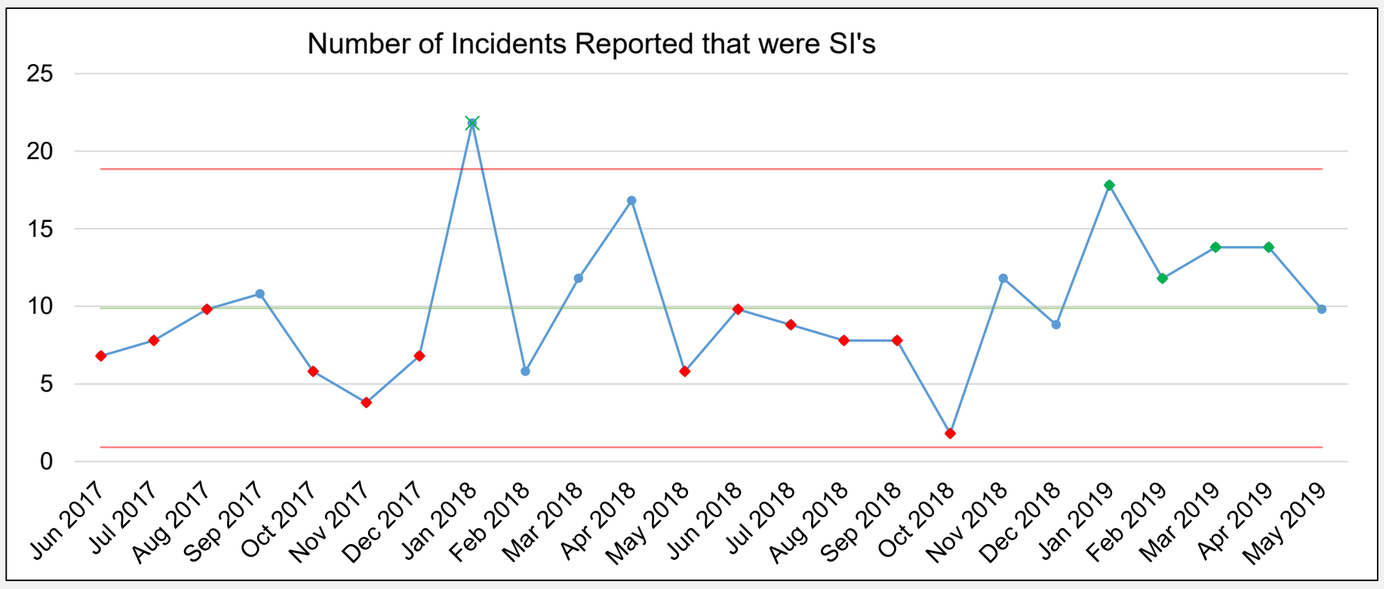


In May, SECAmb reported 858 incidents, this is the highest number reported on Datix to date. The top 5 sub-categories reported are as follows:

1. Clinical Tail Audits – 64
2. SMP No Send – 40
3. Directed Verbal Abuse (General) – 27
4. Meal Breaks Not Taken – 27
5. Physical Assault – 25

Across the organisation the following incidents were reported:

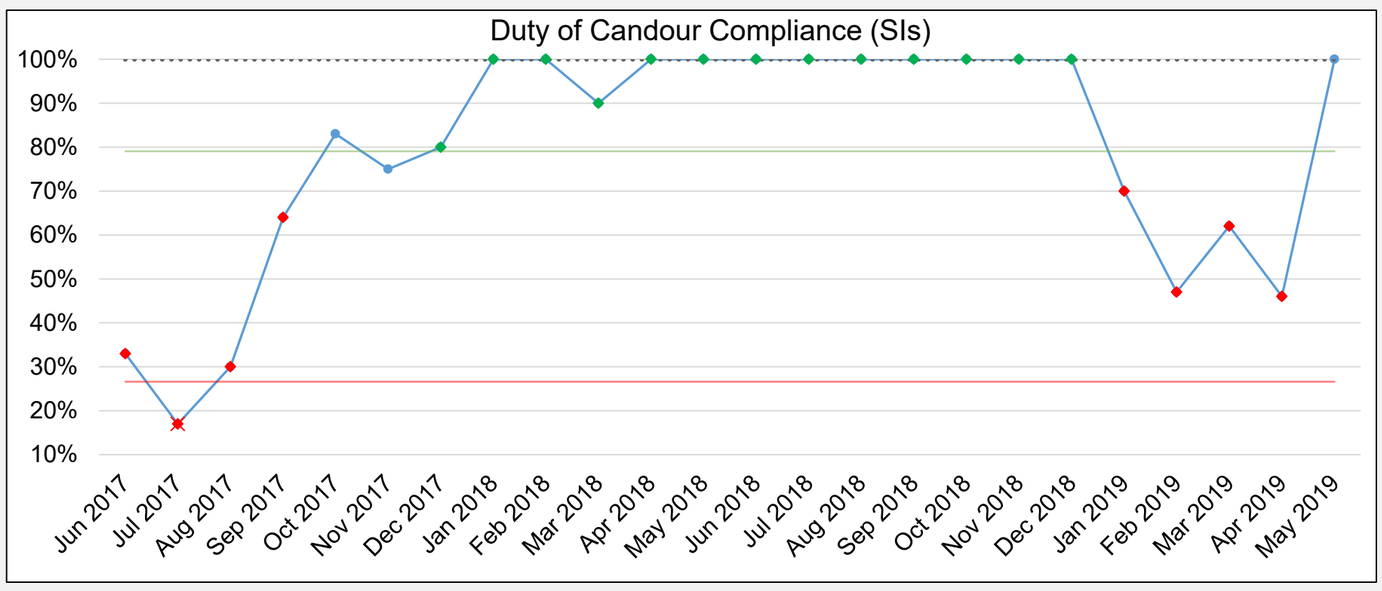
1. EOC Clinical – 121
2. Medway and Dartford – 81
3. West EOC – 77
4. Polegate and Hastings – 71
5. Gatwick and Redhill – 65



10 Serious Incident were reported in May.

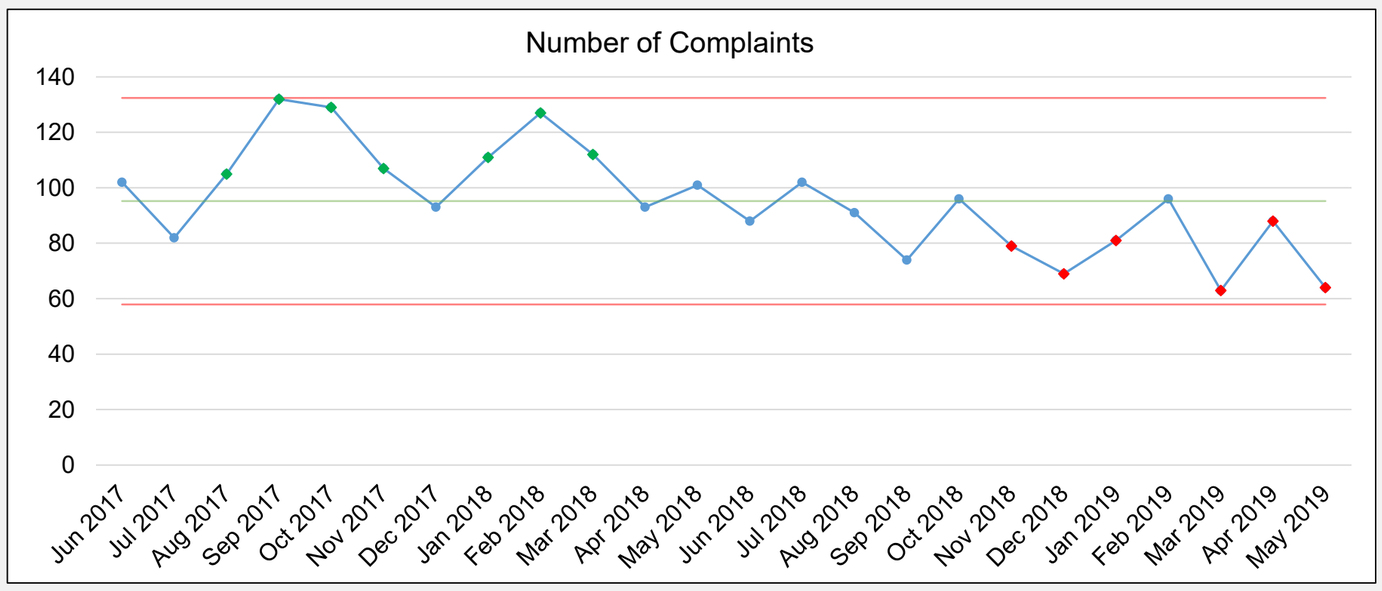
3 x Timeliness/ Delay
2 x Triage/Call Management
2 x Delayed Dispatch / Attendance
1 x Patient Treatment
1 x Medication Incident
1 x Patient Care

22 SIs overall were closed on STEIS in May with another 5 being de-escalated.



Compliance with DoC for SIs where DoC was required in May 2019 is: (due in the month)

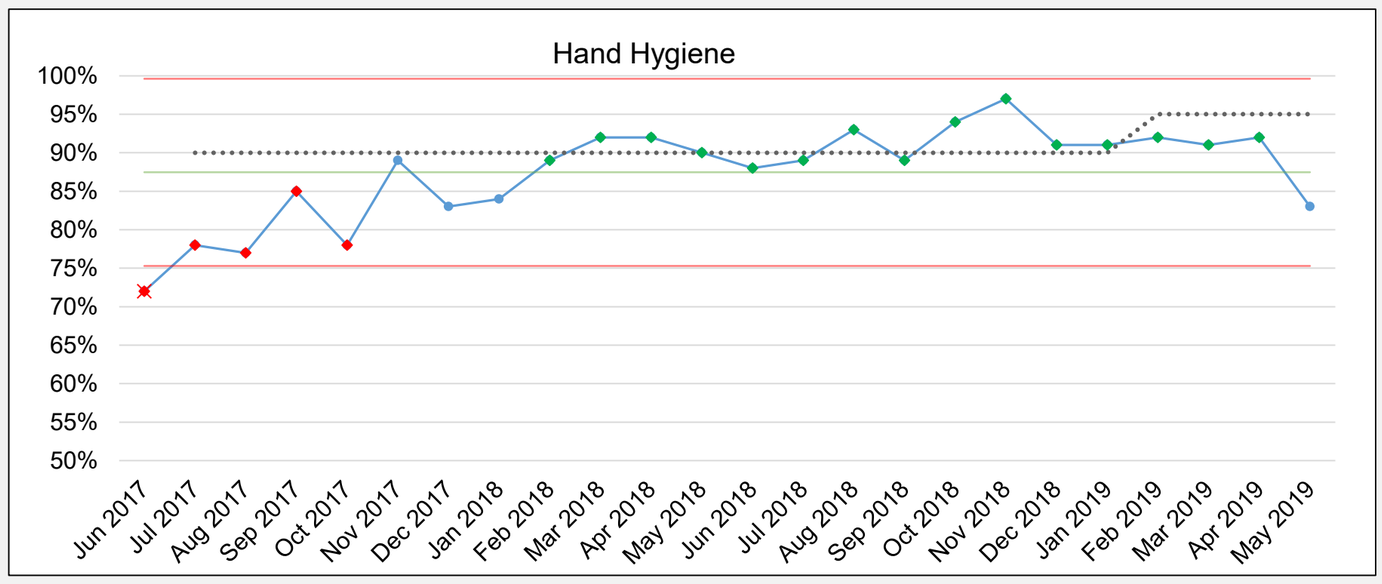
SIs reported (where DoC due in March) - 16
Number where DoC required - 15
DoC made/attempted within 10 working day deadline - 15 (100%)



The Trust received and opened 88 complaints during April.

The Trust responded to 36% complaints within timescales.

Delays were mainly due to capacity issues within patient experience team and OUs in relation to investigations, in part due to the increase in complaints in previous months. Most of these issues have been addressed and improvements should be notable in the coming months.



We show a drop in compliance for hand hygiene for May and only 83% of the audits carried were compliant, which is below the lower limit of 90%.

The IPC Team will be doing some internal communications to raise the awareness of the need for the correct hand hygiene to be followed at all times by staff.

Clinically Ready was 95% compliant this month, which still requires improvement and again the IPC Team will raise the non-compliant issues locally.

SECAmb Health and Safety Reporting

Since the implementation of the annual Health and Safety Audit programme 60 audits have been completed. The audits were undertaken in different working environments across the organisation.

The Health and Safety team have started to develop an enhanced training package for our Managers. The aim of the course is to ensure that safety requirements are appreciated by line managers and enable them to review their own departmental systems for safety, introducing new controls or implementing changes as appropriate to make their workplace safer.

Violence and Aggression Incidents - See Figure 1 below

Violence and Aggression incidents towards staff in May 2019 were 79 which is an increase of 34 incidents from the previous month. All staff are encouraged to report incidents of any nature and whilst May incidents are high in this category its positive that our staff are reporting these type of incidents.

Manual handling Incidents - See Figure 2 below

Manual handling incidents reported in May 2019 were 23 which is a decrease of 13 incidents from the previous month.

Health and Safety Incidents - See Figure 3 below

Health and Safety incidents reported in May 2019 were 18 which is an increase of 10 incidents from the previous month.

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

RIDDOR incidents reported in May 2019 were 2 and both incidents were reported on time to the Health and Safety Executive.

Figure 1

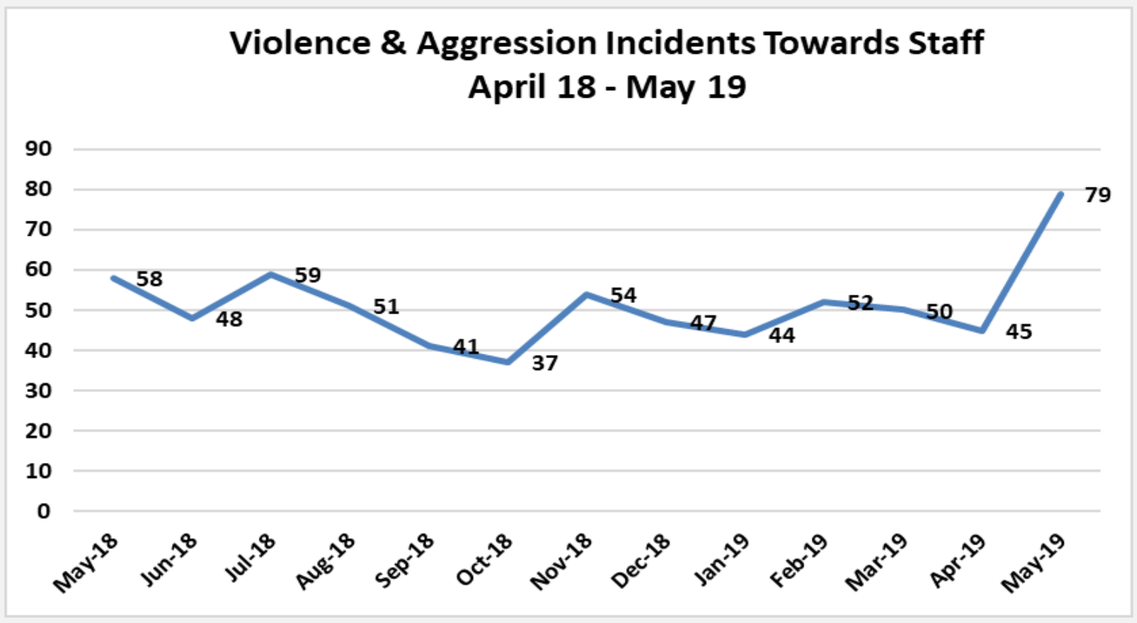


Figure 2

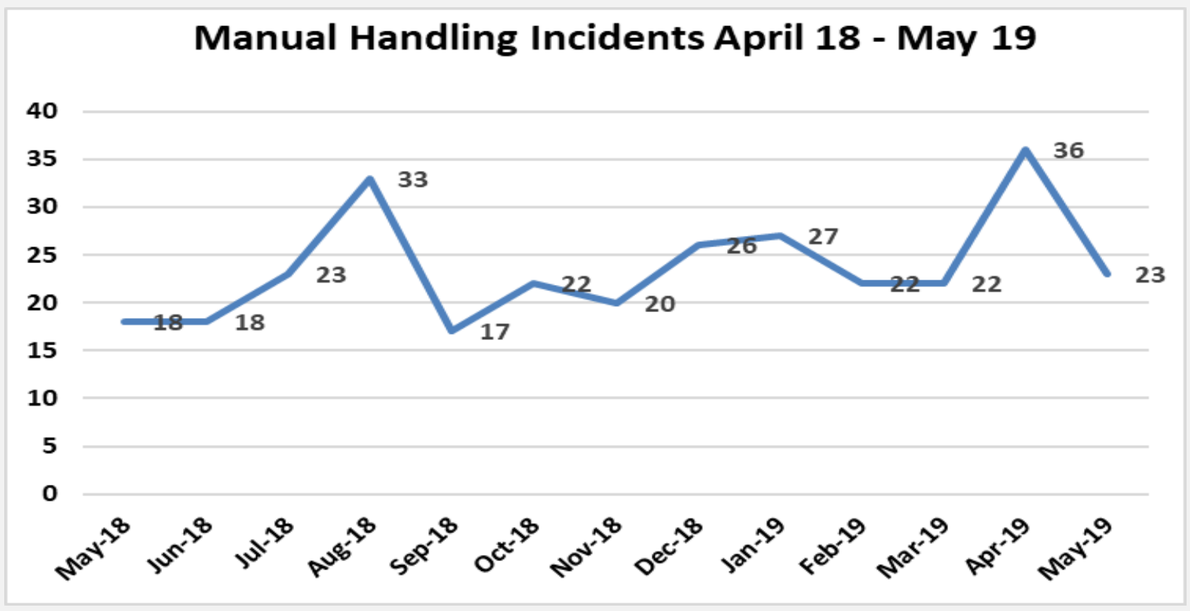


Figure 3

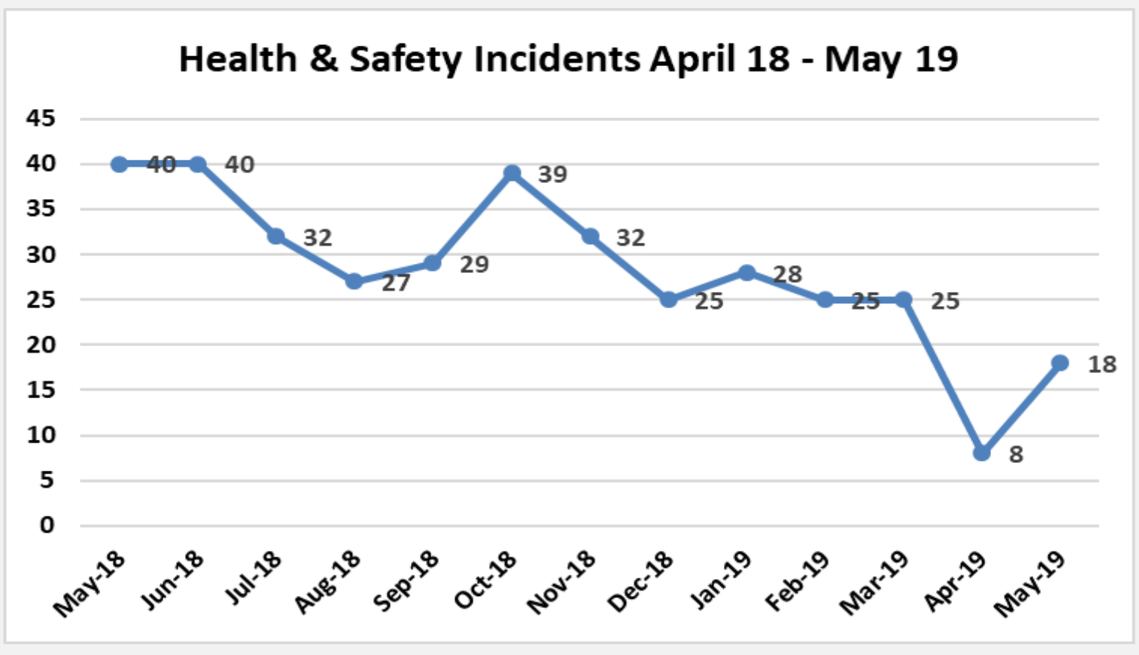
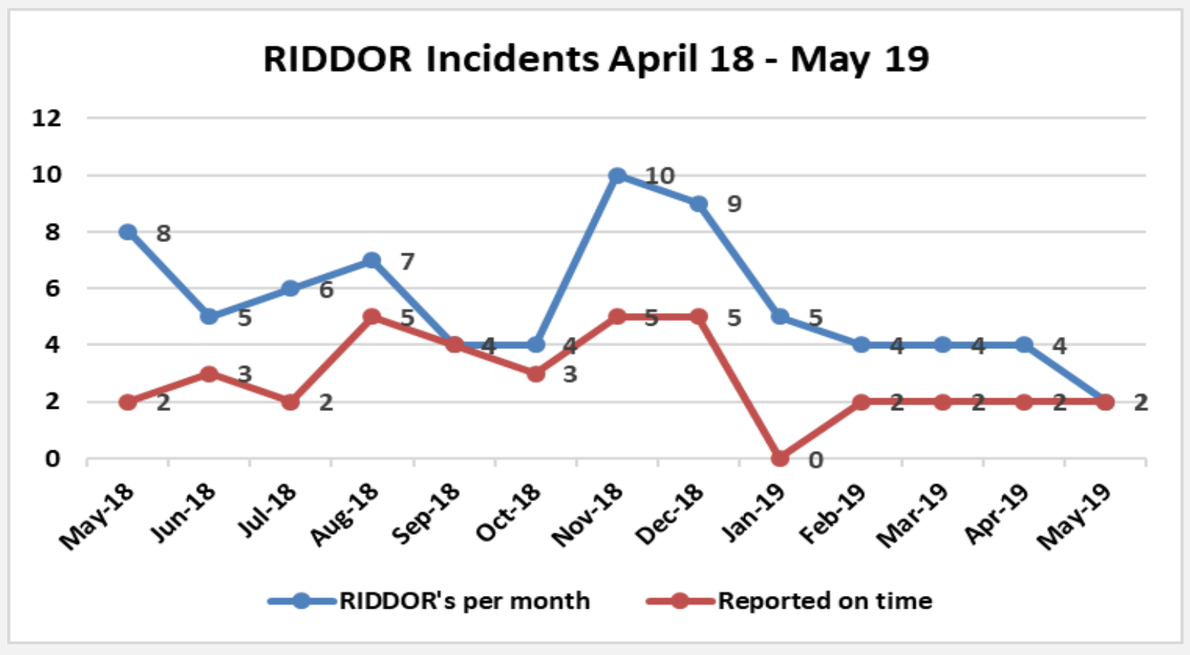


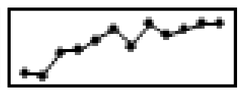
Figure 4



Our Enablers

SECAmb 999 Operations Response Time Performance Scorecard

Call Handling

	Mar-19	Apr-19	May-19	12 Months
5 Sec Performance (95% Target)	89.4%	91.7%	91.4%	
Mean Call Answer Time (secs)	6	5	5	
95th Centile Call Answer (Secs)	37	27	28	
National Mean Call Answer	5	5	5	
National 95th Centile Call Answer	31	29	27	

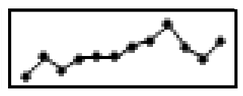
Category 1 Performance

	Mar-19	Apr-19	May-19	12 Months
Mean (00:07:00)	00:07:31	00:07:20	00:07:18	
90th Percentile (00:15:00)	00:13:50	00:13:59	00:13:37	
Mean Resources Arriving	1.67	1.69	1.69	
Count of Incidents	3708	3552	3594	
National Mean	00:07:00	00:07:01	00:06:54	

Category 1T Performance

	Mar-19	Apr-19	May-19	12 Months
Mean (00:19:00)	00:09:47	00:09:23	00:09:27	
90th Percentile (00:30:00)	00:18:13	00:17:31	00:17:23	
Mean Resources Arriving	1.69	1.70	1.72	
Count of Incidents	2376	2187	2268	
National Mean	00:10:46	00:10:47	00:10:32	

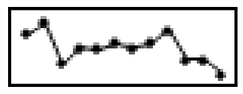
Category 2 Performance

	Mar-19	Apr-19	May-19	12 Months
Mean (00:18:00)	00:20:12	00:19:18	00:20:54	
90th Percentile (00:40:00)	00:38:10	00:36:10	00:40:16	
Mean Resources Arriving	1.08	1.09	1.08	
Count of Incidents	32586	31793	31330	
National Mean	00:21:15	00:21:13	00:21:01	

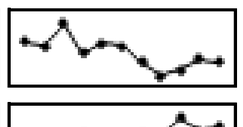
Category 3 Performance

	Mar-19	Apr-19	May-19	12 Months
Mean	01:46:30	01:33:31	01:38:23	
90th Percentile (02:00:00)	04:09:41	03:37:28	03:56:04	
Mean Resources Arriving	1.06	1.06	1.07	
Count of Incidents	18478	19756	19166	
National Mean	01:01:24	01:01:15	01:00:29	

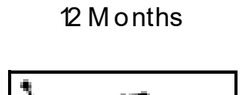
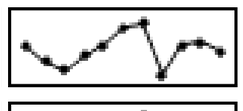
Category 4 Performance

	Mar-19	Apr-19	May-19	12 Months
Mean	02:15:17	01:52:44	01:58:37	
90th Percentile (03:00:00)	05:06:19	04:30:42	04:52:54	
Mean Resources Arriving	1.05	0.92	0.90	
Count of Incidents	745	606	495	
National Mean	01:20:29	01:20:55	01:16:02	

Health Care Professional

	Mar-19	Apr-19	May-19	12 Months
HCP 60 Mean	01:46:22	01:37:01	01:31:54	
HCP 60 90th Percentile	03:53:10	03:34:57	04:07:19	
HCP 120 Mean	01:53:29	01:49:28	01:43:46	
HCP 120 90th Percentile	04:07:43	04:10:37	03:45:51	
HCP 240 Mean	02:39:51	02:17:07	02:15:07	
HCP 240 90th Percentile	06:06:01	06:02:04	05:16:00	

Call Cycle Time

	Mar-19	Apr-19	May-19	12 Months
Avg Allocation to Clear at Scene	01:16:00	01:16:29	01:15:30	
Avg Allocation to Clear at Hospital	01:47:13	01:47:54	01:47:21	
Turnaround Hrs Lost at Hospital (> 30mins)	4673	5054	4946	
Number of Handovers >60mins	525	628	508	

Incident Outcome AQI

	Mar-19	Apr-19	May-19	12 Months
Hear & Treat	5.5%	5.7%	5.6%	
See & Treat	31.8%	32.2%	32.1%	
See & Convey	62.7%	62.1%	62.3%	

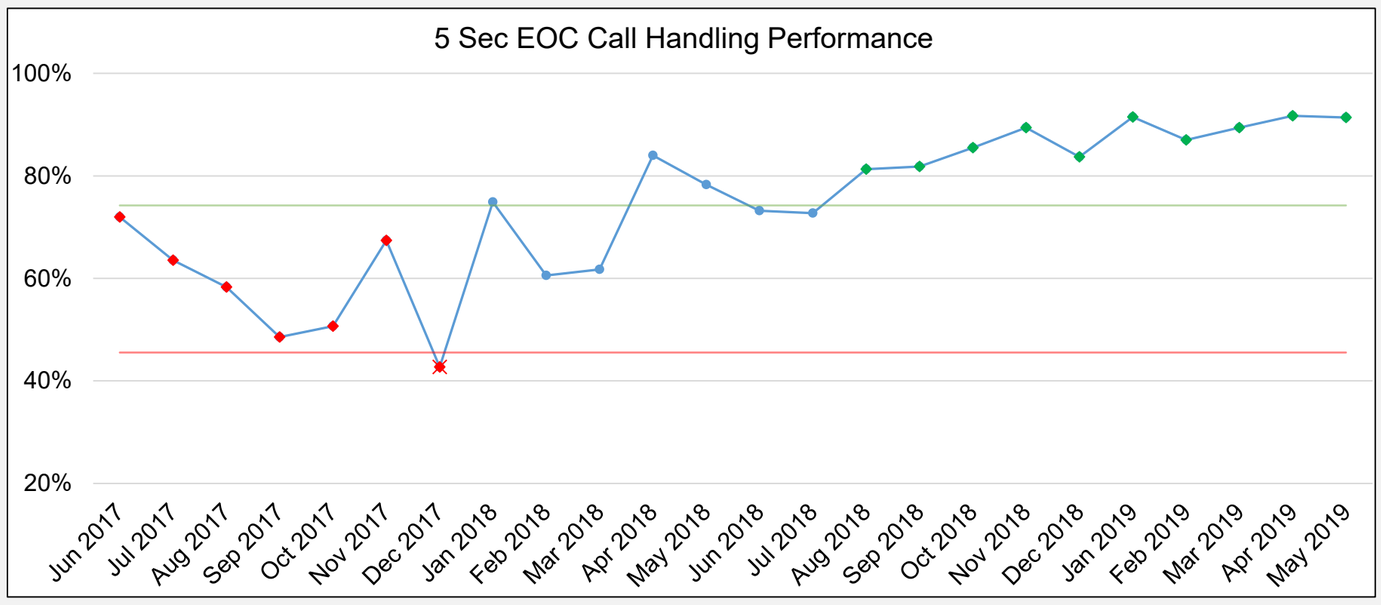
Community First Responders

	Mar-19	Apr-19	May-19	12 Months
Volume of Incidents Attended	1484	1319	1420	

Demand/Supply AQI

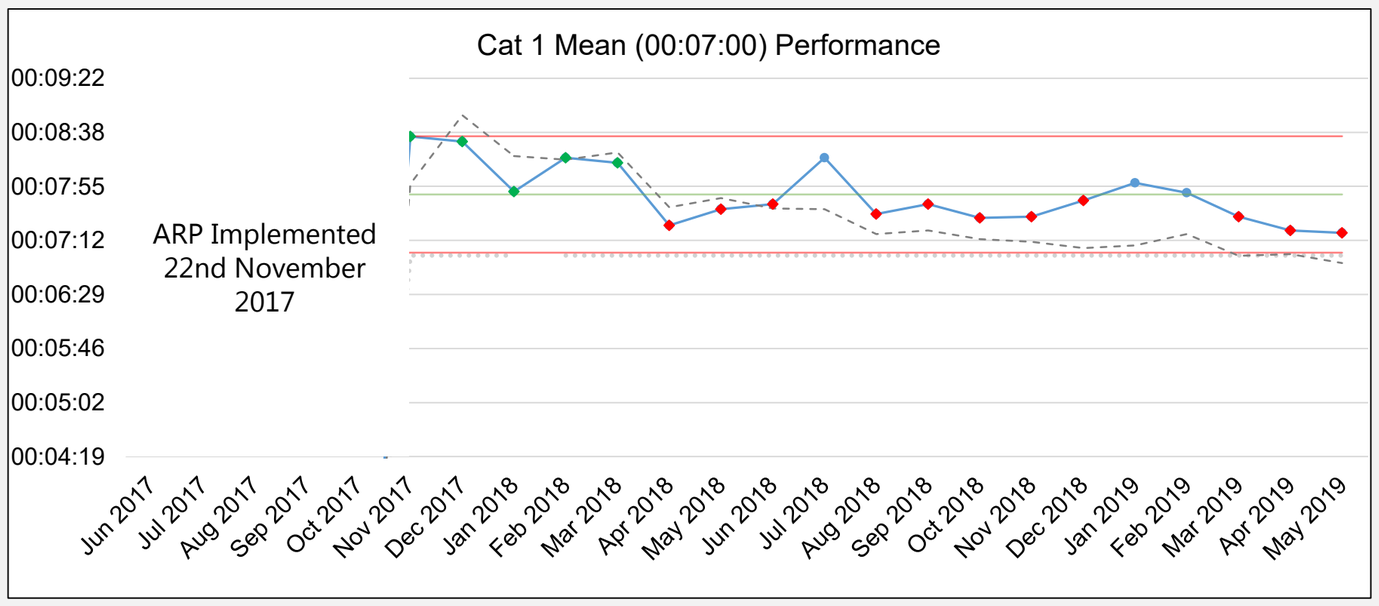
	Mar-19	Apr-19	May-19	12 Months
Calls Answered	66945	65412	65410	
Incidents	60991	61449	60075	
Transports	38229	38177	37410	

SECAmb 999 Operations Response Time Performance Charts



Call answering performance in EOC for May remained stable above 91% on average, whilst the Trust continues to exceed the revised trajectory agreed with the Commissioners in September 2018. National Call Answer performance demonstrates that the Trust's performance for 90th Centile Performance has improved to 2nd position overall and the other metrics remain stable at positions 6/7 in the national AQI tables compared to other ambulance services.

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

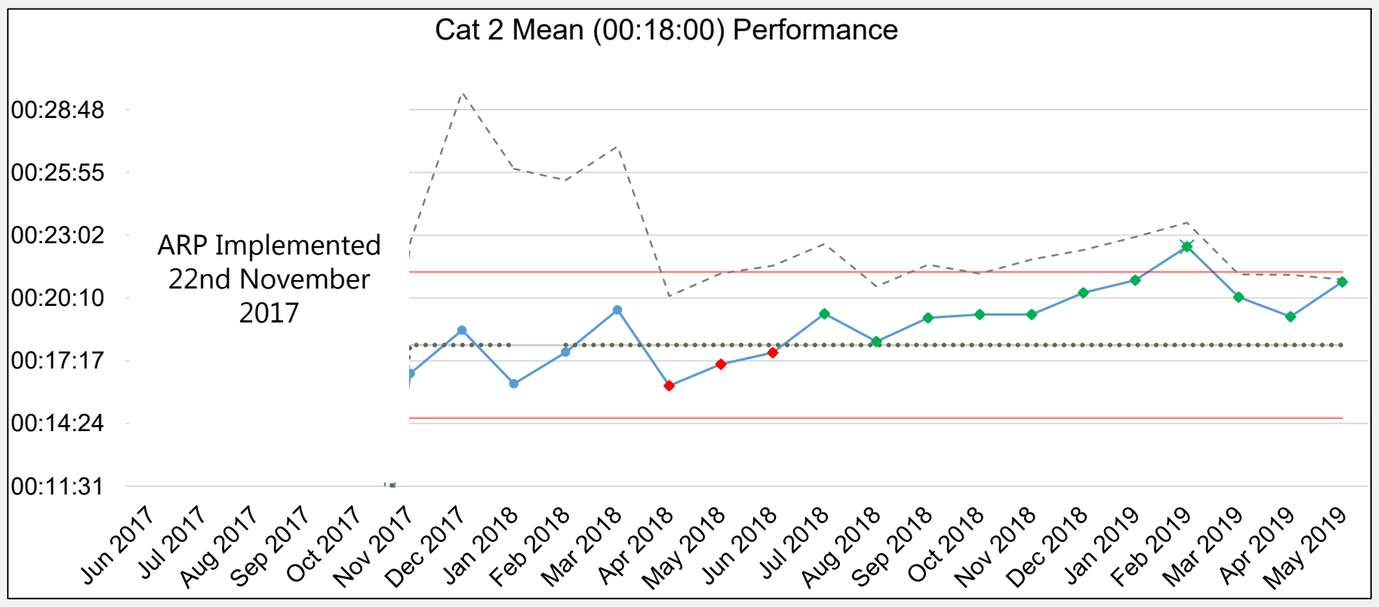


The Category 1 (C1) mean response in May illustrates a further improvement of 2 seconds, achieving an average of 7:18. The number of incidents remained consistent with the previous month.

Whilst the Trust is not yet delivering the Ambulance Response Programme (ARP) target of seven minutes for C1 Mean, the Trust has delivered the C1T Mean and C1 90th centile against ARP standards and resides at positions 4 and 9 respectively for C1 Transport, when measured against all other English ambulance services.

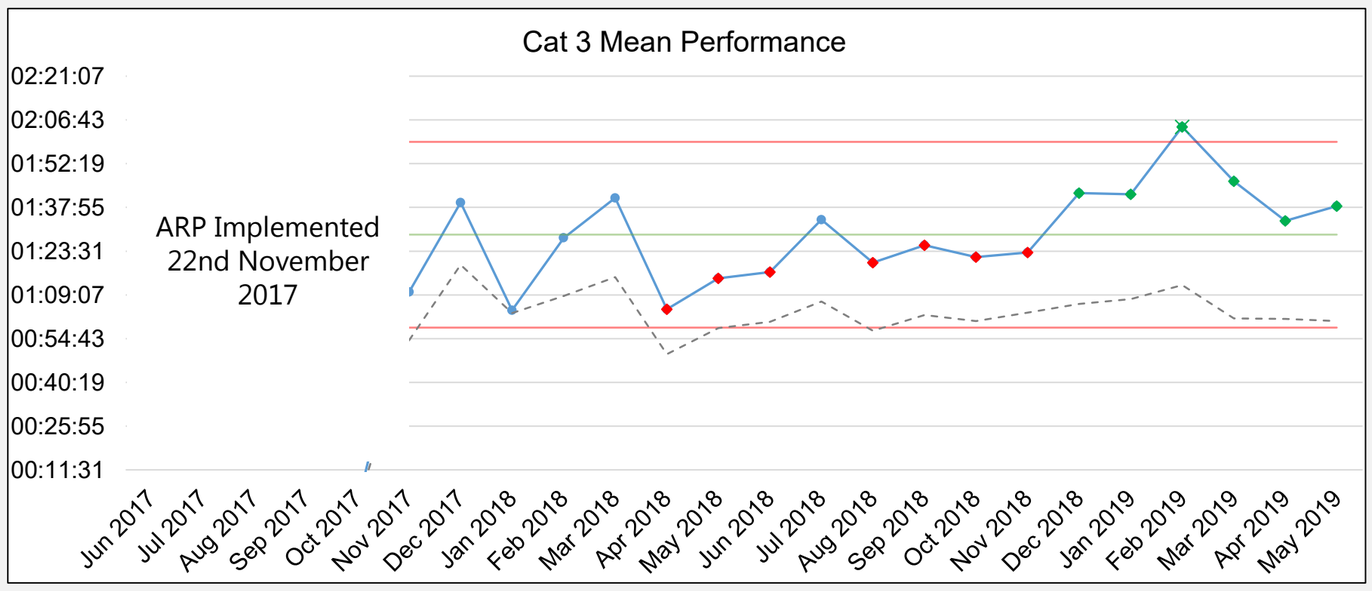
There remains significant focus given to this high acuity patient group.

----- National Mean



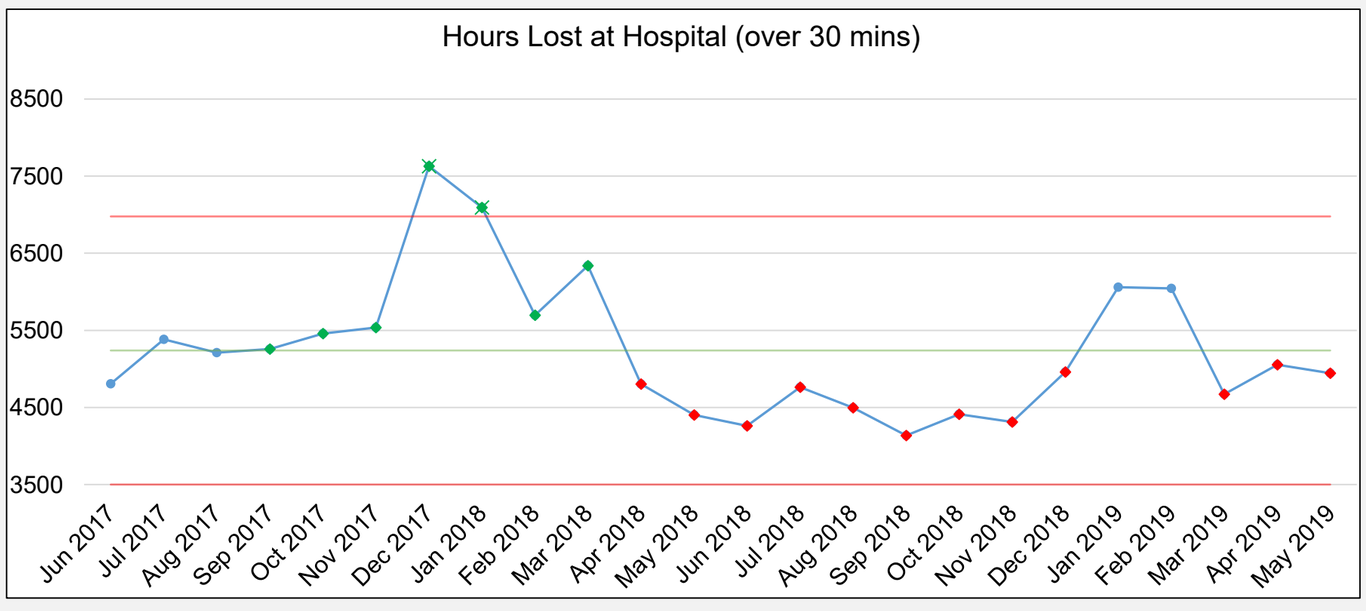
The Category 2 (C2) Mean Performance in May declined by a further 1 minute and 36 seconds compared to the previous month, to an average mean performance at 20:54. In comparison to other ambulance services, the Trust continues to achieve middle table status for both Mean and 90th centile. The Trust did not achieve the ARP standard in May for C2 performance.
As one of the initiatives to improve out Category 3 (C3) performance, the SRV targeted Dispatch Trial was implemented, thereby deploying SRVs with a qualified clinician to C3 calls, backed up by NET vehicles. This enabled DCA's to attend the higher acuity calls that would be more likely to require conveyance. The trial did not deliver the anticipated results and it was identified that this was in part due to inconsistency in the provision of operational hours (right hours, wrong times), increased Job Cycle time due to the inability to access clinical advice in a timely manner and some Trust policies

----- National Mean



Response to C3 incidents continues be well outside of the ARP target and remains a significant challenge to the Trust. The average mean response is 1:38:23.
The Trust's performance nationally remains sub-optimal for both C3 Mean and 90th Centile remain at the bottom of the AQI table. The average national performance remains approximately 2.5 hours better than SECAmb.
This position is of significant concern and the Trust is now working closely with Dr Anthony Marsh to identify ways that can significantly improve response to this category of patients, who are waiting too long. Actions have already been taken to ensure that there is more resource available, including the deferral of some of the key skills training days to later in the year. Although the Trust should be assured that all staff will receive the appropriate training, albeit at a later date and in a phased fashion.

----- National Mean



In May there was a decrease of 150 hours lost >30 minute turnaround compared to April. Comparing overall hours lost >30 minute turnaround in May 2019 with May 2018, there was 12% increase lost>30 minute turnaround .
In May 12.7% of patients waited between 30 and 60 minutes for a hospital handover and 1.5% of patients waited over 60 minutes.

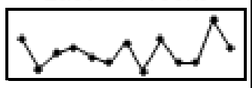
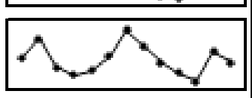
The ambulance handover steering group continues to meet and local joint hospital and SECAmb operational meetings are also continuing.

The national programme has been refreshed and all hospital sites have submitted trajectories for improving handover performance over 2019/20. The most challenged trusts will be monitored by the national programme as well as locally through the steering group .

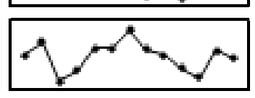
SECAmb unvalidated weekly Response Time Performance

SECAmb Weekly Operational Performance - 8th July 2019

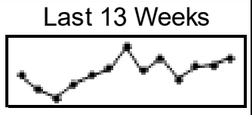
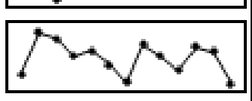
CAT 1

	17/06	24/06	01/07	Last 13 Weeks
Mean	00:07:05	00:07:53	00:07:20	
90th Centile	00:13:49	00:13:38	00:13:45	
RPI	1.73	1.80	1.77	
Count of Incidents	799	854	833	

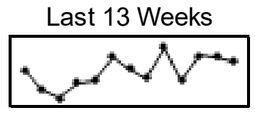
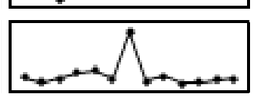
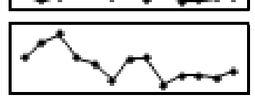
CAT 1T

	17/06	24/06	01/07	Last 13 Weeks
Mean	00:09:19	00:10:11	00:10:08	
90th Centile	00:18:42	00:17:55	00:19:20	
RPI	1.75	1.85	1.83	
Count of Incidents	493	530	518	

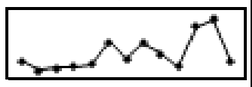
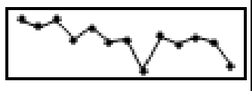
CAT 2

	17/06	24/06	01/07	Last 13 Weeks
Mean	00:21:13	00:21:25	00:21:59	
90th Centile	00:40:32	00:41:06	00:42:48	
RPI	1.10	1.10	1.09	
Count of Incidents	7446	7587	7447	

CAT 3

	17/06	24/06	01/07	Last 13 Weeks
Mean	01:51:15	01:50:40	01:47:33	
90th Centile	04:15:39	04:20:37	04:08:33	
RPI	1.06	1.07	1.07	
Count of Incidents	4292	4253	4347	

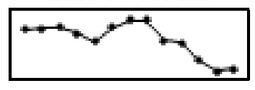
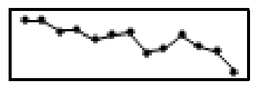
CAT 4

	17/06	24/06	01/07	Last 13 Weeks
Mean	02:51:01	03:00:36	02:05:59	
90th Centile	06:18:58	06:23:37	04:20:04	
RPI	1.09	1.05	1.03	
Count of Incidents	104	99	72	

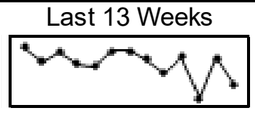
HCP 60

	17/06	24/06	01/07	Last 13 Weeks
Performance	45.5%	34.8%	22.2%	
Count of Incidents	22	23	18	

HCP 120

	17/06	24/06	01/07	Last 13 Weeks
Performance	54.9%	50.4%	51.6%	
Count of Incidents	370	357	308	

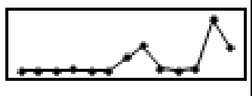
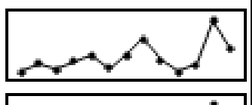
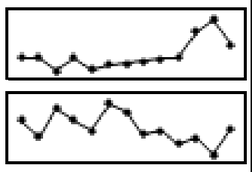
HCP 240

	17/06	24/06	01/07	Last 13 Weeks
Performance	55.4%	80.3%	63.6%	
Count of Incidents	65	61	66	

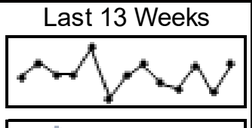
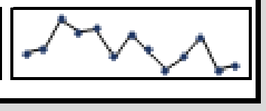
Call Cycle Time

	17/06	24/06	01/07	Last 13 Weeks
Clear at Scene (hh:mm)	01:15	01:14	01:13	
Clear at Hospital (hh:mm)	01:47	01:48	01:48	
Hours Lost at Hospital	1104	1143	1216	

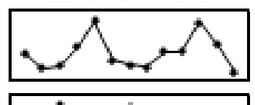
Call Handling

	17/06	24/06	01/07	Last 13 Weeks
Mean Call Pickup Time (Seconds)	5	12	6	
Call Pickup Time 90th Percentile (Seconds)	4	39	18	
Call Pickup Time 95th Percentile (Seconds)	27	75	43	
Call Pickup Time 99th Percentile (Seconds)	77	163	93	
Average Call Length (seconds)	420	353	369	
Abandon Rate	0.70%	0.80%	0.60%	
Staff Hours Provided Vs 6413 Hours 2019/20 Q1 2019/20 Q2 to be	81.09%	78.05%	82.87%	

Community First Responders

	17/06	24/06	01/07	Last 13 Weeks
Volume of Incidents Attended	334	279	336	
Hours Provided	2750.6	2354.1	2399.4	

Incident Outcome

	17/06	24/06	01/07	Last 13 Weeks
See and Convey	63.0%	62.3%	61.5%	
See and Treat	31.7%	32.5%	33.0%	
Hear and Treat	5.4%	5.2%	5.5%	

Demand/Supply

	17/06	24/06	01/07	Last 13 Weeks
Call Volume	15682	16215	16056	
Incidents	13171	13309	13123	
Transports	8806	8796	8548	
Staff Hours Provided Vs 65153 Hours 2019/20 Q1 67087 Hours 2019/20 Q2	100.56%	101.08%	93.37%	

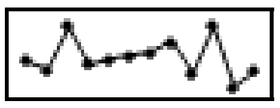
Our Partners

SECAmb 111 Operations Performance Scorecard

Calls Offered

	Mar-19	Apr-19	May-19	12 Months
Actual	78251	75211	74311	
Previous Year	112748	93916	92737	

Calls answered in 60 Seconds

	Mar-19	Apr-19	May-19	12 Months
Actual %	83.8%	63.1%	68.5%	
Previous Year %	45.1%	73.6%	74.0%	
Target %	95%	95%	95%	

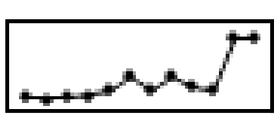
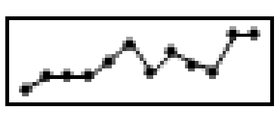
Calls abandoned - (Offered) after 30secs

	Mar-19	Apr-19	May-19	12 Months
Actual %	2.6%	9.1%	7.7%	
Previous Year %	15.7%	4.8%	4.7%	
Target %	5%	5%	5%	

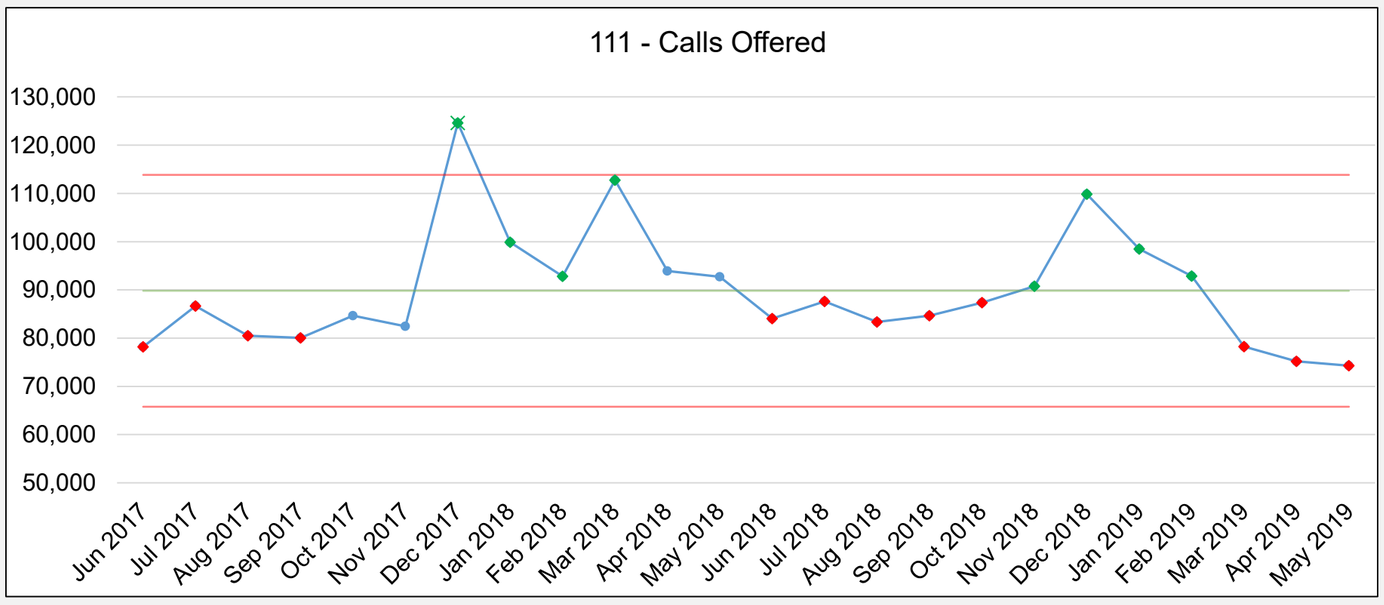
A&E Dispositions

	Mar-19	Apr-19	May-19	12 Months
A&E Dispositions % (Answered Calls)	8.2%	8.5%	9.2%	
A&E Dispositions (Actual)	6202	4822	5135	
National	7.7%	8.7%	9.1%	

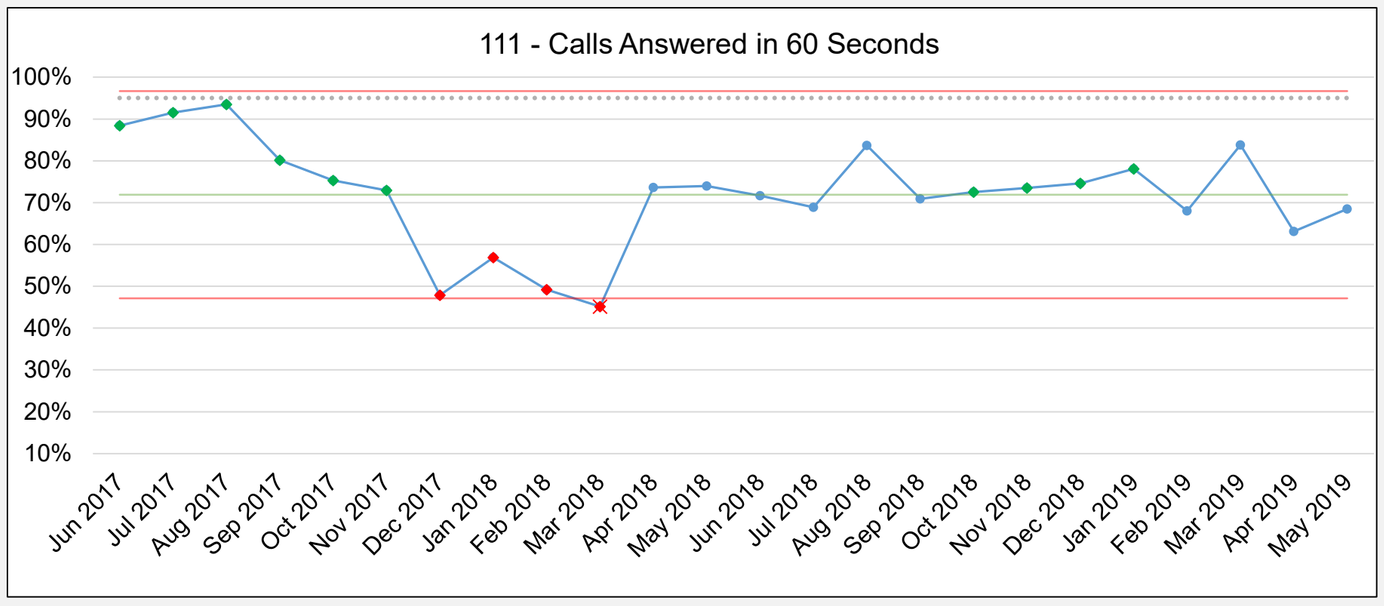
999 Referrals

	Mar-19	Apr-19	May-19	12 Months
999 Referrals % (Answered Calls)	11.6%	15.4%	15.5%	
999 Referrals (Actual)	8779	8743	8649	
National	11.7%	12.9%	12.9%	

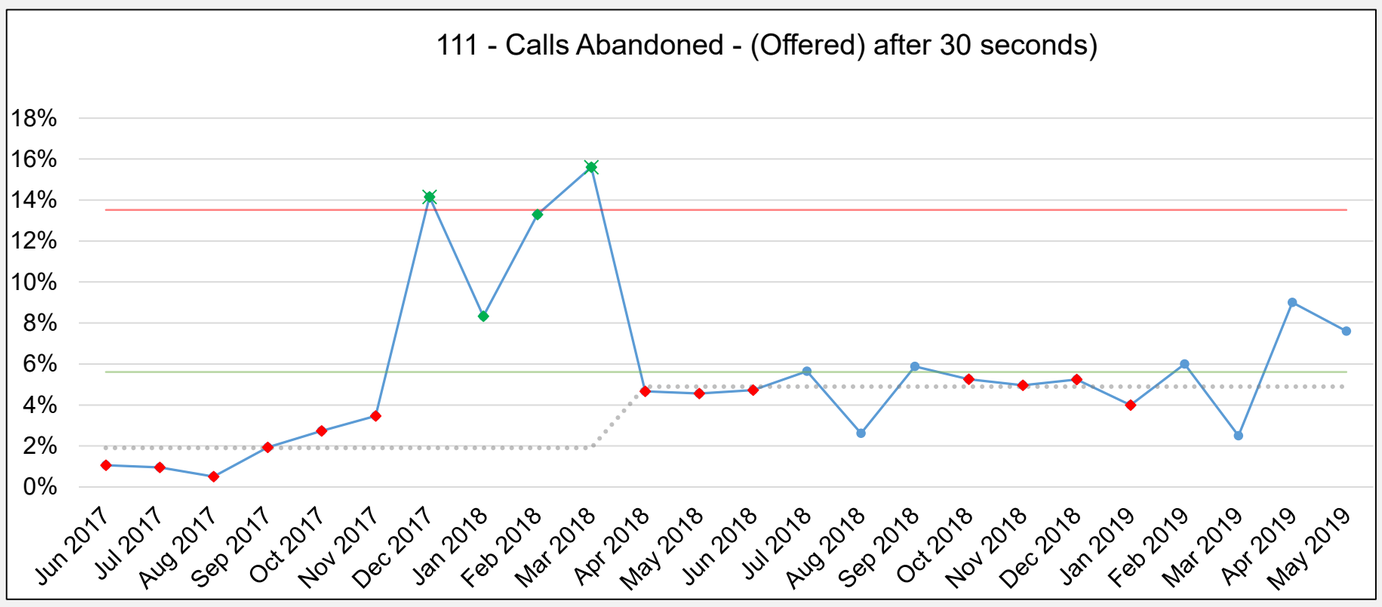
SECAmb 111 Operations Performance Charts



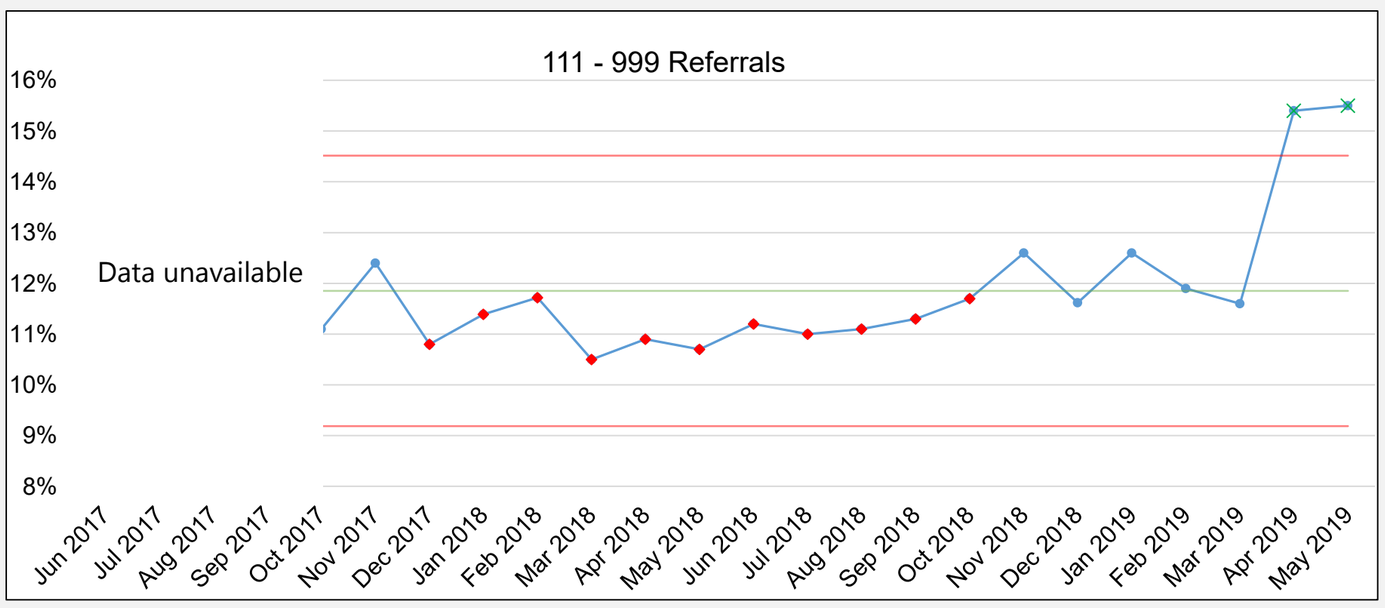
The call volume of 74311 was similar to the April volume. Two bank holidays occurred in May. Call profiles are volatile due to frequent activation of National Contingency by other 111 / IUC providers, and also unannounced PLT events.



The SECAMB service improved its service level to 68.5%. Further work is being conducted to maximise productivity, reduce Average Handling Time, and reduce unplanned absence.



The ABD rate reduced to 7.7% in line with the service's improvement trajectory. The Average Speed to Answer fell to 102 seconds, demonstrating an underlying improvement in answering calls promptly.

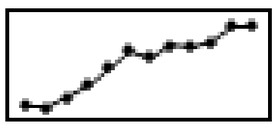
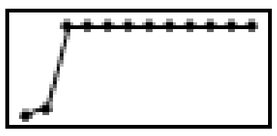
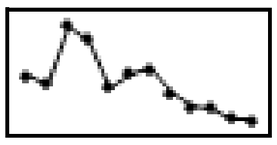


The AMB referral rate remained high due to staff tenure and risk aversion by users new to the Cleric platform. Validation of C3 / C4 dispositions via Clinical Inline Support is still provided. Nationally there has been an upward trend in AMB referral rates

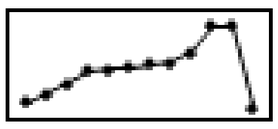
Our People

SECAmb Workforce Scorecard

Workforce Capacity

	Mar-19	Apr-19	May-19	12 Months
Number of Staff WTE (Excl bank & agency)	3436.0	3515.5	3517.6	
Number of Staff Headcount (Excl bank and agency)	3724	3813	3811	
Finance Establishment (WTE)	3837.50	3837.50	3837.50	
Vacancy Rate	11.29%	8.39%	8.34%	
Vacancy Rate Previous Year	12.82%	12.23%	12.63%	
Adjusted Vacancy Rate + Pipeline recruitment %	5.46%	4.85%	4.79%	

Workforce Compliance

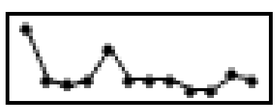
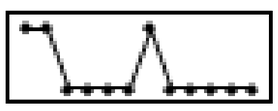
	Mar-19	Apr-19	May-19	12 Months
Objectives & Career Conversations %	89.57%	90.21%	13.27%	
Target (Objectives & Career Conversations)	80%	80%	80%	
Statutory & Mandatory Training Compliance %	93.58%	12.55%	26.78%	
Target (Stat & Mand Training)	95%	95%	95%	
Previous Year (Stat & Mand Training) %	93.24%	6.54%	85.68%	

* Objectives & Career Conversations and Statutory & Mandatory training has been measured by financial year. The completion rate is reset to zero on 01/04/2019

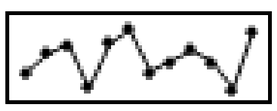
Workforce Costs

	Mar-19	Apr-19	May-19	12 Months
Annual Rolling Turnover Rate %	14.07%	14.10%	14.72%	
Previous Year %	17.19%	16.50%	17.42%	
Annual Rolling Sickness Absence	5.00%	5.00%	5.17%	
Target (Annual Rolling Sickness)	5%	5%	5%	

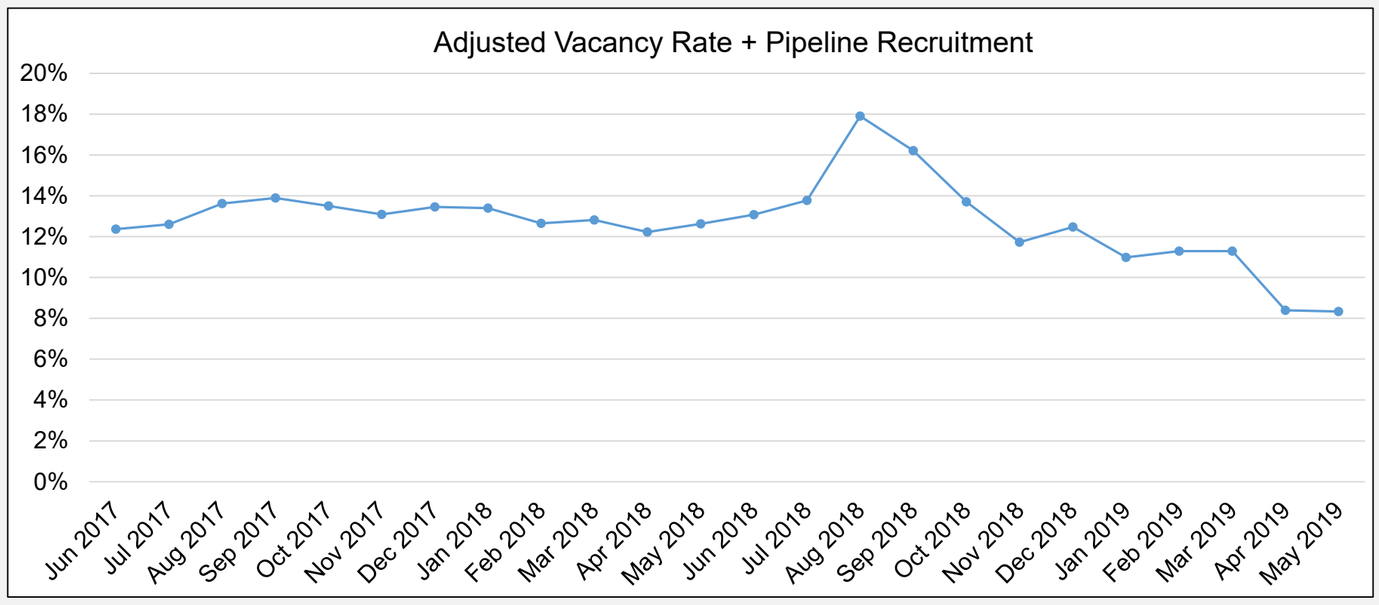
Employee Relations Cases

	Mar-19	Apr-19	May-19	12 Months
Disciplinary Cases	2	5	4	
Individual Grievances	9	10	7	
Collective Grievances	1	3	0	
Bullying & Harassment	2	2	1	
Bullying & Harassment Prev Yr	1	2	3	
Whistleblowing	0	0	0	
Whistleblowing Previous Year	0	0	1	

Physical Assaults (Number of victims)

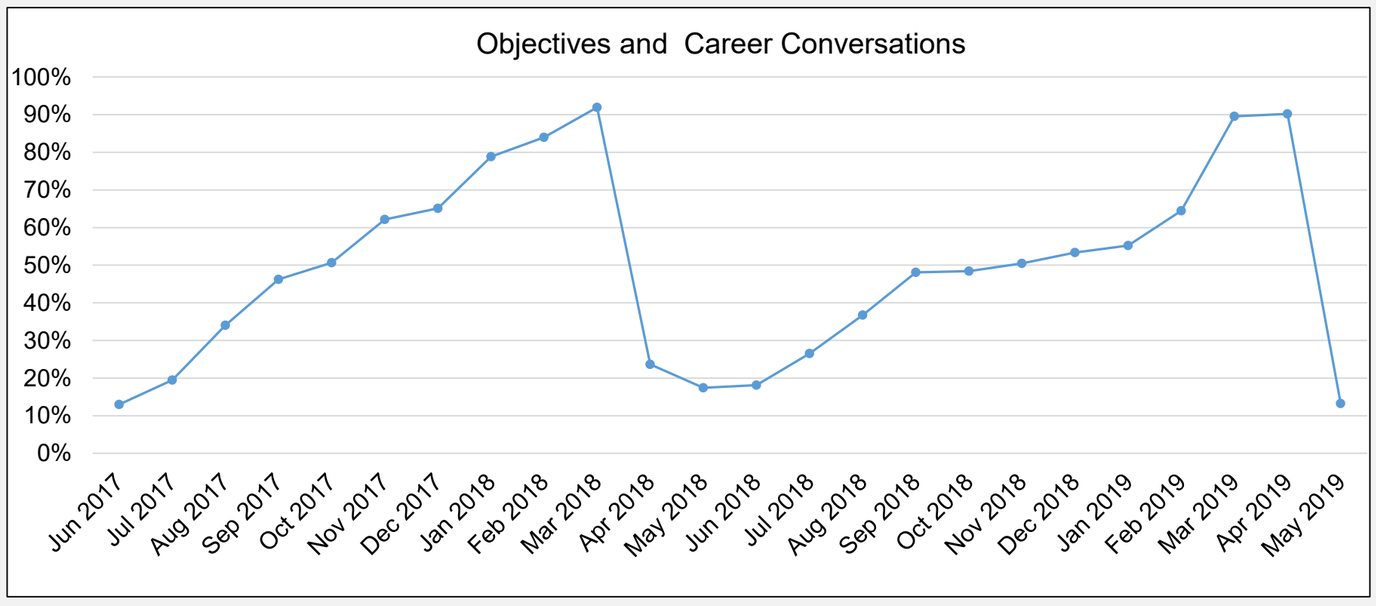
	Mar-19	Apr-19	May-19	12 Months
Actual	18	8	29	
Previous Year	17	22	13	
Sanctions	3	0	4	

SECAmb Workforce Charts



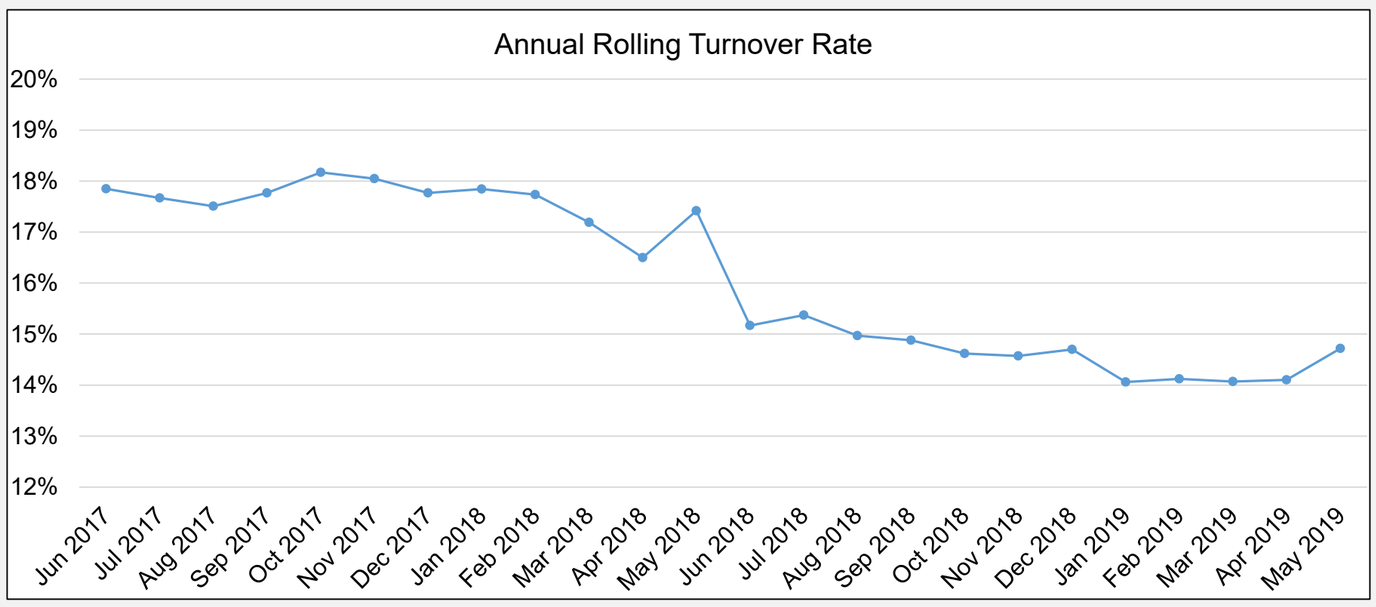
In May we recruited 18 new staff into the Trust. Our adjusted vacancy rate fell from 4.85% to 4.79%.
Our ECSW pipeline continues to be affected by candidate's ability to gain a C1 licence and as a result we had 15 unfilled ECSW course spaces in May. We anticipate that for courses starting after August 2019, this problem will be resolved as we have increased the period from offer to course start to 12 weeks.
For external NQPs graduates due to qualify this summer, we have offered 136 a job, against a target of 135.2.
A further 9 are due to be assessed in July. Attraction of external NQPs will continue until the autumn.
The celebratory event for our 73 in-service (internal) NQP graduates will take place on the 16th and 17th July 2019, we plan to confirm all 73 as Trust NQPs.
For experienced paramedics, 5 have been offered during April and May. A Trust task force has been agreed to establish how and what steps the Trust needs to take to make our experienced paramedic opportunities attractive to potential candidates.

Focus for 111 and EOC continues on Clinician recruitment which remains challenging. The work to secure the arrival of the first 4 of a 9 potential international clinicians in late summer is on-going.



These figures are based on a current headcount of 3737 substantive staff. The exceptions are bank staff, people on maternity and those on career breaks.

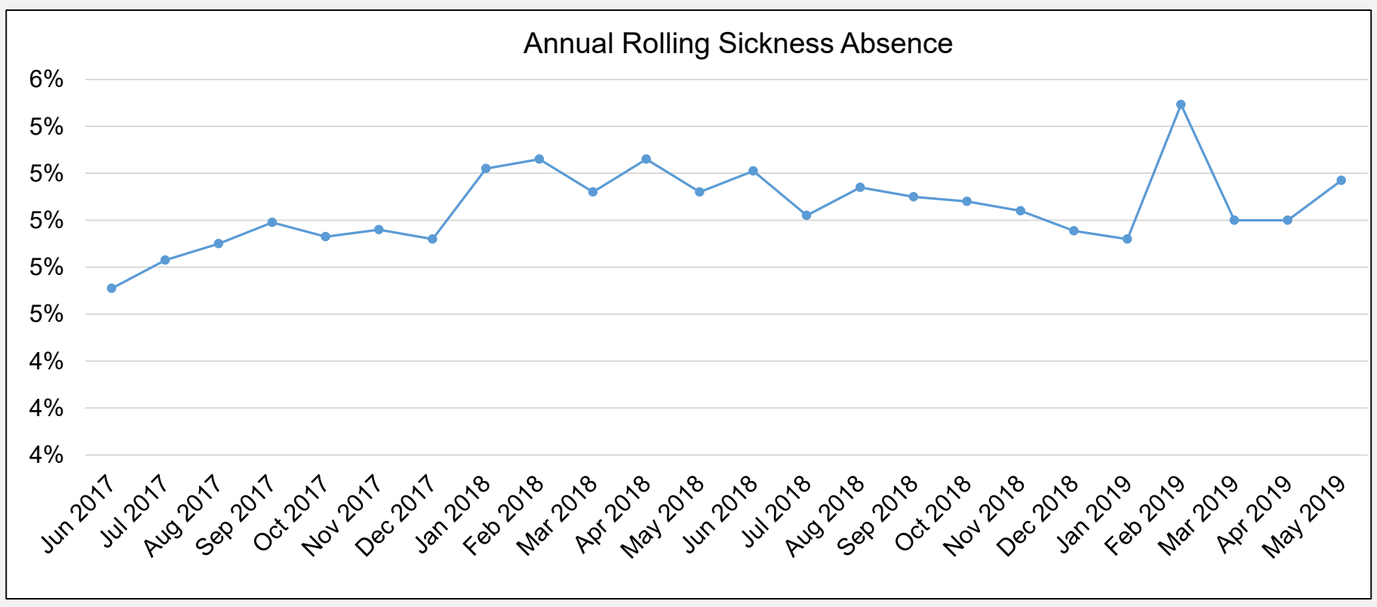
The figures are currently reported annually and as such are reset in April. (We are developing a report that will provide the rolling total)
The total % of appraisals completed year to date is 13.27%. This equates to 496 people having received an appraisal since April 2019.



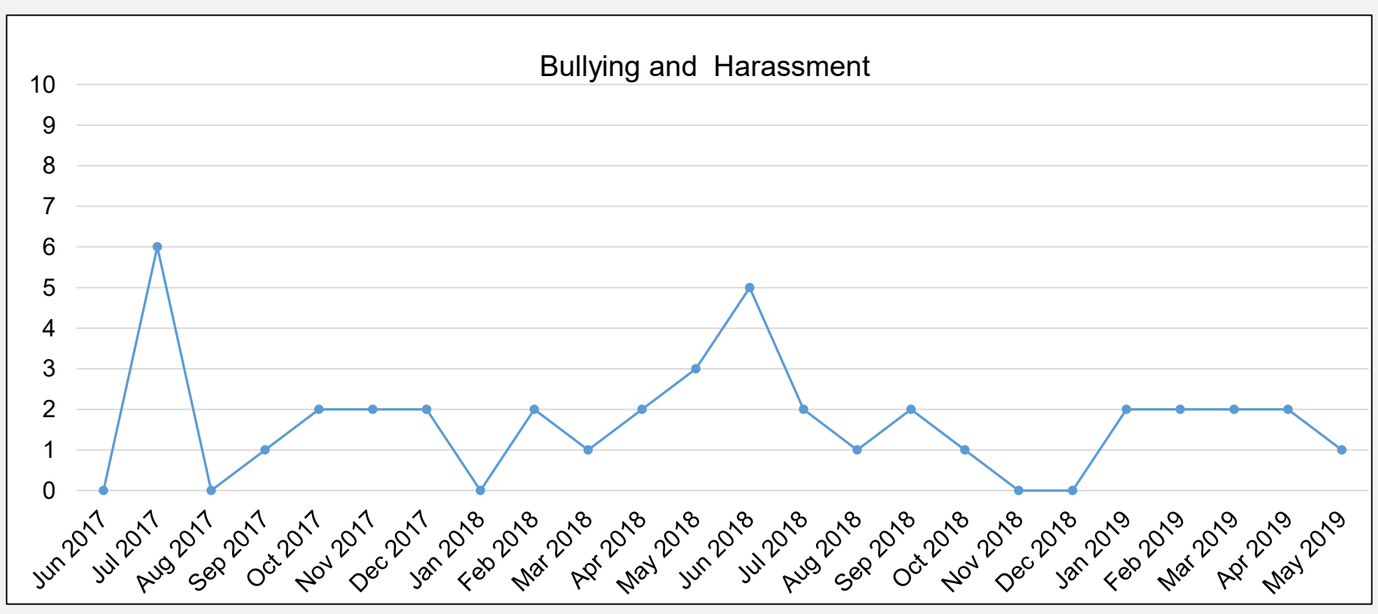
Following a period of continued downward trend on turnover, and a plateau for February, March and April, we have seen a slight increase in staff turnover for May at 14.7%. We continue to provide regular updates to WWC.

EOC East Turnover for May 19 - 32% (By comparison EOC East for the same period last year was 29%)
EOC West Turnover for May 19 - 36.22% (By comparison EOC West for the same period last year was 44.27%)
111 Turnover for May 19 - 46.57% (By comparison 111 for the same period last year was 46.31%)

An updated paper on Exit Interview Data has been written for the HRD, with a focus on the EOC's



Sickness absence was fractionally above target again at 5.2% for May 2019. Work is in place to reduce this



There was 1 reported case of Bullying and Harassment (Band H) in May 19 with the rolling total no at 40 cases since June 2017.

We have now established a new induction (local) with a Corporate Induction, in groups of 30 staff, 3 months into their employment. This will allow for greater understanding of what's good and what's not so good, and head off some of the not so goods quickly.

There will be focus on behaviours and values, and a session on challenging bad behaviour.

There is also a new First Line Managers Programme with a focus on Culture, values and behaviours.

Our Enablers

nditure

	Mar-19	Apr-19	May-19	12 Months
Actual £	£ 2,660	£ 1,172	£ 1,021	
Previous Year £	£ 3,190	£ 299	£ 142	
Plan £	£ 2,800	£ 1,765	£ 1,719	
Actual Cumulative £	£ 13,037	£ 1,172	£ 2,193	
Plan Cumulative £	£13,304	£ 1,765	£ 3,484	

Cost Improvement Programme (CIP)

	Mar-19	Apr-19	May-19	12 Months
Actual £	£ 1,786	£ 83	£ 585	
Previous Year £	£ 1,406	£ 392	£ 308	
Plan £	£ 1,801	£ 83	£ 781	
Actual Cumulative £	£ 11,401	£ 83	£ 668	
Plan Cumulative £	£ 11,411	£ 83	£ 864	

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)

	Mar-19	Apr-19	May-19	12 Months
Actual £	£ 2,374	-£ 1,454	-£ 484	
Actual YTD £	£ 2,388	-£ 1,454	-£ 1,938	
Plan £	£ 701	-£ 1,098	-£ 348	
Plan YTD £	£ 707	-£ 1,098	-£ 1,446	

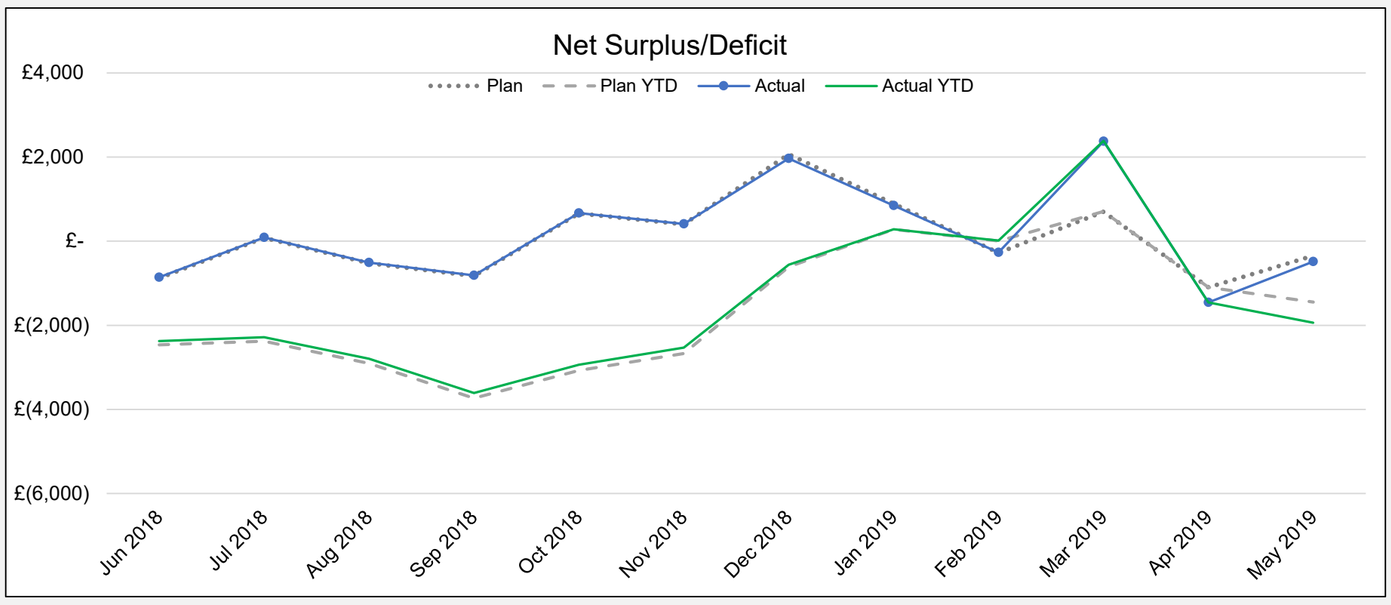
Cash Position

	Mar-19	Apr-19	May-19	12 Months
Actual £	£ 24,154	£ 22,332	£ 17,271	
Minimum £	£ 10,000	£ 10,000	£ 10,000	
Plan £	£ 17,794	£ 16,616	£ 16,736	

Agency Spend

	Mar-19	Apr-19	May-19	12 Months
Actual £	£ 457	£ 447	£ 526	
Plan £	£ 200	£ 295	£ 291	

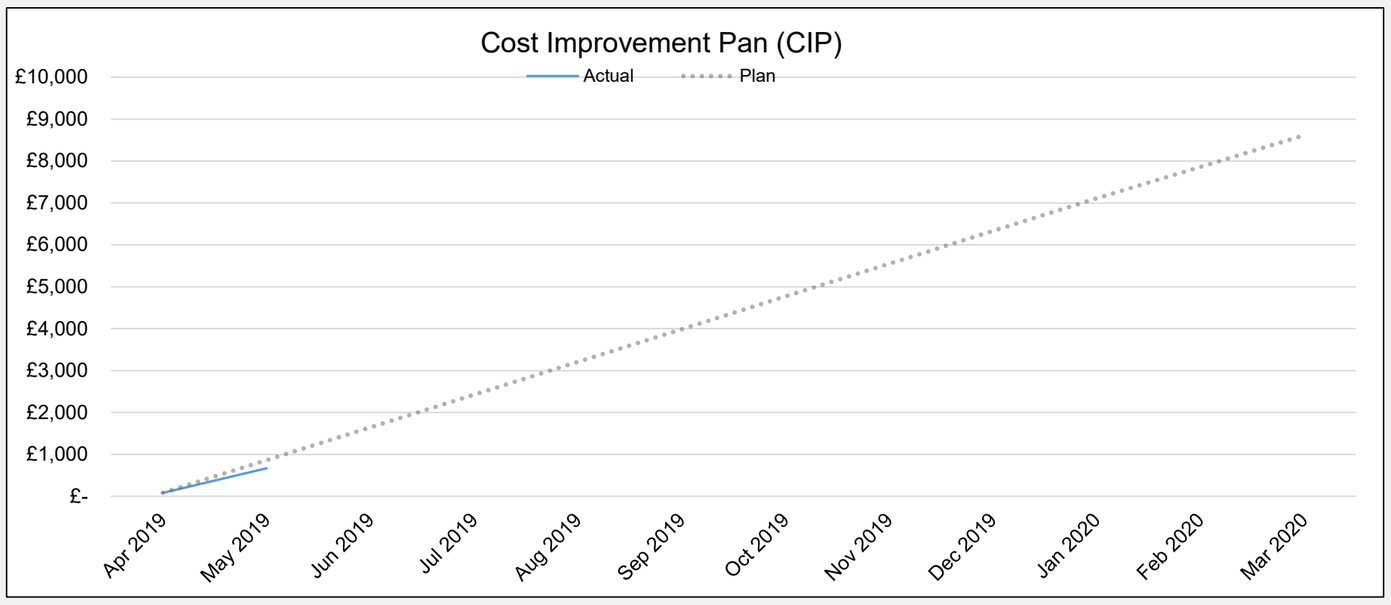
SECAmb Finance Performance Charts



The Trust's land E position in Month 01 was a deficit of £0.5m, this is £0.1m adverse to plan.

Year to date the deficit was £1.9m, this is £0.5m adverse to plan.

The main reason for this variance was due to 999 activity being less than planned where the Trust is currently unable to meet the demands on its service.



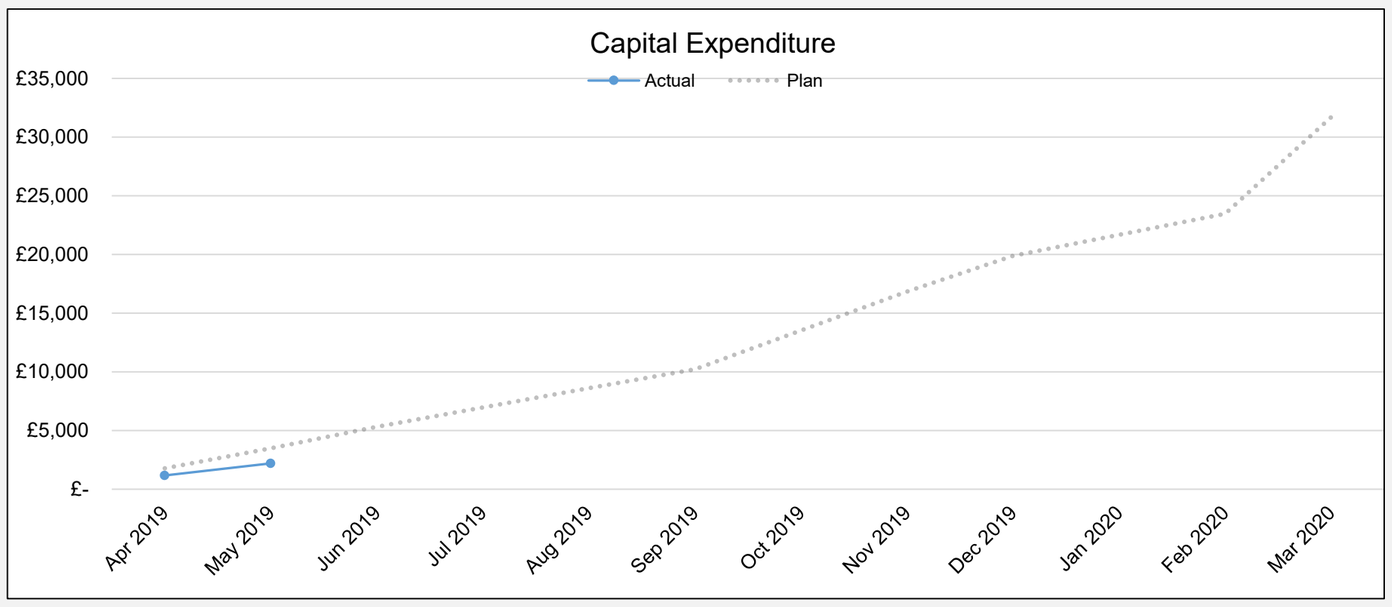
CIPs to the value of £0.6m were achieved in the month, as planned.

Year to date, we have reported £0.7 which is £0.2m behind plan.

This underachievement is mainly due to timing of reporting and is expected to catch up over the next few months.

The full year CIP plan and forecast is £8.6m.

As part of budget setting CIPs have been devolved to budget holders and schemes are being developed the achieve the efficiencies required.



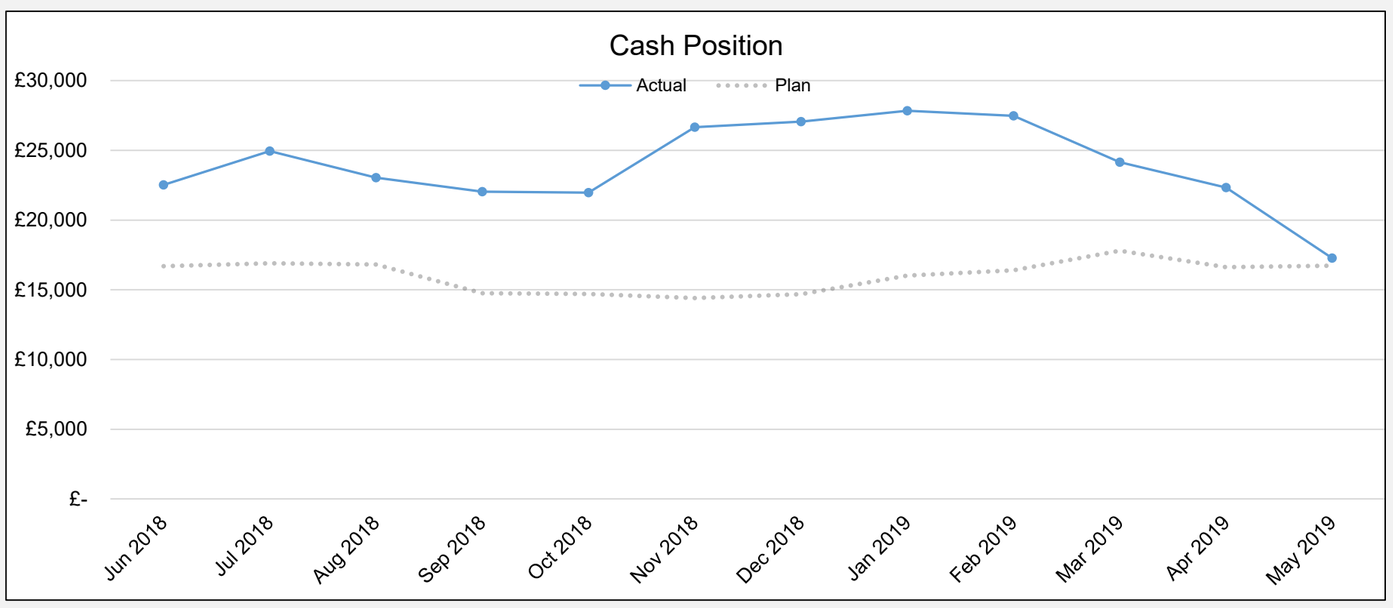
Capital for the month of May was £1.0m, £0.7m below plan.

Year to date expenditure is £2.2m, £1.3m below plan.

This shortfall is due to timing, partly due to awaiting approval on the 'Wave 4' capital bids.

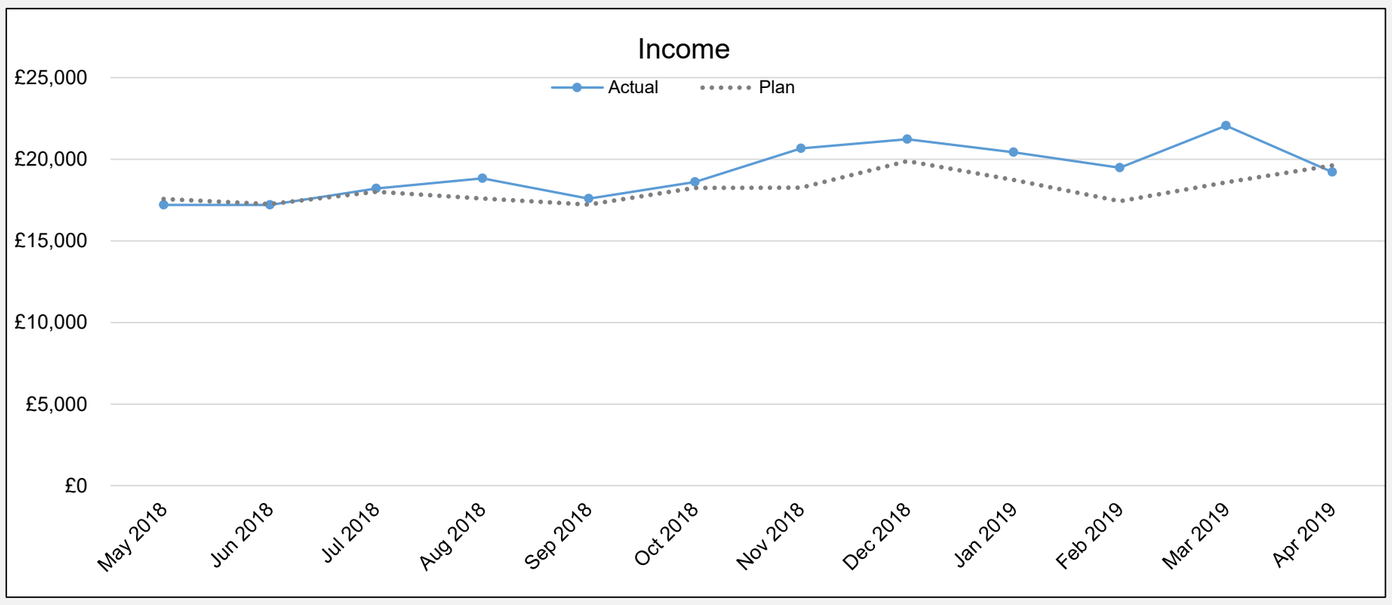
The plan and forecast for the year is £31.7m.

The Trust is seeking formal approval from the Department of Health and Social Care (DHSC) for the £19.1m of schemes that were the subject of successful 'Wave 4' capital bids. The schemes are Brighton, Medway and Worthing Make Ready Centres and Nexus House HQ expansion. £15.8m of the expenditure is planned for 2019/20.



The cash position as at 31 May 2019 was £17.3m which was £0.5m greater than planned and £6.9m lower than the end of the last financial year, mainly driven by trade payables (£2.4m), PDC payment (£1.4m) and capital cash spend (£1.2m).

Performance for the year to date against the 'Better Payment Practice Code', measured by payment of suppliers within 30 days of a valid invoice, was 95.6% by value against a target of 95.0%.

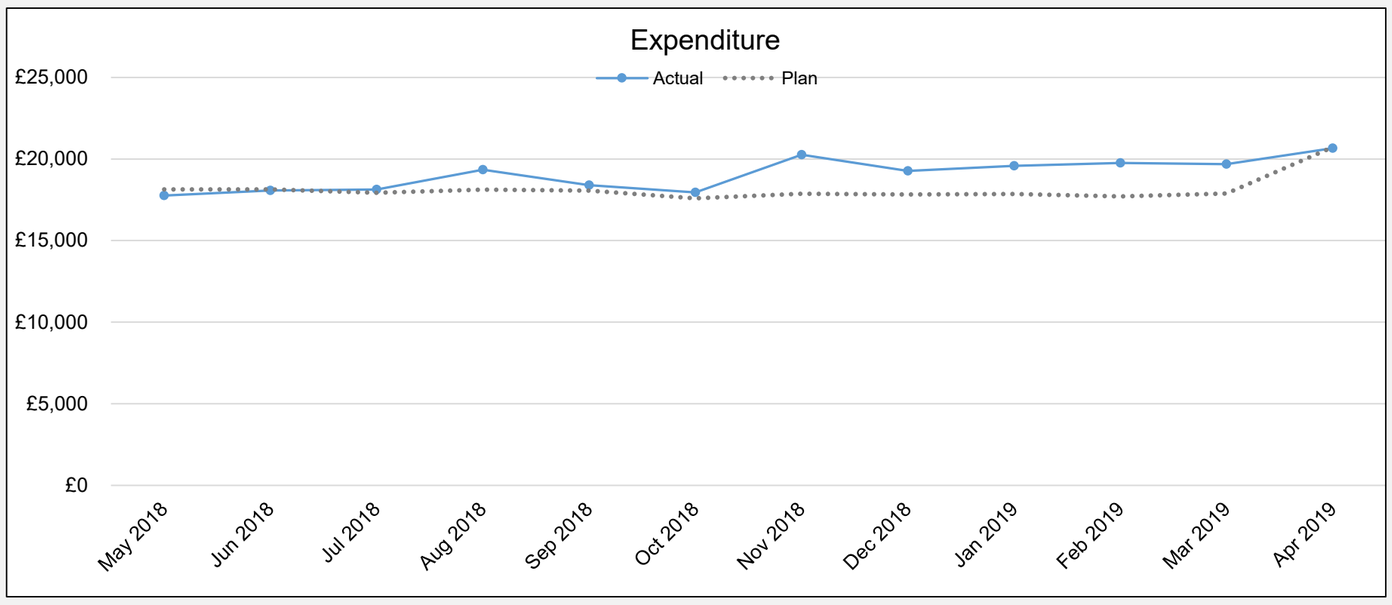


Income for the month was £20.1m, this was £0.2m worse than plan.

Year to date was £39.3m, £0.6m worse than plan.

The main reason for the adverse variance was due to reduced 999 income as a result of less activity being met than planned.

SECAmb Finance Performance Charts



Total expenditure for the month of May was £20.6m, this was £0.1m less than planned.

Year to date was £41.3m, £0.1m less than planned.

Pay costs were £0.4m less than planned, mainly through EOC vacancies.

Non pay costs were £0.3m worse than plan through overspends in Estates, Procurement, Fleet and Medical.

Finance costs are as planned.

SECAMB Board

QPS Committee Escalation report to the Board

Date of meetings	20 June 2019
Overview of key issues/areas covered at the meeting:	This meeting was attended by three Governors who were present to observe the committee and gain assurance on its effectiveness. As is usual, the committee started by considering ***Management Responses*** (*response to previous items scrutinised by the committee)*, including: **Cluster Serious Incident (re 111 mobilisation) Assured** This was an update on the review of the incidents that occurred shortly after the launch of the interim 111 service between in March 2019, where some calls reaching an ambulance disposition were closed in error. A detailed paper was received setting out how the Trust responded to the incident and the committee explored the learning and related action that was taken. It was assured that, despite this issue, mobilisation went well and that when the issue was identified management responded decisively. **Co-Responders Assured** The committee was assured by the processes in place to ensure adequate DBS records for co-responders. **Medical Equipment Partially Assured** The committee received a paper relating to the maintenance of non-medical equipment, including the process of checks and where this is recorded and audited. In the context of missing equipment being the third highest reason for a reported incident in the annual incident report, the committee asked for evidence of the workshop equipment checks including bariatric equipment once the data is available on the new fleet management system. 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 three specific aspects of the overarching EOC improvement plan; 1. Dispatch – the committee was updated on the different work-streams. There is an ongoing peer review of dispatch to help establish where improvements can be made, including the apparent disparity between East and West. 2. Call Handling – good assurance was received by the positive impact of EMA recruitment and improved retention. The fragility of hours, including abstraction rates was explored; the committee asked WWC to pick up the issue of EMA abstraction to ensure better sustainability of hours. Overall, the committee felt there is good understanding of issues and with the

improved data available this helps to ensure targeted corrective action.

3. Clinical Capacity – there is continued progress being made in increasing clinical capacity, although there is a greater challenge in the East, compared with the West. The committee explored how management looks to mitigate the risks where gaps exist.

Although the committee received good assurance on call handling, EMA recruitment in particular, it was partially assured when taking all three areas together.

Consent to Treatment Partially Assured
The central issue here for the committee was whether consent to treatment is being sought in line with legislation and guidance. An honest appraisal was provided by management, which confirmed that it could not currently provide full assurance largely on the basis of the gaps in some patient care records. The actions taken to address this were set out in the paper and while the committee therefore could not be fully assured consent is always obtained, it was assured with the plan in place which focusses particularly on the benefits of the new ePCR..

SRV Trial Dispatch Model Assured
The committee was updated on the outcome of the pilot to introduce the targeted dispatch model and was assured that the process and planning for the trial had been appropriate. It noted that the model appeared effective where resources matched demand, but as soon as this balance was not met the benefits were not realised. In other words, it helped to clarify that it is about having not just the resources/hours, but ensuring they are allocated in the right places and the right time. The pilot did demonstrate that SRVs have a role to play, but predicated on the right skill mix being in place.

Operating Model Adjustment / Key Skills Assured
This paper clearly articulated the context of some of challenges that exist to ensuring timely response to patients. It helped to highlight the root causes, relating to gaps in rotas and its impact on performance during specific times of the day and week. A range of actions have been agreed, one of which was to look at where hours are lost, e.g. abstraction. This led to a decision to re-phase key skills so that it is delivered through the year, rather than 90% by the end of Q2, as has been the case in the recent past. The committee noted the immediate impact of this on the better utilisation of hours from the end of June. It also noted that the senior operational leadership team has been tasked with providing a plan to deliver key skills by March 2020.

In summary, the committee was assured that the management actions taken in testing conditions are well thought out and based on good evidence. The committee requested a management response to provide further assurance on how key skills will be delivered throughout the year to ensure patient safety.

The Committee also referred the matter of supporting policies to WWC and has requested a scrutiny paper in September to provide assurance on how we ensure the right staff are working at the right time to deliver safe care.

	The committee also noted the importance of effective engagement and communication with staff on changes of such significance. **Medicines Governance** **Assured** The committee received the quarterly report setting out the outcome of the inspections undertaken in the period. It explored some of the issues arising from Q4 and two main concerns related to tagging (leading to a risk that staff take pouches that are incomplete) and completing paperwork. The committee was however assured with the continued good progress and the comprehensive action plan that is in place. **Medicines (Drug Losses)** **Assured** This was referred by the Audit Committee and the paper provided a clear and comprehensive analysis of the issues. Having experienced issues with temperature control last summer, the committee was pleased to note that the Trust is the first in the country to bring in an automated temperature control system, which is working well. With regards to lost and missing drugs, plans are currently progressing, working with other ambulance trusts, to look into an electronic system which would provide the required level of track and trace. The committee also received a number of reports under its section on *Monitoring Performance*: **Incident / SI Annual Report** Overall the committee was happy with progress and noted that this seems to be a view shared by external stakeholders who provide much scrutiny of process and outcomes. Some feedback was provided on how to enhance the report, before it comes to the Board. **Vehicle Cleanliness Update** **Not assured** This paper confirmed that there continues to be issues with vehicle deep cleans. This is linked to vehicle availability and so the immediate mitigation is to focus on daily cleaning. The committee felt that the paper could have provided more concise information as there were lots of questions and issues arising. It has therefore asked for a scrutiny paper in Q3.
Any other matters the Committee wishes to escalate to the Board	None.

SECAMB Board

QPS Committee Escalation report to the Board

Date of meetings	18 July 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: **SI investigations Assured** Despite there being a backlog of open actions arising from SI investigations, which the committee will monitor until it is cleared, assurance was provided on the process in place to ensure agreed actions are taken in a timely way. The committee has requested a management response on the timeline to clear the out of time actions. **Key Skills Delivery Not Assured** This paper was requested in June, to provide assurance that key skills will be delivered by March 2020, following the decision to phase it across the year. The committee was not assured because the paper lacked sufficient detail demonstrating the current position and the plan(s) to deliver key skills between now and March. This led to a discussion about the likely risks, in the context of operational performance challenges, and the executive will bring an assurance paper to the Board in due course [*Tricia I have phrased like this as we need to await confirmation from the Chairman that he will now call a meeting in August*]. 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 Head of PMO provided a presentation on the overall programme of work, giving an update against progress with each of the objectives. The committee noted that this programme is under review with some aspects moving to business as usual and new objectives being developed. The committee confirmed its view on the plan to bring some of the areas in to business as usual which the executive will review and report to the Board in the usual way through the Delivery Plan. The committee also explored why despite exceeding the trajectory for EMA recruitment, call answer performance has in recent weeks deteriorated. A request was made for the executive to explain this at the July Board meeting when operational performance is discussed under the IPR. The committee was grateful for the really good overview and noted the assurance the executive is seeking to ensure sufficient confidence to move some areas in to business as usual. Going forward, the committee will review the key clinical indictors to inform how it will prioritise its focus in this important area. **111 Clinical Effectiveness Partially Assured** The committee received an overview of the effectiveness of the 111 service, noting some of the initial feedback following the recent CQC inspection. Specifically, the

	committee explored performance, which is on the expected improvement trajectory, but still not meeting contractual standards. The remedial actions aim to achieve the expected standards by the end of August 2019. There is a similar positon with audit, which expects to be back at the right level by Q3. The committee also explored why referrals to 999 are 2% above the national average and was assured that the 111 senior leadership team has sufficient grip and focus to reduce this within the next two months. A detailed review of the related 111 Service Delivery Improvement Plan is scheduled. **CFR/co-responder Administration of Salbutamol** **Assured** Ahead of the Board meeting, the committee discussed this paper, which recommends the use of salbutamol for CFRs and co-responders. While the committee supported this, it asked for a review of the paper, as it lacked some information, such as a third party view and confirmation that the rationale for recommending this is consistent with any other ambulance services who take the same approach. **SI Thematic Review** **Assured** The committee welcomed this overview of the themes arising from incidents, SIs, and complaints, and took good assurance from the processes now in place to ensure better triangulation. There were some examples where the data showed some spikes and / or variables across the OUs and the executive will ensure for future reports that these are explained. The committee also asked that some work be undertaken to map the complaints, incidents and SIs, by time of day / week. **Duty of Candour** **Assured** Assurance was received that appropriate action was taken to address the recent dip in compliance with duty of candour; we are now back to 100% compliance. The committee also received a number of reports under its section on *Monitoring Performance*: **Quality and Safety Report** This is a temporary report provided monthly until the new IPR is introduced. The committee confirmed its overarching view on what it would like from this, with relevant KPIs and data trends, so that the narrative report is then only by exception; this will ensure the committee focusses on the right areas. **QAVs / Patient Safety Leadership Visits** Management set out how the intelligence from these visits, plus the A&E leadership visits, is reviewed. Although work is still required to ensure better triangulation, an example was provided which demonstrated how this can work well; where concerns raised about a specific OU, concerns following a patient safety leadership visit and QAV, then during an A&E visit, was assessed against an increase in complaints and two serious incidents. This has led to the executive asking for an urgent review, which is ongoing. The committee acknowledged the benefit of the patient safety leadership visits for board members, in particular, and asked for more analysis of the outcomes of the

	QAVs, including themes and actions taken. **Risk Register / BAF Risk** The committee is assured that it has good visibility and focus on the most significant risks on the risk register. It will continue to keep this under review to ensure sight on any emerging risks. With regards the BAF risks under its purview, some feedback was provided which will be reflected in the version that is on the Board agenda.
Any other matters the Committee wishes to escalate to the Board	None

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	33/19

Name of meeting	**Trust Board**
Date	20th June 2019
Name of paper	Incident and Serious Incident Annual Report 2018/2019
Responsible Executive	Bethan Haskins, Executive Director of Nursing and Quality
Author(s)	Tam Moorcroft, Head of Patient Safety Colin Taylor, SI Lead Catherine Bell, Serious Incident Analyst Benjamin Bartlett, Datix Manager
Synopsis	The attached report highlights the incident and serious incident activity during 2018/2019; it highlights the challenges and successes, key actions that have taken place and those that have been identified for the year ahead. The report also elucidates the lessons that have been learned from certain incidents and how they have been implemented to prevent incident reoccurrence.
Recommendations, decisions or actions sought	The Board is asked to review the report and the progress made during the past year.

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

Contents

1.0 Introduction

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) endeavours to always ensure patients, staff and the public are safe when in our care, and that the quality of the care they receive is consistently at the highest possible standard. However, even with the best of intentions, inevitably sometimes things go wrong, and occasionally these incidents can lead to harm. SECAmb is committed to investigating incidents when they occur, to ensure causes can be identified and learned from to improve practice and reduce the likelihood of a recurrence.

The purpose of this report is to provide an overview of all incidents and their associated workstreams, that were reported during the period of 1st April 2018 to 31st March 2019. The report will explain the route incidents can take to be investigated, depending on their severity, and the processes that underpin this, it will also highlight any notable themes and explain any actions that were taken to mitigate risks relating to them.

To ensure a holistic representation, and meaningful reflection of the last year's work the report incorporates incident reporting, escalation, investigation, Serious Incidents, the Duty of Candour and the management of alerts received via the Central Alerting System, as many of these alerts are generated because national themes of incident occurrences has been identified.

It is mandatory, and an intrinsic component of patient safety for all NHS Trusts to report near miss and actual incidents. SECAmb's risk management and patient safety management system is the web-based version of Datix; all incidents, serious incidents, complaints, compliments, CAS alerts, risks and litigation claims are captured on, and managed within the system. This enables SECAmb to identify and manage risks effectively and efficiently, utilising all the available elements.

2.0 Definitions

Incidents can be defined as any untoward or unexpected event that interferes with the orderly progress of day to day activity; and may have (but not necessarily) led to harm to individual(s) or damage to equipment or property. A near miss incident is an event that could have resulted in an incident but did not, either by chance or well-timed intervention.

Serious incidents (SI) are those incidents where the potential for learning is so great, or the consequences to the affected person(s) / organisation are so significant that they warrant a deeper investigation and response.

Never Events (NE) are SIs that were wholly preventable, because the existence of national guidance or safety recommendations are in place to provide barriers to their occurrence. If a never event occurs, it essentially means that guidance has not been followed.

The statutory **Duty of Candour (DoC)** relates to the necessity for the Trust to be open, transparent and inclusive with patients and their families when an incident has occurred, which has led to harm of a moderate or higher degree.

When **harm** is considered it is pertinent to the harm SECAmb are attributable for, not explicitly the outcome for an individual. Harm is categorised the following way:

- Near miss – a prevented incident
- No harm – incident occurred but resulted in no harm to the individual(s)
- Low harm – led to minor treatment of the individual(s)
- Moderate harm – led to further treatment, cancellation of planned treatment or surgical intervention for the individual(s)
- Severe – led to long-term harm or permanent injury to the individual(s)
- Death – led to the death of the individual(s)

The **National Reporting and Learning System (NRLS)** is a national function to which NHS trusts are mandated to submit reportable patient safety incidents. A reportable patient safety incident is an incident that affected, or potentially affected a patient, and the cause can be attributed to SECAmb. Patient safety incidents that are recorded on behalf of another organisation are not reportable to the NRLS. The information gathered by the NRLS is used to both benchmark safety information for NHS trusts for learning purposes and significantly aids the development of safety alerts with NHS Improvement. The NRLS also provide incident reporting data to the Care Quality Commission (CQC).

The **Central Alerting System (CAS)** is a web-based cascading system; it is utilised to issue patient safety, medical device and drug alerts and other safety critical information. Alerts contain background information on why they have been issued, including the related risks and incidents that have occurred nationally and the actions that healthcare organisations must undertake to mitigate the risks and comply with the alert.

3.0 Incident Reporting

SECAmb insists that all actual and near miss incidents are reported onto Datix to aid the broader adverse event management, identity of risks, analysis of themes and the learning of lessons.

Acknowledging that a high incident reporting rate represents a healthy safety culture, improving incident reporting has been a key priority for SECAmb during the past two years, primarily working to ensure that staff understood why incidents are reported and what the information is used for. Previously an apparent culture of blame existed within the organisation and this undoubtedly impacted significantly on staff feeling safe to report incidents and/or to raise concerns. The targeted work to address this Trustwide, via many routes, including training by the Datix Team, encouraging messaging from the Executive Team and senior leaders, all in conjunction with SECAmb's Freedom to Speak Up Guardian has positively impacted the culture, which can be evidenced by the year on year increase in incident reporting, as shown below.

Fiscal year	Number of incidents reported
2016/2017	5906

2017/2018	7510
2018/2019	9216

Recognition by SECAmb that the incident reporting form was taking staff too long to complete, which added to the barriers to reporting, led to it being reviewed and improved during Spring 2018; a shortened reporting form and a more streamlined investigation form was introduced, which has also aided the increase in reporting.

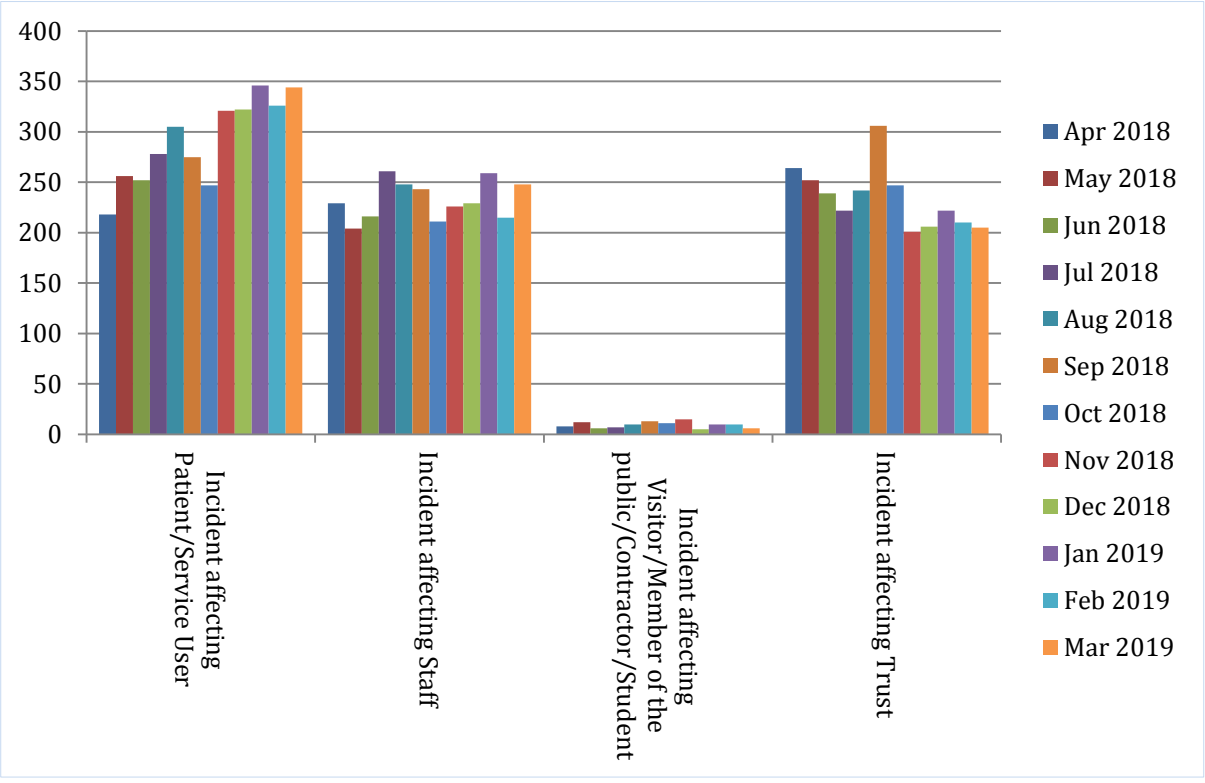
The increase in incident reporting could raise a question as to whether staff are getting better at recognising and reporting incidents and feel more confident in doing so, or whether more incidents are simply occurring. During 2007 research was carried out in the United States which found that on average only 5% of incidents that occurred in a healthcare organisation were reported; bearing this in mind, SECAmb can take some assurance that the incidents were likely to have been already occurring but were not being reported. Further assurance can be gained from knowing that of the incidents that were reported during 2017/2018, 5.7% of those were graded as moderate or above harm, whereas during 2018/2019 the number of incidents reported increased, but the percentage of moderate and above harm incidents dropped to 2.1%, leading to the belief that the majority of the more serious incidents were previously being reported, however the less serious incidents were not.

When reported, incidents are categorised as one of four types:

- Incident affecting a patient / service user
- Incident affecting staff
- Incident affecting visitor / member of the public / contractor / student
- Incident affecting Trust

The following graph demonstrates that each of the four areas have seen an increase. There is a slight drop towards the end of the year, but reporting early year suggests the drop was temporary.

Incidents reported by Type for 2018/2019

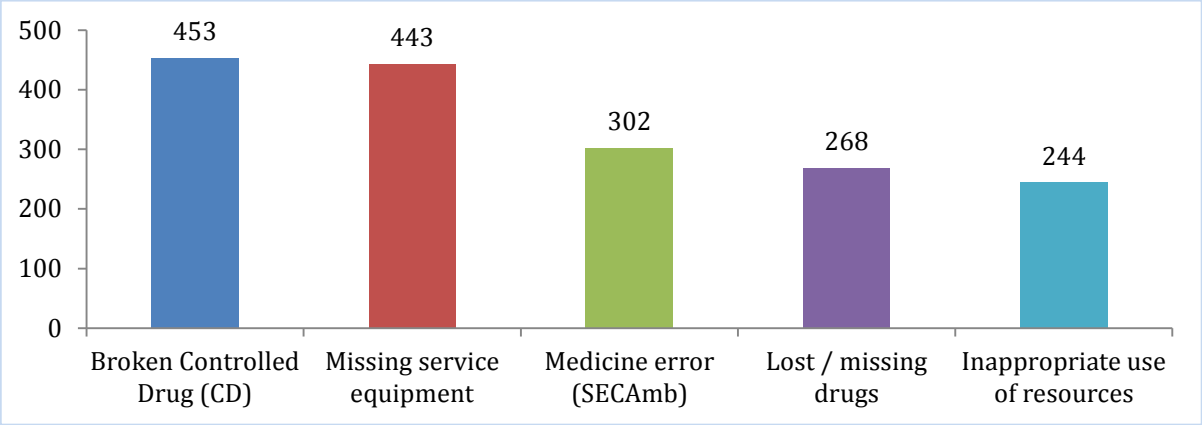


Whilst most incidents are unsurprisingly reported as incident affecting patient/service user, there has been a notable increase in reports submitted for incidents affecting staff and the Trust, which can be attributed to staff being better informed and more confident to report.

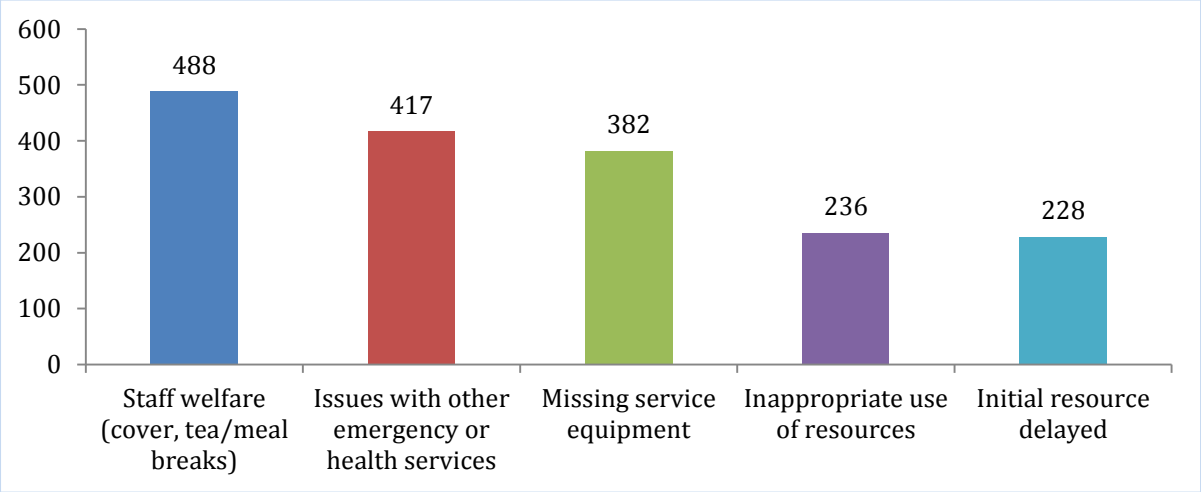
It is also imperative that SECAmb knows what category an incident relates to i.e. medication error, staff injury, delays to attending a patient etc. Incidents are reported against a category and a sub-category so the granular detail can aid the review and analysis.

The following two graphs show the shift of the top five reported sub-categories from 2017/2018 to 2018/2019.

Top five sub-categories reported during 2017/2018



Top five sub-categories reported during 2018/2019

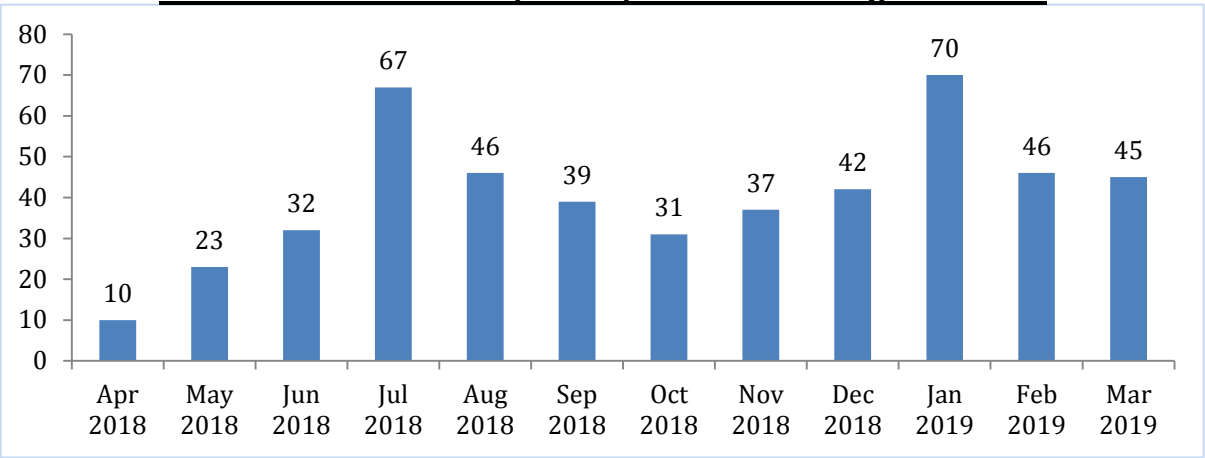


The previous year evidences issues relating to the management of medicines, with four of the five top sub-categories relating this this. Following significant targeted intervention and training the 2018/2019 top five sub-categories have no mention of

medicines issues; this echoes that the embedding of learning from incidents can have a positive impact.

Staff welfare, with an emphasis on missed meal breaks featured considerably during 2018/2019, with it being the top reported sub-category. The following graph shows the breakdown of when they were reported throughout the year.

Meal break incidents reported per month during 2018/2019



Incidents are recorded by the Emergency Operations Centre (EOC) for any crew member that has failed to have a meal break within their shift. There were 488 incidents recorded on Datix during 2018/2019, this is a 290% increase on 2017/2018 where 126 were recorded. However, PowerBI (SECAmb's business intelligence system) reflects 9867 missed meal breaks, highlighting that only 5% of those were recorded on Datix. The data displayed within Datix does not give the same outcome as the data displayed on PowerBI; 70 records were recorded in January, the highest number through the year, however, PowerBI states that January was close to average for meal breaks having been taken within time, with 50.87% (52.47% is the average for 2018/2019) and a better than average no meal break percentage 3.22% (3.81% is the average from 2018/2019). Data from July 2018 is in line with the data from Power BI with 5.91% of shifts not receiving a meal break and only 48.88% receiving them in the allotted window.

Acknowledging that crews not being able take their meal breaks was a concern led to the Meal Break Policy being amended for 8+ hour shifts in August 2018. This has positively affected 8+ hour shifts, with a reduction from 30.54% of shifts without a meal break in June 2018 to 19.93% in February 2019.

Missing service equipment was also identified as a significant theme across the year with 441 incidents reported during 2017/2018. However, during 2018/2019 missing service equipment dropped to third place, averaging 32 incidents reported per month. Whilst the number appears high, very few of them resulted in an adverse impact on clinical care; of the 382 incidents reported, one was graded as severe harm and was declared a serious incident, the rest were graded as low or no harm.

However, noting that the sub-category was too broad, in March 2019 missing service equipment was replaced with new sub-categories which examine specifically what

pieces of equipment are missing. This improvement will aid SECAmb to carry out targeted intervention during the year ahead.

During October 2018, concerns regarding SECAmb's satellite navigation systems (GPS) were reported on Datix by Thanet Operating Unit. Further probing identified that these may not have been isolated incidents, so a new code was added to Datix to trace any new incidents. Over the course 2018/2019 77 incidents were reported, 36 of those were reported in Thanet alone.

By February 2019 multiple incidents had been recorded across the Trust, two recorded during February 2019 were declared serious incidents as they potentially led to harm. Additional investigation into the reasons behind why these incidents were occurring was commissioned, and it was identified that in some cases crews were changing the settings to lorry mode. On testing it was found that this caused more difficulties and made the GPS system more likely to send an ambulance via an incompatible route. Unfortunately, it was also identified that crews could not be stopped from selecting this setting, so the following guidance was issued:

1. Make sure U-turn avoidance is turned off;
2. Double check the unit is set for fastest route;
3. Use local knowledge if appropriate and look at signs. Use major roads if the job is a long run, then the GPS for the final section;
4. MDT has maps with main roads, these should be considered when planning routes with distance to travel;
5. Zoom out of the Garmin map and see the route, if it's routing cross-country then use main roads to get to the town/village etc.;
6. The units recalculate very quickly so any veer-off route is soon back on track with a new route.

Since the guidance was issued the occurrence of GPS incidents has started to reduce, however it does remain a risk which is being closely monitored.

The Surge Management Plan (SMP) identifies certain categories of calls and patients where, due to a current high demand on SECAmb's service it is not possible to respond with an ambulance; these occurrences are now being recorded as incidents on Datix to enable the Trust to monitor them and identify if any 'SMP no-sends' have led to any adverse clinical outcomes. Also now being captured as incidents, are failed tail end audits. These incidents relate to EOC call audits that fail compliance. This is to ensure the concerns found within the audit are picked up and managed appropriately.

4.0 Serious Incidents

When it comes to SIs SECAmb endeavours to consistently undertake open, transparent and thorough investigations to ensure the root cause and any contributory factors of incidents are revealed, to enable the learning to be identified, shared and embedded for improved practice, and to reduce the likelihood of reoccurrence.

Although SIs are managed in accordance with NHS England's Serious Incident Framework, maintaining the process has been a challenge for SECAmb in the past. However, the last two years reflects an improvement journey, that whilst still ongoing, evidences significant improvement with the recognition and declaration of SIs, the management of the process and the quality of investigations and final reports.
The Serious Incident Group (SIG) is a multi-disciplinary group, chaired by the Executive Director of Nursing and Quality, it meets weekly to review all potential SI; these are identified from incidents and complaints recorded during the preceding week where the grade of harm has been reported as moderate or above; cases identified by the coroner where they have raised concerns about SECAmb and safeguarding / social services concerns. Once declared the SI is reported to the Lead Clinical Commissioning Group (CCG) via the Strategic Executive Incident System (StEIS). All elements of the SI are recorded within the Datix incident report. Of the SI declared during 2018/2019 81% were identified from incident reports, 15% from complaints and 4% from the other routes mentioned above.

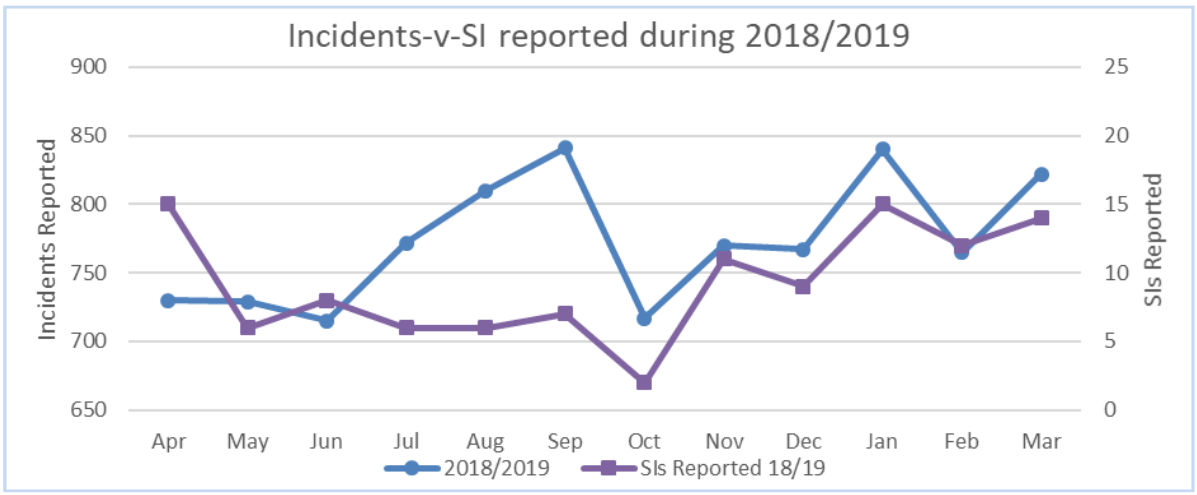
Areas of the SI process SECAmb has historically struggled with have been the allocation of investigation managers, the timeliness of investigation completion, the poor quality of investigations and final reports, which have all led to a poor submission rate. Multiple factors contributed to these deficiencies, however the key facets were an under resourced SI Team; a significant lack of trained investigators across the Trust; poor collaboration with the Operations directorate. Significant work has taken place to address these factors and although the impact is demonstrable, the full impact of the improvement will be more palpable in the 2019/2020 annual report, as most of the progress occurred very late in this year; however, it is noteworthy that SECAmb's CCG has openly acknowledged the progress made, and are satisfied that the Trust's SI management is heading in the right direction.

Approximately 140 staff were trained in root cause analysis (RCA) during 2018 and the SI Team has also become better resourced, with the recruitment of an interim SI Manager and SI Analyst during Summer 2018, and a substantive SI Manager in January 2019. A second substantive SI Manager is currently being recruited and will be in post during Summer 2019. The SI Managers have been able to support the newly trained investigators with their investigations and further develop their report writing skills. This has proved challenging as report writing is inevitably not always their forte, but the standards are improving.

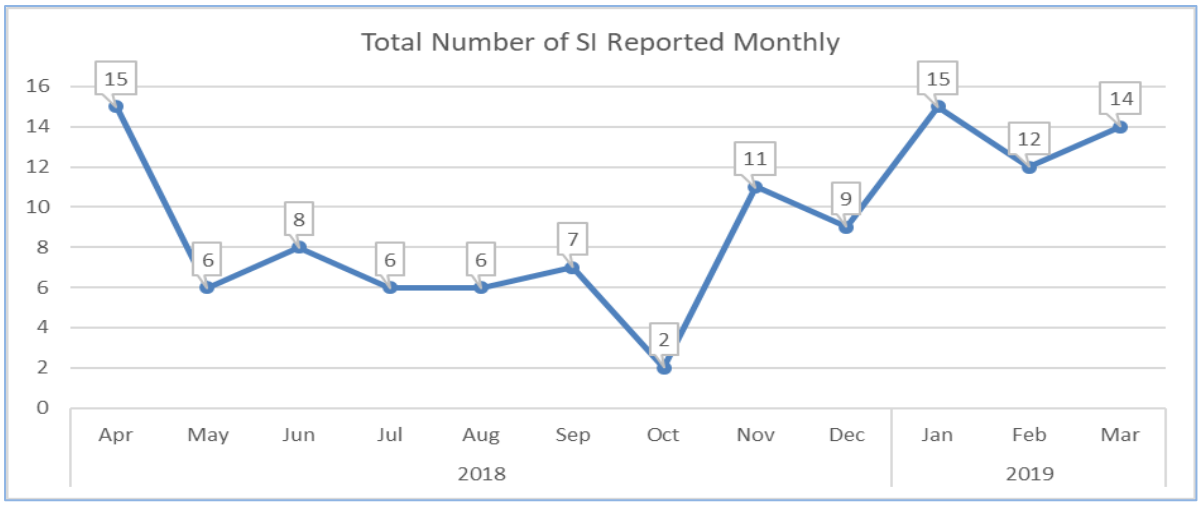
As of May 2019, the backlog of 50 outstanding SI, that were being intensively monitored by the CCG was cleared; prioritising this backlog has however, unavoidably led to a new, smaller backlog being formed; a realistic trajectory to clear this new backlog, without allowing another to form, is in place and is being progressed.

During 2018/2019 SECAmb declared 125 SI, however, once investigated it was agreed with the CCG that 14 of them did not meet the SI criteria so they were de-escalated from SI status; resulting in the net figure of 111 SI; this is relatively comparable to 2017/2018 when 99 were declared.

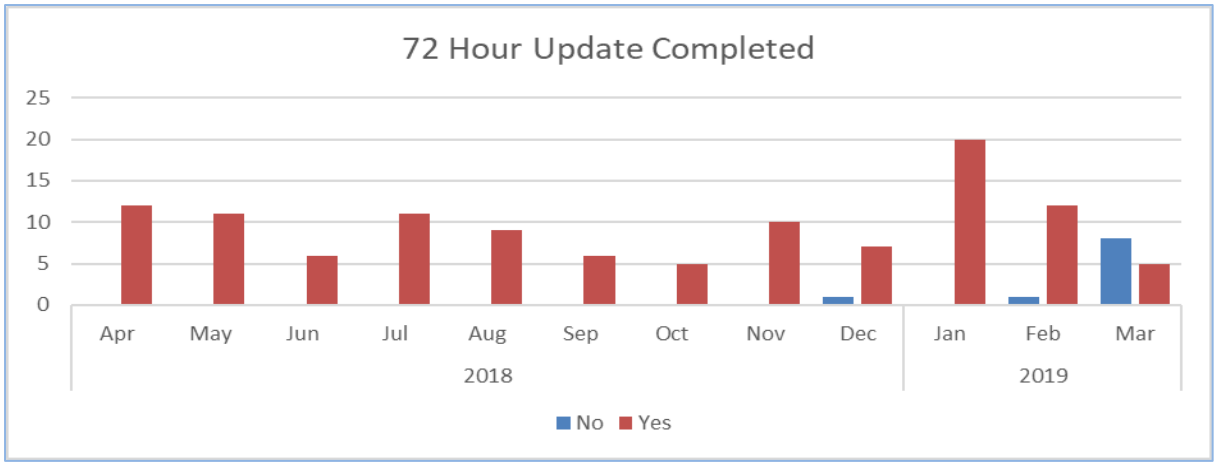
The following chart shows the number of incidents reported during 2018/2019 alongside the number of those declared as SI.



This chart breaks down the number, by month, of SI declared during 2018/2019.

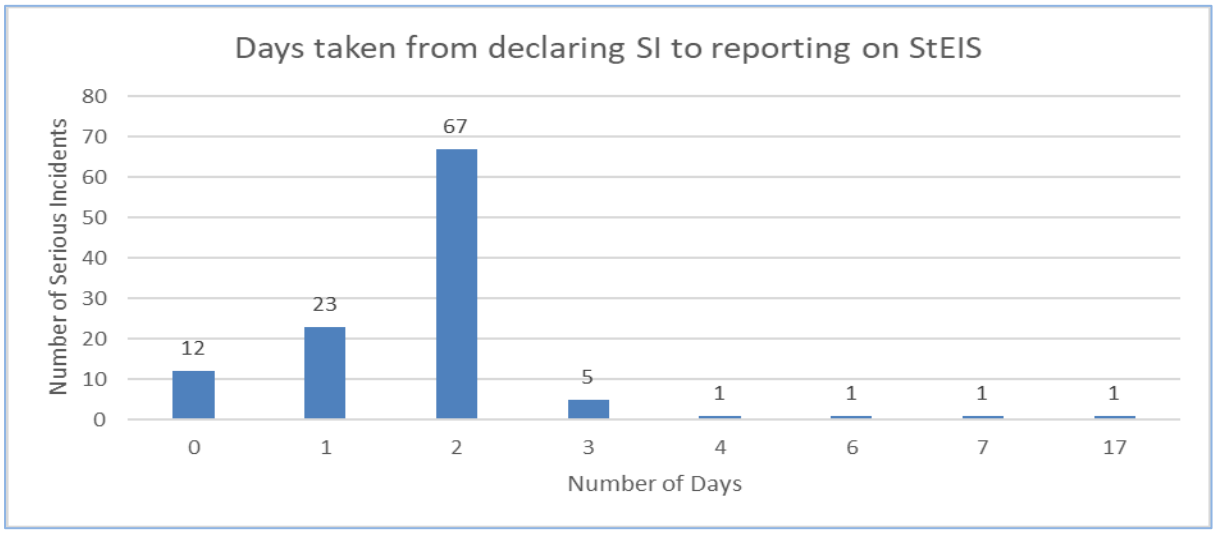


During 2017/2018 1.3% of the reported incidents were declared as SI, for 2018/2019 1.2% were declared. As stated in the above incident's section, the Trust's reported number of incidents has increased, however the number of the more serious incidents has remained relatively stable, reaffirming that the increase is likely to reflect an improved safety culture, as opposed to an increase in the occurrence of incidents.

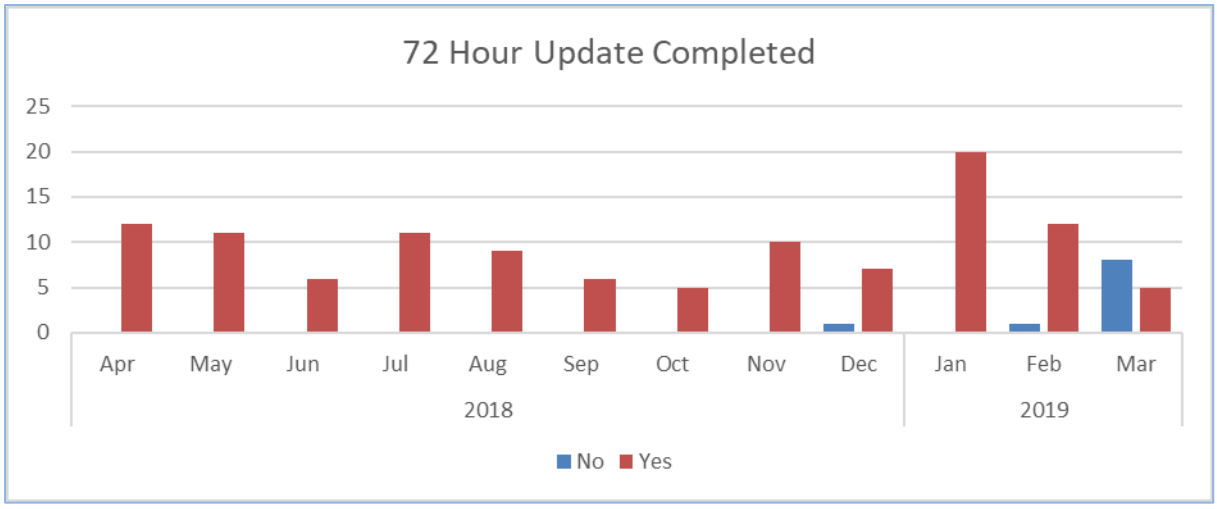


The SI Framework sets out clear timescales the Trust must adhere to for each declared SI, from their declaration on StEIS within 48 hours of identification, the submission of an update within 72 hours of the StEIS report, and the completion of the investigation and submission of the report within 60 working days. The following charts reflect the Trust's compliance with each of these standards.

102 SI were reported within the required timescale, reflecting a 92% compliance rate. Through the latter part of the year the issues preventing the timely declaration were addressed and has aided this increase in compliance. This will be monitored to ensure it is maintained in the future.



Generally, SECAmb is consistent with submitting 72-hour updates on StEIS, however for 8% of cases this deadline was missed; this primarily related to resourcing issues within the SI Team which have been addressed for the future.

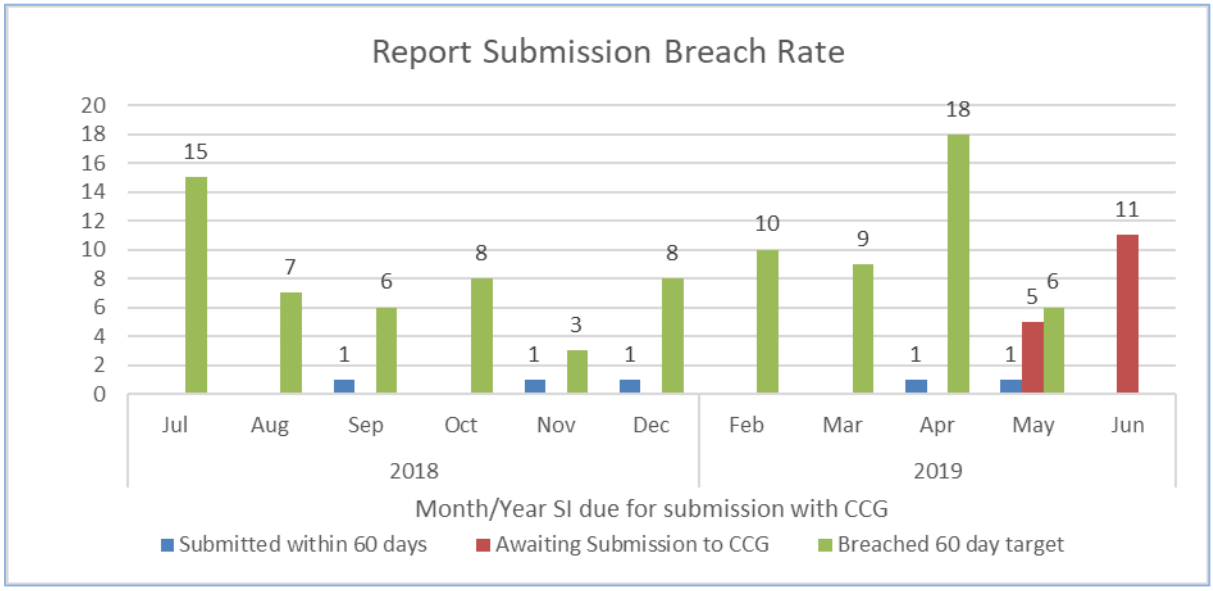


When declaring an SI on StEIS most NHS Trusts utilise the StEIS categories to analysis their themes and trends, however, for two reasons SECAmb uses internal categorisation for this; firstly, the StEIS categories relate more to acute hospital trusts, so are less informative for ambulance trusts, and secondly, SECAmb finds it more meaningful to align SI categorisation to the local incident categorisation, this enables better cross theming and adds more value to the analysis. The table below shows the breakdown for 2018/2019. Delayed dispatch/attendance is the highest reported category, followed by triage/call management, this correlates with the findings of analysis of both local incidents and complaints received. This triangulated data is used to identify themes for 'deep dive' analysis and is reviewed at SECAmb's Mortality and Morbidity Group, the lessons from which are shared Trustwide.

Serious Incident category (as per Datix)	Number of SIs
A&E	
Call Answer Delay	1
Delayed Dispatch / Attendance	14
Incident affecting Trust	1
Non-Conveyance / Condition deteriorated	5
Patient Care	6
Staff Conduct	4
Timeliness/Delay	1
Treatment / Care	4
Triage / Call Management	1
EOC	
Attendance Delay	2
Call Answer Delay	8
Delayed Dispatch / Attendance	22
EOC Systems	1
Patient Care	6
Timeliness/Delay	3
Treatment / Care	1
Triage / Call Management	10

HR	
Staff Conduct	2
KMSS111	
Delayed Dispatch / Attendance	2
Incident affecting Patient/Service User	1
Patient Care	1
Timeliness/Delay	2
Treatment / Care	2
Triage / Call Management	9
Trustwide	
Incident affecting Trust	1
Power/ Systems failure	1
Grand Total	**111**

At the time of writing of this report, of the 111 SI declared during 2018/2019, 90 of them had breached their submission deadline; 35 currently remain outstanding and are being managed via the previously mentioned trajectory. The following chart represents the breach rate for 2018/2019.



As previously elucidated, SECAmb was acutely aware of its challenges with investigating SI in a timely way, and prioritised diagnosing and addressing the issues. Actions to address these are either completed or in train; they include:

- Revision of the SI Procedure which has streamlined the previous version and focusses on SI Managers supporting investigators to complete the investigations and to write thorough reports. – **Completed**

- Better resourcing of the SI Team- two SI Managers are in post (one substantive and one interim (a further substantive role is being recruited to at the time of writing this report)). A further seconded SI Manager is also being recruited, to assist with the progression of the breached SI trajectory and to

aid the embedding of a new SI process. A substantive SI Analyst is also in post – **Partially completed**

- 140 staff trained in RCA during Spring/Summer 2018. This initially helped with available investigators but did not teach them how to write appropriate reports. The under-resourced SI Team did not have capacity to support the new investigators which led to them being anxious about writing reports and resulted in dis-engagement. SI Managers had to spend an inordinate amount of time re-writing final reports - **Completed**

- Better engagement with the Operations Directorate now helps with allocating SI to investigators; previous lack of engagement added to frustrations and blockages in the process – **Completed, but will be ongoing**

- Attendance of a Regional Operations Manager (ROM) at the weekly SIG meeting – **In place**

- SI Team attendance at the weekly Quality Improvement Hub conference call to update on SI status for areas and escalate any concerns – **In place**

- Since Spring 2019 a new RCA training course has been rolled out, which also includes Duty of Candour, Human Factors and report writing skills – **Ongoing**

- ROM have issued a directive for at least six staff per Operating Unit to be trained in RCA – **Completed**

- Re-design of the SI section on the Datix incident record; this will enable better reporting and internal monitoring of the status of SI – **Partially completed**

5.0 Actions from Serious Incidents

All SI investigations generate an action plan; the actions should work to address gaps identified within a service or care delivery and should, where possible, mitigate against a reoccurrence of the incident. Actions should always be SMART

Specific
Measurable
Achievable
Realistic
Timebound

Approximately a year ago the Trust identified a significant number of historic SI actions that had not been progressed. A plan was established to review, progress and close, where possible, all overdue actions, and a process for the management of future of SI actions was developed. The table below shows the status of the pre-2018 actions:

Row Labels	Count of Record name
Evidence Found & Closed	373

Execs to Close	1
Email Sent to Action Owner	11
To Be Reviewed	33
Reviewed	1
Grand Total	**419**

Actions generated from SI are now captured on Datix, and their progress is monitored by the most appropriate governance group i.e. the group for the area the SI was aligned to. The SIG also monitors the progress made with the actions.

6.0 Never Events

There were no never events reported by SECAmb during 2018/2019.

7.0 Duty of Candour

The Statutory Duty of Candour (DoC) became legislation in November 2014. It is invoked when a reportable patient safety incident occurs, where the level of harm was to a moderate or higher degree. The Duty insists that NHS Trusts will communicate with patients and/or their families about the incident within ten days (or as soon as is practicable) and apologise, this should also be confirmed in writing, along with the details of a point of contact should they like to do so. Patients and/or their families should be invited to raise any specific elements they would like to be included in the investigation and should be kept informed throughout the process. The final element of the Duty is for a meeting to take place with the patient and/or their families to discuss the findings of the investigation.

During 2018/2019 SECAmb's Duty of Candour (DoC) compliance was 82%; this is measured on whether a conversation with an affected patient and/or their family took place within ten days of the SI being declared. Of the 111 SI declared, 106 invoked the statutory duty. DoC was undertaken for the remaining 18% but this was completed outside of ten days.

The process to complete DoC has undergone some changes during the past year, some of which have been more effective than others, which led to the drop-in compliance. However, SECAmb is confident that the current process is robust and moving forwards will aid the achievement of 100% compliance.

8.0 Central Alerting System

SECAmb is committed to embedding learning identified from external routes, the most notable of which is the Central Alerting System (CAS).

Until August 2018 CAS was managed by the Trust's Health and Safety Team but noting how key the alerts are to patient safety as well as wider safety management, the function was transferred to the Datix Team. The Team immediately developed and utilised the safety alerts module on Datix, to ensure the existence of a central repository for all alerts and the evidence of implementation.

Alerts are developed and issued by NHS Improvement, NHS England, Medicines and Healthcare Regulatory Agency, Chief Medical Officer (CMO) or NHS Estates and Facilities. Upon receipt of an alert via CAS, and after an initial assessment by the Datix Team, it is cascaded to the most appropriate leader in SECAmb for ongoing review, dissemination and implementation of actions. Alerts will relate to medical devices, patient safety, field safety notices, drug alerts or CMO alerts. Many alerts are more acute hospital specific and not relevant to ambulance trusts and can be closed immediately after initial review, however there are still many that are more generic and relate to medications or equipment that are relevant.

During 2018/2019 eighty-two alerts were received by SECAmb, 100% of them were actioned and closed within the prescribed deadline. To provide assurance for this report a random sample of seven alerts were selected and evidence reviewed to assess their suitability for closure; the evidence did support the closure of these alerts.

9.0 Learning Lessons

Amongst the different sections of this report there are numerous examples of lessons that have been identified during the past year, and beyond in some cases, however, for the ease of the reader and to assist SECAmb to both continue to improve and to celebrate the improvements already achieved, it felt appropriate to collate the various elements into one section.

The regular occurrence of incidents relating to medicines governance and management was identified to be a significant issue during the previous year and early this year, and whilst most of these resulted in no harm, and only 2.5% resulted in low harm (2018/2019) there was a potential at any time for an occurrence that would cause substantial harm to patient. To prevent this from happening the incidents were analysed, the common issues extracted, and the lessons identified. The lessons these incidents generated led to targeted work to change existing poor practice and strengthen good practice. The improvement work in this area, to embed lessons learned was paramount in significantly reducing SECAmb's medication risk to patients.

Ambulance crews receiving their meal breaks is not only their entitlement and key to ensuring they are rested and sustained for the rest of their long shifts, but not being able to take them can have an enormous impact on their morale and ability to manage their busy workload effectively and professionally, which could potentially lead to errors. Recognising the absence of meal breaks was theming high in incident reports and had been identified as a contributory factor on SI led to a more concentrated dive into the reasons why they were being missed and the subsequent consequences. Analysing the causes of the missed breaks and identifying the lessons highlighted an obvious requirement for a policy change to ensure staff could take their breaks, even at times of high demand. This policy change took place in August 2018 and has already resulted in a drop missed meal breaks.

Local incident reporting and SI exhibited a rise in issues relating to the GPS systems; crews were being directed via inappropriate routes or being taken to an area they could not access a property e.g. the back of a road. These incidents were

reportedly causing delays in attendance and in some cases were resulting in harm to patients. The investigation into the issue found key learning, that if immediately addressed could reduce, if not entirely halt the occurrences. Unfortunately, it was noted that many of the issues occurred because the settings on the GPS units had been interfered with and inappropriately changed. A directive was issued stating how the GPS units be set up and that they are not to be changed. A drop in the number of incidents reported for this category is already noted, however it remains closely monitored.

SECAmb's Mortality and Morbidity Group also works to identify themes to extract and share learning by carrying out deep dives into incidents, SI and complaints. Aside to those mentioned above deep dives have been undertaken for recognition of sepsis, patient re-contacts, delayed dispatch, telephone triage (999 and 111), hospital handover delays, Careline calls, business continuity and the care of children under the age of two. Where considerable issues have been identified from these deep dives it has led to or assisted with more targeted work, for example, the Hospital Handover Task and Finish Group.

To ensure the Executive Management Team are aware of any rising themes, and to aid the horizon scanning of potential concerns, a monthly SI theme report is prepared for the committee. The report highlights key themes identified from SI during the preceding three months. During the coming year, to ensure a holistic approach, it is expected this report will expand to also incorporate the themes identified from incidents and complaints.

10.0 Conclusion

2018/2019 reflects a year for significant development and improvement for SECAmb. There have still been pitfalls, but this is to be expected with any improving organisation, however, the incident reporting culture has demonstrably improved, evidenced by the increased number reported, and this is expected to continue. Plans are underway to improve the incident reporting system in the year ahead, to make it more accessible for ambulance crews on the road.

The SI improvement journey, whilst slow going, has gained significant traction during the latter part of 2018/2019; the progress has also been positively noted by the CCG. With the expanded team, better operational engagement and a robust RCA training programme SECAmb is optimistic that this will continue to improve.

The existence of collaborative working with other areas i.e. complaints, has strengthened the way SECAmb learns from adverse events, and the further development of the 'deep dive' process and presentation at the Mortality and Morbidity Group aids the wider sharing and embedding of learning.

Consistent use of quality improvement methodology will support further improvements and assist SECAmb to measure all progress, to analyse what is working effectively, what does not work and what requires further development.

2019/2020 is predicted to be an exciting year for patient safety in SECAmb!