South East Coast Ambulance Service NHS Foundation Trust

Extraordinary Trust Board Meeting to be held in public.

26 September 2019
10.00-12.45

Trust HQ, Nexus House, Crawley

Agenda

Item No.	Time	Item	Encl	Purpose	Lead
Introduction					
51/19	10.00	Apologies for absence	-	-	Chair
52/19	10.01	Declarations of interest	-	-	Chair
53/19	10.02	Minutes of the previous meeting: 29 August 2019	**Y**	Decision	Chair
54/19	10.03	Matters arising (Action log)	**Y**	Decision	PL
55/19	10.05	Board Story	-	Set the tone	Chair
56/19	10.15	Chief Executive's report	**Y**	Information	PA
Strategy					
57/19	10.25	Delivery Plan	**Y**	Information	SE
58/19	10.45	Integrated Performance Report / Committee Escalation Reports	**Y**	Assurance	SE
	11.40	**Break**			
59/19	11.50	BAF Risk Report	**Y**	Information	PL
60/19	12.00	Infection Prevention & Control Enabling Strategy	**Y**	Decision	BH
Quality & Performance					
61/19	12.10	Annual Safeguarding Report	**Y**	Information	BH
Workforce					
62/19	12.20	Workforce Race Equality Standard & Workforce Disability Equality Standard Report	**Y**	Information	PR
Governance					
63/19	12.30	Audit Committee Escalation Report	**Y**	Information	AS
64/19	12.40	Kent and Medway STP Transformation Programme	**Y**	Decision	BH
Closing					
65/19	12.45	Any other business	-	Discussion	Chair
66/19	-	Review of meeting effectiveness	-	Discussion	ALL

Close of meeting
After the meeting is closed questions will be invited from members of the public

Date of next Board meeting: 28 November 2019

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 29 August 2019

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

Present:

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

In attendance:

Paul Renshaw	(PR)	Director of HR
Janine Compton	(JC)	Head of Communications
Isobel Allen	(IA)	Assistant Company Secretary

Chairman's introductions

DA welcomed members to this extraordinary meeting. He thanks FM for her work as interim CEO.

42/19 Apologies for absence

Peter Lee	(PL)	Company Secretary
Tricia McGregor	(TM)	Independent Non-Executive Director

43/19 Declarations of conflicts of interest

The Trust maintains a register of directors' interests. TP declared that he was now employed by NHSE/I as Children Services Adviser, Transforming Care Programme. This would be added to the Register.

44/19 Minutes of the meeting held in public 25 July 2019

The minutes were approved as a true and accurate record.

45/19 Action Log

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

46/19 CQC Inspection Report Findings and Next Steps

DA advised that the Board was meeting today primarily to formally receive the Trust's CQC report.

DA, on behalf of the Board, noted the credit to the organisation and everyone in the Trust. He congratulated FM and the Executive Team, and thanked NEDs who had stuck with the Trust. It had been a pleasure to receive the report, although there were still issues to address. He thanked all staff for their hard work.

BH noted the improved rating from Requires Improvement to Good, and the Outstanding rating for the majority of our business, urgent and emergency care. Also, staff had received outstanding for the caring domain. They should all be incredibly proud of this. There were no regulation requirement notices. There were no 'must-dos' within the 999 report but one within the 111 report.

Of note were our Wellbeing Hub and the difference that was making to staff, our falls work, our handover work, our Paramedic Practitioner Hubs and Longest One Waiting vehicle, our Joint Response Unit and our medicines management.

There were four 'should dos' around EOC, all of which the Trust was already working on:

- Sufficient number of clinicians;
- Meeting call answer times;
- Recording of training in EOC; and
- Undertaking clinical welfare calls within the target time.

The 111 'must do' was related to meeting performance targets around call answer and abandonment. The Executive had agreed to bring this into its weekly scrutiny programme.

An action plan on the 'must do' was required by mid-September, but the Trust would submit and publish an action plan for all areas. The new CQC tracker would come to the September Board.

The CQC would now only have quarterly monitoring meetings with the Trust.

BH noted the great communications around this and thanked JC for her work on balancing the message of thanks without being complacent. JC noted that soundings had been taken to help decide on the approach. There had been positive coverage overall. It had been lovely to have so many messages of congratulation from partners. DA agreed that it had been quite a day, but it was recognised that there was more to do.

BH also formally noted that SECAmb had been removed from Special Measures.

FM thanked BH for her hard work on the CQC visits. She noted that staff were now able to feel like they work for a good trust. She also recognised those staff in support services who had worked hard behind the scenes.

JG echoed comments on the frontline leaders. The Board had taken the decision to enable frontline leadership to be protected from responding to calls, and the Trust was now seeing the dividend of that in providing support to their staff. He thanked the leadership teams in Operations for their hard work.

MW echoed the thanks and comments of others. He asked whether the Trust was investing the resources into the areas needed to make the rest of the improvements necessary. BH confirmed that there was money for full establishment in EOC, the issue was recruiting the numbers. MW noted that in this case, the improvement in performance was a sustainable one.

AR advised that he had been around the Board table for a while and this was fantastic news. One challenge faced was recognising concerns raised externally and taking action on them: the Trust was now responsive to this. We were now able to identify our own areas for improvement, and it was important to continue to

get this right when we were not under such scrutiny any longer. It was imperative that colleagues continued that self-scrutiny and improvement.

TP noted that the report found that perhaps we did not sufficiently capture the challenge in attracting high quality BME candidates to sit on the Board. TP thought we had strategies in place to do this but it was understandable that, looking at the Board, this was felt to be the case. DA concurred that this was important to address.

LB noted the importance of the issues in the report being known to us. This was a vast step forward.

The CQC action plan would go to QPS.

47/19 999 Performance

JG advised that the performance report highlighted the contemporary position with performance delivery, and the focus and scrutiny being put on delivery at present. It showed what some of the efficiency improvements had delivered. We had reduced our job cycle time by 2 minutes in a matter of weeks.

JG gave an overview of performance, noting improvements but there was more to do to meet targets, particularly for Cat 3 and 4 patients.

Our resources sent per incident was not far off that of the best ambulance service, which also helped us attend more incidents.

LB noted that meeting the targets in the week displayed was to be very much welcomed. JG advised that during earlier parts of the day, Cat3&4 were also met but this tended to slip later in the day. JG felt that incentivised shifts were working in this respect.

LB noted that we have a target of zero for Non-Emergency Transport (NET) vehicles, but there was a level of usage remaining. JG advised that the Red Cross were a private provider which used non-clinically qualified crew so were classed as NET for reporting purposes. While SECAmb did not want to use our own crews for this, a targeted dispatch model was still our aspiration.

LM asked what had driven down the job cycle time, to be assured that it was a sustainable improvement. JG advised that a tactical performance cell was now on duty every shift to support crews involved in longer cases to aid decision-making. This would be sustainable once the operational restructure was completed.

FM noted that there were other issues where continued work with partners was needed, including hospital handovers. There was a national adviser visiting challenged hospitals across the country to look at improving handover times. We must also tighten up how we lose hours waiting for GP call-backs (average 19 minutes' wait). The ePCR will allow us to capture these delays across the patch.

AR had noted the 1% reduction in the number of resources sent meant the equivalent of 30 WTE staff back on the road. This was powerful for communications internally and externally. SE noted that we do this for handover WTE lost. AR would expect staff would find these types of statistics motivating.

On call answer times, the 90th percentile was lower than the mean time, which implied some incredibly long waits. AR asked for assurance that this was being focused on. JG provided reassurance and noted that a tail audit was undertaken in respect of patient harm on the longest calls. There had been no SIs as a result of a long wait.

MW congratulated JG, he asked for assurance that the short-term decisions taken to improve performance did not have longer term consequences that may need to be remedied later on. Were we taking a medium to long-term view, for example on abstraction and training, and the incentivised payments scheme? JG believed we were not doing anything that would be difficult to unpick. On payments, incentivising these shifts was cancelled out by overtime previously and also may lead to income due to responding to more patients.

DH advised that the Trust was prioritising patient care over efficiency, but over time as we became more efficient in the right ways, the system may work more efficiently e.g. around GP call backs.

MW noted that the figures showed an aggregated position but queried whether there were pockets that were less improved. JG noted that there were some OUs working more effectively than others. MW would like to see the breakdown of this detail from time to time.

DA thanked JG and the staff for the improvements. The key was to sustain it and sense variation when needed and adjust as relevant.

JG then presented the national ambulance comparator performance. AR was pleased to see these figures and would like to see and discuss them frequently. SE suggested this be included in the Integrated Performance Report.

Action
Include national ambulance comparators within the IPR.

48/19 Use of Salbutamol

RQ introduced the paper. He explained the purpose of salbutamol and how it could be life-saving. He noted the complexities in relation to the use of this by volunteers and had reviewed the governance, considered other Trusts' activities, and thought-through training. The Quality and Patient Safety Committee had been considering this and Non-Executive Directors had submitted useful and insightful questions. He acknowledged that Community First Responders were eager to begin using it, but it was important to address the concerns.

DA advised that the areas of concern could be summarised as:

- A request for third party assurance from CQC, commissioner;
- Understanding what other Trusts are doing; and
- Clarity around the level of training given to match those already doing it and inspected by the CQC as outstanding.

The paper presented had not clearly addressed these concerns.

TP added that he was concerned about volunteers who were clinically qualified but when administering salbutamol would be outside their scope of practice in a voluntary capacity. This point needed to be clearly answered. BH agreed.

LM would like to see more clarity in how we utilised volunteers. AS noted that the law was not preventing us from doing this, so if the concept was approved by the Chief Medical Officer, it was fine to go ahead. DA was clear that at one level it looked straight forward but we did need to clarify the serious queries raised.

MW would like to see more analysis of the inherent risks and some quantification of them: perhaps West Midlands Ambulance Service had taken their decision to use salbutamol with this cohort of volunteers based on some analysis.

FM advised that salbutamol was used within Staffordshire by CFRs in West Midlands, it was also used by St John as well so we had two comparators.

The Quality and Patient Safety Committee would meet on 9 September and make a decision on behalf of the Board.

Action
Salbutamol assurance would come to QPS on 9 September.

AR stated he would like the full Board to make the decision. DA would seek to ensure that any NED who submitted questions was involved and received information.

49/19 AOB

There was no additional business.

50/19 Review of meeting effectiveness

The meeting was deemed to be effective.

There being no further business, the Chair closed the meeting.

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
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	Q3 2019/20	Board	IP	SE updated that this will be reviewed as part of strategy review as aims and objectives will be amended.
24.01.2019	145/18d	Confirm to the Board the timeline and approach to developing the CFR / Volunteer strategy.	JG	28.11.2019	Board	IP	The draft strategy was consider by QPS on 09.09.2019 and some feedback was provided to help strengthen the strategy. This will be brought to the Board in November.
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	28.11.2019	Board	IP	The aim was to bring this in Sept but other priorities has meant that this will be deferred to November.
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	167/18	Paper to the Board in due course setting out the implications of the new national guidance on learning from deaths.	FM	28.11.2019	Board	IP	Update scheduled
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	21.11.2019	WWC	IP	On WWC COB for its meeting in November 19
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	30.01.2019	Board	IP	The Audit and Risk Committee had this scheduled for its meeting in Sept - to review the design and effectiveness of the various arrnagements in place, FTSU, Whistelblowing etc. It was deferred and no planned for December. An update will be provided at the Board meeting in January following the review by the committee.
25.07.2019	31 19a	RQ to confirm why the data in the July IPR is showing cardiac survival is down 8%.	RQ	26.09.2019	Board	IP	Verbal update to be provided at the meeting on 26.09.2019
25.07.2019	31 19b	The Executive to confirm the root cause of the decline in hand hygiene and through QPS Committee set out the steps being taken to address this.	BH	21.11.2019	Board	IP	
25.07.2019	31 19c	As part of the review of the IPR, national comparators will be included for hospital handover delays, to show how we compare with other parts of the country.	SE	21.11.2019	Board	IP	Considered as part of the ongoing review.
29.08.2019	47 19	Include national ambulance comparators within the IPR.	SE	26.09.2019	Board	C	Included in the IPR - item 58-19

29.08.2019	48 19	Use of Salbutamol assurance would come to QPS Committee on 9 September.	FM	09.09.2019	QPS	C	Received on 09.09.2019 and a decision made to reintroduce the use of salbutamol for CFRs and Co-Responders with a review after 6 months

Key

	Not yet due
	Due
	Overdue
	Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	56-19

Name of meeting	Trust Board
Date	26.09.2019
Name of paper	Chief Executive's Report
Executive sponsor	Chief Executive
Author name and role	Philip Astle
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 Trust's key activities and the local, regional and national issues of note in relation to the Trust during July and August 2019.

2. Local issues

2.1 Changes at Board level

2.1.1 On 1 September 2019, I joined the SECAmb team as Chief Executive Officer.

2.1.2 I would like to put on record my gratitude to Fionna Moore for doing such an excellent job as Acting Chief Executive Officer during the past six months. Her commitment and leadership enabled the Trust to make real progress during this period.

2.1.3 The process is now underway to recruit a substantive Director of People & Culture and I am very pleased to hear that there has been significant interest in this role. An interview and assessment day is scheduled for 21 October 2019.

2.1.4 Ahead of this, Paul Renshaw continues to cover the role on an interim basis and will remain with the Trust until a permanent appointment is made.

2.2 Executive Management Board (EMB)

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

2.2.2 As part of it's weekly meeting, the EMB regularly considers quality, operational (999 and 111) and financial performance. It also regularly reviews the Trust's top strategic risks.

2.2.3 During recent weeks, the EMB has focussed on a number of key issues, including:

- Closely monitoring the Trust's response time performance and delivery of the Performance Improvement Plan
- Overseeing the work underway to prepare for the new NHS 111/CAS contract

2.2.4 The latest meeting of the Resilience Committee also took place on 28 August 2019. The key agenda item for discussion and considerations was planning for the UK's exit from the EU and the impact on SECAmb (see below).

2.3 Care Quality Commission (CQC) report

2.3.1 On 15 August 2019, the CQC published their most recent report on the Trust, following their inspections in June & July.

2.3.2 This saw the Trust receive an overall rating of 'Good', with Urgent & Emergency Care rated as 'Outstanding' overall, including 'Outstanding' for Caring. Each of the CQC domain areas were rated as 'Good' individually and our NHS 111 service was also rated as 'Good'. It was also extremely heartening to see many areas of good and outstanding practice within the Trust recognised by the CQC in their report.

2.3.3 Following the recommendation made by the CQC, we were subsequently informed by NHS Improvement that they had also decided to take the Trust out of Special Measures.

2.3.4 It was heartening to read that the fantastic progress that has been made during the past few years has been recognised. Although I've not been with the Trust very long, I can already clearly see the areas of excellence highlighted by the CQC and appreciate the effort and commitment from all staff into making these improvements.

2.3.5 We know that we have areas on which we need to continue to focus our attention but I am confident that can build on this improvement and continue our journey of improvement.

2.4 Operational Performance

2.4.1 Further to previous up-dates, the focussed work to improve our response to patients, especially to our less seriously ill and injured patients & to improve our 999 call answer performance, is continuing and is closely monitored on a daily basis by the Operational Leadership Team and by the Executive Team on a weekly basis.

2.4.2 During the past three months, we have been supported in this by the NHS national performance team. As well as scrutiny of our own performance, the national team have also looked closely at regional system issues, particularly hospital handover delays.

2.4.3 As part of our improvement work, we have established an Operational Strategic Hub, which has allowed us to tightly manage delivery of our Performance Improvement Plan, including:

- Taking a more proactive approach to planning the resources we need to match demand
- Targeting overtime to when it's most needed
- Ensuring we are making the most efficient use of the resources we have available, without impacting on the care we provide to patients, for example, by paying close attention to the number of vehicles we send to incidents
- Working with our system partners to ensure we are working effectively together, including ensuring our staff can access support if needed from other healthcare professionals without significant delays

2.4.4 As you will see from the detailed performance information presented to the Board, we are now seeing real improvements in our performance in all categories,

especially in our Category 3 response, where we had previously seen unacceptably long waits at times.

2.4.5 However, we still have a long way to go to hit all our performance targets consistently and we are not yet resilient enough to withstand peaks in demand, as we saw recently around the August Bank Holiday period. However, I have been encouraged by the improvements and will ensure that the focus continues.

2.4.6 Our 111 performance is close to the national average and so we have plenty of room to improve there as well and we need to keep trying to improve our 111 to 999 transfer rates particularly.

2.5 Operational re-structure

2.5.1 A key piece of work that has been on-going during recent months has been Phase One of the Operational Leadership re-structure. This has seen the re-design of the senior leadership team structure, with the aim of strengthening governance, increasing resilience and introducing clearer accountability.

2.5.2 Following a robust assessment and interview process, I am pleased to confirm that the following appointments have been made, with a number of people already in post:

- Emma Williams will be joining the Trust on 30 September as the Deputy Director of Operations
- Mark Eley (Associate Director of Operations West) and Ian Shaw (Associate Director of Resilience) have both recently jointed SECAmb
- John O'Sullivan (Associate Director for Contact Centres and Integrated Care), Chris Stamp (Head of Emergency Planning Resilience & Response) and James Pavey (Head of Production and Workforce Planning) all took on their new roles on 1 September 2019, whilst Andy Cashman is joining the Medical Directorate Leadership Team, on a temporary basis, to provide advice and support to the Clinical Education Team

2.5.3 Phase Two of the re-structure, which will cover the remaining middle management layers, will commence in Spring 2020.

2.6 Clinical Education

2.6.1 On 31 July and 1 August 2019, the Trust underwent a two-day Ofsted Monitoring Visit, looking specifically at our apprenticeship training provision. This report was published by Ofsted on their website on 29 August 2019.

2.6.2 The results of this visit unfortunately showed that the Trust had made 'insufficient progress' in two of the three areas inspected. These findings, together with the results of a subsequent Peer Review commissioned by the Trust, have clearly shown that we need to take immediate action to address the issues identified.

2.6.3 We therefore agreed to undertake a planned, 6-week closure of our Clinical Education Department, during which we will be looking to undertake a complete re-

structure through consultation. This temporary closure will also allow us to undertake a thorough gap analysis before implementing immediate improvement measures.

2.6.4 The 6 week period began on 3 September 2019 and has seen us pause the delivery of the majority of our classroom-based learning. Following this pause, we are confident that, by working with our staff and utilising support from a range of external sources, we will be able to re-start delivery of a full programme of education and training.

2.7 ePCR (electronic Patient Care Record) roll-out

2.7.1 The roll out of our new eCPR continues to go very well. We now have several Operating Units online, namely Brighton, Chertsey, Dartford and Medway, Gatwick and Redhill and Guildford. In addition, Paddock Wood started their transition into go live on 2 September 2019.

2.7.2 Our remaining OUs – Ashford, Thanet, Tangmere & Worthing and Polegate & Hastings will all start to migrate onto the new system shortly and this should be completed by the end of October 2019.

2.7.3 I am very pleased that we are seeing good ePCR completion rates for what are still early days in terms of system usage. Thank you to our staff who have embraced the new platform so enthusiastically.

3. Regional Issues

3.1 NHS 111 service

3.1.1 On 7 August 2019, it was announced that our bid to provide the NHS 111 and Clinical Assessment Service (CAS) across Sussex, Kent and Medway from April 2020 was successful.

3.1.2 The contract, worth £18.1million in 2020/21, includes being able to issue prescriptions and have access over the phone to a wider range of Health Care Professionals such as GPs, Paramedics, Nurses and Pharmacists, who will be able to directly book people into urgent care appointments, if they need one.
3.1.3 We will act as lead provider with Integrated Care 24 (IC24) working in partnership with us to deliver key elements of the new service.

3.1.4 A great deal of work is currently underway as part of the pre-mobilisation phase, recognising that the new service to be provided from next year will differ significantly from 111 services provided previously by SECAmb.

4. National issues

4.1 EU Exit

4.1.1 Despite an uncertain national picture, we are still working extremely hard to plan and prepare for the potential impacts that the UK's exit from the EU could have on SECAmb and our ability to provide a responsive service to our patients.

4.1.2 As part of our planning, we have agreed mutual aid (for front-line ambulance staff & EOC staff) from the other English ambulance services, to provide us with additional resource and help us mitigate against the impacts of increased traffic congestion, if needed. We will have a team in place to ensure that these staff are properly inducted into SECAmb and supported during their time with us

5. Recommendation

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

Philip Astle, Chief Executive

19 September 2019

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	57-19

Name of meeting	Trust Board
Date	26 September 2019
Name of paper	PMO Delivery Plan Progress Update
Responsible Executive	Steve Emerton, Director of Strategy and Business Development
Author	Eileen Sanderson, Head of PMO
Synopsis	This paper describes the progress against the projects within the Delivery Plan, and is supported by the following appendicies; • Appendix A – CQC Tracker (2018) • Appendix B – CQC Tracker (2019) • Appendix C – Portfolio Timeline • Appendix D – DPB Dashboard • Appendix E – QCSG Dashboard • Appendix F – CIP Delivery Tracker • Appendix G – CIP Pipeline Tracker • Appendix H – HR Transformation update
Recommendations, decisions or actions sought	Information

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. The 2018 CQC Must & Should Do Tracker has been approved for closure at the Quality & Compliance Steering Group and is included in Appendix A for completeness.

2. Closure of the EOC Clinical Safety & Performance Project set up to address the 2018 CQC Must Do and 3 of the Should Do's has been approved by the Quality & Compliance Steering Group. This is now awaiting Executive Sponsor approval and will be formally closed during the next reporting period. Further information can be found in the body of the report.

3. A 2019 CQC Must & Should Do Tracker has been created (this can be found in Appendix B) following publication of the CQC Inspection Report in August 2019 which has resulted in the development of two new plans:

    a. Improve Operational Performance in 111.
    b. EOC Call Answer Performance.

    Further information can be found in the body of the report.

4. A fortnightly Transforming Clinical Education Programme Board has been established which will be chaired by the Executive Director of Finance to address the concerns raised by the recent Ofsted unannounced visit. Further details will be provided in due course.

5. Estates Programme:
    a. The Worthing Phase 1 Development has now completed and been handed over to operations. The project is expected to be formally closed during the next reporting period.
    b. NHS Improvement funding has now been approved for Brighton Make Ready. Over the coming weeks, a Project Board will be established to agree the project baselines and subsequently a project plan to ensure that the intended benefits and outcomes are achieved within the agreed timescales.
    c. Work is also commencing with the redevelopment of Sheppey Ambulance Station to increase capacity for staff, vehicles and driver training and in Banstead to provide a new Make Ready Centre for Gatwick and Redhill Operating Units.
    d. It is anticipated that once the Project Boards for the respective projects have been formally established, a more detailed update will be provided in the main body of the Delivery Plan.

6. The Service Transformation & Delivery Programme has transitioned to Business as Usual (BAU) and formally closed on 16 August 2019. Outstanding activities have been identified and documented as part of closure and BAU owners have been assigned. These outstanding activities will be monitored by the PMO and a review of progress will be undertaken at 3 months post closure. The Operational Lead is working with Operating Unit Managers to develop operational readiness actions plans to progress outstanding key objectives. Further information is detailed in the main body of the report.

7. An updated PMO Portfolio timeline is included in Appendix C which provides a clear snapshot of all the projects governed by the PMO along with projects that are in the pipeline.

8. The following change requests have been approved:

a. Cyber Network Upgrade projected end date extended from 2 August 2019 to 30 September 2019
b. EOC East project end date extended from 31 July 2019 30 September 2019.

The Impact of the change in timeline is explained in the relevant section of this report.

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 (also see Appendix D)
- Quality and Compliance (also see Appendix E)
- HR Transformation

1.2 In this reporting period, there is a Dashboard for Quality and Compliance and the Sustainability Steering Group. Service Transformation and Delivery Programme is now closed, so a Dashboard has not been produced for this reporting period. A dashboard for the HR Transformation Programme will be produced in the next reporting period once the projects move into implementation/delivery phase.

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.

1.5 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 RAG has moved from Amber to Blue as the project has transitioned into Business as Usual and formally closed on 16 August 2019. The Operational Lead is working with Operating Unit Managers (OUMs) to develop Operational Readiness Action Plans. The plans focus on recruitment and retention, efficient use of fleet, operational facilities and reduction of handover delays. All Operating Unit plans are scheduled to be completed by 13 September 2019.

Work has been initiated on the Trusts Power BI dashboard which will report on all the relevant KPI's as well as including benefits realisation charts. The newly branded Demand & Capacity Operational Readiness Plan (D&C ORP), along with workforce updates, will form part of the agenda on the Teams A Council chaired by the Executive Director of Operations.

3.0 Sustainability

3.1 **Worthing Ambulance Make Ready Conversion (Phase 1) –** The RAG project rating has moved from Green to Blue as the project has now been completed. The redevelopment of the site has supported improved operational capacity and enhanced the Trust's capability to deploy clinical resources. It will also enable the Trust to increase compliance with Infection Prevention and Control, Medicines Management and Health and Safety.

4.0 Digital Programme

4.1 **Cyber Network Upgrades** – The project RAG rating has moved from Green to Amber as SECAmb is experiencing delays in getting the VPN solution in place despite using third party resources and support from the vendor Microsoft. However, work continues, and progress is being made as the VPN solution is now working and next steps will be to fully test it within IT. The solution will then be deployed to all staff and enable SECAmb to decommission existing Telehouse Cisco equipment by end of September 2019. The Trust remains vulnerable to Cyber-attacks so it is necessary that the remaining works are completed to ensure effective Cyber Security is in place at SECAmb. The expectation is that the project will be formally closed in the next reporting period.

4.2 **ePCR** –The Project RAG rating has moved from Green to Amber from a project assurance perspective due to concerns raised by the project team regarding training uptake. The project team is currently looking at other innovative solutions to deliver interactive training which is not classroom based.

The RAG rating remains Green from a technical perspective as the system was successfully launched in the live environment. An external penetration testing took place in August 2019 to evaluate the security of the system and no major concerns were highlighted.

It has been highlighted that 2 serious incidents have been raised onto Datix as 2 crews have inputted wrong Data information in the ePCR form, which resulted in further system changes by our supplier to ensure no wrong information could be inputted into the system

Real time reporting is still to be delivered and due to be in place by October 2019 to assure the organisation that ePCR usage is being monitored. The phased roll-out will continue by OU, as follows:

1. Guildford, Gatwick & Redhill - 19 August 2019 – Now live
2. Paddock Wood - 2 September 2019 – Now live
3. Ashford & Thanet - 16 September 2019 – Now live
4. Tangmere & Worthing - 30 September 2019
5. Polegate & Hastings - 14 October 2019

4.3 **Replacement Fleet Management System** – The project RAG has moved from Amber to Blue as the project has now formally closed and has transitioned into business as usual. At project closure, not all historic data was transferred into the new system however a project manager is now onboard to work with Jaama (previous supplier) on how to import the data into the new Key-2 system. Ultimately a final back up of data will be taken and the legacy Fleet man system can be decommissioned – this is being monitored as part of BAU.

4.4 **NHS Spine Connect** – The Project RAG rating remains Amber. The system is currently being tested by EOC Systems team and testing will be completed by 20 September 2019. A change request will be submitted to extend the go-live date, which is currently end of September 2019, due to the project scope now including 111 and the additional requirement to develop a roll out plan to ensure a smooth transition to the live environment.

4.5 **Station Upgrades** – The project RAG rating has moved from Amber to Blue as the project has now closed with the 5 outstanding sites moved into business as usual. Since project closure, only 3 sites (Worthing, Banstead and Polegate) remain outstanding and a process is in place to closely monitor progress for the remaining sites through the IT managers meeting.

4.6 **East EOC –** The project RAG rating remains Green as the installation and migration of services to the replacement UPS and associated electrical cabling was successfully completed overnight on 25 June 2019. The project is on track to deliver the final element required to ensure that no failure of critical systems occurs at East EOC. It is expected that the project will be formally closed in the next reporting period

4.7 **Electronic Clinical Audit System (ECAS) –** The project RAG rating remains Amber as progress has been affected by connectivity issues at Paddock Wood. This risk has been monitored and resolved by an infrastructure upgrade at Paddock Wood. The change control process will be enacted to ensure that any impact with this delay has been considered and this will be continuously monitored at the fortnightly Task & Finish Group.

5.0 Financial Sustainability

5.1 **CIP –** The RAG rating for the Cost Improvement Programme remains Amber as at month 5, August 2019. The current pipeline schemes of £9.0m is on track to deliver the annual savings target of £8.6m. £6.4m of schemes have been fully validated and transferred to the CIP Delivery Tracker. This represents approximately three quarters of the annual savings target. The validated and scoped schemes of £1.1m are awaiting Executive Sponsor and QIA approval prior to moving to delivery. Positive engagement with budget leads continues to further the development and validation of schemes to achieve the remaining £1.5m "proposed" value on the Pipeline tracker.

CIP achievement for the five months ending August 2019 of £3.1m is £0.1m below plan. The shortfall is mainly driven by the difficulties in delivering the planned improvements in handover delays. Finance is working collaboratively with operations budget leads to scope alternative schemes to compensate for the year to date underachievement. The full year projected savings target of £8.6m is expected to be met, although this remains challenging. The CIP Pipeline and Delivery Tracker (Appendices F and G) provide more detail on the progress of the Programme.

6.0 Quality & Compliance

6.1 **EOC Clinical Safety & Performance** – The project RAG has moved from Amber to Blue as closure has been approved by the Quality & Compliance Steering Group (QCSG). This is now awaiting Executive Sponsor approval and will formally close during the next reporting period. All areas with the exception of Clinical Recruitment, NHS Pathways Audit and Rota Compliance have transitioned into BAU. Action plans have been produced for Clinical Recruitment and NHS Pathways Audit and are monitored by QCSG. The Safe Staffing (Rota Compliance) Action Plan will be developed and progress will be reported on in the next reporting period.

6.2 **Clinical Recruitment (Action Plan) –** The Action Plan is RAG rated Amber. Recruitment of Clinical Supervisor establishment is on track to reach the full establishment of 43 by 31 December 2019. There are 24 potential international recruits in the pipeline to begin employment by 30 November 2019, however, although they have been offered and are undertaking current clearance there is no guarantee that they will be successful. This is being actively monitored. There is a full establishment of Operational Managers Clinical.

The action plan is rated as Amber as there is an issue with recruitment of NHS Pathways trained Clinical Safety Navigators resulting in the need to recruit from the internal pool of Clinical Supervisors. Although Clinical Supervisors are currently being recruited and will be eligible to apply for the Clinical Safety Navigator role after 6 months in post; there is no assurance that they will be interested in this role. Again, this is being closely monitored.

6.3 **NHS Pathways Audit (Action Plan) –** The Action Plan is RAG rated Red. The consultation for the new staffing model for the Clinical Audit Team has been delayed due to a long-standing grievance within the team not having been resolved, this has had impact on compliance with clinical audit; the Interim Director of HR is pursuing this. Mitigations are in place to provide temporary cover for audit but compliance for clinical audit remains poor.

6.4 **Improve Operational Performance in 111 (Action Plan) –** This is the first reporting period and the Action Plan is RAG rated Green. There are 6 aspects to this plan:

1. **Daily 111 to 999 Reporting:** A sustainable downward trend in ambulance referral rate is beginning to be demonstrated.
2. **Ambulance Validation:** Validation for CAT 3 and 4 in accordance with NHSE directive has been successful, where it is identified 90.20% (6167 cases) were validated, with 62.27% of these resulting in a non-ambulance dispatch outcome (01/08/2019 – 31/08/2019).
3. **Average handling time (AHT):** Changes to agent scripts, and individual performance management, have delivered a significant lowering of AHT and, therefore, an increase in productivity and service level. The daily AHT is now significantly below 600 seconds each day.
4. **Staffing levels:** There is a full establishment of Health Advisors, Service Advisors and Clinical Advisors, however, the rota balance is not optimal particularly at weekends. The Health Advisors rotas will be reviewed in October 2019, using the

template provided by NHS England, in order to measure rota efficiency. The Clinical Advisors will be reviewed and recommended changes discussed with clinicians in January 2020.

5. **Abandoned calls:** Call abandonment rate has been significantly below the 5% NHSE benchmark.
6. **Calls answered in 60 Seconds:** The service achieved a monthly service level of 80.8% in August 2019. This was due to an effective and sustainable step-change in call AHT, and productivity. The service has outperformed the National 111 / IUC service level during the last fortnight of August (including the Bank Holiday weekend).

6.5 **EOC Call Answer Performance (Action Plan) –** This is the first reporting period and the Action Plan is RAG rated Green. In the first 12 weeks of 2019/20, 999 call answering was relatively stable, achieving the mean 10 out of 12 weeks, and the 90th percentile 11 out of 12 weeks. Since then there has been a period of inconsistency with 3 out of 10 weeks where the mean was achieved, and 4 out of 10 for the 90th percentile. A review from Association of Ambulance Chief Executives (AACE) provided a focus on key areas to be improved. An improvement trajectory sets a target of achieving the standards defined by the Trust by 2 December 2019.

An Action Plan has been developed and a Task & Finish Group established and scheduled to meet fortnightly. This group will focus on 4 key themes:

1. Management Information
2. Real time agent monitoring
3. Reduction of routine call activity
4. Availability of in line support

The Task & Finish Group will also monitor sickness and attrition rate which will have an impact on call performance.

7.0 HR Transformation

7.1 **Applicant Management System (TRAC) –** The project RAG remains Green. The project is on track and it is anticipated TRAC will be live during week commencing 28 October 2019. Implementation of the new system will improve both candidate and hiring manager experience. It will also support with increased compliance and process time. Once the system is live, the Trust will be able to generate a suite of reports using real time data. To ensure that the resourcing team and hiring managers are confident with using the system, the supplier will be providing remote support for a period of four weeks from the initial go live date.

A Task and Finish group has now been formally established which meets fortnightly to monitor and track progress against the project plan. Currently there are no risks or issues to report within this reporting period.

7.2 **Implementation of E-Expenses –** The project RAG remains Green. Implementation of the new system will improve the time currently spent on processing expenses and will reduce the number of payment errors due to manual input. ESR hierarchies have now been updated and testing has commenced. Over recent weeks, the introduction of the new system has been widely cascaded to staff and this will continue until the system is live to ensure that staff are aware of the change. A hotline within the Service Centre will be set up to support with queries post go live and this will be in addition to user guides and resources made available on the intranet.

The project is currently experiencing issues with reduced service centre capacity until early November 2019 due to annual leave and long-term sickness. This is being mitigated by a phased roll out across the Trust with an initial go-live for corporate staff currently based at Crawley HQ on 1 October 2019.

There is an additional risk of staff not engaging with the change. This is being mitigated by the creation of a communication plan and using the monthly Senior Leadership Committee to communicate the change to their respective teams. The Quality Improvement Hub will also support with the disseminating the change to operational staff. A Task and Finish group has now been formally established which meets fortnightly to monitor and track progress against the project plan.

7.3 **Implementation of E-Timesheets –** The project RAG remains Green. Implementation of the new system will improve the time currently spent on processing timesheets and will reduce the number of payment errors due to manual input. Currently the system is being tested to ensure the system interfaces with ESR and GRS with training planned for January/ February 2020.

At the recent Task and Finish Group, an issued was identified in relation to the Trust not having a Procurement Contracts Manager to support with the GRS contract. This is currently being looked into by the Procurement team with the view that a new Contracts Manager will be appointed in late September/October 2019.

There is an additional risk of staff not engaging with the change and as a result, staff not fully understanding the impact e-timesheets will have. The project team are working to mitigate this risk by ensuring that they continue with ongoing channels of communication and with the support of the Quality Improvement Hub to ensure that operational staff are aware of the impact of the introduction of the e-timesheets system. An issue has also been identified in terms of team capacity due to the departure of the Business Analyst. Arrangements have now been made to ensure that this gap is filled. With all the mitigations in place and the project being closely monitored, the project is on track and it is anticipated that the e-timesheets will be live in March 2020.

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

The agreed aim of the Culture Change work is that ‘Our people are 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 actions to deliver this will be completed by December 2019, and outcomes measured against results of the NHS Staff Survey 2020 published in 2021.

Work is also underway to simplify the current appraisal system (hosted on the Actus system) by September 2019 and then a plan is to be developed to have this hosted on the ESR system by April 2020. A longer-term plan to support culture improvement (phase 2) will be developed by 31 March 2020.

7.5 **ESR Manager Self Service -** Further options will be explored in coming weeks to review the best platform to implement e-forms. Reporting will cease until a preferred solution has been agreed.

7.6 **Implementation of the HR Structure -** The consultation period has now concluded, and recruitment is underway to recruit into the senior positions within the structure.

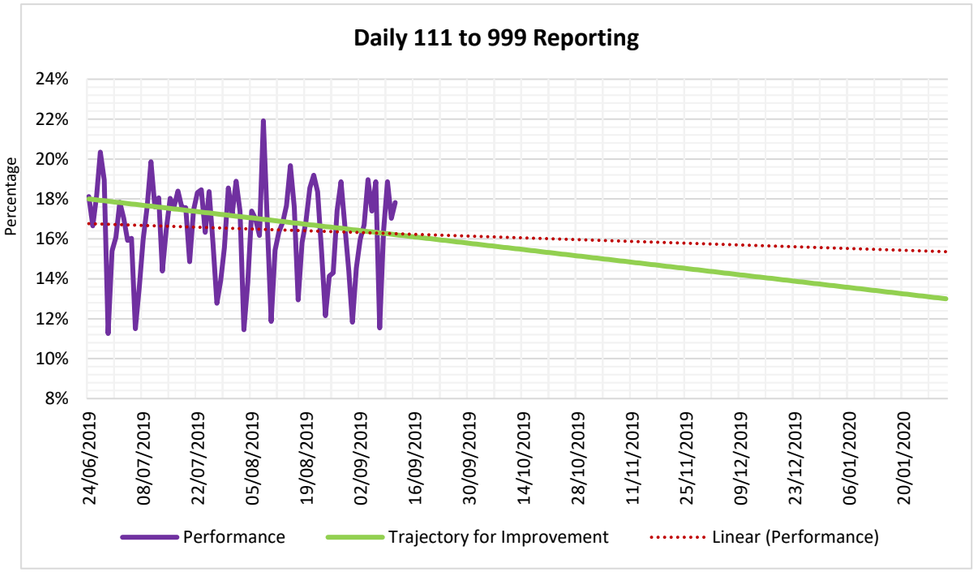
Domain	CQC Findings ('Must or Should Do')	Metrics / Governance Arrangements
Safe	The Trust **must** ensure that their processes to assess, monitor and improve the quality and safety of services and also to assess, monitor and improve the assessment of risk relating to the provision of the service are operating effectively.	The EOC Clinical Safety Project addressed this CQC Must Do. Within this, metrics and trajectories were set for key targeted measures to ensure effective monitoring and compliance for the provision of the service operating safely and effectively. Included within these measures were the following: 1. Clinical staffing required to fulfil EOC Clinical Activities – Target: 100% (Current: 75.9%). The weekly rota fill to meet clinical demand activities will form part of the EOC Safe Staffing (Rota Compliance) Action Plan which will be reported to the Trust Quality and Compliance Steering Group (QCSG) on a monthly basis, with monitoring and escalations also through the Trust Clinical Governance Group and Executive Management Board. 2. Identification of completed / Required Clinical Welfare calls for delayed dispatch – Target: 100% (Current: 32%). Going forward this will be monitored via EOC Teams B and Quality & Patient Safety (QPS) and reported monthly. 3. Surge Management No Send Audit compliancy – Target: 100% (Current: 98.2%) Going forward this will be monitored via EOC Teams B and Quality & Patient Safety (QPS) and reported monthly. 4. Tracking of all risks and issues through Datix, the Trust's Risk Management System. These are monitored via the EOC Teams B Meeting. Work was undertaken to look at the historic auditing of no send and clinical welfare calls and the weekly publication of the look back reports. This will be monitored via the NHS Pathways Audit Action Plan which will report into QCSG.
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 incorporated activities to review EOC clinical working practices, policies and procedures to ensure the efficacy of systems and processes to assess and mitigate patient risk within EOC. Included within this review, was the creation of new Trust quality assured procedures, policies and the review and implementation of key clinical bulletins to align and optimise EOC Clinical working practices. The current position is as follows: 1. Clinical Safety Navigator Procedure (100% complete) – published and live 2. Clinical Supervisor Procedure (100% complete) – ready for publication, awaiting upload to Trust intranet w/c 09/09/19 3. Clinical & Operational In-Line Support Procedure (100% complete) – ready for publication, awaiting upload to Trust intranet w/c 09/09/19 4. Crew Call Back Procedure (100% complete) – ready for publication, awaiting upload to Trust intranet w/c 09/09/19 5. Clinical Tail Audit Procedure (100% complete) – ready for publication, awaiting upload to Trust intranet w/c 09/09/19 6. No-Send Audit Procedure (100% complete) – ready for publication, awaiting upload to Trust intranet w/c 09/09/19 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) Outstanding procedures/bulletins have been incorporated into BAU and monitored via the EOC Governance Group and EOC Teams B.
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) was 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 was captured to identify efficacy of the role, development and support framework opportunities . Measures included the below: 1. Clinical Safety Navigator Substantive staffing levels – Target: 100% (Current: 50%). Outstanding activities have been included within the Clinical Recruitment Action Plan which is reported into QCSG. 2. Clinical Safety Navigator Cover 24/7 – Target: 100% (Current: 88.7% - due to sickness) Outstanding activities relating to recruitment have been incorporated into the Clinical Recruitment Action Plan which is reported at QSCG. Those relating to ensuring 24/7 cover will be included in the EOC Safe Staffing (Rota Compliance) Action Plan and will be reported to QCSG. 3. Identification of completed / Required Clinical Welfare calls for delayed dispatch – Target: 100% (Current: 32%) Welfare call compliance is monitored daily via the Teams E Conference Call.

		4. Trust Faller Flowchart application compliancy – Target: 100% . Development of a report to monitor this is anticipated to be completed by 17 September 2019. Currently 0% of 29 August 2019. Activities to implement the faller flowchart and the monitoring of compliance via metrics has been incorporated into the EOC Clinical Recruitment Action Plan and reported at QCSG. 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.
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 identified a series of activities and Trust strategies to monitor staffing levels, as well as HR External and Internal Recruitment to ensure there are sufficient clinicians within EOC. Staffing levels were monitored via recruitment trackers and metrics used to show weekly staffing clinical hours within the EOC against the targeted required and include the below: 1. EOC Clinical Staffing Weekly Hours Actual Vs Required (%) – Target: 100% (Current: 77%) 2. Internal Staff Optimisation rota fill (Utilisation of Trust EOC Support Clinicians to meet required Hours - Target: 100% (Current: 16.1% average over past 6 weeks) 3. EOC Clinical Supervisor WTE Substantive – Target: 100% (Current: 65%) 4. EOC Cinical ICAS WTE Substantive – Target: 100% (Current: 20%). 5. EOC Clinical Safety Navigator WTE Substantive – Target: 100% (Current: 50%) Outstanding activities relating to recruitment have been incorporated into the Clinical Recruitment Action Plan which is reported at QSCG.
Safe	The Trust **should** ensure the processes for providing staff with feedback from safeguarding alerts is improved to strengthen and develop learning.	The Action Plan is now complete and the 'should do' has been fully addressed. 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.

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 was 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. The Executive Management Board has made the decision to removal all map books from vehicles.
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 2019 was delayed due to the manufacturer of the blood glucose machines being unable to fulfill the order for the Trust. On-goiong discussions are being had between Trust Procurement and the Supplier in a bid to resolve this. The Standard Operating Procedure was approved at the May 2019 JPPF – this includes the importance of staff checking their equipment. This will continue to be monitored as part of Business As Usual.
Effective	The Trust **should** ensure that pain assessments are carried out and recorded in line with best practice guidance	The Action Plan is now complete and the 'should do' has been fully addressed. 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.
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 2019 Performance Improvement Plan was produced which included 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.

Safe	The Trust **should** consider producing training data split by staff group and core service area for better oversight of training compliance.	The Action Plan is now complete and the 'should do' has been fully addressed. 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.
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. A draft dashboard has been created and it is anticipated that this will be available mid-September 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 an interactive form. Unfortunately the tool identified to build the form, Power Apps, is no longer a viable option due to high licencing costs. The tool to replace this requires the builing of a new SQL Database and there is currently no timescale for this being available. Therefore, in the interim, a manual workaround is in place in the form of a downloaded table for the inputting of data. To continue monitoring as part of Business As Usual.

South East Coast Ambulance Service NHS Foundation Trust

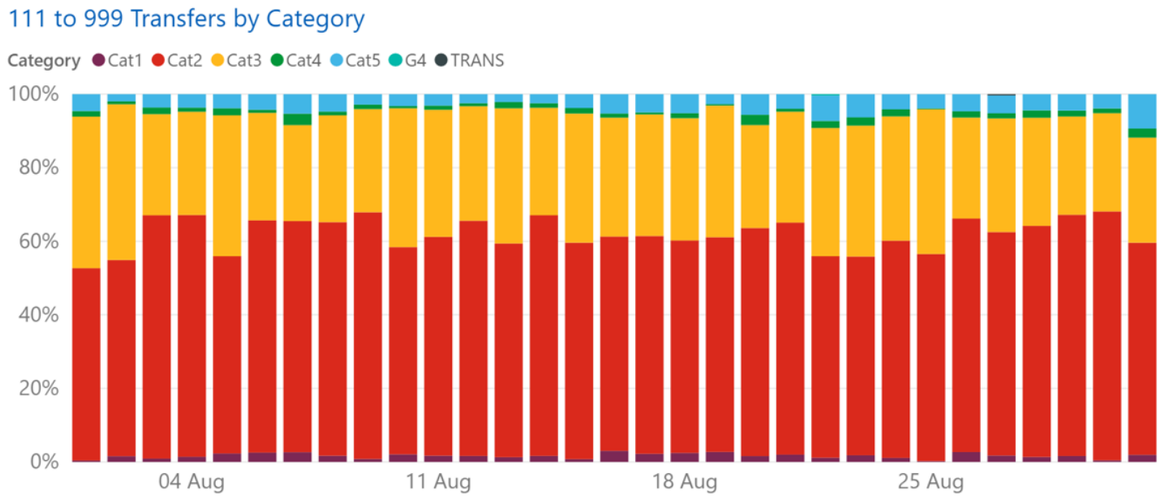
Domain	Service	CQC Findings ('Must or Should Do')	Metrics	Monitored via	RAG Rating
Safe	111	111 - The Trust must ensure care and treatment is provided in a safe way to patients.	To meet contractual performance key indicators for 95% calls answered in 60 seconds/sustained abandoned calls <5% and ambulance transfer rates <13% by 31/10/2019: 1. **Daily 111 to 999 Reporting** A sustainable downward trend in ambulance referral rate is starting to be demonstrated. Improvement has been delivered by: (a) deployment of new validation procedure via clinical queue; (b) focus on individual "outlier" agents, in order to reduce the referral rate. Further work will continue to approach the 13% target.  Data Source: Power BI 2. **Ambulance Validation** In August 2019 the Trust implemented a new process of referring CAT 3 and 4 non-emergency ambulance dispositions to the clinical queue in accordance with NHSE directive. Initial analysis of the impact of the new process on performance suggests that the service is now validating circa 90% of CAT 3 and 4 cases on a daily basis during week days, with a successful downgrade outcome following clinician intervention of in excess of 60%. This bulletin has made a positive impact as, while Clinical In Line support remains in place for Health Advisors (HA's), it has seen a significant reduction in activity following process introduction. Further analysis and work is ongoing to focus on Health Advisor (HA) call handling of potential ambulance cases to identify key areas of learning no longer provided by Clinical In Line Support, with a view to mitigating appropriately and safely, the initial Health Advisor triage in relation to ambulance dispositions that the service is generating: • Probing/Ambulance Awareness workshops have been scheduled through to the end of November 2019. • Outlier performance is being scrutinized and individual action plans developed. • In the longer term there will be an overhaul of the NHS Pathways training for new staff.	Improve Operational Performance in 111 Action Plan	

Ambulance Validation for CAT 3 and 4 in accordance with NHSE directive has been successful, where it is identified 90.20% (6167 cases) were validated, with 62.27% of these resulting in a non-ambulance dispatch outcome (01/08/2019 – 31/08/2019).

111 Calls Validation Data

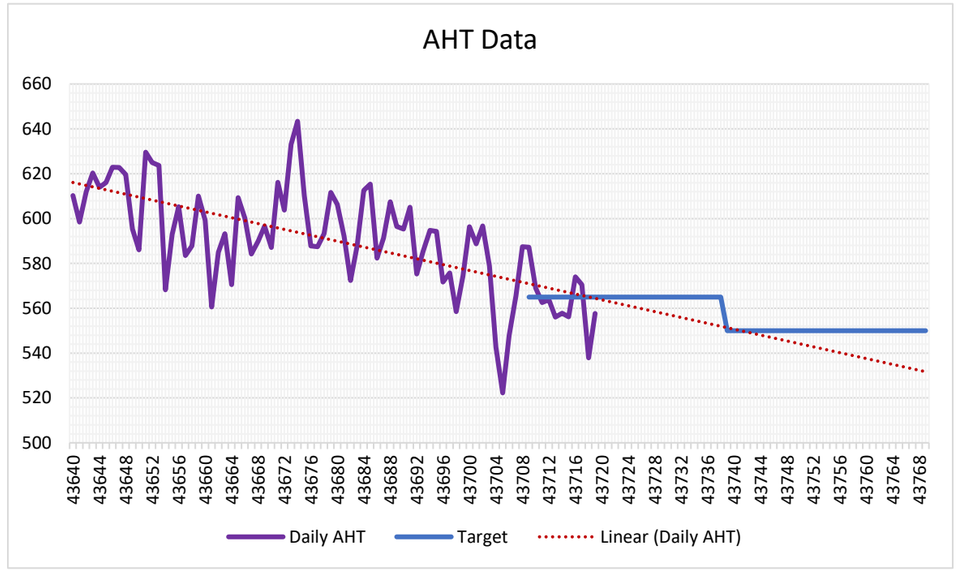
Data Source: Power BI

Following shared learning with other 111 providers (North East Ambulance Service), it was identified staff tenure, training and cognitive load as being the route cause to impact the quality of initial Health Advisor triage and where assurance for apposite ambulance dispatches is anticiapted to be effective. On-Going work relating to induction, training and outlier performance mangement is focused to address this.



Data Source: Power BI – August 2019

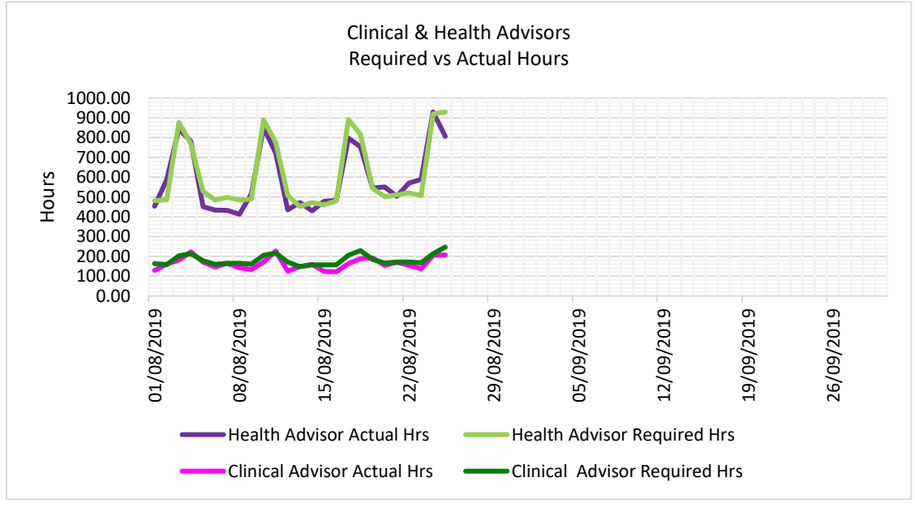
3. **Average handling time (AHT)**
   Changes to agent scripts, and individual performance management, have delivered a significant lowering of AHT and, therefore, an increase in productivity and service level. The daily AHT is now significantly below 600 seconds each day.



Data Source: Power BI

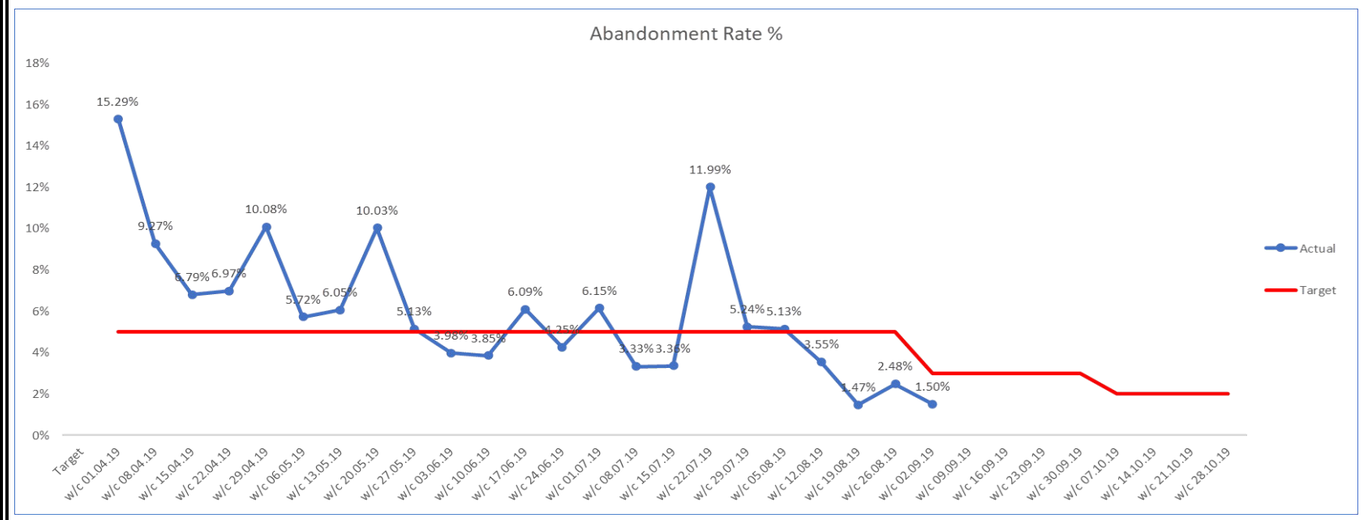
4. **Staffing levels**

There is a full establishment of Health Advisors, Service Advisors and Clinical Advisors, however, the rota balance is not optimal particularly at weekends. The Health Advisors rotas will be reviewed in October 2019, using the template provided by NHS England, in order to measure rota efficiency. The Clinical Advisors will be reviewed and recommended changes discussed with clinicians in January 2020.



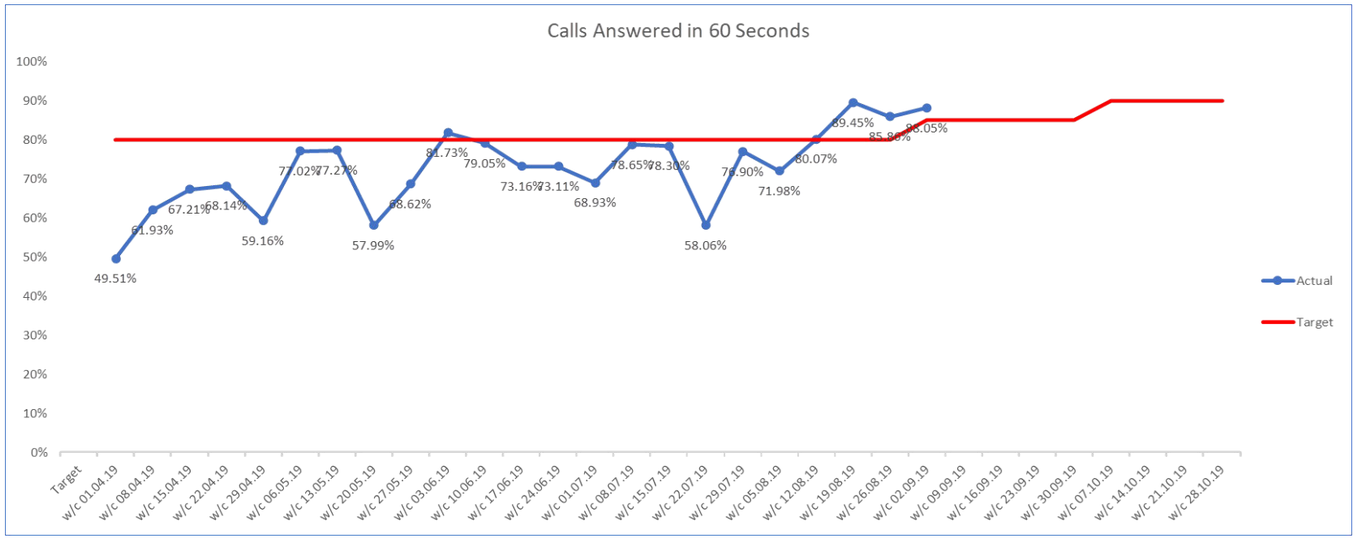
Data Source: Directory of Services Lead /BI Specialist for Integrated Care

5. **Abandoned calls**
   Call abandonment rate has been significantly below the 5% NHSE benchmark.

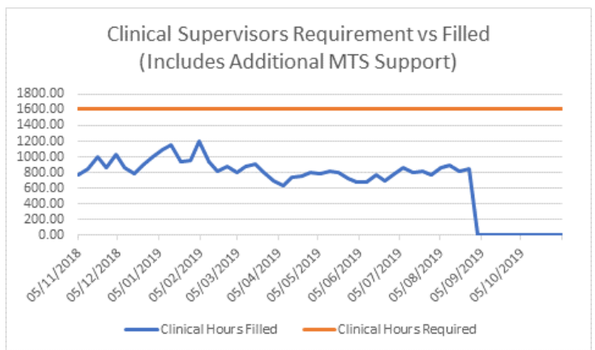


Data Source: Directory of Services Lead /BI Specialist for Integrated Care

6. **Calls answered in 60 Seconds**
   The service achieved a monthly service level of 80.8% in August 2019. This was due to an effective and sustainable step-change in call AHT, and productivity. The service has outperformed the National 111 / IUC service level during the last fortnight of August (including the Bank Holiday weekend).



Data Source: Directory of Services Lead /BI Specialist for Integrated Care

Safe	111	111 - The Trust should take action to ensure patient feedback mechanisms are fully established.	Patient Satisfaction: The SEC 111 IUC Service has an agreement in place with a suitable provider to commence the use of a texting service to evaluate patient feedback (mirroring the process in place previously for the KMSS 111 contract). However, due to a change in General Data Protection Regulation requirements resulting in the need to ask for patient consent rather than assume consent following the Front End Message (FEM), the service needs to identify a solution which has a minimal impact on patient flow and call Average Handling Time (AHT). Following consultation with, and support from the Trust's Information Governance and Data Protection Office lead manager, a proposal paper will be submitted to the SEC 111 IUC Senior Leadership Team with a two phase solution: Phase 1 - Identify clinical staff to ask for consent and identify in the Cleric host system "key words" so that the service's Quality Team can create a report retrospectively to the designated provider to send a text monthly and collate subsequent responses for the report. Paper to be drafted by 30/09/2019 along with completion of the Data Protection Impact Assessment and Quality Impact Assessment. This will most likely adversely impact clinical call AHT. Phase 2 - Utilise Post Event Message (PEM) process to patients with an IVR/Automated attendant to pro-actively ask consent for non-ambulance outcomes. This will then generate reports as per phase 1 solution and should have minimal impact on call AHT. Placeholder: Number of responses against number of texts sent.	SEC 111 IUC Senior Leadership Team	
Safe	EOC	The Trust should take action to ensure there are a sufficient number of clinical staff in each emergency operations centres at all times.	Since January 2019 the clinical staffing numbers have been fairly stable with attrition remaining low. However, the Manchester Triage System (MTS) was implemented towards the end of 2018 which saw a spike in numbers over the winter period (as seen in graph 1) due to provision of additional operational support; these numbers reduced as the Trust came out of winter pressures. *Graph 1*  *Graph 2* Placeholder: Clinical Supervisor Establishment Target 43 – Current 29	Clinical Recruitment Action Plan	

Graph 3

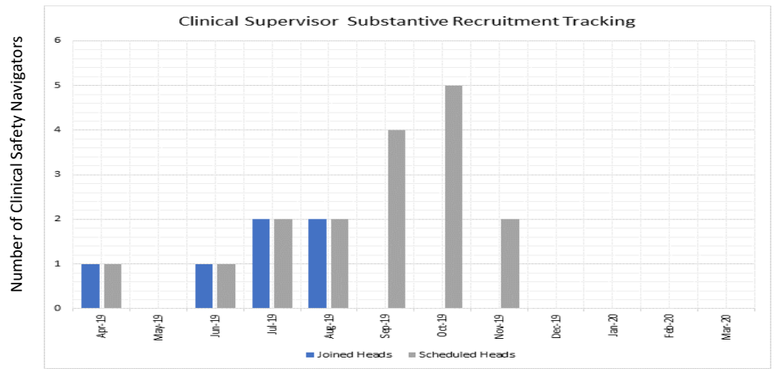
Placeholder: Clinical Safety Navigators
Establishment
Target 14 – Current 10

Graph 4

Placeholder: Operations Managers Clinical
Establishment
Target 5– Current 5

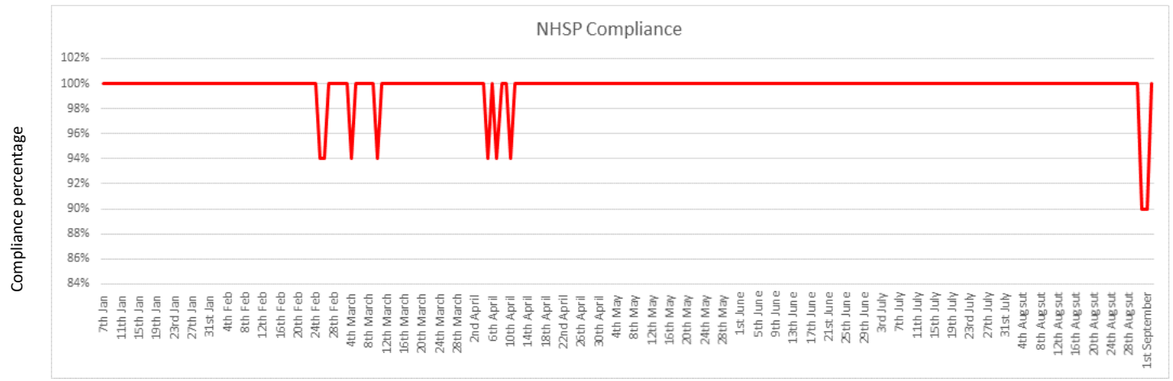
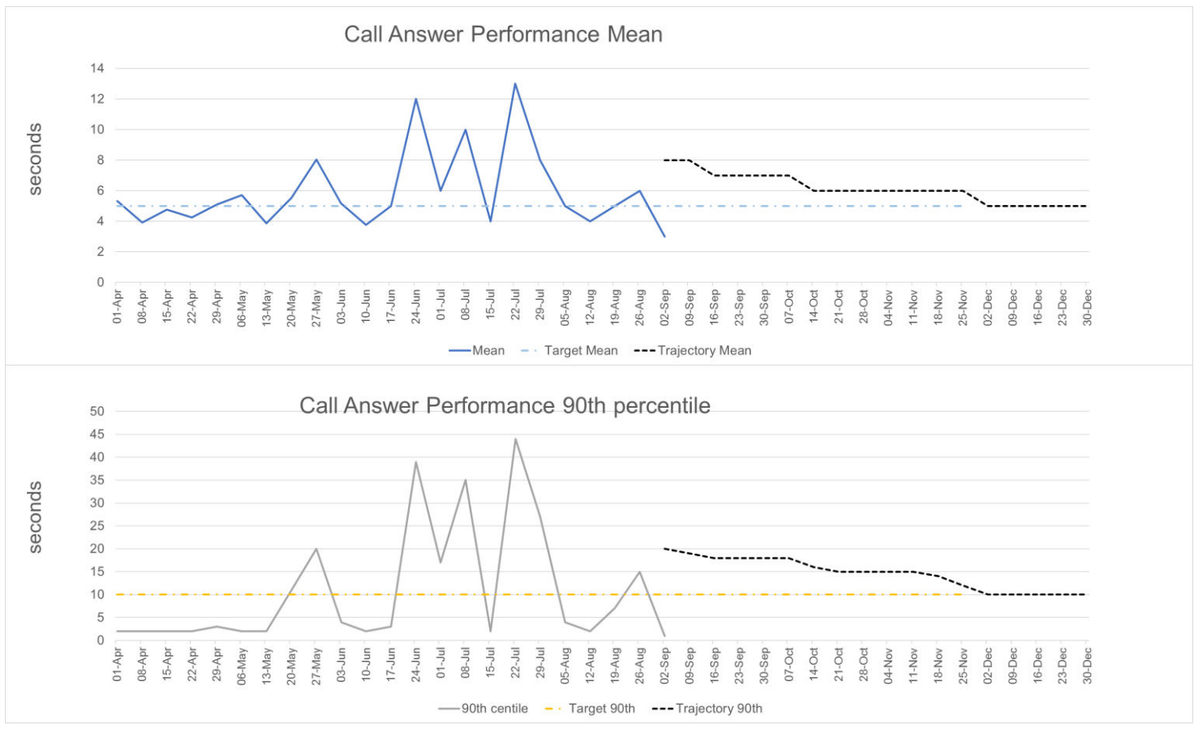
Graph 5 shows the number of Clinical Supervisor (CS) new recruits scheduled to attend training after which they will join the operational establishment. 6 more interviews have been scheduled during September 2019. There are 24 potential international recruits in the pipeline by 30 November 2019. It is anticipated that the full establishment of Clinical Supervisors will be in post by 31 December 2019.

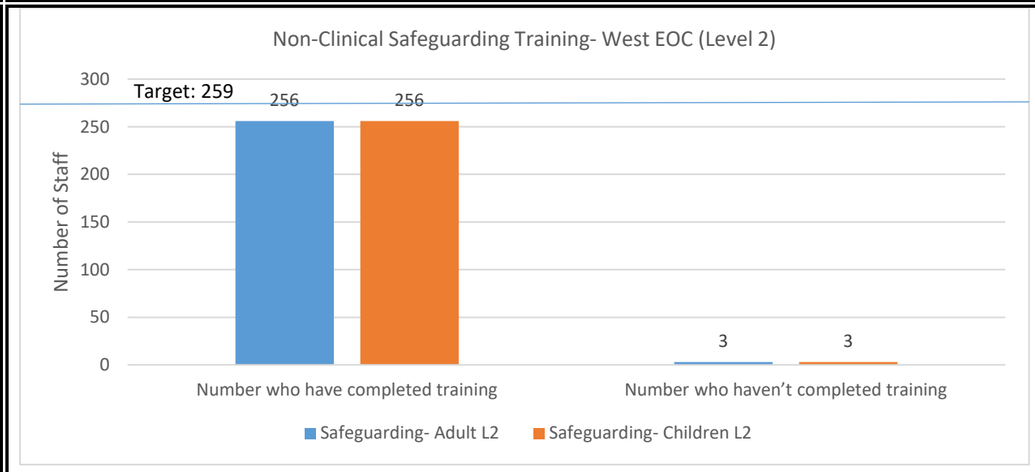
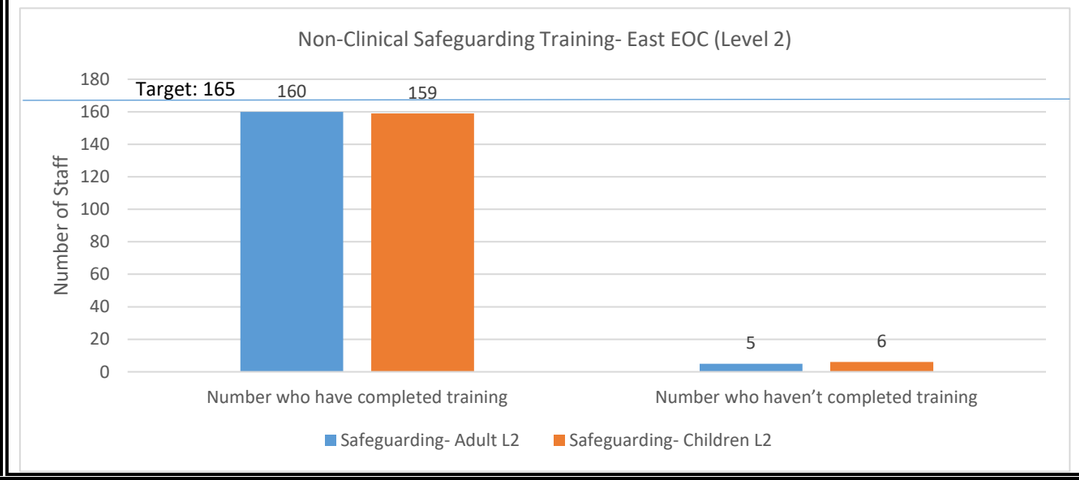
Graph 5

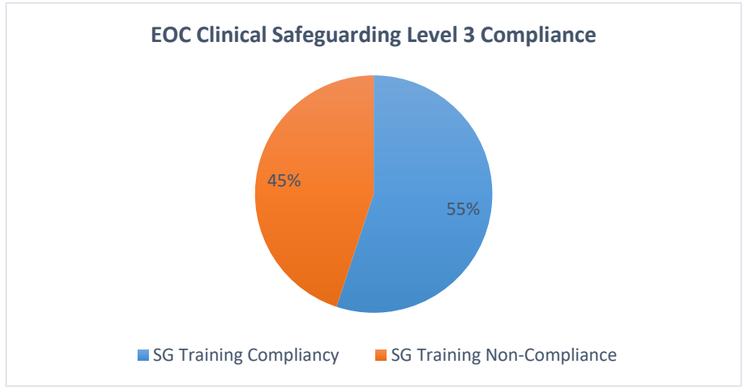


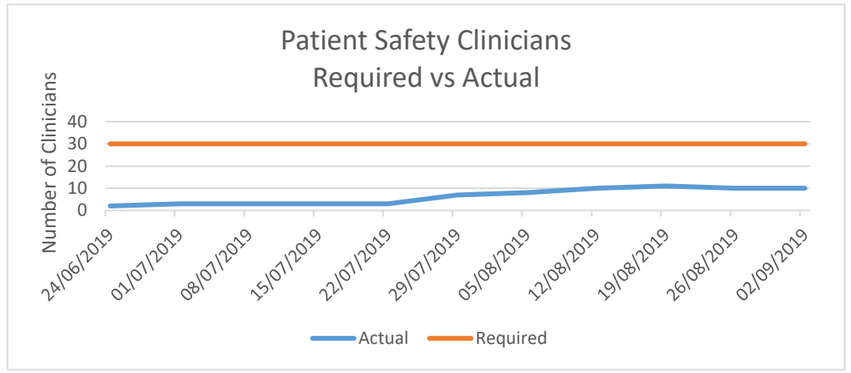
The action plan is rated as Amber as there is an issue with recruitment of NHS Pathways trained Clinical Safety Navigators resulting in the need to recruit from the internal pool of Clinical Supervisors. Although Clinical Supervisors are currently being recruited and will be eligible to apply for the Clinical Safety Navigator role after 6 months in post; there is no guarantee that they will be interested in this role. Therefore, the Clinical Supervisor role is being over recruited to in order to try and mitigate this.

Whilst recruitment is ongoing agency staff and the management team are providing clinical hours to improve our NHS Pathways (NHSP) compliance which can beeen seen in the graph 6.

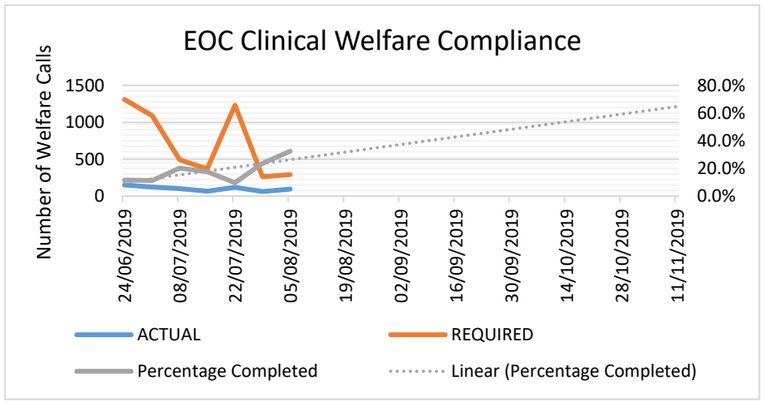
			Graph 6 		
Effective	EOC	The Trust should take action to meet the national performance target relating to call answering times.	In the first 12 weeks of 2019/20, 999 call answering was relatively stable, achieving the mean 10 out of 12 weeks, and the 90th percentile 11 out of 12 weeks. Since then there has been a period of inconsistency with 3 out of 10 weeks where the mean was achieved, and 4 out of 10 for the 90th percentile. A review from Association of Ambulance Chief Executives (AACE) provided a focus on key areas to be improved. An improvement trajectory sets a target of achieving the standards defined by the Trust by 2 December 2019 	EOC Call Answer Performance Action Plan	

			An Action Plan has been developed and a Task & Finish Group established and scheduled to meet fortnightly. This group will focus on 4 key themes: 1. Management Information 2. Real time agent monitoring 3. Reduction of routine call activity 4. Availability of in line support The Task & Finish Group will also monitor sickness and attrition rate which will have an impact on call performance.		
Safe	EOC	The Trust should take action to ensure all staff have completed the level two adult and children safeguarding and all relevant staff have completed level three adult and children's safeguarding.	 West EOC non-clinical staff statutory and mandatory (S&M) training is monitored through an S&M spreadsheet which is administered by the EOC Administrators. Due to the high number of new recruits the compliance figure can vary considerable by month. The aim is to ensure new members of staff complete all their S&M training prior to starting in the live environment. Instructions have been sent out to the Team Leads and EOC Managers to follow up staff who have not undertaken their training. It is anticipated that compliance will be 100% by 13 September 2019, current compliance for both adults and childrens safeguarding L2 is 89%. 	Quality & Compliance Steering Group	

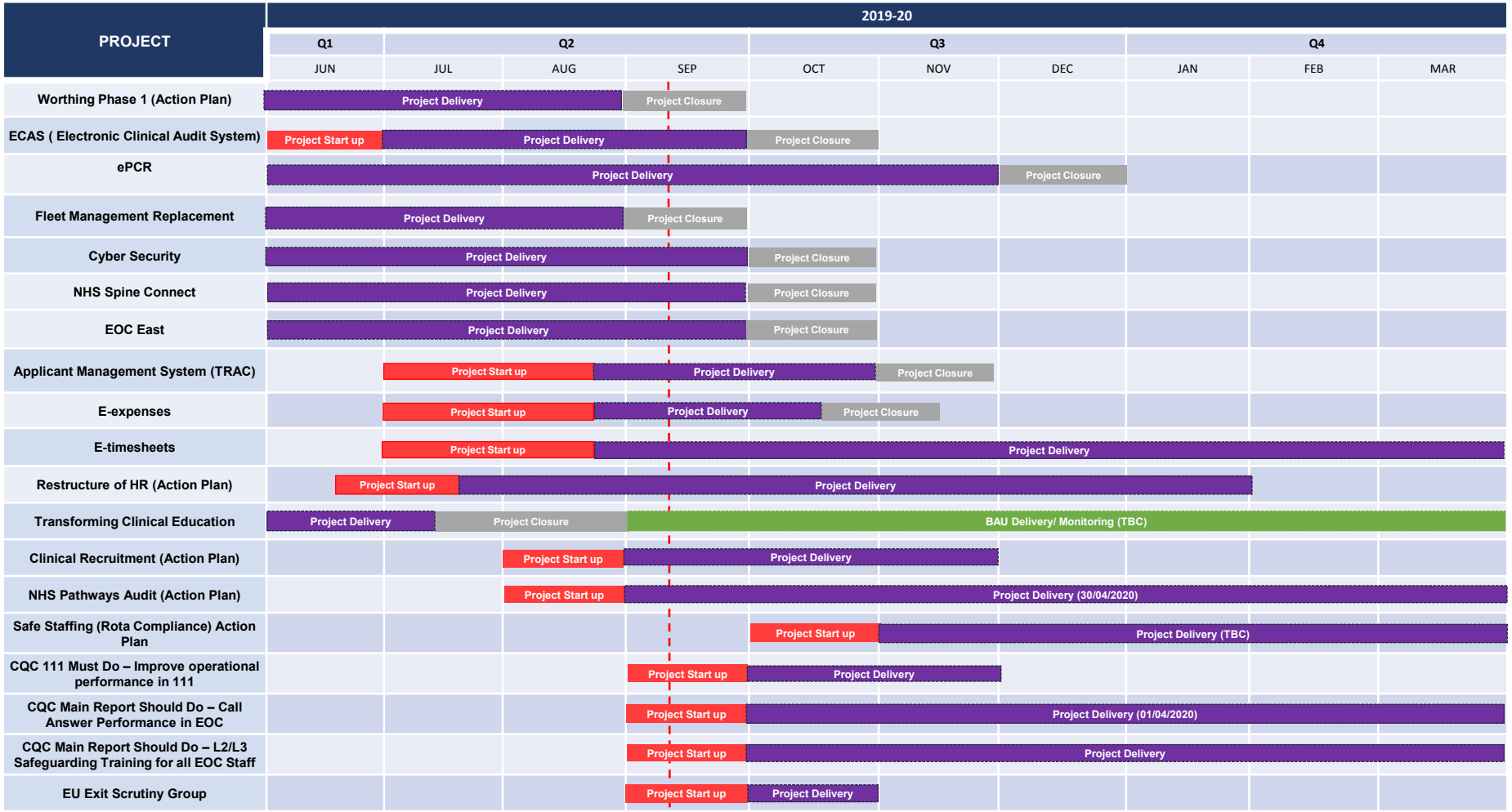
			East EOC non-clinical staff statutory and mandatory (S&M) training is monitored on a weekly basis. The EOC Administrator downloads the data directly from the Trust's learning portal, Discover, and organises it onto a Scorecard. The current compliance is 98% for safeguarding adults L2 and 97% for safeguarding children L2 with a view to achieving 100% by 20 September 2019.  EOC Clinical Safeguarding training (level 3 face to face) is currently 55% complete. Challenges have been the increase in new starters where we have 17 new clinicians who represent 55% of the 45% non-compliancy. The remaining 14 staff members are being pro-actively booked on to courses which are being organised specifically for EOC Clinical. This action plan is rated red for 2 reasons: 1. There is no defined process to monitor the compliance to statutory and mandatory training for EOC clinical staff. 2. There is a mismatch between training records held on ESR and the locally held training logs. The Quality and Compliance Steering Group will be actively monitoring the above to ensure that the above issues are resolved. **PLACE HOLDER:** ESR records vs locally held records of staff having completed safeguarding training.		
Safe	EOC	The Trust should take action to ensure the clinical welfare calls are completed within the targeted timeframes.	The Trust has recognised the need to keep patients safe whilst they are waiting for a response to attend their location. To address this, the Patient Safety Clinician role has been introduced. This is a Band 5 nurse role which is currently being resourced by agency staff along with SECAmb staff who are currently on alternative duties. The graph below shows the current requirement of 30 against actual numbers.	Clinical Recruitment Action Plan	



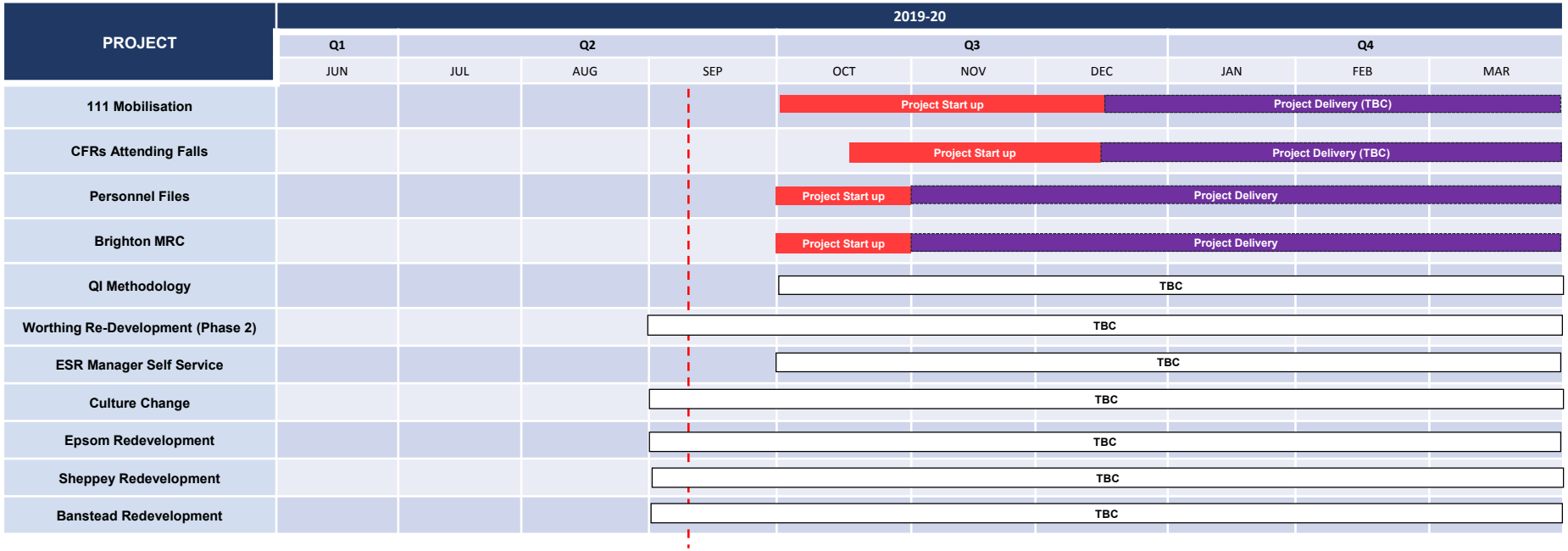
Evaluation of the effectiveness of this role will be undertaken using the Clinical Tail Audit Process where compliance with welfare calls can be identified. The below graph shows our historic and current welfare compliance with the introduction of the Patient Safety Clinicians in mid July 2019.



Appendix C - PMO Portfolio Timeline – Live Projects (Last updated: 13 September 2019)



PMO Portfolio Timeline – Pipeline Projects (Last updated: 13 September 2019)



PMO Portfolio Timeline – PPIRs Due (Last updated: 13 September 2019)

PROJECT	2019-20									
	Q1	Q2			Q3			Q4		
	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Governance & Risk						PPIR				
Health & Safety							PPIR			
IT Helpdesk Software								PPIR		
Medical Devices Management (MDM)			PPIR			PPIR				
Station Upgrades								PPIR		
EOC Clinical Safety & Performance							PPIR			

Digital Programme Board Dashboard

Reporting Period: 16 July 2019 – 13 September 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 18/09/2019 v1.1

Key Points

Project	Brief Summary
EPCR	Progress against the plan remains very positive and the phased roll out is continuing to be delivered OU by OU. An external system penetration test has been undertaken, and no major concerns raised. Temporary reporting is available from the Project Team to enable SECAmb to monitor ePCR usage by Operating Unit. Trust reporting is due to be delivered by 01 October 2019. 2 Serious incidents have been raised due to incorrect information being entered onto the ePCR form. The supplier has provided an update to mitigate against any further user issues.
Electronic Clinical Audit System	The project remains rated Amber as progress has been affected by connectivity issues at Paddock Wood. This risk has been monitored and mitigated by a speed upgrade. A change request will be enacted to ensure that any impact with this delay has been considered.
Station Upgrades	The cut over to new circuits for 105 sites has been completed. It has been agreed that Project is now closed with remaining 5 sites transitioning into business as usual. Since Project Closure 2 sites have been completed and outstanding 3 sites (Banstead, Worthing and Polegate) are due to be completed by end of October 2019. No further update expected for this project in the next reporting period.
NHS Spine Connect	Following the accreditation of the Summary Care Records by NHS Digital. The testing of the Summary care records will be completed by EOC Systems Teams by mid-September 2019. A roll out plan is currently being created to ensure a smooth transition into the live environment. A change request for additional time and increase in scope will be requested to ensure that all deliverables required for the roll out of SCR in EOC and now 111 will be achieved within the timescales.
Replacement Fleet Mgmt. System	The new system went live as scheduled. This project is closed and has transitioned into business as usual. The outstanding activity of transferring all historic data is now being dealt by a project manager working in collaboration with the previous suppler JAAMA. Ultimately a final back up of data will be taken and the legacy Fleet man system can be decommissioned.
Cyber Network Upgrade	SECAmb has experienced some delays in getting the VPN solution in place. However work continues and progress is being made. The VPN solution is now working and it will be tested within IT in the coming week and then deployed to all staff. This will enable us to shut down the existing legacy solution by the end of September 2019. Following testing, a change request for additional time might be requested to ensure that any impact with the delay has been evaluated.
East EOC	A monitoring panel is being installed in the dispatch area on 10/09/2019 which is the last remaining deliverable for this project. This will show the state of UPS and air conditioning providing EOC assurance that the replacement infrastructure is operating normally. It is anticipated that the project will close during the next reporting period.

Project	Current RAG	Previous RAG
ePCR		
Electronic Clinical Audit System (ECAS)		
Station Upgrades		
NHS Spine Connect		
Replacement Fleet Management System		
Cyber Network Upgrade		
East EOC		

Key Risks

Project	Brief Summary	Score
ePCR	There is a risk that EU exit could lead to the mobile networks in Kent becoming congested or saturated due to excessive connections. **Mitigation:** Secamb to monitor cellular network availability via our mobile provider(s) websites.	9
ePCR	There is a risk that there could be constraints around having sufficient staff trained and capable of providing ongoing clinical ePCR support to end users. **Mitigation :** 1. EOC systems team will receive training on ePCR infrastructure and app usage and will support live system in the same way they do the existing Cleric platform 2. IT staff will receive system documentation and training on ePCR infrastructure. Scheduled for 21 Aug 2019	9

Achievements this period

- **ePCR has now launched in the Paddock Wood Operating successfully on 02 September 2019**
- **Haslemere Ambulance Station has achieved 100% of their patient records for a 24h period on ePCR.**
- **Cut over to new circuit have now been completed for Sussex Police HQ and Battle ACRP**

QCSG Dashboard

Reporting Period: 16 July 2019 – 13 September 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 13/09/2019 v0.3

Key Points

Project	Brief Summary
EOC Clinical Safety & Performance	Closure of the EOC Clinical Safety & Performance Project set up to address the 2018 CQC Must Do and 3 of the Should Do's has been approved by the Quality & Compliance Steering Group. All areas with the exception of Clinical Recruitment, NHS Pathways Audit and Rota Compliance have transitioned into BAU. Action plans have been produced for Clinical Recruitment and NHS Pathways Audit and are monitored by QCSG. The Safe Staffing (Rota Compliance) Action Plan will be developed during the next reporting period.
EOC Clinical Recruitment	Recruitment of Clinical Supervisor (CS) establishment is on track to reach the full establishment by 31 December 2019. There is a full establishment of Operational Managers Clinical. However, there is an issue with recruitment of NHS Pathways trained Clinical Safety Navigators (CSNs) resulting in the need to recruit from the internal pool of CS'. Although this group is currently being recruited to and new recruits eligible to apply for the CSN role after 6 months in post, there is no assurance that they will be interested in this role.
NHS Pathways Audit	The Consultation for the new staffing model for the Clinical Audit Team has been delayed due to a long standing grievance within the team not having been resolved. This has led to a delay in the actions required to improve clinical audit compliance, therefore, compliance remains poor.
Improve Operational Performance in 111	The service achieved a monthly service level of 80.8% in August 2019. A sustainable downward trend in ambulance referral rate is being demonstrated. Validation for CAT 3 and 4 in accordance with NHSE directive has been successful. The daily Average Handling Time is now significantly below 600 seconds each day. Call abandonment rate has been significantly below the 5% NHSE benchmark.
EOC Call Answer Performance	A review from Association of Ambulance Chief Executives (AACE) provided a focus on key areas to be improved and an improvement trajectory has been set to achieve the standards defined by the Trust by 2 December 2019. There are 4 areas of focus: management information, real time, agent monitoring, reduction of routing call activity and availability of in line support. Sickness and attrition rate will also be monitored as these impact on call performance.

Key Issues

Project	Brief Summary	Score
EOC Clinical Recruitment Action Plan	Although Clinical Supervisors are currently being recruited and will be eligible to apply for the CSN role after 6 months in post, there is no guarantee that they will be interested in becoming a CSN. Therefore, the Clinical Supervisor role is being over recruited to in order to try and mitigate this.	N/A
NHS Pathways Audit Action Plan	The consultation period for the proposed new staffing model has been delayed. Mitigations are in place to provide temporary cover for audit but compliance for clinical audit remains poor.	N/A

Project	Current RAG	Previous RAG
EOC Clinical Safety & Performance		
Clinical Recruitment		First Reporting Period
NHS Pathways Audit		First Reporting Period
Improve Operational Performance in 111		First Reporting Period
EOC Call Answer Performance		First Reporting Period

Achievements this period

- Closure of the 2018 CQC tracker.
- Creation of 2019 CQC tracker and supporting action plans.
- Closure of the EOC Clinical Safety & Compliance Project and establishment of 2 action plans: EOC Clinical Recruitment and NHS Pathways Audit.

South East Coast Ambulance Service: CIP Workstream

CIP Delivery Dashboard

Reporting Month Aug-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 £3.0m in the year to date period ended August 2019 compared to NHSI plan target of £3.1m.

2. £6.4m of fully validated savings have been transferred to the Delivery Tracker as at month 5, August 2019. The existing projection of fully validated schemes equate to £6.2m. This is approximately three quarters of the savings target of £8.6m and the recurrent element represents 41% of the total.

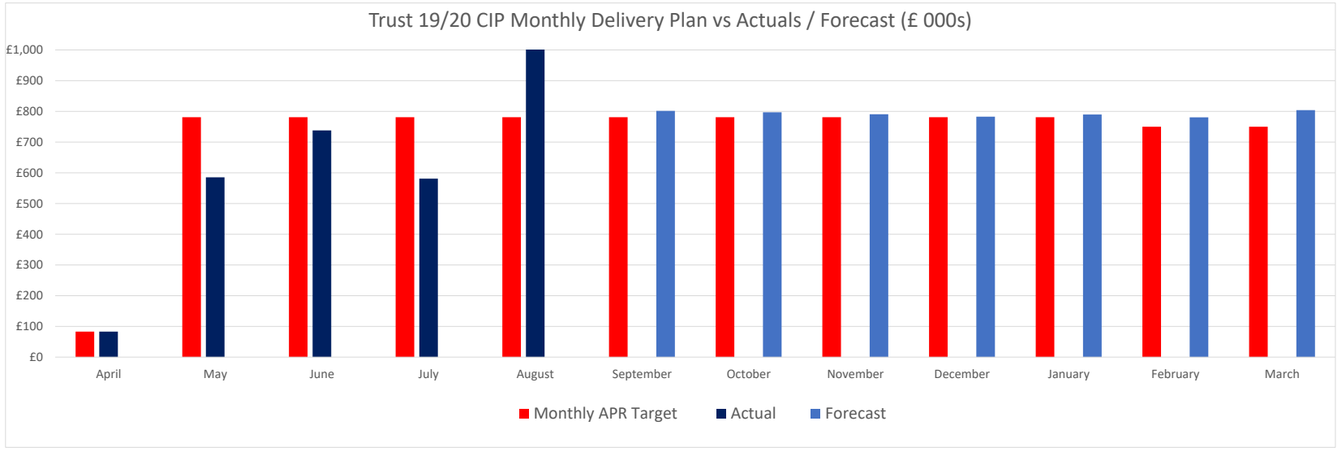
3. Regular review meetings with Budget Leads and Finance Business Partners continues to focus on identifying new schemes to build a sustainable pipeline of recurrent schemes for 2019/20.

4. The CIPs schemes under development include savings arising from i) the actions of the Sustainability Transformation Programmes (STP) that the Trust is engaged ii) the Carter Recommendations for Ambulance Trusts ii) operations efficiencies - the expected reduction in handover delays remain challenging and alternative schemes are being scoped to compensate for the shortfall.

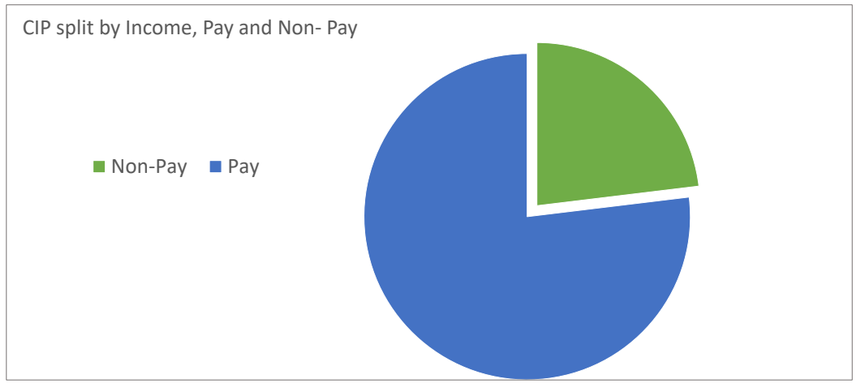
5. The Cost Improvement Programme is currently rated Amber.

1. Monthly CIP Trust Profile - as at 31 August 2019

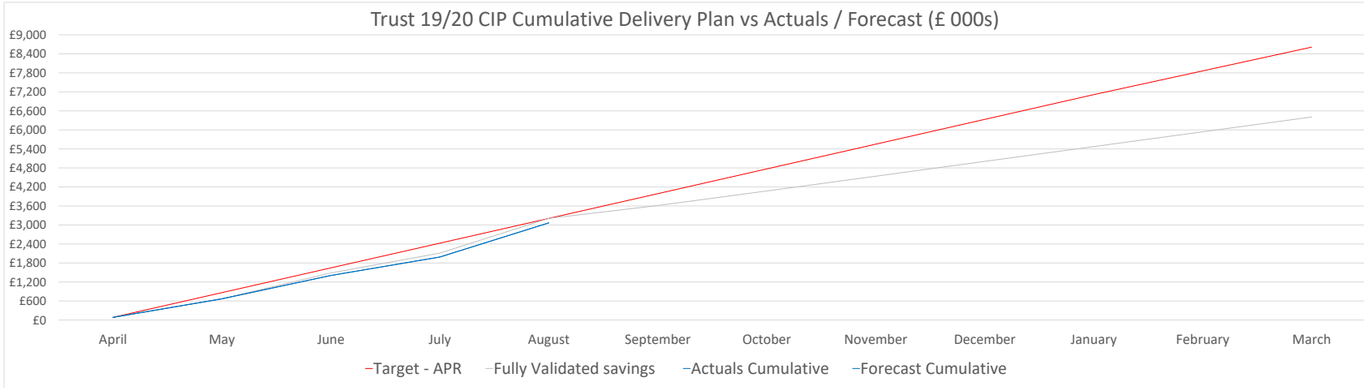
CIP Target for 19/20 £000's	Total planned savings on delivery tracker £000's - as at 31 August 2019	Total forecast savings on delivery tracker £000's - as at 31 August 2019	YTD August 2019 - Target Savings £000's	YTD August 2019 - Actual Savings £000's	YTD August 2019 - variance £000's
8,612	6,407	8,612	3,207	3,066	(£141)



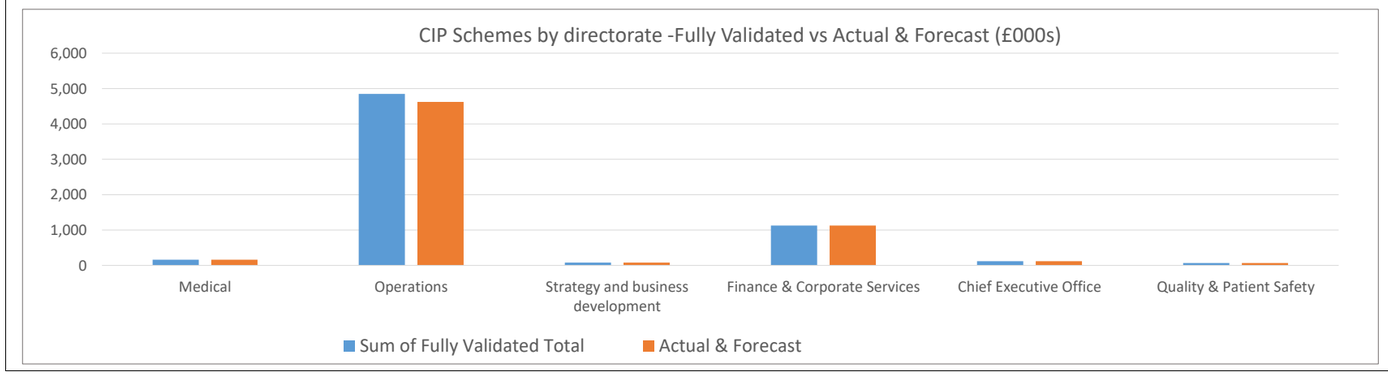
2. CIP - Planned savings split by income, pay and non-pay: as at 31 August



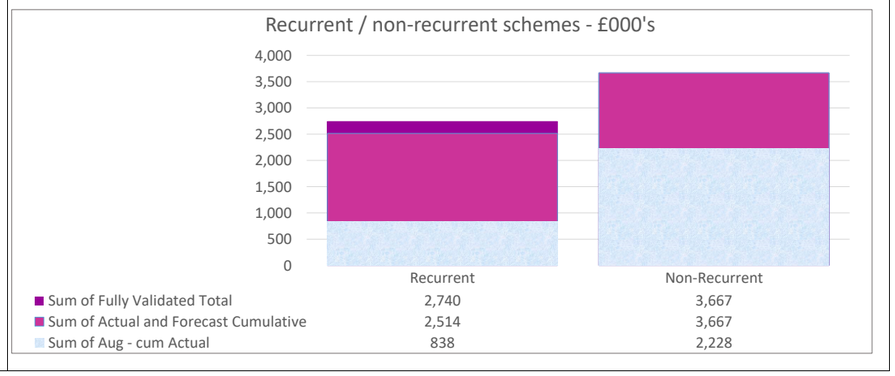
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2019/20



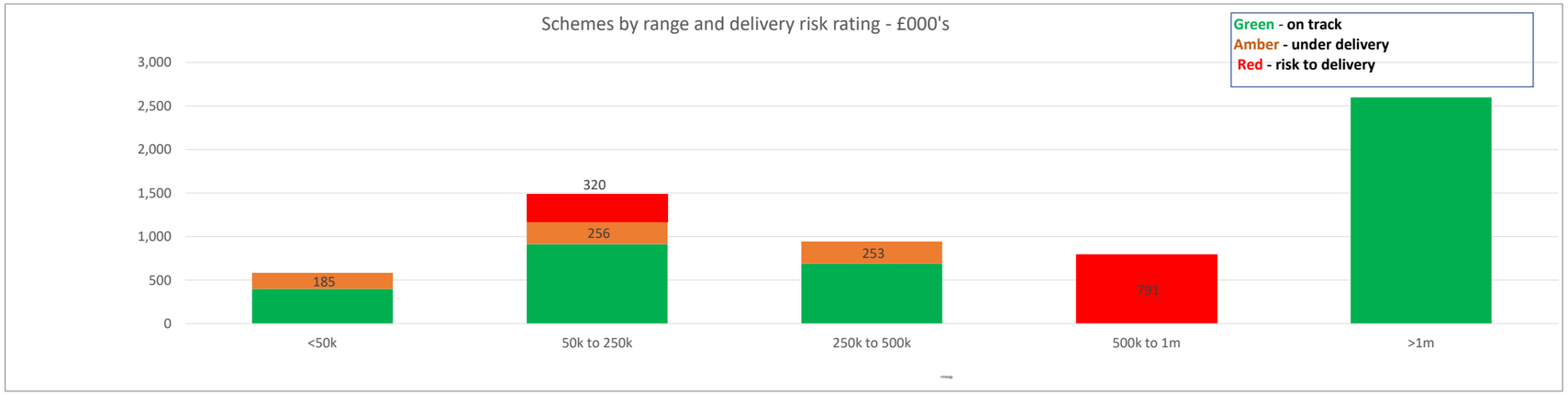
4. CIP schemes by directorate - Fully Validated vs Actual & Forecast 2019/20



5. Value of forecast recurrent and non-recurrent savings - 31 August 2019



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



7. YTD Identified CIPs to Date and Savings - August 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 5): £000	YTD Actuals (Month 5): £000	YTD Variance £000	Comments (+/- £20k variance)
Medicines Management - Equipment	40	40	0	40	40	0	-
Medicines Management - Consumables	137	137	0	58	58	0	-
IT Productivity and Phones	48	48	0	20	32	12	
Discretionary Non Pay	13	13	0	5	5	0	
Training courses & accommodation	219	219	0	184	184	0	-
Operations Efficiencies	2,714	2,488	(226)	967	812	(155)	YTD underachievement in handover delays - alternate schemes are being scoped to compensate for shortfall
Recruitment delays & recharges - clinical	200	200	0	200	200	0	-
Recruitment delays & recharges - non clinical	421	421	0	358	358	0	-
Accounting efficiencies	861	861	0	828	828	0	-
Lease costs - ambulances	120	120	0	0	0	0	-
External Consultancy	24	24	0	10	10	0	-
Legal/Professional Fees	29	29	0	12	12	0	-
Public Relations Expenses	12	12	0	5	5	0	-
Fleet Veh Run Costs - Fuel	200	200	0	0	0	0	-
PAPs/ OT price differential	1,371	1,371	0	521	522	0	-
Total Fully Validated Schemes	6,407	6,181	5,713	3,209	3,066	(143)	
Variance to Year To Date (YTD) Target				(2)		£2	Variance between Fully Validated Schemes and YTD Control Total Target
Total Fully Validated Schemes	6,407	6,181	5,713	3,207	3,066	(141)	

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 5 - August 2019

Programme Summary:

1. Current Pipeline schemes of £9.0m compares with savings target of £8.6m.

2. Fully validated CIP schemes of £6.4m have been moved to the Delivery Tracker after QIA approval.

3. Fully Validated schemes above along with Validated and Scoped schemes of £1.1m represents 87% of the savings target for the year.

4. Positive engagement continues with Executives Directors and CIP Project Leads. The CIP Programme governance framework and processes remains functional in the Trust.

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 currently rated Amber.

CIP Opportunity Classification - KEY

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

CIP Pipeline and Delivery: Risks and Issues

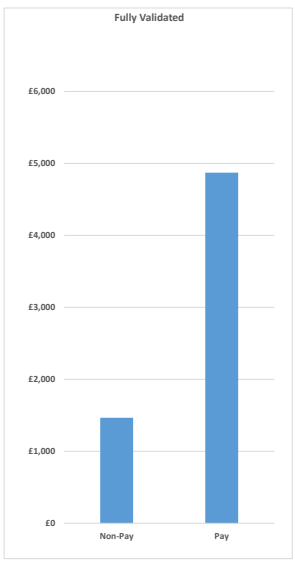
	Risk	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Risk that the 2019/20 CIPs target of £8.6m will not be fully delivered due to uncertainties within the Operations Directorate.	The savings target of £8.6m has been allocated to Directorates based on their individual pro rata 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

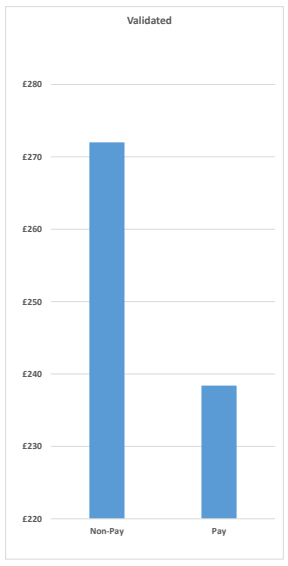
	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	New Lease Cars policy to be agreed.	A Business Case is being finalised based on fit for purpose cars for operational managers aligned to roles. New club car scheme was launched in January - pilot data provided and being evaluated.	John Griffiths/ Paul Renshaw	Amber	Amber	30-Sep-19
2	E-Expenses - potential savings from automation.	E-Expenses system is awaiting the ratification of the Expenses policy. This is expected to be delivered as part of the HR Transformation.	Paul Renshaw	Amber	Amber	30-Sep-19
3	Agency Staff - Potential cost avoidance CIP	Savings plan to be developed for 2019/20.	Priscilla Ashun-Sarpy	Amber	Amber	30-Sep-19
4	Develop further Operations CIP schemes.	Regular liaison with Exec Sponsor and Operations Leads to identify and scope	Priscilla A-Sarpy/Finance Business Partners	Amber	Amber	31-Mar-20
5	Devise a mechanism for recoveries of historic salary overpayments	Ongoing discussions with Payroll Manager/HR Director.	Phil Astell/ Paul Renshaw	Amber	Amber	30-Sep-19

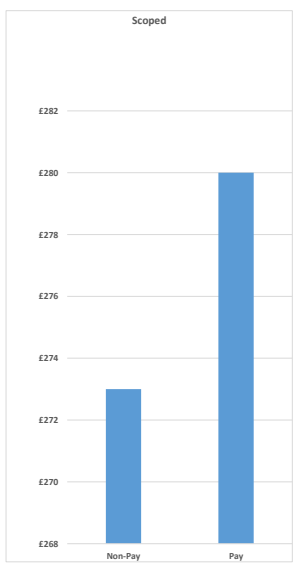
CIP Pipeline Summary

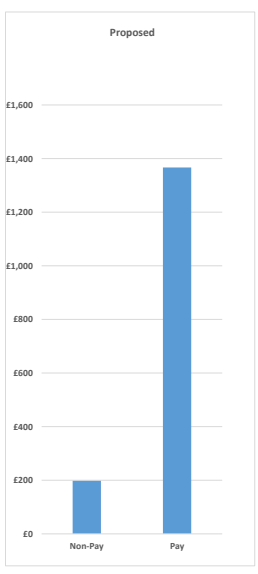
Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£0	£6,407	£510	£553	£1,565	£9,035

Pay / Non-Pay / Income Breakdown and scheme summary









Scheme Category	Fully Validated	Valida	Scoped	Proposed	Total
Accounting efficiencies	861	-	-	68	929
Budget Allocation	-	35	-	180	215
Discretionary Non Pay	13	77	48	-	138
Estates and Facilities management	-	-	100	83	183
External Consultancy	24	-	-	-	24
External consultancy & contractors	-	190	-	-	190
Fleet - Equipment	-	-	-	251	251
Fleet Veh Run Costs - Fuel	200	-	-	-	200
IT Productivity and Phones	48	-	-	72	120
Lease costs - ambulances	120	-	-	-	120
Legal/Professional Fees	29	-	-	-	29
Meal Break Costs	-	-	30	-	30
Medicines Management - Consumables	108	-	-	-	108
Medicines Management - Equipment	40	-	-	-	40
Operations efficiencies	4,085	-	-	761	4,846
Public Relations Expenses	12	-	-	-	12
Recruitment delays & recharges - clinical	229	107	240	-	576
Recruitment delays & recharges - non clinical	421	101	40	150	712
Training courses & accommodation	219	-	-	-	219
Travel & Subsistence	-	-	95	-	95
Grand Total	6,407	510	553	1,564	9,035

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NHS Foundation Trust

HR Transformation and culture update

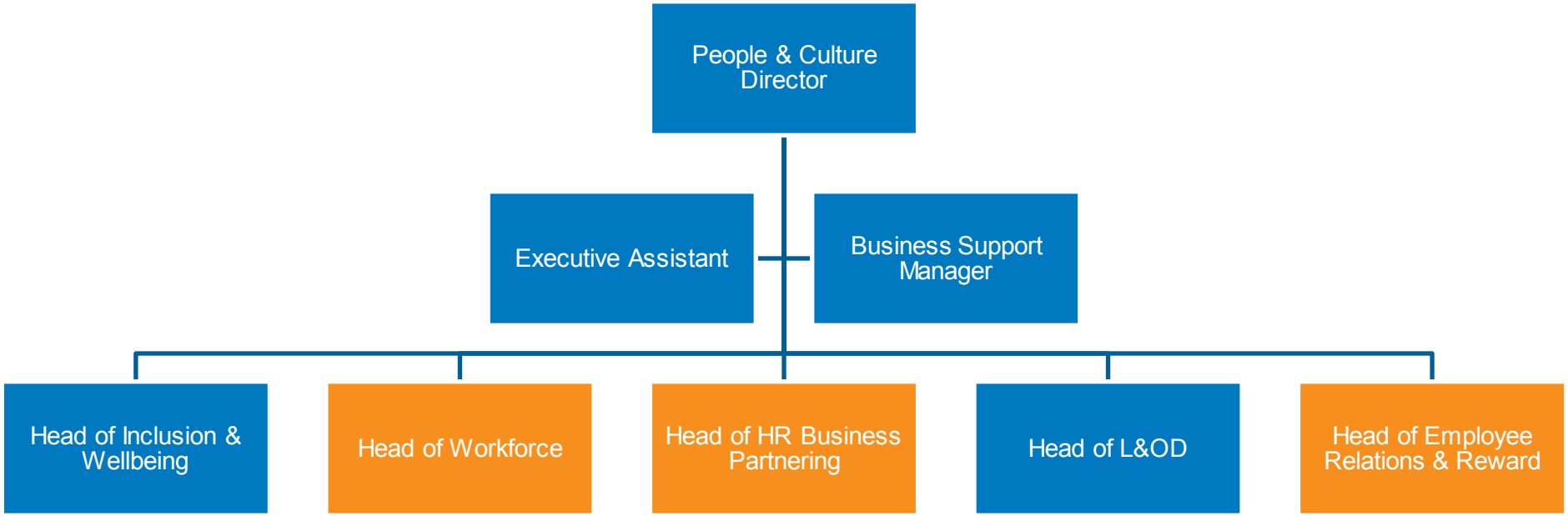
Aspiring to be ***better today*** and even ***better tomorrow***

Our aims

South East Coast Ambulance Service NHS Foundation Trust

- Accurate and efficient E-Systems and process improvements for the service centre
- Systems for high quality and high volume resourcing needs
- A HR Business Partner structure that enables proactive service
- A new Employment Relations and Reward team that effectively and efficiently deals with individual cases and high level union relationships
- A Learning and OD/Engagement function that delivers development, retention and engagement plans

Senior Leadership Team



Senior Team Recruitment update

South East Coast Ambulance Service NHS Foundation Trust

- **Director of People & Culture (HRD)** - Agency search – assessment event on 21 October – high level of interest
- **Head of Learning and Organisational Development and Head of HR Business Partnering** - Searching via Agency and shortlisting in October
- **Head of Workforce**- Assessment event 25 September
- **Head of ER & Reward**- appointed internally – Richard Crouch

- Aim to have all team in place by end of calendar year – Head of L+D progress is slightly behind initial target due to first advert not giving a strong enough short list

Wider team recruitment update

South East Coast Ambulance Service NHS Foundation Trust

Progress is an expected and budgeted for in business case

Learning and OD progress
2x OD and Engagement advisors now appointed
1 x L+D advisor offered last week

Remaining roles to recruit to :
Digital Learning specialist- still working on if we can combine with other Trusts
OD Manager- budget used to cover Ian Jefferys costs into 2020- work focussed on Appraisal process and Retention strategy

HR and ER
Search in October :
1x fixed term HRBP to start to aid restructuring work/ consultations
1x Permanent Senior ER advisor
Team workshop with HRBPS in November to discuss how we implement the change in expectation for role

Wider team recruitment update

South East Coast Ambulance Service NHS Foundation Trust

Resourcing

As per Business case Team structures to be filled in December once TRAC system is implemented

Wellbeing and Inclusion

Separate review to bring to EMB in October as agreed

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Systems Implementation

- A project team consisting of programme management, project management, IT, ESR expertise, business analysts and data cleansing resource will implement the system changes. This team is working within the Trust PMO governance framework
- Investment of up to £250,000 in new systems- we expect to not exceed this budget
- Fortnightly task and finish groups for all systems work
- Risk register established- at present there are no major risks to delivery that we cannot manage appropriately
- Projects are all running to business case timescales to date

Service Centre and Resourcing processes

South East Coast Ambulance Service NHS Foundation Trust

- On schedule for TRAC system launch end October 2019
- E – expenses to be rolled out to HQ in October with gradual roll out to EOC/111 and OU's from November onwards
- Implement E-Timesheets by March 2020
- Implement E-Forms by March 2020
- Be ready to implement ESR Manager Self-Service by March 2020

These changes will improve accuracy, reduce overpayments and duplication of work and improve services for everyone

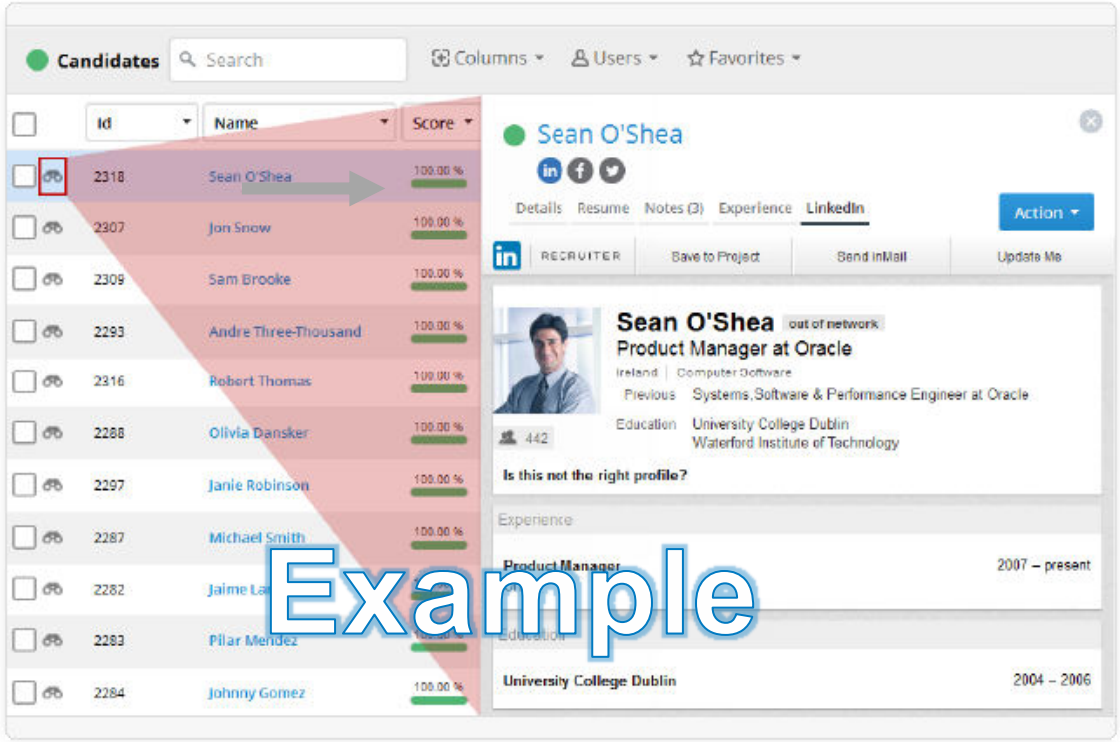
Resourcing processes

NHS
South East Coast Ambulance Service
NHS Foundation Trust

- Implement Applicant Tracking System by October 2019
- Automate recruitment processes & workflows
- Improved applicant communications
- Simplified pre-employment checks
- Real-time information and reporting
- Integrate systems with NHS Jobs

Better candidate and hiring manager experience

Better experience for resourcing team



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Culture workstream update Including: Bullying & Harassment

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

Behaviour in the workplace

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South East Coast Ambulance Service
NHS Foundation Trust

Our vision is to have an organisational culture where **'Our people are listened to, respected and well supported'** with delivery against a plan that enables a positive and sustainable shift by tackling the issues using a multiple level approach:

- ✓ New Induction
- ✓ New Fundamentals of Leadership development to focus on resolution of conflict in the workplace
- ✓ New resilience focused recruitment and assessments
- ✓ A toolkit for all staff focussed on behaviours
- ✓ A video demonstrating good and poor behaviours,
- ✓ 360 degree feedback for managers and leaders
- ✓ Increase in numbers of trained mediators.
- ✓ Proposal for behaviours focused workshop as part of Key Skills 2020-21.
- ✓ New two tier appraisals – for October Launch
- ✓ Values Toolkit

Wider culture work

- October to April – Piloting a new appraisal process to ensure that we have useful and meaningful appraisals that inform succession and talent management work

- October /November- A change recruitment processes in 111 and EOC to assess behaviours and ability to work within high pressure environments

- by November –a proposed comprehensive retention strategy focused on 111, EOC and paramedics , with input from NHSI experts – this is the significant piece of Culture work that must be priority for delivery over next 18 months

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

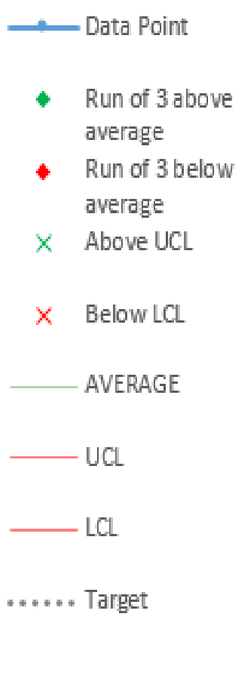
September 2019

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

Contents Summary

SECAmb CQC Rating and Oversight Framework

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

Overview

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.

Status

The performance data shared in this report from Operations 999 is as from 08/07/2019. The Trust Board is asked to note improved response time performance and the trends indicated. This is with continued day-to-day management of resourcing, response time monitoring throughout the 24 hour period and supporting metrics that facilitate improvements in productivity. This will continue as the Trust increases its workforce as well as the need for management of Private Ambulance Provider capacity. Where the Trust is not achieving required response time standards, work is already underway to better forecast and meet demand throughout the 24 hour and 7 day period. Targeted shifts and overtime are being used to amplify performance in the evening / night as well as at weekends.

The Trust Board is also asked to note that the following areas will continue to receive detailed scrutiny in order to sustain the improvements made:

- ✓ Shift / Rota fill
- ✓ Resuscitation Refresher Training
- ✓ The use of ePCR to prompt the completion of all essential documentation
- ✓ The use of National Data to support work in STEMI and call to Angiography
- ✓ Continued management of call answer time and conversion to 999 in the Trust's 111 service
- ✓ Recruitment together with reducing vacancy rates, turnover and sickness
- ✓ Clinical Educational Training

Resilience

The Trust Board is asked to note that the Trust continues to actively plan for Winter and that it is working with Regional and National colleagues in its preparation for EU Exit. This work is subject to standalone reporting submitted to Trust Board, Sub-Committee and the Executive for scrutiny and Assurance

Horizon Scanning and Enhanced Forecasting

As stated above the Trust is actively planning to enhance its preparedness over coming weeks supported by Regional and National Colleagues.

This report will be developed to include a balanced score card format that sets out key metrics. For the purpose of reporting to the Trust Board in September the content of pages 4 and 5 show response times and underlying productivity metrics to provide assurance that management effort is being applied to those areas that support sustained performance. This will be added to capture other measures within different areas of the organisation.

Strategic Alignment and Enablers

The Trust Board is now reviewing the full suite of products for its recent review of Strategy and determining its overall Strategic Vision and Purpose. This follows the recent CQC grading of the Trust as Good and the lifting of Special Measures. The Trust Strategy will enshrine a continued emphasis on response times and quality of its 999 and 111 Services (the later being subject to a successful application for 111CAS services in Kent and Medway and Sussex).

Enabling strategies continue to be reported within the supporting Trust Delivery Plan and narrative. These will be subject to review (to confirm alignment) following the Trust's review and setting of Strategic Vision and Objectives.

SECAmb Financial Performance

The Trust recorded a deficit in July of £0.1m. This was as planned.

Cost improvements of £0.6m were delivered in the month, £0.2m behind plan. The full year target is £8.6m.

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

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

- Achievement of contractual income if activity, demand and performance trajectories are not met.
- Ability to meet the demanding resourcing plans for both 999 and 111, with potential premium costs to ensure delivery of performance trajectories.
- Delivery of cost improvements that are essential to ensure financial balance.

The Finance Team continues to work with budget holders and service leads to mitigate risks as far as possible.

Provider Sustainability Funding (PSF) of £1.8m is planned to be received this financial year, and is contingent on the Trust achieving its control total. The first quarter (£0.3m) has been achieved.

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

SECAmb Performance

August 2019

	Target		AQI		
Category	Mean	90th Centile	Incidents	Mean	90th Centile
C1	00:07:00	00:15:00	3646	00:07:16	00:13:47
C1T	00:19:00	00:30:00	2324	00:09:04	00:17:52
C2	00:18:00	00:40:00	32749	00:18:22	00:34:24
C3		02:00:00	20586	01:23:15	03:10:14
C4		03:00:00	441	01:47:46	04:25:44
HCP 60			84	02:11:07	04:22:18
HCP 120			1549	02:22:52	04:57:06
HCP 240			270	03:10:42	06:14:20
ST	All Incidents		20648	32.53%	
SC	All Incidents		39012	61.46%	
HT	All Incidents		3818	6.01%	
999	Mean Call Answer		67380	00:06	
999	90th Centile Call Answer			00:10	
Trust EOC 999 Abandoned Calls			429	0.6%	

SECAmb Productivity

Week commencing 5th August 2019

	RPI	Job Cycle Time	Qualified Shift Cover	Staff Hours Booked On	SRV Staff Hours	NET Staff Hours	DCA Staff Hours
Actual	1.08	01:35:05	96.66%	61,529	4.6%	2.1%	93.3%
Target	1.12	01:32:00	100%	65,500	3%	0%	97%

Week commencing 12th August 2019

	RPI	Job Cycle Time	Qualified Shift Cover	Staff Hours Booked On	SRV Staff Hours	NET Staff Hours	DCA Staff Hours
Actual	1.08	01:34:42	97.11%	61,438	3.8%	1.7%	94.5%
Target	1.12	01:32:00	100%	65,500	3%	0%	97%

Week commencing 19th August 2019

	RPI	Job Cycle Time	Qualified Shift Cover	Staff Hours Booked On	SRV Staff Hours	NET Staff Hours	DCA Staff Hours
Actual	1.08	01:34:21	97.58%	61,784	3.9%	1.7%	94.4%
Target	1.12	01:32:00	100%	65,500	3%	0%	97%

Week commencing 26th August 2019

	RPI	Job Cycle Time	Qualified Shift Cover	Staff Hours Booked On	SRV Staff Hours	NET Staff Hours	DCA Staff Hours
Actual	1.08	01:36:08	97.45%	62,695	3.9%	1.7%	94.4%
Target	1.12	01:32:00	100%	65,500	3%	0%	97%

SECAmb Benchmarking Data

Response & Call Answer Performance August 2019

	C1	Mean
	England	**00:07:05**
1	North East	00:06:33
2	London	00:06:36
3	West Midlands	00:06:44
4	Yorkshire	00:06:50
5	South Central	00:06:55
6	South East Coast	00:07:15
7	South Western	00:07:15
8	North West	00:07:16
9	East Midlands	00:07:23
10	East of England	00:07:45
11	Isle of Wight	00:13:01

	C2	Mean
	England	**00:21:13**
1	West Midlands	00:12:35
2	South Central	00:15:38
3	Yorkshire	00:17:04
4	South East Coast	00:18:21
5	London	00:18:28
6	North West	00:22:16
7	East of England	00:24:56
8	North East	00:27:11
9	South Western	00:27:52
10	Isle of Wight	00:28:01
11	East Midlands	00:29:39

	C3	90th
	England	**02:28:07**
1	Yorkshire	01:26:58
2	West Midlands	01:28:08
3	South Central	01:50:42
4	London	02:12:57
5	North West	02:42:02
6	South Western	02:57:33
7	East of England	03:05:47
8	South East Coast	03:09:59
9	Isle of Wight	03:22:21
10	East Midlands	03:31:00
11	North East	03:44:46

	C4	90th
	England	**02:50:57**
1	Yorkshire	01:28:02
2	West Midlands	02:07:18
3	South Central	02:43:34
4	East of England	03:00:44
5	North West	03:05:04
6	London	03:20:57
7	East Midlands	03:25:45
8	South Western	03:28:14
9	North East	03:35:32
10	Isle of Wight	04:07:51
11	South East Coast	04:25:38

	Call Answer Times	Mean
	England	**9**
1	East Midlands	3
2	Yorkshire	3
3	North East	4
4	West Midlands	4
5	East of England	6
6	South East Coast	6
7	Isle of Wight	7
8	North West	9
9	South Central	9
10	South Western	10
11	London	20

Clinical Outcomes April 2019**

	Proportion discharged from hospital alive (Utstein comparator group**)	%
	England	**26.5%**
1	South Central Ambulance Service NHS Foundation Trust	40.0%
2	North East Ambulance Service NHS Foundation Trust	35.3%
3	Yorkshire Ambulance Service NHS Trust	35.0%
4	London Ambulance Service NHS Trust	32.4%
5	West Midlands Ambulance Service NHS Foundation Trust	31.6%
6	South Western Ambulance Service NHS Foundation Trust	28.8%
7	East Midlands Ambulance Service NHS Trust	22.2%
8	North West Ambulance Service NHS Trust	21.7%
9	East of England Ambulance Service NHS Trust	20.8%
10	South East Coast Ambulance Service NHS Foundation Trust	8.0%
11	Isle of Wight NHS Trust	0.0%

	Call to door (K1m) For patients in K1n, mean average time from call to hospital arrival (hours:minutes)	Mean
	England	**01:20**
1	London Ambulance Service NHS Trust	01:06
2	West Midlands Ambulance Service NHS Foundation Trust	01:07
3	Isle of Wight NHS Trust	01:12
4	South Central Ambulance Service NHS Foundation Trust	01:12
5	North West Ambulance Service NHS Trust	01:15
6	South East Coast Ambulance Service NHS Foundation Trust	01:15
7	East Midlands Ambulance Service NHS Trust	01:20
8	North East Ambulance Service NHS Foundation Trust	01:24
9	East of England Ambulance Service NHS Trust	01:28
10	Yorkshire Ambulance Service NHS Trust	01:28
11	South Western Ambulance Service NHS Foundation Trust	01:30

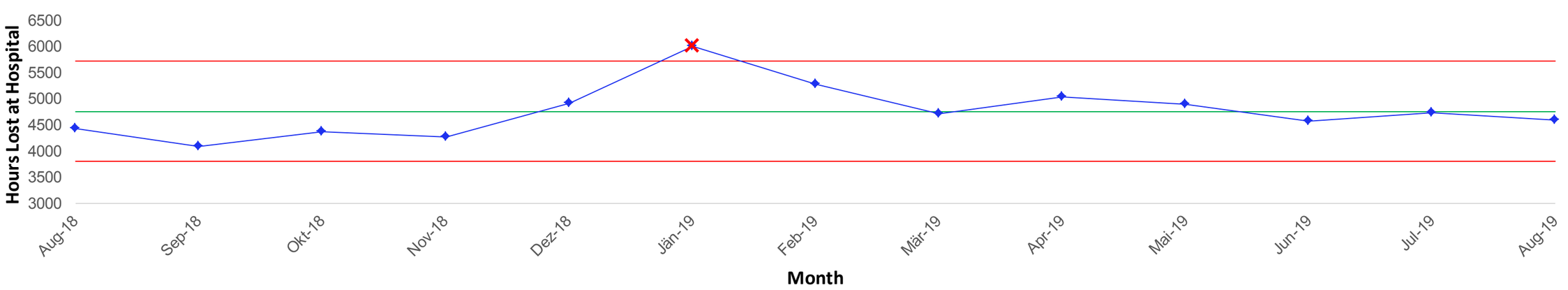
	Call Answer Times	90th centile
	England	**26**
1	Yorkshire	1
2	East Midlands	3
3	Isle of Wight	7
4	East of England	8
5	North East	8
6	South East Coast	10
7	West Midlands	11
8	South Central	12
9	North West	29
10	South Western	34
11	London	77

*** National Clinical Outcomes data is collected & published 5 months behind performance data.*

SECAmb Handover Delay Reporting

August 2019

Hospital	No. of Transports	No. of Handovers	Handover Button Compliance	HO < 15mins	HO < 15mins %	HO > 60mins	HO > 60mins %	Longest Handover	Hours Lost Through Handover
Conquest Hospital	2083	1727	82.9%	639	37.0%	9	0.5%	1:37:07	152.09
Darent Valley Hospital	2081	1738	83.5%	512	29.5%	41	2.4%	1:50:44	321.02
East Surrey Hospital	3083	2988	96.9%	1265	42.3%	9	0.3%	1:12:37	249.47
Eastbourne DGH	1902	1507	79.2%	375	24.9%	19	1.3%	1:52:39	215.26
Epsom Hospital	1096	1014	92.5%	205	20.2%	2	0.2%	1:11:40	119.27
Frimley Park Hospital	2046	1962	95.9%	779	39.7%	4	0.2%	1:08:42	142.80
Kent And Canterbury Hospital	128	37	28.9%	13	35.1%	0	0.0%	0:54:02	4.20
Maidstone Hospital	1304	1170	89.7%	520	44.4%	5	0.4%	1:18:15	93.57
Medway Maritime Hospital	3588	3339	93.1%	1838	55.0%	65	1.9%	2:44:56	321.09
Princess Royal Hospital	804	702	87.3%	195	27.8%	19	2.7%	1:36:38	93.65
Queen Elizabeth Queen Mother Hospital	3011	2869	95.3%	1530	53.3%	0	0.0%	0:57:51	143.38
Royal Surrey County Hospital	1337	1201	89.8%	482	40.1%	6	0.5%	1:39:56	104.49
Royal Sussex County Hospital	3290	2994	91.0%	1118	37.3%	43	1.4%	1:50:27	401.11
St Peter's Hospital	2465	2304	93.5%	1105	48.0%	5	0.2%	1:34:04	121.22
St Richard's Hospital	1868	1785	95.6%	549	30.8%	14	0.8%	1:38:45	196.55
Tunbridge Wells Hospital	2536	2370	93.5%	874	36.9%	36	1.5%	1:27:48	293.19
William Harvey Hospital	3266	3114	95.3%	835	26.8%	18	0.6%	1:19:48	382.87
Worthing Hospital	2300	1991	86.6%	891	44.8%	27	1.4%	1:55:47	177.30



Our Patients

SECAmb Clinical Safety Scorecard

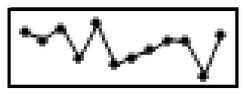
Cardiac Return of Spontaneous Circulation (ROSC) - Utstein (a set of guidelines for uniform reporting of cardiac arrest)

	Mar-19	Apr-19	May-19	12 Months
Actual %	50.0%	34.6%	58.1%	
Previous Year %	56.4%	40.9%	50.0%	
National Average %	53.3%	TBC	TBC	

Cardiac ROSC - ALL

	Mar-19	Apr-19	May-19	12 Months
Actual %	33.0%	19.2%	23.7%	
Previous Year %	22.9%	29.7%	25.1%	
National Average %	33.0%	TBC	TBC	

Cardiac Survival - Utstein

	Mar-19	Apr-19	May-19	12 Months
Actual %	28.1%	8.0%	32.3%	
Previous Year %	22.2%	21.4%	20.7%	
National Average %	30.4%	TBC	TBC	

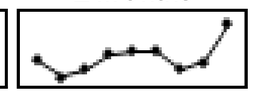
Cardiac Survival - All

	Mar-19	Apr-19	May-19	12 Months
Actual %	9.8%	6.0%	6.4%	
Previous Year %	5.5%	8.6%	4.5%	
National Average %	9.5%	TBC	TBC	

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

	Mar-19	Apr-19	May-19	12 Months
Actual %	61.9%	57.5%	59.0%	
Previous Year %	67.8%	69.1%	69.6%	
National Average %		TBC	TBC	

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

	Mar-19	Apr-19	May-19	12 Months
Mean (hh:mm)	02:29	TBC	TBC	
National Average	02:11	TBC	TBC	
90th Centile (hh:mm)	03:31	TBC	TBC	
National Average	02:56	TBC	TBC	

Stroke - call to hospital arrival

	Mar-19	Apr-19	May-19	12 Months
Mean (hh:mm)	01:15	01:11	01:14	
National Average	01:14	TBC	TBC	
Median (hh:mm)	01:06	01:04	01:04	
National Average	01:06	TBC	TBC	
90th Centile (hh:mm)	01:55	01:44	01:51	
National Average	01:50	TBC	TBC	

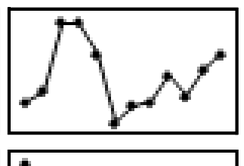
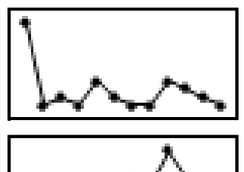
Stroke - assessed F2F diagnostic bundle

	Mar-19	Apr-19	May-19	12 Months
Actual %	97.5%	97.8%	95.8%	
Previous Year %	96.5%	97.4%	98.7%	
National Average %		TBC	TBC	

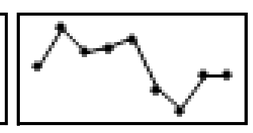
Post ROSC Care Bundle

	Mar-19	Apr-19	May-19	12 Months
Actual %	80.4%	87.5%	85.3%	
National Average %		TBC	TBC	

Medicines Governance

	May-19	Jun-19	Jul-19	12 Months
Total Number of Medicines Incidents	192	169	128	
Single Witness Sig/Inapt Barcode Use CDs Omnicell	7	12	15	
Single Witness Sig/Inapt Barcode Use CDs Non-Omnicell	2	1	0	
Total Number of CD Breakages	19	10	15	
Key Skills Medicine Governance	218	340	241	

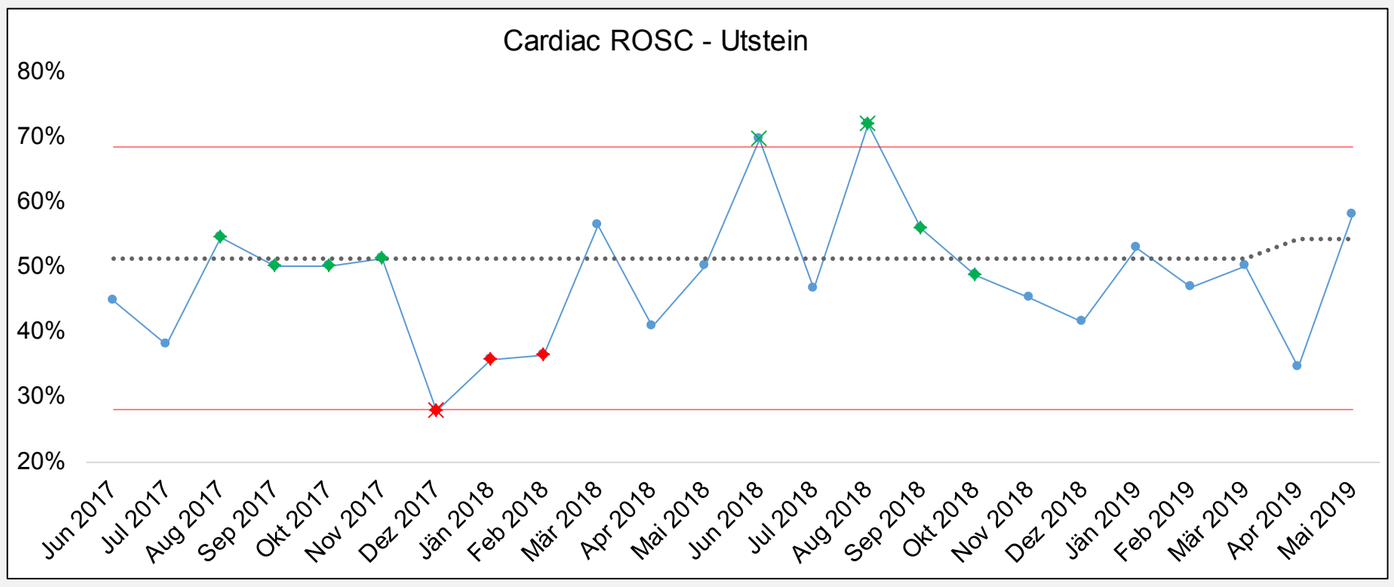
Sepsis Care Bundle Compliance

	Mar-19	Apr-19	May-19	12 Months
Actual %	74.9%	78.9%	78.8%	

Medicines Management

	May-19	Jun-19	Jul-19	12 Months
Number of Audits	192	164	192	
Percentage of Audits	99.6%	99.2%	99.1%	

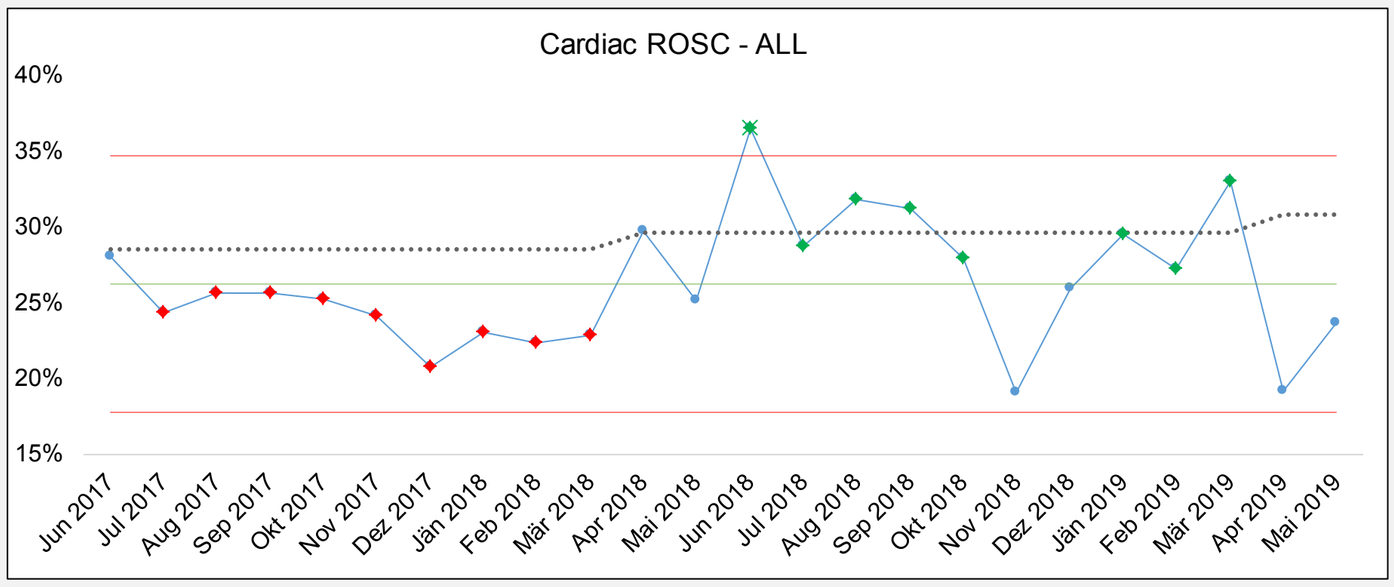
SECAmb Clinical Safety Charts

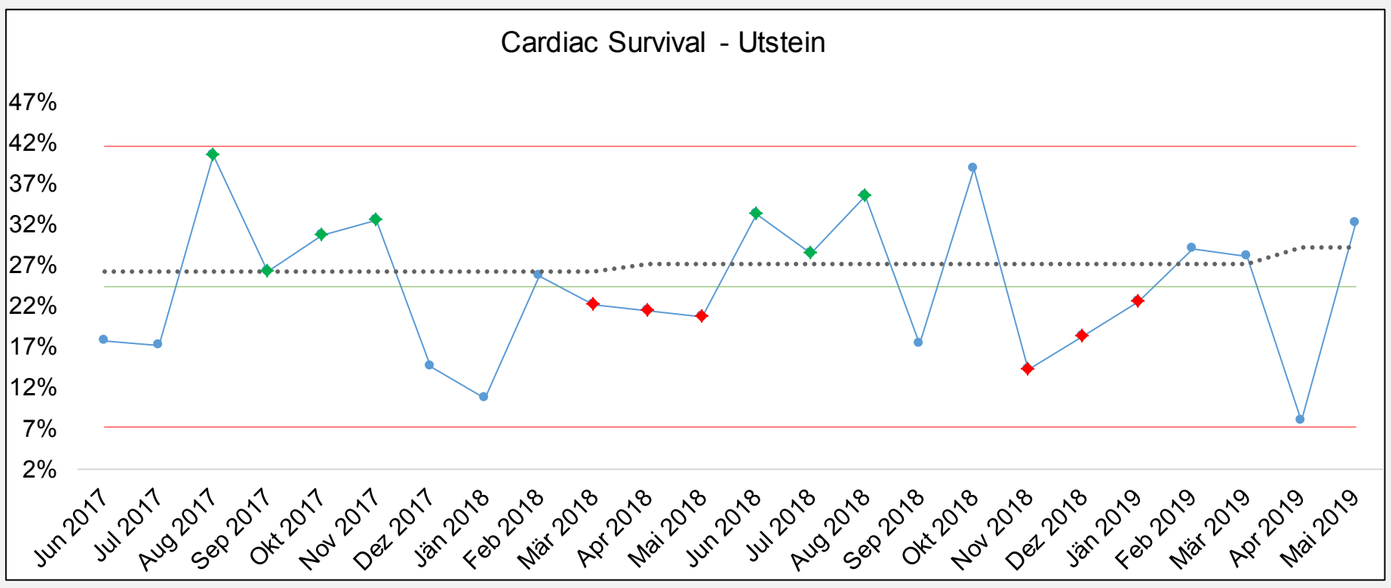


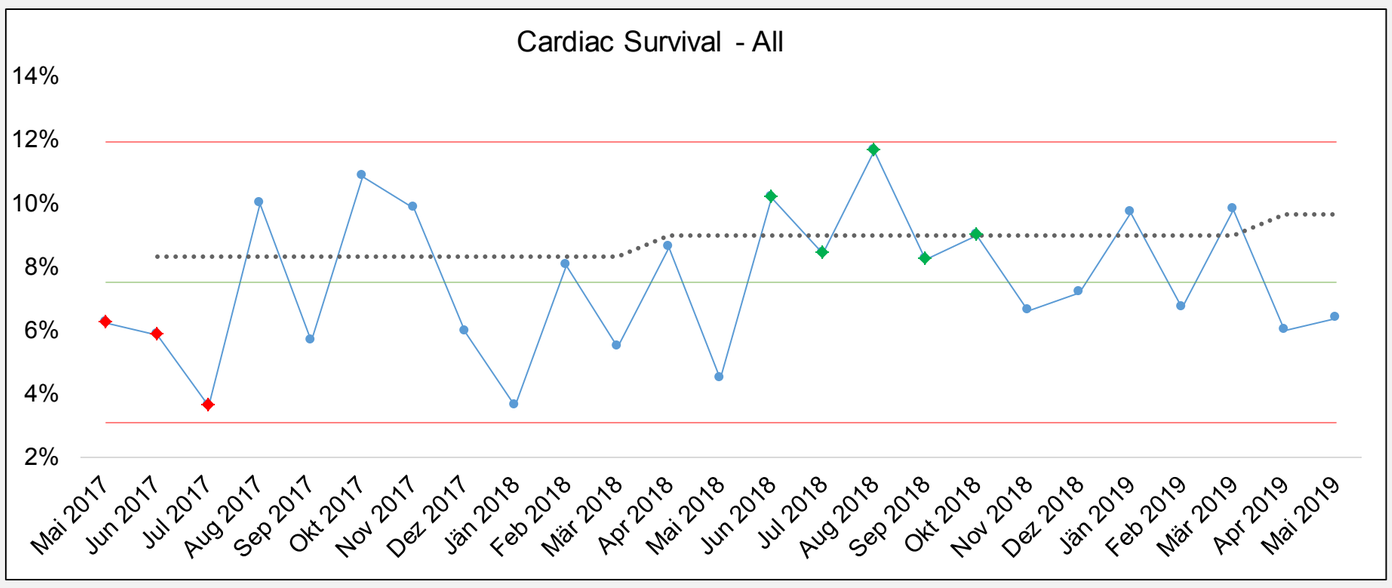
This measure shows the proportion of resuscitation attempts that had a return of spontaneous circulation on arrival at hospital in the Utstein denominator group.

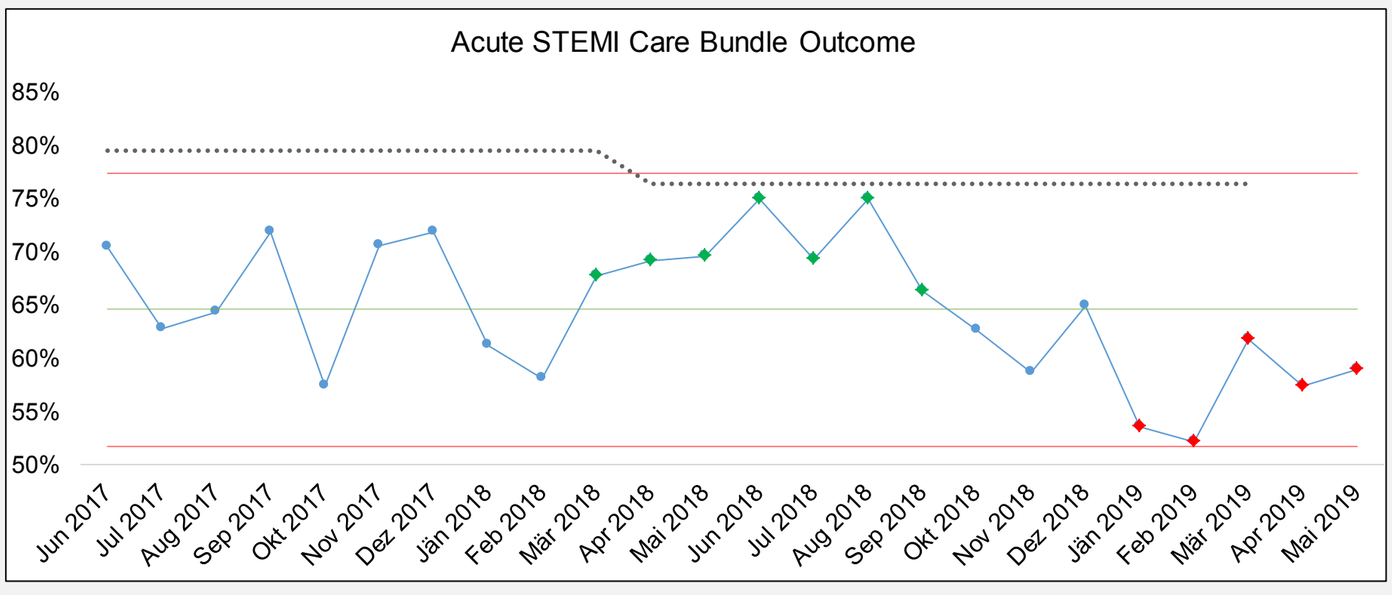
Utstein ROSC performance continues to show normal levels of variation.

Resuscitation refresher training continues as part of 2019/20 Key Skills training.





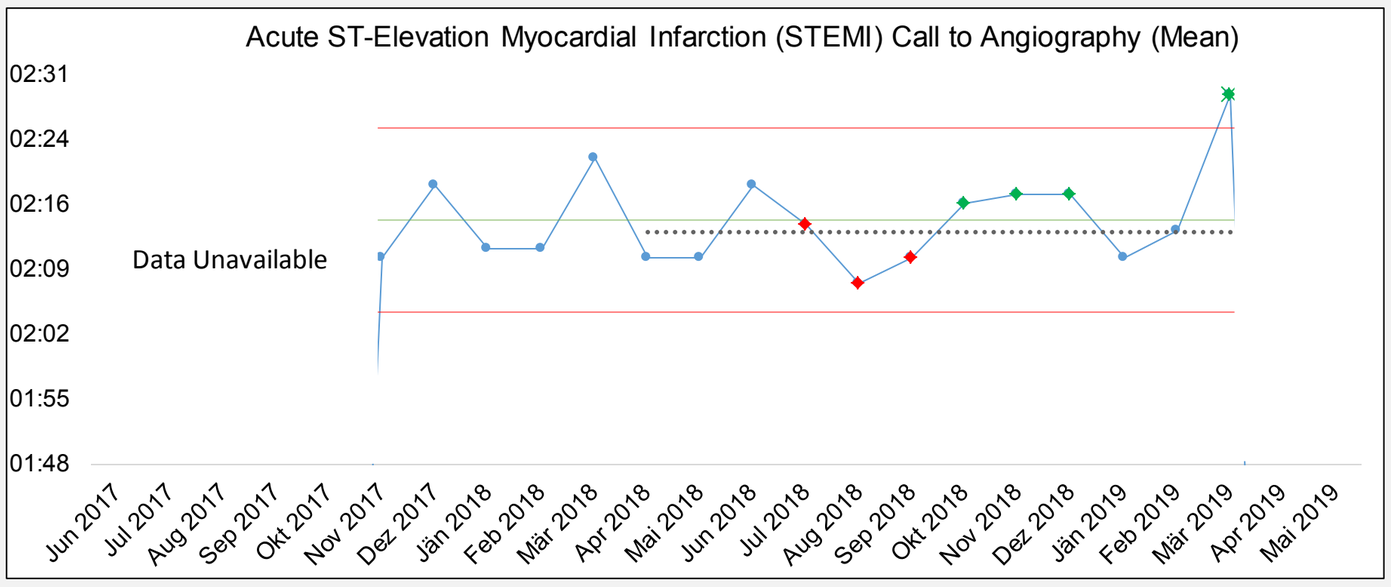




This measure shows the proportion of acute ST elevation myocardial infarction patients who received a full bundle of care.

This measure continues to show a reduction in performance. Improvements are expected with the introduction of ePCR, which prompts completion of essential documentation.

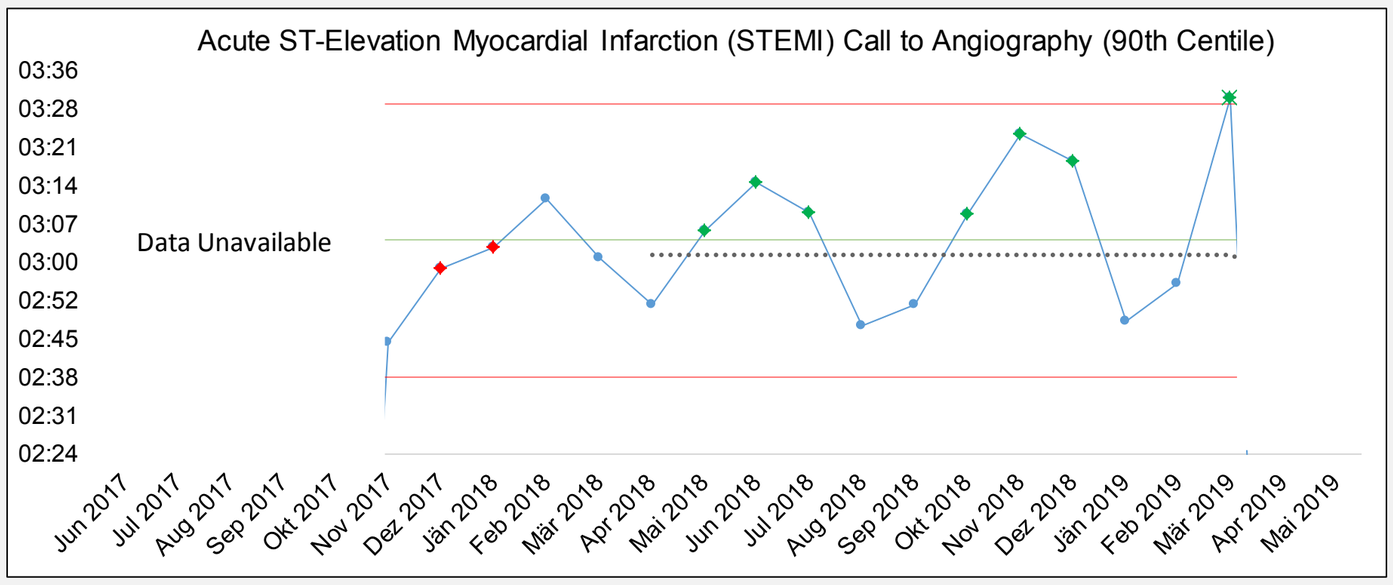
SECAmb Clinical Safety Charts

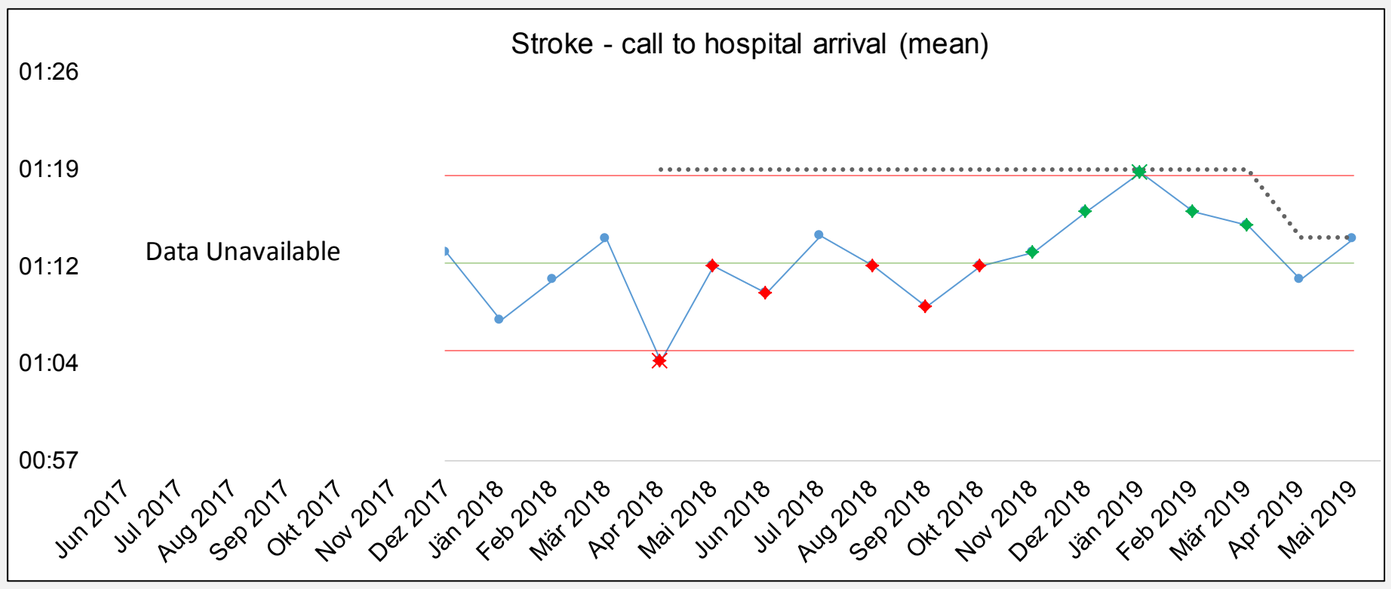


This chart shows the mean call to angiography time for patients who are suffering a STEMI.

The measure for March 2019 (latest available data) shows a data point outside of the upper control limit and suggests a special cause variation.

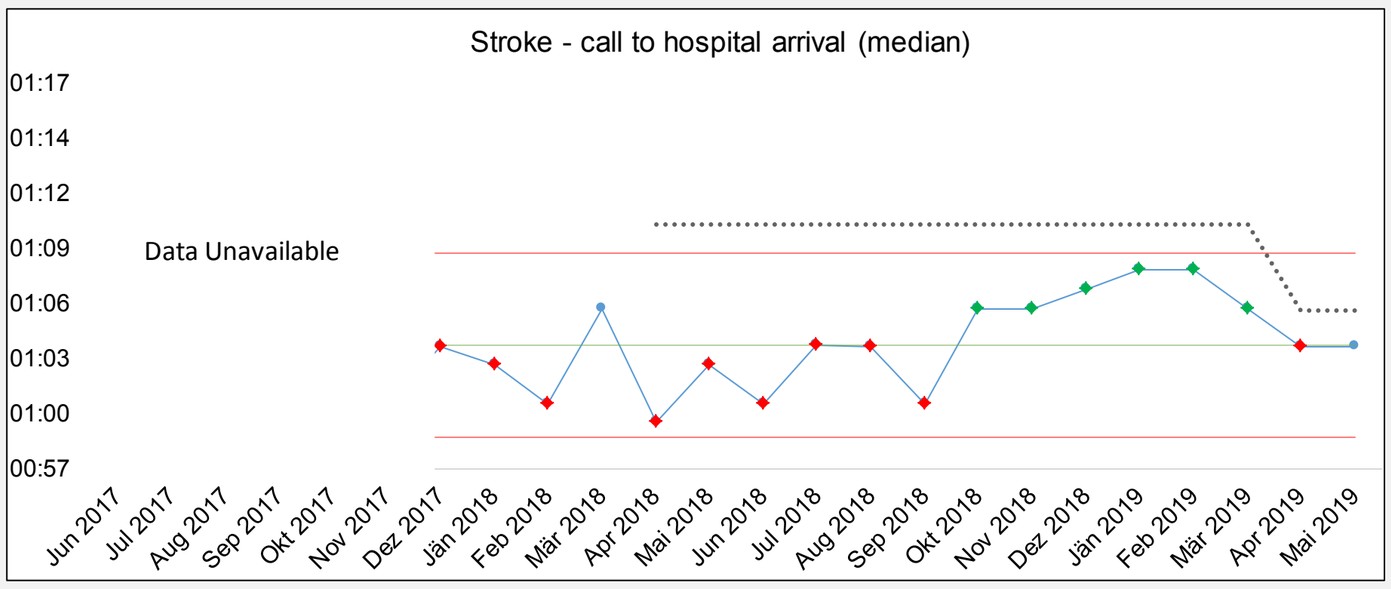
The cause of this variation is unknown. Work is ongoing nationally to give SECAmb access to the platform through which STEMI data is collected. This will allow local accuracy checks to take place.

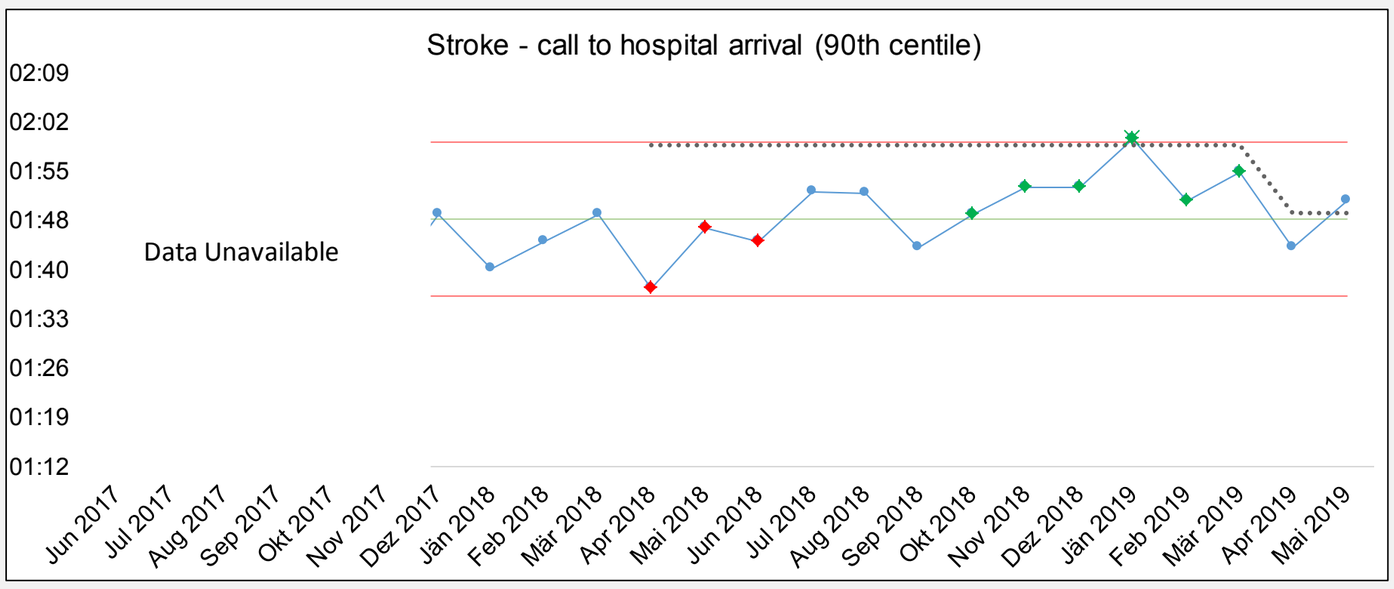




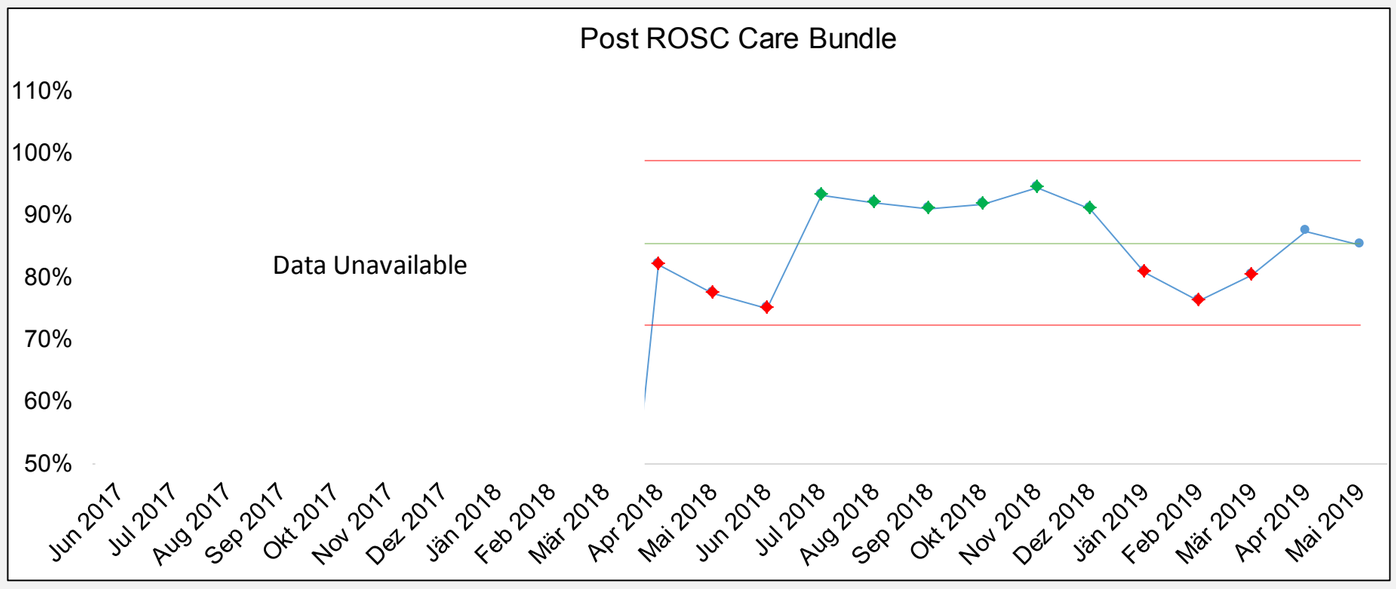
This chart shows the mean call to hospital time for patient's who are suffering a suspected stroke.

This measure shows normal levels of variation.



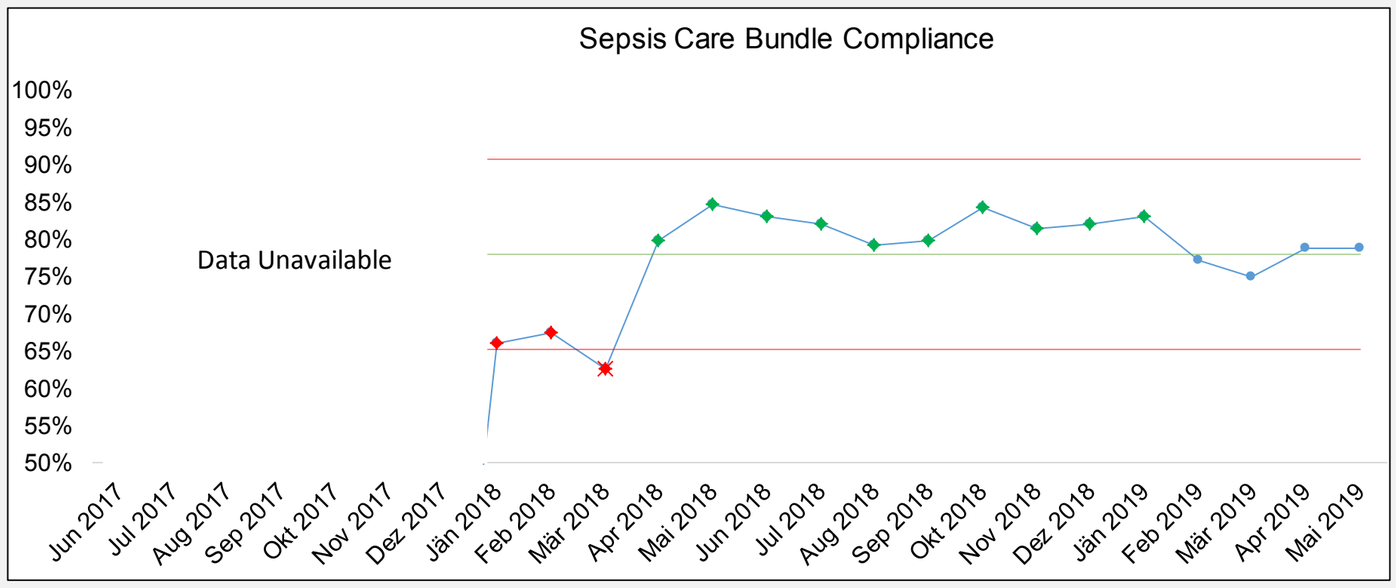


SECAmb Clinical Safety Charts



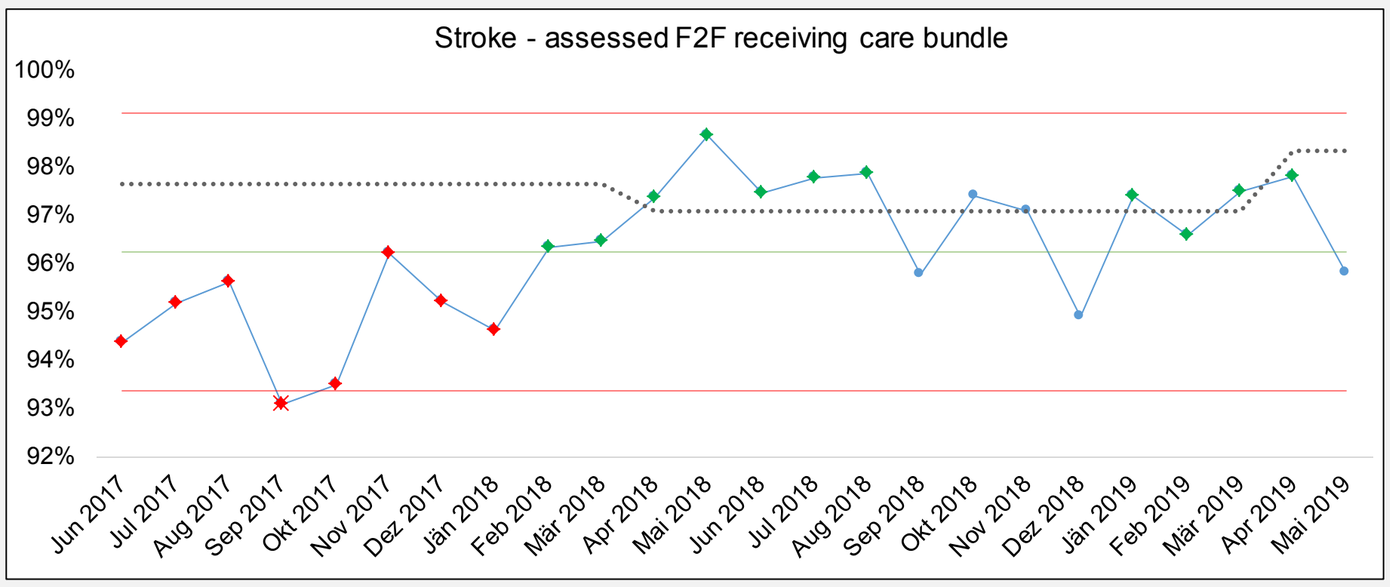
This chart shows the proportion of patients who received a full bundle of care after a return of spontaneous circulation had been achieved.

This measure continues to show normal levels of variation.



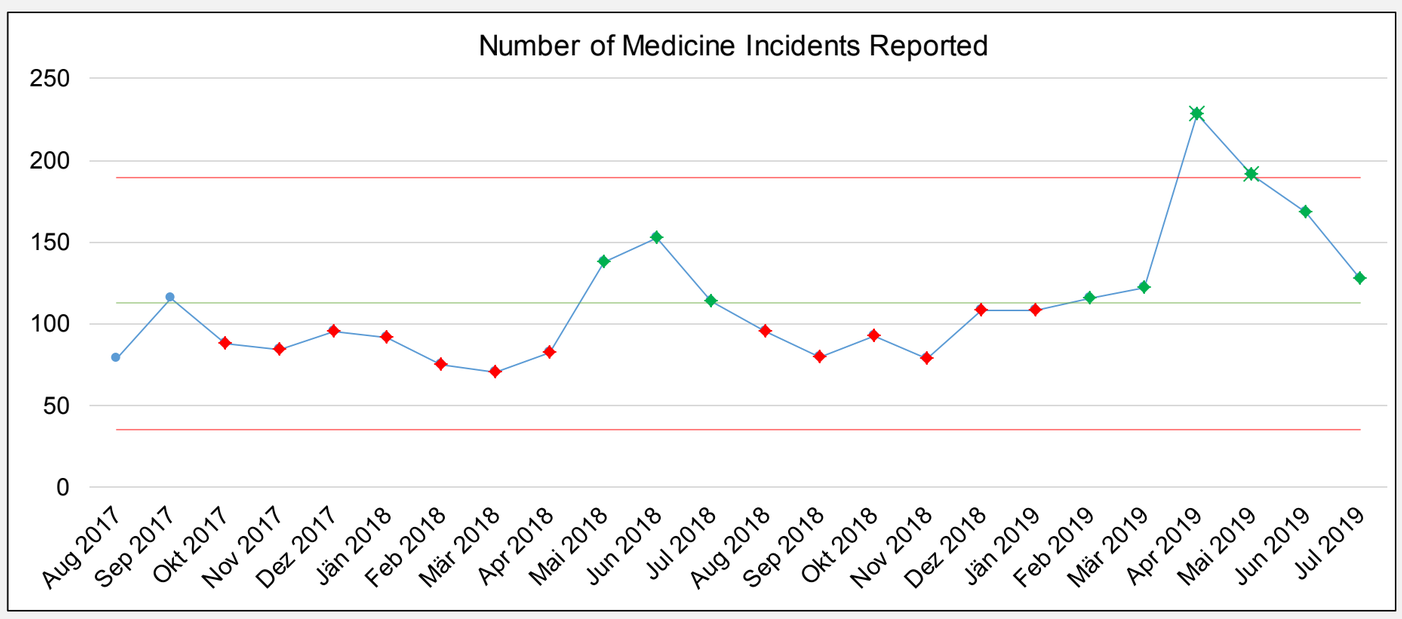
This chart shows the proportion of patients with suspected sepsis who receive a full bundle of care.

This measure continues to show normal levels of variation.

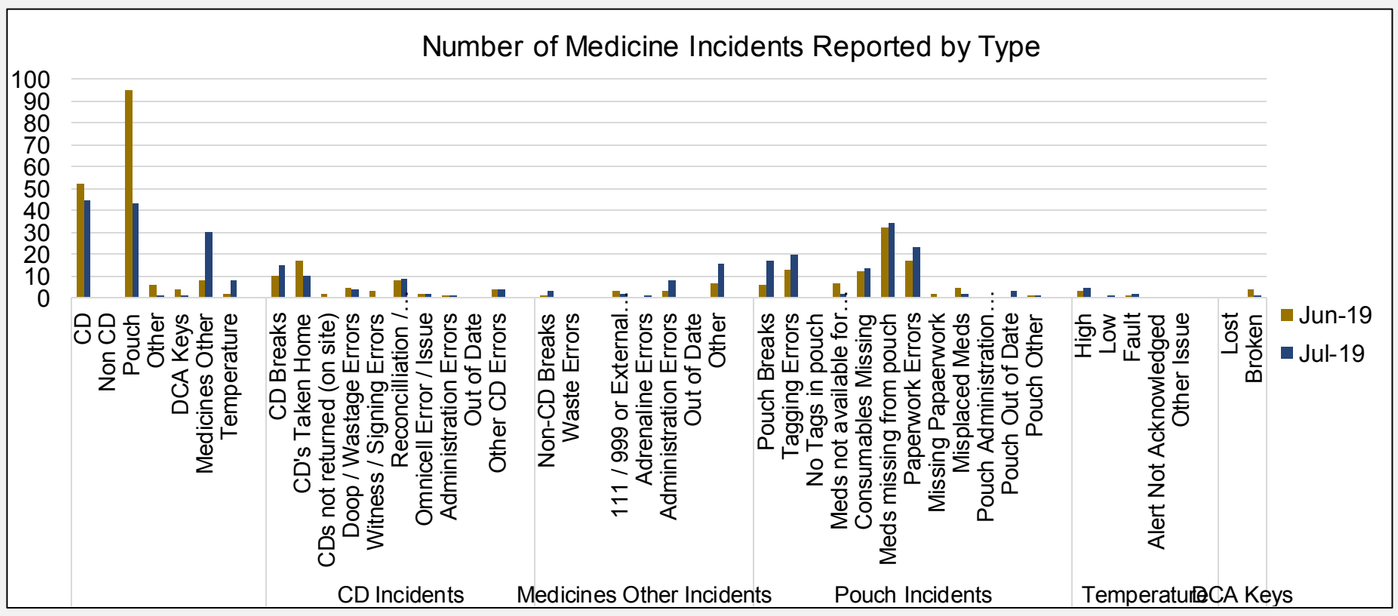


This chart shows the proportion of patients with suspected stroke who receive a full diagnostic bundle.

This measure continues to show normal levels of variation.

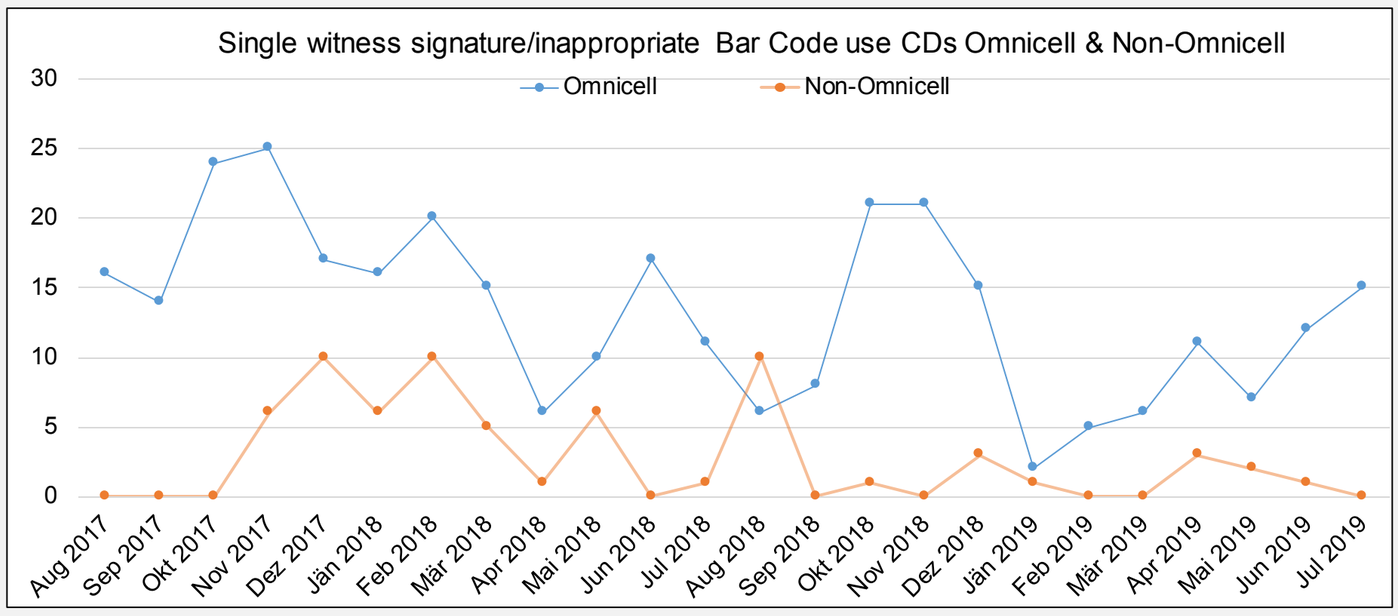


Commentary is by exception only. This metric currently has nothing to note.



Commentary is by exception only. This metric currently has nothing to note.

SECAmb Clinical Safety Charts



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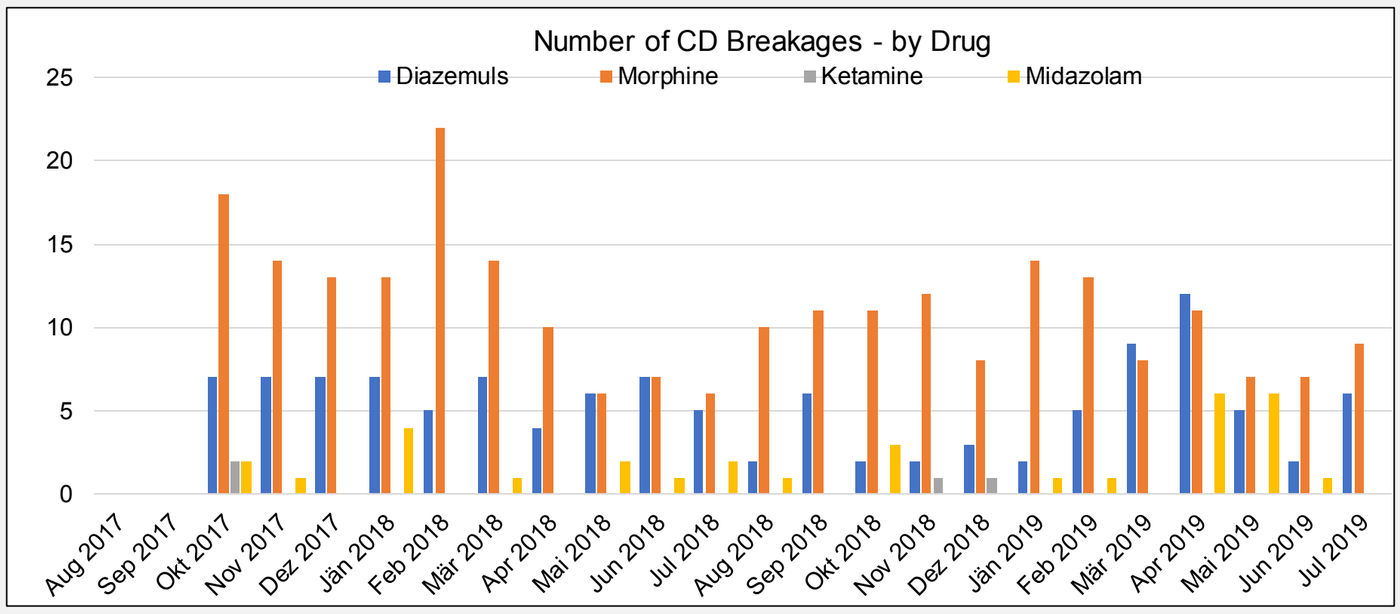
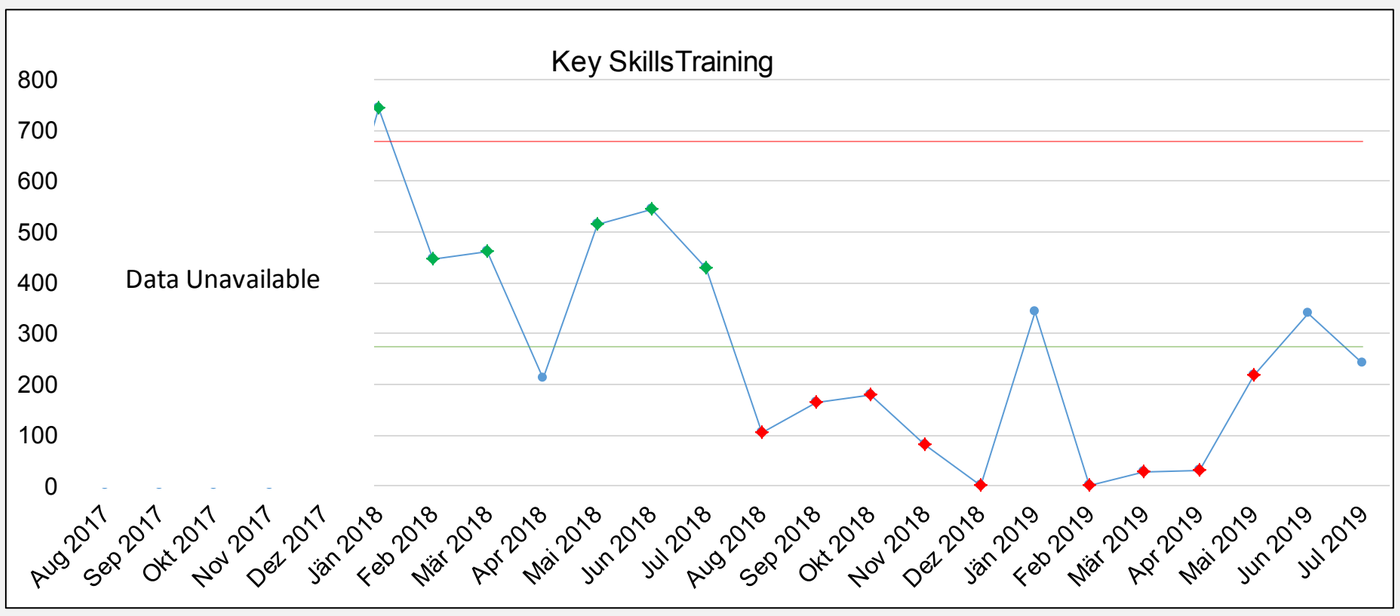


Commentary is by exception only. This metric currently has nothing to note.



Commentary is by exception only. This metric currently has nothing to note.

Sec 136 data June for July report

Mental Health Response Times (Section 136 MHA)
During July 2019, the mental health indicator demonstrates there were 197 (June n=129) Section 136 related calls to the service. Of these 142 (June n=109) received a response resulting in 133 (June n=98) conveyances to a place of safety by an ambulance.

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 **AMBER** as the mean response measures are outside of the cat 2 standard on the 18 minute response, although within 40 minute 90th centile response.

Cat 2	00:19:32	(June 00:21:11)
90th Centile	00:38:33	(June 00:39:16)

During July 2019, there were 197 Section 136 related calls to the service.142 (72.1%) of these calls received a response (84.4% in June) resulting in a conveyance to a place of safety by an ambulance on 133 (67.5% of total calls) of these occasions. (In June, this was 75.9% of total calls).

The overall performance mean shows a Cat 2 response time across the service as 00:19.32 (June was 00.21:11). Against the 90th centile measure, the response was 00.38.33 (June was 00.39:16).

Data for transports of under 18 is currently not available via Power BI., although Business Intelligence will look to stratify data by age.

There were 55 occasions when SECAmb did not provide a response. This is up from 20 in June. 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, and HCP60 (these are likely to be secondary conveyances and are not RAG rated) and these are as follows:

Cat 3:	Total calls 3	Total responses 1	Total transports 1
C60 HCP:	Total calls 10	Total responses 4	Total transports 3

SECAmb Quality and Patient Safety

Quality and Patient Safety Report:

During August 2019 Safeguarding referral rates decreased slightly from July 2019 from 1382 to 1332. Increasing care needs and areas of self-neglect and environmental concerns remain to be top themes. Currently all SECAmb referrals follow the safeguarding route irrespective of whether the patient concerns are suggestive of increasing care needs rather than indicators of harm, abuse or neglect. Following discussions with Safeguarding leaders at Surrey County Council (SCC) a joint project between SECAmb and SCC will focus on a more streamlined triage process of referrals. It is anticipated that an outcome of the project will evidence more appropriate referrals to the local authority in the event of increasing care needs. The project will be co-ordinated and monitored through the Safeguarding Sub-Group.

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 1057 incidents during August 2019. The highest reporting categories remain relatively consistent, and are: SMP no send; clinical tail audits; delay in attending a category 3 response; staff welfare i.e. missed meal breaks; injury whilst lifting or moving a patient or other person. The OUs reporting the highest number of incidents are EOC Clinical; West EOC; and Gatwick and Redhill OU. 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 via the Serious incident Group. The Risk Management 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 June 2019. The Trust achieved 100% compliance with DoC requirements for SI's; this reflects the amount that were undertaken within timescale. Overall compliance continues to be monitored weekly by the Serious Incident Group.

Patient Experience: The Trust received and opened 78 complaints during August 2019. The Trust responded to 59% of complaints within the Trust's 25 working day timescale this month, the target is 95%; The challenge in responding within timescale predominantly relates to EOC complaints due to historic capacity and resilience issues which have been impacted by sickness. A plan is in place to manage this and remains under constant review. The Trust recorded 223 compliments during August, which has cleared the backlog.

Clinical Audit: the 2019/20 Clinical Audit annual plan has been agreed and is on track for delivery. Measurement of NEWS2 is being reported into the Clinical Audit and Quality Sub-Group (CAQSG) each month. An audit of the mental capacity assessment and best interest decisions was recently completed. Following this an entry was made on the Trust risk register, regarding non-compliance with Trust processes. This risk is being managed through the Safeguarding Sub-Group. A business case has recently been approved to significantly increase the size of the EOC audit team, in order to improve NHS Pathways audit compliance. A consultation to change structures and increase the team size is in the planning phase. The Patient clinical record completion audit is ongoing, performance has increased from 30% initially to over 70%. This audit process is being migrated to the Trust's new electronic audit system, 'Doc-Works'.

Learning from Deaths: The national framework on learning from deaths has been published and the Trust's new Learning from Deaths policy will come to December board for approval. Work continues to progress the development of the Trusts internal arrangements for the management of LFD. Work continues to scope resourcing opportunities to fund capacity to drive this work forward longer term. In the interim, staff on alternative duties continue within the team and a bid for special measures funding to increase capacity has been submitted – outcome awaited. Engagement continues with the LeDeR central team and the regional teams across KSS – work continues as per the plan. The Trust undertakes monthly Mortality and Morbidity Deep Dives. The 24 June 2019 deep dive theme was Anticoagulation. Prevention of Future Deaths (from coroners) continue to be reported into the LFD Group as a standing agenda item. The Trust has collaborated with the AHSN to undergo Structured Judgement Review (SJR) training for Learning from Deaths (LfD) for a handful of staff (standard SJR training for the LfD Team, and specialised mental health training (MH) for the MH Team

Clinical Outcome Indicators: The Trust saw a reduction in outcomes from cardiac arrest for the month of April with improved figures in May. These reflect the expected levels of variation month to month . April reductions can be attributed to a greater number of asystolic arrests and a reduction in the number of arrests that met Utstein criteria. These types of arrest are generally associated with poorer outcomes. The Trust has ongoing plans in place to address a reduction in performance against the STEMI care bundle. The Trust has sustained performance against other indicators.

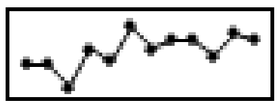
Our People

SECAmb Clinical Quality Scorecard

Number of Incidents Reported

	May-19	Jun-19	Jul-19	12 Months
Actual	858	929	1040	
Previous Year	722	712	770	

Number of Incidents Reported that were SI's

	May-19	Jun-19	Jul-19	12 Months
Actual	10	16	14	
Previous Year	6	10	9	

Duty of Candour Compliance (SIs)

	May-19	Jun-19	Jul-19	12 Months
Actual %	100%	100%	95%	
Target	100%	100%	95%	

Number of Complaints

	May-19	Jun-19	Jul-19	12 Months
Actual	64	80		
Previous Year	101	88	102	
Complaints Timeliness (All	55.0%	61.0%		
Timeliness Target	95%	95%	95%	

Compliments

	May-19	Jun-19	Jul-19	12 Months
Actual	47	61		

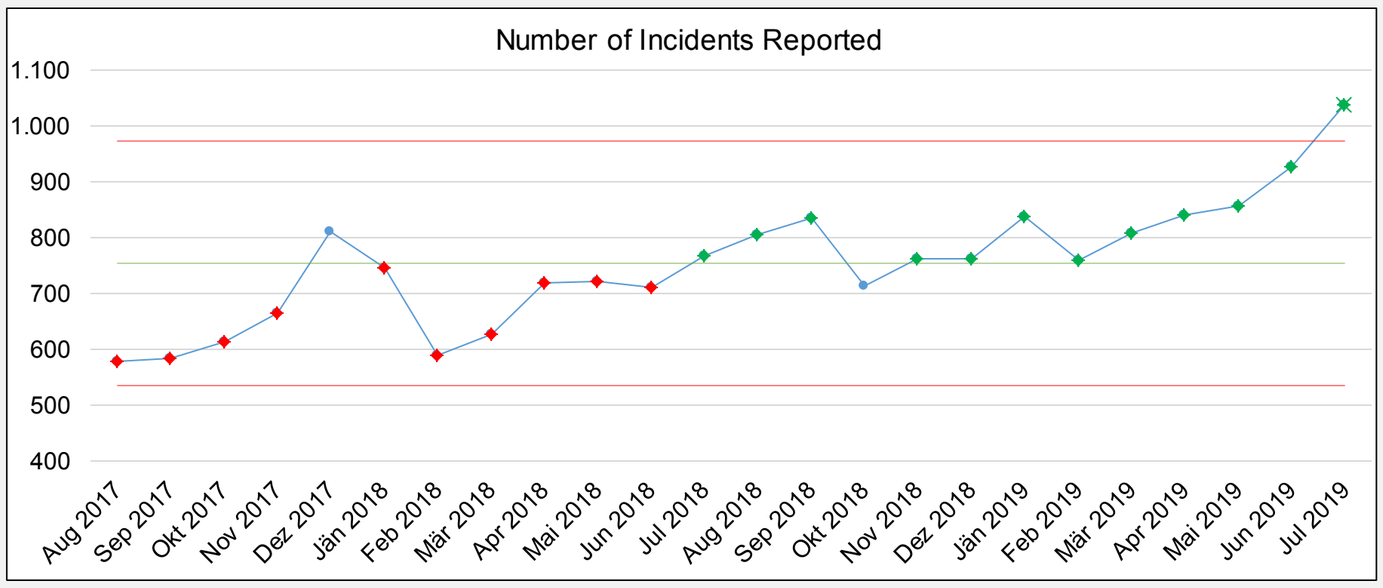
Hand Hygiene

	May-19	Jun-19	Jul-19	12 Months
Actual %	83%	91%	93%	
Upper Target	95%	95%	95%	

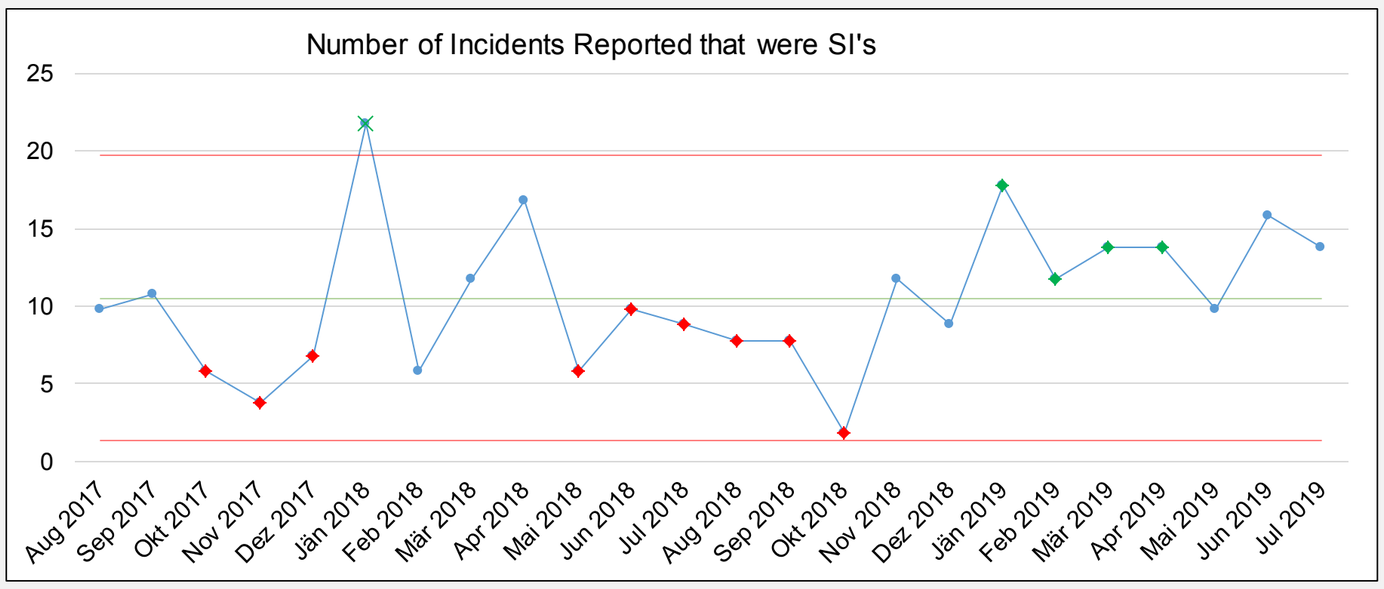
Safeguarding Training Completed (Children) Level 2

	May-19	Jun-19	Jul-19	12 Months
Actual %	21.46%	32.79%	40.75%	
Previous Year %	25.88%	38.18%	57.62%	
Target	85%	85%	85%	

SECAmb Clinical Quality Charts



Commentary is by exception only. This metric currently has nothing to note.



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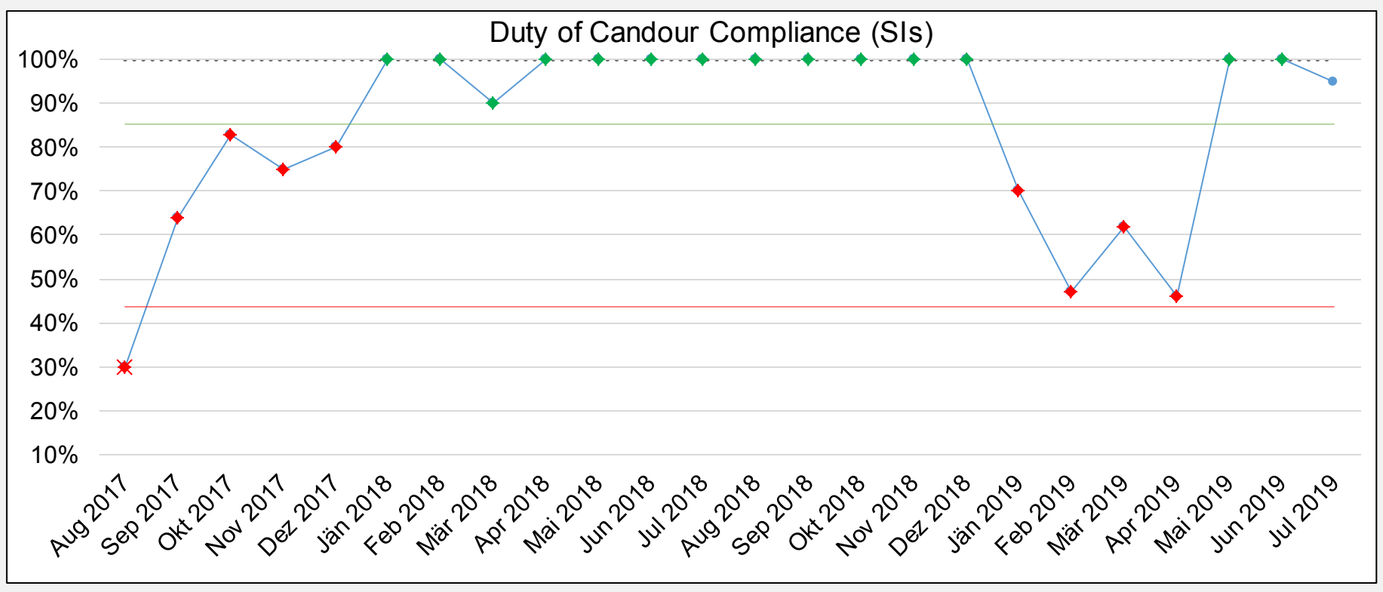

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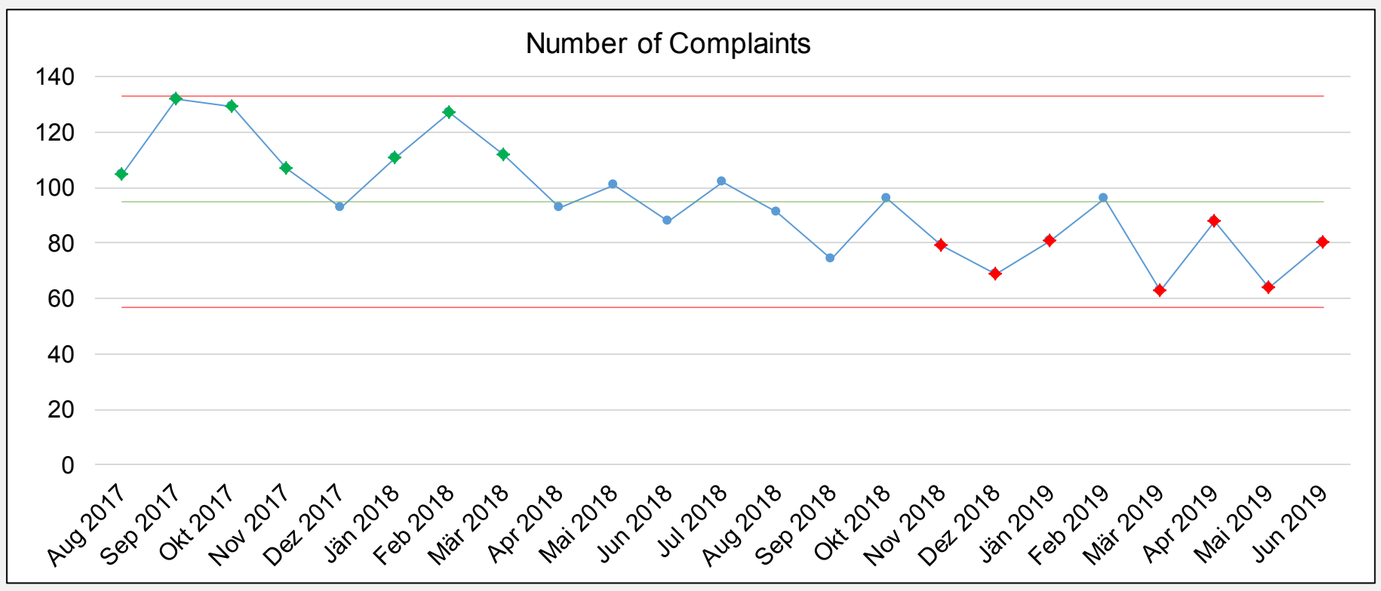

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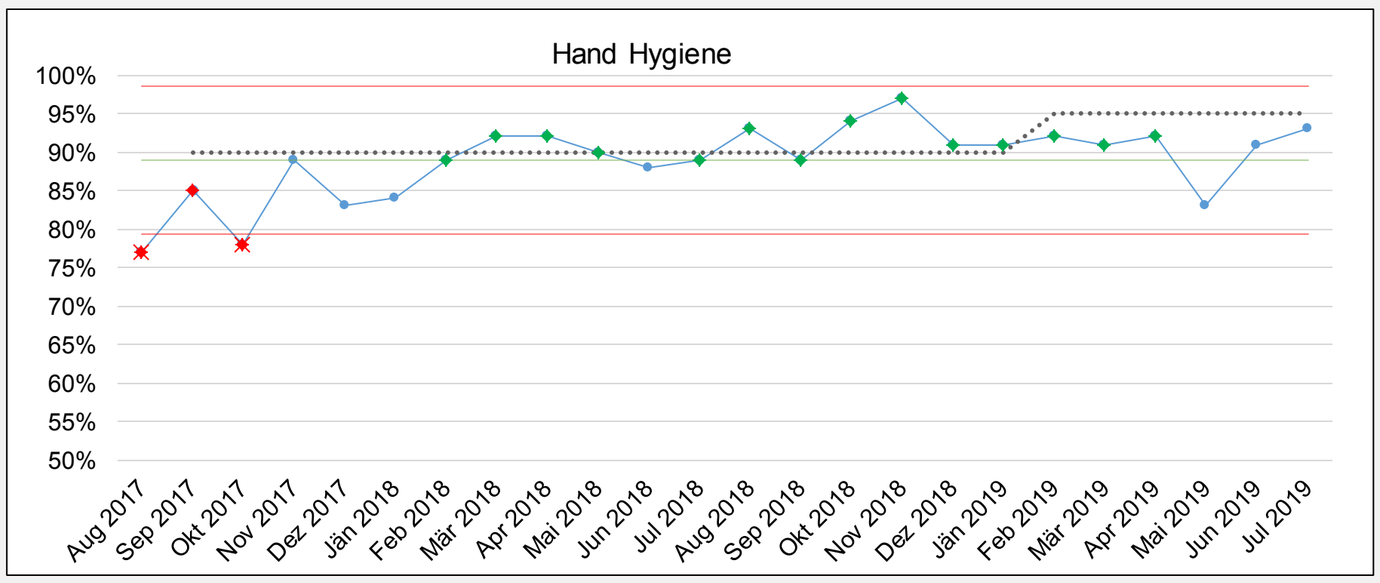


Compliance met for the second month in a row after falling below the level back in May of this year.
We are still seeing the monthly Deep Cleans being well below the 99% target and the Head of IPC has written a report on the issues, which will be presented to the Executive Management Team.

Health & Safety Audits

Since the implementation of the annual Health & Safety Audit programme 80 audits have been completed. The audits were undertaken in different working environments as per the list below.

- **Ambulance Community Response Post**; a small base with facilities, where ambulance crews can wait between calls
- **Ambulance Station**; where ambulance crews begin & end shifts
- **Emergency Operation Centre** - control room, where 999 calls are received, clinical advice provided, and emergency vehicles dispatched as needed.
- **Make Ready Centre**; a large depot where ambulance crews start & end shifts & where vehicles are cleaned, maintained & re-stocked.

Following a completed audit an action plan is produced which identifies improvement areas. The action plan is monitored with the local site management team to ensure that specified improvements are completed.

Violence and Aggression Incidents - See Figure 1 below
Violence and Aggression incidents towards staff in July 2019 were 66. The data below is a break down of the incidents reported by category type.

- Physical Assaults (18)
- Direct verbal Abuse (30)
- Anti-social behaviour/aggression (9)
- Attempted physical assault/ non-physical (9)

Manual handling Incidents - See Figure 2 below

Manual handling incidents reported in July 2019 were 23 which is a decrease of 6 incidents from the previous month.

Health & Safety Incidents - See Figure 3 below
Health and Safety incidents reported in July 2019 were 14 which is a decrease of 18 incidents when comparing to the same period in July 2018.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) - See Figure 4 below
RIDDOR incidents reported in July 2019 were 9 with 4 incidents reported on time to the Health & Safety Executive.

Figure 1

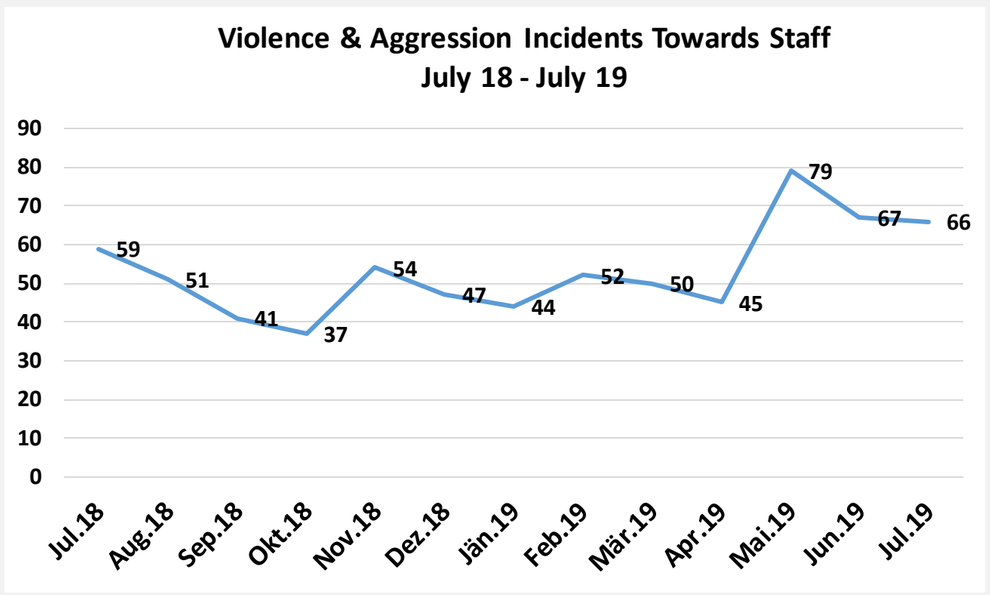


Figure 2

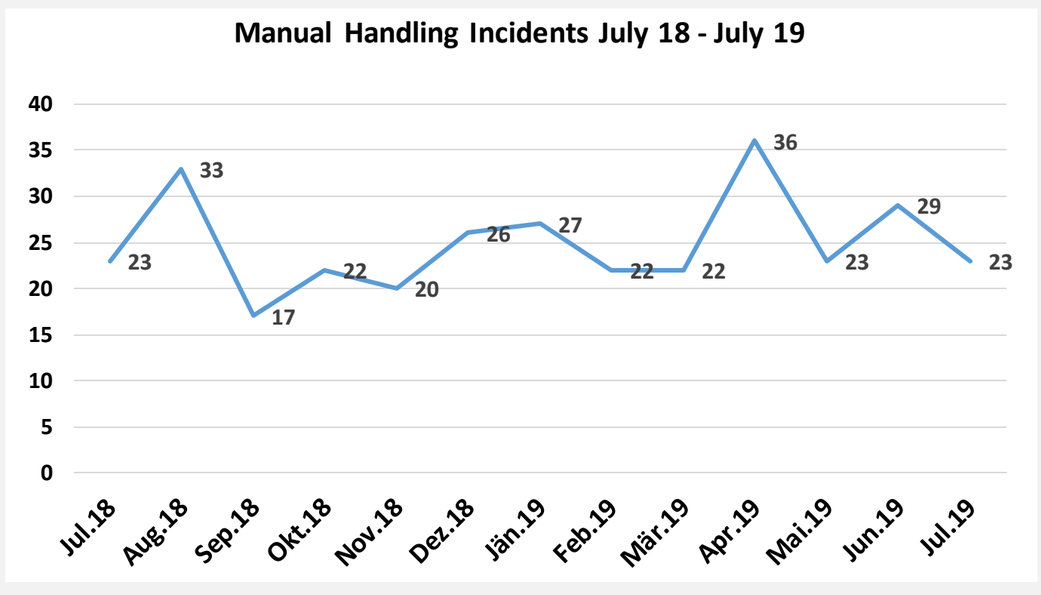


Figure 3

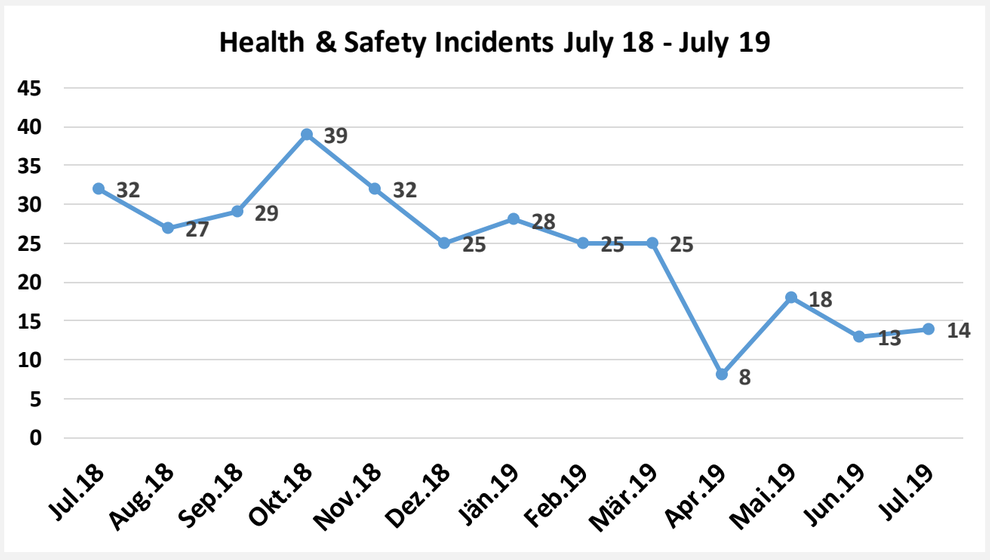
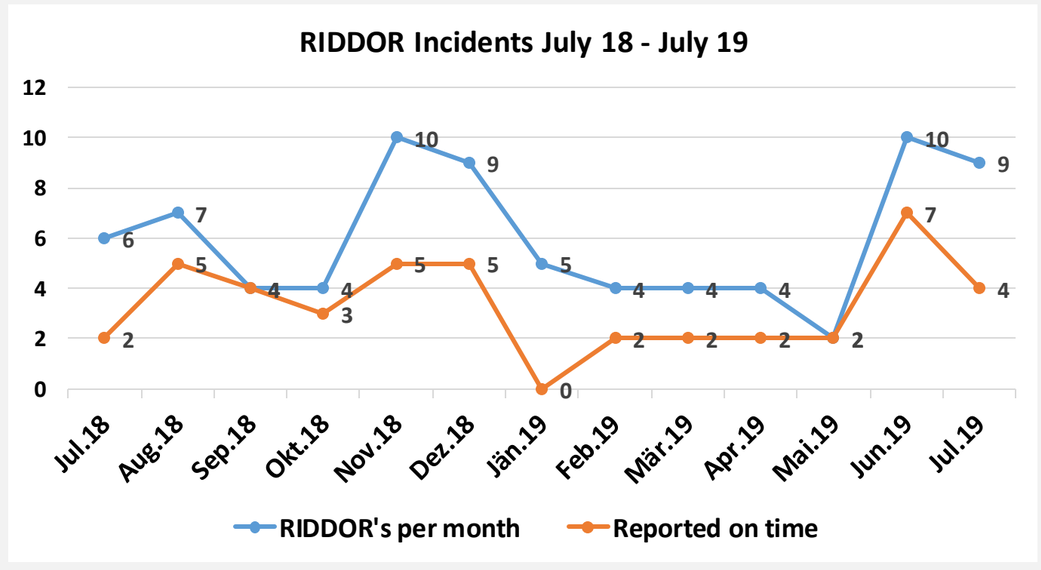


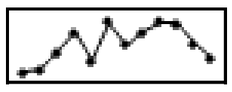
Figure 4



Our Enablers

SECAmb 999 Operations Response Time Performance Scorecard

Call Handling

	May-19	Jun-19	Jul-19	12 Months
5 Sec Performance (95% Target)	91.4%	87.3%	84.3%	
Mean Call Answer Time (secs)	5	7	9	
95th Centile Call Answer (Secs)	28	46	55	
National Mean Call Answer	5	9	10	
National 95th Centile Call Answer	27	51	59	

Category 1 Performance

	May-19	Jun-19	Jul-19	12 Months
Mean (00:07:00)	00:07:18	00:07:30	00:07:21	
90th Percentile (00:15:00)	00:13:37	00:13:52	00:13:52	
Mean Resources Arriving	1.69	1.64	1.61	
Count of Incidents	3594	3572	3813	
National Mean	00:06:54	00:07:11	00:07:14	

Category 1T Performance

	May-19	Jun-19	Jul-19	12 Months
Mean (00:19:00)	00:09:27	00:11:15	00:09:33	
90th Percentile (00:30:00)	00:17:23	00:18:48	00:18:23	
Mean Resources Arriving	1.72	1.67	1.63	
Count of Incidents	2268	2224	2373	
National Mean	00:10:32	00:11:07	00:11:12	

Category 2 Performance

	May-19	Jun-19	Jul-19	12 Months
Mean (00:18:00)	00:20:54	00:21:31	00:20:01	
90th Percentile (00:40:00)	00:40:16	00:41:14	00:38:34	
Mean Resources Arriving	1.08	1.08	1.08	
Count of Incidents	31330	31819	33774	
National Mean	00:21:01	00:22:26	00:23:18	

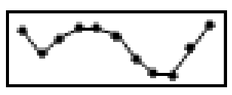
Category 3 Performance

	May-19	Jun-19	Jul-19	12 Months
Mean	01:38:23	01:50:34	01:33:53	
90th Percentile (02:00:00)	03:56:04	04:17:58	03:33:52	
Mean Resources Arriving	1.07	1.06	1.05	
Count of Incidents	19166	18194	20434	
National Mean	01:00:29	01:08:54	01:11:30	

Category 4 Performance

	May-19	Jun-19	Jul-19	12 Months
Mean	01:58:37	02:20:40	02:03:54	
90th Percentile (03:00:00)	04:52:54	05:29:06	04:41:02	
Mean Resources Arriving	0.90	1.03	1.02	
Count of Incidents	495	464	436	
National Mean	01:16:02	01:22:25	01:25:45	

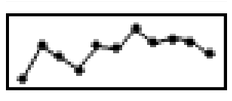
Health Care Professional

	May-19	Jun-19	Jul-19	12 Months
HCP 60 Mean	01:31:54	01:47:15	02:23:31	
HCP 60 90th Percentile	04:07:19	04:06:44	05:16:52	
HCP 120 Mean	01:43:46	02:13:07	02:28:47	
HCP 120 90th Percentile	03:45:51	04:40:28	05:17:32	
HCP 240 Mean	02:15:07	02:55:09	03:29:19	
HCP 240 90th Percentile	05:16:00	06:42:20	07:37:10	

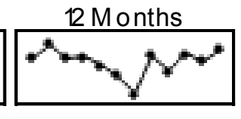
Call Cycle Time

	May-19	Jun-19	Jul-19	12 Months
Avg Allocation to Clear at Scene	01:15:30	01:15:27	01:14:03	
Avg Allocation to Clear at Hospital	01:47:21	01:48:00	01:47:46	
Turnaround Hrs Lost at Hospital (> 30mins)	4946	4574	4745	
Number of Handovers >60mins	508	415	325	

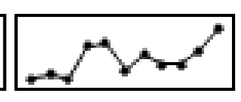
Incident Outcome AQI

	May-19	Jun-19	Jul-19	12 Months
Hear & Treat	5.6%	6.2%	5.7%	
See & Treat	32.1%	31.6%	32.6%	
See & Convey	62.3%	62.2%	61.7%	

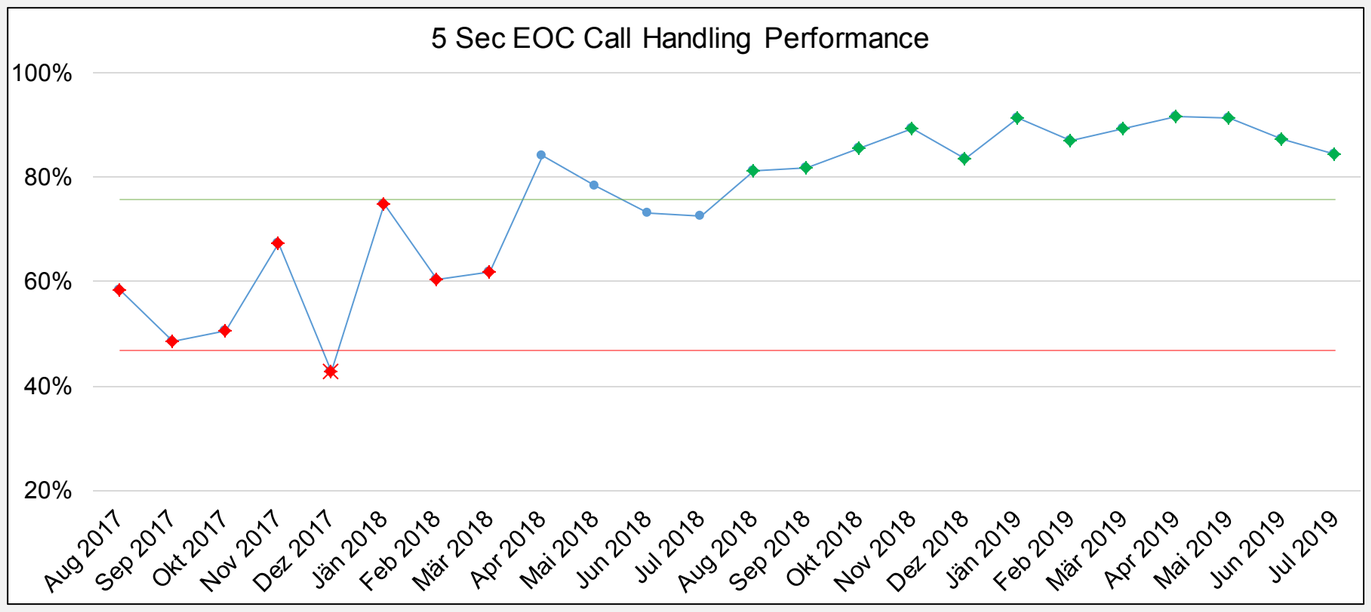
Voluntary Attendances

	May-19	Jun-19	Jul-19	12 Months
Community First Responders	995	948	1024	
Fire First Responders	425	349	358	

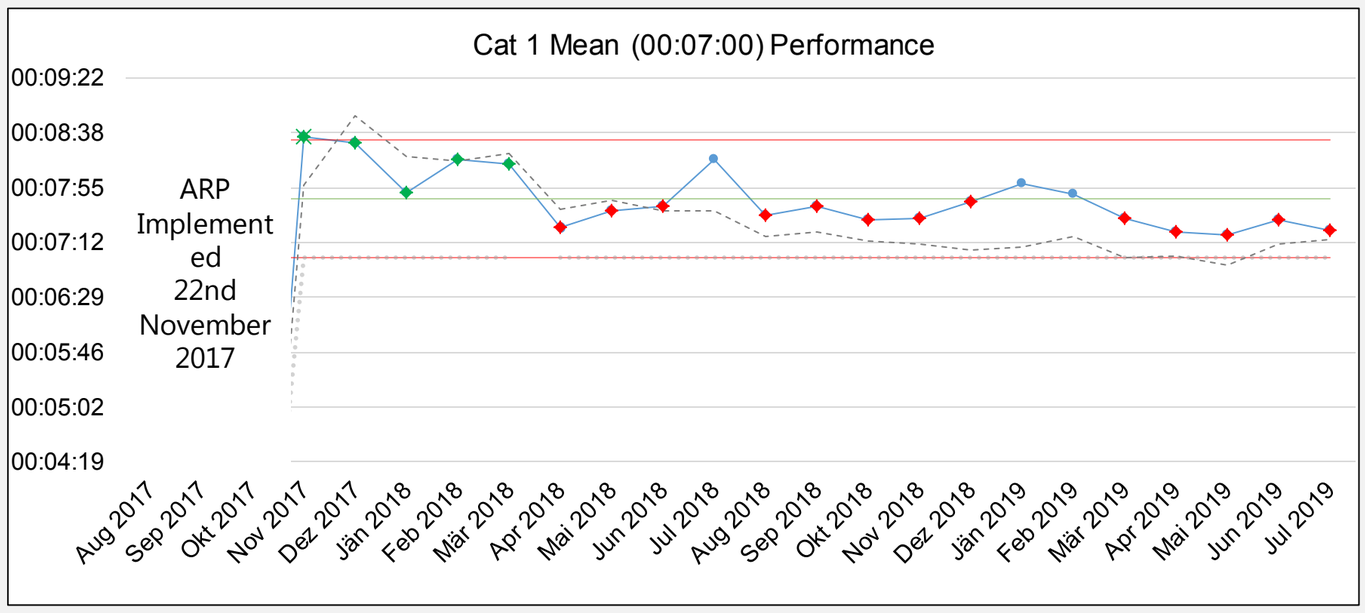
Demand/Supply AQI

	May-19	Jun-19	Jul-19	12 Months
Calls Answered	65410	67514	70863	
Incidents	60075	59601	64052	
Transports	37410	37121	39493	

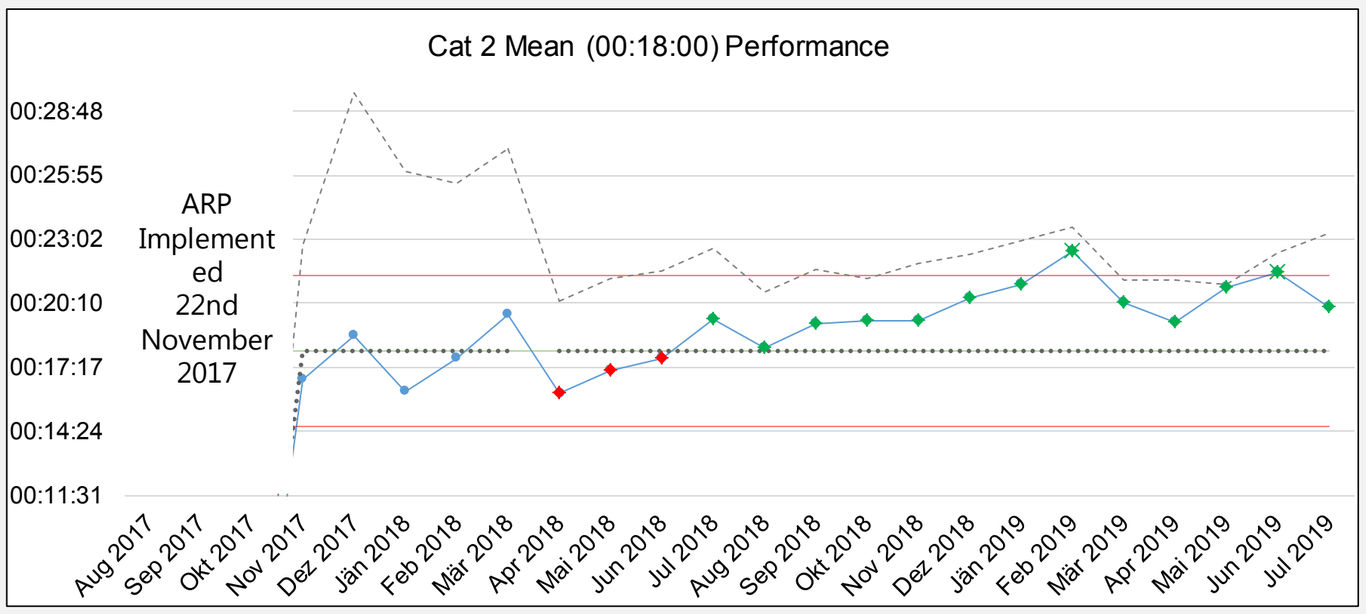
SECAmb 999 Operations Response Time Performance Charts



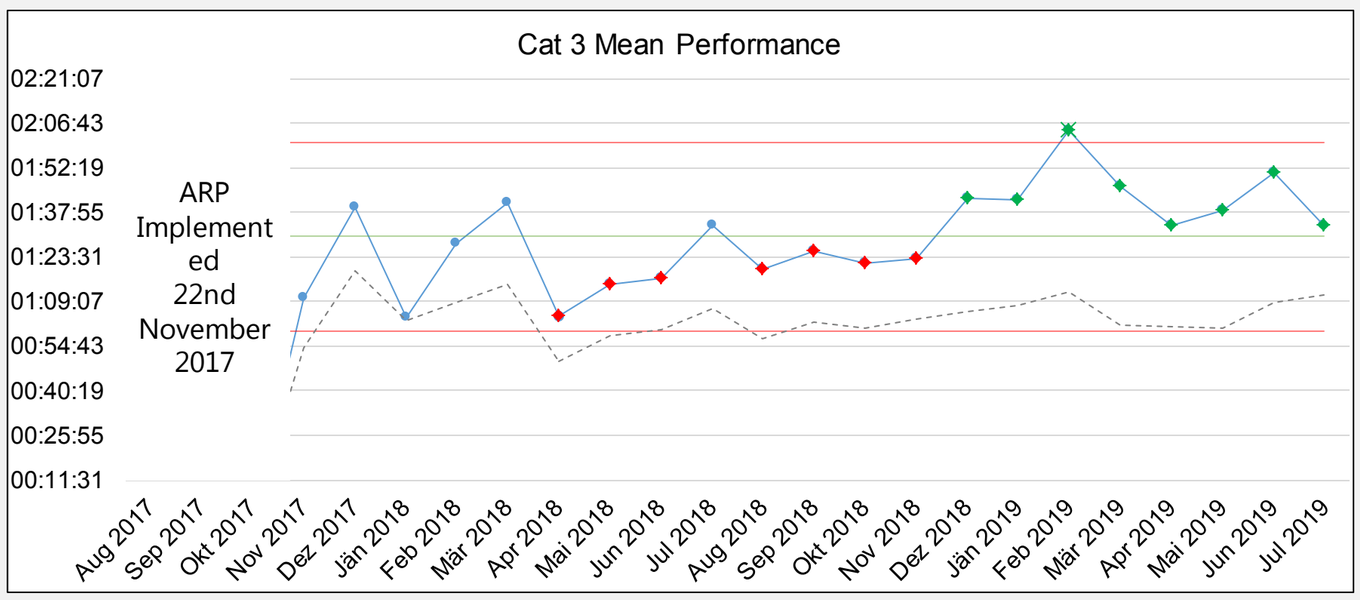
Commentary is by exception only. This metric currently has nothing to note.



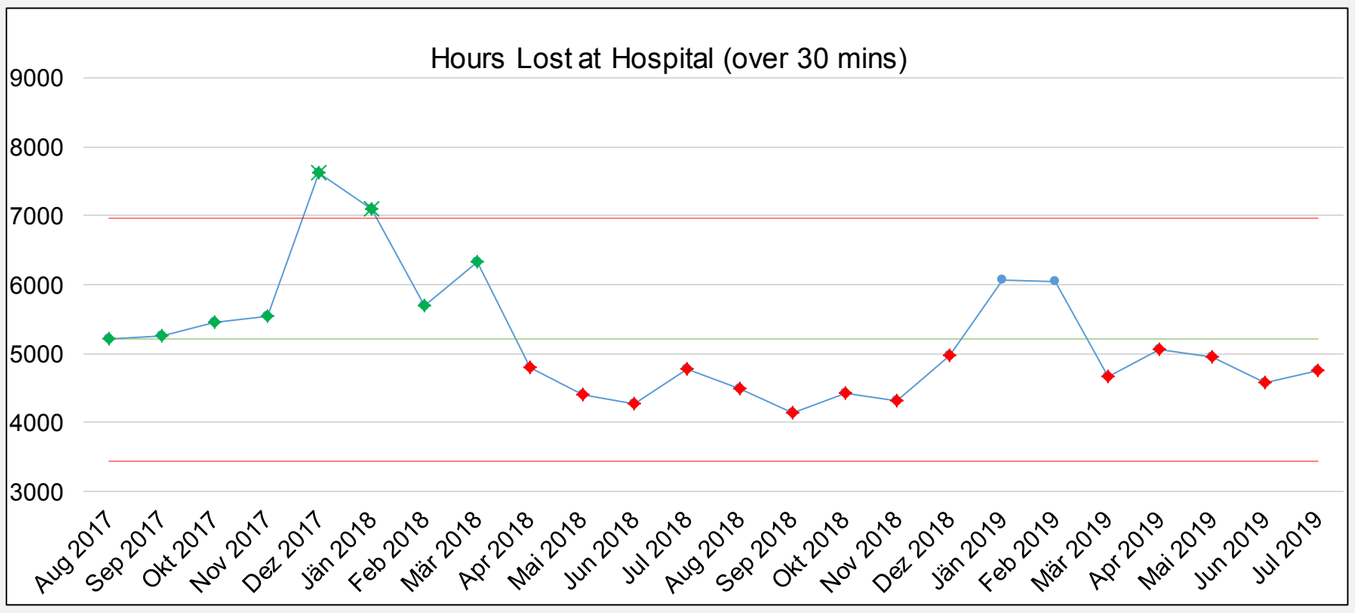
Commentary is by exception only. This metric currently has nothing to note.



Commentary is by exception only. This metric currently has nothing to note.



Commentary is by exception only. This metric currently has nothing to note.

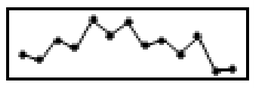


Commentary is by exception only. This metric currently has nothing to note.

SECAmb unvalidated weekly Response Time Performance

SECAmb Weekly Operational Performance - 2nd September 2019

CAT 1

	19/08	26/08	02/09	Last 13 Weeks
Mean	00:07:11	00:07:12	00:07:17	
90th Centile	00:13:34	00:13:32	00:13:33	
RPI	1.54	1.53	1.55	
Count of Incidents	865	769	774	

CAT 1T

	19/08	26/08	02/09	Last 13 Weeks
Mean	00:09:00	00:08:56	00:09:00	
90th Centile	00:17:17	00:17:56	00:16:20	
RPI	1.57	1.58	1.57	
Count of Incidents	549	491	477	

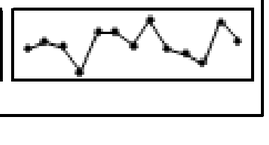
CAT 2

	19/08	26/08	02/09	Last 13 Weeks
Mean	00:17:59	00:19:09	00:17:04	
90th Centile	00:33:56	00:36:08	00:31:49	
RPI	1.08	1.07	1.07	
Count of Incidents	7275	7689	6815	

CAT 3

	19/08	26/08	02/09	Last 13 Weeks
Mean	01:19:04	01:32:52	01:00:26	
90th Centile	02:56:55	03:32:41	02:18:12	
RPI	1.05	1.05	1.05	
Count of Incidents	4804	4617	4673	

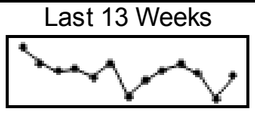
CAT 4

	19/08	26/08	02/09	Last 13 Weeks
Mean	01:28:20	02:11:47	01:27:25	
90th Centile	02:53:00	04:16:07	02:45:13	
RPI	0.93	0.81	0.95	
Count of Incidents	81	126	106	

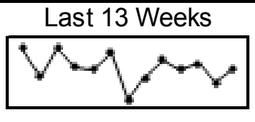
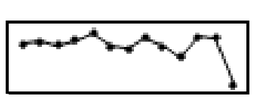
HCP 60

	19/08	26/08	02/09	Last 13 Weeks
Performance	13.3%	8.3%	16.0%	
Count of Incidents	19	17	9	

HCP 120

	19/08	26/08	02/09	Last 13 Weeks
Performance	49.1%	36.0%	48.0%	
Count of Incidents	376	314	89	

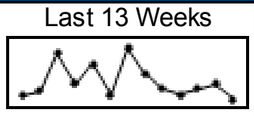
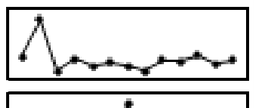
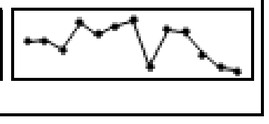
HCP 240

	19/08	26/08	02/09	Last 13 Weeks
Performance	66.7%	51.3%	63.2%	
Count of Incidents	70	68	19	

Call Cycle Time

	19/08	26/08	02/09	Last 13 Weeks
Clear at Scene	01:13:43	01:14:53	01:13:22	
Clear at Hospital	01:47:23	01:49:14	01:48:00	
Hours Lost at Hospital	1022	1168	986	

999 Call Handling

	19/08	26/08	02/09	Last 13 Weeks
Mean Call Pickup Time (Seconds)	5	6	3	
Call Pickup Time 90th Percentile (Seconds)	7	15	1	
Call Pickup Time 95th Percentile (Seconds)	34	42	14	
Call Pickup Time 99th Percentile (Seconds)	84	96	69	
Average Call Length (seconds)	373	362	367	
Abandon Rate	0.14%	0.11%	0.09%	
Staff Hours Provided Vs 4783 target	98.7%	95.8%	95.1%	

Incident Outcome

	19/08	26/08	02/09	Last 13 Weeks
See and Convey	61.9%	60.2%	62.4%	
See and Treat	33.0%	33.7%	33.1%	
Hear and Treat	5.1%	6.1%	4.5%	

Community First Responders

	19/08	26/08	02/09	Last 13 Weeks
Volume of Incidents Attended	367	337	276	
Hours Provided	2355	2707	2773	

Demand/Supply

	19/08	26/08	02/09	Last 13 Weeks
999 Call Volume	15290	15781	13779	
Incidents	14227	14486	13558	
Transports	8819	8733	8470	
Staff Hours Provided Vs 65153 target	94.4%	93.1%	92.6%	

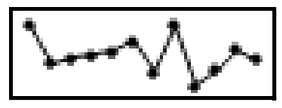
Our Partners

SECAmb 111 Operations Performance Scorecard

Calls Offered

	May-19	Jun-19	Jul-19	12 Months
Actual	74311	70989	73544	
Previous Year	92737	84042	87586	

Calls answered in 60 Seconds

	May-19	Jun-19	Jul-19	12 Months
Actual %	68.5%	75.4%	71.8%	
Previous Year %	74.0%	71.7%	68.9%	
Target %	95%	95%	95%	

Calls abandoned - (Offered) after 30secs

	May-19	Jun-19	Jul-19	12 Months
Actual %	7.7%	4.6%	6.2%	
Previous Year %	4.7%	4.8%	5.7%	
Target %	5%	5%	5%	

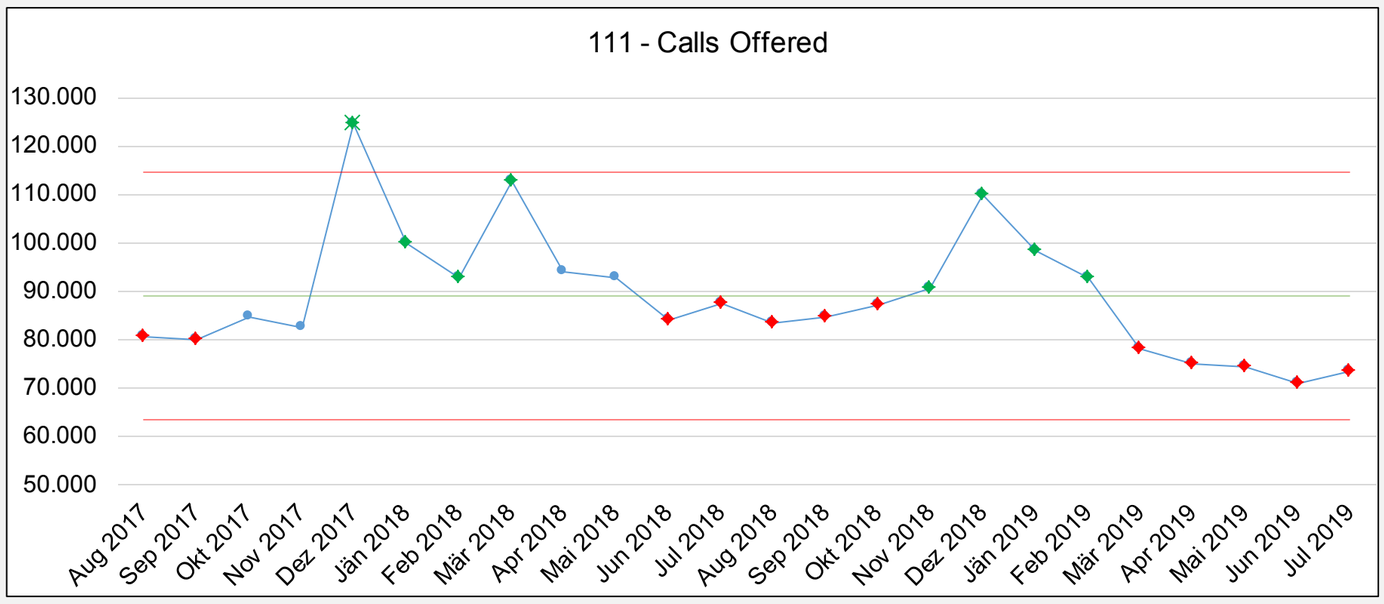
A&E Dispositions

	Mar-19	Apr-19	May-19	12 Months
A&E Dispositions % (Answered Calls)	8.2%	8.5%	9.2%	
A&E Dispositions (Actual)	5135	5424	5674	
National	7.7%	8.7%	9.1%	

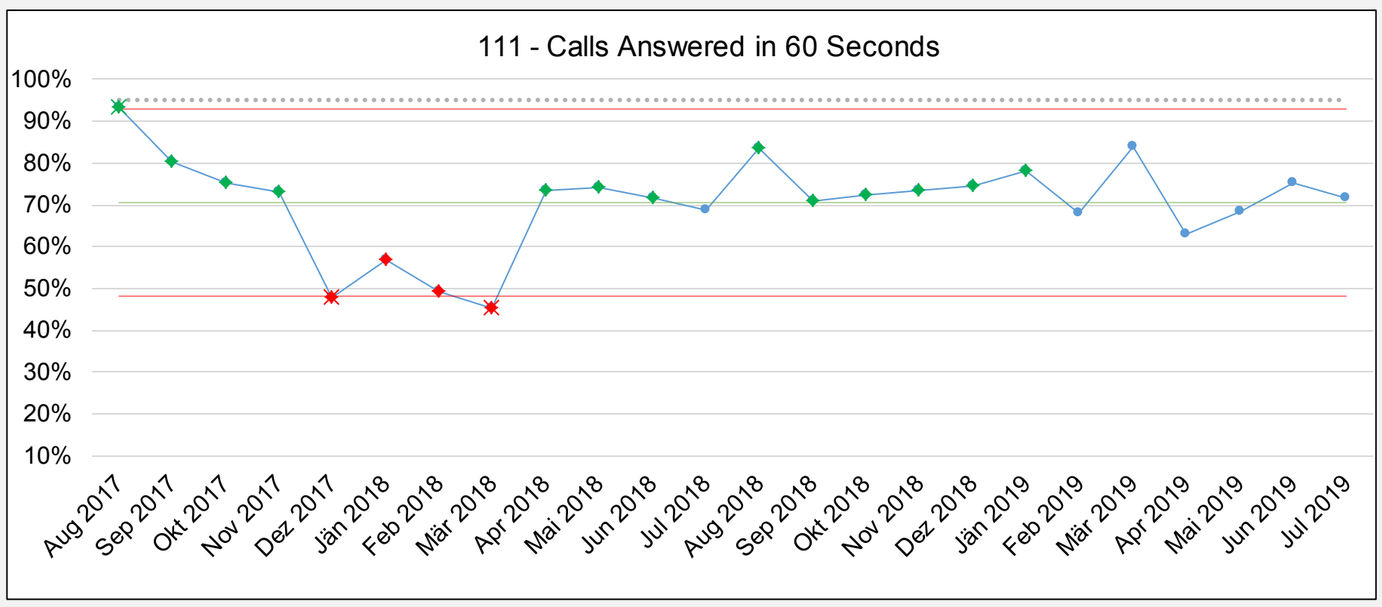
999 Referrals

	May-19	Jun-19	Jul-19	12 Months
999 Referrals % (Answered Calls)	15.5%	15.4%	16.1%	
999 Referrals (Actual)	8649	8378	8791	
National	12.9%	13.1%	13.6%	

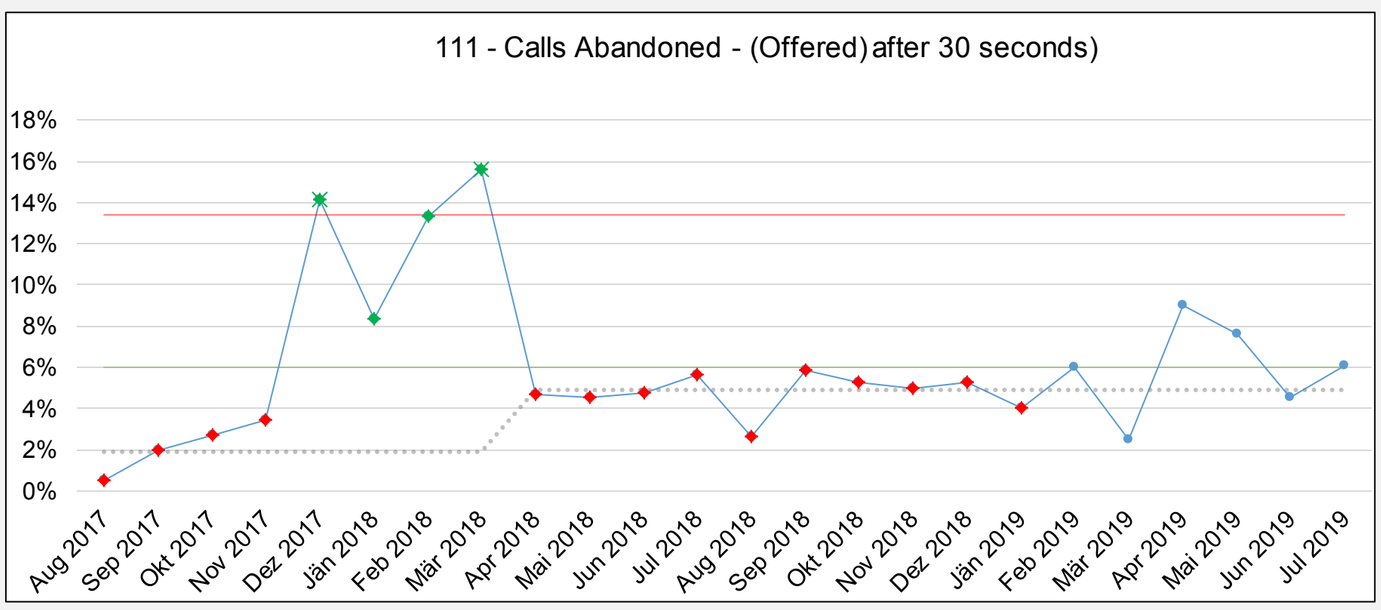
SECAmb 111 Operations Performance Charts



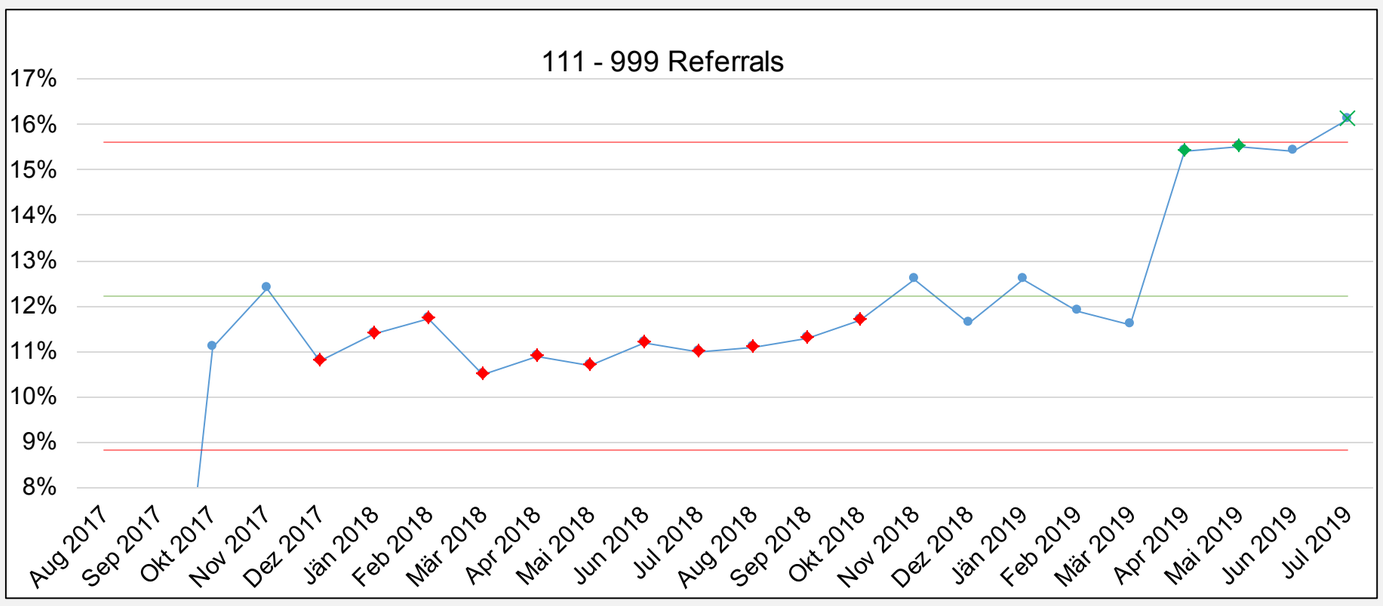
Commentary is by exception only. This metric currently has nothing to note.



Commentary is by exception only. This metric currently has nothing to note.



Commentary is by exception only. This metric currently has nothing to note.

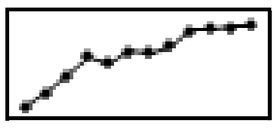
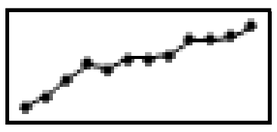
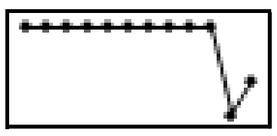
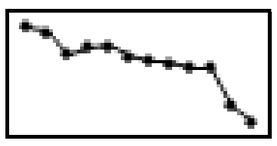


Commentary is by exception only. This metric currently has nothing to note.

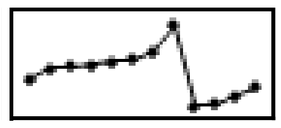
Our People

SECAmb Workforce Scorecard

Workforce Capacity

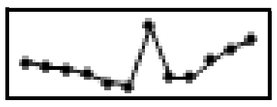
	May-19	Jun-19	Jul-19	12 Months
Number of Staff WTE (Excl bank & agency)	3517.6	3529.4	3541.6	
Number of Staff Headcount (Excl bank and agency)	3811	3836	3897	
Finance Establishment (WTE)	3837.50	3724.30	3768.39	
Vacancy Rate	8.34%	5.23%	6.02%	
Vacancy Rate Previous Year	12.63%	13.08%	13.78%	
Adjusted Vacancy Rate + Pipeline recruitment %	4.79%	0.08%	-1.84%	

Workforce Compliance

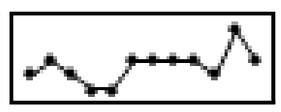
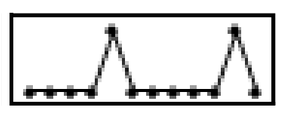
	May-19	Jun-19	Jul-19	12 Months
Objectives & Career Conversations %	13.27%	20.16%	28.68%	
Target (Objectives & Career Conversations)	80%	80%	80%	
Statutory & Mandatory Training Compliance %	26.78%	37.45%	43.84%	
Target (Stat & Mand Training)	95%	95%	95%	
Previous Year (Stat & Mand Training) %	85.68%	18.11%	58.99%	

* 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

	May-19	Jun-19	Jul-19	12 Months
Annual Rolling Turnover Rate %	14.72%	14.98%	15.01%	
Previous Year %	17.42%	15.17%	15.37%	
Annual Rolling Sickness Absence	5.17%	5.28%	5.36%	
Target (Annual Rolling Sickness)	5%	5%	5%	

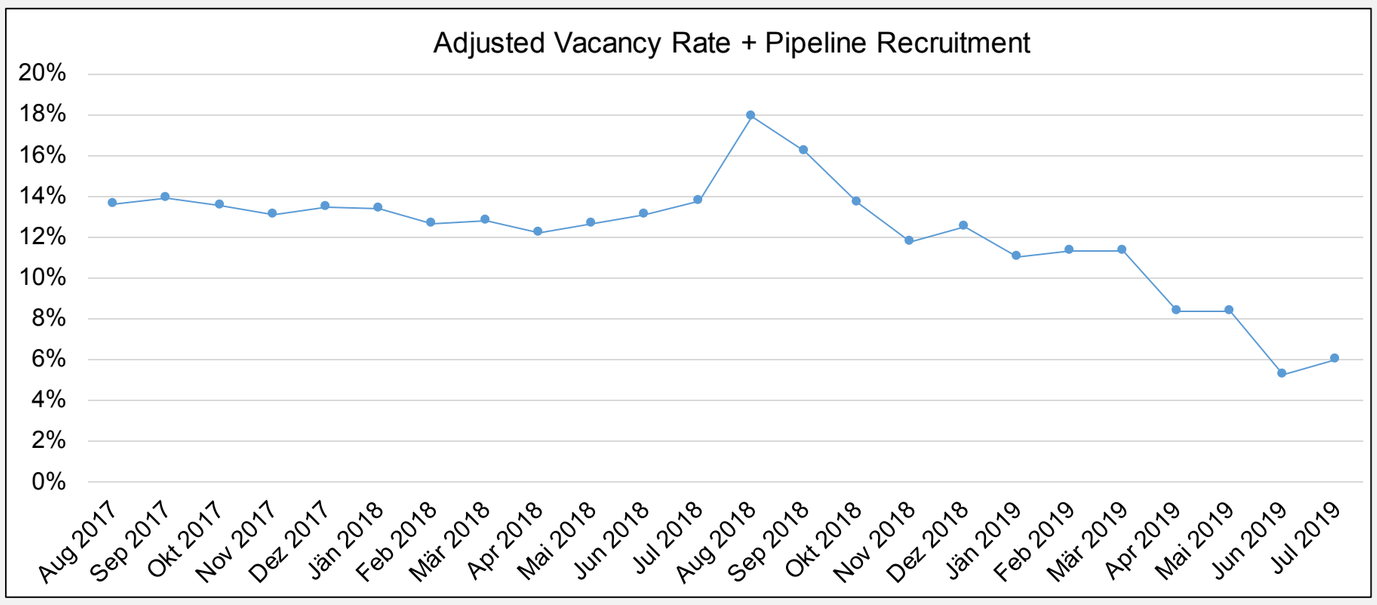
Employee Relations Cases

	May-19	Jun-19	Jul-19	12 Months
Disciplinary Cases	4	6	8	
Individual Grievances	7	4	12	
Collective Grievances	0	0	1	
Bullying & Harassment	1	4	2	
Bullying & Harassment Prev Yr	3	5	2	
Whistleblowing	0	1	0	
Whistleblowing Previous Year	1	1	1	

Physical Assaults (Number of victims)

	May-19	Jun-19	Jul-19	12 Months
Actual	29	18	19	
Previous Year	13	14	21	
Sanctions	4	5	4	

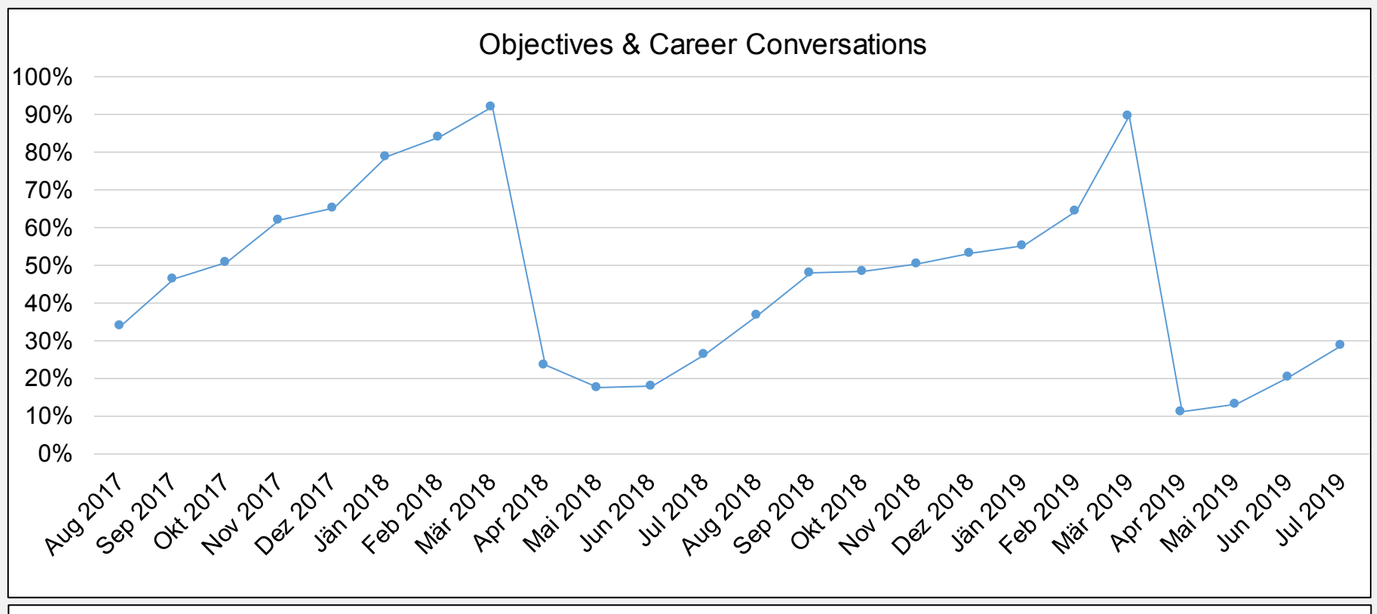
SECAmb Workforce Charts



In April we recruited 93 new staff into the Trust. This will increase in coming months based on ARP programme. Our adjusted vacancy rate decreased from 5.46% to 4.85%.

Our pipeline for ECSW has been affected by candidates ability to gain a C1 licence, therefore we have had 17 unfilled course spaces. To mitigate this, we have increased the period from offer to the course start to 12 weeks, which will allow time for applicants to pass their C1 test.

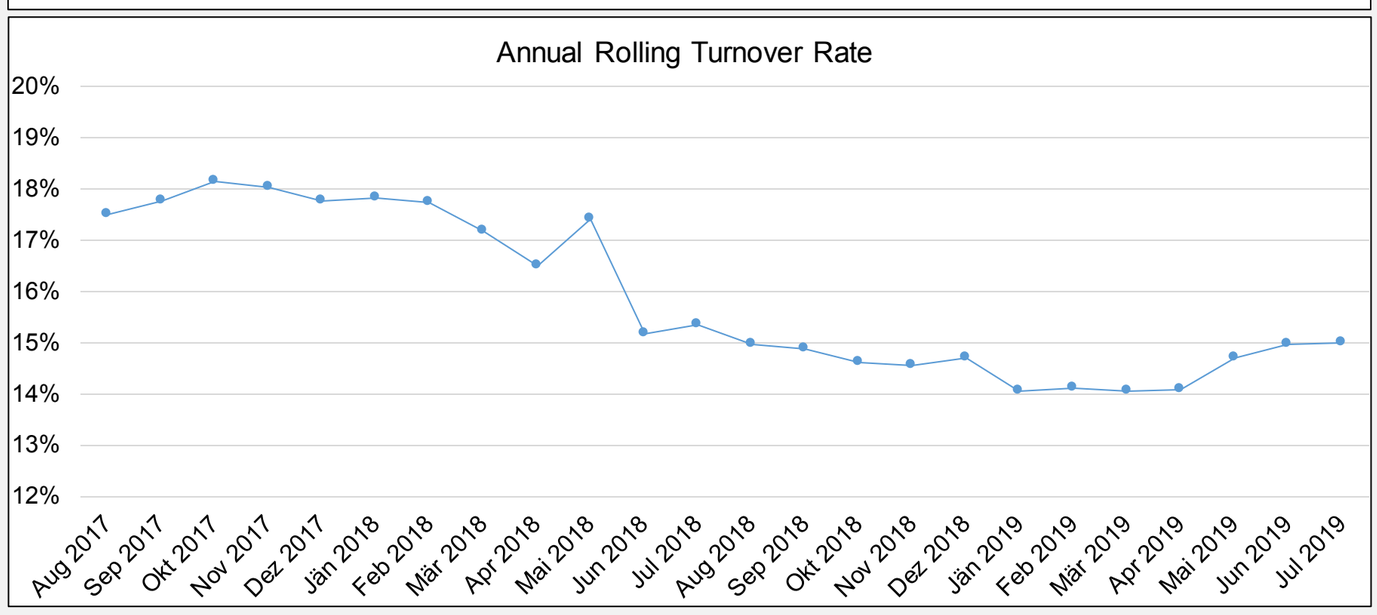
111 have had recent success and course numbers are steadily increasing for HAs and Clinicians. Focus has moved to Clinicians for EOC and a strategy is being developed in order to meet the establishment requirements. We are also focusing our efforts on the international Clinicians who are likely to join from July onwards in order to reduce the risk to Clinical governance in EOC.



The reported total of appraisals completed is based on a headcount of 3456 substantive staff. We define an appraisal as 'undertaking meaningful conversations about performance during a review meeting set up for that purpose'. Exceptions from the appraisal final count were employees on maternity leave, a career break, bank staff and new starters after December 2017.

The figures of in-progress and published records were combined to give an overall accumulative percentage rate of all staff who started prior to December 2017. Employees after this date did not require a full appraisal, however in good practice objectives and regular 1-2-1s were necessary for feedback and review progress whilst in the probation period.

During the appraisal year April-March 2018-2019, 84.49% of staff had an appraisal, which equated to 2929 staff.

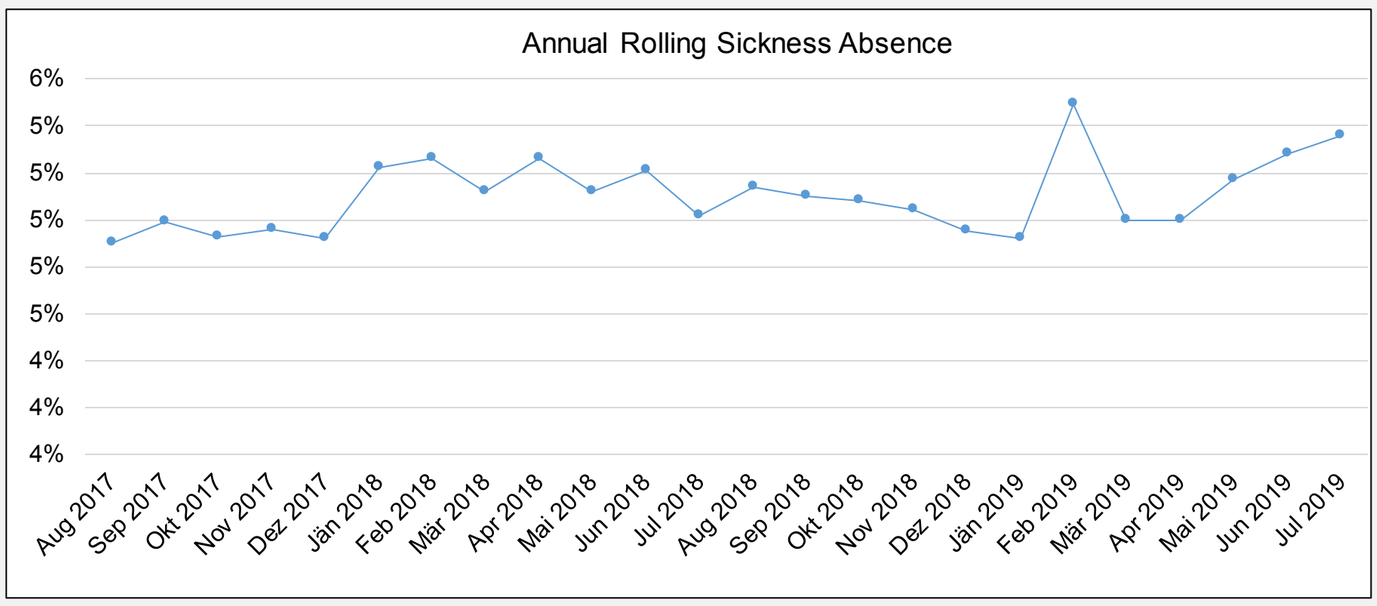


Following a period of continued downward trend on turnover, and a plateau for February, March and April, we have seen a slight increase in staff turnover for May at 14.7%

We continue to provide regular updates to WWC.

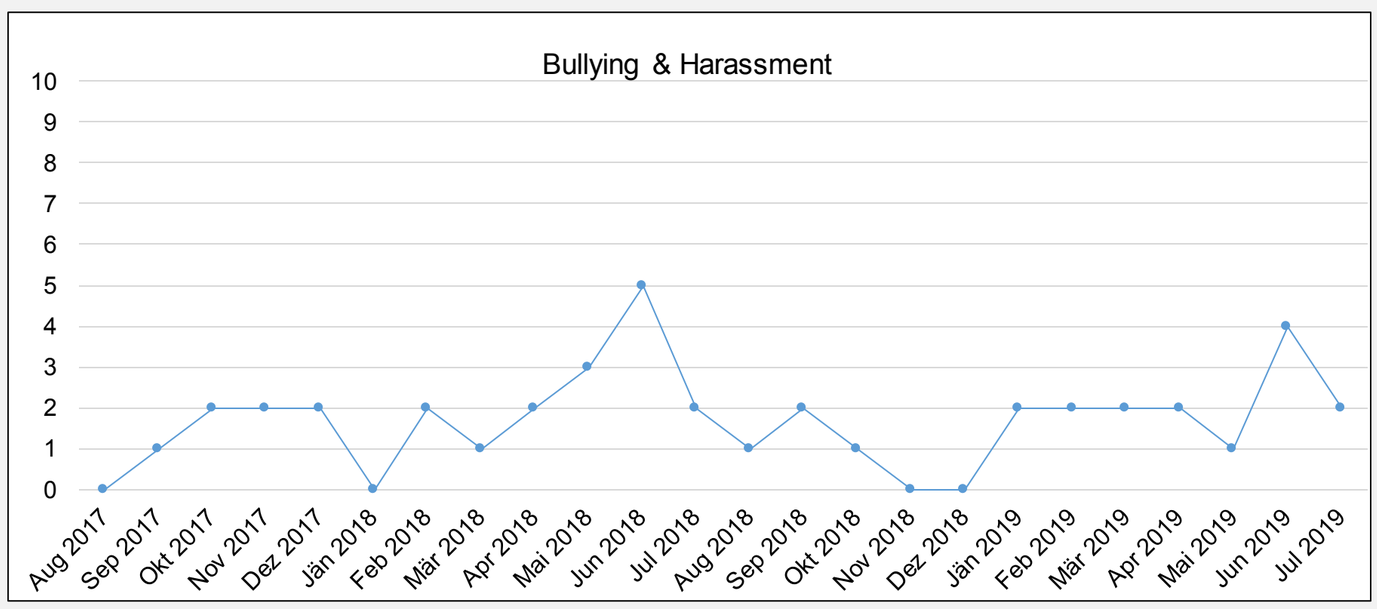
EOC East Turnover for May 19 - 32% (By comparison EOC East for the same period last year was 29%)
EOC West Turnover for May 19 - 36.22% (By comparison EOC West for the same period last year was 44.27%)
111 Turnover for May 19 - 46.57% (By comparison 111 for the same period last year was 46.31%)

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.

We unfortunately lost a couple of HR Advisors and have had to re-advertise. Recruitment has now been completed and we will be back on target for sickness absence by the August IPR report.



There was 1 reported cases of Bullying and Harassment (B&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 there employment. This will allow for greater understanding of what's good and what's not so good, and head of some of the not so goods quickly.

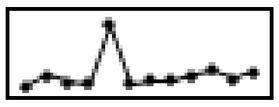
There will be focus on behaviours and values, and a session on challenging bad behaviour.

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

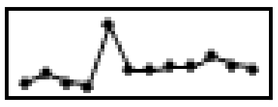
Our Enablers

SECAmb Finance Performance Scorecard

Income

	May-19	Jun-19	Jul-19	12 Months
Actual £	£ 20,103	£ 19,143	£ 20,801	
Previous Year £	£ 17,205	£ 17,208	£ 18,211	
Plan £	£ 20,325	£ 19,525	£ 21,005	

Expenditure

	May-19	Jun-19	Jul-19	12 Months
Actual £	£ 20,586	£ 19,458	£ 20,864	
Previous Year £	£ 17,756	£ 18,069	£ 18,122	
Plan £	£ 20,673	£ 20,337	£ 21,091	

Capital Expenditure

	May-19	Jun-19	Jul-19	12 Months
Actual £	£ 1,021	£ 1,033	£ 1,790	
Previous Year £	£ 142	£ 1,589	£ 238	
Plan £	£ 1,719	£ 1,837	£ 1,635	
Actual Cumulative £	£ 2,193	£ 3,226	£ 5,016	
Plan Cumulative £	£ 3,484	£ 5,321	£ 6,956	

Cost Improvement Programme (CIP)

	May-19	Jun-19	Jul-19	12 Months
Actual £	£ 585	£ 739	£ 580	
Previous Year £	£ 308	£ 519	£ 1,200	
Plan £	£ 781	£ 781	£ 781	
Actual Cumulative £	£ 668	£ 1,407	£ 1,988	
Plan Cumulative £	£ 864	£ 1,645	£ 2,426	

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)

	May-19	Jun-19	Jul-19	12 Months
Actual £	-£ 484	-£ 315	-£ 62	
Actual YTD £	-£ 1,938	-£ 2,253	-£ 2,315	
Plan £	-£ 348	-£ 812	-£ 86	
Plan YTD £	-£ 1,446	-£ 2,258	-£ 2,344	

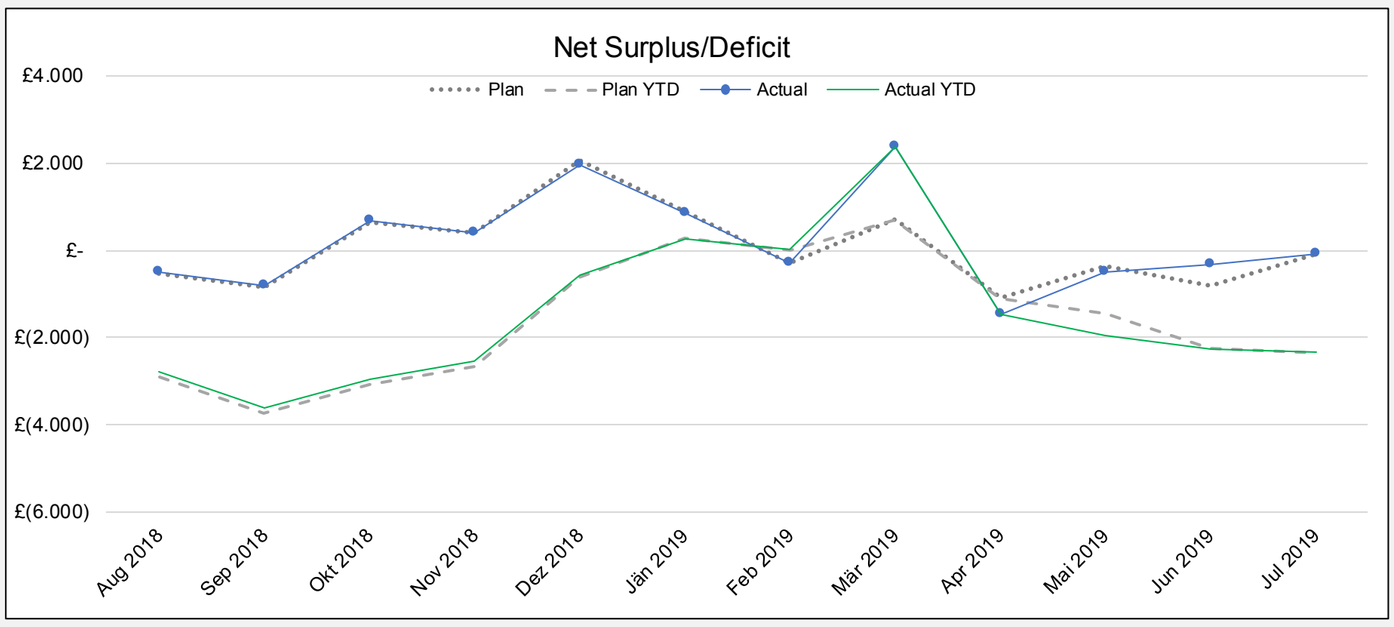
Cash Position

	May-19	Jun-19	Jul-19	12 Months
Actual £	£ 17,271	£ 15,668	£ 22,780	
Minimum £	£ 10,000	£ 10,000	£ 10,000	
Plan £	£ 16,736	£ 16,123	£ 13,610	

Agency Spend

	May-19	Jun-19	Jul-19	12 Months
Actual £	£ 526	£ 678	£ 625	
Plan £	£ 291	£ 286	£ 282	

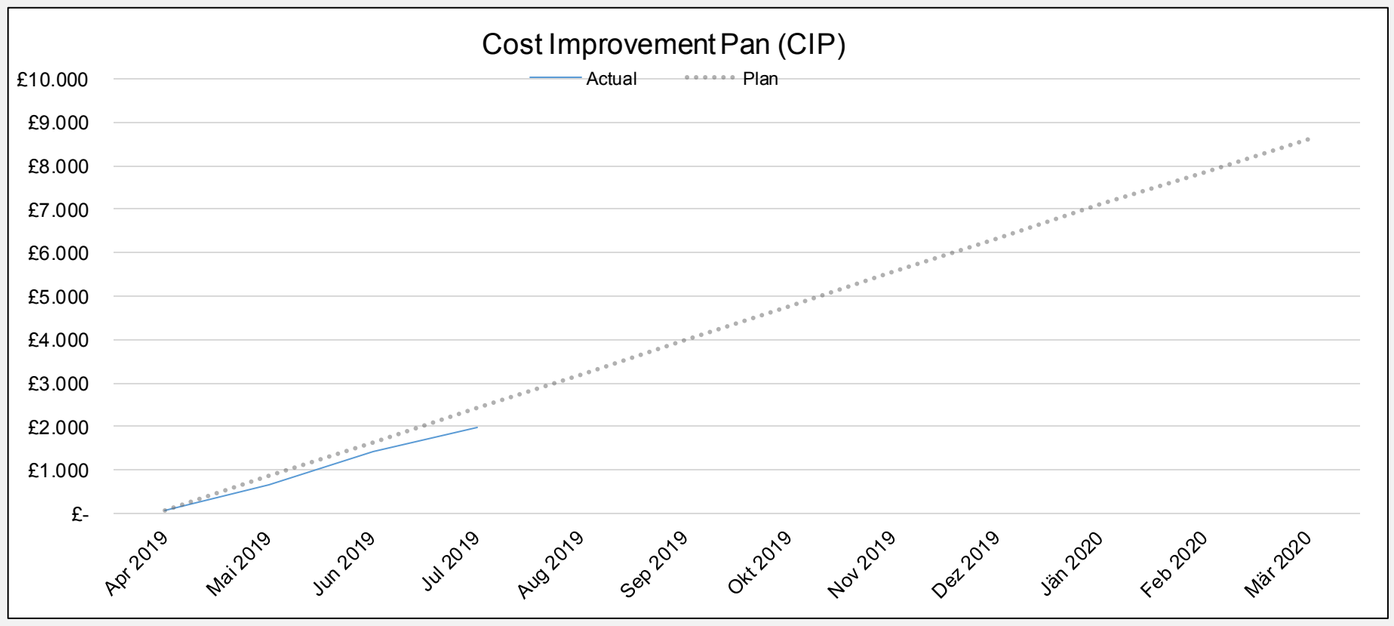
SECAmb Finance Performance Charts



The Trust's I&E position in Month 4 was a deficit of £0.1m, which is as planned.

Year to date the deficit was £2.3m, as planned.

Shortfall on planned 999 income has been in part mitigated by the release of unrequired dilapidation provision and by vacancies.

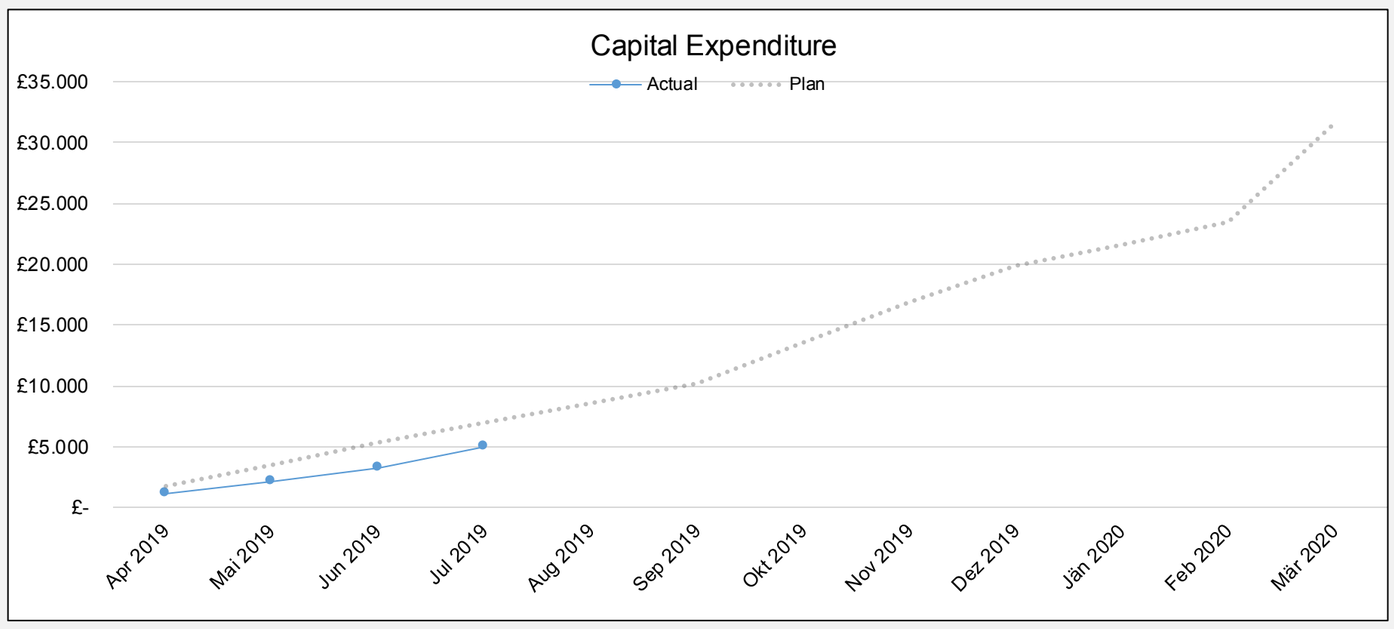


CIPs to the value of £0.6m were achieved in June, against a plan of £0.8m.

Year to date achievement is £2.0m, which is £0.4m behind plan.

This underachievement is partly due to the timing of schemes that are yet to be fully validated and the shortfall in the month of £0.2m relating to handover delays. This is expected to catch up over the coming months.
The full year CIP plan and forecast remains £8.6m.

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

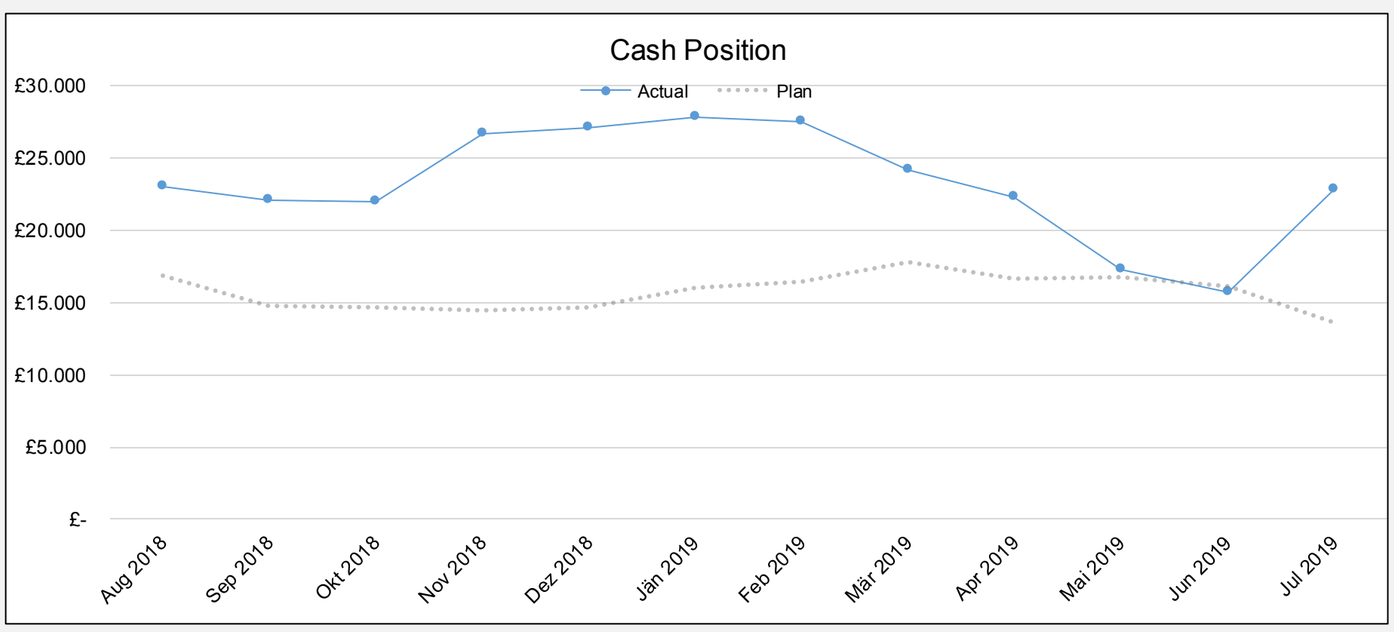


Capital for the month of July was £1.8m, as planned.

Year to date expenditure is £5.0m, £2.0m below plan.

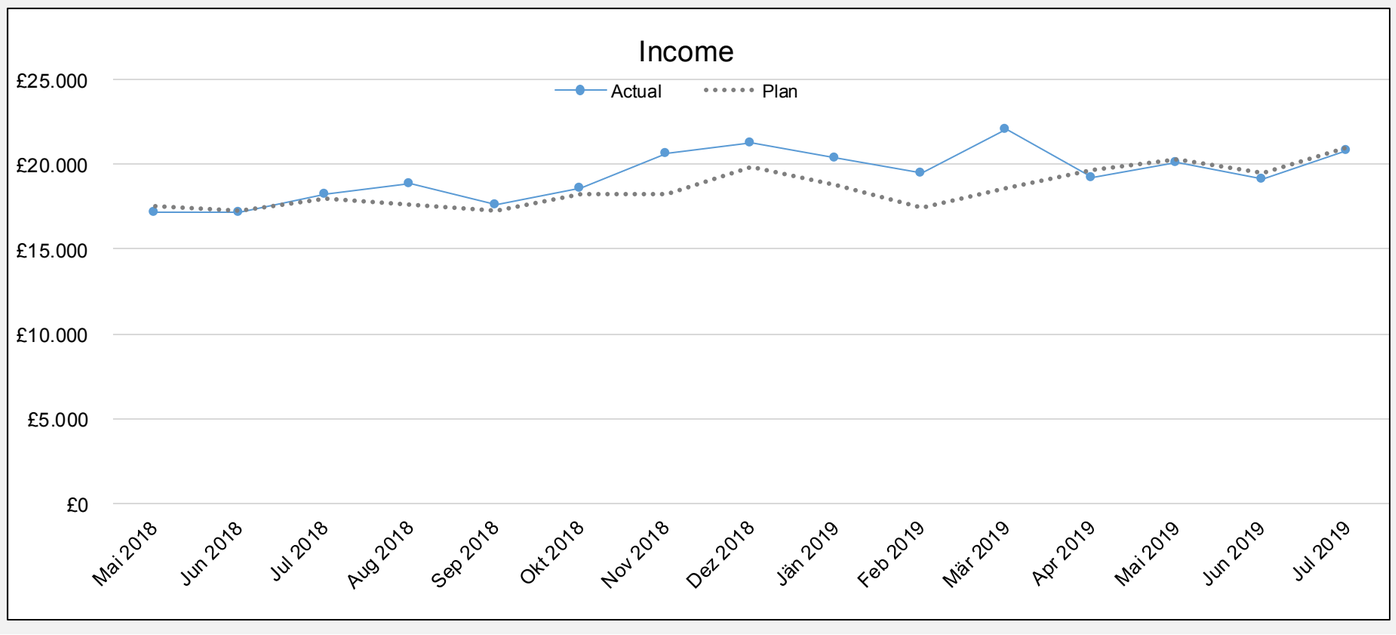
This shortfall is due to timing, partly due to pending approval of business case funding for the 'Wave 4' capital bids.

The forecast for the year has been revised down to £20.2m against the original plan of £31.7m. This is due to £8.3m from the delay in 'Wave 4' schemes and £3.2m of vehicle equipment, now being acquired through operating leases. The revised plan has been submitted to the Regulator as part of a national review of capital plans.



The cash position as at 31 July 2019 was £22.8m, which was £9.2m greater than planned and £1.4m lower than at the end of the last financial year end. The £9.2m improvement in the month was mainly driven by £4.5m of contractual catch-up invoicing and £3.3m of PSF funding for 2018/19.

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 94.8% by value against a target of 95.0%.

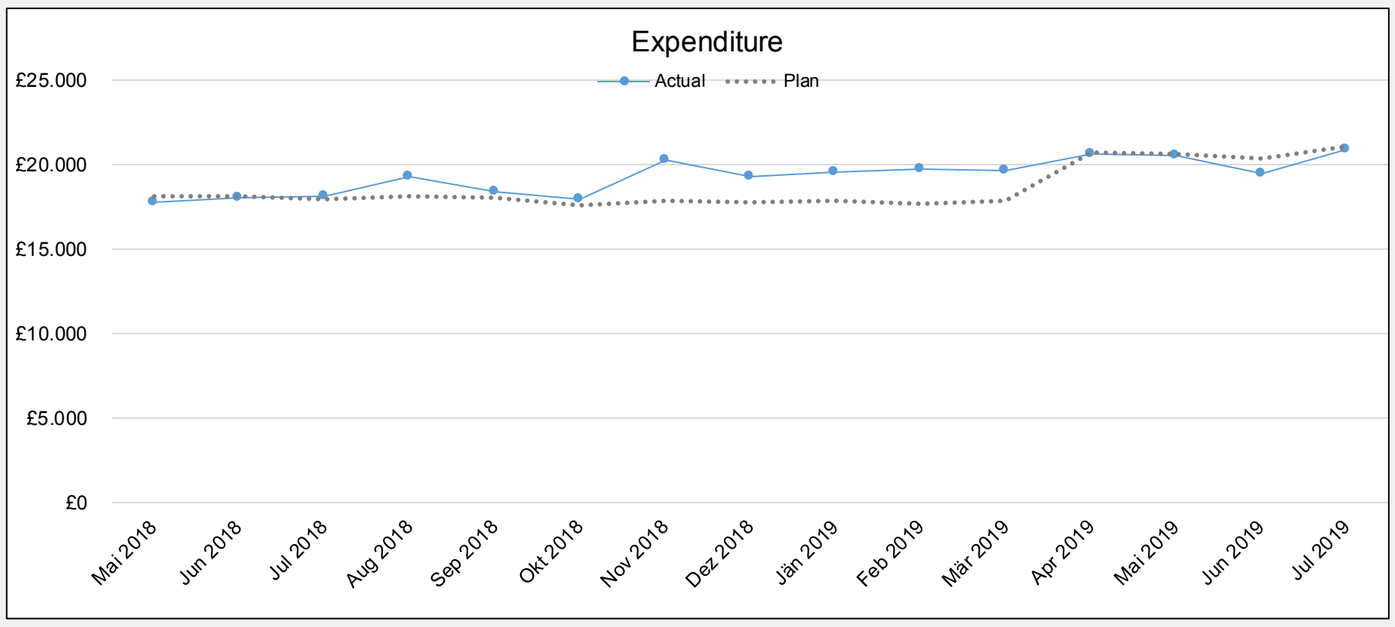


Income for the month of June was £20.8m, which was £0.2m less than plan.

Year to date income was £79.3m, £1.0m less than plan.

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

SECAmb Finance Performance Charts



Total expenditure for the month of July was £20.9m, which was £0.2m less than planned.

Year to date expenditure was £81.6m, £1.3m less than planned.

Pay costs were £0.3m less than planned in the month, mainly through reduced frontline hours provided, EOC and Clinical Team vacancies.

Non pay costs were £0.1m less than planned in the month, This is mainly due to increased costs in fleet and estates.

Finance costs are as planned.

SECAMB Board

Finance and Investment Committee Escalation report to the Board

Date of meetings	8 August 2019 22 August & 17 August 2019 (extraordinary meetings)
Overview of key issues/areas covered at the meeting:	***Finance Partial Assurance*** The committee explored the adverse variance from plan, arising in the main due to a shortfall in income, which is directly linked to operational performance. Expenditure is more under control. The committee is assured with the strength of the financial stewardship but acknowledges the significant risks to achieving the control total for the year. In the context of the current financial results the committee took time to review the different risks. It reinforced the importance of forensically analysing the cost base so that we can develop a robust plan to manage the year-end position. The driver for this is delivering operational performance, which must be the focus of every department. **999 Performance Not Assured** The committee then undertook a detailed review of the recovery actions being taken to help ensure improved ARP performance. It noted that one of the factors adversely affecting the improvement trajectory is the operating model of the wider organisation not effectively being aligned to operations. For example, the issues within HR and Clinical Education which the Board will know is now well understood and being addressed. In summary, the committee supports the work plan agreed by the executive to improve performance, but as yet is not assured there is a sustainable long term position that will ensure consistent compliance with ARP. **Fleet Strategy Implementation** The committee welcomed receipt of the timeline for the development of the fleet strategy implementation plan. It will come to the committee meeting in October for review. ***111/CAS*** The extraordinary meetings were arranged to receive updates with the progress in the 111/CAS preparations; specifically in relation to the conditions set out by commissioners. Given the commercially sensitive nature of this, a detailed update is provided in Part 2.
Any other matters the Committee wishes to escalate to the Board	None

SECAMB Board

QPS Committee Escalation report to the Board

Date of meetings	09 September 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: **CFRs Partially Assured** A paper was received in May, which addressed concerns of the committee about how we are approaching CFRs who are not compliant with specific requirements, such as training. The committee acknowledged that this has caused some confusion and ill-feeling, but was assured that a proper process had been followed. The committee also tested the mechanisms in place to ensure timely and effective communication with CFRs; for example, how we get important messages through if an urgent issue arises. Management confirmed some of the things in place, which includes having a database for every CFR; email addresses; and meetings led by the head of community engagement. The Chief Pharmacist also confirmed that with regards medicines, we can now link pouches to individuals. However, the committee had continuing concerns about some aspects of communication and so asked for further assurance. The response did not fully assure the committee that the measures in place ensure that all urgent messages get through in a timely way. Further assurance will be requested in due course. **Key Skills Delivery Not Assured** In June the committee supported the plan to phase Key Skills differently, and asked management to provide assurance that it would be delivered by March 2020. The paper received in July did not assure the committee that there are robust plans in place and so it asked management to set out the current positon, and evidence that there is a plan by OU to ensure delivery by March 2020. It also asked for a review of the risks, including how the risk of abstraction will be mitigated in the likely event that the performance challenge will continue through the year, compounded by the EU Exit. The committee agreed that there is a significant risk to delivering all three days of Key Skills by March 2020 and, in the event of this risk materialising, supported a plan to extend this in to 2021, noting the provision required when planning the Key Skills programme for 2020/21. A paper has been requested for the October meeting to set out an assessment of what training is at greatest risk and the consequences of any delay. The committee also asked the finance and investment committee to review the extraction rate as the Trust appears to require a greater number than it is commissioned for. 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**
This has been a standing agenda items for several months now and this latest update demonstrated a good understanding of where there continue to be challenges; specifically the committee received much comfort by the governance oversight and grip that is in place.

One of the continuing challenges are with welfare calls and clinical reviews, and while some improvement was noted the committee will continue to monitor this to ensure it continues.

Private Ambulance Providers **Assured**
This paper provided a summary of the current Trust governance mechanisms and oversight of Private Ambulance Providers contracted to undertake work on behalf of the Trust, including their levels of compliance.

The committee remains assured, but asked for a paper to come back to a future meeting to confirm where there is third party assurance. It also asked the finance and investment committee to review the related supply chain risks, in light of what has happened with SSG.

Medical Equipment **Partially Assured**
In February, the committee asked specific questions which were addressed by this paper and reviewed against the Improvement Action Plan. The committee noted that the issues re leadership and stability of the team, and some posts are still covered on an interim basis, and that a business case is to be developed to ensure more robust grip and control. The committee was therefore partially assured by the good progress being made.

Complaints **Partially Assured**
The committee received a good report, which helped focus the discussion on the quality of complaints management. The current backlog of complaints was the primary reason only partial assurance was noted. A management response will be considered next time to confirm when the backlog will be reduced.

Dispatch Safety Model **Assured**
The committee reviewed the changes to the dispatch arrangements should certain risks materialise following the UK's exit from the EU. It was assured by the rationale, and the balance of risk that has been considered.

The committee also received two *Enabling Strategies*:

Infection Prevention and Control Strategy
The committee reviewed this enabling strategy, and provided some specific feedback, such as being clearer about the improvement plan and the objectives, and making the strategic themes more holistic. Subject to these changes the committee recommends this strategy to the Board (agenda item 60-19).

	Volunteer Strategy The committee acknowledged that volunteers are a core part of the Trust's workforce. It provided feedback on how to be clearer in the strategy, especially as it set out as much a plan than a strategy. Specifically, the committee noted that it needs to set out how CFRs will be able to raise issues, as they might arise, and how to recognise CFR team members that aren't CFRs. Overall, it was agreed that the strategy needs to be brought together more. The aim will be to bring to the Board in November 2019. The committee also received a number of reports under its section on *Monitoring Performance*: **Accountable Officer for Controlled Drugs** This annual report was well received by the committee. It reflected the good work with medicines management, as reflected by the CQC following its recent inspection. The committee specifically noted the improvement in breakages, which has been an issue for the Trust in the past. **Safeguarding Annual Report** The committee reviewed this annual report which is also on the Board agenda (item 61-19), and acknowledged the positive progress in this important area. **Quality and Safety Report** This temporary report which is considered at each meeting until the new IPR is introduced. There was nothing specific to escalate this month and the committee will receive an update in October, on progress with the learning from deaths policy now the national guidance has been provided. The policy will come to the Trust Board in November.
Any other matters the Committee wishes to escalate to the Board	**CFR Administration of Salbutamol** The committee considered this as delegated to it by the Board at its meeting in August. There was a detailed discussion about the pros, cons, risks and benefits and the committee unanimously supported the re-introduction of the use of Salbutamol for CFRs and Co-Responders. It concluded that with the plan to only use this drug for patients who are already prescribed it and with the strong governance arrangements in place, the benefit outweighs the risks. It asked that there be a review after 6 months. **Complaints / Incidents Trends** At its meeting in July the committee received a thematic review of serious incidents. In the context of the challenges to ensure adequate resource/hours at specific times of the day/week, it hypothesised that there would be a correlation to the times of the day/week that lead to complaints and incidents. The committee therefore asked management to test this hypothesis, and to set out from the data the categories of complaints/incidents. It came as some surprise that this is not supported by the data, as there are no specific spikes at evenings or weekends. The committee will continue to monitor any trends.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	12th September 2019
Overview of issues/areas covered at the meeting:	Three governors were in attendance. Attendance by staff was, as always, good and papers of a good standard. The meeting was quorate. The meeting 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; **Personnel Files Not Assured** It is increasingly clear that this is a significant risk, as reflected in the BAF risk report. Although programmed to be considered at this meeting, the Chair decided at pre-agenda to escalate this directly to the Board. **HR Transformation Programme Assured** To reduce workloads on staff, the Chair had agreed to receive the Minutes of the Transformation Programme Board at each meeting rather than a formal report. The suitability of this approach was reviewed at the end of the item and members felt we had sufficient detail and information for consideration. The Board would want to be aware that E-expenses and the applicant management system, TRASC, go live in October and E-timesheets, E-forms and manager self-serve for staff changes go live next March. Properly implemented, these will have the ability to address the key issues of concern to this Committee. The committee is assured that the rate of progress is satisfactory, and the Board will receive a usual update as part of the Delivery Plan. **Safe Staffing Partially Assured** This item focused on the *oversight* of safe staffing and discussed the KPIs and various other indicators available to monitor this, rather than recruitment and retention issues. Much of the discussion was taken-up with the use of the word 'safe': deviation from 'safe staffing' levels might imply 'unsafe', but this is not necessarily so. The assumption should be that the targeted despatch model provides sufficient staff for the system to manage to an agreed level of risk. Monitoring delivery of targeted despatch will then form a proxy for safe staffing. In effect, safe staffing is a product of the agreed outcomes of the demand and capacity view balanced with demand profiling. WWC was assured that there is a good grip on the metrics needed to understand and monitor this aspect of our work, but there continues to be significant challenge in providing the operational hours modelled as part of the demand and capacity review. Management was asked to come back to the next meeting with a series of proposals for suitable measures. These should form part of the larger piece of work underway on metrics across the organisation.

Clinical Education Partially Assured
WWC was disappointed at the outcome of the recent Ofsted monitoring visit of our apprenticeship programme and note that the external review commissioned subsequently by the Medical Director confirmed its findings. The Committee was very clear that there should be no further surprises and asked that a review should take place by the Executive so that both it and the Board are aware of all external accountabilities and when they might be assessed.

Concerns were expressed regarding those currently under training and the Committee heard of plans to ensure they could complete their courses. Similarly, it is hoped that new apprentices will be able to be enrolled but with training overseen by a high quality external provider.

WWC was partially assured that the Medical Director had a sound plan to move forward but requested that external validation of any changes should be sought from an experienced provider, familiar with the Ofsted framework at or around the point of implementation.

Paramedic Training Assured
Completion rates remain high and concerns expressed by Governors earlier in the year about insufficient opportunities for placements proved unfounded. Mentoring remains a concern for WWC and a further note was sought from the head of clinical education later in the year to confirm that we have sufficient mentors for students.

With that caveat, WWC was assured that the training of undergraduate paramedics is on plan.

Health and Safety (Fleet) Assured
WWC chose to focus on fleet issues and was assured that all outstanding issues have now been identified with appropriate plans to rectify and address in place. However, we are still not meeting external reporting requirements in all cases and the Board will want to be aware that RIDDOR reporting still lags behind statutory requirements.

The committee also received a number of reports under its section on *Monitoring Performance, including*:

Staff Survey Actions Assured
WWC received a presentation on the expectations placed upon local teams with respect to their action plans to address perceived weaknesses in their response to last year's staff survey. It was assured that the programme would focus on addressing underlying issues and not *working to the test*. To ensure WWC has a better oversight of actions, it intends to invite teams to future meetings to share their proposals and actions.

Workforce Race Equalities Standard and Workforce Disability Equality Standard
WWC received an excellent report on these related topics and supported them going to the full Board for consideration.

WWC would recommend that the organisation considers setting specific targets to improve representation of both BME staff and disabled staff in the workforce, and associate these with fully funded action plans that make improving opportunities and representation the business of all managers.

Reports *not* received as per the annual work plan and action required	None. The pre-agenda meeting now works effectively to ensure required Reports are developed in a timely manner.
Changes to significant risk profile of the trust identified and actions required	WWC is confident that the major risks are captured and considered by the Executive. Board members will note the very high risk ascribed by WWC to the issue of personnel files.
Weaknesses in the design or effectiveness of the system of internal control identified and action required	WWC believes it would be timely for a register of external accreditations and so on, to be developed and maintained as we must never again be surprised by an external accountability as we were with Clinical Education apprenticeship responsibilities. Members pointed-out that we had seen similar issues with Health and Safety accountabilities in the past and that Executive might consider how best to give assurances to the Board that we will have no repeat of these.
Any other matters the Committee wishes to escalate to the Board	None

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	59-19

Name of meeting	Trust Board
Date	26.09.2019
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 and sets out the controls, assurances, and actions. This version includes some changes to the risks included in the BAF risks report, demonstrating the dynamic nature of the risk.
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 agree the changes proposed in section 4.

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, directly or via the relevant Board committee, for decision. The current 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 meeting(s), 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
	Medium Term Plan / forecast	178
	999 performance	123
Quality and Patient Safety	EOC clinical safety	269 & 579
	Dispatch Safety Model	587
Workforce and Wellbeing	Personnel Files	362
	H&S Plans	517
	Safe Staffing	111
	Staff Survey	334

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, and update accordingly. 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 committee is asked to consider the following recommendations:

i. Add BAF Risk 178 (risk of failure to achieve the planned financial target / control total).
ii. Add BAF Risk 587 (EU Exit)
iii. Increase the risk score for Risk 362 (safer recruitment) in light of the issues with incomplete personnel files
iv. Decrease the risk score for Risk 517 (H&S) on the basis of the improving controls in health and safety demonstrated by completion of the improvement plan where all objectives were met; as received by the WWC on 12 September 2019
v. Note the slight amendment to the risk description in BAF Risk 529.
vi. Support the change in committee oversight for Risk 966 (111 standards) moving to FIC as this is the committee responsible for scrutinising operational performance.
vii. Support the change in committee oversight for Risk 529 (engagement with ICSs) moving from AUC to FIC as this risk is about how the Trust seeks to ensure it influences the system in investing in its strategic direction.

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.

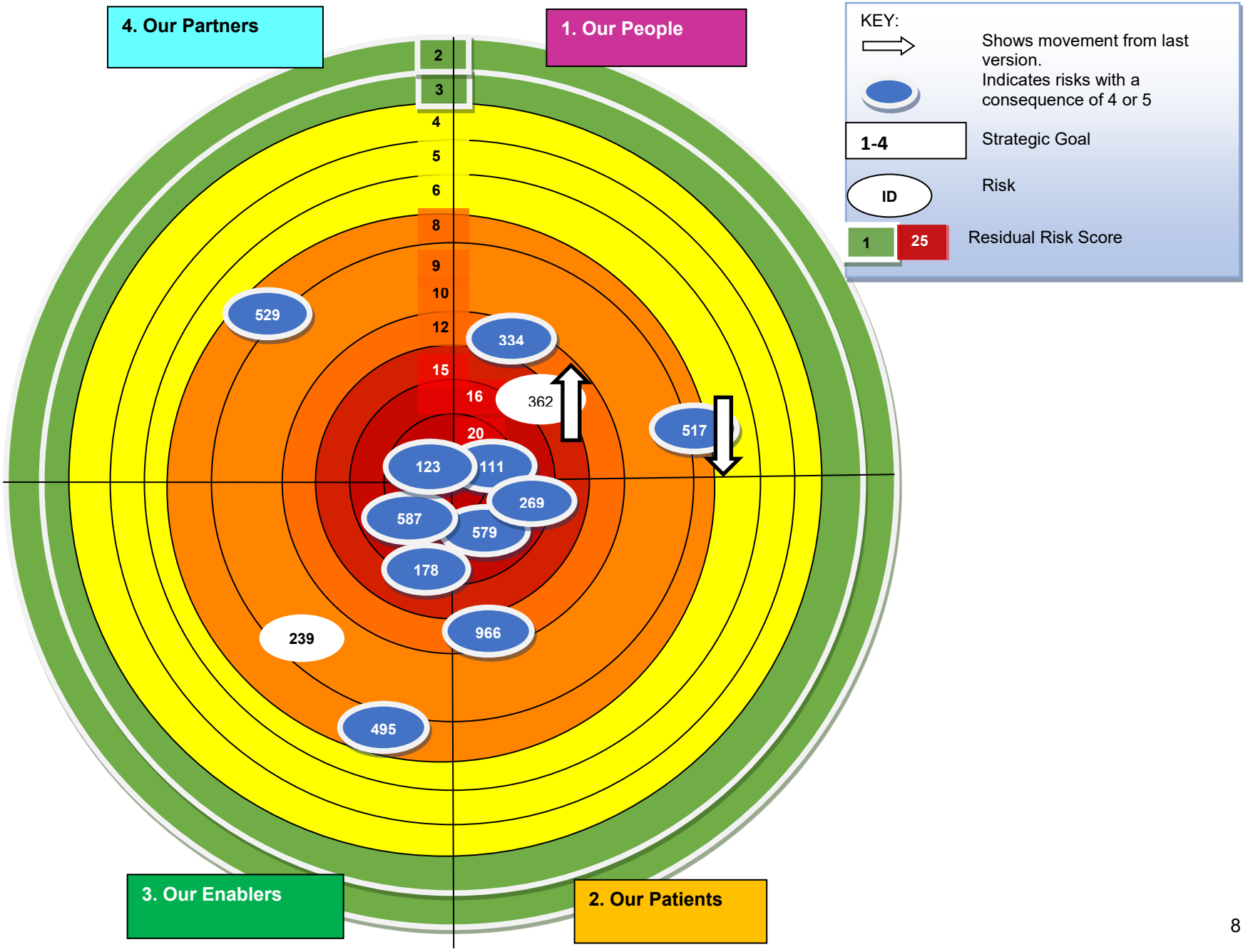
Dashboard

Links to objectives	Link to Delivery Plan (current RAG)	Risk ID / Theme	BAF Dashboard	Initial Score	Current 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. Currently, the principal risk relates to Cat 3 patients.	25	25	10	01.04.2020	FIC
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
5, 6, 7, 8	EOC	Risk ID 269 EOC	Risk that the Trust does not consistently answer calls within the national standards (Mean 5 seconds & 90th Centile 10 seconds) as a result of; •non-delivery of the planned workforce	25	20	5	To be revised	QPS

			(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						
8, 9,		*New* Risk ID 587 EU Exit	There is a risk that the Trust's ability to provide effective services is significantly affected by the UK's exit from the European Union, especially in the event of a 'no deal'.		20	20	10	31.03.2020	AUC
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	To be revised	QPS
8, 9, 12, 13		*New* Risk ID 178 Control Total	Risk that the Trust fails to achieve its planned income and expenditure targets (control total), as a result of loss of financial control. This may lead to limiting or delaying key investments and the Trust being place in 'Financial Special Measures'.		16	16	4	31.03.2020	FIC
2, 7	**Personnel Files**	Risk ID 362 Safer Recruitment	Risk that the Trust is not able to always provide evidence of the relevant employment checks, as a result of inadequate internal controls / record keeping, which may lead to sanctions and reputational damage.		15	15 ⇧	6	To be revised	WWC
5, 6, 7, 8	CQC tracker	Risk ID 966 111 Service	Risk that the Trust does not achieve operational standards for 111 as a result of increased pressure on the service, which may lead to patient harm.		16	12	4	To be revised	~~QPS~~ FIC

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	To be revised	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	08 ⇩	4	To be revised	WWC
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	To be revised	FIC
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	To be revised	AuC
13, 14, 15	N/A	Risk ID 529 Change	Risk that the Trust is unable to substantively engage with Integrated Care Services and the service delivery		12	8	4	To be revised	~~AuC~~ FIC

			architecture in place across region, as a result of capacity. This may lead to the inability to pursue the Trust's overall strategy and supporting objectives.						


4. Our Partners
1. Our People
3. Our Enablers
2. Our Patients
2
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529
334
362
517
123
111
269
587
579
178
966
239
495
KEY:
Shows movement from last version.
Indicates risks with a consequence of 4 or 5
1-4
Strategic Goal
ID
Risk
1
25
Residual Risk Score

Appendix A

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

Underlying Cause / Source of Risk:		
Risk that the Trust will not delivery the planned workforce as a result of; •inability to recruit to the current gaps •not retaining current staff •inability to recruit to the future needs Due to; •not having optimal HR support functions •not having optimal education and training This may lead to poor patient (and staff) outcomes and experience, and not meeting national performance targets.	**Accountable Director**	Director of HR & OD
	Scrutinising Forum	HR Working Group
	Initial Risk Score	**25** (Consequence 5 x Likelihood 5)
	Current 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	Improving working conditions, e.g. meal breaks / shift overruns Rotational paramedic roles aimed and better attraction and retention Different approach to student paramedics ensuring higher number of job offers

Gaps in Control
Overseas Recruitment HR transformation programme (Phase 2 – improving functions) Retention Strategy

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) IA sickness absence reporting (2016/17) / sickness rates above the 5.2% target. (-) High Turnover (-) skill mix (+) leavers reduced (+) Resourcing Plan delivered. (+) Numbers of student paramedics joining the Trust	

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 4. Development of a retention strategy	1. Workforce model provides a detailed, evidence-based and robust approach to strategic workforce modelling. Plans are monthly to end 2024/25, then annual for 2025-28. 2. Contracts in place for 8 new staff from overseas 3. HRT business case approved in June 2019 – see delivery plan. 4. Scheduled to come to Board in November 2019

Last management review	Executive Management Board	**Last committee review**	12.09.2019 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: 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.	**Accountable Director**	Director of HR & OD
	Scrutinising Forum	HR Working Group
	Inherent Risk Score	**15** (Consequence 3 x Likelihood 5)
	Residual Risk Score	**15** (Consequence 3 x Likelihood 5)
	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 (renewals/no initial) are being regularly monitored daily.

Gaps in Control
Policy to be reviewed relating to renewal of DBS checks HR Transformation Plan (Phase 2) – aimed at improving basic controls Specific Plan to ensure all personnel files are complete with key documents

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 (-) Number of files incomplete (-) WWC (+) 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. 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. 2. Delivery of phase two of the HRT Plan 3. Personnel file rectification plan ensure files for current staff are complete	1. Policy to come to Trust Board in Q3 2. HRT Business Case was approved by the Trust Board in June 2019 (see delivery plan for progress). 3. The approach was agreed by the Executive on 16 Sept, and the project plan will now be delivered and reported through the Delivery Plan.

Last management review	Executive Management Board	**Last committee review**	12.09.2019 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
	Initial Risk Score	**12** (Consequence 4 x Likelihood 3)
	Current 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 New vision established to have an organisational culture where **'Our people are listened to, respected and well supported'**
Gaps in Control
Delivery of the plan to ensure the vision for the new culture

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) feedback from staff following the launch of the values and behaviours (+) Wellbeing Hub (+) 2018/19 Staff Survey (+) CQC inspection June 2019 (-) High number of grievances (-) LCFS Annual Report – on the question of an open culture	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
Culture Plan	Initial focus on; induction; quality of appraisals; anti-bullying and harassment; and staff retention. See Delivery Plan for progress.

Last management review	Executive Management Board	**Last committee review**	12.09.2019 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
	Initial Risk Score	**16** (Consequence 4 x Likelihood 4)
	Current 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)

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

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Independent Review May 2018 (-) manual handling incidents high (-) RIDDOR reporting (+) HSE inspection visit in February 2018 focussing on Muscular Skeletal Disorders (+) violence and aggression to staff showing a slow downward trend. (+) increase in H&S reporting – showing greater awareness (+) Delivery Plan showing H&S as Green (+) WWC Sept 19 – assured with delivery of the improvement plan	

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. Completed in July 2019 – all objectives met. 2. Completed. 3. Over 200 operational managers have received classroom based H&S training

Last management review	Executive Management Board	**Last committee review**	12.09.2019 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:		
Risk that the Trust does not consistently answer calls within the national standards (Mean 5 seconds & 90th Centile 10 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	**Accountable Director**	Director of Operations
	Scrutinising Forum	Teams A/B (EOC)
	Initial Risk Score	**25** (Consequence 5 x Likelihood 5)
	Current 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

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) NHS Pathways / MT audit compliance (-) Call Answer performance (+) EMA capacity above trajectory (+) reduction on EMA turnover against trajectory	

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
EOC improvement plan	Improvement plan focus on staffing

Last management review	Executive Management Board	Last committee review	09.09.2019 Quality & Patient Safety Committee

Goal 2 Our Patients	**BAF Risk ID 579** [link to BAF 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
	Initial Risk Score	**20** (Consequence 4 x Likelihood 5)
	Current 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 EOC improvement plan has been developed and is in place (see delivery plan)
Overseas recruitment - 8 with contracts (3 started 5 due to start by the end of the year)
Implementation of Clinical Support Worker to support patient welfare calling
Clinical recruitment – target is 76 which is expected to be exceeded by Jan 2020.
Agency pathways clinicians introduced.
Revised EOC governance group.

Gaps in Control	
Delivery of the Audit & Training Business Case Welfare calls - <40% focus at QCSG. 990 ARP Performance equals less need for welfare calls.	Pathways & Clinician Audits / Live feedback Staffing numbers EOC Improvement Plan implementation

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) CQC – assured that improvements are being made (+) greater clinical support compared to previous year (-) ARP performance, especially in Cat 3 (-) compliance with welfare calls (-) Instances of surge (-) staff retention	Delivery Plan (first reporting against new IP due in September)

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. New EOC improvement plan created with focus on; Audit; Clinical Recruitment; Staffing. 2. Audit & Training Business Case	1. See Delivery Plan for progress against the EOC improvement plan 2. Audit & Training Business Case has been approved by the Trust Board and the restructure / recruitment is due to begin in Q3.

Last management review	Executive Management Board	**Last committee review**	09.09.2019 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:	**Accountable Director**	Director of Operations
Risk that the Trust does not consistently achieve operational standards for 111 as a result of increased pressure on the service, which may lead to adverse patient experience and / or harm.	**Scrutinising Forum**	Teams A/B (111)
	Initial Risk Score	**16** (Consequence 4 x Likelihood 4)
	Current 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 (-) High number of 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/	Operational Performance has significantly improved with the introduction of specific recovery action plans. The monthly operational KPIs for August were the best since the Service began and were aligned with NHS E 111 performance

Last management review	Executive Management Board	**Last committee review**	09.09.2019 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. The principal risk relates to Cat 3 patients.	**Scrutinising Forum**	Executive Management Board
	Initial Risk Score	**25** (Consequence 5 x Likelihood 5)
	Current 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

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Performance under trajectory (-) CPN with commissioners (-) Lost hours from handover delays (-) Call answer performance (-) FIC August not assured with sustainable long term plan to meet ARP	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Handover Programme 2. 999 Transformation & Delivery	1. On-going 2. Operational performance showing improving trajectory

Last management review	Executive Management Board	**Last committee review**	08.08.2019 Finance & Investment Committee

Goal 3 Our Enablers	**BAF Risk ID 178** Financial control total	**Date risk opened: 01.04.2019**

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Finance & Corporate Services
Risk that the Trust fails to achieve its planned income and expenditure targets (control total), as a result of loss of financial control. This may lead to limiting or delaying key investments and the Trust being place in 'Financial Special Measures'.	**Scrutinising Forum**	Heads of Finance
	Initial Risk Score	**16** (Consequence 4 x Likelihood 4)
	Current Risk Score	**16** (Consequence 4 x Likelihood 4)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)
Cost improvement programme (CIP) Contracts with NHS commissioners (currently only for one year) that secure planned income subject to successful service delivery. Robust financial governance processes to support sound financial management. Approved budgets and a system of budgetary control. Promotion and increased awareness of financial governance issues across the organisation.

Gaps in Control
Robust CIP plans Operational performance resulting in reduced income. Identity of additional income opportunities.

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) Use of Resource Metric for I&E Margin 2 or better on a consistent basis (+)The Trust met its Control Total for the first five months (-) but this was supported with the non-recurrent release of £0.7m of provisions. (-) £1.5m shortfall in income as a result of failure to meet activity. (-) level of cost pressures (-) CIP shortfall of £0.8m in handover delays	Long term financial plan – due to be considered by the Board in October 2019

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Improving performance to ensure generation of planned income 2. Focus on budgetary control, specifically around Fleet, Procurement and Estates 3. A rigorous process to consider the merit of identified cost pressures and to approve additional budget funding through critical scrutiny of business cases	1. Operational performance showing improving trend 2. Ongoing 3. EMB has approved the cost pressures.

Last management review	Executive Management Board	**Last committee review**	08.08.2019 Finance & Investment Committee

Goal 3 Our Enablers	**BAF Risk ID 587** EU Exit	**Date risk opened: 27.09.2018**

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Operations
There is a risk that the Trust's ability to provide effective services is significantly affected by the UK's exit from the European Union, especially in the event of a 'no deal'.	**Scrutinising Forum**	Resilience Forum
	Initial Risk Score	**20** (Consequence 5 x Likelihood 4)
	Current Risk Score	**20** (Consequence 5 x Likelihood 4)
	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)

Engagement at LHRP, LRF, horizon scanning meetings
Technical notes from NHS confederation
Resilience forum
Gov.UK documentation in place
EU Focus Group (internal) established to advise Trust
EU Lead appointed and in place
EU Planning Group in place
Department / OU EU Exit Operational Readiness
BC Plans complete and tested
Management of linked risks e.g. infrastructure, medicines, logistics.
Mutual aid arrangements in place

Gaps in Control

Central Business Case to cover costs of mutual aid

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Central Business Case to cover costs of mutual aid 2. Engagement meetings with system partners	1. Complete and with Treasury for sign off 2. Ongoing

Last management review	Executive Management Board	**Last committee review**	

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
	Initial Risk Score	**16** (Consequence 4 x Likelihood 4)
	Current 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 (-) BCI Coxheath	

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**	08.08.2019 Finance & Investment Committee

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

Underlying Cause / Source of Risk:		
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.	**Accountable Director**	Director of Strategy
	Scrutinising Forum	Information Governance Group
	Initial Risk Score	**09** (Consequence 3 x Likelihood 3)
	Current 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 repository 3. GDPR Action Plan Delivery	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. 2. There are Information Asset Owners in place and this will remain a standard agenda item for the monthly IGWG meetings. Work is to commence on implementing the new IAR during

4. IG Manager Recruitment has been completed. Individual to commence in post 2 January 2019 5. FOI process mapping underway 6. Baseline submission of Data Protection & Security Toolkit due 31 October 2019 and completion of DSPT Action Plan 7. RA local model – initial scoping has taken place in conjunction with NHS Digital 8. Localised training for HR Portfolio in relation to SAR Process – September 2019 9. ICO Action Plan completion – target date November 2019			Quarter 3 2019, meetings have now been scheduled for late November / December 2019 3. PMO engaged. The 'Peer to Peer' review of the revised GDPR Action plan took place with London Ambulance Service on 20 August 2018. A summary report and updated GDPR action plan was presented to the Audit Committee and IGWG in September 2018. 4. Interviews for the IG Manager role have taken place – at this time an unconditional offer has been made subject to suitable references. IG Manager insitu from 2 January 2019 5. Due to report to senior leadership committee in November 2019 6. Baseline submission completed. This is currently at an unsatisfactory level as we would expect at this time and further work must commence during the coming months in order to remain compliant. 7. Meetings have taken place with NHS Digital RA Lead to review gaps in assurance around Registration Authority (smartcards). Printers have been potentially sourced at no cost to the organisation – this is to be confirmed. New roles / sponsors allocated and confirmed within Trust to locally manage process and roll out within EOC
Last management review	Executive Management Board	**Last committee review**	Audit and Risk Committee 11.07.2019

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

Underlying Cause / Source of Risk:		
Risk that the Trust is unable to substantively engage with Integrated Care Services and the service delivery architecture in place across region, as a result of capacity. This may lead to the inability to pursue the Trust's overall strategy and supporting objectives. ~~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
	Initial Risk Score	**12** (Consequence 4 x Likelihood 3)
	Current 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 the relevant Boards Identified Trust personnel attend core work-stream and pathway development meetings within local systems. Reciprocate sharing and agreement of overall strategic planning with ICSs in terms of clinical case for change and to support work of Trust services. Re-focussed System Assurance Meeting where the Trust and its partners consider development risks and issues in the context of urgent and emergency care.

Gaps in Control
Programmes of work within the systems across the region will be reflected in the Trust's review of its strategy. Cannot always attend core work-stream and pathway development meetings within local systems.

Assurance: Positive (+) or Negative (-)	Gaps in assurance
	System Assurance Meeting (first revised meeting to take place in Q3)

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
System Assurance Meeting has a standing agenda item where it will require reporting on the efficacy of system engagement in urgent and emergency care.	(new) System Assurance Meetings from Q3 to be scheduled – frequency to be determined.

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
NHS Foundation Trust

		Agenda No	60/19
Name of meeting	Trust Board		
Date	26 September 2019		
Name of paper	Infection Prevention and Control Strategy 2019 / 2022		
Responsible Executive	Bethan Eaton-Haskins Executive Director for Nursing & Quality		
Report Author	Aide Hogan Head of Infection Prevention and Control		

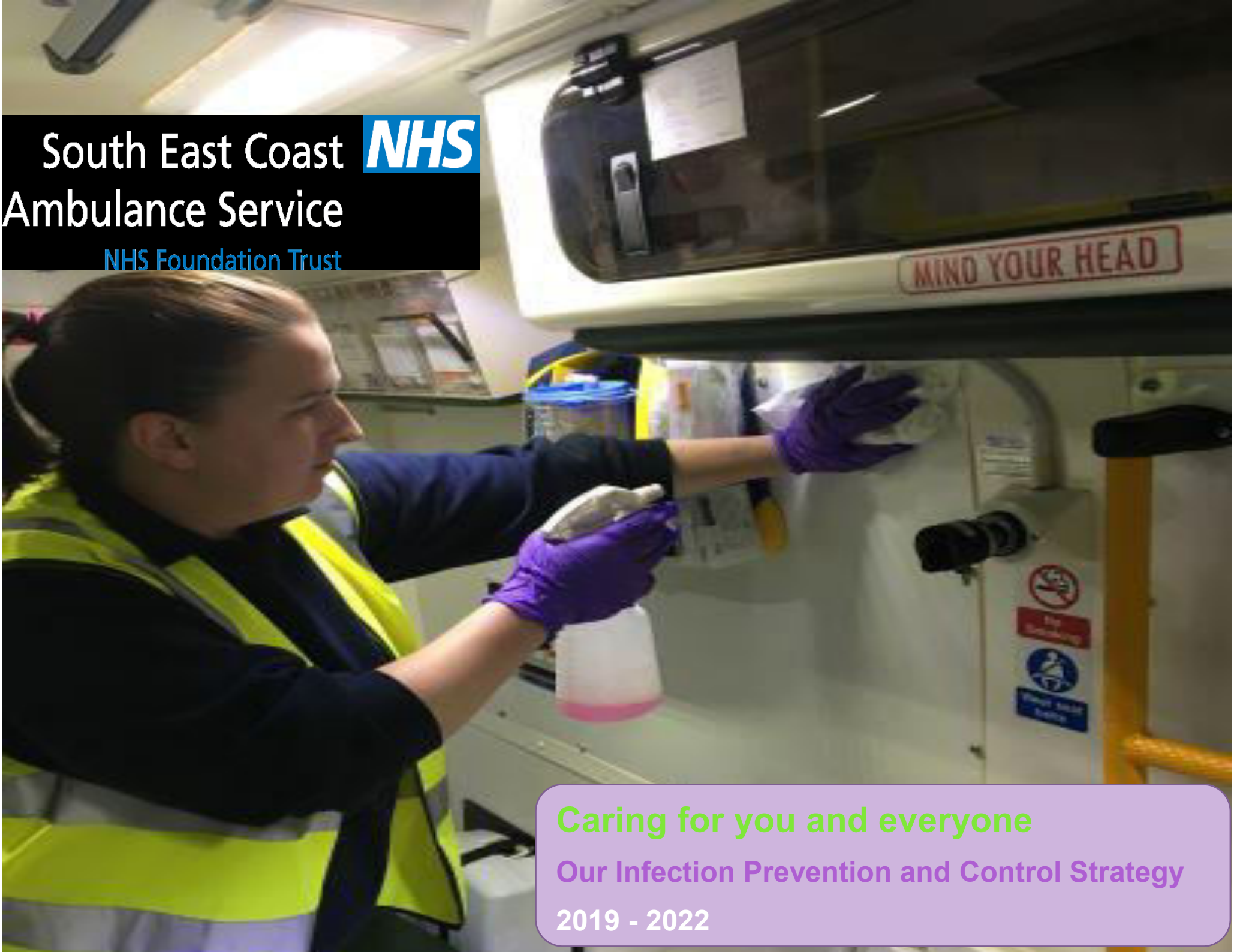
This is the first Infection Prevention and Control (IPC) Strategy produced for the Trust and sets the way forward on how it will monitor compliance with IPC standards and best practice.

The strategy is based on the improvement plan that was developed following feedback from the previous Care Quality Commission inspections and the content and work plan has been agreed as the way forward by the Trusts IPC Sub Group.

The main aim of the strategy is to change the culture for IPC within the ambulance service and allow staff to relate to different terminology for certain procedures that were previously seen as hospital based.

The IPC Sub Group will be responsible for monitoring and regular reviews of the strategy to ensure we are embedding the cultural change for IPC into day to day practice.

It was considered by the Quality and Patient Safety Committee at its meeting on 9 September and the feedback provided then has been reflected in this version.



South East Coast Ambulance Service

NHS

NHS Foundation Trust

Caring for you and everyone

Our Infection Prevention and Control Strategy

2019 - 2022

Our Trust Mission

Aspiring to be

Better Today and Even Better Tomorrow

for our people and our patients

Contents

Introduction

Introduction from the Director for Infection Prevention and Control

Executive Director of Nursing & Quality

I am very pleased to introduce the first Infection Prevention and Control Strategy for South East Coast Ambulance Service NHS Foundation Trust. This Infection Prevention and Control (IPC) strategy is central to our work on patient safety and demonstrates the continued journey of improvement for the Trust. We have already made considerable improvements in relation to infection prevention and control which were noted by the Care Quality Commission in both 2018 and 2019. Considerable investment has been provided to ensure that we have a reactive IPC service which actively promotes best practice. This work has included the development of our IP Ready Procedure which translates best practice guidance into every day practice specifically for ambulance staff.

SECAmb is taking a whole organisational approach to IPC that promotes and embodies Best Practice standards and procedures to ensure that IPC will be embedded across all service areas and in every aspect of the Trust's work. This will be underpinned with robust governance arrangements to ensure that we will meet our statutory responsibilities. This strategy sets out how we will continue to develop our care.

Bethan Eaton-Haskins, Executive Director of Nursing & Quality

Introduction

About this Strategy

Keeping our patients and staff safe by breaking the chain of infection

This strategy document will guide the ongoing development and enactment of South East Coast Ambulance Service NHS Foundation Trust (SECAmb) Infection Prevention and Control function (IPC). It provides a strategic approach to IPC across the organisation, ensuring that our approach is pro-active and that the organisation meets its statutory responsibilities.

SECAmb is committed to providing a high quality infection prevention and control service in order to reduce the risk of infection and to ensure the safety of service users/patients, staff, visitors, and members of the public in all the settings we work in.
The aim of this strategy is to ensure that the Trust continues to be compliant with the Trust's IPC Policies. Good standards of cleanliness, and good infection prevention and control practices will continuously be embedded throughout the whole organisation in every team and service. The Trust's Infection Prevention and Control Team (IPCT). The Board ensures that effective infection prevention and control is everybody's business and is embedded into the day-to-day practice of all staff and services with the expert support coming from the Trust's Infection Prevention and Control Team (IPCT).

The strategy is a dynamic document that will be reviewed and updated should national guidance change within this time period, and in the event of any internal learning or change of process that triggers the need for a review of practice.

Background and Policy Context

The Care Quality Commission Inspection Report 2019 stated 'The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. There were procedures for emergency medical advisor staff to manage information about infection prevention to minimise the risk when patients were transported. Emergency medical advisors staff relayed information related to health associated infections through to dispatch teams and then onto ambulance crews. The risks or concerns were recorded on the computer aided dispatch system. This allowed crews to take additional precautions for their own safety, such as personal protective equipment to minimise the spread of infections

The improvement plan for IPC is managed by the IPC Team who report any issues to the IPC Sub Group. The objective is 'keeping patients and staff safe by breaking the chain of infection'.

This is to be achieved by the implementation of a new strategic, sustainable approach to Infection Prevention & Control, including the "Infection Prevention Ready" procedure, which was developed and rolled out in July 2018. The measures undertaken in this approach covered the issues highlighted by CQC and following their recent inspection in 2019 the improvements made already were complimented on.

The provision of local IP Champions at each site has been developed to further embed this process and improve communications and knowledge sharing. The project includes the following defined areas of focus:

1. Process Ready (Policy/Champions)

2. Make Ready (Environment)
3. Person Ready (Health & Immunisation)
4. Protection Ready (Uniform & PPE)
5. Hands Ready (Hand Hygiene)
6. Competence Ready (Knowledge)
7. Effectiveness Ready (How do we know we did not cause harm).

The six clinical care protocols are:

1. Standard (universal) infection control precautions;
2. Aseptic technique;
3. Safe handling and disposal of sharps;
4. Prevention of occupational exposure to blood-borne viruses, including prevention of sharps injuries;
5. Management of occupational exposure to blood-borne viruses and post-exposure prophylaxis;
6. Hand hygiene and care.

Our Strategic themes and focus

The Trust provides services to a diverse catchment of 4.7 million people. The area that we cover is 9,400 square kilometres and includes Kent, Surrey, Sussex and North East Hampshire.

We receive and respond to 999 calls from the public and health care professionals; receive and respond to 111 calls and also provide the regional Hazardous Area Response Team (HART) which responds to specialist emergency challenges.

To ensure we are able to deliver our services we employ over 3,500 staff, 85 % of whom are directly involved in patient care.

The aim of this IPC strategy is to ensure everyone is as safe as possible and it is a fundamental component to realising our overall vision and mission which is outlined in the Trust's Five-Year Strategic Plan.

The Strategic Plan demonstrates how the Trust will ensure the provision of safe, quality care to its communities and to its staff.

As a trust we are determined to continue to learn from feedback from our staff, our volunteers and our patients and embed Trust-wide change as a result of this learning.

The next five years is focused on delivery of our four strategic themes which are:
Our people – supporting and developing our staff and volunteers;

Our patients - ensuring timely quality of care, in the right place by the right people;

Our enablers – fit for purpose technology, fleet and estates, underpinned by sustainable financial performance;

Our partners – working with health, 'blue lights' and education partners. These strategic themes are translated into our strategic focus over the next five years.

This strategy outlines the approach to IPC for the next 3 years.

IPC relates to a range of objectives across all of our four strategic themes but mainly sits under the themes 'Our Patients and Our People' within our Strategic Plan.

In developing this strategy, we have taken account of our obligations in adhering to legislation and National Policy. The Health and Social Care Act 2008 (Code of Practice on the prevention and control of infections and related guidance) established a clear legal framework for how the NHS, local authorities and other statutory agencies, should protect service users and staff from infection. It further states that good infection prevention (including cleanliness) is essential to ensure that people who use health and social care services receive safe and effective care.
Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone.

Good management and organisational processes are crucial to make sure that high standards of infection prevention (including cleanliness) are developed and maintained.

The Act is reinforced by published guidance to all NHS organisations on their responsibilities to protect service users in relation to infection prevention and control.

The Trust is, as required for all providers of healthcare services, registered with the CQC. Registration requires that the Trust must ensure that those who use the service are assured that the treatment they receive is compliant with the registration requirement relating to IPC control and that staff are suitably trained, skilled and supported.

As a healthcare provider the Trust is required to demonstrate, and evidence, that it has IPC leadership and has commitment at all levels of the organisation. In addition, we must ensure that there is full engagement and joint working with NHS partner organisations, other provider partners, commissioners, NHS England and Public Health England.

As well as our obligations to patients, we also understand our obligations as an employer to protect and care for our staff.

Our Infection Prevention and Control Vision and Values

Our Vision

SECAmb is taking a whole organisational approach to IPC that promotes and embodies Best Practice standards and procedures.

IPC will be embedded across all service areas and in every aspect of the Trust's work. This will be underpinned with robust governance arrangements.

Our Values

As an organisation we aim to continually learn and develop. Feedback from our patients, our people and partners is essential to this learning. Our vision for IPC embodies this approach.

Our IPC Strategic Themes

Development of this IPC strategy is to divide into two overarching themes:

- In developing its Strategic Plan, the Trust has identified IPC as a quality improvement priority area. The Strategic Plan emphasises that the Trust is committed to consolidating and continuing to improve its IPC practices and procedures.

- To ensure the Trust has competent, confident and empowered staff, with awareness of their IPC responsibilities, and a supportive internal response to incidents that minimise the risk of infections to patients, carers and staff.

In line with our overarching five-year strategy the Trust has identified four strategic areas:

- Our People: develop a highly professional robust IPC Team with strong leadership which drives changes and compassion of care throughout the Trust.

- Out Patients: protect them against the risk of infections and provide the clinical care they deserve.

- Our Enablers: using existing and developing standards in training and raising awareness tools.

- Our Partners: professional collaborative working partnerships with other healthcare providers specifically for IPC.

Our Infection Prevention and Control Objectives

The Trust Board and the Trust's senior management will provide effective leadership on infection prevention and control in order to ensure high quality services. The Director for Infection Prevention and Control (DIPC) will work with the IPCT, service managers, team leaders, and professional leads, to take forward the following annual infection prevention and control quality assurance programmes for 2019-2022:

The Trust has 6 objectives for IPC:

1. Ensuring compliance with the following IPC audits and reviews:

- Hand hygiene audits
- Clinically Ready audits
- Environment Cleanliness audits
- Vehicle Cleanliness audits
- IPC Environmental audits
- Post Patient Care reviews

Compliance levels are reviewed for each audit/review tool on a quarterly basis at the IPC Sub Group.

Target for meeting compliance for the new standards to be met by end of March 2020 and then maintained.

2. Raising awareness of best practice procedures for IPC:

- Hand Hygiene
- Aseptic Non-Touch Techniques
- Safe sharps disposal
- Personal Protective Equipment compliance

Working with our local IPC Champions the IPC Team will hold roadshows and awareness events to support this aim on a going basis throughout the three years.

Target for completion of initial roadshows is end of March 2020

3. Cleanliness standards:

- Vehicle cleaning procedures
- Environmental cleaning standards

There will be monthly meetings with the cleaning contractors for environmental cleaning and the Make Ready / Vehicle Preparation Programme Managers to discuss any issues raised from the audits carried out locally. The Trust will use contract performance monitoring mechanisms to support this.

Compliance to both standards will be in line with contracted targets.

4. Basic and advanced infection prevention and control knowledge testing

All clinical staff will complete annual IPC Level 2 training and Level 1 training every three years for support staff.

Completion for both levels of training to reach 95% for staff completion every year.

5. Infection Prevention and Control Awareness raising campaigns

The Trust will engage in regular awareness programmes led by our IPC Team and international awareness campaigns.

In line with National and International timeframes we will monitor compliance levels for our routine audits and reviews and look for any post campaign improvements.

6. Flu Vaccination programme

To match or exceed the national target for seasonal vaccination in order to provide a workforce that protects our patients and staff as well as their families.

Traditionally the annual target is set by Public Health England and is always 75% of staff vaccinated. However, for 2019/2020 there is also a CQUN target of 80% of staff vaccinated. Following every annual flu vaccination programme we will perform a review and report to the Board on lessons learnt.

Implementing our Strategy

The overriding objective for this strategy is to keep patients and staff safe by breaking the chain of infection. This will be achieved by the implementation of the new strategic, sustainable approach to Infection Prevention and Control, including the "Infection Prevention Ready" procedure. The measures undertaken in this approach will adhere to evidence based best practice guidelines.

The provision of local IP Champions at each site will further embed this process and improve communications and knowledge sharing. The implementation will be broken

down into the following defined areas of focus:

1. Process Ready (Policy/Champions)
2. Make Ready (Environment)
3. Person Ready (Health & Immunisation)
4. Protection Ready (Uniform & PPE)
5. Hands Ready (Hand Hygiene)
6. Competence Ready (Knowledge)
7. Effectiveness Ready (How do we know we did not cause harm)

Reactive Work

The IPC Team will also provide advice and support during outbreaks, such as measles and norovirus, to help prevent the spread of infection to both our patients and staff. This will be managed and overseen by the Head of IPC. We will have clear processes in place to manage these. We will hold a learning event after each outbreak.

Summary of Our Improvement Plan

IPC Commitment	IPC Aim	Action in Improvement Plan
1. Process Ready (policy, procedures and Champions)	• Embedding IPC practices into every day work practices across the whole Trust	IPC team to provide the wording to Operations regarding Clinical Dress Code to ensure alignment between IP Ready and Uniform Procedure
	Ensuring that National IPC Best Practice guidance is adhered to within the Trust	Adapt Five Moments of Hygiene to 3 Rs. Remove / Reduce / Reclean (relevant for ambulance staff) for incorporation into IP Ready Procedures
		Ensure that all operational staff are aware of the changes from Five Moments of Hand Hygiene to 3Rs (once IP Ready released)
		IPC to meet with Human Resources/Occupational Health/Health & Wellbeing to discuss the element of Health and Wellbeing element to be incorporated
		IPC Team to develop new IP Ready procedure, incorporating all elements for IPC practice to ensure the principles of 'No harm to patients and / or staff'.
		IP Ready procedure to be finalised for roll out

		IP Ready procedure will be communicated and rolled out across the Trust
		IP Ready system to incorporated into audit dashboards and where required new audit tools developed to match the system
		Develop EOC Champions role profile, identifying standard tasks
		Identify candidates for appointment to role of EOC Infection Prevention Champion
		One day induction training course to be held
		Ensure all IP Champions receive adequate training - one day course initially with further development days planned throughout the year
		Communicate role of IPC Champion to all staff, providing them with names and how they can support staff in connection to IPC activities
		Ensure ongoing review of role
		Ensure ongoing support to IP Champions
		Develop strategy for development
		Develop strategy for replacement (to include performance related issues) and re-recruitment

		Engagement with staff by use of survey to assess the impact of the IP Ready procedure and IPC awareness
		Confirm Google platform is secure in order to capture audit results
		Confirm IT has capacity to help deliver the new ATP swabbing audits
		Change audit tools in line with IP Ready Go-Live
2. Make Ready (vehicle / environment cleanliness)	• Improve on all cleanliness standards throughout the Trust • Monitor compliance and action any areas of non-compliance • Provide support to the Estates Team on any new or refurbishment building works	A new vehicle audit tool to be developed
		New audit tool, alongside a dashboard showing live updates, will be available on the iPad to OTLs and IPC Champions
		ATP swabbing machines to be purchased
		Local ATP swabbing schedule to be developed for vehicle cleanliness (example 4 vehicles per month per OU)
		Local ATP swabbing schedule to be developed for built environment cleanliness

		All IPC Champions and IPC Practitioners will have training to use the ATP swab test equipment
		IPC Team to become more involved in the programme for environmental cleaning systems. Process to be discussed and agreed for the future
		ATP swab testing reports will be reviewed and shared by the IPC Team / IPC Sub Group and learning will lead to new ways of working
3. Person Ready (staff health and immunisation)	• Ensure all staff are fit to deliver patient care on a face to face basis • Ensure support staff are aware of risks with communicable infections in the work place • Staff are appropriately immunised following national guidance	Alignment of sickness absence policy with IP Ready
		The IPC Team to provide awareness sessions for Line Managers to explain the principles behind Person Ready in regard to health concerns.
		Create a new system that allows staff access to their up to date immunisation records
		Inform and educate staff about the reasons behind this new system for immunisation records
4. Protection Ready (uniform and PPE)	• Uniform and PPE that is fit for purpose in the ambulance setting	Eliminate ambiguity of BBE by adapting current BBE guidance and uniform guidelines into one new hand hygiene and clinical dress code policy within IP Ready
		Review and introduce a new risk assessment for the wearing of PPE to take into account the ambulance working environment

		Review PPE equipment we use
		Continue to monitor BBE audits until clinical dress code policy is rolled out in IP Ready
5. Clinically Ready (hand hygiene and Bare Below the Elbows compliance levels)	• To provide staff with a procedure that supports their working environment • Promote Best practice for hand hygiene procedures	Ensure that all operational staff are aware and compliant with hand hygiene audits (current process)
		Ensure that all operational staff are aware and compliant with Five Moments for Hand Hygiene (current process)
		Schedule of HH audits to be distributed
		Eliminate ambiguity of BBE by adapting current BBE guidance and uniform guidelines into one new hand hygiene and clinical dress code policy within IP Ready
		Complete regular HH audits
		Learning outcomes for HH to be generated
		If required, ensure IPC training module is available in Level 1 training

6. Competence Ready (knowledge)	• Provide high quality training that is based on national and local standards to all Trust staff that is evaluated reviewed and effective • Raise awareness for IPC practices	Ensure IPC training modules are available in Level 2 training
		Monitor compliance to Level 2 training in IPC - all clinical staff to complete IPC module once every year
		Ensure ESR issues resolved so that system shows updated training records
		Ensure that requisite training equipment is acquired
		Development plan to be produced and implemented regarding use of HH training kits
		Videos to be developed to support the IP Ready process
		Develop library framework for IPC
		Upload educational videos onto Discovery
		Regular review of IPC incidents on Datix to ensure clarity around types of incidents and what measures need to be put in place to ensure learning outcomes are produced
		Develop Comms plan for IP Ready Procedure
		Weekly bulletins leading up to roll out

		Comms team to send out Comms to all staff via Team Briefing Update
		Announcements on intranet
		2x announcements on CE weekly Comms bulletin
		Framework for cascade of information via IPC Champions to be developed
7. Effectiveness Ready (how do we know we did not cause harm)	• Monitor compliance for all IPC activities • Involve patients and other healthcare providers in this monitoring	Secret Shoppers will be utilised at the QAV to carry out observational audits
		The IPC Team will carry out spot check audits once the second IPC Practitioner is in place
		IPC Team to review and share audit results
		Improvements seen in the satisfactory investigation and completion of IPC Datix incidents
		Complete regular vehicle cleanliness audits
		Complete regular all environmental cleanliness audits in the OU

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