South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

28 November 2019
10.00-13.00

Trust HQ, Nexus House, Crawley

Agenda

Item No.	Time	Item	Encl	Purpose	Lead
Introduction					
67/19	10.00	Apologies for absence	-	-	Chair
68/19	10.01	Declarations of interest	-	-	Chair
69/19	10.02	Minutes of the previous meeting: 26 September 2019	**Y**	Decision	Chair
70/19	10.03	Matters arising (Action log)	**Y**	Decision	PL
71/19	10.05	Board Story	-	Set the tone	Chair
72/19	10.15	Chief Executive's report	**Y**	Information	PA
Strategy					
73/19	10.25	Delivery Plan	**Y**	Information	SE
Quality & Performance					
74/19	11.10	Integrated Performance Report / Committee Escalation	**Y**	Assurance	SE
		Break			
75/19	11.40	Winter Plan	**Y**	Information	JG
76/19	11.45	Emergency Prepardenss Response & Resilience	**Y**	Assurance	JG
77/19	11.50	Public Awareness of CPR	**Y**	Assurance	JG
78/19	12.00	Learning from Deaths Policy	**Y**	Decision	FM
79/19	12.10	BAF Risk Report Incl. Risk 362 Deep Dive (safer recruitment)	**Y**	Decision	PL
Workforce					
80/19	12.20	Clinical Education	**Y**	Assurance	FM
Governance					
81/19	12.40	Freedom to Speak Up Guardian Report / Draft Strategy	**Y**	Information	FTSUG
82/19	12.50	IG Annual Report	**Y**	Information	BH
Closing					
83/19	13.00	Any other business	-	Discussion	Chair
84/19	-	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: 30 January 2020

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 26 September 2019

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

Present:

David Astley	(DA)	Chairman
Philip Astle	(FM)	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
Fionna Moore	(FM)	Medical Director
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
Steve Emerton	(SE)	Executive Director of Strategy & Business Development
Terry Parkin	(TP)	Independent Non-Executive Director
Tricia McGregor	(TM)	Independent Non-Executive Director

In attendance:

Paul Renshaw	(PR)	Director of HR
Janine Compton	(JC)	Head of Communications
Peter Lee	(PL)	Company Secretary

Chairman's introductions

DA welcomed members and, in particular PA to his first Board meeting. DA also thanked FM for stepping in to the CEO role while PA was recruited and to Richard Quirk for covering as medical director.

51/19 Apologies for absence

There were no apologies.

52/19 Declarations of conflicts of interest

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

53/19 Minutes of the meeting held in public 29 August 2019

The minutes were approved as a true and accurate record.

54/19 Action Log

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

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55/19 Board Story [10.02 -10.10]
This story focused on the value of flu vaccinations and the impact of flu on individuals. The Board reflected on the power of this film, which is being made available to other organisations in the health system, and the importance of the flu vaccine. After the meeting board members are receiving their flu vaccine.

56/19 Chief Executive Report [10.10 – 10.25]
PA started by acknowledging the great work FM has done since April. He noted the findings of the recent CQC inspection and how the Trust was able to demonstrate significant improvement in many areas; resulting in not just an overall 'Good' rating, but being taken out of special measures for quality too.

In terms of operational performance, PA outlined the challenges over the summer, which he stated would continue as we on-board higher numbers of staff than before. Some progress is being made, but there is a way to go, and so most likely the winter this year will be particularly difficult as it takes time for the new staff to become effective. PA reassured the Board that he and his executive team have significant focus on this.

PA acknowledged the disappointing Ofsted report, and put this in to context by explaining that it was not critical of the training or the outcomes, but instead of compliance with the contractual requirements. There is a great deal of work being done to ensure the Trust takes the right corrective actions.

PA concluded by highlighting how the 111/CAS bid demonstrates how well the Trust is now regarded, and with regards EU Exit, that he is assured by the robust planning, which is focussed on the worst case scenarios.

DA then opened it up for questions.

MW sought assurance from PA that we are supporting new staff properly as they join, and also asked regarding ECPR whether the Trust us in position to transfer electronically to hospitals.

On EPCR PA explained that connectivity is not yet in place across all hospitals, but plans are in place to ensure this is achieved. DH added that records are transferred as a PDF and so we can be assured we are delivering what is expected of us. Other trusts have system issues they are addressing and we will support appropriately.

PA then confirmed that he is not aware of any current issues with supporting new staff; training, induction and supervision is in place.

AR asked about clinical education and felt that we must seize this opportunity to review all our training to ensure it is as good as it can be. PA agreed, and reinforced this is precisely what the actions in place aims to do.

DA confirmed that a question from the public has been received which he would like to take here as it related to the impact of the current issues within clinical education, on advanced apprenticeships. FM explained that we are not yet delivering level 6 apprenticeships, and meetings are planned shortly to agree how best to ensure this is taken forward.

57/19 Delivery Plan [10.25 – 11.13]
SE introduced the report and confirmed that it will be reviewed following conclusion of strategy review and related objectives. After confirming that the service transformation and delivery (STAD) programme is now being managed as business as usual, he handed over to the executive leads to report by exception.

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Sustainability and Digital

DH set out the changes in RAG-rating, where some projects have moved from Green to Amber, due to the re-focus of priorities. With regards, EPCR DH explained that since going live, the completion of electronic records is good and can be monitored by individual; so those not using as much as others are being provided targeted support. There is still a gap in the training requirement and the Project Board (LB attends) is reviewing how we approach training in different ways. JG added that EPCR data is helping to better understand efficiencies, e.g. time taken for GP ring-backs. The Board reinforced the need for this intelligence to be shared with commissioners.

The CIP programme is on track, at this stage, but there are significant risks to some of the primary schemes in the second half of the year.

Questions:

TM reflected on some of the recent leadership visits and an emerging themes related to an uncertainty among some staff about the plan for estates; this appears to be about communication. DH confirmed that we do have an estates pipeline, which is aligned to the strategy. While he acknowledged there is always more we can do to communicate with staff, plans are communicated, but there is a balance on what we say in public due to commercial sensitivities.

MW asked whether we get feedback from staff, for example at Banstead, about the quality of our training estate. DH explained that we work with OUMs to ensure we prioritise local estate needs in context of the finite resources we have available. MW responded by suggesting we need to look at training more holistically, including where training is provided given its importance. DH agreed and stated that this will come through the development of our training strategy. FM supported this but added that despite some of the negative feedback, there are some advantages of Banstead, such as the space and availability of parking.

AS reminded the Board of a paper that came recently to the finance and investment committee that demonstrated that while there are some issues with the estate the Trust estate was fit for purpose.

LB reflected that there is more going on with estates than the delivery plan suggests. DH confirmed that the estates plan is a standing item at the finance committee.

LB asked for assurance that the fleet data has been transferred to the new fleet management system. DH responded that this is not yet the case, but additional expertise has secured to ensure this happens.

Action

FIC to confirm that the fleet data has been transferred to the new fleet management system and confirm the same in its report to the Board.

DA summarised that the Board cares about ensuring the right working environments and so supports the need to look at estates solutions in the round, as part of an overarching strategy.

Quality and Compliance

BH confirmed that the EOC project is closed with two separate plans remaining; clinical recruitment and NHS pathways. Clinical recruitment is rated Amber due to the challenge recruiting clinical safety navigators. NHS Pathways is rated Red because there has been a delay implementing the changes agreed by the Board in June (in approving the business case) as a consequence of a grievance holding up the restructure. In meantime, however, there is a plan to recruit on fixed term contracts to ensure improvement in audits.

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Operational Performance in 111 is Green given improvement being made; this is the one CQC must do.

Questions:
TP noted the mitigation re NHS Pathways audit, and asked when improvement will be made. BH confirmed that she would provide more clarity on this in the report to the Board in November.

HR Transformation
PR updated on the progress with the systems work, explaining that while the deadlines are deliberately challenging, he is confident they will be delivered on schedule. With regards the culture work, PR outlined the aims and priorities for this year, which include, appraisals, to introduced 360 feedback; induction, where we are changing the process from October to ensure better local induction and a new corporate induction from January 2020 to take place 3 months after joining; and tackling bullying and harassment.

Questions:
LB asked about the process of delivering the objectives within the culture work, and was assured this would be supported by the PMO. The mandate is being developed and some concern was expressed that aspects of the work are being delivered without a mandate. SE reminded the Board that the PMO portfolio timeline sets out the plan.

AR felt that it would be helpful to get a report back on projects now in BAU and noted that the PMO post project review will be included in the delivery plan report; the schedule will be available shortly.

In summary, DA felt there has been good discussion and challenge and the plan helps to keep the Board focussed on key issues.

58/19 IPR / Board Escalation Report [11.13 – 12.16]
SE introduced the IPR, the format and content of which is currently under review by the audit committee. In the meantime, some new data is included, as requested by Board, such as performance benchmarking data and handover delays. Directors then reported by exception, with DA asking the committee chairs to intercede at the relevant points with their escalation reports.

Clinical safety
FM highlighted the areas needing improving, such as the care bundle for myocardial infarction, which will be addressed through EPCR. We are leading the way for the post ROSC care bundle and also performing well in the newly introduced Sepsis care bundle.

There were no questions.

Quality
BH explained that the RAG rating for mental health indicators has dipped as we have not achieved the C2 response times in all cases. This is an area of focus.

Duty of candour is now back to 100% compliance, but complaints response rates (timeliness) is a concern. This has been explored by the quality committee; the specific issue relates to EOC and an identified single point of failure. Corrective action is being taken.

Hand hygiene is improving following some targeted work.

Questions:

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TP asked about safeguarding training, expressing some anxiety that that we are slipping with this. This led to a discussion about the need for individuals to take personal responsibility rather than relying on managers to keep chasing.

Action
QPS Committee to explore compliance with safeguarding training and the extent to which there is any adverse impact from the lower completion of training.

LB referred to violence and aggression to staff showing a higher trend. BH believed this is in part due to better recording, although there is also an increase in incidents; there are some national trials ongoing for body worn cameras as a deterrent. The Board were in agreement that it must do all it can to ensure staff are protected.

Action
At its meeting in January, the Board will receive a report on the reasons for higher reported incidents of violence and aggression toward staff, and the pro-active and reactive steps being taken to support staff.

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QPS Committee escalation report
TM took the Board through the report, highlighting the risk to delivery of Key Skills this year. The mitigation will be focus at the next meeting.

In terms of EOC clinical safety the committee has asked for more information on rota-fil to get a better sense of safety. It also agreed the reintroduction of Salbutamol, having reviewed in detail the risks and benefits. A post-implementation review will be undertaken in 6-months, and sooner if an issue should arise.

Questions:
There were some questions about CFRs, in the context of the Council of Governors meeting in September where Governors were asking how the Trust is supporting and enabling CFRs. JG reinforced the importance of CFRs, and so this is why we have taken the measures we have to ensure better governance arrangements. The volunteer / CFR strategy is being developed and will come to Board in due course.

LM welcomed this noting that we need to be nimble in how we engage volunteers system wide in to urgent and emergency care pathways.

Operational Performance
The IPR includes contemporary data and the productivity metrics which we focussing on to ensure the best use of resources. JG set out the different metrics and the reasons why they were chosen as areas to focus. The report also now shows where we sit against ARP when compared with other ambulance trusts. JG then drew attention to weekly scorecard; highlighting the improving performance, which is mostly due to better use of resources.

The 111 scorecard is included and JG referred the Board back to the Delivery Plan which shows the improvement plan and the good progress being made in a relatively short period. He reflected that there is work still to do, but an improving trajectory.

Questions:
LM referred to the handover data and the significant differences in hours lost by hospital, and asked whether we are doing all we can and if so, what is happening at the hospitals to have such differences. JG

confirmed that we have good engagement with all hospitals following the system-wide approach that is in place to look at this. Some hospitals have improved, but as the report shows, there are some outliers. There is national focus through NHSI/E on the sites where there is less success and this is starting to have a positive impact.

AS noted the 111 to 999 referral rates and asked what underlies the increase and how it relates financially. JG confirmed that the way 999 referrals is measured has changed and this coincided with the rates increasing. However, we are working to bring this down. DH added that financially if we send a response and provide a response we get paid, but the main issue is clinical priority; if calls are not routed through 111 they would be received by 999. PA added that the process is not entirely within our gift and every time we change NHS pathways the referral rate changes. Version 18 helps to adjust those calls that might not be appropriately allocated.

AR asked about winter plan and noted this will come to the Board for information in November.

TP reflected that the data pack is improving, but we need to understand the profile of patients, especially in the outcome data, e.g. are we responding to older/sicker people.

Workforce

PR highlighted staff retention and the work to bring to the workforce and wellbeing committee (WWC) a retention strategy in November.

The WWC report was then taken, with TP confirming that papers coming through are of better quality. In terms of areas of focus, the committee is becoming increasingly confident that solutions are being found to improve the issues with staff records. TP reflected that safe staffing is an interesting concept for an ambulance trust, and so we are working as a committee to better understand this. The committee feels there is good grip on what needs to happen, and this is being taken forward at the right pace, which the committee appreciates might appear too slow for some.

TP then referred to the Ofsted findings, which were disappointing. However, the response from the executive was prompt and appropriate, demonstrating good leadership. The committee has asked for third party assurance to check the actions being taken have the intended benefit.

Questions:

AS referred to the rolling sickness absence showing increasing trend. PR confirmed that the increase is consistent across OUs and there are weekly/monthly reviews with OUs to manage better. Sickness in 111 and EOC is a specific concern and the inputs are not having desired outcome. AS asked whether the increase is due to pressure to meet ARP. JG explained he has worked through by OU to understand the key issues and nothing specific has been identified. However, occupational health support is provided for MSK injuries, which is the only real trend as a larger part of the profile of sickness absence.

Finance

DH explained that the figures in the pack are from July and in August the trend is similar; forecast is still as planned. There are some significant challenges, and there is a risk to income.

The finance committee report was then taken and MW explained the focus of the committee as set out in the report. Summary of finance is that THE pressure is due to a reduction in income and cost pressures in terms of spend we are committed to. So the focus of the committee was on getting assurance on the investments already approved; the committee is assured that budgets were not being adjusted down. There is concern that we must quickly take a more medium to long term view so where we make investment decisions we take a longer view to say we invest to increase capacity and become transformational to

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understand underlying costs to ensure value for money. The 3-5 year financial plan will come to the next Board meeting.

D A summarised that the finance risks are being anticipated, but pressures are building. There is good control and this requires constant management grip.

Break at 12.16 – 12.35

59/19 BAF Risk Report [12.35 – 12.40]
Pl set out the structure of the report reinforcing the review by committees that this constitutes an accurate summary of the principal risks.

The Board reflected that there might be a gap in the report on training / clinical education. DH confirmed there is a project being set up and will use this to assess whether to include as a BAF risk.

LM asked about risk 529 and focus on STPs and the need to focus more on groups at sub-STP level. PA confirmed this is being considered by the executive and will be a focus of the strategic review.

The Board agreed the recommendations set out in section 4.

60/19 IPC Strategy [12.40 - 12.42]
BH asked the Board to consider and approve this strategy, which is based largely on the original CQC improvement plan. Amendments have been made following the quality committee review, specifically to ensure it is more reactive and making objectives smarter.

TM confirmed this was carefully reviewed by the committee and comes recommended for approval.

Decision
IPC strategy was approved by the Board.

61/19 Annual Safeguarding Report [12.42 – 12.44]
BH explained that this annual report sets out progress against the relevant requirements. It has been reviewed by the quality committee.

The Board formally received the report and reinforced this being a really important area to ensure safety to staff and patients.

62/19 WRES /WDES Report [12.44 – 12.57]
PR confirmed that this report has been reviewed by WWC. He explained that there is still scope for improvement and the objective is to become more representative rather than setting targets. The Board expressed its commitment to ensure better diversity. The other areas requiring focus are as set out in the report.

MW is supportive and noted that the actions are very specific, but do not include unconscious bias; he would prefer something deeper to better understand the root causes, e.g. BME staff less likely to be promoted. This led to a discussion about the leadership programme and focus on unconscious bias. Also one action is to do a deep dive where we have diverse candidates not selected, to challenge back to recruiting mangers. This will provide more of a look back and analysis.

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TP confirmed that the view of WWC is that some targets might be helpful, but is for the executive to make a determination. It also recognised the outstanding work undertaken by Asmina, and the need to ensure this is embedded (not just taken forward by Asmina and one or two others) so it becomes part of everyone's business on a daily basis.

DA asked the Board if it is supportive of doing all we can to support this. The Board confirmed that it was.

TM then suggested we can hold to account Universities more to help ensure more diverse paramedic graduates. FM agreed and noted the paramedic profession is still young; the black community in London for example have an issue with uniform and people from India and parts of Asia historically tend to focus on medicine and law. Paramedic profession is often not on in their thinking.

63/19 Audit & Risk Committee Report [12.30 – 12.35]
AS highlighted the main issues as set out in the report. There were no questions

64/19 Kent & Medway STP Transformation Programme [12.57 – 13.09]
BH confirmed this sets out the Kent and Medway STP direction of travel. We have been involved, but harder for use as a regional provider. It asks for our endorsement of the direction of travel. The executive has received it and confirms it is not inconsistent with our objectives.

LM added that it has some weaknesses and there is confusion about the commissioning role and lack of clarity of relationships. Also SECamb is only mentioned right at the back and shows a lack of understanding of our key role in leading integration of urgent and emergency care.

DA stated that we need also to be clear on what our offering. This is one of the more mature STPs in terms of collaboration. We can support it, but it must be a start of a better relationship. DH added that we have a commissioning arrangement with CCGs not STP/ICPs.

Some of the NEDs then highlighted what it seems to be missing, for example, the risks or issues it is creating for the Trust; lack of precision for what they are trying to achieve.

The Board supported the direction of travel, and asked the executive to ensure it is clear what our broad expectations are, linked to our strategy and what we can offer as part of this.

65/19 AOB
DA confirmed that Nigel Sweet (long-standing member of staff) is due to retire and he thanked him for his contribution over the years.

66/19 Review of meeting effectiveness

The meeting was deemed to be effective. Directors felt that discussions were at the appropriate level of detail.

There being no further business, the Chair closed the meeting at 13.11

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

Date _____

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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	Q4 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	30.01.2020	Board	IP	The draft strategy was consider by QPS on 09.09.2019 and some feedback was provided to help strengthen the strategy. The plan was to bring this to Board in November, but a further workshop was held in October and so revisions will mean ti will not be ready until January 2020.
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	C	On agenda 28.11.2019
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	C	Policy on agenda 28.11.2019
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	C	Considered by WWC on 21.11.2019. Management confirmed that on review of other trusts there is no specific benchmark, and so a timeframe has been set of a mean average of 28 days. See WWC report
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 now 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	C	Verbal update to be provided at the meeting on 26.09.2019. Down to low numbers of patients fall in to this group and so can be large swings; within usual variation.

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	tbc	QPS	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	Q4 2019/20	Board	IP	Considered as part of the ongoing review.
26.09.2019	57 19	FIC to confirm that the fleet data has been transferred to the new fleet management system and confirm the same in its report to the Board.	DH	Q4 2019/20	FIC	IP	
26.09.2019	58 19a	QPS Committee to explore compliance with safeguarding training and the extent to which there is any adverse impact from the lower completion of training.	BH	23.01.2020	QPS	IP	Added to agenda for 23.01.2020
26.09.2019	58 19b	At its meeting in January, the Board will receive a report on the reasons for higher reported incidents of violence and aggression toward staff, and the pro-active and reactive steps being taken to support staff.	PR	30.01.2020	Board	IP	

Key

	Not yet due
	Due
	Overdue
	Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	72-19

Name of meeting	Trust Board
Date	28.11.2019
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 September, October and November 2019.

2. Local issues

2.1 Operational Performance

2.1.1 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 by the Executive Team on a weekly basis.

2.1.2 Our Senior Operational Leadership Team are continuing to tightly manage delivery of our Performance Improvement Plan on a daily basis, including:

- Taking a proactive approach to planning the resources we need to match demand
- Focussing overtime to when it's most needed, including the use of targeted incentives for key shifts
- Ensuring we are making the most efficient use of the resources we have available, by paying close attention to on scene times, the number of vehicles we send to incidents and hospital handover times

2.1.3 In common with our colleagues nationally, we are continuing to see high levels of demand from 999 callers. We have seen some improvements in our performance for all categories of call, however, we are still not yet resilient enough to withstand unexpected peaks in demand.

2.1.4 Despite some improvements, we are still seeing unacceptably long waits at times for our Category 3 and Category 4 patients and this remains a key area of focus for us.

2.1.5 After poor performance previously, I have been pleased to see consistent performance improvements recently in our 999 call answer times. This is seeing us currently delivering some of the best performance nationally in this area.

2.1.6 We also closely monitor our 111 performance and are working hard to improve our performance against a number of key metrics, including abandoned call rates and our 111 to 999 transfer rates particularly.

2.2 Executive Management Board (EMB)

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

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

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

- Establishing a senior leadership team to sit across the organisation, to pick up cross-directorate, day-to-day management issues etc.
- Oversight of progress against some of the current priorities;
    - The new 111/CAS service, scheduled to start from April 2020
    - Operational Performance
    - Clinical Education, supporting the outline plan for a new strategy
    - HR Transformation, approving a new approach to appraisals
    - Development of the long term financial strategy

2.2.4 EMB has also approved the following investments:

- Replacement of the HART vehicles and Incident Ground Technology, to ensure the Trust is in line with the national specification for HART services
- Development of the MRC site in Worthing, as part of the capital plan.

2.3 Changes to Trust Board

2.3.1 On 5 November 2011, following an extensive recruitment process, the Trust announced the appointment of Ali Mohammed as the new Executive Director of Human Resources and Organisational Development.

2.3.2 Ali is a successful NHS HR leader and has worked previously at a number of large Trusts, including Barts and Great Ormond Street. I know we will benefit greatly from his significant experience and staff-focussed approach.

2.3.3 Ali will join the Trust at the end of January 2020. Paul Renshaw, who is currently filling the role on an interim basis, will continue with the Trust until then to provide a full hand-over.

2.3.4 We are also currently seeking two Non-Executive Directors (NEDs) to join the Board - one with a financial background and one with a medical/clinical background. The Nominations Committee of the Council, Chaired by the Trust Chair and including six Governors and the Senior Independent Director, manages the recruitment and selection process and the Council of Governors makes the appointments.

2.3.5 The finance brief seeks someone who would ideally also have experience of contract management, new business and IT/infrastructure development. The clinical brief seeks someone with recent urgent or emergency medical experience.

2.3.6 We have engaged two agencies to help us, BAME Recruitment (finance post), and Green Park (clinical). Both are in the search phase and are providing regular updates, which show positive engagement with our brand and recognition that the Trust is on an upward trajectory. There is good interest in both posts.

2.3.7 Interviews will take place for the finance NED on 9 January 2020 and the clinical NED on 31 January 2020.

2.4 Support for the Royal British Legion Poppy Appeal

2.4.1 This year the Trust marked Remembrance Day and showed its support for the Royal British Legion by creating a special 'poppy' design on 12 of our front-line ambulances. All of our other front-line ambulances also received smaller poppy stickers.

2.4.2 I was pleased to see the great reception these received from our local communities and how proud our staff were to be driving these vehicles. Well done to our Fleet Team for arranging this and gaining sponsorship to cover the costs from our suppliers.

2.4.3 I know that many of our staff and volunteers took part in Remembrance Day parades and services, often laying wreaths on behalf of SECAmb. This included a long-established trip to Ypres, which saw colleagues lay a SECAmb wreath at the Menin Gate Memorial.

2.5 ePCR (electronic Patient Care Record) roll-out

2.5.1 The roll out of our new eCPR continues to go very well and all of our Operating Units (OUs) are now live using the new system.

2.5.2 In the last week alone, I have been very pleased to see more than 63% of Patient Care Records completed electronically across the Trust, with some OUs exceeding 80%.

2.5.3 Whilst work is continuing to increase the usage across all areas, we are also to working hard to make further improvements to the system, including an up-dated training app and a number of new features which will be rolled out shortly.

2.6 Flu vaccination campaign

2.6.1 We are now two months into our annual flu campaign and are currently performing above the Trust's trajectory for flu vaccine uptake. We are continuing to work hard to encourage as many staff as possible to have their vaccination.

2.6.2 This year we are again encouraging staff to have their vaccine by offering an incentive, which sees the Trust donate a course of medication to people in developing nations. This is proving very popular among staff.

2.6.3 This year's campaign has focused significantly on social media and utilising various mechanisms to drive uptake, including locally adapted posters using images of our own staff, a live webinar on the Trust's Facebook community page, regular social media messages, articles and jab-o-meter in the bulletin and the Trust's intranet. We have also had support from an operational colleague who sadly lost her father after he contracted flu in 2017.

2.6.4 At the time of writing, our current uptake rate for the Trust as a whole is 58% and I hope this will continue to rise over coming weeks.

3. Regional Issues

3.1 NHS 111 service

3.1.1 Since the Kent, Medway and Sussex NHS 111 and Clinical Assessment Service (CAS) contract award announcement in August 2019, work-stream leads and project managers from all parties have been meeting regularly to mobilise against the agreed project plan.

3.1.2 Pending the final contract signature, work is continuing and sufficient assurance has been signalled by commissioners to permit several key mobilisation milestones to be met. These include commencement of the technical integration work between SECAmb's CLERIC and our sub-contractor IC24's CLEO systems and our respective telephony platforms. Clinical and technical workshops have also been held to articulate the proposed patient flow, demonstrating the positive impact of CAS and which were well received by commissioners.

3.1.3 In terms of communications and engagement activity, a work-stream has been established including Healthwatch (Kent, Surrey & Sussex), Patient Participation Group members and commissioner and provider leads to co-design our launch strategy and approach to community engagement around NHS 111 CAS.

4. National issues

4.1 National Ambulance BME Forum

4.1.1 On 24 October 2019 SECAmb hosted the second National Ambulance BME Forum Conference in Brighton. Our Chair, David Astley, welcomed over 150 colleagues from around the country on behalf of SECAmb to what was, I understand, a thought-provoking and very well-received event.

4.1.2 The conference included a wide range of speakers covering a range of topics, including the sharing of some powerful personal stories and a celebration of black history.

4.1.3 Thank you to members of Aspire, our cultural diversity network, for their hard work in putting the conference together, especially Asmina Islam Chowdhury.

5. Recommendation

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

Philip Astle, Chief Executive

21 November 2019

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	73-19

Name of meeting	Trust Board
Date	28 November 2019
Name of paper	Delivery Plan Progress Update
Responsible Executive	Steve Emerton, Director of Strategy and Business Development
Author	Eileen Sanderson, Head of PMO
Synopsis	This paper describes the progress against the projects within the Delivery Plan, and is supported by the following appendicies; • Appendix A – CQC Tracker • Appendix B – Portfolio Timeline • Appendix C – Digital Dashboard • Appendix D – QCSG Dashboard • Appendix E – HR Transformation Dashboard • Appendix F – CIP Pipeline Tracker
Recommendations, decisions or actions sought	For 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. HR Transformation Programme:

    a. The Culture Change Mandate has been approved and a project plan is being worked on.
    b. The ESR Manager Self Service is currently being scoped and the Trust will be in a position to launch e-forms on 1 April 2020 but a Trust decision will need to be made on when the system will go live.
    c. E-Expenses go live went ahead as scheduled on 1 November 2019 for Corporate Services.
    d. Applicant Management System (TRAC) go live went ahead as scheduled on 29 October 2019
    e. E-Timesheets Project Mandate has been approved.

2. Transforming Clinical Education (TCE) Programme:

    a. Project Mandate approved for the 11 workstreams governed by a fortnightly Working Group which reports to the Transforming Programme Board.
    b. Plan in place to monitor activities required to be undertaken prior to 2020 Ofsted Inspection.
    c. FutureQuals inspection taking place on 29 November 2019.

3. Estates Programme:

    a. The Worthing Phase 1 Development project closure was approved at the Estates Programme Board and formally closed on 8 November 2019.
    b. Brighton Make Ready Project Board has now been formally established – further detail of the project can be found in the main body of the report.
    c. A business case is currently in progress for the redevelopment of Sheppey Ambulance Station.

4. Digital Programme:

    a. Cyber Network project closure was formally closed on 31 October 2019.
    b. EOC East Project Closure was approved at Digital Programme Board on 11 October 2019. This is now awaiting Executive Sponsor approval and will be formally closed during the next reporting period, following completion of the Post Project Quality Impact Assessment (QIA).
    c. A project mandate is currently being drafted for Datix Cloud Migration. The aim of this project will be to move from Datix Web based Risk Management system to a 'Software as a Service' (SaaS) based Datix Cloud system. The new system will allow Community First Responders (CFR's) and Private Ambulance Providers (PAPs) to log incidents directly and will support the development of a purpose-built module to electronically centralise all data.
    d. NHS Spine Connect project will be formally closed in the next reporting period with the delivery of Summary Care Records and Child Protection Information Systems being monitored by the IT Working Group.

5. Quality and Compliance:

    a. EOC Clinical Safety and Performance project now formally closed.
    b. Post Project Implementation Reviews (PPIRs) have been conducted for Governance and Risk and Health and Safety Projects to assess the change after they have transitioned

into business as usual. Both PPIRs were signed off at Quality and Compliance Steering Group on 19 November 2019.

6. The 2019 CQC Must & Should Do Tracker and Portfolio Timeline has been updated and can be found in Appendix A and B.

7. PMO Process Improvement:

   A Go/No Go Project checklist has been introduced by the PMO to ensure all the critical milestones are delivered prior to a system go live to help minimise disruption and ensure a smooth implementation.

8. The following change request have been approved:

   Electronic Clinical Audit System (ECAS) project end date extended from 30 November 2019 to 31 March 2020. The impact of the change in timelines 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:

- Estates Programme
- Digital Programme
- Financial Sustainability
- Quality & Compliance
- HR Transformation

1.2 In this reporting period, there is a Dashboard for:

- Digital Programme (see Appendix C)
- Quality & Compliance (see Appendix D)
- HR Transformation (see Appendix E)

1.3 The 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 Estates Programme

2.1 **Brighton Make Ready Centre –** This is the first reporting period for this project and from a construction perspective, the project RAG is Green, with monthly site meetings in place to monitor and track progress.

In terms of the wider project aspects, the project is RAG rated Amber. A project mandate has been drafted and will be approved in the coming weeks. A Project Board with key stakeholders has been established with the first meeting scheduled for the 25th November 2019, where the deliverables will be agreed to ensure the benefits and outcomes of the project are realised within the agreed timescales.

It is expected the RAG status will move to Green in the next reporting period once the project mandate has been approved and there is a project plan in place to track and monitor progress.

3.0 Digital Programme

3.1 **Cyber Network Upgrades** The project is RAG rated Blue as the project has now formally closed and has transitioned into business as usual. However, several post project activities have been identified – these will be delivered as part of business as usual and monitored by the IT Working Group. The vast majority of at-risk infrastructure has now been replaced and the software solutions have been deployed. Next generation firewall hardware has been installed, tested and operational at all Trust locations.

3.2 **ePCR** –The project RAG has moved from Amber to Green. Phase 1 is now complete with all operating units now live with ePCR. In terms of training, 72% (accurate as of 18 November 2019) have been trained in ePCR. A training plan is currently being developed to target those staff who haven't been trained and to also explore other training methods (e.g. webinar/ e-learning) to make training more accessible. The new reporting platform is now live on Power BI and reports are now produced on a weekly basis to all Operating Units. As of 12 November 2019, 62.6% of incidents now have an ePCR, with 777 staff using ePCR. This project is expected to be formally closed in the next reporting period, once the training can be transitioned into business as usual.

3.3 **NHS Spine Connect** – The project RAG has moved from Amber to Green due to a new version of Cleric now released with the additional functionality of Summary Care Records (SCR)

An Executive decision has been taken to close this project and to manage the two remaining elements, SCR and Child Protection-Information System (CP-IS) as business as usual with progress being tracked through the IT Working Group. It is anticipated that the SCR implementation will be completed by 31 January 2020 and for CP-IS by 31 March 2020. This project is expected to be formally closed in the next reporting period

.

3.4 **East EOC –** The project is RAG rated Blue following approval of closure at the Digital Programme Board on 11 October 2019. There are post project activities which are still outstanding; these will be delivered as part of business as usual and will be monitored by the IT Working Group. East EOC is now equipped with aerials connected to radios and air conditioning units replaced in the fall-back rooms. Additionally, the dispatch area will now provide a modern, clean and safe working environment for the staff.

3.5 **Electronic Clinical Audit System (ECAS) –** The project RAG has moved from Amber to Green as requested changes to the Clinical Audit section of the system have been delivered and significant progress has been made with ensuring ePCR data is available

to the supplier. The system is now embedded in the Health Records Team and the Clinical Audit Team is developing their system capability which will enable clinical staff to reduce hours spent on audit (e.g. in August 2019, time spent on clinical audit was reduced from 300 hrs to 115.5 hrs). The project end date has been extended to the 31 March 2020 to ensure realisation of the benefits of the system will be achieved when the system is fully integrated with ePCR forms.

4.0 Financial Sustainability

4.1 

CIP – The Cost Improvement Programme RAG remains Amber as at month 7, October 2019. The current pipeline scheme value of £9.0m exceeds the annual savings target of £8.6m. £6.9m of schemes have been fully validated and transferred to the CIP Delivery Tracker. This reduces to £5.8m when risk adjusted. Recurrent schemes represent 37% of the total. Validated and scoped schemes of £0.7m are awaiting Executive Sponsor and QIA approval prior to moving to delivery. The Finance Department continues to work with budget leads continues to further the development and validation of schemes required to achieve the remaining £1.4m proposed value on the Pipeline tracker and the potential £1.2m slippage in the fully validated schemes.

CIP achievement for the seven months of £4.1m is £0.7m below plan. The shortfall is largely due to 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 (Appendix F) provide more detail on the progress of the Programme.

5.0 Quality & Compliance

5.1 

Clinical Recruitment (Action Plan) – The action plan RAG remains Amber as there is an issue with recruitment of NHS Pathways trained Clinical Safety Navigators (CSN) resulting in the need to recruit from the internal pool of Clinical Supervisors. In order to mitigate this, shadowing opportunities are being developed, part time roles are being advertised and Clinical Supervisors are approached for expressions of interest to act into these posts.

Clinical Supervisor Recruitment is no longer on track to meet the target of 43 by 31 December 2019, due to new recruits failing courses or not being suitable for the role; the expected number is now 38 by 31 December 2019 with all 43 operational by 31 January 2020. The Trust not being able to achieve the expected numbers of Clinical Supervisors will not have a significant impact as there are currently staff in the mentoring stage with further clinicians starting their NHS Pathways training at the end of November 2019.

Recruitment of international applicants is progressing, with 12 expected to be in post by 31 August 2020.

5.2 

NHS Pathways Audit (Action Plan) – The action plan RAG remains Red as the consultation period for the new Audit Team structure remains paused due to the outstanding grievance. It has been confirmed that there are 8 temporary roles (for a period of 3-6 months) which will be recruited into shortly, to focus on the September 2019 backlog. In the meantime staff have been seconded to support the existing team. Leadership of this team will be transferred to the Head of Clinical Audit from the 25 November 2019. Non-clinical and clinical audit compliance remains a challenge and improvement will be dependent on the introduction of the temporary resource. This will be actively monitored via the Quality & Compliance Steering Group.

To further support with our Pathways Audit, over the coming weeks, North East Ambulance Service (NEAS) will be conducting an independent review of the Trust's audits as well as undertaking an independent levelling exercise.

5.3 **Improve Operational Performance in 111 (Action Plan) –** The action plan RAG has moved from Green to Amber as operational performance within 111 has been variable throughout the course of the month due to volatile call volumes and sickness. Analysis has been undertaken of the volatile call profile and controls have been added to business as usual planning activities to mitigate risks. Over-recruitment is taking place to mitigate the upward trend in sickness.

In the long term, there is a move towards a blended workforce whereby 111 Health Advisors also receive training to handle 999 calls which will allow them to operate for either service dependent on demand. The robust staged approach towards sickness management used in EOC will be replicated within 111, although there are some concerns regarding HR Business Partner Capacity to manage this, this is being looked into. Additional activities are being undertaken to assist the improvement in average call handling time such as training and support to facilitate shared learning for the Health Advisors.

5.4 **EOC Call Answer Performance (Action Plan) –** The action plan RAG has moved from Green to Amber as there was a setback in the improving effectiveness of in line support due to supplier delays. The supplier is now engaged, and this is expected to be rolled out week commencing 2 December 2019. There is still a delay in changing the routine lines and the impact of this on the plan is to be assessed based on the availability of the supplier. All other improvement activities to enhance call answer performance in EOC are on track.

Average call handling time is currently at 365 seconds with the aim of reducing to 346 seconds by 31st December 2019 and call answer performance mean at 3 seconds which is below the set target of 5 seconds by 31 December 2019. As of weeks' commencing 4th and 11th November 2019, SECAmb is currently the top performing Ambulance Trust for call answer performance.

5.5 **Safe Staffing (Rota Compliance) –** This is the first reporting period and the action plan is RAG rated Green as a plan has now been developed to focus on implementation of a Workforce Management (WFM) tool in EOC to ensure rotas are fit for purpose and a training framework is established. A new Teams A meeting has now been established which will focus on a more collaborative approach across A&E field operations, 999 and 111 IUC services. There is ongoing Executive discussion as to whether the plan is extended to Trust wide safe staffing, rather than specifically EOC (e.g. EMAs, dispatch and clinicians).

5.6 **Transforming Clinical Education –** This is the first reporting period and the project is RAG rated Red as some of the 11 workstreams are not fully defined and therefore at this stage, it is difficult to provide visibility of all the issues and risks that need to be addressed to enable the Trust to deliver transformational change within the Clinical Education department.

However, progress has been made in some areas and some of the key points to note are as follows;

- Work is being undertaken to address the backlog of marking student assignments
- Management Plan is now in place to monitor the progress of activities required to be undertaken prior to the 2020 Ofsted Inspection.

- Currently undertaking activities to address the gaps required for the FutureQuals audit on 29 November 2019.
- In preparation for the upcoming audit, the Clinical Education Team visited West Midlands Ambulance Service Academy earlier this month for a peer review to be undertaken.
- The Education & Skills Funding Agency (ESFA) re-application for employer provider status was submitted on 31 October 2019; the review process will take around 12 weeks.
- The outline draft of the Clinical Education Strategy proposed content has been produced and approved in principal at the TCE Programme Board on 12 November 2019.
- Pro-Train to be the third-party supplier to deliver the required functional skills training.
- Progression of a co-delivery model of training for the January/February 2020 AAP courses has been agreed. This activity has now been scoped and due diligence conducted on suitable partner organisations.
- A draft Business Case has been approved for delivery of the Level 6 Paramedic Programme. The preferred option is a is a co-delivery model in partnership with the University of Cumbria. The final version to be submitted to the Business Case Review Group on 3 December 2019.

6.0 HR Transformation

6.1 **Applicant Management System (TRAC) –** The project RAG remains Green. TRAC went live on 29 October 2019 and is now the Trust's default system for recruiting. During the first month of the system being live, the Trust will be supported by the supplier to address any issues that may arise and to also allow the Trust to ensure all of the Resourcing Team are fully trained and are familiar with the system, which includes a 2-day super user system training course. A hotline has been set up by the Trust to allow users to raise any queries/issues along with a pre-recorded Trac webinar which guides users through how to use the system. It is expected that the project will be formally closed in the next reporting period.

6.2 **Implementation of E-Expenses –** The project RAG remains Green as it is on track to deliver a phased roll out by areas, as follows:

- Corporate Services from 1 November 2019 for payment in December 2019
- EOC and 111 from 1 January 2020 for payment in February 2020
- All OU's from 1 March 2020 for payment in April 2020

The first phase successfully went live on the 1 November 2019 for Corporate Services. Staff, including Bank employees, were contacted to set up their profile on the new system in preparation for expenses to be paid.

As part of the scope of this project, the system will also have the functionality to check that staff have the correct driving licence requirements going forward. These checks will be automatically carried out four times a year through the system. Further communication will be disseminated to respective areas ahead of their roll out dates.

6.3 **Implementation of E-Timesheets –** The project RAG remains Green as the project is on track to implement the e-timesheet system by 1 April 2020 and new ways of working by 30 April 2020. The mandate has been approved and the project plan has been developed along with associated mandatory documents. Ongoing communications using different channels within the Trust will ensure staff are engaged with the change and are fully prepared when E-timesheet will be introduced in 2020.

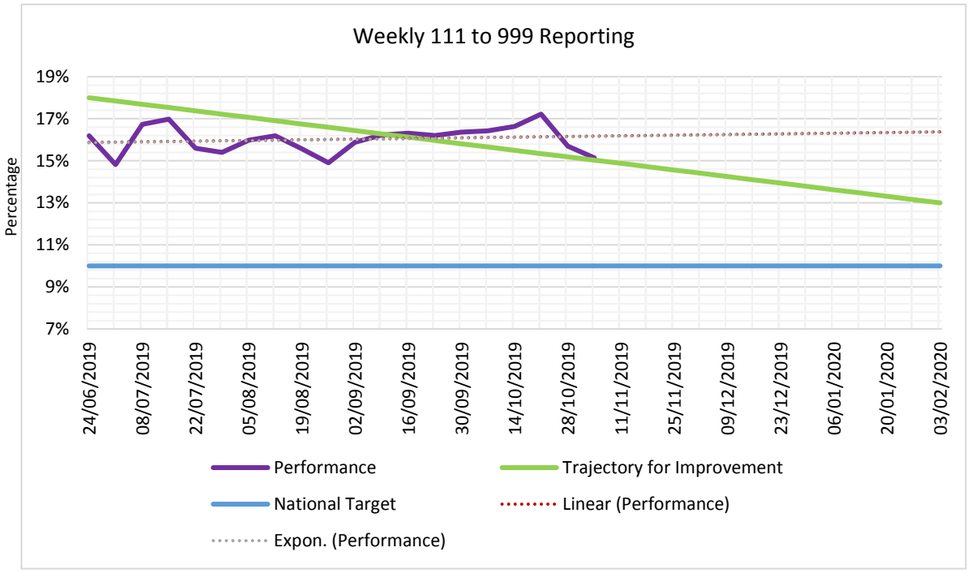
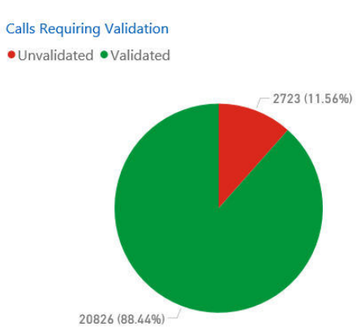
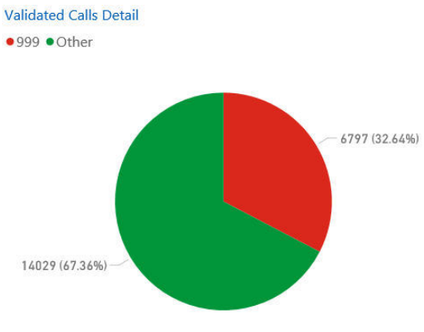
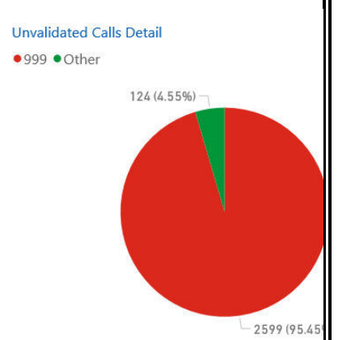
6.4 **Culture Change -** The project RAG remains Amber as there is no project plan in place which provides assurance that the project will be delivered within the agreed constraints.

This project will focus on the following areas:

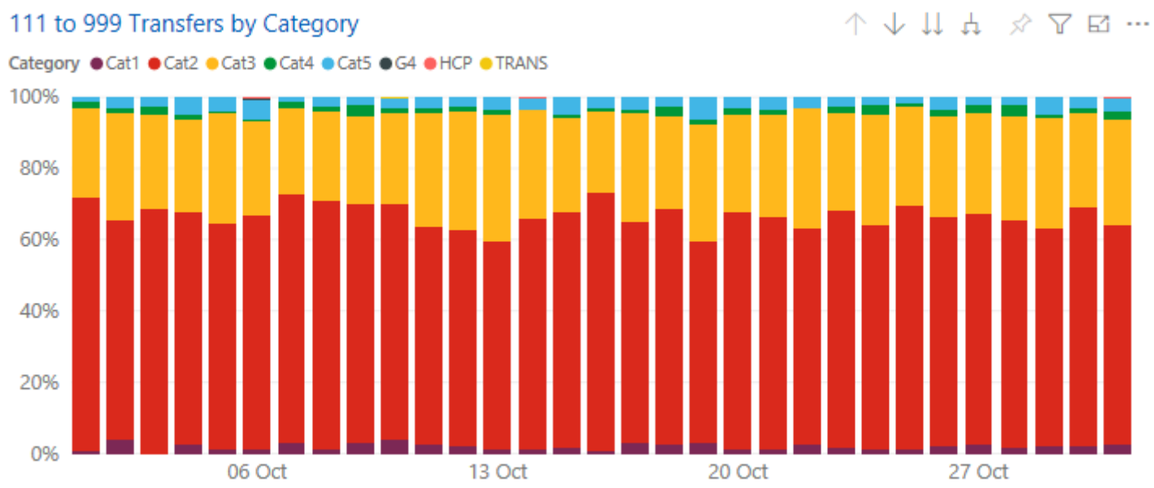
- Improving recruitment and selection
- Reviewing the induction process
- Providing a line management programme
- Improving the appraisal process
- Mediation and a dedicated key skills module around bullying and harassment/dignity in the workplace.

It is expected the RAG status will move to Green in the next reporting period once a project plan is in place to track and monitor progress.

6.5 **Implementation of the HR Structure -** The project RAG remains Green as the project is on track to recruit key roles, e.g. Head of Workforce and Head of Learning and Development. An Action Plan has been produced to monitor progress against the recruitment requirements as specified in the Business Case. This is being monitored monthly through the HR Transformation Steering Group.

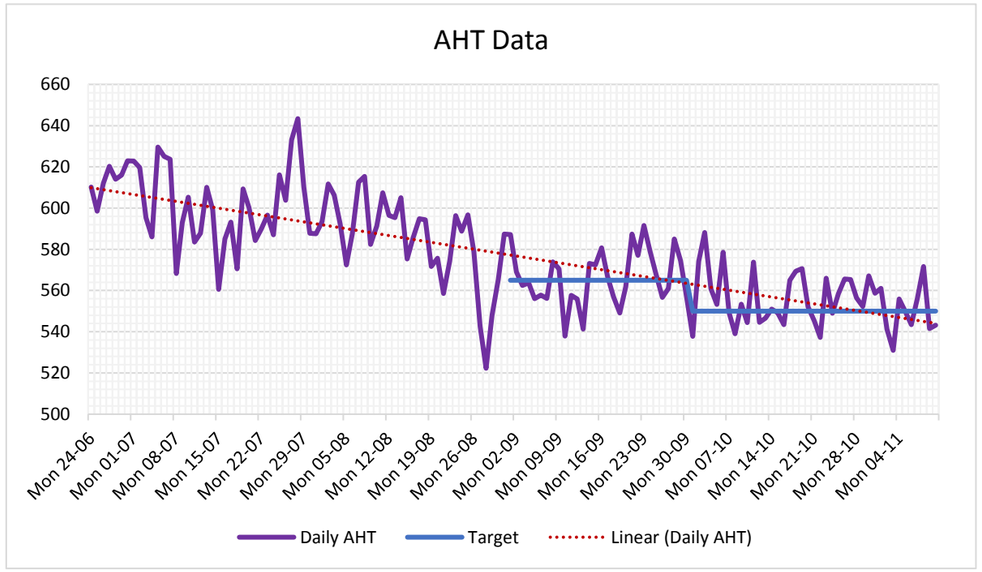
Domain	CQC Findings ('Must or Should Do')	Metrics	Monitored via	RAG Rating
Safe	111 - The Trust must ensure care and treatment is provided in a safe way to patients.	To meet contractual performance key indicators for 95% calls answered in 60 seconds/sustained abandoned calls <5% and ambulance transfer rates <13% by 31 March 2020 1. **Daily 111 to 999 Reporting** Ambulance referral percentages are beginning to reach trajectory following amendments to Category 3 and 4 validation.  Data Source: Power BI 2. **Ambulance Validation** **111 Calls Validation Data** Data Source: Power BI    	Improve Operational Performance in 111 Action Plan	

Audits of category 2 ambulances and ambulance outlier staff training have developed in-roads. The next steps are to establish a robust method for the clinical intervention of calls to drive ambulance dispatch.



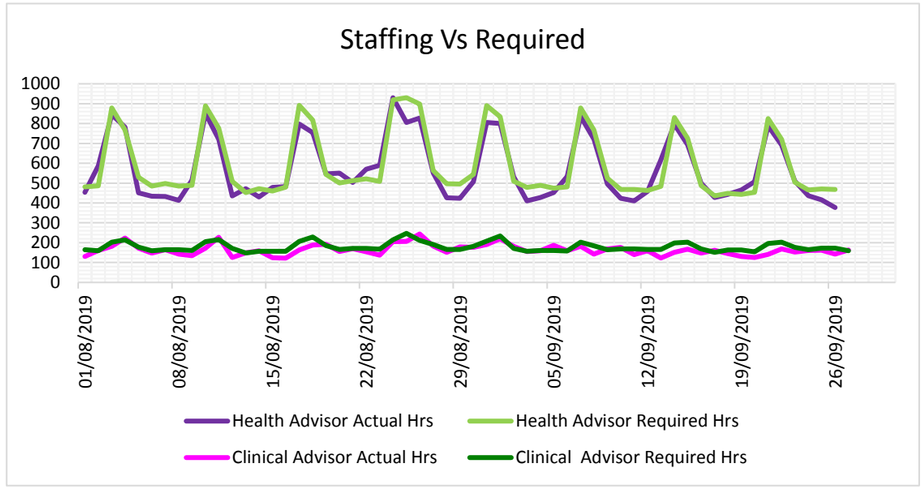
Data Source: Power BI – August 2019

3. **Average handling time (AHT)**
Performance is consistently below target at weekends as this is when the service is vulnerable to external events such as National Contingency.



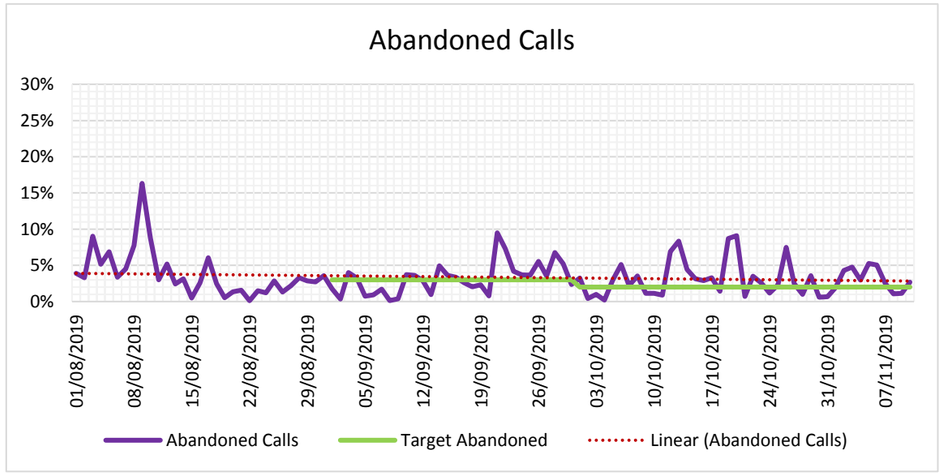
Data Source: Power BI

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. Health Advisor recruitment and rota offerings are targeting weekend working to address shortfalls. The Clinical Advisors will be reviewed, and recommended changes discussed with clinicians in January 2020.

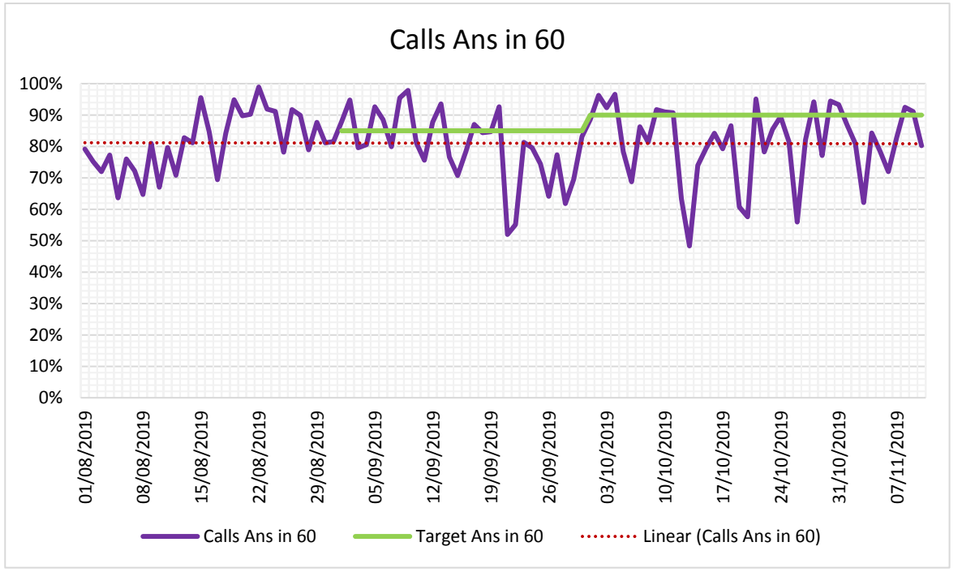


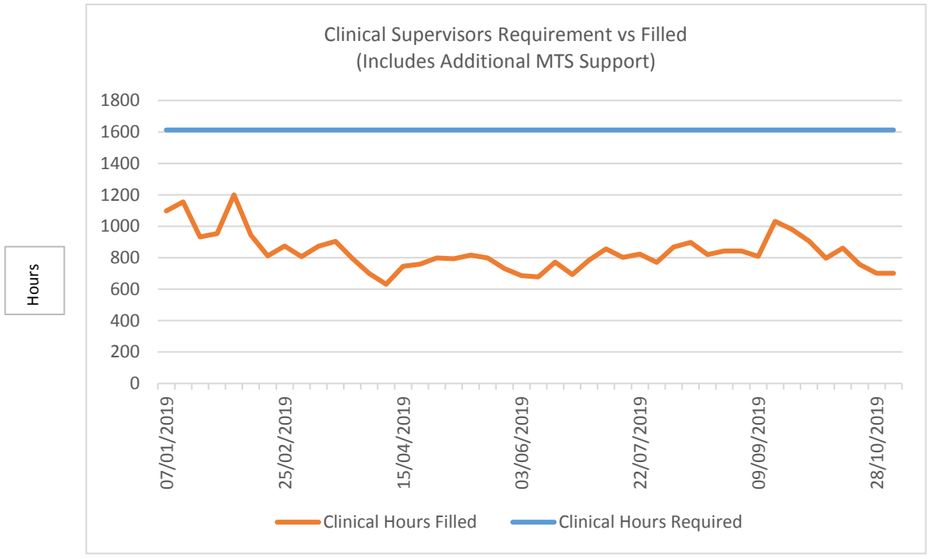
Data Source: Directory of Services Lead /BI Specialist for Integrated Care

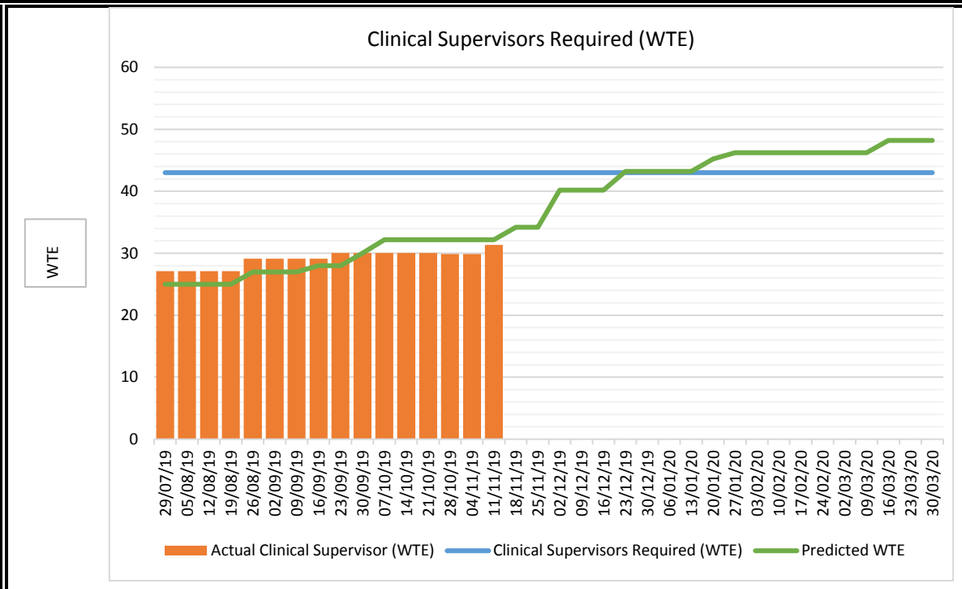
5. **Abandoned calls**
Call abandonment rate remained significantly below the 5% NHSE benchmark.



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 78.3% in October 2019, delivering a similar operational performance to September despite increased volumes. The service recognises the need for further work needs to take place to improve responsiveness whilst maintaining other quality measures, and is working closely with colleagues in 999 to draw out mutual benefits.  Data Source: Directory of Services Lead /BI Specialist for Integrated Care		
Safe	111 - The Trust should take action to ensure patient feedback mechanisms are fully established.	A representative from the 111 Senior Leadership Team attended the Inclusion Hub Advisory Group Meeting on 4 October 2019 to update the group on developments with the Clinical Assessment Service and to emphasise the Service's commitment to engagement with patient-facing groups. 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) via a Patient Satisfaction Survey. The Trust's Information Governance team are currently reviewing the survey to ensure it complies with Data Protection legislation before it can be implemented. It is expected that the survey will go live by the end of December 2019.	SEC 111 IUC Senior Leadership Team	

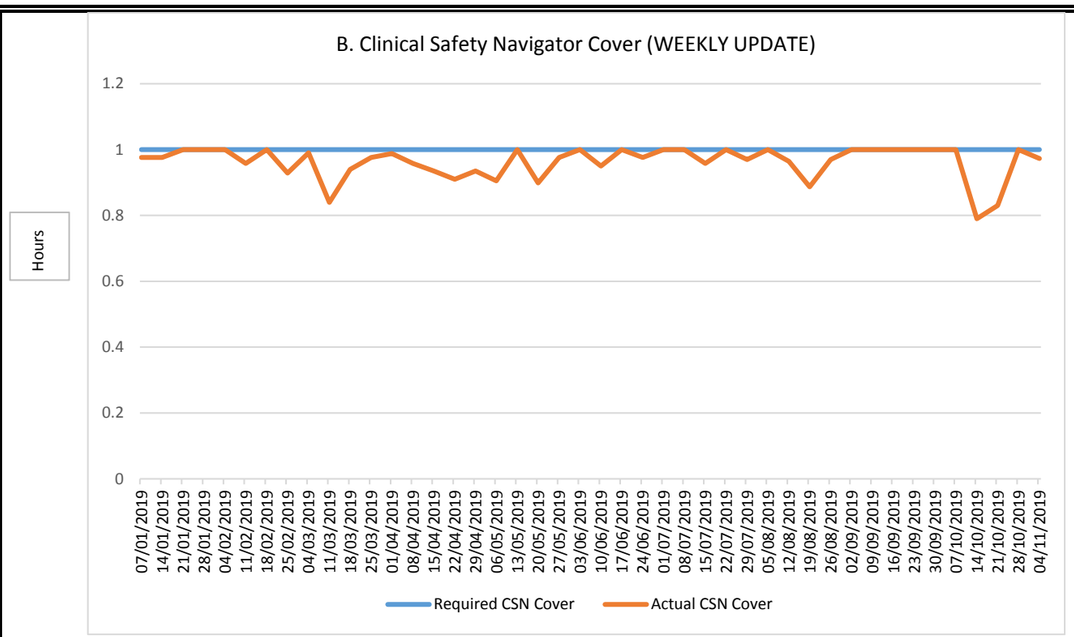
Safe	The Trust should take action to ensure there are a sufficient number of clinical staff in each emergency operations centres at all times.	**Clinical Supervisors (CS)** Since January 2019, the Trust has continued to focus on improving recruitment within the operation centres and as a result, the Trust is on trajectory to be at full establishment for the recruitment into the Clinical Supervisors roles by 31 January 2020. Currently, the Trust has 31 WTE Clinical Supervisors in post, with a further 9 in training due to be operational by 31 December 2019. The CS hours are not being filled as shown by the graph below due to the length of time it takes to train new staff as NHS Pathways Clinicians thereby not available to be scheduled to work the Clinical Supervisors rota. The Trust should start to see the benefit of the 9 currently in training by the end of December 2019. 	Clinical Recruitment Action Plan	



Clinical Safety Navigators

The recruitment of Clinical Safety Navigators has been more challenging due to the experience required with regards to telephone triage. 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.

Current establishment for Clinical Safety Navigators is 8 WTE with 2 in the pipeline who are gaining the required experience to carry out the role.


B. Clinical Safety Navigator Cover (WEEKLY UPDATE)
Hours
1.2
1
0.8
0.6
0.4
0.2
0
07/01/2019
14/01/2019
21/01/2019
28/01/2019
04/02/2019
11/02/2019
18/02/2019
25/02/2019
04/03/2019
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23/09/2019
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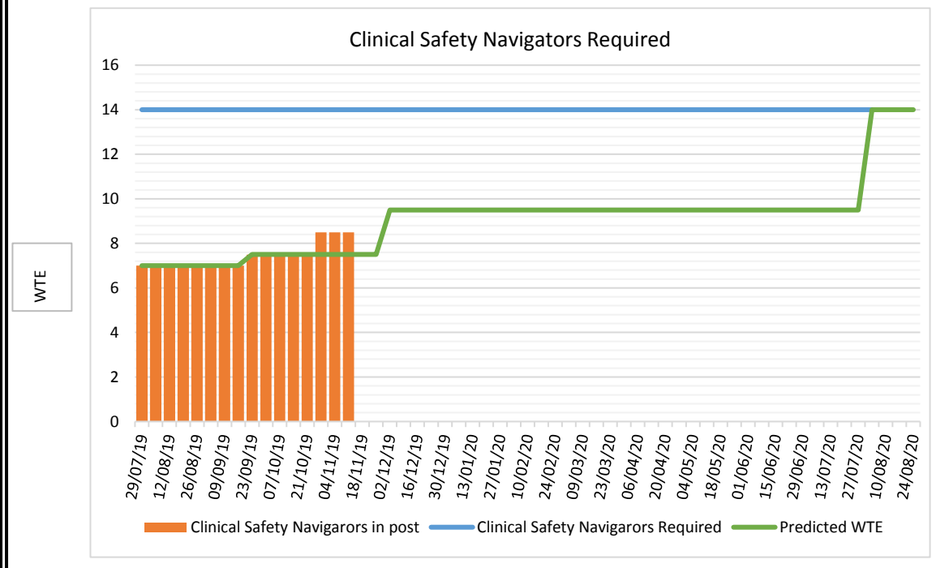
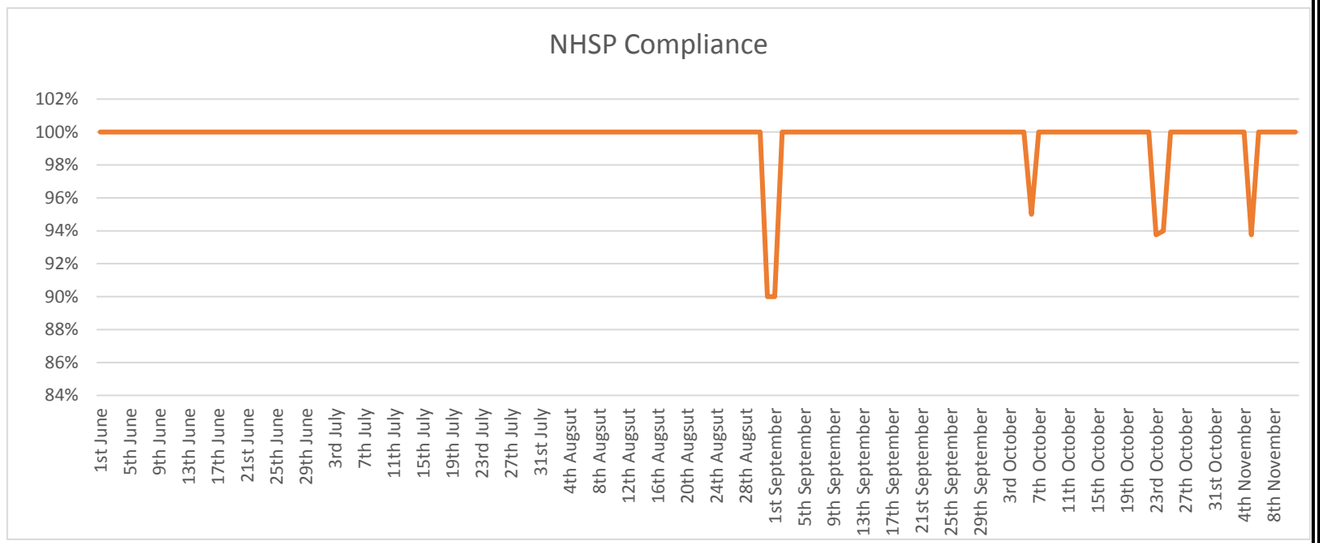
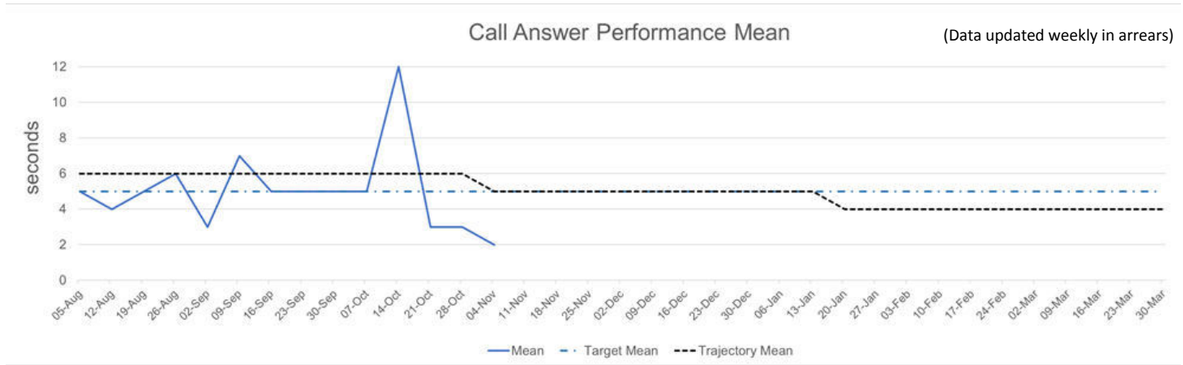
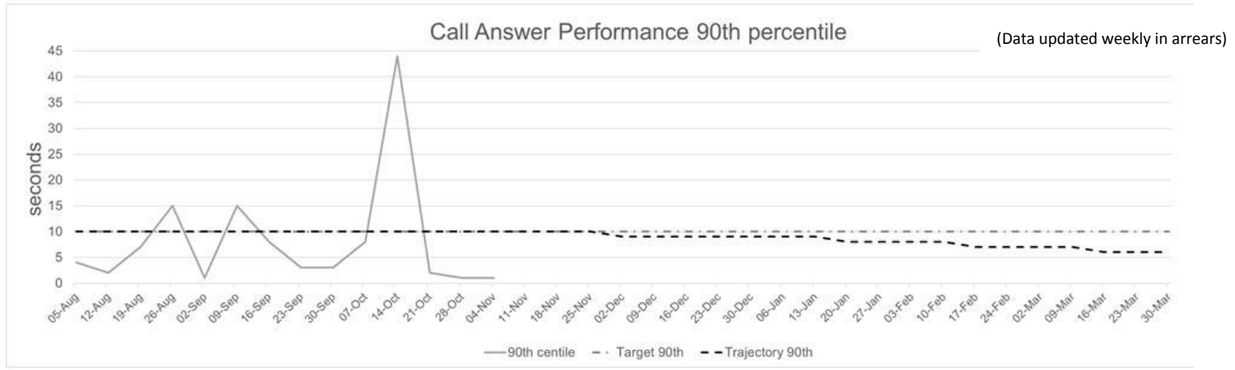
14/10/2019
21/10/2019
28/10/2019
04/11/2019
Required CSN Cover
Actual CSN Cover

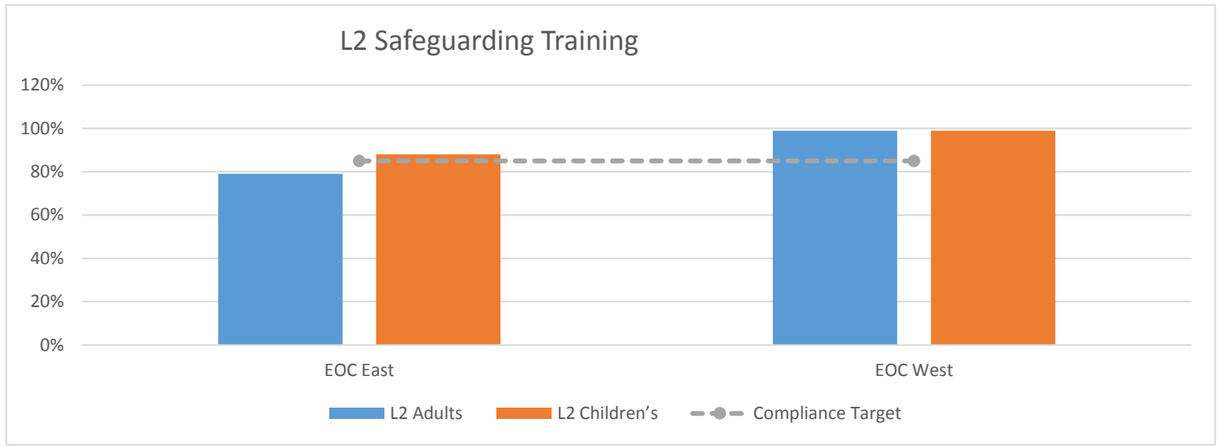
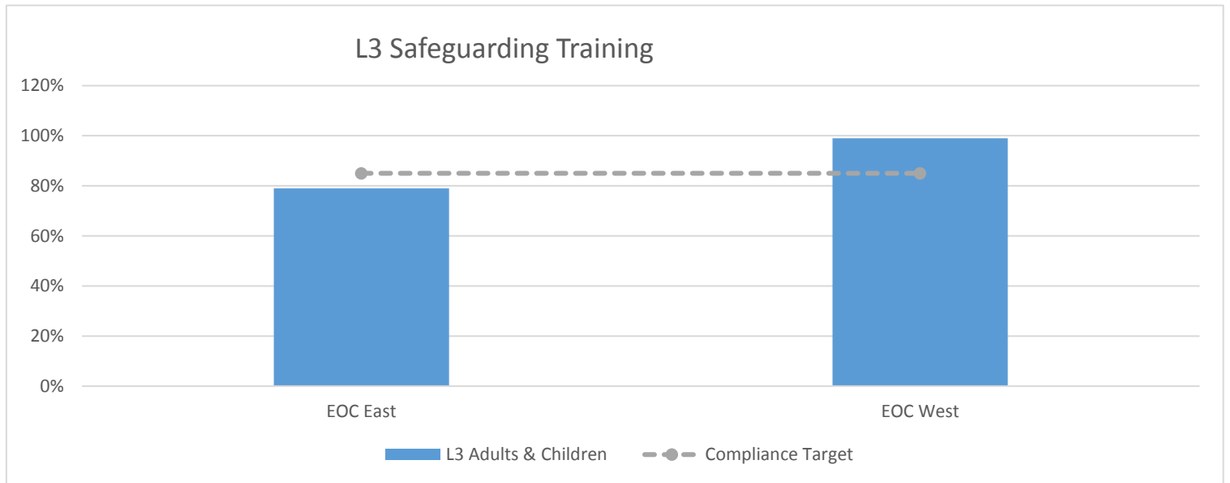

Clinical Safety Navigators Required
WTE
16
14
12
10
8
6
4
2
0
29/07/19
12/08/19
26/08/19
09/09/19
23/09/19
07/10/19
21/10/19
04/11/19
18/11/19
02/12/19
16/12/19
30/12/19
13/01/20
27/01/20
10/02/20
24/02/20
09/03/20
23/03/20
06/04/20
20/04/20
04/05/20
18/05/20
01/06/20
15/06/20
29/06/20
13/07/20
27/07/20
10/08/20
24/08/20
Clinical Safety Navigarors in post
Clinical Safety Navigarors Required
Predicted WTE

NHS Pathways Compliance

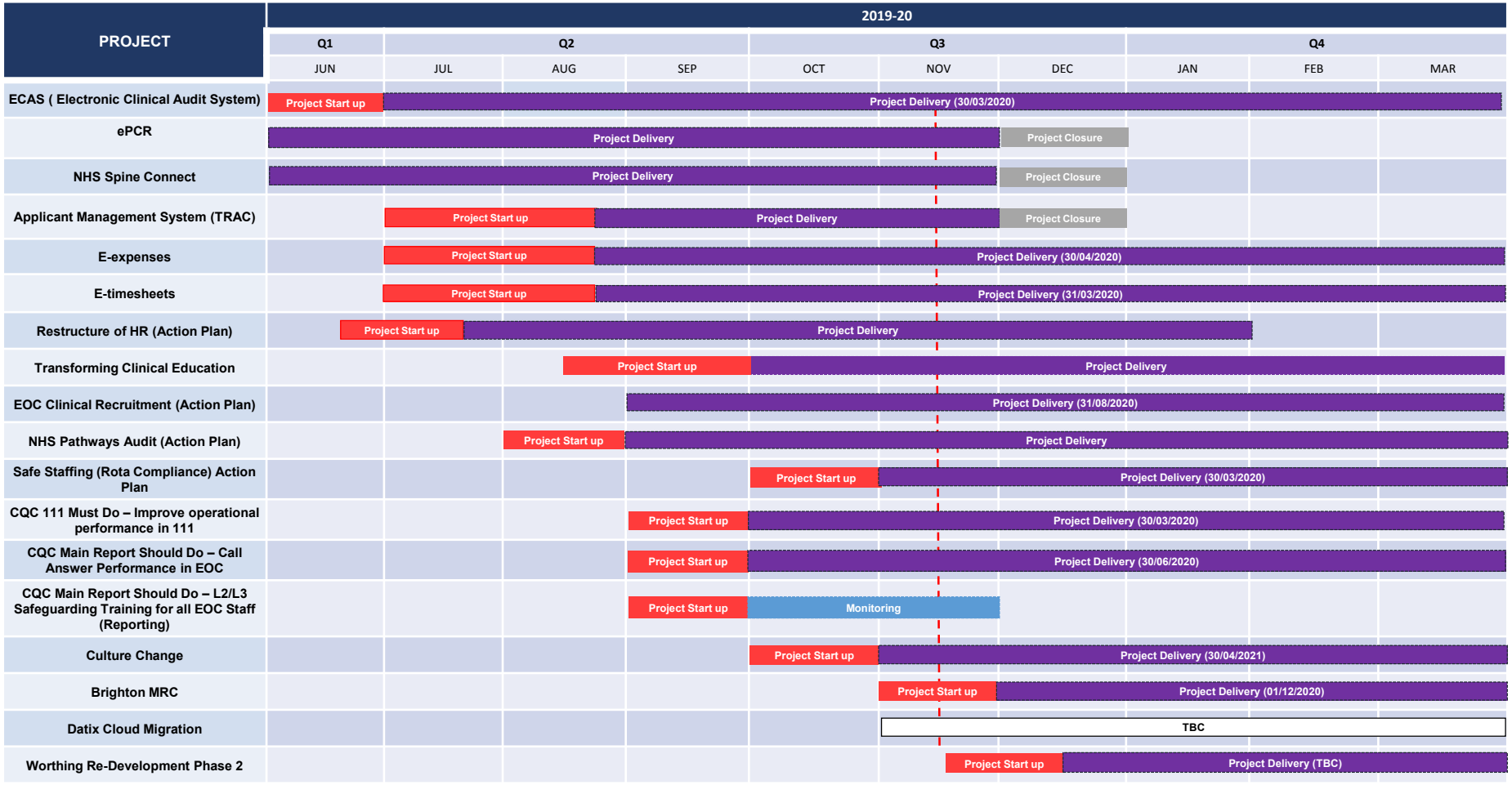
Whilst recruitment is ongoing, agency staff and the management team are providing clinical hours to improve our NHS Pathways (NHSP) compliance which can been seen in the graph below.



Effective	The Trust should take action to meet the national performance target relating to call answering times.	In October 2019, call handling performance achieved a 6 second mean (target is 5 seconds) and 11 second 90th percentile (target is 10 second target) call answer rate. Several factors were identified as key contributors which impacted on the Trust in being able to achieve the national performance targets: • Abstraction was 46% (target is 28%) • Sickness was 9% above target (target is 5.2%) • Annual Leave was 10 % above target (target is 15%). This was due to pre-booked leave from new starters and higher than usual short notice leave   The EOC Leadership team are taking the following actions to prevent a similar performance from occurring: 1. All short notice abstraction requests to be authorised by the Operating Unit Manager 2. Incentive overtime is provided to staff to help bridge the gap in the hours required In addition, a separate workstream has been established to focus on improving sickness and attrition within EOC and 111 call centres. However, there has been some recent improvement - as of weeks' commencing 4th and 11th November 2019, SECAmb is currently the top performing Ambulance Trust for call answer performance.	EOC Call Answer Performance Action Plan	

Safe	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.	This action plan is rated Green as the Trust's compliance rates against the 85% target is shown in the graphs below:   Further work is required to ensure that the training records held on locally training logs is aligned to ESR. The Quality and Compliance Steering Group are actively monitoring progress at bi-monthly meetings.	Quality & Compliance Steering Group	
Safe	The Trust should take action to ensure the clinical welfare calls are completed within the targeted timeframes.	To enable the Trust to ensure clinical welfare checks are completed within the timeframes, the Trust has introduced a Patient Safety Clinician role. This role works closely within the EOC Clinical team alongside the Clinical Safety Navigator and has supported the clinical welfare activity to direct to those patients most at risk. We have not been able to collate the required number of welfare calls against all cases to date, but are finalising our solution, where the complexity of welfare calls requirements/parameters are being built within the Trusts Power BI reporting platform. This report when finalised will be able to identify by ARP Category the number of welfare calls required (denominator) to those that have been completed (numerator), across specified timeframes. This report is anticipated to be live within the next 7 days and will be provided within the next update.	Clinical Recruitment Action Plan	

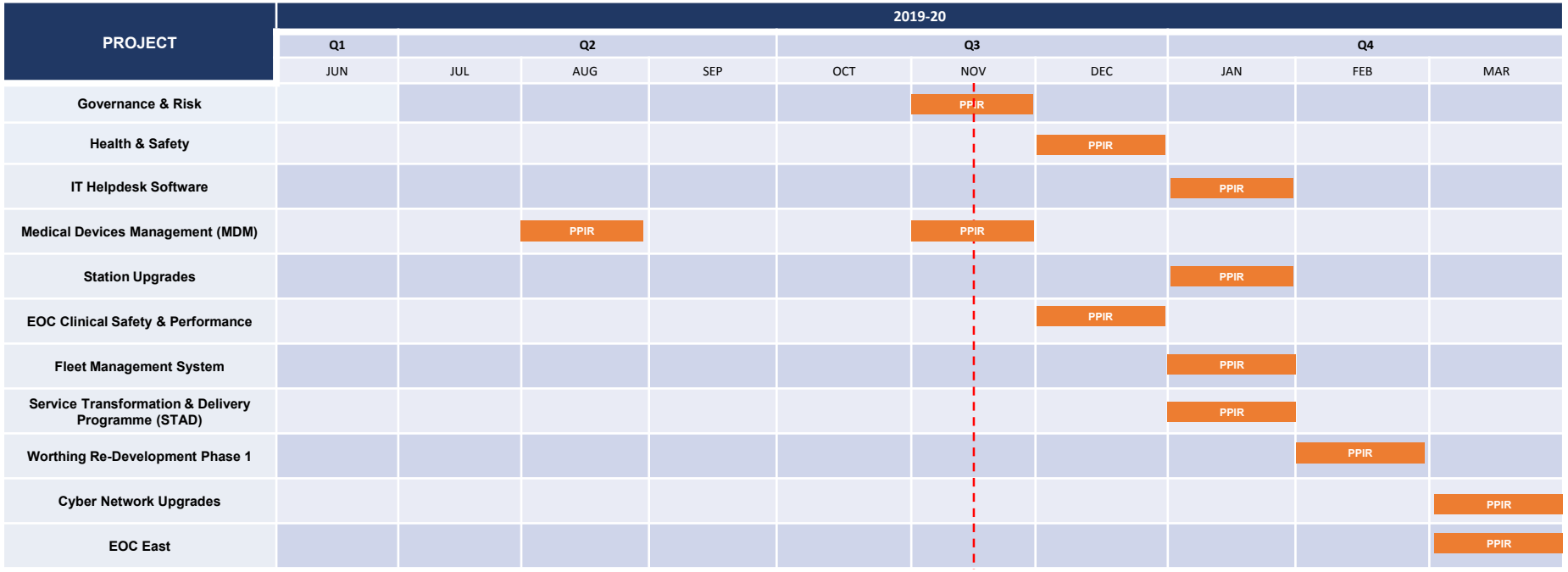
PMO Portfolio Timeline – Live Projects (Last updated: 21 November 2019)



PMO Portfolio Timeline – Pipeline Projects (Last updated: 21 November 2019)

PROJECT	2019-20									
	Q1	Q2			Q3			Q4		
	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
CFRs Attending Falls					TBC					
ESR Manager Self Service					TBC					
Sheppey Redevelopment					TBC					
Banstead Redevelopment					TBC					
Epsom Relocation						TBC				
111 Mobilisation						TBC				

PMO Portfolio Timeline – PPIRs Due (Last updated: 21 November 2019)



Digital Dashboard

Reporting Period: 13 September 2019 – 15 November 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 21/11/2019 v2.0

Key Points

Project	Brief Summary
Electronic Patient Care Records (ePCR)	Phase 1 is now complete with all operating units live with ePCR. In terms of training, 72% (accurate as of 18 November 2019) have been trained in ePCR. A training plan is currently being developed to target those staff who haven't been trained and to also explore other training methods (e.g. webinar/ e-learning) to make training more accessible. The new reporting platform is now live on Power BI and reports are now produced on a weekly basis to all Operating Units. This project is expected to be formally closed in the next reporting period, once the training can be transitioned into business as usual.
Electronic Clinical Audit System (ECAS)	Requested changes to the Clinical Audit section of the system have been delivered and significant progress has been made with ensuring ePCR data is available to the supplier. The system is now embedded in the Health Records team and the Clinical Audit Team is developing their system capability which will enable clinical staff to reduce hours spent on audit (e.g. in August 2019, time spent on clinical audit was reduced from 300 hrs to 115.5 hrs). The project end date has been extended to the 31 March 2020 to ensure realisation of the benefits of the system will be achieved when the system is fully integrated with ePCR forms.
NHS Spine Connect	A new version of Cleric now released with the additional functionality of Summary Care Records (SCR). An Executive decision has been taken to close this project and to manage the two remaining elements, SCR and Child Protection-Information System (CP-IS) as business as usual with progress being tracked through the IT Working Group. It is anticipated that the SCR implementation will be completed by 31 January 2020 and for CP-IS by 31 March 2020. This project is expected to be formally closed in the next reporting period
Cyber Network Upgrades	The project is now formally closed and has transitioned into business as usual. However, several post project activities have been identified – these will be delivered as part of business as usual and monitored by the IT Working Group. The vast majority of at-risk infrastructure has now been replaced and the software solutions have been deployed. Next generation firewall hardware has been installed, tested and operational at all Trust locations.
East EOC	Project closure was approved at the Digital Programme Board on 11 October 2019, pending approval of the Post Project QIA. There are post project activities which are still outstanding; these will be delivered as part of business as usual and will be monitored by the IT Working Group. East EOC is now equipped with aerials connected to radios and air conditioning units replaced in the fall-back rooms. Additionally, the dispatch area will now provide a modern, clean and safe working environment for the staff.

Key Risks/Issues

Project	Brief Summary	Score
Electronic Patient Care Records (ePCR)	There is a risk that insufficient staff will be properly trained in ePCR usage to enable a complete switch from paper to electronic forms by March 2020. Mitigation includes a training delivery action plan has been created to ensure all staff are fully trained.	Risk score 12
Electronic Patient Care Records (ePCR)	There are a few issues resulting from recent software update such as photographs not rendering in app but rendering in case summary. Mitigation includes a new release from Cleric to fix some glitches.	Issue score High
Electronic Patient Care Records (ePCR)	There is an issue that SECAmb IT needs to complete configuration of load balancing (servers) which will alert them when a server is over capacity.	Issue score High
Electronic Patient Care Records (ePCR)	ePCR training was incorporated into the key skills programme after the Programme Board had commenced, which led to some staff not being trained on ePCR. Mitigation includes A training delivery action plan has been created to ensure all staff are fully trained. The different methods of training are currently being explored (e.g. webinar/e-learning).	Issue score High

Project	Current RAG	Previous RAG
Electronic Patient Care Records (ePCR)		
Electronic Clinical Audit System (ECAS)		
NHS Spine Connect		
Cyber Network upgrades		
East EOC		

Achievements this period

- Clinical Audit Procedure is now out for staff consultation.
- 115.5 hrs/month spent in August 2019 on audit compared to 300 hrs/month spent in May 2019.
- As of 12 November 2019, 62.6% of incidents now have an ePCR, with 752 staff using ePCR.

Quality & Compliance Dashboard

Reporting Period: 13 September 2019 – 19 November 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 21/11/2019 v2.0

Key Points

Project	Brief Summary
Clinical Recruitment (Action Plan)	Clinical Supervisor Recruitment is no longer on track to meet the target of 43 by 31 December 2019, due to new recruits failing courses or not being suitable for the role; the expected number is now 38 by 31 December 2019 with all 43 operational by 31 January 2020. The Trust not achieving the expected numbers of Clinical Supervisors will not have a significant impact as there are currently staff in the mentoring stage with further clinicians starting their NHS Pathways training at the end of November 2019. There is also an ongoing issue with recruitment of NHS Pathways Clinical Safety Navigators (CSN's) as explained in the Key Risks/Issues section.
NHS Pathways Audit (Action Plan)	The consultation period for the new Audit Team structure remains paused due to the outstanding grievance. It has been confirmed that there are 8 temporary roles (for a period of 3-6 months) which will be recruited into shortly, to focus on the September 2019 backlog. In the meantime staff are being seconded to support the existing team. Non-clinical and clinical audit compliance remains a challenge and improvement will be dependent on the introduction of the temporary resource. To further support with our Pathways Audit, over the coming weeks, North East Ambulance Service (NEAS) will be conducting an independent review of the Trust's audits as well as undertaking an independent levelling exercise.
Improving Operational Performance in 111 (Action Plan)	Operational performance within 111 has been variable throughout the course of the month due to volatile call volumes and sickness. Analysis has been undertaken of the volatile call profile and controls have been added to business as usual planning activities to mitigate risks. Over-recruitment is taking place to mitigate the upward trend in sickness. In the long term, there is a move towards a blended workforce whereby 111 Health Advisors also receive training to handle 999 calls directly allowing them to operate for either service dependent on demand.
EOC Call Answer Performance (Action Plan)	There was a setback in the improving effectiveness of in line support due to supplier delays. The supplier is now engaged, and this is expected to be rolled out week commencing 2 December 2019. There is still a delay in changing the routine lines and the impact of this on the plan is to be assessed based on the availability of the supplier. All other improvement activities to enhance call answer performance in EOC are on track. There is still a delay in changing the routine lines and the impact of this on the plan is to be assessed based on the availability of the supplier. All other improvement activities to enhance call answer performance in EOC are on track.
Safe Staffing (Rota Compliance) Action Plan	An implementation plan has now been developed to focus on a Workforce Management (WFM) tool in EOC to ensure rotas are fit for purpose, and to create a training framework. A new Teams A meeting has now been established which will focus on a more collaborative approach across A&E field operations, 999 and 111 IUC services.
Transforming Clinical Education	This is the first reporting period and the project is RAG rated Red as some of the 11 workstreams are not fully defined and therefore at this stage, it is difficult to provide visibility of all the issues and risks that need to be addressed to enable the Trust to deliver transformational change within the Clinical Education department.

Key Risks/Issues

Project	Brief Summary	Score
EOC Clinical Recruitment Action Plan	The trajectory to recruit CSN's has not been met. Although Clinicians are currently being recruited, they will not be eligible to apply for the CSN role until after 6 months in post. This is being mitigated by the 4 Operational Managers Clinical covering shifts as required and development of shadowing opportunities and part-time roles.	Issue: High
EOC Clinical Recruitment Action Plan	There is a risk that Coaches courses for EOC Clinicians on NHS Pathways will not be able to be facilitated, due to high demand. This may lead to new starters not being mentored by the most experienced members of the team and result in a poor on boarding experience, new starters leaving due to the lack of support, existing staff not getting the development they require to effectively mentor new staff. To mitigate this 2 NHS Pathways trainers are completing the NHS Pathways train the trainer course and 2 secondments to the EOC training team being advertised November 2019.	Risk: 12
EOC Clinical Recruitment Action Plan	There is a risk that there may not be the capacity to train the number of Clinical Supervisors being recruited as a result of the courses being filled with recruited EMA's. There are normally two spaces held back for Clinical Supervisors on each course but the requirement may be more with current recruitment. Mitigations are to liaise closely with the recruitment and training teams to ensure that recruited staff on put onto courses in a reasonable timeframe.	Risk: 12
NHS Pathways Audit Action Plan	Compliance for clinical audit remains poor. The consultation period for the proposed new staffing model to address this has been delayed due to an outstanding grievance. Mitigations are in place to provide temporary cover for audit.	Issue: High

Project	Current RAG	Previous RAG
Clinical Recruitment		
NHS Pathways Audit		
Improve Operational Performance in 111		
EOC Call Answer Performance		
Safe Staffing (Rota Compliance)		First Reporting Period
Transforming Clinical Education		First Reporting Period

Achievements this period

- Clinical Recruitment: 5 international recruits are in the UK, 3 are registered with the Nursing & Midwifery Council with of these 1 having passed the NHS Pathways course. The other 2 are currently undertaking training.
- As of weeks' commencing 4 and 11 November 2019, SECAmb is currently the top performing Ambulance Trust for call answer performance.

HR Transformation Dashboard

Reporting Period: 13 September 2019 – 15 November 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 21/11/2019 v2.0

Key Points

Project	Brief Summary
Applicant Management System (TRAC)	TRAC went live on 29 October 2019 and is now the Trust's default system for recruiting. During the first month of the system being live, the Trust will be supported by the supplier to address any issues that may arise and to also allow the Trust to ensure all of the Resourcing Team are fully trained and are familiar with the system. It is expected that the project will be formally closed in the next reporting period.
Implementation of E-Expenses	The project is on track to deliver a phased roll out by areas. The first phase successfully went live on the 1 November 2019 for Corporate Services. In addition staff, including Bank employees, were contacted to set up their profile on the new system in preparation for expenses to be paid. As part of the scope of this project, the system will also have the functionality to check that staff have the correct driving licence requirements going forward. These checks will be automatically carried out four times a year through the system. Further communication will be disseminated to respective areas ahead of their roll out dates.
Implementation of E-Timesheets	The project is on track to implement the E-timesheet system by 1 April 2020 and new ways of working implemented by 30 April 2020. The mandate has been approved and the project plan has been developed along with associated mandatory documents. Ongoing communications using different channels within the Trust will ensure staff are engaged with the change and are fully prepared when E-timesheet will be introduced in 2020.
Culture Change	There is currently no project plan in place which provides assurance that the project will be delivered within the agreed constraints. This project will focus on the following areas: improving recruitment & selection, reviewing the induction process, providing a line management programme, improving the appraisal process, as well as mediation and a dedicated key skills module around bullying and harassment/dignity in the workplace. It is expected that the RAG status will move to Green in the next reporting period once a project plan is in place to track and monitor progress.
Implementation of HR Structure	The project is on track to recruit key roles, e.g. Head of Workforce and Head of Learning and Development. An Action Plan has been produced to monitor progress against the recruitment requirements as specified in the Business Case. This is being monitored monthly through the HR Transformation Steering Group.

Key Risks/Issues

Project	Brief Summary	Score
Culture	There is a risk that the First Line Manager training programme would not be able to be delivered within 12 months. This is a result of no agreement having been made for an additional two L&D Advisors on a 12 month fixed term contract. This may lead to a delay in the roll out of this programme.	Risk 10

Project	Current RAG	Previous RAG
Applicant Management System (TRAC)		
Implementation of E-Expenses		
Implementation of E-Timesheets		
Culture Change		
Implementation of HR Structure		

Achievements this period

- Trac system for recruitment went live on 29 October 2019
- E-Expenses phase 1 launched 1 November 2019

South East Coast Ambulance Service: CIP Workstream

CIP Delivery Dashboard

Reporting Month Oct-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 £4.1m in the year to date period ending October 2019 against the NHSI plan target of £4.8m.

2. £6.9m of fully validated savings have been transferred to the Delivery Tracker as at month 7, October 2019. The existing forecast projection of £6.5m is £2.1m (£2.8m risk adjusted) below the target savings of £8.6m. The recurrent element represents 37% of the total, YTD: 28%.

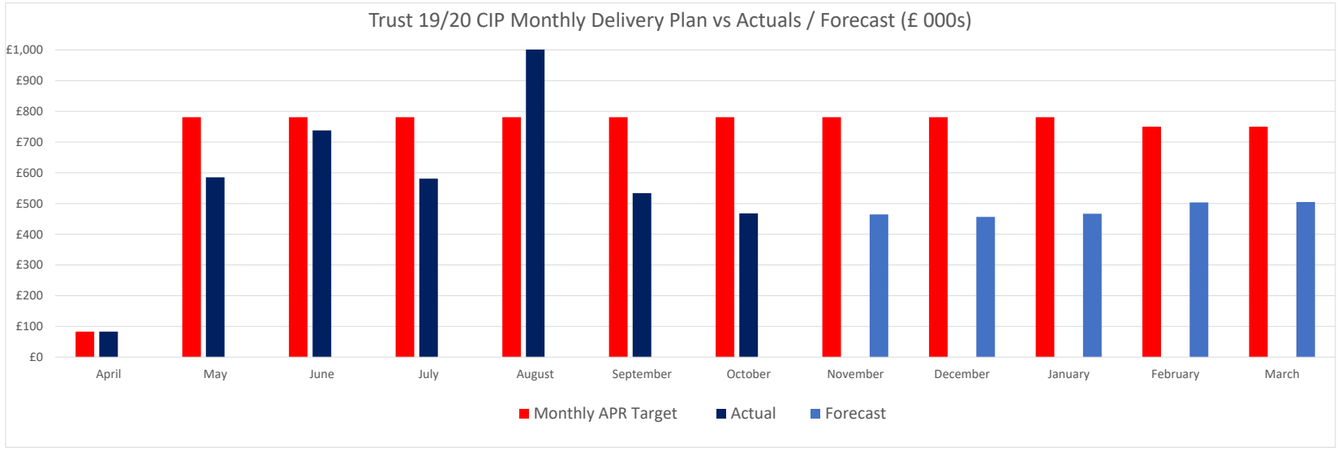
3. Review meetings with Budget Leads and Finance Business Partners continue to focus on identifying new schemes to build a sustainable pipeline of recurrent schemes for 2019/20.

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. Delivery of £4.5m savings from Nov 19 to March 2020. The current CIP risk is rated Amber.

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

CIP Target for 19/20 £000's	Total planned savings on delivery tracker £000's - as at 31 October 2019	Total forecast savings on delivery tracker £000's - as at 31 October 2019	YTD October 2019 - Target Savings £000's	YTD October 2019 - Actual Savings £000's	YTD October 2019 - variance £000's
8,612	6,945	6,464	4,769	4,067	(£702)



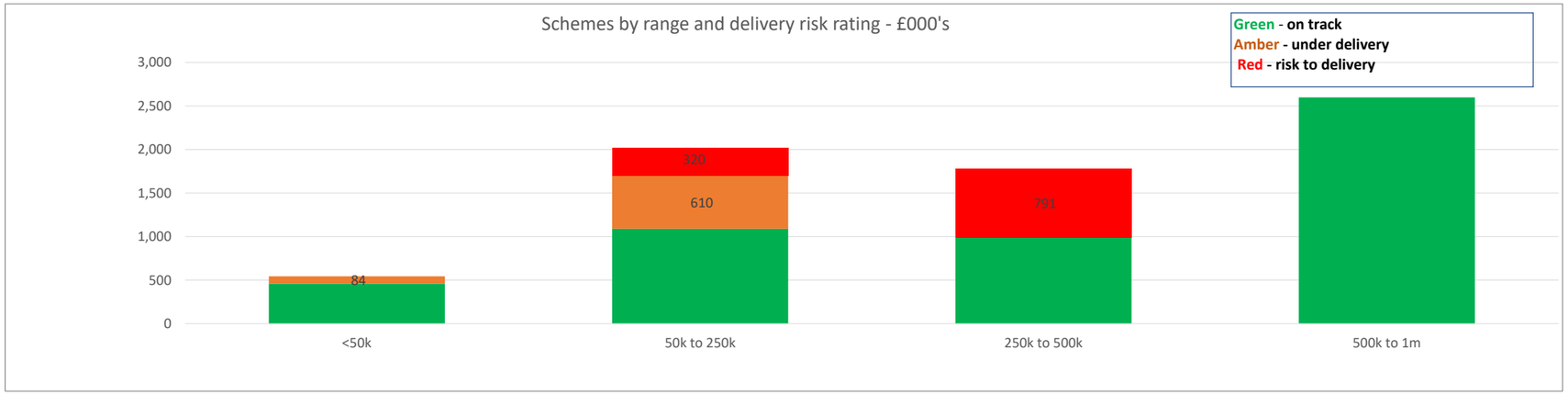
2. CIP - Planned savings split by income, pay and non-pay: as at 31 October

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 October 2019

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



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

Scheme Category	2019/20 Value of Fully Validated Schemes - £000	2019/20 Forecast Value £000	Full Year Variance £000	2019/20 Forecast Value Risk Adjusted £000	Full Year Forecast Risk Adjusted Variance £000	YTD Planned (Month 7): £000	YTD Actuals (Month 7): £000	YTD Variance £000	Comments (+/- £20k variance)
External consultancy & contractors	26	26	0	26	0	26	26	0	-
Stationery	5	5	0	5	0	5	5	0	-
Medicines Management - Equipment	40	40	0	40	0	40	40	0	
Medicines Management - Consumables	48	48	0	48	0	28	28	0	
IT Productivity and Phones	48	48	0	48	0	28	36	8	-
Discretionary Non Pay	18	18	0	18	0	12	12	0	YTD underachievement in handover delays - alternate schemes being scoped to compensate for shortfall
Training courses & accommodation	239	239	0	239	0	214	214	0	-
Medicines Management - Drugs	130	130	0	130	0	105	105	0	-
Operations Efficiencies	2,714	2,342	(372)	1,784	(930)	1,466	1,105	(361)	-
Recruitment delays & recharges - clinical	500	500	0	500	0	500	500	0	-
Recruitment delays & recharges - non clinical	562	562	0	562	0	493	493	0	-
Accounting efficiencies	861	861	0	861	(0)	838	838	0	-
Lease costs - ambulances	120	120	0	60	(60)	40	40	0	-
External Consultancy	24	24	0	24	0	14	14	0	-
Legal/Professional Fees	29	29	0	29	0	17	17	0	-
Public Relations Expenses	12	12	0	12	0	7	7	0	-
Fleet Veh Run Costs - Fuel	200	200	0	0	(200)	0	0	0	
PAPs/ OT price differential	1,371	1,261	(110)	1,371	(0)	696	587	(110)	-
Total Fully Validated Schemes	**6,945**	**6,464**	**(481)**	**5,755**	**(1,190)**	**4,530**	**4,067**	**(462)**	
Variance to Savings Target	(1,667)	(2,148)	(£481)	(2,857)	(£1,190)	(239)		(£239)	Variance between Fully Validated Schemes and Control Total Target
Total Savings Target	**8,612**	**8,612**	**0**	**8,612**	**0**	**4,769**	**4,067**	**(702)**	

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 6 - September 2019

Programme Summary:

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

2. Fully validated CIP schemes of £6.9m have been moved to the Delivery Tracker after QIA approval.

3. Validated and Scoped schemes of £0.7m represents 8% of the savings target for the year. This leads to proposed schemes of £1.4m.

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	

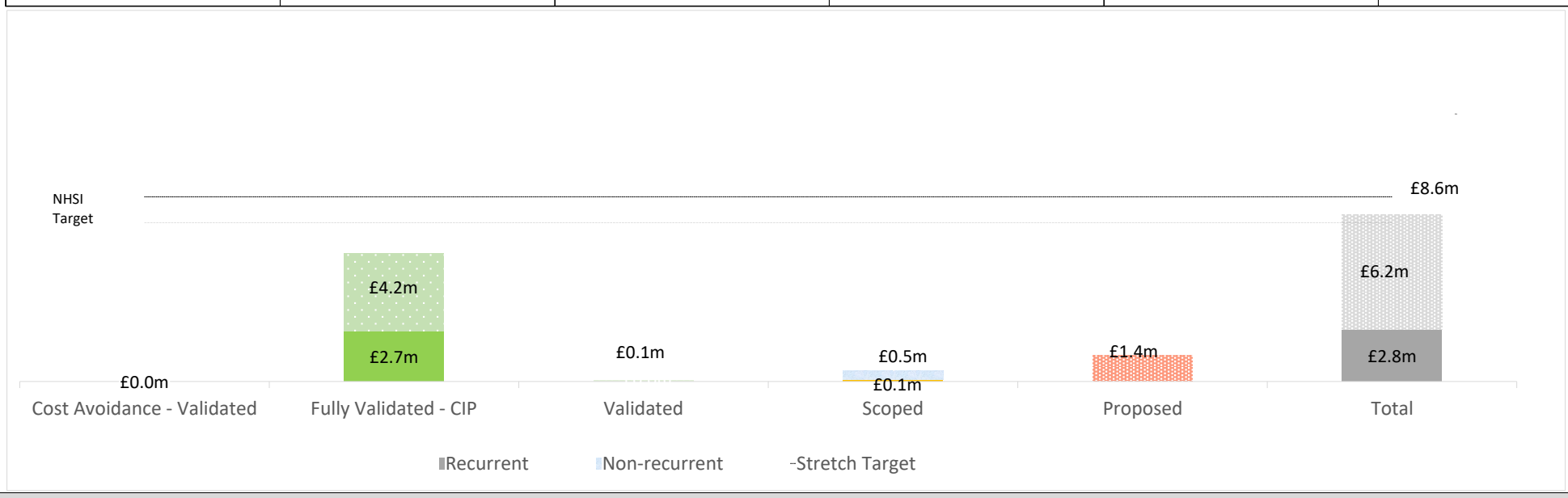
CIP Pipeline and Delivery: Risks and Issues

	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

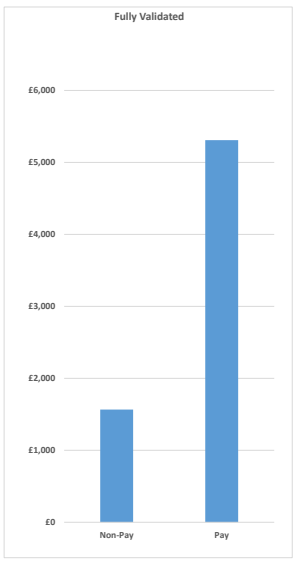
	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	New Lease Cars policy to be agreed.	A Business Case is being finalised based on fit for purpose cars for operational managers aligned to roles. New club car scheme was launched in January - pilot data provided and being evaluated.	John Griffiths/ Paul Renshaw	Amber	Amber	30-Nov-19
2	E-Expenses - potential savings from automation.	E-Expenses system in progress and expected to be delivered as part of the HR Transformation.	Paul Renshaw	Amber	Amber	30-Nov-19
3	Agency Staff - Potential cost avoidance CIP	Development of savings plan in progress.	Joseph I/Priscilla Ashun-Sarpy	Amber	Amber	30-Nov-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-Nov-19

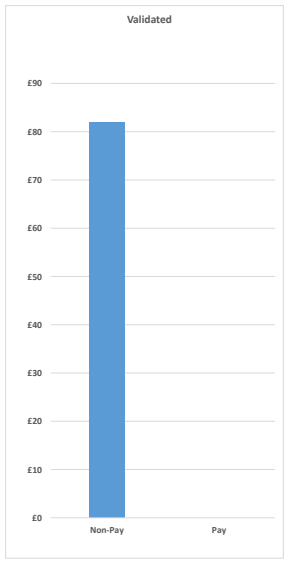
CIP Pipeline Summary

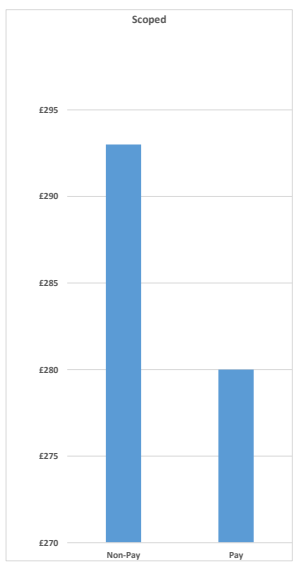
Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£0	£6,945	£82	£573	£1,436	£9,035

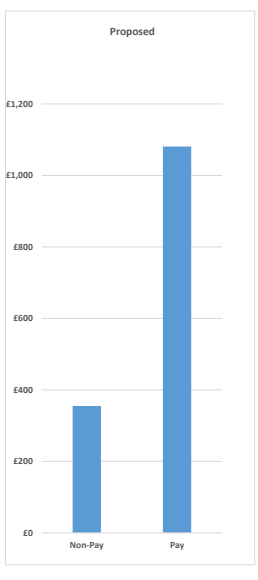


Pay / Non-Pay / Income Breakdown and scheme summary









Scheme Category	Fully Validated	Valida	Scoped	Proposed	Total
Accounting efficiencies	861	-	-	6	866
Budget Allocation	-	5	-	374	379
Discretionary Non Pay	13	77	48	-	138
Estates and Facilities management	-	-	100	83	183
External Consultancy	24	-	-	-	24
External consultancy & contractors	-	-	20	105	125
Fleet - Equipment	-	-	-	251	251
Fleet Veh Run Costs - Fuel	200	-	-	-	200
IT Productivity and Phones	48	-	-	106	154
Lease costs - ambulances	120	-	-	-	120
Legal/Professional Fees	29	-	-	-	29
Meal Break Costs	-	-	30	-	30
Medicines Management - Consumables	208	-	-	-	208
Medicines Management - Equipment	40	-	-	-	40
Operations efficiencies	4,085	-	-	511	4,596
Public Relations Expenses	12	-	-	-	12
Recruitment delays & recharges - clinical	800	-	240	-	1,040
Recruitment delays & recharges - non clinical	287	-	40	-	327
Training courses & accommodation	219	-	-	-	219
Travel & Subsistence	-	-	95	-	95
Grand Total	6,945	82	573	1,435	9,035

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

November 2019

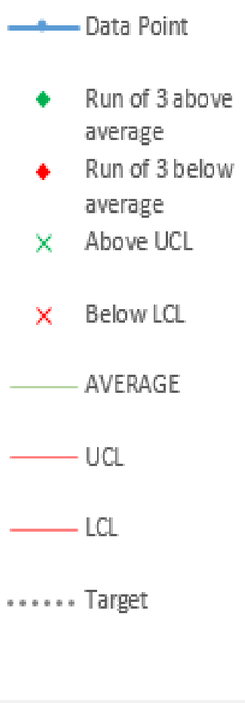
Taking Pride | Striving for Continuous Improvement | Acting With Integrity | Demonstrating Compassion and Respect | Assuming Responsibility

Contents Summary

SECAmb CQC Rating and Oversight Framework

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

Chart Key



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

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

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

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

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

SECAmb Executive Summary

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.

The report has been compiled and reviewed by Directorates. Planning and engagement is underway through the Senior Leadership team to determine reporting at different levels within the organisation and for the purpose of updating the IPR for the Trust Board.

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.
Collaborative working within Trust Directorates and external partners will be key to enabling successful delivery. Whole system working is a mission critical component and vital in any consideration of future sustainability. This is reinforced by the NHS Long Term Plan published December 2018 expecting all to work within these structures for planning, commissioning and delivery of services.

SECAmb Financial Performance

The Trust recorded a deficit in September of £0.5m. This was as planned.
Cost improvements of £0.5m were delivered in the month, £0.5m lower than planned. The full year target is £8.6m.
The Trust's Use of Resources Risk Rating (UoRR) for August 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, which is contingent on the Trust achieving its control total. The first and second quarter (£0.6m) 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

September 2019

	Target		AQI		
Category	Mean	90th Centile	Incidents	Mean	90th Centile
C1	00:07:00	00:15:00	3579	00:07:35	00:13:56
C1T	00:19:00	00:30:00	2317	00:09:25	00:17:33
C2	00:18:00	00:40:00	31785	00:18:51	00:35:49
C3		02:00:00	18565	01:24:56	03:14:16
C4		03:00:00	436	01:54:27	04:35:43
HCP 3			979	02:13:12	04:39:46
HCP 4			903	03:05:36	06:26:22
IFT 3			554	02:24:39	05:16:13
IFT 4			160	03:22:58	07:25:25
HCP 60			13	01:28:31	03:29:18
HCP 120			116	02:08:22	04:49:53
HCP 240			24	02:27:02	05:39:08
ST	All Incidents		19474	32.03%	
SC	All Incidents		37752	62.10%	
HT	All Incidents		3567	5.87%	
Count of Incidents			60793		
Count of Incidents with a Response			57247		
999 Mean	Call Answer Target 00:05		64750	00:05	
999 90th	Call Answer Target 00:10			00:04	
Trust EOC 999 Abandoned Calls			368	0.6%	

SECAmb Productivity

Week commencing 2nd September 2019

	RPI	Job Cycle Time	Qualified Shift Cover	Staff Hours Booked On	SRV Staff Hours	NET Staff Hours	DCA Staff Hours
Actual	1.08	01:35:21	96.98%	62,772	4.7%	2.5%	92.8%
Target	1.09	01:32:00	100%	65,500	3%	0%	97%

Week commencing 9th September 2019

	RPI	Job Cycle Time	Qualified Shift Cover	Staff Hours Booked On	SRV Staff Hours	NET Staff Hours	DCA Staff Hours
Actual	1.07	01:35:03	97.14%	60,895	4.4%	2.2%	93.4%
Target	1.09	01:32:00	100%	65,500	3%	0%	97%

Week commencing 16th September 2019

	RPI	Job Cycle Time	Qualified Shift Cover	Staff Hours Booked On	SRV Staff Hours	NET Staff Hours	DCA Staff Hours
Actual	1.09	01:35:44	97.44%	63,081	4.6%	2.3%	93.1%
Target	1.09	01:32:00	100%	65,500	3%	0%	97%

Week commencing 23rd September 2019

	RPI	Job Cycle Time	Qualified Shift Cover	Staff Hours Booked On	SRV Staff Hours	NET Staff Hours	DCA Staff Hours
Actual	1.07	01:36:25	96.99%	62,608	4.5%	2.3%	93.2%
Target	1.09	01:32:00	100%	65,500	3%	0%	97%

SECAmb Benchmarking Data

Response & Call Answer Performance September 2019

	C1	Mean
	England	00:07:15
1	North East	00:06:39
2	London	00:06:41
3	Yorkshire	00:06:58
4	West Midlands	00:07:00
5	South Western	00:07:11
6	South Central	00:07:15
7	North West	00:07:24
8	East Midlands	00:07:34
9	South East Coast	00:07:35
10	East of England	00:07:55
11	Isle of Wight	00:13:54

	C2	Mean
	England	00:22:22
1	West Midlands	00:13:09
2	Yorkshire	00:18:26
3	London	00:18:27
4	South Central	00:18:40
5	South East Coast	00:18:51
6	North West	00:24:06
7	Isle of Wight	00:27:06
8	East of England	00:27:22
9	East Midlands	00:28:34
10	North East	00:29:49
11	South Western	00:30:04

	C3	90th
	England	02:44:15
1	Yorkshire	01:33:37
2	West Midlands	01:49:15
3	South Central	02:13:42
4	London	02:16:02
5	North West	03:07:42
6	Isle of Wight	03:09:18
7	South Western	03:14:14
8	South East Coast	03:17:42
9	East Midlands	03:29:12
10	East of England	03:49:55
11	North East	04:13:16

	C4	90th
	England	03:03:24
1	Yorkshire	01:28:16
2	South Central	02:46:18
3	East Midlands	02:55:35
4	West Midlands	02:55:44
5	London	03:01:50
6	North West	03:29:27
7	North East	03:31:55
8	South Western	03:34:50
9	East of England	03:38:18
10	South East Coast	04:34:31
11	Isle of Wight	04:39:26

	Call Answer Times	Mean
	England	10
1	East Midlands	3
2	Yorkshire	3
3	West Midlands	4
4	South East Coast	5
5	North East	6
6	Isle of Wight	8
7	East of England	9
8	South Central	10
9	North West	11
10	South Western	11
11	London	26

Clinical Outcomes Jun 2019**

	Proportion discharged from hospital alive (All Patients)	%
	England	10.9%
1	West Midlands Ambulance Service NHS Foundation Trust	16.5%
2	South Central Ambulance Service NHS Foundation Trust	14.5%
3	East of England Ambulance Service NHS Trust	12.0%
4	North West Ambulance Service NHS Trust	10.6%
5	East Midlands Ambulance Service NHS Trust	10.5%
6	South Western Ambulance Service NHS Foundation Trust	9.9%
7	North East Ambulance Service NHS Foundation Trust	9.2%
8	London Ambulance Service NHS Trust	8.7%
9	South East Coast Ambulance Service NHS Foundation Trust	8.5%
10	Yorkshire Ambulance Service NHS Trust	8.3%
11	Isle of Wight NHS Trust	0.0%

	Proportion discharged from hospital alive (Utstein comparator group**)	%
	England	33.8%
1	West Midlands Ambulance Service NHS Foundation Trust	44.1%
2	South Western Ambulance Service NHS Foundation Trust	41.0%
3	East Midlands Ambulance Service NHS Trust	40.0%
4	South Central Ambulance Service NHS Foundation Trust	36.0%
5	North West Ambulance Service NHS Trust	33.3%
6	North East Ambulance Service NHS Foundation Trust	31.8%
7	East of England Ambulance Service NHS Trust	31.0%
8	Yorkshire Ambulance Service NHS Trust	30.8%
9	London Ambulance Service NHS Trust	26.7%
10	South East Coast Ambulance Service NHS Foundation Trust	24.1%
11	Isle of Wight NHS Trust	0.0%

	Call Answer Times	90th centile
	England	32
1	Yorkshire	1
2	East Midlands	3
3	South East Coast	4
4	West Midlands	8
5	Isle of Wight	10
6	North East	12
7	South Central	23
8	East of England	28
9	South Western	35
10	North West	37
11	London	98

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

SECAmb Handover Delay Reporting

September 2019

Hospital	No. of Transports	No. of Handovers	Handover Button Compliance	Sum of HO < 15mins	HO < 15mins %	Sum of HO > 60mins	HO > 60mins %	Longest Handover	Hours Lost Through Handover
Kent And Canterbury Hospital	145	103	71.0%	71	68.9%	0	0.0%	0:46:47	4.36
Queen Elizabeth Queen Mother Hospital	2782	2693	96.8%	1592	59.1%	0	0.0%	0:57:24	105.50
Maidstone Hospital	1362	1265	92.9%	605	47.8%	3	0.2%	1:04:25	87.47
Worthing Hospital	2253	1994	88.5%	823	41.3%	14	0.7%	1:17:51	164.70
Frimley Park Hospital	1976	1907	96.5%	705	37.0%	8	0.4%	1:18:12	168.66
Darent Valley Hospital	1934	1699	87.8%	489	28.8%	13	0.8%	1:24:25	272.96
St Richard's Hospital	1855	1766	95.2%	513	29.0%	13	0.7%	1:24:27	201.49
Royal Surrey County Hospital	1320	1128	85.5%	358	31.7%	17	1.5%	1:29:54	121.61
Epsom Hospital	1006	949	94.3%	224	23.6%	14	1.5%	1:31:31	113.76
East Surrey Hospital	2913	2845	97.7%	1026	36.1%	21	0.7%	1:32:01	274.67
William Harvey Hospital	3166	3039	96.0%	967	31.8%	21	0.7%	1:32:30	371.77
Royal Sussex County Hospital	2953	2739	92.8%	1443	52.7%	34	1.2%	1:33:48	245.96
Princess Royal Hospital	713	653	91.6%	181	27.7%	14	2.1%	1:40:46	89.41
St Peter's Hospital	2373	2285	96.3%	1081	47.3%	5	0.2%	1:45:15	136.97
Eastbourne DGH	1847	1461	79.1%	314	21.5%	25	1.7%	1:48:11	224.61
Tunbridge Wells Hospital	2377	2237	94.1%	757	33.8%	72	3.2%	1:53:38	343.41
Medway Maritime Hospital	3342	3140	94.0%	1611	51.3%	73	2.3%	2:14:06	364.40
Conquest Hospital	1940	1522	78.5%	444	29.2%	6	0.4%	2:15:06	157.20

Our Patients

SECAmb Clinical Safety Scorecard

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

	May-19	Jun-19	Jul-19	12 Months
Actual %	58.1%	31.0%	64.0%	
Previous Year %	50.0%	69.7%	46.7%	
National Average %	59.5%			

Cardiac ROSC - ALL

	May-19	Jun-19	Jul-19	12 Months
Actual %	23.7%	22.5%	31.0%	
Previous Year %	25.1%	36.6%	28.8%	
National Average %	30.8%			

Cardiac Survival - Utstein

	May-19	Jun-19	Jul-19	12 Months
Actual %	32.3%	24.1%	33.3%	
Previous Year %	20.7%	33.3%	28.6%	
National Average %	32.8%			

Cardiac Survival - All

	May-19	Jun-19	Jul-19	12 Months
Actual %	7.0%	8.5%	10.7%	
Previous Year %	4.5%	10.2%	8.4%	
National Average %	10.2%			

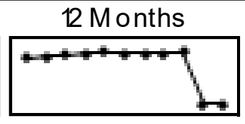
Acute ST-Elevation Myocardial Infarction (STEMI) Care Bundle Outcome

	May-19	Jun-19	Jul-19	12 Months
Actual %	59.0%	66.3%	51.4%	
Previous Year %	69.6%	75.0%	69.4%	
National Average %				

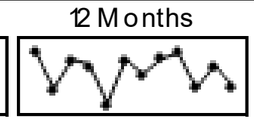
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography

	May-19	Jun-19	Jul-19	12 Months
Mean (hh:mm)	02:10			
National Average	02:09			
90th Centile (hh:mm)	02:48			
National Average	02:56			

Stroke - call to hospital arrival

	May-19	Jun-19	Jul-19	12 Months
Mean (hh:mm)	01:17			
National Average	01:20			
Median (hh:mm)	01:05			
National Average	01:11			
90th Centile (hh:mm)	01:58			
National Average	02:04			

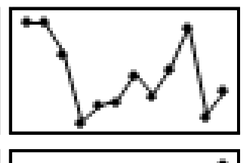
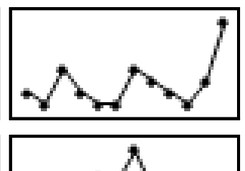
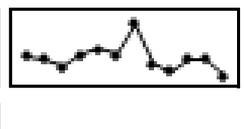
Stroke - assessed F2F diagnostic bundle

	May-19	Jun-19	Jul-19	12 Months
Actual %	95.8%	97.1%	95.9%	
Previous Year %	98.7%	97.5%	97.8%	
National Average %	97.9%			

Post ROSC Care Bundle

	May-19	Jun-19	Jul-19	12 Months
Actual %	82.5%	76.5%	75.6%	
National Average %				

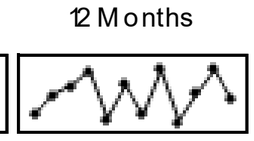
Medicines Governance

	Jul-19	Aug-19	Sep-19	12 Months
Total Number of Medicines Incidents	128	194	132	
Single Witness Sig/Inapt Barcode Use CDs Omnicell	20	3	8	
Single Witness Sig/Inapt Barcode Use CDs Non-Omnicell	0	2	7	
Total Number of CD Breakages	15	15	8	
Key Skills Medicine Governance	43.8%	50.5%	55.7%	

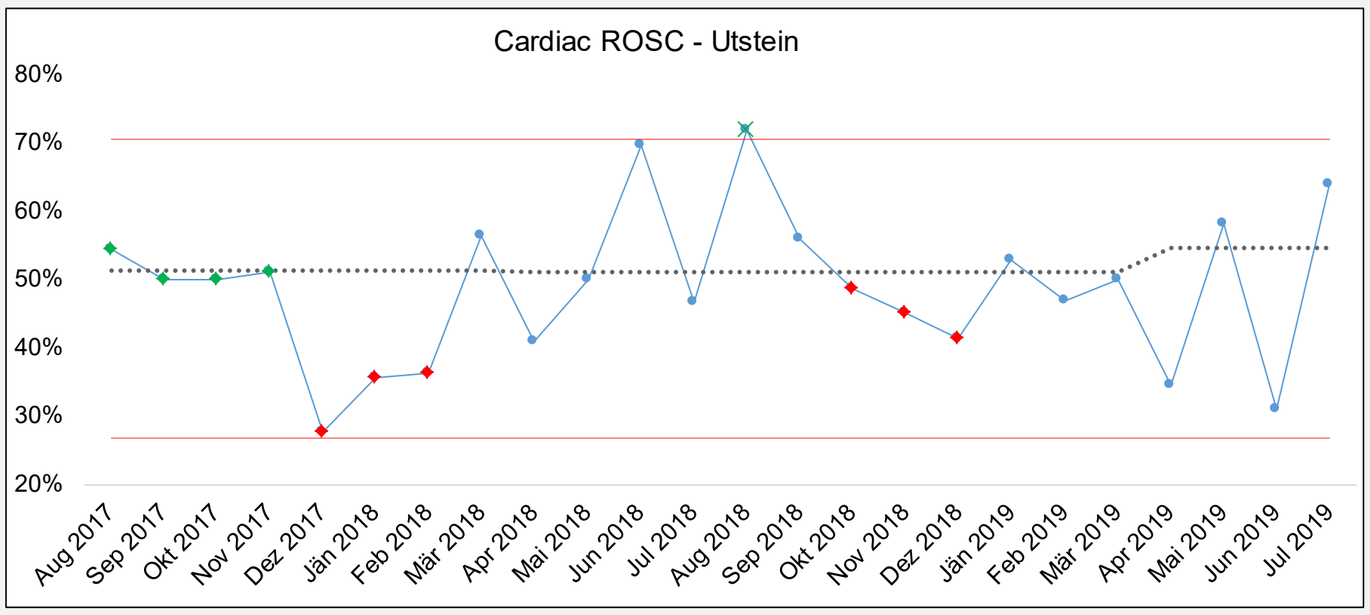
Sepsis Care Bundle Compliance

	May-19	Jun-19	Jul-19	12 Months
Actual %	78.8%	82.1%	79.5%	

Medicines Management

	Jul-19	Aug-19	Sep-19	12 Months
Number of Audits	179	192	176	
Percentage of Audits	99.2%	99.1%	99.6%	

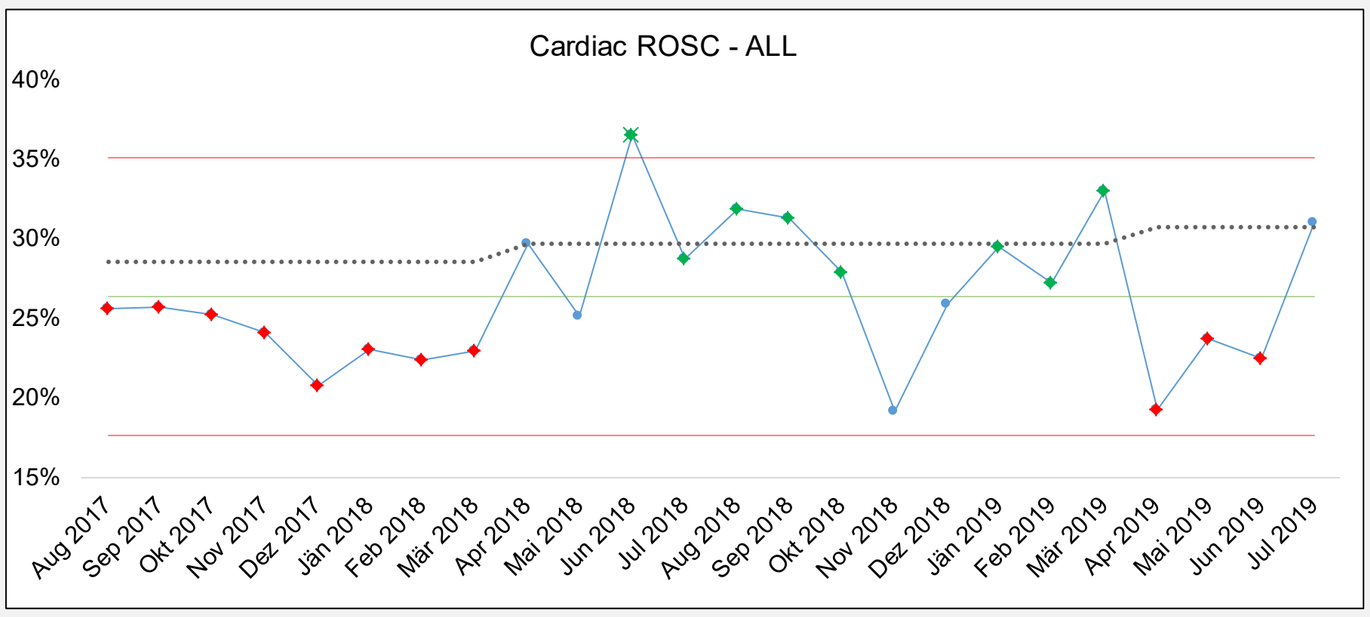
SECAmb Clinical Safety Charts

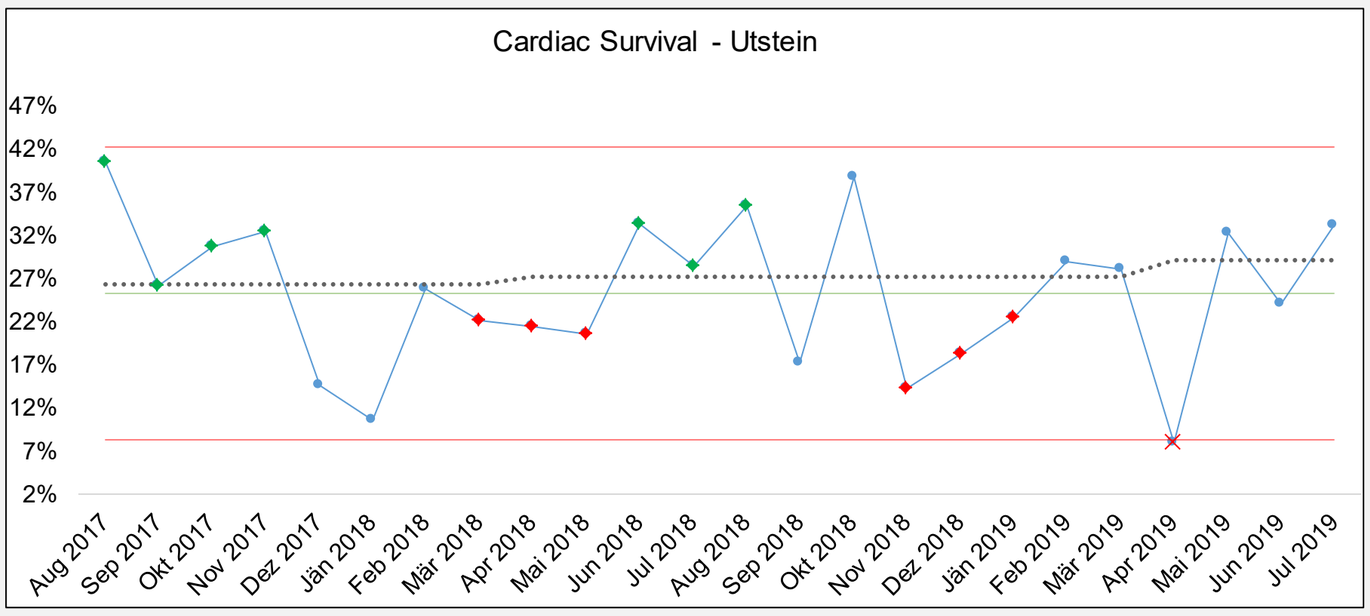


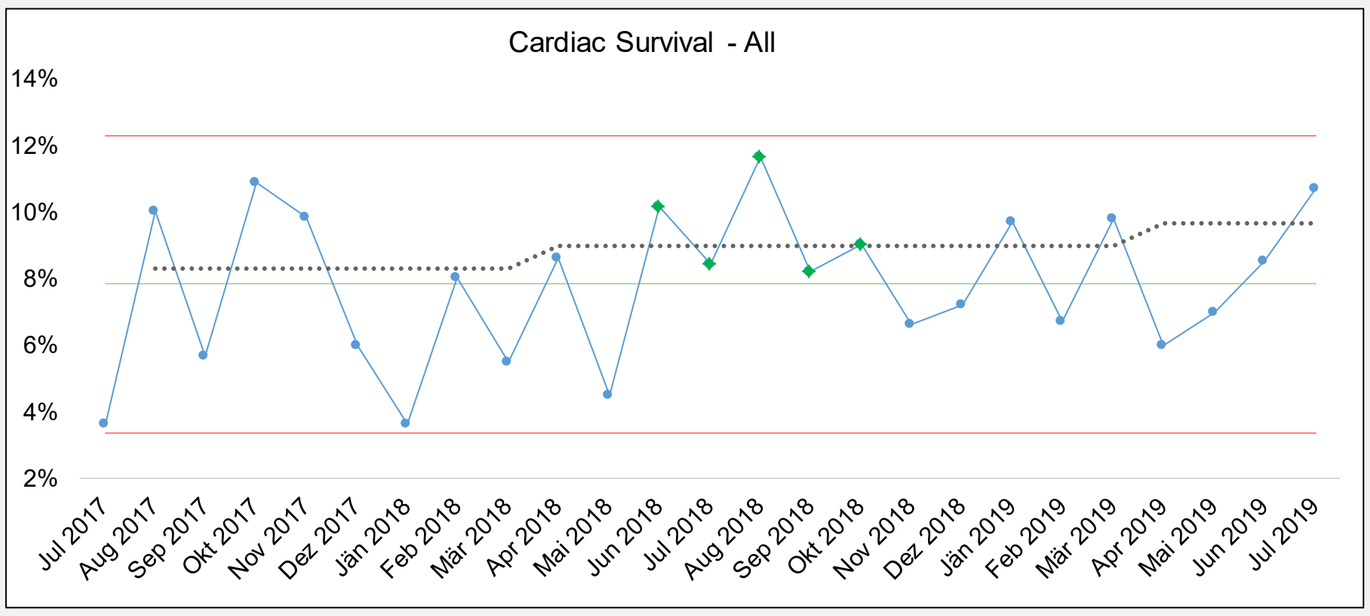
The cardiac arrest charts show the proportion of patients who had a ROSC at hospital and the proportion who survived to be discharged from hospital after resuscitation was attempted.

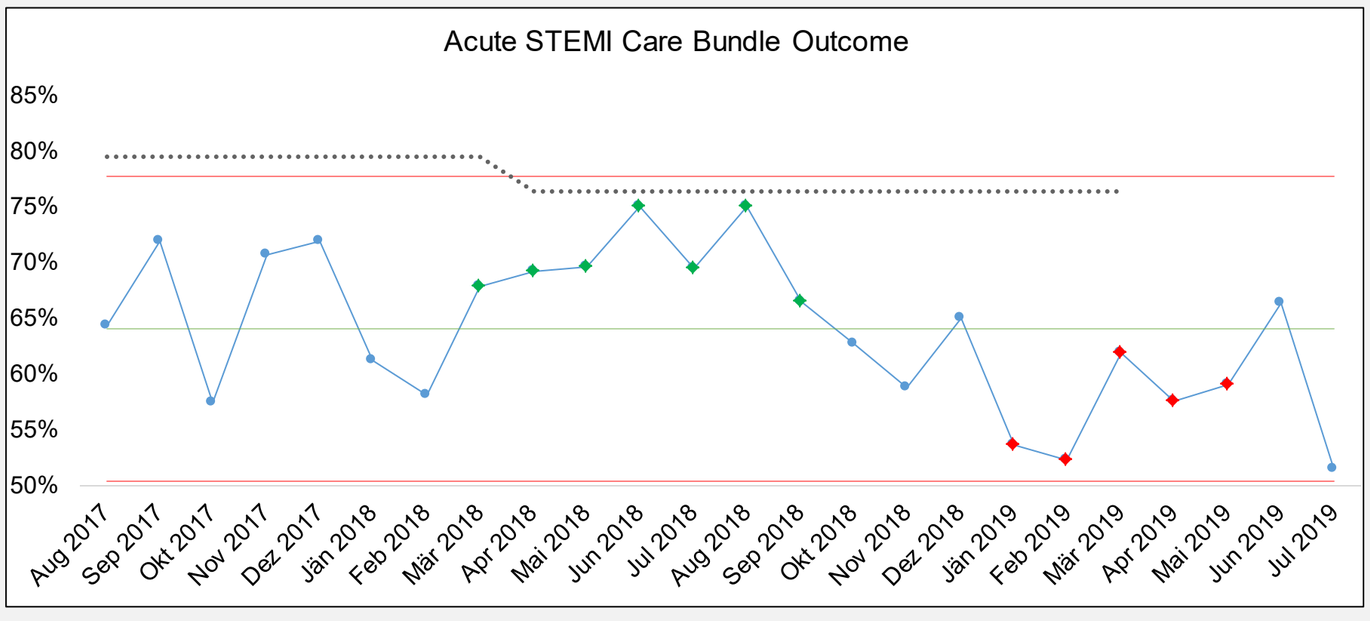
The data continues to show normal levels of variation. The numbers of patients included in this data are low, and so small variations can impact on overall performance. Each case is reviewed. We have not identified any areas of concern when reviewing individual care given.

A full day of resuscitation training is currently being delivered to staff through the 2019/20 Key Skills training programme.







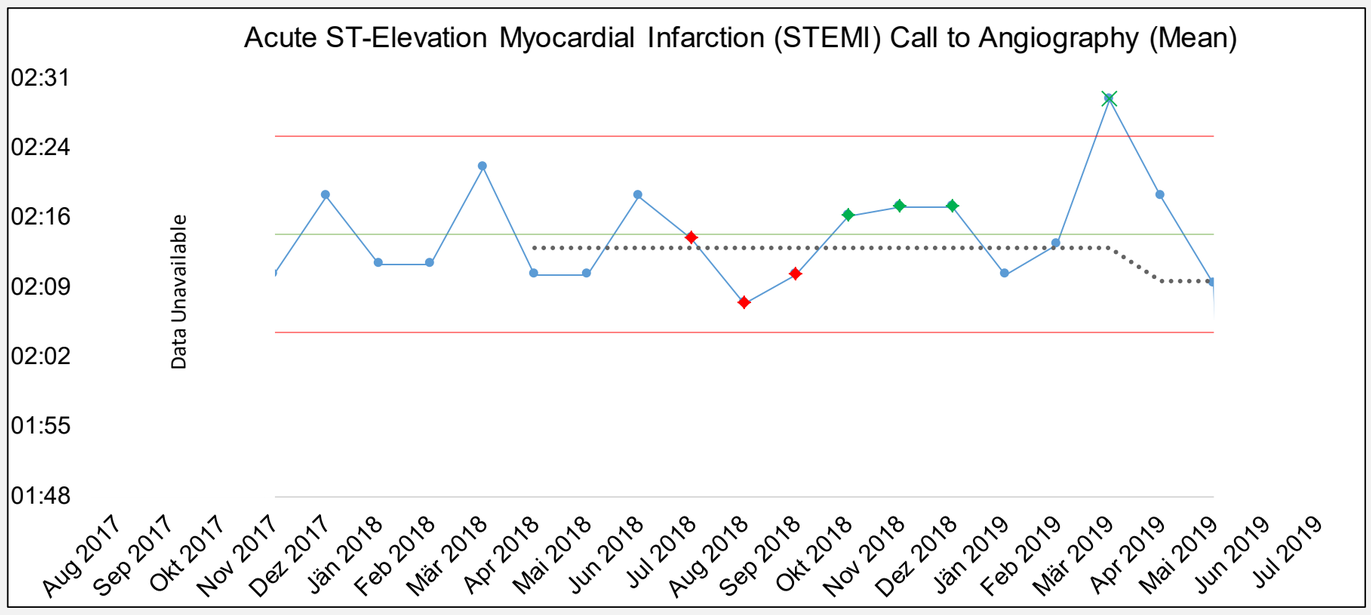


This chart shows the proportion of patients who were suffering a suspected STEMI and received a full care bundle.

There has been a sustained overall reduction in performance against this measure. We have identified that this could be due to poor documentation by staff e.g. not documenting that pain relief was issued.

It is expected that the ePCR system will improve documentation and as such improve performance against this measure. A bulletin has been developed that seeks to address documentation issues and provide clarity over misconceptions. This will provide a point of reference for ongoing improvement work.

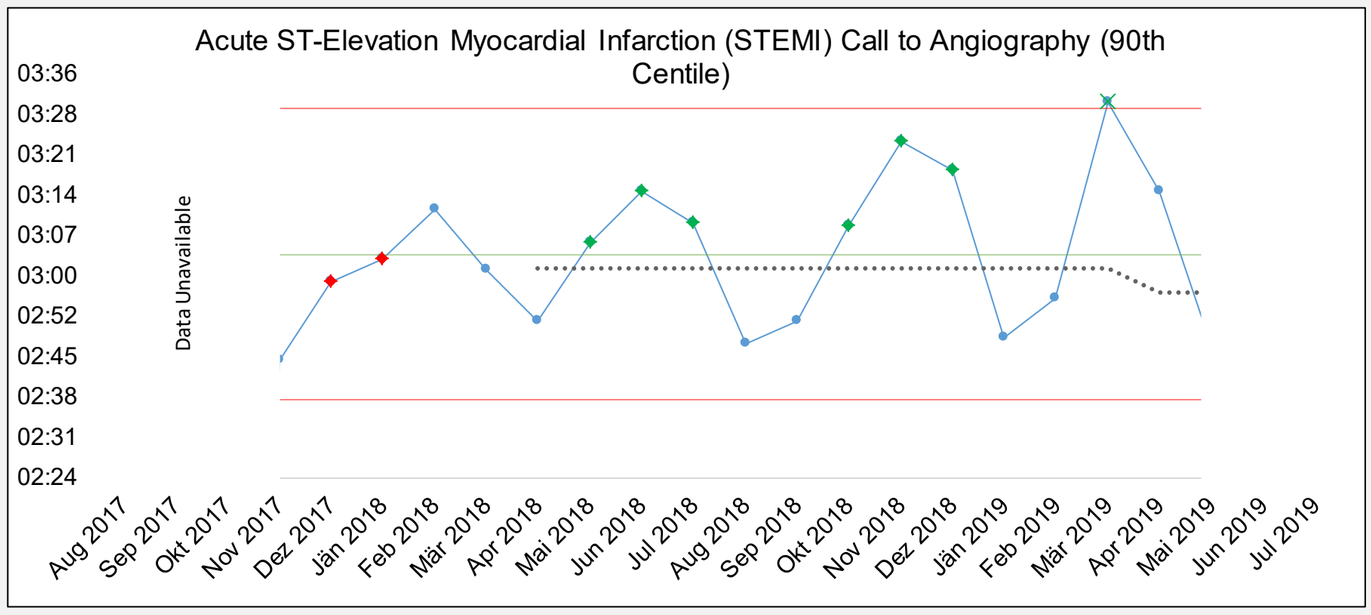
SECAmb Clinical Safety Charts

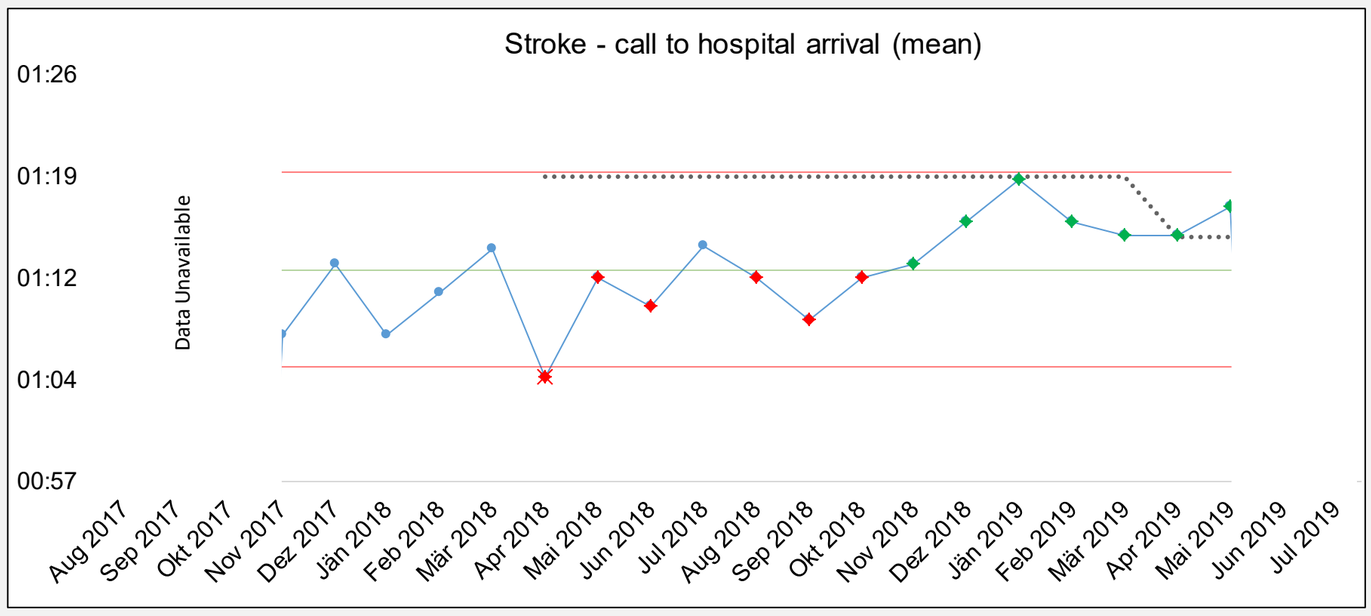


STEMI timeliness charts show the mean and 90th centile call to angiography time for patients who are suffering STEMI.

Trust performance is broadly in line with national averages, excepting this data point.

This data is no longer collected by SECAmb and is released in arrears by NHS England. As such, the latest available data is from May 2019.

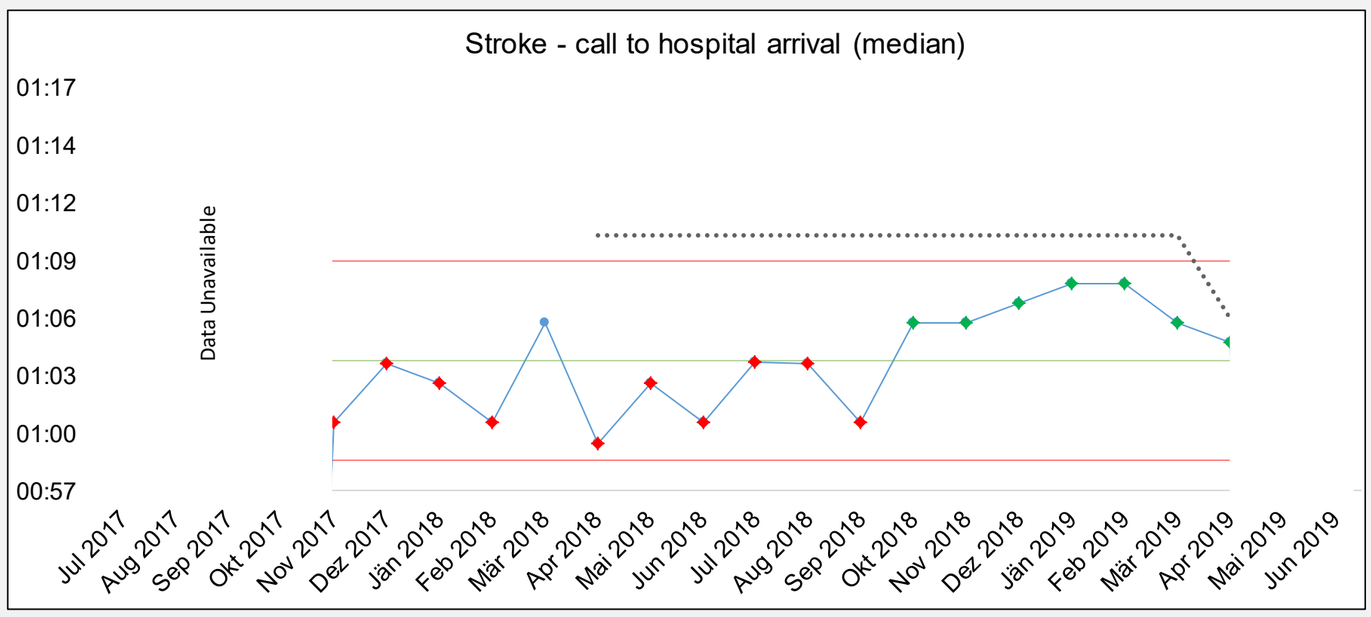


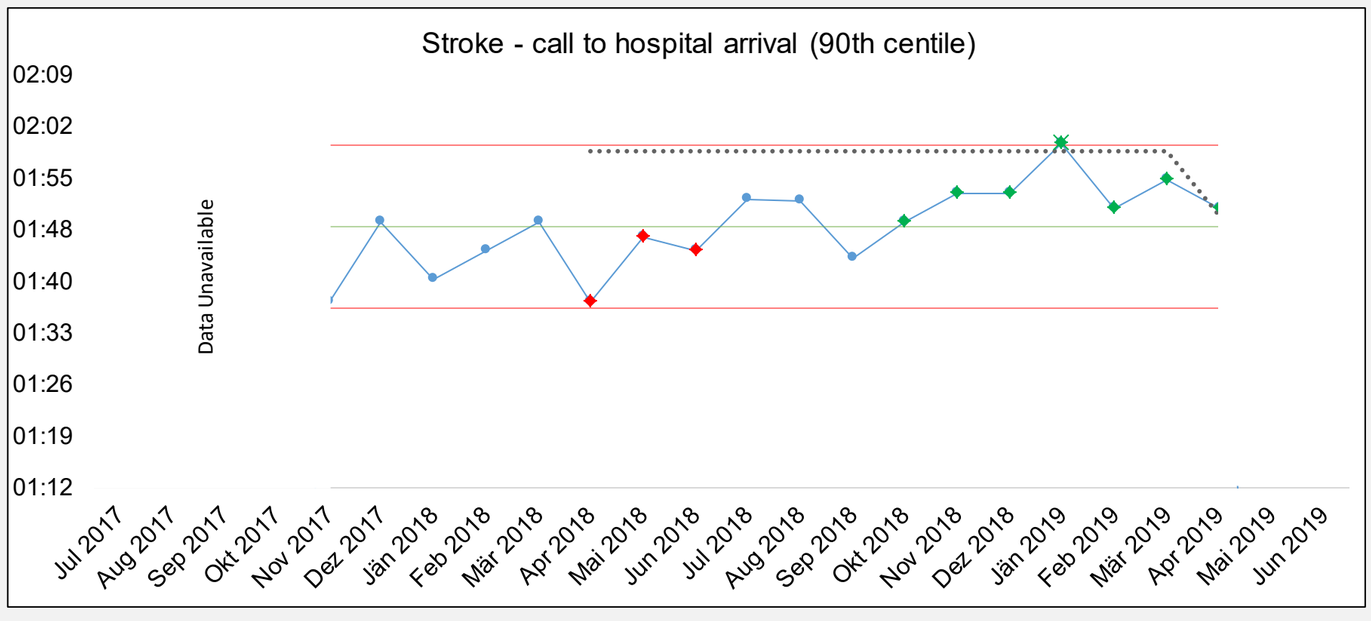


Stroke timeliness charts show the mean, median and 90th centile call to angiography time for patients who are suffering stroke.

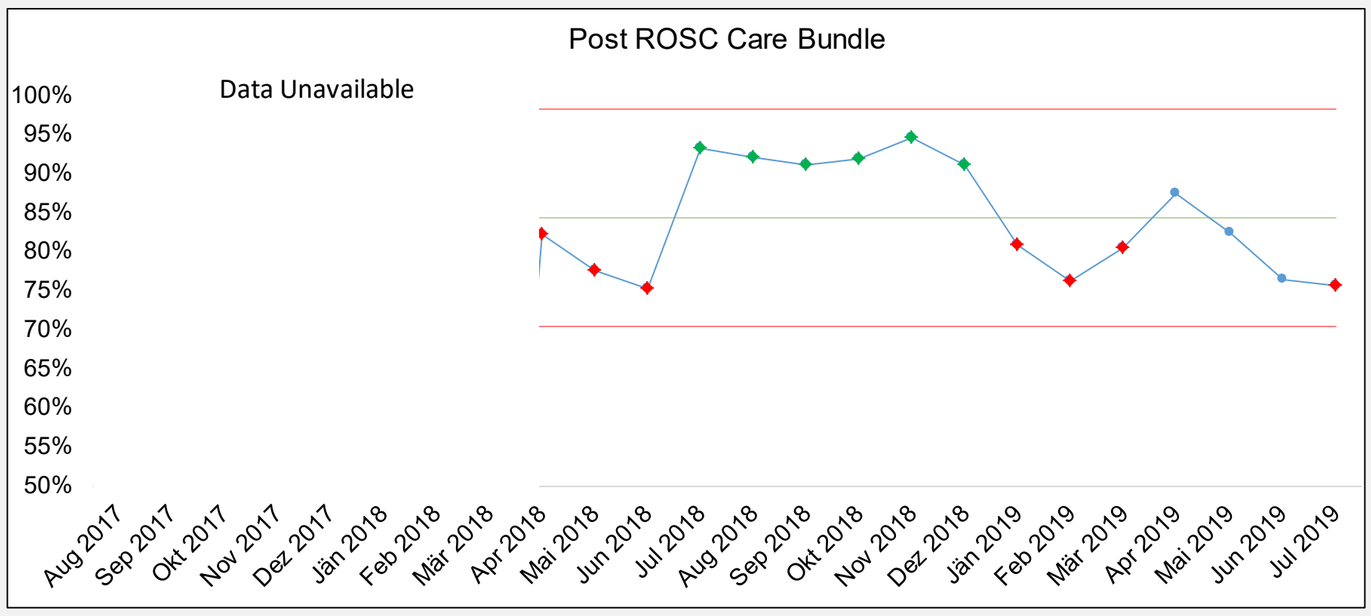
These measures continue to show normal patterns of variation. SECAmb continues to deliver stroke care that is more timely than the national average.

This data is no longer collected by SECAmb and is released in arrears by NHS England. As such, the latest available data is from May 2019.



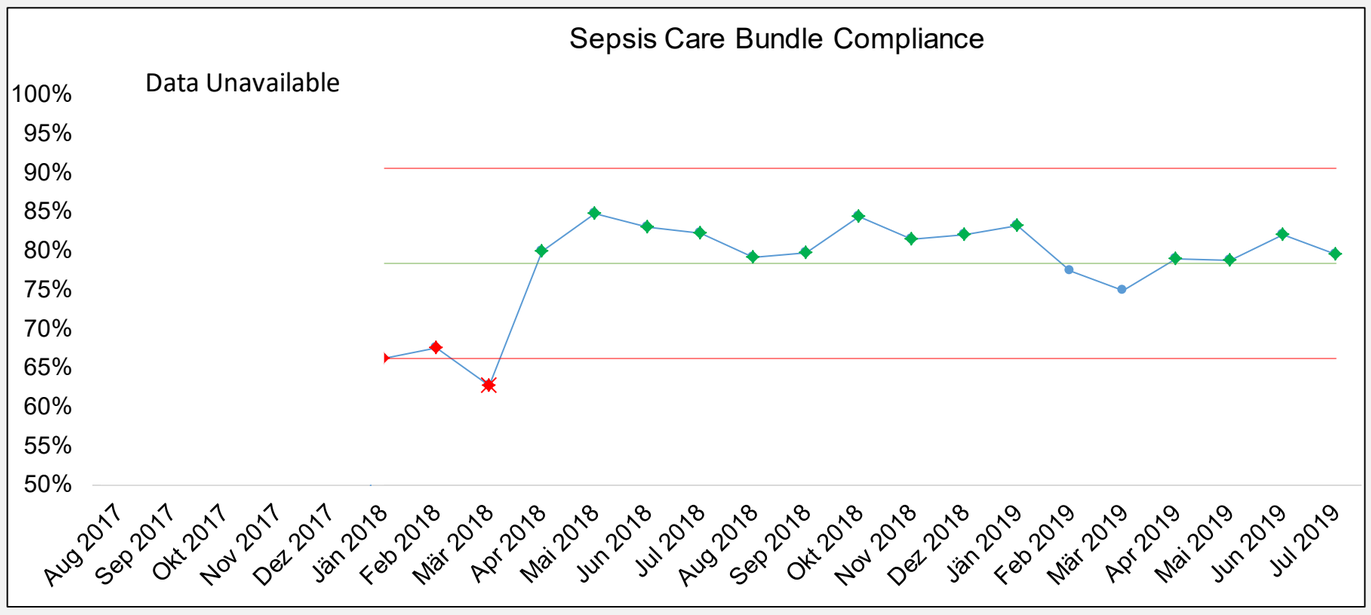


SECAmb Clinical Safety Charts



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

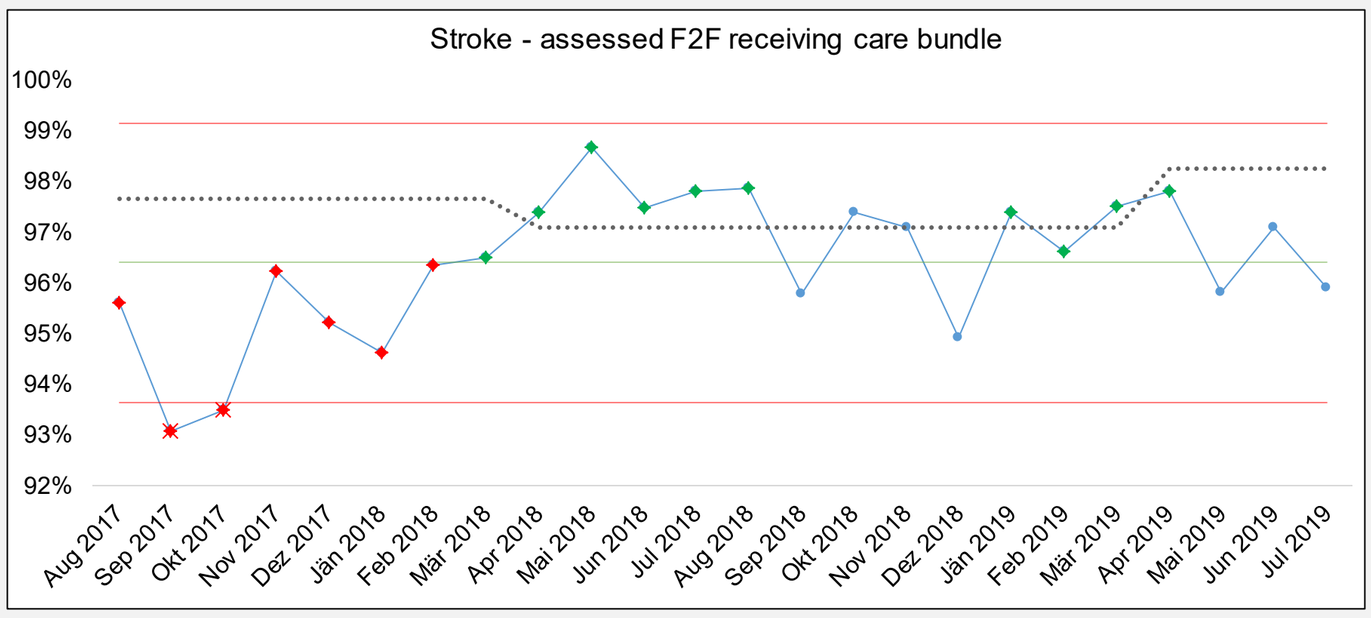
The data continue to show normal levels of variation. SECAmb continues to perform above the national average.



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

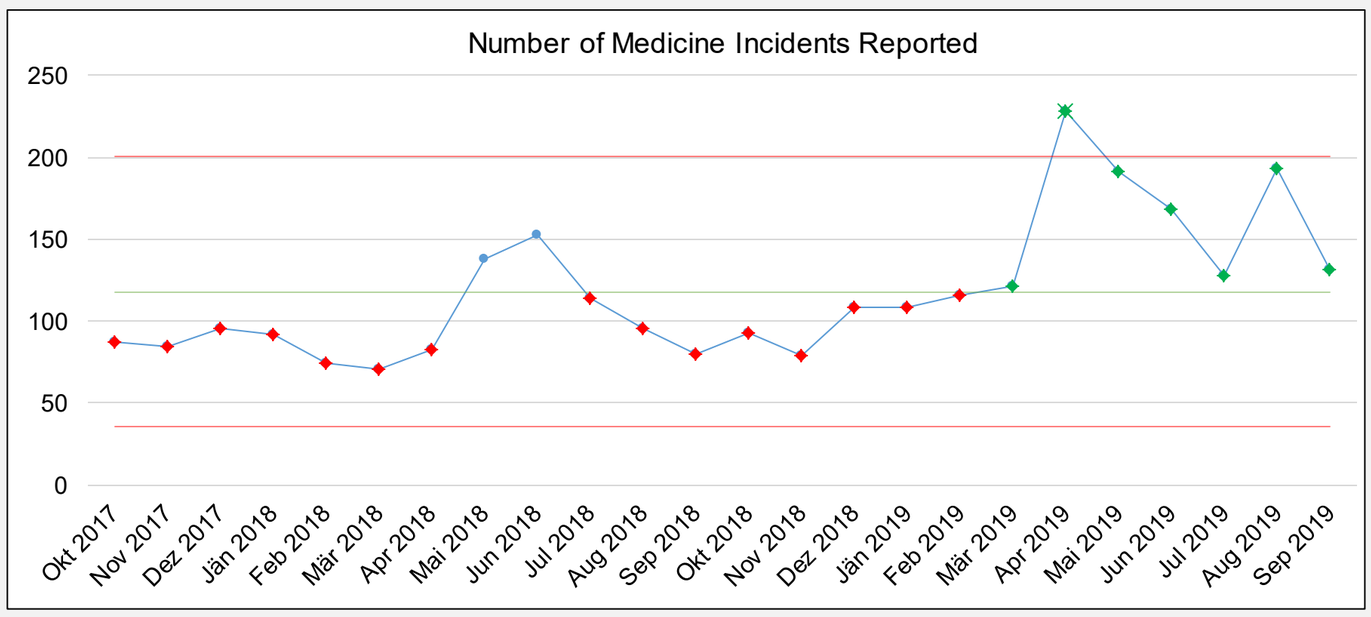
The data continues to show normal levels of variation. SECAmb continues to perform above the national average.

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

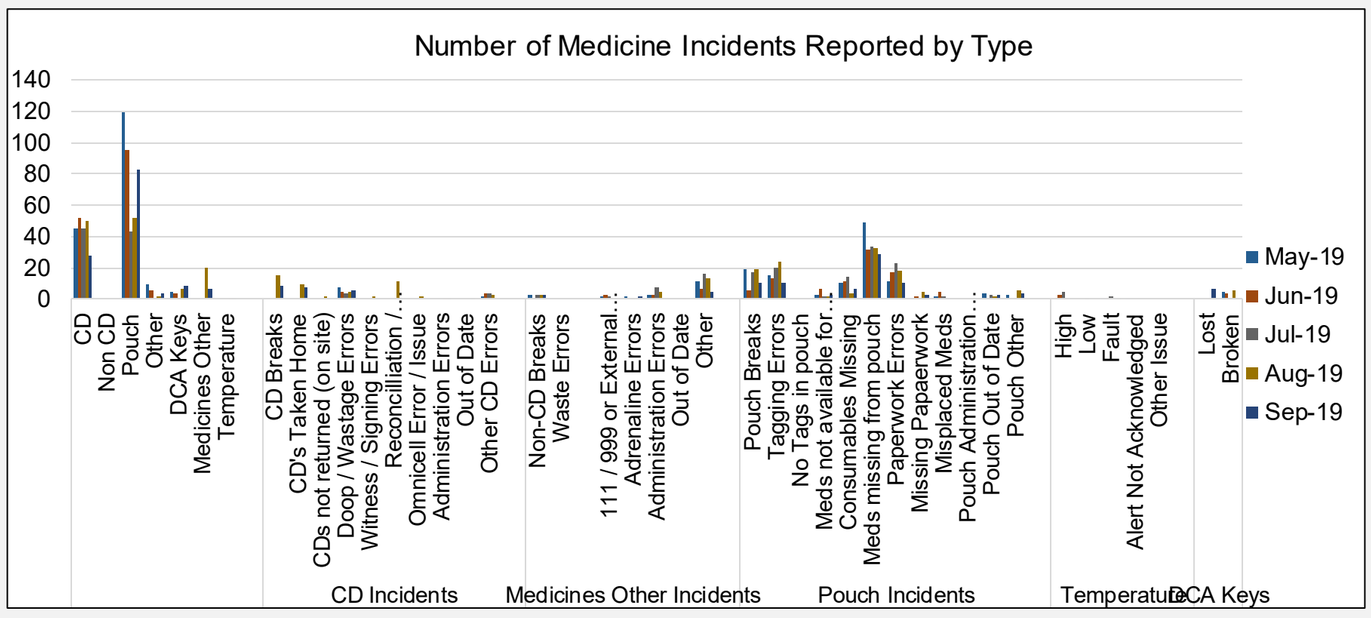


This chart shows the proportion of patients with a suspected stroke who received a full bundle of care.

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

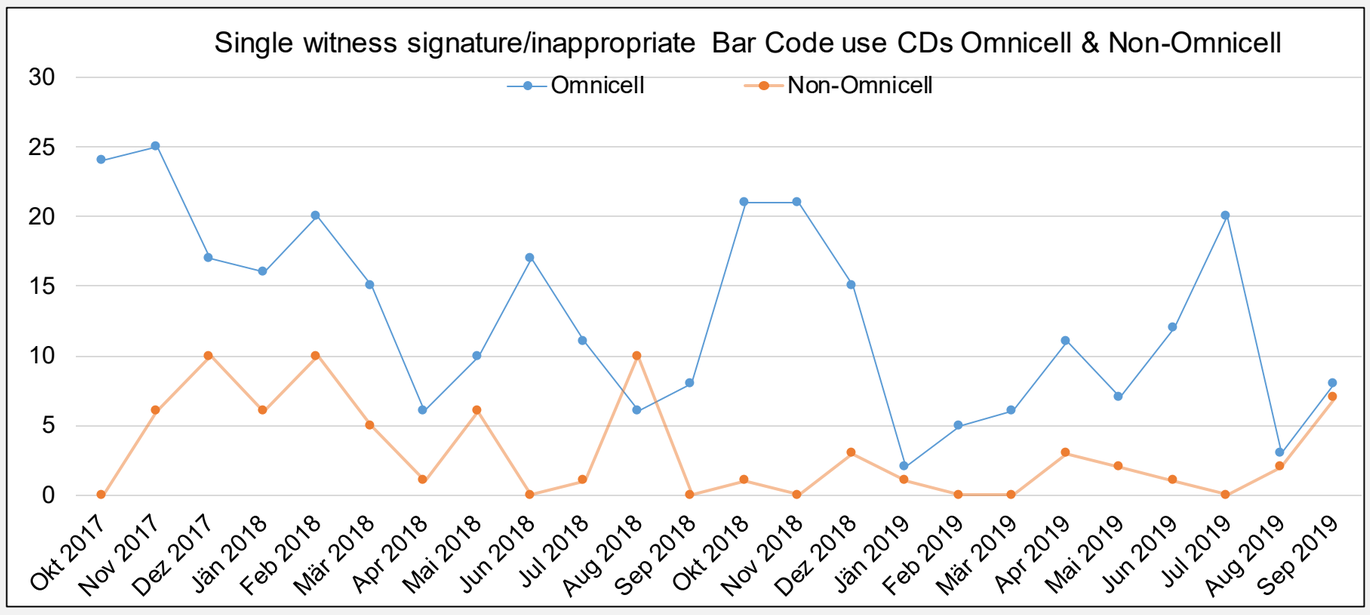


Rate of incidents and incident reporting remain similar to those seen in previous months
QI hub continue to highlight during their weekly conference call the administration errors and the need for learning around incidents

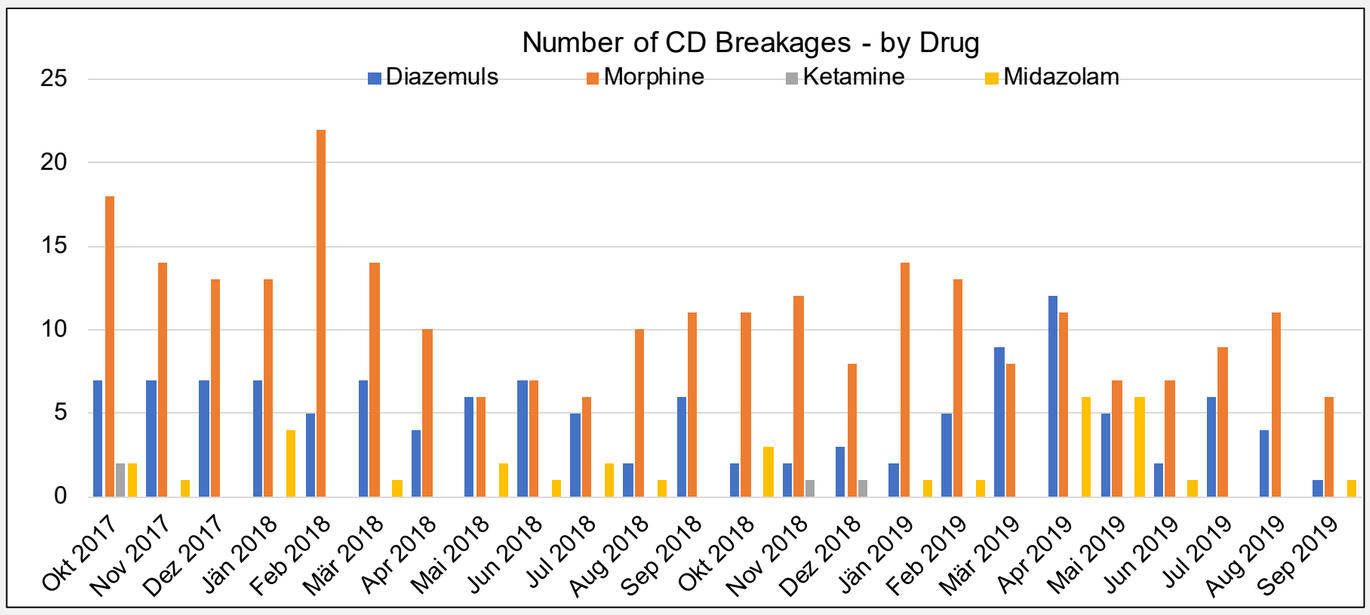


Pouch errors continue to be the most frequent error type and although the specific number appear high, these need to be considered in light of total number of pouches in use across the trust. On-going review of pouch contents aims to reduce the number of medicines stored in some pouches, which will reduce the chance of breakages.

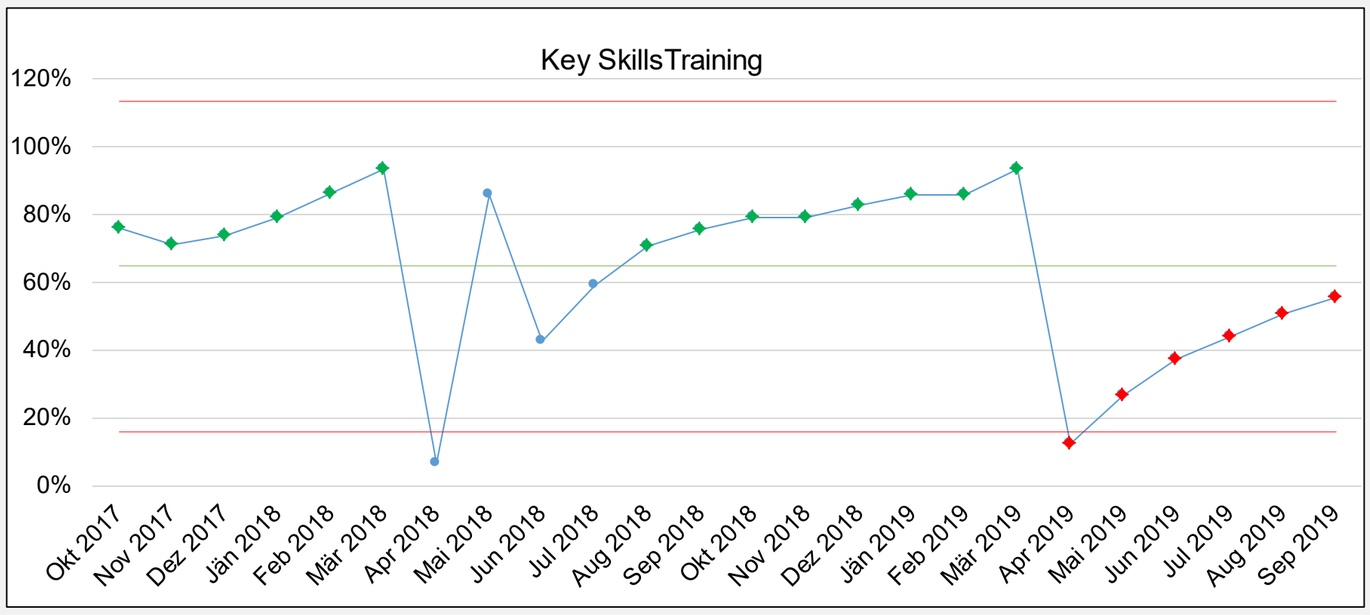
SECAmb Clinical Safety Charts



Recent update of Omnicell system has allowed OTLs to identify and follow-up occasions where CDs are not returned within 16 hours of being issued.



Morphine is most frequent CD breakage, but this is in line with its widespread use. Ketamine and midazolam are only used by specialist paramedics.



SECAmb Clinical Safety Mental Health

During September 2019, the mental health indicator demonstrates there were 183 (August 163) Section 136 related calls to the service. Of these 131 (August 132) received a response resulting in 122 (August 124) 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 minutes 90th centile response.

Cat 2 = 00: 18:18 (August 00:18.42)
90th Centile = 00: 33:17 (August 00:37.12)

During September 2019, there were 183 Section 136 related calls to the service.131 (71.5%) of these calls received a response (81% in August) resulting in a conveyance to a place of safety by an ambulance on 122 (66.6% of total calls) of these occasions. (In August, this was 76.07% of total calls).

The overall performance mean shows a Cat 2 response time across the service as 00:18.18 (August this was 00:18:42). Against the 90th centile measure, the response was 00.33.17 (August was 00:37:12).

Data for transports of under 18 is currently not available via Power BI.

There were 52 occasions when SECAmb did not provide a conveyance. This is up from 31 in August. This report RAG rates against both mean ARP standards within Cat 2; these being 18 minutes and the 90th percentile within 40 minutes.

Quality and Patient Safety Report:

Infection prevention and control (IPC): the previous months reduction in hand hygiene compliance has recovered to within compliance levels, and was 98% for compliance for September 2019. Unfortunately we have seen another drop in compliance with Clinically Ready, down to 92% for September. The Vehicle Preparation Programme (VPP) teams have once again matched the monthly targets for July, August and September and the reason we can see an above 100% is due to them catching up with previously missed Deep Cleans. However, we are now seeing problems in the Make Ready areas, and the Deep Cleans carried out have declined since May 2019. There are now monthly meetings set up with Churchills, Senior Trust Managers and Make ready Managers to try and resolve some of the issues affecting compliance and we hope to see improvements once these are resolved.

Safeguarding: September 2019 referral rates increased by 30% compared to the previous year. Referrals for increasing care needs continue to rise and there was a notable 50% rise in concerns highlighting domestic abuse (DA) compared to the same reporting period in 2018. One of the key priority areas of Safeguarding for 2019/20 is to increase awareness of DA throughout the organisation – this has included greater focus on DA within face to face safeguarding training. 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; September also saw the introduction of a new West Sussex CC on-line safeguarding referral process. This new process deviates from the agreed processes SECAmb has in place with the other local authorities across the East Sussex, Brighton & Hove, Surrey, Kent and Medway – any risks or concerns as a result of the new process will be monitored at the Safeguarding Sub-Group and escalated through the Clinical Governance 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 reported 852 incidents during September 2019. The highest reporting categories remain relatively consistent, and are: SMP no send; clinical tail audits; verbal and physical abuse. The highest reporting OU during September was Gatwick and Redhill who reported 103 incidents.

Serious Incidents (SIs) and Duty of Candour (DoC): 9 SIs were reported during September 2019. The Trust achieved 90% 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 59 complaints during September 2019. The Trust responded to 59% of complaints within the Trust's 25 working day timescale this month. 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 147 compliments during September.
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: Post publication of the national framework on learning from deaths from NHSI the Trust's Learning from Deaths policy is to be discussed at October QPS and be approved by November's Trust Board ahead of publication on 1st December 2019. Work continues to progress the development of the Trusts internal arrangements for the management of LFD: Quarterly LFD Group meetings; Quarterly data analysis based on the national framework and new Trust policy; Management of identified risks – ongoing as per the risk register; Quarterly reporting and escalation into the Clinical Governance Group - ongoing; Development of a sustainable reporting platform on Datix – under development; Communications materials. Engagement continues with the LeDeR central team and the regional teams across KSS – work continues as per the plan. PFDs continue to be reported into the LFD Group as a standing agenda item. The Trust now needs to move from data collection and analysis to sharing learning from death reviews.

Our People

SECAmb Clinical Quality Scorecard

Number of Incidents Reported

	Jul-19	Aug-19	Sep-19	12 Months
Actual	1040	1057	947	
Previous Year	770	806	837	

Number of Incidents Reported that were SI's

	Jul-19	Aug-19	Sep-19	12 Months
Actual	14	10	9	
Previous Year	9	8	8	

Duty of Candour Compliance (SIs)

	Jul-19	Aug-19	Sep-19	12 Months
Actual %	95%	100%	90%	
Target	95%	100%	90%	

Number of Complaints

	Jul-19	Aug-19	Sep-19	12 Months
Actual	91	78	59	
Previous Year	102	91	74	
Complaints Timeliness (All	75.0%	77.0%	59.0%	
Timeliness Target	95%	95%	95%	

Compliments

	Jul-19	Aug-19	Sep-19	12 Months
Actual	144	220	147	

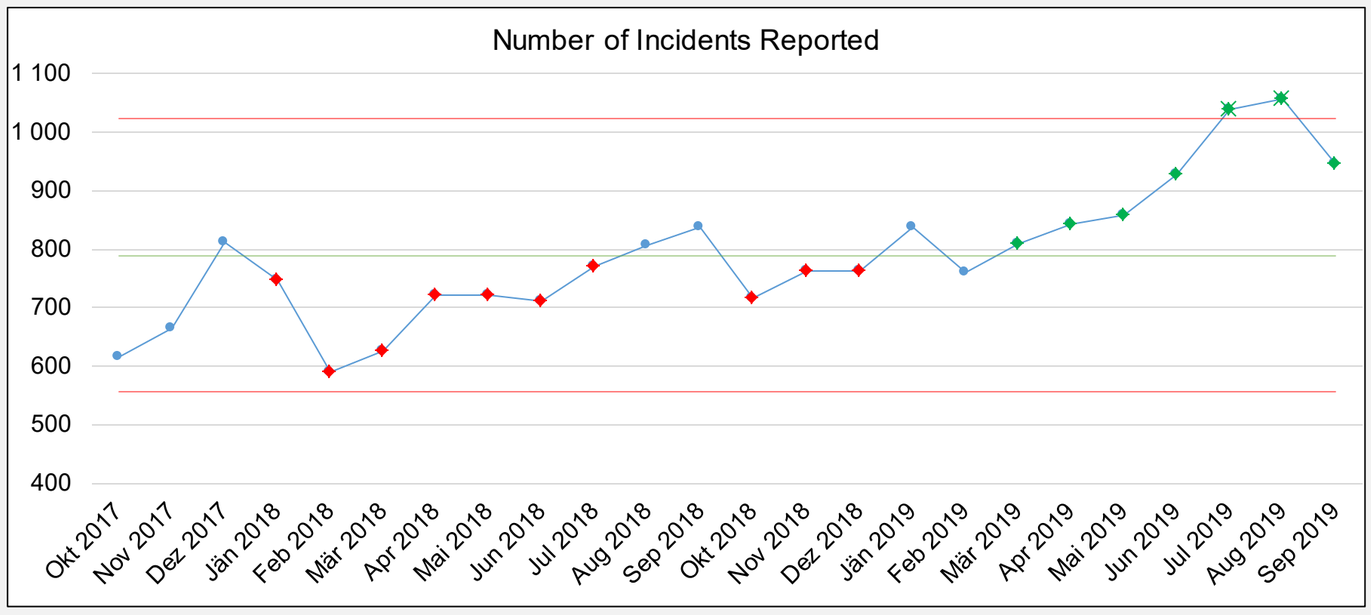
Hand Hygiene

	Jul-19	Aug-19	Sep-19	12 Months
Actual %	93%	94%	98%	
Upper Target	95%	95%	95%	

Safeguarding Training Completed (Children) Level 2

	Jul-19	Aug-19	Sep-19	12 Months
Actual %	40.75%	47.97%	53.45%	
Previous Year %	57.62%	71.20%	76.20%	
Target	85%	85%	85%	

SECAmb Clinical Quality Charts

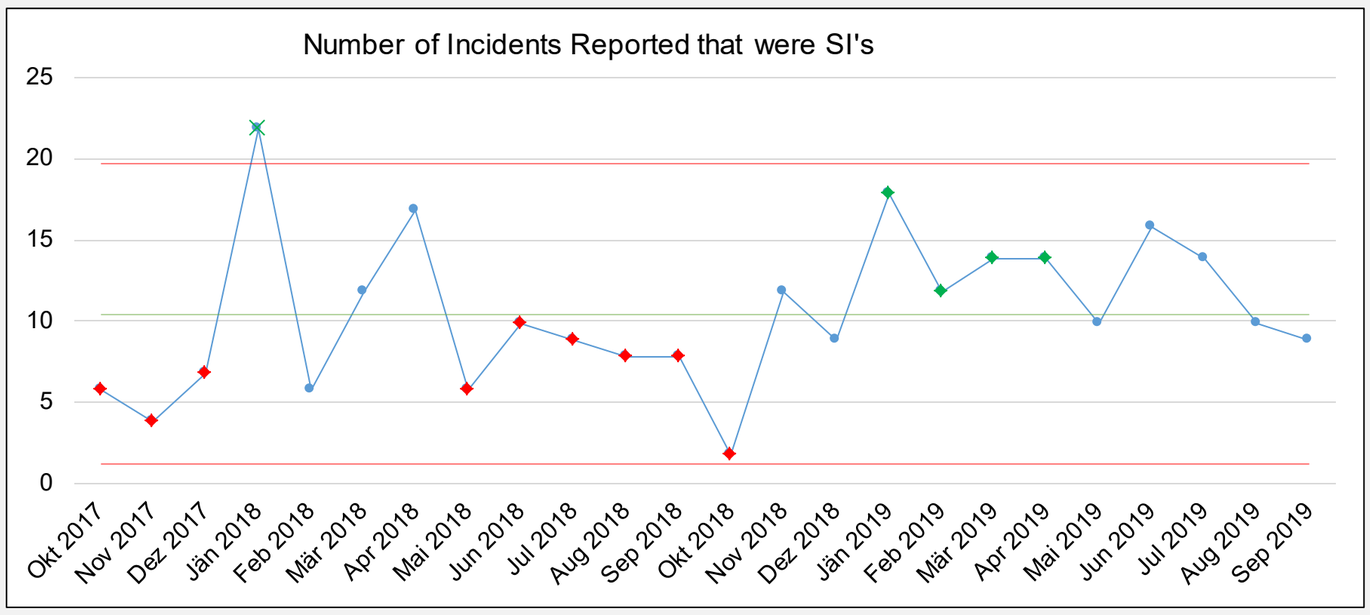


The number of incidents reported was 852 for September 2019.

The most reported area was Gatwick and Redhill with 103 incidents.

The most reported sub-category in September 2019 was Clinical Tail Audit with 67 incidents.

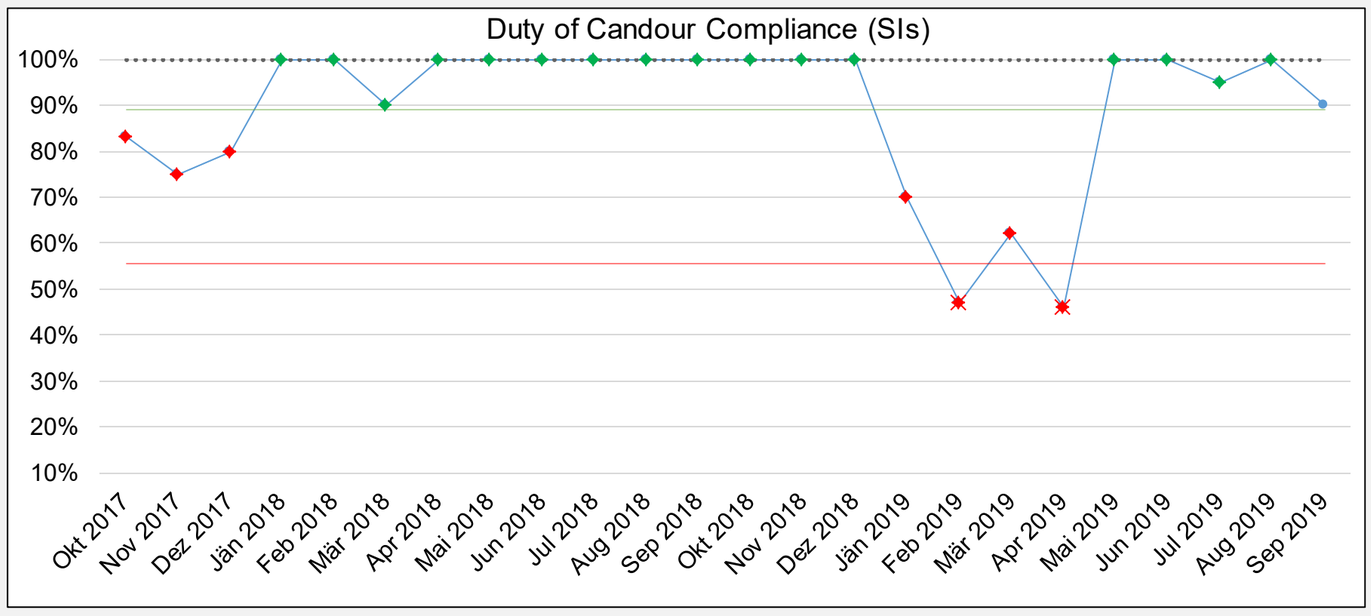
The Trust reported 833 no harm/near misses or low harm incidents, this means that 97.7% of our reported incidents are within the NHS target of 96% of incidents being no/low harm for September 2019.



9 Serious Incident were reported in September 2019.

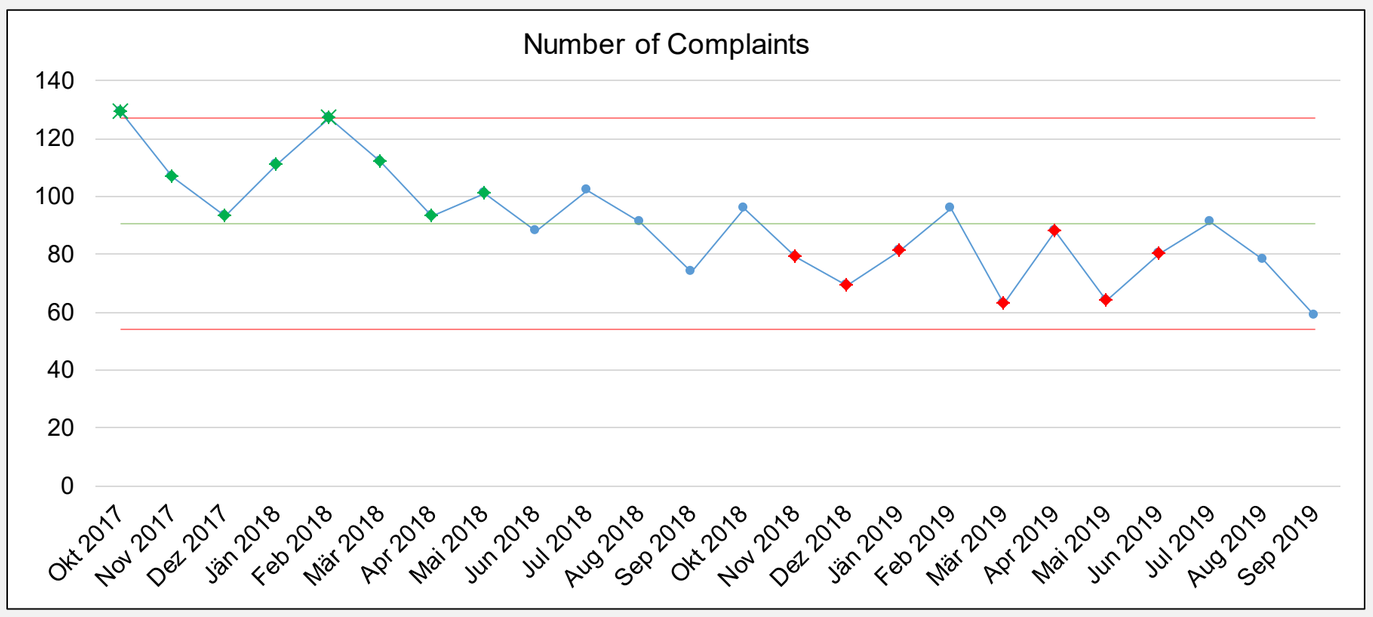
4 x Delayed Dispatch / Attendance
3 x Triage / Call Management
1 x Information Governance Breach
1 x Staff Conduct

12 SIs overall were closed on STEIS in September with another 1 being De-escalated.

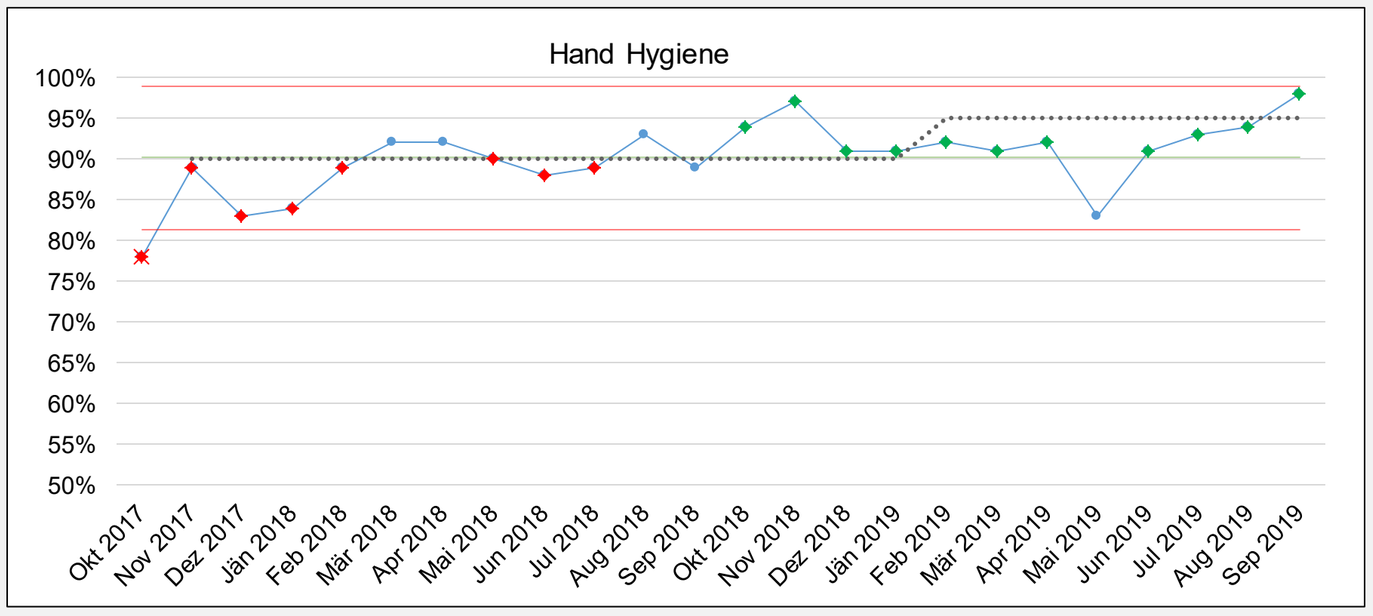


Compliance with Duty of Candour (DoC) for SIs where DoC was required in September 2019 is:10

DoC made/attempted within 10 working day deadline - 9 (90%)



The Trust received and opened 59 complaints during September 2019.
The Trust responded to 59% complaints within timescales. The majority of the delays are attributable to the Emergency Operations Centre which has historic capacity and resilience issues. In addition there was some long term sickness. A trajectory to address the backlog of EOC complaints is in place and being progressed well.



Hand Hygiene compliance has exceeded expectation again this month and is showing as 98% compliant.

However, we have seen another drop in compliance with Clinically Ready, down to 92% for September.

However, two OU's didn't carryout any audits at all during September and the Head of IPC has arranged for the IPC Leads to attend every Team C meeting across the Trust to address this.

Upper Target
Lower Target

Health & Safety Audits

Since the implementation of the annual Health & Safety Audit programme 90 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.

Violence and Aggression Incidents - See Figure 1 below
Violence and Aggression incidents towards staff in September 2019 were 62. The data below is a break down of the incidents reported by category type.

- Physical Assaults (23)
- Direct verbal Abuse (19)
- Anti-social behaviour/aggression (14)
- Attempted physical assault/ non-physical (6)

Manual handling Incidents - See Figure 2 below
Manual handling incidents reported in September 2019 were 28 which is an increase of 7 incidents from the previous month.

Health & Safety Incidents - See Figure 3 below
Health and Safety incidents reported in September 2019 were 40 which is an increase of 26 incidents from the previous month.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) - See Figure 4 below
RIDDOR incidents reported in September 2019 were 10 with 5 incidents reported on time to the Health & Safety Executive.

Figure 1

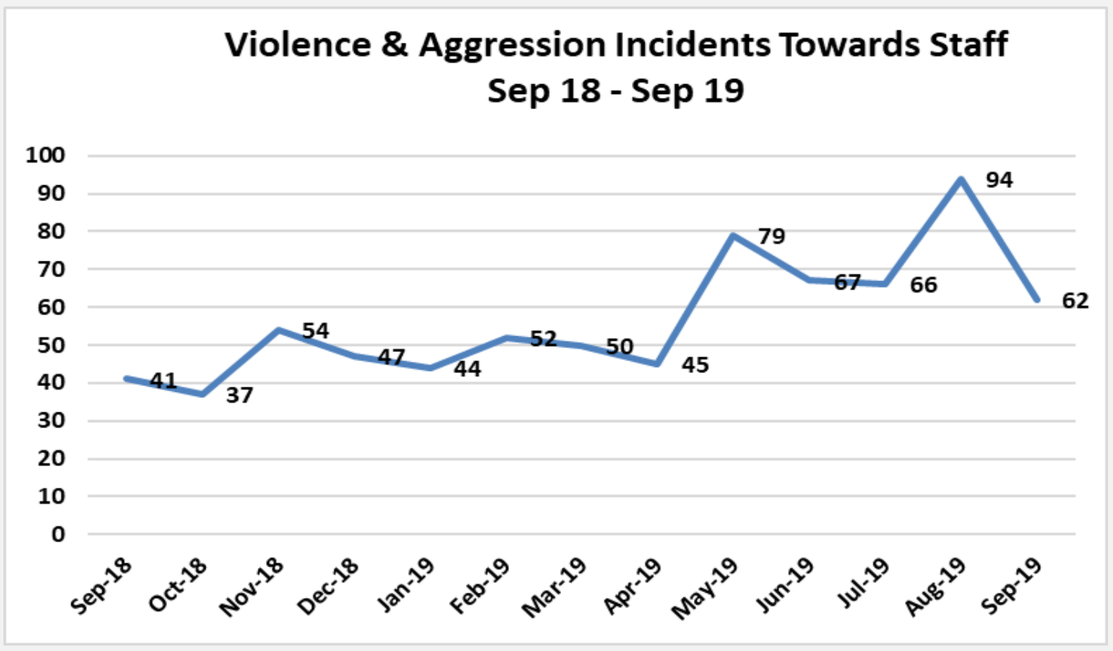


Figure 2

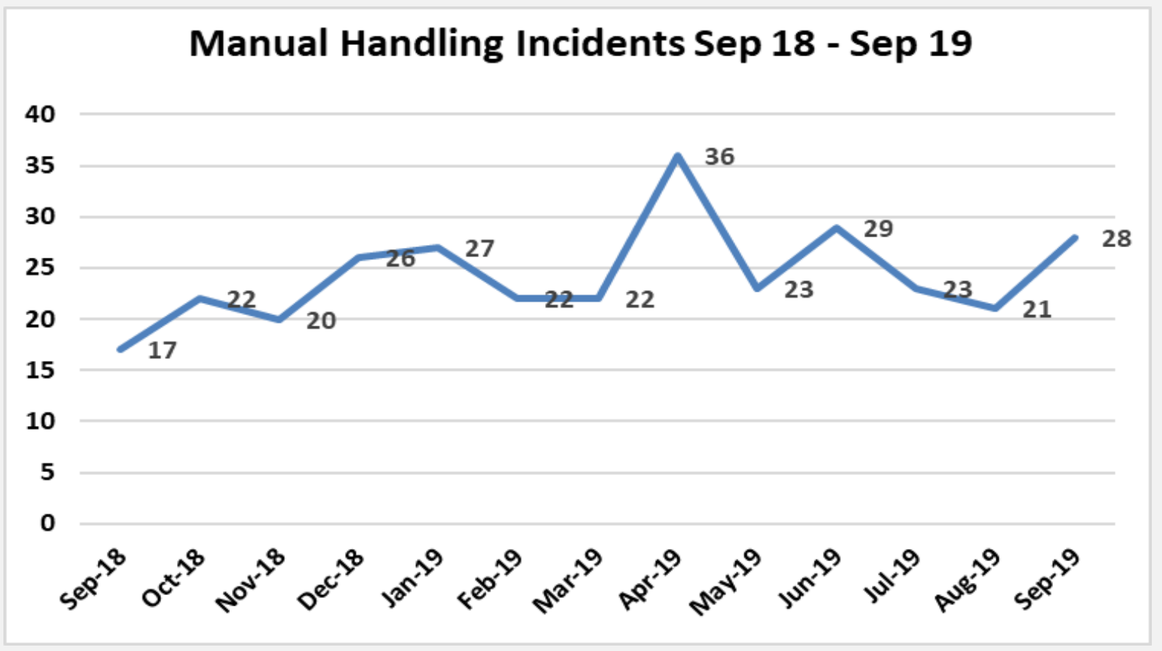


Figure 3

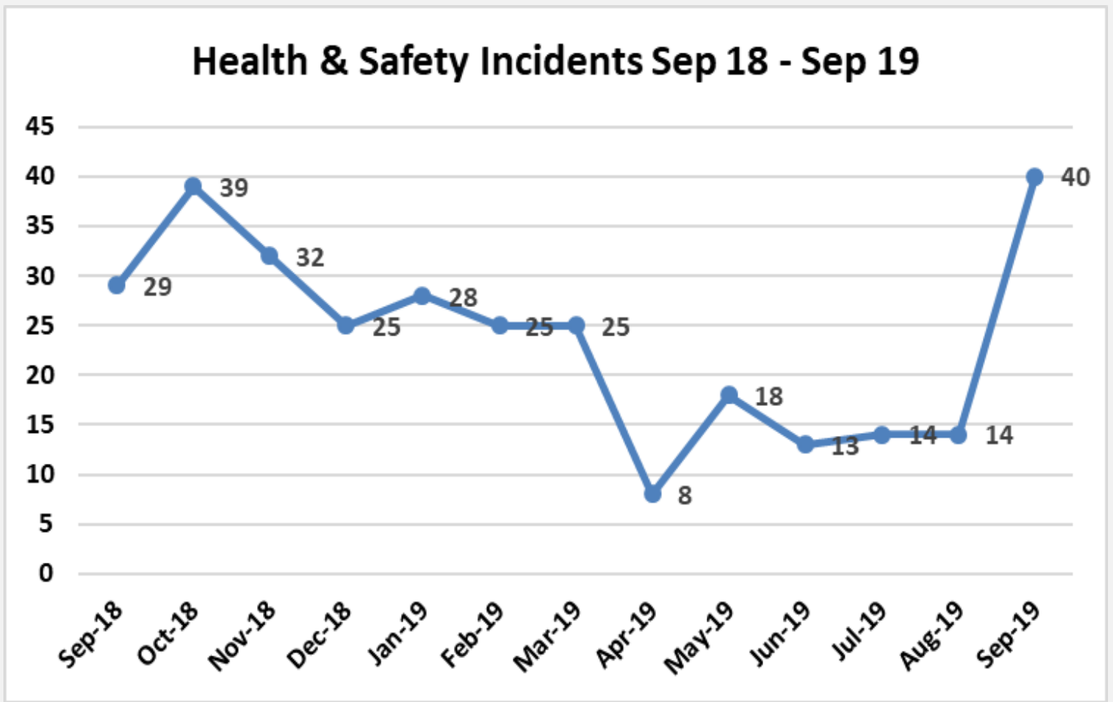
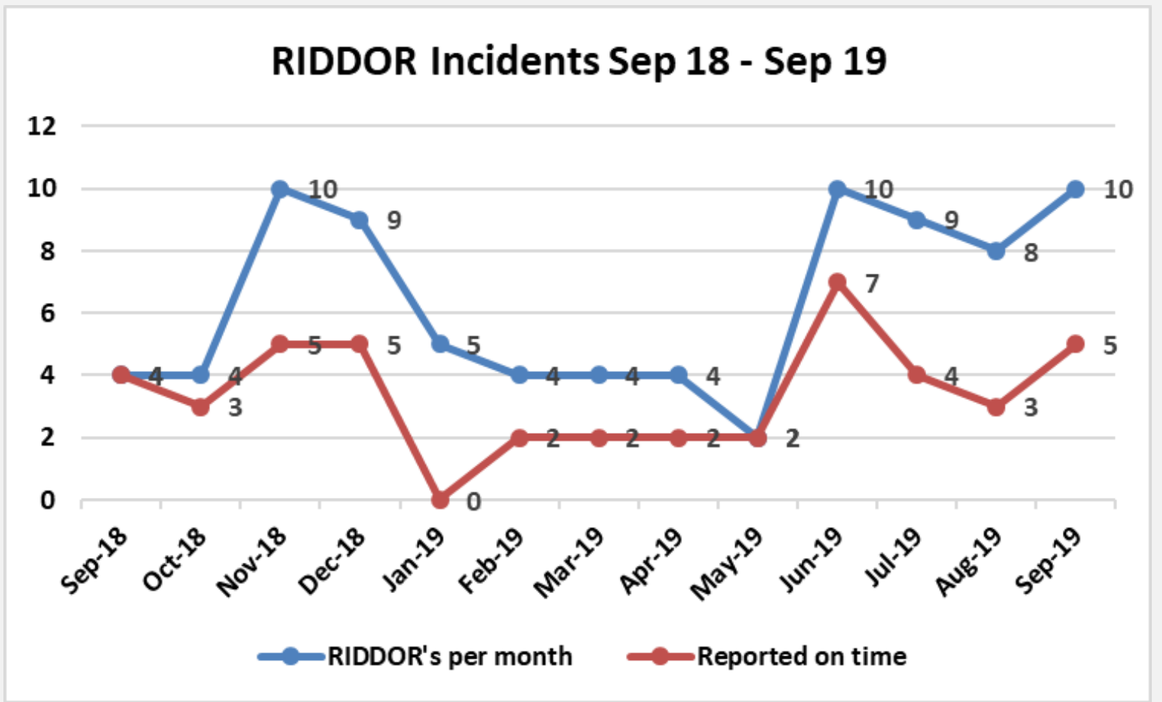


Figure 4



Our Enablers

SECAmb 999 Operations Response Time Performance Scorecard

Call Handling

	Jul-19	Aug-19	Sep-19	12 Months
5 Sec Performance (95% Target)	84.3%	88.5%	90.3%	
Mean Call Answer Time (secs)	9	6	5	
95th Centile Call Answer (Secs)	55	38	32	
National Mean Call Answer	10	9	10	
National 95th Centile Call Answer	59	52	60	

Category 1 Performance

	Jul-19	Aug-19	Sep-19	12 Months
Mean (00:07:00)	00:07:21	00:07:15	00:07:35	
90th Percentile (00:15:00)	00:13:52	00:13:44	00:13:56	
Mean Resources Arriving	1.61	1.53	1.49	
Count of Incidents	3813	3646	3584	
National Mean	00:07:14	00:07:05	00:07:15	

Category 1T Performance

	Jul-19	Aug-19	Sep-19	12 Months
Mean (00:19:00)	00:09:33	00:09:04	00:09:25	
90th Percentile (00:30:00)	00:18:23	00:17:52	00:17:36	
Mean Resources Arriving	1.63	1.55	1.50	
Count of Incidents	2373	2317	2300	
National Mean	00:11:12	00:10:44	00:10:48	

Category 2 Performance

	Jul-19	Aug-19	Sep-19	12 Months
Mean (00:18:00)	00:20:01	00:18:21	00:18:51	
90th Percentile (00:40:00)	00:38:34	00:34:23	00:35:49	
Mean Resources Arriving	1.08	1.07	1.07	
Count of Incidents	33774	32747	31781	
National Mean	00:23:18	00:21:13	00:22:22	

Category 3 Performance

	Jul-19	Aug-19	Sep-19	12 Months
Mean	01:33:53	01:23:00	01:26:21	
90th Percentile (02:00:00)	03:33:52	03:09:59	03:17:42	
Mean Resources Arriving	1.05	1.05	1.02	
Count of Incidents	20434	20625	19031	
National Mean	01:11:30	01:02:42	01:09:03	

Category 4 Performance

	Jul-19	Aug-19	Sep-19	12 Months
Mean	02:03:54	01:45:54	01:53:03	
90th Percentile (03:00:00)	04:41:02	04:25:38	04:34:31	
Mean Resources Arriving	1.02	0.98	1.03	
Count of Incidents	436	462	440	
National Mean	01:25:45	01:14:34	01:19:34	

Health Care Professional

	Jul-19	Aug-19	Sep-19	12 Months
HCP 60 Mean	02:23:31	02:04:59	01:28:31	
HCP 60 90th Percentile	05:16:52	04:07:01	03:29:18	
HCP 120 Mean	02:28:47	02:22:36	02:08:55	
HCP 120 90th Percentile	05:17:32	04:56:32	04:37:13	
HCP 240 Mean	03:29:19	03:09:01	03:03:00	
HCP 240 90th Percentile	07:37:10	06:08:40	06:20:46	

Call Cycle Time

	Jul-19	Aug-19	Sep-19	12 Months
Avg Allocation to Clear at Scene	01:14:03	01:14:47	01:15:21	
Avg Allocation to Clear at Hospital	01:47:46	01:47:34	01:48:04	
Turnaround Hrs Lost at Hospital (> 30mins)	4745	4594	4593	
Number of Handovers >60mins	325	394	393	

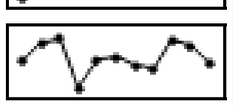
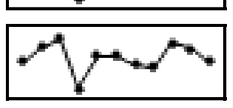
Incident Outcome AQI

	Jul-19	Aug-19	Sep-19	12 Months
Hear & Treat	5.7%	5.9%	5.8%	
See & Treat	32.6%	32.4%	31.9%	
See & Convey	61.7%	61.7%	62.3%	

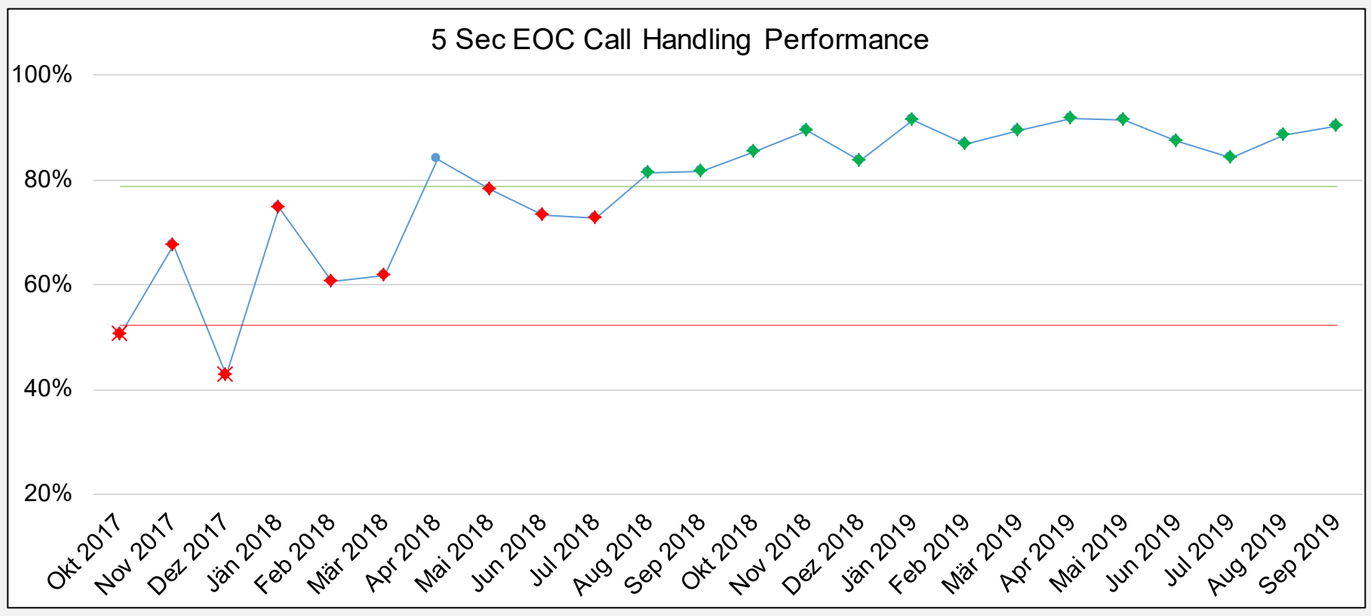
Voluntary Attendances

	Jul-19	Aug-19	Sep-19	12 Months
Community First Responders	1024	1105	997	
Fire First Responders	358	341	266	

Demand/Supply AQI

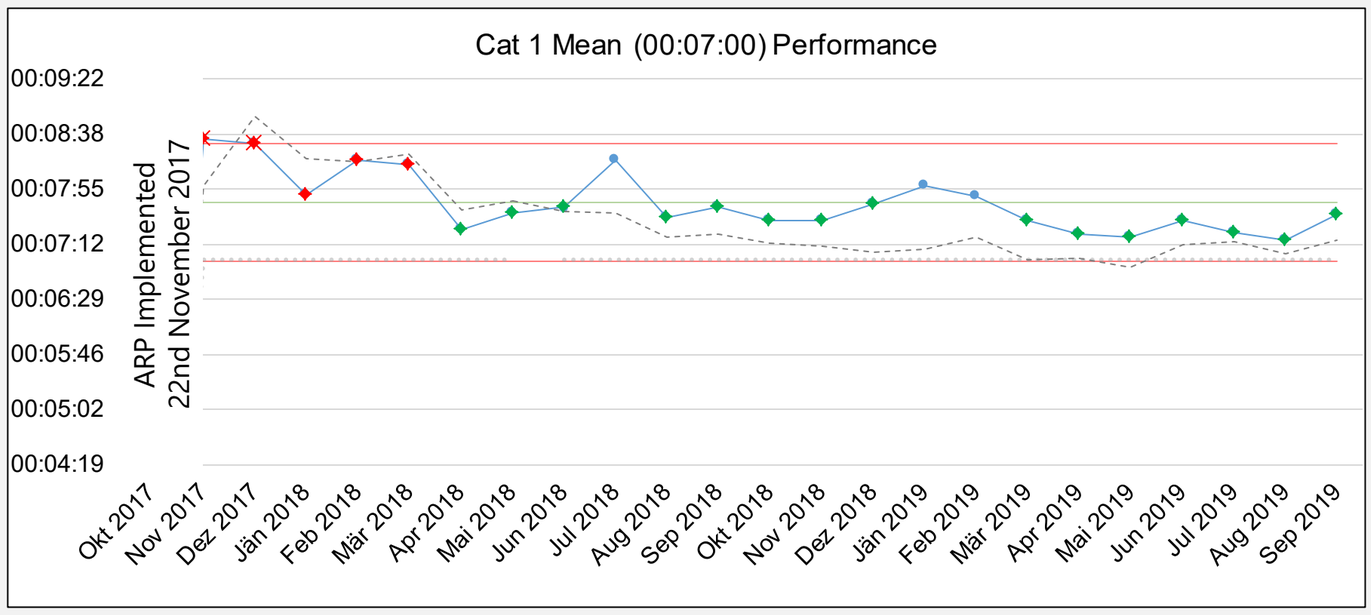
	Jul-19	Aug-19	Sep-19	12 Months
Calls Answered	70863	67178	64525	
Incidents	64052	63107	60410	
Transports	39493	38881	37621	

SECAmb 999 Operations Response Time Performance Charts



In September 2019, call answering performance within EOC rose again, this time by 1.8%, to 90.3%. During this month, call volume decreased slightly, to 64,525.

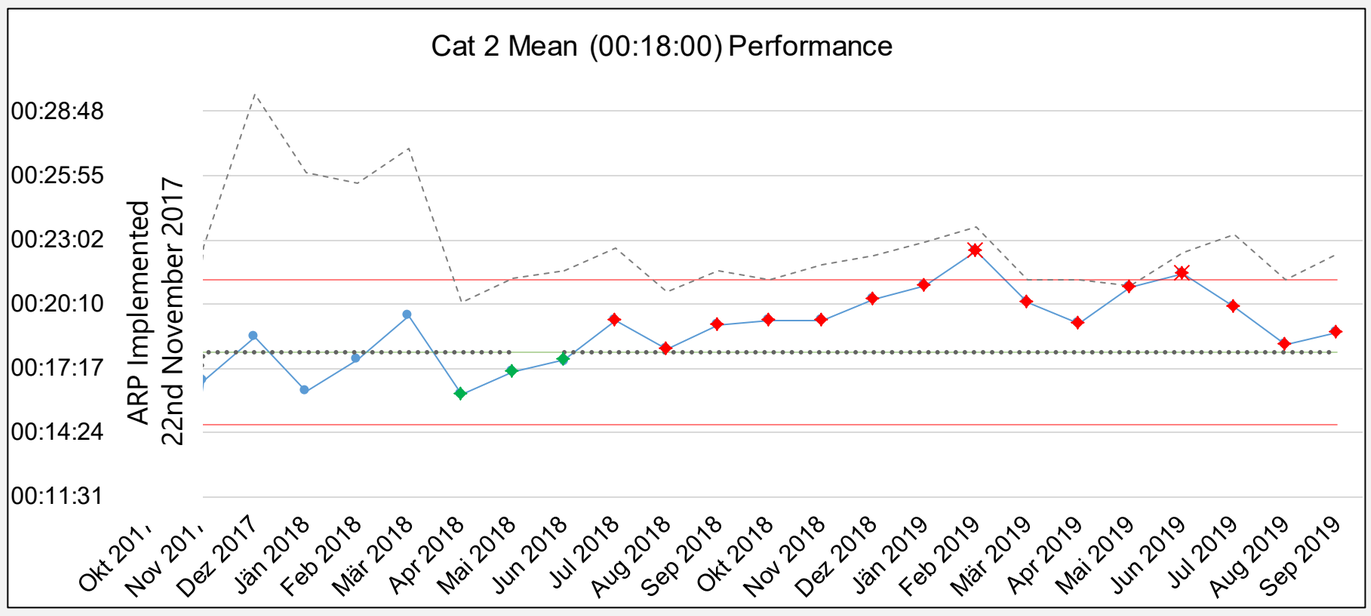
Against this backdrop the Trust improved in the national table, achieving 4/3 for mean and 95th centile performance compared to the other English Ambulance Trusts, with continued improvement for the latter measure.



As anticipated the implementation of Pathways 17 on 4 September 2019 has impacted on Category 1 activity. The Category 1 mean response time in September 2019 was 07:35, compared to 07:15 in the previous month.

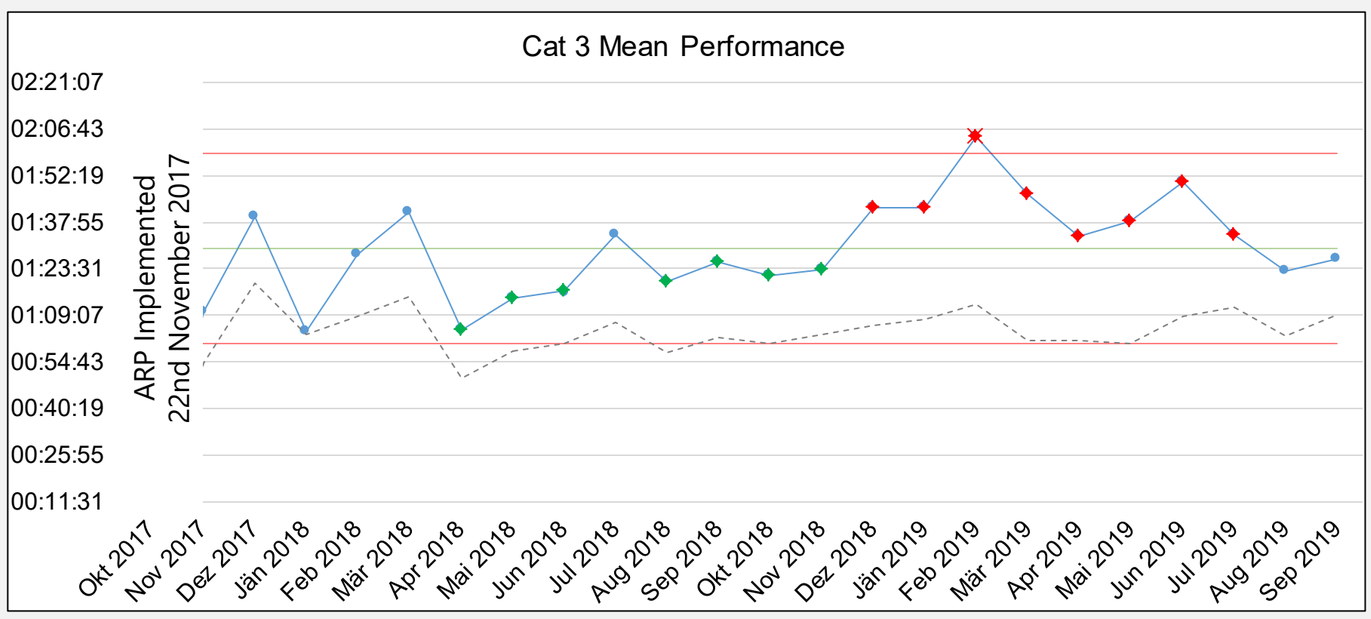
The number of incidents remained relatively steady, and there is a continued improvement in the mean resources arriving; with a reduction of 0.12 from July 2019.

The Trust continues to deliver against C1T Mean and C1T 90th centile against ARP standards and remains at mid table for its C1 Mean response.



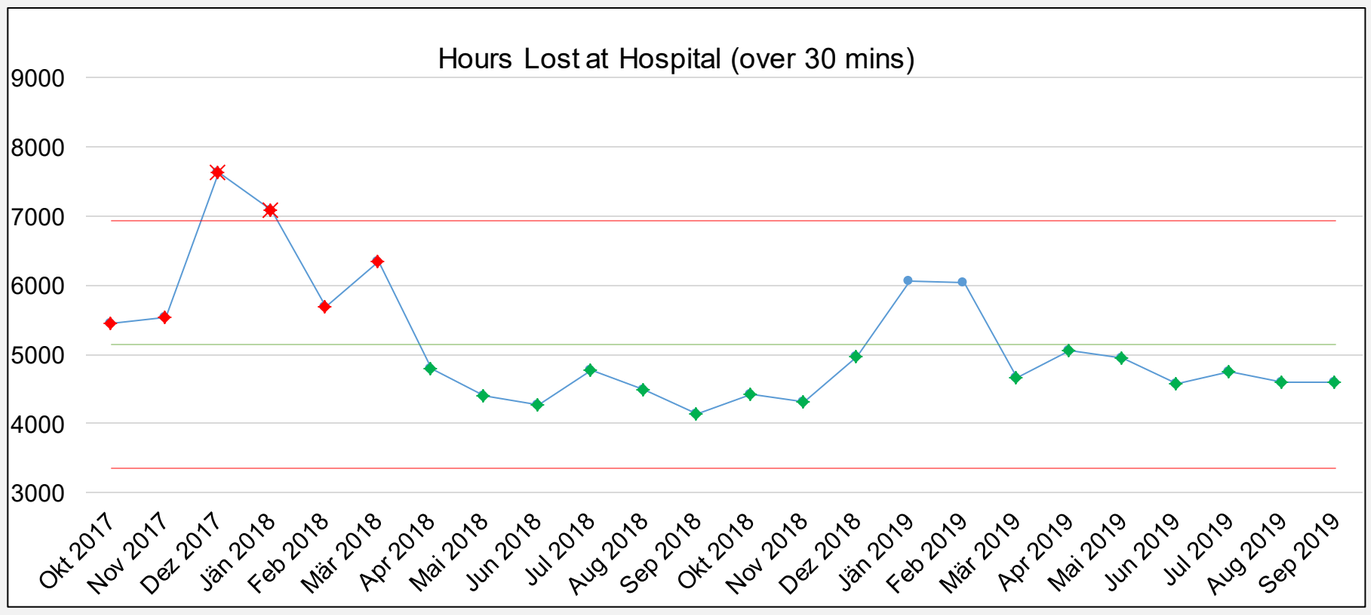
The Category 2 mean response time in September 2019 was also higher than the preceding month, with a mean of 18:51, 30 seconds worse than in August 2019. It should be noted that whilst Trust performance remains sub optimal, other Ambulance Services are also finding meeting this ARP Standard a challenge, with a national average reported at 22:22, 1 minute and 7 seconds worse that on prior month

The Trust's 90th centile performance has increased from 34:23 to 35:49, however this still places it second in the national ranking table for the month.



In September 2019 the Trust achieved the Category 3 mean, achieving 01:26:21. However the 90th centile performance was 03:17:42. The Trust's position in the ranking tables for Mean and 90th centile performance is 9 /8 respectively.

Job Cycle Time is one area the Trust is focussing on to improve its Category 3 response, and the Trust is now able to review a suite of ranking tables for Job Cycle Time at Operational Unit level. The operational leadership team reviews and manages Job Cycle Time as appropriate, focusing on the lowest and highest times at present. Work is continuing to be able to report on this metric by team and individual.



In September there was a decrease of 100 hours lost >30 minute turnaround compared to August. Comparing overall hours lost >30 minute turnaround in September 2019 with September 2018, there was an 11% increase in hours lost >30 minute turnaround.

In September 12.2% of patients waited between 30 and 60 minutes for a hospital handover and 1.1% of patients waited over 60 minutes.

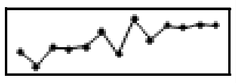
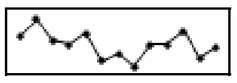
The Ambulance Handover Steering Group continues to meet local joint hospitals and SECAmb operational meetings are also continuing.

The steering group is also linking in with the National Programme, and is receiving support from the regional NHSE/I team.

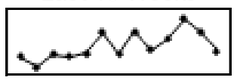
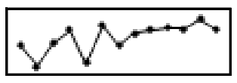
SECAmb unvalidated weekly Response Time Performance

SECAmb Weekly Operational Performance - W/C 28th October 2019

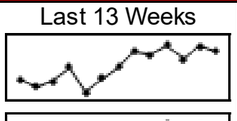
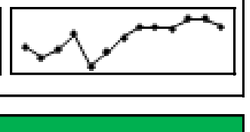
CAT 1

	14/10	21/10	28/10	Last 13 Weeks
Mean	00:07:47	00:07:58	00:07:40	
90th Centile	00:14:31	00:14:42	00:14:39	
RPI	1.55	1.50	1.52	
Count of Incidents	879	885	937	

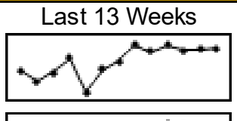
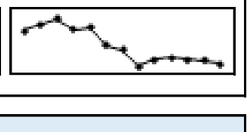
CAT 1T

	14/10	21/10	28/10	Last 13 Weeks
Mean	00:10:05	00:09:41	00:09:06	
90th Centile	00:17:58	00:18:30	00:17:56	
RPI	1.57	1.52	1.51	
Count of Incidents	560	577	619	

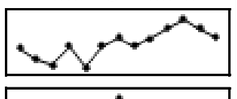
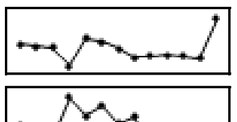
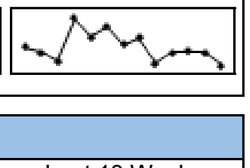
CAT 2

	14/10	21/10	28/10	Last 13 Weeks
Mean	00:19:46	00:20:49	00:20:24	
90th Centile	00:37:29	00:39:38	00:38:29	
RPI	1.06	1.06	1.06	
Count of Incidents	8141	8131	7923	

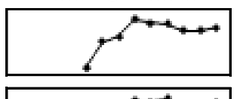
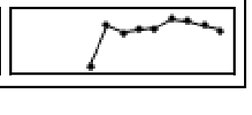
CAT 3

	14/10	21/10	28/10	Last 13 Weeks
Mean	01:40:00	01:41:21	01:41:42	
90th Centile	03:59:11	03:50:55	03:57:09	
RPI	1.05	1.05	1.05	
Count of Incidents	4157	4143	4094	

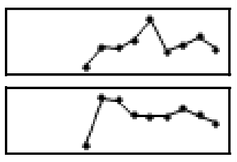
CAT 4

	14/10	21/10	28/10	Last 13 Weeks
Mean	03:12:10	02:51:15	02:30:40	
90th Centile	05:32:00	05:20:59	05:50:06	
RPI	0.87	0.86	1.10	
Count of Incidents	92	91	77	

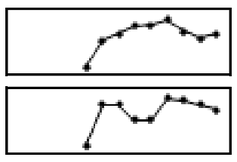
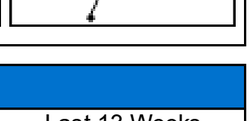
HCP Level 3

	14/10	21/10	28/10	Last 13 Weeks
Mean	02:16:12	02:16:46	02:21:30	
90th Centile	04:41:30	05:02:47	05:19:55	
Count of Incidents	283	273	259	

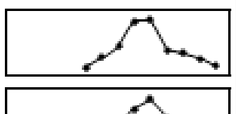
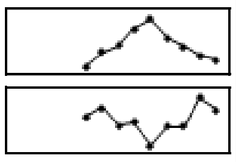
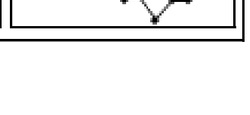
IFT Level 3

	14/10	21/10	28/10	Last 13 Weeks
Mean	02:30:01	02:39:56	02:22:46	
90th Centile	05:22:00	06:06:08	05:01:07	
Count of Incidents	145	136	124	

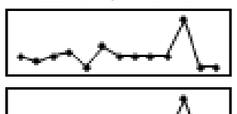
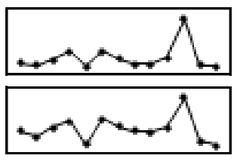
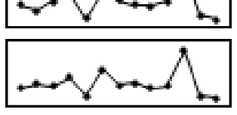
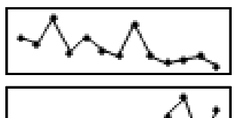
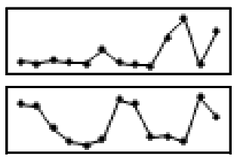
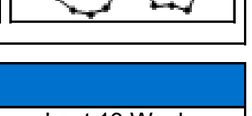
HCP Level 4

	14/10	21/10	28/10	Last 13 Weeks
Mean	03:18:25	03:08:45	03:06:30	
90th Centile	06:37:03	06:09:13	06:30:01	
Count of Incidents	262	252	241	

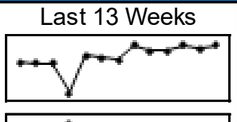
IFT Level 4

	14/10	21/10	28/10	Last 13 Weeks
Mean	03:07:18	02:51:40	02:26:36	
90th Centile	06:53:27	05:35:48	04:54:56	
Count of Incidents	33	53	44	

999 Call Handling

	14/10	21/10	28/10	Last 13 Weeks
Mean Call Pickup Time (Seconds)	12	3	3	
Call Pickup Time 90th Percentile (Seconds)	44	2	1	
Call Pickup Time 95th Percentile (Seconds)	72	17	12	
Call Pickup Time 99th Percentile (Seconds)	135	69	66	
Average Call Length (seconds)	360	361	358	
Abandon Rate	0.80%	0.08%	0.60%	
Staff Hours Provided Vs 4783 target	95.8%	105.9%	101.3%	

Incident Outcome

	14/10	21/10	28/10	Last 13 Weeks
See and Convey	62.9%	62.7%	62.9%	
See and Treat	31.9%	32.3%	31.2%	
Hear and Treat	5.2%	5.0%	5.8%	

Call Cycle Time

	14/10	21/10	28/10	Last 13 Weeks
Clear at Scene	01:16:05	01:18:08	01:16:48	
Clear at Hospital	01:49:02	01:49:11	01:49:12	
Hours Lost at Hospital	1089	1105	1084	

Community First Responders

	14/10	21/10	28/10	Last 13 Weeks
Volume of Incidents Attended	314	340	402	
Hours Provided	2285	2515	2570	

Demand/Supply

	14/10	21/10	28/10	Last 13 Weeks
999 Call Volume	15848	15669	15415	
Incidents	14685	14622	14462	
Transports	9247	9183	9123	
Staff Hours Provided Vs 65153 target	96.4%	95.6%	95.4%	

Our Partners

SECAmb 111 Operations Performance Scorecard

Calls Offered

	Jul-19	Aug-19	Sep-19	12 Months
Actual	73544	74832	68451	
Previous Year	87586	83359	84650	

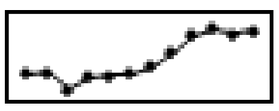
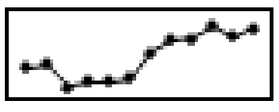
Calls answered in 60 Seconds

	Jul-19	Aug-19	Sep-19	12 Months
Actual %	71.8%	80.8%	78.5%	
Previous Year %	68.9%	83.7%	70.9%	
Target %	95%	95%	95%	

Calls abandoned - (Offered) after 30secs

	Jul-19	Aug-19	Sep-19	12 Months
Actual %	6.2%	3.6%	3.6%	
Previous Year %	5.7%	2.7%	6.0%	
Target %	5%	5%	5%	

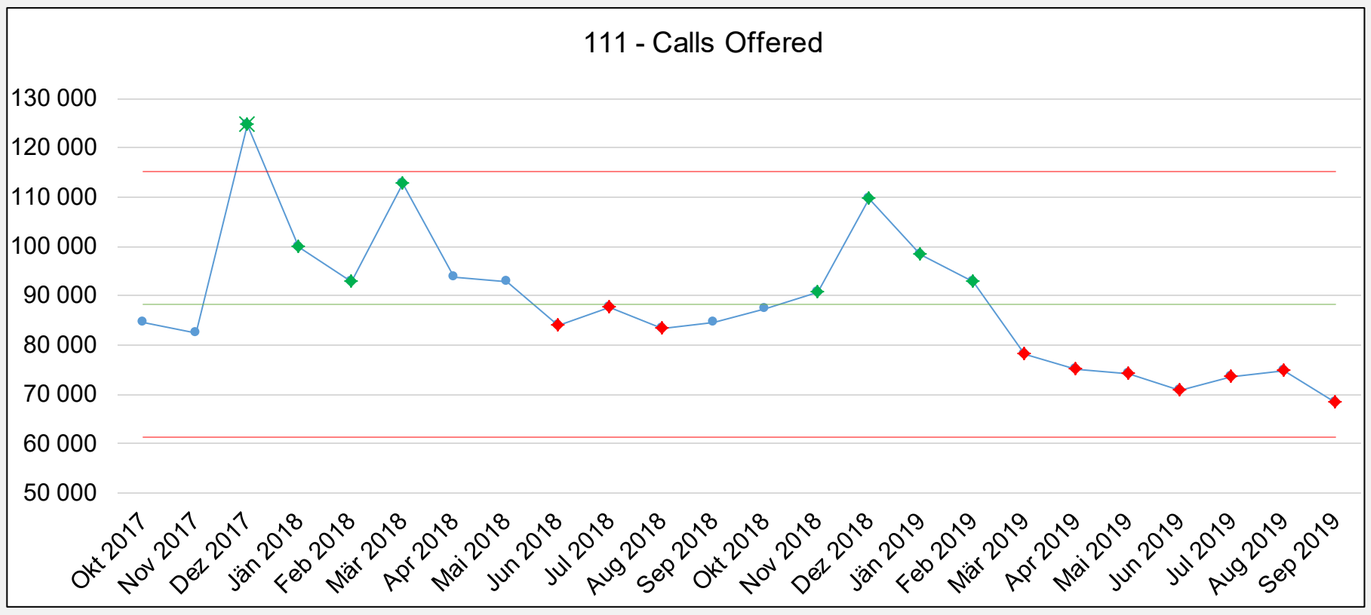
A&E Dispositions

	Mar-19	Apr-19	May-19	12 Months
A&E Dispositions % (Answered Calls)	8.2%	8.5%	9.2%	
A&E Dispositions (Actual)	5674	5808	5460	
National	7.7%	8.7%	9.1%	

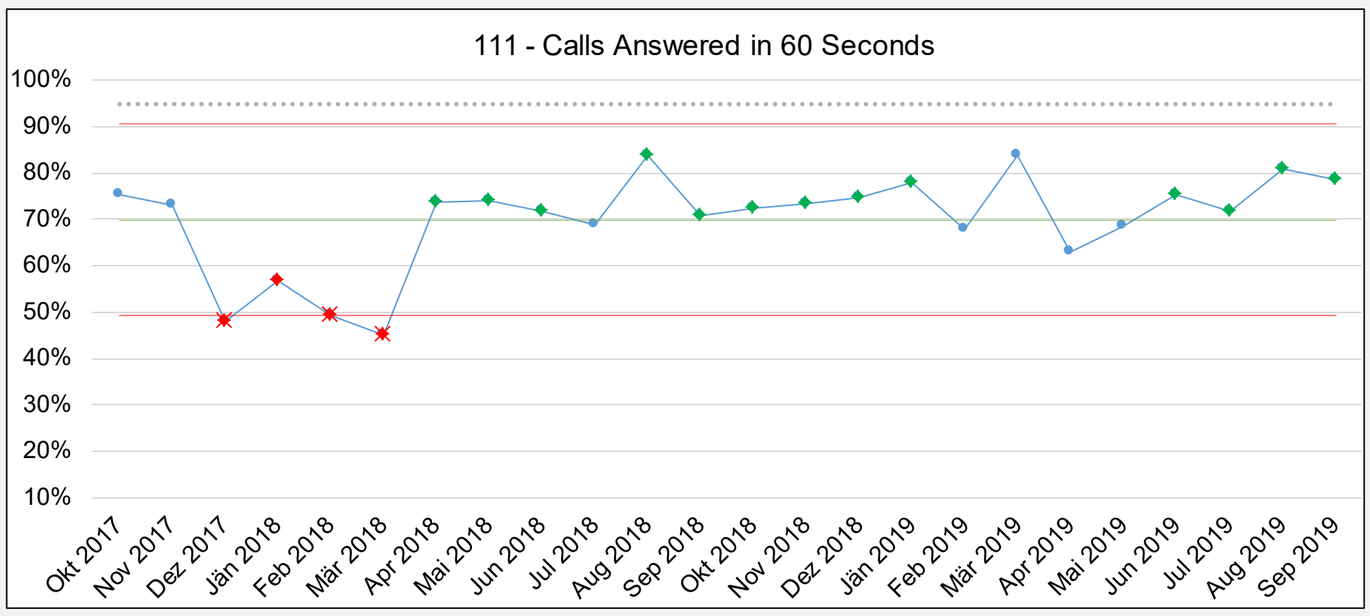
999 Referrals

	Jul-19	Aug-19	Sep-19	12 Months
999 Referrals % (Answered Calls)	16.1%	15.5%	16.1%	
999 Referrals (Actual)	8791	8961	8514	
National	13.6%	13.0%	13.7%	

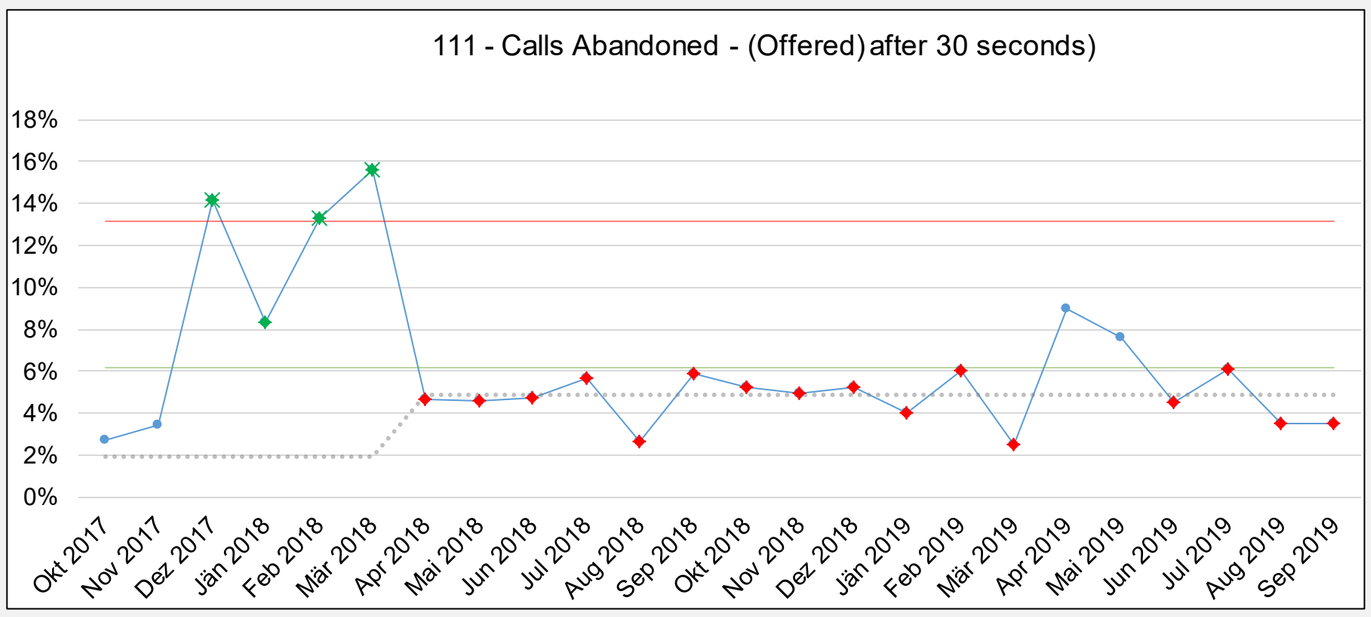
SECAmb 111 Operations Performance Charts



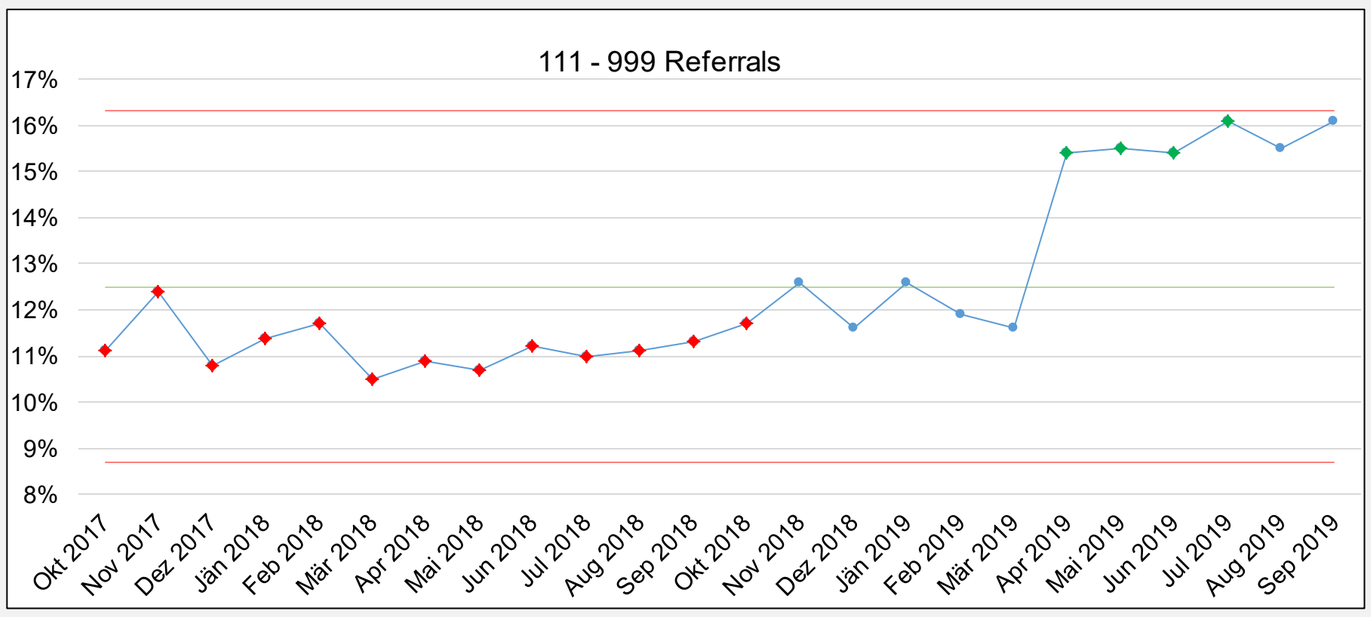
The call volume was 68451. Although overall call activity was in line with forecast, the intraday profiles were volatile and the wider system saw increased pressure during the second half of the month



The SEC 111 service delivered a service level of 78.50%. This is a slight month-on-month reduction in performance, however the underlying measures of Speed to Answer (49 seconds) and Average Handling Time (568 seconds) are both demonstrating increased productivity.



The Call Abandonment rate remained static at 3.6%.

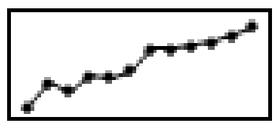
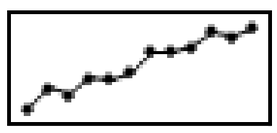
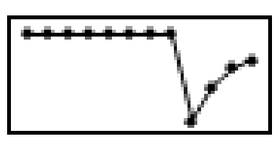


The 999 referral rate continues to be high. We validated 88% of Category 3 / Category 4 dispositions during September, and are focusing on improvement in call control to reduce the AMB rate. Conveyance rate, as a measure of appropriateness of referral, is higher than our peer group of providers.

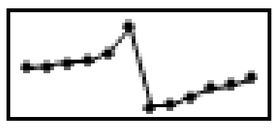
Our People

SECAmb Workforce Scorecard

Workforce Capacity

	Jul-19	Aug-19	Sep-19	12 Months
Number of Staff WTE (Excl bank & agency)	3541.6	3564.9	3602.1	
Number of Staff Headcount (Excl bank and agency)	3897	3879	3918	
Finance Establishment (WTE)	3768.39	3791.51	3803.68	
Vacancy Rate	6.02%	5.98%	5.30%	
Vacancy Rate Previous Year	13.78%	17.91%	16.21%	

Workforce Compliance

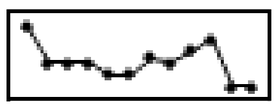
	Jul-19	Aug-19	Sep-19	12 Months
Objectives & Career Conversations %	28.68%	33.19%	38.60%	
Target (Objectives & Career Conversations)	80%	80%	80%	
Statutory & Mandatory Training Compliance %	43.84%	50.47%	55.74%	
Target (Stat & Mand Training)	95%	95%	95%	
Previous Year (Stat & Mand Training) %	58.99%	70.83%	75.50%	

* 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

	Jul-19	Aug-19	Sep-19	12 Months
Annual Rolling Turnover Rate %	15.01%	15.62%	15.52%	
Previous Year %	15.37%	14.97%	14.88%	
Annual Rolling Sickness Absence	5.36%	5.45%	5.43%	
Target (Annual Rolling Sickness)	5%	5%	5%	

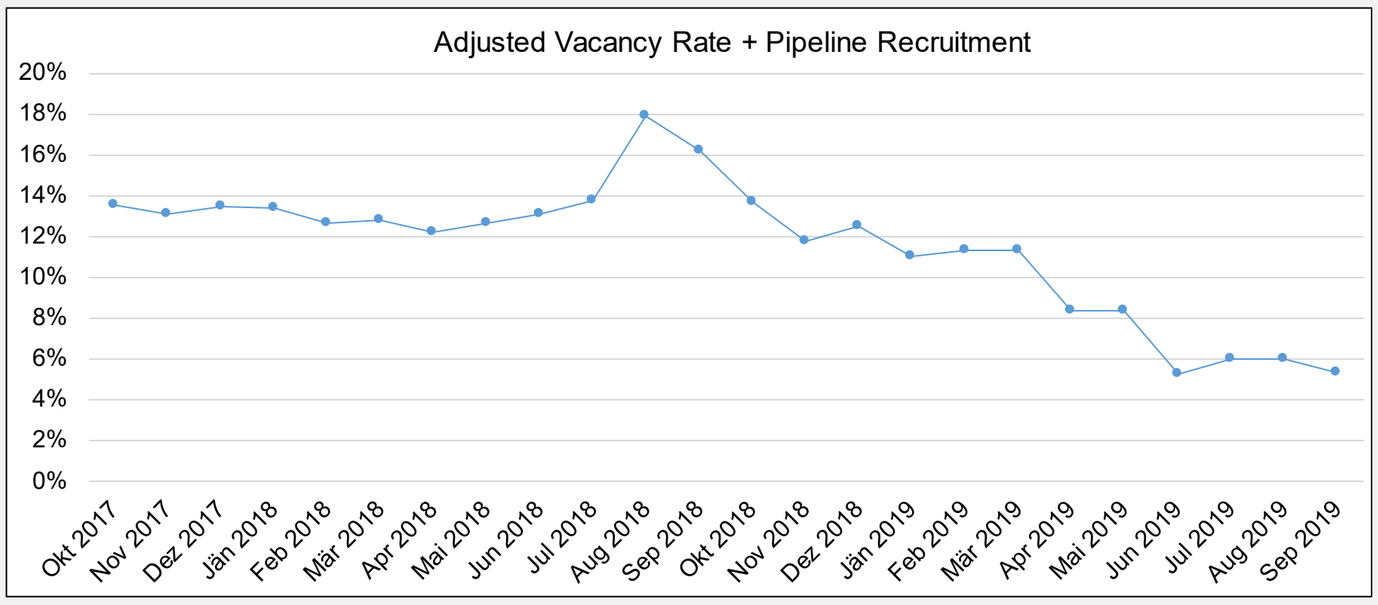
Employee Relations Cases

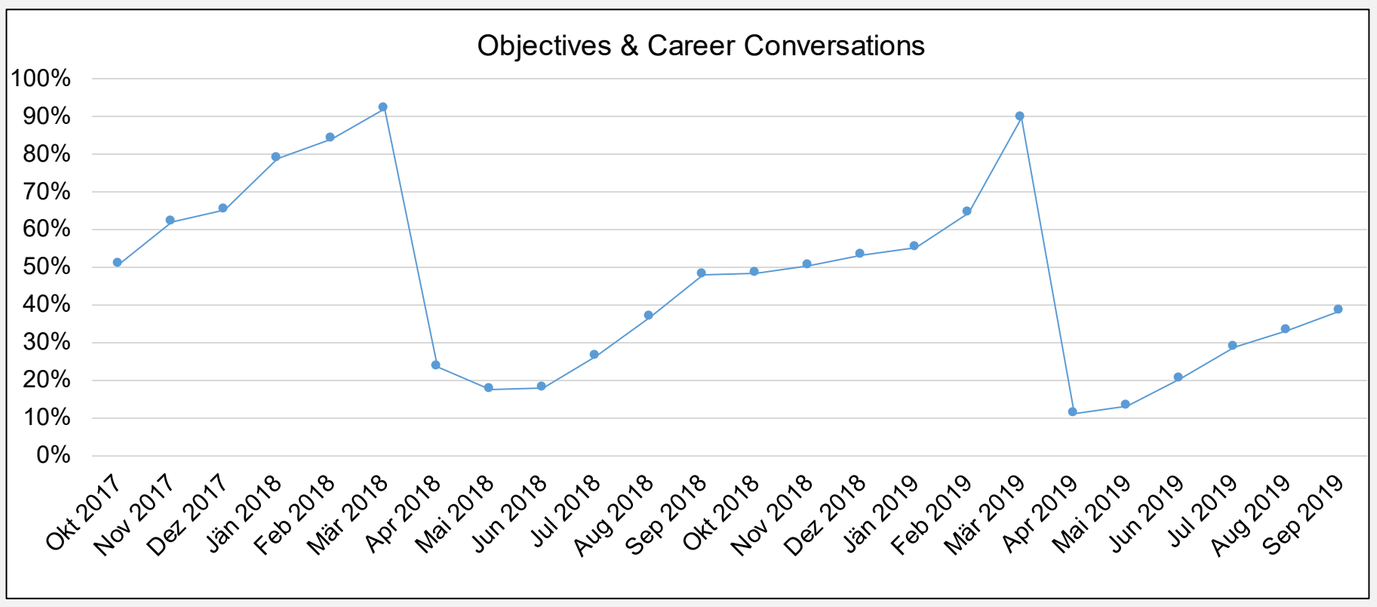
	Jul-19	Aug-19	Sep-19	12 Months
Disciplinary Cases	8	0	0	
Individual Grievances	12	0	2	
Collective Grievances	1	0	1	
Bullying & Harassment	2	0	1	
Bullying & Harassment Prev Yr	2	1	2	
Whistleblowing	0	0	0	
Whistleblowing Previous Year	1	0	0	

Physical Assaults (Number of victims)

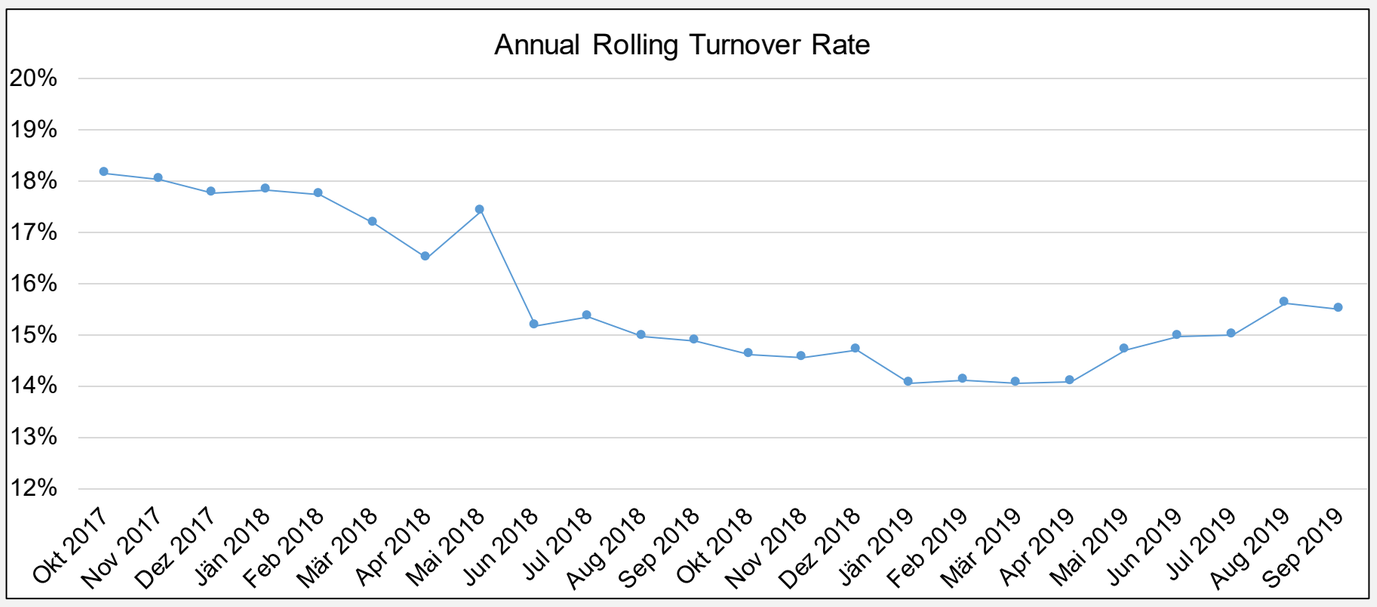
	Jul-19	Aug-19	Sep-19	12 Months
Actual	19	38	25	
Previous Year	21	24	9	
Sanctions	4	9	2	

SECAmb Workforce Charts



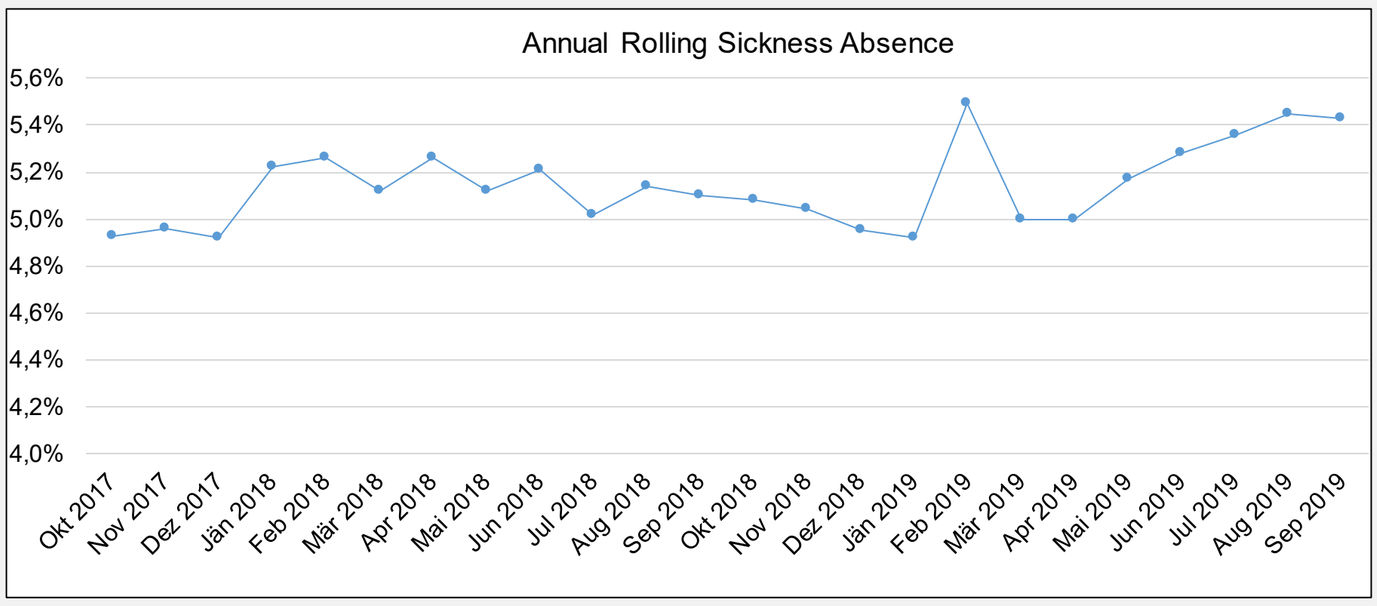


In December we will shortly be introducing as a pilot a new Appraisal form, which has been designed to simplify the process, be more user friendly, and enable us report more effectively and accurately. Work continues to focus on improving the % of appraisals having been started in 19/20 since we are c 10% points lower than the equivalent period least year.

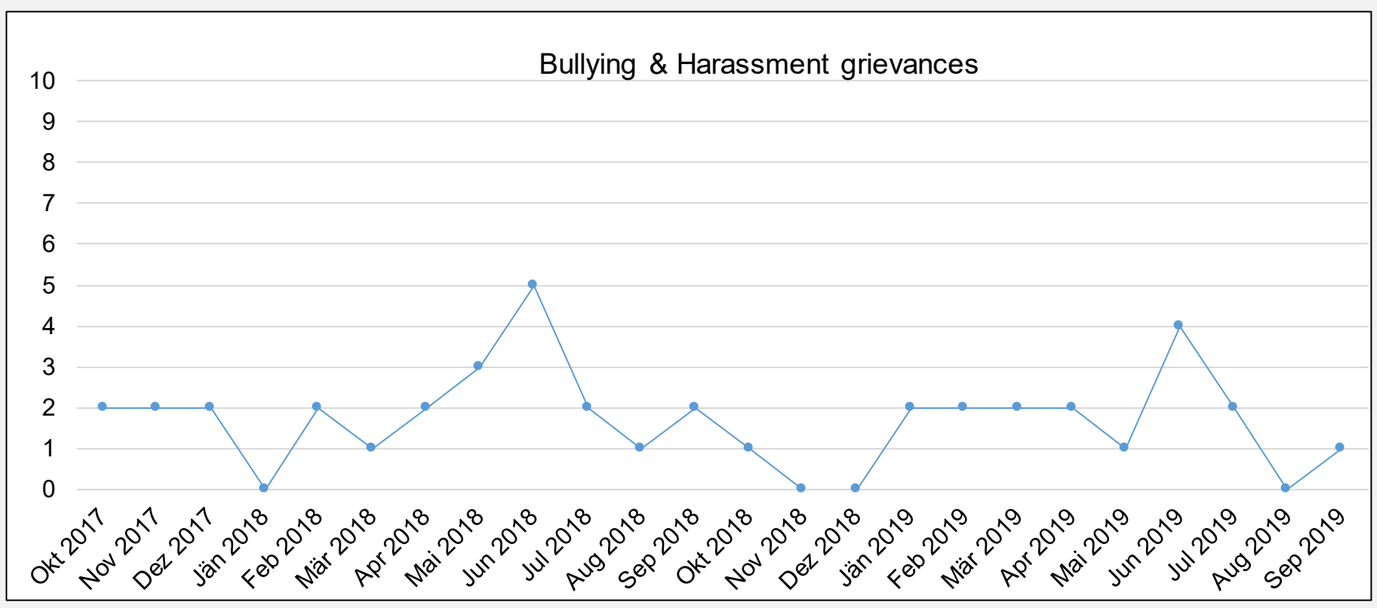


The rolling 12 month turnover rate is 15.52% which compares pares to 14.9% at September 2018.

We are piloting changes to the recruitment processes within EOC and 111 during Q4 and are producing a retention strategy's for EOC and 111 and paramedics to be reviewed by EMB in January.



Absence is 5.40% , compared to 5.1% at September18. This level is in line with the average for all Ambulance Trusts



The level of cases continues to fluctuate within normal variation.

Our culture work continues to focus on our aim to reduce the levels of poor behaviour in the workplace and during Q4 will be introducing our values toolkit, new leadership development, improved induction, a behaviours video and 360 degree feedback for leaders.

All these are focussed on improving behaviour in the workplace

Our Enablers

SECAmb Finance Performance Scorecard

Income

	Jul-19	Aug-19	Sep-19	12 Months
Actual £	£ 20,801	£ 19,995	£ 19,553	
Previous Year £	£ 18,211	£ 18,830	£ 17,589	
Plan £	£ 21,005	£ 20,293	£ 19,837	

Expenditure

	Jul-19	Aug-19	Sep-19	12 Months
Actual £	£ 20,864	£ 20,271	£ 20,095	
Previous Year £	£ 18,122	£ 19,341	£ 18,402	
Plan £	£ 21,091	£ 20,562	£ 20,391	

Capital Expenditure

	Jul-19	Aug-19	Sep-19	12 Months
Actual £	£ 1,790	£ 1,270	£ 989	
Previous Year £	£ 238	£ 795	£ 555	
Plan £	£ 1,635	£ 1,644	£ 1,609	
Actual Cumulative £	£ 5,016	£ 6,286	£ 7,275	
Plan Cumulative £	£ 6,956	£ 8,600	£10,209	

Cost Improvement Programme (CIP)

	Jul-19	Aug-19	Sep-19	12 Months
Actual £	£ 580	£ 1,078	£ 534	
Previous Year £	£ 1,200	£ 517	£ 1,242	
Plan £	£ 781	£ 781	£ 781	
Actual Cumulative £	£ 1,988	£ 3,066	£ 3,600	
Plan Cumulative £	£ 2,426	£ 3,207	£ 3,988	

CQUIN (Quarterly)

	Q4 18/19	Q1 19/20	Q2 19/20
Actual £	£ 1,088	£ 648	£ 646
Previous Year £	£ 2,745	£ 871	£ 870
Plan £	£ 870	£ 654	£ 654

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

Surplus/(Deficit)

	Jul-19	Aug-19	Sep-19	12 Months
Actual £	-£ 62	-£ 276	-£ 542	
Actual YTD £	-£ 2,315	-£ 2,591	-£ 3,133	
Plan £	-£ 86	-£ 269	-£ 554	
Plan YTD £	-£ 2,344	-£ 2,613	-£ 3,167	

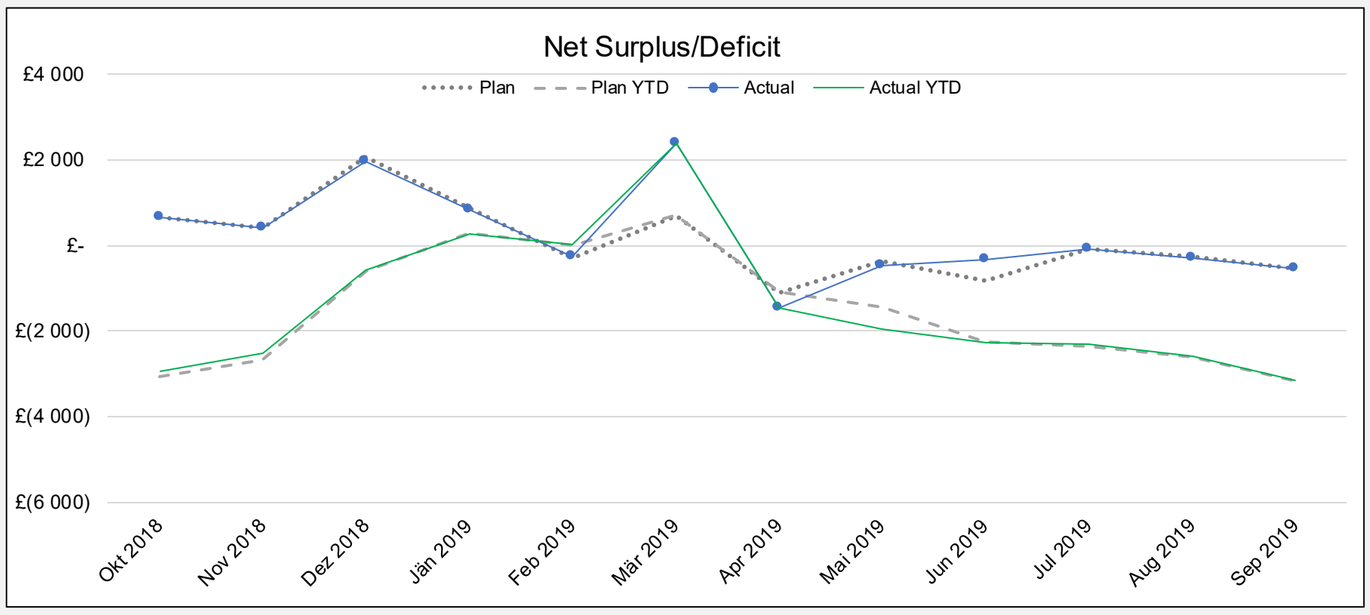
Cash Position

	Jul-19	Aug-19	Sep-19	12 Months
Actual £	£ 22,780	£ 24,597	£ 24,561	
Minimum £	£ 10,000	£ 10,000	£ 10,000	
Plan £	£ 13,610	£ 11,089	£ 8,840	

Agency Spend

	Jul-19	Aug-19	Sep-19	12 Months
Actual £	£ 625	£ 152	£ 243	
Plan £	£ 282	£ 277	£ 273	

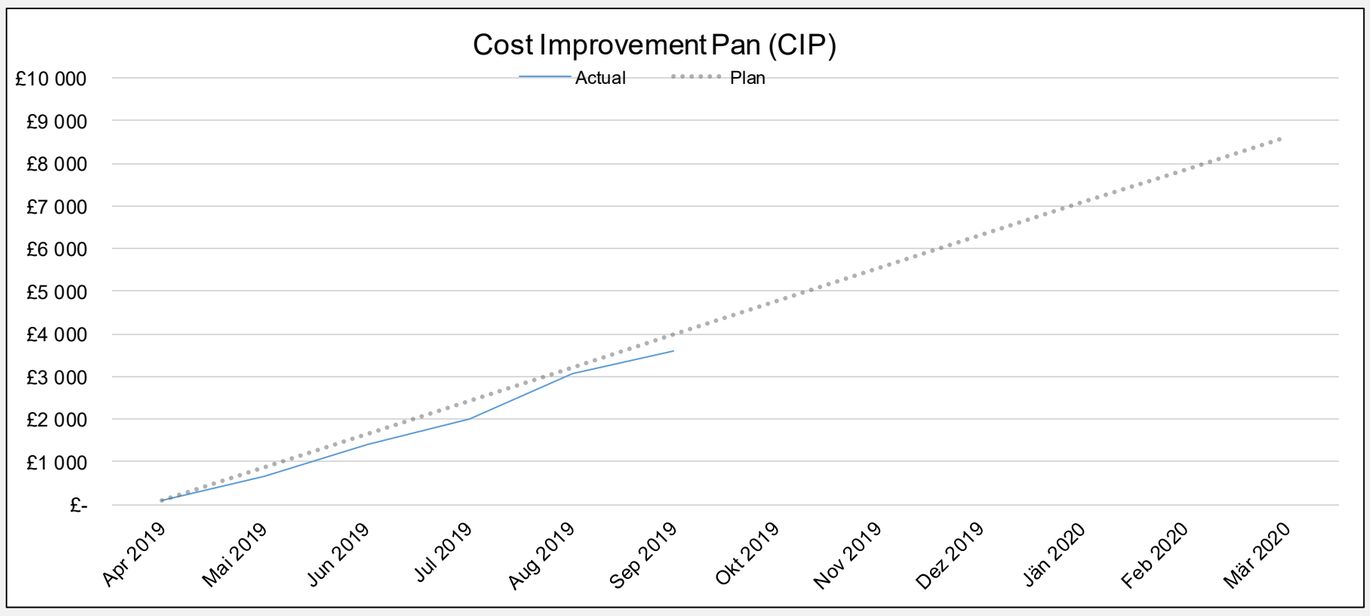
SECAmb Finance Performance Charts



The Trust's I&E position in Month 6 was a deficit of £0.5m, which is as planned.

Year to date the deficit was £3.1m, as planned.

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



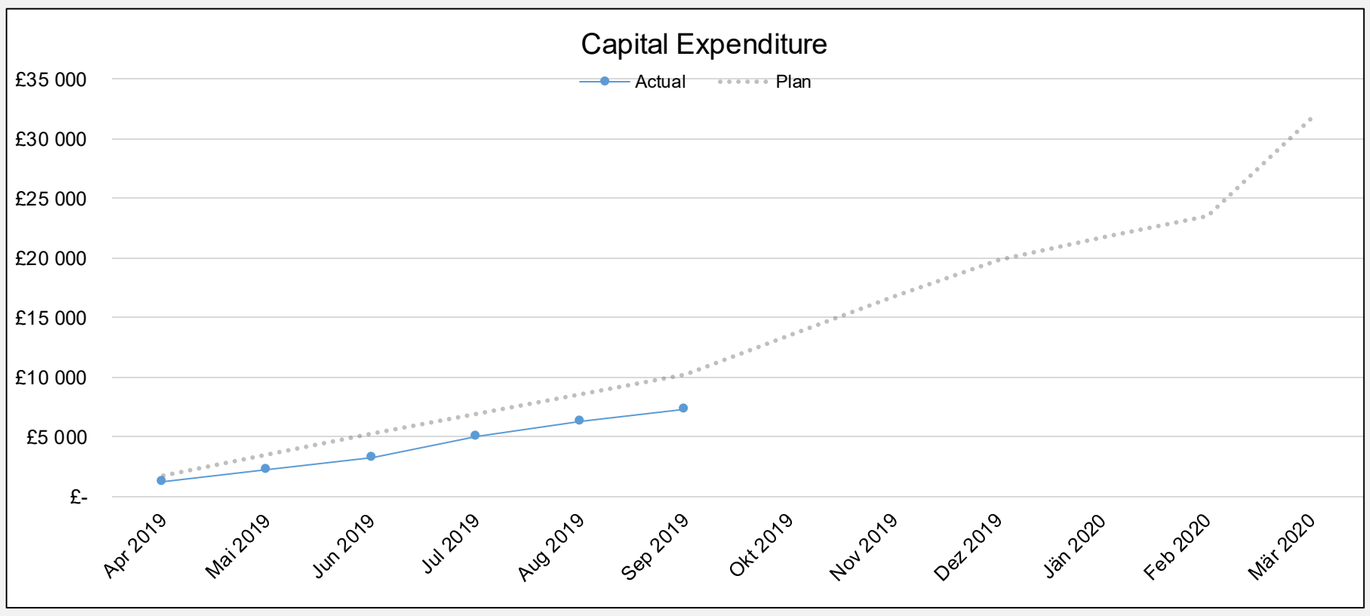
CIPs to the value of £0.5m were achieved in August, against a plan of £0.8m.

Year to date achievement is £3.6m, which is £0.4m behind plan.

The shortfall relates to handover delays. Alternative schemes are being developed to mitigate this shortfall.

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.

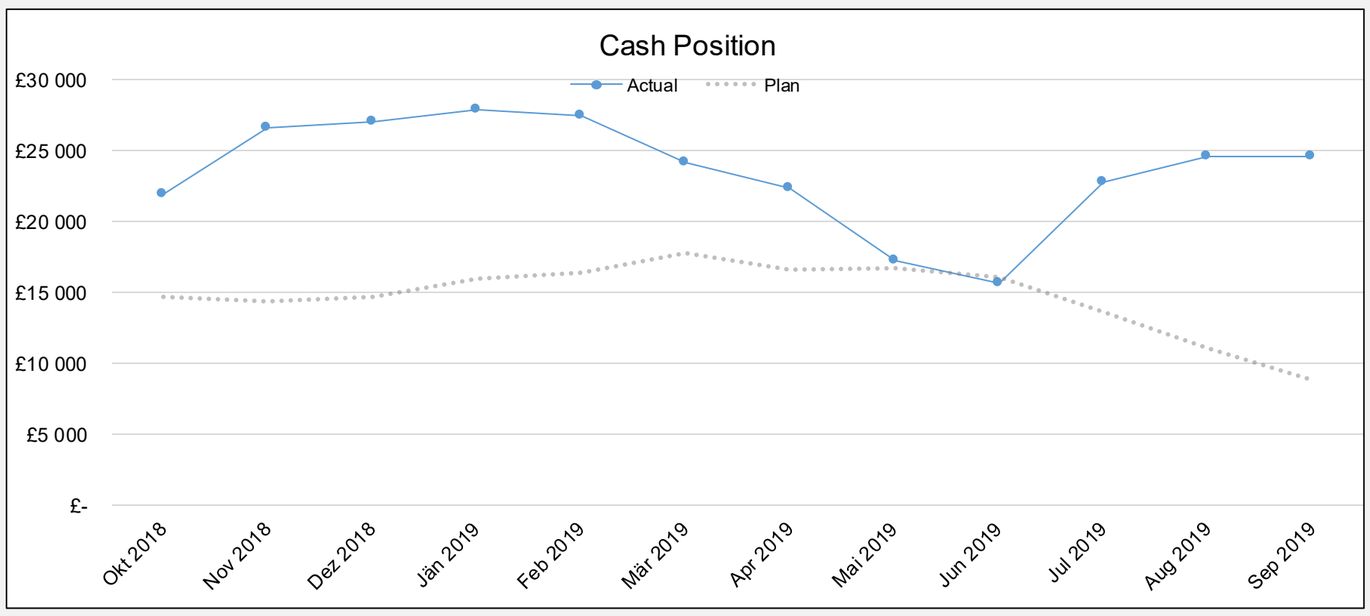


Capital expenditure for the month of September was £1.0m, £0.6m lower than planned.

Year to date expenditure is £7.3m, £2.9m below plan.

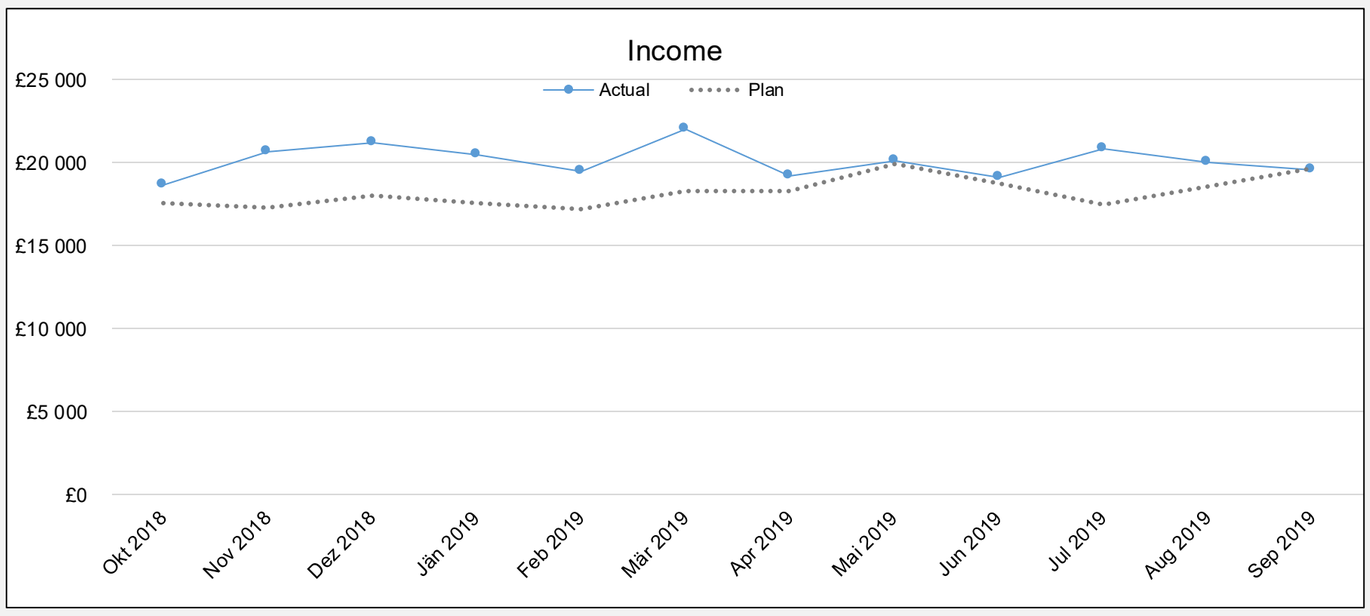
This shortfall is one of timing, partly due to pending approval of business case funding for the 'Wave 4' capital bids.

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 30 September 2019 was £24.6m, which was £15.7m greater than planned. PDC dividend payment of £0.4m was offset by a reduction in non-pay expenditure in month.

Performance for the year to date against the 'Better Payment Practice Code', measured by payment of suppliers within 30 days of a valid invoice, was 95.4% by value against a target of 95.0%.

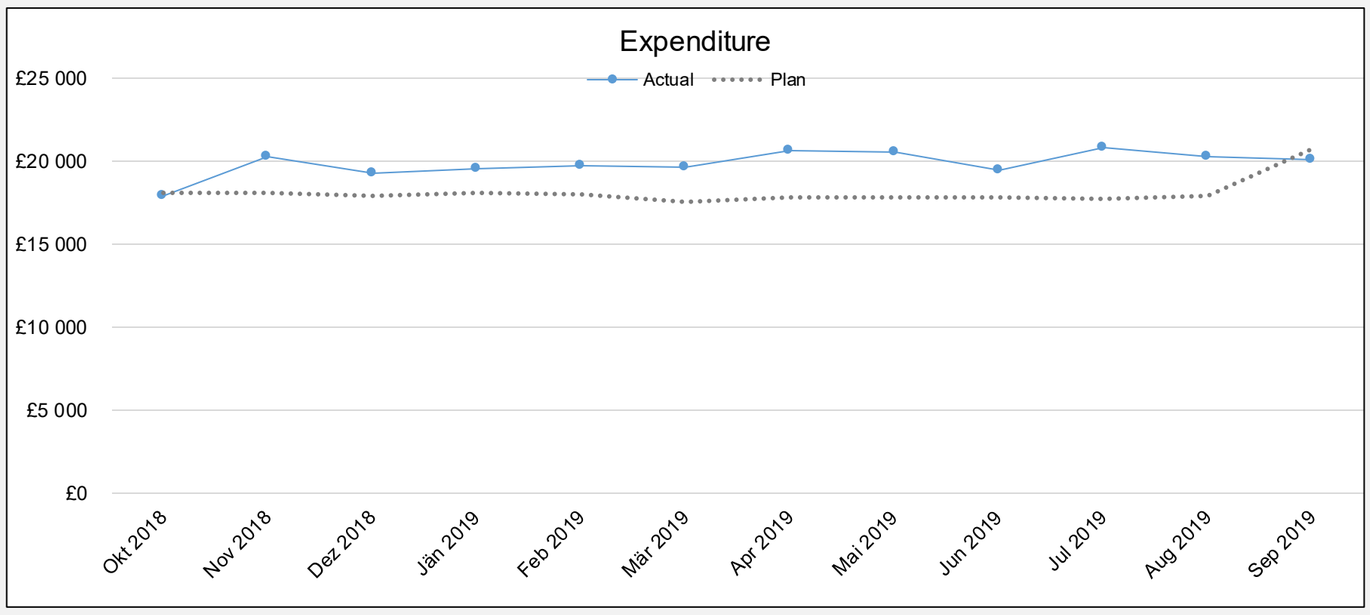


Income for the month of September was £19.6m, which was £0.3m worse than plan.

Year to date income was £118.8m, £1.8m below plan.

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

SECAmb Finance Performance Charts



Total expenditure for the month of September was £20.1m, which was £0.3m less than planned.

Year to date expenditure was £121.9m, £1.8m below plan.

Pay costs were as planned in the month, year to date is £1.1m behind plan, mainly through reduced frontline hours provided, EOC and Clinical Team vacancies.

Non pay costs were £0.3m lower than plan in the month and £0.7m lower for the year to date. Increased costs in support costs (mainly fleet and estates) are mitigated by the release of dilapidation provision of £0.7m.

Financing costs are as planned.

SECAMB Board

QPS Committee Escalation report to the Board

Date of meetings	24 October 2019
Overview of key issues/areas covered at the meeting:	This meeting was Chaired by Laurie McMahon, as Tricia McGregor was not able to join the meeting in person; instead taking part by teleconference. This meeting considered a number of ***Management Responses*** (*response to previous items scrutinised by the committee)*, including: **CAS Alerts Assured** The committee was assured by the process in place to manage alerts; specifically those that come through out of hours. On an annual basis the committee will ask for an assurance statement, with evidence that the process is working effectively. **SI Investigations Partial Assurance** This related to the extent to which there is timely closure/actions from the learning identified from SIs. Partial assurance was obtained on the basis of the relatively new process in place. However, the committee remains concerned by the high number of actions still open; some are very old, and so has asked for a further management response to confirm progress. The committee acknowledged the context to this where it has been difficult to unpick historical practice and in obtaining the evidence to enable closure of some of the SIs that pre-dated many of the current staff. It therefore supported management to take a pragmatic view on some of these actions, especially those several years old. **Key Skills Delivery Not Assured** The paper received by the committee helped to quantify the risk by OU, of delivering all of Key Skills. There is greater confidence in some areas compared with others, with the view of management being that, subject to some risks, the majority of OUs should be able to deliver by April 2020; two specific OUs were assessed as requiring 4-5 weeks longer. The committee received comfort by the way management is prioritising specific elements of training. For example, the medical director explained that some elements that are more safety-related, such as resuscitation, are prioritised over some of the other elements more quality-related, where the focus is on reinforcing existing practice. This is in the context of needing to continually balance the need for abstracting staff at a time when there are operational performance challenges. The planning for 2020/21 Key Skills will be reviewed by the committee in January 2020, to help ensure there is careful planning for abstraction, acknowledging the balance of risk between abstracting for training and ensuring maximum hours to ensure operational performance/quality.

	Overall, and in the context of the existing risks and the unknown (EU Exit) the committee could not be assured that Key Skills will be delivered. However, it was assured by the way management is seeking to prioritise. **Operating Model (right staff at right time) Assured** The committee explored how management uses data to allocate the resources to best effect. It was impressed by the way operations uses the rich data that is available. It noted the balance between offering flexible working in a way that meets needs of patients, and supported the ongoing policy work to ensure the right balance is struck. **Agile Working Assured** The committee received assurance that following agile (home/remote) working for clinicians, no adverse clinical safety incidents have been reported as a result. It acknowledged that workforce committee is reviewing this from a HR perspective, and that this type of agile working has been in place for some time in 111. The committee is assured it is working as intended and that there are no issues. **EOC Complaints Not Assured** There is still a significant backlog of complaints. While it was reassuring to hear that more resource has been secured to deal the backlog, with a clear timeline, the committee could not be assured until the targets are back on track. 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 Partial Assurance** The focus this meeting was on clinical recruitment and welfare check compliance. In terms of clinical capacity, the Trust remains fully compliant with the NHS Pathways license. However, in relation to quality, to help close the gap while recruitment continues there is use of BANK and agency. Going forward the committee has asked for a breakdown of actual clinical hours versus the target / what is planned. The committee is currently unable to confirm it assurance in relation to welfare calls due to the way the data is captured. It has therefore asked for a management response to show a timeline to develop this data so that it is clearer whether we are complying with the requirements. EOC has been a standing agenda item now for several months and this latest update helped to demonstrate the good level of understanding that exists about where there continue to be challenges. Specifically, the committee received much comfort by the governance and management oversight and grip that is in place. One of the continuing challenges is with welfare calls and clinical reviews, and while some improvement was noted the committee will continue to monitor this to ensure it continues.

Frequent Callers Assured
The number of frequent callers is increasing and the individual risk assessments help to ensure we can prioritise the individuals we need to develop plans for. The committee is assured that all plans are in place for all frequent callers that have been identified as needing one. It noted that a new strategy is being developed and it will review progress in six months' time.

Patient Records / EPCR Assured
In the context of the false start with EPCR in 2016/17, the committee is really pleased to be assured by the good progress being made with implementing EPCR; over 50% of patient care records are now electronic.

QIA (mid-year review) Partial Assurance
An update was received on the now well-established QIA process; from April to September 2019 352 QIAs have been completed.

The committee could not be fully assured as the paper omitted to include the number of changes not initially approved and/or rejected, on the basis of the assessed impact on quality. This is being provided at the next meeting.

In addition, while the process is well-embedded, there are still occasions where management identify changes that have been made without a QIA. When identified these are done retrospectively, and the committee has asked for a management response on this, to confirm the action being taken to ensure all staff are aware of the requirement.

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

Clinical Audit Review
The committee noted that the audit programme is on track, although there was some discussion about developing the "so what"– how it is making a difference to patients.

Quality Account
The Q1 update confirmed that progress against the priorities are on track to deliver. The committee was assured that the priority on cardiac arrest is not affected by the issue with key skills, as it is one of the areas prioritised.

For the next update the committee has asked management to demonstrate more clearly the impact of the actions being taken.

Learning from Deaths Policy
The committee acknowledged that this policy follows a national template. It was supportive and recommends it to the Board for approval.

The committee explored the issue of 'responsible NED' and felt that this probably ought to be a member of the committee, if not the Chair, on the basis that it is about assuring delivery, which is the role of the committee. It will regularly test the compliance and effectiveness of the policy.

Any other matters the Committee wishes to escalate to the Board	During Q4 the TOR will come to the Board, along with the other board committees, but in the meantime the committee is planning to move from 6 weekly to bi-monthly meetings, to align with the frequency of the other main board committees.

SECAMB Board

Finance and Investment Committee Escalation report to the Board

Date of meetings	17 October 2019
Overview of key issues/areas covered at the meeting:	**999 Performance Not Assured** The committee explored the steps being taken to help ensure improvement in operational performance. A very detailed update was provided by the director of operations, setting out the areas of focus within the recovery plan. This includes specific attention to efficiency metrics, such as responses per incident (RPI), job cycle time and those related to ensuring more available resources, i.e. hours booked on. In overall terms, there is good progress against the efficiency metrics, for example RPI was at a level that difficult to improve on and job cycle time is 5 minutes short of the target. However, there continue to be challenges in getting the right number of hours booked on, although the incentive scheme for specific shifts has helped ensure better utilisation of hours, such as at weekends. Management very clearly demonstrated to the committee that it is now data-led. This is helping with understanding the issues and therefore where to focus. For example, the data helps to demonstrate the correlation between training abstraction increasing from September, and a downturn in performance. The committee is aware of the scrutiny provided by the quality committee, on the delivery of key skills and the difficult balance there is between arranging abstraction and ensuring maximum hours. The committee also noted that investment in the recruitment pipeline is helping to ensure the Trust is at least meeting, in overall terms, the numbers planned as part of the demand and capacity review. However, there is significant shortfall of PAP hours, against the same plan, hence the shortfall in hours booked on. The committee challenged the executive to be clearer with its expectations on when it reasonably believes we are likely to meet the ARP targets. It asked for a trajectory so that it and the Board understands what it can expect, and it can then hold management to account for the same. The committee also asked for this so the Board could be clear with commissioners. It was told that there is a workshop being held with Deloitte / ORH to re run the model with more accurate assumptions and current ARP data. This will determine the trajectory. There was then a detailed discussion about the gap in hours, which the committee acknowledged was complex and multi-factorial; it asked the executive to provide a clear story that narrates this and draws the link between workforce and performance. In summary, the committee is assured that the executive has identified all the major issues to be tackled to achieve sustained performance. It recognised that the next six months will be difficult, but felt that management is doing all it we can to ensure timely response to patients. A clear communication plan is required to ensure key stakeholders understand the issues and what we are doing to address them, and to ensure expectations are managed.

	111/CAS **Partial Assurance** An update was provided on the progress with finalising the prime and sub-contracts. The committee sought assurance that the key risks are being mitigated as far as reasonably practicable. No specific concerns were escalated by the executive at this stage. In terms of mobilisation the committee asked for a paper that sets out the plan / timetable and the governance arrangements. **EU Exit** **Assured** The committee noted the plans to prepare for EU Exit (which at the time of the meeting was scheduled for 31 October 2019, and explored the principal risks. The committee was assured that the Trust was as well prepared as it could be in what is a very difficult and high risk situation. **Finance** **Partial Assurance** At month 6 we are still on plan. However, the committee is ware that the end of year position relies on discussions with commissioners about the income shortfall. In meantime, management is ensuring there is grip on the internal efficiencies. In terms of the cost improvement programme (**CIP)** while the committee noted that we are on track for delivery against the target at M6 much of this is non-recurrent. A different approach is needed for 2020/21 to ensure more transformational change.
Any other matters the Committee wishes to escalate to the Board	The committee reviewed the current assumptions underpinning the **Financial Long Term Plan**, which was received by the Board at its meeting on 31 October 2019. As confirmed then the committee explored the CIP assumptions and the significant challenge this will be. The **Fleet Strategy Implementation Plan** was not received as planned, due to other priorities, including planning for EU Exit. The plan is to bring this to the meeting on 14 November.

SECAMB Board

Finance and Investment Committee Escalation report to the Board

Date of meetings	14 November 2019
Overview of key issues/areas covered at the meeting:	This meeting focussed on three areas: **Fleet Strategy Implementation Plan** **Partial Assurance** A high level update was given outlining the approach to the fleet strategy implementation plan. This will be informed by Deloitte / ORH workshop in December 2019, which will determine the final plan. In the context of the assumptions in the demand and capacity review, the committee tested the extent to which they are being met, and confirmed that the Trust is ahead of schedule; there have been over 100 new fleet added in the past 12 months. However, despite having the number of vehicles they are not always in the right place and so operations is looking at how to better utilise the fleet. The committee noted that while it has previously commended management for being data-led, it was not sure confident this is the case when it comes to vehicle utilisation. It acknowledged the plans to remedy this, with the new fleet system helping to ensure data informs decision-making and planning. The aim is that this will be in place by January 2020, The committee is confident that we are moving forward and will review the plan at its next meeting. **EPCR** **Assured** An update was received on the current position, with the plan to have full roll out by the end of November being on track. The KPI is that by the end of 2019/20 60% of EPCR forms will be used; at the meeting the figure was 62.6%, so well ahead of plan. Phase 2 of the project will focus on the use of EPCR from the perspective of quality. **111/CAS** **Assured** As agreed by the Board on 31 October, the committee sought assurance on the main areas, such as IT, deliverability, contract conditions, finance, and the risk and contingency planning. It was assured that there has been considerable review of the contract and was confident that the Trust is now in a position to sign the contracts, subject to the Chairman having sight of the legal report that will follow.
Any other matters the Committee wishes to escalate to the Board	None.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	**21 November 2019**
Overview of issues/areas covered at the meeting:	Two governors were in attendance. Attendance by staff was, as always, good and papers of a good standard. The meeting was quorate. Before the formal start of the meeting, a number of telephone presentations were received (from the EOCs East and West and the 111 service) on the work being done to address issues raised in last year's staff survey and to address the underlying issues. 111 had a focus on morale and staff engagement. Some concerns with regard to duplicating work on attendance with HR interventions, so not a focus for 111. Maximise use of wellbeing hub – discussed with all staff. Waiting for data but confident it is being used well and proactively. Quality of appraisals – linking training to targeted needs with a menu of options available. In early stages due to operational pressures but packages now in place. EOC (East) four main areas – health and wellbeing, morale appraisals, attendance and staff engagement. Focus on staff engagement with initial meeting but poorly attended. Introduced one a week dial-in session – *Call Cinical* – but tends to be same staff using it. Focus now moving to appraisals and 1-1 meetings to ensure there is a quality understanding of how staff feel but staff shortages placing pressure on the system to make time available for face to face meetings. New rota in place to equalise opportunities for day and night shift staff and giving better cover for duty clinical navigator. Home working for clinicians to be introduced to allow greater flexibility in filling rota time – morale should show improvement next year because of the greater support and flexibilities introduced. Appraisals should reveal the key areas and the importance of the appraisal processes reinforced EOC (West) has a similar plan – morale would seem to relate mostly to annual leave structure and the restructure. This is now being addressed – speaking about career opportunities seems to have had a positive impact on morale. Drop-in sessions as well as formal meetings with staff in place so many channels of communications now available. Very high rates of survey return. Quality issues seem to relate to patient waiting time and the clinical risk. Addressed through an increased support for leadership – dealing with difficult conversations, and so on. Changes in policies now involve working groups so staff feel engaged and can shape 'their EOC'. This will also impact on morale. No recent grievances and linked directly to this work. The Action Log is used to monitor various strands of work, rather than expecting papers for all items, to reduce the drafting load on staff. Good progress is evident in a number of priority areas including: Development of a suite of KPIs for WWC (now for Jan WWC); Leavers' processes (Jan WWC); Paramedic retention strategy (Jan WWC); Induction processes for student paramedics; and, Workplace Disability Standards.

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;

HR Transformation Programme **Assured**

To reduce workloads on staff, WWC receives the Minutes of the Transformation Programme Board at each meeting. E-expenses (including driving license checks) 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/April. The impact of manager self-serve will have significant implications for how the Trust works and will need further consideration. Properly implemented, these will have the ability to address the key issues of concern to this Committee. The Committee felt from the evidence presented there is a good grip on this work, and that the rate of progress is satisfactory. The programme is coming-in slightly under budget. The Board will receive a formal update as part of the Delivery Plan.

WWC noted that the issue of holiday pay for staff required to do overtime is yet to be resolved with the intention to put a provisional settlement to staff by the end of this month. Some discussion took place about shift patterns which although not on the agenda, remains under consideration. WWC heard that there is good evidence that three successive 12 hour night shifts may not be in the best interest of staff and patients: further there is some evidence that 12 hour shifts themselves may produce unnecessary risks to staff and patients. This may need further consideration at Board level.

Recruitment to OD team is now complete, on-line for L&OD and with 'heads of' interviews next week. HR restructuring will also make more time available to address grievance issues proactively.

Personnel Files **Partially assured**

Very positive response from the Information Commissioner and from our staff with a great deal of openness reported. Investment has been made in intelligent scanners using TrustID. The processes now in place are rigorous, include compliance and monitored effectively. WWC wondered earlier about the self-imposed deadline of 31st December for project completion and see this as an aspirational target but one fully supported by Execs and this Committee. WWC was assured that all paper files are now secured appropriately.

Grievances **Partially assured**

An oral update was given on grievances. It has proved impossible to find benchmarking data so agreed that year-on-year measures (reducing) should be used. Numbers year to date and how long they take to be addressed are now the key indicators used by HR. Typically resolved within 80 days with provisional target agreed with staff side of 28 days in future and performance now to be measured against this target, including tail data. We now have 100 hours a week to address employment relation issues and so expect times to decrease. Training mediators to reduce numbers of grievances as this is still the default position for too many staff.

Appraisals **Partially Assured**

WWC received an update on the proposed appraisal system. WWC welcomed the fact that following consultations, some significant changes have been made to improve the process. It focuses more strongly on individual and organisational goals within the context of a quality conversation, as well as career planning and is to be commended. WWC was assured that full training will be given to all first line managers through the Fundamentals training programme which will be launching in January 2020 as well as through the new training and development

programme although it was also noted that this is dependent upon increased resources. A key change is that the system will relate to the year staff started and so will not be based on financial years, reducing the pressures on the system. The link across to clinical supervision was considered. It will also have a quality assurance process built-in and this is being developed.

Induction Programme Assured
The whole staff induction programme is now underway with the first 'pilot' day on 5th December. Again this has been widely consulted on and WWC felt it was most welcome.

Statutory and Mandatory Training Partially Assured
An oral update was given. Some lack of clarity around what is needed was discussed, and a significant range of performance was noted. QPS is monitoring this and a specific scrutiny item will be examined at a future meeting.

Clinical Education Partially Assured
WWC welcomed the very detailed paper and noted the very considerable work underway to isolate the root cause of problems and address the key issues in the work of Clinical Education. It was confirmed that those signed-off as passed were signed-off appropriately with independent QA a feature of their course. 39 staff await validation. Alignment with an outstanding HE provider is being proposed and supported by WWC. Concern was expressed that a decision has been made to move the expected level of entry qualification to level 2 standards in literacy and numeracy. This was referred back for further consideration and was felt to not be acceptable to the Board.

At this stage, the Committee cannot be assured that the causes of the problems have been fully identified and addressed, but was reassured by the rigorous programme of work underway, although surprised that the external investigator appointed appeared to be a patient safety expert rather than an education expert although it was assured that she had relevant experience in clinical education. It is felt necessary that the team return to the next WWC with their interim findings, as well as that they determine full costings for each course of action to be proposed, and seek the proper approvals where they move outside of existing budgets. WWC would also wish to be assured about the root cause(s) and the actions being implemented to prevent a recurrence before any Report leaves the organisation.

HR Dashboard
WWC noted the good recruitment levels of ECSWs and the very high retention of paramedics on our in-service programme (100%). Recruitment of newly qualified paramedics remain strong and slightly over budget. This is offset by the continuing challenges in recruiting experienced practitioners: we are likely to be around 100 below establishment his winter. The dashboard also shows that sickness remains a challenge but that the dataset shows this to be variable by base. WWC noted that Polegate and Hastings seems to be presenting particular challenges both for retention and sickness.

Annual Wellbeing Report
This was received.
WWC noted the very significant activity from the wellbeing hub and recognise that many of its interventions will impact positively on the staff survey. It noted also the likelihood that the increasing profile of this work has meant that many staff now self-refer who may otherwise have not engaged in any similar work placed based activities. As a consequence, it seemed unsurprising that numbers of referrals continue to increase. The number of referrals to physiotherapy was

	noted and WWC sought assurances that lifting and handling programmes were having an appropriate impact. It also welcomed the referrals for PTSD. WWC was concerned at the low uptake of vaccinations for so-called childhood illnesses and would look for assurances that those missing pre-arranged appointments are followed-up. Taken together, it was felt this was a positive initiative and well worth persevering with, although further work on metrics might be of value to demonstrate the impact on wellbeing of those using the various services such as a bundle of indicators within the staff survey rather than looking for a new survey.
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. Staff are to be commended for the pace at which the issues in Clinical Education are being identified and addressed. A full review of risks has been undertaken by the HR Working Group with 12 risks remaining Open. The HR Transformation Programme shows three open (Projects) one of which has been reassigned to Estates. The following risks are considered serious enough to appear on our BAF: 111; Safer Recruitment, including personnel files; Culture change; and, Health and Safety The actions recorded would seem adequate in terms of addressing the identified risks, however, 111 brings with it significant workforce issues with both sickness and retention rates challenging. The Executive will want to continue its considerable focus on this area after contracts are sealed.
Weaknesses in the design or effectiveness of the system of internal control identified and action required	WWC believe that the work on clinical education needs Board governance, including in the setting of entry level qualifications for the organisation, and requests that the end-point of the various worktreams is better aligned to the WWC calendar so that it can provide appropriate support and challenge to any draft findings.
Any other matters the Committee wishes to escalate to the Board	None

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	75/19

Name of meeting	Trust Board
Date	28 November 2019
Name of paper	Winter Capacity Plan 2019-20
Responsible Executive	Joe Garcia, Director of Operations
Author	Anne Harvey, Contingency Planning Manager
Synopsis	The Winter Capacity Plan has been shared with the Trust's Lead Commissioner, Associate Commissioners and A&E Delivery Boards, as is the usual process. Internally, it has been circulated to all Operations Directorate Managers and to other Directorates via their Business Support Managers. It was also included in the Trust's weekly bulletin with a copy made available on The Zone.
Recommendations, decisions or actions sought	The Board is asked to note the contents of the Winter Capacity Plan 2019-20.

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**

PLAN

South East Coast Ambulance Service
NHS Foundation Trust

Winter Capacity Plan 2019-20

Contingency Planning and Resilience

OFFICIAL

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

July 2019

Document Number	n/a
Version:	V 5.0
Name of originator/ author:	Anne Harvey
Winter Capacity Plan 2018/19	
Approved by:	Teams A
Date approved:	15th July 2019
Ratified by:	Executive Management Board
Date ratified:	24th July 2019

Date issued:	5th August 2019
Date next review due:	n/a
Target audience:	Trust Managers and External Stakeholders
Replaces:	Winter Capacity Plan 2018-19

Contents

1. Introduction

The South East Coast Ambulance Service NHS Foundation Trust (SECAmb) has developed this document to ensure that the high quality of service delivery expected by our patients and stakeholders is maintained throughout the winter period.

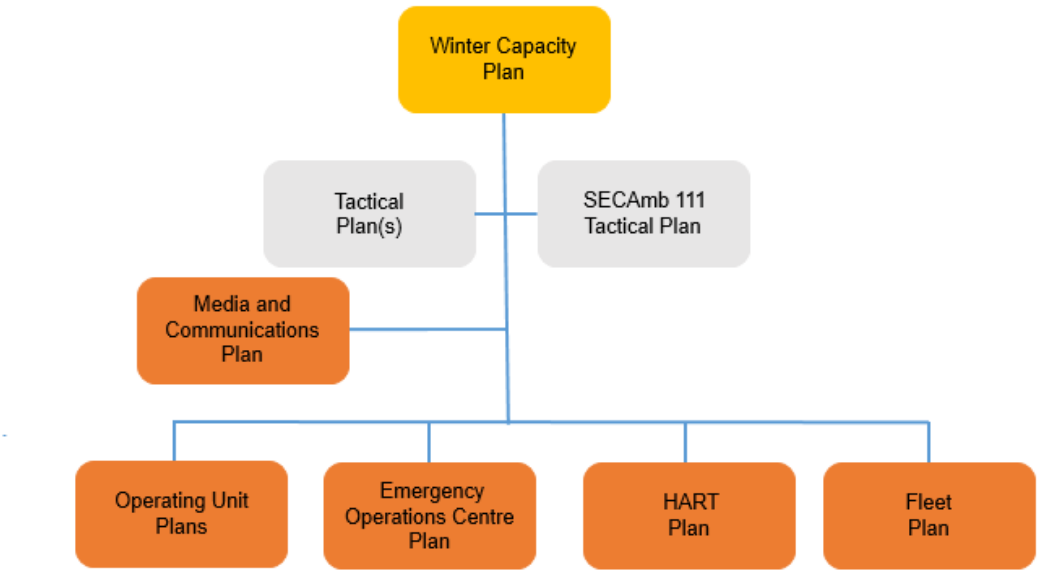
It is recognised that historically increased activity during the winter period has presented significant challenges to the Trust, however these demands are not always those placed directly onto the Trust but can be those affecting the wider health and social care system. This year is anticipated to be no exception, set against increased activity, staff deficiencies and the continued drive to reduce expenditure. The difficulties presented by these factors when combined with similar situations in partner organisations across the wider health community, may make the challenges of this winter even more acute and unpredictable.

This document is intended to draw on the experiences of past winters and integrates NHS England recommendations, guidance and criteria for winter capacity planning.

This document concentrates on a number of year round processes and key seasonal initiatives that will deliver real resilience during the winter period and ensure engagement with local health systems. In doing so this plan aims to support the delivery of the programme of work set out in the Trust's current Five Year Strategy.

It is designed to offer assurance at a strategic level that the levels of preparedness for winter in SECAmb is high and that this will contribute to the resilience of the whole system. It also serves as an overarching plan to bring together the arrangements detailed in the individual Operating Unit, Emergency Operations Centre winter plans and the SECAmb 111 Winter Plan.

Plan Structure Framework



2. Strategic Aim

The overarching strategic intent of the Winter Plan is to provide safe, high quality and effective services to patients and members of the public accessing the Trust's services during the winter period.

2.1. Strategic Intention:

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

2.2. Tactical Intention

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

3. Plan Scope

The Winter Capacity Plan covers the period 1st November 2019 until 31st March 2020.

- The plan covers the identified winter pressure reporting period (to be advised) and details the Trust's intentions for delivering its core business.
- Analysis of historical data for this period over the past four years will be utilised to identify the anticipated periods of increased demand.

3.1. Christmas and New Year

There will be specific arrangements for the key dates over the Christmas and New Year period, which include provision of additional operational resources and appropriate, focused managerial support. In addition, these arrangements will be

extended in response to challenges posed by prolonged increased activity, system pressures, seasonal flu, and other forecasted challenges.

3.2. EU Exit Planning

The Trust continues to plan for an EU Exit, engaging with LRFs and wider NHS partners ensuring cognisance of potential issues and dependencies which can be fed back into the SECAmb strategic and tactical planning.

4. Review of Winter 2018/19

A full review of the arrangements put into place last year has been undertaken on both a local and national basis with the following outcomes:

Areas which went well:

- Early planning & resourcing
- Clinical staff in EOC
- Optimise urgent tier
- Use of community /primary care pathways
- Increased numbers of paramedics /recruitment drive
- Additional Command support (Strategic hub)
- Continued development of escalation plan
- More collaboration of winter rooms to reduce reporting burdens

Areas for improvement:

- Continue on improving hospital turnaround.
- Resilience of Command support

These aspects have been built into planning for this year.

5. Method

The delivery of this plan will be achieved through comprehensive operational and organisational arrangements, which are designed to provide a quality service to meet the needs of our local communities. The overall strategy will be delivered through the Tactical Winter Plan and the Operating Unit plans so that the arrangements remain sufficiently flexible to match more local workloads.

The operational arrangements include the identification of ‘key dates’ of anticipated high demand which are derived from analysis of historical data. Such predictions will be subject to adjustment based on shorter-term impacts such as forecasts of severe weather, high seasonal flu levels, fuel shortages or other Business Continuity challenges including industrial action within or outside of the NHS.

This section of the Plan describes the processes to predict, monitor and mitigate the demands that are likely to be placed upon the Trust over the winter period, and looks

to ensure delivery of service is maintained during surges in demand or reduced capacity. The Plan describes the arrangements for:

- Processes to monitor planned activity and resource planning
- Internal escalation triggers
- Provision of additional resources to meet surge requirements
- Support for other priority areas

5.1. Demand Analysis

Planned levels of activity have been based on historic data, present performance and growing demand. This trajectory is reviewed on a regular basis by Teams A, the Trust's senior operational leaders.

The graphs in Appendix A show both the activity over the past three years and the forecast activity for the winter period of 1st November 2019 – 31st March 2020.

Forecasting activity is not an exact science and therefore it is recognised that the Trust may experience unplanned short-term/sustained periods of increased activity. Therefore the predicted activity is revised on a regular basis to take into account factors which may change predictions in order to manage resourcing and provision of unit hours.

5.2. Operational Resource Planning

The Trust scheduling team are responsible in conjunction with the OU leadership to ensure that Operational and Fleet Resource Planning reflects forecast demand. This also applies to the Emergency Operations Centres with regard to call handling, clinical and dispatch functions.

The Trust forecasting tool is used to assist with the planning of shifts, and utilising historic data to define "the hard-deck" which is based on the resource requirement for the busiest quarter of the busiest day, with the objective to never go below this number of resources.

5.3. Activity and Resource Profiling

Based on analysis of historic data, experience and lessons learned from previous years key dates of anticipated high demand and high abstraction rates dates have been identified across the Christmas and New Year period.

Previous experience has shown that the period from 18th December to 27th December; along with New Year's Eve night shifts will see reduced overtime uptake and PAP coverage without incentives being offered to staff.

As we move towards the winter period a more accurate picture of the available resource against the predicted demands will emerge. This will be kept under constant review by Teams A to ensure that risk periods are identified and mitigating actions are put in place.

5.4. Staff Abstraction

The Trust's Annual Leave Policy details the arrangements for annual leave over the Christmas period, which limits annual leave abstraction at 50% of normal levels. All short notice leave will be authorised at Operational Unit Manager level or above.

In addition to the above arrangement it is proposed that there are no additional abstractions other than pre-booked annual leave.

5.5. Financial Incentives For Targeted Shifts

To incentivise and maximise overtime uptake, consideration will be given that key risk days will be targeted to provide overtime rates outside those available under Agenda for Change. The related cost pressures will be identified and calculated for all additional resources required and the Trust's Operations Team will work in collaboration with both the Trust's Financial Directorate and staff-side to ensure a uniformity of approach to the issuing of incentives.

5.6. Surge Demand Mitigation

The Trust employs the following measures to enhance service delivery during periods of increased activity:

Resource Escalatory Action Plan (REAP)

The Trust's REAP identifies rising trends in operational and organisational demands and facilitates escalation/de-escalation through the nationally set REAP levels.

Trigger mechanisms have been established through REAP arrangements that allow the Trust to respond to substantial increases in demand, in either specific areas or Trust wide.

REAP arrangements remain active at all times.

Surge Management Plan (SMP)

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

5.7. Additional Operational Capacity

Based on the variations and gaps in demands a number of options can be considered / included as part of the mitigation / additional resourcing:

Co-Responder Schemes

We continue to collaborate with Kent Fire & Rescue Services (FRS) across the region who can be called upon to provide an initial response to agreed categories of 999

calls. Additionally all FRS across the Trust region will carry out forced entry on our behalf. These partnerships will be utilised following the agreed protocols.

Community First Responders

During the period of this plan Operating Units will highlight to the Community Resilience team where community responder schemes may support resourcing gaps.

Requests for additional community first responders in hours will come through the Community Resilience Team in the first instance. During the OOH's period, EOC will cascade a message through the Response Desk targeted at local OUs that require operational support. The Community Resilience Team (in conjunction with the SECAmb communication team) will consider the use of social media to cascade messages where appropriate. Again, during the OOH's period, this will be led through the SECAmb communications team.

During high periods of demand where conference calls are held to ascertain situational awareness, consideration must be given to the use of CFRs and Fire and Rescue responders to assist the Trust in providing a timely response to our patients.

Operationally Capable Managers (OCM)

Teams A will work with Departmental Heads and OCMs to ensure that they are targeted effectively to support operational response as required, as it is recognised that there are a number of key work areas, which if not maintained and continued may cause additional problems and issues.

OCMs may be redeployed from their normal duties to support the delivery of the operational service as required.

Private Ambulance Provision (PAP)

PAP is used throughout the year to support gaps in establishment and all are currently provided under Direct Award Contracts totalling around 23,222 staff unit hours per month. In December last year 25,000 hours were provided and the same levels are contracted for this year.

Direct awards are being designed to cover the winter period and will include an uplift in supply, however we should be realistic in our expectations and recognise that the order we place may not be fulfilled. PAP have been informed that we do not expect them to overpromise and then under deliver, hours not provided will not be paid for.

5.8. Additional actions if Winter Funding is provided centrally

There are a number of additional actions which the Trust will look at implementing, should central winter resilience funding be provided centrally. These include:

- Expanding the current "Thanet Paramedic Practitioner (PP) Model" across all Operating Units across the Trust. This enables a greater autonomy at a local level to manage clinical risk, and to support A&E road crews in having more informed clinical decision-making following prompt support, guidance and expertise from a more higher skilled healthcare professional

- The Trust will consider extending proofs of concept and specialist activity i.e. the Mental Health Car, expanded clinical multi-disciplinary team in the interim Clinical Advice Service etc.
- Improved operating model for the tactical Hub, with a designated team focussed on crew-call backs and supporting the reduction of on-scene time and hospital conveyance delays though the delivery of expert clinical and operational advice

5.9. Maintaining Key Management Priorities

It has been identified that the following management duties will continue to be prioritised in addition to maintaining an operational response to patients;

- Focused HR Attendance Management support
- Return to work interviews
- SI's
- Incident investigations
- Complaints
- Patient Experience Team support
- Appraisals

In order to maintain these key functions, support may be requested from other Directorates and work areas within the Trust. Directors and functional Heads will identify staff within support functions who will undertake identified duties under the guidance of senior/operational managers.

It is proposed that a series of workshops/exercises are held prior to the winter period to provide Managers and staff with the training and familiarity to carry out supporting functions.

6. NHS Winter Resilience Planning

Recognising the continued increase in pressures on the wider health system over the past few winters, in July 2017 NHS England and NHS Improvement circulated guidance to all CCGs and providers regarding planning for winter 2017/18 details of which can be found on the NHS England website.

In line with this guidance and the operational priorities set out by the NHS England Board on 30 November 2017, for 2018/19, the Trust will continue to engage with the wider NHS through A&E Delivery Boards and Collaborative ICP/ICS/STP sessions in order to influence and shape local initiatives, whilst continuing to focus on delivering 999 and 111 core services safely and timely.

While planning for this period the Trust will continue to engage with and seek assurance from the CCGs and acute hospitals that their plans have sufficient capacity to manage surges in demand.

6.1. Hospital Handover Delays

Frequently system pressures experienced by the NHS/acute hospitals result in significant ambulance handover and turnaround delays at the majority of the acute

hospitals across the Trust region, these delays subsequently impact on the Trust's ability to deliver a safe service to the community.

All hospital trusts have been required to submit trajectories for improving handover delays (targeting delays >30 and >60 minutes as part of their operating plan). Seven trusts within SECAmb's geographical footprint are being monitored as part of a national hospital handover programme, with monthly reporting against progress Locally SECAmb has been working closely with hospitals across the region to reduce handover delays as part of system wide programme of work led by a dedicated programme director . The work programme includes SECAmb working to improve crew to clear times and optimising community pathways.

The Trust will work closely with Acute Trusts to seek early resolution where a hospital handover delay occurs following an established escalation process. However, if these actions fail to resolve the issue in a timely manner, the following Trust handover procedures may be implemented with the aim to expedite a safe method to release ambulance resources from A&E.

- Immediate Handover – Standard Operating Procedure
- Conveyance, Handover and Transfers of Care Procedure.

Both processes are currently being reviewed ahead of winter.

6.1.1. Hospital Diverts

A draft SOP for hospitals requesting a divert is in place and has been presented to lead and associate commissioners .The SOP will ensure requests are managed in a robust and consistent way with the appropriate governance framework in place . The SOP will be socialised with the COOs from each acute trust as a next step, with the aim of having it in place across SECAmb's footprint ahead of winter

6.2. NHS Operational Pressures Escalation Level (OPEL) Framework

NHS England has distinct escalation levels in the management of surge pressures as set out in OPEL, which standardised local, regional and national escalation levels to respond to severe pressures on the NHS. These levels are used by the wider health community. To ensure a consistent approach the Trust's REAP has adopted the same system of escalation over four levels with related triggers and actions. The Trust's REAP status is formally reviewed every week by the Director of Operations at the Teams A meeting.

7. Adverse Weather

As part of business as normal procedures it is the responsibility of the Contingency Planning & Resilience Team to monitor any approaching adverse weather via Met Office and Local Resilience Forum (LRF).

The Trust's Tactical Advisors provide a 24 x 7 on call and act as a single point of contact for external agencies to alert for incidents or significant events.

Tactical Advisor - SPOC - 07003 900765

Warnings of any potential adverse weather are communicated through the organisation to on-call commanders, relevant managers and functional heads.

At times of severe weather during the winter period or access via difficult terrain, the Trust needs to be able to deploy four-wheel drive (4x4) resources to provide access to patients and retrieval to road based resources.

The Trust operates a variety of vehicles with 4x4 capability across its geography and a range of operational staff across the organisation are trained to drive these vehicles. The Trust also maintains a contract to hire in additional 4x4 vehicles. These will be deployed under the direction of Tactical Commanders in preparation for or during any adverse weather.

All of the Trust's ambulances/response cars have all-weather tyres fitted in readiness for adverse weather conditions.

The Trust also has Memorandum of Understandings (MOU's) in place with Voluntary Aid Societies (VAS) who can also mobilise 4x4 vehicles and ambulances as required to support operations. In addition, a number of Memorandum of Understandings (MOU's) are in place with volunteer 4x4 groups to provide assistance at times of severe weather.

Around 30 Community First Responders have their own 4X4 vehicles. A contact list is held by production and during an emergency or BCI situation, for example inclement weather, the CFR volunteers can be called upon to support the Trust in either responding to patients within their communities or moving Trust staff from A to B such as EOC staff.

The Logistics department robustly plans for the distribution of supplies of winter stock in advance of and throughout periods of adverse weather.

The Trust's MI Plan - Additional Contingencies - Adverse Weather provides further guidance and information.

8. Major Incident

In the event of a Major Incident being declared during this period, procedures as detailed in the Trust's Major Incident Plan with be followed. Please refer to the Trust's Major Incident Plan and Additional Contingencies and EOC Action Cards for further information.

9. Key Support Services

9.1. Fleet Resource Planning

Fleet services are responsible for ensuring that the Trust's vehicles are available to operations when required. However, this must be based on an effective working relationship with operational managers to ensure that vehicles are presented for scheduled maintenance and MOTs when requested and that vehicle utilisation is maximised by robust monitoring and implementation of driving standards and vehicle damage.

There are a number of measures for the Fleet Department to take to ensure that vehicle availability is maximised and particularly through Q3 and Q4; these include:

- All MOTs being rescheduled to avoid November and December
- Damage repairs will be 'bundled' to be undertaken in batches (unless it requires to be done for safety / road worthiness)
- The Fleet Department has an escalatory Plan which ensure that additional maintenance capacity can be applied during periods of higher demand
- The Fleet Department will support and work alongside the Make Ready and Vehicle Preparation Programme (VPP) to ensure efficient turnaround of vehicles within the system.

There are risks associated with being able to provide sufficient vehicles to meet peak demands, however we are currently refreshing our fleet to increase vehicle numbers.

9.2. Make Ready

The Make Ready system is responsible for cleaning, restocking and checking equipment on ambulances and SRVs in readiness for operational shifts.

The Make Ready system has an escalatory plan, which extends the Make Ready programme and allows for vehicles to be "hot loaded", in that they are not put through the full Make Ready system to ensure that sufficient vehicles are available for operational response.

Contractual arrangements are in place with the Make Ready provider to enable optimal staffing levels over the Christmas period.

9.3. Logistics Resource Planning

The Logistics Support Department are responsible for ensuring that all Trust locations have the availability of medical consumables, gases, medical paperwork and sundry items to ensure that the Operational vehicles can be maintained to the required stock levels for effective patient treatment and care.

There are a number of measures taken by the Logistics Support Department to ensure that stock levels are pre-positioned and maintained to ensure maximum availability, particularly in the lead up to and through Q3 & Q4, these include:

- Medical equipment servicing is not planned during the Q3/Q4 period.
- Medical consumables stock is uplifted to account for the increase in demand.
- Medical gas supplies are uplifted and pre-positioned in certain Trust areas to allow for increase in demand.

The Logistics Support Department has an escalatory Plan which ensures that additional capacity can be applied during periods of higher demand to ensure logistic support to stations/Make Ready.

The Logistics Support Department will support and work alongside the Make Ready and Vehicle Preparation Programme (VPP) to ensure efficient turnaround of equipment and consumable requests required to support the vehicles within the system.

9.4. IT/Systems

The Head of Information Management and Technology is responsible for ensuring 24-hour IT support which is delivered through an on-call system.

Dedicated support is provided to the EOCs by the EOC Systems team, again through an on-call system.

Additional arrangements for the provision of on-site support for key dates such as New Year's Eve will be in place

10. Seasonal Influenza and Norovirus Outbreaks

The Head of Infection Prevention and Control and the Medicine Management Team is responsible for the delivery of the seasonal influenza vaccination programme for Trust staff. Staff communications processes will be run prior to and throughout the winter period to encourage uptake. Following an established model, specially trained Trust clinicians will be available at workplaces across the Trust to undertake vaccinations. We anticipate that the vaccination programme will start as soon as the vaccine has been produced and distributed to areas. Last year the Trust was one of the leading Ambulance Trusts with a 77% uptake, the aim for this year is to achieve the same level for a second consecutive year.

Any flu or norovirus outbreaks in the community are monitored by the IPC Team via the Public Health England Daily Outbreaks reporting system (these reports are also shared on a daily basis with 111). Local IPC Alerts will be sent out as and when required as well as regular updates on procedural compliance to IPC Universal Standard Precautions for staff to maintain.

Any flu or norovirus outbreaks within the Trust will be investigated and managed by the IPC Team with all necessary actions put in place. This will include local IPC Champions supporting the team and occupational health support from Optima.

The IPC Team will also liaise with EOCs, Make Ready Teams and Production Desk to provide advice on the decontamination requirements for vehicles and staff involved in any possible post treatment / transportation contamination issues.

The Trust's Pandemic Influenza Plan has been maintained in line with national guidance. Due to the variables associated with pandemic flu there are no specific triggers for implementing pandemic specific arrangements, therefore the Trust response to a pandemic influenza outbreak will be guided by the NHS response.

11. Command and Control

The normal command structure will be in place throughout the Trust, details of which can be found on the on-call rota, accessible on the Trust's intranet @ info.secamb.nhs.uk or via Operational Commander rotas.

In the event that our external partner organisations need to make contact with the Trust on-call commander, initial contact will be made via the EOCs who will escalate as required.

To ensure that the Trust maintains the capability to respond to a range of issues/incidents that may arise, on-call Strategic and Tactical Commanders and Tactical Advisors should not be tasked to operational shifts, they can, however be called upon to provide support within the Incident Command Hubs (ICH) / Command Suite as required.

During the period of this plan day to day responsibility of operations remains with the Director of Operations (or their nominated deputy). They are responsible for triggering a Trust wide response if the demands are outside the scope of normal procedures.

The following table outlines additional measures to be considered to support an extended command structure in the event of increased pressure on Operations.

Item	Details
Increased Managerial Oversight	The Director of Operations (or their nominated deputy) will consider establishing increased managerial oversight during key periods of this plan. This may include: additional (24/7) commander cover in the ICHs, additional support to the ICHs, additional performance teleconference and information sharing as required, to review the actions undertaken and consider additional measures.
Strategic Suite	The Director of Operations (or their nominated deputy) may consider establishing a Command Hub within the Strategic Suite to support the Trust's normal management and command structures. This will provide additional Senior management support to assist the Trust to coordinate its response.
Clinical Oversight	Senior clinical oversight may be required to review risks and impacts to patients and provide support and advice.

12. Risk

The following risks have been identified within the period; however, this list should not be seen as exhaustive.

Risk	Details	Mitigation
Impact on Core Services / Patient Care	It is expected that during this period there may be times when operational resources will not match demand.	Daily performance conference calls Regular/weekly performance reviews and oversight from Teams A/Exec, to monitor activity and resourcing.
Impact on wider Health Service	There is a risk that the numbers of patients being taken to the A&E departments will cause patient flow issues and exacerbate the availability of operational resources.	Trust engaged with NHE winter resilience planning through the A&E Delivery Boards.
Organisational Reputation	Failure to manage the forecast demand and attend our patients in an appropriate time could lead to additional damage to the Trust's reputation.	Regular/weekly performance reviews and oversight from Teams A/Exec, to monitor activity and resourcing. Trust winter communications plan. Account Managers to support communication to partner organisations.
EU Exit	There is a significant risk that the UK may leave the European Union (Brexit) on or before the 31st October 2019 with a No Deal outcome. As a result of this there may be significant impact on several areas of SECAmb as an organisation.	The Head of EPRR is responsible for EU Exit Planning The Trust continues to plan for an EU Exit, engaging with LRFs and wider NHS partners ensuring cognisance of potential issues and dependencies to be fed back into the SECAmb strategic and tactical planning.
Adverse Weather	There is a potential for adverse weather during this period which could further exacerbate the challenges faced at this time, when resources are under pressure.	Adverse weather preparation and planning.

National 111 awareness campaign	Activity flow from the NHS 111 service will be exacerbated during November by a national 111 awareness campaign across various media. This occurred in 2018 and contributed to increased call volumes in excess of 10%, with an impact on 999 and EDs.	Trust to seek assurance that all 111 providers for the region have robust plans in place to maximise operational and clinical capacity to manage any increase in call volume, whilst maintaining patient experience and mitigating pressure on the wider health economy.
Activity flow from SECAmb111	Previously throughout this period 999 has seen an increased activity flow from SECAmb111.	The SECAmb111 Escalation Plan is in place to mitigate pressure on the 999 service.
East Kent 111 Provider	That the East Kent 111 Provider does not have the clinical governance arrangements in place.	Trust to seek assurance that they have a robust plan in place to maximise operational and clinical capacity, whilst maintaining patient experience and mitigating pressure on the wider health economy.
Surrey 111 Provider (Care UK)	That the Surrey 111 Provider does not have the clinical governance arrangements in place.	Trust to seek assurance that they have a robust plan in place to maximise operational and clinical capacity, whilst maintaining patient experience and mitigating pressure on the wider health economy.
PTS Provision	The Trust is not commissioned to provide PTS, if the PTS providers do not have robust resourcing over this period, this could impact on A&E departments when hospitals booked discharges are required to enable capacity.	This risk will need to be addressed through continued engagement with the Local Delivery Boards.
High Dependency Intermediate Care Transfers	The Trust is not commissioned to provide high dependency intermediate care transfers, except when this is shown to be an escalation of care.	This risk will need to be addressed through continued engagement with 999 commissioners and the Local Delivery Boards.
Access to Primary Care	The Christmas and New Year bank holidays result in an extended weekend. There is limited access to primary care	Links to NHS Winter Resilience Planning key priorities.

	throughout this period adding to Ambulance/NHS111 activity.	
Flu and Norovirus Outbreaks	The increase in winter related illnesses during this period can affect our ability to respond to demand. Both community and Trust outbreaks of flu and norovirus need to be managed appropriately and quickly to reduce the risk.	The Trust's IPC Team will lead on managing outbreaks within the Trust and providing expert advice to staff. They will also provide regular community outbreak information.

It is proposed that the Trust's Resilience Forum will review these risks at their monthly meetings in order to manage and mitigate these risks.

13. Communication

During this period the Trust's internal and external communications will include general and specific communications which support the delivery of this plan. Led by the Trust's Communications team and its Winter Communications Plan this will include internal and external messages some of which will be prepared based on foreseeable issues including the following:

- Adverse weather
- Stay Safe messages
- Extended periods of excess demands or in advance of known key dates
- Staff communications

The team will continue to engage with partner NHS communications teams to ensure co-ordinated messaging.

Regional Operations Mangers, Operating Unit Managers and Operations Managers will be responsible for liaison with operational staff within their Operational areas, as well as engaging with key stakeholders such as hospitals, CCGs and A&E Delivery Boards.

The Trust Business Account Managers will act as commissioner liaison and provider through engagement with the Lead CCGs and the A&E Delivery Boards.

14. Review

The Executive Director of Operations has overall responsibility for this plan.

This is a living plan and will be subject to a monthly review by Teams A, who will continue to develop this plan prior to implementation, and throughout the Q3 period.

During periods of extended escalation, the Executive Director of Operations will report to the Executive, who will review the on-going impact of escalation on the Trust.

Testing of the plan will be undertaken through attendance at NHS winter capacity exercises across the Trust's region.

15. Associated Documents

This plan is underpinned by a number of Trust procedures and plans which may be invoked during periods of high demand or when system pressures in the local health economy impact on the Trust's operational response. These include:

- SECAmb Tactical 111 Winter Plan
- SECAmb New Year Tactical Plan
- SECAmb EU Exit Plan(s)
- Operating Unit Winter Plan(s)

- Resourcing Escalatory Action Plan (REAP)
- Surge Management Plan
- Immediate Handover-Standard Operating Procedure
- Conveyance, Handover and Transfers of Care Procedure (Clinical Processes)
- Major Incident Plan & Additional Contingencies
- Business Continuity Management Plan
- NHS England Operational Pressures Escalation Level Framework (OPEL)
- Infection Prevention Ready Procedure
- Infection Prevention and Control Manual

16. Distribution

Internal Distribution

Teams A

Executive Management Board

Communications Team (for publication on Staff Zone)

Business Account Managers

External Distribution

NHS England and NHS Improvement -South East

Lead Commissioners

A&E Delivery Boards

Document Control

Manager Responsible

Name:	Anne Harvey
Job Title:	Contingency Planning & Resilience Manager
Directorate:	Operations

Committee to approve	Executive Team	
Version No. 5.0	Final	Date: 23rd July 2019

Approval

Person/ Committee	Comments	Version	Date
Anne Harvey	Appendix A – forecast data produced by Alex Croft and reviewed by Joe Garcia added. Plan updated to V5.0	V5.0	05/08/19
Sue Lavender	Plan updated to reflect correct page numbering and version number	V4.4	23/07/19
Anne Harvey John O'Sullivan	Plan updated to reflect Team A discussion	V4.3.1	18/07/19
Teams A	Approved subject to amendment/inclusion of additional comment as minuted	V4.3	15/07/19
Teams A	For discussion and approval	V4.3	15/07/19
Anne Harvey	Plan reviewed and updated for use for Winter 2019/20 with input from Matthew England, Gillian Wieck, Jay Agostinelli ,Gavin Thompson, David Wells, Dan Garratt, Alison Stebbings, Greg Walsh and Andy Taylor in relation to their service areas	V4.3	11/07/19
Joe Garcia	Appendix A – revised forecast data produced and graphs updated using Trust new reporting systems	V4.2	22/11/18
Anne Harvey	Appendix A – data rerun and updated graphs added	V4.1	01/11/18
Executive Management Board	For ratification	V4.0	01/08/18
Resilience Forum	For information	V4.0	26/07/18
Teams A	Plan approved subject to minor grammatical amendments	V3.1	16/07/18
Teams A	For discussion and approval	V3.1	16/07/18
Anne Harvey	Plan reviewed and updated based on feedback and lessons learned from previous winters, with input from key stakeholders	V3.1	13/07/18
Trust Board	For information	V3	25/10/17
Anne Harvey	Section completed following input from Barry Thurston and Chris Evans	V2.3	05/10/17

Executive Team	Plan ratified subject to inclusion of completion of EOC IT systems risk mitigation.	V2.3	27/09/17
Anne Harvey	Plan updated to reflect comments received.	V2.3	22/09/17
Executive Team	Plan agreed subject to inclusion of additional comments from Strategy and Business Development Team	V2.2	20/09/17
Executive Team	For information	V2.2	20/09/17
Teams A	For approval and recommendation to executive team.	V2.2	18/09/17
Anne Harvey	In response to comments received IPC Team - addition of section 3.12 and associated risk. KMSS111 – addition of a new risk relating to EK111 provider	V2.2	15/09/17
Anne Harvey	Plan circulated to various stakeholders for review and comment.	V2.1	11/09/17
Sue Skelton, James Pavey, Andy Cashman, Anne Harvey	Review of changes made to plan and minor amendments made Table @3.6.2 updated Section 5 risks and mitigations reviewed. Appendix A – tables updated	V2.1	11/09/17
Anne Harvey	Plan updated to reflect outcomes of Plan review workshop held on 07.08.17	V2.1	August 2017
Executive Team	For ratification	V2.0	12/10/16
Teams A	Plan agreed subject to minor amendments.	V2.0	04/10/16
Teams A & Anne Harvey	Teleconference to discuss and approve the plan	V1.1	04/10/16
Teams A	Circulated for review and comment following update to plan.	V1.1	30/09/16
Anne Harvey	Document reviewed by various stakeholders and plan reworked to reflect winter planning data and arrangements for 2016 -2017.	V1.1	September 2016
Executive Team	Plan ratified	V1.0	09/09/15
Executive Team	For information and ratification	V0.02	09/09/15
OPWG	For approval and recommendation to the Executive Team	V0.02	01/09/15
Anne Harvey	Amendments made following review & comment from SOLT 3.4.6 section on incentives rewritten and table included 3.4.9 section rewritten 3.4.11 section rewritten	V0.01	

	Addition of appendices		
Teams A	For review and comment	V0.01	17/08/15

Circulation

Records Management Database	Date:
Internal Stakeholders	Yes
External Stakeholders	Yes

Review Due

Manager	Teams A	
Period	Annually	Date: TBC

Record Information

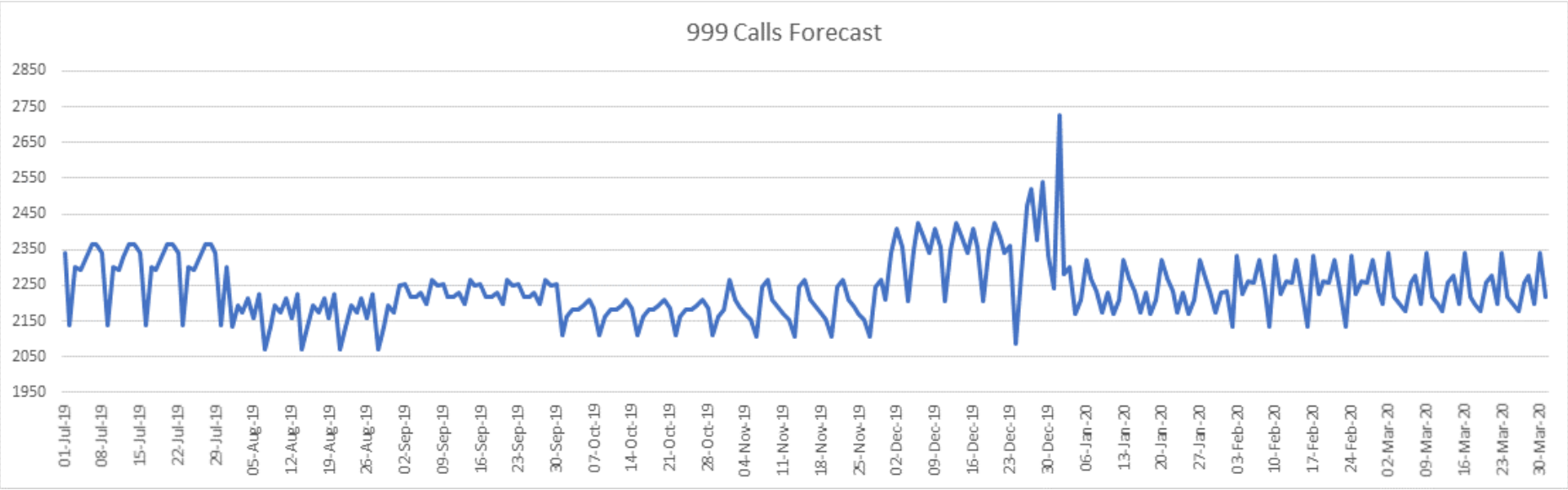
Security Access/ Sensitivity	Official
Publication Scheme	No
Where Held	Records Management database (secure area). Permission to access: on a need to know basis
Disposal Method and Date	

Supports Standard(s)/KLOE

	Care Quality Commission (CQC)	**IG Toolkit**	**Other**
Criteria/KLOE:	Name core service area and CREWS elements		

Appendix A: Activity Data

Below is the forecast for 999 call volume across the winter period



South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	76-19

Name of meeting	Trust Board
Date	28 November 2019
Name of paper	NHS England EPRR Assurance 2019
Responsible Executive	Joe Garcia, Director of Operations
Author	Chris Stamp, Head of EPRR
Synopsis	Further to the South East Coast Ambulance Service EPRR Assurance review meeting and, on assessment of the evidence presented, the Accountable Emergency Officer at Surrey Heartlands CCGs has written to the Trust (Appendix A) confirming that the CCG considers the Trust's overall position to be Substantially Compliant with this year's NHS England EPRR core standards. The Trust's position in relation to Interoperable capabilities has also been assessed as Substantially Compliant, which is a significant improvement from last year's assurance.
Recommendations, decisions or actions sought	This is to provide assurance that the Trust is compliant with the EPRR core standards and interoperable capabilities

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**

58 Church Street
Weybridge
Surrey
KT13 8DP

Tel: 01372 232400

Joe Garcia
Executive Director of Operations and Accountable Emergency Officer (AEO)
South East Coast Ambulance Service NHS Foundation Trust

Private and confidential

09 October 2019

Re: **NHS England EPRR Assurance 2019 – South East Coast Ambulance Service NHS Foundation Trust**

DRAFT OUTCOME

Dear Joe,

Firstly, can I thank your team, Ian Shaw, Chris Stamp, Anne Harvey and Steve Carpenter for meeting the EPRR Team on 16th September 2019.

Further to the South East Coast Ambulance Service EPRR Assurance review meeting, and on assessment of the evidence presented, the CCG considers the Trust's overall position to be **Substantially Compliant** with this year's NHS England EPRR core standards. The Trust's position in relation to Interoperable capabilities has also been assessed as **Substantially Compliant,** which we recognise is a significant improvement from last year's assurance. It is pleasing to note that all providers assured directly by Surrey Heartlands CCGs are considered substantially compliant, subject to the outcome of the forthcoming review meeting with NHS England and NHS Improvement.

NHS England define substantial compliance as: *The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.*

The rationale for this assessment is contained in the table below for those standards that were assessed to be partially compliant (please note the deep dive standards do not form part of the overall assessment of compliance):

Ref	Standard	Rating	Commentary
CS40	LHRP attendance	Partial	AEO to have attended the annual assurance meeting and a Director to attend 75% of LHRP Exec meetings.
CS55	Assurance of commissioned providers / suppliers BCPs	Partial	Further work to be completed on supply chain resilience.

Deep Dive			
DD11	Flood response	Partial	Overarching Risk assessment for estate and Flood plans to be developed
DD13	Supply chain	Partial	Further work to be completed on supply chain resilience.
DD16	Risk assess	Partial	Climate change risk to be added to register
DD19	Flooding	Partial	Flooding survey to be commissioned for additional sites.
AR2	Telephony	Partial	Safe systems in place but CAD upgrade required to improve resilience
AR4	EOC	Partial	Safe systems in place but CAD upgrade required to improve resilience
Interoperability			
H8	Six operational HART staff on duty	Partial	Cannot be guaranteed due to levels of commissioned staffing
H32	Equipment asset register	Partial	Bespoke asset management system being researched
M11	Staff training requirements	Partial	Additional evidence required to demonstrate full compliance.
B5	Commander competence	Partial	Additional evidence required to demonstrate full compliance.
C24	Commanders – maintenance of CPD	Partial	Additional evidence required to demonstrate full compliance.
C25	Commanders – exercise attendance	Partial	Additional evidence required to demonstrate full compliance.
C32	Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor	Partial	Progress with Options paper and implementation of Medical Advisor Role

Next steps

If you have any questions around our assessment, or have any points requiring clarification, please contact Mark Twomey, Head of EPRR, Facilities Management and Business Support (**m.twomey@nhs.net**) or a member of his team by close of play on Monday 14th October 2019.

The CCGs want to support system partners and as such would like to extend an offer and invite to our new training which is now available. We hope that this will help bring teams supporting resilience together going forward across the ICS and within the ICPs, strengthening the relationships between colleagues across the system.

DRAFT OUTCOME

On behalf of the Surrey Heartlands CCGs, our thanks for your help and assistance in completing this year's annual EPRR assessment.

Yours sincerely,

Elaine Newton,
ICS Director of Corporate Affairs and Governance
(Accountable Emergency Officer – Surrey Heartlands CCGs)

Cc
Jack Wagstaff, ICP Director North West Surrey

Mark Twomey, Head of EPRR, Facilities Management and Business Support, SHCCGs

Ian Thomson, Deputy Head of EPRR, Facilities Management and Business Support,

SHCCGs

Ian Shaw, Associate Director Operations – Resilience and LHRP Executive representative, South East Coast Ambulance Service NHS Foundation Trust

Chris Stamp, Head of EPRR, South East Coast Ambulance Service NHS Foundation Trust

Anne Harvey, Contingency Planning & Resilience Manager, South East Coast Ambulance Service NHS Foundation Trust

Steve Carpenter, Head of HART, South East Coast Ambulance Service NHS Foundation Trust

DRAFT OUTCOME

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Agenda No	77/19
Name of meeting	Trust Board		
Date	28 November 2019		
Name of paper	Public Awareness and Training i.e. CPR		
Responsible Executive	Joe Garcia, Executive Director of Operations		
Report Author	David Wells, Head of Community Engagement		
Synopsis	At the meeting in February 2019, the Board received a Board Story highlighting the importance of public awareness in how to perform CPR; the story was of a patient who went in to cardiac arrest and received prompt CPR from a passer-by, almost certainly helping to save his life. Acknowledging the importance of bystander awareness, the Board asked for an overview of how the Trust is supporting this; noting that it had trained circa 11,000 members of the public during 2018.		
Response	The Community Resilience Team has developed a draft Community Resilience Strategy, the focus of which is based upon having Resilient Communities. This will assist people in understanding their ambulance service and how to engage with us. Engagement with local communities allows us to be more aware of their needs and breaks down perceived barriers. This will allow us to empower communities to take a greater responsibility for their own health and look out for other vulnerable persons. The Community Resilience Team, along with SECAmb volunteers, staff and partner agencies, already provide valuable training and education to members of the public around ambulance services and emergency care through specific and often targeted events arranged locally and nationally. **Public Access Defibrillators (PAD Sites)** The Trust currently maintains a database and has recorded and logged within the Emergency Operations Centre (EOC) over 3000 PAD sites across its geographical area. PAD sites are managed through a network of different people within the local communities and our own staff. CFR Volunteers play a huge part in identifying, installing and maintaining PAD sites to benefit local communities. We will utilise this data to better understand the coverage of the Trust and identify areas that are poorly covered by both ambulance responses and Public Access Defibrillators. This will help us to ensure that Public Access Defibrillators are targeted to areas that need them the most, and that communities are encouraged to take pride in fundraising for and maintaining defibrillators within their area.		

	The British Heart Foundation will be taking over the database of PAD sites nationally for all ambulance services over the next year. This will ensure all PAD sites have guardians ensuring they remain active and ready to use. **Restart a Heart Campaign (RSAH)** The national RSAH campaign took place in October 2019. The event nationally is organised by the British Heart Foundation (BHF). The main advertised day was on 14 October 2019. Delivery of the event is a partnership between volunteers and Fire and Rescue Staff. The Trust entered the planning phase for RSAH late this year due to capacity within the Team. Planning started in earnest in July 2019 using two alternative duty staff. Over the past three years over 35,000 people have been trained in CPR by our staff, volunteers and Fire Service Personnel. Engagement and delivery of RSAH has taken place this year with local schools, community groups and other stakeholders. Media has been managed through the Trust's communication team. Considering our late entry into the process, this year we have trained over 10,000 people across the geographical area of the Trust. This is in line with previous years and testament to our volunteers, staff and partners who dedicated their time and effort to make the event a success. Figures for RSAH will continue to grow as we will collate numbers until the end of December 2019 before the BHF debrief in the New Year. As a Trust we can be proud of what we have delivered along with our staff, volunteers, partners and stakeholders. The whole public engagement programme requires a co-ordinated approach by the Trust. With the right investment and commitment from the Trust more can be achieved year on year with our public engagement and training. The benefits of this public engagement and training has paid dividends in places such as Seattle in America. Some literature states over 60% of cardiac arrest patients survive to be discharged from hospital. The UK is around 6%. Currently CFR teams take local responsibility for community education and engagement, although it is the department's intention to learn from existing good practice and standardise its approach. This will ensure that every CFR team has access to the support and resources they need to proactively undertake successful community engagement. **The Future** There is an opportunity for Community First Responders to play a wider role within their community, which can help to improve awareness of the Trust's work, visibility, and improve overall relationships and engagement. Some of the innovative ideas that will help support the Trust and, more importantly, benefit patients will be, for example, a CFR falls response model, whereby specially trained CFRs will attend our lower acuity C3/C4 falls patients, where the patient is believed to have fallen and not sustained any injury. In these cases, CFRs would be able to undertake an assessment,

	supported remotely by a clinician in EOC and telemedicine and, if safe to do so, assist the patient to stand. This reduces the length of time the patient remains on the floor, and consequently improves patient outcome by minimising the risk of complications associated with long waits. **Engagement with Local Resilience Forums** Local Resilience Forums play a key role in preparing for emergencies, in line with the Civil Contingencies Act (2004), and includes representatives from several local agencies. The Trust, as a category 1 responder, has a duty to warn and inform the public. By improving our presence in the community and establishing communication channels with community groups, the Trust is better placed to engage with the public in an emergency to carry out this vital role. Each Local Resilience Forum has representation from the voluntary sector, of which SECAmb currently have no representation. However, many LRFs have an additional Community Resilience Sub-Group whereby SECAmb can engage with other agencies and remain up to date with matters affecting the community.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	78-19

Name of meeting	Trust Board
Date	28.11.2019
Name of paper	Learning from Deaths Policy
Responsible Executive	Medical Director
Author	Richard Quirk, Deputy Medical Director
Synopsis	This Learning from Deaths Policy is based on the national template stipulated in the National Guidance for Ambulance Trusts on Learning from Deaths published by the National Quality Board in July 2019. The guidance also mandates that the policy be approved by the Board and published by 1 December 2019. It has been considered and approved by the JPPF; the Trust's policy approval group. However, as per the guidance, it is a policy reserved to the Board for approval and, as set out in its report to the Board, it comes recommended by the Quality & Patient Safety Committee. On behalf of the Board, the committee will monitor ongoing compliance with the policy and will refer any issues, as they might arise.
Recommendations, decisions or actions sought	For approval

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**Yes** – this was completed on 14th October 2019 and no issues were identified**.**

Learning from Deaths Policy

Version:	V2.00
Name of originator/ author:	Dr Richard Quirk, Deputy Medical Director
Responsible management group:	Learning from Deaths Group
Directorate/team accountable:	Medical Directorate

Policy:	
Approved by:	Trust Board
Date approved:	
Fit for purpose according to:	Quality and Patient Safety Committee
Date approved:	

Date issued:	[To be inserted by Corporate Governance Team]
Date next review due:	
Target audience:	
Replaces (version number):	

Equality Analysis Record		
Approved EA included	Dated:	14th October 2019
Quality Impact Assessment		
Approved QIA included	Dated:	30th September 2019
Data Privacy Impact Assessment		
Approved DPIA included Dated:		Sent to team 14/10/19

Document Control

Formal approval:

Final approval by:	Trust Board	
Version No. V2.00	Final	Date:
Responsible Management Group approval by:	Learning from Deaths Group	
Version No. V2.00	Draft	Date: 30th September 2019

Review/comments:

Person/ Committee	Comments	Version	Date
Learning from Deaths Group	New Policy in line with national guidance	1.1	15/10/19

Circulation:

Records Management Database upload	Date: [to be added by Corporate Governance Team]
Internal Stakeholders	
External Stakeholders	

Review Due by responsible Management Group:

Period	Every three years or sooner if new legislation, codes of practice or national standards are introduced	Date: November 2022

Record Information:

Security Access/ Sensitivity	Official Public Domain
Where Held	Corporate Records Register
Disposal Method and Date	In line with national guidelines

Contents

1 Purpose

1.1. South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to reviewing practice, learning from events and improving practice.

1.2. It is recognised by the Trust that learning from deaths of people in our care has the potential to improve the quality of care we provide to patients and their families.

1.3. The purpose of this policy is to set out the governance structure and process for undertaking and reporting on mortality reviews. This policy follows the National Guidance for Ambulance Trusts on Learning from Deaths published by the National Quality Board in July 2019.

1.4. This national guidance requires Ambulance Trusts to:

1.4.1. Have a Learning from Deaths Policy that reflects national guidance which has been agreed by the Trust Board of Directors, shared with stakeholders and published by 1 December 2019.

1.4.2. Publish information, on a quarterly basis, of deaths, reviews and investigations via an agenda item and paper to public Board meetings.

1.4.3. Have a considered approach to the engagement of families and carers in the mortality review process.

1.4.4. Publish evidence of learning and actions taken as a result of the mortality reviews in the Trust's Quality Account

2 Scope

2.1. This policy is applicable to all staff including volunteers and those working on behalf of the organisation.

3 Duties and Responsibilities

3.1. The **Trust Board** is accountable for the quality of the healthcare the Trust provides, including safety. The Learning from Deaths policy places particular accountabilities on the Board, including;

3.1.1. Ensuring effective systems for recognising, reporting and reviewing or investigating deaths where appropriate are in place.

3.1.2. Ensuring learning identified by reviews or investigations as part of a wider process that links different sources of information provides a comprehensive picture of care provided.

3.1.3. Ensuring effective, sustainable action to address key issues associated with problems in care are taken.

3.1.4. Ensuring the needs and views of patients and the public are central to how the Trust operates.

3.2. The **Non-Executive Director** identified by the Trust to oversee the Trust's approach to Learning from Deaths is responsible for;

3.2.1. Understanding the review process and ensuring the processes for reviewing and learning from deaths are effective and can withstand external scrutiny.

3.2.2. Championing quality improvement that leads to actions that improve patient safety.

3.2.3. Assuring published information accurately reflects the Trust's approach, achievements and challenges.

3.3. The **Executive Medical Director** is the director responsible for the learning from deaths agenda.

3.4. The **Executive Director of Nursing & Quality** is the director responsible for the patient safety investigation process and the patient experience/patient engagement processes.

3.5. Operating Unit **Governance Leads** are responsible for ensuring that mortality reviews are completed in a timely manner within their Operating Unit.

3.6. All **Clinical Staff** are responsible for being aware of the Learning from Deaths policy, escalating any concerns regarding the death of a patient to their line manager and recording this on Datix and sharing learning from deaths with their colleagues.

3.7. Learning from Deaths is overseen by the Trust's Learning from Deaths Group.

3.8. The Learning from Deaths Group reviews the data of the number of deaths in each quarter by category, the numbers of deaths which have been selected for a mortality review, the outcomes of those reviews and the learning taken from those reviews. The Group will also monitor how families and friends have been engaged in mortality reviews (where relevant).

3.9. The learning taken from the Learning from Deaths Group will be cascaded to each Operating Unit, Emergency Operation Centres (EOCs) and 111 by the Governance Leads assigned to each of these services.

3.10. The Learning from Deaths Group reports to the Clinical Risk Learning Group which then reports to the Trust Clinical Governance Group which is chaired by the Executive Director of Nursing and Quality or Executive Medical Director. Any areas of concern are further escalated to the

Executive Management Board. Assurance reports are reported to the Quality and Patient Safety Committee of the Trust Board.

4 Learning from Deaths

4.1. Determining Deaths in Scope for Review

4.1.1. The following deaths will be in scope for the review process, this does not mean that all deaths in scope must be reviewed, only that they are eligible for consideration for review and should be reviewed as considered appropriate as described in 4.2.

4.1.1.1. Any patient who dies whilst under the care of the ambulance service (999/111). This is defined as the patient dying between the 999/111 call being made and their care being transferred to another part of the system, or to the point of the patient being discharged from ambulance care after a decision is made not to convey them to hospital. This includes cases where patients are transported using subcontracted alternative ambulance resource.This means that a patient should be considered under the care of the ambulance service.

- while the 999 call is being handled (this will include 111 calls transferred to the ambulance service);
- prior to the arrival of the ambulance resource;
- at scene;
- while the patient is being transported;
- prior to handover being concluded.

4.1.1.2. Any patient who dies within 4 hours after handover. It is acknowledged that identification of these patients may be an issue and that the Trust is only under this obligation when notified of these deaths. In such cases, it is good practice to undertake a joint review with the setting where the patient died.

4.1.1.3. Any patient who dies within 24 hours of contact with the Trust where a decision was taken not to convey them to hospital. This contact includes “hear and treat” patients as well as patients who were visited by ambulance personnel. This criterion excludes patients at the end of life and recognised to be in the dying phase of their illness, where their documented wish was to remain at home.

4.2. Determining Which Deaths Should be Reviewed

4.2.1. Annex A provides a flowchart summarising the process for selecting deaths for review.

4.2.2. The national guidance stipulates that the Trust must review all deaths where ambulance service personnel, other health and care staff, and/or families or carers have raised a concern about the care provided, including concerns about end of life care. This includes any concern raised that cannot be answered fully at the time or anything not answered to the satisfaction of the person raising the concern.

4.2.3. In addition, the Trust will review a sample of each of the four categories listed below (see 4.4.2 for the process of identifying these deaths).

4.2.3.1. Deaths of patients assessed as requiring category 1 and category 2 responses where there has been a delayed ambulance response*.

4.2.3.2. Deaths of patients assessed as requiring category 3 and category 4 responses*.

4.2.3.3. Deaths that occur following handover to an NHS acute, community or mental health trust or to a primary care provider, when this information is known.

4.2.3.4. Deaths of patients who were initially not conveyed to hospital and who then subsequently had re-contact with the ambulance service within 24 hours. The death should have occurred as part of that episode of care and not during a subsequent episode of care.

4.2.4. The Trust will determine a number across the four identified categories listed above which equates to 40 to 50 case reviews per quarter in total. This is in line with the findings that this number produces a rich source of information on care quality and on problems in care, as described in Royal College of Physicians (2016) 'Using the Structured Judgement Review Method: A Guide for Reviewers (England)'.

*A delayed response is as defined by the Ambulance Response Programme.

4.3. Additional Reporting Requirements

4.3.1. Deaths of Patients with Learning Disabilities

4.3.1.1. The Trust must report all deaths of those aged over four with a known learning disability to the Learning Disabilities Mortality Review (LeDeR) Programme. The Trust will contribute to their review processes when approached, and share its review findings with LeDeR when relevant.

4.3.2. Deaths of Patients with Severe Mental Illnesses

4.3.2.1. Serious mental illness (SMI) is **defined** as a **mental**, behavioural, or emotional **disorder** resulting in **serious** functional impairment, which substantially interferes with or limits one or more major life activities The Trust should report these deaths to the relevant mental health trust and/or management team where the person was known to be under their care. The Trust should also contribute to their review processes where approached.

4.3.3. **Maternal and Neonatal Deaths**

4.3.3.1. These should be reported to the HSIB (Healthcare Safety Investigations Branch) and MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK).

4.3.4. **Paediatric Deaths**

4.3.4.1. The Child Death Review Statutory and Operational Guidance outlines the Trust's statutory duties with regards to notification and information gathering. The Trust should participate in child death review meetings, i.e. Child Death Overview Panel (CDOP) meetings, when approached.

4.3.5. **Safeguarding Concerns**

4.3.5.1. Any deaths where there are safeguarding concerns should be referred to the Trust's Head of Safeguarding in line with statutory duties.

4.3.6. **Deaths in Custody**

4.3.6.1. These deaths fall under the relevant police forces' remit.

4.3.7. In some cases, in addition to reporting arrangements listed above, there may be occasions when the Trust will make the decision to conduct its own review of the death, for example, to identify early learning improvement actions in advance of the national review process or where there are concerns about the care towards the end of life. However, this is discretionary and is in addition to the Trust's requirements to notify the national review programmes of the death.

4.4. **The Trust's Approach to Case Review**

4.4.1. **Concerns raised by staff, relatives, carers and other professionals**

4.4.2. Concerns about the care of a patient who has died may be raised by staff (via Datix), relatives and carers (via complaints or PALs) and other professionals (via correspondence received). All of these concerns will be notified to the Learning from Deaths Coordinator within the Clinical Audit team in the Medical Directorate. All such concerns will receive a

Structured Judgemental Review and if poor care is identified will be referred to the Trust's Serious Incident Group for consideration of further investigation.

4.4.3. Concerns will be managed through the Trust's current processes (e.g. relatives or carer complaints will be managed through the complaints processes). Relatives and Carers will be fully involved with meaningful and compassionate engagement in the review and will be encouraged to give their views of the care and will receive feedback once the review has been complete. Duty of Candour processes will be followed. This immediate action could also include contacting the Police, Coroner and regulators.

4.4.4. **Quarterly Review of Deaths**

4.4.5. The Clinical Audit Team will provide a list of all deaths within the Trust on a monthly basis. The Learning from Deaths coordinator (overseen by the Deputy Medical Director) will randomly select 20 patients who have died per month for review. These will be selected from the following four categories: -

- Deaths of patients assessed as requiring category 1 and category 2 responses where there has been a delayed ambulance response.
- Deaths of patients assessed as requiring category 3 and category 4 responses.
- Deaths that occur following handover to an NHS acute, community or mental health trust or to a primary care provider, when this information is known.
- Deaths of patients who were initially not conveyed to hospital and who then subsequently had re-contact with the ambulance service within 24 hours. The death should have occurred as part of that episode of care and not during a subsequent episode of care.

4.4.6. Consideration will be taken to ensure that those patients selected for review are fairly distributed between the 10 Operating Units.

4.4.7. The Learning from Deaths coordinator will notify the Operating Unit (OU) Clinical Governance Lead for each OU of the 2 patients (approx.) requiring a structured judgemental review (SJR) each month. The OU Governance Lead will be asked to complete and return the SJR within 4 weeks. The Learning from Deaths coordinator will collate the reviews once they have been completed.

4.4.8. The purpose of the case review is to identify any avoidable contributory factors and good practice in relation to the person's death. Consideration will be given to if on balance, there were any aspects of care and support

that, had they been identified and addressed, may have changed the outcome will also be given.

4.4.9. Any SJR that concludes that there was poor care given to the patient, will be referred to the following week's Serious Incident Group (SIG) for consideration of whether an investigation is required. If it is considered that poor care has contributed to the death of a patient and a Serious Incident is declared, then the relatives and/or carers will be notified in accordance with the Duty of Candour legislation.

4.4.10. All OU Governance Leads will receive training in how to complete a Structured Judgemental Review.

4.4.11. The SJR aims to identify lessons to learn, if there is a need to change local practices as a result of the findings or if there are any wider recommendations that should be made to other healthcare providers. The outcome of the SJR will be documented on the standard template. If a further investigation is recommended by the Serious Incident Review Group, an action plan will be developed and implemented to ensure that it is translated into improvements in the delivery of care.

5 Definitions

5.1. Some of the terms used in the Learning from Deaths Policy could be misunderstood, the terms used in this policy have the following specific meaning;

5.2. **Case record review:**

5.2.1. A structured desktop review of a case record/note carried out by the Operating Unit Governance Lead to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely in the absence of any particular concerns about care, to learn and improve. The 'Structured Judgemental Review' template will be used to complete the review and ensure all reviews are standardised. An SJR will also be completed where concerns exist, such as when the bereaved or staff raise concerns about care.

5.3. **Investigation:**

5.3.1. A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigation draws on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of

similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first. This process is overseen by the Serious Incident Group (SIG).

5.4. **Death due to a problem in care:**

5.4.1. A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel the death is more likely than not to have resulted from problems in care delivery/service provision. Note, this is not a legal term and is not the same thing as 'cause of death'. The term 'avoidable mortality' should not be used as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

5.5. **Quality improvement:**

5.5.1. A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

6 Investigations

6.1. The Learning from Deaths process enhances and does not replace the Trust's existing Serious Incident Policy.

6.2. Any concerns with care identified during the Structured Judgemental Review process will be reported immediately on the Trust's Patient Safety Management System (Datix). The case will be reported to the next Serious Incident Group (SIG) which meets weekly. If the concerns meet the criteria of the National Serious Incident Framework, these will be reported on the Strategic Executive Information System (StEIS).

6.3. The Trust will ensure that it meets its statutory requirements under the Duty of Candour with contact being led by the relevant investigation manager.

6.4. The Trust will ensure that any staff involved in the investigation are treated in a consistent, constructive and fair way throughout the process.

7 Bereaved Families and Carers

7.1. The Trust is committed to engaging in a meaningful and compassionate way with bereaved families and carers.

7.2. Bereaved families and carers who have concerns about the care provided by Secamb normally raise these concerns through the Patient Experience Team via the Trust's complaints process or Patient Advice and Liaison Service (PALS). Please refer to the Complaints Policy for information on

how these concerns are managed and how the Trust learns from patient/relatives concerns.

7.3. The Trust meets its statutory requirement of Duty of Candour, by notifying relatives and carers if an investigation is to take place into the care provided. As part of the Trust's Duty of Candour processes, relatives and carers are to be fully engaged in the investigation process and are provided with the outcome of the investigation and next steps.

7.4. If the Trust is about to undertake an investigation into the deceased person's care, the bereaved family and carers will be informed.

7.5. Bereaved families and carers will be informed of the outcome of the investigation. In particular they will be informed if the care is thought more likely than not to have contributed to the death, or indeed that the care is thought to have caused moderate to severe harm unrelated to the death, in order to fulfil the trust's duties in relation to the statutory Duty of Candour.

7.6. The Trust will involve families and carers in any learning and actions following reviews and investigations when they want to be involved.

7.7. The Trust will support bereaved families and carers and will refer families and carers to further support and to advocacy services where requested.

7.8. The Trust will engage with families where a death has been referred to the coroner and will be the subject of an inquest. Where required, this section should set out:

8 Supporting Staff

8.1. The Trust recognises that caring for a patient who has died can be distressing. Staff receive day to day support from their line manager and staff are encouraged to contact their manager if they would like to debrief following the death of a patient.

8.2. Staff have access to the Trust's Wellbeing Hub if they would like to receive additional support following the death of a patient. The Trust's wellbeing hub is a confidential service.

8.3. The Trust is a listening organisation and managers and leaders want to hear from staff if there are any suggestions of how the Trust can improve the care to patients.

8.4. If any member of staff has concerns about how the Trust is responding to care issues identified, they can contact the Freedom to Speak Up Guardian – contact details are available on the Trust's intranet site.

9 Learning from Reviews

9.1. Learning from death reviews will be shared and discussed at the Trust's Learning from Deaths Group which reports to the Clinical Risk Learning Group. Highlights will be shared with the Trust's Clinical Governance Group.

9.2. Immediate patient safety issues will be cascaded to staff via the Trust's Clinical Bulletin services.

9.3. Trust wide learning and suggestions for Clinical Audit will be provided to the Quality and Patient Safety committee of the Trust Board.

10 Reporting Arrangements

10.1. The Trust will present quarterly reports on the outcomes of the Learning from Death Reviews to the Board of Directors. These reports will be published and will include the following information:

10.1.1. A summary of the learning themes from reviews and investigations undertaken in the previous quarter and resulting recommendations and actions taken. This includes recognising examples of good quality care.

10.1.2. How the Trust is assessing whether its learning and actions are improving patient safety.

10.1.3. The number of completed reviews.

10.1.4. The number of deaths for which an investigation was indicated and, of these, the number of completed investigations.

10.1.5. The number of deaths in which a problem in care was identified which was considered more likely than not to have contributed to the death. This judgement should be made from reviews undertaken following the initial case record review.

10.1.6. A consolidated total of the number of live and completed reviews and investigations relating to that financial year (from quarter two 2020/21 onwards).

10.2. The Trust will produce an annual summary of learning from deaths within its Quality Account (from June 2021). This will provide a consolidation of the quarterly reporting information together with a narrative analysis of learning and resulting key themes, actions taken and the outcomes of these.

11 Training Requirements

11.1. All Operating Unit Governance Leads will receive training in how to complete a Structured Judgmental Review (SJR).

12 References

12.1. The following references informed the development of this policy:

12.1.1. National Guidance for Ambulance trusts on Learning from Deaths, National Quality Board, June 2019;

12.1.2. Learning from Deaths: Guidance for NHS Trusts on Working with Bereaved Families and Carers, National Quality Board, 2018;

12.1.3. Just Culture Guide, NHS Improvement, 2018;

12.1.4. Learning, Candour and Accountability: A Review of the Way NHS Trusts Review and Investigate the Deaths of Patients in England, CQC, 2016;

12.1.5. Serious Incident Framework, NHS England, 2015;

12.1.6. Using the Structured Judgement Review Method: A Guide for Reviewers (England), Royal College of Physicians, 2016.

13 Associated Documents

13.1. Serious Incident (SI) Framework

13.2. Risk Management Strategy Policy and Procedure

13.3. Incident Reporting and Investigation Manual

13.4. Being Open and Duty of Candour Policy

13.5. Safeguarding Policy

13.6. Complaints Policy

13.7. Complaints procedure

13.8. Risk Register and Associated Risk Assessments and Action Plans

13.9. Board Assurance Framework

14 Audit and Review (evaluating effectiveness)

14.1. All policies have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.

14.2. Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

14.3. This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.

14.4. All changes made to this policy will go through the governance route for development and approval as set out in the Policy on Policies.

15 Equality Analysis

15.1. The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

15.2. Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.

Name of author and role	Richard Quirk		
Directorate	Medical	**Date of analysis:**	14th October 2019
Name of policy being analysed	Learning from Deaths		
Names of those involved in this EA	Richard Quirk		

1. Trust policies and procedures should support the requirements of the Equality Duty within the Equality Act:	• Eliminate discrimination, harassment and victimisation; • Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; • Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.	In submitting this form, you are confirming that you have taken all reasonable steps to ensure that the requirements of the Equality Duty are properly considered.

2. When considering whether the processes outlined in your	For example: • Local or national research • National health data	If so, please give details: The Learning from Deaths policy

document may adversely impact on anyone, is there any existing research or information that you have taken into account?	• Local demographics • SECAmb race equality data • Work undertaken for previous EAs	is created using the national template from NHS Improvement. A national group of experts were used to create the template ensuring that Equality needs were discussed and met.

3. Do the processes described have an impact on anyone's human rights?	If so, please describe how (positive/negative etc): Positive: The aim of reviewing the care records of patients who have died within our care is to identify if the Trust's care standards contributed to the death and to learn how we can care for those patients who are dying better.

4. What are the outcomes of the EA in relation to people with protected characteristics?			
Protected characteristic	**Impact** Positive/Neutral/Negative	**Protected characteristic**	**Impact** Positive/Neutral/ Negative
Age	Neutral	Race	Neutral
Disability	Neutral	Religion or belief	Neutral
Gender reassignment	Neutral	Sex	Neutral
Marriage and civil partnership	Neutral	Sexual orientation	Neutral
Pregnancy and maternity	Neutral		

5. Mitigating negative impacts:
If any negative impacts have been identified, an Equality Analysis Action Plan must be completed and attached to the EA Record. A template for the action plan is available in the Equality Analysis Guidance on the Trust's website. Please contact inclusion@secamb.nhs.uk for support and guidance.

Protected characteristic:		Issue identified:		
Action required:				
Action lead:				
How will impact/outcome be measured?		Timescale:		
Resolution of actions:				

Protected characteristic:		Issue identified:		
Action required:				
Action lead:				
How will impact/outcome be measured?		Timescale:		
Resolution of actions:				

EA Sign off	
EA checkpoint (Inclusion Working Group member, preferably from your Directorate)	Michael Bradfield, Consultant Paramedic
By signing this, I confirm that I am satisfied the EA process detailed on this form and the work it refers to are non-discriminatory and support the aims of the Equality Act 2010 as outlined in section 1 above.	
Signed: M. Bradfield	Date: 14/10/2019

16 Resources

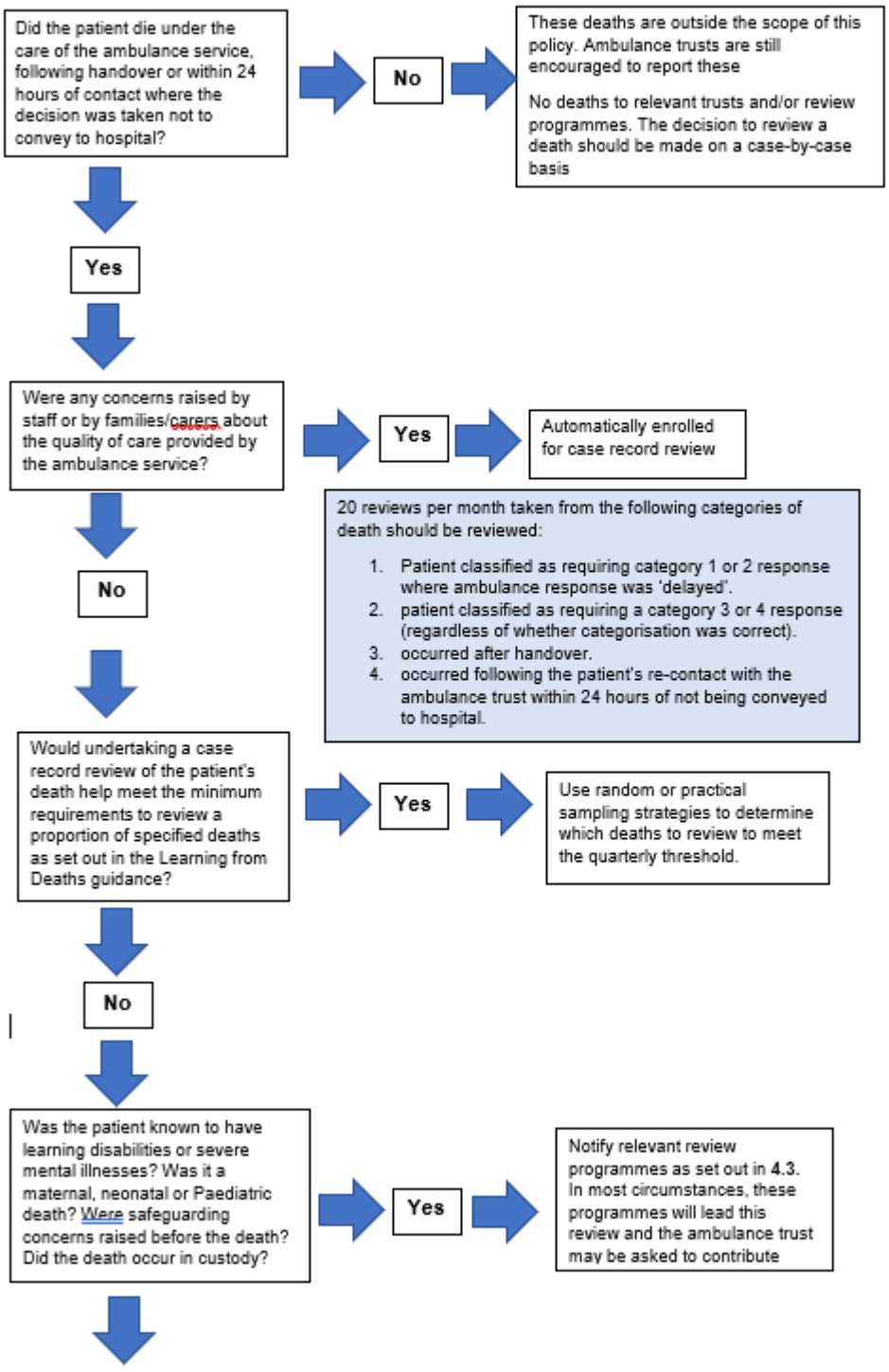
16.1. Learning from deaths dashboard
https://improvement.nhs.uk/resources/learning-deaths-nhs-national-guidance

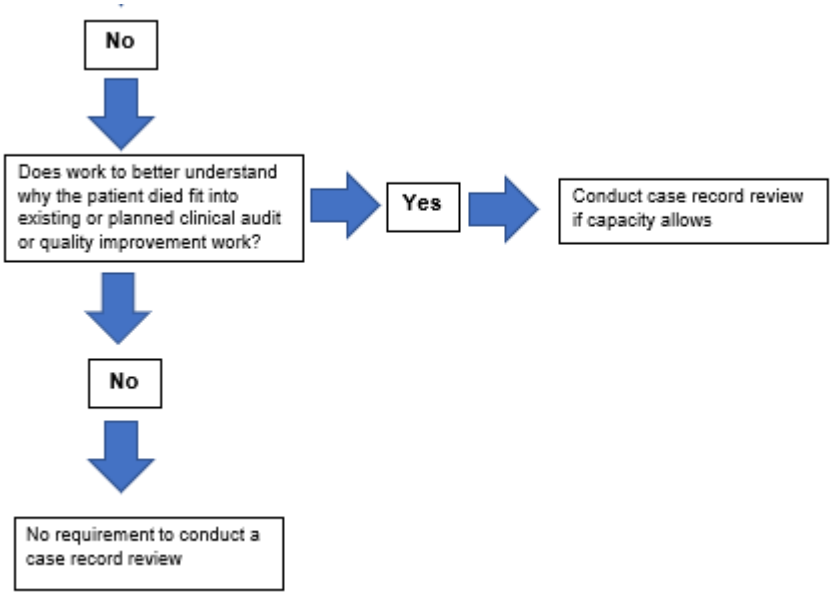
16.2. Resources from the national patient safety team;
https://improvement.nhs.uk/resources/patient-safety-alerts/

16.3. The Improvement Hub
https://improvement.nhs.uk/improvement-hub/

16.4. Using the structured judgement review method Data collection form (RCP)
https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrrprogramme-resources

Appendix A: Process for selecting deaths for review




No
Does work to better understand why the patient died fit into existing or planned clinical audit or quality improvement work?
Yes
Conduct case record review if capacity allows
No
No requirement to conduct a case record review

Appendix B: Contents of Quarterly Public Board Papers

Frequency	Information on deaths must be published in the quarter after which the death occurred in the public Board paper. If the review or investigation is on-going this information should be included and updated in subsequent publications.
Contents	• Number of deaths in the Trust's care. • Number of deaths subject to case record review (desktop review of case notes using a structured method). • Number of deaths investigated under the Serious Incident framework (and declared as serious incidents) • number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care • number of reviews/investigations on-going • themes and issues identified from review and investigation (including examples of good practice) • actions taken in response, actions planned and an assessment of the impact of actions taken.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	79/19

Name of meeting	Trust Board
Date	28.11.19
Name of paper	BAF Risk 362 - Personnel Files Update
Executive sponsor	Interim Director of HR
Author name and role	Paul Renshaw, Interim Director of HR
Synopsis	As set out in the BAF risk report, Risk 362 – Safer Recruitment, is the 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. This paper updates the Board on the progress taken to mitigate this risk.
Recommendations, decisions or actions sought	For assurance

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

Summary

At its meeting in September 2019, the Board considered the emerging issues highlighted by management, relating to gaps in some staff records, specifically identity documentation.

A range of measures have been put in place to support the collection of this documentation and during the w/c 18 November a letter was sent to all staff and volunteers, asking them to provide specific identification documents. It also explained the reasons for the request.

A new government-approved secure scanning system has been purchased, which enables significantly greater levels of assurance as to the authenticity of documents provided to the Trust.

The issue

As confirmed in September, the Trust retains personnel files in different systems. A full review of the data from each personnel file was carried out and of the 3684 files checked, a number of gaps were identified, with either identification documents not being found or evidence that they have been verified.

In September the Board received assurance that due to the new process established earlier in the year, all staff that joined the Trust from May 2019 do have the correct identification documents, verified and saved. It was also assured that there is robust systems for criminal record checks via the DBS system, which both the quality and workforce committees have separately received assurance on, and for monitoring professional registrations.

In light of this, the Board agreed a number of steps. Its primary concern was to be able to evidence identification documents for all Trust staff, and so the focus has been on achieving 100% compliance in this area.

Progress since September 2019

1. The Senior Information Risk Owner formally advised the Information Commissioner's Office (ICO) and the ICO has responded to confirm its assurance with the steps the Trust is taking.

2. A communications plan has been agreed and all staff have been sent a letter as outlined above.

3. Staff have been asked to provide the identity documentation by 31 December 2019.

4. Specific resource has been identified within the resourcing team to deliver this project in terms of receiving documents from local administrators and effectively storing this information on the electronic personnel file.

5. A decision was made to extend the request for information to all volunteers since an audit of these records also highlighted gaps in documentation compliance.

6. An effective and efficient software scanning solution has been purchased to enable local administrators to copy documents and have them checked for authenticity by a Government approved third party supplier.

   Each document takes a few seconds to scan and upload, using a Trust mobile device. Advanced scanning captures information visible to the naked eye and non-visible information that is far more difficult for counterfeiters to imitate, such as the data held within the document's chip. This makes scanners highly effective when compared to a visual inspection by employees. By scanning documents and checking them against the relevant authority systems the risk around acceptance of illegal documents is removed.

7. A self-audit process within the project team has been established to compliment compliance spot-checks by the QI and Quality teams.

8. The progress of the project (proportion of staff having returned their documents) will be supported by the PMO and monitored by the Quality and Compliance Steering Group.

Conclusion

The executive is confident that, in addition to the steps already taken to improve the internal controls for staff records, these specific measures will result in being able to evidence these key documents for every member of staff.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	80/19

Name of meeting	Trust Board
Date	28 November 2019
Name of paper	Clinical Education Update
Responsible Executive	Dr Fionna Moore
Author	Nicola Brooks – Associate Director Effectiveness & Experience
Synopsis	This paper is to provide an update and assurance following the Trusts Ofsted visit/report that there is clear leadership to ensure the necessary corrective actions are being taken at an appropriate pace. Significant work has been undertaken to focus and strengthen the clinical education department, its functions and corporate governance arrangements. This includes the establishment of a Transforming Clinical Education Programme Board and the development of eleven comprehensive work streams. The Trust has submitted its application to continue to remain on the register of apprenticeship providers as an employer provider. The Trust is exploring options to potentially recommence apprenticeship courses as a joint venture working with a Main Provider.
Recommendations, decisions or actions sought	For information and assurance

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**

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SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Clinical Education Update (November 2019)

1. Background

1.1 End July/early August 2019, the Trust underwent an Ofsted Monitoring Visit. These visits are to directly funded providers of apprenticeship training provision to assess compliance against the Ofsted contract requirements and standards. Feedback was received under three themes:

a) Theme 1: Leadership and Management - how much progress have leaders made in ensuring that the provider is meeting all the requirements of successful apprenticeship provision? The Ofsted judgement was 'Insufficient Progress'.
b) Theme 2: Teaching and Learning - what progress have leaders and managers made in ensuring that apprentices benefit from high-quality training that leads to positive outcomes for apprentices? The Ofsted judgement was 'Insufficient Progress'.
c) Theme 3: Safeguarding Learners - how much progress have leaders and managers made in ensuring that effective safeguarding arrangements are in place? The Ofsted judgement was 'Reasonable Progress'

1.2 The Trust was advised by the Education and Skills Funding Agency (ESFA), that it would not be authorised to commence new apprenticeship programmes until such time as compliance against the standards was achieved. Existing apprenticeship programmes were unaffected by the outcome. A root cause analysis investigation is underway to explore how this had not been escalated through the line management and/or governance structures. The Board will be appraised of the progress and outcomes of this at future meetings.

2. Transforming Clinical Education Programme Board

2.1 Accountable to the Executive Management Board (EMB), the Programme Board is working to deliver a clinical education function that delivers the needs of the business incorporating the concerns raised by Ofsted. The eleven work streams are as follows:

i) Marking
   a) Completion of the marking of assessments for those apprentices that have completed their courses but not yet sat their end point assessment
   b) Marking of all submissions, with only submissions made within the past 30 days being open (as BAU).

ii) Clinical Education Courses:
   a) Mapping of clinical education courses from 1 October 2019 to 31 March 2020 (by end December 2019).
   b) Mapping the future requirements for 2020/21 clinical education courses (based on the workforce modelling programme/outputs) by end January 2020.

iii) HEI Contracts: Scoping and development of standardised contracts for the placement of students from our partner HEIs (by end December 2019).

iv) Ofsted Compliance (by end January 2020):
   a) Development and implementation of systems and process to ensure compliance with the identified issues in the 2019 Ofsted Monitoring Inspection Report.
   b) Preparation for the Full Ofsted Inspection Visit

DRAFT

v) Co-delivery of Apprenticeships (by end January 2020): Commissioning of an external provider organisation(s) to deliver clinical apprenticeship courses pending Trust reaccreditation.

vi) Functional Skills:
   a) Commissioning of an external provider organisation to deliver Level 2 Maths and English to 48 existing students that require this support (by end December 2019)
   b) Mapping of any students in the pipeline to join apprenticeship programmes, to ensure they have Level 2 Maths and English and to provide access to training as required (by end March 2020).

vii) Level 6 Paramedic Programmes: Outsourcing the delivery of the Level Six Paramedic Apprenticeship Programme from September 2020 (by end August 2020).

viii) Key Skills Programme: Development of the key skills programme for 2020/2021 for all clinical staff working for the Trust (by end December 2019).

ix) Tutor Qualifications: Mapping the clinical education tutor qualification requirements to deliver clinical apprenticeship courses and identification of any training gaps (by end November 2019).

x) Workforce Education Development Review: Implementation of the Paramedic B5-B6 uplift (Workforce Education Development Review) education requirements.

xi) Clinical Education Strategy: Development of an agreed Clinical Education Strategy (by end March 2020).

2.2 The work streams address the immediate issues and align the Trusts clinical education function to the needs of the whole organisation. It is anticipated that in the main these will be concluded by the end of March 2020, following which the second phase will look at the longer term to ensure the department is structured, resourced, and funded appropriately to deliver the needs of the organisation based on a clear Clinical Education Strategy.

3. Governance:

3.1 Further to the decision from Ofsted reporting insufficient progress, the Trust received notification of a forthcoming audit to be undertaken by FutureQuals, the awarding organisation. The purpose of which is for the awarding body to gather assurance that the Ofsted identified outcomes have had no adverse effects on the delivery of regulated qualifications or the centres ability to manage the contract accordingly to deliver regulated qualifications effectively.

3.2 The Trust is registered as an Employer Provider. Re-registration was required by the ESFA at the end of October 2019 and a re-application (of the same status) has been submitted. The review process takes circa twelve weeks by the ESFA, during which time the Trust can continue to operate as an Employer Provider, but remains unable to commence new apprenticeship programmes internally.

3.3 Health Education England and the ESFA have confirmed the Trust can work with accredited Main Providers to provide apprenticeship training at this current time. A programme of work is now underway to scope the options for this.

END

DRAFT

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	81-19

Name of meeting	Trust Board
Date	November 2019
Name of paper	Freedom to Speak Up
Executive sponsor	Bethan Haskins – Director of Quality & Nursing
Author name and role	Kim Blakeburn Freedom to Speak up Guardian
Synopsis	This report updates the Board on the Freedom to Speak Up (FTSU) implementation and progress since for the last quarter. It will also provide information on activities and engagement connected to the role and a summary of themes connected to speaking up. Appendix A includes the draft FTSU strategy.
Recommendations, decisions or actions sought	The Board is asked to consider the information provided

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

South East Coast Ambulance Service NHS Foundation Trust

Trust Board

Freedom to Speak Up

1. FTSU activity update

- October was National FTSU month. The FTSU Guardian held a number of events both in the East and West to engage with staff. These included Joint collaborative events with South Central Ambulance Service, Frimley Park, London Ambulance Service and Surrey and Sussex Healthcare. The Guardian also manned a FTSU exhibition stand at the BME Conference hosted by SECAmb at the Amex centre in Brighton.

- The FTSU Guardian is attending team meetings where possible to raise awareness and offer reassurance on subjects relating to raising concerns.

- FTSU training to Paramedic students during their SECAmb induction.

- Presenting at Corporate Inductions/SECAmb Inductions.

- Working with the Learning and Organisational Development team to incorporate Raising Concerns/Freedom to Speak Up into Leadership training programmes.

- Power BI dashboard now in draft form to highlight hotspots for FTSU support.

- RSM Audit

- Supporting other Trusts and NHSi in building a working FTSU model

2. Concerns Raised

A total number of 54 concerns have been raised since the last FTSU report.

Q1 = 20

Q2 = 21

Q3 = 13 (04/11)

The following table shows a breakdown of this data for SECAmb reported to the NGO for Q1. On this occasion no comparable data from other ambulance trusts is available. Once this becomes available it will be published in the next FTSU Board report.

*Please note, not all concerns raised will fit into a category and on some occasions a concern will be highlighted in more than one category.

Q1 Ambulance Trust	Total	Raised Anon	Pt Safety	B&H	Detriment
SECAmb	20	1	0	10	0

Q2 Ambulance Trust	Total	Raised Anon	Pt Safety	B&H	Detriment
SECAmb	20	2	0	9	1

In Q1 - of the 20 concerns raised 11 related to HR processes. In Q2 - 8 of the 20 concerns related to HR processes.

I would ask the Board to note that there has been one concern raised where there is a suggestion that this person has suffered detriment as a result of previously raising a complaint. Due to the importance of anonymity this will be discussed further during the private session of Board.

3. NGO FTSU Index

The National Guardians Office (NGO) published a FTSU Index report for 2019. The FTSU index was calculated as the mean average of responses to four questions from the NHS Annual Staff Survey.

The survey questions that have been used to make up the FTSU index are:

- % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)
- % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)
- % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)
- % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

SECAmb featured in the top 10 list of Trusts with the greatest overall increase in the FTSU Index.

Trust	2015	2018	2015 - 18
London Ambulance Service NHS Trust	57	75	**18**
Isle of Wight NHS Trust (ambulance sector)	62	79	**17**
North East Ambulance Service NHS Foundation Trust	64	76	**12**
East Sussex Healthcare NHS Trust	66	78	**12**
South East Coast Ambulance Service NHS Foundation Trust	64	74	**10**
The Royal Orthopaedic Hospital NHS Foundation Trust	73	82	**9**
Sherwood Forest Hospitals NHS Foundation Trust	70	79	**9**
Isle of Wight NHS Trust (mental health sector)	69	77	**8**
Gloucestershire Care Services NHS Trust	74	82	**8**
Lincolnshire Partnership NHS Foundation Trust	72	80	**8**

4. Priorities for next quarter

- Developing an interactive FTSU training presentation with Clinical Education team to roll out at Key Skills 2020.

- NGO Training for FTSU Advocates and building the FTSU Advocate network

- Updating The FTSU/Raising concerns area on The Zone which will include a link to a quarterly Newsletter and will include examples of learning.

5. Themes

Key themes gathered from concerns raised are as follows:

5.1 **Lack of trust/confidence in HR**– There has been a number of references made to the FTSU Guardian that HR are seen to take the side of management during hearings such as a disciplinary or grievances. There also continues to be a strong theme arising from those that have been through a formal process that this is often investigated or heard by managers that are either not impartial or who do not have the correct understanding of the process. A possible solution to this could be to consider an independent investigations team.

The FTSU Guardian has discussed this with our Interim HR Director and he has offered assurance that they are in discussions with the Unions who had also recently raised this matter to the Senior HR team.

5.2 **Receiving concerns/feedback**– Encouraging all colleagues/managers to receive concerns should be an important focus for SECAmb. The sometimes defensive response to a concern being raised can occasionally come across as quite aggressive or even threatening and this has been highlighted by some colleagues but also experienced first-hand by the FTSU Guardian.

There are a few examples of grievances being upheld and the only information given to the person who has put in the grievance is a standard letter. Not one person that has gone through this process and has spoken to the FTSU Guardian has had experience of being thanked for speaking up. No further support is given or advice on how they can move on from the experience which will no doubt have been a stressful one.

5.3 **Operational Culture/Leadership -** Several concerns were reported from colleagues in one particular OU. These concerns highlighted issues with a poor culture and a number of people experiencing bullying, harassment, sexist comments or being reprimanded for striving for improvement in the team. An independent survey was conducted and the results shared with the FTSUG. The comments reinforced the concerns raised.

The FTSUG has highlighted these concerns to the Associate Director Operations (Resilience) and has been assured that this is being investigated.

In another area which sits under Operations there sadly continues to be a significant number of concerns raised. Each quarter there continues to be a theme on suggestions of nepotism for acting up opportunities/development

opportunities, culture issues (bullying and harassment for new staff), some managers not behaving with integrity and suggestions of a lack of leadership in some areas.

There has also been pockets of areas where senior leaders are seen to not act impartially in disciplinary matters, demonstrating a culture of one rule for one, a different rule for another.

The FTSUG will continue to highlight these concerns to the relevant leadership teams.

6. **The NGO regularly publish case studies which conclude with a list of recommendations for guardians to highlight any gaps in ways of working at our organisations.**

   A case study took place at North West Ambulance service and I am referencing a snap shot of these here for consideration from the Board for any gaps that could be at SECAmb :

Theme	Actions at NWAS in response to findings
Thanking workers for speaking up	The trust's new speaking up policy will include a reference to thanking all workers who speak up. The trust is continuing to train managers in investigation training to address this is
The independence of investigators into speaking up matters	The trust will review its relevant policies in relation to investigations to ensure that - They take proper and reasonable account of workers' objections relating to the perceived independence of investigators, and that a clear rationale for any decisions regarding investigators is given to workers in response to such objections. They provide more transparency about the way in which the trust will manage potential conflicts of interest relating to investigations.
Mediation	Taking appropriate steps to ensure that managers and HR staff are up to date with existing guidance on explaining the value of mediation to workers

7. Summary

Freedom to Speak Up Guardians help:

- Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement

By ensuring that:

• Workers are supported to speak up

• Barriers to speaking up are addressed

• A positive speaking up culture is fostered

• Issues raised are used as opportunities for learning and improvement

As implied by this summary, the range of issues that a Freedom to Speak Up Guardian can support a worker to raise is not restricted to any particular type and instead covers a wide range of matters, including, but not limited to:

• concerns about unsafe clinical practice

• staffing and resource levels

• cultural concerns

• bullying and harassment

• training and improvement ideas

• personal employment issues

• dignity at work issues

The NGO has observed in its case reviews that a barrier to speaking up has been created where workers are told by their employer that the matters they wish to speak up about are not within the scope of the Guardian to support. Many of the matters a Guardian can support a worker to raise will carry their own set of policies and procedures. In such circumstances, the Guardian can help a worker explore the best way to speak up under those processes, including helping them to understand their rights and obligations under that policy. As stated in the job description, Guardians also promote learning and improvement within their organisation, helping to ensure that lessons learned from the issues raised by workers are actioned appropriately to deliver lasting improvement.

8. Recommendation

8.1. The Board is asked to note this report.

Caring for you and everyone
Freedom to Speak Up strategy
2019 - 2024

Introduction from the Director of Nursing
Effective Speaking Up arrangements are there to protect patients and improve the experience of staff. Having a healthy speaking up culture is an indicator of a well-led trust.

We take seriously our duty to provide the highest quality care to our patients and to create a positive environment for our staff to work and develop in.

We need to be confident that our staff would say something if they think we are providing care in an unsafe way or that poor culture is impacting on our ability to effectively look after our patients. The risk, if they don't, is that we miss the opportunity to learn, to refine and improve our practice and procedure or to address damaging culture. This document sets out our objectives for ensuring we have a successful set of arrangements in place for Freedom to Speak Up.

Our Ambition
Our ambition is to be an organisation that listens to its staff's concerns and learns and improves as a result. We want to be an organisation where all our staff raise any concerns they might have with their line manager, and receive a positive, sensitive response that demonstrates they have been listened to, and they can see how their concern has resulted in learning and improvement. We need staff to feel safe to speak up without fear of repercussion.

We know that we are not quite there yet and that we are still learning about how FTSU needs to work at SECAmb.

Where we are now
We have already appointed a full time FTSU Guardian and a growing group of FTSU Advocates who encourage and support staff to raise concerns about things that are happening in the work place. They have been in place since September 2018. More and more people are speaking up to them which is fantastic and indicates that we are on the right track. We have also revised our speaking up policy and put in place a governance structure around FTSU to ensure that the themes and learning are regularly discussed by our Exec team and our Board.

Speaking up is everyone's business
We know that there is more to do. Leaders need to be visible, approachable, open and responsive and managers need to be able to deal with concerns sensitively, compassionately and quickly. We want staff to know how to speak up and to be able to do so promptly, confidently and constructively. Consistently applying these behaviours will help a healthy speaking up culture develop where staff feel confident that when they speak, they will be listened to and that change will occur. Achieving this will make SECAmb a more open and transparent place to work, where all staff feel included. Relationships across the organisation will strengthen and staff satisfaction will increase. As a result, SECAmb will be better at providing safe and effective care to the patients it serves.

This strategy sets out our vision through five key objectives. Each of those commitments is supported by several actions, time frames and measures and apply equally to everyone. This will ensure that developing a positive speaking up culture is everyone's business.

Objective	Measure	Target (1/3/5 years)	Initiative
Strengthen leadership behaviours around FTSU	• NHS Staff survey results and verbatim comments • 360 degree performance feedback	• NHS Survey Results – Improvement yr 1 – Average yr 3 – Above average yr 5 • Improvement in comments received at QAV regarding a willingness to address DoC and Raising concerns	• Develop/embed 360-degree feedback and reflection loop • Board development sessions – learning from staff concerns • Strengthen Exec visibility and engagement with staff • Develop a meaningful way for Execs to celebrate changes that occur from speaking up
Improve staff understanding and awareness of speaking up	• NHS Staff survey • Pulse survey • Contacts with FTSUG and advocates • Concerns raised during walkabouts • A&E QAV Visits - record numbers of Staff who are aware of avenues to Raise concerns	• NHS Survey Results – Improvement yr 1 – Average yr 3 – Above average yr 5 • Use Intranet analytics – count page views or document downloads in relation to FTSU. • Use online discussion forum /social media live events– number of participants/comments. Quantify the number of positive versus negative verbatim comments. • Annual pulse survey increase for colleagues understanding route to raise concerns	• Train and develop champions • Create presentation for SECAmb Induction • Attend Keyskills • Develop a comms and engagement strategy around learning and change because of FTSU (to include evaluation)
Improve managers' ability to respond to staff concerns	• NHS Staff survey • Pulse survey • Reduction in formal grievances/B&H claims • Manager pulse survey • Increase in informal solutions to tackle relationship issues: mediation/coaching • 1-1s – line managers to evidence how they dealt with difficult conversations	• Reduction at 1, 3 and 5 yrs for formal grievance/B&H claims • OTL, OM and OUM Leadership training and guidance • Numbers increased for Mediation at yr 1,3 and yr 5. • NHS Survey Results – Improvement yr 1 – Average yr 3 – Above average yr 5	• Develop leadership development programme: challenging conversations; EI; coaching; conflict de-escalation etc • Develop a range of initiatives that enable managers to explore informal resolution to relationship issues: mediation/coaching/team building etc • Investigation training to enable managers to look into patient safety concerns • Review how effective performance feedback is • Develop/embed 360-degree feedback and

			reflection loop
Identify and remove barriers to speaking up	• NHS Staff survey • Pulse survey • Contacts with FTSUG and advocates • Reduction in formal grievances/B&H claims	• NHS Survey Results – Improvement yr 1 – Average yr 3 – Above average yr 5 • Reduction in number of Grievances – Yr1 – yr 3 – yr 5	• Develop patient safety/HR triangulation dashboard • Analyse speaking up culture in conjunction with bullying and harassment hot spots • Proactively identify poor behavioural culture in OUs – incivility, banter, cliques etc • Develop a FTSU focus group to include relevant networks and support groups • Communicate clearly and widely the action we have taken to address poor culture and improve inclusivity • Create FTSU quarterly newsletters addressing hot topics/barriers
Develop a listening and learning culture	• NHS Staff survey • Increased number of QI projects on the go	• Reductions annually in concerns needing to be raised to the FTSU Guardian • NHS Survey Results – Improvement yr 1 – Average yr 3 – Above average yr 5 • Reduction in Grievance yr 1 – Yr 3 and yr 5	• Develop routine ways to gather and share staff opinion and concerns ie 1-1s/team meetings • Develop and embed feedback process to staff who speak up during the various walkabouts • Develop a process to collate and review themes arising from informal feedback mechanisms • Proactive engagement in relation to future service/organisation change

Transparency

As a sign of our commitment to develop our culture and support our staff we will publish our FTSU strategy, action plan and regular progress updates on our FTSU intranet page.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

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Information Governance Annual Report 2018/19

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

Agenda No	82-19

Name of meeting	Trust Board
Date	28th November 2019
Name of paper	Information Governance – Annual Report
Responsible Executive	Executive Director of Nursing & Quality
Author	Caroline Smart – Head of Information Governance
Synopsis	Information Governance is the term used to describe the framework that brings together the requirements, standards and best practice that apply to the handling of information. It enables organisations and individuals to ensure that information is dealt with legally, securely, efficiently and effectively in order to deliver the best possible care. Information Governance is an enabler for Confidentiality, Information Security, appropriate Information Sharing and predominately covers the following criteria: • Information Governance Management • Confidentiality & Data Protection Assurance • Information Security Assurance • Clinical Information Assurance • Corporate Information Assurance This is the second Information Governance Annual Report from the Executive Director of Nursing and Quality. It provides a high-level summary documenting the progress and IG Framework status within SECAmb during 2018 / 2019 whilst illustrating the priorities for the forthcoming year.
Recommendations, decisions or actions sought	For assurance. This Annual Report has undertaken a full review by the Audit Committee (as confirmed in its report to the Board in July) and Executive Management Board with subsequent recommendations made. These changes have now been incorporated with the report. The report includes an assurance rating, which is based on the Information Commissioners Office (ICO) audit format methodology.

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

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Executive Summary

Information Governance is the term used to describe the framework that brings together the requirements, standards and best practice that apply to the handling of information. It enables organisations and individuals to ensure that information is dealt with legally, securely, efficiently and effectively in order to deliver the best possible care.

Information Governance is an enabler for Confidentiality, Information Security and appropriate Information Sharing and predominately covers the following criteria:

- Information Governance Management
- Confidentiality & Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Corporate Information Assurance

Confidentiality and compliance with Data Protection legislation remains at the forefront of our organisation. As an Ambulance Trust South East Coast Ambulance service handles a variety of personal data, this information relates to both our employees and the patients who enter our service. The Trust is geographically challenged, covers a wide remit covering the Kent, Sussex and Surrey localities and has a significant number of partner organisations. It has a high volume of front line staff all of which process patient data as part of their responsibilities.

The General Data Protection Regulation (GDPR) 2016 / Data Protection Act 2018 implemented on the 25 May 2019 are a strengthening of the former Data Protection Act 1998. This legislation provides individuals with stronger rights over their personal data and the need for organisations to clearly set out their information is used, stored, processed and shared.

Therefore, as a Trust we must ensure there is a legal basis for sharing information, that we clearly document the information which we hold, ensure this is securely held and is only accessible or shared with those individuals or partner organisations who have a legitimate reason (legal basis).

Risk of non-compliance with legislation may result in the Trust receiving financial penalties or Decision Notices by the Information Commissioners Office. Under GDPR there is a significant rise in financial penalties for non-compliance and breaches of data protection can amount to 1-4% of an organisations global turnover or up to 20,000,000 Euros. This does not take into the account of the reputational damage that such breaches incur.

It is therefore essential that the Trust continues to demonstrate assurance and ensures that information governance awareness remains high profile within the organisation. This is achieved through robust policies, mandatory IG training, completion of Data Protection Impact Assessments, a fully functioning operational IG Working Group, Privacy Notices and Information Leaflets. In addition, continued collaborative working with partner organisations and strategic information governance groups at a local and national level provides additional assurance.

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Overall Risk

There is always a degree of risk associated with the processing of personal data and ensuring compliance with legislation. As an organisation key risks associated with information governance include:

- Compliance with statutory timeframes, Freedom of Information and Subject Access requests.
- Minimising data breaches
- Ensuring systems which process personal data are secure
- Demonstrating role based access levels
- Adequate records management in place
- Contracts and Third party processing

The Information Commissioners Office undertook an audit of the Trust in May 2019, which reviewed the Trusts compliance with information governance and predominately covered the above criteria.

The audit provided an independent assessment relating to good data protection practice. Its purpose was to review whether the Trust has effective controls in place, together with fit for purpose policies and procedures to support data protection obligations.

Examples of areas covered within the audit included:

- Data protection governance, and the structures, policies and procedures to ensure compliance with data protection legislation;
- Processes for managing both electronic and manual records containing personal data;
- Processes for responding to any request for personal data, including requests by individuals for copies of their data as well as those made by third parties, and sharing agreements;
- Technical and organisational measures in place to ensure that there is adequate security over personal data held in manual or electronic form;
- Provision and monitoring of staff data protection training and the awareness of data protection requirements.

ICO assurance ratings are divided into 4 categories:

1. High assurance
2. Reasonable assurance
3. Limited assurance
4. Very limited assurance

Following the audit, South East Coast Ambulance Service overall compliance rating was ‘Reasonable assurance’.

For consistency this method of rating will be applied within this report.

Summary

This is the second Information Governance Annual Report from the Executive Director of Nursing and Quality, it provides a high-level summary documenting the progress and current IG Framework status within SECAmb during 2018 / 2019 and illustrates the priorities for the forthcoming year.

The report provides information and evidence of the ongoing commitment of the Trust to continue to ensure that data protection principles and legislation are embedded throughout the organisation and illustrates the significant improvements which the Trust has achieved during this time.

The Trust has demonstrated a satisfactory level of compliance with its annual Data Security & Protection Toolkit submission. It has a good framework in place, operational IG Working Group, robust Polices and has embedded the new data protection legislation, General Data Protection Regulation 2016 / Data Protection Act 2018 within its BAU activities.

Areas of improvement have been identified and are illustrated within this report with associated timelines.

Key Achievements 2018 / 2020

- IG Framework in place
- Implementation of the General Data Protection Regulation 2016 and Data Protection Act 2018
- GDPR awareness training
- Peer review of Trust GDPR Action Plan with London Ambulance Service
- Successful toolkit submission 2018
- Positive internal audit with RSM
- Engagement with outside regulators – Information Commissioners Office
- Collaborative membership within the NAIGG (National Ambulance Information Governance Group) and local IG Groups within the Sussex and Surrey localities
- Operational IG Working Group with robust Terms of Reference and organisation wide membership
- Trust IG training reviewed and updated in line with new Data Protection legislation
- Peer review of internal training with satisfactory assurance
- Completion of bespoke IG training within specialised portfolios
- Internal Trust wide engagement now in place and developing
- Implementation of new Data Protection Impact Assessments within PMO function
- External / Internal website information updated in line with new legislation
- New Privacy Notices in place and updated Information Leaflets
- IG policies reviewed
- Information Asset Register updated in line with GDPR
- Appointed IAO/IAA's in situ
- Updated GDPR compliant Information Sharing Agreements in place
- Continued working in collaboration with external stakeholders / organisations
- New Information Governance Manager in post
- Accredited external training sourced and completed for key roles within the organisation

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Key Actions 2019 / 2020

- Attain Cyber Essentials + accreditation
- Adopt a streamlined process for recording IG training completion.
- Continued allocation of time for mandatory IG training
- Ongoing development of the IG Portfolio with additional resource
- Continued review of Information Sharing Agreements
- Continue development and 6-month review of the Information Asset Register
- Collaboration with Procurement and Contract portfolios
- Create and implement a Trust wide model for Registration Authority process
- Additional resource within the Information Governance portfolio to enhance Registration Authority compliance
- Completion of the Trust wide records review.
- Implement and resource a robust process for supporting the investigation of IG related DIF-1's
- Continued development of Information Governance Manager to provide contingency
- External training for specialised roles
- Develop a strategic approach through undertaking 'service visits' and QAV inspections

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Introduction

Information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services, resources and performance. It is therefore paramount that SECAmb has an appropriately robust Information Governance Framework in place. This acts as an enabler to ensure that all confidential information is processed legally, securely, efficiently and effectively, in order to deliver the best possible care to our patients and employees.

Information Governance stipulates / sets out the way in which NHS organisation should handle information, particularly personal / sensitive data. This refers to personal information about identifiable individuals, whether alive or deceased, for whom there is a duty to maintain confidentiality, and includes patients, and employees. The definition also incorporates sensitive data, such as race, political opinion, religion, trade union membership, physical or mental health, sexual life and criminal conviction.

All employees of the Trust, regardless of grade or profession, must adhere to an Information Governance Framework. This also includes any Local Authority employees, medical employees, directly employed, bank, agency, contractors and locum employees working in Trust services. Plus, non-medical employees and internal appointments, seconded staff volunteers and any other iteration of personnel considered staff.

Executive Directors, Directors, Heads of Department, Managers and Team Leads all have a responsibility for promoting and enabling good IG practices within the work environments they manage. Each service in the Trust must ensure that a member of staff within the service has been tasked with departmental responsibilities for leading Information Governance.

This includes but is not limited to ensuring that national and local Information Governance standards are upheld within their department(s). Ensuring that ALL staff complete their mandatory IG training on an annual basis, and advising staff of their responsibilities regarding information security, confidentiality and data quality. They also have a responsibility to contact the Trust Head of Information Governance where necessary regarding issues and/or incidents of concern.

Background

Corporate Responsibility

GENERAL DATA PROTECTION REGULATION (GDPR) 2016 / DATA PROTECTION ACT 2018

The General Data Protection Regulation (GDPR) 2016 & Data Protection Act 2018 are 2 key pieces of legislation which came into force on the 25 May 2018. In essence they are a strengthening of what was already in place (Data Protection Act 1998) although the primary aim is to give individuals greater control over their personal data.

To summarise the General Data Protection Regulation is a regulation in EU law on data protection and privacy for all individuals within the European Union (EU) and the European Economic Area (EEA). It also addresses the export of personal data outside the EU and EEA areas.

The DPA 2018 sets out the framework for data protection law in the UK. It updates and replaces the Data Protection Act 1998, sits alongside the GDPR, and tailors how the GDPR applies in the UK - by providing exemptions.

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The Head of Information Governance has taken a proactive approach regarding the implementation of this new legislation which is now embedded into BAU. This has included collaborative working within the Trust and with external peer groups.

Information relating to GDPR is available within the Trust intranet and the public facing website. The Trust continues to embrace a transparent approach which is demonstrated through a variety of Privacy Notices (including a stand-alone Employee Privacy Notice), Information leaflets and a published high-level repository relating to Data Protection Impact Assessments.

Progress to date:

- Data Protection Officer appointed and registered with the ICO
- Substantive IG Manager in post
- Implementation and 'Peer' review of GDPR action plan.
- GDPR embedded within BAU activities
- IG Mandatory training updated
- Peer to Peer review of Trust mandatory IG training
- Localised IG Awareness training in place
- Privacy Notices / Information Leaflets in place.
- Employee Privacy Notice / Information Leaflet in place.
- Continued collaboration with Sussex Wide Information Governance Group, Surrey IG Leads Group and National Ambulance Information Governance Leads Group.
- 'Third Party' suppliers contacted to confirm compliance with new legislation.
- Information Asset Register updated
- Internal bespoke training completed within specialised work streams
- Data Protection Impact Assessments embedded within the organisation
- Ongoing development of the 'Zone' and updating of public facing website

Forward Plan 2019 / 2020:

- Increase resource within the IG Portfolio
- Develop a robust process for DIF-1 IG breaches and efficient reporting
- Continued specialised IG training for key roles
- Strategic plan for ongoing IG awareness within the Trust
- IG representation within Quality Assurance Visits
- New reporting for Subject Access Requests
- Develop an RA model and resource appropriately
- Develop a central repository for records management in line with GDPR Article 30
- Efficient reporting of IG training through the Trust Data Warehouse
- Attain Cyber Essentials + Accreditation – collaboration with IT
- Continued development of intranet

Assurance level: Reasonable Assurance

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Information Governance Framework

Information Governance Working Group

The Trust IG Working Group has been operational since June 2017 and meets on a monthly basis. It has defined, ratified Terms of Reference (ToR) in place and members have clear expectations of their roles and responsibilities.

There continues to be positive widespread engagement which includes the Senior Information Risk Owner (SIRO), Caldicott Guardian and Senior Managers. The agenda is robust with regular reports presented at each meeting. All meetings are thoroughly minuted with documented actions in place. There is also an escalation process whereby if appropriate issues are highlighted to the Executive Team.

Assurance level: Reasonable Assurance

Information Governance Training

Fundamental to the success of a robust Information Governance agenda across the organisation is the ongoing development of an IG-aware culture.

SECAmb's objective in line with its mandatory DSPT requirements is to demonstrate that 95% of employees have completed their IG training, this figure is required for the toolkit submission on the 31 March 2019. Data Security & Protection Toolkit submission.

*The Trust achieved its 95% target figure relating to IG training completion of 95.39% for the March 2019 submission.

IG training is provided to all staff to promote this ethos and ensure that the Trust meets its statutory requirements under the Data Security & Protection Toolkit.

The 2019 / 2020 IG training package has undertaken a full annual review which was completed by the Head of Information Governance. The updated training material also takes into account internal incidents / trends which have occurred during 2018 / 2019, the new training modules were published on the 1 April 2019.

Reporting: Historically the Trust continues to use ESR as the 'gold standard' for reporting on training completion. However, as the internal training system is not integrated with ESR, training completion needs to be manually recorded. However, it is currently reviewing this process with the intention of utilising its Data Warehouse facility. This would provide a more seamless process for obtaining and reporting completion figures.

It is anticipated that this will be rolled out during Quarter 2 2019 once due diligence and IG requirements are completed.

Action: Adopt a streamlined process for recording IG training completion through utilising the Trust Data Warehouse. This will be led by the Head of Information Governance / Head of Business Intelligence with a planned roll our commencing end of Quarter 2 2019.

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Training Compliance

Since 2017 the Trusts internal IG training material has undertaking an external 'Peer' review on an annual basis. This review process was implemented by the Head of Information Governance and was adopted previously whilst working in within a partner NHS organisation. It measures assurance and is conducted by one of our acute partner organisations with an outstanding CQC rating.

In addition to providing assurance and evidence for the Trust DPST, the review also provides due diligence and evidence for the CQC around the standard of our internal training. Following review in January 2019 a comprehensive findings / report was produced. This was presented to the IGWG for formal noting and also provided to the Head of Learning and Development.

Forward Plan 2019/2020

Continue with the annual 'Peer' training review. This provides assurance for the Trust, demonstrates collaborative working and will be reciprocated by SECAmb during 2019/2020.

The Head of Information Governance continues to work collaboratively with the Learning & Development Lead. A new updated IG training module was released on the 1 April 2019 and there are plans to review the current Corporate Induction / Local Induction materials. This continued collaborative working between portfolios ensures that learning packages remain compliant and up to date.

Service Visits / Localised training

On a strategic level there is a need to continue to promote IG awareness within the organisation. During 2018 / 2019 the Head of Information Governance facilitated localised training sessions within the Trust. These were focused predominately around the implementation of GDPR / Data Protection Act 2018 and Subject Access Request training.

Attendance was well received and feedback obtained from attendees was positive. There is now an appetite to strategically expand on this during 2019 / 2020, through independent service visits, dovetailing to team meetings, arranging bespoke training sessions and Quality Assurance Visits.

From April 2019 IG will be incorporated within the QAV criteria, this includes Private Ambulance Providers.

Action: Quarter 1 2019, undertake planning for internal service visits and localised training.

Specialised training

Trust IG training is designed to raise general awareness and a local level understanding of information governance which then effectively 'dovetails' to the more specific IG training.

However, there is a requirement for specific / specialised roles within the organisation to undertake additional training. At a minimum this includes the Caldicott Guardian, SIRO, Head of Information Governance and Associate Director of Quality and Compliance.

During 2018 / 2019 external practitioner-level training was completed to support these specialised roles and ensure that expertise and knowledge remain current with legislation.

The Trust SIRO and Caldicott Guardian completed formal certified training in February 2019. The Head of Information Governance and Associate Director of Quality and Compliance completed professional data protection training in October 2019.

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Action: Ensure knowledge and expertise remain up to date through annual specialised training during 2019 / 2020. Head of Information Governance will facilitate training to support these key roles within the organisation.

Assurance level: Reasonable Assurance

Cyber Security

During May 2017, the NHS experienced a national 'cyber-attack' of its systems, which infiltrated a significant amount of Trusts within the UK. This was known as the 'WannaCry' malware attack and affected around 45 NHS organisations although SECAmb was not affected.

As part of a national directive, there has been an increased focus on cyber security. This element is incorporated into mandatory IG training; the IG Working Group also has active membership from the Trust IT Department.

With the implementation of the new General Data Protection Regulation and Data Protection Act 2018 there has been greater focus on cyber security. The mandatory Data Protection & Security Toolkit was released in May 2018 and is based around the 10 National Data Guardian Security Standards. Half of the new requirements now known as 'Assertions' are cyber security related.

The Trust is actively progressing Cyber Essentials Accreditation and an audit benchmarking the Trust current position was completed in December 2018. The Trust must reach this standard by 2021 and additional funding has been provided to ensure this is obtained. We are the first ambulance service to work towards this accreditation and therefore this is a two-way learning for the Trust and the consultants involved.

Action: Attain Cyber Essentials + Accreditation by June 2021 in line with direction issued through NHS Digital. Allocate resource to manage the accreditation process.

Assurance level: Reasonable Assurance

Data Security & Protection Toolkit (DSPT)

The Trust's Information Governance compliance is measured through the completion of a mandatory self-assessment process of specific standards. This is now known as the Data Security & Protection Toolkit (DSPT), which all NHS organisations and providers of services to the NHS must complete on an annual basis.

With the implementation of new data protection legislation in May 2018, the historic IG Toolkit was updated. This is now in keeping with new legislation, electronic communications and is based on cyber security in line with the 10 National Data Guardian Security Standards.

The Trust completed its annual return on the 29 March 2019 and published the toolkit via NHS Digital. This year 2018 / 2019 the Trust achieved an overall satisfactory completion of 96/100 assertions, with an action plan in place for 4 assertions. As Trusts need to achieve 100% to report a satisfactory submission, the toolkit has by default been reported as non-satisfactory.

For transparency the Head of Information Governance formally advised the Executive Team (29/03/2019) of the Trusts toolkit position prior to publication and also confirmed next steps. Details will be formally presented to the IG Working Group on the 3 May 2019 at the next scheduled meeting.

Following national guidance issued by NHS Digital an action plan was created which was signed off by the Trust SIRO. For assurance the plan has also been countersigned by the Trust Data Protection Officer

although this is not a mandatory requirement. The Head of Information Governance has also formally notified the Executive Team of the Trusts position.

NHS Digital have now reviewed the submitted action plan and the Trust now has an action to provide an Improvement Plan by June 2019. The Head of Information Governance and Trust SIRO are leading on this action. NHS Digital have confirmed that once the Improvement Plan is approved then the status of the toolkit will be updated to read 'non-satisfactory action plan approved'.

Assertion Ref.	Assertion Question
1.8.3	Provide details of when personal data disposal contracts were last reviewed/updated.
1.8.4	Date of last audit being made on data disposal contractors to ensure security is of the appropriate agreed standard.
7.2.1	Scanned copy of data security business continuity exercise registration sheet with attendee signatures and roles held.
10.2.2	Percentage of suppliers with data security contract clauses in place.

Assurance level: Provided that the Trust can meet and complete the above actions by the 31 October 2019 then it will attain a reasonable assurance. The Trust is currently on track to meet this target date.

Corporate Risk Register

For transparency and internal assurance our limited non-compliance with the toolkit has been formally recorded on the corporate risk register. This will now have oversight by the Trust Board and will be reviewed on a monthly basis.

Assurance level: Reasonable Assurance

RSM Tenon - Internal Audit

To provide internal and external assurance the toolkit submission is audited on an annual basis. This audit effectively 'dovetails' to NHS contracts which stipulate that organisations must attain a satisfactory level and demonstrate assurance.

RSM Tenon completed their DSPT audit on the 18 April 2019, the Trust is currently awaiting a draft report which will be presented to the IG Working Group / Executive Team when received.

As with previous audits RSM audited the Trust on 10 assertions although this year's audit (for 2018 / 2019 submission) although is based on a new style of toolkit with different requirements.

Last year's internal audit took place on 9th April 2018 following the Trusts final toolkit submission. The final report did not present any significant shortfalls with only minimum actions required which were completed during 2018 / 2019. As with previous audits the final report was presented to the IG Working Group for assurance.

Assurance level: Reasonable Assurance

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Records Management

The IGA Records Management Code of Practice for Health and Social Care 2016 sets out the requirements, which NHS organisations in England must comply with to manage records correctly.

This document is based on current legal requirements, professional best practice and was published on 20 July 2016 by the Information Governance Alliance (IGA).

The Trust holds a localised Records Management policy although reference is also made to the national Records Management Code of Practice for Health and Social Care 2016 (above).

General Information

Records of NHS organisations are public records in accordance with Schedule 1 of the Public Records Act 1958. This includes records controlled by NHS organisations under contractual or other joint arrangements, or as inherited legacy records of defunct NHS organisations. This applies regardless of the records format.

The Public Records Act 1958 requires that all public bodies have effective management systems in place to deliver their functions. For health and social care, the primary reason for managing information and records is for the provision of high-quality care.

The Secretary of State for Health and all NHS organisations have a duty under this Act to arrange for the safekeeping and eventual disposal of all types of records. This is carried out under the overall guidance and supervision of the Keeper of Public Records, who is answerable to Parliament.

The NHS Standard Contract notes a contractual requirement to manage records for those health and social care records in organisations that are not bound by the Public Records Act 1958 or the Local Government Act 1972.

The General Data Protection Regulation 2016 and Data Protection Act 2018 (DPA) are the principal legislations governing how care records are managed. These set out in law how personal and sensitive personal information may be processed.

Under Article 30 of the new GDPR, organisations need to evidence 'Records of their processing activities. This specifically would apply to Information Asset Registers, Data Flow Mapping and Records Management repositories.

Records Management Review

Current position

It is accepted that the Trust is of a significant size, geographically challenged with a large number of sites / silos spread across three counties all of which have the potential to hold information. There is also a significant volume of historic records held following the merger of Surrey, Sussex and Kent Ambulance Trusts in 2008.

The Trust has recently undertaken an organisational wide records review to ascertain where documents and personnel records which held. This project was sponsored by HR Executive Director, commenced in June 2018 and has recently been completed.

The project objective was to review all paper and electronic files within the Trust.

This included;

- Record the paper files, document where these are held (ensuring they are secure),
- Recording what is held in the electronic file and confirm where this is held (Papervision/SharePoint)

- Review pre-employment check documents to ensure compliance.

Progress to date:

- A review of Trust sites has taken place and records have been reviewed and catalogued.
- A gap analysis will produce a cost/risk-based options paper for the Executive Team to confirm next steps.
- If agreed, this overall project will be closed and a new project put in place as an implementation project.
- The HR Transformation Lead is managing the Employee Records project
- The Interim Head of HR is managing the DBS project

Following completion of the overarching project 2 further projects have been initiated. A review of Employee Records, which is currently ongoing and the reviewing of files without DBS. DBS is now a BAU project which is led by the Interim Head of HR, reporting to the Trust Quality Compliance Steering Group (QCSG)

Formal reporting has been undertaken and presented to the following groups:

- Employee Records reports into the HR Transformation Steering Group and Quality Compliance Steering Group
- DBS project reports to the Quality Compliance Steering Group

Documenting Records

Whilst records are still retained within their original locations a Trust wide inventory is now in place. This is held on the T drive with restricted access and contains employee information as of the end June 2018. All new employees have now been set up on SharePoint following the correct process.

Forward Plan 2019 / 2020

An options paper has been produced, this will presented to the Executive Team, timeframes will be decided by the Trust interim HR Executive Director.

Implement and maintain a framework for the audit and control of Trust records. From an information governance perspective it is recommended that a Standard Operating Procedure document is produced to complement the local Records Management policy. This will provide local information regarding record retention times and the recording of information.

It is also recommended that for audit and assurance a separate repository is created directorate wide to demonstrate records management. Each directorate will 'own' and catalogue those records held, this information will then feed into a Trust wide 'master' database. This repository will 'dove tail' to the Trust Information Asset Register, which holds details around information flows.

Assurance level: Limited to Reasonable Assurance

The Trust must continue with the work undertaken during 2018 / 2019 regarding records management. This includes cataloguing historical records, ensuring that records are centrally retained and that it continues to build on and update its records management inventory.

Information Governance Policies

Organisation wide policies apply to all relevant staff and are a 'must do' requirement. A policy document is a formal document that is regarded as a legally binding document and therefore its purpose, definitions and the responsibilities outlined within its content must be upheld in order that it may be used to support an individual or the Trust during legal action.

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Policies provide a consistent logical framework for Trust action across different functions or directorates. All policies must be reviewed at least every 3 years or sooner if there is a significant change either on a local or national level such as new legislation.

Current position

IG related policies were reviewed and ratified during November 2017. However, whilst these are 'current' there is a need to ensure that they are GDPR / Data Protection Act 2018 compliant.

With the exception of 3 policies, illustrated below there will only be minimal changes. These were historically held under other Directorates and not within Information Governance portfolio.

- Data Subject Access Request Policy
- Confidentiality Code of Practice Policy
- Patient Video and Photographic Policy

The Confidentiality Code of Practice Policy heavily references HR and engagement is required from this Directorate to ensure compliance and accuracy with contractual terms and conditions.

Forward Plan 2019 / 2020

Arrange for the full review, update and ratification of IG related policies. Ensure that the IG portfolio lists those related policies within a repository and monitor in line with Data Protection Legislation

Assurance level: Reasonable Assurance

Data Protection Impact Assessments (DPIA's)

DPIA's became a legal requirement under GDPR (Article 25 Data Protection by Design) and their completion forms part of the Trust IG requirements. These are essentially a 'Risk Assessment tool', which must be completed when new or significant changes to the Trust's processes or systems, using personal / sensitive information are being implemented.

Their role is to ensure that the Confidentiality, Integrity and Availability of personal / sensitive information is maintained and highlight any associated privacy risks.

Current Position

New GDPR compliant forms were implemented post GDPR and are now a legal requirement where new systems or processes involving personal information are being made.

The forms are currently being used within the Trust and are built into the PMO function to ensure that a DPIA is completed within the initial 'scoping' or 'project initiation' stage. There is a multi-layered approach relating to the review and sign off process, this includes initial review by the IG Manager, then final review and sign off by the Trust Data Protection Officer and SIRO.

Further work is needed during 2019 / 2020 to ensure that awareness of this process is embedded throughout the Trust.

To support this process a DPIA register is now in place. This is 'owned' by the Trust IG Manager, updated and maintained within the IG portfolio and contains information relating to DPIA's which have been completed.

For transparency the Head of Information Governance has arranged for information relating to DPIA's to be uploaded to The Zone and also our public facing website. This also includes an extract of the DPIA register to evidence that these are being completed and are embedded within the organisation. A Data Protection Impact Assessment report was presented to the IG Working Group in February 2019 for assurance.

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Forward Plan 2019 / 2020

Continue internal engagement within the Trust through training sessions and BAU to highlight the completion of DPIA forms.

Assurance level: Reasonable Assurance

Information Sharing Agreements (ISA)

Information Governance is not a 'blocker' for sharing information but as an organisation we must ensure that any information shared has a legal basis in accordance with Data Protection legislation.

It is accepted that the sharing of information between partner agencies is vital to the provision of co-ordinated and seamless provision of care services. The need for shared information standards and robust information security to support the implementation of joint working arrangements is widely recognised.

An ISA is good practice and can be a useful way of providing a transparent and level playing field for organisations that need to exchange information on a regular basis. They provide assurance in respect of the standards that each party to an agreement will adopt. This ensures that each organisation is aware of their obligations and adherence to Data Protection legislation and those legal and regulatory requirements are met. ISAs are not required where the sharing is for an ad hoc request for information.

However, whilst they must stipulate a lawful basis for sharing confidential information (in accordance with the GDPR) they are not legally binding. Equally, the completion of an ISA is not a prerequisite for automatic data sharing and consent must always be sought unless there is a legal requirement to share information such as public interest / safety or it is in the patient's vital interest.

Should a serious breach occur, which later requires reporting to the ICO, the completion of an ISA will demonstrate that the Trust has undertaken due diligence and has an internal assurance process in place.

It is important to note that in addition to having an ISA in place, organisations must ensure that when data is shared with outside organisations patients / employees are informed of this through Privacy

Notices and Information Leaflets. This is paramount under the new Data Protection legislation, which stipulates that all organisations are open and transparent about the sharing of data.

ALL ISA's are reviewed by the Head of Information Governance, reported to the Information Governance Working Group and signed off by the Trust SIRO. The IG Portfolio now holds a centralised repository of signed ISA's in place, this process is 'owned' by the Trust Information Governance Manager.

Current position

During 2018 / 2019 considerable progress has been made relating to ISA's. A new repository is in place and a GDPR compliant ISA has been created. This was formally ratified by the IG Working group in January 2019.

This new agreement is more succinct then previous historical agreements. It is based on the overarching Sussex Wide Information Governance Group (SWiGG), issued last year following the implementation of GDPR / Data Protection Act 2018.

New ISA templates have been provided to the Trust Head of Clinical Audit, Head of Business Intelligence and Head of Effectiveness & Experience. Completion will ensure that information sharing between SECAmb and partner organisations has undertaken due diligence and assurance.

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For transparency and compliance the Head of Information Governance now holds a central repository register which details those agreements which are currently in place.

Forward Plan 2019 / 2020

Continue with the review and ratification process within the IGWG. Utilise the' Zone' and our public facing website to communicate information relating to those agreements which are in place. Provide an 'extract' of the ISA register to evidence that these are being completed and are embedded within the organisation.

Assurance level: Reasonable Assurance

Information Asset Register (IAR)

ALL NHS organisations must have a fully functioning information asset register. This register acts as a repository for all the information assets held within the Trust. It also measures how information is 'flowed' within the Trust and who is responsible for access and use of this information.

Under Article 30 of the GDPR ALL organisations must have a robust record of their processing activities and this is demonstrated through completion of an information asset register

The Trust SIRO has overall responsibility for the IAR. The Trust must also have appointed *Information Asset Owners (IAO's) and Information Asset Administrators (IAA's) within each directorate who are responsible for their respective information assets and the information they contain.

These roles are mandatory in line with IGT and NHS requirements.

*IAO's are usually Heads of Department and IAA's are Department Managers

Current position

This is a risk area within the IG Framework and continues to be a work in progress. The previous register has been updated to ensure that it is GDPR compliant. This now records the 'legal basis 'for sharing information and confirms where the information is held, example within the EEA.

For assurance there must be a multi-layered approach. As a 'gold standard' the Trust needs to undertake the following to ensure that this is correctly completed:

- Ensure that Contracts (if applicable) fulfil GDPR compliance
- Complete Data Flow Mapping for each information asset
- Undertake a Data Protection Impact Assessment for the information flows

The programme is being led by the Information Governance Manager with engagement with Information Asset Owners / Information Asset Administrators.

A 'Roles and Responsibilities' procedure document is now in place for IAO/IAA's. This clearly defines expectations, roles and responsibilities and evidences the Trusts internal assurance process.

Forward Plan 2019 / 2020

A strategy for the ongoing update and review of the information asset register is required. This caveat has been written into the IG Working Group Terms of Reference for 2019 / 2020. This must be reviewed on a six-monthly basis with a formal report presented to the SIRO for sign off.

Action: Information Asset Register review to be undertaken in October 2019 and March 2020, this is in line with the revised Terms of Reference for the IG Working Group.

Assurance level: Reasonable Assurance

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Data Flow Mapping

Data Flow Mapping is a mandatory requirement for the DSPT and demonstrates internal assurance. It must be completed on an annual basis and incorporated within an IG work plan for 2019 / 2020. As with previous exercises a formal report to the Trust SIRO was presented at the annual Exceptional IG Working Group prior to the final submission of the DPST on the 31 March 2019.

It is essential that this process is embedded within any significant Trust projects or system changes which involve personal information.

Forward Plan 2019 / 2020

Complete a Data Flow Mapping exercise on an annual basis in order to provide assurance and meet requirements for the DSPT. This requirement has been added to the IG Working Group Terms of Reference for 2019 / 2020.

Assurance level: Reasonable Assurance

Third Party Contracts

Historically there were 'pockets' within the organisation who independently sourced contracts which may also include organisations who handle personal information.

GDPR ensures that individuals have greater rights over access to personal information and all organisations must ensure that their contracts with third party suppliers are GDPR compliant. The Procurement team have a centralised repository of such contract suppliers and have contacted those parties to ensure that they are compliant with new legislation.

In readiness for GDPR the Head of Information Governance drafted letters relating to third party contractors. These templates were forwarded to the Procurement Department who then distributed to our suppliers. A completion statement was requested to confirm that compliance with the new Data Protection legislation was in place.

In addition to this the Contracts Manager arranged for information relating to GDPR to be added to SBS, this was used to prompt awareness and compliance with legislation.

Forward Plan 2019 / 2020

Undertake a formal contract review within the Trust. Arrange for those which were independently agreed outside of the Trust Contracts Department to be reviewed and 'fed into' the centralised contracts repository.

Ensure that all contracts are GDPR compliant and in line with NHS standard contract conditions.

Action: Contracts Department and IG Portfolio to review Quarter 3 2019

Assurance level: Reasonable Assurance

Subject Access Requests

Under Article 15 of GDPR individuals have a right of access to the personal information held by organisations, this is commonly known as a 'Subject Access Request'. Under the new Data Protection Legislation there have been key changes to the subject access request process:

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Reduction in statutory timeframes to one month.

- Extensions of up to 3 months when dealing with convoluted requests – engagement with the requestor must remain and the reason for extension explained.
- No administration fees payable for requests unless a request is deemed to be excessive.
- Consent – this must be clearly defined and an explanation provided around the retention and sharing of personal information. The latter is explained within the Trust Privacy Notice which must be 'sign posted' to within request responses.

Within SECAmb the subject access request process operates in 'silos':

- Legal Services Department – Police, Solicitor, Coroners and Claims
- Patient Experience Team – Individual requests for patient information
- HR – Requests made for Staff/HR related information

During Quarter 4 2018 the Head of Information Governance conducted bespoke SAR training within the HR portfolio. In addition to this a local process review was completed, a SAR Lead appointed, and standard operating procedures were created, these were presented to the IG Working Group for approval in February 2019.

Forward Plan 2019 / 2020

Ensure that subject access requests and standard operating procedures are fully embedded within the organisation.

Arrange for a quarterly subject access report to be presented to the IG Working Group covering all key SAR portfolios within the Trust. This will incorporate volumes, breaches and trends and will be presented by the Head of Information Governance.

Action: Formal Subject Access reporting to commence July 2019.

Assurance level: Reasonable Assurance

Registration Authority - SMARTCARDS

The NHS Spine allows information to be shared securely through national services such as the Electronic Prescription Service, Summary Care Record, Patient Demographic Service and ESR.

Smartcards are required to access NHS Spine information systems with Registration Authorities roles and responsibilities defined by NHS policy.

NHS Digital develops and maintains the NHS Spine through the Digital Delivery Centre and adequate procedures are needed to ensure all NHS Smartcards and access profiles are issued appropriately.

Registration Authorities are responsible for issuing smartcards to authorised staff with an approved level of access to patient information. This is essential to protect the security and confidentiality of every patient's / employees personal and healthcare information and to ensure that information is accessed with a legitimate basis.

It is essential that the Trust can evidence that it has robust controls and procedures in place as RA is reliant on having appropriate 'position-based roles' assigned to users. There must be a legitimate reason for access and all new users must comply with e-GIF level 3 identity checks which is a government standard.

The RA Manager is ultimately responsible Trust wide for this process, and for monitoring / troubleshooting system access and overseeing those individuals appointed as RA agent's / RA super users / Sponsors who

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undertake key operational work requirements. In addition to this, the Trust must audit access to the NHS spine on a regular basis. This auditing is undertaken by appointed Data Privacy Officers and is a mandatory process within the RA function.

Current position

From the 1st April 2018 responsibility for Registration Authority was transferred to the Head of Information Governance under the Nursing & Quality Directorate. This process necessitates tight controls due to the nature of access to the NHS Spine. Namely Summary Care Record (SCR) and Patient Demographic Service (PDS).

The Head of Information Governance previously completed an overarching operational review which was presented to the IG Working Group in March 2018, this was later updated in September 2019. This review provided a summary and recommendations relating to a Trust operational model and resource.

Due to resource limitations this has not been progressed sufficiently and there are gaps within the process. There is still a considerable volume of work to undertake to ensure that the Trust is fully compliant and a robust 'business model' still needs to be agreed and implemented. However, additional registration authority roles have recently been allocated within the Clinical Operations Team.

These 'super user positions' are in place to ensure the management of clinical role out of SCR and PDS within the EOC.

This will ensure that the Trust is able to utilise the use of NHS numbers which may be drawn down from the NHS spine and information integrated into our CAD system and will support Emergency Operations Centre clinicians to ensure a seamless care pathway.

Additional smartcard printers (x2) have now been sourced through NHS Digital, at no additional cost to the Trust. This provides a strengthening in contingency as previously the Trust only had one workable printer located within the 111 Service in Ashford. The Trust IT department is currently arranging for these to be integrated and configured.

Forward Plan 2019 / 2020

There is still significant work to be undertaken around this process, but the Trust is starting to formulate a more robust RA function. A review of the organisational users within SECAmb still needs to be completed.

This is a risk issue for the Trust as it needs to determine level of access versus users and ensure that it does not breach data protection legislation by having roles and positions open in instances where an individual has left the Trust.

NHS recommendations are that all Trusts have a minimum of two RA Managers or more (for contingency), although this is dependent on the size of the organisation. Therefore, a further 2 Registration Authority Manager positions are required due to the size and geographical constraints within the Trust.

Robust RA training needs to take place, this is currently being sourced by the Head of Information Governance. A substantive Band 5 IG / RA Officer is needed to support the IG portfolio.

The Trust Information Governance Manager will also be appointed as an additional RA Manager once appropriate training has been completed. However, a Trust wide business model still requires review, approval, adequate resourcing and implementation.

Action: Agree a robust Registration Authority process and model within the organisation. Ensure that this is adequately resourced, and accountabilities are defined. Allocation of additional RA Managers to meet the needs of the organisation.

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Assurance level: Limited to Reasonable Assurance

At the time of writing there is a requirement for the Trust to implement a robust operating business model. Adequate resource needs to be in place to manage the Registration Authority process which includes utilising NHS Spine systems such as Patient Demographic Service, Summary Care Record and the automatic downloading of NHS numbers within patient / clinical records.

This is currently recorded within the Trust BAF Framework and Corporate Risk Register under 1071. A full business case will be presented in Quarter 3 2019 which will set organisational recommendations.

IG Incident Reporting – DIF - 1

The internal reporting of incidents is vital to all organisations. SECAmb is a substantially sized organisation, which manages a significant volume of sensitive information. The recording of Incidents demonstrates shortfalls, risks and in some cases highlights the need to improve or change processes.

Incident reporting is integral within the Trust for the following reasons:

- They illustrate that the Trust has an 'open and transparent' culture
- Provide excellent 'shared learning'
- Improve processes and reduce risk

The Trust uses an internal incident reporting system – Datix, a centrally held database used to record IG incidents. In order to demonstrate a sound IG Framework, the Trust must have a robust internal reporting system in place for the recording of IG incidents. This reporting must follow clear, defined end-to-end processes, followed through with clear findings / lessons learnt implemented.

Current Position

Incident reporting is noticeably increasing which is in line with the Trust's desire to promote a positive reporting culture. Historically the organisation was 'under reporting' and therefore the increase in incidents is not necessarily due to increased errors.

Key increases in reporting, are collectively attributed to:

- Raised staff awareness around the importance of incident reporting
- Staff now being confident that the reporting of incidents is not a 'finger pointing' exercise
- An improved culture the Trust with it demonstrating that incidents will be acted upon

The review of DIF-1 forms is undertaken and managed by the Trust IG Manager. Incidents are reviewed and completed with appropriate feedback / shared learning completed. Trends around incidents are identified and if appropriate built into localised training and awareness.

Conversely serious IG related incidents are managed by the Head of Information Governance in line with the new GDPR compliant incident reporting tool.

Significant IG breaches must be reported to the ICO within 72 hours and recorded through the Data Security & Protection Toolkit. There is a local process in place whereby the incident is 'graded' by the Head of Information Governance and then reviewed by the Trust Caldicott Guardian and SIRO. This provides assurance and transparency.

In addition to this serious IG breaches are reported to the IG Working Group and within the Trust Annual Report.

Forward Plan 2019 / 2020

Incorporate IG breach information into the new Datix Incident Reporting policy. Continue to develop the recording and managing of IG related breaches within the IG portfolio. This is the responsibility of the Information Governance Manager.

Assurance level: Reasonable Assurance

FREEDOM OF INFORMATION REQUESTS (FOI'S)

The Freedom of Information Act 2000 provides public access to information held by public authorities. Public authorities are required to publish certain information and members of the public can also request information. This also promotes a culture of being open and transparent.

The FOI Act does this in 2 ways:

- Public authorities are obliged to publish certain information about their activities; and
- Members of the public are entitled to request information from public authorities.

The Act covers any recorded information that is held by a public authority in England, Wales and Northern Ireland, and by UK-wide public authorities based in Scotland.

Information held by Scottish public authorities is covered by Scotland's own Freedom of Information (Scotland) Act 2002. All requests received must be responded to within 20 days as per statutory requirements.

The Act does not give people access to their own personal data. If an individual wishes to see information a public authority holds about them, they should make a subject access request under the Data Protection Act 2018

The Trust upholds is obligations under this legislation and has a functioning publication scheme whereby redacted responses are uploaded to its pubic website. It is fully aware of its responsibilities to comply with this statutory process and volumes have been consistent throughout the year. FOI's remain a standing agenda item for the monthly IG Working Group meetings and a quarterly report is presented for assurance.

This statutory process sits within the IG portfolio, is managed by the Information Governance Manager, with the Head of Information Governance as the Trust FOI Lead.

Current Position

During 2018 / 2019 the Trust has continued to receive high volumes of FOI requests, averaging around 40-50 requests per month. These requests can cover all manner scenarios some of which are convoluted and require information from more than one directorate.

Requests are reviewed on a case by case basis, however, where appropriate the Trust will apply an exemption if the request exceeds 18 hours.

At this time (April 2019) the process is currently being resourced through temporary measures due to a change in operational structure. For assurance and transparency, this has been recorded as a risk on the Corporate Risk register until substantive recruitment is achieved.

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It is anticipated that the FOI Coordinator position will be advertised via NHS Jobs as a fixed term contract once internal secondment requirements have been completed. The Information Governance Manager is continuing to review and report on workflows and volumes with short term support also being utilised directly from the Nursing & Quality portfolio.

Action: Ensure that there is adequate resource within the FOI portfolio to meet demand. This will continue to be monitored by the Head of Information through SiP Rep and regular reporting to the IG Working Group where this is a standing agenda item.

Assurance level: Reasonable Assurance

ICO Decision Notice

As reported to the Executive Team in September 2018 and IG Working Group in October 2018 SECAmb was issued with a Decision Notice by the ICO on the 7 September 2018. This was published on the 13th September 2019 and related to a breach in statutory timeframes whilst completing a FOI request.

The issuing of a Decision Notice is a significant action as it is published on the ICO website and is consequently within the public domain. This information is also accessible to the CQC, NHSi and CCG's. The issue of the notice highlights the significance of FOIs and the need for the Trust to comply with the statutory timeframes and provide adequate resource.

Forward Plan 2019 / 2020

Undertake a full review of the internal FOI process to ensure that there is no replication of dual recording. This will be completed by the Trust Information Governance Manager by the end of Quarter 2 2019, with a full report submitted to the IGWG for review.

Due to the high profile of this process requests will continue to be locally monitored with high level reporting taking place.

Conclusion

The IG portfolio has continued to make significant progress during 2019 / 2020. The appointment of a substantive IG Manager in January 2019 brings greater contingency to the organisation and will build on the framework which is currently in place. The Head of Information Governance will look to increase the portfolio further during 2019 / 2020 and is currently working on a business case to recruit a substantive Band 5 IG / RA Officer. This will provide much needed support for the RA function within the Trust.

The Registration Authority function still requires further resource and a Trust wide operating model needs to be agreed and implemented. This will continue to be developed during 2019 / 2020.

The General Data Protection Regulation / Data Protection Act 2018 have been implemented within the Trust although it is recognised that there are areas which require support and resource. Organisational gaps were highlighted following the Data Security & Protection Toolkit submission in March 2019.

Data Protection Impact Assessments are fully integrated within the PMO process and GDPR compliant Information Sharing Agreements are in place. A Trust wide Records Management review is underway, which will strengthen the Trust statutory obligations relating to records of processing activities.

IG awareness within the Trust continues to strengthen. The mandatory training in place is succinct and has been externally assured. Historic processes and agreements continue to be highlighted and departments take a very proactive approach.

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Collaboration with STP's and good working relationships with positive IG engagement continues. It is widely recognised that IG is not a 'blocker', it is about the appropriate legal sharing of information and is pivotal to the success of the Trust. Patients and employees have the right and expect their information to be kept safe, secure and managed within the bounds of our legal obligations.

This assurance is evidenced through a strategic IG framework which is 'fit for purpose' within the organisation. The Head of Information Governance will continue to build on this, ensure Trust wide engagement takes place and provide regular updates through the Trust operational / executive groups.

Overall Assurance level: Reasonable Assurance

Caroline Smart
Head of Information Governance
April 2019

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